ACRA Newsletter

June 2014

Artwork courtesy of St John of God Health Care

Nominations for Alan Goble Distinguished Service Award

Winners 2012 and 2013. Who is the next worthy winner?

AUSTRALIAN CARDIOVASCULAR HEALTH AND REHABILITATION ASSOCIATION

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Challenge...Change...Achieve

This Edition

Editor's Note

This edition sees the cooler months settling in for the southern states and for some of us turning into mushrooms – going to and from work in the dark and not seeing much daylight! As we know the cooler weather can also bring an increase in patients experiencing cardiac symptoms so we hope you don't get overwhelmed with new clients needing the support of cardiac rehabilitation services.

There have been some interesting education sessions round the nation and there are reports on some of these in this edition (see state reports). There was also a most successful webinar organised by Dawn McIvor on behalf of CRA NSW/ACT and ACRA. Congratulations on a job well done. This was the pioneer webinar for the association and we are planning more in the coming months – stay tuned.

Many members attended the World Cardiology Congress in Melbourne in early May. What an incredible event. We all were able to get most of our daily 10,000 steps as the venue was huge!

One very enthusiastic member was absolutely determined to get her steps every day – she had an electronic counter to make sure! Robert Zecchin's 'Research Corner' has some great abstracts from a variety of presenters for your information and to encourage you to carry out research in your service.

The EMC had a very productive meeting at the end of May, also in Melbourne. We met at a venue close to the airport, saving taxi fares and some accommodation costs as most of us were able to fly in on the morning of the meeting and fly out at the end of Sunday. Due to unforseen circumstances, we did have a couple of absentees but it was great to have the expanded EMC members with state presidents or an additional person as well as state representatives around the table. We also welcomed Professor Alun Jackson, Director of the Heart Research Centre, as the new representative for that organisation. His experience and contributions will be invaluable. As usual, discussions were robust with productive outcomes.

A couple of important reminders for all members – nominations for the Alan Goble Distinguished Service Award and for Merit Awards – please consider who you would like to nominate and forward to admin@acra.net.au and steve.woodruffe@health.qld.gov.au.

Don't forget the annual scientific meeting is just a few weeks away in Sydney – "Sex, Drugs, and Rock 'n' Roll. Who can resist that title? We look forward to seeing you there. Remember you may be eligible for a travel grant to support your attendance at the conference. Check the website www.acra.net.au

Happy re-habbing

Sue Sanderson

We welcome articles for publication in this newsletter

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

Author guidelines are available on request

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President's Corner

Dear members,

I write this report following my second ACRA Executive Management Committee (EMC) face to face meeting as President. It was however a "first" for a number of reasons. Several decisions that were made at previous meetings came to fruition over the weekend.

It was our first official meeting of our Extended EMC in which additional representatives from each state were invited to participate in our planning discussions. This should have seen our meeting grow from 10 people to 16, but unfortunately health and logistical issues meant we had 12 representatives from across the country.

Our new members on the committee will be highlighted in this edition so I will mention them only briefly here. They included: CRANSW/ACT President Dawn McIvor, VACR President Emma Boston, SACRA President Dianna Lynch and QCRA committee member Jess Auer. Thank you for your involvement over the weekend, I look forward to working with you to continue to achieve ACRA's mission and vision.

It was also our first meeting since the appointment of Professional Association Management Services (PAMS) as our Association Managers. PAMS will be working closely with ACRA on membership and financial management issues as well as the development of a new website by the end of this year. Managing Director, Stephen Lake attended the meeting and advised that a highly experienced, newly recruited Manager, Victoria Robinson will be our new contact and will oversee all ACRA business at PAMS.

Some of the key agenda items discussed and to be actioned in the coming six to twelve months include:

- New website with online membership application and payment functionality
- Collaboration with NHFA to produce up to date "Google Maps" Cardiac Rehabilitation and Heart Failure Service Directories
- Production of more, modern professional development opportunities including webinars – four to be held in the next twelve months, and the use of *Camtasia* to record and upload presentations to our website
- Publication of the ***Core Components of Cardiac Rehabilitation in Australia***, a document currently being developed by the ACRA EMC and invited members
- Planning for the 2015 ACRA Annual Scientific Meeting – to be held in Melbourne, 10-12 August 2015. This event will mark the 25th Anniversary of this meeting and thus will have a definite Silver Theme. Although the conference was held in Melbourne just last year, the ACRA EMC will coordinate the organisation of this meeting with a view to closer collaboration with CSANZ organisers.
- Collaboration, via representation, with international and national Secondary Prevention/Cardiac Rehabilitation groups continues in earnest; to drive the agenda of better outcomes for all patients with cardiovascular disease. These include:
  - Secondary Prevention Alliance (Australia)
  - Global Alliance for Secondary Prevention of Cardiovascular Disease
  - International Council of Cardiovascular Prevention and Rehabilitation

In closing this report I would like to focus on two important issues: the upcoming Annual Scientific Meeting (ASM) and the name of our association.

It is vitally important that as many members, and non-members, attend the upcoming ACRA ASM in Sydney, 21-23rd August 2014. The organisers of this conference have done a fantastic job developing a great scientific and social program, available for a significantly reduced registration fee than previous years. The scientific program consists of a variety of well-known National and International speakers on a range of fascinating topics aligned to the theme, "Sex, Drugs and Rock n Roll". Also, their efforts to gain significant sponsorship are to be congratulated. It is of great importance that we support this meeting with our "bums on seats" if we wish to see this continue in the future.

Finally, a word on the name of our Association. By the time of publication of this newsletter, all members should have received an email link to a survey about the name of our association. This issue was raised by members themselves, during the ASM held in Melbourne last year. The ACRA EMC has held long discussions over two face to face meetings and included state EMCs into the decision making process. I encourage all members to complete the very short, one question survey to have your say in whether the name of our association should stay the same or change to **Cardiovascular Health Australia (CVHA)**. Please see the included letter to members within this edition for further information about this proposed change.

As always I encourage feedback, both good and bad, on the job the ACRA EMC and I am doing in representing the ACRA membership, my *electronic* door is always open. I also hope to see everyone in Sydney. Please come up and say hello and have a chat about the world of cardiovascular health. I'd like to meet as many members as possible during the conference.

Stephen Woodruffe,
ACRA President

FINANCIAL REPORT

As you are aware ACRA has made significant structural change to its administration processes in the last six months. These changes offer many valuable opportunities to utilise infrastructure that allows maturity and evolution of the Association. These changes will also encompass the way in which we process and record our financial transactions allowing us to provide a more robust and mature reporting format. Modifying the processes and detail in which we can report the Association's financial activities will therefore be maintained in a different format to what has previously conveyed to the membership, particularly the way we structure the annual budget.

As you are aware the ACRA maintains a procedure to ensure budgets for the upcoming financial year are displayed prior to our annual general meeting and therefore open for discussion at both our members' forum and formally approved at the Annual General Meeting.

The ACRA is currently working with the accountant at PAMS (Professional Association Management Services) to develop the reporting format that will be standardised for subsequent years. This will allow, as we have done in the past, mapping of our financial activities over sequential years. The Association sees it necessary to deviate from its current reporting format as it does not provide a robust format in keeping with the growth and maturity of the Association.

We look forward to posting the annual budget for the 2014/15 financial year in the near future. The report will be available on our website and also circulated via email to our membership.

As always the ACRA executive welcome your comments and feedback.

Any questions or queries please do not hesitate to contact me or any member of the executive including your state representative.

Warm regards

Craig Cheetham

ACRA Treasurer

Dear Member

Our association's name, the Australian Cardiovascular Health and Rehabilitation Association (ACRA), was raised as an issue that required review by members at the ACRA Annual Scientific Meeting held in Melbourne, August 2013. It was requested by members that the ACRA Executive Management Committee (EMC) initiate discussions about the possibility of a change to the association's title.

This issue has been discussed at considerable length at the ACRA EMC Face to Face meetings held in November 2013 and May 2014. Between these meetings, the proposed title was reviewed by State EMCs with a majority agreement for change. Through these discussions and with reference to our Strategic Plan, the elected state representatives agreed that the following title be put forward for consideration by ACRA members:

Cardiovascular Health Australia (CVHA)

This title is put forward for numerous reasons:

- It is simple in its appearance however a more inclusive statement
- It encompasses all facets of cardiovascular care including treatment, prevention, rehabilitation and maintenance
- It is more reflective of the activities of our membership and potential members
- It is more appealing to sponsors
- Is more readily understood by consumers and other health professionals
- State groups will be seen as having greater connection to the national body through the use of the title, e.g.:
  - Cardiovascular Health Australia – Queensland
  - Cardiovascular Health Australia – Victoria
- The acronym CVHA, was chosen rather than CHA to avoid turning state names into words e.g. CHAT, CHAV, CHAQ, CHAWA, CHASA

All members have been sent a link to a survey requesting all to vote for a change to the name of the Association. It will take just a minute to complete and your response will be valuable in determining the direction in which the Association moves in the future. All members are strongly encouraged to complete the survey. The results will be shared with the membership at the Annual General Meeting at which time these results will be ratified and a decision will be made for, or against a change.

Thank you for your consideration,

Steve Woodruffe

ACRA President

A CORNER OF RESEARCH FOR AUSTRALIA

BY ROBERT ZECCHIN RN MN

The following are excerpts of recent research articles which may:

a. encourage further research in your department

b. make you reflect on your daily practice

c. enable potential change in your program

d. All of the above

The following abstracts are a selection from the World Congress of Cardiology recently held in Melbourne 2014.

1. Eating Behaviours and Predicting Weight Loss in Cardiac Rehabilitation Patients.

Frances Wise*[1, 2], Darren Harris[3], Robyn Sheppard[2], Jennifer Patrick[2]

[1]Epworth Monash Rehabilitation Medicine Unit, Epworth Hospital, [2]Cardiac Rehabilitation Unit, Caulfield Hospital, [3]Aspex Consulting, Melbourne, Australia

Introduction: The prevalence of overweight and obesity is increasing globally and is an acknowledged risk factor for coronary artery disease. Eating behaviours such as emotional eating and cognitive restraint (the self-initiated intent to limit food intake) have more recently been cited as determinants of weight loss. Such behaviours may guide development of successful weight loss strategies but their predictive value in cardiac rehabilitation patients is unknown.

Objectives: To evaluate potential predictors of fat loss (including eating behaviours) in cardiac rehabilitation patients.

Methods: A sample of 56 consecutively admitted cardiac rehabilitation outpatients (Mean age: 60.4yrs SD 12.9; 21% female) were recruited to this study. They completed the Three-Factor Eating Questionnaire, Hospital Anxiety and Depression Questionnaire and 6 Minute Walk Test, and were weighed using Body Composition scales. All measures were completed on admission to and discharge from a 6 week outpatient cardiac rehabilitation program.

Results: Thirty-three subjects (59% of the sample) lost body fat from admission to discharge, with a mean loss of 1.5kg fat (SD 1.0). Both reduction in fat mass, and percentage fat loss, from admission to discharge, correlated significantly with levels of cognitively restrained eating. Subjects who lost fat had significantly higher cognitive restraint scores compared with those who lost no fat ($p = .004$). Fat loss was not associated with overeating or emotional eating behaviours, nor with exercise capacity, improvement in exercise capacity, sex, age, anxiety, depression or initial fat mass or BMI.

Conclusion: Cognitive restraint was the only significant predictor of fat mass loss and percentage fat loss in cardiac rehabilitation patients. Weight loss strategies that increase overweight cardiac patients' ability to employ cognitive restraint may result in greater weight loss and prevent weight gain in this group.

The Good News: You are what you eat!

2. Training effect on the recovery of the kinetics of oxygen, in patients with low ejection fraction

Hermes L. Ilarraza*[1], Garcia S. Marianna[1], Castaneda L. Javier[1], Bueno Leopoldo[1], Jorge V. Lara[1], Rafael D. Chavez[2], Carlos-Felipe R. Barrera[3], Maria Dolores S. Rius[1], Maria Esther O. Franco[1]

[1]Cardiac Rehabilitation, [2]Epidemiology, National Institute of Cardiology Ignacio Chavez, Mexico City, [3]Cardiology, Hospital La Concepcion, Saltillo, Mexico

Introduction: Heart failure (HF) is the final common pathway of most heart disease and a major cause of death and disability for humans. Physical training (PT) has been shown to increase exercise tolerance and survival in these patients. On the other hand, patient's exercise behaviour, during the recovery period of cardiopulmonary exercise testing (CPX), has a prognostic value in the medium and long term.

Objectives: The study objective was to evaluate the effect of a PT program on the recovery of oxygen kinetics.

Methods: We evaluated a cohort of patients with chronic HF admitted to an outpatient cardiac rehabilitation program. All patients met a PT program during 4 weeks, which included 30 minutes of moderate-intensity resistance exercise using a cycle ergometer, five days a week, supplemented by a program of kinesiotherapy and control of cardiovascular risk factors. All patients underwent a symptom-limited CPX before and after the PT program. Results are shown as mean (SD) and frequency (%). Differences were assessed using the Chi2 test, Student's t test and Wilcoxon rank-test, as needed. All p value <0.05 were considered stochastically significant.

Results: We evaluated 213 patients, 84% were men, mean age 54±12 years and a LVEF of 33±9%. The most prevalent underlying diseases were coronary artery disease (73%), dilated cardiomyopathy (17%) and valvular heart disease (7%). After 4 weeks of PT, treadmill exercise-time increased from ➤

5.8±1.6 to 6.7±1.6 minutes ($p<0.001$) and peak oxygen consumption rose from 19.7±6 to 21.7±7 mlO2/kg/min, ($p<0.001$). Recovery time of the oxygen kinetics decreased from 265±102 to 240±77 seconds ($p<0.05$).

Conclusion: Patients with chronic heart failure improve after an PT program, both in peak oxygen consumption as in the recovery time of the kinetics of oxygen.

The Good News: Exercise those failing hearts!

3. The Country Access to Cardiac Health (CATCH) Program: evaluation of a telephone phase 2 cardiac rehabilitation program using a standardised program framework and evaluation procedures

Rosy Tirimacco[1], Philip Tideman*[1], Susan Jones[1], Robyn A. Clark[2]

[1]iCCnet, Country Health South Australia, [2]Flinders University, Adelaide, Australia

Introduction: International research priorities for heart disease in rural and remote areas recommend that different options for delivering cardiac rehab programs be developed to increase participation. One method of overcoming geographic barriers is the use of telehealth to supplement in-person contact between patients and health professionals. The Integrated Cardiovascular Clinical Network Country Health South Australia has partnered with Country South Medicare Local to improve uptake of phase 2 cardiac rehabilitation by implementing Country Access to Cardiac Health Program (CATCH) which has implemented telehealth cardiac rehab to supplement face to face programs in their catchment region.

Objectives: To develop and implement a telephone phase 2 cardiac rehabilitation program using a standardised program framework and evaluation procedures.

Methods: CATCH engaged the services of the Health Information Service (HIS) of the Heart Foundation to provide the coaching services for the provision of telephone based phase 2 cardiac rehabilitation in accordance with the SPAN (Secondary Prevention for All in Need) guidelines. This involved seven standardised phone calls with first call duration of approximately 30 minutes and subsequent calls lasting approximately 15 minutes. Evaluation of participants using a survey was carried out to determine their satisfaction with telephone program.

Results: To date 53 patients have been enrolled in the telephone phase 2 cardiac rehabilitation program developed by CATCH program. Thirty seven patients (69.8%) have successfully completed the program, 5 (9.4%) have withdrawn and 11 (20.8%) are still active. If these 11 patients complete program our completion rate could be as high as 48 (90.6%). Participants of the telephone service reported general satisfaction with the format of the telephone program with a majority indicating content could be covered in 5 calls.

Conclusion: Introduction of a telephone based phase 2 cardiac rehabilitation program has achieved high completion rates and provided access to phase 2 cardiac rehabilitation in rural area where no face-to-face programs existed. As per SPAN recommendations our team is intending to offer a web based phase 2 option in the next stage of this project.

The Good News: Hello, is it me you're looking for! – Lionel Ritchie

4. Attendance to a cardiac rehabilitation program results in modest and differential improvements in adherence to post-AMI management and lifestyle change from a patient versus carer perspective

Yih-Kai Chan*[1], Melinda Carrington[1], David Thompson[2], Tone Norekval[3], Simon Stewart[1]

[1]Preventative Health, Baker IDI Heart and Diabetes Institute, [2]Cardiovascular Research Centre, Australian Catholic University, Melbourne, [3]Institute of Medicine, University of Bergen, Bergen, Australia

Introduction: Acute myocardial infarction (AMI) is a major cause of death and disability with high risk of secondary events. It is known cardiac rehabilitation programs improve the overall health and well-being of individuals who survive an AMI but their specific impact on long-term health behaviours and carers is less certain.

Objectives: To determine the impact of cardiac rehabilitation on individuals and carers of individuals who survived an AMI.

Methods: This was a prospective designed, Australia-wide survey that applied specific peer-validated tools to evaluate the experiences of subjects and the carers of individuals with a past AMI in surviving and coping with the event. We compared the attendance to a cardiac rehabilitation program and the consequential post-event management and pharmacotherapy adherence, knowledge, awareness and attitudes towards living with a heart condition.

Results: A total of 536 post AMI subjects (mean age 64 ± 8 years, 72% male and 31 months since AMI) and 511 carers of person with a past AMI (mean age 55 ± 14 years, 79% female)➤

were studied. Overall, the uptake of cardiac rehabilitation programs was sub-optimal (54% and 39% among male and female subjects, respectively). Compared with non-attendees, those subjects who attended cardiac rehabilitation programs were more likely to follow their doctor's advice (63% vs. 57%), adhere to a healthy diet (45% vs. 41%), and make the appropriate lifestyle modifications (80% vs.72%; *p<0.05*). These modest effects were more profound according to the carers whereby cardiac rehabilitation attendance was positively associated with increased management and pharmacotherapy concordance (84% vs. 72%), a healthy diet (49% vs. 39%), regular exercise (33% vs. 20%) and more positive attitudes and capacity to adopt healthy lifestyle changes (57% vs. 48%; all *p<0.05*). AMI subjects who attended a cardiac rehabilitation program did, however, self-report significantly better control of their total cholesterol (<4mmol/L; OR 1.57; 95% CI 1.03-2.38) and BP (<130/80mmHg; OR 1.42; 95% CI 0.95-2.12) levels.

Conclusion: With low uptake, cardiac rehabilitation attendance among post AMI subjects results in modest improvements in post-event management adherence and lifestyle modifications. Cardiac rehabilitation also appeared to 'sensitise' individuals to the potential adverse consequences of an AMI, at the same time, enhancing perceptions of the importance of treatment and education for both subjects and their carers.

The Good News: Cardiac Rehabilitation is just not for the patient but also the carers who mostly suffer in silence!

5. Innovative model of care for cardiovascular patients across the continuum

Mary Boyde*[1, 2], Robyn Peters[2, 3], Vivian Bryce[3], Nicole New[3]

[1]Cardiology/Nursing Practice Development Unit, Princess Alexandra Hospital, [2]School of Nursing and Midwifery, The University of Queensland, [3]Cardiology, Princess Alexandra Hospital, Brisbane, Australia

Introduction: Traditionally management for patients with cardiovascular disease has occurred according to their current diagnosis within distinct Cardiac Rehabilitation (CR) and Heart Failure (HF) management programs. Contemporary management of cardiovascular disease over the last decade has moved towards an integrated service based on chronic disease models.

Objectives: To amalgamate the CR and HF Management Services and provide evidence based care for people across the continuum from acute care to the community.

Methods: In a tertiary hospital, the Heart Recovery Service (HRS), an amalgamated multidisciplinary CR and HF management program, was established. A service profile was developed by senior CR and HF staff in consultation with Nursing Executive, Cardiologists and Allied Health Staff. Patients diagnosed with Acute Coronary Syndrome, post cardiac surgery, elective angioplasty, and HF were eligible for management by the HRS. The HRS implemented case management teams of nurses to facilitate patient centred care, peer teaching and development of advanced cardiac nursing skills. Data collection methods were established to enable evaluation of key performance indicators (referral for CR, commencement of CR education and exercise program, post discharge follow-up for HF).

Results: From 1/03/2013 to 31/08/2013, 1431 in-patients were screened for eligibility for the HRS, on average 11 patients/day. Of the CR patients screened, 963 were appropriate for further CR post discharge management; 868 (90%) had a referral completed to a CR program. Of the 898 patients, 130(14.5%) were suitable for management by our HRS; 118 received telephone follow-up and of the 130, 72(55%) commenced our outpatient CR program. Mean time to follow-up was 12(±5.40; range 2-44) days and mean time to commencement of this program was 34(±10.19; range 9-67)days. Of the HF patients screened, 161 were referred to a HF management program: of these 98(61%) patients were suitable for our HRS; 94 received follow-up with a phone call, home visit or clinic visit. Mean time to contact post discharge was 9(±2.40; range 1-32) days and 85% of patients received follow-up within 14 days. Of the 161 patients with HF 31% had a new diagnosis.

Conclusion: A new patent-centred service has been established with initial results indicating the service model has resulted in achievement of key performance indicators.

The Good News: Very promising effective model of care!

6. Potential impact of depression on health outcomes in a randomised control trial of multidisciplinary, nurse-led, home based intervention (HBI) to reduce secondary cardiac events

Christina E. Kure*[1], Chantal F. Ski[1], Simon Stewart[2], Yih-Kai Chan[2], Melinda J. Carrington[2], David R. Thompson[1] and the Young @ Heart Investigators

[1]Cardiovascular Research Centre, Australian Catholic University, [2]Preventative Health, Baker IDI Heart and Diabetes Institute, Melbourne, Australia

Introduction: Routine screening for depression is mandated for all individuals following an acute cardiac event. However, the potential to subsequently improve health outcomes is unknown.

Objectives: To examine whether screening for depression using the Patient Health Questionnaire-2 (PHQ-2) in combination with a nurse-led, multidisciplinary home-based intervention (HBI) reduces hospital readmissions, future cardiac events and death in patients at high risk of chronic heart disease.

Methods: Multicentre, randomised trial involving privately insured, hospitalised cardiac patients (n=602; aged ≥45 years). Subjects were randomised into HBI (n=306) or usual care (UC; n=296). HBI comprised at least one home visit (7-14 days post discharge) by a cardiac nurse, regular telephone calls and referrals to primary care physicians, pharmacists and medical services. Baseline screening for potential depression using the PHQ-2 and The Centre for Epidemiologic Studies Depression Scale (CESD) was applied. Health outcomes during an average of 2.5 years follow-up were then compared according to depression status.

Results: The HBI and UC groups were well matched by age (69.5±9.9 versus 69.8±9.3 years), gender (males, 70.3% versus 73.0%) and risk of depression (CESD≥16, 16.1% versus 13.9%). After adjusting for age, gender, smoking status and alcohol risk, logistic regression analysis showed that, depressive status in the HBI group was associated with increased risk of all-cause mortality (CESD≥16, 16.3% versus 7.0% adjusted odds ratio (OR)=3.9, 95%CI 1.4-10.6, p<0.01), a future cardiac event (e.g. acute myocardial infarction, unstable angina; PHQ-2, 62.7% versus 42.9% OR=2.8; 95%CI 1.5-5.2, p<0.01) and an unplanned hospital readmission (PHQ-2, 57.3% versus 39.4% OR=2.3; 95%CI 1.3-4.1, p<0.01). Additionally, male HBI depressive status was associated with increased risk of all-cause mortality (PHQ-2, 20.0% versus 7.6% OR=4.2; 95%CI 1.4-12.0, p<0.01) and future cardiac events (PHQ-2, 68.9% versus 35.9% OR=4.5; 95%CI 2.1-9.4, p<0.001). No such observations were made in those randomised to UC.

Conclusion: Screening for depression in cardiac patients receiving HBI has the potential to predict, but not attenuate, poor health outcomes, particularly in male patients. Future programs need to be modulated accordingly to respond to this elevated risk.

The Good News: You all know that being able to predict events is knowing and knowing is better than not knowing, you know!

7. What is the Quality of Life of Australian patients 1 year post PCI? Results from a national multi-centre registry.

Karen J. Patching*[1], Catherine Oliver[1], Lesley Bryant[2], Lara Waltham[3], Stephanie Nagel[4], Ann-Maree Mitchell[5], Estelle Beevors[6], David Eccleston[7]

[1]Research, Heart Care Victoria , Melbourne, Victoria, [2]Research, Heart Care Partners, Brisbane, Queensland, [3]Adelaide Cardiology, Adelaide, South Australia, [4]Heart Care Cardiology Western Australia, Perth, Australia, [5]Research, Adelaide Cardiology, Adelaide, South Australia, [6]Heart Care Partners, Brisbane, Queensland, [7]Interventional Cardiology, Heart Care Victoria, Melbourne, Victoria, Australia

Introduction: Several large multi-centre registries have evaluated outcomes after percutaneous coronary intervention (PCI) in the USA. However, few data exist regarding Quality of life (QOL) after PCI in Australia. The aim of this study was to report long-term QOL from the multicentre national Genesis Heart Care Group PCI Registry, This will allow comparison of clinical and PCI outcomes with international standards, and improve patient management by facilitating the appropriate application of clinical guideline.

Objectives: To evaluate the long-term QOL of patients after PCI, utilizing a large Australian registry.

Methods: We prospectively enrolled 5002 consecutive patients undergoing PCI to 6837 lesions at 8 Australian private hospitals from November 2008 - August 2013. Baseline patient/procedural data, in-hospital, and 1 year outcomes and QOL (using the EQ-5D scale) were recorded and stored electronically in the Department of Epidemiology at Monash University.

Results: The mean age was 67 ± 12 years. Females comprised 25.1 %, diabetics 23.3%, 35.3% were obese (BMI>30) and 37.2% had acute coronary syndromes. At least one DES was used in 64.9% of PCI. Procedural success rates were 97%. In patients not taking Warfarin, 99.0% were taking aspirin and 97.7% clopidogrel at discharge. Obese patients were more likely to be readmitted by 12 months (p=0.002) At baseline, 18.71% of patients reported moderate or severe anxiety or depression; this was not significantly different (19.86%) at 12 month.

Conclusion: In Australian patients undergoing PCI, nearly one fifth describe moderate or severe levels of anxiety or depression prior to their procedure. Despite good adherence to guideline therapies these psychosocial issues remain a significant concern at 1 year.

The Good News: This group of patients requires more attention and surveillance than the patient, the cardiologist and the interventionist think they do! ➤

8. The effect of a 12 week exercise and lifestyle change programme on cardiac risk reduction: A Pilot using a kaupapa Māori philosophy.

Anna Rolleston*[1], Robert Doughty[1]

[1]Medicine, University of Auckland, Auckland, New Zealand

Introduction: Cardiovascular disease (CVD) remains the leading cause of premature death and disability for all New Zealander's. Māori are the indigenous people of New Zealand and are disproportionately affected by CVD. The New Zealand Māori Health Policy recognises that "health and wellbeing are influenced and affected by the 'collective' as well as the individual, and the importance of working with people in their social contexts, not just with their physical symptoms." In a Māori worldview, a holistic approach to health and wellbeing is innate and it is difficult to separate overlapping and interconnected elements.

Objectives: The overall purpose of the project was to trial a kaupapa Māori approach within the existing structure of a 12 week clinical exercise and lifestyle change programme. The specific aims of the project were to determine the effectiveness of a kaupapa Māori 12 week exercise and lifestyle change programme on parameters of cardiac risk and quality of life.

Methods: 12 participants were recruited from a Kaupapa Māori healthcare service. Participants attended, three times per week, over a 12 week period for monitored, supervised and individualised exercise. Participants performed a progressive aerobic only (AO) programme for the first 6 weeks and then commenced a combined aerobic and resistance training (AR) programme from week 7 through 12. Education was administered in an ad hoc manner throughout the programme.

Results: There was a statistically significant improvement in waist circumference (-3.7cm; $p = 0.05$), hip circumference (-4.6cml $p = 0.03$), systolic blood pressure (-22mmHg; $p = 0.01$) and HDL cholesterol (0.22; $p = 0.01$) in response to the 12 week programme. There were no medication changes and no correlation between type of medication and change in cardiac parameters. In addition, overall quality of life improved ($p = 0.03$).

Conclusion: A kaupapa Māori approach within a structured lifestyle change programme modifies cardiac risk parameters in a small cohesive group of Māori.

The Good News: Make your programs culturally appropriate!

9. Availability, use, and barriers to cardiac rehabilitation in low- and middle-income countries: A systematic review.

Loheetha Ragupathi[1], Rajesh Vedanthan*[2], Judy Stribling[3], Valentin Fuster[2], Mary Ann McLaughlin[2]

[1]Thomas Jefferson University Hospital, Philadelphia, [2]Icahn School of Medicine at Mount Sinai, [3]Weill Cornell Medical College, New York City, United States

Introduction: Cardiovascular disease (CVD) is the leading cause of death in low- and middle-income countries (LMIC). Cardiac rehabilitation (CR), a cornerstone of secondary prevention, is critically important given the burden of CVD in LMIC. However, the availability of CR in LMIC is not systematically known.

Objectives: To conduct a systematic review of the literature to determine the availability, use, and barriers to CR in LMIC.

Methods: Electronic databases (Cochrane, EMBASE, PubMed, Web of Science) were searched from 1980 to May 2013 for articles on CR in LMIC. English-language articles dealing with availability, use, and/or barriers to CR were screened by title, abstract, and full text. Additional references were identified by review of reference lists of the included articles. Data were summarized by region/country to determine the status and characteristics of CR in LMIC, and gaps in the literature.

Results: Our search yielded 5208 citations, of which 20 satisfied full inclusion/exclusion criteria. Notably, there was a dearth of literature from Asia and Africa. The number of CR programs available ranged from one in Paraguay to over 50 in Serbia. Referral rates for CR ranged from 7.3% in Turkey to 90.3% in Lithuania. Attendance rates ranged from 31.7% in Bulgaria to 95.6% in Lithuania. CR attendance was correlated with older age, female sex, higher education, and non-smoking status.

Conclusion: Our results illustrate the heterogeneity of CR availability and use in LMIC. In many countries, CR is insufficiently available and under-utilized. There are several barriers to CR in LMIC; however, strategies can be pursued to improve this. Further characterization of CR in LMIC is necessary to develop targeted strategies to improve availability and utilization.

The Good News: What is Lithuania doing right!

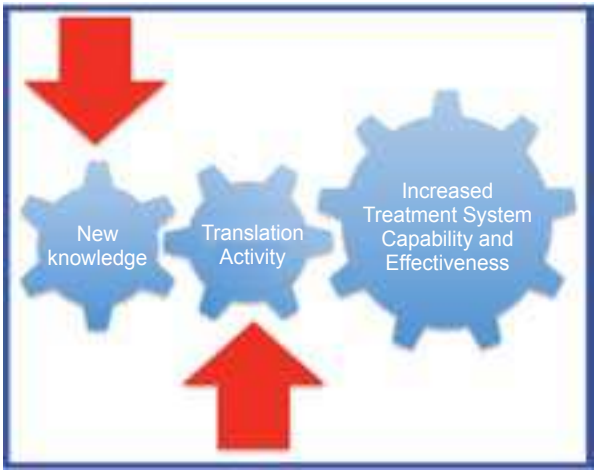
More next time!

Heart Research Centre Report

Professor Alun Jackson

Under the leadership of our new Director, Professor Alun Jackson, the Heart Research Centre has undertaken a review of its research program over the past few months and has developed a theme-based research program which will guide its work over the next three years. These themes are: anxiety, stress and depression; childhood heart disease; patient self-management; screening and assessment; sleep disorders and cardiovascular health; physical activity and sedentary behaviour; and positive psychology.

We are pursuing these research themes in the context of our overall goal of contributing to best practice in secondary prevention. We are seeking to generate new strategic knowledge and conduct knowledge translation activities, resulting in increased treatment system capability and effectiveness. We do not merely do research and then hope this somehow translates into improved capacity and effectiveness; we provide this key link through a range of targeted activities such as training, research capacity building for health professionals, and the provision of best practice guidelines and resources. The diagram below illustrates the link the Centre provides between knowledge generation and increased system capability and effectiveness.



A good example of this model is the **Cardiac Blues** Project, which forms part of the Anxiety, Stress and Depression research theme. As we know, a heart event is an emotional experience, not just a physical one. Our past research in this area has demonstrated that symptoms of distress or depression are highest close to the time of the acute event. For most patients, the initial symptoms of distress resolve in the first few months, whereas for others depression is still evident some months later.

The Centre's research over the past five years has shown that patients want information from health professionals about distress after a cardiac event, and that health professionals want specific resources to assist them to support patients in their emotional recovery. To date no such distress focussed resources have been available.

With assistance from *beyondblue*, the Heart Research Centre has developed a new suite of resources for patients and health professionals. These resources are designed to normalise the emotional roller coaster that patients often experience, to reassure patients that feeling down or having the blues will most likely resolve, and to alert patients to the 'red flags' that might signal ongoing difficulties. Both the resources and the associated training have been extensively evaluated by the Centre.

The **Cardiac Blues** resources have now been distributed nationwide to over 600 centres including all cardiac rehabilitation programs, coronary care units and cardiothoracic units across Australia. Dr Barbara Murphy, the Centre's Director of Research explains that:

"These resources will help in two ways. They will support patients through normal emotional adjustment, and they will encourage patients at risk of depression to get help early. This is imperative because patients with ongoing depression are at increased risk of another heart attack and premature death".

For further information on the Cardiac Blues project, contact Dr Barbara Murphy on 03 9326 8544 or 0439 376 280, or barbara.murphy@heartresearchcentre.org

You can find details of the Centre's training program at: http://www.heartresearchcentre.org/health-professionals/ or contact the training manager, Elizabeth Holloway, directly on training@heartresearchcentre.org.

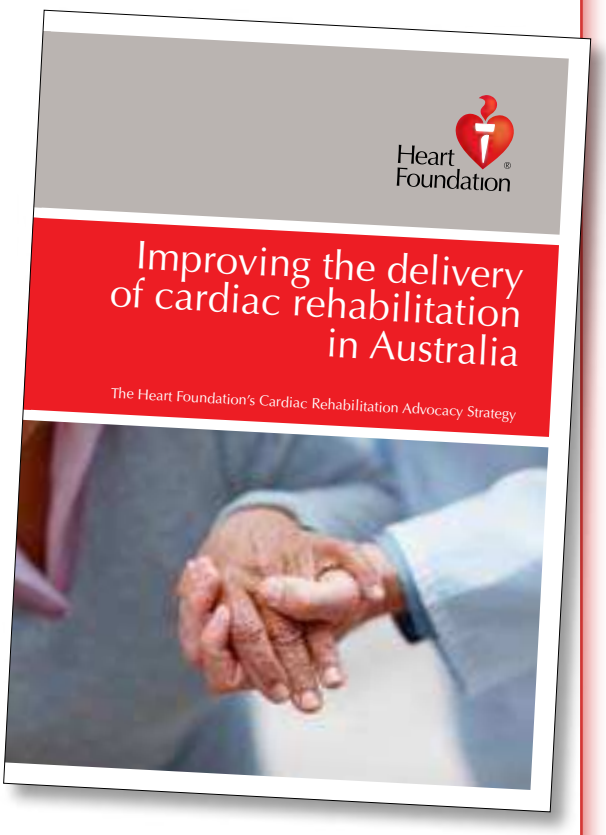
News From *Across The Nation*

Priority actions to improve cardiac rehabilitation delivery in Australia

The Heart Foundation has developed a strategy to define our role in improving cardiac rehabilitation service provision in Australia. The six key priority action areas are:

1. Support national, state and territory efforts to integrate referral to cardiac rehabilitation services as a standard component of cardiac care.
2. Establish uniform quality performance measures, data collection and routine reporting.
3. Increase public awareness of cardiac rehabilitation and its benefits.
4. Enhance health professional engagement and education on the importance of cardiac rehabilitation.
5. Identify funding reform to drive service improvements and boost referral and participation.
6. Document and promote key principles and examples of good practice in the provision of different models of cardiac rehabilitation throughout Australia.

We have developed an advocacy brochure to communicate our strategy and promote the need for action in these areas. Download the brochure at www.heartfoundation.org.au/cardiac-rehabilitation



Heart Online – supporting heart health professionals

Heart Online is a web resource developed by health professionals for health professionals. It promotes best practice for people who have (or are at high risk of) cardiovascular disease and heart failure by:

- synthesising best evidence on safe and effective practice
- providing practical clinical tools
- promoting delivery of multi-disciplinary care
- stimulating clinician engagement in ongoing service improvement initiatives and research.

Heart Online supports practice in the areas of:

- risk and symptom management
- medication management
- exercise and activity prescription
- psychosocial wellbeing
- patient education
- behaviour change support
- performance evaluation of program process and outcomes.

The Heart Online team are dedicated to providing a relevant web resource that supports best practice. The website will be regularly reviewed; to inform this process we encourage your feedback and ideas so that the site may grow to better serve the needs of heart health professionals.

Visit: www.heartonline.org.au

SMALL STEPS

To increase awareness about secondary prevention among patients with cardiovascular disease, the World Heart Federation, in collaboration with the British Heart Foundation, American Heart Association and National Heart Foundation of Australia, has developed a light-hearted animation of a patient, George, who has recently experienced a cardiac event.

Small Steps to secondary prevention of cardiovascular disease encourages people who have experienced a cardiac event to take small 'heart healthy' steps to reduce the risk of another cardiac event. Patients can benefit enormously from taking one small step at a time to make favourable lifestyle changes and improve adherence to treatment programs. This can lead to positive behavioural changes and reduce their risk of experiencing another event.

Check out George's story at https://www.youtube.com/watch?v=GNFGipzmwOs

Half price

Chronic heart failure care consensus statement

Order your copy of the Heart Foundation's *A systematic approach to chronic heart failure care: a consensus statement* for half price – just $2.50. Order before 31 July, by calling the Health Information Service on 1300 36 27 87 or visit the 'On sale' page of the online shop www.heartfoundationshop.com

Congratulations to ACT Heart Care Ambassadors!

The Heart Foundation ACT would like to congratulate the 12 inaugural Heart Care Ambassadors. The successful applicants attended the first of four workshops on 18 March 2014. The Ambassadors have a variety of health backgrounds such as nursing, pharmacy and exercise physiology, and work in primary or secondary care. All Ambassadors have an interest in heart health and will learn and discuss clinical updates on cardiovascular disease and risk factors, contemporary issues facing cardiovascular health professionals and patients, and current Heart Foundation programs and messages. As part of the program, Ambassadors are required to complete a workplace activity in their hospital, clinic or health service to support the Heart Foundation's priorities. This program is an excellent opportunity for networking with other health professionals and experts in the field of cardiovascular health to improve the heart care of all Australians.

My heart, my life mobile application

The Heart Foundation has recently developed a new mobile app to assist patients to:

- manage their medicines
- manage their health stats including blood pressure and cholesterol
- learn the heart attack warning signs

On a mobile device or tablet go to www.myheartmylife.org.au to download the app.

UPCOMING EVENTS

August 21st-23	ACRA 2014, Sydney – "Sex, Drugs and Rock 'n' Roll"
July 16th	Annual SACRA dinner and education evening which will be sponsored by Astra Zeneca with our speaker confirmed and it will be Dr Rajeev Pathak presenting his PhD research on a study examining the outcomes on intense cardiovascular risk management outcomes after AF ablation.
August 6th	WACRA annual education symposium – contact WACRA for more details
October 24th	QCRA Symposium: "Meeting the Need: How Cardiac Rehab is meeting the needs of the current health environment and our patients". Mater Hospital, South Brisbane. There will be limited videoconferencing available. This meeting will include the QCRA AGM.
October 23rd-24th	VACR two day conference incorporating the Alan Goble lecture. Stamford Plaza, 111 Little Collins Street, Melbourne.
November 12th	SACRA World Diabetes Day Seminar, Calvary Wakefield Hospital Auditorium; 6-9pm. 300 Wakefield St, Adelaide.

State presidents, representatives contact details

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Paul Camp - *president/state rep*
Paul.camp@mater.org.au

CRANSWACT
Dawn McIvor - *president*
Dawn.McIvor@hnehealth.nsw.gov.au

Lis Neubeck - *state rep*
lis.neubeck@sydney.edu.au

VICTORIA
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Emma.boston@sjog.org.au

Kim Gray - *state rep*
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SA/NT
Dianna Lynch - *president*
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Jenny Finan - *state rep*
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WA
Craig Cheetham
president/state rep
craig.cheetham@cprwa.com.au

TASMANIA
Sue Sanderson - *president*
sue.sanderson@dhhs.tas.gov.au

John Aitken - *state rep*
john.aitken@dhhs.tas.gov.au

State presidents' reporting

Tasmania

State representative
John Aitken

President
Sue Sanderson

Our AGM was held on March 15th, coinciding with our annual education day. The following were elected:

President: Sue Sanderson

Vice President: Terri Wieczorski

State Representative: John Aitken

Treasure: Dinah Payton

Secretary: Gillian Mangan.

Subsequent to the meeting Gillian stepped down from the secretary position and Emma Curnin was elected in her place.

Our next meeting will be held on 17th September via video conference.

The quarterly Heart Care Network session was held on June 18th, hosted by Tasmanian Medicare Local who spoke about their work in the heart care space across the state.

Annual education seminar

The theme of the day was the non-healing sternum with guest speakers:

- Dr Doa El-Ansary, Senior Lecturer Department of Physiotherapy Faculty of Medicine, Dentistry and Health Sciences University of Melbourne, and
- Sue Sanderson Nurse Practitioner Chronic Cardiac Care Coordinator Cardiac Rehabilitation Service Tasmanian Health Organisation South Royal Hobart Hospital.

Unfortunately the cardiothoracic surgeon was unable to attend due to unforseen circumstances.

Presentations included a case study and discussions regarding the consequences of a sternal breakdown or instability for the patient and the family. We had the opportunity for 'hands on' with a workshop examining a patient's sternum using ultrasound and manual palpation. We had 2 volunteer patients for the day – one with a very unstable sternum and one with normal healing. It was a great opportunity to gain knowledge and experience in examining patients with possible sternal instability, management and the use of supports to promote healing. To learn direct of the patients' experience over many months of instability and his frustrations with the support garment meant that we have been able to feedback to the manufacturer some of the issues with long term use of the garment.

Dr Doa El-Ansary stated "the day was attended by a dynamic and enthusiastic multidisciplinary team of health professionals. Both Sue and John arranged a stimulating program where we had much discussion and sharing of expertise. What was evident to me was the commitment to learning and patient care that exists in Tasmania where the leadership of Dr Hardikar, Sue, John and others seeks to ensure best practice and optimal patient care. I would personally like to thank your two Clients, Darryl and Steve for their participation - if it wasn't for these two great guys the day would not be possible or so successful".

We gained 7 new members as a consequence of the education day and we welcome new allied health professional members Christine Duggan (OT - RHH), Emma Dwyer, Julia Gheller, Thomas Shepherd, Kate Sullivan, Nadia Zalucki (Physios -LGH), Vicki Johnson (GV Health).

Another exciting initiative is the potential development of a pilot in Launceston - Heart Care Ambassadors. Heart Care Ambassadors have been successfully operating in South Australia and ACT for some time and are a way of the Heart Foundation working more closely in the clinical space. It means that the Ambassadors work on a small, clinical improvement initiative with the availability of four professional development days of workshops, spread over the year. The Ambassadors will also have the option of attending the network sessions to increase their engagement with other cardiac professionals around the state. Hopefully, we can nurture our young!

Sadly another cardiac rehabilitation program is discontinuing in Tasmania. Maternity leave is not going to be back-filled at the Hobart Private Hospital and the role is to be reviewed after the leave is completed. We wish Alyson all the very best in the future and trust that she will be able to resume the role and continue to promote cardiac rehabilitation on her return to work.

World Congress of Cardiology report

I was privileged to receive a travel grant to attend the Congress in May held at the Melbourne Convention and Entertainment Centre. It was great to see so many ACRA members there although I'm certain I missed many in the crowds that came – I understand that there were well over 6000 delegates!

An incredible array of presentations across the vast spectrum that is cardiology were available from experts from around the globe. It was very hard to choose sessions to attend and I found that, once 'locked into' a session it was not wise to move unless it was to a room close by. The Centre is vast and very easy to get your 10,000 daily steps moving from one end to the other!

I attended the International Women's Conference on the Sunday and one of the features was the emphasis on maintaining exercise and leading active lives across the lifespan – something which is most important from a CR prospective as we all know that women are reluctant to attend our programs. Many of the presenters were from the USA and are well known in cardiology circles, and with all due respect they are not young women, yet they have maintained active lives and obviously "practiced what they preach". We all know that most of the research over the years in cardiology has seen men the majority of subjects. Thankfully this is being addressed with several studies now recruiting women only or focusing on outcomes for women.

Leading active lives across the lifespan was also the theme of a session during the main Congress. Speakers addressed the issue of lifestyle risk that can be addressed by being physically active from a very early age and reducing sedentary behaviour. Encouraging parents to be active with their children and eating healthy diets. Reducing obesity by using the 5-2-1-0 approach: 5 servings fruit and vegs daily; limiting screen time to 2hrs/;day; having 1 hour of activity daily and zero sugar drinks (or occasional only).

Closer to my own heart (pardon the pun) were the sessions on heart failure, of which there were many and varied and impossible to attend them all. The speaker who stood out for me was Carolyn Lam, a passionate and enthusiastic cardiologist researcher from Singapore – her special area of research is heart failure with preserved systolic function especially in women.

The global perspective on CR was also of interest especially as there is the ongoing international concern regarding the uptake of services for the reasons with which we are all familiar. I firmly believe we need to support the development of CR services in developing countries but we must also concentrate and focus on the ongoing underutilisation in our own backyard.

Western Australia

State representative
Craig Cheetham

Upcoming events

Annual research symposium

WACRA will be hosting its annual research symposium on the 6 August. The event is an opportunity to anyone presenting at the annual conference to showcase their work at a local level but provide opportunity to gain feedback and rehearse their presentation. The details of the event will be forward to you individually with all the presentations outlined.

Cardiovascular Health Networks

Cardiac Rehabilitation and Secondary Prevention working group

It is with great excitement that I can announce the document "Cardiac rehabilitation and secondary prevention pathway principles Western Australia" has been finalised and has completed the approval and endorsement process. This was informally launched at a recent WACRA event but planning is under way to formally launch the document in late July. WACRA will be co-hosting the launch alongside the cardiovascular health network and the Heart Foundation. This documentation provides endorsement and the justification of key elements of service provision for patients with all forms of cardiac disease across the whole spectrum of healthcare. Details relating to this event will be emailed soon.

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

Craig Cheetham
WACRA President

WA state representative on the ACRA Executive Management Committee

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

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

NSW / ACT

State representative
Lis Neubeck

President
Dawn McIvor

CRA NSW ACT has commenced some exciting work with the National Heart Foundation (NHF) and Agency for Clinical Innovation (ACI) Cardiac network regarding outcome measures for Cardiac Rehabilitation, education and a review of NSW Health policy document "Rehabilitation for chronic disease". This was as a result of a forum in November 2013 held by the NHF whereby a number of key clinicians across the state met to develop a seven point action plan for Cardiac rehabilitation for NSW. The seven point plan was:

1. **Workforce:** develop an education model on Cardiac rehabilitation
2. **Data review:** previous minimum dataset for Cardiac rehabilitation for NSW and survey clinicians to see if is still relevant to implement state-wide.
3. **Resources:** CRA NSW/ACT supports the NSW ACT Directory be converted into a Google map.
4. **Advocacy:** re-establish Cardiac rehabilitation as a standing agenda item on the ACI clinical network (completed)
5. **Advocacy:** advocate for better secondary prevention services/ alternative models of care for aboriginal people in NSW
6. **Monitoring:** the NHF to hold annual NSW rehabilitation forum each year to monitor progress on actions.
7. **Case studies:** capture and share examples of good practice across NSW.

The **webinar** by Professor David Sullivan on "Cholesterol, the myths" hosted by NSW was a great success with over 65 registrants from across the country. CRA NSW/ACT, similar to other state based organisations, have found it challenging to get bums on seats to attend conferences, so the use of technology whereby people can attend from where they are may be the way forward for smaller rural sites.

ACRA 2014 is rapidly approaching see (acra2014.com.au), the theme of "Sex, Drugs and Rock and Roll" has led to an interesting and innovative education and social program. The organising committee have tried hard to keep the registration rate lower than in previous years, however to keep rates this low in future years we need at least 200 registrants! So if you haven't registered please do so and bring a friend!

The board of CRA NSW/ACT have discussed a restructure of positions in an attempt to streamline some of the work we do and encourage more involvement from members in the day to day activities of managing CRA NSW/ACT. Once the details are finalised members will receive information to enable them to vote for or against the change at the AGM in August.

Queensland

State representative
Paul Camp

Welcome New Members

QCRA would like to extend a warm welcome to our new members: Amanda Hannan, Alex Kong, Karen Pye and Marlien Varnfield.

We were also pleased to have Jess Auer, QCRA vice-president as an extra representative for Queensland on the ACRA EMC at the recent meeting in Melbourne. Jess brings a perspective from the northern part of the state.

Cardiac Rehab in State Parliament

The Heart Foundation hosted a parliamentary breakfast which highlighted the vital role cardiac rehab has in the lives of Queenslanders.

The April breakfast at parliament house was attended by members of parliament, the Heart Foundation, CSANZ representatives, ACRA, QCRA presidents and invited speakers.

Professor Darren Walters (Prince Charles Hospital, University of Qld) presented statistics to show that up to 50% of heart attacks in Queensland were repeat events. He emphasized that many inpatient interventions were not a cure and that there was a need for a greater emphasis on CR to prevent secondary events and rehospitalisation.

Rachelle Foreman (Health Director for Heart Foundation Qld) spoke of the need for greater CR referrals and how this was even more important given our aging population.

Professional Development Opportunities

Webinar: "Smoking Cessation in Cardiac Rehab" was presented as part of the Australian Association of Smoking Cessation Professionals (http://aascp.org.au/) monthly webinar series. Paul Camp – who runs a smoking cessation clinic for cardiac patients was presenting. This was an excellent session discussing the importance of including smoking cessation support in CR programs. Thank you Paul. The slides of the presentation will be available on the ACRA website.

Symposium: Friday October 24th, Mater Hospital, South Brisbane. Limited videoconferencing available.

The theme is "Meeting the Need: How Cardiac Rehab is meeting the needs of the current health environment and our patients".

This meeting will include the QCRA AGM.

Updated Qld CR Service Directory

The updated service directory is now complete and has now been forwarded to ACRA to include in the national directories.

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.

South Australia & NT

State representative
Jenny Finan

President
Dianna Lynch

It has now been exactly one year since I have stepped in to the president's role at the last AGM. I must say it has been a very busy year learning the ropes of the role, and so far it has been interesting with some highs and some lows. I however have just returned from the ACRA EMC meeting in Melbourne and feel that we as an organisation are in for some exciting times.

As you may all be aware one of the main items on the agenda is the proposal for a formal change of the association to *Cardiovascular Health Australia* with our branch SA& NT following.

We have had discussions around this at our meetings and also at our AGM in April. Our state was not unanimous with this decision; however we were in the minority. You will be sent a very short survey and I urge you to vote and have your say, and this item will be on voted on at the AGM in August at the conference.

Executive News

I would like to acknowledge the support of our Executive Committee and regretfully say goodbye to Celine Gallagher our Secretary whose tenure has ended. I would like to extend our thanks and good wishes to her, and we will still see her as an ordinary member.

I would like to welcome an old friend back in to the EC – Sindy Millington will step in to the secretarial role.

All other EC positions will remain the same, however Kathy Read our Treasurer has given us ample notice that she will not be continuing as of the next AGM, and is happy to ➤

mentor and handover during the coming year .

SACRA Annual Dinner

We have our annual SACRA dinner and education evening coming up in July which will be sponsored by Astra Zeneca and will be held on Wednesday July 16th with our speaker confirmed and it will be Dr Rajeev Pathak.

Dr Pathak will be resenting his PhD research on a study examining the outcomes on intense cardiovascular risk management outcomes after AF ablation.

We hope this dinner will be well attended as we unfortunately had to cancel our April education seminar due to lack of numbers.

PLEASE NOTE: Our next ordinary SACRA meeting will be held prior to our annual dinner 5-6 pm.

Metro News

Renee Henthorn – Cardiac Rehabilitation Clinical Practice Consultant at the QEH - travelled with the cardiology team who travel to the Anangu Pitantjatjara Yankunytjatjara (APY) lands which consists of 103,000 square km or arid land in the far northwest of South Australia.

This team consisted of a Cardiologist, a Sonographer and Renee.

The team visit the Iwantja & Mimili communities reviewing a number of different patients, but mainly with Rheumatic Heart Disease (RHD).

The communities are very welcoming and appreciative of the visiting clinic. This was the team's first visit, and they plan to visit three times a year.

The team will look forward to building relationships with the communities and their health workers in the future, and make the patient journey from "the lands" to the city for treatment a better experience for the patient.

Rural Health

Country health SA has been progressing well with its new programs and has a new Cardiac Rehabilitation steering committee.

CATCH has developed their own data set which they are collating, and currently will be looking at extending this to 6 and 12 month follow ups.

Country health across all sites, have been experiencing a growing number of clients with heart failure, seeking support from Country Local cardiac nurses. Three nurses, Nicole Dawes – Adelaide Hills, Frank Circelli – South East & Ann Felder – Riverland, will be attending a 3 day intensive course on *Integrated disease management for patients with chronic heart failure*, facilitated by the Heart Research Centre in Melbourne.

Caroline Wilksch – Gawler Inner North Community Health Service, has shared the story of one of clients, Tim Temple and his journey experiencing cardiovascular disease.

Clinician and Consumer Perspective

Inner North Community Health Service Cardiac Rehabilitation Program

A joint presentation was given to the Acute Nursing staff at Gawler Hospital targeted at improving the understanding of clinical staff of the client journey through the continuum of care for clients experiencing cardiovascular disease. Tim Temple gave a powerful recount of his personal experience including living a life as a 'rock star' and the life style choices that contributed to his heart disease, the impact of a chronic back injury, losing his job, the death of his mother and the depression that followed. The experience of acute hospital care, urgent bypass surgery and progressing to cardiac rehabilitation and life beyond rehab.

Tim talked about the fear and anxiety associated with open heart surgery and the early days of his recovery. He highlighted the difference 'taking the time to care' can make to our clients. In this day and age of wonderful technology and major advances in cardiovascular medicine it is easy to lose sight of the impact to the lives

3 days after bypass surgery ICU RAH April 2012

Caroline and Tim presenting at Gawler Hospital April 2014

of individuals and their loved ones travelling the road of heart disease. A few minutes to offer an ear to a patient can have a huge impact on their road to recovery.

I recall Tim being in a very dark place when I first meet him. His PHQ-9 score was 18 at his initial assessment for cardiac rehab and he could not complete a 6 minute walk test, weight 160 kgs. His list of risk factors was enormous and I really doubted if he was ever going to be able to make the necessary changes to be able to lead a productive happy life.

Rehab started with literally one step at a time. Tim embraced the entire rehab program and did not miss a session. 1:1 physiotherapy time made the difference between Tim dropping out because of a flare up of his back pain or continuing. Despite feeling like the baby of the group Tim built a strong peer support with others in the program.

Tim has proved to be an inspiration to others, having turned his life around. 2 years following his cardiac event he has maintained the recommended life style changes, he exercises every day (despite ongoing chronic pain) and makes careful dietary choices. Tim has lost over 50 kgs in weight, he has ceased insulin, his cholesterol and HbA1C are at target and in his own words 'can now plan for the future'.

Caroline Wilksch
Heart Health Rehabilitation Coordinator

Upcoming Events

July 16
Ordinary SACRA meeting 5-6pm
followed by Annual SACRA dinner

August 21-23
ACRA 24th Annual Meeting
Novatel Sydney, Brighton Beach, NSW

October
Date TBA
SACRA education session ➤

November 12
World Diabetes Day Seminar
Calvary Wakefield Hospital
Auditorium
300 Wakefield St, Adelaide
6-9pm

November
Date TBA
SACRA meeting and Christmas Dinner.

Victoria

State representative
Kim Gray

President
Emma Boston

Committee:

President: Emma Boston

Vice President & State Rep: Kim Gray

Treasurer; Deb Gascard

Secretary: Meg Ryan

General Committee: Alison Beauchamp, Niahm Dormer, Ailish Commane.

NHF Rep: Harry Patsamanis

HRC Rep: Elizabeth Holloway.

Resignations: Adrienne Caulfield

Co-opted to vacant position: Carmel Bourne.

Membership

Our membership is currently 158 members.

Administration:

VACR has continued to undertake its own administration without a paid position. To assist with this process a low cost teleconferencing provider was sourced. This has facilitated the process of meetings and event planning over 2014 with a minimal finanical outlay (approximately $25.00 every two months).

Education Events:

The VACR hosted its Clinical Practice Day on the 3rd March 2014 at The Stamford Hotel, Melbourne; a new venue.

Emma welcoming delegates.

The event was sponsored by St John of God-Frankston Rehabilitation Hospital (gold sponsor) and AstraZeneca (silver sponsor).

This was the best attended CP Day for a number of years with 130 delegates.

The topics presented included;

- Super foods in heart disease
- Novel oral anti-coagulants
- AF and Heart Failure
- Cardiac Angiograms in Contrast Induced Nephropathy
- "The Two Hearts One Future" study
- Exercise: Too much, too little, how much is enough?
- Medication management in the acute decompensating heart failure patient.

Professor Bruce Jackson speaking on decompensated heart failure

The program content and the venue were overall well received. There were 14 new member applications on the day; again a notable increase in recent times.

'The Two Hearts One Future' study

Presented by Melinda Carrington
Researcher Baker IDI (July 2013)

This is a brief summary of some of the points discussed and presented on the day.

This study reported on patients and carers experiences in surviving and coping with a first heart attack .A total of 1047 eligible respondents were studied from all over Australia. The respondents were self –selected as opposed to a randomly selected study cohort. In this study 536 subjects and 511 carers were studied (not necessarily the same ones).

The majority had experienced their first heart attack more than 3 years previously. Half had attended a Cardiac Rehabilitation program. There were broad misperceptions in both subjects and carers concerning the causes and triggers of heart attacks. An over- emphasis on psychosocial factors especially stress as a cause. A lack of knowledge in the recognition of a secondary event was found. Cardiac Rehabilitation attendance was associated with more positive attitudes to healthy lifestyle. While there were some benefits derived from attending a cardiac rehabilitation program there were areas that require action. Firstly to increase the participation rate attending cardiac rehab programs. Secondly, to improve the efficacy of these programs with regard to the retention of important knowledge. Adherence to a healthy lifestyle remains challenging, also the challenge of adhering to prescribed pharmacotherapy. There were few differences between men and women subjects. There were few socio-economic differences noticed, those that could most afford to recover had more favourable findings. ➤

The response of carers to treatment adherence was more realistic. Overall carers appeared to be more deeply affected emotionally and physically following a heart attack when examining perceptions of illness. Cardiac Rehabilitation appeared to highlight to individuals the potential adverse consequences of a heart attack and the importance of treatment and education. However the overall levels of awareness and knowledge concerning secondary events were poor.

This data provides a framework to improve education and support programs that include caring and positive relationships. Greater efficiency to improve these mechanisms is required particularly for those who can least afford to implement positive changes. When there are two hearts affected, it makes sense to ensure their collective futures are a priority with the focus on future developments of health programs.

Farewell

During the day Committee member Adrienne Caulfield anounced her resignation not only from VACR but also from her cardiac rehabililtation position at Peninsula Private and nursing in general. Adrienne together with husband Mark have taken a "sea change" from their professinal lives and are now taking tourists on outback tours for days at a time in far north west WA and the Northern Territory. Adrienne's hard work, support of VACR and as a Committee member was recognised on the day when Adrienne was formally acknowledged and presented with a gift. We wish Adrienne and Mark all the very best.

Upcoming event

The VACR Committee is busy planning our next education event - the two day conference which will incorporate the Alan Goble lecture. The Conference will be held on the 23rd & 24th October 2014 at the Stamford Plaza, 111 Little Collins Street, Melbourne. This is the same site location that our recent Clinical Practice day was successfully run.

Once again the Committee is busily working behind the scenes to engage a broad range of speakers from a variety of backgrounds to present exciting topics very relevant to the cardiac rehabilitation clinician. Some of the speakers and topics have aready been confirmed and we are continuing scouting for potential sponsors for the event.

The theme for the Conference will be around the old Shakespearian phrase …"to be or not to be"….conveying the array of conumdrums we can often face in caring for our clients.

Victorian Cardiac Clinical Network

The Department of Health Victoria is currently undergoing a restructure which includes reallocation of the Clinical Networks. At the moment the Leadership group is meeting every two months and overseeing the Heart Failure and Cardiac Rehabilitation projects that were successful in their bids in late 2013. There will be a new round of funding later in 2014.

A number of Victorian hospitals have put up bids for recurrent funding for the cardiac facilitator positions that have been a project over the past three years. These facilitators have not only been key in the improvement of inpatient care but have driven referral to and the uptake of cardiac rehabilitation and secondary prevention programs in regional centres.

The next meeting will be July 8th and Kim Gray will be representing VACR.

Victorian Directory

VACR has undertaken the process of updating the Victorian Directory over the past few months.

VACR iPad Gift to Monash Health

Recently VACR donated an iPad specifically to be used for children admitted to Monash Health's Operating Department. Meg Ryan on behalf of VACR presented the iPad to Anaesthetist Dr. Val Taylor who was …"thrilled to receive the iPad…" thanking the organisation for their generosity.

Adrienne Caufield accepting gift on retirement.

Meg Ryan presenting iPad to Dr Taylor