Artwork courtesy of St John of God Health Care

ACRA Newsletter

AUSTRALIAN CARDIOVASCULAR HEALTH AND REHABILITATION ASSOCIATION

December 2014

Christmas edition

AUSTRALIAN CARDIOVASCULAR HEALTH AND REHABILITATION ASSOCIATION

ACRA Executive Officer
PO Box 193, Surrey Hills Vic. 3127 Phone/Fax 1300 662 272 Web www.acra.net.au

ACRA Newsletter Editor
Sue Sanderson Email: sue.sanderson@dhhs.tas.gov.au

Challenge...Change...Achieve

This Edition

Editor's Note

The ACRA year is winding down and it is interesting to reflect back on what has happened in that time. A highly successful annual scientific meeting in Sydney – great venue, fabulous speakers addressing some of the issues that have perhaps only been paid 'lip service' in previous meetings. A most entertaining debate complete with costuming and light-hearted banter between the proponents for each side of the argument. The patients' perspective on their cardiac experience – the event and the aftermath with the support received through cardiac rehabilitation. Those personal stories serve to remind us as to why we so enjoy the work we do and how much we can contribute to lifestyle adjustment processes our patients need to make as a consequence of that event. Job satisfaction is something I believe we are all blessed with. I know I most certainly am.

Your EMC members continue to work collaboratively to promote CR services at local, state, national and international levels. However at the last meeting at the end of November our focus was specifically on you, the members of ACRA, as we revisited our Vision and Mission statements and reviewed the strategic and operational plans for the next 3 years. Steve Woodruffe has given more detail in his report of these important discussions. Sub committees have been charged with addressing various aspects of the plans to ensure progress is sustained.

Educational opportunities have been the focus for many members at state level with states holding annual educations days or members attending meetings organised by other organisations. There were several ACRA members who attended the World Congress in May. Steve Woodruffe is committed as ACRA representative on international organisations fostering cardiac rehabilitation and secondary prevention and this representation helps to raise the profile of ACRA outside of Australia. At state level many ACRA members are present on clinical networks, cardiac advisory groups and liaise closely with NGO's promoting cardiovascular health.

Planning is well in hand for the next ACRA scientific meeting which will be in Melbourne August 10-12th 2015. This will celebrate our 25th year so 'silver' will be the focus as we review cardiac rehabilitation "Past, Present and Future". So save the dates and plan to be there! The CSANZ meeting will immediately follow and there are plans to have a 'cross-over' session. Keynote speakers have been 'locked in'. Check out the website www.acra2015.com.au.

Compliments of the season to all and I trust you will have a happy, safe and restful holiday season and return in 2015 refreshed and reinvigorated.

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

Contents

President's Corner

What will ACRA do for its members?

In my report for our last newsletter I aimed to answer the question; *What has ACRA done for its members?* This report will be focused on the future, specifically; *What **will** ACRA do for its members?*

This question summarises the aims of the recent ACRA Executive Management Committee (EMC) meeting, where the EMC developed a new Strategic Plan and Operational Plan, for the forthcoming three years.

For this iteration of the Strategic Plan, the EMC chose firstly to redefine the environment in which ACRA operates. While many factors remained unchanged, several emerging elements were highlighted. The EMC believe the important factors we need to consider are:

- An aging population, with complex chronic diseases, placing increasing demands upon our health system
- Government health reforms increasingly focussing on strategies that reduce the pressure on health services
- Rapidly evolving health technology, treatment and knowledge
- Inequity in access to health services
- Emerging models of service provision for cardiovascular health services
- Health professional responsibility and accountability for their own continuing professional development
- Other professional organisations competing to provide a service to our members
- The need for timely access to evidence-based information to inform practice
- Utilisation of information technology to facilitate communication and service provision
- Emerging opportunities for National, Regional and Global collaboration
- Fiscal constraints and responsible management of resources
- Consideration of generational change and its impact on membership, demand for services and succession planning
- The work of the Association is performed largely by volunteers

As part of the strategic planning process we also redefined our Vision and Mission. Our Vision, what we aim to do, has changed slightly:

- *To achieve optimal and equitable outcomes for all affected by cardiovascular disease.*

This encompasses everyone from the patient, their family, their carer, the cardiac rehabilitation practitioner, the researcher, the general practitioner and the cardiologist. If what we do as an organisation improves the outcome for all these individuals, we will have achieved our Vision.

Our Mission is mostly unchanged, as we feel it accurately reflects our current position in the health industry:

- *ACRA provides support and advocacy for multidisciplinary health professionals to deliver evidence-based best practice across the continuum of cardiovascular care.*

The ACRA EMC strives to maintain this Mission and to achieve our Vision through the implementation of our Organisational Plan.

At this point in time our Organisational Plan is very much a working draft which will be confirmed after preliminary work done by numerous subcommittees. I hope to finalise our Organisational Plan at the next EMC meeting, via teleconference, in February. At that time I hope to be able to present a blue print for our association's future planning.

During the face to face meeting held recently the ACRA EMC made significant steps in developing this plan. Four key areas were highlighted as priority areas of development; Membership Services, Professional Development, Advocacy and the multi-layered, Corporate Services. ➤

Underneath the sub-heading of **Membership Services** we highlighted the goals of increased membership, greater benefits and value of membership and the production of resources specifically for members. Key deliverables in this area include the maintenance of at least 30% of our membership from allied health professions and overall stability in membership numbers for the next 12 months with growth over the following 24-36 months. We also aim to develop a high-quality, useful, welcome pack for members highlighting the many benefits of joining ACRA and how to access these benefits.

Professional development is one of ACRA's core priorities. Within this sub-heading we identified the importance of increased opportunities for professional development in multiple modes. We aim to achieve this by providing at least four national webinars over the next 12 months. We will also be bringing together a formal calendar of education events from across the country. In addition we hope to see greater collaboration between states for the delivery of education events. ACRA aims to formalise our Mentorship Initiative via greater promotion and development of processes to facilitate inexperienced clinician's and researcher's own professional development. My major goal is to finalise the ACRA Core Components document, which is in the final revision stages before re-submission to Heart, Lung and Circulation for publishing. After this, work will begin immediately on the second stage of this document's development – a larger, more comprehensive web-based document to promote evidence-based best practice in Cardiac Rehabilitation and Secondary Prevention services.

An area that we aim to grow our profile is in the **advocacy** of our field. We aim to do this by developing statements of support for the work we do to ensure the maintenance, perhaps growth of our services. Specific deliverables that we aim to develop in this area include an annual media release on the "state of play" within cardiac rehabilitation, developing an infographic statement that speaks to all levels of the importance of cardiac rehabilitation and secondary prevention initiatives, and a "three-minute pitch" that can be used to provide guidance to potential sponsors, politicians and health service directors. Aligned with these local initiatives ACRA intends to continue to collaborate at the global level. Specifically, ACRA will carry a leadership role within the Global Alliance for CVD Prevention in Clinical Practice and has a strong link to the International Council of Cardiovascular Prevention and Rehabilitation.

Perhaps the area that we will see the greatest change in the short term is in **Corporate Services**. This sub-area includes reforming our administrative management, developing an up-to-date, adaptive website, ensuring financial security, marketing/ branding our "product", succession planning for our EMC, developing a stronger national identity and the role of our endorsements. In the very short-term, i.e. within 3 months our main goals are:

- Transition to new association management company for administrative/corporate services , which will be in addition to organisation of our conference
- New website to be operational
- Plan to be confirmed regarding move to annual membership renewal rather than by anniversary
- Logo and name of association to be trademarked

This is a large area that we are committed to seeing significant change in the next 12 months.

At the core of all actions of the ACRA EMC in the future, all committee members agree, is effective communication. I acknowledge that this is an area that may have been lacking in the last twelve months and it is something I am committed to rectifying. The newsletter in which this report appears continues to be the primary source of communication between the EMC and the members. I will be working with State Presidents and Representatives to ensure other means of communication are explored also.

In closing this report I wish to encourage any members with a hint of motivation to see things improve in their area, their state or even nationally, please become involved. We will be seeking volunteers to assist our work within our subcommittees, so please let us know if you would like to help.

I hope everyone has a happy and safe holiday period.

Cheers,
Steve

Stephen Woodruffe,
ACRA President
steve.woodruffe@health.qld.gov.au

MORE FROM THE ACRA CONFERENCE

2 papers presented in the "Best Clinical" and Best Research" prize sessions, August 2014.

Optimising delivery of the resource "What's wrong with my Heart" DVD during a hospital admission

Tracy Swanson [1,2]
Craig Cheetham [2,3]

1 - Hollywood Private Hospital, 2 - Cardiovascular Care WA 3 - School of Exercise, Sports Science and Health – University of Western Australia

"What's wrong with my heart" is a 2-disc DVD developed by SA Heart and Ashford Hospital-South Australia which aims to promote holistic cardiovascular health, risk factor modification and encourage attendance to cardiac rehabilitation. Inpatient education is an important component of patient care, with evidence demonstrating adults benefit from receiving information provided in various formats. Traditionally education has been delivered in 2 main modes, verbal and written. Implementing different education methods can provide more opportunities for patient education and can assist to generate efficiencies within ward settings.

The purpose of this study was to assess:

- The optimal time to view the DVD during admission
- If the DVD content complemented existing resources within Coronary Care Unit (CCU) at Hollywood Private Hospital (HPH)
- If verbal information delivered on the ward was consistent with DVD content
- If the content was perceived as valuable
- If the modality effective

The introduction of the DVD was trialled to complement usual care. It was viewed on a portable 10" DVD player (unit cost = $140). A survey was developed and the DVD was randomly introduced during any of the 4-phases of a patient's admission, on admission, pre-procedure, post- procedure or on discharge. It was delivered to patients with ischaemic heart disease (Non-ST segment myocardial infarction and elective angiography +/- intervention).

40 patients were randomly assigned to view the resource. 38 patients (26 male, 12 female) reviewed the DVD and completed the survey in its entirety.

The significant finding from this study showed there was a clear preference in preferred time to view the DVD. Most patients preferred to view the DVD pre-procedure. Of those who watched the DVD pre-procedure 93% considered this the optimal time, however patients who watched the DVD after their procedure 61% would have preferred a different time.

All patients indicated verbal and printed information was consistent with DVD content and their perceived understanding improved. They would recommend the DVD to fellow patients and are keen to purchase the DVD so they can revisit the information post discharge and share with family members. The portable DVD modality was effective, it is affordable in any health care setting and holds the potential to increase clinical staff availability assisting efficiencies in the acute care setting.

As a result of this study the DVD will now be offered to patient's pre procedure as a part of usual care and the concept will be discussed with other departments. Delivering information pre-procedure will allow clinical staff to reinforce important health messages. ➤

Patient's perceptions of text messaging to improve secondary prevention of cardiovascular events – Laura de Keizer

The secondary prevention of cardiovascular disease by text message

Mobile phone text messaging may be an effective way of motivating lifestyle changes for patients who survive cardiovascular events. We evaluated patient's perceptions of the TEXT ME Study, a text message-based intervention for the secondary prevention of coronary disease.

The TEXT ME Study is a randomised control trial which enrolled 710 patients with coronary disease. The intervention involved sending four text messages per week for 6 months. Messages contain tips & tricks, reminders, support and health education. Topics include diet, physical activity, medications and smoking cessation (if relevant).

At the end of the program, intervention participants completed a survey that asked for feedback on usefulness, content and program delivery.

Message usefulness

As a result of the program, 82% reported they had adopted a healthier diet, 74% reported increased physical activity levels and 79% had been reminded to take their medications. Overall, 81% agreed the messages motivated lifestyle change.

More broadly, participants reported feeling reassured by the messages. Message content reminded and reinforced advice given by other health providers.

Participants requested more prescriptive information such as meal plans and exercise routines.

Program acceptability

The messages were rated as easy to understand by 98% and useful by 92% of participants. Program length of 6 months was rated appropriate by 78%, with 15% requesting a longer duration.

Program delivery

Message frequency was rated appropriate by 85%. The majority of participants (94%) read more than three-quarters of the text messages and shared them with friends and family (54%). Some patients (14%) forwarded messages onto friends and family members.

Suggestions for improvement

A common suggestion from majority of participants was to introduce two way messaging. Participants expressed interest in being able to reply to a message and receive a response via text message.

In terms of program frequency and length, participants requested more messages. A common suggestion was to gradually decrease the message frequency ending with one message a month for three years or for the messages to be sent for an indefinite amount of time until the recipient wishes to unsubscribe.

In conclusion we report that text message based interventions show great potential with high user acceptance and perceived effects.

State presidents, representatives contact details

QUEENSLAND
Paul Camp – *President*
Paul.camp@mater.org.au
Jessica Auer - State rep
Heartstart @bundaberghealthpromotions.org

CRANSWACT
Dawn McIvor - *President*
Dawn.McIvor@hnehealth.nsw.gov.au
Robyn Gallagher – *State Rep*
Robyn.gallagher@sydney.edu.au

VICTORIA
Emma Boston – *President*
Emma.boston@sjog.org.au
Kim Gray – *State Rep*
kim.gray@austin.org.au

SA/NT
Dianna Lynch – *President*
dianna.lynch@acha.org.au
Jenny Finan – *State Rep*
Jenny.Finan@calvarycare.org.au

WA
Craig Cheetham - *President/State Rep*
craig.cheetham@healthcarewa.org.au
Helen McLean – *State Rep*
Helen.mclean@health.gov.au

TASMANIA
Sue Sanderson – *President*
sue.sanderson@dhhs.tas.gov.au
John Aitken – *State Rep*
john.aitken@dhhs.tas.gov.au

A CORNER OF RESEARCH FOR AUSTRALIA

BY ROBERT ZECCHIN RN MN

The following excerpts of recent research articles may:

a. Encourage further research in your department;

b. Make you reflect on your daily practice;

c. Enable potential change in your program to become evidence based

d. All the above.

1. Exercise self-efficacy and symptoms of depression after cardiac rehabilitation: predicting changes over time using a piecewise growth curve analysis. Howarter AD. Bennett KK. Barber CE. Gessner SN. Clark JM. Journal of Cardiovascular Nursing. 29(2):168-77, 2014 Mar-Apr.

Background: Cardiac rehabilitation is often recommended after experiencing a cardiac event and has been shown to significantly improve health outcomes among patients. Several psychosocial variables have been linked with cardiac rehabilitation program success, including exercise self-efficacy. However, little is known about temporal patterns in patients' exercise self-efficacy after program completion.

Objective: This study examined changes in exercise self-efficacy among 133 cardiac rehabilitation patients and whether symptoms of depression impacted the rate of change in exercise self-efficacy.

Methods: Participants completed questionnaires at the beginning and end of cardiac rehabilitation and at 6-month intervals for 2 years.

Results: Growth curve analyses showed that exercise self-efficacy levels were highest at the beginning of cardiac rehabilitation, significantly declined 6 months after cardiac rehabilitation, and levelled off over the next 18 months. Results also showed that baseline depressive symptoms interacted with time. Compared with participants with fewer symptoms, participants high in depressive symptoms began cardiac rehabilitation with lower levels of exercise self-efficacy and evidenced significant declines 6 months after cardiac rehabilitation. At no time were they equal to their counterparts in exercise self-efficacy, and their means were lower 2 years after cardiac rehabilitation than before cardiac rehabilitation.

Conclusions: Our findings imply that patients show unrealistic optimism surrounding the ease of initiating and maintaining an exercise program and that integrating efficacy-building activities into cardiac rehabilitation, especially for patients who show signs of distress, is advisable.

The Good News: Treat the person not just the disease for better outcomes!

2. Cardiac rehabilitation is associated with lasting improvements in cognitive function in older adults with heart failure.

Alosco ML. Spitznagel MB. Cohen R. Sweet LH. Josephson R. Hughes J. Rosneck J. Gunstad J.

Acta Cardiologica. 69(4):407-14, 2014 Aug.

Background: Heart failure (HF) is a known risk factor for cognitive impairment. Cardiac rehabilitation (CR) may attenuate poor neurocognitive outcomes in HF via improved physical fitness - a significant promoter of cognitive function. However, no study has examined the possible acute and lasting benefits of CR on cognitive function in persons with HF.

Methods: Fifty-two patients with HF completed a 12-week Phase II CR program. All participants were administered neuropsychological testing and completed a brief physical fitness assessment at baseline, completion of CR (i.e. 12 weeks), and 12-month follow-up.

Results: Repeated measures analyses showed a significant time effect for both attention/executive function and memory ($P < 0.05$). Attention/executive function performance increased from baseline to 12 weeks and these gains remained up to 12 months; memory was unchanged from baseline to 12 weeks, but then improved between the 12-week and 12-month time points. Physical fitness improved from baseline to 12 weeks and these benefits were maintained 12 months later. Changes in physical fitness and cognitive function over time did not reach a statistically significant association, though poorer physical fitness was associated with decreased cognitive performance at the baseline and 12-month time points.

Conclusions: CR is associated with both acute and lasting cognitive benefits in patients with HF. Prospective studies with extended follow-ups are needed to clarify the mechanisms that underpin cognitive improvements following CR (e.g., improved cerebral perfusion) and whether CR can ultimately ➤

reduce risk for cognitive decline and conditions like Alzheimer's disease in HF.

The Good News: Don't forget (pun intended) that heart, brain and body as a whole should be treated equally in CR!

3. Greater improvement in cardiorespiratory fitness using higher-intensity interval training in the standard cardiac rehabilitation setting. Keteyian SJ. Hibner BA. Bronsteen K. Kerrigan D. Aldred HA. Reasons LM. Saval MA. Brawner CA. Schairer JR. Thompson TM. Hill J. McCulloch D. Ehrman JK. Journal of Cardiopulmonary Rehabilitation & Prevention. 34(2):98-105, 2014 Mar-Apr.

Background: We tested the hypothesis that higher-intensity interval training (HIIT) could be deployed into a standard cardiac rehabilitation (CR) setting and would result in a greater increase in cardiorespiratory fitness (ie, peak oxygen uptake, (VO2) versus moderate-intensity continuous training (MCT).

Methods: Thirty-nine patients participating in a standard phase 2 CR program were randomized to HIIT or MCT; 15 patients and 13 patients in the HIIT and MCT groups, respectively, completed CR and baseline and follow-up cardiopulmonary exercise testing.

Results: No patients in either study group experienced an event that required hospitalization during or within 3 hours after exercise. The changes in resting heart rate and blood pressure at follow-up testing were similar for both HIIT and MCT. VO2 at ventilatory-derived anaerobic threshold increased more (P < .05) with HIIT (3.0 + 2.8 mLkg-min-) versus MCT (0.7 + 2.2 mLkg-min-). During follow-up testing, submaximal heart rate at the end of stage 2 of the exercise test was significantly lower within both the HIIT and MCT groups, with no difference noted between groups. Peak VO2 improved more after CR in patients in HIIT versus MCT (3.6 + 3.1 mLkg-min- vs 1.7 + 1.7 mLkg-min-; P < .05).

Conclusions: Among patients with stable coronary heart disease on evidence-based therapy, HIIT was successfully integrated into a standard CR setting and, when compared to MCT, resulted in greater improvement in peak exercise capacity and submaximal endurance.

The Good News: What type of training modality do you use in your CR?

4. Gender differences in illness behaviour after cardiac surgery. Modica M. Ferratini M. Spezzaferri R. De Maria R. Previtali E. Castiglioni P.

Journal of Cardiopulmonary Rehabilitation & Prevention. 34(2):123-9, 2014 Mar-Apr.

Background: Differences in the ways male and female patients confront their illness after cardiac surgery may contribute to previously observed gender differences in the outcomes of cardiac rehabilitation. The aim of this cross-sectional study was to verify whether there are gender-related differences in illness behaviour (IB) soon after cardiac surgery and before entering cardiac rehabilitation.

Methods: Patients (N = 1323) completed the IB Questionnaire and Hospital Anxiety and Depression Scale (HADS) 9 + 5 (mean + SD) days after cardiac surgery. The scores were tested for gender differences in score distributions (Mann-Whitney U test) and in prevalence of clinically relevant scores (the Pearson chi2 test). Multivariate regression analyses were made with IB Questionnaire and HADS scores as independent variables, and gender, age, education, marital status, and type of surgery as predictors.

Results: Denial was significantly (P < .01) prevalent among the men (3.6 + 1.4) versus women (3.2 + 1.6), whereas disease conviction (men = 2.1 + 1.5, women = 2.5 + 1.6), dysphoria (men = 1.5 + 1.5, women = 2.0 + 1.6), anxiety (men = 6.0 + 3.6, women = 6.9 + 3.9), and depression (men = 5.3 + 3.8, women = 6.5 + 4.0) were significantly more prevalent among women. The prevalences of clinically relevant scores for disease conviction, anxiety, and depression were also significantly higher in women. Multivariate analysis showed that gender predicted these scores even after the removal of confounders.

Conclusions: Gender differences exist in denial, disease conviction, and dysphoria, probably depending on the culturally assigned roles of men and women. As these aspects of IB may compromise treatment compliance and the quality of life, the efficacy of cardiac rehabilitation programs might be improved taking into account the different prevalences in men and women.

The Good News: A "Men are from Mars and Women are from Venus" study!

5. The influence of non-modifiable illness perceptions on attendance at cardiac rehabilitation.

Blair J. Angus NJ. Lauder WJ. Atherton I. Evans J. Leslie SJ.

European Journal of Cardiovascular Nursing. 13(1):55-62, 2014 Feb.

Background: Despite the established benefits of cardiac rehabilitation (CR) attendance rates remain variable. Physical barriers to attendance have ➤

been extensively investigated but relatively less is known about the relationship between attendance at CR and psychosocial variables such as illness perceptions and social isolation.

Aim: To examine the influence of socio-demographic factors, illness perceptions and social isolation on patient attendance at cardiac rehabilitation.

Methods: All individuals offered CR over a two-year period were invited to take part in a postal survey. The survey collected socio-demographic data and included completion of the Friendship Scale, to assess social isolation, and the Brief Illness Perceptions Questionnaire. Parametric and non-parametric statistical tests were used as appropriate.

Results: One hundred and twenty-eight (47%) questionnaires were returned. Non-attendees reported higher total illness perception scores and those who attributed their illness to non-modifiable factors were significantly less likely to attend CR ($p = 0.042$). Attendees reported lower levels of social isolation; however, this finding was not statistically significant. No differences were found between attendees and non-attendees in terms of their age, gender, educational status or proximity to cardiac rehabilitation centre.

Conclusion: Psychosocial barriers, specifically illness perceptions and attributions, were found to be significant with patients who did not attend CR reporting more negative illness perceptions. Distance to CR was not a significant factor influencing attendance. Early screening of perceived causal attributions may help to identify those who would benefit from early and targeted intervention to increase participation in CR. Future prospective studies would permit testing of screening approaches and early interventions.

The Good News: Do you screen for psychosocial issues with your patients?

6. The effect of referral for cardiac rehabilitation on survival following acute myocardial infarction: a comparison survival in two cohorts collected in 1995 and 2003.

Lewinter C. Bland JM. Crouch S. Doherty P. Lewin RJ. Kober L. Hall AS. Gale CP.

European Journal of Preventive Cardiology. 21(2):163-71, 2014 Feb.

Background: International guidelines recommend referral for cardiac rehabilitation (CR) after acute myocardial infarction (AMI). However, the impact on long-term survival after CR referral has not been adjusted by time-variance. We compared the effects of CR referral after hospitalization for AMI in two consecutive decades.

Methods: A total of 2196 and 2055 patients were recruited in the prospective observational studies of the Evaluation of the Methods and Management of Acute Coronary Events (EMMACE) -1 and 2 in 1995 and 2003, (1995: median age 72 years, 39% women, 74% referred vs 2003: median age 71 years, 36% women, 64% referred) and followed up through September 2010.

Results: Survival functions showed CR referral to be an independent predictor for survival in 2003, but not in 1995 (hazard ratio (HR), 0.90; 95% confidence interval (CI); 0.70 to 1.17, p=0.44 in 1995 vs HR, 0.80; 95% CI, 0.66 to 0.96, p=0.02 in 2003) when patients entered the model at three months after discharge and had a common exit at 90 months. Significant positive and negative predictors for CR referral were beta-blocker prescription (+), reperfusion (+) and age (-) in 1995, and reperfusion (+), revascularization (+), heart failure (HF) (+), antiplatelets (+), angiotensin-converting-enzyme inhibitor (ACE-I) (+), statins (+), diabetes (-), and the modified Global Registry of Acute Cardiac Events (GRACE) risk score (-) in 2003.

Conclusions: CR referral was associated with improved survival in 2003, but not in 1995 in patients admitted with acute MI.

The Good News: More evidence for the referral of cardiac patients to CR!

7. Sex differences in cardiac rehabilitation enrollment: a meta-analysis.

Samayoa L. Grace SL. Gravely S. Scott LB. Marzolini S. Colella TJ.

Canadian Journal of Cardiology. 30(7):793-800, 2014 Jul.

Background: The present systematic review and meta-analysis examines studies published in the past 10 years that described cardiac rehabilitation (CR) enrolment among women and men, to determine whether a significant sex difference persists despite the evidence supporting the benefits of CR to women as well as men.

Methods: Scopus, MEDLINE, CINAHL, PsycINFO, PubMed, and The Cochrane Library databases were systematically searched for peer-reviewed articles published from July 2000 to July 2011. Titles and abstracts were screened, and the 623 selected full-text articles were independently screened based on predefined inclusion/exclusion criteria (guided by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses; PRISMA) and assessed for quality using the Strengthening the ➤

Reporting of Observational studies in Epidemiology (STROBE) statement form. The meta-analysis was undertaken using Review Manager Software.

Results: Twenty-six eligible observational studies reporting data for 297,719 participants (128,499 (43.2%) women) were included. On average, 45.0% of men and 38.5% of women enrolled in CR. In the pooled analysis, men were more likely to be enrolled in CR compared with women (female enrolment vs male enrolment odds ratio, 0.64; 95% confidence interval, 0.57-0.72; P < 0.00001). Heterogeneity was considered high (I(2) = 78%). In the subgroup analyses, systematic CR referral during inpatient tertiary care resulted in significantly greater enrolment among women than non-systematic referral.

Conclusions: Overall, rates of CR enrolment among women are significantly lower compared with men, with women being 36% less likely to enrol in a rehabilitation program. Copyright 2014 Canadian Cardiovascular Society. Published by Elsevier Inc. All rights reserved.

The Good News: The reason for lower CR enrolment for women may be in the next abstract!

8. Physicians' tacit and stated policies for determining patient benefit and referral to cardiac rehabilitation.

Beckstead JW. Pezzo MV. Beckie TM. Shahraki F. Kentner AC. Grace SL.

Medical Decision Making. 34(1):63-74, 2014 Jan.

Background: The benefits of prescribing cardiac rehabilitation (CR) for patients following heart surgery is well documented; however, physicians continue to underuse CR programs, and disparities in the referral of women are common. Previous research into the causes of these problems has relied on self-report methods, which presume that physicians have insight into their referral behaviour and can describe it accurately. In contrast, the research presented here used clinical judgment analysis (CJA) to discover the tacit judgment and referral policies of individual physicians. The specific aims were to determine 1) what these policies were, 2) the degree of self-insight that individual physicians had into their own policies, 3) the amount of agreement among physicians, and 4) the extent to which judgments were related to attitudes toward CR.

Methods: Thirty-six Canadian physicians made judgments and decisions regarding 32 hypothetical cardiac patients, each described on 5 characteristics (gender, age, type of cardiovascular procedure, presence/absence of musculoskeletal pain, and degree of motivation) and then completed the 19 items of the Attitude towards Cardiac Rehabilitation Referral scale.

Results: Consistent with previous studies, there was wide variation among physicians in their tacit and stated judgment policies, and self-insight was modest. On the whole, physicians showed evidence of systematic gender bias as they judged women as less likely than men to benefit from CR. Insight data suggest that 1 in 3 physicians were unaware of their own bias. There was greater agreement among physicians in how they described their judgments (stated policies) than in how they actually made them (tacit policies). Correlations between attitude statements and CJA measures were modest.

Conclusions: These findings offer some explanation for the slow progress of efforts to improve CR referrals and for gender disparities in referral rates.

The Good News: Told you so!

9. Impact of cardiac rehabilitation on angiographic outcomes after drug-eluting stents in patients with de novo long coronary artery lesions.

Lee JY. Yun SC. Ahn JM. Park DW. Kang SJ. Lee SW. Kim YH. Lee CW. Park SW. Yoo YS. Park EK. Jin YS. Kim J. Nam HJ. Min SY. Park SJ.

American Journal of Cardiology. 113(12):1977-85, 2014 Jun 15.

Background: Cardiac rehabilitation (CR) can reduce cardiovascular mortality and morbidity in coronary artery disease. Long coronary artery lesions may be associated with adverse outcomes after drug-eluting stent (DES) implantation. The purpose of this study was to evaluate angiographic outcomes after a comprehensive CR program in patients with DESs for long coronary artery lesions.

Methods: A total of 576 patients treated with DESs for long (>25 mm) coronary lesions were enrolled in this prospective CR registry. Comprehensive CR programs were successfully performed in 288 patients (50%). The primary end point was in-stent late luminal loss at the 9-month angiographic follow-up.

Results: There were few significant differences between the CR and non-CR groups in terms of baseline characteristics, including clinical, angiographic, and procedural variables. The rate of in-stent late luminal loss in the CR group was 35% less than in the usual care group (0.19 + 0.33 mm in CR vs 0.29 + 0.45 mm in non-CR, difference 0.08 mm, 95% confidence interval 0.01 to 0.16, p = 0.02) at the 9-month follow-up. After propensity-matched analysis (224 pairs), the results were consistent (0.18 + 0.31 mm in CR vs 0.28 + 0.41 mm in non-CR, difference 0.10 mm, 95% confidence interval 0.02 to 0.18, p = 0.02). The CR ➤

group showed a significant improvement in the overall risk profile compared with the non-CR group, including current smoking, biochemical profiles, depression, obesity, and exercise capacity.

Conclusion: In conclusion, the comprehensive CR program significantly reduced late luminal loss after DES implantation for long coronary lesions. This may be associated with significant improvements in exercise capacity and overall risk profile.

The Good News: Great study on PCI patients who need to be referred to CR and not told that they are "fixed"!

10. Participation in cardiac rehabilitation, readmissions, and death after acute myocardial infarction.

Dunlay SM. Pack QR. Thomas RJ. Killian JM. Roger VL.

American Journal of Medicine. 127(6):538-46, 2014 Jun.

Background: Participation in cardiac rehabilitation has been shown to decrease mortality after acute myocardial infarction, but its impact on readmissions requires examination.

Methods: We conducted a population-based surveillance study of residents discharged from the hospital after their first-ever myocardial infarction in Olmsted County, Minnesota, from January 1, 1987, to September 30, 2010. Patients were followed up through December 31, 2010. Participation in cardiac rehabilitation after myocardial infarction was determined using billing data. We used a landmark analysis approach (cardiac rehabilitation participant vs not determined by attendance in at least 1 session of cardiac rehabilitation at 90 days post-myocardial infarction discharge) to compare readmission and mortality risk between cardiac rehabilitation participants and nonparticipants accounting for propensity to participate using inverse probability treatment weighting.

Results: Of 2991 patients with incident myocardial infarction, 1569 (52.5%) participated in cardiac rehabilitation after hospital discharge. The cardiac rehabilitation participation rate did not change during the study period, but increased in the elderly and decreased in men and younger patients. After adjustment, cardiac rehabilitation participants had lower all-cause readmission (hazard ratio (HR), 0.75; 95% confidence interval (CI), 0.65-0.87; P < .001), cardiovascular readmission (HR, 0.80; 95% CI, 0.65-0.99; P = .037), non-cardiovascular readmission (HR, 0.72; 95% CI, 0.61-0.85; P < .001), and mortality (HR, 0.58; 95% CI, 0.49-0.68; P < .001) risk.

Conclusions: Cardiac rehabilitation participation is associated with a markedly reduced risk of readmission and death after incident myocardial infarction. Improving cardiac rehabilitation participation rates may have a large impact on post-myocardial infarction healthcare resource use and outcomes.

The Good News: DER!

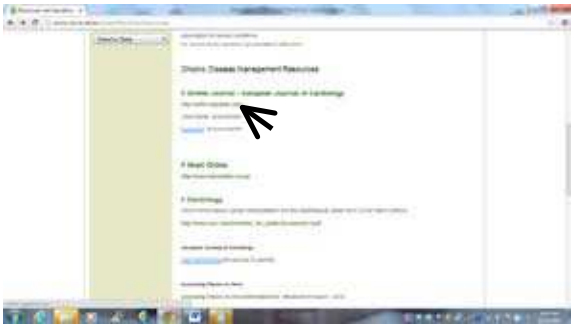
Merry Christmas and see you in the New Year!

Accessing the ACRA Online Subscription to the European Journal of Preventive Cardiology

How to Guide

1. Login to the acra.net.au website using your email address as username and your surname (with capital letter) as password

2. Place cursor over Membership, scroll down to Resources and Education and select (click)



3. Scroll down to Online Journal subheading and click on website http://online.sagepub.com/

Internet browser will navigate away from ACRA website

4. Click on Sign In

5. Type in login details

User Name: acramember

Password: acramember01

Click on Sign In

6. Type: European Journal of Preventive Cardiology into search bar and click Go

7. This gives you access to all Full Text articles of the EJPC

8. Use the text bar to search for specific terms within journal articles

News From *Across The Nation*

New Heart Foundation Walking website – coming soon!

The new and improved Heart Foundation Walking website is in the very final stages of testing with a planned rollout throughout December. The easy-to-use site means that participants can register, set goals and track their progress online.

Is your organisation interested in setting up walking groups? We can help you. A wide range of organisations have already successfully set up groups including community centres, councils, Medicare Locals and Cardiac Rehabilitation groups. Partnering with Heart Foundation Walking has already proven itself to be an effective way of improving health and social outcomes for the local community. For more information on Heart Foundation Walking, visit heartfoundation.org.au/walking or call 1300 36 27 87.

Blueprint for an active Australia

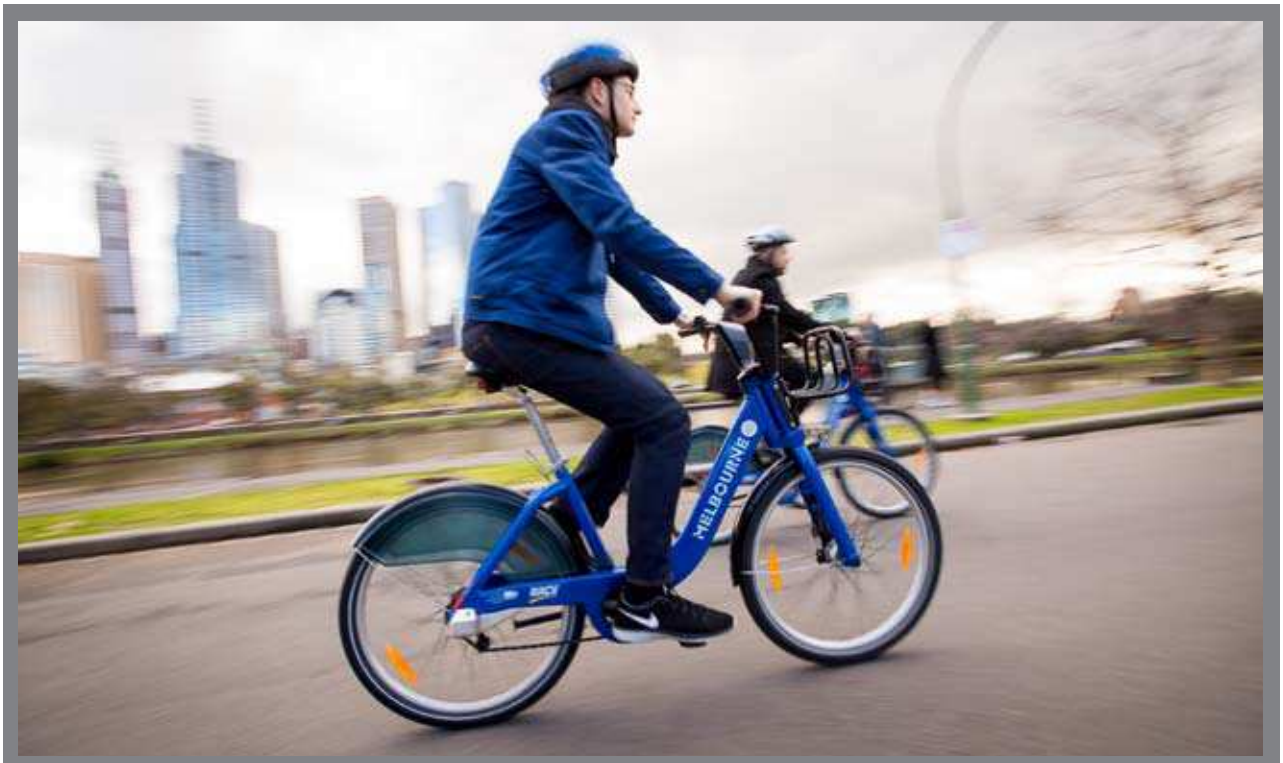
The recent release of Blueprint for an active Australia is a call to all Australian governments to implement our 13-point plan to get the nation moving. The evidence demands that Australians act quickly to increase their physical activity levels. Sedentary behaviour and inadequate physical activity are hazardous to our health.

Read more about the Blueprint at www.heartfoundation.org.au/news-media

Does density matter?

Our new discussion paper 'Does Density Matter?' stresses that well-designed, well-located higher density neighbourhoods with accompanying amenities encourage more walking. This paper is for residents and built environment experts and showcases eight case studies of neighbourhoods that encourage walking and offer real transportation options.

If we want people to walk more, then density matters. Visit www.heartfoundation.org.au/density



Would you ride to work?

Fifty per cent of Australian workers said they would be enticed to ride to work if a financial incentive was available, such as those currently offered in the UK, Europe and North America. The data comes from the national survey we conducted with the Cycling Promotion Fund of more than 2,000 workers aged 25 to 54, who do not currently cycle to work and work less than 15 kilometres from home.

We support people to exercise on the way to work, visit www.heartfoundation.org.au/news-media

New alliance for better health

We recently announced the National Physical Activity Alliance, a group that is committed to reducing Australia's rate of chronic disease by prescribing physical activity. Currently, 60% of Australian adults don't get enough exercise to gain a health benefit and more than 63% are overweight or obese.

Find out who the 11 members of the NPAA are at www.npaa.org.au

heart
RESEARCH CENTRE

The Heart Research Centre (HRC) continues to develop its themed research program, as detailed in last year's Report to ACRA EMC. Highlights of HRC's research and training for 2014 include the Cardiac Blues Project; our national survey of cardiac rehabilitation co-ordinators; and our workforce development through the HRC Network. Further organisational highlights are the establishment of an international Scientific Consultative Committee and the Centre's lead in establishing a Psychocardiology Mental Health Professionals Network.

Cardiac Blues

The 'Cardiac Blues' project is a translational research study aimed at supporting cardiac patients in their emotional recovery after an acute cardiac event. Led by Dr Barbara Murphy, the Centre's Director of Research, the Cardiac Blues project builds on several of our previous studies into anxiety and depression in cardiac patients.

Most patients go on an emotional rollercoaster after an acute cardiac event such as a heart attack or heart surgery. Patients often feel sad, anxious, fearful, confused and angry, and experience a range of unexpected symptoms including tiredness, irritability, tearfulness, sleep disturbance and forgetfulness. Our research has shown that for most patients, these symptoms – known as the 'Cardiac Blues' – resolve during the first few months after the acute event. However, one in five patients become seriously depressed after their acute event and, for some, the symptoms worsen over time. A significant minority of patients remain depressed even 12 months after their event.

Patients tell us that they want to know about what to expect emotionally after their cardiac event, and health professionals tell us that they want skills and training in this important area. Unfortunately, most patients are discharged from hospital without being told about the cardiac blues or the potential for serious depression.

Funded by *beyondblue*, the 'Cardiac Blues' project has involved the development and piloting of a range of resources for both patients and health professionals. The resources aim to support normal emotional adjustment and to alert patients to the potential risk of serious depression. The resources include pamphlets for patients, a waiting room poster, and an implementation guide and online training program for health professionals.

Following qualitative and quantitative testing, the resources were launched in July 2014 and have now been disseminated to over 600 health professionals nationally including all cardiac rehabilitation co-ordinators, all coronary care units, all cardiothoracic units and all Medicare Locals across Australia. A second phase dissemination to general practices across Australia will occur during 2015. We are now monitoring uptake and use of the resources by health professionals and patients across Australia.

Screening and assessment practice within cardiac rehabilitation: A survey of cardiac rehabilitation co-ordinators

Screening and assessment of cardiovascular risk factors is a vital step in effective secondary prevention. Cardiac rehabilitation provides an ideal opportunity for health professionals to screen patients across a range of cardiovascular disease risk factors. However, little is known about current practices in screening and assessment in the CR setting. Led by the Centre's Director, Professor Alun Jackson, this project focuses on this important area of screening, assessment and monitoring, with attention to measurement tools and methods.

The aim of this study was to investigate and document current practice in cardiac rehabilitation (CR) in screening for a range of cardiac risk factors. The study also aimed to document the difficulties that health professionals encounter when undertaking screening in cardiac rehabilitation setting.

For some risk factors there are clear guidelines as to when and how to undertake screening. For other risk factors, however, there are no evidence-based guidelines, which underscores the difficulties faced by health professionals in undertaking effective and efficient screening.

In March this year we conducted an online survey of the coordinators of Australia's 350 CR programs to assess screening activities across a range of traditional and new cardiac risk factors. The study has provided a detailed picture of the range ➤

and extent of screening currently undertaken in Australia's CR programs, and has highlighted important gaps and areas of need. The findings provide an important benchmark for assessment and screening activities, and will inform our training programs and the development and testing of new assessment and screening instruments.

We were pleased to have over 50% of CR programs nationally included in the survey. Data is currently being analysed and prepared for publication.

Workforce capacity building and the HRC Network: Connecting health professionals for improved practice

Many health professionals, particularly those practicing in regional, rural and remote areas, find it difficult to attend centre-based training programs. The HRC Network, with funding from the Victorian Cardiac Clinical Network, is an exciting new initiative aimed at connecting health professionals across Victoria and supporting translation of chronic disease self-management (CDSM) knowledge and skills into practice. A central goal of the project is to increase health professionals' capacity to support patients in the self-management of their health conditions.

The HRC Network includes modules from our online *Supporting Chronic Disease Self-Management and Cardiac Blues* training programs. The CDSM training incorporates evidence-based strategies from motivational interviewing and cognitive behaviour therapy, and is based on our original centre-based CDSM training, which was developed with funding from the Commonwealth Department of Health and Ageing (DoHA) in 2010. The one-hour Cardiac Blues training incorporates findings from our research on trajectories of depression and 'red flags' for depression risk. The Cardiac Blues training was developed in 2013 with funding from *beyondblue*.

The HRC Network project is delivering the online training to 150 Victorian health professionals, with preferential targeting to those working in regional, rural and remote areas. We are supporting practice change through a Victoria-wide closed online community, The HRC Network. The HRC Network provides a forum for health professionals to access and discuss information related to CDSM and the cardiac blues following completion of formal training, and access resources developed by the Centre to use in their practice. In addition, the network provides the opportunity for health professionals to connect with each other. We are evaluating the project impact and identifying future training needs.

Scientific Consultative Committee

The Heart Research Centre (HRC) has established a Scientific Consultative Committee which includes a national and international team with expertise in the range of disciplines involved in the work of the HRC.

The Scientific Consultative Committee contributes to HRC's mission by:

- Providing independent, competent and timely advice on research matters to the Director, Research Director and research staff and where appropriate the Board. This includes advice on possible national and international clinical and research partnerships and advice which draws upon their experience in cognate areas such as diabetes and other chronic conditions.
- Assisting the HRC to assess its research performance broadly in relation to best practice in research conducted in relation behavioural, psychological and social aspects of cardiac disease and to advise on research translation.

The members of the SCG are: Professors James Blumenthal , Colette Browning, Michael Jelinek, Dan Penny and Frans Pouwer

Victorian Psycho-Cardiology Mental Health Professionals Network

The Mental Health Professionals' Network (MHPN) is a unique national program, the aim of which is to improve consumer outcomes by championing interdisciplinary practice and collaborative care in Australia's primary mental health sector. It does this through its two core programs: MHPN networks and online professional development. MHPN is a not-for-profit organisation funded by the Australian Government Department of Health and Ageing.

The Heart Research Centre has led the formation of the Victorian Psycho-Cardiology Mental Health Professionals Network held its inaugural meeting on Tuesday 25th November. Over 100 participants registered for the following program:

Topic: Issues in Psycho-cardiology

Chair Dr Rosemary Higgins

- *Depression and the heart - mechanisms of cardiac risk:* Associate Professor David Barton, Consultant Psychiatrist, Ballarat Health Services and Monash University
- *The Cardiac Blues:* Dr Barbara Murphy, Director Of Research, Heart Research Centre
- *Anxiety - The Thinking Heart:* Dr Marlies Alvarenga, Cardiac Clinical Psychologist, Monash Heart
- *General Practice, Cardiology and Mental Health Services - Bridging the Divide:* Ms Freyja Millar, Mental Health Nurse & Diabetes Educator, Eastern Health

State presidents' reporting

Western Australia

State representative
Craig Cheetham

CARDIOVASCULAR HEALTH NETWORKS

Cardiac Rehabilitation and Secondary Prevention working group

Implementation of Pathways Policy Document (Launched: July 2014)

Further to the launch of the policy document by WA Health Dept in July, work has commenced to ensure the document is known, utilised and guides prevention and rehabilitation of cardiovascular disease across all sectors of health care within Western Australia. The intention is to provide a toolkit approach including PowerPoint slides that can be utilised by practitioners to assist them disseminate the content of the document and what is considered best practice in the secondary prevention and rehabilitation cardiovascular disease.

WACRA educational forums.

The WACRA executive will meet over the next few weeks to discuss the content and dates for a series of educational events throughout 2015. The events will be focused upon delivering content that is provided by the membership from feedback and individual discussions. We very much welcome any feedback and suggestions regarding topics, content, format, timing, and location of our educational events.

Next Event

The next WACRA event will be held in February. This will be a large event that will include a formal dinner, presentation and the WACRA Annual General Meeting (AGM). The AGM is always an opportunity for new or long standing members to consider positions on the executive committee. All positions are managed to ensure your commitment to the committee is neither a time burden nor distracting to your weekly demands. They are also structured to support new participants on the committee to work alongside others that may have been long-standing committee members. With the exception of motivation, there is no prerequisite of skills, experience or committee knowledge. We look forward to an exciting 2015.

Merry Christmas

On behalf of the WACRA executive committee and myself I would like to wish you and your families a very Merry Christmas and a safe and healthy New Year.

WA state items prepared by

Craig Cheetham

WACRA President

WACRA representative on the Cardiovascular Health Network's, Executive Advisory Group.

Please don't hesitate to contact me for further information regarding these events or projects.

Queensland

State President
Paul Camp

State Representative
Jess Auer,

Welcome to New QCRA Members

QCRA would like to extend a warm welcome to our new members: Margaret Back, Kathy O'Donnell, Suzanne Banks and Scott Zafir

QCRA 2014 AGM

The QCRA AGM was held on Friday 24th October. Thank you to those who participated in person, through video and teleconference or who sent in their proxy votes. The results of the AGM include:

- Election of Executive Management Committee:

  President: Paul Camp

  Vice President and QLD State Rep to ACRA: Jessica Auer

  Secretary: Kathy O'Donnell

  Treasurer: Karen Healy

  Committee Members: Bridget Abell, Gary Bennett, Catherine Hardy, Ivette Warren, Robyn Williams and Dr Jo Wu

  Invited Committee Members: Karen Uhlmann and Steve Woodruffe.

  Thank you to Sharon Leslie, who has worked tirelessly in the role of Secretary over the past twelve months.

- Special Resolution: The special resolution to reduce the numbers needed for an AGM quorum to that of the EMC plus one was passed overwhelmingly. This resolution is in line with the Qld Office of ➤

Fair Trading's model rules for an Association and will come into effect from the next AGM in 2015.

QCRA-Heart Foundation Cardiac Rehab Symposium

The Secondary Prevention in Cardiology Symposium, 'Cardiac Rehab-Meeting the Need' on October 24th was a great success. There were over 60 registrations including twelve videoconference sites across the state who participated.

Feedback about the event has been very positive, with many commenting on the high quality of the presentations and the positive atmosphere.

The Symposium was opened with a great Welcome to Country by the widely respected Aboriginal Elder and Turrbal man, Uncle Joe Kirk. Joe shared some wisdom about how bush medicine could be used to heal both heart and soul. Steve Woodruffe gave some insights into the larger picture of CR with his national and international perspective. Jane Partridge the Director of the Health Economics and Purchasing Department helped navigate funding of cardiac secondary prevention. Jessica Auer showed how an innovative public-private CR program – HeartStart- could adapt to meet the needs of a community. Karen Uhlmann, Heart Foundation Clinical Manager Acute Sector, discussed the updating of the Queensland CR and Heart Failure Service Directory and how this may fit within Google Maps. Deanne Wooden, Heart Foundation Nutrition Manager, reviewed the evidence behind the Mediterranean Diet. Gary Bennett brought us up to speed with the ongoing great work of the COACH program Queensland. Dr Mohanraj Karunanithi, Group Leader Digital Productivity Flagship CSIRO, shared some exciting findings from the research into smart phone home based CR with the CAP-CR program. Michelle Aust reviewed the benefits to be gained from a well-run inpatient CR program in looking at the Role of Phase One CR Today. The symposium came to a close with an energetic panel discussion about Cardiovascular Secondary Prevention in Queensland, by Dr Steven Barry from the SCCN, Vitoria Chalmers Director of the Health Contact Centre, Rachelle Forman Health Director of the Heart Foundation and Viv Bryce CNC Heart Recovery Service PAH.

The Symposium guest speakers have kindly made copies of their slides available through the QCRA members only accessible Resources/Education webpage: http://www.acra.net.au/qcra

QCRA would like to formally thank our co-host, the Heart Foundation for their significant assistance in making the event possible. QCRA would also like to thank the many guest speakers and all the members of the EMC for contributing to the events success.

The QCRA EMC looks forward to providing other professional development (PD) opportunities for our members in the future. Please let us know what PD activities or topics you would like included in the future at: qcra@acra.net.au

Updated Qld CR Service Directory

QCRA continues to update the Queensland Directory through our Directory Coordinator – Bridget Abell. The most recent update occurring on the 10th November

Generic email addresses are strongly preferred for this directory to allow for better long-term communication. We encourage anyone who has not provided a 'generic email' to please consider this or to contact us qcra@acra.net.au for further information.

Tasmania

State representative
John Aitken

President
Sue Sanderson

Membership 23

A relatively quiet few months in the island state. However, there is a lot happening on the political front in the state with threatened cuts to frontline staff top of the agenda in the public service (not just health where approximately 120 FTE positions are threatened). The state is also to move (at last) to a single health service (from the current 3 THO's) from the next financial year.

To assist planning of services there have been several Clinical Advisory Groups formed reporting up through the line to the Minister. Pleasingly one Group is specifically targeting statewide cardiac services and Sue Sanderson is on this CAG which is chaired by Dr Paul MacIntyre. Erica Summers is also a member as is Gillian Mangan from the Heart Foundation so cardiac rehabilitation proponents are well represented.

We had a small representation of members at the ACRA conference in August.

We are busily planning the next TACR Education Day and AGM to be held on the 14th March 2015 at the Northern Integrated Care Centre adjacent to the Launceston General Hospital. Following up on a successful event this year where we looked at the non-healing sternum, we plan to have a broader multidisciplinary discussion focussing on exercise specifically adapting for non-union, precautions, and nutrition for healing. All ACRA members are welcome to attend.

The Tasmanian Medicare Local recently launched statewide Healthcare pathways which included links to cardiac rehab services. The pathways are based on those developed in the Canterbury Health region in New Zealand and used also in the Hunter New England Health Service in NSW. It is pleasing to note that we have received some referrals to our CR service from GP's since the launch.

A small working group has been working within the RHH to develop a Heart Failure pathway for patients coming in through our emergency department. This is part of an overall strategy to reduce admissions and readmissions of these patients who we acknowledge consume a high proportion of health resources.

Advanced Heart Failure Symposium

Sue Sanderson was able to attend this symposium held at the Alfred in Melbourne on October 10th which was well attended by multidisciplinary health professionals. A broad range of expert speakers spoke on the day covering topics under the headings: "Current state of advanced heart failure", "Difficult dilemmas in heart failure", "Beyond guideline directed medical therapy" and "Mechanical options in the failing heart". From drug therapy to device therapy, the ➤

importance of rehabilitation and exercise, the prevention of readmission, to the management of different forms and causes of heart failure - all these were addressed during a very comprehensive day.

Sue had also been supported to spend a few days at the Alfred Hospital observing clinics and working with patients with LVAD's and waiting transplants. The RHH refers all patients for these procedures across to the Alfred and this provided an opportunity to upskill particularly in LVAD management.

Personal reflection: LVAD's provide mechanical circulatory support and are implanted for various reasons often as a 'bridge to transplant' or as 'destination therapy'. Two types are implanted at the Alfred – the HeartMate II and the Heart Ware device. In Hobart at the present time we have 2 patients with each of these devices attending our clinics so it was extremely valuable to spend the time at the hospital with the expert nurses. Education of the patient and family are vital for the ongoing management of the device. The patients also participate in intense exercise sessions pending transplant and again following their transplant surgery. These classes provided a different perspective on cardiac rehabilitation as it was both humbling and challenging to observe patients with LVAD's riding exercise bikes, lifting weights and participating in life. I don't get the opportunity to observe the sessions at the RHH but patients with these devices do attend a program here run by the physios.

Journal club

Round table discussion with TACR colleagues round the state reviewing the recently published article "Prescription of secondary prevention medications, lifestyle advice, and referral to rehabilitation among acute coronary syndrome inpatients results from a large prospective audit in Australia and New Zealand", Redfern J et al, doi:10,1136/heartjnl-2013-305296.

Results of "Snapshot" on which article is based showed that overall only 27% patients received the 'full package' while inpatients - at least 4 medications, dietary and exercise advice, smoking cessation referral and referral to cardiac rehabilitation. Those identified as being less likely to receive information - elderly, private hospital, UAP and non-intervention.

Discussion round how we perceive we are doing in Tasmania and how we might improve. Resource issue. Also inter-hospital referrals for management and feedback to local CRN's not always supported.

South Australia & NT

SACRA

State representative
Jenny Finan

President
Dianna Lynch

As we draw to another years end we reflect on a busy last few months. After the last newsletter we were preparing for our July SACRA meeting followed by our annual members' dinner which was held at Ayers house.

Dr Rajeev Pathak presented his research work he and his colleagues have been undertaking with Professor Sanders on *"Arrest AF – The implications of aggressive cardiac risk factor management on catheter ablation for AF"*

This presentation provoked quite a robust discussion with many of our members challenging Dr Pathak and his colleagues to be more proactive in their support for cardiac rehabilitation and the importance of risk factor management, which reflects the same group of risk factors of cardiovascular disease.

This talk perfectly introduced and complimented Professor Prash Sanders talk who discussed the AF Arrest study at our ACRA conference in August, in which he focussed on prevention, pathophysiology and treatment of AF.

October Education Seminar

We had another successful education seminar held once more at Hampstead Day Rehabilitation Centre on Saturday 18th October, in which we had 30 attendees with a door prize of a free membership to SACRA for 12 months which was won by one of our speakers on the day Dr Angela Kucia.

We were delighted to have three very different topics however equally entertaining and informative.

Professor John Beltrame presented *Chest Pain in "Normal Angiography"* which gave us real insight into the challenges of treating patients who quite often are repeat visitors to our hospitals with very real chest pain symptoms, but have little measurable answers due to the possibility that it is microvascular in origin and therefore more difficult to diagnose and treat.

Dr Angela Kucia presented *"Stress in heart disease"* which explored the effects of different stresses on the heart such as heart failure in pregnancy, takotsubo, and chronic stress.

Dr Michael Worthington then presented a very enlightening presentation on *"Obesity in cardiac surgery"*. This was most interesting as the talk progressed as it challenged a lot of misconceptions that we have about surgery and the studies undertaken on obesity vs underweight and surgical risk and outcomes.

I would also like to make a special mention and thank Dr Worthington as he agreed to fill in at very late notice for another speaker, then was on call, had cardiac surgery to perform prior to attending our seminar, and he did not wish to let us down, so we juggled the speakers and he still delivered his presentation.

(President Dianna Lynch with Dr Angela Kucia) Photograph taken by Jenny Finan

I believe from our feedback on this event that it was well worth continuing with this style of events for our members.

World Diabetes Day Education Session:

This was a new event offered to SACRA members and was convened by Jenny Finan & Maureen Carey, ➤

Cardiac Rehabilitation Coordinators and Diabetes Educators for the Calvary Care group, in preparation for World diabetes day. This event was sponsored by the Police Credit Union.

This was such an enjoyable and informative session which really gave practical considerations across two chronic diseases, which we so often see overlap.

There we three very dynamic speakers including Ms Claire Trimingham, - dietitian; Dr Hamish Eaton – Physician with strong interests in cardiovascular and diabetes health and Mr Russ & Dr Janett Jackson who delivered a patient's review.

Claire Trimmington started the evening with a dynamic and informative lecture on diabetes and kidney disease. Dr Hamish Eaton's passion to achieve best outcomes for people with diabetes and heart disease was demonstrated in his enthralling presentation resulting in a revealing insight into how diabetes impacts on cardiovascular disease outcomes. One of his key messages was that as health professionals we must continue to support people with smoking cessation. Janett and Russ were both engaging and insightful when talking about their experience as consumers of our health system. Their session was invaluable and has resulted in SACRA and the Heart Foundation agreeing to join forces in 2015 for 'Heart Week' to campaign 'Joining of the Hearts'. The money raised ($200) during this event will be donated to Diabetes Australia.

Executive News

We have commenced succession planning for our Treasurer – Kathy Read will be retiring at our next AGM in 2015; we have 2 applicants who may share the role to facilitate leave and succession planning. This will be confirmed at the AGM on 29th April 2015.

I would also like to acknowledge and thank Susan Treadwell who has been our Heart Foundation Representative for the past 12 months. Susan has done an excellent job, stepping in to Vanessa Poulsen's position whilst she was on maternity leave. Vanessa will be returning in February 2015. Susan will be returning to Flinders hospital.

We are very grateful & pleased to announce that Astra Zeneca will be continuing with their sponsorship to assist us with the costs of providing education sessions and our annual dinner meeting for 2015.

We as a state and nationally have been working towards having standardised KPI's, minimum data set, and core component documents which are in different stages of progress however in 2015 we are planning for completion and commencement of implementation.

We also will be introducing a standardised referral form which is in draft format and will be "going live" on December 1st 2014 and will be reviewed on April 1st 2015. Thank you to Kath O'Toole & Michelle Iadanza for this work.

Jenny Finan attended our ACRA EMC meeting on 21-22nd November for a very busy but productive weekend.

See details of the many discussions in the President's report.

An annual date of membership renewal has been proposed and SACRA will support this. ACRA is also negotiating to have the updated website available early in the year allowing for online registration renewals, ease of use of our websites and information to members.

Rural Reports:

All current reports can be requested from Caroline Wilksch Caroline. wilksch@health.sa.gov.au

Financial Report:

All current reports can be requested from Kathy Read

Kathy.read@health.sa.gov.au

Heart Foundation report:

All current reports can be requested from Susan Treadwell.

Susan.treadwell@heartfoundation.org.au

SA Health has approved the proposal to extend the standard cardiac resources contract until June 30th 2017 which includes "My Heart My Life" "My Family, Our Culture" and 2 heart failure booklets.

These resources will be extended to cardiologists and primary health centres

MHML app is now available free of charge for iphone, ipad and android devices.

Work is still in progress in getting a Google maps style cardiac rehabilitation service guide for consumers.

Online learning for Phase 1 education for nurses, based on six step recovery conversion guide.

Save the Dates: Ordinary Meetings

- Wednesday 18th February – 1630-1800 Heart Foundation
- Wednesday 29th April – AGM 6pm – 8pm Heart Foundation (Catering provided)
- Wednesday 17th June – (prior to Annual Dinner ? Ayers House
- Wednesday 9th September – 430pm-6pm
- Wednesday 25th November (prior to Christmas dinner)

Special Dates / Education Sessions

- Saturday 21st March Education Session – Hampstead Day Rehab
- Saturday 17th October Education Session – Hampstead Day Rehab

ACRA conference commencing August 10 -12 – ACRA 25th Anniversary

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

Dianna Lynch
SACRA President

Victoria

State representative
Kim Gray

President
Emma Boston

VACR Committee

Following Committee nominations at the AGM 24th October 2014 the Committee has appointed the positions noted below. For risk management and attrition planning the Committee has included a deputy position to the President, Secretary and Treasurer roles.

President: Emma Boston

Vice President: Kim Gray

Secretary: Niamh Dormer

Vice Secretary: Meg Ryan

Treasurer: Deb Gascard

Vice Treasurer: Ailish Commane

ACRA State Rep: Kim Gray

General Committee: Alison Beauchamp, Carmel Bourne

HRC Rep: Elizabeth Holloway

NHF Rep: Harry Patsamanis

We thank Meg Ryan who has stepped down from her role as VACR Secretary and acknowledge her assistance to the incoming Secretary Niamh Dormer.

VACR Policy and Procedures

The Committee resolved to comply with the Consumer Affairs Victoria legislation and promptly supply the change of VACR Secretary details. This process has been completed for 2014.

VACR Membership

Membership has again risen; 167 members currently. Welcome to our new members. We currently have the largest state member number so well done to those who have actively recruited new members to VACR.

State Conference

The VACR two day State Conference and Dr Alan Goble Lecture was held 23rd and 24th October at the Stamford Plaza, Little Collins Street, Melbourne. The conference theme was around the current conundrums we are facing in cardiac rehabilitation treatment therapies; what to use, how much, when and where.

VACR officially recognises and appreciates the sponsors of this event and in particular thanks the efforts of;

- Sally Faulkner CEO, St John of God Frankston Rehabilitation Hospital – Gold sponsor
- Anthony Fornaro, Representative Servier- Silver Sponsor
- Michele Amour and Shane Shrugg, Representatives Zoll – Bronze Sponsor

We were also fortunate for the assistance in the running of the "wake-up" sessions by Exercise Physiologists Trent Malcolm from "Active One" and Zoe Lechte from "PACE Exercise Physiology". Thank you for getting us up, moving and laughing. The support of these organizations is essential to assisting the conference organisers to produce an informative, professionally invigorating program enjoyed by many.

VACR was very fortunate to have sourced a great variety of experts representing a range of professional backgrounds from both the public and private industry. The topics delivered were from both clinical and research points aimed to provide the clinician with best evidence to base their practice upon.

Dr Jeffrey Lefkovits got the Conference off to a great start with a very relevant and brilliant key note address on day one, raising interesting discussions around the cost, impact and sustainability of health care in Australia with a cardiac perspective.

Dr Alan Goble Lecture

Dr Barbara Murphy is to be congratulated on her excellent informative and engaging Dr Alan Goble Lecture that concluded the first day. This evening event was attended by not only by the VACR conference delegates but also by some current eminent National Heart Foundation and Heart Research Centre representatives. As well, some of Dr Goble's close peers and friends attended demonstrating how important this annual event has become, held in recognition of the great cardiac rehabilitation work undertaken by the innovative, multi-talented, dedicated expert.

Dr Murphy spoke about how advanced at the time Dr Goble was in his initial cardiac rehabilitation research; how very relevant Dr Goble's work remains in best evidenced practice today and how very fortunate we who work in cardiac rehabilitation are to have had Dr Goble pave the way. Dr Murphy pointed out how Dr Goble's work remains deeply respected by cardiac rehabilitation practitioners around Australia as well as by his peers; many of whom regard Dr Goble fondly as ..."the father of cardiac rehabilitation".

This evening event was exceptionally well received by the audience and at conclusion of Dr Murphy's lecture Dr Goble's memory was celebrated appropriately.

The VACR Committee was challenged again on the second day with similar issues to the day before with presenter illness, Melbourne traffic issues, IT clichés and the required necessary sudden unplanned changes to the program. We were fortunate for Dr Alison Beauchamp's patience, IT skills and ability to work under duress with the third and fourth back-up laptops also presenting issues. Dr Beauchamp helped to ensure the program ran as close as possible to time. Thank you Dr Beauchamp.

VACR also wishes to acknowledge it's appreciation for the flexibility of the presenters and thanks in particular Damian Flenley and Kirstan Corben who with less than 48 hours' notice were able to change the time of their presentations. For both of these presenters it was their first official contact with VACR. Note that at short notice Damian happily complied with the Committee's urgent request and altered his power point; still managing to jam-pack the presentation with engaging, informative and relevant information around permanent pacemakers, Internal Cardiac Defibrillators and the latest developments in implantable device therapies.

Deb Gascard's iPhone Apps session gained a lot of questions from the audience about how to utilise health directed iPhone apps in the workplace. ➤

This hands-on session saw many in the audience pulling out their own iPhones and installing some very handy cardiac tools.

Stavroula Zandes' e-Cigarettes focused on the newer generation of the methods of nicotine "vaping" delivery that is currently rapidly developing. Stav cautioned that this is "new" technology which has grown so quickly that there is a real need for the smoking cessation clinician to be vigilant as evidence based research and legislation "catches up" to the tobacco industry's rush to grab market share.

Kirstan Corben's presentation closed the second conference day with an emotional and thought invigorating note with the brief video for clinicians encouraging them …"to start the smoking cessation conversation"… If you have not had the opportunity to view this very short but impacting video I encourage you to do so.

Conference registrations were lower than we had hoped; 54 delegates for the Conference participating in either one or both days with a subsequent financial impact on VACR funds. This was felt to be due to competing with other major Melbourne events including the Cardiac Conference and Alfred Hospital's inaugural HF symposium as well as other issues.

The Trybooking site for Conference continues to be working easily and well from both organizer and registrant's point of view.

The AGL was well attended and included VIPs and other participants not included in the official Conference attendee number count.

A detailed audit from the Conference feed-back forms indicated that the conference provided the delegates with broad and interesting information relevant to their practice. There was a strong push amongst responders for access to power point presentations and or handouts. Due to the power point size particularly where gifs were included as well as some presenters declining permission to release their presentation the power points have not been loaded onto the VACR website.

Printing of power points available in the Conference packs was further limited by the lack of timely availability of power points for printing. The Committee is also conscious that there previously have been a number of delegates feed-back to the Committee not wanting to have power points provided in hard copy.

Amongst the October 2014 feed-back there was a request for more clinical and less research focused topics from a portion of responders. Traditionally the Clinical Practice Day has focused on this clinical aspect with the ACRA Conference having a more scientific base.

Food and venue was identified as a strong positive amongst the majority of delegates. Despite IT issues and unplanned presenter illnesses all responders to the feedback report that they intend to participate in future VACR education events.

VACR AGM

The AGM was held during the VACR Conference.

The number of nominations for the Committee equaled positions available with all the nominations accepted unchallenged.

Concerns regarding the potential impacts the unplanned state change of the ACRA 2015 location back to Victoria when it was run only last year here in Melbourne was raised from the floor. These concerns have since been tabled at the latest ACRA Committee face to face meeting 22nd and 23rd November 2014. The VACR Committee is continuing to work with ACRA Committee following through on ACRA's strategic plan to collaboratively re-align with the Cardiac Society of Australia and New Zealand (CSANZ) and the potential benefits this could bring to both organisations.

VACR Educational Events for 2015

Planning for the Clinical Practice Day is now well under way with the theme built around the tyranny of distance and the impact this can have on cardiac rehabilitation from both the program organiser and attendees. Negotiations are currently underway by the VACR Committee as we continue to strive to contain costs for our members whilst aiming to provide a suitable venue for the event. The date and venue are yet to be confirmed but will be either late February or March 2015 and located in the Melbourne CBD.

The 2015 State Conference, VACR AGM and Dr Alan Goble Lecture will be convened after the ACRA National Conference. Potentially this will be held late October or early November; and to hopefully be as far away as possible from a timing point to reduce the impact from competing events.

The VACR Committee is interested and happy to receive further comments or suggestions regarding our members' thoughts around their personal professional development requirements during next year when an unexpected ACRA and CSANZ Conference will be convened also in Melbourne. In considering this matter members may like to consider how many days or part there of days they would like to allocate to their own professional development from both time and revenue perspectives.

In the meantime stay tuned to the VACR email site for further updates as they come to hand.

On behalf of your VACR Committee I wish you a very Merry Christmas and a Happy New Year.

Emma Boston

Ed. Note: see also Emma's story around the organisation of the 2-day event "How to run a successful state conference".

NSW / ACT

State representative
Robyn Gallagher

President
Dawn McIvor

Board members

President: Dawn Mcivor

Vice president Elect: Jo Leonard

Secretary: Leonie Saddler

Treasurer: Juilie Belshaw

Chair of PDC: Deb Hendy/Jo Leonard

Rural Member: Robyn Leece

Metropolitan Member: Susan Hales

ACI Representative: Kellie Roche

NHF Representative: Cate Ferry

ACRA state representative: Robyn Gallagher

Following our AGM there has been a board restructure at CRA NSW ACT.

We have removed the necessity for a board member to be a cardiac rehabilitation clinician. The rationale for this was that many of our members work in research, education etc. and would not be considered cardiac rehabilitation clinicians therefore are ineligible for the board. Our president is to be voted in for a period of two years with a vice president (president elect) voted (similar to ACRA) in the second year. This supports new member's joining the board and allows for a smooth handover. The professional education committee is now changed to the Professional Development Committee to reflect the diversity of the work the Professional Education committee has undertaken over the years. Originally the board had two member at large positions which could be from any discipline. These positions have now changed to one rural representative and one metropolitan representative to reflect the different geography and location in which our members work.

CRA NSW ACT continues to work collaboratively with the National Heart Foundation (NSW branch) and the Agency for Clinical Innovation (ACI) on issues pertinent to cardiac rehabilitation. We are also working with the NHF and Heartonline to develop an educational component to Heartonline. Part of our commitment to our members in rural areas is our determination to hold at least one rural conference each year in one of our more rural and remote areas. The conference in 2014 was held in Wagga in November. Unfortunately there were only 23 participants able to attend. While we appreciate that this is a reasonable number of participants for a rural area and the conference was evaluated well, it is not necessarily a cost effective approach. We would appreciate some input/ideas from our rural sites as to how best to support their educational needs. Please email me your suggestions dawn.mcivor@hnehealth.nsw.gov.au. I would also like to take this opportunity to thank the NHF NSW branch and in particular Cate Ferry and Julie-Ann Mitchell for their ongoing support of CRA NSW ACT.

Finally, it is with great sadness that I can announce that our secretariat Juilie Rhodes is leaving us for pastures new on the 31st December. We thank Julie for all her hard work and wish her well for the future. The board is exploring other options for our secretariat. May I also take this opportunity to thank the board and professional development committee for CRA NSW ACT for all their hard work over the last 12 months and wish everyone a happy Christmas and a happy new year.

Dawn

CALENDAR OF EVENTS

ACRA
AUSTRALIAN CARDIOVASCULAR HEALTH AND REHABILITATION ASSOCIATION

February 18th	SACRA meeting Heart Foundation 1630-1800
March 15th	TACR education day and AGM
March 21st	SACRA Education session Hampstead Day Rehab
April 29th	SACRA AGM Heart Foundation 1800-2000
June 17th	SACRA meeting
August 10-12th	ACRA Annual Scientific Meeting, Melbourne
September 9th	SACRA meeting 1630-1800
October 17th	SACRA Education session Hampstead Day Rehab
November 25th	SACRA meeting

Reflections

Notes to self on how to run a successful state conference
Emma Boston October 2014

- Realise when you advertise competing professional PD activities on your member email site that your attendance numbers and conference profitability to your own conference will be impacted
- Remember that power point presentations will arrive late (if at all) at the same time as office printer develops major printer error and IT assistance are off site for the week
- Hide lap top that has been allocated to replace newly broken conference presentation lap top so work colleague who quietly borrows said lap top can't forget to inform anyone of the new cupboard and new department location they have decided to store conference laptop in the evening before the conference
- Never assume commercial IT hired to assist on the day really does know more than you on how to maintain AC/DC power to third back up laptop whilst a speaker is presenting the statistical data of their research
- Again never assume commercial IT hired to assist on the day really does know how to piggy back two USB sticks at the same time and connect to projector
- Organise family members to have their CVA and skiing induced concussion with C3 involvement after Conference
- Recognise that typos to VIPs will appear on important documents when you are alerted that said documents should have been mailed three weeks ago and then attempt to complete the paperwork in between hospital visits to family
- Be prepared to run "an acknowledgement to country" if indigenous elder becomes unavailable and unreplaceable within one week of the conference
- Maintain hearty relationships with speakers who can change their presentations and timing within 24 hours of conference to cover unplanned key note speaker illness
- Don't worry about venue fire alarms triggering during presentations; even when you realise that number three alarm has just rung the please evacuate now announcement has happened
- Book company sponsors who have a second representative who can efficiently replace the one that is experiencing palpitations secondary to diarrhoea seamlessly
- Never under estimate the patience of the audience and the support of a great committee who can think on their feet

In reflection the delegate feedback survey strongly indicates that the content, food, networking opportunities and range of speakers more than met their expectations with all responders intending on returning next year. At the end of the day a successful conference comes down to planning with a robust and hard working committee, having brilliant "phone a friend" contacts available at the hour of need and a great deal of luck.

New EMC member reflections on first meeting

I joined ACRA/WACRA 10years ago and was the WA secretary for 6 years. I have a long nursing/midwifery career with many years of experience in cardiac care including, CNS cardiothoracic, staff development cardiothoracic, cardiothoracic patient educator, cardiac COACH and A/ Clinical Nurse Specialist for the Cardiac Rehabilitation at Royal Perth Hospital.

I was very pleased to be attending my first ACRA executive committee meeting in November 2014. Spending two days of meetings with presidents and state reps from each of the Aussie states was really enlightening. I felt honoured to be a part of a group of volunteer health practitioners who embrace change. A group with a vision whose collective mission is to improve the lives of those with cardiovascular disease. The group drew on their collective expertise (more than 500 years of health professional expertise!), they refreshingly made decisions not to revamp old ideas and ideals but commence new means of helping cardiac practitioners. Through advocacy, provision of forums and mentorship the individuals' wealth of knowledge and skills are openly available to you as a member. I urge you to contact the executive members - they are only an email, a phone call or a click away...we may be a small association but when we all pull together we can achieve great things for you and ultimately for your patients.

Helen's ACRAnym for the EMC:

A is for Attitude …I loved everyone's can do attitude.

C is for commitment…which I was privileged to see.

R is for resilience, … great to see always striving to improve the lives of our patients and those caring for them

A is for arithmetic… I reckon there was over 500 years of combined experience in health in the room!!

Helen Mclean

WORLD WALKING – get 2015 off on the right foot. An initiative developed in Glasgow by Duncan Taylor, a BACPR exercise instructor in Greenock. He formed a group – "Inverclyde Globetrotters" – to encourage active walking between cardiac rehab classes and to promote the benefits of programs. He is now planning a 'walk around the world'.

What?

To virtually walk round the world to promote the benefits of cardiac rehabilitation.

Why?

To show the world how much of a difference cardiac rehabilitation can make by encouraging people to remain physically active after a heart event.

We wish to use the opportunity of this challenge to raise the profile of cardiac rehabilitation in the media and with Government.

If we can pull this off it may well be the longest heart health walk ever undertaken and the first to circumnavigate the globe involving partner organisations on all continents. Even if is isn't we reckon it will be fun and give us all something to 'put our heart and soul into'.

How?

CRIGS has teamed up with the Inverclyde Globetrotters, CHSS, BACPR, and the Royal College of Physicians & Surgeons of Glasgow.

The Inverclyde Globetrotters will create a worldwide route on their World Walking website based on countries that are members of the International Council of Cardiovascular Prevention and Rehabilitation.

A group will be created on World Walking specifically for the challenge. All national associations will be invited to participate and encourage cardiac rehabilitation classes and groups around the globe to record the steps/distances they walk during the challenge and that together we will walk round the world in one week!

When?

The walk will be held next February to coincide with the AACVPR's Cardiac Rehabilitation Week.

What happens next?

Nearer the time we'll send you a link which will make it easy for you to sign up your service to take part.

What can you do?

Start to think up ways to take part, for example:

- Encouraging your patients to record how many steps they walk during the week of the challenge;
- Noting the distances clocked up on treadmills, cycles, rowing machines etc. by your patients during your classes ; or
- For circuit classes, inviting one patient to wear a pedometer and then simply multiply the number of steps which he/she clocks by the number of patients in the class.

You could also begin to think of how you might use your participation in this challenge to generate some local publicity for your service.

This event will provide a fun way to get the word out again about the benefits of cardiac rehabilitation and the message that it can really make a world of a difference. We'd love to have your support.

Check out the website - www.worldwalking.org

To register your interest, please email Duncan@worldwalking.org

Read the blog below:

Heart health exercise can truly make a world of a difference

This is the story of the Inverclyde Globetrotters. Our continuing mission:

- To explore new worlds
- To seek out new friends
- To boldly go where no cardiac rehabilitation class has gone before.

I am delighted to have this opportunity to share it with you. I hope you enjoy it.

So who are the Inverclyde Globetrotters?

The Inverclyde Globetrotters were formed 6 years ago from ➤

our weekly Phase IV cardiac rehabilitation class in Greenock, 25 miles west of Glasgow. We're now one of many classes delivered through the Live Active Exercise Referral Scheme that operates in our area. We now cater for a variety of conditions - although we still have more than our fair share of by-passes, stents and pacemakers.

Our average age is over 65 and one or two of us are in their 80s.

It is a widely known fact that as soon as someone is asked to walk on a treadmill time immediately slows down and they mistakenly think that by staring at the clock on the machine they can will it to go faster.

So, to address this problem, in February 2008 our members were asked a question by our instructor – "Do you fancy walking round the world?" – Not the kind of question you get asked every day.

Luckily, once we had stopped laughing at the very idea of it we agreed to have a go.

Our approach is very simple. It's certainly not new. But it's given us a lot of fun.

The hope was that our walk round the world would encourage us to stay active between classes. It was also hoped that achieving a long term goal – a journey that would take years to complete - would provide a real sense of accomplishment.

We gratefully accepted a box of pedometers from the cardiac rehabilitation team at Inverclyde Royal Hospital, bought a map and set off on our virtual journey round the world.

We timed the start our walk to coincide with the launch of the 2008 Scottish campaign to promote cardiac rehabilitation. It was our way of saying thanks.

Contact was made with Olympic rowing legends, Sir Steve Redgrave and Sir Matthew Pinsent, more in hope than expectation, to ask if they would be kind enough to send a few words of encouragement and they did!

Each week pedometers were handed over and steps recorded and distances walked, cycled and rowed during the class captured. We tallied up our figures on a spreadsheet and plotted our progress on our map.

And two things happened.

1. We began to look at the distance screen on the machine instead of the clock; and
2. We became a team.

In May 2010, after 117 weeks on the road, having made it to Beijing in time for the 2008 Olympics, we arrived back in Greenock having clocked up 30,688 miles.

And we're still going. We've just walked our 250 millionth step! We can't believe it.

Our virtual travels have seen us clock up over 105,000 miles to over 100 countries worldwide so far.

But it's not all about steps and miles - it's about having fun.

We've made lots of friends along the way who have encouraged, supported and inspired us to keep going. We didn't think about any of that when we set off. We just went for a walk.

So what lessons have we learned?

- We've learned that using pedometers to accomplish virtual walks around the world can be fun and can help develop a sense of community and achievement.
- We've learned that you never know where you your journey will take you when you take that first step and who you might meet along the way.
- We've learned that there are lots of people out there willing to help;
- We've also learned again that cardiac rehabilitation can indeed make a world of a difference.

If you're looking for that little bit extra motivation and fancy exploring our amazing world as you walk to work, walk with friends or walk to health you can join us on www.worldwalking.org where you'll find a range of virtual walks from taking in the sights of top cities to trekking across a continent.

Hopefully, we'll bump into you on your travels.

Duncan Galbraith

Trail Leader – World Walking

Email: duncan@worldwalking.org.