ACRA NEWSLETTER

MARCH 2017

Australian Cardiovascular Health and Rehabilitation Association

AUSTRALIAN CARDIOVASCULAR HEALTH AND REHABILITATION ASSOCIATION

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CHALLENGE...CHANGE...ACHIEVE

EDITOR'S NOTE

Happy new year to you all. Welcome to 2017 and all that it may have in store for you individually, your family and friends, for your program and for your Association. I would like someone to tell me where January went to as I can't believe we are already in March and will be almost a quarter of the way through this year by the time you read this newsletter!

This is a much shorter edition of the newsletter this time round focussing on reports from each state – an opportunity to catch up on what is happening around the country. There is another great compilation of the latest research from Robert Zecchin – thanks Robert.

The clock is winding down, and the excitement mounting, to this year's annual ACRA scientific meeting in Perth, WA. Have you done your early bird registration? Submitted an abstract? Confirmed time away from work with your manager? Check flight times and prices? Helen McLean has provided us with a very detailed overview of what to expect at the conference – I can't wait! Looks like she has a great supporting team who are working hard to bring us another great conference.

It's time to get your thinking caps on – the election of the next president-elect will be held at this year's AGM in August. As per the recent constitutional changes, this is now a 2-year position serving as vice-president for that time mentored by the current president before stepping into the president's role.

The Alan Goble Distinguished Service Award – is there a person in your state who has given exemplary service to cardiac rehabilitation and the Association over the years, who is a strong advocate for the service and is a supporter of, and example to colleagues? Nominate them for this annual award. Only one person per year can receive the award. Merit awards are also available for members. Nomination forms for both awards are available in the Members Lounge on the website.

Came across this in a "Happy Friday" moment from a colleague. Would you like to rehabilitate a cat with hypertension? This fellow looks very calm and relaxed having his BP checked at the vet. Hope they didn't sedate him for the picture. Are your patients this relaxed in similar circumstances? He doesn't seem to be at all fazed by white coats, cameras, lights, etc.

He looks a younger, slightly slimmer version of my late faithful old moggy!

Happy re-habbing
Sue Sanderson

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

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PRESIDENT'S REPORT

As you head into the cooler months, spring is in the air in Scotland. Our first winter as a family in Edinburgh has been very mild, but I am enjoying the longer days as we get into spring, and definitely not missing the Australian summer heat! I'm looking forward to seeing friends and colleagues when I come back for the ACRA executive meeting in May, and to seeing many more of you in Perth in August.

We are now approaching our first year of annualised membership, and we hope that the systems that have been put in place will make renewing your membership much easier. If you have difficulty logging on to the ACRA website, please do let us know. Sometimes hospital firewalls cause some difficulties, and we will try to find a solution for this.

Work has been underway to review our use of our secretariat services, and we have negotiated a fixed amount contract to prevent us exceeding our budget for this. Our focus on growing our membership continues, and here is a reminder that to the individual member who recruits the greatest number of new members over the next six months, we will pay for his/her registration to the annual conference this year! This friendly competition can become a state based challenge and we will give an award to the state who recruits the greatest percentage of new members relative to size. Make sure you send an email to our secretariat admin@acra.net.au when you recruit someone. Cindy is keeping track and we will announce the winner in June. Have fun recruiting!

Best wishes,
Lis Neubeck
L.Neubeck@napier.ac.uk
ACRA President 2015-2017

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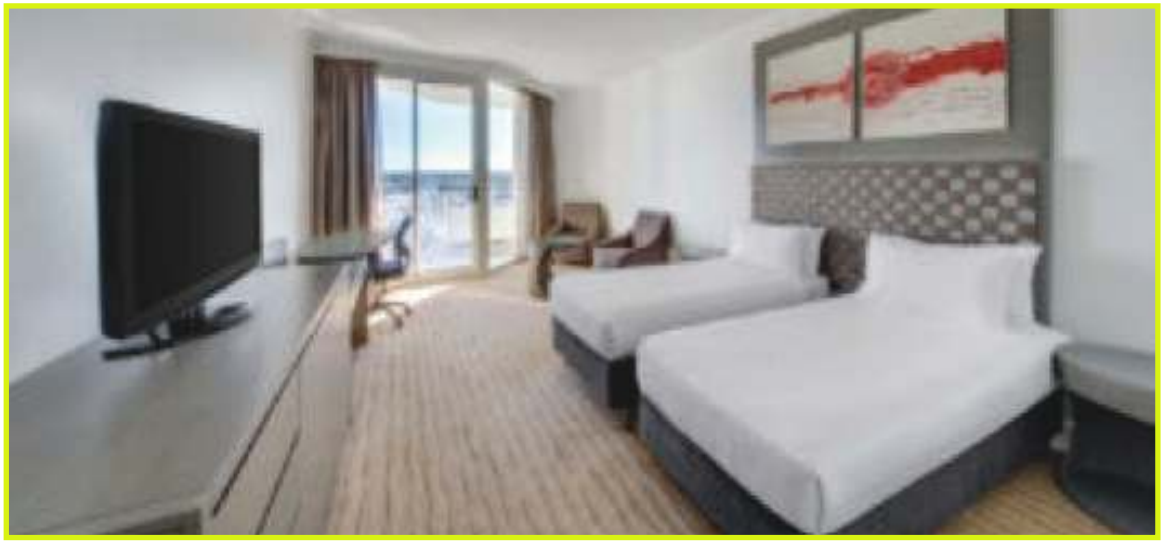
ACRA CONFERENCE

By the time you receive your newsletter it will be less than 150 days till the ACRA Annual Scientific meeting in Perth……. might be less depending how long it takes you to read the ACRA news!!! Call for abstracts has seen lots coming in and the closing date for abstract submissions is Wednesday 29 March 2017 – so please get yours in – we will be ensuring whether oral presentation or poster your work will truly be given pride of place!

The weblink is **http://www.acra.net.au/acra-2017-asm/** - each presenter's profile is being uploaded as received and we hope you will check this link regularly to "get-to-know" all invited speakers, international, national and local and learn about their ideas around Cardiac rehabilitation pertaining to their presentation.

Shelley McRae, our scientific lead, and her team have been working tirelessly and I believe have thought of something for everyone, clinicians, researchers, and policy makers! There are booked presentations for emergency care, risk factor management, exercise experts, cardiac psychology, technology, atrial fibrillation, compassion, cardiac mental health, nutrition, rural and remote issues, Aboriginal cardiac health, new interventions, Heart Failure, undertaking clinical trials, Familial Hypercholesterolaemia, social determinants of cardiac health and more to be confirmed! There will be different modes of delivery with Q&A style, workshops and fun audience participation!

Registration for the ACRA 2017 ASM opened on **Tuesday, 28 February 2017** and I'm very excited to let you know the numbers have been steadily coming in!



Organising a conference is a team effort and I feel very privileged to have a great team on board and I'd like to take this opportunity to introduce them:

Peta from TAS has a wealth of knowledge and also a highly organised common sense approach which is invaluable!

2017 Co-convenor – Paul Camp (Paul's gentle supportive leadership style is making my job much easier).

2017 Scientific lead – Shelley McRae (will a little help from her friends! Dr Andrew Maiorana, Hazel Mountford, Jo Crittenden, Sandy Hamilton, Craig Cheetham, Paul Crabtree)

This HUGE job can never be underestimated…and Shelley held this position for our last Perth Conference…amazing work Shell!

2017 Sponsorship lead – Lily Titmus (will a little help from her friends! Julie Prout, Julie Smith)

Lily has shared her experience so far: *"I am currently involved in being the lead for obtaining sponsorship for the ACRA conference. With Peta and the rest of the committee's support we have managed to register interest for 70% of our target range and are awaiting response from some companies to commit to the 20% of the remaining sponsorship. My job has been made much easier with the wonderful team members that have assisted and passed on the leads that they have identified. Hoping to meet you all when you attend this conference at our very picturesque venue and discovering our beautiful state."*

2017 Social lead – Tracy Swanson (will a little help from her friends! Joanna Clark, Julie Smith)

As the lead of the ACRA conference social committee I am excited to inform you all that the plans are well and truly under way. The gala event will be held Tuesday 8th August the theme chosen is totally tropical. It promises to be a colourful and fun night. We have started the research to find just the right band as we certainly want to dance the night away. We have already secured the photo booth as we know how much you all enjoyed that last year.

I have secured 3 exciting opportunities for delegates so why not think about coming the weekend prior to the event or even stay a day longer. These include discount 20% discount on Captain Cook Swan River cruises. They have a great range of tours which cover Perth, Fremantle and the Swan Valley, for lunch, dinner, craft beer and wine. 20% discount with Out and About Tours for the ultimate winery experience tour. Rottnest express has offered delegates a 30% discount off our ferry and tour bookings and tickets valid from 1st to 15th August 2017 - a great opportunity to meet Quentin the quokka in person. All additional information can be found on the conference website.

Look forward to seeing you all in August. Cheers Tracy Swanson

A CORNER OF RESEARCH FOR AUSTRALIA

NB: The title reflects ACRA's continuing efforts to provide its members with up to date research, both locally and internationally, to highlight potential best practice and evidence in cardiac rehabilitation.

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. Medicare Program; Advancing Care Coordination Through Episode Payment Models (EPMs); Cardiac Rehabilitation Incentive Payment Model; and Changes to the Comprehensive Care for Joint Replacement Model (CJR). Final rule.

Centres for Medicare & Medicaid Services (CMS), HHS. Federal Register. 82(1):180-651, 2017 01 03. .

This final rule implements three new Medicare Parts A and B episode payment models, a Cardiac Rehabilitation (CR) Incentive Payment model and modifications to the existing Comprehensive Care for Joint Replacement model under section 1115A of the Social Security Act. Acute care hospitals in certain selected geographic areas will participate in retrospective episode payment models targeting care for Medicare fee-for service beneficiaries receiving services during acute myocardial infarction, coronary artery bypass graft, and surgical hip/femur fracture treatment episodes. All related care within 90 days of hospital discharge will be included in the episode of care. We believe these models will further our goals of improving the efficiency and quality of care for Medicare beneficiaries receiving care for these common clinical conditions and procedures.

The Good News: Is an incentive payment model for cardiac rehabilitation needed in Australia?

2. Efficacy of an early home-based cardiac rehabilitation program for patients after acute myocardial infarction: A three-dimensional speckle tracking echocardiography randomized trial.

Xu L; Cai Z; Xiong M; Li Y; Li G; Deng Y; Hau WK; Li S; Huang W; Qiu. J.Medicine. 95(52):e5638, 2016 Dec.

BACKGROUND: The effect of an early short-term home-based cardiac rehabilitation (CR) program on ventricular function in acute myocardial infarction (AMI) patients is not yet clear. The purpose of this study was to evaluate the efficacy of our CR program on the improvement of myocardial function using three-dimensional speckle tracking echocardiography (3D-STE) in AMI patients.

METHODS: Fifty-two AMI patients were randomly assigned to 2 groups after discharge: the rehabilitation group, which participated in an early, home-based CR program, and the control group, which received only usual care. All subjects in both groups underwent 3D-STE examinations of the left ventricle within 48 hours of percutaneous coronary intervention and again 4 weeks after discharge. Global longitudinal strain (GLS), global radial strain (GRS), global area strain (GAS), global circumferential strain (GCS), left ventricular ejection fraction (LVEF), and segmental strains were computed. The CR program was initially conducted with supervised inpatient training, followed by an unsupervised home-based training program during a 4-week follow-up.

RESULTS: We obtained segmental strains from 832 segments, of which 319 were defined as interventional segments, 179 as ischemic segments, and the remaining segments as normal segments. At the 4-week follow-up, when controlling for baseline values, the rehabilitation group showed significant improvements in GLS, GRS, GCS, GAS, LVEF, and in all of the segmental strains of the 3 subgroups compared with the control group ($P < 0.05$).

CONCLUSION: Our study suggests that an early, home-based CR program can greatly improve the ventricular function of AMI patients in a short period of time.

The Good News: Another way of looking at the benefits of cardiac rehabilitation.

A CORNER OF RESEARCH FOR AUSTRALIA CONT.

3. Effects of outpatient followed by home-based tele-monitored cardiac rehabilitation in patients with coronary artery disease.

Szalewska D; Zielinski P; Tomaszewski J; Kusiak-Kaczmarek M; Lepska L; Gierat-Haponiuk K; Niedoszytko P.
Kardiologia Polska. 73(11):1101-7, 2015.

BACKGROUND: Cardiac rehabilitation (CR) has been shown to reduce the cardiovascular mortality of patients with coronary artery disease (CAD) and help people to return to professional work. Unfortunately, limited accessibility and low participation levels present persistent challenges in almost all countries where CR is available. Applying tele-rehabilitation provides an opportunity to improve the implementation of and adherence to CR, and it seems that the hybrid form of training may be the optimal approach due to its cost-effectiveness and feasibility for patients referred by a social insurance in stitution.

AIM: To present the clinical characteristics and evaluate the effects of hybrid: outpatient followed by home-based cardiac tele-rehabilitation in patients with CAD in terms of exercise tolerance, safety, and adherence to the programme.

METHODS: A total of 125 patients (112 men, 13 women) with CAD, aged 58.3 +/- 4.5 years, underwent a five-week training programme (TP) consisting of 19-22 exercise training sessions. The first stage of TP was performed in the ambulatory form of CR in hospital; then, patients continued to be tele-monitored TP at home (hybrid model of cardiac rehabilitation - HCR). Before and after completing CR, all patients underwent a symptom-limited treadmill exercise stress test. Adherence was reported by the number of dropouts from the TP.

RESULTS: The number of days of absence in the HCR programme was 1.50 +/- 4.07 days. There were significant improvements ($p < 0.05$) in some measured variables after HCR in the exercise test: max. Workload: 7.86 +/- 2.59 METs vs. 8.88 +/- 2.67 METs; heart rate (HR) at rest: 77.59 +/- 12.53 bpm vs. 73.01 +/- 11.57 bpm; systolic blood pressure at rest: 136.69 +/- 17.19 mm Hg vs. 130.92 +/- 18.95 mm Hg; double product at rest: 10623.33 +/- 2262.97 vs. 9567.50 +/- 2116.81; HRR1: 97.46 +/- 18.27 bpm vs. 91.07 +/- 19.19 bpm; and, NYHA class: 1.18 +/- 0.48 vs. 1.12 +/- 0.35.

CONCLUSIONS: In patients with documented CAD, HCR is feasible and safe, and adherence is good. Most patients were on social rehabilitation benefit, had a smoking history, and suffered from hypertension, obesity, or were overweight. A hybrid model of CR improved exercise tolerance.

The Good News: Again women are underrepresented in a cardiovascular study. May not be applicable to all patients but not a bad concept.

4. Visit-to-Visit Variability and Reduction in Blood Pressure after a 3-Month Cardiac Rehabilitation Program in Patients with Cardiovascular Disease.

Ishida T; Miura S; Fujimi K; Ueda T; Ueda Y; Matsuda T; Sakamoto M; Arimura T; Shiga Y; Kitajima K; Saku K.
International Heart Journal. 57(5):607-14, 2016 Sep 28.

Visit-to-visit variability (VVV) in blood pressure (BP) has been shown to be a predictor of cardiovascular events. It is unknown whether CR can improve VVV in BP as well as reducing BP. We enrolled 84 patients who had cardiovascular disease (CVD) and participated in a 3-month CR program. We measured systolic and diastolic BP (SBP and DBP), pulse pressure (PP), and heart rate (HR) before exercise training at each visit and determined VVV in BP or HR expressed as the standard deviation of the average BP or HR. Patients who had uncontrolled BP at baseline and who did not change their antihypertensive drugs throughout the study period showed a significant reduction of both SBP and DBP with a decrease in PP after 3 months. Patients who did not change their antihypertensive drugs were divided into larger (L-) and smaller (S-) VVV in the SBP groups and L- and S-VVV in the DBP groups according to the average value of VVV in SBP or DBP. In the L-VVV in the SBP and DBP groups, VVV in SBP and DBP in the 1st month was significantly decreased after the 3rd month in both groups. HR at baseline was significantly decreased after 3 months. In addition, CR induced a significant increase in the level of high-density lipoprotein cholesterol (HDL-C) in blood. In conclusion, CR improved VVV in BP in patients with L-VVV in BP and evoked a significant reduction in HR and an increase in HDL-C. These effects due to the CR program may be cardio-protective.

The Good News: More evidence why CR is important in risk factor modification.

5. Knowledge Level of Coronary Heart Disease and Risk Factors Among Post-Percutaneous Coronary Intervention Patients Adequate?

Nolan MT; McKee G.
Journal of Cardiovascular Nursing. 31(3):E1-9, 2016 May-Jun.

BACKGROUND: Percutaneous coronary intervention (PCI) is now commonly used in the treatment of coronary heart disease. However, shorter hospital stays after intervention may affect patients' knowledge and subsequent required lifestyle changes.

OBJECTIVE: The aim of this study is to investigate participants' risk factor profile, knowledge of coronary heart disease, and the influence of demographic and risk factors on this knowledge.

METHODS: This prospective, cross-sectional 1-site study recruited both elective and emergency PCI patients post-discharge. The questionnaire collected data on demographics, risk factor profile, and coronary heart disease knowledge as measured on the Bergman Heart Disease Knowledge Questionnaire. Bivariate and multivariate analyses were used to analyse the influence of 11 risk and socio-demographic factors on knowledge.

RESULTS: The response rate was 67% (n = 84). The sample was mostly male and aged 65.79 +/- 9.9 years, and 59% had an elective PCI. Risk factor burden was high; 2 or more risk factors were seen in 66% of participants. Mean knowledge score overall was 51%, with the highest score achieved in the risk factor domain (61%). Lowest scores were in the medical and symptoms domains (both 46%). Neither the bivariate nor the multivariate analyses were significant. A large proportion of patients believed that coronary heart disease was no longer a concern for them after PCI.

CONCLUSIONS: As expected, the risk factor profile of post-PCI patients was high. However, their knowledge levels and awareness were unrelated to risk factor profile and poor in comparison with studies in other cardiac patients. This, in addition to the short stay in hospital and the low attendance of this cohort at cardiac rehabilitation, identifies this group of patients as a priority for further targeted education. Innovations are needed to increase knowledge and begin behavioural change pre-discharge after PCI. This should include target and goal setting for lifestyle change to avail of this critical education opportunity.

The Good News: This is in line with notion that if you have a stent put in you are "fixed" and/or "cured"!

6. Cardiac rehabilitation patients' perspectives on the recovery following heart valve surgery: a narrative analysis.

Hansen TB; Zwisler AD; Berg SK; Sibilitz KL; Buus N; Lee A.
Journal of Advanced Nursing. 72(5):1097-108, 2016 May.

AIMS: To explore the structure and content of narratives about the recovery process among patients undergoing heart valve surgery participating in cardiac rehabilitation.

BACKGROUND: Several studies with short-term follow-up have shown that recovering from cardiac surgery can be challenging, but evidence on the long-term recovery process is very limited, especially following heart valve surgery. Furthermore, few studies have explored the recovery process among cardiac rehabilitation participants.

DESIGN: A qualitative study with serial interviews analysed using narrative methods. METHODS: We collected data over 18 months (April 2013-October 2014). We recruited nine patients undergoing heart valve surgery from a randomized trial, CopenHeartVR and conducted 27 individual narrative interviews at 2-3 weeks, 3-4 months and 8-9 months after surgery.

FINDINGS: Following heart valve surgery, the participants expected to return to normality. The analysis identified four courses of recovery, with three non-linear complex pathways deviating from the classic restitution narrative: the frustrated struggle to resume normality, the challenged expectation of normality - being in a limbo and becoming a heart patient. These deviating pathways were characterized by physical, existential and mental challenges even up to 9 months after surgery.

CONCLUSION: The recovery processes of participants' in cardiac rehabilitation were often more complicated than anticipated. Patients undergoing heart valve surgery may benefit from more extensive medical follow-up immediately after discharge, individual psychological assessment and individualized, realistic information about the recovery trajectory.

The Good News: Good insight into cardiothoracic patient's feelings and frustrations.

7. Long-term Exercise Adherence After High-intensity Interval Training in Cardiac Rehabilitation: A Randomized Study.

Aamot IL; Karlsen T; Dalen H; Stoylen A.
Physiotherapy Research International. 21(1):54-64, 2016 Mar.

BACKGROUND AND PURPOSE: Exercise adherence in general is reported to be problematic after cardiac rehabilitation. Additionally, vigorous exercise is associated with impaired exercise adherence. As high-intensity interval training (HIT) is frequently used as a therapy to patients with coronary artery disease in cardiac rehabilitation, the objective was to assess long-term exercise adherence following an HIT cardiac rehabilitation programme.

METHODS: A multicentre randomized study was carried out. Eligible participants were adults who had previously attended a 12-week HIT cardiac rehabilitation programme, as either a home-based or hospital-based HIT (treadmill exercise or group

exercise). The primary outcome was change in peak oxygen uptake; secondary outcomes were self-reported and objectively measured physical activity.

RESULTS: Out of 83 eligible participants, 76 were available for assessment (68 men/8 women, mean age 59 (8) years) at a one-year follow-up. Peak oxygen uptake was significantly elevated above baseline values, (treadmill exercise: 35.8 (6.4) vs. 37.4 (7.4) ml kg(-1) min(-1) , group exercise: 32.7 (6.5) vs. 34.1 (5.8) ml kg(-1) min(-1) and home-based exercise: 34.5 (4.9) vs. 36.7 (5.8) ml kg(-1) min(-1) at baseline and follow-up, respectively), with no significant differences between groups. The majority of the participants (>90%) met the recommended daily level of 30minutes of moderate physical activity. The home-based group showed a strong trend towards increased physical activity compared with the hospital-based groups.

CONCLUSIONS: The results from this study have shown that both home-based and hospital-based HIT in cardiac rehabilitation induce promising long-term exercise adherence, with maintenance of peak oxygen uptake significantly above baseline values at a one-year follow-up. The implication for physiotherapy practice is that HIT in cardiac rehabilitation induces satisfactory long-term exercise adherence.

The Good News: What intensity are exercising your patients at?

8. Predictors of exercise capacity following exercise-based rehabilitation in patients with coronary heart disease and heart failure: A meta-regression analysis.

Uddin J; Zwisler AD; Lewinter C; Moniruzzaman M; Lund K; Tang LH; Taylor RS. European Journal of Preventive Cardiology. 23(7):683-93, 2016 May.

BACKGROUND: The aim of this study was to undertake a comprehensive assessment of the patient, intervention and trial-level factors that may predict exercise capacity following exercise-based rehabilitation in patients with coronary heart disease and heart failure.

DESIGN: Meta-analysis and meta-regression analysis.

METHODS: Randomized controlled trials of exercise-based rehabilitation were identified from three published systematic reviews. Exercise capacity was pooled across trials using random effects meta-analysis, and meta-regression used to examine the association between exercise capacity and a range of patient (e.g. age), intervention (e.g. exercise frequency) and trial (e.g. risk of bias) factors.

RESULTS: 55 trials (61 exercise-control comparisons, 7553 patients) were included. Following exercise-based rehabilitation compared to control, overall exercise capacity was on average 0.95 (95% CI: 0.76-1.41) standard deviation units higher, and in trials reporting maximum oxygen uptake (VO2max) was 3.3ml/kg min (-1) (95% CI: 2.6-4.0) higher. There was evidence of a high level of statistical heterogeneity across trials (I (2) statistic>50%). In multivariable meta-regression analysis, only exercise intervention intensity was found to be significantly associated with VO2max (P=0.04); those trials with the highest average exercise intensity had the largest mean post-rehabilitation VO2max compared to control.

CONCLUSIONS: We found considerable heterogeneity across randomized controlled trials in the magnitude of improvement in exercise capacity following exercise-based rehabilitation compared to control among patients with coronary heart disease or heart failure. Whilst higher exercise intensities were associated with a greater level of post-rehabilitation exercise capacity, there was no strong evidence to support other intervention, patient or trial factors to be predictive.

The Good News: Yes, Cardiac Rehabilitation increases your functional capacity but it does more that!

9. Effect of High-Intensity Interval versus Continuous Exercise Training on Functional Capacity and Quality of Life in Patients with Coronary Artery Disease.

Jaureguizar KV; Vicente-Campos D; Bautista LR; de la Pena CH; Gomez MJ; Rueda MJ; Fernandez Mahillo I. Journal of Cardiopulmonary Rehabilitation & Prevention. 36(2):96-105, 2016 Mar-Apr.

PURPOSE: There is strong evidence that exercise training has beneficial health effects in patients with cardiovascular disease. Most studies have focused on moderate continuous training (MCT); however, a body of evidence has begun to emerge demonstrating that high-intensity interval training (HIIT) has significantly better results in terms of morbidity and mortality. The aim of this study was to compare the effects of MCT versus HIIT on functional capacity and quality of life and to assess safety. METHODS: Seventy-two patients with ischemic heart disease were assigned to either HIIT or MCT for 8 weeks. We analyzed cardiopulmonary exercise test data, quality of life, and adverse events.

A CORNER OF RESEARCH FOR AUSTRALIA CONT.

RESULTS: High-intensity interval training resulted in a significantly greater increase in (Equation is included in full-text article.)O2peak (4.5 +/- 4.7 mL.kg.min) compared with MCT (2.5 +/- 3.6 mL.kg.min) (P < .05). The aerobic threshold (VT1) increased by 21% in HIIT and 14% in MCT. Furthermore, there was a significant (P < .05) increase in the distance covered in the 6-minute walk distance test in the HIIT group (49.6 +/- 6.3 m) when compared with the MCT group (29.6 +/- 12.0 m). Both training protocols improved quality of life. No adverse events were reported in either of the groups.

CONCLUSIONS: On the basis of the results of this study, HIIT should be considered for use in cardiac rehabilitation as it resulted in a greater increase in functional capacity compared with MCT. We also observed greater improvement in quality of life without any increase in cardiovascular risk.

The Good News: More evidence for HIIT!

More next time!

Treasury Interim Report:

This ACRA interim treasury report is to provide a timely update of the changes of services that are paid for and supplied by our management team 'The Association Specialists' (TAS). Pursuant to ACRA's requirements to reduce expenditure, TAS has reduced the annual cap to $25,000 as previously discussed. However, in order to make this saving, TAS has removed the following from the included services, which is reflected in the contract.

Event Management:

TAS will provide limited State Associations event management. Those services will include the set-up of the event on Currinda only as well as promotion of all State Association events as these are of benefit to all ACRA members including:

- Proof read event communication prepared by the State Associations (with all event communications to be prepared by State Associations)
- Distribute State Associations event communications with clear instructions on when communication should be sent by the ACRA Secretariat
- Website Event Updates provided by State Associations by using the Event Calendar plugin
- Set-up of event on Currinda only. State Association Committee members will be given access to the backend of the system allowing them to monitor registrations for their event as well as giving them the opportunity to chase any outstanding payments (not part of TAS duties).

Meeting Administration:

TAS will no longer provide organisation of ACRA's two F2F meetings, including liaison with hotel (e.g. dietary requirements, hotel accommodation requirements, etc.) However, TAS will still process refunds of Board Member expenses as part of the financial management services.

TAS Contract:

TAS' yearly management contract is currently before the ACRA treasury committee for review.

Requests outside TAS' management contract will be deferred back to the state associations.

Payment of Membership Renewals:

Please consider payment of your annual membership renewal via direct transfer *if possible* to reduce the transaction fees.

Natalie Simpson
ACRA Treasury, on behalf of the treasury team.

ACRA Newsletter

Heart Foundation Report February 2017

Submitted by: Cate Ferry – Heart Foundation representative

Heart Foundation's Heart Attack Survivor Support (HASS) Project

The Heart Foundation's mission is to reduce premature death and suffering from heart, stroke and blood vessel disease. As such, a critical role of the Heart Foundation is to provide support and resources for heart attack survivors and their carers. We do this through a range of channels including stakeholder engagement (e.g. hospitals, GPs), publications, our website and Health Information Service (HIS) phone service, as well as research and guidelines for health practitioners.

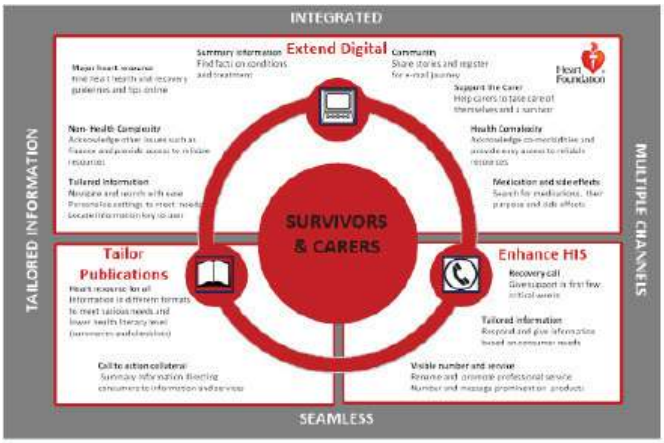
Extensive recent research with patients and carers has highlighted that the Heart Foundation already produces much of the information required by survivors and their carers - we just need to adjust how it is presented and disseminated across our channels and ensure it appeals to consumers at different stages of their recovery journey.

With this need in mind, the Heart Foundation is working on a Heart Attack Survivor Support (HASS) project. The HASS project will develop an integrated suite of products for heart attack survivors and their carers in the first year following their heart attack to help them feel empowered, supported, connected and understood. We shall do this through online resources, use of our highly skilled HIS team and printed material at key touch points through hospitals and general practitioners.

The objective of HASS project is for the Heart Foundation to develop an integrated suite of products for heart attack survivors which will enhance the current heart attack survivor experience.

A lot of market research and validation workshops have occurred with consumers (patients and carers) to confirm the core products that would meet their needs. The core product suite is as per the diagram below.

The HASS website will be available June 2017. A marketing campaign will also better promote what we have to offer to this target audience.



Heart Foundation Report Feb 2017 cont.

Funding confirmed for The Lighthouse Project Phase 3 (2017 – June 2019)

The Department of Health has confirmed their commitment of $7.98million for Heart Foundation and Australian Healthcare and Hospitals Association (AHHA) to implement Phase 3 of The Lighthouse Project (1 January 2017- 30 June 2019).

The Lighthouse Hospital project is aimed at driving change within the acute care setting to improve the health outcomes for Aboriginal and Torres Strait Islander peoples experiencing Acute Coronary Syndrome.

Heart disease remains Australia's biggest single killer and sadly, even more so among our Indigenous population. There remain significant gaps in the quality of treatment accessed by Aboriginal and Torres Strait Islander Australians and we at the Heart Foundation have a key aim in this regard and to close the life expectancy gap.

The initial work of the project in 2012 focused on the key elements of culturally safe, positive consumer experiences as reviewed by 10 organisations recognised by their peers as providing exemplary care in the treatment of Aboriginal and Torres Strait Islander patients with ACS.

In Phase 2, a quality improvement toolkit, 'Improving health outcomes for Aboriginal and Torres Strait Islander peoples with acute coronary syndrome', was developed to provide a framework to address the disparities between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians with ACS.

The toolkit outlines four domains that are critical in the provision of holistic care for Aboriginal and Torres Strait Islander peoples and their families as they journey through the hospital system and return to their communities.

The four domains are:

- governance
- cultural competence
- workforce
- care pathways.

The advances made across all eight pilot sites included:

- Improved relationships with Aboriginal and Torres Strait Islander patients;
- Development and strengthening of relationships with the Aboriginal and Torres Strait Islander community and medical services;
- Creation of a culturally safe environment for Aboriginal and Torres Strait Islander patients;
- Increase in the self-identification of Aboriginal and Torres Strait Islander patients;
- Streamlining of processes related to the culturally appropriate and clinical care of Aboriginal and Torres Strait Islander patients; and
- Enhanced staff capacity to respond to the needs of Aboriginal and Torres Strait Islander patients.

Phase 3 aims to reach almost half of all cardiac condition separations for Indigenous Australians. Eighteen hospitals across Australia will be supported to implement the quality improvement toolkit and strengthen relationships and coordination of care with local Aboriginal Community Controlled Health Organisations and Primary Health Networks.

Heart Foundation Report Feb 2017 cont.

Heart Week 2017

The theme for Heart Week 2017 (Sunday 30 April - Saturday 6 May) is hypertension. Hypertension, as a condition, is very broad, and to ensure effective targeting and messaging we are narrowing the theme to a clear direction, which will be reflected through all our activities and supported by secondary messaging to support our recently updated Heart Foundation hypertension guidelines.

Heart Week 2017 will have targeted messages for both the general public and health professionals to ensure they get the cut through:

General population: focus on undiagnosed hypertension (referred to as high blood pressure for plain English) and the risk this holds (i.e. its symptoms are silent; you may be heading for a heart attack and not know it).

Health professionals: focus on their awareness that the hypertension guidelines have been updated. That undiagnosed hypertension is a problem. That best practice is to assess (45+/35+, as per our new 2016 hypertension guidelines, or younger where a clinician judges to be relevant, e.g. smoker, family history, etc.). That it is important to treat to target (i.e. with appropriate medication and regular review).

Secondary messaging for the campaign will include: that hypertension is only one heart disease risk factor and a full heart health check (AR) should be undertaken to determine true heart attack risk; that appropriate hypertension treatment includes medication and lifestyle changes (diet and exercise).

As in 2016, this campaign will be primarily digitally delivered.

Heart Week shines a spotlight on Australia's heart health. We've talked about heart attack warning signs, physical activity, and cardiovascular rehabilitation, and in 2017 we'll be talking about the importance of diagnosing and treating high blood pressure. We'll share some great resources with you to get the discussions going and organise your own Heart Week event.

STATE PRESIDENTS' REPORTING

SA/NT REPORT

State representative: **Natalie Simpson**

President: **Dianna Lynch**

Welcome members to 2017. I cannot believe we were just finishing Christmas and now we are heading into mad March!!!!

I do hope you all had some time to recharge your batteries and be refreshed to get stuck into another busy year. This year will seem a bit quieter for some of our committee members as we will have finished our conference commitments.

This year our focus will be getting back to our core business with more education sessions scheduled for the year with plans already being implemented, with some of our guest speakers already locked in.

This will be my last newsletter as president after almost 5 years, and in the next newsletter I will look back over and summarise my presidency.

Executive News:

We will be having our **AGM on 1st April 2017** after our education session. Venue TBA.

We will be looking for members to nominate and step into the role of state Secretary which will be a one year commitment (2017-18). However this is normally a two year commitment but due to no one taking up this role last year, Sindy Millington stayed on and will be happy to assist with mentoring for 6 months, however due to her heavy commitments with Adelaide University and progressing her PhD, she would like to step down.

As Jenny Finan will be stepping into the President's role, we will also require a Vice President (President-elect); this is a two year position.

The position of rural and country representative will also be vacated as Jacinta Macarthy is now on maternity leave; with Teena Wilson currently backfilling her Rural Rep role temporarily.

We also require nominations for ordinary members; please forward to Dianna.lynch@acha.org.au or Sindy.millington@adelaide.edu.au

Treasury Report:

Treasury report is available from Renee Henthorn on request Renee.henthorn@health.gov.au

Rural Report:

No rural report available at time of this newsletter, as Jacinta Macarthy from CATCH has now gone on maternity leave and has also moved with her husband to Queensland and we would like to wish her all the very best in her new ventures and as a mum.

Congratulations to Claudine Clark who has recently accepted a position in CATCH to move into Jacinta's role for a 12 month secondment.

Heart Foundation Report:

Heart Foundation Nurse Ambassador Program: Heart Foundation Nurse Ambassador Program Workshop 1 Friday 24 February. There were 23 participants, including Nurses from Lyell McEwin, FMC, FPH, RAH, Calvary Rehab, and primary care. Funding from the SA Country PHN has allowed us to offer scholarships for country practice nurses to attend. Nurses will be required to undertake a workplace activity to support Phase 1 cardiac rehabilitation/patient education for ACS and/or heart failure patients, or if working in primary care Absolute Risk screening.

Heart Foundation Heart Week 2017: The Health Professional Seminar will be held on **Friday 5th May** at the Education Development Centre at Hindmarsh. The theme for Heart Week is hypertension - more information to come on resources available to promote this event.

Heart Foundation Heart Attack Survivor Support: New resources (hard copy and website) are being developed including a low literacy version of My heart, my life. We may need to review the 6 step resources to align with the content of the new My heart, my life. We will be consulting with ACRA – SA/NT members and other key stakeholders on the new version to see if we are happy to transition to it. No launch date yet for the survivor support program – anticipated early-mid 2017.

Heart Foundation My heart my life e-learning training: We would like to establish an E-learning Review Group. This would entail reviewing the modules every 3/12 (links, content, suggest new content etc.). Please let Sabine Drilling know if you are interested in joining the group. A new Heart Failure Module will be released in Heart Week at the Health Professional Seminar. We will be doing pilot testing in April, prior to the launch. We anticipate this new module to assist with education of heart failure patients especially in medical units.

RHD Education Workshop: In conjunction with the SA RHD Control Program, RHDAustralia will host a two-day RHD Education Workshop focusing on the prevention, control and management of acute rheumatic fever (ARF) and rheumatic heart disease (RHD) in Australian Aboriginal and Torres Strait Islander people.

STATE PRESIDENTS' REPORTING CONT.

The event times are as follows: Wednesday 29th March & Thursday 30th March at SAHMRI North Terrace Adelaide.

For further information go to:

https://www.eventbrite.com.au/e/sa-rhd-education-workshop-tickets-30572942494

If you would like further information about anything in this report please contact:

Sabine Drilling- sabine.drilling@heartfoundation.org.au

Vanessa Poulsen -vanessa.poulsen@heartfoundation.org.au or phone 82242888

Membership Recruitment:

Don't forget the war we have with the other states..... The gauntlet has been laid down and the state or person with the most new members will win a complimentary conference attendance ticket, and our state or territory (SA/ NT) winner will receive a mystery gift.

Membership Profiles:

Daphne Perry

Daphne Perry, Clinical Nurse, Project Manager: Cardiac Surgery Research – Lighthouse and Heart Foundation Project

Flinders Medical Centre (FMC), Bedford Park, South Australia

The Lighthouse project, which has been undertaken by the National Heart Foundation in partnership with the Australian Healthcare and Hospital Association with funds from the Department of Health, aims to develop a model that drives efficiency and change within the health system to improve care and outcomes for Aboriginal and Torres Strait Islander Peoples experiencing an acute coronary syndrome (ACS).

Flinders Medical Centre provides 30% of the Cardiac Surgery performed for the Aboriginal and Torres Strait Islander population in Australia. Working alongside Assoc. Professor Jayme Bennetts, Professor Robert Baker, Bronwyn Pesudovs, Theresa Francis from Flinders Medical Centre, with Sabine Drilling from the Heart Foundation (SA Division), Daphne has worked to improve outcomes and patient care provided to Aboriginal and Torres Strait Islander patients who undergo Cardiac Surgery at Flinders Medical Centre in Adelaide.

Phase One of the Lighthouse Project:
During the first phase of the Lighthouse project Daphne reviewed models of care, considered the barriers and opportunities to improving the patients' experience and outcomes, and attended workshops which allowed the transfer of existing models of care from other participating hospitals around Australia into local practice. Some of the Lighthouse projects included changing the way in which discharge medications were distributed to remote area patients. For example, GTN was changed from a tablet format to a spray for patients who lived in areas of high humidity, and dosette boxes were introduced to assist those patients with limited English.

Phase two of the Lighthouse Project:
Eight hospitals were recruited to pilot the Lighthouse Tool Kit – 5 metro and 3 regional hospitals in South Australia, Victoria, New South Wales, Western Australia and Queensland.

During Phase two of the Lighthouse project Daphne worked with the Lighthouse team at FMC to introduce cultural awareness for Nursing and Medical staff with in-service lectures, and the introduction Aboriginal and Torres Strait Islander Patient Care and Sad News and Sorry Business guideline booklets. A poster which highlighted "Ten Top Tips" was also introduced. Changes to the Cardiothoracic Surgical Unit (CTSU) waiting list are also ensuring faster access to care and consistency for patients.

To improve discharge follow up, procedures were put in place to ensure that remote area health clinics received copies of discharge summaries in a timely manner to assist and support transient and permanent remote community health centre staff in the preparation and care of Aboriginal and Torres Strait Islander patients' pre and post cardiac surgery.

The FMC Lighthouse team received two awards for their work from SA Health/ Southern Adelaide Local Health Network (SALHN): Excellence in Teamwork; and runner up, Excellence in partnering with community and consumers.

New Member Profile:

Julia Spiti

Ms Julia Spiti, Coordinator of the Graduate Diploma in Health Science – Cardiac Nursing

University of Adelaide, North Terrace, Adelaide, South Australia

I am taking over from Adrian de Luca, and I

STATE PRESIDENTS' REPORTING CONT.

do realise I have big shoes to fill. Adrian has done an amazing job over the last 5 years.

Despite having a Greek surname, I am Brazilian, with not a drop of Greek blood, which is a pity. If only a Greek surname helped with the cooking… But anyway, most of my training as a Nurse was conducted in Brazil, where I worked in ED and Trauma Intensive Care. In Brazil I also completed a Graduate Diploma in Cardiac Nursing.

In 2011 my husband and I moved to Adelaide and I started working as an RN in a Cardiac Intensive Care, with mostly surgical patients. Not long after moving I completed a Graduate Certificate in Intensive Care, and I am now taking an Honours Degree. Apparently I keep forgetting how hard it is to study and before I know it I have enrolled myself in something else.

Over the last 3 years I have been expanding my experience in teaching. I have taught mostly undergraduates from Flinders and UniSA. Teaching is my passion. What drives me is the "light bulb" moments that students get, and the knowledge that by teaching and supporting them I can indirectly contribute to patient's outcomes.

If I had more time, and a lot more money, I would travel to Florence to study Art's History, or maybe the South of France (or Greece!) to learn how to cook properly.

Well, that is me. Thank you for welcoming me into ACRA, and please know that I am eager to learn from all of you and on my part support you to the best of my abilities. Please do not hesitate to contact me on Julia.mullerspiti@adelaide.edu.au should you have any queries about the Graduate Diploma in Cardiac Nursing program.

ACRA SA/NT Education Events:

We have recently our annual members' dinner which was deferred due to our recent successful National ACRA conference here last year. Steve Pados from Astra Zeneca sponsored the event on the 14th February at Ayres House; Dr Phil Tideman presented the National Heart Foundation and CZANZ ACS guidelines.

Figure 1: Dr Phil Tideman (L), Di Lynch (Pres), Mr Steve Pados (Astra Zeneca)

Dr Phil Tideman was a contributor to these guidelines and is a staunch cardiac rehabilitation and country health service equity advocate.

An important emphasis was made on the correct and timely chest pain assessment, which is now integrated in the guidelines and also included the incorporation of the "Flinders model" for ACS management.

Save The Dates:

- **1st April 2017:** Education seminar and AGM to be held following our education session – venue TBA.

Invited speakers:

1. Assoc. Professor, *Matthew Worthley, Interventional Cardiologist* will discuss 'Dissolving scaffolding systems – dissolvable stents'

2. *Shirley Chui* FMC Cardiology Department Pharmacist will provide an update on medications for heart failure plus broader CVD medications.

New members welcome, attendance free of charge for ACRA SA/NT members

- **5th May 2017:** Heart Foundation Heart Week - The Health Professional Seminar will be held at the Education Development Centre at Hindmarsh. The theme for Heart Week is hypertension, more information to come on resources available to promote this event. All welcome.
- **14th June 2017:** Members annual dinner again kindly sponsored by Astra Zeneca with invited speaker Dr Alicia Chan who will speak on Iron Deficiency and clinical implications for patients' cardiac function and dysfunction, diagnosis, assessment, treatment and management, plus new infusion (Ferinject) now available. Venue: planning for Ayres House
- **7-9th August 2017:** ACRA ASM held in Perth, WA this year. Therefore no SA/NT meeting scheduled at this time.
- **21st October 2017:** Education seminar and Ordinary meeting. Potential diabetes, heart disease, renal and heart failure.
- **29th November 2017:** Ordinary meeting and members Christmas Dinner TBC /advised re speaker and venue.

Dianna Lynch
SACRA President

STATE PRESIDENTS' REPORTING CONT.

WESTERN AUSTRALIA

State representative: **Helen McLean**

President: **Craig Cheetham**

In February Lily Titmus and Julie Smith organised our Annual General meeting – this was a cocktail/canapes evening of learning at a river restaurant, many thanks to Lily Titmus for her networking and connecting skills! The presentations were outstanding from both Cardiologists with Prof Markus Schlaich's casual and fun delivery of the new Heart Foundation guidelines for hypertension and Dr Jay Baumwol's flexible approach to her presentation on Chronic Heart failure current best practice was refreshing to see. We gained another 3 new members from this evening – making 9 new members since November.

We do love our Perth and right now we are in the process of beautifying Scarborough beach to make it ready for you all! We are really looking forward to welcoming you all so please come and join us for great learning, networking and relaxation in August.

Helen Mclean
ACRA WA State Representative

Please don't hesitate to contact me for further information regarding what's happening in WA, helen.mclean@health.wa.gov.au

Victorian State Report

State representative: **Emma Boston**

President: **Kim Gray**

The ACRA-Victoria committee didn't rest on their laurels over the Christmas New Year period working hard to prepare for their first education event for 2017. On March 3rd with excitement and a few nerves they launched themselves into cyber world with their first live video conferenced event thanks to Cliftons Melbourne.

Present were 80 delegates in person in addition there up to 15 delegates at any one time logging from all states of Australia via PC, laptop, tablet or smart phone. Special thanks to the Western Australian delegates who had a 6.30am start thanks to daylight saving on the east coast.

The day started with Tess Pryor presenting on the work the Heart Foundation in Victoria has undertaken on under 40s with heart disease and the tools they have developed from this work. The patient story of Peter Gallagher, 'The Heart Guy', reinforced not only the physical healing but the emotional healing required if you are a young person with heart disease but also the challenges of cardiac rehabilitation programs accommodating the needs of people of all ages and physical capabilities.

Dr Minz Cheah a General Physician from Monash health provided us with an overview of atrial fibrillation and its management highlighting again the physical impacts of AF as well emotional. He addressed the idea of the multidisciplinary team and the importance of allied professionals in encouraging medication compliance and self-management. A/Prof Omar Farouque, Director of Cardiology at Austin Health, presented on spontaneous coronary artery dissection. This is a topic that some delegates weren't even aware and many had come across but had little confidence in how to approach. Dr Farouque's covered the diagnosis and medical management for the condition but the importance of attending an outpatient rehabilitation program not only for the physical recovery but for the emotional support.

Andrea Jasper, dietician Epworth Healthcare, decoded nutriceuticals and dietary myths in heart disease. Dr Rosemary Higgins provided an entertaining but informative workshop in motivational interviewing. Last but definitely not least Dr Hendrick Zimmet, Epworth Hospital, exuded his passion in heart failure management. He is a passionate supporter of exercise in heart failure as a key component in management of the disease as well as the importance of the whole multidisciplinary team.

Throughout the course of the day remote delegates could communicate via live chat allowing them to ask their questions to the presenters. Thank you for the positive feedback already provided in the days immediately after the event. The event has been recorded and will be uploaded to the ACRA Vimeo site.

Finally I'd like to welcome the 7 new members that joined ACRA on the day

Samuel Buchanan

Meredith McPherson

Terri Guy

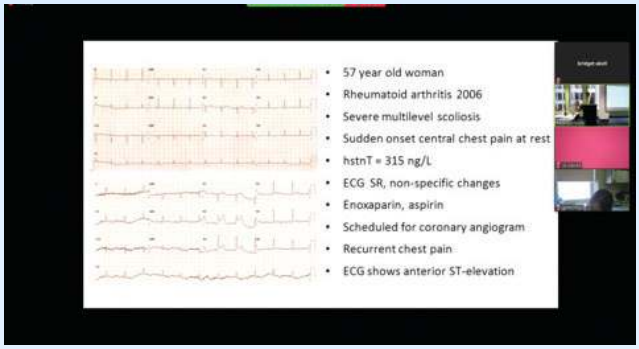
Jenine Adlersten

Anita Stieglbauer

Susan Cameron

Raja Swaminathan

STATE PRESIDENTS' REPORTING CONT.



Report prepared by ACRA Victoria President Kim Gray

TAS REPORT

A quiet few months to start the year but planning is well in hand for our annual education seminar which concludes with the AGM. The seminar is scheduled for **Friday April 7th at the Northern Integrated Care Centre** adjacent to the Launceston General Hospital, a relatively central venue for our delegates. The program includes presentations on TAVI, surgical AVR, exercise and heart failure. Speakers include a local Launceston cardiologist; Mr Ash Hardikar, cardiothoracic surgeon; Caroline Hanley, physiotherapist LGH; and Sue Sanderson, Heart Failure nurse practitioner THS-S. We have secured some financial support from Astra Zeneca and for this we are very appreciative.

We have 2 new members – Kylie Watts and Leeanne Gibbs, both at the Royal Hobart Hospital. We welcome them both. Kylie is an experienced cardiac nurse from Christchurch NZ, and Leeanne has many years' experience in the cardiothoracic and general intensive care unit as well as clinical teaching.

Several of our cardiac rehabilitation nurses met with Mr Hardikar informally earlier in the year. It was an opportunity for Ash to meet the girls from the north and to see how are cardiac rehabilitation programs, while having local differences, essentially manage his patients in the same way. Some logistical issues, for example, timely referral were also discussed.

The cardiac rehabilitation programs in Tasmanian public hospitals are participating in the 2nd NSW Minimum Data Set Collection. We thank the NSW Cardiac Rehabilitation Data Sub Working Group under the auspices of the Heart Foundation (NSW Division), the Agency for Clinical Innovation (ACI) and the Cardiovascular Health and Rehabilitation Association (NSW & ACT) for the opportunity to be a part of this second round. Data collection commenced on March 1st and will continue for 3 months, finishing after a further approximate 3-month period until patient discharge from programs. Each site is collecting the data individually. This will be the first time we have been able to benchmark against each other and other programs elsewhere in Australia.

Heart Foundation report

The Heart Foundation Tasmania, in collaboration with Primary Health Tasmania (PHT), the Australian Healthcare & Hospitals Association (AHHA), Novartis, the Department of Health & Human Services and the Tasmanian Health Service, recently conducted a chronic disease seminar for GP's and primary care health professionals. The diseases specifically addressed were heart failure, COPD, diabetes and kidney failure. Each disease focus had a plenary followed by breakout workshops individually for doctors and other health professionals, principally practice nurses.

The heart failure component of the 1½ day seminar is part of a collaborative project to support the management of patients with heart failure in primary care and reduce hospitalisations/readmissions. The second part of the project involves targeted education and support for general practices and practice nurses to improve the management of patients with heart failure. The goal being collaborative quality improvement and enhanced communication between the acute and primary card health sectors. The Heart Foundation low literacy "Living well with heart failure" will be a vital resource in the project.

STATE PRESIDENTS' REPORTING CONT.

Dr Nathan Dwyer, cardiologist RHH – workshop with GP's.

Representatives of collaborative partners – Geoffrey Chin (Novartis), Susan Powell (PHT), Sue Sanderson (Heart Foundation, THS), Janelle Cragg (PHT), Gillian Mangan (Heart Foundation, Kate Silk (AHHA)

As in other states, the Heart Foundation Tasmania is planning a Clinical Ambassador program specifically targeting primary care nurses. Three workshops are planned with expert speakers providing their time for a broad spectrum of sessions. Workplace projects for those participating will be supported through the program, with a focus on Absolute risk/integrated health checks.

Sue Sanderson State President
John Aitken State representative.

NSW REPORT

State representative:
Jane Kerr

President:
Jo Lennard

Upcoming events

1) CRA NSW ACT state conference will be held on the Friday13th of October 2017 at Kirribilli Club, north Sydney

2) State evening seminar at John Hunter Hospital to be held on the 2nd of May during Heart week.

Topic: Hypertension

Time: TBA

3) National Heart Foundation celebrating Heart Week 30th of April to the 6th of May. The topic for 2017 is Hypertension.

State network reports NSW Cardiac Rehabilitation (CR) State working party in conjunction with their Data Sub Working Group have commenced a second pilot program across NSW, Tasmania, South Australia.

The pilot data collection will commence on 1 March 2017 and conclude on 30 May 2017. From there will await feedback about any improvements required and/or suggestions and correlate this data to the State CR working party.

CRA NSW ACT state report from President Jo Leonard, date: 3/3/17

QLD REPORT

QLD Events for 2017

State representative:
Steve Woodruffe

President:
Bridget Abell

The ACRA-Qld EMC is once again planning on delivering a range of professional development opportunities in 2017.

The first of these will be an **evening workshop and dinner** to coincide with the end of Heart Week, at **5:30pm on Friday the 5th May**. This will have a practical, hands-on approach but will hopefully also be recorded for later viewing. It will also be a great opportunity to socialise with other ACRA-Qld members over dinner and drinks after the workshop. Registration details and program to follow shortly.

We have also confirmed that our popular one-day symposium (with off-site videoconferencing) will this year be held on **Friday the 20th October** at the **Gold Coast University Hospital**, so why not plan a weekend away to coincide with the event!

STATE PRESIDENTS' REPORTING CONT.

Please feel free to get in touch with us at qcra@acra.net.au if you would like further details about either of these events, or to suggest activities or topics you would like included in these and future professional development events.

ACRA Annual Scientific Meeting, Brisbane 2018: We Need Your Help!

Are you good at managing budgets and timelines? Do you like organising social events? Want some experience in promotion and marketing? Do you have a skill for thinking outside of the box? ACRA-Qld is now inviting expressions of interest from any member who is interested in joining the organising committee or scientific committee for the annual ACRA ASM to be held in Brisbane in early August 2018. We are more than happy to welcome members from other states onto our committee.

In particular we have spots on our organising committee for people interested in assisting with sponsorship, marketing, social events, finance and registrations. Previous experience in event planning isn't necessary, just enthusiasm and commitment to the task. If you are interested, or would like further information about what may be involved please get in touch via qcra@acra.net.au

New Queensland CR services

Within the last 6 months we have seen the addition of 2 new cardiac rehabilitation services in Queensland: one at Goondiwindi Hospital and another servicing Gayndah and the surrounding region. For information about these and all other CR services in Queensland please see the latest version of the service directory online at http://www.acra.net.au/cr-services/cr-directory/

Submitted by: Bridget Abell – ACRA Qld President & Steve Woodruffe – ACRA Qld Vice President and State Rep