ACRA NEWSLETTER

DECEMBER 2016

Australian Cardiovascular Health and Rehabilitation Association

SEASONS GREETINGS

President elect

New EMC members

ACRA promotional infographic

EMC reports

More conference photos

AUSTRALIAN CARDIOVASCULAR HEALTH AND REHABILITATION ASSOCIATION

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CHALLENGE...CHANGE...ACHIEVE

EDITOR'S NOTE

Welcome to the final edition for 2016 of your newsletter. I hope you enjoy reading it. There are some very comprehensive state reports and a comprehensive overview of recent published research about the benefits of cardiac rehabilitation – something we all appreciate. Thanks to Robert Zecchin as always for searching and collating these articles for your perusal and piquing your interest.

The EMC had 2 very full days meeting in Sydney last month with very robust round the table discussions. Unfortunately, Craig Cheetham and Alun Jackson were not able to be with us on this occasion.

There are 4 sub-committees or working groups of the EMC each of which met during the weekend – see the reports from each lead elsewhere in the newsletter. This sub-committee structure spreads and shares the workload amongst the EMC members and the ideas and strategies determined in the working groups are brought back to the full EMC for further discussion and ratification. In between face-to-face meetings each sub-committee will follow-up via teleconference.

A quick "look at moi" moment in between discussions.

We have some new members on the EMC – Bridget Abel is the Queensland president replacing Paul Camp who did an amazing job on the EMC especially leading the membership sub-committee. Steve Woodruffe (not new) is now the Qld state rep. Jane Kerr joins the EMC as the NSW state rep replacing Robyn Gallagher who was elected as ACRA incoming president at the AGM. Kim Gray and Emma Boston have 'swapped' state roles – president and state rep respectively. There may be some further changes after AGM's early in the new year.

Have you visited the "Members' Lounge" on the website? I encourage all to do so. You can access the following as a member:

- Educational Resources
- Mentoring Program
- Awards, Scholarships & Travel Grants
- ACRA Newsletters
- State Chapter Newsletters
- Access to European Journal of Preventive Cardiology
- Vimeo - Recording of ACRA webinars

Please encourage your colleagues to become members – there is a challenge to see which state can recruit the most new members over the next 12 months!

While the dust has settled on this year's conference (and there a few more photos published in this edition) it's time to start planning and saving to go to Perth in 2017. Calls for abstracts have just gone out.

May I take this opportunity to wish you and your families a very happy and safe festive season. As always – everything in moderation. Come back refreshed in 2017.

Best wishes
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

ACRA continues to grow and flourish. Following our highly successful conference in August 2016, we have continued to progress activities across our four key areas: membership; research and education; advocacy; and treasury.

The membership committee, under the leadership of Paul Camp, has been particularly active. I have sent my sincere thanks to Paul, who has stepped down from the committee. We will miss him greatly. Included in the remit of the membership committee has been development of new member resources, including new banners, membership exit surveys, and more proactively seeking the engagement across the states to support membership growth.

We were asked to contribute to a number of activities, most of which have fallen under the remit of our research and education committee chaired by Robyn Gallagher. Briefly, they include participation in a global survey of CR services, and review and comment on a Baker IDI white paper. The British Association of Cardiac Prevention and Rehabilitation (BACPR) have approached us to enquire about the potential of using their annual travel scholarship to fund a visiting scholar from BACPR to spend 10 days in Australia to learn about our innovative programs. We look forward to working together on this exciting opportunity.

Our advocacy group developed, with the strong support of the NSW Cardiac Rehabilitation Working Group, a fantastic infographic to communicate to health care professionals key points about cardiac rehab in Australia. Under the leadership of Cate Ferry, there is an ongoing focus on clear communication strategy and improving the way we engage with key stakeholders in CR. A copy of this resource is elsewhere in the newsletter.

I was fortunate to be asked to present on ACRA's behalf at the Cardiac Rehabilitation Interest Group in Scotland. This group expressed a keen interest to learn from our experiences. Steve Woodruffe and I have also been invited to contribute to a paper on exercise and diabetes written by the BACPR. These opportunities truly reflect the increased profile and value of ACRA globally.

We now have a focus on growing our membership, and I offer a challenge and an opportunity to the members. 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. Have fun recruiting!

As many of you know, I am now living and working in Scotland. It has been a hectic few months as I find my feet in a new job, somewhere new to live, a school for my daughter, and adjusting to the cooler weather! The new job is challenging and exciting, it is a big change to get to grips with, and although I completed my undergraduate degree in the UK, I have never worked in the higher education sector here. In fact, it is 19 years since I last lived in Edinburgh, and there have been significant changes, including a new hospital, and most notably, terrible traffic - seems we can't leave that behind in Sydney. We are finally settling in though, have now got a new house, and my daughter loves her new school. I miss my Aussie colleagues though, and it was great to be back in Sydney November for the ACRA executive management committee meeting.

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

Ed: *Lis celebrated her birthday at the recent EMC meeting in November. The committee marked the occasion with a small presentation.*

VICE-PRESIDENT/PRESIDENT ELECT

Robyn Gallagher Vice-president/President elect
RN, BA(Psychology), MN, PhD

Biographical details

Robyn Gallagher is Professor of Nursing at Sydney Nursing School based at the Charles Perkins Centre and an Adjunct Professor at the University of Technology, Sydney. Professor Gallagher's clinical and academic career focusses on understanding and supporting patients who have cardiovascular disease throughout their recovery, encouraging and enabling good self-management and reducing their risk of future cardiovascular events through secondary prevention. She has led weight loss and physical activity intervention programs for overweight and obese patients with coronary heart disease or diabetes and has extensive experience in establishing multidisciplinary research teams. Her work with these teams has been internationally recognised, won awards and altered clinical practice leading to significant changes in policy.

She is an experienced academic and research degree supervisor and was previously Director of Research Students at the University of Technology, Sydney, where she received the Postgraduate Supervision Award for Excellence. She has contributed to several Policy Standards and advisory documents including on the implementation and impact of the Australian Commission on Safety and Quality in Health Care National Labelling Recommendations (2011), which the Federal Department of Health and Aging adopted. Professor Gallagher is elected Chair of the Cardiac Society of Australia and New Zealand Cardiovascular Nursing Council, Fellow of the American Heart Association Cardiovascular Nursing Council and Nurse Fellow of the European Society of Cardiology.

Bridget Abell – New QLD President

Following the completion of her Exercise Science degree, Bridget has worked as a Cardiac Physiologist in both Australia and the United Kingdom. During this time she has experienced many aspects of Cardiology, having been employed in diagnostics, private practice, clinical research, and as the coordinator of a successful cardiac rehabilitation program for several years. Most recently she has been able to combine her professional experience with her passion for research, and is about to complete her PhD within the Centre for Research in Evidence-Based Practice at Bond University.

With a strong interest in improving the use of exercise as a treatment for coronary heart disease, her thesis examines whether the prescription and delivery of exercise-based cardiac rehabilitation in Australia is congruent with the best available research evidence. It is hoped that this research will provide a clearer understanding of current practice, as well as help to develop useful strategies to improve the service delivery of cardiac rehabilitation, and application of evidence into clinical practice.

Bridget has also been a member of the Executive Management Committee of QCRA for the past 3 years, most recently as the program directory co-ordinator and now looks forward to her role as president.

NSW State representative

Jane Kerr: Chronic Disease Network Manager, Hunter New England Local Health District

It is a privilege to be part of the ACRA management team. Cardiac rehab (CR) is in my blood I think given my 30-year history working in, or aligned to, cardiac rehab services.

My first experience came in 1985 where I was encouraged, as a ward nurse, to provide inpatient rehab on the cardiology ward at Royal North Shore Hospital in Sydney. My interest was piqued and I grabbed every opportunity to learn more. In 1987 an irresistible opportunity arose and I was given the chance to establish outpatient CR, amongst other services, at RNSH.

A tree change in 1995 gave me the chance to establish CR services across north western NSW. As services grew more opportunities came my way to the point where I now work closely in a management capacity with the teams who deliver both CR and pulmonary rehab across communities throughout the Hunter and north west of NSW. The teams of committed clinicians are equally as passionate as yourselves and we work hard to ensure service delivery is patient-centered, evidence-based and flexible.

As my interest and capacity to network with colleagues grew I became one of a small team within NSW and across Australia actively working towards the establishment of a professional organization to support the development of CR to improve patient access to effective and evidence based rehabilitation.

The outcome was the establishment of a state-based Cardiac Rehabilitation Association of NSW (later including ACT) and very soon after, the Australian Cardiac Rehabilitation Association. I have been involved in both Associations either at an executive level or simply as a member ever since. The greatest gain I have seen is the growth in patient access to service, the expansion of the service to include many more disciplines and the strength of the evidence supporting service delivery.

Professionally I have may have moved away from direct patient care, however I can now sit in my office and still feel a great sense of satisfaction listening to the music and the laughter of the participants exercising in the group program that I established in 1995.

My role these days, however, is much more focused on ensuring adherence to evidence based best practice and measuring and responding to the outcomes that reflect an effective quality patient centred service.

Equally as important though is my all male household, 11 dogs, pet lamb, chooks, cattle, horses, fish, snakes, the odd goanna and a growing veggie patch. It is a good thing I learnt early on in my career about managing funds as that is my job when I get home, along with the feeding, watering and nurturing of teenage boys.

Please be in touch – our representation is only valuable with your input.

Ed note: *Jane was the recipient of the Alan Goble Distinguished Service Award in 2014.*

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. Cardiac rehabilitation improves coronary endothelial function in patients with heart failure due to dilated cardiomyopathy: A positron emission tomography study.

Legallois D; Belin A; Nesterov SV; Milliez P; Parienti JJ; Knuuti J; Abbas A; Tirel O; Agostini D; Manrique A.
European Journal of Preventive Cardiology. 23(2):129-36, 2016 Jan.

BACKGROUND: Endothelial dysfunction is common in patients with heart failure and is associated with poor clinical outcome. Cardiac rehabilitation is able to enhance peripheral endothelial function but its impact on coronary vasomotion remains unknown. We aimed to evaluate the effect of cardiac rehabilitation on coronary vasomotion in patients with heart failure.

METHOD: We prospectively enrolled 29 clinically stable heart failure patients from non-ischaemic dilated cardiomyopathy and without coronary risk factors. Myocardial blood flow was quantified using (15)-O water positron emission tomography at rest and during a cold pressor test, before and after 12 weeks of cardiac rehabilitation and optimization of medical therapy.

RESULTS: Rest myocardial blood flow was significantly improved after the completion of rehabilitation compared to baseline (1.31+/-0.38mL/min/g vs. 1.16+/-0.41mL/min/g, p=0.04). The endothelium-related change in myocardial blood flow from rest to cold pressor test and the percentage of myocardial blood flow increase during the cold pressor test were both significantly improved after cardiac rehabilitation (respectively from -0.03+/-0.22mL/min/g to 0.19+/-0.22mL/min/g, p<0.001 and from 101.5+/-16.5% to 118.3+/-24.4%, p<0.001). Left ventricular ejection fraction, plasma levels of brain natriuretic peptide, maximal oxygen consumption and the Minnesota Living with Heart Failure Questionnaire score were also significantly improved. The improvement was not related to up-titration of medical therapy.

CONCLUSIONS: Coronary endothelial function is altered in patients with heart failure due to non-ischaemic dilated cardiomyopathy. In these patients, cardiac rehabilitation significantly improves coronary vasomotion.

The Good News: More evidence of the power of cardiac rehabilitation!

2. Short-term results of a 5-week comprehensive cardiac rehabilitation program after first-time myocardial infarction.

Fallavollita L; Marsili B; Castelli S; Cucchi F; Santillo E; Marini L; Balestrini F. Journal of Sports Medicine & Physical Fitness. 56(3):311-8, 2016 Mar.

BACKGROUND: A prospective single-centre interventional cohort study was conducted to evaluate the effects of a 5-week comprehensive cardiac rehabilitation program on terms exercise capacity, quality of life, echocardiographic findings and autonomic modulation after first-time myocardial infarction.

METHODS: We studied 37 consecutive post-myocardial infarction patients (mean age 66 years). All patients began a 5-week cardiac rehabilitation supervised training. The exercise program consisted of 40 minutes of training, three times a week, on a cycle ergometer at 60-80% of the maximal heart rate. At baseline and after training program we analyzed: the distance walked after the Six-Minutes Walking Test (6MWT); quality of life (QoL) assessed using the Psychological General Well-Being Inventory (PGWBI) questionnaire; echocardiographic finding and autonomic balance assessed heart rate variability (HRV).

RESULTS: We observed statistically significant improvement in exercise capacity (from 423+/-94 to 496+/-13 m; P<0.05). Also we observed statistically significant improvements in the many PGWBI dimensions; particularly, anxiety +5.8% (from 18.11+/-5.2 to 19.12+/-4.4); depression +6.0% (from 12.00+/-3.0 to 12.73+/-2.4); positive well-being +6% (from 11.55+/-3.5 to 12.23+/-4.0); general health +10.3% (from 9.48+/-3.5 to 10.46+/-2.87); vitality +6.8% (from 12.96+/-4.2 to 13.85+/-4.2). Finally, we observed changes in HRV indices after training program: RR (from 903+/-169 ms to 952+/-163 ms; P<0.05), pNN50% (from 4.74+/-4.89 to 6.23+/-5.53; P<0.05), in time-domain; LF (from 274+/-169 to 362+/-233 ms2; P<0,05); HF (from 214+/-154 to 314+/-194 ms2; P<0.05) and LF/HF (from 1.53+/-0.54 to 1.24+/-0.47; P<0.05) in frequency-domain.

CONCLUSIONS: The study suggests that a cardiac rehabilitation program in post-myocardial infarction improves exercise capacity, QoL and autonomic modulation.

The Good News: Derrrrr! Where have these guys been?

3. Degree and Direction of Change of Body Weight in Cardiac Rehabilitation and Impact on Exercise Capacity and Cardiac Risk Factors.

Gomadam PS; Douglas CJ; Sacrinty MT; Brady MM; Paladenech CC; Robinson KC. American Journal of Cardiology. 117(4):580-4, 2016 Feb 15.

BACKGROUND: Cardiac rehabilitation (CR) improves functional capacity and reduces mortality in patients with cardiovascular disease. It also improves cardiovascular risk factors and aids in weight reduction. Because of the increase in morbidly obese patients with cardiovascular disease, the prevalence of obesity and patterns of weight change in those undergoing CR merit fresh study.

METHODS: We studied 1,320 participants in a 12-week CR program at our academic medical centre. We compared 5 categories: 69 class III obese (body mass index (BMI) >40) patients, 128 class II obese patients (BMI 35.0 to 39.9), 318 class I obese patients (BMI 30.0 to 34.9), 487 overweight patients (BMI 25.0 to 29.9), and 318 normal weight patients (BMI 18.5 to 24.9). Exercise capacity in METs, weight, blood pressure, and fasting lipid profile were measured before and after CR.

RESULTS: Overall, 131 patients gained weight, 827 had no significant weight change, and 363 lost weight (176 lost 3% to 5% of their baseline weight, 161 lost 5% to 10%, and 26 lost >10%). Exercise capacity, blood pressure, and low-density lipoprotein cholesterol improved in all patients. Class III obese patients had the smallest improvement in peak METs (p <0.001), but the greatest weight loss. Patients who lost >10% of their baseline weight had the greatest improvements in exercise capacity, low-density lipoprotein, and triglycerides.

CONCLUSIONS: In conclusion, after CR, a minority of patients lost weight. Most patients had no significant weight change and some even gained weight. The greatest loss was seen in class III obese patients. All patient groups showed improvements in exercise capacity and risk factors, regardless of the direction or degree of weight change.

The Good News: What should we be measuring then? Waist circumference, BMI, % body fat, all the above – food for thought!

4. Hospital revascularisation capability and quality of care after an acute coronary syndrome in Switzerland.

Welker J; Auer R; Gencer B; Muller O; Cornuz J; Matter CM; Mach F; Windecker S; Rodondi N; Nanchen D.
Swiss Medical Weekly. 146:w14275, 2016.

BACKGROUND: Patients with acute coronary syndrome (ACS) transferred to regional non-academic hospitals after percutaneous coronary intervention (PCI) may receive fewer preventive interventions than patients who remain in university hospitals. We aimed at comparing hospitals with and without PCI facilities regarding guidelines-recommended secondary prevention interventions after an ACS.

METHODS: We studied patients with ACS admitted to a university hospital with PCI facilities in Switzerland, and either transferred within 48 hours to regional non-academic hospitals without PCI facilities or directly discharged from the university hospital. We measured prescription rates of evidence-based recommended therapies after ACS including reasons for non-prescription of aspirin, statins, beta-blockers, angiotensin converting-enzyme inhibitors (ACEI) / angiotensin II receptor blockers (ARB), along with cardiac rehabilitation attendance and delivery of a smoking cessation intervention.

RESULTS: Overall, 720 patients with ACS were enrolled; 541 (75.1%) were discharged from the hospital with PCI facilities, 179 (24.9%) were transferred to hospitals without PCI facilities. Concomitant prescription of aspirin, beta-blockers, ACEI/ARB and statins at discharge was similar in hospitals with and without PCI

facilities, reaching 83.9% and 85.5%, respectively (p = 0.62). Attendance at cardiac rehabilitation reached 55.5% for the hospital with PCI facilities and 65.7% for hospitals without PCI facilities (p = 0.02). In-hospital smoking cessation interventions were delivered to 70.8% patients exclusively at the hospital with PCI facilities.

CONCLUSION: Quality of care for patients with ACS discharged from hospitals without PCI facilities was similar to that of patients directly discharged from the hospital with PCI facilities, except for in-hospital smoking cessation counselling and cardiac rehabilitation attendance.

The Good News: What are the non-PCI hospitals doing better in regards to CR attendance then PCI hospitals?

5. Multiple differences between patients who initiate fish oil supplementation post-myocardial infarction and those who do not: the TRIUMPH Study.

Harris WS; Kennedy KF; Maddox TM; Kutty S; Spertus JA.
Nutrition Research. 36(1):65-71, 2016 Jan.

BACKGROUND: The utility of fish oil supplements (FOS) in patients who survive an acute myocardial infarction (MI) remains controversial, with randomized trials showing less benefit than observational studies would suggest. The differences in the characteristics of MI patients who use FOS in routine clinical care are unknown but may help explain this discrepancy.

METHODS: We used data from a 24-site registry study in which extensive information was available on 4340 MI patients at admission and 1, 6, and 12 months post-discharge. After excluding those using FOS at admission (n = 651), those who died before the 1-month follow-up visit (n = 63), and those with missing data at 1 month (n = 1228), 2398 remained.

RESULTS: Of them, 377 (16%) started FOS within 1 month of their MI. We analyzed 53 patient characteristics associated with FOS use. We observed differences (P < .001) in 20 demographic, socioeconomic, treatment, disease severity, and health status domains. The FOS users were more likely than nonusers to be white, married, financially secure, highly educated, and eating fish. They also had a higher ejection fraction at discharge, were more likely to have had in-hospital percutaneous coronary interventions, and were more likely to have participated in cardiac rehabilitation programs. The FOS users were less likely to have a history of diabetes, alcohol abuse, stroke, MI, and angina.

CONCLUSION: Post-MI patients who initiate FOS within 1 month of discharge in routine clinical practice differ substantially from those who do not. These differences are strongly associated with a better post-MI prognosis and may illuminate several sources of unmeasured confounding in observational studies.

The Good News: Ahoy there Captain Birdseye – CR may have some influence on Fish Oil Supplement consumption – it has me Breaming from ear to ear. OK, OK don't go the raw prawn with me. I am only here to kelp oops I mean help.

Ed: Holy mackerel this is a gunny errrr punny man!

6. Economic and Social Impact of Increasing Uptake of Cardiac Rehabilitation Services–A Cost Benefit Analysis.

De Gruyter E; Ford G; Stavreski B.
Heart, Lung & Circulation. 25(2):175-83, 2016 Feb.

BACKGROUND: Cardiac rehabilitation can reduce mortality, improve cardiac risk factor profile and reduce readmissions; yet uptake remains low at 30%. This research aims to investigate the social and economic impact of increasing the uptake of cardiac rehabilitation in Victoria, Australia using cost benefit analysis (CBA).

METHODS: Cost benefit analysis has been undertaken over a 10-year period to analyse three scenarios: (1) Base Case: 30% uptake; (2) Scenario 1: 50% uptake; and (3) Scenario 2: 65% uptake. Impacts considered include cardiac rehabilitation program costs, direct inpatient costs, other healthcare costs, burden of disease, productivity losses, informal care costs and net deadweight loss.

RESULTS: There is a net financial saving of $46.7-$86.7 million under the scenarios. Compared to the Base Case, an additional net benefit of $138.9-$227.2 million is expected. This results in a Benefit Cost Ratio of 5.6 and 6.8 for Scenarios 1 and 2 respectively. Disability Adjusted Life Years were 21,117-37,565 years lower than the Base Case.

CONCLUSIONS: Greater uptake of cardiac rehabilitation can reduce the burden of disease, directly translating to benefits for society and the economy. This research supports the need for greater promotion, routine referral to be made standard practice and implementation of reforms to boost uptake.

The Good News: CR – cheap as chips (goes well with No. 5.) and effective to boot.

7. High Intensity Interval versus Moderate Intensity Continuous Training in Patients with Coronary Artery Disease: A Meta-analysis of Physiological and Clinical Parameters.

Liou K; Ho S; Fildes J; Ooi SY.
Heart, Lung & Circulation. 25(2):166-74, 2016 Feb.

INTRODUCTION: Exercise-based cardiac rehabilitation for patients with coronary artery disease (CAD) significantly improves their outcome, although the optimal mode of exercise training remains undetermined. Previous analyses have been constrained by small sample sizes and a limited focus on clinical parameters. Further, results from previous studies have been contradicted by a recently published large RCT.

METHOD: We performed a meta-analysis of published randomised controlled trials to compare high intensity interval training (HIIT) and moderate intensity continuous training (MCT) in their ability to improve patients' aerobic exercise capacity (VO2peak) and various cardiovascular risk factors. We included patients with established coronary artery disease without or without impaired ejection fraction.

RESULTS: Ten studies with 472 patients were included for analyses (218 HIIT, 254 MCT). Overall, HIIT was associated with a more pronounced incremental gain in participants' mean VO2peak when compared with MCT (+1.78mL/kg/min, 95% CI: 0.45-3.11). Moderate intensity continuous training however was associated with a more marked decline in patients' mean resting heart rate (-1.8/min, 95% CI: 0.71-2.89) and body weight (-0.48kg, 95% CI: 0.15-0.81). No significant differences were noted in the level of glucose, triglyceride and HDL at the end of exercise program between the two groups.

CONCLUSION: High intensity interval training improves the mean VO2peak in patients with CAD more than MCT, although MCT was associated with a more pronounced numerical decline in patients' resting heart rate and body weight. The underlying mechanisms and clinical relevance of these results are uncertain, and remain a potential focus for future studies.

The Good News: This article is a HIIT with me!

8. Feasibility of Financial Incentives to Increase Exercise Among Canadian Cardiac Rehabilitation Patients.

Mitchell MS; Goodman JM; Alter DA; Oh PI; Leahey TM; Faulkner GE.
Journal of Cardiopulmonary Rehabilitation & Prevention.
36(1):28-32, 2016 Jan-Feb.

PURPOSE: To examine the feasibility of conducting a randomized controlled trial investigating the effectiveness of financial incentives for exercise self-monitoring in cardiac rehabilitation (CR).

METHODS: A 12-week, 2 parallel-arm, single-blind feasibility study design was employed. A volunteer sample of CR program graduates was randomly assigned to an exercise self-monitoring intervention only (control; n = 14; mean age +/- SD, 62.7 +/- 14.6 years), or an exercise self-monitoring plus incentives approach (incentive; n = 13; mean age +/- SD, 63.6 +/- 11.8 years). Control group participants received a "home-based" exercise self-monitoring program following CR program completion (exercise diaries could be submitted online or by mail). Incentive group participants received the "home-based" program, plus voucher-based incentives for exercise diary submissions ($2 per day). A range of feasibility outcomes is presented, including recruitment and retention rates, and intervention acceptability. Data for the proposed primary outcome of a definitive trial, aerobic fitness, are also reported.

RESULTS: Seventy-four CR graduates were potentially eligible to participate, 27 were enrolled (36.5% recruitment rate; twice the expected rate), and 5 were lost to follow-up (80% retention). Intervention acceptability was high with three-quarters of participants indicating that they would likely sign up for an incentive program at baseline. While group differences in exercise self-monitoring (the incentive "target") were not observed, modest but non-significant changes in aerobic fitness were noted with fitness increasing by 0.23 mL.kg-.min- among incentive participants and decreasing by 0.68 mL.kg-.min- among controls.

CONCLUSION: This preliminary study demonstrates the feasibility of studying incentives in a CR context, and the potential for incentives to be readily accepted in the broader context of the Canadian health care system.

The Good News: Show me the money, I mean show the patient the money!

A CORNER OF RESEARCH FOR AUSTRALIA CONT.

9. Enhancing Cardiac Rehabilitation with Stress Management Training: A Randomized, Clinical Efficacy Trial.

Blumenthal JA; Sherwood A; Smith PJ; Watkins L; Mabe S; Kraus WE; Ingle K; Miller P; Hinderliter A.
Circulation. 133(14):1341-50, 2016 Apr 5.

BACKGROUND: Cardiac rehabilitation (CR) is the standard of care for patients with coronary heart disease. Despite considerable epidemiological evidence that high stress is associated with worse health outcomes, stress management training (SMT) is not included routinely as a component of CR.

METHODS AND RESULTS: One hundred fifty-one outpatients with coronary heart disease who were 36 to 84 years of age were randomized to 12 weeks of comprehensive CR or comprehensive CR combined with SMT (CR+SMT), with assessments of stress and coronary heart disease biomarkers obtained before and after treatment. A matched sample of CR-eligible patients who did not receive CR made up the no-CR comparison group. All participants were followed up for up to 5.3 years (median, 3.2 years) for clinical events. Patients randomized to CR+SMT exhibited greater reductions in composite stress levels compared with those randomized to CR alone (P=0.022), an effect that was driven primarily by improvements in anxiety, distress, and perceived stress. Both CR groups achieved significant, and comparable, improvements in coronary heart disease biomarkers. Participants in the CR+SMT group exhibited lower rates of clinical events compared with those in the CR-alone group (18% versus 33%; hazard ratio=0.49; 95% confidence interval, 0.25-0.95; P=0.035), and both CR groups had lower event rates compared with the no-CR group (47%; hazard ratio=0.44; 95% confidence interval, 0.27-0.71; P<0.001).

CONCLUSIONS: CR enhanced by SMT produced significant reductions in stress and greater improvements in medical outcomes compared with standard CR. Our findings indicate that SMT may provide incremental benefit when combined with comprehensive CR and suggest that SMT should be incorporated routinely into CR.

CLINICAL TRIAL REGISTRATION: URL: http://www.clinicaltrials.gov. Unique identifier: NCT00981253.

The Good News: Does your program have a regular Stress Management Program (SMT)?

10. English as a second language and outcomes of patients presenting with acute coronary syndromes: results from the CONCORDANCE registry.

Juergens CP; Dabin B; French JK; Kritharides L; Hyun K; Kilian J; Chew DP; Brieger D. Medical Journal of Australia. 204(6):239, 2016 Apr 4.

OBJECTIVES: To investigate whether patients with English as their second language have similar acute coronary syndrome (ACS) outcomes to people whose first language is English.

DESIGN: Retrospective, observational study, using admissions, treatment and follow-up data.

PARTICIPANTS AND SETTING: A total of 6304 subjects from 41 sites enrolled in the investigator-initiated CONCORDANCE ACS registry.

MAIN OUTCOME MEASURES: Baseline characteristics, treatments, and in-hospital and 6-month mortality.

RESULTS: English as a second language (ESL) was reported by 1005 subjects (15.9%). Patients with English as their first language (EFL) were older, and were less likely to have diabetes mellitus or to smoke than the ESL patients. Prior myocardial infarction, heart failure and chronic renal failure were more common in the ESL group. In-hospital mortality was also higher in these patients (7.1% v 3.8% for EFL patients; P < 0.001). Predictors of in-hospital mortality included presentation in cardiogenic shock, cardiac arrest in hospital, and a history of renal failure, prior cardiac failure, and ESL. Rates of cardiac catheterisation, percutaneous coronary intervention rates, and referral to cardiac rehabilitation were lower in the ESL group; at 6 months, all-cause mortality was also higher (13.8% v 8.3% for EFL group; P < 0.001). Logistic regression identified language, age, in-hospital renal failure, and recurrent ischaemia as predictors of 6-month mortality.

CONCLUSION: Patients presenting with an ACS who report English as their second language have poorer outcomes than patients who use English as their first language. This difference may not be entirely explained by baseline demographic disparities or management differences.

The Good News: Perhaps an increase in education to the general population with English as their second language, in their own language, would be required!

A CORNER OF RESEARCH FOR AUSTRALIA CONT.

11. Relationship Between Exercise Workload During Cardiac Rehabilitation and Outcomes in Patients With Coronary Heart Disease.

Brawner CA; Abdul-Nour K; Lewis B; Schairer JR; Modi SS; Kerrigan DJ; Ehrman JK; Keteyian SJ.
American Journal of Cardiology. 117(8):1236-41, 2016 Apr 15.

BACKGROUND: The purpose of this retrospective, observational study was to describe the relation between exercise workload during cardiac rehabilitation (CR), expressed as metabolic equivalents of task (METs), and prognosis among patients with coronary heart disease.

METHODS: We included patients with coronary heart disease who participated in CR between January 1998 and June 2007. METs were calculated from treadmill workload. Cox regression analysis was used to describe the relationship between METs and time to a composite outcome of all-cause mortality, nonfatal myocardial infarction, or heart failure hospitalization.

RESULTS: Among 1,726 patients (36% women; median age 59 years (interquartile range, 52 to 66)), there were 467 events (27%) during a median follow-up of 5.8 years (interquartile range, 2.6 to 8.7). In analyses adjusted for age, sex, Charlson co-morbidity index, hypertension, diabetes, and CR referral diagnosis, METs were independently related to the composite outcome at CR start (Wald chi-square 43, hazard ratio 0.59 (95% confidence interval 0.51 to 0.70)) and CR end (Wald chi-square 47, hazard ratio 0.68 (95% confidence interval 0.61 to 0.76)). Patients exercising below 3.5 METs on exit from CR represent a high-risk group with 1- and 3-year event rates >7% and >18%, respectively.

CONCLUSIONS: In conclusion, METs during CR is available at no additional cost and can be used to identify patients at increased risk for an event who may benefit from closer follow-up, extended length of stay in CR, and/or participation in other strategies aimed at maximizing adherence to secondary preventive behaviours and improving exercise capacity.

The Good News: Functional capacity tests are a good prognostic tool with a previous study showing for every 1 MET increase there is a 12% decrease in all course mortality (Kokkinos et al. Circulation 2010).

12. Exercise-based cardiac rehabilitation for adults after heart valve surgery.

Sibilitz KL; Berg SK; Tang LH; Risom SS; Gluud C; Lindschou J; Kober L; Hassager C; Taylor RS; Zwisler AD.
Cochrane Database of Systematic Reviews. 3:CD010876, 2016.

BACKGROUND: Exercise-based cardiac rehabilitation may benefit heart valve surgery patients. We conducted a systematic review to assess the evidence for the use of exercise-based intervention programmes following heart valve surgery.

OBJECTIVES: To assess the benefits and harms of exercise-based cardiac rehabilitation compared with no exercise training intervention, or treatment as usual, in adults following heart valve surgery. We considered programmes including exercise training with or without another intervention (such as a psycho-educational component).

SEARCH METHODS: We searched: the Cochrane Central Register of Controlled Trials (CENTRAL); the Database of Abstracts of Reviews of Effects (DARE); MEDLINE (Ovid); EMBASE (Ovid); CINAHL (EBSCO); PsycINFO (Ovid); LILACS (Bireme); and Conference Proceedings Citation Index-S (CPCI-S) on Web of Science (Thomson Reuters) on 23 March 2015. We hand searched Web of Science, bibliographies of systematic reviews and trial registers (ClinicalTrials.gov, Controlled-trials.com, and The World Health Organization International Clinical Trials Registry Platform).

SELECTION CRITERIA: We included randomised clinical trials that investigated exercise-based interventions compared with no exercise intervention control. The trial participants comprised adults aged 18 years or older who had undergone heart valve surgery for heart valve disease (from any cause) and received either heart valve replacement, or heart valve repair.

DATA COLLECTION AND ANALYSIS: Two authors independently extracted data. We assessed the risk of systematic errors ('bias') by evaluation of bias risk domains. Clinical and statistical heterogeneity were assessed. Meta-analyses were undertaken using both fixed-effect and random-effects models. We used the GRADE approach to assess the quality of evidence. We sought to assess the risk of random errors with trial sequential analysis.

MAIN RESULTS: We included two trials from 1987 and 2004 with a total 148 participants who have had heart valve surgery. Both trials had a high risk of bias. There was insufficient evidence at 3 to 6 months follow-up to judge the effect of exercise-based cardiac rehabilitation compared to no exercise on

mortality (RR 4.46 (95% confidence interval (CI) 0.22 to 90.78); participants = 104; studies = 1; quality of evidence: very low) and on serious adverse events (RR 1.15 (95% CI 0.37 to 3.62); participants = 148; studies = 2; quality of evidence: very low). Included trials did not report on health-related quality of life (HRQoL), and the secondary outcomes of New York Heart Association class, left ventricular ejection fraction and cost. We did find that, compared with control (no exercise), exercise-based rehabilitation may increase exercise capacity (SMD -0.47, 95% CI -0.81 to -0.13; participants = 140; studies = 2, quality of evidence: moderate). There was insufficient evidence at 12 months follow-up for the return to work outcome (RR 0.55 (95% CI 0.19 to 1.56); participants = 44; studies = 1; quality of evidence: low). Due to limited information, trial sequential analysis could not be performed as planned.

AUTHORS' CONCLUSIONS: Our findings suggest that exercise-based rehabilitation for adults after heart valve surgery, compared with no exercise, may improve exercise capacity. Due to a lack of evidence, we cannot evaluate the impact on other outcomes. Further high-quality randomised clinical trials are needed in order to assess the impact of exercise-based rehabilitation on patient-relevant outcomes, including mortality and quality of life.

The Good News: More data is required for this population subgroup but we know that CR are helping them immensely.

As you can tell the silly season is with me. I hope that you all have a very Merry Christmas and a Happy New Year!

More next year!

WOULD YOU LIKE TO BE INVOLVED WITH PLANNING THE ACRA ANNUAL SCIENTIFIC MEETING IN 2018?

ACRA-Qld is now inviting expressions of interest from any ACRA 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 welcome members from all states who might like to be involved, and will begin some preliminary planning in the first half of next year.

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.

Conference Pics

The WA team promoting 2017 conference at this year's event

Past and present DSA recipients at the dinner

Enjoying the welcome reception 2016

Fun and laughter at the Conference dinner

Relaxing after the event

Finance and Corporate Working Group Report:

For ACRA to remain in a positive fiscal position and to remain positioned as a guiding voice for cardiac rehabilitation on a national platform, ACRA's financial position continues to be under review. Whilst the budget presented at our scientific meeting in August was based on conservative modelling, we (ACRA) remain buffeted by rising costs. We are currently financial, but with a changing workforce, ACRA must continue to review its processes to stay relevant to our members and find ways to maintain and grow our diverse membership.

At our Face to Face meeting in November, the ACRA EMC undertook a strategic review to reduce expenditure. As a collective we made the following decisions:

- The ACRA 1300 phone number has been officially cancelled
- Streamline our next Face to Face meeting in Sydney in May - from a two-day weekend meeting to a one day, fly in/out meeting. This greatly moderates our costs as a result of a reduction in venue room hire for the meeting, and accommodation for our EMC members.

  The venue for our meeting will be at the Heart Foundation in Sydney – with many thanks to the Heart Foundation to facilitate with this meeting venue.
- Negotiate with TAS to reduce management costs.
- Further budget restructuring is in progress, everything is on the table.
- There will be a five dollar increase in our yearly memberships from June 2017. This is less than a 3% increase.
- Members will also be absorbing Currinda costs.

Speak to your state representative or president if you require any further information or clarification regarding the above decisions.

Please contact your State representative if your CR or HF service contact details require updating.

On behalf of the Treasury Working Group, I would like to take this opportunity to wish everyone a safe and prosperous Christmas and holidays.

Natalie Simpson
ACRA Treasurer.

Membership Working Group

Firstly, we would like to say a big thank you to Paul Camp for his leadership of the ACRA Membership Committee to date – Paul your expert opinion, leadership, drive, and level of commitment has been deeply appreciated. Under Paul's reassuring lead we have been willing to try new ideas to benefit our member and our achievements include:

Changes to the ACRA Website.

- **ACRA Homepage** changed to have Membership feature on first opening the site.
- **Establishment of a link to a Members Lounge** on the homepage, thus bringing together many of the member's resources in one easy to find location.
- **Promoting Vimeo** as an established video channel to upload recordings of professional development presentations.
- **ACRA Photo-Video Consent** – creation of a consent form to assist ACRA meet its Intellectual Property responsibilities in using/uploading photos and videos for marketing purposes.
- **Collation of stock photos on the ACRA Website and Banner.** Almost completed the ACRA Website and Banner.

Many thanks to Paul, Jo Lennard and Sue Sanderson. Jo and Sue will continue on the membership committee with new members John Aitken, Bridget Abel, Dianna Lynch and Natalie Simpson to progress the great work.

Many thanks to all

Helen McLean
(interim lead of the membership committee).

ACRA **Advocacy** Working Group Report December 2016

The purpose of the ACRA Advocacy Working Group, which was established in November 2014, is to identify opportunities to advocate for cardiac rehabilitation health professionals.

Members of the ACRA Advocacy Working Group include:

- Cate Ferry (Lead)
- Robyn Gallagher
- Lis Neubeck
- Emma Boston
- Steve Woodruffe
- Jane Kerr

The ACRA Advocacy Working Group members are responsible in leading:

- The development of a suite of media statements that are available to promptly respond to media requests e.g. the evidence about cardiac rehabilitation, the demonstrated cost-benefits of cardiac rehabilitation etc. Two media releases have been produced to date.
- The identification of champions for cardiac rehabilitation and secondary prevention including leading cardiologist/s and patients who can supply statements and/or head shots to support cardiac rehabilitation and secondary prevention. This is currently being progressed.
- The development of an infographic statement that simplifies and explains to all about the importance of cardiac rehabilitation and secondary prevention. The info graphic can be down loaded via http://www.acra.net.au/why-cardiac-rehabilitation-really-matters/ and is published in the newsletter.

The intension is for the infographic to be used by CR clinicians as an advocacy tool to facilitate a conversation with relevant cardiac colleagues, senior management/executive staff, politicians etc. about the importance of CR and the imperative to refer all eligible patients.

Cate Ferry

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Australian Cardiovascular Health and Rehabilitation Association

Why Cardiac Rehabilitation Really Matters

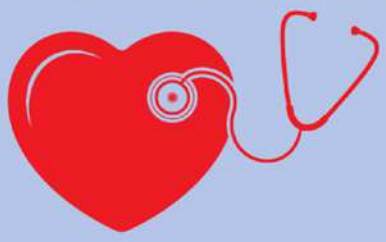
Heart disease is a lifelong condition that needs ongoing management
Cardiac rehabilitation is a critical step in a heart patient's journey

Cardiac Rehabilitation (CR) benefits patients

- 26% reduction in mortality
- 18% reduction in readmissions [1]
- Improved quality of life

Referral is essential

All eligible patients must be offered referral to a CR Service which best suits their individual needs, as soon as possible after diagnosis or before discharge from hospital, including a referral to a GP for long term care.[2]



Uptake of CR remains low fewer than 30% of eligible patients participate [3]

An option to suit every patient

Flexible services will facilitate increased participation

- Facility-based exercise, education and psychosocial components or a combination of services
- Home-based services
- Telephone-based services
- Mobile phone and internet-based services

CR reduces costs $$$

Increasing participation by 65% attendance nationally per annum could result in

- $35.5m savings in health care costs
- 2,100 fewer myocardial infarction admissions [4]

Patients are missing out

Reasons for low participation:

- lack of referral from in-patient services
- lack of a referral from the patient's cardiologist
- competing work & home responsibilities
- distance and transportation
- lack of CR service availability

Heart Attack Survivor Survey

Almost 2 in 3 (65%) patients reported they were not advised by staff to attend CR

Benefits reported for those who did attend:

Encouragement to make healthier lifestyle choices
Provided an **understanding** of the emotions/fears they faced
Reduction in their anxiety/depression [5]

1. Anderson L, et al. Exercise – Based Cardiac Rehabilitation for Coronary Heart Disease: Cochrane Systematic Review and Meta – Analysis. J Am Coll Cardiol. 2016 Jan 5; 67 (1):1 – 12. doi:10.1016/j.jacc.2015.10.044
2. Woodruffe S et al. Australian Cardiovascular Health and Rehabilitation Association (ACRA) Core Components of Cardiovascular Disease Secondary Prevention and Cardiac Rehabilitation 2014. Heart, Lung and Circulation (2015)
3. Clark RA, Conway A, Poulsen V, et al. Aletrnative models of cardiac rehabilitation: a systematic review. Eur J Prev Cardiol 2013; 0 (00), 1 – 40
4. Heart Foundation, Data and Evaluation Unit. Unpublished report 2015
5. Heart Foundation Heart Attack Survivor Survey 2015

Content adapted from the NSW Cardiac Rehabilitation Working Group 2016 Info graphic

News From
Across The Nation

Warning Signs education campaign is saving lives

Cate Ferry – Heart Foundation representative

The Heart Foundation's 'Warning Signs' public awareness campaign led to 1,300 fewer deaths from cardiac arrest in the Melbourne region between 2009 and 2013, a new study has shown. New research shows a push to have people recognise the signs of a heart attack has led to saving 1300 lives across Melbourne in four years.

The research published in November in the European Heart Journal found the Heart Foundation's 'Warning Signs" education campaign prevented one-in-six heart attack patients deteriorating and suffering a fatal cardiac arrest between 2009 and 2013.

Ambulance Victoria and Monash University conducted the research with Heart Foundation Victoria through an analysis of cardiac arrest cases recorded by the Victorian Ambulance Cardiac Arrest Registry (VACAR).

"Impact of a public awareness campaign on out-of-hospital cardiac incidence and mortality rates", by Ziad Nehme et al. European Heart Journal. doi:10.1093/eurheartj/ehw500

TEXTCARE wins the judges' vote in Australian Google Impact Challenge

The George Institute's lifesaving SMS program, TEXTCARE, was awarded $750,000 in this year's Google Impact Challenge by a panel of judges including Lucy Turnbull, CSIRO chief executive Dr Larry Marshall, David Gonski and the worldwide head of Google.org, Jacquelline Fuller. The Google Impact Challenge supports non-profit innovators using technology to tackle the world's biggest social challenges.

TEXTCARE is a personalised text messaging support program designed to support people with cardiovascular disease. It uses complex algorithms to deliver SMSs that encourage people to make changes such as taking their medications as prescribed, stopping smoking, taking up exercise or eating more healthily.

The funds will enable the TEXTCARE program to reach 100,000 Australians with

cardiovascular disease over the next year. The project will then be rolled out to countries such as China and India and expanded to other chronic diseases, including asthma.

Professor Clara Chow, Director of Cardiovascular Division at The George Institute is the lead investigator on this initiative and The Heart Foundation, is represented by Cate Ferry, NSW Senior Manager Clinical Issues.

The original research for this project, TEXTME, was supported by Heart Foundation funding.

News From **Across The Nation**

CONT.

The Lighthouse Project Phase 2 (2013 – June 2016)

The aim was to drive systemic change in acute care hospital settings to improve care for and the experience of Aboriginal and Torres Strait Islander peoples experiencing ACS.

In Phase 2, the scope was to develop and implement a quality improvement approach to activities in eight public hospital sites across Australia to improve the clinical and cultural care of Aboriginal and Torres Strait Islander patients with ACS.

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 aims to:

- ensure that minimum standards of care, cultural safety and quality are met
- identify practices and actions that can and/or should be improved
- foster engagement
- enhance service appropriateness
- improve service delivery for the care of Aboriginal and Torres Strait Islander peoples 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.

Eight pilot hospitals participated in testing the toolkit:

- Bairnsdale Regional Health Service, Victoria
- Coffs Harbour Health Campus, New South Wales
- Flinders Medical Centre, South Australia
- Liverpool Hospital, New South Wales
- Princess Alexandra Hospital, Queensland
- Royal Perth Hospital, Western Australia

News From **Across The Nation**

CONT.

The Lighthouse Project Phase 2 (2013 – June 2016) continued

- St Vincent's Hospital, Victoria
- Tamworth Rural Referral Hospital, New South Wales.

Each site developed a hospital action plan that outlined the domain(s) they would address and the quality improvement activities they would undertake during the pilot.

The project outcomes were dependent on community engagement, capacity to embed change, project support and the governance structures at each site.

Key Phase 2 achievements include:

- 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
- Enhanced staff capacity to respond to the needs of Aboriginal and Torres Strait Islander patients

The Heart Foundation has submitted an application to secure funding to conduct Phase 3 of the Lighthouse Project. Phase 3 will aim to increase the reach and thus the critical mass of Aboriginal and Torres Strait Islander peoples experiencing an acute coronary syndrome who receive evidence based care in a culturally safe manner. Within this phase there will be a focus on integration of health services and care coordination by enhancing the relationships between local community groups, hospitals, local Aboriginal Community Controlled Organisations and Primary Health Networks. The implementation of this phase would enable hospitals to address the actions in the revised Australian Commission on Safety and Quality in Healthcare National Safety and Quality Health Service.

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 them 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).

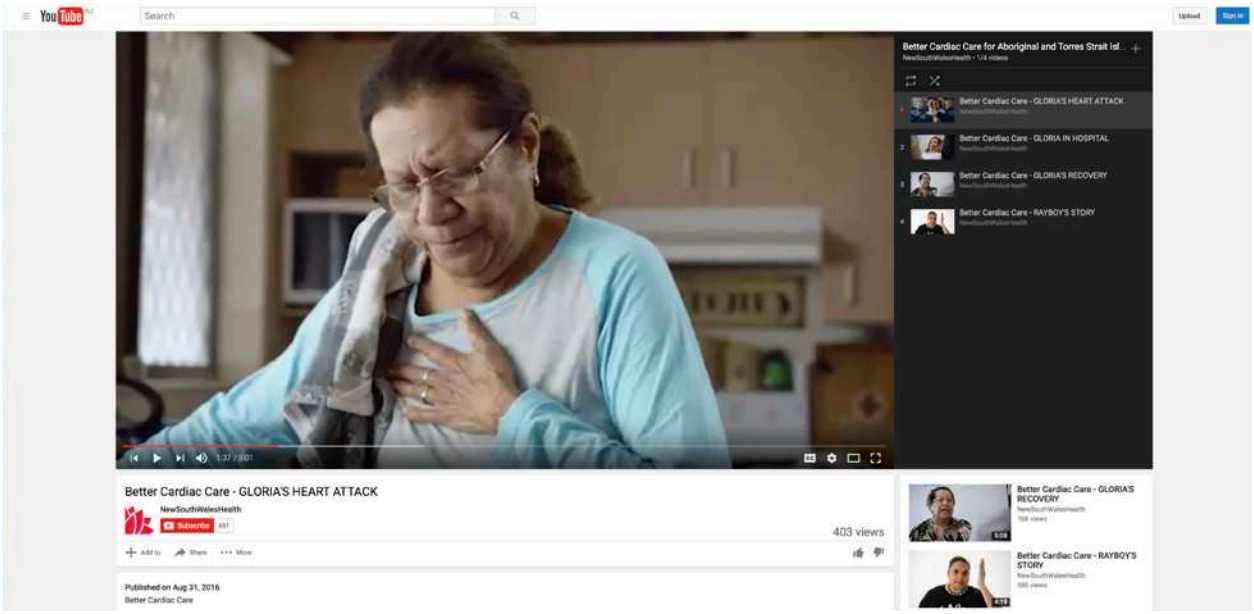
Secondary messaging for the campaign will include: that hypertension is only one heart disease risk factor and a full heart health check (AR) should be undertaken to determine true heart attack risk; that appropriate hypertension treatment includes medication and lifestyle changes (diet and exercise).

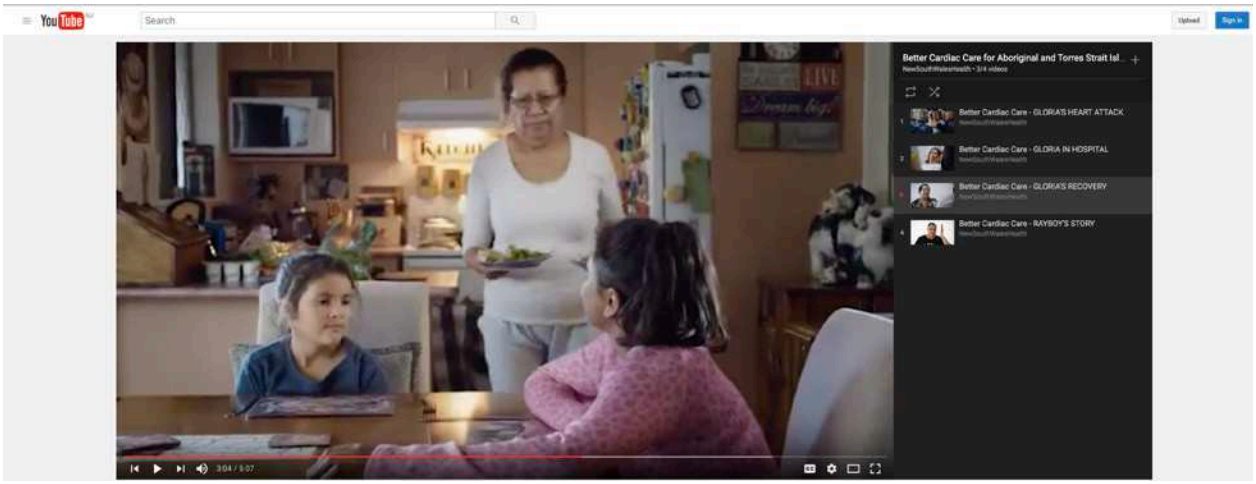
As in 2016, this campaign will be primarily digitally delivered.

News From **Across The Nation**

CONT.

NSW Health release a suite of videos for Aboriginal people with cardiac and chronic disease conditions





As part of the NSW Better Cardiac Care for Aboriginal People Implementation plan, NSW Health has developed of a series of short videos to help raise awareness of cardiovascular disease and the importance of early diagnosis and treatment for Aboriginal people.

Focused around recognising the warning signs of a heart attack; what to do in an emergency; and how to support family and friends living with a heart condition, these videos were developed through a collaboration between the NSW Ministry of Health, the Better Cardiac Care Aboriginal Advisory Group, the Heart Foundation, NSW Ambulance and clinicians from Aboriginal Medical Services and Local Health Districts.

The power of these videos is that they have been developed in strong consultation with local Aboriginal community and as such resonate strongly. Several well-known Aboriginal actors as well as members of the Orange Aboriginal Community and local medicos, enact a range of common scenarios that any family could experience.

To view the videos, click on https://www.youtube.com/playlist?list=PLpXDJ5In7QhRBS6EzC3x3598t_xa_3LSR

Australian Centre for Heart Health Report

Professor Alun C Jackson

Since the 'soft' launch of the re-structured and re-branded Heart Research Centre as the Australian Centre for Heart Health, we have continued to conduct a range of activities related to the core mission of the Centre, of improving the lives of people with heart disease, by:

- Researching the psychosocial and behavioural aspects of cardiac disease
- Training the cardiac rehabilitation workforce
- Providing psychological support to patients, families and carers.

Two of our papers, including our ACHH / ACRA position statement on OSA screening in cardiac rehab have been highlighted in the **Cardiology Research Review** and the **Cardiology Practice Review,** which will increase visibility of the papers.

Research

We continue to conduct research within our main areas of research concentration, but recognise that this is being done in a fiercely competitive research funding environment and that we are operating at present with a very lean research team.

Konica/Minolta Cardiac Coaching Avatar Development

ACHH has been working for some time in partnership with Konoica Minolta Health Development and Clevertar, a Flinders University spin-off company,to develop an avatar-based online program for cardiac rehabilitation using the Anna Cares platform. This replicates a Clevertar / BUPA program which provides an avatar coach for Type 2 diabetes patients.

We have now written the introductory module and are developing further modules on diet, exercise and mood management, with the aim of having a Phase 1 version of the Cardiac avatar program available in the new year. Other modules will be added as they are developed. We will convene an expert panel to assist in the development of the content. This panel will include members of the ACRA Executive.

The prototype was unveiled at the Australian Cardiovascular Health and Rehabilitation Association 26th Annual Scientific Meeting in Adelaide in early August and was received enthusiastically.

Cardiac Wellbeing Program (CWP)

Funding

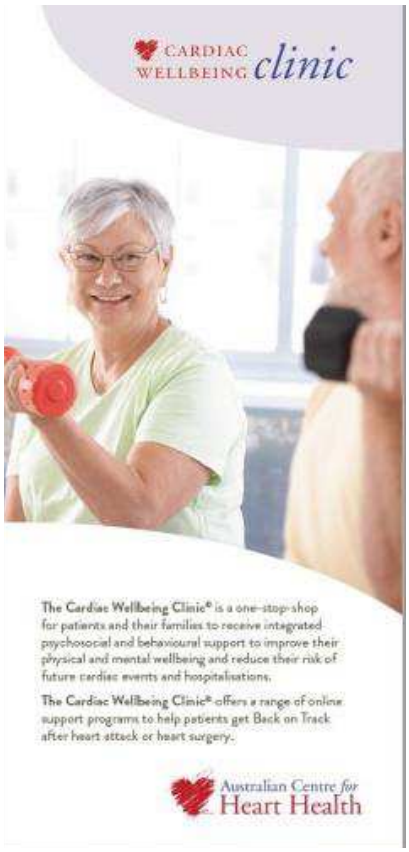
Following the release in May 2016 of the Victorian state-wide Cardiac Care Plan which noted that the government should *"Establish a cardiac wellness program and models of care that focus on patient wellbeing and the psychological and psychosocial aspects of living with ongoing heart disease"* the Centre believed that this would be the best opportunity yet, for tapping into government funding for the development of the innovative Cardiac Wellbeing Program, at the Centre.

The Health Department official tasked with the Plan's implementation, however, advised that although this was a priority area of the Plan, there was no budget attached to its implementation and that the establishment of such a program would have to be funded by each hospital from their own existing resources, which means that it will not happen.

Australian Centre for Heart Health

Report continued

The Centre is continuing to pursue philanthropic and corporate sources of support for the program.



Ronin Films Production

The Centre is working with Ronin Films, in the development of a documentary about the cognitive and emotional impacts of cardiac surgery. Andrew Pike, Director of the film and Managing Director of Ronin Films has edited interviews with two patients, Barb Murphy, Rosemary Higgins and Alun Jackson, into a nine minute film to use for publicity purposes, to raise funds for the full production.

"Post-perfusion syndrome, also known as "pumphead", is a constellation of neurocognitive impairments attributed to cardiopulmonary bypass (CPB) during cardiac surgery …"

(Wikipedia)

PUMPHEAD will be a 75 minute documentary exploring the gulf that can exist between advances in medical science and the patient experience. Andrew Pike says of the film:

4 years ago I had open-heart surgery. I discovered that 75% of patients like me suffer distressing psychological after-effects generally known as the 'pumphead' syndrome, referring to the Heart-Lung Pump used in the operation.

We will explore the long dark nights of the patient experience and we will survey the minimal professional support available to us. Our film will gain its narrative structure through the work of a new clinic about to open in Melbourne which will specialise in this problem. Significantly, and it's a blessing for our film, this clinic will be the first of its kind anywhere in the world.

Our film will be at the centre of an international awareness campaign. No book, no film has ever touched on this problem, and we see our work not as the last word on the subject, but very much as the first word.

Professor Alun C Jackson Director

International Council of Cardiovascular Prevention and Rehabilitation (ICCPR)

Report

by Steve Woodruffe

ACRA has been an active member of the ICCPR for the past four years with representation on this council by ACRA Secretary and Past President, Steve Woodruffe. The following is a report of ICCPR recent activity.

The two main projects of the ICCPR over the past two years have been:

- The writing of the Consensus Statement for delivering cardiac rehabilitation in Low-Resource Settings
- The writing of an International Advocacy Guide promoting the value of cardiac rehabilitation, especially for countries wishing to initiate the use of CR as part of standard cardiology services and cardiovascular health programs.

The Consensus statement has been accepted by the journal *Heart* with ePublication in May of 2016.

Abstracts for these two papers follow this report. Full text for both articles available at www.globalcardiacrehab.com. I encourage you to access them there and to check out the website.

The ICCPR continues to increase its awareness and respect amongst the world leaders of cardiology and cardiac care as it has consistently been invited to participate as a stakeholder in high level meetings of the WHO and WHF in their efforts to reduce the burden of CVD around the world, and especially considering the WHO 25 x 25 program (reducing premature death of non-communicable diseases by 25% by the year 2025).

The ICCPR has maintained a number of mutual support and endorsement activities with the World Hypertension League Membership and Communications.

ICCPR has grown from 20 to 26 member associations. Recognition of the activities within and between the member associations and their representatives is demonstrated by the website (www.globalcardiacrehab.com), with an exemplary focus on sharing/providing mutual access to examples of good practice, program and service developments, guidelines and standards, knowledge translation of evidence into practice, advocacy of programs and program service management.

ACRA Members are encouraged to check out the website for access to ICCPR events and initiatives as well as links to other member associations and their events.

Member organisations:

Cardiac rehabilitation delivery model for low-resource settings

Sherry L Grace, Karam I Turk-Adawi, Aashish Contractor, Alison Atrey, Norm Campbell, Wayne Derman, Gabriela L Melo Ghisi, Neil Oldridge, Bidyut K Sarkar, Tee Joo Yeo, Francisco Lopez-Jimenez, Shanthi Mendis, Paul Oh, Dayi Hu, Nizal Sarrafzadegan

ABSTRACT

Objective

Cardiovascular disease is a global epidemic, which is largely preventable. Cardiac rehabilitation (CR) is demonstrated to be cost-effective and efficacious in high-income countries. CR could represent an important approach to mitigate the epidemic of cardiovascular disease in lower-resource settings. The purpose of this consensus statement was to review low-cost approaches to delivering the core components of CR, to propose a testable model of CR which could feasibly be delivered in middle-income countries.

Methods

A literature review regarding delivery of each core CR component, namely: (1) lifestyle risk factor management (ie, physical activity, diet, tobacco and mental health), (2) medical risk factor management (eg, lipid control, blood pressure control), (3) education for self-management and (4) return to work, in low-resource settings was undertaken.

International Council of Cardiovascular Prevention and Rehabilitation (ICCPR)

Report continued

Recommendations were developed based on identified articles, using a modified GRADE approach where evidence in a low-resource setting was available, or consensus where evidence was not.

Results

Available data on cost of CR delivery in low-resource settings suggests it is not feasible to deliver CR in low-resource settings as is delivered in high-resource ones. Strategies which can be implemented to deliver all of the core CR components in low-resource settings were summarised in practice recommendations, and approaches to patient assessment proffered. It is suggested that CR be adapted by delivery by non-physician healthcare workers, in non-clinical settings.

Conclusions

Advocacy to achieve political commitment for broad delivery of adapted CR services in low-resource settings is needed.

Heart Online First, published on May 15, 2016

Advocacy for outpatient cardiac rehabilitation globally

Abraham Samuel Babu, Francisco Lopez-Jimenez, Randal J. Thomas, Wanrudee Isaranuwatchai, Artur Haddad Herdy, Jeffrey S. Hoch, Sherry L. Grace and in conjunction with the International Council of Cardiovascular Prevention and Rehabilitation (ICCPR)

Abstract

Background: Cardiovascular diseases (CVD) are the leading cause of death globally. Cardiac rehabilitation (CR) is an evidence-based intervention recommended for patients with CVD, to prevent recurrent events and to improve quality of life. However, despite the proven benefits, only a small percentage of who would benefit from CR actually receive it worldwide. This paper by the International Council of Cardiovascular Prevention and Rehabilitation forwards the groundwork for successful CR advocacy to achieve broader reimbursement, and hence implementation.

Methods

First, the results of the International Council's survey on national CR reimbursement policies by government and insurance companies are summarized. Second, a multi-faceted approach to CR advocacy is forwarded. Finally, as per the advocacy recommendations, the economic impact of CVD and the corresponding benefits of CR and its cost-effectiveness are summarized. This provides the case for CR reimbursement advocacy.

Results

Thirty-one responses were received, from 25 different countries: 18 (58.1 %) were from high-income countries, 10 (32.4 %) from upper middle-income, and 3 (9.9 %) from lower middle-income countries. When asked who reimburses at least some portion of CR services in their country, 19 (61.3 %) reported the government, 17 (54.8 %) reported patients pay out-of-pocket, 16 (51.6 %) reported insurance companies, 12 (38.7 %) reported that it is shared between the patient and another source, and 7 (22.6 %) reported another source.

Conclusions

Many patients pay out-of-pocket for CR. CR reimbursement around the world is inconsistent and insufficient. Advocacy campaigns forwarding the CR cause, supported by the relevant literature, enlisting sources of support in a unified manner with an organized plan, are needed, and must be pursued persistently.

Keywords: Cardiovascular disease, Reimbursement, Cardiac rehabilitation, Insurance

Abbreviations: CR, Cardiac rehabilitation; CVD, Cardiovascular disease; DALYs, Disability-adjusted life years;

ICCPR, International Council for Cardiovascular Prevention and Rehabilitation; SD, Standard deviation;

WHO, World Health Organization

BMC Health Services Research (2016) 16:471

STATE PRESIDENTS' REPORTING

SOUTH AUSTRALIA

State representative: **Natalie Simpson**

President: **Dianna Lynch**

Dear Members,

As another year draws to an end we can reflect on what has been a very busy year for SACRA.

This year we really highlighted our local and national speakers, who contributed to one of ACRA's "most successful conferences in years," and I believe our fresh and extensive program was the key, along with our amazing and dedicated cardiac nurses, practitioners, researchers and education colleagues who contributed to the design and program, and of course the delegates who showed their support by attending the conference and submitting so many diverse but interesting papers and posters.

The down side to having the conference was not having any education sessions as we traditionally have had in previous years. I would really like to thank you, our members, for your patience and understanding as it really is a huge undertaking to organise such an event, and we will be looking forward to bringing you some more educational sessions in the new year.

This will be one of my last newsletter reports as my term as President will come to an end after our AGM in April, however using the mentorship and succession planning we have put in place I will be replaced by Jenny Finan at our AGM. (More to come in next edition).

Executive News:

Natalie Simpson (State Representative) and Di Lynch (President) have just returned from the National Executive Board Meeting (EMC), in Sydney and once again it was a very busy meeting.

This meeting discussed our state reports, and reports and outcomes from our Membership, Professional Development & Advocacy, Research, and Finance & Corporate groups.

We also used this weekend to strategise for the coming year with the management of ACRA, and new ways to strengthen our membership where there are ever changing environments.

We also initiated some friendly rivalry between the states in doing a membership drive and the state who delivers the most memberships pro rata will win a free conference ticket, so members: the challenge has been set…….. let's go SA…..

Member News:

Renee Henthorn, Cardiac Rehabilitation Coordinator from the Queen Elizabeth (and our SACRA treasurer) and Dr Chris Zeitz have running clinics in the APY lands near Alice Springs with patients who have rheumatic heart fever (RHF).

Renee Henthorn

Renee was recently nominated for a S.A. Health award for this program "Recognising outstanding leadership and outcomes in forging and/or maintaining partnerships". It acknowledges the importance of partnerships across regions, sites and across country South Australia, and included the Medical Directorate Central Adelaide Local Health Network.

Rheumatic heart disease (RHD) remains a significant issue for Indigenous Australians with a high prevalence in remote communities. This preventable disease requires a coordinated health system that readily identifies acute infections, provides appropriate secondary prevention therapies and monitors those with established valvular disease. The Central Adelaide Cardiology Service partnered with the SA Health RHD Program Advisory Group and Nganampa Health Council to facilitate such a system and realise significant beneficial outcomes.

This service was formed to support the delivery of primary and secondary prevention strategies for Rheumatic Heart Disease (RHD) in the APY lands. Each day, globally, 1000 people die from RHD and the important thing to remember is that RHD is a completely preventable disease. Unfortunately, the Australian Indigenous population has the highest rates of RHD in the world.

The program is a great incentive as we can take the Cardiology clinic to the Indigenous population of the APY lands. For this indigenous population to access this service it would normally require a 3-day round trip into Alice Springs on the Bush Bus, while it is a service that is very easily accessed by those who live in the metro area.

Thus far, the program has been very successful and the compliance with preventative strategies has dramatically increased in the APY lands and we look forward to seeing the benefits of that in the coming years as we continue to work closely with the Nganampa Health Council.

STATE PRESIDENTS' REPORTING CONT.

Ashford's Cardiothoracic Surgery Milestone:

Ashford Hospital, one of Adelaide's largest private cardiac centres, last month celebrated 25 years of Cardiothoracic Surgery being performed in a private hospital.

Although cardiac surgery was not new, it was performed mainly in the major public hospitals e.g. Royal Adelaide Hospital.

Mr Ian Ross was a driving force in the introduction of cardiothoracic surgery into the private hospitals, and he wanted a service that both public and private patients could access, but those who had private health could access from a private hospital. This was also quite politically and medically controversial at the time, as nobody thought it could be done outside a major public hospital, and took many attempts before it became tenable.

Mr Ross was already performing his surgery at the RAH and reduced his lists to accommodate a 2 day list at Ashford. His original team which included the late Dr Greg Trevaskis, Dr Bronte Ayres, Dr Andrew Holt and several other staff, some of whom are still working at Ashford.

Ashford celebrated this occasion at the gorgeous Adelaide Oval where many of the past and present surgeons, cardiologists, and nursing, theatre and allied health staff gathered to acknowledge this milestone.

From a cardiac rehabilitation point of view Ashford was quite proactive, and has had a cardiac rehab service from the inception of surgery. Cardiac rehab nurses past and present were there to enjoy the reunion.

Ashford CCR Coordinators: Sarah Cotton, Eni Marzullo, Dianna Lynch, Nicci Van De Ven, Vanessa Poulsen, Brenda Mangelsdorf

Mr Greg Rice, Mr James Edwards, Mr Michael Worthington – current surgeons

Dr Bronte Ayers, cardiologist, Dianna Lynch, CR Coordinator

Mr Ian Ross, Mr Bronte Ayers, Dr Andrew Holt – the original team

Working Groups:

The SA State-wide Cardiac Clinical Network arrangement with SA Health ended in May 2015 with the introduction of Transforming Health. To prevent loss of formalised and successful cardiac networking with service-providers, policymakers and researchers, a new collaborative process was devised and implemented. The SA Academic Health Science & Translational Centre, and the Cardiac Rehabilitation and Secondary Prevention Working Group are two groups which work in collaboration.

The South Australian Academic Health Science & Translational Centre is a collaboration between the South Australian Health and Medical Research Institute (SAHMRI), the three South Australian universities, SA Health and other health and research institutions.

The integration of the SA Centre with Transforming Health will be the vehicle that provides the link between the research outcomes and translating advances in medical research into clinical practice, day-to-day care of patients and training of health professionals.

The SA Cardiac Rehabilitation and Secondary Prevention Coalition is an important and vital link between the Translation Centre and the cardiac

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STATE PRESIDENTS' REPORTING CONT.

rehabilitation providers and key stakeholders across South Australia.

Reporting Relationships

Cardiac Rehabilitation and Secondary Prevention Working Group (Coalition) will report to the SA Centre's Translational Health Committee.

This workgroup will formally link to the Cardiac Rehabilitation and Secondary Prevention Coalition. The Coalition membership consists primarily of Cardiac Rehabilitation service providers. The Chair of the Coalition will provide feedback & distribute information to the Coalition from this working group and reports and meeting minutes will be shared. The Coalition will be a standing Agenda item.

The workgroup will give special attention to the needs of priority groups that carry the biggest burden of heart disease.

A workshop was conducted on Thursday 8th September covering the following.

- Data collection, processes and data quality
- Linked data project
- Referrals to CATCH – potential models for changing environment
- KPIs
- Refining the minimum data set
- Improving process of reporting

Transforming Health SA:

A meeting was held on the 8th November discussing the second stage of CR roll out where the Flinders Model was explained. This model will represent the pathway through the public hospital for ACS management.

Flinders Model pathway:

- Patient triaged to either high risk or low risk:
    - Low Risk e.g. CPFI → stent = Low Risk, OPD 5-7 days, 1:1 appointment with CR nurse +/- cardiologist if required
    - High Risk: CPFI → stent, CABG, OPD with cardiologist
    - Phase 1 CR will be undertaken by IP nursing staff
    - Each patient on discharge will be provided with a pack which will include a discharge summary, ECG, Cath report, MHML booklet & follow up appointment.

No preventative care is mentioned, and this gap may be addressed in the primary care sector.

Heart Foundation SA Report:

ACS & Hypertension Guidelines

- New ACS & HT Guidelines available online both of which highlight importance of CR
- Resource audit i.e. MHML, LWWHF
- eLearning is being regularly reviewed
- Commenced new HF strategy for survivor support
- MHML, HF strategies are now being written for low literacy, was at year 11 standard to now be at year 7 standard.
- Scoping on training video for 6 step MHML/ CR referral/ warning signs
- Six step video on YouTube channel courtesy of Victorian branch of HF

Rural Representative Report:

The updated Virtual Clinical Care (VCC) model is currently being rolled out across CHSALHN Better Care in the Community sites. This program continues to support patients with chronic diseases such as heart failure, COPD/COAD, diabetes and/ or hypertension, empowering patients to manage their condition within their community. VCC enables patients to increase their understanding of their condition, improve outcomes, increase quality of life and reduce hospital admissions and length of stay. The VCC model has had significant success in the past and all staff are committed to continuing this trend.

iCCnet CHSALHN staff are also working with IT staff from the Royal Adelaide Hospital, Flinders Medical Centre and soon to be included Lyell McEwin Hospital to implement 'CHSALHN Automatic Electronic Cardiac Rehabilitation Referrals'. This process involves an automatically generated patient list emailed daily to the CATCH Central Referral office highlighting all patients who were discharged from selected cardiac unit codes, from these hospitals the previous day. The list of patients is filtered to only include patients discharged who have a CHSALHN post code. This process was implemented to ensure patients with various cardiac conditions who reside in Country SA are offered the support of cardiac rehabilitation. Please see attached 'CHSA Cardiac Rehabilitation Inclusion Criteria' (Flinders model).

PLEASE NOTE: The 'CHSALHN Automatic Electronic Cardiac Rehabilitation Referrals' process is currently in a trial period, therefore, all current referral procedures for all Country and Metropolitan Cardiac Rehabilitation patients should continue until further notice.

STATE PRESIDENTS' REPORTING CONT.

If other LHN's would like to implement a similar process for 'Automatic Electronic Cardiac Rehabilitation Referrals' for their area/site, please contact Jacinta McCartney, Jacinta.McCartney@sa.gov.au or Teena Wilson, Teena.Wilson@sa.gov.au at iCCnet or phone 8201 7840.

Financial report:

A current financial report can be requested from Renee Henthorn R.henthorn@sa.gov.au

Save the Dates:

We will have our last meeting by the time this newsletter will be in print so the SAVE the DATES will be clarified at this meeting.

On a final note for the year, I would like to sincerely 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, friends and family, and hope you have time to relax and refresh for another busy and exciting year.

Dianna Lynch
SACRA President

WESTERN AUSTRALIA

State representative: **Helen McLean**

President: **Craig Cheetham**

Well if you didn't attend this year's ACRA Scientific Meeting in Adelaide you certainly missed out! What a great event Di, Robyn, Peta and their committee brought to us. The learning was excellent and the networking and social events were really memorable and on a personal level I learnt quite a few more dance moves…….move over John Travolta!

The great success of Adelaide has certainly motivated us in the west and we are really into the swing of organising another fantastic event and welcoming you to Scarborough, Perth in 2017. Please note: the original dates had to be changed (CSANZ changed their dates) so in 2017 the ACRA scientific meeting will be the **7th, 8th and 9th of August** at the Rendezvous Hotel in Scarborough. It's time to plan your leave and get your abstracts ready!

Some pictures to entice you to the West and to spend some extra time here.

If you have a water bottle from this year's event and you would like a waterproof sticker showing the correct dates please email your address to helen.mclean@health.wa.gov.au and I will gladly send you a sticker so you can advertise the correct dates. Many of you met Quentin the Cardiac Quokka in Adelaide, our 2017 ACRA conference mascot. Quentin thoroughly enjoyed the conference but that little one loves to travel and think he must have snuck into someone's suitcase……..pretty sure I saw him in Rome at the ESC! That little one does get about so if anyone knows of his whereabouts please keep a good watch out for Quentin on the ACRA twitter page as soon the "**where's Quentin**" competition will commence!

ANNUAL SYMPOSIUM

Locally we at WACRA thank Tracy Swanson for providing a fantastic evening for our **annual symposium.** Tracy's professionalism in running this event for many, many years is awesome and much appreciated by us all. Thanks Trace! This year's symposium provided a chance for those who had abstracts selected for this year's ACRA conference to be critiqued by the WA clinicians prior to ensure polished presentations for the ACRA SM. Topics

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included: *"A Case Study of cardiac rehabilitation for a diabetic patient who has CABG and develops an unstable sternum"* (Craig Cheetham + Doa El-Ansary); *"Communication, Collaboration, Cooperation"* (Helen M McLean); *"The effects of community-based exercise training in adults with a history of a Fontan procedure"* (Andrew Maiorana); and *"Future innovative solutions for Aboriginal and Torres Strait Islander CR"* (Lyn Dimer). We hope those of you who attended these sessions at the Adelaide meeting found the learning engaging and useful - the feedback certainly reflected this.

PROFESSIONAL DEVELOPMENT FORUM

Our professional development forum on the **4th of November** was a world café style event where, through creative conversations, all clinicians took a good look at WA cardiac rehabilitation services and how they meet each of the Core Components of cardiac rehabilitation. The discussion in the room was robust with 31 participants and this included 6 new members. Feedback included: 'the discussions were informative'; 'the discussions were relevant'; 'as a result of this session, my awareness of the core components of Cardiac Rehabilitation has increased'. Overall comments included: "Great format to meet other like-minded health professionals and be involved in discussions". "Wonderful, professional interaction". "The café approach worked well, wide variety of discussions and experience". "Perth/WA needs a linked database". "Loved the networking and not sitting with my own work colleagues". "Fantastic opportunity to network; discuss current challenges, ideas and feel reassured that everyone is continuing to work very hard to provide the best service/care they can within their available resources". "Excellent opportunity to mix with many important people in my area". "Would be nice to have a plan for the end of the day. What will WACRA do with the information and recommendations made today"?

ANNUAL GENERAL MEETING

The WACRA Annual General meeting will be held in February. It will be a cocktail/canapes format at a river restaurant. Many thanks to Lily Titmus for her expertise in organising this event. Presentations will include the new Heart Foundation guidelines for hypertension and also Dr Jay Baumwol, Cardiologist presenting Chronic Heart Failure current best practice.

Helen Mclean
ACRA WA State Representative

Please don't hesitate to contact me for further information regarding what's happening in WA.

VICTORIA

Victorian Committee

Victoria held it's AGM on the 14th of October 2016 and the new committee was elected, positions for the next 12 months will be as follows

President: Kim Gray

Vice President: Abi Oliver

Secretary: Niamh Dormer

Treasurer: Debra Gascard

State Rep to ACRA: Emma Boston

General Committee: Margaret Ryan, Ailish Commane, Susie Cartledge

Coopted member: Carmel Bourne

Heart Foundation Rep: Harry Patsimanis

State representative: **Emma Boston**

President: **Kim Gray**

The committee would like to thank Emma Boston for her hard work over the last 3 years as President and she will continue to represent Victoria as the state representative on the ACRA national executive committee.

Professional Development

Victoria held a hugely successful Education Day on the 14th of October 2016, themed "Motivation in Cardiac Rehabilitation'. 100 delegates attended the day held at the Oaks on Collins. Topics included

- Improving heart failure self-management
- Motivation in exercise and new technologies
- Maintenance programs
- Hypertension Update and ACS guidelines

Three Victorian members who presented at the ACRA 2016 ASM in Adelaide were also given the opportunity to showcase their work locally. The team at Monash Health Clayton were the people's choice in the poster competition with their abstract "How has heart disease affected you? An interactive Cardiac Rehabilitation group 'Heart Tree' activity involving clients, their family and staff during Heart Week, 2016". 6 abstracts were accepted - posters do not need to be research based and provide delegates the opportunity to showcase innovations in their programs. The committee would like to welcome all members who joined prior to the event and on the day.

Planning is underway for the next event in March 2017. The committee hopes to offer at least part of this event live via videoconferencing.

STATE PRESIDENTS' REPORTING CONT.

Heart Foundation

The Victorian committee has been invited to attend the nurse ambassador meeting on the 8th of December to discuss how to facilitate referral to cardiac rehabilitation.

Kim Gray.

TASMANIA

State representative: **John Aitken**

President: **Sue Sanderson**

The TACR membership is very small with a dedicated group maintaining active participation in the association. The core group of cardiac rehabilitation nurses at each of the public hospitals contribute as do the physios in Launceston. We need to actively look to colleagues in our programs and in cardiology areas to participate and enjoy the benefits of ACRA membership. The strategies being considered by the EMC membership sub-committee will support us in our endeavours locally to attract membership.

The Heart Foundation Tasmania has written a Statewide Cardiac Services Plan which is pending sign-off by government. It is anticipated that the Cardiac Clinical Advisory Group, established by government to develop cardiac services statewide, will morph into a Cardiac Clinical Network. It is proposed that a clinical director be appointed and drive the Network. ACRA-Tas members are active on the CAG and will be similarly involved in the proposed Network.

A HeartSafe committee has been established by the state Safety and Quality Unit to review the pre-hospital management of ACS patients in Tasmania, recognising the diversity of patient demographics and the need to offer evidence-based management. The capacity for pre-hospital thrombolysis has been introduced in other states where ambulance paramedics or accredited health professionals can administer this life-saving medication in areas where distance from a PCI facility compromises myocardial viability and potential future morbidity. The prompt transfer of patients to a PCI facility following thrombolysis is also being reviewed to ensure time to PCI is reduced. Sue Sanderson and Gillian Mangan are members of this committee.

John Aitken and Sue Sanderson are both members of EMC sub-committees – Finance, and Membership. These committees (as well as the Research and Education, and Advocacy sub-committees) met for strategic planning at the recent EMC meeting in Sydney. Further meetings will be held via teleconference in late January and subsequently report back at the planned EMC face-to-face meeting in May. Reports from each of these sub-committees are printed elsewhere in this edition.

We'd like to wish all TACR and ACRA members the compliments of the season. Enjoy the festive season – in moderation – relaxation and return refreshed in 2017.

Sue Sanderson
ACRA-Tas president

NEW SOUTH WALES / ACT

State representative: **Jane Kerr**

President: **Jo Lennard**

AGM

CRA NSW ACT AGM 24th October, 2016.

New board members for 2016/2017

President- Jo Leonard
President elect- Robert Zecchin
State representative- Jane Kerr
Treasurer- Susan Hales
Secretary- Dawn McIvor
Metro representative- Karen Dickson
Rural Representative- nil
PDC chair- Cate Ferry
ACI – representative- Kellie Roach
NHF representative- Cate Ferry
Public officer- Kellie Roach

Completed or Upcoming events

1) **CRA NSW ACT State Conference and AGM** held on the Monday 24th October 2016 at University of Sydney. "Patients Journey"

Successful conference with 63 delegates.

State network reports

2) **The NSWCRWG Annual Forum was held on 18th November, 2016.**

Teleconference also held in February and May, 2016.

Aim is to build on the cardiac rehabilitation action plan that was developed in 2015, the following items were identified to progress in 2016.

a. WORKFORCE:

Explore the option of having online cardiac rehabilitation training modules developed by the Health Information & Training Institute (HETI).

STATE PRESIDENTS' REPORTING CONT.

b. DATA:

Work with the Local Health Districts and Epidemiology Unit at the NSW Ministry of Health to progress the piloting and refinement of the cardiac rehabilitation minimum data-set/clinical indicators (11 items) and data dictionary for monitoring cardiac rehabilitation services in NSW. The pilot was conducted from March – May 2016. The data collection was presented at ACRA conference in Adelaide and the NSW ACT state conference in October.

c. RESOURCE DEVELOPMENT:

Heart Foundation developed an infographic using NSW specific data regarding the economic and social impact of increasing the uptake of CR Services.

d. ADVOCACY:

Advocate for better secondary prevention services/ alternate models of care for Aboriginal and Torres Strait Islander peoples in NSW.

e. CASE STUDIES:

Heart Foundation of NSW has captured examples of good practice via case studies, video vignettes and other media for sharing around the state. Identify and cultivate relationships with case studies to promote findings and identify supporters to assist advocacy.

f. RESEARCH:

Contribute to the evidence-base on health technology use and acceptance in cardiac rehabilitation.

CRA NSW board meets

Teleconference February, 2017

Face to face April or May 2017

Teleconference July 2017

AGM October, 2017

Membership numbers

October members report NSW ACT currently 101 which is down from previous months

Non-financial members- 56

CRA NSW ACT New Board members for 2016-2017

QUEENSLAND

Submitted by: Bridget Abell – ACRA Qld President & Paul Camp - Immediate Past President ACRA Qld

State representative: **Steve Woodruffe**

President: **Bridget Abell**

2016 AGM: New Name "ACRA-Queensland"

The QCRA AGM occurred in the lunch session of the QCRA-Heart Foundation Conference on Friday 28th October. Thank you to those who participated in person, through video and teleconference or who sent in their proxy votes.

The overwhelming majority of members voted in favour of the AGM special resolution for the new name: ACRA-Queensland. The special resolution is similar to that voted on in the other states of South Australia, Tasmania and Victoria.

We also welcomed Michelle Aust and Katina Corones-Watkins to our EMC, and would like to thank our departing committee members (Catherine Hardy, Robyn Williams and Ivette Jude) for their hard work and dedication to the association. The EMC would also like to express our sincerest thanks to outgoing President Paul Camp, who has worked tirelessly over the past few years, and demonstrated a real dedication to advancing our state association.

New ACRA-Qld EMC: (L-R) Karen Uhlmann, Gary Bennett, Paul Camp, Karen Healy, Katina Corones-Watkins, Steve Woodruffe, Bridget Abell, Michelle Aust. Absent from photo: Jessica Auer, Kathy O'Donnell, Jo Wu.

State Conference Gets Great Feedback

Participants at the QCRA-Heart Foundation Conference were impressed with the great content and expert presenters. Our keynote speaker Professor John Atherton (Director of Cardiology, Royal Brisbane and Women's Hospital) traced the history of Queensland's state-wide Heart Failure service.

STATE PRESIDENTS' REPORTING CONT.

Keynote Speaker Professor John Atherton

QCRA Members Sueann Hillman and Radha Naidu enjoying the Conference

QCRA EMC Members Gary Bennett and Karen Ulhmann enjoy opportunity to networking

Professor Robyn Clark maps out future areas for CR development

Many also liked the theme – "Ideas, Innovation and Inspiration from the Coalface", which gave plenty of opportunity to share new research and fresh clinical practice, including from fellow participants via submitted abstracts. Over 80 participants attended the day, with videoconference available for those outside Brisbane. QCRA would like to formally thank our co-host, the Heart Foundation, for their significant assistance in making the event possible. This annual meeting continues to grow in popularity and we are already planning for next year.

We hope to have a selection of presentations from the day available through the QCRA/ACRA members only lounge, http://www.acra.net.au/members-lounge/, sometime in early 2017.

The QCRA EMC is currently planning professional development (PD) opportunities for our members in 2017. Please let us know what PD activities or topics you would like included in the future at: qcra@acra.net.au

Queensland CR Service Directory

The Heart Foundation and QCRA continue in their efforts to update and maintain the Cardiac Rehabilitation & Heart Failure Services Directory. Considerable work has been done in QLD piloting information capture via an interface where services can login and update their own data, and where consumers can access these details on a Google maps style interface at https://heartfoundation.org.au/cardiac-services-directory. It is hoped this may eventually roll-out into a nationwide directory.

An up-to-date QLD directory in Excel format is still also being maintained on the ACRA website http://www.acra.net.au/cr-services/cr-directory/ and was most recently updated on the 18th November. Please send any enquires about updating your service to the Service Directory Coordinator at qcra@acra.net.au