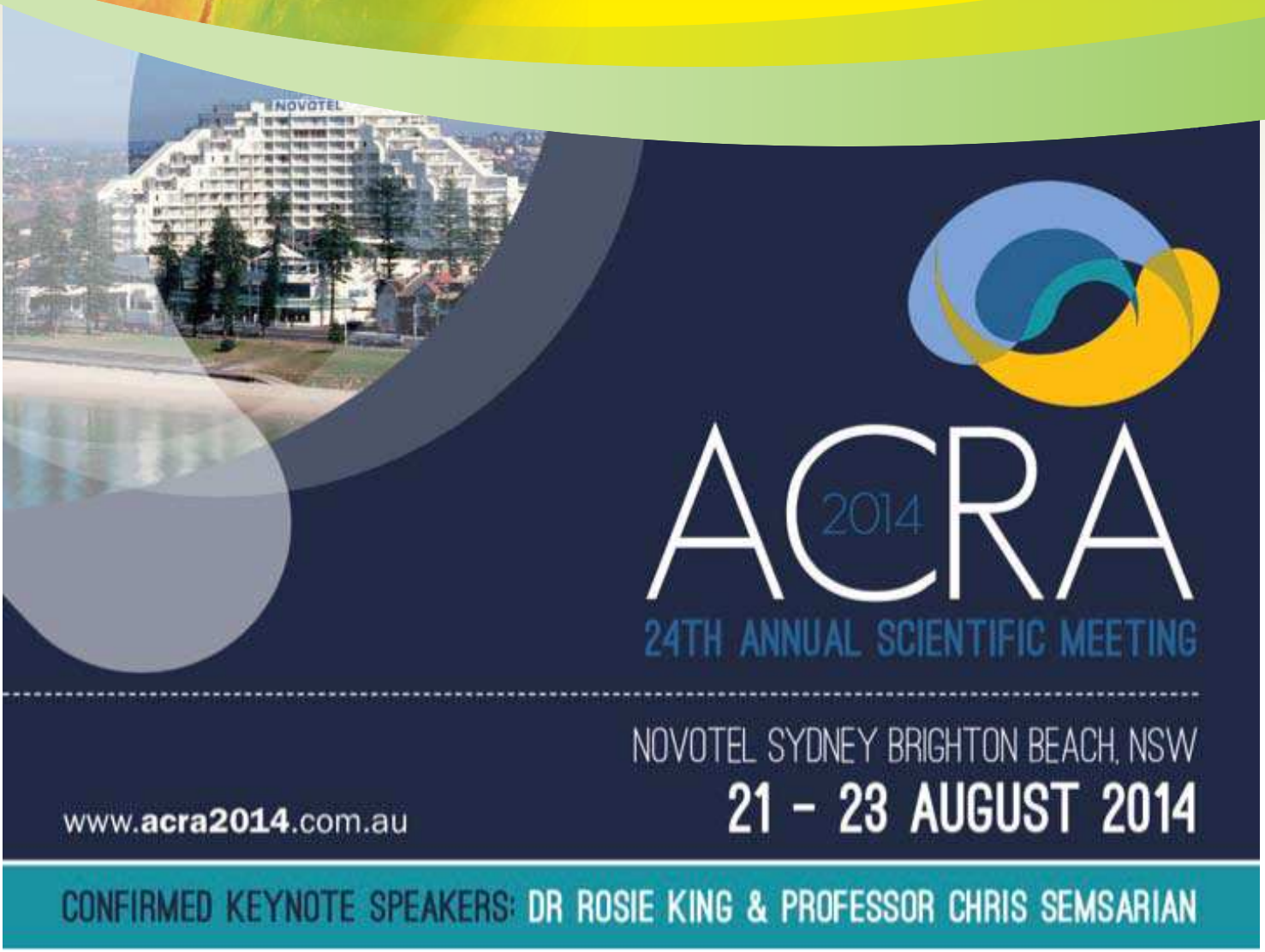
Artwork courtesy of St John of God Health Care

ACRA Newsletter

March 2014



AUSTRALIAN CARDIOVASCULAR HEALTH AND REHABILITATION ASSOCIATION

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Challenge...Change...Achieve

This Edition

Editor's Note

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

By the time you are reading this latest newsletter the year will be almost a ¼ of the way through yet it seems Christmas was only a few days ago! By now you will have settled back into the routine of your programs after the festive season break and perhaps be planning innovative ways to manage your programs and ever-increasing workloads. We hope you take every advantage to "recharge your batteries" and networking with like-minded colleagues is a great way to do that. The ACRA annual scientific meeting to be held in August in Sydney will provide a fantastic opportunity to do just that. The meeting title, "Sex, Drugs and Rock & Roll" is a very enticing one that promises lots of great information as well as a fun time. We hope to see as many of you there as possible. Those of you from rural areas can apply for funding support through ACRA as there are scholarships available. If you have a paper accepted you can apply for a travel grant. The organisers have called for abstracts for the meeting – is your program one that could be showcased to your peers nationally? Are you engaged in research you would like to share? Please see "Call for Abstracts" for more details.

It is also timely to give consideration to a suitable recipient for the Alan Goble Distinguished Service Award. Do you know of a colleague who has given exemplary service in cardiovascular care, rehabilitation and secondary prevention in your area, state or nationally. You can access details re nominations and forms on the ACRA website.

While Steve Woodruffe has only been in the President's chair for a few months, it is also time to plan for the future presidency role in nominating a member for the Vice-president President-elect position. This person will work alongside Steve for the 12 months from the AGM before stepping into the position themselves. Again, details and nomination forms are available on the website. Steve has very kindly given us an insight into the president's role in his report.

I'm always very happy to receive feedback re the content of the newsletter. It is a major means of communication for our members so it is essential that we give you what you want. Please don't hesitate to contact me, provide an article, tell us about your program, pen a 'letter to the editor'.

Happy reading
Sue Sanderson

Contents

President's Corner

Firstly I would like to wish all ACRA members a happy New Year. I trust that it has been a busy time for everyone over the past two months as things return to "business as usual" in your workplace. For me personally it has been a very busy time following my Christmas/New Year break. The first months of the year always seem to bring new challenges, which has certainly been the case for the President.

For this newsletter I wanted to give readers a snapshot of the life of the ACRA President. Much of my week is spent doing my "day job" as an Accredited Exercise Physiologist with the Ipswich Cardiac Rehabilitation Service. Our Service is one of the largest in Queensland for referral numbers and indeed exercise program participation. My role is immensely rewarding given the positive impact that exercise has on the lives of our patients. I often tell patients that enrol in a program with our Service that they should take a photo of themselves prior to commencing the program. That they will not believe the change in themselves they will see over the course of their program.

Mostly, my role sees me either spending time in the gym with a group of patients or one-on-one in assessments. I am constantly surprised by the individuality of the patients I deal with. In age alone, I provide exercise prescription and advice to twenty year olds and those in their eighties. Likewise, my role sees me working with some with little to no detriment to their fitness following their heart event compared to some who struggle to hang out their washing. I am constantly reminded of the importance of providing services that are specifically individualised, for the benefit of the patient.

Part of my day is always devoted to time spent on ACRA business. Some days this may be as little as responding to a few casual emails from my colleagues on the ACRA Executive Management Committee, at the Heart Foundation and State Presidents and reps. Other days require greater dedication including teleconferences, 1:1 phone calls and email requests for feedback, involvement or endorsement by ACRA. Currently, on behalf of ACRA, I sit on numerous committees and working groups including the International Council on Cardiovascular Prevention and Rehabilitation, the national Secondary Prevention Alliance and the writing group for the update of the NHF/CSANZ Guidelines for the Management of ACS. This work has its pros and cons but is vitally important to ensure ACRA continues to have a voice in the current health industry. I have included 2 letters received seeking feedback and input from myself or colleagues – you may wish to give feedback as well.

What's left of my day is spent in the company of my family; my wife of 10 years, Eliza and my two sons; Harrison aged eight and Griffin who is almost seven. As everyone with children this age will know your life after work is now devoted to spelling words, times tables and reading. Thankfully my boys are reasonably studious and still enjoy school and homework at this stage. My wife and I are sports nuts. We will pretty much watch any sport. As I write this the Aussie cricket team is doing battle with South Africa. I still enjoy the occasional social cricket match and have signed up for the local, slightly demeaningly named, "Golden Oldies" Rugby Union team. I have a few grey hairs but at the age of 34 I would hardly classify myself as an "oldie". Nevertheless, I may feel that way after the first game. Our boys have certainly caught the sports bug with Harrison a regular in the local Rugby team over the last three years and thanks to the recent Ashes series, is now cricket-mad.

I provide this report more as an autobiography as a means of showing you, the member, who this fellow is that is the current President. As always I encourage members to actively be involved with the direction ACRA takes in the future. I am very keen to hear comment on how your membership can be improved. Please do not hesitate to send me an email - steve.woodruffe@health.qld.gov.au

I also hope to meet you at either the World Congress of Cardiology conference in Melbourne in May or at the annual ACRA conference in Sydney in August.

Stay happy and healthy

Stephen Woodruffe,
ACRA President

Re: Update of the National Heart Foundation of Australia/ Cardiac Society of Australia and New Zealand Guidelines for the Management of Acute Coronary Syndromes (ACS)

As you know, the National Heart Foundation (NHFA) has begun a process to update the national clinical Guideline for the Management of ACS (2006). ACRA endorsed the 2006 ACS guideline, and we would like to seek endorsement by your organisation at completion of this updated guideline as well. We are grateful that you are participating in this work as a representative of ACRA.

We would also appreciate your help in recruiting a rehabilitation nurse to participate in a Writing Group (WG) around secondary prevention on an honorary basis.

The updated guideline will provide a synthesis of evidence-based guidance for health professionals caring for ACS patients. It is anticipated that the process to develop the new guideline will take approximately two years to publication. The new guideline will complement existing clinical guides covering pre-hospital treatment and secondary prevention care.

A guideline development Executive Working Group (EWG) facilitated by the NHFA is established and scoping of the work is underway. The group's membership will include Cardiologists (and Interventionists), Emergency Medicine Physicians, Clinical Directors of both urban and regional acute centres and regional cardiac clinical networks, a consumer, as well as Heart Foundation staff. The Executive will oversee 4 writing groups, which cover *Chest Pain, ST segment Elevation Myocardial Infarction (STEMI), Non-STEMI* and *Secondary Prevention.*

The writing groups will communicate by teleconference, email or e-platforms as needed – potentially every 4-6 weeks during the writing phase. Teleconferences are generally 60 minutes in duration, with communication by email or e-platforms between meetings.

A list of organisations which have been approached for representation is detailed overleaf. If you would like to nominate a new honorary member to the Secondary Prevention Writing Group kindly furnish us with contact details as appropriate.

We look forward to hearing from you.
Yours sincerely,

Maree Branagan

Project Officer – Clinical Programs and Executive Officer for the ACS Guideline update
Ph: 03 9321 1560 E: maree.branagan@heartfoundation.org.au

National Heart Foundation of Australia/ Cardiac Society of Australia and New Zealand Update of the Guidelines for the Management of ACS.

Organisations approached for representation within working groups:

Australasian College for Emergency Medicine (ACEM)
Australasian Cardiovascular Nursing College (ACNC)
Royal College of Pathologists of Australasia (RCPA)
Australian College of Rural and Remote Medicine (ACRRM)
Cardiac Society of Australia and New Zealand (CSANZ)
Internal Medicine Society of Australia and New Zealand (IMSANZ)
Royal Australian College of General Practitioners (RACGP)
Australian and New Zealand Society of Cardiac and Thoracic Surgeons (ANZSCTS)

Dear colleague

National Clinical Care Standard

I am writing to you regarding the draft National Clinical Care Standard for ACS which is now available for consultation. The Clinical Care Standard marks a significant development in the quest for improving the quality of ACS care in Australia.

ACS encompasses a spectrum of acute heart disease such as heart attack and angina and accounts for over 120,000 hospitalisations and more than $1.8 billion in costs to the Australian healthcare system annually. While there is a strong evidence-base to support the delivery of ACS care, there are significant variations in the quality of care provided in Australia to people with ACS resulting in varying health outcomes and contributing to health disparities in vulnerable populations.

The National Clinical Care Standard has been developed by the Australian Commission on Safety and Quality in Health Care (ACSQHC) and aims to support the delivery of appropriate care, reduce unwarranted variation in care, and aid shared decision making between patients, carers and clinicians. It is made up of six quality statements that outline a consistent level of care ACS patients can expect from health services Australia-wide. Indicators are also defined to facilitate health organisations with monitoring their progress in meeting the National Clinical Care Standard.

The Heart Foundation, which is dedicated to saving lives by supporting patient care and improving the heart health of all Australians, strongly supports the draft National Clinical Care Standard for ACS because it:

- is evidence-based and aligned to the current Guidelines for the management of acute coronary syndromes 2006;
- reflects the critical stages in delivering acute care for ACS from first emergency clinical contact to hospital discharge;
- demonstrates an integrated approach to quality of care involving all levels of the healthcare system; and
- has the potential to improve access to care and reduce health disparities which exist across geographical boundaries and disadvantaged population groups.

As such, the Heart Foundation urges you to express your support for the National Clinical Care Standard for ACS by providing comment during the public consultation period which is open until Friday, 14 March 2014.

Some key questions posed by the ACSQHC for respondents to provide comment on include:

- How well do the quality statements cover the key aspects of ACS care?
- How relevant are the proposed indicators in supporting the monitoring of the quality statements?
- What factors will prevent and support the application the Clinical Care Standard?

For more information about the public consultation process visit:
www.safetyandquality.gov.au/our-work/clinical-care-standards/consultation

If you would like to discuss the draft National Clinical Care Standard for ACS or this request further please contact our Health Director, Rachelle Foreman via email at rachelle.foreman@heartfoundation.org.au or phone on 3872 2506.

A CORNER OF RESEARCH FOR AUSTRALIA

BY ROBERT ZECCHIN RN MN

The following are excerpts of recent research articles which may:

a. encourage further research in your department

b. make you reflect on your daily practice

c. enable potential change in your program

d. All of the above

1. Cardiovascular fitness and mortality after contemporary cardiac rehabilitation.

Martin BJ. Arena R. Haykowsky M. Hauer T. Austford LD. Knudtson M. Aggarwal S. Stone JA. APPROACH Investigators. Mayo Clinic Proceedings. 88(5):455-63, 2013 May.

OBJECTIVE: To assess the association between cardiorespiratory fitness (CRF) and outcomes in a cardiac rehabilitation (CR) cohort.

METHODS: We conducted a retrospective study of 5641 patients (4282 men (76%) and 1359 women (24%); mean ± SD age, 60.0+10.3 years) with coronary artery disease who participated in CR between July 1, 1996, and February 28, 2009. Based on peak metabolic equivalents (METs), patients were classified as low fitness (LFit) (<5 METs), moderate fitness (5-8 METs), or high fitness (>8 METs).

RESULTS: Baseline fitness predicted long-term mortality: relative to the LFit group, patients with moderate fitness had an adjusted hazard ratio of 0.54 (95% CI, 0.42-0.69), and those with high fitness a hazard ratio of 0.32 (95% CI, 0.24-0.44). Improvement in CRF at 12 weeks was associated with decreased overall mortality, with a 13% point reduction with each MET increase (P<.001) and a 30% point reduction in those who started with LFit. At 1 year, each MET increase in CRF was associated with a 25% point reduction in overall mortality in the whole group (P<.001).

CONCLUSION: In this study of contemporary CR patients, higher baseline fitness predicted lower mortality. The novel finding was that improvement in fitness during a CR program and improvements that persisted at 1 year were also associated with decreased mortality, most strongly in patients who start with LFit.

The Good News: All patients benefit from cardiac rehabilitation!

2. Neighbourhood income and cardiac rehabilitation access as determinants of non-attendance and non-completion.

Lemstra ME. Alsabbagh W. Rajakumar RJ. Rogers MR. Blackburn D. Canadian Journal of Cardiology. 29(12):1599-603, 2013 Dec.

BACKGROUND: Despite known benefits of exercise-based cardiac rehabilitation (CR), attendance and completion rates remain low. Our objective was to review attendance and completion of CR overall and by level of neighbourhood income in Saskatoon, Canada and then determine the effect of opening a new CR facility in close proximity to low-income neighbourhoods.

METHODS: From January 2007 to December 2011, our retrospective cohort included hospital discharge data, CR attendance, and completion rates, stratified according to neighbourhood income, and adjusted for sex and age.

RESULTS: Residents from low-income neighbourhoods were more likely (odds ratio (OR), 1.76; 95% confidence interval (CI), 1.60-1.94) to be hospitalized for ischemic heart disease (IHD), percutaneous transluminal coronary angioplasty (PTCA), or coronary artery bypass graft (CABG) than residents from high-income neighbourhoods. Among those hospitalized for IHD, PTCA, or CABG, 12.7% attended CR. Patients of low-income neighbourhoods were less likely (OR, 1.58; 95% CI, 1.39-1.71) to attend CR than patients of high-income neighbourhoods. Among those who attended, 66.7% quit before program completion. Participants from low-income neighbourhoods were more likely (OR, 1.38; 95% CI, 0.57-3.50) to not complete CR. In total, only 4.2% of patients hospitalized for IHD, PTCA, or CABG started and completed CR. Expanding access to those living in low-income neighbourhoods did not increase attendance (OR, 1.31; 95% CI, 0.79-2.19) or completion rates (OR, 1.25; 95% CI, 0.23-2.41) to a significant level.

CONCLUSIONS: High rates of non-attendance and non-completion of CR were observed. Living in a low-income neighbourhood was associated with lower rates of attendance and completion. Expanding access to CR did not increase attendance or completion among patients of low-income neighbourhoods to a significant level.

The Good News: You may create a large dam but the horse may still not drink. Access issues to cardiac rehabilitation are very multi-factorial. ➤

3. Temporal trends and referral factors for cardiac rehabilitation post-acute coronary syndrome in Ontario: insights from the Canadian Global Registry of Acute Coronary Events.

Nguyen TN. Abramson BL. Galluzzi A. Tan M. Yan AT. Goodman SG. Canadian GRACE Investigators. Canadian Journal of Cardiology. 29(12):1604-9, 2013 Dec.

BACKGROUND: Despite the beneficial effects of cardiac rehabilitation (CR) on morbidity and mortality after an acute coronary syndrome (ACS), CR referral rates have been lower than recommended. Using the Canadian Global Registry of Acute Coronary Events (GRACE) database, we examined the temporal trends of CR referral rates in Ontario and its associated factors.

METHODS: From the main Canadian GRACE, we retrospectively analyzed data from 11 Ontario hospitals. CR referral rates were analyzed over time. Using multivariate logistic regression, we examined patient characteristics, in-hospital diagnosis, clinical events, and investigations associated with CR referral.

RESULTS: From 2000 to 2007, 3338 ACS patients (median age, 64 years; 32% women) were assessed. CR referral rate increased from 2.7% in 2000 to 51.2% in 2007 ($P < 0.0001$ for trend). Multivariate analysis identified increasing age per decade (odds ratio (OR), 1.21; 95% confidence interval (CI), 1.14-1.29), presentation Killip class > 2 (OR, 1.42; 95% CI, 1.09-1.84), non-ST-elevation ACS (OR, 1.60; 95% CI, 1.35-1.89), no left ventricular function assessment (OR, 1.33; 95% CI, 1.11-1.59), heart failure during hospital admission (OR, 1.48; 95% CI, 1.10-2.00), and in-patient cardiac revascularization (OR, 1.70; 95% CI, 1.38-2.09) as independently associated with lack of CR referral.

CONCLUSIONS: CR referral rate after ACS in Ontario continues to be lower than recommended, although there has been a steady increase over time. Factors independently associated with lack of CR referral include advanced age, higher Killip class, non-ST-elevation ACS, lack of left ventricular function assessment, in-hospital heart failure, and revascularization. Targeting non-referred populations might improve quality of care and close care gaps in secondary prevention.

The Good News: The Canadians are on a good thing in relation to increasing referral rates.

4. Physician factors affecting cardiac rehabilitation referral and patient enrolment: a systematic review.

Ghisi GL. Polyzotis P. Oh P. Pakosh M. Grace SL. Clinical Cardiology. 36(6):323-35, 2013 Jun.

BACKGROUND: Physicians play an important role in CR referral and enrolment. Despite established benefits and recommendations, cardiac rehabilitation (CR) enrolment rates are pervasively low. The reasons cardiac patients are missing from CR programs are multifactorial and include provider factors. A number of studies have now investigated physician factors associated with referral to CR programs and patient enrolment. The objective of this study was to qualitatively and systematically review this literature.

METHODS: A literature search of MEDLINE, PsycINFO, CINAHL, Embase, and EBM was conducted for published articles from database inception to October 2011. Overall, 17 articles were included following a process of independent review of each article by 2 authors. Seven (41.2%) were graded as good quality according to Downs and Black criteria. There were no randomized controlled trials.

RESULTS: Results showed that medical specialty (ie, cardiac specialists more likely to refer; n=8 studies) and other physician-reported reasons (eg, physician report of their reasons for CR referral and physician sex) were related to referral. Physician factors related to patient enrolment in CR were physician endorsement, medical specialty, being referred, and physician attitudes toward CR.

CONCLUSIONS: Physician factors are consistently related to CR referral and enrolment. The role of physician endorsements in promoting patient enrolment should be optimized and exploited.

The Good News: How good are your cardiologists/VMOs at referring their patients to you? Who are your Champions and who are your Chumps!

5. Randomized trial of Nordic walking in patients with moderate to severe heart failure.

Keast ML. Slovinec D'Angelo ME. Nelson CR. Turcotte SE. McDonnell LA. Nadler RE. Reed JL. Pipe AL. Reid RD. Canadian Journal of Cardiology. 29(11):1470-6, 2013 Nov.

BACKGROUND: Patients with heart failure are a growing population within cardiac rehabilitation. The purpose of this study was to compare, through a single-centre, parallel-group, randomized controlled trial, the effects of Nordic walking and standard cardiac rehabilitation care on functional capacity and other outcomes in patients with moderate to severe heart failure.

METHODS: Between 2008 and 2009, 54 patients (aged 62.4 ± 11.4 years) with heart failure ➤

(mean ejection fraction = 26.9% ± 5.0%) were randomly assigned to standard cardiac rehabilitation care (n = 27) or Nordic walking (n = 27); both groups performed 200 to 400 minutes of exercise per week for 12 weeks. The primary outcome, measured after 12 weeks, was functional capacity assessed by a 6-minute walk test (6MWT).

RESULTS: Compared with standard care, Nordic walking led to higher functional capacity (125.6 ± 59.4 m vs 57.0 ± 71.3 m travelled during 6MWT; P = 0.001), greater self-reported physical activity (158.5 ± 118.5 minutes vs 155.5 ± 125.6 minutes; P = 0.049), increased right grip strength (2.3 ± 3.5 kg vs 0.3 ± 3.1 kg; P = 0.026), and fewer depressive symptoms (Hospital Anxiety and Depression Scale score = -1.7 ± 2.4 vs -0.8 ± 3.1; P = 0.014). No significant differences were found for peak aerobic capacity, left-hand grip strength, body weight, waist circumference, or symptoms of anxiety.

CONCLUSIONS: Nordic walking was superior to standard cardiac rehabilitation care in improving functional capacity and other important outcomes in patients with heart failure. This exercise modality is a promising alternative for this population.

The Good News: Don't worry I had to google Nordic Walking too!

6. Increased confidence to engage in physical exertion: older ICD recipients' experiences of participating in an exercise training programme.

Morken IM. Norekval TM. Isaksen K. Munk PS. Karlsen B. Larsen AI. European Journal of Cardiovascular Nursing. 12(3):261-8, 2013 Jun.

BACKGROUND: Research suggests that exercise training (ET) programmes may improve both physical and psychosocial functioning in implantable cardioverter defibrillator (ICD) recipients. Most of this research has been conducted by means of quantitative methods. However, knowledge of older ICD recipients' experiences of participating in such programmes is sparse. There is thus a need for more detailed qualitative data from the perspective of older patients. AIM: To describe older ICD recipients' experiences of participating in an ET programme.

METHODS: A qualitative design with semi-structured interviews involving 12 older ICD recipients who had participated in a 3-month ET programme. Mini-disc recordings of the interviews were transcribed verbatim and analysed using content analysis.

RESULTS: The analysis revealed two major themes: (1) 'increased confidence to engage in physical exertion'; and (2) 'increased satisfaction with life'. The first theme is illustrated by three subthemes: 'perceived support from physiotherapists', 'perceiving the heart rate monitor as a motivation to exercise', and 'perceiving peers as motivators for enjoyment and making the effort to exercise'. The second theme was illustrated by the following subthemes: 'perceived psychosocial benefits', 'perceived physical benefits', and 'exercise as a new health habit'.

CONCLUSION: The findings indicate that exercising in a cardiac rehabilitation centre together with peers and supervised by skilled healthcare professionals may increase motivation to exert oneself, leading to emotional and physical benefits as well as a more social and active lifestyle for older ICD recipients.

The Good News: How many older ICD patients are in your program? Are you getting similar outcomes?

7. Cardiac rehabilitation patient and organizational factors: what keeps patients in programs?. Turk-Adawi KI. Oldridge NB. Tarima SS. Stason WB. Shepard DS. Journal of the American Heart Association. 2(5):e000418, 2013 Oct.

BACKGROUND: Despite documented benefits of cardiac rehabilitation, adherence to programs is suboptimal with an average dropout rate of between 24% and 50%. The goal of this study was to identify organizational and patient factors associated with cardiac rehabilitation adherence.

METHODS: Facilities of the Wisconsin Cardiac Rehabilitation Outcomes Registry Project (N = 38) were surveyed and records of 4412 enrolled patients were analyzed. Generalized estimating equations were used to account for clustering of patients within facilities.

RESULTS: The results show that organizational factors associated with significantly increased adherence were relaxation training and diet classes (group and individual formats) and group-based psychological counselling, medication counselling, and lifestyle modification, the medical director's presence in the cardiac rehabilitation activity area for > 15 min/ week, assessment of patient satisfaction, adequate space, and adequate equipment. Patient factors associated with significantly increased adherence were aged > 65 years, the American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR) high-risk category, having received coronary artery bypass grafting, and diabetes disease. Non-white race was negatively associated with adherence. There was no significant gender difference in adherence. None of the ➤

baseline patient clinical profiles were associated with adherence including body mass index, total cholesterol, low-density lipoprotein, high-density lipoprotein, triglycerides, and blood pressure.

CONCLUSIONS: Factors associated with adherence to cardiac rehabilitation included both organizational and patient factors. Modifiable organizational factors may help directors of cardiac rehabilitation programs improve patient adherence to this beneficial program.

The Good News: A positive look on what makes patients come and stay in cardiac rehabilitation!

8. Barriers to cardiac rehabilitation use in Canada versus Brazil. de Melo Ghisi GL. Oh P. Benetti M. Grace SL. Journal of Cardiopulmonary Rehabilitation & Prevention. 33(3):173-9, 2013 May-Jun.

PURPOSE: Despite its well-established benefits, cardiac rehabilitation (CR) is greatly underutilized globally. Barriers to its utilization have been identified in high-income countries. Given the growing epidemic of non-communicable diseases in low- to middle-income countries, the identification of barriers to use of these low-cost interventions is warranted. The aim of this study was to describe and compare barriers to CR use in Brazilian and Canadian cardiac outpatients.

METHODS: Two cardiac samples consisting of 237 Brazilian (recruited from 2 CR centres in southern Brazil) and 1434 Canadian (recruited from 11 community and academic hospitals in Ontario) outpatients were compared cross-sectionally. Barriers were assessed by using the Cardiac Rehabilitation Barriers Scale, psychometrically validated in English and Portuguese. Mann-Whitney U tests were used to compare barriers between samples.

RESULTS: Overall, 139 (58.6%) Brazilian and 779 (54.3%) Canadian respondents were enrolled in CR. The mean total barriers score for Brazilian respondents was 1.71 $\pm$ 0.63, and 2.37 $\pm$ 1.0 ($P < .01$) for the Canadians. For 17 of 21 barriers, Canadians reported significantly greater barriers than Brazilians ($P < .02$). As their greatest barriers, Canadians rated already exercising at home or in the community and personal travel, while Brazilians identified distance to and cost of the CR program.

CONCLUSION: Despite the significantly lower availability of CR in Brazil and the universal health care system in Canada, cardiac outpatients in Canada perceived significantly greater CR barriers. Arguably, however, these barriers were more modifiable.

The Good News: Different strokes for different blokes (and sheilas)!

9. Fear-avoidance beliefs and cardiac rehabilitation in patients with first-time myocardial infarction. Ahlund K. Back M. Sernert N. Journal of Rehabilitation Medicine. 45(10):1028-33, 2013 Nov.

OBJECTIVE: The aim of this study was to examine fear-avoidance beliefs in patients after first-time myocardial infarction and to determine how such beliefs change over time. A further aim was to analyse fear-avoidance beliefs and physical activity levels in patients attending exercise-based cardiac rehabilitation led by a registered physiotherapist, compared with a control group.

METHODS: Prospective cohort study. A total of 62 patients after first-time myocardial infarction were consecutively included in the study, mean age 61 years (range 42-73). Thirty-four patients chose exercise-based cardiac rehabilitation and 28 carried out the exercise regime on their own (controls). At follow-up, 57 patients (n = 30 and n = 27, respectively) responded. The Fear-Avoidance Beliefs Questionnaire and the Exercise and Physical Activity questionnaires were completed at 1 and 4 months post-infarction.

RESULTS: Clinically relevant fear-avoidance beliefs were seen in 48% of all patients at baseline, compared with 21% at follow-up ($p = 0.01$). Corresponding baseline values were 62% for the cardiac rehabilitation group and 29% for controls ($p = 0.02$). At follow-up, 4 months post-infarction, the difference between the groups was no longer seen. The total amount of physical activity increased over time for the cardiac rehabilitation group ($p = 0.03$), and this was also significant compared with the control group ($p = 0.02$).

CONCLUSION: Compared with controls, patients attending exercise-based cardiac rehabilitation led by a registered physiotherapist, demonstrated higher levels of fear-avoidance beliefs at baseline, which decreased over time. Furthermore, attendees increased their level of physical activity and exercise over time. Participation in exercise-based cardiac rehabilitation is therefore strongly recommended for patients with myocardial infarction, especially for those with increased fear of movement.

The Good News: Fear is a good motivator for change!

More next time!
Robert Zecchin

CALL FOR *Abstracts*

ACRA 2014
24TH ANNUAL SCIENTIFIC MEETING
NOVOTEL SYDNEY BRIGHTON BEACH NSW 21 - 23 AUGUST 2014

On behalf of the Organising Committee, we invite you to submit abstracts for oral and poster presentations at ACRA ASM 2014, to be held at Novotel Sydney Brighton Beach from Thursday, 21 – Saturday, 23 August 2014.

The closing date for abstract submissions is

Friday, 4 April 2014

The Annual Scientific Meeting is the Australian Cardiovascular Health and Rehabilitation Associations' major forum for the exchange of ideas and for discussion around clinical and research issues, including the latest developments in prevention and management of cardiovascular disease. This is one of the major national cardiovascular meetings in 2014.

The scientific committee are working tirelessly on an outstanding and innovative program. The emphasis of the 2014 meeting is on

"Sex, Drugs and Rock n Roll"

For more information on abstract submission, please visit the **ACRA 2014 Website.**

Please circulate this information as widely as possible and encourage your colleagues to submit abstracts for this forum. This Meeting is not to be missed!

Heart Research Centre Report

Congratulations to Scholarship Recipients

The Heart Research Centre congratulates the ten recipients of training scholarships who attended the Centre's Training Program in Integrated Disease Management for Chronic Heart Failure (CHF) in November 2013. Scholarship recipients were fully funded to attend the training, reducing financial barriers to training participation. Competition for the limited scholarship places was intense with almost 50 applications for the ten scholarship places. Considering that only Victorian health professionals were eligible to apply for the scholarships, the large number of applicants indicated a high level of unmet need for training in Victoria.

Applicants were chosen on the basis of personal excellence and capacity to develop and deliver evidence-based programs for patients. In addition, need for and geographical distribution of services was considered in the selection of applicants including score on the heart failure 'hot spot' measure. The maps are available at www.heartfoundation.org.au/heartmapvic. Scholarship recipients were also selected on the basis of their vision for extending integrated disease management services to patients living with chronic heart failure.

Scholarships were funded by the Victorian Department of Health under their Victorian Cardiac Clinical Network (VCCN) Heart Failure Improvement Program 2013 grant scheme.

The Scholarship recipients were:

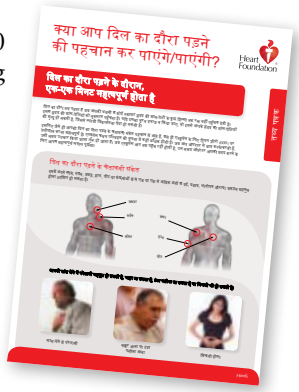
Donna Mortlock, Registered Nurse, Maryborough; Cathryn McDonald, Registered Nurse, Edenhope; Sarah Boorman, Practice Nurse, Caroline Springs; Carolyn Alkemade, Registered Nurse, Orbost; Manuja Inaganti, Physiotherapist, Wonthaggi; Vivienne Cole, Registered Nurse, Stawell; Farah El-Chami, Dietitian, East Wimmera; Fiona Caracella, Registered Nurse, Broadmeadows; Katherine Taylor, Social Worker, Colac; Leeanne Rankin, Registered Nurse, Rochester/Elmore.

The Heart Research Centre congratulates all these recipients. Further funding for scholarships has been obtained from the Victorian Government to address unmet needs for training in this area.

The scholarship recipients with Ms Eileen Thompson, Program Manager VCNN, Professor Alun Jackson, Dr Rosemary Higgins and Ms Elizabeth Holloway, Heart Research Centre.

News From *Across The Nation*

Heart attack action plan now available in Hindi



A heart attack occurs every 10 minutes in Australia. Knowing the warning signs of heart attack could save your life, or the life of someone you love. The Heart Foundation's free action plan, fact sheet and information resources about risk factors are now available in 11 languages including Hindi.

Download and print resources for your patients from heartattackfacts.org.au

Heart Foundation Walking

A step towards fun, friendship and maintaining an active lifestyle

Linking patients to appropriate community-based programs beyond cardiac rehabilitation can be challenging. Heart Foundation Walking (HFW) is one of Australia's most successful and sustainable community-based activity programs that is free for participants and has an impressive retention rate of approximately 83% of walkers after 6 months, making it an ideal option for your patients.

The Heart Foundation works in partnership with Local Coordinators to set up and maintain walking groups. Local Coordinators are provided resources and training from the Heart Foundation, and can engage patients/staff or community members to become volunteer Walk Organisers. The Heart Foundation provides training and resources to Walk Organisers, who are also covered under the Heart Foundation's volunteer insurance policy.

"With the support provided by the Heart Foundation there is a sense of belonging to a program that tracks the group's activity and offers recognition/small rewards for their attendance.

We can target our resources on improved phase 1 and 2 service provision, and we have empowered clients to exercise independently in the community."

NSW physiotherapist/Local Coordinator of Cardiac Rehabilitation HFW group

How can you get involved?

Refer your patients to a local HFW group

With over 1,500 groups nationally there are many options available. Visit www.heartfoundation.org.au/walking or call 1300 36 27 87 to find your nearest group or for more information on HFW.

Why not start your own?

HFW is great way to support your patients to develop healthy habits. The program can facilitate an informal 'peer support' group which builds social connections, and motivates participants to stay active!

Do you have your ticket yet?

Register today for the World Cardiology Congress, held in Melbourne, 4–7 May. With a specific nursing, allied health and cardiac rehabilitation stream, some of the exciting topics include:

- Guideline based CV care: the important role of nursing
- Health behaviours and CVD prevention across the life course
- Preventive Cardiovascular Nurses Association session –Blood pressure, sodium and cardiovascular disease: a global call to action for nurses in prevention of CVD
- Risk prediction in global CVD prevention: absolute or relative?
- An integrated team approach for management for heart failure
- Secondary prevention efforts and challenges: a global perspective ➤

- Increasing access to post-discharge rehabilitation programmes.

This is an event not to be missed. Register today at www.worldcardiocongress.com

Cardiac rehabilitation and secondary prevention pathway in WA

The Department of Health (WA) Cardiovascular Health Network has developed a statewide cardiac rehabilitation (CR) and secondary prevention (SP) pathway that is currently out for comment. As a member of the network's CR and SP working group, the Heart Foundation had the opportunity to be involved with this great work. This pathway describes the patient journey from the time of a cardiovascular disease diagnosis, through exacerbations and possible hospital admissions and emphasises the importance of self-management, outpatient and community-based care.

The document makes the case for CR and SP to be part of usual care for everyone, to be patient centered, and flexible. The core components of care include: assessment, education, exercise, psychosocial support and regular medical follow-up.

Recognising that ongoing attendance at these programs is difficult to maintain, the pathway encourages a structured follow-up or case management approach. This pathway also raises awareness among health professionals and consumers that CR and SP is a life-long approach to management of cardiovascular health. If you would like a copy of the draft pathway please email Shelley.McRae@heartfoundation.org.au or telephone (08) 9382 5923.

Heart Foundation welcomes Victoria's first heart health plan

The Victorian Government has launched the first heart health plan for the state, setting priority areas to improve Victorians' health which, if implemented, will save lives.

The plan, *Heart health: improved services and better outcomes for Victorians*, is an essential guide to direct government investment in heart health in a coordinated way in future years.

At the launch at Monash Medical Centre in Clayton, Hon. David Davis, Minister for Health, stressed that heart disease remains the single biggest killer of men and women in the state.

It's estimated that more than 300,000 adult Victorians are living with heart disease and around 20 Victorians die every day, which highlights the importance and significance of this plan to reduce disease and death rates.

While many of our medical advances and awareness campaigns mean more Victorians survive their heart attack, it also means services that support cardiac recovery are increasingly essential.

It is a common misconception that the treatment people receive for their heart attack is a cure; it is not. Heart disease is a life-long condition and without proper management, such as attending cardiac rehabilitation, one in three people will go on to have a second heart attack.

This plan reviews the spectrum of heart health from disease prevention, management of people at risk of chronic disease through to care of people living with heart disease.

Bond University's 'Exercise As Treatment' Conference

Bond University's Centre for Research in Evidence Based Practice and The Collaborative Research network: Advancing Exercise and Sports Science is sponsoring a conference "Exercise As Treatment". Topics include, but not limited to Cardiac Rehabilitation, Obesity, and Diabetes and speakers include Prof Tom Briffa.

Speakers have been invited to provide the evidence and rationale for the different types of exercise for different clinical conditions, practical tips on the "how to" of different disease-specific exercise regimes, evidence of a variety of clinical conditions where exercise has been found to be most effective and discuss some of the important cognitive, social, and logistical issues that form part of an effective "exercise prescription".

Information about the conference and speakers is available at **www.exerciseastreatment.net.au**

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State News

Western Australia

State representative
Craig Cheetham

The WACRA Annual General Meeting was held at the very pleasant Jo Jo's restaurant on beautiful Swan River on March 7th and included a presentation by Dr Robert Grenfell, National Director, Cardiovascular Health from the Heart Foundation.

The AGM also saw the election of a new committee and we welcome those willing to be involved in the executive committee of the WACRA.

An update on the event and the new committee will be in the next report.

Cardiovascular Health Networks

Cardiac Rehabilitation and Secondary Prevention working group

There has been a continued progress on the policy document for Cardiac Rehabilitation and Secondary Prevention in WA. It is almost at the final end of the consultation phase. This document will play a pivotal role for all practitioners in the future and we welcome your input. The WACRA executive cannot thank enough Kim Goodman, Jacquie Garton-Smith and Stephen Bloomer from the Cardiovascular Health Network, Shelley McRae and Julie Smith from the Heart Foundation and all the WACRA Exec and members as well as the practitioners that have assisted and contributed to the document.

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

WA state items prepared by

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@cprwa.com.au

Victoria

State representative
Kim Gray

State Events

Wow Christmas has been and gone and March is rapidly drawing to a close with the first VACR educational event just around the corner. Whilst the year has taken off to a brisk start the VACR Committee has been busily sourcing a variety of cardiac rehabilitation experts and securing AstraZenica as sponsor for the 2014 VACR Clinical Practice Day (CPD). This event will be held at the Stamford Plaza, 111 Little Collins Street, Melbourne; a change of site location from recent VACR educational events.

The confirmed CPD speakers come from a variety of back grounds both research and clinical, and will be presenting a range of exciting topics very relevant to the cardiac rehabilitation clinician.The topics to be covered include Heart Failure, Atrial Fibrillation, Medication Compliance and Anticoagulation, Angiograms in Chronic Renal Failure, Super Foods in Heart Disease, and Exercise. We have had a good response with registrations via our 'Trybooking" site.

Membership

Our membership is currently 152 members with many new members joining us this year.

Department of Health and Cardiac Clinical Network

The Victorian Minister of Health the Honorable David Davis recently announced the State's first comprehensive cardiac plan with the launch of the "*Heart heath: improved services and better outcomes for Victorians*" plan detailing the Government's actions to fight heart disease and boost access to vital cardiac care services. As part of this commitment the Government has developed a detailed five-year plan to prevent heart disease, and to further develop and improve outcomes for Victorians with heart disease and stroke. This plan will build on some of the best cardiac services provided by experts in their fields that we are fortunate to have by further developing and improving these Victorian cardiac health services in the future.

The plan includes ensuring that Victorian's living in rural and remote areas have access to the best possible cardiac treatment. This includes $500,000 allocated for cardiac rehabilitation projects, expansion of the Victorian outcomes register with $250,000 and a further $300,000 to improve cardiac surgery referrals particularly for outer metropolitan and rural people for this year.

At the same time a partnership between the Victorian DOH and the New Zealand DOH has commenced with both organisations agreeing to collaborate last week via focusing on New Zealand's learnings of best practice and service delivery with smoking cessation. Currently 4,000 people die each year from smoking related disease in Victoria. The smoking cessation collaboration is predicted to dramatically save and improve lives of Victorian smokers with a significant set of initiatives, including banning of smoking onsite in all state prisons.

Committee and meetings

A review has been completed of VACR committees meetings with aim of maximising attendance. A 12month trial of rotating between sites was completed last year with success and will continue. The VACR has also sourced a low cost teleconferencing provider to facilitate the meeting process in particular around education events. ➤

With the resignation of Nicole Banks a business office service provider, "Professional Association Management of Services (PAMS) has been appointed to a 12 month contract to take over from Nicole. On behalf of the Victorian committee and our members we wish to acknowledge Nicole's support, dedication, hard work, professionalism and loyality to VACR. We wish Nicole all the very best success in her new venture. Thank you Nicole.

Emma Boston
VACR President

Tasmania

State representative
John Aitken

John Aitken recently attended a round table discussion titled "*How to increase community engagement with the Tasmanian Health system*" as part of the commission on delivery of health services in Tasmania.

The commission was established in 2012 to provide advice to federal and Tasmanian Ministers on clinical redesign of the Tasmanian health system, to ensure quality health outcomes for Tasmanians and long term system sustainability.

The work of the commission is funded under the Tasmanian Health Assistance Package – a four year investment by the Australian Government, aimed at getting Tasmania's health system back on track.

The objectives of the meeting were to gather representatives from a broad range of organisations actively engaged with local community interest, to exchange ideas on:

- Ways to improve community awareness of health system capabilities, limitations and processes
- Effective mechanisms for engaging health consumers in health system decisions-making practices
- Effective tools for increasing health literacy and
- Effective tools for increasing health consumer advocacy skills.

Sincere thanks to Trudie Williams who has worked with John over the past year. She has moved to greener pastures and is now working in Sydney with the Australian Defence Force. It's been a pleasure working with her and we wish well in her future endeavours.

Sue Sanderson has been invited to participate in a Clinical Working Group on Cardiovascular Disease as part of the Tasmanian *HealthPathways* Project. The Project is a collaboration between Tasmania Medicare Local, the three Tasmanian Health Organisations and the Department of health & Human Services Tas. It is anticipated that the project will lead to "localised" pathways for persons with CVD including, but not limited to, AF, heart failure, ACS, risk assessment, drugs and monitoring and referrals, building on pathways already developed for chest pain, STEMI and NSTEMI management in the emergency department.

Heart Care Network

The Heart Care Network was founded in September 2013 by the Heart Foundation in Tasmania. It is a group of Tasmanian health care practitioners that all share an interest and enthusiasm in improving the heart health of all Tasmanians through engagement with the Heart Foundation and each other. Professionals from any discipline and any region get access to regular email updates, a Facebook page, a quarterly newsletter and the option to attend informal education sessions that run on a state-wide basis every few months, organised and supported by the Heart Foundation.

The group is currently well supported by a wide variety of professionals such as cardiac rehab nurses, physiotherapists, nurse educators, academics, pharmacists and Clinical Nurse Consultants in heart failure and emergency care. It is anticipated that there will be a growing number of primary care practitioners in 2014 as the network forms further connections in collaboration with Tasmania Medicare Local.

Last year, the Heart Care Network hosted face to face events in the Southern, Northern and North Western regions of Tasmania. The inaugural state-wide education session in December 2013 was joined by Professor Mark Nelson who educated the members on the benefits of integrating an Absolute Cardiovascular Disease (CVD) Risk approach into health assessments (see www.cvdcheck.org.au for more information on Absolute CVD Risk).

For more information on the Heart Care Network in Tasmania contact emma.curnin@heartfoundation.org.au or call (03) 6220 2234. Alternatively, information from the Heart Foundation can be found at www.heartfoundation.org.au or by contacting the Health Information Service on 1300 36 27 87.

South Australia & NT

State representative
Jenny Finan

Welcome and Happy New Year to our South Australian members.

Executive News

We would like to extend our sincerest thanks to Nicole Banks for her dedication and hard work as she leaves ACRA to take up her new position with HETI (NSW). She will be replaced by the management company PAMS, who will incorporate her role and expand to assist with future growth and conference planning and coordination, web development and other major executive requirements of ACRA and its state branches.

Jenny Finan, our State Representative, and Dianna Lynch, our President, attended their first EMC meetings in November and will be going to Melbourne in May for the next to face to face meeting and will continue to keep the board and its members informed.

Rural report

Caroline Wilksch has reported that the CATCH program has received further funding and all referrals will continue to be sent to the central point of referral where they will disseminate and book cardiac rehabilitation appointments with the patients. The telephone service or delivery of phase 2 cardiac rehabilitation continues to be offered.

A committee has been developed ➤

to implement the Model of Care in country areas and have commenced developing KPI's which are awaiting endorsement.

The program structure is also being standardised across country health.

Excitingly the CATCH website is now live (www.catchsa.com.au).

We welcome a new Cardiac rehabilitation program in Ceduna.

Financial report

Kathy Read has reported on our financial situation again highlighting the benefits of our education sessions to assist with our revenue and with our investments we have a surplus at the time of report even with the extra expenses of increasing speaker gifts for our education days and sending a second board member to the ACRA executive face to face meeting in November.

A full report is available from the treasurer on request.

Sponsorship

We are very pleased to have received further sponsorship and support from Steve Pados from Astra Zenica to assist with running our education seminars.

We also have received a generous offer of some sponsorship for funding to promote a research project. We discussed at our last meeting some ideas that would benefit cardiac rehabilitation e.g. longer term outcome information / data collection post 12 months post event, or an audit or intervention trial.

SACRA Education Seminar

April 6 2014 – Hampstead Centre

The focus of our first education session of the year will be country health with Dr Phil Tideman, Rosy Tirimacco, Caroline Wilksch and Tim Temple presenting.

We look forward to your attendance and we have now made EFT be available for this seminar.

We are also excited to announce that there will be two rural grants of $250 will be offered to encourage attendance by our country members or health practitioners.

PLEASE NOTE our AGM will follow this seminar.

Heart Foundation

We would like to share some baby news – Vanessa Poulsen and her husband Peter welcomed the birth of their first baby – a little boy "Hugo".

We would like to welcome Sue Treadwell who will step into this role whilst Vanessa is on maternity leave.

The Heart Foundation will be launching their new My Heart My Life version 3 once all remaining stock has been used.

This resource has been adjusted to incorporate feedback from both nursing staff, cardiac educators and consumers.

Lots of preparation is underway for Heart Week Sunday 4th – Saturday 10th May 2014 including the launch of a telephone application.

Queensland

QCRA
QLD Cardiovascular Health & Rehabilitation Association Inc.

State representative
Paul Camp

Membership

A warm welcome to the newest QCRA member Annabel Hickey – Qld Statewide Heart Failure Services Coordinator

QCRA Members Working Hard to Benefit their Patients

Feedback from the Service Directory survey responses (see below) indicates that our members are working extremely hard and sometimes under challenging circumstances, to improve outcomes for their patients. The QCRA EMC would like to acknowledge the great work done by all its members.

One such member is Judith Brown, coordinator of the Mossman Cardiac Rehabilitation and Prevention Programme who is stepping down from this role in April. Thank you to Judith for her dedication and service over many years to the care of patients with cardiovascular disease.

Join the New Service Directory

The QCRA EMC is updating details in the Qld Cardiac Rehabilitation Service Directory and inviting all Queensland cardiac rehabilitation programs to please complete and return a survey form with their current details.

Copies of the form are available on request by emailing qcra@acra.net.au

We had originally asked that all completed survey forms be returned by email to qcra@acra.net.au by Friday 14th February. However, QCRA will continue to accept these forms until March 14th. Please return all completed surveys as soon as possible.

We have had a great response so far with over 48 programs responding at the time of writing. A big thank you to those of you who have already completed the survey form. Also many thanks to those of you who have informed us of where programs are no longer operating or have changed their contact details. All this information is extremely useful.

http://www.acra.net.au/qcra/news

New Webinar and Symposium

QCRA members can look forward to some exciting content and new research findings at two professional development events being planned for this year.

A web based seminar is being planned for July, as well as a full day symposium with video conferencing facilities for October.

The July webinar will look to provide clinicians with a brief update on a topic of interest. In contrast, the symposium will present important new research findings and will be presented in conjunction with the Heart Foundation - Queensland.

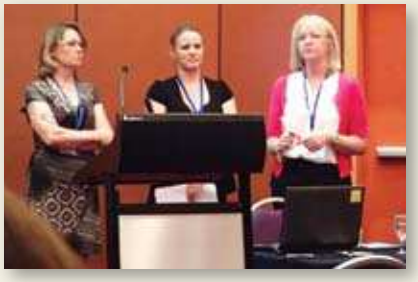
Please see the QCRA Events page for details as they are announced. http://www.acra.net.au/qcra/event-conferences

Australasian Cardiovascular Nursing College (ACNC) Annual Scientific Meeting.

QCRA and ACRA were well represented at the recent ACNC conference at Surfers Paradise Feb 21-22.

QCRA member Sharon Leslie and her colleagues Joanne Crook and Debora Snow were able to show that significant improvement in 6MWT in females over 80 years of age. ➤

Sharon and her team at the Gold Coast Hospital Cardiac Rehabilitation Service performed a chart audit of 959 participants and found significant improvements in 6MWT across all age groups. However, this was particularly evident in females over the age of 80. This finding is significant as the Gold Coast Hospital services a generally older population.



Sharon Leslie and colleagues

ACRA Vice President Dr Lis Neubeck presented some exciting research on the use of a smart phone app to screen for Atrial Fibrillation (AF) in a community pharmacy setting.

Lis highlighted that many patients with AF are often asymptomatic, but at the same time carry a significant risk for developing ischaemic stroke. Using an established protocol that involved Cardiologist oversight and validation of ECG diagnosis, Lis and her team were able to screen over a thousand people. Importantly, they uncovered 10 new cases of people with AF who were at significant risk for ischaemic stroke (CHADS-VASc 2 or greater) and would benefit from anticoagulation therapy.

Lis pointed out the clinical significance of this technology and its potential for screening for other arrhythmias.

Karen Uhlmann, QCRA member and Heart Foundation Clinical Manager – Acute Sector, presented some of the Heart Foundation's online learning tools for health professionals including – HEART Online, and Improving Adherence in Cardiovascular care and the new My Heart My Life app. The app to be launched in March and will include links to MIMS and consumer medicines information.

Karen Uhlmann

Other links to the app include the Heart Foundation's "Warning Signs of Heart Attack" video and a recipe library with over 500 heart smart recipes.

To register for news about the app, log onto www.myheartmylife.org.au

Karen also reminded the audience to register for the monthly Heart Health Network e-newsletter.

NSW / ACT

State representative Lis Neubeck

We are working hard on education events at the moment. Our first educational event will be our webinar with A/Prof David Sullivan of Royal Prince Alfred Hospital in Sydney. David will be familiar to those who watched the Catalyst programs on lipids and statins. He will be providing us with an update and response to the programs. Registration for the program will open very soon and costs will be a very reasonable $10 to members and $20 to non-members.

In May, we will be hosting our annual rural conference together with the Heart Foundation. This year we will be in Goulbourn for "Beats in the Bush" during Heart Week, on May 9th. Professor Robyn Gallagher will be delivering the keynote presentation on the importance of interdisciplinary collaborations. Details of this meeting will be available shortly.

We continue our hard work on the program for the 2014 Annual Scientific Meeting (ASM). Our theme is "Sex, Drugs and Rock 'n' Roll", and we have secured fantastic keynote speakers on this topic. Our first keynote address will be given by Dr Rosie King, international sex guru, and author of "Where has my libido gone?" Professor Chris Semsarian will deliver the keynote address on day 2 on the effects of caffeine and other drugs on the heart. The provisional program will be available on the website in the next week.

Please remember to submit your abstract for the ACRA meeting. Abstract submission is open now. Visit the website www.acra2014.com for more details.

Make sure you are following ACRA on Twitter for regular updates. Our Twitter handle is @ACRA_ACRA. We are tweeting daily and we provide relevant content for professional development, information about upcoming ACRA events and other relevant courses or conferences. We are in discussions to hold a bi-monthly Twitter chat together with the Cardiac Society of Australia and New Zealand Cardiovascular Nurses Council (@CSANZCNC) and the Australasian Cardiovascular Nursing College (@ACNCconference). These chats will be an opportunity to engage with other associations and societies around areas of common interest.

Email: lis.neubeck@sydney.edu.au
Twitter: @lisneubeck

Calendar of Events

March 28th	Country Health day, Adelaide Pavilion on the Park
April 26th	SACRA Education day and AGM, Hampstead Rehabilitation Centre
May 4th-10th	Heart Week
May 4th-7th	World Congress of Cardiology, Melbourne
May 9th	CRA NSW/ACT "Beats in the Bush", Goulbourn
Aug 21st-23rd	ACRA Conference "Sex, Drugs & Rock 'n' Roll", Brighton Le Sands, Sydney