Artwork courtesy of St John of God Health Care

ACRA Newsletter

AUSTRALIAN CARDIOVASCULAR HEALTH AND REHABILITATION ASSOCIATION

December 2013

This Edition

AUSTRALIAN CARDIOVASCULAR HEALTH AND REHABILITATION ASSOCIATION

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Challenge...Change...Achieve

Editor's Note

We welcome articles for publication in this newsletter

Please send any items to: sue.sanderson@dhhs.tas.gov.au

Author guidelines are available on request

The year is coming to an end and yet it seems only a couple of months ago that we last celebrated Christmas but it is almost here again. Where does the time go? Are our lives so busy that the time just passes us by in a blur? But I know I look back on 2013 and ponder on all that's been achieved during the year with a sense of personal satisfaction and I trust that is the same for all of you.

This edition of your newsletter has a specific member focus and to that end we are featuring past Distinguished Service Award winners. Two recipients have moved away from the field but still have a great interest in cardiac rehabilitation and secondary prevention and have obligingly provided an update on their current activities.

Thanks to all who completed an evaluation from the conference. I have included a summary of some comments and passed the results on to the 2014 committee for consideration. We also have reports from travel grant scholarship recipients and their impressions of the 2013 conference. Plans are well in hand for the 2014 conference to be held in Sydney with the theme "Sex, Drugs and Rock 'n' roll" – be sure to save the date!

We had a most interesting story from a patient telling her journey and experience of cardiac surgery and rehabilitation. She is a GP who suddenly found herself in the patient role. Unfortunately it is too long to fit in the newsletter so I have attempted to summarise the main points. She does however highlight some issues she experienced and draws attention to the way in which we approach our patients both in the acutely ill phase (ICU and immediately after) as well as during the recovery phase. She promotes cardiac rehabilitation and will be a great advocate with her patients. The full letter will be available on the website. It is something that could be raised at state based seminars for debate.

The EMC has farewelled our long serving executive officer, Nicole Banks. Unfortunately she was unwell and unable to attend the last face-to face meeting where we could acknowledge her immense contribution to the Association. However, Lis Neubeck kindly volunteered to deliver a gift from us in appreciation of her commitment and hard work. I personally have appreciated her support and friendship in all aspects of the EMC work and this newsletter – a very capable proof-reader. We wish her all the best in her new role.

I'd like to take this opportunity to wish you all the joys of the festive season. Remember – everything in moderation!!.

Happy re-habbing
Sue Sanderson

President's Corner

I write this report following the second face to face meeting of the ACRA Executive Management Committee for 2013, held over the weekend 23-24 November 2013. The meeting, held twice a year, is an opportunity for representatives of each state and invited delegates to meet to discuss and plan for the future of our association. The recent meeting was the first for me as president and chair of the committee. I entered the weekend uncertain exactly of how things would go but with some level of optimism. Following the weekend of discussions I left with a stronger degree of confidence in the future of our association, thanks mainly to the dedication and enthusiasm of the committee. My thanks to the Committee; Lis Neubeck (Vice President, CRA NSW/ACT rep), Craig Cheetham (Treasurer, WACRA president/rep), Kim Gray (Secretary, VACR rep), Jenny Finan (SACRA rep), John Aitken (TACR rep), Paul Camp (QCRA president/rep) and invited guests, Cate Ferry (NHF rep), Elizabeth Holloway (HRC rep), Sue Sanderson (TACR president/ACRA newsletter editor), Dawn McIvor (CRA NSW/ ACT President), Di Lynch (SACRA President).

I would like to highlight some key areas that the ACRA EMC aims to work towards in the coming year.

Expanding the ACRA Executive Management Committee

It is increasingly evident that working in the health and medical sector requires completing greater workloads in paid and voluntary positions. All positions within our EMC are voluntary, unpaid positions, some requiring several hours of "work" per week. This has been the case for many years and is unlikely to change. The current structure of the committee is such that one individual represents the state chapters of ACRA. This arrangement limits the scope of succession planning at a national level, to a degree. These two issues, as well as others, are reasons for the proposal of an expansion of the EMC to include an additional representative from each ➤

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state. State reps have been asked to take this proposal to their respective states for agreement. It is hoped that by expanding the EMC the workload may be shared more evenly, we will be more productive with planned projects and our committee will maintain its progression.

Guidelines/Position Statement

One of my key agenda items for my time as President is to see ACRA produce a document to aid our members in the delivery of best practice care within cardiac rehabilitation and secondary prevention services. We took the first steps in the process of developing this document, firstly agreeing that this was in the best interests of our association and that it was achievable. A clear timeline has been established and several EMC members and invited academics will start working on this as soon as possible.

Increased Professional Development opportunities

One issue that became abundantly clear during our meeting was that each state is working very hard to provide benefits to our members in many ways. One issue that we have been aware of for some time is that individual states run great professional development events. The EMC will be working with the states to assist them to provide webinars associated with state-run education activities to increase the availability of professional development opportunities to our members nationally.

Executive Officer role

It is with regret that we say goodbye to our beloved ACRA Executive Officer Nicole Banks. Nicole has been an absolute asset to the association for many years. I wish her my sincerest thanks for the job she has done, especially over the past six months. I would also like to wish her the best of luck in her new adventures.

Recruitment to the Executive Officer Position required significant discussion during the face to face meeting. Initially ACRA advertised the position and called for applicants. Applications were received from individuals and professional management companies. During this process we were advised of a company that we were strongly encouraged to investigate. The company, Professional Association Management Services (PAMS) Pty Ltd, put forward an impressive proposal and CEO Richard Gerner was invited to present to the EMC at our face to face meeting. After significant discussion the ACRA EMC decided to appoint PAMS to conduct Executive Officer Services for ACRA for the next year with potential to extend to a three or five year contract. An extract of the PAMS proposal is included in this newsletter.

Representing ACRA

As president, I continue to represent ACRA in multiple arenas including the International Council of Cardiovascular Prevention and Rehabilitation and the national Secondary Prevention Alliance coordinated by The George Institute. More recently ACRA has been requested to contribute to the review and updating of the National Heart Foundation ACS guidelines. I have nominated and been endorsed by the EMC to represent ACRA through this process. Additionally I have met recently with NHF representatives to discuss further opportunities to collaborate in the future specifically around the development and maintenance of service directories. I will keep the membership up to date as things progress with regard to projects and groups that ACRA continue to be involved in.

Items to remember

Journal Subscription

Don't forget that ACRA members can access up to date online articles of the European Journal of Preventative Cardiology. These articles may be accessed via the Members section of the ACRA website. Please visit acra.net.au, login with your details and follow the instructions to access the journal. If you are having trouble accessing the site let me know.

ACRA on Twitter

Please check out the article in this newsletter about Twitter. This is a great way to quickly share information on any topic, but particularly useful for sharing professional, relevant information. The EMC will be working to actively increase our Twitter profile in the future. I encourage all members interested in social media to "follow" ACRA and it's EMC.

Twitter usernames to follow: @ACRA_ACRA, @SteveWoodruffe, @lisneubeck, @CraigCheetham4, @kimgray75

Feedback

I encourage all members to provide feedback to the EMC at any point. I am grateful for any ideas or suggestions to improve the association in any way. Many of the key agenda items for the EMC to progress in the coming year were initiated as ideas from our members. Please email me at steve_woodruffe@health.qld.gov.au or stephenwoodruffe@gmail.com

Stay happy and healthy

Stephen Woodruffe,
ACRA President ➤

Professional Association Management Services - Executive Summary

Professional Association Management Services Pty Ltd (PAMS) is pleased to be invited to lodge its proposal for administrative services for the Australian Cardiovascular Health and Rehabilitation Association (ACRA).

PAMS is the market-leading Australian-based secretariat for non-profit professional and industry associations. In its short ten year life, PAMS has accrued around thirty client associations, many of them in the Australian health industry. PAMS believes it can offer ACRA a superior secretariat service as testified by our clients.

What makes PAMS different is the fact that we uniquely specialise in the full set of services and professional systems needed to run a high performance professional association within the not-for-profit sector. All of PAMS' clients are not-for-profit.

Our strengths lie in the focus of our staff, the technology we have employed, the business model we use to support our clients, its price, and the spirit of continuous improvement to which we adhere.

The purpose of this proposal is to provide an approximate quotation for an administration solution which will provide the national ACRA organisation with a full-time national office: this will make it easy for all stakeholders nationally to liaise with ACRA through a central point, M-F, 9-5, Sydney/Melbourne time, a central phone number to be answered in ACRA's name, by a nominated person, a central administrative email address to be monitored daily, advanced systems: database, online database access, an online payment & registration system, other online member services, accounting, outwards communications, design and formatting, web and email hosting, printing.

The extent to which these are implemented will depend on the eventually agreed services to be provided.

We see great opportunity to extend this proposal to provide value-adding services to the state divisions, while these are not included in the immediate quotation, but warrant investigation. ACRA can take the opportunity to provide advanced services to its state operations.

PAMS' role is to ORGANISE, GUIDE and ASSIST. This enables the ACRA office bearers to focus on the best practices of cardiovascular health, rather than association administration.

We look forward to being of excellent service to ACRA for the forthcoming years.

DID YOU KNOW?

Financial members of ACRA are eligible to apply for a scholarship to the value of $500.00 to attend the national or a state conference. The ACRA Executive Management Committee has made available four scholarships. Two are for Co-ordinators of Cardiac Rehabilitation Programs and the other two are for rural members. Each scholarship is to the value of $500.

More details are available on the ACRA website – www.acra.net.au

Recipients of scholarships must provide two written reports back to the Executive Management Committee within a month of attending the course or conference. These reports must be suitable for publication in the ACRA newsletter and will include one report on a topic relevant to your work place (ie a new project you are working on) and the other report will be your findings of the course or conference (ie what you found interesting or what you learnt)

The deadline for receipt of applications is 28 days prior to the start of the conference.

Travel grants may also be offered to members who have submitted an abstract or poster which has been accepted for presentation at the national conference. Travel grants of up to $500 are offered to financially assist presenters to attend the conference. Travel Grants applications must be received in writing. Acceptance of a scholarship is conditional on providing a written report for publication in the ACRA newsletter.

Please contact the above should you require any further information.

See the report from recent scholarship recipients, Leonie Sadler and Barbara Schiappadori.

Distinguished Service Award Winners

1998 A. Goble

2000 M. Worcester

2004 P. Cohen

2005 H. McBurney

2008 S. Sanderson

2013 S. McKellar

2012 C. Cheetham

2009 S. Bunker

2003 T. Briffa

2007 S. Hooper

2006 D. Hare

RUSSELL LEE AO – DSA RECIPIENT 1999

Russell is recognised both nationally & internationally as a leading clinician and educator in Cardiovascular and Pulmonary Rehabilitation. Russell brings to his role now as a business strategist and manager, extensive experience in health administration and, more recently, in the development, operations and administration of business's both large and small, Australia wide.

This knowledge has largely been developed through the significant outcomes achieved in a relatively short period in primary health care, with the implementation of Accountability, Innovation & Key Performance Indicators (at all levels), in what was a fractionated cottage industry but now a growing united corporate body.

He is also one of the founders and co-ordinator of the volunteer surgical team 'Operation Open Heart' that performs lifesaving surgery in twelve developing countries in the Pacific, Asia & now Africa.

The story of Operation Open Heart starts with Russell when he first visited Tonga where his missionary parents were living at the time. Inspired to make a difference, he returned home and collaborated with his colleagues at Sydney Adventist Hospital, where he was working, to establish the organisation.

Achievements so far

- 4500 + patients have received life changing surgery
- 1500 + individuals have given their time and expertise on our team
- 13 countries we have implemented projects
- 15-20 tonnes of equipment freighted around the world each year

Here are some links to that program:

www.ohi.org.au

https://www.facebook.com/OpenHeartInternational

In Russell's words:

I have not been involved in Cardiac Rehab for a long time but still very passionate about it, I read the ACRA newsletter and try and keep abreast of what is happening.

Re my work, for the last 10 years I have worked as a Management Consultant & Strategist, predominantly in Health Care. But often get pulled into other areas which makes life interesting.

In the last 4 years I have been doing a lot of work in rural Australia, particular central Queensland, both in primary health care as well as attempting to improve tertiary services to these communities, it has been difficult to get busy city based specialists to go to rural Australia so have developed Telemedicine services via way of a virtual surgery.

I also continue to work in the Charity I set up 28 years ago "Open Heart International" sitting on the management committee as well as coordinating both Papua New Guinea and Rwanda programs. I am taking a team to Rwanda in November, & after that program will visit a hospital in Tanzania to see if we can assist them develop a cardiac surgical program.

KERRY INDER – WHERE AM I UP TO NOW?

I was very honoured to be awarded the ACRA Distinguished Service Award in 2002. This was a wonderful moment for me and one that I will always cherish. My life has taken different twists and turns in this past decade and a new direction. During 2002 I was employed as a clinical nurse consultant in cardiac rehabilitation at John Hunter Hospital, Newcastle. I was involved in the new chronic disease management programs for patients with heart failure while primarily coordinating and supervising inpatient and outpatient cardiac rehabilitation services. That year I had also commenced a masters by research in community medicine and clinical epidemiology at the University of Newcastle which later became a PhD and heralded the beginning of my academic career.

In 2004 I left John Hunter Hospital to take up a full-time scholarship to complete my PhD under the supervision of a local cardiologist, Associate Professor Jonathan Silberberg, and Professor of Biostatistics Cate D'Este. My PhD evaluated health outcomes associated with attending outpatient CR services at John Hunter in terms of mortality and unplanned hospital readmission. The findings supported work from meta-analyses at the time, suggesting that those who attend outpatient cardiac rehabilitation have a survival benefit compared with those who were eligible but didn't attend.

Following completion of my PhD I was awarded a research fellowship in health services research with the Newcastle Institute of Public ➤

Health. This came at a challenging time for the University which was undergoing a major restructure and involved a teaching component. I spent the next 5 years involved in undergraduate and postgraduate teaching for students enrolled in a Bachelor of Medicine or a Masters of Clinical Epidemiology program. I taught courses such as Clinical epidemiology and Quality and safety in health care. In 2009 I established the new Master of Public Health program and developed a number of courses including Introduction to public health and Chronic illness and injury.

In 2010 I returned to research and commenced a fellowship in mental health managing a program of research to examine the role of social networks, relationship breakdown and depression as potential risk factors to suicide across rural and regional communities. The importance of social support for good mental health was a key finding in many of the analyses we undertook as part of this work. As part of this project we also piloted an online intervention for rural participants experiencing coexisting depression and alcohol use problems. This program included supervision of two PhD candidates and is now finishing up.

I have continued to be involved in a number of research projects in cardiac rehabilitation, secondary prevention and cardiology by supervising research higher degree students over the past 8 years. I enjoy this aspect of my work very much. For six years I monitored the progress of approximately 60 PhD and Masters students in public health in a largely administrative role. My primary research interests are in the links between mental and physical health and in ageing, chronic illness and comorbidity. I hope to be able to pursue these interests over the coming years. From July this year I have been working with the NHMRC Centre for Research Excellence in Mental Health and Substance Use and the Hunter Institute of Mental Health where a number of researchers are interested in co-morbidity.

Outside of work life is great. I love cooking and gardening and being outdoors. I regularly do yoga and meditation and walking but like many I don't move enough (spending too much time sitting!). I am fortunate to have a lovely supportive relationship with a beautiful gentleman and we very much enjoy the lifestyle that Newcastle offers. I am facing the challenges and confrontations of ageing parents while enjoying watching my 13 beautiful nieces and nephews blossom as they head towards adulthood.

I wish all members of ACRA well for the festive season and for a productive and fulfilling 2014 working in cardiac rehabilitation and secondary prevention.

An Unexpected Journey

Why did I write this?

- I love to write about new personal experiences – i.e., self-indulgence.
- I'm a GP and am drawn to examine and reflect on individual experiences of illness, loss, struggle and renewal. I learned some valuable lessons for my future practise.
- This particular experience came out of left field and I felt the need to tease out and understand its impact and then put it to rest, before returning to work to focus on my patients instead of me.

For the last 30 years or so I've been a strong advocate for people to call an ambulance with any new chest pain or possibility of cardiac event. I'm a 54 year old GP with no cardiovascular risk factors.

I was on a brilliant trip to Turkey, including a week sailing, paragliding, ballooning in Cappadocia, joining in the protests in Taksim Square, a vigorous scrub and massage in a traditional hamam, and plenty of walking about archaeological sites. At times my husband strode ahead as we were exploring and I had to ask him to slow down.

Shortly before we were due to head home, as we walked up a stone road back to our cave hotel in Ürgüp, I developed my usual shortness of breath and chest tightness, and complained to my husband that "even after all this exercise on holiday I'm still so unfit!"

"What do you mean, 'so unfit' exactly?"
"I've got this tightness from my chest into my jaw."
"Stop walking… Now what's happening?"
"It's going away… but that just shows how unfit I am."
"*No*, it means you have angina!"
"I *can't* have angina!"

Cut to a few days later and we are back in Australia seeing a local cardiologist. I explain I've had a heart murmur since I was a medical student – "Just a minor mitral valve prolapse, according to an echocardiogram done in the 1980s". I describe some months of recurrent, increasing episodes of palpitations, chest tightness, shortness of breath walking uphill, tiredness, lack of response to salbutamol inhaler and increasing awareness of my heart murmur (yes, in retrospect a thrill) while lying in bed or sitting quietly.

The cardiologist listens to my heart and says, "Wow, that's ➤

loud," and, "A mitral valve prolapse doesn't radiate to the carotids."

After an echocardiogram it's confirmed that I have severe aortic stenosis and the cardiac surgeon agrees I need an aortic valve replacement within a few weeks. There is no obvious reason for it. No bicuspid valve, rheumatic fever, autoimmune or connective tissue disease.

I did not recognise angina when I had it. In retrospect, I had probably had it a number of times during walks up hill back at home.

Lesson 1:

The symptoms of angina or an acute coronary syndrome are not only diverse and can be vague; even the classic ones are not easy to recognise. Don't be too quick to judge your patient who comes in after seemingly ignoring an obvious problem.

I approached this major surgery with something akin to excitement. How much worse could it be than having obstructed labour and a caesarean? Or a perforated appendix (that pain I had also tried to work through)? I had experienced postnatal depression, a renal biopsy, hyperthyroidism and shoulder capsulitis. I was no wimp.

I had looked up aortic valve replacement via Dr Google but found the details of the surgery too gruesome to read closely. Similarly, I started a video clip showing a surgeon in action but had to switch it off.

A night or two before my admission my husband and I spent time reviewing my wishes regarding treatment, funeral and will, with lots of tears and long hugs. It seems a bit melodramatic now, writing weeks later, but it was very raw and heartbreaking at the time.

In the first hours after surgery I feel ripping, tearing, pulling, choking, and most of all fear. I am scared, frightened, terrified; thinking I might die. This, more than anything, is something I'm not expecting.

Thursday, the day after surgery, and somehow my perception of 'self' has changed. From being an independent, healthy, trim, confident person I now feel like the battered remnant of a car accident. I feel useless. Incredibly, I also feel guilty. I start to tell my husband how bad I feel about leaving him with the business to run on his own.

Somehow I have already received the message that some people are relieved that my surgery is all over and I am on the road to recovery - when I actually feel worse than I ever have in my life and I am scared. I'm also aware that I look much better than I feel and on this day following heart surgery I distinctly remember thinking that I want people to acknowledge how bad I am feeling, not reassure me. It feels similar to the severe lows of postnatal depression.

A brisk person from Cardiac Rehabilitation arrives for a visit at this time. She seems surprised when I become a little irritated when she advises I will definitely not be able to drive for six weeks (I am panicking about not being able to pick up simple groceries while my husband does twice as much work as his usual big load). My husband suggests that it is a bit too early to be discussing these things with me and she says she will be back at around day five "when patients usually see me before they go home", and that by that time I will be "only on paracetamol to go home". The tone of voice implies that it is time for me to be thinking about these things. This is the start of a pattern of communication that makes the rest of my hospital experience harder than it should be. As she walks out I burst into tears.

Saturday, third day post-op and I feel bad. Nausea, sore swollen lips from the endotracheal tube, torn and itchy skin associated with tape, a tightly bound sensation of the chest, aching, burning and tearing along the ribs, fiery sensations in the breasts, total body weakness, a backache that feels too frightening to have any massage as I might tear apart.

Newer symptoms include a horrible awareness of the new heart valve. Initially there was clicking which then settled into what seemed like an exuberant thrill which I can feel all day and all night, especially if I try to lie on my left side. For the first time in my life I lie on my back to sleep. But yes, there's more. Aching shoulders and arms. Is this musculoskeletal or from the heart? There's a dull headache and wavy shimmering lines and flashing lights in my vision similar to a migraine aura, except that it continues for days. I can't focus my thinking and sometimes say things back to front or inside out.

During this, multiple times a day, I am asked, *not*: "How are you feeling?" or, "What are you experiencing?", but to rate my pain on a scale of one to ten. How can I present all of my symptoms as a number? And how do they compare to renal colic or severe burns, which I haven't had? Being a medico, I have already determined that if I say "two" I will get paracetamol. I have also discovered that if I say a higher number than I have said previously the nurse will try to talk me down to my last rating or look sceptical and try to persuade me that I don't really mean that number ("You're feeling better, aren't you?" or "So, that's about a two then?"). I would feel better if instead they simply acknowledge what I am experiencing, spend more time as a reassuring presence, or even suggest a hot pack or gentle massage.

It is around this time that my husband decides he needs to be with me as my advocate as well as for emotional support. Sadly, we get the impression this is interpreted as him interfering or that it is somehow a little indecent that he should be my GP. I trust my husband with my life.

The lack of recognition of my distress becomes a bit of a theme. I write this four weeks post-op knowing that I stopped all stronger analgesics about two days after returning home; that I am now walking up hills and doing half an hour on the exercise bike as well as resistance exercises every day; that over the whole day I have had only two paracetamol. I am no whinger.

From the time of leaving ICU I am constantly reminded that the goal is to get me off analgesics – and from stronger opioids to drop straight down to paracetamol. Mobilisation and breathing exercises tie in with this. The latter I am in total agreement with, but somehow it is sold to me that I am possibly not trying hard enough and that I am in a competition with other heart surgery patients; ➤

that other patients don't need this level of analgesia at this stage; that "other patients have been discharged by now"; and that the atelectasis, some lung collapse and effusion, are likely due to me not doing my breathing exercises effectively enough.

I get the impression that this is not because the nursing staff are heartless or uncaring (certainly they are always pleasant), but that they are protocol-driven. There are charts to complete - and pain levels, exercise goals and bowel evacuations are expected to follow the usual pattern on the way to discharge home. Nevertheless, I feel like a child being reprimanded.

I mention more than once that I have been having visual hallucinations but the response is a brief comment about it being "probably due to the medication" and we move on to the next item on the list. As a doctor, I'm very aware of causes of hallucinations, but they are still scary overnight when I am alone in the room. I wonder how a patient who knew nothing about hallucinations might have responded.

Many times while in hospital and in the days following discharge I experience pain or sensations that I feel at a loss to know what to do about. There are such a variety of chest pains, back pain, upper abdominal or diaphragmatic pain, shoulder pain, neck pain. As an experienced doctor I think: what is this pain? Should I worry about it? Should I tell someone? Is it normal post-op pain or the sign of a complication?

How can I trust my body to look after me in the future? Who do other patients ask about these things? Are they assessed when they do mention them? My first appointment with the cardiologist is in four weeks' time – and I wouldn't want to bother him…

Six days after surgery is my psychological turning point. Although still in pain, short of breath and tired, miraculously I am looking forward to the future, I am writing (including lists!) and enjoying reading. Attending a brief session of cardiac rehabilitation I look at others in the class who are a couple of days behind me and see in their eyes that they are not yet back in the land of the living… hang in there…

My first rehab session had been a little surreal. Sitting, flexing my elbows and doing little circular movements of the shoulders with other patients in their 60s-80s and all in our dressing gowns.

Despite developing some right lower lobe collapse with persisting reduced oxygen saturation, breathlessness, chest tightness and a need to use oxygen overnight, in general progress is steady and after the initial feeling that I would never recover to be myself again, suddenly I am walking up and down a flight of stairs in a soft track suit. I go on a shopping spree to the hospital pharmacy (it's been a long time since I've been able to shop). And I know I'm ready to go home.

Lesson 2

No matter how unconscious or 'moribund' they appear, always assume the patient hears what you are saying and understands much more about their situation than might appear from outward appearances.

Lesson 3

When giving information, find out first where the patient is at and tailor it to their needs. Don't keep repeating the information, particularly if it involves telling the patient what to do: it makes them feel like a child.

Lesson 4

Communicate well with the patient's primary carer/ partner. The knowledge, comfort and reassurance given to them will be passed on to your patient and others and save time and heartache in the longer term.

Lesson 5

The impact of major surgery on our patients is probably much more than we are aware of. After open heart surgery with cardiopulmonary bypass the patient may feel frightened, vulnerable and even scared of dying within the first few days. Physical and emotional changes are variable and should be clearly *acknowledged* as well as reassurance that they will pass given time. The regular presence of a trusted family member or carer to also act as advocate is vital.

Lesson 6

Cardiopulmonary bypass adds additional physiological stress (post-perfusion syndrome or 'pumphead') in addition to the usual effects of cardiac surgery and sternotomy. Patients should ideally have some briefing about this from their doctor.

Lesson 7

Pain Assessment: Don't ask leading questions. Don't assume that once an operation is 'successful', it is all smooth sailing afterwards. Ask what the person is experiencing, and try to gain an understanding of their overall level of distress.

Lesson 8

Pain Management: Treat the person's current pain, not your perception of their pain coloured by, "You will need to get off these soon" or, "We don't want you to get addicted" or, "Other patients haven't complained this much". This may help avoid the 'wind-up phenomenon'.

Lesson 9

Pain Management: Even in hospital, alternative pain management is important. Reassurance, exercise, hot packs and showers are relatively easy to provide. ➤

Looking back now, those early few days in hospital were just a blip in time. If I hadn't written down some of my experiences and talked about them with people close to me at the time, perhaps I wouldn't really remember them at all. On the other hand, at that time it was terrifying and awful and it had a profound impact on my husband. Although I am not disturbed by them now, perhaps it is because I have worked through my thoughts and feelings and hopefully when it comes time to have another valve replacement, I will go into it feeling resilient.

I must put in a plug for the cardiac rehabilitation I've been attending. Despite my companions being universally older than me and at varying levels of general health I have genuinely enjoyed the sense of camaraderie. The one hour exercise program has been helpful and paced appropriately. It even spurred me to buy a colourful set of latex exercise bands. The talks by dietician, pharmacist and physiotherapist to date, I hesitate to admit, have been useful for me. I'm looking forward to the session with the psychologist on psychological and emotional aspects of cardiac surgery.

Seven weeks post op. Why am I still in pain? There are aches, burning sensations and stabs of pain around the wound, at various sites in my chest and upper back, my shoulders, breasts and axillae. The strangest one is vaguely epigastric, seems to come from my diaphragm and makes me feel a little nauseous. I reckon it's related to the old chest drains that came out via the upper abdomen. I also have allodynia and hyperalgesia around the sternum. Chronic post-operative pain is not only common and potentially the most common form of neuropathic pain, but patients don't tend to report it.

The commonly quoted figure for chronic pain following sternotomy is about a third of patients. That is not good news and something I have been sadly unaware of in my own patients. Interestingly, neuropathic pain is apparently more common in women and anecdotally in people with Raynaud's disease and has some genetic component.

It has been instructive observing and talking with my fellow participants at cardiac rehabilitation. We have all been through different experiences, from AMIs to atrial fibrillation, valve repairs to replacements, strokes and different operations; some with pacemakers and some with venous or arterial grafts. However, many do have chronic pain and many experience fear due to uncertainty relating to intermittent palpitations, pacemaker responses, the noise or feel of their heart murmur or artificial valve. This can result in fear of over-exertion or even of going to bed.

Some go into their surgery with poor fitness and others lose their fitness quickly due to their condition or treatment. This affects their confidence and ability to take part in any exercise program. One older woman in our group was notably lacking in confidence when she began. She never quite caught on to the instructions with use of elastic bands or weights, or even stepping. During a session doing simple stepping she suddenly fell straight backwards onto the floor – quite distressing for everyone present. It reinforced how vital it is for exercise to be tailored, supervised and regular – and the critical role of exercise physiotherapists/ physiologists and cardiac rehabilitation. Our program focuses on improving proprioception and balance as well as strength.

Lesson 70

Remember that many patients do not spontaneously admit to fear in relation to surgery or its post-operative symptoms, nor to long term post-operative pain. Ask – using such phrases as, "Many patients experience ..."

Lesson 71

My impression is that people in general feel uncomfortable about sharing negative experiences or emotions. Either they don't want to burden others, think they won't be listened to, or even think they are somehow weaker than others would be in the same situation. When you open up to people and 'tell it as it really is' I think they feel 'permission' to do the same. Suffering is lessened if it is shared

Lesson 72

Encourage everyone who is eligible to attend cardiac rehabilitation and any exercise program or supervision available.

Coming Events

March 3 VACR Clinical Practice Day, Stamford Hotel Melbourne

March 15 TACR seminar – "Non healing sternum" - Launceston

May 4-7 World Cardiology Congress, Melbourne

August 21-23 ACRA 2014 "Sex, drugs and rock 'n' roll"

Report on ACRA Conference 2013

Attendance at ACRA 2013 held in Melbourne presented me a number of opportunities as a delegate.

These included the opportunity to network with all disciplines involved in cardiac rehabilitation at the welcome reception, the early morning walks around Albert Park Lake and the wonderful Athletes of a nation dinner at the AFL dining room at the MCG.

I also had the opportunity to present our research work on Atrial Fibrillation in the research prize session; this experience gave me acquisition of new skills in preparing and doing a presentation at a national conference.

The presentations that I found of particular interest were the work that is happening into the primary prevention of cardiovascular risk factors and the research being done into the inequality of secondary and primary prevention of risk factors between the regional and city centres. Also of interest were the gender inequality of attendance and the reasons for women not attending the cardiac rehabilitation program.

The presentation that immediately changed our cardiac rehabilitation practice was the improved management of patient with diabetes in phase 2. Our service was unaware that the recommendation from the NDPS was that patients with diabetes should not drive if BSL is <5 mmol/L. I have liaised with the diabetes educator and now have pamphlets to inform and give the phase 2 cardiac rehabilitation diabetic patients.

I also attended the workshop on dietary guidelines and their application. This small group activity enabled me to gain ideas as our service is currently changing how the dietitian delivers dietary education. The new dietary guidelines were disseminated to the dietitian.

I would like to thank ACRA for awarding me an ACRA general scholarship and I look forward to attending ACRA 2014 in Sydney.

Leonie Sadler
Clinical Nurse Consultant
Cardiac Rehabilitation,
NBHS, NSW

Summary of presentation at ACRA 2013

"High prevalence of modifiable risk factors in patients admitted to hospital with Atrial Fibrillation"

Presented by L Sadler on behalf of R Gallagher, K Roach, J Belshaw, A Kirkness, R Proctor, L Zhang, L Neubeck.

Introduction: Atrial fibrillation (AF) is a common arrhythmia with 240,000 people diagnosed with AF in 2008/2009; it has a lifetime risk of 1:4. AF increases the risk of stroke 5-7 fold and often these strokes as a result of AF are generally more severe or fatal.

Emerging evidence has shown that modifiable cardiovascular risk factors can contribute to the development of AF; therefore reduction of modifiable risk factors has strong potential to decrease AF and sequel to stroke.

Method: To describe the prevalence and documentation of risk factors contributing to AF in patients admitted with AF to cardiac wards in the northern Sydney local health district and referral patterns for cardiac and other relevant rehabilitation programs for patients with AF from July 2012-June 2013.

Results: 204 medical records were audited, 50% were male; the mean age was 74.65 years (SD 13.48). More patients were identified as having paroxysmal AF (48%) than permanent AF (33%) or persistent (16%). 81% of patients with AF had at least one other diagnosis.

Modifiable risk factors were prevalent with 64% having hypertension, 30%having a sedentary lifestyle and 25% being overweight, the majority had at least 1 modifiable risk factor (86%) and 54% had at least 2 modifiable risk factors.

Despite the high cardiovascular risk profile, worryingly, poor documentation of risk factors was common. The risk factors least likely to be documented were Depression (52%) Smoking (41%), Overweight (35%), Sedentary lifestyle (40%).

Referral: 42% received phase 1 or inpatient education and 25% were referred to outpatient CR, 21% were referred to a heart failure specialist program and 35% had a reason for not being referred. Not all patients were suitable for risk factor reduction promotion through CR because10% are frail, 8% referred to other programs, 4% were undergoing another procedure or refused and some patients had a very short stay (3%).

Conclusion: Inpatients with AF need improved assessment of modifiable risk factors and referral to programs that support reduction of modifiable risk factors and therefore reduce the risk of complications such as stroke.

Recommendations:

- Systematic screening of cardiovascular and AF risk factors in people experiencing AF
- Investigation of practices of CR for patients with AF
- Developing and testing secondary risk factor reduction programs for patients with AF which allow for multiple diagnoses.

Leonie Sadler
Clinical Nurse Consultant
Cardiac Rehabilitation, NBHS, NSW

ACRA Conference Report

Barbra Schiappadori – QLD Member

I am a Clinical Nurse at the Kirwan Community Health Campus in Townsville with QLD Health. My position is Phase Two Cardiac Rehabilitation Outpatient Program (CROP) Coordinator, which is a permanent part-time position (0.8 FTE). I am part of a multidisciplinary team, and have direct access to a network of Allied Health Professionals. I run approximately 22 'fast-track' education groups per year, and a continually rolling 12 week exercise program.

At the beginning of the year I started looking at my 2012 database to compile a report on referral uptake, reasons for decline (to address some of the barriers), and completion rates. I noticed that there were significant differences between Indigenous and Non-Indigenous persons. I was looking for some evidenced based practical information on how to increase participation rates but also equalise the ratio between Indigenous and Non-Indigenous persons.

When I found out that this years ACRA conference was themed 'Bridging the Divide' I was consumed by a feverish desperation to go! Thanks to ACRA I was able to apply for a 'General Scholarship' which allowed me to attend the conference. At the opening of the conference I was astounded by the 'Welcome to Country' by Auntie Diane Kerr (Wurundjeri Elder), and the presentation by Ms Vicki Wade (National Leader of the Aboriginal & Torres Strait Islander program in the Heart Foundation). During these talks I had many "light bulb moments" and finally started to grasp the multifaceted meaning of 'connectedness to the community and land'. What revelations I had made during those three conference days. Now I have fifteen pages of desperate scribbling to decipher, and have met many wonderful, kind and generous people.

Thank you ACRA!!! It was everything I'd hoped for and more.

Barbra Schiappadori
26/8/13

Conference Feedback and Comments

Favourite part of conference:

Excellent plenaries. Best for many years. Pitched well to audience - understandable, clear, but respectful to audience. Loved the focus on bridging the gap - the social determinants of health is a very important concept and area of knowledge. Many examples: low SES, indigenous issues, gender issues.

The conference content was very relevant to my role as a sole practitioner in a rural/remote setting. Information delivered in relation to disparity of services for low socio-economic I found helpful.

The dinner at the MCG was fabulous. The patient experience from Molly Williams – 5 star. CVD Risk Factors. Primary Prevention Prof S Stewart engaging and informative. Wake up breaks – very stimulating.

Key Presenters were excellent and majority of short ones were ok but too many concurrently to be able to absorb information.

Least favourite part of conference

5 minute presentations - superficial, pressurised, disrespectful to presenters who have worked very hard on the studies they are presenting and then have only 5 minutes to describe them. Give them 10 minutes - it would be worth it for the audience and for the presenter.

So much in one day, making it challenging to absorb and process the wealth of information presented "less is more".

Too many statistics - became very boring. Much of the information was repeated or very similar. Didn't learn much new information. Didn't come away from this conference enthused & re-energised.

I felt the conference was expensive for only 2 days and few resources or extras provided. Conference dinner+welcome drink should be an extra cost for people who want to attend so those who don't wish to attend don't have to pay anyway. Would have be happy if conference was $670 instead of $820.

Suggestions to improve future conferences

More time for mini presentations. More exercise & 'lifestyle/behaviour change' information /presentations.

Include delegate's role/position on name badge ie exercise physiologist, physiotherapist, cardiac nurse, etc.

Better choice of food for those people who are limited. The conference itself was really good and big thank you to the organisers as I can only imagine that it is huge undertaking. Well done Tassie and Melbourne. Not enough room in one of the mini oral sessions, people sitting on the floor and disruptive for the presenter.

Cost is a significant impediment to attending. This conference was very expensive - looking at cheaper venue with bigger range of accommodation close by. More time for networking. Less concurrent sessions and mini presentations as all were rushed and therefore didn't get much out of them. Ensuring presentations, especially keynote, related back to audience – some research was interesting but not relevant practically to target audience.

A "Wall of Fame" for DSA. New people to conference - good to know who some of the people in the room are.

Delegate or Committee Member who has attended CSANZ &/or other International Conferences to provide a CR summary or round-up overview. A Workshop or Plenary Session on Research Projects "101". How to get the basics of research correct, particularly for us clinicians. Delegate list should also include option of professions – ie nurse, EP, physio etc.

FAREWELL FROM THE ACRA EXECUTIVE OFFICER!

It is sad that I have to step down from the ACRA Executive Officer position. I have thoroughly enjoyed every minute that I have been doing this role. I have been greatly challenged and have learnt so much sitting around the table with the Executive Management Committee. There is so much knowledge and experience in that room and I have felt truly humbled to be part of such royalty. Thankyou to all of the members for your encouragement and support.

Though I am not working in the Cardiovascular Health and Rehabilitation area, Sue Sanderson has asked me to write about my new role in NSW Health.

I now work for the Health Education and Training Institute (HETI) which is one of the pillars of NSW Health. In July 2012, NSW Health implemented the ClinConnect Application for the booking and administration of all student placements in NSW Health. As the ClinConnect Application Manager, my role is governance of clinical placements in NSW Health and managing the operational side of ClinConnect.

ClinConnect is designed to deliver transparent communication between Education Provider and the NSW Health Local Health Districts and Specialty Health Networks. Education Providers and Local Health Districts have different levels of access to be able to complete different tasks in ClinConnect. ClinConnect works on a series of windows opening and closing. Education Providers request placements, LHDs then approve those placements, Education Providers then accept those placements and assign the students. ClinConnect also helps manage student compliance.

The disciplines which currently use ClinConnect include Nursing and Midwifery, Dental and Oral Health, some Allied Health and Medicine. Amongst other things, we are in the process of including more allied health disciplines, Diabetes Educators and Aboriginal Health Workers.

For more information about clinical placements in NSW Health and ClinConnect, please go to:

http://www.heti.nsw.gov.au/clinconnect/

If you'd like to contact me directly, my electronic door is always open. Please email me on nbanks@heti.nsw.gov.au

HETI ClinConnect NSW Health

All of a twitter

Do you follow our ACRA twitter account? As of November 2013 we have 234 followers. Twitter is a great way to access rapid and ready information, but many people are concerned about being overwhelmed by celebrity gossip. So is that really true? The answer is, it can be. It depends on whom you follow! If you follow celebrities, then you will see celebrity gossip appear in your twitter feed. But if you follow professional organisations and key journals, you will get up-to-date information that is relevant to your work. Key articles that support the use of twitter as a professional tool can be found at http://content.onlinejacc.org/article.aspx?articleid=1676135 and http://onlinelibrary.wiley.com/doi/10.1111/jan.12036/full

But there is a learning process in using twitter. Some of the language can be a bit confusing when you first start out. Here is a simple guide to twitter:

What is it?

Twitter is a micro-blogging site

What do you do?

- Share messages or "tweets" of up to 140 characters
- Follow others for updates on relevant information
- Gain followers to promote your own messages

How do I get started?

Log on to twitter.com and create a username. It starts with @ and then can be anything you choose. Choose a short one though- with only 140 characters you don't want to waste space with a long username. If you use a smartphone or tablet you can download the app.

Do I have to tweet?

No, it's fine to lurk and get a feel for what others are saying before sending that first tweet

What is this sign # used for?

The hashtag sign is used to identify a thread or a common theme. If you are tweeting about cardiac rehab you might use #cardiacrehab to identify your tweet to others, or if you want to find what people are saying about any topic you can try searching by using the # to locate relevant information

Why do I see short, strange-looking links?

Because of the character limit, there are lots of services that will shorten web addresses or URLs so you can share them via twitter (e.g. bitly.com or goo.gl)

Twitter essentials

- Adhere to professional standards- remember what you say is permanent
- Check regularly
- Be selective in who you follow

Who to follow

@ACRA_ACRA
@SteveWoodruffe
@lisneubeck
@calebferg
@JRedHeart
@CSHeartResearch
@HeartAust
@thecsanz
@csanzcnc
@bmj_latest
@MJA

News From *Across The Nation*

Screening for depression in patients with CHD

The Heart Foundation has developed a resource for screening depression in patients with coronary heart disease (CHD). This tool complements the consensus statement on depression and CHD published in the *Medical Journal of Australia* in May 2013.

The prevalence of depression is high in patients with CHD and it has a significant impact on the patient's quality of life, adherence to therapy and an independent effect on prognosis. Recognition of depression allows health professionals to provide the best possible care for patients with CHD.

The Heart Foundation recommends that all patients with CHD be routinely screened for depression at their first presentation, and again at the next follow-up appointment. A follow-up screen should occur 2–3 months after a CHD event. Screening should then be considered yearly, as for any other major risk factor for CHD.

The Heart Foundation's screening tool includes questions from the PHQ-2 and can be incorporated into clinical practice with minimum interference.

Patients with positive screening results may need further evaluation, and appropriate treatment should be commenced, followed by adequate monitoring. Co-ordination of care between healthcare providers is essential for optimal outcomes for patients. If screening is followed by comprehensive care, depression outcomes are likely to be improved.

The benefits of treating depression include improved quality of life, improved adherence to other therapies and potentially improved CHD outcomes.

Access the support tool and consensus statement at http://www.heartfoundation.org.au/information-for-professionals/Clinical-Information/pages/psychosocial-health.aspx

Pharmacy staff receive life-saving training

The Heart Foundation has developed BeAWARE Pharmacy, an online learning module, for pharmacists and pharmacy assistants to help them educate their customers with heart disease about the warning signs of heart attack.

BeAWARE of warning signs of heart attack and stroke, the first online module developed for general practice staff, was launched in May 2012 and has since been completed by more than 3,000 health professionals.

It was so popular that pharmacy professionals asked if there was a module available for them too – and from there BeAWARE Pharmacy was born.

Both e-learning modules can be accessed at www.heartfoundation.org.au/online-learning.

Growing BMI increases risk

Heart Foundation–supported research published in the *International Journal of Obesity* from the Australian National University has, in an Australian first, quantified the effect incremental rises in body mass index (BMI) have on your cardiovascular health – and the results aren't good.

For the first time researchers have quantified that an increasing BMI significantly increases the risk of hospitalisation for ischemic heart disease – the leading cause of heart attack – regardless of exercise level, smoking status and diabetes.

The study found that the risk of heart attack increased by 23 per cent with each 5 unit increase in BMI.

It's incredibly important for all Australians to keep their weight in a healthy range by eating a healthy diet and participating in regular physical activity. The study also demonstrated that if you stop smoking, and manage your blood pressure, cholesterol and blood sugar levels, your risk of a heart attack will decrease.

People with a BMI between 20 and 22.5 have the lowest risk and it increases gradually from there. By the time a person's BMI reaches 32 (about 10–15 kilos heavier), they are twice as likely to be hospitalised with ischemic heart disease as someone who has a BMI in the healthy range.

The results were derived from 158,000 participants in the Sax Institute's 45 and Up study who had no history of cardiovascular disease. Individuals were tracked over four years to see how incremental increases in BMI increased their risk of being hospitalised for a range of cardiovascular diseases.

For more information visit www.saxinstitute.org.au/our-work/45-up-study

World Cardiology Congress 4–7 May 2014 – register online today

The World Congress of Cardiology 2014 is coming to Melbourne, from 4 to 7 May. World-leading experts will present over 150 sessions on cardiology, policy and public health with a spotlight on regional issues. The latest scientific findings will be featured in over 1,000 ➤

new abstracts on the prevention, diagnosis and treatment of cardiovascular disease. Take this opportunity to participate in an international congress on your doorstep!

For more information and to register visit www.worldcardiocongress.org

Keeping an active body and active brain

Heart Foundation Walking (HFW), ACH Group and Alzheimer's Australia encourage more people with dementia to get active and join a HFW group. Early evaluation shows that walking has a positive impact on the quality of life for people with dementia, their families and professional carers.

Residents from Cooinda Lodge in Victoria have joined the walking program and the effects are proving very beneficial for participants.

To find out more contact Helen Morley Helen.morley@heartfoundation.org.au

Sick of the usual office Secret Santa?

Why not get together with your work colleagues and make your Christmas mean more this year by Doing it for Heart. There are plenty of ways to get involved. Instead of a Secret Santa, why not donate in lieu of a gift? You could dress in red for contributions or have a festive morning tea – if you're really inspired you could even do them all, or dream up your own fundraiser.

You'll be helping to save lives. Find out more at www.doitforheart.org.au

Cards that make a difference

Heart Foundation Gift Cards are now available. Check out the online shop for cookbooks, clothing and even jewellery – a perfect gift for your loved one. Help us make a difference to the heart health of all Australians. Shop now at www.heartfoundationshop.com

Heart Online

The Heart Foundation's Heart Education Assessment and Rehabilitation Toolkit (HEART) Online website has been developed by clinicians for clinicians.

Ongoing evaluation of the site has been positive – Google Analytics reports show that the site has had 14,800 visitors since its launch six months ago and 9,600 are new users.

The response from the HEART Online survey has been fabulous, with 340 responses received so far. Seventy-five per cent of respondents are nurses and the Heart Foundation would like to encourage people from other disciplines to complete the survey as well.

You can complete the survey at https://www.surveymonkey.com/s/N63J2ML

Initial evaluation suggests that HEART Online is reaching a large audience. The content is considered trustworthy, useful to clinical practice and has the potential to improve standards of practice.

Lead content writers are currently reviewing all comments and categorising them into the following four areas.

- future development of content, design or technology (dependent on further funding)
- technical areas that need to be addressed, such as errors and enhancing search functions
- content enhancement that can be achieved without further funding
- content or theory questions requiring action.

The ACRA logo is on the endorsements page, which links back to the ACRA website.

View the Heart Online website at http://www.heartonline.org.au/Pages/default.aspx

Advocacy strategy for Cardiac Rehabilitation

The Heart Foundation is currently developing an advocacy strategy for Cardiac Rehabilitation. This strategy articulates actions the Heart Foundation can drive to improve Cardiac Rehabilitation provision in Australia. The strategy will be final at the end of 2013, and will set out actions for 2014 – 2017. The advocacy strategy will augment the work of the Secondary Prevention Alliance, ACRA and state and territory Clinical Networks.

Key actions under this strategy

Needs Assessment

- Undertake an environmental scan ("state of play" assessment) of current cardiac rehabilitation programs and systems across the country to identify areas of need and examples of good practice to inform strategy development ➤

Stakeholder relations

- Continue to leverage state, territory and national alliances to strengthen support for cardiac rehabilitation service delivery reform in Australia

Communication

- Develop and implement a communication strategy that simplifies the language, demystifies the experience of participating in a cardiac care program and highlights the benefits of survival post a heart event
- Mobilise community understanding and support of the physical and psychosocial benefits of cardiac rehabilitation, to lifelong management and care of those living with heart disease

Promotion of existing services and identification of alternate models of care

- Convert existing CR directories to a Google map format (with ACRA's approval) for easier searching.
- Identify and promote examples of the various service options available (face to face, electronic and self managed) to overcome current barriers to participation

Advocacy

- Through advocacy, strengthen integration and emphasis on cardiac rehabilitation as an essential and vital step in a patient's cardiac journey or ongoing management of their heart disease.

Data

- Work with key bodies to establish standardised data collection and develop national key performance indicators for cardiac rehabilitation services and patient outcomes - ACS Standard

Workforce development

- Support efforts to develop continuing professional development messages and resources around cardiac rehabilitation so that the importance of cardiac rehab is reinforced and supported amongst clinicians, nurses and primary care professionals.

HRC Report

Elizabeth Holloway

Since July 2013 the Heart Research Centre has been led by the new director Professor Alun Jackson (See Brief Bio in last edition).

He is committed to evidence-led practice, and translational research, and has been involved in the design and direction of many large scale research projects in the area of behavioural addiction including a study on family violence and problem gambling; a study of risk factors for the children of problem gamblers; and the development of the NH&MRC-endorsed *Clinical Guidelines for Screening, Assessment and Treatment of Problem Gambling*. He has also authored or co-authored 20 books and research monographs, over 150 academic papers and supervised more than 50 higher degree students to completion.

His research has produced a range of clinical tools such as the: *Paediatric Discharge Planning Screening Tool* (2003); *Craniopharyngioma Symptom and Treatment Impact Scale* (2003); *The PreFACE (Pre-operative FAcial Cosmetic surgery Evaluation tool); The Problem Gambling Significant Other Impact Scale (PG-SOIS)*; the *One Item Problem Gambling Screening Tool for Primary Care Settings;* and the *Problem Gambling Family Impact Scale*. He also designed school-based AIDS Prevention Education for the Commonwealth Government while his general work in relation to HIV/AIDS prevention education set the direction for a number of years, for community-based and national AIDS education programs; devised a Drug Education Strategy for Victoria; and conducted research on Vietnam Veterans and their counselling needs commissioned by the Australian Senate.

Activities at the Centre

Health Professional Training:

Training held since June 2013:

- 'Cardiac Medications Update' a 1-day workshop addressing CAD and CHF medications, managing barriers to compliance and adherence, and health beliefs and health literacy.
- 'Cardiac Blues: Supporting emotional adjustment after a cardiac event' - a half day workshop addressing prevalence of depression, red flags, assessment and strategies to support patients to support their emotional wellbeing.
- 'Encouraging physical activity in patients with chronic illness'.

'Integrated disease management for patients with chronic heart failure' was held on 27-29 November. The HRC submitted a grant application to the Victorian Cardiac Clinical Network funded by the Department of Health. We were successful in receiving a grant for ten scholarships, eight of which were for CHF health professionals working in rural and regional areas. These eight scholarships are also supported by an accommodation and expenses allowance. We received many enquiries and forty two applications for the places. A steering committee ➤

was formed with representatives from other institutions, to award the scholarships.

Another grant application to the Victorian Cardiac Clinical Network funded by the Department of Health by Dr Rosemary Higgins, for 'Health professional online training and flexible support to improve delivery of Chronic Disease Self-Management care' was also successful.

The Supporting Chronic Disease Self Management (CDSM) online health professional training program has attracted continued interest from individuals, health organisations and government. Enrolments continue from health professionals and health organisations across Australia. The CDSM training teaches health professionals skills and strategies to help them support individuals with a chronic disease, to actively participate in their own health care.

Research Projects Include:

'Preparing for the Cardiac Blues': Supporting patients and health professionals in understanding emotional adjustment after an acute cardiac event

Led by Dr Murphy and Dr Higgins

To develop and pilot-test:

- A patient resource to support emotional adjustment after an acute cardiac event.
- A health professional resource for the development of an online training program to assist health professionals to talk with patients in hospital about common emotional responses

The Heart Research Centre received funding from Beyond Blue.

Update for the 'cardiac Blues' as the completion date approaches:

Both the written resources (brochure and double sided pamphlet) have been extensively focus tested with current and former heart patients and health professionals. The online training was undertaken and evaluated by 40+ health professionals. The resources will be developed with regards to feedback received from the focus groups and the Expert Working Group.

The final report is almost finished with decisions in process as to the finalisation and dissemination of the resources.

The following research projects reported in in the ACRA June 2013 report are ongoing:

- Indigenous Heart Health
- Wurundjeri Community Health Project
- The TIARA Evaluation, Part 1: Patient Satisfaction and Emotional Recovery
- Depression in rural cardiac patients
- Promising practices in cardiac rehabilitation and secondary prevention for Aboriginal and Torres Strait Islanders
- Return to work after an acute cardiac event
- CBT intervention study
- Predictors of mortality in HRC cohorts
- Music therapy for language recovery following stroke
- Impact of CDSM training in health professionals

A new research project **Sedentary Behaviour,** is being developed. This builds on previous work and the training 'Encouraging physical activity in patients with chronic illness' held by the HRC in September, facilitated by Dr Michelle Rogerson and Dr Steven Bird.

This was a topic of great interest at the ACRA conference where the question was controversially asked "Is sedentary behaviour the 'new smoking'?'

Recent Publications For 2013:

Worcester M, Elliott P, Turner A, Pereira J, Murphy B, Le Grande M, Middleton K, Navaratnam H, Nguyen J, Newman R, & Tatoulis J. Resumption of work after acute coronary syndrome or coronary artery bypass graft surgery. Heart Lung & Circulation Accepted November 2013

Rogerson M, Murphy B, Le Grande M & Worcester, M. Physical inactivity at leisure and work: A 12-month study of cardiac patients. J Cardiopulm Rehabil Prev 2013; 33:385-395.

Murphy BM, Worcester MU, Higgins RO, Elliott P, Navaratnam H, Mitchell F, Grigg L, Tatoulis J, Goble AJ. Reduction in two-year recurrent risk score and improved behavioural outcomes after participation in the Beating Heart Problems self-management program: results of a randomised controlled trial. J Cardiopulm Rehabil Prev 2013; 33:220-228.

Murphy BM, Ludeman D, Elliott PC, Judd F, Humphreys J, Edington J, Jackson A, Worcester MU. Red flags for persistent or worsening anxiety and depression after an acute cardiac event: a 6-month longitudinal study in regional and rural Australia. Eur J Prev Cardiol 2013 (in press, accepted 10 May 2013) .

Murphy BM, Rogerson M, Worcester MU, Elliott P, Higgins R, Le Grande M, Turner A, Goble A. Predicting mortality 12 years after an acute cardiac event: comparison between in-hospital and 2-month assessment of depressive symptoms in women. J Cardiopulm Rehabil Prev 2013 ;33:160-167

Beauchamp A, Worcester M, Ng A, Murphy B, Tatoulis J, Grigg L, Newman R, Goble A. Attendance at cardiac rehabilitation is associated with lower all-cause mortality after 14 years of follow-up. Heart 2013; 99:620-625. (Get Full-text pdf)

Murphy BM, Le Grande M, Navaratnam H, Higgins R, Elliott PC, Turner A, Rogerson M, Worcester MUC, Goble AJ. Are poor health behaviours in anxious and depressed cardiac patients explained by sociodemographic factors? Eur J Prev Cardiol. 2013 20:995-1003.

A Corner of Research for Australia

By Robert Zecchin RN MN

The following are excerpts of recent research articles which may:

a. encourage further research in your department

b. make you reflect on your daily practice

c. enable potential change in your program

d. All of the above

1 Cardiorespiratory fitness changes in patients receiving comprehensive outpatient cardiac rehabilitation in the UK: a multicentre study. Sandercock GR. Cardoso F. Almodhy M. Pepera G. Heart. 99(11):785-90, 2013 Jun.

BACKGROUND: Exercise training is a key component of cardiac rehabilitation but there is a discrepancy between the high volume of exercise prescribed in trials comprising the evidence base and the lower volume prescribed to UK patients. **OBJECTIVE:** To quantify prescribed exercise volume and changes in cardiorespiratory fitness in UK cardiac rehabilitation patients. **METHODS:** We accessed n=950 patients who completed cardiac rehabilitation at four UK centres and extracted clinical data and details of cardiorespiratory fitness testing pre- and post-rehabilitation. We calculated mean and effect size (d) for change in fitness at each centre and converted values to metabolic equivalent (METs). We calculated a fixed-effects estimate of change in fitness expressed as METs and d. **RESULTS**: Patients completed 6 to 16 (median 8) supervised exercise sessions. Effect sizes for changes in fitness were d=0.34-0.99 in test-specific raw units and d=0.34-0.96 expressed as METs. The pooled fixed effect estimate for change in fitness was 0.52 METs (95% CI 0.51 to 0.53); or an effect size of d=0.59 (95% CI 0.58 to 0.60). **CONCLUSION:** Gains in fitness varied by centre and fitness assessment protocol but the overall increase in fitness (0.52 METs) was only a third the mean estimate reported in a recent systematic review (1.55 METs). The starkest difference in clinical practice in the UK centres we sampled and the trials which comprise the evidence-base for cardiac rehabilitation was the small volume of exercise completed by UK patients. The exercise training volume prescribed was also only a third that reported in most international studies. ***If representative of UK services, these low training volumes and small increases in cardiorespiratory fitness may partially explain the reported inefficacy of UK cardiac rehabilitation to reduce patient mortality and morbidity.***

The Good News: To increase fitness the patients need to exercise with greater intensity and more often. Researchers need to be careful when comparing CR with alternative models especially if the CR is not well resourced or do not provide best practice methods.

2 Patients' perceptions of depression and coronary heart disease: a qualitative UPBEAT-UK study. Simmonds RL. Tylee A. Walters P. Rose D. BMC Family Practice. 14:38, 2013.

BACKGROUND: The prevalence of depression in people with coronary heart disease (CHD) is high but little is known about patients' own perceptions and experiences of this. This study aimed to explore (i) primary care (PC) patients' perceptions of links between their physical condition and mental health, (ii) their experiences of living with depression and CHD and (iii) their own self-help strategies and attitudes to current PC interventions for depression. **METHOD:** Qualitative study using consecutive sampling, in-depth interviews and thematic analysis using a process of constant comparison. 30 participants from the UPBEAT-UK cohort study, with CHD and symptoms of depression. All participants were registered on the General Practitioner (GP) primary care, coronary register. **RESULTS:** A personal and social story of loss underpinned participants' accounts of their lives, both before and after their experience of having CHD. This theme included two interrelated domains: interpersonal loss and loss centred upon health/control issues. Strong links were made between CHD and depression by men who felt emasculated by CHD. Weaker links were made by participants who had experienced distressing life events such as divorce and bereavement or were living with additional chronic health conditions (i.e. multimorbidity). Participants also felt 'depressed' by the 'medicalisation' of their lives, loneliness and the experience of ageing and ill health. Just under half the sample had consulted their GP about their low mood and participants were somewhat ambivalent about accessing primary care interventions for depression believing the GP would not be able to help them with complex health and social issues. ***Talking therapies and interventions providing the opportunity for social interaction, support and exercise, such as Cardiac Rehabilitation, were thought to be helpful whereas anti-depressants were not favored.*** **CONCLUSIONS:** The experiences and needs of patients with CHD and depression are diverse and include psycho-social issues involving interpersonal and health/control losses. In view of the varying social and health needs of patients with CHD and depression the adoption of a holistic, case management approach to care is recommended together with personalised support providing the opportunity for patients to develop and achieve life and health goals, where appropriate.

The Good News: CR can help patients with depression through exercise and social interaction with other patients.

3 Modifiable factors associated with failure to attain low-density lipoprotein cholesterol goal at 6 months after acute myocardial infarction. Martin SS. Gosch K. Kulkarni KR. Spertus JA. Mathews R. Ho PM. Maddox TM. Newby LK. Alexander KP. Wang TY. American Heart Journal. 165(1):26-33.e3, 2013 Jan.

BACKGROUND: Although controversial, reducing low-density lipoprotein cholesterol (LDL-C) to target levels remains a common therapeutic goal after acute myocardial infarction (AMI). We sought to illuminate patient and provider characteristics associated with ➤

LDL-C goal nonattainment after AMI. METHODS: In an observational registry of 24 US hospitals, we included 366 patients with AMI who had baseline LDL-C levels >=100 mg/dL and underwent 6-month fasting LDL-C reassessment. Our primary outcome was failure to reach the guideline-recommended LDL-C goal of <100 mg/dL at 6 months post-AMI. RESULTS: One in 3 patients with AMI with initially elevated LDL-C failed to attain LDL-C goal at 6 months. Compared with those who attained LDL-C goal, those who did not were more often discharged without a statin (21% vs 9%, P < .001), despite only 4% having documented contraindications. Patients not achieving LDL-C goal also more frequently discontinued statin use by 6 months (24% vs 6%, P < .001). Multivariable modelling (c index, 0.78) revealed the absence of a statin prescription at discharge and lack of persistence on statin therapy as the strongest independent factors associated with failure to reach LDL-C goal. *Additional independent risk factors were patient report of not consistently adhering to prescribed medications, not participating in cardiac rehabilitation, non-white race, and lack of insurance.* CONCLUSIONS: One-third of patients with AMI with baseline hyperlipidemia do not attain the LDL-C goal of <100 mg/dL at 6 months. Our findings support targeted interventions in the transition of AMI care to promote affordable statin prescription at discharge, medication persistence and adherence, and cardiac rehabilitation participation. Copyright 2013 Mosby, Inc. All rights reserved.

The Good News: CR is an important adjunct therapy to obtaining target LDL levels.

4 Participation in cardiac rehabilitation and survival after coronary artery bypass graft surgery: a community-based study. Pack QR. Goel K. Lahr BD. Greason KL. Squires RW. Lopez-Jimenez F. Zhang Z. Thomas RJ. Circulation. 128(6):590-7, 2013 Aug 6.

BACKGROUND: Cardiac rehabilitation (CR) is recommended for all patients after coronary artery bypass surgery, yet little is known about the long-term mortality effects of CR in this population. **METHODS:** We performed a community-based analysis on residents of Olmsted County, Minnesota, who underwent coronary artery bypass surgery between 1996 and 2007. We assessed the association between subsequent outpatient CR attendance and long-term survival. Propensity analysis was performed. Cox proportional hazards regression was then used to assess the association between CR attendance and all-cause mortality adjusted for the propensity to attend CR. **RESULTS:** We identified 846 eligible patients (age 66+/-11 years, 76% men, and 96% non-Hispanic whites) who survived at least 6 months after surgery, of whom 582 (69%) attended CR. During a mean (+/-SD) follow-up of 9.0+/-3.7 years, the 10-year all-cause Kaplan-Meier mortality rate was 28% (193 deaths). Adjusted for the propensity to attend CR, participation in CR was associated with a 10-year relative risk reduction in all-cause mortality of 46% (hazard ratio, 0.54; 95% confidence interval, 0.40-0.74; P<0.001) and a 10-year absolute risk reduction of 12.7% (number needed to treat=8). There was no evidence of a differential effect of CR on mortality with respect to age (>=65 versus <65 years), sex, diabetes, or prior myocardial infarction. **CONCLUSIONS:** CR attendance is associated with a significant reduction in 10-year all-cause mortality after coronary artery bypass surgery. Our results strongly support national standards that recommend CR for this patient group.

The Good News: Great study in support of cardiothoracic surgery patients' attendance at CR.

5 Long-term results of a 12-week comprehensive ambulatory cardiac rehabilitation program. Blum MR. Schmid JP. Eser P. Saner H. Journal of Cardiopulmonary Rehabilitation & Prevention. 33(2):84-90, 2013 Mar-Apr.

PURPOSE: To evaluate the long-term outcome of a 12-week outpatient cardiac rehabilitation (CR) program. **METHODS:** In a prospective single-centre interventional cohort study, 201 consecutive patients (133 patients after acute coronary syndrome, 32 patients after heart surgery, and 36 patients with heart failure) attending a 12-week comprehensive outpatient CR program were evaluated for exercise capacity, cardiovascular risk factors (CvRFs), and quality of life at entry, end, and 1.4 years after completion of the program (follow-up). **RESULTS:** Physical exercise capacity improved significantly from program entry to program end and remained at this level at follow-up (P <= .006). CvRFs at follow-up were significantly reduced with regard to smoking prevalence and blood lipids (P < .001). At program end and follow-up, MacNew heart disease-specific emotional, physical, and social quality of life was improved significantly compared with those at program entry (P < .001). Use of cardio-protective medication remained equally high over the entire study period. However, significantly fewer patients reached blood pressure (<140/90 mm Hg, P = .034) and body mass index (<30 kg/m, P = .017) goals at follow-up than at program end. **CONCLUSION:** The 12-week comprehensive outpatient CR program was successful at reducing important CvRFs long-term.

The Good News: More evidence that CR works!

6 Exercise training early after acute myocardial infarction reduces stress-induced hypoperfusion and improves left ventricular function. Giallauria F. Acampa W. Ricci F. Vitelli A. Torella G. Lucci R. Del Prete G. Zampella E. Assante R. Rengo G. Leosco D. Cuocolo A. Vigorito C. European Journal of Nuclear Medicine & Molecular Imaging. 40(3):315-24, 2013 Feb.

PURPOSE: Exercise training might exert its beneficial effects on myocardial perfusion by inducing coronary vascular adaptations or enhancing collateralization. We evaluated whether long-term exercise-based cardiac rehabilitation started early after ST-elevation acute myocardial infarction (STEMI) improves myocardial perfusion and left ventricular (LV) function. **METHODS:** Forty-six patients with recent STEMI and residual inducible hypoperfusion were randomized into two groups: 25 enrolled in a 6-month outpatient exercise-based cardiac rehabilitation programme (group T) and 21 discharged with generic instructions for maintaining physical activity and correct lifestyle (group C). All patients underwent cardiopulmonary exercise test and dipyridamole rest gated myocardial perfusion single photon emission ➤

computed tomography within 1week after STEMI and at 6-month follow-up. **RESULTS:** At follow-up, group T showed an improvement in peak oxygen consumption, oxygen pulse and in the slope of increase in ventilation over carbon dioxide output (all p<0.01) associated with a reduction of stress-induced hypoperfusion (p<0.01) and an improvement in resting and post-stress wall motion score indexes (both p<0.01), resting and post-stress wall thickening score indexes (both p<0.05) and resting and post-stress LV ejection fraction (both p<0.05). On the contrary, no changes in cardiopulmonary indexes, myocardial perfusion and LV function parameters were observed in group C at follow-up. **CONCLUSION:** Exercise training started early after STEMI reduces stress-induced hypoperfusion and improves LV function and contractility. Exercise-induced changes in myocardial perfusion and function were associated with the absence of unfavourable LV remodelling and with an improvement of cardiovascular functional capacity.

The Good News: How early do you start STEMI patients in your program? This study suggests the earlier the better.

7 Cardiovascular fitness and mortality after contemporary cardiac rehabilitation. Martin BJ. Arena R. Haykowsky M. Hauer T. Austford LD. Knudtson M. Aggarwal S. Stone JA. APPROACH Investigators. Mayo Clinic Proceedings. 88(5):455-63, 2013 May.

OBJECTIVE: To assess the association between cardiorespiratory fitness (CRF) and outcomes in a cardiac rehabilitation (CR) cohort. **PATIENTS AND METHODS:** We conducted a retrospective study of 5641 patients (4282 men [76%] and 1359 women [24%]; mean +/- SD age, 60.0+/-10.3 years) with coronary artery disease who participated in CR between July 1, 1996, and February 28, 2009. Based on peak metabolic equivalents (METs), patients were classified as low fitness (LFit) (<5 METs), moderate fitness (5-8 METs), or high fitness (>8 METs). **RESULTS:** Baseline fitness predicted long-term mortality: relative to the LFit group, patients with moderate fitness had an adjusted hazard ratio of 0.54 (95% CI, 0.42-0.69), and those with high fitness a hazard ratio of 0.32 (95% CI, 0.24-0.44). Improvement in CRF at 12 weeks was associated with decreased overall mortality, with a 13% point reduction with each MET increase (P<.001) and a 30% point reduction in those who started with LFit. At 1 year, each MET increase in CRF was associated with a 25% point reduction in overall mortality in the whole group (P<.001). **CONCLUSION:** In this study of contemporary CR patients, higher baseline fitness predicted lower mortality. The novel finding was that improvement in fitness during a CR program and improvements that persisted at 1 year were also associated with decreased mortality, most strongly in patients who start with LFit.

The Good News: CR is better for the more deconditioned patient than the less deconditioned patient. However, both types of patients overall benefit from CR attendance.

More next time!

What's in a name? Cardiac rehabilitation

Summary of debate from CRANSWACT state conference 25th October 2013

FOR: Julie Ann Mitchell NSW Director of Cardiovascular Health
Julie Redfern, Head of Public Health and Health Services program, Cardiovascular Division, the George Institute for Global Health; A/Professor, Sydney Medical School, University of Sydney

AGAINST: Dawn McIvor, CNC cardiology Hunter New England Local Health district, President CRA of NSW ACT
Robyn Gallagher, Associate Professor Chronic and Complex Care UTS Sydney

At the recent ACRA AGM the need for a name change to describe what we do in cardiac rehabilitation was raised, however there is considerable debate about whether a name change is needed and what to change the name too. With tongue-in-cheek a debate was held at the annual CRA NSW state conference highlighting the 'for' and 'against' reasons for a name change.

The 'for' team, argued that many large companies such as Telstra have changed their name over the years with no detriment to their service. The team also highlighted that less than 30% of eligible patients attend traditional cardiac rehabilitation so there is a definite need to increase uptake and access. In addition, some of the evidence around traditional programs is somewhat outdated in terms of contemporary medical care including PCI and day admissions post MI. The team highlighted that a more unified voice with a more contemporary name may help to increase meaningfulness for patients, providers and decision-makers. The 'for' team clearly acknowledged that cardiac rehabilitation does a great job for the people that attend.

The 'against' team, argued that old is good. William Shakespeare isn't known as Will, vintage clothes and fine wine are in vogue. Changing the name of cardiac rehabilitation will not necessarily increase attendance and that thousands of people worldwide have benefited from what is known as cardiac rehabilitation and changing it is not necessary.

After the rousing debate, a vote was put to all in attendance. With an overwhelming majority, the vote went 'for' the name change. Even the evocative 'dress-ups' of the 'against' team couldn't persuade the audience.

State News

Western Australia

State representative
Craig Cheetham

Recent Events

Annual WACRA Symposium

The annual WACRA half day symposium was held on the 8th of November. The day saw a series of presentations covering a range of contemporary and innovative clinical topics.

The event was almost singlehandedly organised by Lily Titmus who worked tirelessly to make the event a success. The WACRA exec cannot thank Lily enough for all her effort.

NEWS FLASH

WACRA "Christmas get together"

The Executive Committee of WACRA would like you to invite you to an informal Christmas "get together" to help celebrate a productive year as well as providing a great networking opportunity and also the opportunity to share your thoughts on what role WACRA can play to assist its members in 2014.

This will be held at the **Byrneleigh (156 Hampden Road, Nedlands) on Wednesday the 4th of December from 6pm.**

Cardiovascular Health Networks

Cardiac Rehabilitation and Secondary Prevention working group

There has been a significant amount of work performed under the momentum of the working group. A policy document for Cardiac rehabilitation and secondary prevention in WA has been tirelessly refined over the past 6 months and the final daft is currently out for broader consultation. This document will play a pivotal role for all practitioners in the future. The WACRA executive cannot thank enough Kim Goodman, Jacquie Garton-Smith and Stephen Bloomer from the Cardiovascular Health Network, Shelley McRae and Julie Smith from the Heart Foundation and all the WACRA Exec and members as well as the practitioners that have assisted the contributing to the document.

Furthermore the Cardiovascular Health Network has been successful in ensuring referral to cardiac rehabilitation and secondary prevention services are part of the "ABF premium payment" for Myocardial Infarction. The premium payment is a means of providing eligible institutions additional revenue for meeting a series of steps identified and approved under the ABF framework as meeting best practice and supporting optimal clinical and health outcomes. This is a significant step to demonstrate cardiac rehabilitation and secondary prevention services are an important component in the management of MI, but also linked with a direct revenue stream for institutions. Again thank you to Kim Goodman, Jacquie Garton-Smith and Stephen Bloomer from the Cardiovascular Health Network for their efforts to get this over the line.

If you would like more information please feel free to contact me.

WA state items prepared by

Craig Cheetham
WACRA President
WA state representative on the ACRA Executive Management Committee
WACRA representative on the Cardiovascular Health Network's, Executive Advisory Group.

Further information regarding these events please refer to details specific to each event or contact: craig.cheetham@cprwa.com.au

Victoria

State representative
Kim Gray

VACR Committee

The VACR held its AGM on the 14th of November 2013. The new committee was elected at this meeting.

The new VACR committee is

President:	Emma Boston
Vice President:	Kim Gray
Secretary:	Margaret Ryan
Treasurer:	Debra Gascard
State Rep to ACRA:	Kim Gray
General Committee:	Alison Beauchamp, Adrienne Caulfield, Ailish Commane, Niamh Dormer

The VACR would like to acknowledge the contributions of Moira Craig and Lisa Jenkins who chose not to renominate and welcome Ailish and Niamh

VACR Constitution

In accordance with Consumer Affairs Victoria the VACR was required to review their constitution or adopt the New Rules of Incorporated Associations (CAV). The VACR committee chose to review their rules with reference to the new rules of the ACRA as voted on at the ACRA 2013 AGM. A Special Resolution was held at the VACR AGM on the 15th of November 2013 and the Special Resolution to adopt the VACR Rules was passed by the membership present.

Education events

The VACR held its first Research and Data Collection on the 14th November 2013 at the Rendezvouz Grand Hotel, Flinders St Melbourne. As a result of the positive feedback to research and data collection content at the Clinical Practice Day in the March a 3 hour workshop was designed around members' desired topics.

Thanks to facilitators Alison Beauchamp, Karen Page and Jan Cameron 40 clinicians armed with laptops were introduced to topics including:

: Overview of research and quality processes (all rooms)

: Using Excel to enter and report cardiac rehabilitation data ➤

: Showcasing your work - included:

- : How to write an abstract for conference presentations
- : Designing a research poster
- : The 'elevator pitch'
- : Tips for power points and oral presentations

: Collecting and using data and Quality activities - included:

- : Collecting and using data about your program.
- : Overview of quality activities including clinical audits
- : Identifying your research question
- : Differences between quality and research activities
- : The ethics process

Early review of the feedback suggests it is a workshop the VACR would consider running again.

The afternoon was followed by the VACR AGM and the Alan Goble lecture and dinner in the evening. Dr Karen Page provided a thought provoking presentation, "Challenge is in the Moment", highlighting past successes, driving influences and where the future lies and the challenges ahead, and cardiovascular health and rehabilitation.

Next event: VACR Clinical Practice Day 3rd March 2014, Stamford Hotel Melbourne

Victorian Cardiac Clinical Network

The Victorian Cardiac Clinical Network has awarded its first round of successful projects in heart failure and cardiac rehabilitation as part of the funding announced by the Victorian Government early in 2013 for these disease groups.

Cardiac Roundtable

The cardiac roundtable of key stake holders involved in cardiovascular health reconvened at the Heart Foundation Melbourne on the 12th of November 2013 to discuss progress over 12months. The key action areas are 1) Models of Care, 2) Advocacy and 3) Data. A working party has been set up to review what is happening with data within Australia, minimum data sets that are already being used in Australia , further explore the road blocks to data collection that exist at the clinician level as identified by VACR and the impact of data recording as required for activity based funding.

Tasmania

State representative
John Aitken

Upcoming Events:

Heart Health Care Net Work: 10th December via Teleconference 'Absolute Risk Explained'

TACR meeting 11th December via video conference

TACR Education Day 15th March 2014: 'Non Healing Sternum' with Dr Hardikar and Dr Doa El-Ansary (more detail below)

TACR Meeting 18th September

The members of this TACR meeting agreed that they were not averse to the idea of having 2 representatives from each state – one being the State President, and the other being a State Representative.

There was general discussion regarding suggestions for a new name for ACRA. Looking for a new name (the word "rehabilitation" has caused confusion for some) that reflects the multidiscipline of professions involved.

A couple of suggestions that had been made were discussed.

We have reviewed our meetings being a small state but our centres where cardiac rehabilitation services are held are geographically separate. Our meetings are now held primarily via videoconference quarterly. Meetings held after the ACRA EMC meeting are used to provide feedback from that meeting and to discuss issues that arise. The other 2 meetings are 'journal clubs' where we discuss an article of interest but also follow-up on discussions from the EMC.

Journal club

The article for discussion was from *Brieger, D & Redfern, J, Contemporary themes in acute coronary syndrome management: from acute illness to secondary prevention, MJA 199 (3), 5 August 2013, pp.174-178*. Broad discussion followed around what was and wasn't working in the programs run by those members present.

Some issues raised and discussed included

- cardiac rehab and activity based funding.
- patients getting access to follow-up cardiology appointments at in another region

New service

A new 6 week Heart Health Program that has started at the Clarence Integrated Care Centre servicing patients who reside on Hobart's eastern shore, the lower east coast or Tasman peninsula – providing easier access than coming to the RHH. Initially introduced as a pilot project, the Program is now taking regular referrals. It is specifically for patients following an ACS event with or without a PCI. We are not taking those post-sternotomy at this time. However we are able to cater for patients following an elective PCI, a group that previously we had not included in our programs. This is an exciting venture fully supported and run by the community nurses and physiotherapy service. We anticipate that as other Integrated Care Centres are introduced that the Heart Health Program will be incorporated into each. The Program is coordinated from the RHH using the same model.

2014 education seminar

Our annual seminar to coincide with the AGM will be held on March 15th at the Northern Integrated Care Centre. The theme is "The non-healing sternum" and Dr Doa El-Ansary has agreed to be a speaker along with one of the surgeons from Hobart. We plan to demonstrate some of Doa's research using ultrasound to detect potential issues that may impact on healing and we have patients who have volunteered for the day. We welcome members from interstate who may wish to attend.

Heart Care Network

The Heart Care Coordinator at the Heart Foundation (Tasmania) has been instrumental in establishing the Heart Care Network in the state for multidisciplinary health professionals with expert skills and knowledge to share with each other. Meetings have ➤

been held both in the north and the south with educations sessions planned via teleconference.

The network provides a way for facilitating communication and sharing knowledge with colleagues within a professional context. The network features include:

- A close connection and positive relationship with the Heart Foundation Tasmania and other professionals with an interest in improving the heart care of all Tasmanians.
- A way to find out key and current Heart Foundation messages, clinical guidelines and consumer resources.
- Access to free professional development and social knowledge sharing sessions
- Regular email newsletter with Heart Foundation and Heart Care Network news from around the state
- Social media discussion board

South Australia & NT

SACRA

State representative
Jenny Finan

Current SACRA executive committee:

President – Dianna Lynch

Vice president – Renee Henthorn

State Representative – Jenny Finan

Secretary – Celine Gallagher

Treasurer – Katy Read

Rural Rep – Caroline Wilksch

Committee Members – Rhonda Naffin, Sancha Shute, Jessica Northcott

SACRA seminar Hampstead Day Rehabilitation Centre

Our most recent seminar was held on Sat 19/10/11. There were 37 attendees. Topics discussed on the day included:

o Achieving perfect lipid control for patients with Coronary Disease - Prof Stephen Nicholls, Cardiologist, Royal Adelaide Hospital.

o The role of cardioprotective medications in patients with ischaemic Heart Disease - Daniel Schandrett-Smith, Cardiac Pharmacist, Ashford Hospital.

o The role of ECHO in Heart Failure - Dr Devan Mahadavan, Cardiologist, Queen Elizabeth Hospital and Lyell McEwin Hospital.

The seminar was sponsored by AstraZeneca.

Door Prize sponsored by Police Credit Union – SA Shorts Holiday voucher - won by Jo Pillay (Adelaide Cardiology)

Photo: Daniel Scandrett-Smith & guide dog in training – Daniel was one of our speakers and he is a keen guide-dog trainer. The dog attended the seminar with Daniel and literally "stole the show"! He was very popular with delegates.

SACRA Christmas dinner was on November 20th.

World Diabetes Day

world diabetes day

A part of SACRA's commitment to supporting education on both diabetes and cardiovascular disease, Calvary Rehabilitation Hospital held a joint educational session on World Diabetes Day.

Diabetes and Cardiovascular Health seminar – Thurs 14/11/13. There were 25 attendees who heard the following presentations:

o Heart Disease and Diabetes - Dr R Waltham, Cardiologist

o Management of Type 2 diabetes in Hospital – Dr N Laddipeerla, Endocrinologist

o Energy In = Energy Out - Dr B Lorenzen, Bariatrics Physician

This event was proudly sponsored by the Police Credit Union.

SA Shorts Holiday voucher, won by Rula Hockley - CNAHC.

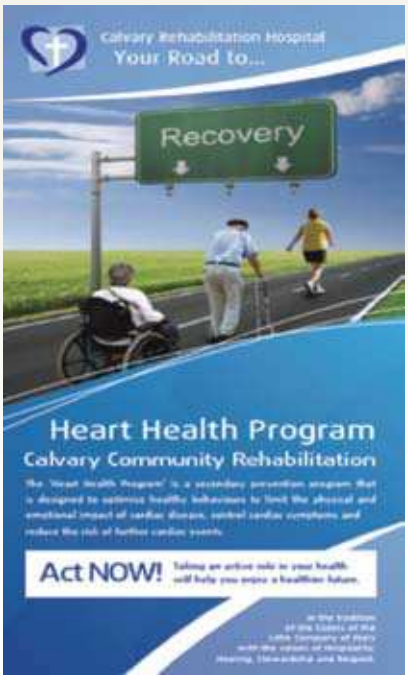
The next sessions will be held on World Diabetes Day 2014.

Introducing Calvary Community Rehabilitation, Heart Health Program

The 'Heart Health Program' provides a comprehensive multidisciplinary approach to cardiovascular health. The program consists of two sessions per week for six weeks.

All sessions include education and exercise. The exercise program is supervised by a physiotherapist and cardiac nurse. Educational sessions are conducted by a team of health professionals including a cardiologist, cardiac nurse, physiotherapist, pharmacist, dietitian, occupational therapist and psychologist.

At the end of the program patients are re-assessed and encouraged to attend maintenance sessions, to minimise the risk of secondary acute coronary syndrome events.



On behalf of SACRA I would like to wish you all a Happy Christmas and New Year.

Jenny Finan
Cardiopulmonary Coordinator
Credentialed Diabetes Educator
Calvary Rehabilitation Hospital
Calvary Community Rehabilitation ➤

Queensland

State representative
Paul Camp

New QCRA Executive Management Committee

At the most recent AGM, four members who had provided QCRA with distinguished service stepped down from the elected EMC: Kylie Houlihan, Michelle Aust, Karen Uhlmann and Maree Lorensen. QCRA would like to sincerely thank them for their dedication and tireless efforts in advancing our state association.

We would like to welcome the members of the new EMC:

President: Paul Camp (Mater Public Hospital- Metro)

Vice President: Vacant (EOI disseminated)

Secretary: Sharon Leslie (Queensland Health – Metro)

Treasurer: Karen Healy (Queensland Health – Metro)

Committee:

Bridget Abell (Researcher - Bond University)

Jessica Auer (Private Sector- Regional)

Gary Bennett (Queensland Health – Health Contact Centre)

Cathie Hardy (Private Sector- Metro)

Ivette Warren (Queensland Health – Regional/Rural)

Invited Committee Members:

Karen Uhlmann (Heart Foundation)

Steve Woodruffe (Queensland Health – Metro)

New Members

A warm welcome to new members Cara Tickelpenny – Chronic Disease Program Coordinator, Longreach and John Turnball - Eden Rehabilitation Hospital, Cooroy.

Food for Thought

The Heart Foundation – Queensland partnered with QCRA to present a State-wide Clinical Update Videoconference on the 14th October. The Topic was "Mindful eating, psychosocial risk factors & coronary heart disease"

Key note speakers included Assoc. Prof David Colquhoun (Cardiologist, Heart Foundation Board Director), Deanne Wooden (Nutrition Manager, Heart Foundation) and Stephen Vines (CEO, Heart Foundation Qld). Steve Woodruffe ACRA President, spoke to the many benefits of belonging to ACRA -QCRA.

This popular event was organised by Karen Uhlmann and her team from Heart Foundation-Qld. A total of 21 sites accessed the videoconference and 45 clinicians participating face to face.

Pilot trial of automated cardiac rehabilitation referrals

A clinical trial between the Princess Alexandra Hospital (PAH) and the Health Contact Centre (HCC) was carried out around automated referrals to outpatient cardiac rehabilitation/ heart failure programs. The Final Report for this trial is currently before the State-wide Clinical Cardiac Network (SCCN) steering committee. The SCCN report will particularly examine the IT systems and processes used to automatically/electronically identify patients during the trial.

Telehealth streaming of Cardiac Rehab/Heart Failure Education from Ipswich and PAH

Telehealth equipment has been installed in both hospitals to allow live streaming of their Cardiac Rehab and Heart Failure multidisciplinary education sessions. A number of rural and remote sites are now taking up the opportunity to link in with these education sessions.

Seasons greetings from the QCRA Executive Management Committee.

Please don't hesitate to contact us with any questions or feedback on our email: qcra@acra.net.au

NSW / ACT

State representative
Lis Neubeck

After the whirlwind of the national election campaign, CRA had our own change of leadership on 25th October this year! Our new board has taken the reins and are looking forward to a wonderful year ahead.

CRA Board

President: Dawn McIvor
Vice President: Kellie Roach
Secretary: Leonie Sadler
Treasurer: Julie Belshaw
Chair of PEC: Deborah Carter Hendy
Public Relations: Dr Ritin Fernandez
Chair of Membership: Vacant
Class Representatives:
Nursing- Robyn Gallagher
Physiotherapy- Nicole Lowres
Exercise Physiology- vacant
Members at Large:
Jo Leonard
Catherine Melville
Representatives:
ACRA- Lis Neubeck
Agency for Clinical Innovation- Kellie Roach
National Heart Foundation of Australia- Cate Ferry

- We had an outstanding State Conference on Friday 25th October. It is hard to pick a highlight: we were lucky enough to have NSW Health Minister Jillian Skinner opening the conference and presenting rural travel scholarships. We also had outstanding presentations from all our invited speakers and selected abstracts. My personal favourite part of the day was the debate whether to change to name of Cardiac Rehabilitation. For the change were the fabulous Dr Julie Redfern and Julie-Anne Mitchell. Against were the awesome Dr Robyn Gallagher and Dawn McIvor. The fun, energy, not to mention the rabble-rousing was both uplifting and engaging. We have started a CRA tradition with the debate that I look forward to seeing at many future events.

- Date for your diary! The ACRA Annual Scientific Meeting will be held from 21-23 August 2014 in Sydney. Our conference theme is Sex, drugs and rock and roll. Check out the website www.acra2014.com.au for speaker information and regular updates.

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6TH EXERCISE & SPORTS SCIENCE AUSTRALIA CONFERENCE AND SPORTS DIETITIANS AUSTRALIA UPDATE: RESEARCH TO PRACTICE

Organiser: Exercise & Sports Science Australia
Date: 10 – 12 April 2014
Location: Adelaide Convention Centre, South Australia
Contact: Sarah Hall
Email: conference@essa.org.au
Website: www.essa.org.au/2014conference

Overview: "Exercise and sports sciences have a long, proud tradition of basing practice on scientific evidence. In an era where information is everywhere, but knowledge is harder to come by, this conference is a MUST." Quote by Co-Chairs, Winthrop Professor Daniel Green and Professor Jeff Coombes.

The program incorporates streams on: Sports Science, Exercise Science, Exercise is Medicine, and Nutrition. Other activities, including special interest groups, award presentations, exercise sessions, and social events, will contribute to an exceptional opportunity for both professional development and networking.

This conference is the full package. Registration now open at www.essa.org.au/2014conference