ACRA Newsletter

Australian Cardiovascular Health and Rehabilitation Association

DECEMBER 2015

In this issue...

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www.acra.net.au

Editor's Note

Another year is almost over – where has the time gone?

We have seen some changes within the Association – a new presidential term commenced in August at the AGM with the dynamic Lis Neubeck taking over the reins from Steve Woodruffe. Lis has outlined her goals while in office – see her report.

Steve is still heavily involved on behalf of ACRA internationally as you will see from his reports. Under his leadership ACRA has assumed a greater role in like-minded associations internationally and raised our profile to the extent where our opinion counts. Great work Steve and many thanks for your ongoing contribution to ACRA.

The dust has settled after our silver celebrations in August and we have included some more photos from that event. Remember if you would like a copy of any photos please let me know. It's time to start saving for the next conference in Adelaide and to consider submitting an abstract.

There has been some bad news regarding the Heart Research Centre but very exciting news about the future – see Prof Alun Jackson's report detailing the plans for the Australian Centre for Heart Health – a new chapter for the Centre and an opportunity to lead the world. We look forward to ACRA's ongoing collaboration with the new organisation.

I must admit I was disappointed with the last newsletter format. We were trying a new program for publishing the newsletter and unfortunately it didn't work. Hopefully the issue will have been resolved for this edition.

Remember to check the ACRA website for upcoming events. States are entering their local events and anyone can attend. Watch out for upcoming webinars too.

I'd just like to take this opportunity to wish you all the joys of the season. If you are having holidays, enjoy, relax and don't over indulge. Drive carefully and return refreshed. If you are working still try to have time to relax and have family time. Remember – everything in moderation.

Best wishes and happy re-habbing
Sue Sanderson

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President's Note

It has been a whirlwind start to my time as ACRA president. There are a number of exciting opportunities for ACRA and we have incredibly passionate and dedicated members who are working hard across Australia to achieve substantial improvements in cardiovascular health care. As I mentioned in my previous report, we had our strategic planning meeting in November. We agreed to continue our drive to improve membership services, professional development, and advocacy. We also added a new focus area of research. Chairs of these working groups will develop a plan for 2016 and we have set measurable targets, including improvements to the online CR directories, agreed national minimum dataset, and publication of resources to support your clinical practice. We welcome any feedback - the good, the bad, and the ugly - so that we can work together to grow and improve ACRA.

During our meeting we considered the role of the Vice President. As per my previous report, our ACRA Vice President is only President Elect for one year. During the other year, the Vice President is selected from the existing Executive Management Committee, and can only be someone who is not an office bearer for their state board (i.e. not President, Vice President, Treasurer or Secretary). This means only a limited number of people can be Vice President in a non-election year. It also means that the President Elect, who can be nominated from outside the Executive Management Committee, may only have attended two Executive meetings prior to becoming our President. For succession planning, and ensuring continuity of goals, we support that the ACRA President Elect should be a two-year term, and therefore we will ask you to vote on this change to our constitution at our next AGM in August 2016.

While I am on the subject of succession planning, we also discussed the term of the other office bearers; the Secretary and the Treasurer. There is currently no fixed length of service for these critically important roles. In theory these people could step down at the same time as the President and Vice President, leaving us with entirely new office bearers. We agreed that these positions will now be two-year terms. Since the ACRA President and Vice President begin their tenure in 'odd' years, the treasurer and secretary will start in 'even' years.

As we move towards 2016, Di Lynch, and her team in Adelaide are working hard to put together our national conference. This is our flagship event, and I am impressed how the bar is raised ever higher by each conference committee. We are also working with CSANZ, the Heart Foundation, and the Secondary Prevention Alliance to deliver another shared event on the day between ACRA and CSANZ meetings. I am also really delighted to let you know that we will be providing an atrial fibrillation pre-conference workshop on the Monday afternoon. Professor Prash Sanders' group in Adelaide is the global leading authority on atrial fibrillation and lifestyle risk factor management, and so it is fitting that we should have this workshop while we are in South Australia.

Atrial fibrillation risk factor management is something I feel very passionate about. This interest is shared by a number of ACRA clinicians and researchers, and therefore we have developed an Atrial Fibrillation special interest group of ACRA. This group will be chaired by Dr Nicole Lowres and Dr Jeroen Hendriks. They will be focussing on education and developing resources for clinicians. As this group evolves, we will update you.

Establishing a special interest group is a different way of approaching all the varied clinical interests within ACRA. Previously, we have co-opted representatives to the ACRA EMC. This approach could mean additional costs to ACRA to cover attendance at the EMC, and representatives may have to attend parts of the EMC meeting that are not necessarily of interest to them. By changing our approach, we can now enable the formation of special interest groups which have a specific purpose. All members of the group must be members of ACRA. In order to be a special interest group, there must be at least one representative of the EMC engaged. Special interest groups will have a specific purpose and agenda, and will have to comply with ACRA policy and procedures.

As always, I welcome any feedback at lis.neubeck@sydney.edu.au about what we need to do to improve ACRA for you, and if there are is anything you think we have got right, so that we can keep on doing it!

Best wishes,

Lis Neubeck
ACRA President 2015-2017

ACRA Immediate Past President Report

By Steve Woodruffe

Although I have stepped out of the big chair, I continue to represent ACRA in several arenas. At our recent face-to-face meeting I volunteered to continue on the committee for the next year in an ex-officio capacity to continue to progress these projects.

ACRA Core Components

Following the publication of the ACRA Core Components earlier this year, the plan was always to develop this statement further into a broader web-based, interactive resource. Unfortunately, due to a number of factors, only a small amount of progress has been made with developing this. I am still motivated to progress this project, as initially planned and have re-affirmed that commitment to the ACRA Executive. The next stage is to re-engage the core writing group and additional ACRA Executive members in the process of expanding and refining the current body of work. More to come on this in the future.

ICCPR Role

The International Council of Cardiovascular Prevention and Rehabilitation (ICCPR) continues to progress viably. The ICCPR is ACRA's direct link to the WHF as a member organisation. Achievements include regular meetings of member organisations via teleconference and at prominent world meetings, the development and maintenance of a website with links to all other member organisations and development of several journal articles. Recently a core, writing group developed a Consensus Statement on Cardiac Rehabilitation in Low and Middle Income Countries. This paper is currently under review and will be published in Nature Reviews: Cardiology, in 2016.

At our most recent Executive meeting of the ICCPR, I was humbled to be nominated to take on the role of Chair for this important group. After considerable thought, I have agreed to fulfil this role, commencing in June 2016.

NHF/CSANZ ACS Guidelines Update

I am currently involved in the development of the 2016 edition of the NHF/CSANZ ACS Guidelines. Most recently, I attended a face-to-face meeting of the executive writing group in Melbourne on 25 November 2015. This meeting followed the initial drafting of evidence based information in four core areas; Chest Pain Management, Non ST-Elevated Acute Coronary Syndromes, ST-Elevated Myocardial Infarction and Secondary Prevention Interventions. Along with senior writer for the Secondary Prevention section, Tom Briffa, we are both pleased to be able to contribute to this important guideline. Following completion of the initial draft (~January 2016), the guideline will go through a rigorous consultation and review process prior to final drafting Mid-Year and planned official release during CSANZ 2016 in August.

AACVPR@30: Optimal Care, Exceptional Quality

By Steve Woodruffe

I was fortunate to attend the 30th Annual Meeting of the American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR), held in Washington DC, during September. The two and a half day conference proved to be a fantastic opportunity to experience how cardiovascular and pulmonary rehabilitation is delivered on the other side of the world.

The conference was held at the Marriot, Wardman Park, approximately 5 kilometres north-east of the famous landmarks of Washington DC. This did allow for some sightseeing, either side of the days of the meeting. The weather was unseasonably hot while I was there, topping ~36 degrees Celsius on a number of days. It did remind me of the hot summer to come when I returned home.

I attended this meeting with two purposes in mind; as a representative of ACRA, to gain information on how things are managed at an organisational level

by our colleagues in America; and also as a cardiac rehabilitation clinician, to see whether there were things I could learn at the clinical level that could be implemented to my own practice.

The program started with the interestingly named keynote address, "Stressed is Desserts Spelled Backwards". While I was expecting a lecture about the link between psychological distress and poor nutrition, what was delivered was something completely different. Dr Brian Seaward presented a very thought-provoking and entertaining view on the importance of total body wellness in the treatment of chronic disease. Dr Seaward highlighted that almost all of our focus, in treating the "patient" is focussed on the physical element of the disease and that we perhaps neglect the elements of the mind, spirit and emotion in our treatments. Dr Seaward proposed the importance of spiritual aids, or as he called them – muscles of the soul: faith, patience, persistence, optimism, love and perhaps most importantly, humour, as crucial in the treatment and management of chronic disease.

My first exposure to clinical education at the meeting was the following session, "Cardiac Rehabilitation of Heart Failure Patients: Current and Future Care of this Population". I was once again surprised by what was delivered, this time for the fact that this was seemingly a new concept to our colleagues in the USA. While exercise therapy to manage heart failure has been routinely provided in Australia for many years, this is an emerging area in the USA. This is primarily due to the funding structure for health service delivery in America, where patients must have health insurance and services may only provide programs if they will receive reimbursement. This proved to be an ongoing theme across the following two days. In summary, I believe our model of care for the management of the patient with heart failure is well ahead.

The conference organisers made good use of lunch periods by offering sponsored sessions, whereby delegates could eat their lunch while attending a further professional development session. The first of these was a nice review of functional capacity testing and exercise training in cardiac rehabilitation. While this session did not add greatly to my knowledge base, it was good to hear that my current practice is up to scratch. Some interesting stats and information presented included: participation in exercise reduces the likelihood of CAD death by 25%; exercise in this population is safe (1 death per 10,000 diagnostic tests, 1 major CVD complication in 60,000 participant hours). The presenter highlighted the measure of MET minutes (number of minutes exercised multiplied by intensity of exercise in METs (metabolic equivalents) as a useful indicator of assessing risk [eg a treadmill at 4 miles per hour for 40 minutes = 160 MET min]. Studies suggest there is a 30% mortality risk reduction at 500 MET min per week (MMPW) and that this increases to 50% with 1,000 MMPW. This highlights the strong dose-response relationship for MMPW, i.e. the more you do, the more benefits you get. The session concluded with a look through the range of functional testing available to us today. Six minute walk test continues to be the most widely used assessment and is most valid for lower functioning CR and PR patients, but that it does have a ceiling effect. The 12 minute walk test, essentially two six minute walks in succession, was recommended as a better indictor for higher functioning patients. In closing, three key elements were advised for individualised exercise prescription; the FITT principle is still key; the patient's goals should be central to this, and persistence should be encouraged.

The first day of the conference concluded with the L. Kent Smith Award of Excellence, presented by Randal Thomas. Dr Thomas took the audience on a trip down memory lane followed by a view toward the future of CR in five years time. His four key points from the past included. 1. CR was born of genius, boldness and work; 2. CR works! 3. CR has remained relevant and important, and 4. We can do better! His three points for us to consider as we look forward: 1. That to remain relevant and important, CR will require more genius, boldness and work; 2. That we need to demonstrate value, and 3. Innovation will improve CR value – central to this is the emergence of innovative models such as telephone based services. This is again where it was highlighted that the Australian model may be a step ahead of the USA. Our use of telephone and mobile phone based applications in the delivery of CR is a concept that is only emerging in the USA.

The second day of the meeting commenced with a keynote address entitled, "Resilient Living" delivered by Dr Amit Sood. This session brought together the importance of resilience in dealing with chronic stress, a situation familiar to many patients with chronic disease. Dr Sood highlighted that resilience is characterised as "flexibility with strong principles" and involves the cognitive, physical, emotional and spiritual realms of health. He challenged delegates to implement two elements of thinking into their routine day: attention and attitude; and that with slight changes in these two aspects our lives would change and the patients lives we treat would change as well.

Attention – we were encouraged to find joyful attention: to think about the five people who make us happiest; to be like a three year old child and give one thing deep attention by finding novelty and freshness; and to meet our families at the end of the day as if we had not seen them for a month and give them our full attention for the first few minutes.

Attitude – we were encouraged to think about seven key principles and to choose a daily theme from: gratitude, compassion, acceptance, meaning, forgiveness, celebration and reflection.

The two other highlights from this day of the conference were to hear about the progress that AACVPR had made in CR Professional Certification and its National Data Registry. The AACVPR offers a course, linked to the national conference, from which clinicians may complete study, be examined and be awarded professional certification in CR. This certification is strongly linked to two of AACVPR's guiding documents - their Core Components and Core Competencies statements. The reason for developing the certification process was to recognise CR professionals who have an exceptional sub set of health care skills, in addition to their core professional responsibilities as nurses or exercise specialists. The idea of certification for CR professionals in Australia has been debated for some time, and I feel we are moving closer to developing something to equate to the AACVPR model.

I found the session on The National Data Registry very interesting because the topic of data is front-of-mind by all working in the health sector currently. The session offered some insight into the AACVPR's challenges and achievements in developing and maintaining a national registry for CR. The development of State-based minimum data sets for CR is ongoing here and at this stage, we may be a way off having a national registry. Based on the information delivered though, we are moving in the right direction.

The conference as a whole provided a wealth of opportunities for further professional development and networking. In this report I have barely scratched the surface of what was provided during the conference. One thing the organisers did very well was to encourage presenters to provide copies of their presentations prior to the meeting so that handouts could be made available to delegates online. These continue to be available via the AACVPR website, via the link below. This webpage provides a comprehensive list of the sessions provided and power-point handouts are available for almost all sessions.

https://www.aacvpr.org/Events-Education/Annual-Meeting/2015-Annual-Meeting-Handouts

I was fortunate to be awarded an International Delegate scholarship, from AACVPR to attend this meeting. Thanks also to the ACRA Executive for approving an International Travel Grant to assist in offsetting the costs of my travel to this meeting. I strongly encourage ACRA members to add the AACVPR meeting to their to-do list.

Steve Woodruffe
Immediate Past President ACRA

HRC Report

Cardiac Blues Awareness Day

During Mental Health Awareness Week, the Centre designated Thursday 8th October as Cardiac Blues Awareness Day. This was held to promote the message that a heart event is an emotional event, not just a physical one. The team at the Heart Research Centre supported more than 50 health care organisations from across Australia to host an event .The Cardiac Blues Awareness Day attracted good media attention, with Dr Barbara Murphy and our Awareness Day Ambassador, Andrew Pike, interviewed on several programs on the ABC in the lead up to, and on the day, including:

- Dr Murphy interviewed by Dr Norman Swan on Radio National Health Report
- Dr Murphy and Andrew Pike interviewed by Rachael Brown on Radio National The World Today
- Dr Murphy and Andrew Pike interviewed by Fiona Wyllie on ABC NSW Statewide Drive
- Dr Murphy interviewed by Tony Easterly and Kumi Taguchi on ABC News 24

Andrew Pike is the Director of Ronin Films and is making a documentary on the cognitive and affective impacts of cardiac surgery, particularly CABGS.

Victorian Psychocardiology Mental Health Professionals Network

The Heart Research Centre continues to provide leadership of the **Victorian Psychocardiology Mental Health Professionals Network (MHPN).** The MHPN is a unique national program which aims to improve patient outcomes by encouraging health professionals from different disciplines who support people with mental health issues to work together better. It does this through its two core programs: MHPN networks and online professional development. MHPN is a not-for-profit organisation funded by the Australian Government Department of Health and Ageing.

The Heart Research Centre formed the Victorian Psycho-Cardiology Mental Health Professionals Network in 2014, and this currently has an active membership base of over 240 health and mental health professionals. Meetings to date have focused on: *Issues in Psycho-cardiology,* with presentations by Professor David Barton, Dr Barbara Murphy, Dr Marlies Alvarenga and Ms Freya Miller; *Managing the Psychosocial Impacts of Heart Disease,* presented by Professor David Thompson and Associate Professor Chantal Ski; the *Pathophysiology of Stress and Heart Disease*, presented by Professor Murray Esler; and *Psychosocial aspects of heart failure* with Professor Karen Page.

We will be working on facilitating, with the MHPN Secretariat, the formation of Psychocardiology MHPNs in other states, with ACRA involvement.

Publications

We have 14 papers published, in press or under review, for the year. A further 7 are in preparation for submission by January 31st.

Ski CF, Jelinek M, Jackson AC, Murphy BM, Thompson DR. Psychosocial interventions for patients with coronary heart disease and depression: A systematic review and meta-analysis. Eur *J Cardiovasc Nurs.* 2015. doi: 10.1177/1474515115613204

Higgins R.O, Rogerson M, Murphy, B.M, Navaratnam H, Butler M.V., Barker L, Turner A, Lefkovits J, Jackson A.C. (2015) Cardiac rehabilitation online pilot: extending reach of cardiac rehabilitation. *J Cardiovasc Nurs.*doi: 10.1097/JCN.0000000000000297

Le Grande M, Murphy B, Rogerson M, Elliott, P, Worcester, M. (2015) Determinants of physical activity guideline attainment in Australian cardiac patients: A 12-month longitudinal study *J Cardiopulm Rehabil Prev.*doi: 10.1097/HCR.0000000000000137

Murphy, B.M., Higgins, R.O., Jackson, A.C. Ludeman, D, Humphreys, J., Edington, J., Jackson, A., Worcester, M. (2015). Patients want to know about the 'cardiac blues'. *Australian Family Physician*, 44,11, 826-832

Jobling, K., Lau, P., Kerr, D., Higgins, R.O., Worcester, M.U., Angus, L., Jackson, A.C., Murphy, B.M. (2015). Bundap Marram Durn Durn: Health service engagement with urban Aboriginal women experiencing comorbid chronic physical and mental health conditions. *ANZ Journal of Public Health*. doi: 10.1111/1753-6405.12382

Le Grande, M.R., Jackson, A.C., Murphy, B.M., Thomason, N. (2015). Relationship between sleep disturbance, depression and anxiety in the 12 months following a cardiac event. *Psychology Health and Medicine* .DOI 10.1080/13548506.2015.1040032

Jackson, A.C., Frydenberg, E., Liang, R. P-T., Higgins, R.O., Murphy, B.M. (2015). Familial coping with child heart disease: A systematic review. *Pediatric Cardiology,* 36, 4, 695-712, DOI 10.1007/s00246-015-1121-9

Jackson, A.C., Le Grande, M., Higgins, R.O., Rogerson, M., Murphy, B.M. (in press November 2015). Psychosocial screening and assessment practice within cardiac rehabilitation: A survey of cardiac rehabilitation coordinators in Australia, *Heart, Lung and Circulation* (Under review)

Jackson, A.C., Murphy, B.M., Ski, C. F., Thompson, D.R. (in press November 2015). Psychosocial interventions for patients after a cardiac event. Commissioned chapter for the *Handbook of Psychocardiology,* (Eds. D. Byrne & M. Alvarenga), Springer.

Murphy, B.M., Higgins, R.O., Jackson, A.C. (in press November 2015). Anxiety, depression and psychological adjustment after an acute cardiac event. Commissioned chapter for the *Handbook of Psychocardiology,* (Eds. D. Byrne & M. Alvarenga), Springer.

Jackson, A.C., Frydenberg, E., Liang, R. P-T., Higgins, R.O., Murphy, B.M. (in press November 2015). Parental coping programs for special needs children: A systematic review, Journal of Clinical Nursing

Higgins, R.O., Murphy, B.M., Navaratnam, H., Saltmarsh, N., Gascard, D., Jackson, A.C. Telephone cardiac rehabilitation pilot: Extending cardiac rehabilitation reach, *The Journal of Clinical Nursing* (Under review)

Rogerson, M., Le Grande, M., Dunstan, D., Murphy, B.M., Salmon, J., Gardiner, P., Jackson, A.C. Television viewing time and mortality risk in adults with cardiovascular disease: The Australian Diabetes, Obesity and Lifestyle Study (AusDiab), *Circulation* (Under review)

Murphy, B.M, Higgins, R.O., Shand, L., Page, K., Holloway, E., Jackson, A.C. Assisting health professionals to support patients' emotional recovery after heart attack and heart surgery: The 'Cardiac Blues Project', *European Journal of Cardiovascular Nursing* (Under review)

Organisational developments

In an exciting development we are working towards a significant organisational development: the transition of the Heart Research Centre into the Australian Centre for Heart Health (ACHH). This will bring together the internationally recognised research of the HRC and its highly successful cardiac rehabilitation workforce development program with a new program, the **Cardiac Wellbeing Clinic.** This combination of cardiac secondary prevention research with the twin translational pillars of training and clinical behavioural and psychological interventions is unique, not just in Australia, but internationally.

The Clinic itself would be a first for the Asia Pacific region, and one of only three in the world. The Clinic will serve people affected by heart disease with psychological issues. Help Yourself Online, online individual counselling and online delivery of a Family Coping (with congenital heart disease) program have the capability of reaching a national population of people living with heart disease and very importantly, also have the potential to reach an international population throughout the Asia Pacific region. It will also serve people with serious mental illness with, or at risk of, heart disease.

The ACHH will, in addition to being a recognised research centre of the University of Melbourne, become an affiliated research centre of the Faculty of Health at Deakin University.

Some points of difference of the ACHH from the HRC are:

Cardiac rehabilitation quality improvement and program evaluation

With its emphasis on the development of evidence-led practice in cardiac rehabilitation, the ACHH will be well placed to work with cardiac rehabilitation (CR) service providers to embed strong evaluation and outcomes-focused frameworks into CR programs. The Centre would offer a range of services to CR programs to assist in achieving best possible outcomes for CR patients while achieving operational efficiency. Services would include:

- Evidence reviews including systematic reviews, as well as rapid evidence reviews for the development of evidence-informed program development;
- Outcome measurement and data management. This includes Identification of robust, psychometrically sound, standardised outcome measures and measurement of fidelity to evidence-informed models of practice.
- Building practice research partnerships which support practitioners to undertake practitioner-driven research in their CR programs and which build a research and evaluation- oriented organisational culture.

Heart Health Connect

Recently, all HRC trainees have had the opportunity for ongoing networking through participation in the HRC Network, which in the ACHH will be known as Heart Health Connect. This is an important aspect of the translational work of the Centre and is one example of the innovative work of the HRC and the ACHH in driving best practice in the delivery of care to people with heart disease.

Alun Jackson
Director Heart Research Centre

Heart Foundation Report

Update re enhancement of Heart Foundation CVH Services Online Directory

The Heart Foundation (Queensland Division) has secured $100,000 from the Queensland Department of Health to upgrade the Heart Foundation Cardiac Rehabilitation and Heart Failure Services Online Directory.

The project will deliver a range of enhancements including improved search and geolocation functionality.

A project manager has been contracted to work one day per week to help coordinate this work. A small steering group is currently being convened. ACRA will be invited to nominate a representative.

The upgrade will be completed by 30 June 2016.

Upgrade to Heart Education Assessment Rehabilitation Toolkit (HEART) Online

The Heart Education Assessment Rehabilitation Toolkit (HEART) Online website has recently been upgraded - http://www.heartonline.org.au/

The National Heart Foundation of Australia has agreed to continue to support the site.

The content revision was outsourced to Litmus Marketing and Medical Education in the UK who reviewed the Google analytics and our user surveys and was able to bring a wealth of experience and expertise to the project. Google analytics revealed that some parts of the site were seldom or never accessed and this information provided a basis for reform. The main changes to the site content are:

- Integration of cardiovascular disease prevention and rehabilitation, and heart failure management content to enhance navigation, minimise duplication and improve ease of future updating.
- Adoption of the term Cardiac Rehabilitation (as recommended by the editor's review of Google analytics) to enhance visibility through search engines and to align with current Heart Foundation terminology.
- Headings and content structured for ease of access on mobile platforms
- Use of diagrams and images to enhance understanding of complex information or replace text
- Provision of a patient information section that will provide resources and link patients to the parts of the site that are most relevant
- Structuring the site so that clinical reflection pages can be included in the future.

Report on the third Australian Health Policy Collaboration November 2015

On Wednesday 25th November ACRA President Lis Neubeck requested Emma Boston to represent ACRA at the AHPC (Australian Health Policy Collaboration) policy forum …*Chronic Disease in Australia: Targets, indicators and accountability*" … at the Windsor in Melbourne. It was a great opportunity for ACRA to attend this full day work shop to address health inequity lead by Rosemary Calder Director, AHPC.

Summary:

- Third forum over past 12 months held since inception 3 years ago for a national unified approach to apply a scorecard tool using a multi-faceted approach; Government, private, public, community.
- Attended by 90 participants from across the Australian health sector including policy makers and health clinical leaders contributing to a national intellectual fire power think tank.
- Robust discussions, ideas and action plan formulation occurred.
- The day's forum was to review targets, indicator reports & timetables of previously set strategies from the working groups from the earlier forums. How to work together and use the report focusing on action outcomes for the next 12 months in line with WHO 25/25
- Twitter #AHPC15
- Next steps are to report on this latest forum and develop a political campaign to launch query in possibly June 2016, aimed at all political parties. Therefore the Collaboration is looking for capacity from participants from within the Collaboration to form working groups.
- **Mandate to transform Australian health outcomes & social inequalities; Australia's greatest health challenge – *Prevention 1st campaign*** aimed at political parties to get health on to the agenda for the next federal election; as analysis shows there has been a lack of action on preventative health.

Emma Boston

















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. Intention to abstain from smoking among cardiac rehabilitation patients: the role of attitude, self-efficacy, and craving.

Bakker EC; Nijkamp MD; Sloot C; Berndt NC; Bolman CA. Journal of Cardiovascular Nursing. 30(2):172-9, 2015 Mar-Apr.

BACKGROUND: Smoking cessation after developing coronary heart disease improves disease prognosis more than any other treatment. However, many cardiac patients continue to smoke after hospital discharge.

OBJECTIVE: The aim of this study was to investigate factors associated with the intention to (permanently) abstain from smoking among cardiac rehabilitation patients 2 to 4 weeks after discharge from hospital.

METHODS: A cross-sectional survey was conducted among 149 cardiac rehabilitation patients recruited from 2 cardiac rehabilitation centres in The Netherlands 2 to 4 weeks after hospital discharge, at the start of the cardiac rehabilitation period. Psychosocial cognitions including attitude toward non-smoking, social influence, and self-efficacy were measured with a standardized and validated Dutch questionnaire based on the Attitude-Social Influence-Self-efficacy model. Anxiety was measured using the shortened version of the State-Trait Anxiety Inventory. Craving for cigarettes was assessed with 6 items measuring the urge to smoke. Intention toward non-smoking was assessed with 2 visual analogue scales indicating the strength and probability of the intention to permanently refrain from smoking. RESULTS: Of all patients, 31% still smoked after hospital discharge. The smokers had a lower self-efficacy and intention to abstain from smoking and reported higher craving. Logistic regression analyses revealed that attitudes that embraced the advantages of not smoking, self-efficacy, and craving were significantly related to the intention to (permanently) abstain from smoking, whereas social influence and anxiety were not. Actual smoking behaviour moderated the relation between self-efficacy and intention: only the quitters showed a significant positive relation. Anxiety did not moderate the relationship between psychosocial cognitive factors and intention.

CONCLUSIONS: The intention to (permanently) abstain from smoking, measured 2 to 4 weeks after hospitalization for a cardiac event predominantly depends on attitude, self-efficacy, and craving. Interventions aimed at smoking cessation among cardiac rehabilitation patients should focus on these factors.

The Good News: Do you monitor smoking cessation in your program?

2. Temporal Trends and Factors Associated With Cardiac Rehabilitation Referral Among Patients Hospitalized With Heart Failure: Findings From Get With The Guidelines-Heart Failure Registry.

Golwala H; Pandey A; Ju C; Butler J; Yancy C; Bhatt DL; Hernandez AF; Fonarow GC. Journal of the American College of Cardiology. 66(8):917-26, 2015 Aug 25.

BACKGROUND: Current guidelines recommend cardiac rehabilitation (CR) in medically stable outpatients with heart failure (HF); however, temporal trends and factors associated with CR referral among these patients in real-world practice are not entirely known.

OBJECTIVE: The purpose of this study was to assess proportional use, temporal trends, and factors associated with CR referral at discharge among patients admitted with decompensated HF. METHODS: Using data from a national Get With the Guidelines-Heart Failure registry, we assessed the temporal trends in CR referral among eligible patients with HF with reduced ejection fraction (HFrEF) and HF with preserved ejection fraction (HFpEF) at discharge after HF hospitalization between 2005 and 2014. On multivariable analysis, we also assessed patient- and hospital-level characteristics that are associated with CR referral.

METHODS: Among 105,619 HF patients (48% with HFrEF, 52% with HFpEF), 10.4% (12.2% with HFrEF, 8.8% with HFpEF) received CR referral at discharge. A significant increase in CR referral rates was observed among both HFpEF and HFrEF patients over the study period (p trend <0.0001 for HFrEF, HFpEF, and overall). Compared with patients discharged without CR referral, patients referred for CR were younger, predominantly men, and more likely to receive evidence-based HF therapies at discharge. On multivariable analysis, younger age, fewer comorbid conditions, and in-hospital procedures such as coronary artery bypass grafting, percutaneous coronary intervention, and cardiac valve surgery were most strongly associated with CR referral.

CONCLUSIONS: Only one-tenth of eligible HF patients received CR referral at discharge after hospitalization for HF. The proportional use of CR referral is increasing over

time among both HFrEF and HFpEF patients. Further strategies to improve physician and patient awareness in regard to the benefit of CR should be used to increase CR referral among patients with HF.

THE GOOD NEWS: Both forms of heart failure patients are increasingly referred to CR – is your program prepared for this?

3. Cardiac rehabilitation is associated with reduced long-term mortality in patients undergoing combined heart valve and CABG surgery.

Goel K; Pack Q; Lahr B; Greason KL; Lopez-Jimenez F; Squires RW; Zhang Z; Thomas R. European Journal of Preventive Cardiology. 22(2):159-68, 2015 Feb.

BACKGROUND: No reports have been published to date on the impact of cardiac rehabilitation (CR) on mortality in patients undergoing combined heart valve and coronary artery bypass graft (CABG) surgery (V+CABG), a procedure that has increased significantly in frequency in recent years.

METHODS: We identified consecutive patients who underwent V+CABG surgery in the Olmsted County from 1996 to 2007. Propensity scores were developed using more than 40 clinical, operative, and post-operative characteristics. The impact of CR on long-term mortality was assessed via landmark analysis and using propensity score regression adjustment and stratification techniques.

RESULTS: A total of 201 patients were included in our study, in whom 86 deaths occurred over a mean follow up of 6.8 years. Forty-seven per cent of patients participated in CR, with a significant trend towards increased participation in recent years (p=0.04). Conditional on 6-month survival and controlling for propensity factors as well as mortality risk factors, CR participation was associated with a significant reduction in mortality (propensity score adjustment: HR 0.48, p=0.009; propensity score stratification: HR 0.48, p=0.016). The absolute risk reduction over 10 years was 14.5% (number needed to treat=7). Results did not differ significantly based on age, gender, emergent status, or history of heart failure or arrhythmias, but CR participation was more beneficial for patients who underwent a mitral valve procedure (HR 0.24, 95% CI 0.08-0.77).

CONCLUSIONS: This is the first study reporting a significant survival benefit with CR participation in patients who have undergone combined V+CABG surgery. These findings provide evidence in support of recommendations for CR participation after V+CABG surgery.

THE GOOD NEWS: More evidence that CR works!

4. Optimizing Value From Cardiac Rehabilitation: A Cost-Utility Analysis Comparing Age, Sex, and Clinical Subgroups.

Leggett LE; Hauer T; Martin BJ; Manns B; Aggarwal S; Arena R; Austford LD; Meldrum D; Ghali W; Knudtson ML; Norris CM; Stone JA; Clement F. Mayo Clinic Proceedings. 90(8):1011-20, 2015 Aug.

OBJECTIVE: To assess the cost utility of a centre-based outpatient cardiac rehabilitation program compared with no program within patient subgroups on the basis of age, sex, and clinical presentation (acute coronary syndrome [ACS] or non-ACS).

METHODS: We performed a cost-utility analysis from a health system payer perspective to compare cardiac rehabilitation with no cardiac rehabilitation for patients who had a cardiac catheterization. The Markov model was stratified by clinical presentation, age, and sex. Clinical, quality-of-life, and cost data were provided by the Alberta Provincial Project for Outcome Assessment in Coronary Heart Disease and Total Cardiology.

RESULTS: The incremental cost per quality-adjusted life-year (QALY) gained for cardiac rehabilitation varies by subgroup, from $18,101 per QALY gained to $104,518 per QALY gained. There is uncertainty in the estimates due to uncertainty in the clinical effectiveness of cardiac rehabilitation. Overall, the probabilistic sensitivity analysis found that 75% of the time participation in cardiac rehabilitation is more expensive but more effective than not participating in cardiac rehabilitation.

CONCLUSION: The cost-effectiveness of cardiac rehabilitation varies depending on patient characteristics. The current analysis indicates that cardiac rehabilitation is most cost effective for those with an ACS and those who are at higher risk for subsequent cardiac events. The findings of the current study provide insight into who may benefit most from cardiac rehabilitation, with important implications for patient referral patterns.

THE GOOD NEWS: Yes CR cost more but we are well worth it!

5.Higher fine particulate matter and temperature levels impair exercise capacity in cardiac patients.

Giorgini P; Rubenfire M; Das R; Gracik T; Wang L; Morishita M; Bard RL; Jackson EA; Fitzner CA; Ferri C; Brook RD. Heart. 101(16):1293-301, 2015 Aug.

OBJECTIVE: Fine particulate matter (PM2.5) air pollution and variations in ambient temperature have been linked to increased cardiovascular morbidity and mortality. However, no large-scale study has assessed their effects on directly measured aerobic functional capacity among high-risk patients.

METHODS: Using a cross-sectional observational design, we evaluated the effects of ambient PM2.5 and temperature levels over 7 days on cardiopulmonary exercise test results performed among 2078 patients enrolling into a cardiac rehabilitation programme at the University of Michigan (from January 2003 to August 2011) using multiple linear regression analyses (controlling for age, sex, body mass index).

RESULTS: Peak exercise oxygen consumption was significantly decreased by approximately 14.9% per 10 mμg/m(3) increase in ambient PM2.5 levels (median 10.7 mμg/m(3), IQR 10.1 mug/m(3)) (lag days 6-7). Elevations in PM2.5 were also related to decreases in ventilatory threshold (lag days 5-7) and peak heart rate (lag days 2-3) and increases in peak systolic blood pressure (lag days 4-5). A 10 degree C increase in temperature (median 10.5 degree C, IQR 17.5 degree C) was associated with reductions in peak exercise oxygen consumption (20.6-27.3%) and ventilatory threshold (22.9-29.2%) during all 7 lag days. In models including both factors, the outcome associations with PM2.5 were attenuated whereas the effects of temperature remained significant.

CONCLUSIONS: Short-term elevations in ambient PM2.5, even at low concentrations within current air quality standards, and/or higher temperatures were associated with detrimental changes in aerobic exercise capacity, which can be linked to a worse quality of life and cardiovascular prognosis among cardiac rehabilitation patients.

THE GOOD NEWS: All the more reason to do functional capacity testing indoors and with air-con on!

6. Comprehensive cardiac rehabilitation improves outcome for patients with implantable cardioverter defibrillator. Findings from the COPE-ICD randomised clinical trial.

Berg SK; Pedersen PU; Zwisler AD; Winkel P; Gluud C; Pedersen BD; Svendsen JH. European Journal of Cardiovascular Nursing. 14(1):34-44, 2015 Feb.

AIMS: The aim of this randomised clinical trial was to assess a comprehensive cardiac rehabilitation intervention including exercise training and psycho-education vs 'treatment as usual' in patients treated with an implantable cardioverter defibrillator (ICD). METHODS: In this study 196 patients with first time ICD implantation (mean age 57.2 (standard deviation (SD) =13.2); 79% men) were randomised (1:1) to comprehensive cardiac rehabilitation vs 'treatment as usual'. Altogether 144 participants completed the 12 month follow-up. The intervention consisted of twelve weeks of exercise training and one year of psycho-educational follow-up focusing on modifiable factors associated with poor outcomes. Two primary outcomes, general health score (Short Form-36 (SF-36)) and peak oxygen uptake (VO2), were used. Post-hoc analyses included SF-36 and ICD therapy history.

RESULTS: Comprehensive cardiac rehabilitation significantly increased VO2 uptake after exercise training to 23.0 (95% confidence interval (CI) 20.9-22.7) vs 20.8 (95% CI 18.9-22.7) ml/min/kg in the control group (p=0.004 (multiplicity p=0.015)). Comprehensive cardiac rehabilitation significantly increased general health; at three months (mean 62.8 (95% CI 58.1-67.5) vs 64.4 (95% CI: 59.6-69.2)) points; at six months (mean 66.7 (95% CI 61.5-72.0) vs 61.9 (95% CI 56.1-67.7) points); and 12 months (mean 63.5 (95% CI 57.7-69.3) vs 62.1 (95% CI 56.2-68.0)) points (p <0.05). Explorative analyses showed a significant difference between groups in favour of the intervention group. No significant difference was seen in ICD therapy history.

CONCLUSION: Comprehensive cardiac rehabilitation combining exercise training and a psycho-educational intervention improves VO2-uptake and general health. Furthermore, mental health seems improved. No significant difference was found in the number of ICD shocks or anti-tachycardia pacing therapy.

THE GOOD NEWS: If they are implanted, they need to come!

7. Participation in cardiac rehabilitation after hospitalisation for heart failure: a report from the BIO-HF registry.

Pardaensi S; Willems AM; Vande Kerckhove B; De Sutter J. Acta Cardiologica. 70(2):141-7, 2015 Apr.

OBJECTIVE: Participation in cardiac rehabilitation (CR) after hospitalisation for heart failure (HF) is estimated to below, but specific data for Belgium are lacking. Therefore, we wanted to evaluate attendance after HF hospitalisation compared to patients after cardiac surgery or acute coronary syndrome (ACS). Moreover, the improvement in exercise capacity was compared with the other patient groups.

METHODS AND RESULTS: Patients who were hospitalized for HF (n=428), cardiac surgery (n=358) or ACS (n=467) in a single hospital, were prospectively included between January 2010 and May 2012. After hospitalisation for HF only 9% participated, compared to 29% after ACS and 56% after cardiac surgery. Non-participants in HF were older, more frequently women (P <0.01) and had a better left ventricular ejection fraction (P < 0.05). In addition, they had more frequently atrial fibrillation and problems to walk independently (P <0.01). At the start of the CR, HF patients had a worse clinical status and exercise capacity than patients after cardiac surgery or ACS (all P <0.001). However, exercise training resulted in a significant improvement in each group separately (all P < 0.001) and the relative improvement in exercise capacity in HF was comparable with the other groups.

CONCLUSIONS: Only 9% of HF patients participated in CR after hospitalisation. Age, female gender, a relatively well-preserved ventricular function and atrial fibrillation seem to impede attendance to CR. However, HF patients can have as much improvement in exercise capacity as other patient populations, suggesting that more effort is needed to increase participation in CR among HF patients.

THE GOOD NEWS: How many heart failure patients attend your program – you may need to collect data to find this out?

8. Gaps in referral to cardiac rehabilitation of patients undergoing percutaneous coronary intervention in the United States.

Aragam KG; Dai D; Neely ML; Bhatt DL; Roe MT; Rumsfeld JS; Gurm HS. Journal of the American College of Cardiology. 65(19):2079-88, 2015 May 19.

BACKGROUND: Rates of referral to cardiac rehabilitation after percutaneous coronary intervention (PCI) have been historically low despite the evidence that rehabilitation is associated with lower mortality in PCI patients.

OBJECTIVES: This study sought to determine the prevalence of and factors associated with referral to cardiac rehabilitation in a national PCI cohort, and to assess the association between insurance status and referral patterns.

METHODS: Consecutive patients who underwent PCI and survived to hospital discharge in the National Cardiovascular Data Registry between July 1, 2009 and March 31, 2012 were analyzed. Cardiac rehabilitation referral rates, and patient and institutional factors associated with referral were evaluated for the total study population and for a subset of Medicare patients presenting with acute myocardial infarction.

RESULTS: Patients who underwent PCI (n = 1,432,399) at 1,310 participating hospitals were assessed. Cardiac rehabilitation referral rates were 59.2% and 66.0% for the overall population and the AMI/Medicare subgroup, respectively. In multivariable analyses, presentation with ST-segment elevation myocardial infarction (odds ratio 2.99; 95% confidence interval: 2.92 to 3.06) and non-ST-segment elevation myocardial infarction (odds ratio: 1.99; 95% confidence interval: 1.94 to 2.03) were associated with increased odds of referral to cardiac rehabilitation. Models adjusted for insurance status showed significant site-specific variability in referral rates, with more than one-quarter of all hospitals referring <20% of patients.

CONCLUSIONS: Approximately 60% of patients undergoing PCI in the United States are referred for cardiac rehabilitation. Site-specific variation in referral rates is significant and is unexplained by insurance coverage. These findings highlight the potential need for hospital-level interventions to improve cardiac rehabilitation referral rates after PCI.

THE GOOD NEWS: Have you got automatic referral status at your place of work for PCI patients?

9. Exercise training is safe after coronary stenting: a prospective multicentre study.

Iliou MC; Pavy B; Martinez J; Corone S; Meurin P; Tuppin P; CRS investigators and GERS (Groupe Exercice Readaptation, Sport) from French Society of Cardiology. European Journal of Preventive Cardiology. 22(1):27-34, 2015 Jan.

BACKGROUND: Data on the safety of exercise training after coronary stenting are scarce.
DESIGN: This is a prospective cohort study of 3132 patients with coronary stenting within the last 12 months, recruited by 44 cardiac rehabilitation centres; patients were included in a cardiac rehabilitation programme with training sessions 3-5 days a week. Cardiac rehabilitation was defined as early rehabilitation when starting <1 month after coronary stenting and as late rehabilitation when starting later.

METHODS: Rate of acute coronary syndrome (ACS) after coronary stenting was estimated according to time to training session. ACS was defined as related to exercise when it occurs during or within the hour after an exercise stress test or a training session. All ACS were documented by an angiographic control.

RESULTS: Overall 5016 stents (41.4% drug-eluting stents) were implanted in 3132 patients aged 56.5 +/- 12.9 years (84.7% men) with a median of 1 stent (range 1-8) per patient. Indication of coronary stenting was ACS (86.4%), angina pectoris (8.6%), and silent ischaemia (5%). Combined antiplatelet treatment was used in 97.2% of the patients. Overall rate of ACS after coronary stenting was 2.9/1000 patients, corresponding to 1.7 complications out of 10(6) patient-hours of exercise. There were four stent thromboses related to exercise (1.2/1000 patients, 0.8/10(6) patient-hours of exercise): two in the early rehabilitation group (days 9 and 11), and two in the late rehabilitation group (days 77 and 228).

CONCLUSIONS: Exercise training seems safe and there is no justification to delay cardiac rehabilitation after coronary stenting.

THE GOOD NEWS: Early referral and commencement to CR after stenting should be the "norm"!

10. Tai Chi Chuan improves functional capacity after myocardial infarction: A randomized clinical trial.

Nery RM; Zanini M; de Lima JB; Buhler RP; da Silveira AD; Stein R.American Heart Journal. 169(6):854-60, 2015 Jun.

BACKGROUND: Patients with a recent myocardial infarction (MI) present a reduction in functional capacity expressed as a decrease in peak oxygen consumption (Vo2 peak). The impact of a Tai Chi Chuan (TCC) cardiac rehabilitation program for patients recovering from recent MI has yet to be assessed. Our goal is to evaluate functional capacity after a TCC-based cardiac rehabilitation program in patients with recent MI.

METHODS: A single-blind randomized clinical trial was conducted. The researchers who performed the tests were blinded to group allocation. Between the 14th and 21st days after hospital discharge, all patients performed a cardiopulmonary exercise testing and a laboratory blood workup. Mean age was similar (56+/-9 years in the TCC group and 60+/-9 years in the control group). Patients allocated to the intervention group performed 3 weekly sessions of TCC Beijing style for 12 weeks (n=31). The control group participated in 3 weekly sessions of full-body stretching exercises (n=30).

RESULTS: After the 12-week study period, participants in the TCC group experienced a significant 14% increase in Vo2 peak from baseline (21.6 +/- 5.2 to 24.6 +/- 5.2 mL/kg per minute), whereas control participants had a non-significant 5% decline in Vo2 peak (20.4 +/- 5.1 to 19.4 +/- 4.4 mL/kg per minute). There was a significant difference between the 2 groups (P<.0001).

CONCLUSIONS: Tai Chi Chuan practice was associated with an increase in Vo2 peak in patients with a recent MI and may constitute an effective form of cardiac rehabilitation in this patient population.

THE GOOD NEWS: White Stork Spreads Wings, Strum the Pei Pa, Go Back to Ward Off Monkey, Carry Tiger to Mountain, Push Needle to Sea Bottom, Golden Cock Stands on One Leg, Step Up to Grasp Bird's Tail, Creeping Low Like a Snake, Step Up to Seven Stars, Retreat to Ride Tiger, Fair Lady Works Shuttles, Turn Around to Sweep Lotus, Draw Bow to Shoot Tiger. You have now finished grasshopper!

11. Effect of Lifestyle-Focused Text Messaging on Risk Factor Modification in Patients With Coronary Heart Disease: A Randomized Clinical Trial.

Chow CK; Redfern J; Hillis GS; Thakkar J; Santo K; Hackett ML; Jan S; Graves N; de Keizer L; Barry T; Bompoint S; Stepien S; Whittaker R; Rodgers A; Thiagalingam A. JAMA. 314(12):1255-63, 2015 Sep 22-29.

IMPORTANCE: Cardiovascular disease prevention, including lifestyle modification, is important but underutilized. Mobile health strategies could address this gap but lack evidence of therapeutic benefit.

OBJECTIVE: To examine the effect of a lifestyle-focused semi-personalized support program delivered by mobile phone text message on cardiovascular risk factors.

DESIGN AND SETTING: The Tobacco, Exercise and Diet Messages (TEXT ME) trial was a parallel-group, single-blind, randomized clinical trial that recruited 710 patients (mean age, 58 [SD, 9.2] years; 82% men; 53% current smokers) with proven coronary heart disease (prior myocardial infarction or proven angiographically) between September 2011 and November 2013 from a large tertiary hospital in Sydney, Australia.

INTERVENTIONS: Patients in the intervention group (n=352) received 4 text messages per week for 6 months in addition to usual care. Text messages provided advice, motivational reminders, and support to change lifestyle behaviours. Patients in the control group (n=358) received usual care. Messages for each participant were selected from a bank of messages according to baseline characteristics (e.g., smoking) and delivered via an automated computerized message management system. The program was not interactive.

MAIN OUTCOMES AND MEASURES: The primary end point was low-density lipoprotein cholesterol (LDL-C) level at 6 months. Secondary end points included systolic blood pressure, body mass index (BMI), physical activity, and smoking status.

RESULTS: At 6 months, levels of LDL-C were significantly lower in intervention participants, with concurrent reductions in systolic blood pressure and BMI, significant increases in physical activity, and a significant reduction in smoking. The majority reported the text messages to be useful (91%), easy to understand (97%), and appropriate in frequency (86%).

CONCLUSIONS AND RELEVANCE: Among patients with coronary heart disease, the use of a lifestyle-focused text messaging service compared with usual care resulted in a modest improvement in LDL-C level and greater improvement in other cardiovascular disease risk factors. The duration of these effects and hence whether they result in improved clinical outcomes remain to be determined.

TRIAL REGISTRATION: www.anzctr.org.au Identifier: ACTRN12611000161921.

THE GOOD NEWS: Need to read the article in full to appreciate the complexity of this adjunct therapy to CR. If u need help ring me, I mean text me!

Merry Christmas and Happy New Year for all in cardiac rehabilitation land!

More Next Year!

State Reports


NSW ACT Report

CRA Strategic Operational Plan

In April of 2015 the CRA NSW board came together at a face to face meeting to develop the strategic operational plan for the organisation. This plan reflects ACRA's strategic plan and incorporates four key areas which will form the basis for this report.

- Advocacy
- Membership services
- Corporate services
- Professional Development

Advocacy

CRA NSW ACT has been working closely with National Heart Foundation, Ministry of Health, and the Agency for Clinical Innovation advocating for a Cardiac Rehabilitation minimum dataset for NSW. The dataset has 11 key item's relating to clinical processes, and patient outcomes. The 11 items have been developed based on evidence, ACRA core component's document and feedback from clinician's in a survey conducted by the NHF. Several sites across the state are exploring how easy it will be to extract and report on this data given our different information systems, resources and service types.

CRA NSW ACT has advocated with the NHF for Cardiac rehabilitation become a standing item on the agenda for the Agency for Clinical Innovation quarterly meetings. This has significantly raised the profile of CR, the role of the organisation and it is hoped that this will assist us moving forward.

Membership Services

The focus of membership services is about providing value for members. Although much of this is done through ACRA itself with the:

- ACRA Website
- Access to the journal
- Webinars
- Conferences.

It is necessary for us as a state to provide value through educational support, networking, support and mentorship to our member's, especially as while overall the numbers of member's of ACRA has increased, CRA NSW ACT membership has decreased.

PLAN: One of the tasks for the 2016 will be to explore why this is the case and look at ways of perhaps communicating more with our members to ensure they see the value of being part of the organisation.

Professional Development

There was a change format to education for state members slightly for 2015, with the state conference 9th of October and webinar in August. Previously the CRA provided both state and rural meetings as a key part of education. However recent times have seen numbers decrease at these meetings, less sponsorship than previous years, and they are incredibly time consuming to organise and develop. The PDC and board have also been working with the NHF to support the development of an educational component for HEARTONLINE.

PLAN: In the next twelve months the PDC and the board will need to review how best to deliver cost effective education to our member's.

Corporate services

The focus of corporate services is how we run our organisation (finance, secretariat etc.), the main challenge this year has been the loss of our secretariat in January and the board employed a professional organisation The Association Specialist's (TAS). This has resulted in some challenges financially and in working together as a board to find a solution which best meets our needs.The board voted to continue with TAS but alter the contract to an annual figure capped to our present level of services.

PLAN: This will need to be reviewed at the end of 2016 to determine the financial viability of TAS as secretariat. The board needs to consider proposing to ACRA EMC that TAS become responsible for all the secretariat of ACRA including the states.

Plans for 2016

- **Fiscal viability**, we can no longer depend on our state conference to raise significant amount of sponsorship and have significant attendance as a means of providing income. We need to explore other options and perhaps we need to discuss with ACRA EMC new ways of working together to maintain the viability of the state chapters of the organisation.
- **Membership**, maintaining and developing new member's to ensure the viability and future of CRA NSW ACT.
- In line with other states explore the idea of a **name change** to ACRA NSW Act as a means of maintaining a corporate identity reducing confusion and attracting sponsorship as an entity.

I would like to acknowledge aspects of this report coming from CRA NSW ACT past president, Dawn McIvor. And thank her again for her leadership over the last two years with CRA NSW &ACT.

Regards
Joanne (Jo) Leonard

VIC Report

Following the 2015 ACRA Scientific meeting in August VACR Members have been busy participating in other professional development activities both here in Melbourne and interstate. An evening dinner held at the Hellenic Republic in Kew recently was sponsored by AstraZeneca. Melbourne Cardiologist Dr Ron Dick was the guest speaker and gave an informative presentation on the latest developments with bio disposable Coronary Artery Stents. The October Novartis Pharmaceutical Heart Failure Nurses' weekend in Brisbane was attended by a good contingent of VACR Members. VACR Life Member Professor David Thompson was busy presenting on more than one occasion during the weekend.

The VACR education afternoon, Annual General meeting and Dr Alan Goble Lecture was held at Graduate House, Melbourne University, Carlton on Monday 9th November 2015. Approximately 50 delegates attended the event which is lower than the previous year of 90 participants. However the lower registration number was expected due to other competing PD events and is consistent with the last time Victoria hosted the ACRA Scientific Meeting in 2013.

Susie Cartledge PhD Candidate set a high bar for the education afternoon starting off the programme. Returning a few hours earlier from Europe where Susie had been attending the release of the latest international guidelines on resuscitation, she gave a comprehensive run down on BLS. Later Susie returned to the podium to present on a topic she is becoming known for being passionate about BLS training for family members of high-risk cardiac patients. Well done Susie; made even more exceptional operating seamlessly with the demands of "jet lag".

To cap-off a full and vibrant education programme afternoon Dr Om Narayan presented "ACS management in 2015 – Guideline recommended pharmacotherapy." A Cardiologist and Research fellow at Monash Cardiovascular Research Centre Dr Om Narayan gave an informative and very comprehensive presentation. The VACR Committee sincerely thanked Damon Crewdson from AstraZeneca for his efforts in securing Dr Narayan for the event, the sponsorship provided by AstraZeneca, as well as Damon's flexibility and patience in working with VACR once again.

The VACR AGM was held during the education afternoon with the 2015 Committee standing down as per normal practice in line with the Constitution. Sadly Dr Alison Beauchamp did not re-nominate and was formally thanked for her many years of hard work. Alison is well known amongst the Committee for her cool head under pressure and has displayed many talents that have ensured that VACR events have run so smoothly. Thank you Alison; we will miss you very much.

The VACR Committee for 2015 is Emma Boston – President; Margaret Ryan - Deputy President; Kim Gray - VACR State Representative; Niamh Dormer – Secretary; Carmel Bourne - Deputy Secretary & official photographer; Deb Gascard – Treasurer; Ailish Commane - Vice Treasurer; with Abi Oliver joining the Committee for the first time. The Committee has also co-opted Susie Carteldge and wish to warmly welcome both Susie and Abi on board.

Harry Patasmanis remains the State Heart Foundation Representative. The Heart Research Representative is yet to be announced. In the interim Professor Alun Jackson will sit on the VACR Committee as the HRC Representative.

A major highlight of the VACR November PD day was the Dr Alan Goble Lecture Dinner with Dr Rob Grenfell as the 2015 guest speaker. The event was made all that more special with the attendance by some of our VACR Life Members. Life Member Dr Michael Jelinek kindly volunteered to formally introduce Dr Grenfell. Dr Jelinek's introduction was engaging, entertaining and informative setting the appetite for the lecture. Dr Grenfell who is very well known, expertly qualified and passionate in the area of cardiac rehabilitation did not disappoint delivering a very high calibre, entertaining and relevant presentation. On behalf of the VACR Members and Committee Emma Boston formally thanked both doctors, giving them each a gift as a small token of appreciation.

On behalf of the Members and Committee VACR wishes to acknowledge and thank St John of God Frankston Rehabilitation Hospital and AstraZeneca's generous financial support of the event. Both these organisations have continued to support VACR over the years. Without their assistance the Committee would not be able to continue to provide the professional development activities for our Members at such low costs.

On closing we wish every VACR Member a warm, happy Christmas season and look forward to catching up with everyone in the New Year at our first VACR event for 2016, which will be held on Friday February 26th. A survey monkey has been emailed to Members to assist the Committee in the planning the event, which is already well under way with the venue and Programme in first draft.

Emma Boston
State President on behalf of the VACR Committee.

Prof David Thompson and VACR delegates at heart failure weekend

Dr Rob Grenfell presenting the Dr Alan Goble 2015 Lecture

QLD Report

Great Membership Support for AGM

We would like to thank the many QCRA members who attended the AGM (Friday October 16th) or sent their proxy votes. With over half the membership participating we were able to discuss some important issues and vote on key special resolutions. I would like to congratulate our new EMC for 2015-16: Vice President/ State Rep Jessica Auer; Secretary: Kathy O'Donnell; Treasurer: Karen Healy; Committee Members: Bridget Abell, Garry Bennett, Catherine Hardy, Robyn Williams, Steve Woodruffe, Dr Jo Wu and Invited Committee Members: Rural Rep: Ivette Jude and Heart Foundation Rep: Karen Uhlmann.

Symposium Success

Over 90 registrants attended (in person and via videoconference) the QCRA-Heart Foundation Symposium on Friday October 16th. The Symposium videoconference went out to many Queensland and interstate locations, with over a dozen sites participating. The feedback evaluation has been overwhelmingly positive with registrants saying they enjoyed the variety of content, the quality presentations and the focus on the patients' perspective. QCRA and our partners the Heart Foundation are really looking to build on the success of this event and providing an even better Symposium in October 2016. Stay tuned for news about this and other QCRA professional development events to be announced over the coming twelve months.

Rachelle Foreman - Health Director Heart Foundation Qld leads panel discussion at the QCRA-Heart Foundation Symposium

Radha Naidu – ACRA DSA 2015

A highlight at this year's ACRA conference was the awarding of the Alan Goble Distinguished Service Award to long time servant of Cardiac Rehab in Queensland–

QCRA president, Paul Camp and Dr Alan Goble Distinguished Service Award, 2015, recipient, Nadha Naidu

Radha Naidu. Unfortunately Radha was unable to attend in person to receive this award at the August conference. However, as part of the recent QCRA-Heart Foundation Symposium we were able to celebrate Radha's important ACRA achievement.

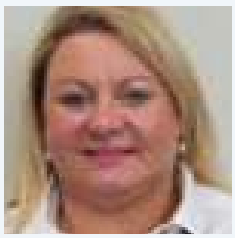
QLD Health Minister Cameron Dick announces Quality Improvement Payment to improve uptake of Cardiac Rehab

Quality Improvement Payments for Cardiac Rehab

The Queensland Health Minister has announced that a $5M Quality Improvement Payment is being funded by the state Government to improve uptake to cardiac rehabilitation across the state. The Minister acknowledged the important role of the Heart Foundation and applauded the partnership efforts between Queensland Health and Heart Foundation to improve patient care. The Statewide Cardiac Clinical Network Cardiac Rehab Work Group chaired by past ACRA President Steve Woodruffe is looking at how the QIP can be used best to improve referral and uptake of Cardiac Rehab. To receive information about these initiatives, please keep QCRA informed of changes to your program contact details at qcra@acra.net.au.

Heart Foundation's Advocacy Toolkit

The Toolkit for Improving Cardiac Rehab and Heart Failure Services continues to be available on the new look Heart Foundation website. QCRA has been working with the Heart Foundation Queensland to build on this document. A new version of this excellent resource is being planned for the future.



SA Report

So we wind down another year – ever so quickly I might add! We have had a lot happen since our conference edition.

Our health care services as we have known them are now currently in the midst of "Transforming" into different models, and whilst there will be significant changes still to come and possibly some we are not yet cognizant of, it is encouraging to see our members embracing these changes and also to see the different strategies being used to provide good quality cardiac care and support for the people that matter the most, and that is our patients and their families.

Big congratulations are to be given to all that have been and are involved with the CATCH program as they have recently won a SA Health award for Out of Hospital Strategies and Care.

Executive News

Natalie Simpson (State Representative) and Di Lynch (State President) have just returned from the National Executive Board Meeting, which was the first with Lis Neubeck as President. It was a busy weekend with many items on the agenda to be attended.

There was a formation of four subgroups to achieve many ambitious targets for the incoming term. The subgroups are: Membership, Professional Development, Advocacy, Research as well as Finance/Corporate. We will be working towards streamlining our name and logo to become more synonymous and marketable.

Locally our name will change from SACRA to ACRA – SA/NT. We will be changing in 2016 to an annual membership which will be paid pro rata and members will also notice a small increase of $5 to this annual membership to cover the cost of having the extra member attend the national meetings which will reduce the financial burden to each state.

Education Seminar

Our last education seminar for the year was held at the end of October at Ashford Hospital, "The Warehouse" with some more amazing contributors and presenters. It was lovely to have some colleagues from the SA Cardiomyopathy Association attend including two consumers who have had PPM and ablations.

Dr Richard Hillock, a cardiologist who specialises in electrophysiology was our first presenter and discussed "Cardiology Interventions and Heart Failure." This was such an interesting presentation, as the technology in this area evolves so quickly and the advances are enormous, but also what was highlighted was the appropriateness of interventions and device implantations.

Dr Fahmida Ilyas, an Advanced Cardiology Trainee with a keen interest in interventional and cardiology imaging then provided a wonderful overview of Athletic Heart Disease, an area we are starting to see more of and have a better understanding of. Fahmida explained its pathophysiology and in particular with right sided heart failure, and the appropriate use of interventions such as defibrillators of which she showed a cardiac internationalist favourite 'You tube' clip of a soccer players' ICD discharge during a match (http://icdusergroup.org).

Our third speaker for the seminar was Mrs Kath O'Toole one of SACRA's Nurse Practitioners and director of her own cardiovascular prevention and rehabilitation service - CPRSA. Kath regularly participates in several

committees' looking at health policies. She presented on the most recent ACS Clinical standards of which she an integral contributor.

I would like to acknowledge the ongoing support and sponsorship from Astra Zeneca and also from Pfizer Direct for without their support we would find it very difficult to hold these events.

SACRA welcomes our newest members who joined at this seminar.

Heart Foundation Report

Applications for the Heart Foundation Ambassador Program (NAP) 2016 are now open, and I highly recommend this program as a past ambassador. It is very beneficial for a new or experienced clinician. The NAP provides learning about other services on several platforms, structures, and how these services work. The NAP also supports and promotes initiating new changes in processes to suit your service.

MHML e-learning resource has been quite successful with over 1000 registrations since becoming live in early May, and will undergo formal review next year.

HF Website has now been updated with improved updates for mobile and tablet applications, easier navigation and readability, so don't forget to visit the site again soon.

The HF has released an updated information statement for the recommendation of the consumption of fish, Omega 3 and Omega 3 supplementation for the prevention and treatment of cardiovascular disease.

ACS Capability Framework – the booklet is now available to clinicians to support the national delivery of evidence based care for those experiencing acute coronary syndromes http://heartfoundation.org.au/for-professionals/clinical-informaiton/acutecoronary-syndromes.

Hypertension guidelines are currently under review.

Rural and Country Report

Metropolitan hospitals are now included to being able to use the centralised referral service, which is working extremely well with a large increase in referrals. This means great avenues for data collection to advocate for continuation and further extension of cardiac services.

Congratulations also to the CATCH service through the ICCNET, they won a SA Health award in the category of Out of Hospital Strategies and Care.

The virtual clinical care program (VCC) is now looking after over 100 country patients with monitoring COPD, HF and diabetes patients and have been responsible for identifying other health issues which were able to be treated in a timely manner.

Financial Report

Current financial report can be requested from Michelle Iadanza M.Iadanza@health.sa.gov.au or Renee Henthorn R.henthorn@health.sa.gov.au

2016 National Conference

Adelaide will be hosting the 2016 ACRA annual scientific conference at the Grand Chancellor Hotel in August 1-3 preceding the CZANZ conference.

The planning is well underway and we are working to provide all our members with a memorable and relevant program to keep your attention piqued and promote great robust discussion.

Save the Date for 2016

- Feb 10 – Ordinary Meeting
- April 9 – Education Seminar / AGM
- Aug 1-3 ACRA conference – Grand Chancellor
- Nov 2- Annual Dinner – Education Seminar

On a final note for the year, I would like to sincerely like to thank the SACRA executive team and members for another year of support, dedication and hard work. I would like to wish you all a very Merry Christmas, and hope you spend some valuable time with your loved ones and friends and you have time to relax and refresh your batteries for another busy and exciting year.

Dianna Lynch
SACRA President

TAS Report

A Merry Christmas and a Happy New Year to all in cardiac rehab!

Firstly, I would like to thank, Stephanie Crawford, Irene Thompson and Brigitte de Boer North West Regional Hospital, Amanda Wood and Victoria Brown Mersey Community Hospital, and Kathryn Gibb Royal Hobart Hospital, for their invaluable help while covering leave in cardiac rehab programs through 2015.

Congratulations to the Cardiac Rehab team at Launceston for winning The Tasmanian Allied Health Professional Advancement Committee (TAHPAC) research initiatives award. The purpose of these awards is to reward allied health professional excellence in Tasmania and to promote the role of allied health professionals in the provision of all levels of health care.

All Cardiac Rehab Nurse's and Allied health professionals are now using the ABC activity bar coding system. The ABC uses a low-cost battery operated, portable barcode scanner (size of a matchbox) which records up to 5000 codes and includes a timestamp. The software system then analyses the stream of barcodes to assemble an activity profile of the professional, and track the interventions that happen to the patient. It generates a suite of reports by staff member, by patient, by referring department, and by activity type.

- Clinical Care - Identify actual clinical time as a percentage of overall time.
- Patient Journey - Identify and adjust patient interventions along their clinical journey.
- Staff Activity - Shows time spent on different activities, in different locations, for different clinical units.
- Audit & Data Quality - Unusually long activities can be identified.
- Referrals - Identifies the specific effort provided to different referring units
- Custom - Allows the capturing and reporting of clinical outcomes
- Clinics - Tracks activities, time and utilisation of inpatient and outpatient clinics

John Aitken and Caroline Hanley with award certificate.

Ophelia

The Cardiac Rehabilitation team at the Northern Integrated Care Service has been working with the University of Tasmania to investigate ways to help their clients to access, understand and apply health-related information. Helping people to understand health information is an important part of what we do as health professionals. Presenting information in easily digestible and relatable ways is critical to fostering therapeutic relationships and client engagement.

This all depends on the health literacy needs of the client and the health literacy responsiveness of the health professional. Health literacy is the skills and knowledge, motivation and beliefs, confidence and resources and supports that a person has that help them to find, understand and apply health information. Everyone is different in regards to what they have and what they need to be health literate. Therefore, health professionals need to respond appropriately to health literacy needs to make information, resources, supports and the environment accessible.

The project has been funded through a Research Enhancement Grants Scheme within the University and is due for completion at the end of 2015. Based on the Ophelia (OPtimising HEalth LIteracy and Access to health information and services) approach, the health literacy of the clients is assessed at the commencement and end of their participation in the cardiac rehabilitation program. The Cardiac Rehabilitation team have implemented many changes to their program on the basis of identified needs.

The health literacy needs of the clients who attend the service have been assessed using the Health Literacy Questionnaire (HLQ). The results from a group of clients

have been aggregated and discussed by the team to determine how the delivery and content of information can be tailored to address the identified needs. For example, one group of clients scored quite low on items relating to active participation in the management of their health. When this finding was discussed with the team, together with their observations and those of the researchers, it was suggested that clients may consider that their heart condition was "fixed" after surgical intervention and they were "cured", rather than living with a chronic condition. Subsequent to this, the team have debunked this misconception which has in turn fostered clients' participation and understanding of the importance of their rehabilitation program.

For more information about Ophelia, please go to www.opehlia.net.au . For more information about the project, please contact John Aitken (Cardiac Rehabilitation) john.aitken@ths.tas.gov.au or Dr Shandell Elmer (University of Tasmania) Shandell.Elmer@utas.edu.au.

Other news

Well done all ACRA-Tasmania members for collaborating this year and working hard towards the ACRA core components of cardiovascular disease secondary prevention and cardiac rehabilitation and we look forward to 2016 as we continue to move forward.

Some cardiac rehab team members from each of the hospitals met in Launceston in early November to brainstorm evaluation and data collection processes that we can all use in our programs. Using the ACRA document published earlier this year, we acknowledged that while we are 'collecting' a lot of the data as per the document, we have no concrete means of analysing it. The LGH is seeking assistance from IT students at UTAS for data analysis as a starting point.

Discussions also centred on assessment processes and the management of patients referred 'out of area' for procedures, and capturing their details for follow-up on return to their local region. We are using different referral and assessment forms and have individual hospital based databases with the conundrum of how we can have 1 statewide process/form/database. A work in progress!

Our annual education day and AGM is planned for April 15th, 2016. We are going to a weekday for a change (previously always on a Saturday) and we will invite local staff members to attend individual sessions of interest. A varied program is being planned.

John and Sue

WA Report

WACRA has been having good attendance at its professional development forums throughout 2016. Cardiac Goal setting presented by Jessica Sharp and Helen Mclean from the Training Centre in Subacute Care was no exception with the 33 participants finding the session informative and fun with many saying it could have been 4 hours instead of 2.

The Cardiovascular Health Network and the Heart Foundation presentation included

- Video Conference for Rural and Metro Practitioners
- A state wide update on Cardiac Rehabilitation and Secondary Prevention

Program

- Research findings from an "An in-depth assessment of cardiac rehabilitation services in Western Australia" - Dr Sandy Hamilton (WA Centre for Rural Health)
- An alternative model of cardiac rehabilitation for cost effective secondary prevention (ACCES) at RPH: study findings
- Cardiac Rehabilitation and Secondary Prevention update - Julie Smith (Heart Foundation).

Plans are well underway for the WACRA AGM which will be a dinner event with presenter Professor Graham Hillis on the topic of Heart failure – more details will follow soon.

From the state representative point of view it has been a privilege to attend the ACRA EMC's with such a committed group ensuring ACRA provides support and advocacy to all interprofessional members across the continuum of cardiovascular care. Sue and I were having a chat about her dual roles now with the Heart Foundation and in her Nurse Practitioner clinical role. I myself am now pleased to be working in dual part-time roles: one clinical as a Clinical Supervisor for Cardiac Rehabilitation at Edith Cowan University's Interprofessional Ambulatory Care Unit and one teaching as a Development Facilitator in the Training Centre for sub-acute care (TRACS WA). Sue and I have many years specialising in the care of cardiac patients and their families, like Sue we share a simple philosophy patients and their loved ones must always be front and centre of all we do, there would be no need of health professional without patients!

Helen McLean

ACRA 2016 ASM – Calling for Abstracts!

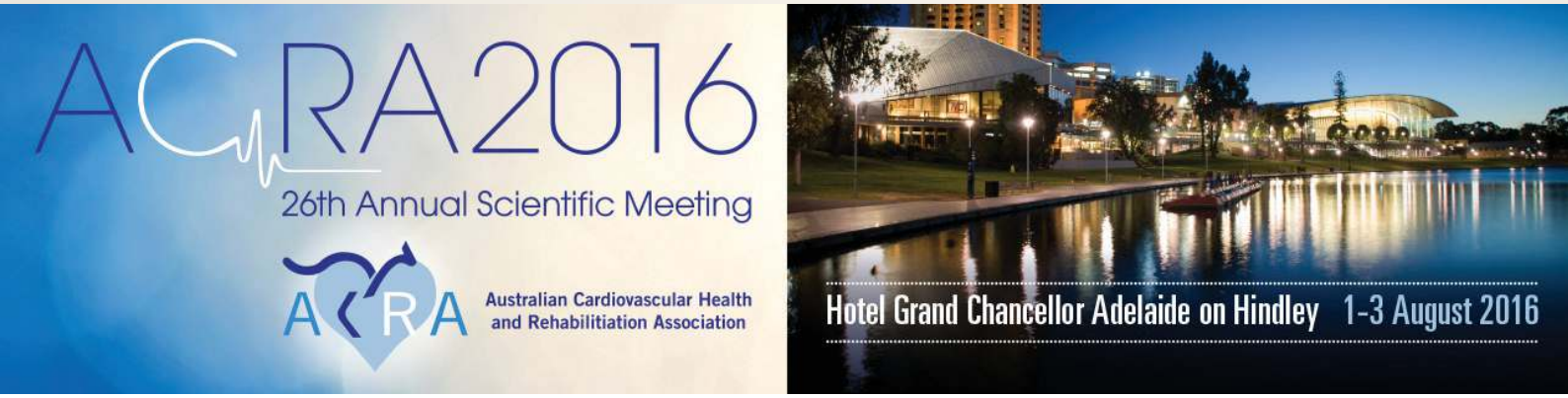
The Scientific Committee would like to encourage all members and supporters who are interested in presenting at the 2016 Annual Scientific Meeting to submit an abstract for review.

The theme for 2016 is "transforming into the future" and with a full two day conference program of national keynote speakers, workshops and concurrent sessions being planned - you won't want to miss this meeting!

There are two different abstract categories available, research and clinical. You will be asked to indicate your preferred presentation format, either oral or poster.

Abstract submission closes Wednesday 30 March 2016.

CLICK HERE TO SUBMIT AN ABSTRACT.



WORLD CONGRESS OF CARDIOLOGY & CARDIOVASCULAR HEALTH 2016 (WCC 2016)

The World Congress of Cardiology & Cardiovascular Health 2016 (WCC 2016) will gather cardiovascular health experts and specialists from related disciplines in Mexico City from 4-7 June 2016. The biennial event organised by the World Heart Federation will explore ground breaking research into cardiovascular health from the perspective of cardiology, nursing and other specialities including public health, with a spotlight on Latin America.

Join world leaders in heart health at WCC 2016, a global interactive event, to network, share knowledge and build innovative solutions to reduce premature mortality from cardiovascular disease by 25% by 2025.

Register now to join world leaders in heart health to network, share knowledge and build solutions to reduce premature CVD mortality by 25% by 2025

www.worldcardiocongress.org