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ACRA Newsletter

AUSTRALIAN CARDIOVASCULAR HEALTH AND REHABILITATION ASSOCIATION

September 2014

2014 Conference

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

Another ACRA conference has been and gone – and what a great event it was! This edition of your newsletter is specific to the conference and aspects of it. Hopefully those of you unable to attend will get a sense of the variety of presentations and speakers as well as the social side. Please also see the convenors' report on the conference.
It is very difficult to select an individual highlight – but for me I will never look at another male with a beer gut without thinking of it as his "verandah over the tool shed"! Thanks Rosie King – a lively and entertaining opening keynote speaker. There were diverse presentations from new and established researchers and clinicians including those in the prize sections. Award winners have provided summaries or abstracts of their presentations published in this edition. Congratulations to the winners – Jan Cameron (Research), Sasha Bennett (Clinical), Jo Crittenden (poster) and Bridget Abel (Physical Activity and People's Choice). We will include summaries from some of the other presenters in these sections in the next newsletter. Please excuse the dress of our esteemed president in presenting the awards – he had just been playing the role of Dr Nick in the great debate (you can read his contribution elsewhere in this newsletter).

Jane Kerr was a most worthy winner of the Alan Goble Distinguished Service Award. She has had a long standing association with the ACRA having been at the meeting in Broadbeach in 1989 when this organisation was 'born'. I have known Jane for many of those years and offer my personal hearty congratulations on this recognition by her peers and cardiac rehabilitation colleagues across the country. Her nomination was announced by the CRA/ACT president Dawn McIvor.

We also belatedly acknowledged the contribution of the previous ACRA president, Sindy Millington, with a presentation at the conference dinner. Thanks Sindy for all your hard work for, and commitment to, the Association while fulfilling that role. Our very best wishes as you continue to undertake your PhD with slightly less pressure!

I trust you enjoy this newsletter. It is missing some of the regular features as I've focussed on the conference. These will return in the next edition.
Happy re-habbing
Sue Sanderson

Contents

President's Corner

What has ACRA done for its members?

This very question was asked of me at the recent ACRA conference held in Sydney. At the time, I must admit I found it difficult to answer. I resolved to make this question the focus of my report for this newsletter.

2014 and 2015 Conference

Firstly, the 2014 conference. Each year this event is a significant achievement for our association. It is a meeting for the sharing of recent research and clinical studies in cardiovascular health and rehabilitation. This year, the organising committee, backed by the ACRA Executive Management Committee sought to make several improvements to the organisation and running of this conference. Achievements included: significant reduction in registration fees, the highest number of delegates attending for many years, engagement of a new Professional Conference Organiser (The Association Specialists) and a very full, interesting and thought provoking scientific program. The engagement of a new PCO should not be overlooked as a considerable achievement. Credit to the ACRA 2014 organising and scientific committees and TAS for a wonderful conference.

Organisation of the 2015 conference is already underway. Next year will see ACRA re-align with the CSANZ schedule for what should be a massive week of information sharing and networking. The extended ACRA EMC will be organising this conference, which will be held in Melbourne. This will be our 25th Annual Scientific Meeting and will take on a Silver Anniversary theme. Throughout this conference we will aim to look at the past, present and future of cardiovascular disease rehabilitation and management. Collaboration with CSANZ has commenced to ensure a mutually beneficial outcome for our members and greater potential for members to attend both events. This may include significant reduction in registration fees for delegates of both events. Our collaboration will culminate in a "shared" symposium between conferences. I hope to see as many members as possible in Melbourne, August 2015.

Core Components

One of the key deliverables I identified early for my term as President was for ACRA to produce an up to date document identifying the Core Components of cardiovascular disease secondary prevention and cardiac rehabilitation in Australia. I am pleased to say that the writing team, composing ACRA EMC members, invited members with academic expertise, and a Heart Foundation representative finalised this document earlier this month. Earlier this year ACRA was invited to submit a piece for consideration in an upcoming edition of Heart, Lung and Circulation. This core components document has now been submitted to HL&C for review. The authors recognise the limitations of this type of document, and decided during the development process that a further document would need to be developed as an extension of this initial document, to provide a greater depth of information. Work on the second stage of this document development will commence after confirmation of publication of our initial document. My goal for this next stage will be to recruit interested members and external individuals to be involved in the development of a guidelines type of document, with the initial document at its core. Members will be notified as soon as I know more about the progress of this initial document with HL&C. Following this I will call for nominations from those interested in developing the next stage of this document. Thank you to the writing team; Lis Neubeck, Robyn Clark, Kim Gray, Cate Ferry, Jenny Finan, Sue Sanderson and Tom Briffa.

Administrative Services

Perhaps the biggest challenge for ACRA this year has been the transition to an external company for administrative services. ACRA signed a one-year contract with Professional Association Management Services (PAMS) in January. ➤

This came after an extended period of recruitment following the departure of Nicole Banks from our Executive Officer role. I must admit that this process was a new experience for me and is something we could have done better and more quickly. Unfortunately the first half of this year proved challenging for ACRA and PAMS as we adjusted to different methods of reporting, communication strategies and generally going about business a different way. Going from a situation where an individual essentially knew all there was to know about the running of our business to a company who, while very experienced in association management, did not understand our business needs, has proved time consuming for me and the committee.

At the time of writing this report, the ACRA EMC is exploring our options for next year which may include expanding our arrangement with TAS to provide administrative services along with the current agreement to provide conference organising services. Members will be notified of our decision in the coming months.

Collaboration

ACRA representatives continue to represent its members in numerous forums. Our involvement is important as this representation gives a voice for our members and ultimately advocates for the benefit of the clinicians and researchers in our field. ACRA continues to liaise very closely with the Heart Foundation and the Heart Research Centre. While our relationship with HRC is somewhat historic, it continues to be relevant as a leading provider of education and training for practitioners. Our relationship with the Heart Foundation is as strong as ever with multiple collaborative efforts at national level and more at state level also. Some significant projects that ACRA is currently collaborating with the NHF include:

Updating of NHF/CSANZ guidelines for treatment of Acute Coronary Syndrome

- ACRA was invited to provide a rep for this important body of work, for which I volunteered and was endorsed by the ACRA EMC. Importantly, this version of the guidelines will include a more significant emphasis on Secondary Prevention than in previous editions. Tom Briffa and I co-chair the SP sub-committee which includes cardiology, general practice and nursing reps. ACRA newsletter editor and life member, Sue Sanderson will provide some valuable input in this process.

Development of an online CR services map

- A project to develop an easy to use online CR services map was identified by the NHF as a priority last year. Over the past twelve months I have been working with Michelle Stewart (NHF) to develop this resource. The goal is to have a "Google maps" style application where clinicians or patients may be able to search for services based on their location. A small amount of information will be available on the initial user interface with links to more detailed information on service capabilities. Through this process, each state was requested to update their directories so that the most up to date information could be put into this application. These updated directories are currently available on the ACRA website while the online map continues to be developed. Thank you to the state reps who worked to update these directories, it is a time consuming activity.

International perspective

ACRA reps continue to liaise with international groups with a goal of improving the delivery of secondary prevention and cardiac rehabilitation. These roles are not onerous and ensure we are considered in the international landscape. Our ideas and experiences are valuable in the promotion of CR worldwide. Specifically, models of care developed in Australia for low-resource services are being considered for low and middle income countries as a means of delivering CR to patients in these countries.

EMC activities

- A couple of notable activities that the EMC has been working on over the past six months include our endorsement policy and the website. I do wish that I had better news about the website but all I can say at this point is that it has been identified as a priority area and work continues currently towards the production of a new website. I am hopeful of the development of a new website by the end of this calendar year.

- The ACRA endorsement policy was identified as something that needed to be addressed at our June face to face meeting. I get numerous requests from many individuals and organisations requesting "ACRA support or endorsement". Some of these are quite reasonable but others are not suitable. Our previous policy was quite outdated and a small sub committee reviewed this policy following our recent meeting. The current policy is now available on the ACRA website. Since it's completion we have had two requests that members will hear about in the future. These include a survey of CR services that provide CPR training to its participants and a survey of the exercise program capabilities of CR services. Surveys endorsed by ACRA will include the line, "*This survey is endorsed by ACRA*" and the ACRA logo.

Benefits of ACRA membership

As always I need to remind members of the continued benefits of remaining a member of ACRA. Firstly, you are ACRA. The members are what make ACRA what it is. Without you the association fails to exist. Please be as involved as you can within the demands of your work role and other commitments. I am open to feedback at any time, good and bad. The ACRA EMC is made up of people that are members of the association first, and your representatives, second. We are all doing what we think is in the best interest of our association.

The conference was a fantastic event and one that will be memorable for quite some time. The ability to attend these events with a significantly reduced registration fee is a right of membership that we will continue to maintain. We are constantly looking for "add-ons" to membership that (1), cost the member nothing and (2) costs ACRA minimal outlay as well. ACRA seeks to provide low and no cost professional development activities, namely webinars for its members on a regular basis. Two have been held this year so far with good participation. ACRA continues to have subscription access for all members to the journal, *European Journal of Preventive Cardiology*. I encourage everyone to access this resource for up to date research. As always I am open to suggestions on how your membership may be improved.

Name of the association

By now all members have had the opportunity to respond to the survey sent several months ago requesting feedback on the name of the association. This survey was to gauge a greater input from the membership than the small numbers at last year's conference who requested we look at our name. While a majority of respondents were agreeable to a change, the heartfelt comments of those not in favour of change was too great a reason to not change the name. This sentiment was endorsed by members at the Member's forum at at this year's conference. At this point in time there will be no change to the name of association. We will continue to be the Australian Cardiovascular Health and Rehabilitation Association.

As always I welcome the input of members to the continued management of ACRA business. Please get in touch and advise if there is something you wish to see addressed.

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

President-elect

At the AGM held during the conference, Lis Neubeck was unanimously elected as Vice-President/ President-elect of ACRA. She will work closely with Steve during the next 12 months and step into the President role at the next AGM in Melbourne. Congratulations Lis.

ACRA 2014 "SEX, DRUGS, ROCK AND ROLL" IN SYDNEY

The ACRA family came to Sydney for the 24th annual scientific meeting held at the Novotel Brighton le Sands. 190 delegates attended what is widely regarded as one of ACRA's best ever conferences. Proceedings commenced on the Thursday with an atrial fibrillation workshop funded by BMS Pfizer.

Prash Sanders, Sasha Bennet and Lis Neubeck, took us through the management of AF including risk prevention of AF through risk factor modification , medication for controlling rate, rhythm and reducing the risk of stoke, finally followed by some patient case studies to assist our understanding. A great workshop, looking forward to the follow on in Sydney in the near future.

The member's forum was an opportunity for member's to meet the EMC and discuss any issues, concerns, in regard to ACRA and its running. The president shares more of this information in his report. This was followed by the first social function, the welcome reception - an opportunity to meet new and old friends, listen to the moderated posters presentation's and get excited for the conference opening proper the next day.

Following a walk on the beach, the NHF held a breakfast meeting with a panel discussing how to manage Media messages. This was an excellent way of understanding how health messages are highlighted in the media. The process for the publication of the message and how we as health professionals can learn to understand fact from fiction.

The conference then was opened with a welcome to country, and as per tradition a story of a patient experience. Chris Russell described his AMI and his subsequent lifestyle changes and management since. This was followed by sex and food! Dr Rosie King gave the opening address discussing sex, sexuality and relationships in cardiovascular disease.

Dr Rosie King.

Followed by Susie Burrell with a common sense approach to managing diet and losing weight.

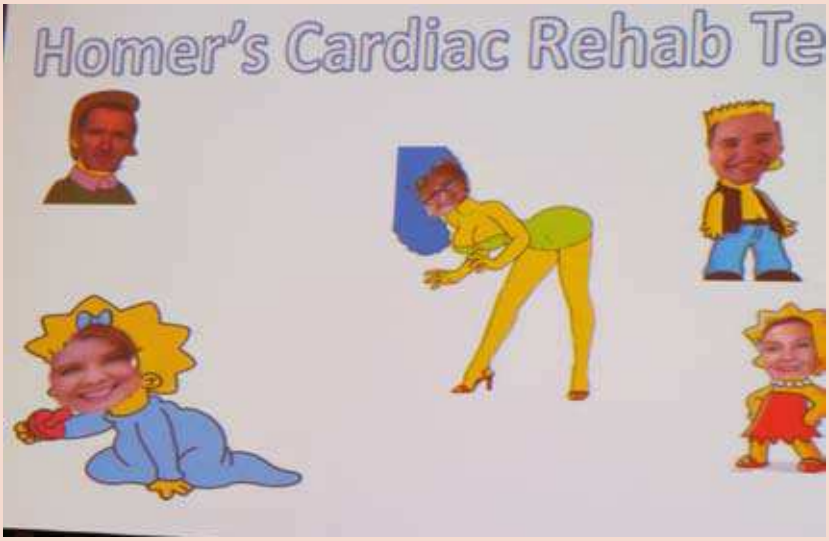
The rest of the morning was free papers with varied programs from our research prize session and concurrent sessions covering heart failure, research and psychosocial aspects of cardiovascular care. Following lunch we had a fascinating presentation from Dr Gemma Figtree and Dr Claire Lawley on chemotherapy and the heart. Finally Rachel Wotton described her experience and role as a sex worker for people with disabilities, giving us an insight into the importance of sex and sexuality for our patients. This theme was explored further in the sex, cardiovascular disease ad co-morbidities workshop with Rachel and Dr Bill Lynch a urologist from Sydney. An interesting mix of the medical and emotional to sex and sexuality. Other workshops available were technology and innovation, and cardiac rehab 101 introduction to exercise participation for CR. Phew this was just day 1 and the conference dinner to attend.

ACRA member's embraced the theme of rock and roll and were dressed to impress. Best dressed on the night went to Eliza Woodruffe (The first lady) and Sergeant Pepper. This was followed by ➤

Best dressed award – Eliza Woodruffe (The first lady) and Sergeant Pepper.

some rocking and rolling with some live entertainment - a great night for all.

The following morning there was some bleary eyes, so it was quite fitting that Chris Semsarian was presenting caffeine, drugs and heart. I will never have an energy drink again. This was followed by an interesting presentation from Lee Stoner on non-invasive measures for cardiovascular disease. Free papers followed with the clinical prize session and concurrent sessions on physical activity, nutrition and service delivery. The afternoon led us into workshops on Cardiac Rehabilitation, advanced exercise prescription from the frail to the fit, cultural safety issues and Tai chi which invigorated us for the great debate "Rehab for Homer Simpson - Home Telehealth versus Traditional outpatient. Despite some fancy outfits the traditional



outpatient group were victors, however in reality as chair Lis Neubeck pointed out neither was the winner as the choice would actually be Homer's! Following the prize session was a final word from a patient, Tanya Hall and her personal reflection and experience. The conference closed and the delegates left, weary but invigorated to advance their clinical practice with knowledge gained, new friends made and eager anticipation for ACRA 2015 the 25th anniversary on the 10th to 13th August next year.

Thank you to the organising and scientific committees, the Association Specialist's, the EMC and most importantly the delegates for making ACRA 2014 simply the best!

Dawn McIvor
Conference Convenor

Congratulations to the organising committee chairs, Dawn McIvor and Lis Neubeck, and the scientific committee chairs, Ritin Fernandez and Robyn Gallagher on a fantastic conference. The feedback that has been shared by some in this newsletter supports this as a most successful and enjoyable event.

Ed.

Dawn McIvor and Lis Neubeck.

Ritin Fernandez and Robyn Gallagher.

The Alan Goble Distinguished Service Award Nomination

Jane Kerr, MA (Psychology), RN, Cert. Coronary Care

CVD Coordinator, Cardiac Stream Coordinator, Vascular Network Manager, Hunter New England Health, was unanimously nominated by the CRA NSW/ACT board.

In their nomination statement the following was expressed by her colleagues:

Jane is an exceptional member of ACRA, having contributed in many ways over her years of service. She has served on local, state and national committees and is highly respected for her knowledge and dedication. Jane has constantly championed the need to bridge the gap re equity of access to CR and cardiovascular care for aboriginal people and those who live in rural areas, resulting in significant achievements and improvements in her local area for these patient groups. Jane has mentored and supported many clinicians in cardiac rehabilitation and is a strong advocate and voice for rural CR clinicians across NSW.

Jane is a highly committed individual, with strong professional values and a superior knowledge of CR and the systems which affect the services we deliver. She is continuously striving for the best possible standards for herself and others. Jane is an advocate for the profession and not afraid to stand up for her beliefs and values if she sees they benefit the patient and/or their community.

Jane is past president of CRA, and has championed the role of cardiac rehabilitation in Australia. She is a strong advocate for evidence based service development with the patient at the centre.

Jane is a very positive role model. She has mentored junior clinicians and fostered a warm and welcoming environment in CRA. She is highly regarded for her work in promoting CR across NSW and nationally. Jane works tirelessly to encourage new members to become part of ACRA, and supports and encourages them to be active participants within the organisation. Several members of the current CRA NSW ACT board are there through Jane encouraging them to get involved with ACRA.

Her exceptional commitment to the development and promotion of cardiac rehabilitation makes her an outstanding candidate for the Alan Goble Distinguished Service Award.

Jane Kerr - My Story in brief

I first came to cardiac rehabilitation in 1985 providing inpatient rehab on the cardiology ward at Royal North Shore Hospital. As my interest and capacity to network with colleagues grew I became one of a small team within NSW and across Australia actively working towards the establishment of a professional organisation to support the development of CR in its own right. The fundamental principle was to improve patient access to effective and evidence based rehabilitation.

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

Professionally I have moved away from direct patient care but I now sit in my office and still feel a great sense of satisfaction listening to the participants in rehab program in Tamworth that I first got going back in 1995. I can proudly look back on services that I established in both metropolitan and rural contexts to enable patient access to a service that could save their life. My role these days, however, is much more focused on ensuring adherence to evidence based best practice and measuring and responding to the outcomes that reflect an effective quality patient centred service across the chronic disease spectrum.

Outside of my work I am the luckiest girl as I get to go home to 2 gorgeous teenage boys and their farmer father and do my other very rewarding job running a 1400 acre farm with my husband.

I would also like to add that the personal support I have received from the Association over the past few years has also been an added bonus for which I am very grateful.

Best research award recipient - Jan Cameron

Sensitivity and specificity of a five minute cognitive screen in heart failure patients

J Cameron[1], R Gallagher[2], SJ Pressler[3], CF Ski1, A Sullivan[4], R Burke[4], S Hales[4], G Tofler[4], DR Thompson[1]

[1]Cardiovascular Research Centre, Australian Catholic University, Melbourne, [2] Charles Perkins Centre, University of Sydney, Australia, [3]School of Nursing, Ann Arbor, University of Michigan , Michigan, United States, [4]Royal North Shore MACARF program , Sydney, Australia

Introduction: Up to 75% of heart failure (HF) patients exhibit cognitive dysfunction on screening.

Objective: To examine whether three items from the Montreal Cognitive Assessment (MoCA) have adequate sensitivity (>85%) and specificity (≥70%) to be recommended as a five minute cognitive screen in HF patients.

Methods: The MoCA was administered to HF patients (n=221) enrolled in one disease management program in Sydney, and one in Melbourne. The five minute screen uses three MoCA items (verbal fluency, delayed recall and orientation) with possible scores of 1 to 12 (lower scores indicate poorer cognitive function). Receiver operator characteristics (ROC) were constructed with MoCA <26 as the positive test, to determine the sensitivity and specificity and appropriate cut-score of the five minute cognitive screen.

Results: In the elderly sample (M=76 years, SD=12.3) of predominately male (66%) HF patients, 134 (61%) were identified as having possible cognitive dysfunction. Actual scores on the five minute screen ranged from 3 to 11 (x 8.56, SD 1.8) and as expected were strongly correlated with overall MoCA score (r=0.72, p<0.001) and MoCA cut-off score <26 (r=0.63, p<0.01). A cut-off score ≤9 on the 5-minute cognitive screen provided 89% sensitivity and 70% specificity, and the area under the ROC curve was good (0.88, p<0.01, 95% CI 0.83 to 0.92).

Conclusion: This preliminary evaluation of the three recommended items from the MoCA (verbal fluency, delayed recall and orientation) indicated that a cut-off score ≤9, had adequate sensitivity and specificity to be used as a five minute screen to detect possible cognitive dysfunction in HF patients.

Implications for clinical practice: It should be noted that this is a screening and not a formal diagnosis for cognitive impairment. In the event that a HF patient scores ≤9, it would suggest that further assessment may be warranted. First and foremost this would include asking the patient, or their carer, if they have noticed any worrisome changes in their memory in recent months and if this is the case then administering the full MoCA might be the considered next. However, further evaluation of the test accuracy of the three MoCA items (verbal fluency, delayed recall and orientation) need to be evaluated in broader cardiovascular disease populations before recommendations can be made about appropriate cut-off scores in screening for cognitive dysfunction in these populations.

Best Physical Activity paper and People's choice awards - Bridget Abell

"Reducing mortality with exercise-based cardiac rehabilitation: Is it what patients do well or how well they stick with it?"

Cardiac rehabilitation provides significant benefit to patients with coronary heart disease however. there is significant variation between individual interventions in terms of program characteristics. Individual components of the intervention such as exercise intensity, setting or duration may provide different relative contributions to the clinical outcomes observed. My study aimed to examine published evidence about cardiac rehabilitation interventions to determine the influence of individual components on clinical outcomes.

Methods:

A systematic search of multiple databases and additional sources was used to identify all trials of exercise-based cardiac rehabilitation versus usual care, reporting on the clinical outcomes of all-cause and cardiovascular mortality. Data describing both clinical outcomes and intervention characteristics was extracted from all publications. Trial authors were also contacted via email to provide missing intervention details. Meta-analysis and meta-regression techniques were then used to examine the relative contribution of individual components such as provider, duration and exercise dose (intensity, frequency, time) on overall intervention outcome.

Results:

Fifty-eight studies were identified, evaluating seventy-five individual cardiac rehabilitation interventions which differed markedly in terms of individual program characteristics. These were published between 1975 and 2013 and included intervention such as home-based walking programs, high-intensity interval training, case-management and more traditional centre based models. Meta-regression did not identify any particular intervention component which significantly influenced mortality outcomes, although several approached significance (program duration for all-cause mortality; session time for cardiovascular mortality). Analysis was limited however by substantial missing information about the characteristics of individual programs. For studies which reported on the compliance of participants with the prescribed program, the level of compliance did however significantly predict the risk of subsequent all-cause and cardiovascular mortality. Where participants were able to maintain moderate or high levels of compliance (versus low levels of compliance) for the duration of an intervention, the relative risk of mortality was reduced by almost 50% ($p<0.05$).

Conclusion:

Current research does not provide evidence that any one cardiac rehabilitation program characteristic is more influential in effecting subsequent mortality, although this analysis is limited by missing intervention descriptions. Findings suggest it may be more important to increase participant compliance regardless of the characteristics of the individual program.

Best Clinical Paper award winner Sasha Bennett

Promoting quality use of medicines for acute coronary syndrome and heart failure at discharge: National indicators for hospitals

Alexandra (Sasha) Bennett, Katie Kerr, Gillian Sharratt
NSW Therapeutic Advisory Group (TAG)

Quality use of medicines (QUM) describes the wise selection of management options, the appropriate choice of medicines if a medicine is considered necessary, and the safe and effective use of medicines. (1) Unfortunately there are gaps in its application. For example, it is well known that there is a gap in the prescription of evidence-based medicines in acute coronary syndromes and heart failure. This was recently illustrated in the ACS Snapshot study in 2013. (3) Preliminary results of Heart Failure (HF) Snapshot in NSW hospitals last year also indicate gaps in the prescription of HF guideline recommended medicines. (4)

In 2007, two cardiology indicators targeting the discharge prescription of evidence-based medicines in patients with ACS or HF were published as part of a set of 30 validated QUM indicators. (5) An indicator usage survey conducted in 2011 showed poor uptake of the cardiology indicators unlike many of the other QUM indicators.

QUM Indicator 5.1: *Percentage of patients with acute coronary syndrome that are prescribed appropriate medications at discharge* and QUM Indicator 5.2: *Percentage of patients with systolic heart failure that are prescribed appropriate medications at discharge* have recently been updated by ensuring inclusion of current guideline recommendations and field testing in hospitals to ensure clarity, measurability, relevancy and usefulness. Data collection tools have been developed, which will automatically calculate the indicator results, provide rates of use of individual medicines, the reasons for non-prescription and a breakdown according to the specific ACS diagnosis or HF type.

The two cardiology indicators are now in a set of thirty-seven National QUM indicators. Although the indicators have only been tested at hospital discharge, it is likely that they could be applied to discharge from cardiac rehabilitation or community HF programs providing evidence for the impact of these programs. Each indicator states its purpose, the background and evidence, key definitions, how the indicator is calculated, its limitations and interpretation and reference to the National Safety and Quality Health Service Standards Accreditation action items (6) that will be met by using the indicator. There is also accompanying guidance about how to optimise the use of the indicators including establishment of a local multidisciplinary advisory group of stakeholders who can provide advice with respect to the audit process and quality improvement strategy.

The National QUM Indicators for Australian Hospitals (7) will be published at the end of September 2014 and available on the NSW TAG website, http://www.ciap.health.nsw.gov.au/nswtag and the Australian Commission on Safety and Quality in Health Care website, www.safetyandquality.gov.au . Use of these QUM indicators will assist hospitals measure their performance, inform minimum data sets, undertake quality improvement projects, assist in accreditation activities and have potential for benchmarking. As we seek to reduce clinical variation and optimise adherence to evidence-based recommendations, these indicators will help us monitor the effectiveness of our quality improvement activities and ultimately improve patient outcomes.

References:

1. The National Strategy for Quality Use of Medicines. Commonwealth of Australia, 2002

2. National Medicines Policy. Department of Health and Ageing, Commonwealth of Australia, 2000.

3. Chew D, French J, Briffa TG, et al. Acute Coronary Syndrome care across Australia and New Zealand: the SNAPSHOT ACS study. Med J Aust 2013; 199:1-7.

4. P. Newton and P Macdonald. Heart Failure Snapshot Presentation. World Congress of Cardiology, Melbourne, May, 2014.

5. NSW Therapeutic Advisory Group. Indicators for the Quality Use of Medicines in Australian Hospitals. NSW TAG, Sydney, 2007.

6. Australian Commission on Safety and Quality in Health Care. National Safety and Quality Health Service Standards. ACSQHC, Sydney 2012.

7. Australian Commission on Safety and Quality in Health Care and NSW TAG Inc. National Quality Use of Medicine Indicators for Australian Hospitals. ACSQHC, Sydney, 2014.

Best poster award winner - Jo Crittenden

Perceived barriers and facilitators to screening for depression in an Coronary Care Unit

Introduction

Although it is recommended that formal screening procedures for depression be integrated into clinical practice (1) this remains a challenge with little guidance available on how to translate the evidence into practice. This qualitative research study explored the barriers and facilitators to depression screening in a CCU as perceived by medical and nursing staff.

Methods

Ten members of clinical staff with varying professional roles and experience were recruited to the study. Data were obtained from ten semi-structured, individual interviews. A Thematic Framework was used to analyze the qualitative data.

Results

In total 23 themes and sub-themes were identified from the data. Interpretation of the data resulted in the identification of 12 major issues related to depression screening in the CCU. Issues related to current practice included a lack of a systematic approach to identifying depression and poor access to specialized psychiatric support services. Major barriers to screening included perceived time constraints, staff's lack of mental health related skills and lack of specific knowledge related to depression in cardiac patients. Staff identified four requirements for change: that screening must lead to improved patient outcomes and a management plan; that a strong evidence base was required to underpin change; further staff education was required; a change facilitator was essential.

Quotations in support of results:

- ***Lack of psychiatric liaison support.***

"…unless they are so depressed they are a threat to themselves…they're going to abscond…we probably wouldn't get psych (psychiatric liaison services) involved…we certainly don't have ready access to an inpatient psychologist… not in that time frame so basically it gets ignored" (Cardiologist).

- ***Time constraints.***

"… the length of stay now is so short and we concentrate so much on getting the medical stuff sorted out and some education that we …I don't think that we make any effort at all into it" (Cardiologist).

- ***Perceived lack of mental health related skills.***

"I previously had a patient on the telephone that was threatening to do harm and I have no ability to cope with that…. I certainly don't have the skills, I think, to deal with that sort of reaction" (Cardiac Rehab. Nurse).

- ***Perceived lack of knowledge regarding depression in cardiac patients***

"…part of the barriers I think is education as to why you are doing it, what the importance is. Probably we don't learn enough about depression and its relation to ACS so we don't think about it and we don't probably perceive it as important as it is… the 'clinical importance', getting the education out there is an important thing" (Consultant).

Conclusion

Important insights into the context of practice can be gained from qualitative data collected at individual hospitals. The findings from this study have informed further qualitative research being conducted in the department leading to an integrated model of depression screening and management.

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WELCOME RECEPTION

ACRA 2014 CONFERENCE REFLECTIONS

Sex, Drugs and Rock n Roll was certainly the agenda at the ACRA 2014 Conference. As only my second ACRA Conference I found this year's theme to be most enlightening and educational in terms of addressing the issues of sex and drugs with cardiac patients. The 2014 Conference was over in the blink of an eye and in a good way, there was no room for yawning or napping due mostly to the 40minute Keynote Speaker sessions which I found to be very interesting and entertaining in terms of both the individual speakers and content of presentations. For me personally the Conference ended on a high note with the Advanced Exercise Prescription session providing some new ideas for exercise prescription for varied cardiac conditions and patient types. In conclusion I would add comment to the fact that this year's conference dinner was a highly entertaining and relaxing evening with plenty of laughter and a definite rock n roll theme.

Jess Auer Qld.

QCRA Well Represented at ACRA Conference

It was my great please to attend the ACRA Conference in Sydney in August. A fascinating meeting and a credit to the Organising and Scientific Committees. Being a little parochial, I really enjoyed catching up with the many Queensland delegates and presenters. Among the Queensland presenters there were:

- Bridget Abell (Bond Uni-CREBP) who looked at, amongst other issues, how well CR research was reported in the literature and found there was a real need for improvement in this area.
- Helen Callum and Greg McDougall (Wesley Hospital- Heartwise CR) found cognitive behavioural therapy based counselling was more effective with females than males in achieving lifestyle changes, and identified a need to explore this further.
- Annabelle Hickey (QLD Heart Failure Service) reported on how HEARTOnline continues to go from strength to strength, with over 3000 hits per month and has plans to refine the content and improve site navigation.
- Melanie McAndrew (West Moreton HHS, Ipswich) presented on how using a risk formulae could be used to identify high risk clients and reduce their possible readmission.
- Debora Snow and Kathy O'Donnell (Gold Coast HHS) were encouraged by the significant improvements in older clients attending their program and felt that this had implications for broadening referrals.
- Marlien Varnfield (Aust e-Health Research Centre, CSIRO) presented on a home-based CR program delivered using smart phone technology and found it well received and offered great potential for those not attending centre-based CR.
- Steve Woodruffe (West Moreton HHS, Ipswich) presented on how they found that attendance at outpatient CR was heavily influenced by the recommendations of inpatient clinicians.

Well done to everyone and we look forward to seeing equally good participation from Queensland at next year's conference in Melbourne.

Paul Camp

SA Conference perspective

Hello Members,

I and several other delegates from SA recently returned from the 24th annual ACRA Conference which was held in Sydney. The theme was Sex, Drugs and Rock n Roll, and as the name implies, it was going to be very interesting how this would be linked with cardiovascular management and prevention, but this was done brilliantly.

It is an understatement to state how good the conference was. The conference commenced with an Atrial Fibrillation workshop supported by a research presentation by Professor Prash Sanders who discussed the Arrest AF study that focused on prevention, pathophysiology ➤

and treatment of AF. It was particularly interesting to see the importance of risk factor management that is reflective of the same group risk factors of cardiovascular disease.

We were also delighted to have the entertaining and knowledgeable Dr Rosie King, who facilitated more than enough visual images in our thoughts of the elderly "going at it", and the more sombre, silent and somewhat embarrassing patient issue of sexual dysfunction. She discussed many ways of discussing impotence and facilitating the conversations with patients in relation to returning to sexual activity following a cardiac event. She suggested a few great catch phrases "The more you smoke the less you poke" and "What is bad for your heart is bad for your penis".

We were also challenged and some delegates were a little uncomfortable as we heard from Rachel Wotton, a sex worker who openly discussed sex, her experiences as a sex worker, including the benefits of including sex into a persons' holistic recovery, especially those who have a pre-existent disability.

Susie Burrell, a well-known and respected dietician highlighted some of the contemporary diet fads in relation to cardiovascular disease. In light of the recent media attention it was very interesting to hear her thoughts on saturated fats. Her take home message was moderation, and the biggest issue we need to address is portion size.

Dr Chris Semsarian provided great insight in his presentation "Caffeine, drugs and the heart" as we were all gulping down our early morning coffee. He discussed the growing evidence that excess caffeine and other additives from energy drinks can have serious health risks and trigger cardiac events such as long QT syndrome or Brugada syndrome for those that are predisposed. He called for greater community awareness especially addressing the use of these energy drinks for children and adolescents.

Craig Cheetham's session was another standout, discussing "Cardiac Rehabilitation: Advanced exercise prescription from the frail to the fit" and was done in a very interactive way with scenarios that we were able to work through.

ACRA news: We had our members' forum which gave our members opportunity to discuss the association's activities and the majority of the time focussed on the change of name debate. This generated robust discussion, however the outcome is that despite a majority vote for our name change there was insufficient votes received to represent the majority of the membership, and therefore there will be NO name change at this time. This forum did highlight some more pressing issues i.e. the website upgrade which we will be reviewing in the very near future.

We also attended the Sex drugs and Rock n Roll dinner which was so much fun seeing the effort of those who attended dressing in theme. I had the pleasure of judging the best outfits, and SA unbiasedly fared very well, Sindy Millington & Sue Treadwell in their rock n roll dresses, and the best in my opinion was 2nd place winner: Sabine Drilling who dressed as Sgt Pepper and even had the accent down pat, but the winner was Eliza Woodruffe ("first lady" wife of Stephen Woodruffe – President ACRA) who looked amazing in her rock n roll outfit complete with hairstyle of the era.

I would thoroughly recommend our members attend our next years ACRA Conference which will be held in Melbourne.

Save the Date: 10-15th August 2015

This will also overlap by a day so those who wish to attend CZANZ could attend both.

SACRA DIARY DATES:

Wednesday 17th September – SACRA ordinary meeting, Heart Foundation Office, 155 Hutt St Adelaide 4.30pm–6.30pm

Saturday 18th October – SACRA education Seminar – Hampstead Centre 9.15am–12.00pm

Guest Speakers include - Dr John Beltrame, Mr James Edwards.

Wednesday 12th November – World Diabetes Seminar, Wakefield Hosptial

November Date TBA – SACRA ordinary meeting followed by Christmas Dinner.

Dianna Lynch

"Sex, Drugs and Rock n Roll". It had it all. This year at the ACRA Conference there was much talk about sex, interesting discussions about the affects of various drugs on the heart and there was 60's rock n roll, with dancing a plenty. A departure from many of the traditional topics was a welcome surprise and overall a thoroughly entertaining and thought provoking conference that the organisers should be proud of.

There were many highlights. I shall just mention a few.

Chris Russell an Agricultural Scientist, well known for his role as judge in "The New Inventors" on the ABC, gave a humorous and interesting account his experience following a heart attack on 2004. I never get sick of hearing these kind personal experiences. It reminds us of why we are all doing what we do.

Rosie King wasn't feeling too great on the day with a cold, but that didn't stop her from giving a very informative keynote presentation about sexuality, sexual relationships and cardiovascular disease. She talked about the association between erectile dysfunction and cardiovascular disease and highlighted the importance of allowing patients the opportunity to discuss sexual function and resumption of sex following a cardiac event. Rosie's frank approach was refreshing, with many anecdotes and just the right amount of humour. She very successfully challenged the notion that old people don't have sex.

Susie Burrell, Dietician, gave the next keynote, discussing nutrition, contemporary diets and cardiovascular disease. Susie is a great speaker. She gave very practical information and examples of diets that she recommends in her practice and discussed some of the diet trends that are getting a lot of traction publicly at the moment such as the paleo and low sugar diets. Moments later we found ourselves nervously circling the morning tea table laden with danish pastries and muffins.

Later that day there was a fantastic presentation from Rachel Wotton, a sex worker who featured in the SBS documentary "Scarlet Road" and who advocates actively for the rights of people with disabilities. Wow! What an amazing woman and whilst some of it was a little confronting it was inspiring to hear a woman talk so compassionately, respectfully and openly about the sexual needs of the elderly and the disabled.

The highlight of day two was Dr Chris Semsarian's very entertaining and informative presentation on caffeine, drugs and the heart. It was largely about the very popular energy drinks that are being increasingly consumed by children and teenagers and carry with them a risk of sudden cardiac death. He shared his thoughts about the need for regulation of these drinks, including access to children and labelling. He cited a number of reports where these drinks have triggered cardiac events, and even unmask underlying disorders such as long QT and Brugada syndrome.

I think the organisers got it right. It was a great mix of the new, the usual and the funny.

Shelley McRae
Travel Grant Recipient.

BMS/Pfizer Atrial Fibrillation Workshop

Professor Prash Sanders
Royal Adelaide Hospital, SA, Australia

Sasha Bennett Executive Officer, NSW Therapeutic Advisory Group, Darlinghurst, NSW, Australia

Atrial Fibrillation is rapidly overtaking other cardiovascular conditions as the leading cause of rehospitalisation and rates are predicted to increase exponentially. New treatments and an increased awareness of AF as a lifestyle disease, has made cardiac rehabilitation a highly appropriate place for management of people with AF.

There are many challenges to providing care to AF patients. There is a rapid increase in the prevalence of AF associated with an aging population, regular updates in international guidelines for care but lack of local guidelines and ongoing changes in the availability of medications including stroke prevention medications.

One of the most important challenges is that AF is seen as merely an inconvenience and not a serious health

problem potentially resulting in stroke, loss of function and increased anxiety. There is a lifetime risk of developing AF of 1:4 in those aged over 40 years. In AF patients there is a 5 times risk of stroke, 2 times risk of death and overall reduced quality of life. There is a need for an individual risk of stroke assessment into low, moderate and high risk stratification. There are the widely used assessment scores - ChADS2 and HAS-BLED. These tools enable risk assessment for stroke risk and for bleeding risk.

AF is a very common often asymptomatic condition that can present for the first time as a devastating stroke. The decision about appropriate stroke thromboprophylaxis requires individual assessment of stroke risk and risk of bleeding on such therapy. Use of risk schemas can help to inform the choice of antithrombotic agents and the management strategy. Discussion of these risks with the patient is essential and regular reviews of the risk profiles.

Recent consensus conference, Royal college of Physicians of Edinburgh 2012: Key Recommendations:

- Detection of AF must be improved; a national screening program should be introduced;
- Uptake of oral anti-coagulation must be increased and methods of engaging patients in their AF management should be improved;
- Aspirin should not be used for stroke prevention in AF;
- In relation to rate/rhythm control for AF, relief of symptoms should be the goal of treatment;
- All AF patients should have a formal stroke risk assessment with a scoring tool e.g.CHA2DS2-VASc and HAS-BLED.

Sexuality, Sexual relationships and Cardiovascular Disease

Dr Rosie King Lecturer, University NSW, Randwick, NSW, Australia

Sexual relationships are a major quality of life issue for CVD patients and their partner. Fear of precipitating an infarct reduces the frequency and quality of sexual relations. Up to 60% cease sexual relations.

Ageism is an assumption that older people are not interested in sex.

Following a Myocardial Infarction 40% of male patients experience erectile dysfunction from the side effects of medications e.g. beta blockers and diuretics.

Surgical patients worry about their wounds, suffer from fatigue, pain and emotional changes.

Despite the importance and effectiveness of discussing sexual activity, evidence suggests that staff are reluctant to raise the issue.

It is important to address this topic during cardiac rehabilitation. Asking the question allows the door to open if the patient has further concerns. Keep language simple, professional and neutral.

Question to get started e.g. how are things in your relationship going?

Compare the effort used to the exercise in CR.

Sex after MI – 25% stop, 50% decrease, 25% no change.

Sex after Coronary artery bypass surgery, most patients resume after 8 weeks.

The healing power of touch cannot be highlighted enough, the release of endorphins, relaxation and pain relief.

Niamh Dormer.

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Nutrition Susie Burrell - Dietician, Clinical Practice, NSW, Australia

Dietary Patterns

Target weight control/calorie control

Controlled Fasting beneficial 2:5; powerful effect on cardiovascular markers in particular inflammatory markers.

At 12 months all diets yield similar results.

Diet has to be sustainable, assessable everyday foods.

Evidence based diet; Mediterranean diet -30% reduction in events (NEJM 2013)

7/10 serves of vegetables, red meat twice weekly, white meat and fish 3-4 times weekly

Calorie Control is the key

Fat Balance

Carbohydrates –no rice crackers/no white bread/no white rice

Timing

Superfoods

Liquid Calories

Consider Nutrient Balance

Good stuff in more often

Consider how we eat

Eat more vegetables….

Give the pro/cons of full fat milk and butter or the processed version

DINNER

THE GREAT DEBATE

What is best for Homer Simpson – outpatient-based or telehealth based cardiac rehabilitation?

Great Debate – Steve/Dr Nick

Hello everybody, I'm Dr Nick!

Thanking you for inviting me to be speaking with you about my patient, Mr Homer J Simpson.

As this patient's cardio ticker surgeon let me be giving my opinion about Mr Simpson's ongoing recovery.

Do these other speakers really think he is going to be going somewhere that peoples will be telling him to exercise more, telling him to stop eating donuts, to be decreasing his beer drinking and to stop being so lazy.

Let me be talking about why I am inviting to be here; Telehealth Cardiac Rehabilitationment.

My esteemed colleague here Professor (but not real doctor lady) Gallagher and other not real doctors be telling me that these telehealthing things are flexible and cater to the individualised patient.

Also that these servicings may be delivered at times outside of normal business working hours.

The other things I am being told about these programming interventions are that they may be going for much longer than traditional programs that be going for only 4-8 weeks

Other peoples also be telling me that the clinical nursing like people that be providing these servicings are just as qualified as traditional clinical nursing like people.

Actually, my friend President Steve is telling me about a fantastic Evidence Based Telephone Delivered Coaching Program that is being provided up in his home state of Queensland.

It is being called the "The COACH Program".

It was developed here in Australia, nearly 20 years ago and is the world's only evidence based coaching program for prevention of chronic type diseases – so says their interwebsite: www.thecoachprogram.com

It is unfortunate for patients like my Mr Simpson that there is a "treatment gap in the management of common chronic conditionings like ticker disease and the sugar diabetes.

President Steve is saying a treatment gap is a gap between what we be knowing patients should be receiving and what do they actually be receiving in the real world.

The Coaching program peoples say there is 3 possible reasons for this gap.

Number 1. Patients may not be going to the doctor.

Why would they not want come see me? I charge low, low prices and if I kill you, you don't pay.

Number 2. Patients may not be taking the advice or treatments that their doctor be prescribing .

I don't blame them, some of my treatments you would be crazy to take.

Number 3. Their doctor may not be treating them accordingly to National Clinical Practice Guidelines

The Coaching Program says they be bridging these treatment gaps in the management of cardiac diseases.

Their benefits be including:

Helping peoples achieve and maintain guideline recommended target levels for risky factors

Reducing their anxiety feelings and improving their mood

And generally coaching peoples to be taking control over their health situations

I am thinking this Coaching style program will be working much better for Mr Simpson.

Robyn Gallagher, speaker for telehealth based cardiac rehabilitation.

No-one questions whether outpatient based cardiac rehabilitation works - as the Heart Foundation states in their cardiac rehabilitation advocacy strategy (2014): 'We know it works, we need to make sure it works for everyone!" We know that outpatient based cardiac rehabilitation (CR) doesn't work for everyone, because many eligible patients don't participate. The patients who don't participate are also likely to be the same as the patients who didn't participate in the excellent well-controlled outpatient CR trials. A review of 90 studies by Clark et al., (2013) found the people who don't go to CR are the patients who don't believe it will work, who have limited resources and are working and can't miss that work. We can't change those barriers so we need to be flexible and outpatient based programs are not flexible in that way. Telehealth is ideal because it is able to be flexible and engaging (games/incentives can be built in), two of the many reasons telehealth works. Neubeck and colleagues review of 3000 plus patients (2011) found compared to usual care telehealth resulted in lower total cholesterol and systolic blood pressure and fewer smokers. In Clark and colleagues review of 83 studies (2013) it was demonstrated that telehealth achieves virtually the same results in multiple cardiac risk factors as outpatient based CR. In fact she challenged with this: "Our review indicates there is no need to rely on hospital-based strategies alone to deliver effective CR."

Why is it the only time we use telehealth is to remind patients to come to visit outpatient based CR? Why is it when we use technology it is primarily for us, for example our data bases, teleconferencing and webinars?

Telehealth is interactive, flexible and can even be fun. It includes telephones, the internet, video and transmission technology. Patients can participate from work, home or on holiday. Screening, surveillance and goal setting are possible through text messaging and traffic light responses, skype and videoconferencing. Patients can enter their own data to the extent of taking their own ECG. Why aren't we using the technology we have to be more effective for Homer?

References:

Clark AM, King-Shier KM, Spaling MA, Duncan AS, Stone JA, Jaglal SB, Thompson DR, Angus JE. Factors influencing participation in cardiac rehabilitation programmes after referral and initial attendance: qualitative systematic review and meta-synthesis. Clin Rehabil. 2013 Oct;27(10):948-59.

Neubeck L, Briffa T, Freedman SB, Clark AM, Redfern J. Nurse-led telephone interventions for people with cardiac disease: the importance of the multi-disciplinary approach. Eur J Cardiovasc Nurs. 2011 Mar;10(1):70-1.

Clark RA, Conway A, Poulsen V, Keech W, Tirimacco R, Tideman P. Alternative models of cardiac rehabilitation: a systematic review. Eur J Prev Cardiol. 2013 Aug 13. (Epub ahead of print)

The Case For facility-based CR:

- Not about facility-based vs telehealth CR as both complement one another
- Evidence base for CR-facility is higher and stronger than for CR-tele-health
- Homer (with support from Lisa) is the perfect candidate for CR-facility, given the severity of his coronary artery disease, psychological profile and approach to life.

News From *Across The Nation*

People in regional areas have greater risk of heart disease

The Heart Foundation has produced a geographical snapshot of heart disease which shows one in four people living in regional and rural areas suffers from the disease compared to one in five in metropolitan areas. People living in regional areas have a greater risk of heart disease because they are more likely to be physically inactive, daily smokers and overweight or obese, than those living in major cities.

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

Systematic approach to chronic heart failure care

Despite significant advances, the prevalence of chronic heart failure remains high, clinical outcomes are poor, and healthcare costs are rising. The Heart Foundation advocates for a systematic approach to chronic heart failure care, as outlined in our consensus statement recently published in the *Medical Journal of Australia*.

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

Screening for depression and CHD

Depression is common among patients with coronary heart disease (CHD) and it has a significant impact on a patient's quality of life and adherence to therapy. In partnership with *beyondblue*, the Heart Foundation advocates for routine screening for depression in all patients with CHD, in order to provide the best possible care.

Print the CHD, anxiety and depression factsheet at www.heartfoundation.org.au/psychosocial-health

Cardiac rehabilitation poster

A poster to help promote cardiac rehabilitation to patients with heart disease and their families has been developed by the Heart Foundation in Western Australia. The poster features school teacher Trisha Langridge (aged 59), who experienced a heart attack 14 years ago while playing netball. She credits her recovery, and ability to cope, to family support and cardiac rehabilitation. Trisha is quoted on the poster: "Cardiac rehabilitation saved my life after I had a heart attack and helped me build a healthier future".

For more information please contact Shelley McRae via email Shelley.McRae@heartfoundation.org.au

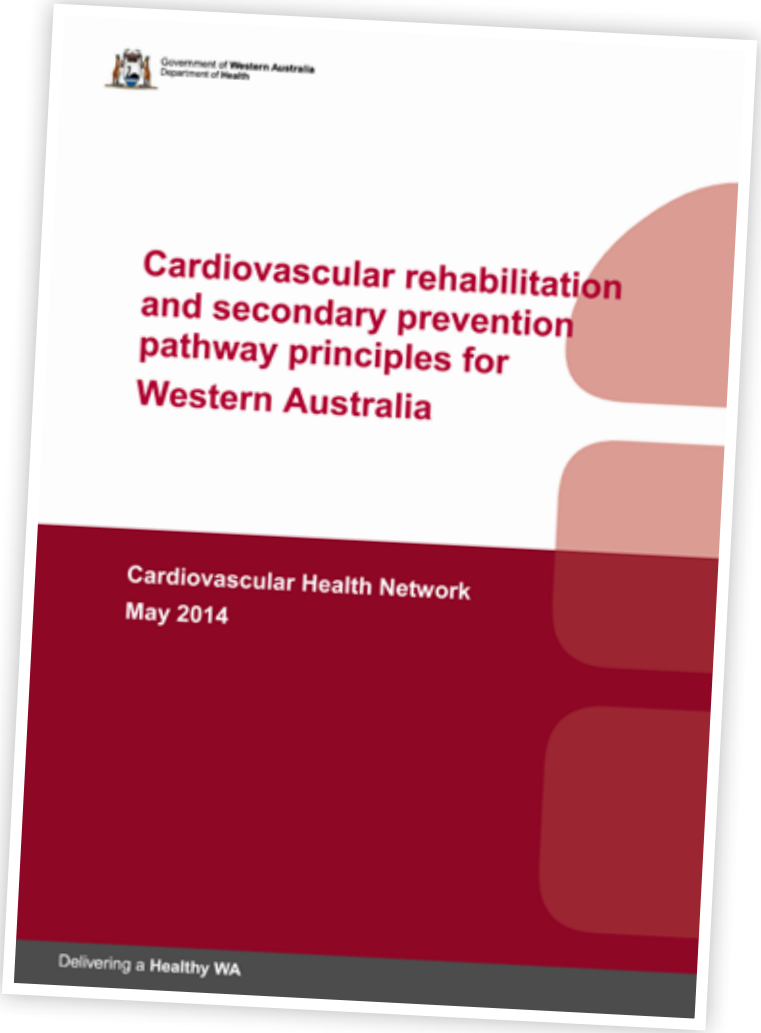
Cardiac rehabilitation and secondary prevention pathway principles launch in WA

The Health Department of WA recently launched the Cardiovascular Health Network's *Cardiac rehabilitation and secondary prevention pathway principles* at an official gathering. View the document here:

http://www.healthnetworks.health.wa.gov.au/docs/1405_CRSP_Pathway_Principles_WA.pdf

Attending the launch was the Heart Foundation's Dr Rob Grenfell who, as a passionate advocate for change, spoke about the strategy to improve cardiac rehabilitation service provision in Australia. He discussed the six key priority areas for action to increase patient participation, reduce hospital readmissions and improve health and quality of life outcomes. The Heart Foundation publication *Improving the delivery of cardiac rehabilitation in Australia* also outlines these priorities.

http://www.heartfoundation.org.au/SiteCollectionDocuments/Improving-the-delivery-of-cardiac-rehabilitation.pdf



QCRA-Heart Foundation Symposium & AGM

QCRA would like to invite all interested health professionals to the Secondary Prevention in Cardiology Symposium jointly hosted by QCRA and the Heart Foundation. This exciting one day symposium will not only be the premier event in Queensland this year for QCRA members, but for all health professionals who have an interest in secondary prevention in heart disease.

The symposium's theme of 'Cardiac Rehabilitation—meeting the need', will cover the spectrum of challenges facing professionals today, such as funding and meeting KPIs through to the future of cardiac rehabilitation. Don't miss this opportunity to learn best how to meet the challenges ahead, to network with like-minded professionals in a relaxed atmosphere and to accumulate CPD points towards professional registration.

The symposium will also be offered through videoconference to those outside Brisbane (limit of 20 sites). It will also include the QCRA AGM at lunchtime and a post event social 'catch-up' at the Ship Inn hotel at nearby Southbank.

Details:

- Location: Des O'Callaghan Auditorium, Mater Adult Hospital, South Brisbane.
- When: Friday October 24th, 8am-4pm.
- Registration: All welcome. Register on-line at: https://www.registernow.com.au/secure/Register.aspx?E=14209
- More Information: On the QCRA Events/Conference webpage http://www.acra.net.au/qcra/event-conferences or email us qcra@acra.net.au or contact Paul Camp on 0432 567 166.

We look forward seeing you there!

Qld Clinical Engagement Toolkit

The Heart Foundation Clinical Engagement Toolkit is a set of documents that assists health professionals in making the case for improved access to cardiac rehabilitation and heart failure services in Queensland. This toolkit is now available on the Heart Foundation's website: http://www.heartfoundation.org.au/information-for-professionals/Clinical-Information/Cardiac-rehabilitation/Pages/default.aspx

In creating this toolkit, the Heart Foundation has consulted with Statewide Cardiac Clinical Network CN, Heart Failure Steering Committee and AMAQ. Health professionals are in an influential position to be the voice for their patients and steer system change to improve cardiac rehabilitation and heart failure services in our local areas.

This Toolkit is designed to support health professionals with an action plan of how to improve services and two factsheets outlining the evidence for and benefits of cardiac rehabilitation and heart failure services.

For more information contact Karen Uhlmann, Acute Sector Manager- Heart Foundation Queensland via (07) 3872 2563 or Karen.Uhlmann@heartfoundation.org.au

New Resource Funding

Great news, the Heart Foundation - Queensland has received funding from the Statewide Cardiac Clinical Network to provide all Queensland Public hospitals with twelve months free supply of *My Heart, My Life (MHML)* (the standard patient resource for ACS patients) and twelve months supply of *Living Well with Heart Failure* and *Living Everyday with my Heart Failure* for heart failure services in Queensland. This will allow 26,000 patients (22,000 ACS, 4,000 Heart Failure) to have access to high quality patient information.

The funding arrangements require the bulk delivery of these resources. We encourage you to make any arrangements for storage of the resources as soon as possible. Delivery of MHML has already commenced.

For sites who use the chronic heart failure resources these booklets will also be sent as a bulk delivery but separately to MHML booklets.

QCRA would like to thank the Statewide Cardiac Clinical Network for funding these vital patient resources and for the ongoing support of the Heart Foundation. If you have any queries please contact Karen Uhlmann, Clinical Manager- Acute Sector, Heart Foundation Queensland via (07) 3872 2563 or Karen.Uhlmann@heartfoundation.org.au

Service Directory and Google Maps

The Heart Foundation has worked extremely hard to design a proof of concept model to link Cardiac Rehab services in the Qld State Directory to Google Maps. The next phase of this model has commenced with 'geo coding' for Heart Failure services. The goal will be to create a model that can be used nationally.

Smoking Cessation Webinar

QCRA presented a webinar "Smoking Cessation in Cardiac Rehab" on Tuesday June 24th to ACRA members. The hour long webinar was well attended with up to 60 sites logging in. The webinar generated some good discussion around the topics E-cigarettes, hypnotherapy and evidenced based treatments. The slides from this webinar are now available through the ACRA member's webpage http://www.acra.net.au/membership/about-membership .

Speaking From the Heart DVD

The Heart Foundation in Queensland have recently developed updated resources for their community speaker program, "Speaking from the Heart", including a DVD containing six targeted chapters that can each be played independently.

The Heart Foundation has also created a free continuous loop edition of the DVD suitable for viewing in health environments, education sessions and public areas.

The topics covered in the material are " Eating for a healthy heart", "Active living for a healthy heart", "Warning signs of a heart attack", "Know your heart disease risk", "Life after a heart attack", and "Yarning for heart health".

To order please contact Sue Hines via email on Sue.Hines@heartfoundation.org.au or for further enquiries on 3872 2562.

Upcoming events for your diary

– more details on website

SACRA and Calvary Hospital present

World Diabetes Education Evening

Calvary Wakefield Hospital
Auditorium – Level 3
12th November 2014
1800 - 2100

QCRA and HEART FOUNDATION present

Secondary Prevention in Cardiology Symposium

'Cardiac Rehab-Meeting the Need'

Jointly hosted by the Queensland Cardiovascular Health and Rehabilitation Association (QCRA), the Heart Foundation and the Mater Hospital
Friday 24th October 2014
8am- 4pm, Mater Adult Hospital, Stanley St South Brisbane, Des O'Callaghan Auditorium - ground floor of Kelly Building

VACR Annual Conference

23rd and 24th October 2014
Stamford Plaza Hotel
111 Little Collins Street, Melbourne
Program includes:
Alan Goble Lecture
Presented by Dr Barbara Murphy
Heart Research Centre