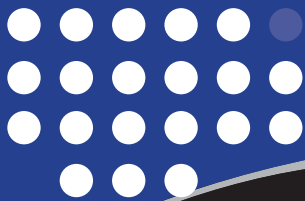
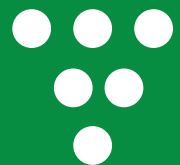


ACRA 2013

Bridging the Divide



12 – 14 AUGUST 2013
PULLMAN MELBOURNE ALBERT PARK



**Conference
Handbook**

Welcome

The Australian Cardiovascular Health and Rehabilitation Association welcomes you to Melbourne and the 23rd Annual ACRA Conference from 12 to 14 August 2013. The theme for the conference is 'Bridging the Divide', reflecting both the joint collaboration between Victoria and Tasmania in co-covering the event, while acknowledging the 'divide' we and our patients experience in terms of the inequalities or gaps in access, resourcing, and barriers relating to program participation.

Broadly the conference will seek to investigate the gap between evidence-based practice recommendations and clinical practice in the care of cardiovascular patients. More specifically, the concurrent sessions will seek to address socioeconomic, cultural, geographic, gender-related and psychosocial barriers and inequalities. Within each sub-theme, both empirical research studies revealing evidence of the 'gap', and evaluations of care to 'address the gap', will be presented.

The impact of a diagnosis of cardiovascular disease (CVD) and the adjustment required for an individual should not be underestimated despite the remarkable diagnostic and interventional advances in management of these diseases and the dramatic improvements in survival rates.

Cardiovascular health practitioners and services provide a comprehensive approach to primary and secondary prevention of CVD. Cardiovascular health services include, and complement, the support and individual medical care given by specialists and general practitioners.

The aim of this conference is to recognise the challenges patients face in dealing with CVD and the implications this has on services and clinicians caring for these patients.

The following sub-themes will be covered during the course of this conference:

- Socioeconomic and social inequalities
- Cultural inequalities and Indigenous health
- Gender gaps
- Geographic inequalities
- Psychosocial barriers
- Heart failure update

The conference aims to recognise the challenges faced by both patients and health professionals in dealing with cardiovascular disease and the implications this has on the delivery of care to patients.

I would like to thank our invited international speakers—Drs Rod Jackson and Tom Marwick, together with all other national and local presenters and members of the faculty.

We would also like to thank the sponsors and exhibitors for their support of the conference.

We trust you will enjoy and benefit from the issues discussed at the conference and have the opportunity to catch up with colleagues and friends as well as the chance to develop new relationships.

Kim Gray
Sue Sanderson
Conference Co-Convenors

Organising Committee

- Kim Gray (Convenor)
- Sue Sanderson (Convenor)
- Emma Boston
- Craig Cheetham
- Kerri Clarke
- Jo-Anne Flood
- Debra Gascard
- Barbara Murphy
- Margaret Ryan
- Terri Wieczorski

Scientific Program Committee

- Dr Barbara Murphy (Chair)
- Dr Alison Beauchamp
- Dr Jan Cameron
- Dr Paul MacIntyre
- Dr Karen Page
- Ms Jennifer Patrick
- Prof. David Thompson
- Dr Frances Wise

Sponsors



Conference Host

Australian Cardiovascular Health
and Rehabilitation Association

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International Keynote Speakers



Professor Rod Jackson

Rod Jackson is a Professor of Epidemiology at the University of Auckland. He is medically trained. He teaches clinical and public health epidemiology to undergraduate and postgraduate students and health professionals. His main research interest is CVD epidemiology. He is one of the architects of New Zealand risk-based clinical guidelines for managing CVD risk. His current research is based on PREDICT—a web-based decision support system for helping clinicians systematically manage CVD and diabetes risk at the ‘moment of care’. PREDICT simultaneously generates a CVD research cohort that currently includes over 250,000 people.



Professor Tom Marwick MBBS, PHD, MPH

Tom Marwick was formerly Head of Cardiovascular Imaging at Cleveland Clinic, and is now Director of the Menzies Research Institute in Hobart, Australia. He completed training in medicine and cardiology in Australia, before undertaking an Imaging Fellowship at Cleveland Clinic, a PhD at the University of Louvain, Belgium and a Masters in Public Health at Harvard. His main research interests relate to myocardial imaging and cost-effective application of cardiac imaging techniques for treatment selection and monitoring. He has published about 600 papers, reviews, chapters and editorials, and is an editor at JACC-Cardiovascular Imaging. Dr Marwick has been the recipient of more than fifty significant research grants and several awards, including the Simon Dack Award from the American College of Cardiology.

National Keynote Speakers



Professor Patricia Davidson

Patricia Davidson is Professor of Cardiovascular and Chronic Care and Director for the Centre for Cardiovascular and Chronic Care, in the Faculty of Health, at the University of Technology Sydney, and Professor of Cardiovascular Nursing Research at St Vincent's Hospital, Sydney. She is Co-Chair of the Cardiac Network NSW Agency for Clinical Innovation and Chair of the Cardiovascular Nursing Council of the Cardiac Society of Australia and New Zealand. Her clinical and research work focuses on chronic cardiovascular disease, heart failure, women's and Indigenous health. A primary objective of Professor Davidson's work has been to improve cardiovascular health of women and underserved populations through development of innovative, acceptable, and sustainable initiatives.



Professor David Dunstan

David Dunstan is an ARC Future Fellow and the Head of the Physical Activity Laboratory at the Baker IDI Heart and Diabetes Institute. His research focuses on the role of physical activity and sedentary behaviour in the prevention and management of chronic diseases. His research program has attracted considerable external funding and he has been an invited speaker at international conferences, including the American Diabetes Association. In 2007, he was awarded a prestigious Young Tall Poppy Science Award (Victoria) from the Australian Institute of Policy and Science which recognises the achievements of Australia's outstanding young scientific researchers.

Speakers



Dr Robert Grenfell

Rob Grenfell is a public health physician who currently holds the position of National Director, Cardiovascular Health at the Heart Foundation. Rob's previous roles include being a strategic health advisor to Parks Victoria and a senior medical advisor in preventive Health, Department of Health, Victoria.

Other positions have included member of the Victorian Quality Council, Chair of General Practice Victoria, member of the Health Advisory Committee of the NHMRC, physician in charge of travel health BHP, and general practice. Until recently Rob ran a general practice in the small isolated rural community of Natimuk, where he still runs a community art space, the Goat Gallery.



Professor Simon Stewart

Simon Stewart NFESC, FAHA, FCSANZ, an NHMRC Principal Research Fellow, is Head of Preventative Health and Director of the NHMRC Centre for Research Excellence to Reduce Inequality in Heart Disease at the world-renowned Baker IDI Heart and Diabetes Institute.

Professor Stewart leads large-scale population surveillance and multicentre clinical trials of pragmatic health service intervention to best understand and respond to an evolving epidemic of chronic heart disease.

He has published >250 research reports and, as Principal Investigator, his research has attracted >\$10million in competitive funding from the NHMRC of Australia in the past five years.



Ms Vicki Wade

Vicki Wade is a proud Aboriginal woman. Her traditional lands are in the south-west of Perth. With strong Noongar ties, her family has and continues to fight for the rights of and preservation of Noongar spirituality and culture, a critical element that Vicki believes needs to be addressed to help close the gap.

Vicki is currently the National Leader of the Aboriginal and Torres Strait Islander program in the Heart Foundation. During Vicki's thirty-year career she has made a significant contribution to Aboriginal health and has been instrumental in developing policy and setting strategic direction for Aboriginal health. Vicki has held many senior positions, including nurse educator, heart failure specialist nurse, clinical nurse consultant in cardiology, and cardiac rehabilitation coordinator. She has held positions as Senior Lecturer with the University of Western Sydney, NSW State Manager of the Aboriginal Vascular Health Program, and Area Director of Aboriginal Health in Sydney South West Area Health Service.

Vicki is a member of the Cardiac Society of Australia and New Zealand's Indigenous working group and, in 2009, was the first Aboriginal nurse invited to deliver the cardiovascular nursing lecture to the annual CSANZ scientific meeting.

Vicki is also an active member of the Local Aboriginal Land Council in NSW and has been instrumental in establishing the first Aboriginal owned and run general practice centre not reliant on government funding. She is a member of the national close the gap committee and the newly formed Indigenous representative body Congress. Vicki has four children and three grandchildren and for their sakes hopes that her commitment and efforts can contribute to closing the gap.

Invited Speakers



Dr Alison Beauchamp

Alison Beauchamp is currently an ARC Post-Doctoral Fellow at Deakin University Population Health Innovation Unit and a Research Fellow at Baker IDI in the Obesity Population Health

Unit. Her research background is in social epidemiology, and she has a strong interest in developing interventions to reduce inequalities in CVD and other chronic diseases. Current projects include designing strategies to improve outcomes for people who have low health literacy, and using epidemiological modelling to assess the socioeconomic impact of obesity prevention interventions. Alison has a clinical background as a cardiac rehabilitation and heart failure program coordinator and retains an active interest in this area. She has a long-standing position on the VACR committee and holds a Senior Research Fellow position with the Heart Research Centre.



Associate Professor Robyn Clark

Robyn Clark is a Registered Nurse, Registered Midwife and Critical Care Nurse who holds a Masters degree in Education and a PhD. She is also a Fellow of the Royal College of Nursing and Life

Member of the Australian College of Critical Care Nurses. Associate Professor Clark was the inaugural recipient of a National Institute of Clinical Studies (NICS-NHMRC) scholarship supported by the National Heart Foundation for researching telemonitored heart failure management in rural and remote Australia. Her current roles include NHMRC Research Fellow at the Queensland University of Technology and a member of the Institute of Health and Biomedical Innovations.

Associate Professor Clark is internationally recognised for her research into the most effective management of patients with heart failure. Her research program has two streams. Stream one focuses upon improving the access of patients to evidence-based heart failure management, especially in rural and remote and other clinically-disadvantaged populations. This suite of research is recognised for its innovative methods, particularly its emphasis on GIS. The second stream involves the use of information technology to bridge the gap between specialist

centres and populations with limited access to cardiology services. Both of these streams underpin a cohesive research development strategy that aims to build capacity in cardiovascular care outside of metropolitan centres.



Dr Marcia George

OAM DN FACN ACSANZ RN RM

Marcia George has worked in senior nursing positions in both Intensive Care and Coronary Care Units since the early

1980s. It was whilst working in these environments that she first became aware of the important role cardiac rehabilitation services have in health care. In addition to her senior clinical and management roles, Marcia was appointed to the role of Adjunct Professor of Nursing and Midwifery at RMIT University from 2003 to 2010.

Marcia's current position is with cardiac rehabilitation services at ISIS Primary Care, a Community Health Care clinic, in a low socio-demographic, multicultural region in the western suburbs of Melbourne.

It has been this community-based, role that continues to challenge and motivate Marcia's commitment to the promotion and ongoing development of cardiac rehabilitation services and preventative health within the broader health care sector and the Australian community as a whole.

Marcia is the current Vice-President of the Nurses Memorial Centre in Melbourne, and the Immediate Past President of the Victorian Cardiac Nurses Association.



Associate Professor Leigh Kinsman

Leigh Kinsman is Director of the Centre of Research Excellence in Rural and Remote Primary Health Care. The Centre is funded

by the Australian Primary Health Care Research Institute and is a collaboration between Bendigo and Gippsland (Monash University), Alice Springs (Flinders and Charles Darwin Universities) and Broken Hill (University of Sydney). The Centre's program of research aims to improve systems to identify what health services are required where, and what works well within the disparate rural and remote Australian contexts. Leigh is also Director of Research for the Monash University School of Rural Health and leads a research program dedicated to reducing the unacceptable disparity in health outcomes between rural and urban Australians.



Workshop Presenters



Dr Jan Cameron

Jan Cameron is an emerging future leader who, from over 20 years of clinical expertise in caring for patients with chronic heart failure (HF) and cardiovascular disease, identified a significant knowledge gap as to the ramifications of cognitive impairment on patient engagement in heart failure (HF) self-care, and the need to develop psychometrically sound clinical tools that screen for self-care capacity. Her extensive program of research is aimed at informing clinical practice in the development of screening and subsequent individualised management strategies for improving functional outcomes among a particularly vulnerable group of cardiovascular patients. Over the seven years as an academic researcher, Dr Cameron's outputs include: \$4.7 million from grants and scholarships, sixteen original research publications, two editorials and thirteen published abstracts.



Ms Barbara Eden

AdvDipSecEd, BA, MA(Educ), MSc (Nut & Diet), APD

Senior Manager, Food Supply
Heart Foundation – NSW

Barbara Eden is a dietitian with extensive experience in education, dietetic and public health work. She has taught in secondary schools, lectured at university and ran her own dietetic consultancy. She has been with the Heart Foundation since 2000 and has been involved in developing and promoting the Heart Foundation's evidence-based nutrition position papers and nutrition messages over this time. Currently her work includes liaising with the NSW State Government and local government councils in NSW to lower the levels of saturated fat in our food supply and to advocate for the healthier choices to be the easier choices.



Dr Robyn Gallagher

Robyn Gallagher has been working in cardiovascular nursing research for many years and was awarded her PhD in 2001 based on a randomised controlled trial

of telephone follow-up for women who had experienced cardiac events. Dr Gallagher is an Associate Professor of Chronic and Complex Care and Director, Research Students at the University of Technology, Sydney. Her program of research has primarily focused on supporting recovery and self-management in cardiovascular disease. Her research has received the Cardiac Society of Australia and New Zealand Nursing Affiliate Prize and the American Heart Association Council on Cardiovascular Nursing Research Article of the Year Award in 2012. Robyn has more than forty original research publications, eight book chapters and more than thirty published abstracts. She has supervised twelve research degree students to completion.



Dr Paul MacIntyre

Paul MacIntyre is Head of Cardiology at the Royal Hobart Hospital. He moved there two years ago from Glasgow, Scotland. He has a longstanding interest in cardiac rehabilitation. He was clinical lead for the 'Have a Heart Paisley' Project in Scotland. This was a national demonstration project which used a multidisciplinary, multi-agency approach to the prevention of coronary heart disease. He was also Chairman of the National Advisory Committee for Cardiology in Scotland from 2005 until 2009. In this role he was also clinical lead for coronary heart disease in Scotland. He has several publications in the field of cardiac rehabilitation.



Dr Barbara Murphy

Barbara Murphy is Principal Research Fellow and Director of Research at the Heart Research Centre (HRC) in Melbourne. Her work focuses on psychosocial aspects of coronary heart disease, particularly depression and emotional adjustment after an acute cardiac event. She has been Chief Investigator on three studies funded by *beyondblue*, including the 'Cardiac Blues Project' in which she is developing resources for patients and health professionals to support emotional adjustment. She is a member of the Evaluation Committee for the federally funded Mental Health Professional Network (MHPN). She has over sixty publications in refereed journals. Dr Murphy holds an honorary position at The University of Melbourne and The University of Newcastle.

Social Functions



Dr Karen Page

Karen Page has recently been appointed as the National Heart Foundation's Manager for Equity and Secondary Prevention, where she continues

to champion the dissemination and implementation of evidence-based practice. Karen is known for her leadership in cardiovascular nursing, and managing risk in heart disease. Her work as a clinician, educator, academic, and researcher has focused on identifying and managing cardiovascular risk across populations including establishing a nurse-led clinic for secondary prevention, implementing screening for depression and identifying risk of re-admission for those with heart failure.



Ms Beth Thomas

APD, National Policy Officer
Heart Foundation
Bachelor Health Science (Nut. & Diet.), APD

Beth is an Accredited Practising Dietitian and works with the National Heart Foundation of Australia to develop policy and position statements in the area of food and nutrition.

In a former life as a clinical dietitian, Beth relished the role of teaching the basics (and not so basics) of nutrition to improve health. This involved work in the acute, rehabilitation and outpatient settings.

Now with the Heart Foundation, Beth enjoys her role exploring the structural determinants of population health through food and nutrition and translating evidence and policy into practical recommendations for the Australian context.

A welcome reception and dinner will be held during the conference.

Welcome Reception

Date	Monday 12 August 2013
Time	1800–1930
Venue	The Lake Room Pullman Melbourne Albert Park
Cost	Inclusive for full registrations \$50 for additional tickets
Dress	Neat casual

Welcome to the Conference! The welcome reception is an ideal opportunity to catch up with your interstate colleagues and exhibitors. The reception is also a great opportunity to meet delegates who are attending the conference for the first time. The moderated poster presentations will also be held during the welcome reception.

Conference Dinner


Date	Tuesday 13 August 2013
Time	1900–midnight
Venue	AFL Dining Room The Melbourne Cricket Ground
Cost	Inclusive for full registrations \$100 for additional tickets
Dress	"Athletes of the Nation"

The conference dinner at the ACRA conference is always a highlight, bringing delegates together for a fun evening. The dinner will be held in the AFL Dining Room in the Great Southern Stand of the Melbourne Cricket Ground. The theme is "Athletes of the Nation" so come dressed as your favourite sporting character or with your favourite piece of sporting/fan paraphernalia. There will be a silent auction during the dinner so come armed with your cash or credit card.

Program



Monday 12 August 2013

1300	Registration opens	Lake Lobby
1330 – 1530	Pre Conference Workshop – Health Change Australia  <i>How to increase patient attendance and build behaviour change support into cardiac rehab groups</i>	Park Room
1600 – 1800	Members Forum	Park Room
1800 – 1930	Welcome Reception – Kim Gray and Sue Sanderson, ACRA 2013 Convenors Welcome Address – Uncle Kevin Coombs Moderated Poster Session – Chairs: Dr Barbara Murphy and Dr Paul MacIntyre	Lake Room

Tuesday 13 August 2013

0645 – 0745	Walking in Albert Park (meet at the front of the hotel)	
0745	Registration opens	State Lobby
0845 – 0910	Conference Opening Chairs: Ms Kim Gray and Ms Sue Sanderson	State 1 & 2
0845 – 0900	Conference Welcome – Sindy Millington, ACRA President; Kim Gray and Sue Sanderson, ACRA 2013 Convenors Welcome to Country – Auntie Diane Kerr, Wurundjeri Elder	
0900 – 0910	The patient experience <i>Molly Williams</i>	
0910 – 1035	Bridging the Gap in Cardiovascular Care Chairs: Dr Paul MacIntyre and Dr Karen Page	State 1 & 2
0910 – 0950	National Keynote Presentation Why don't Aboriginal and Torres Strait Islander peoples access cardiac rehabilitation: Trials and tribulations <i>Ms Vicki Wade</i>	
0950 – 0955	<i>Wake Up</i>	
0955 – 1035	International Keynote Presentation The V ascular I nformatics using E pidemiology and the W eb (VIEW) programme: A major programme of research to reduce evidence–practice gaps and disparities in CVD burden in New Zealand <i>Prof. Rod Jackson</i>	
1035 – 1100	Morning Tea and Exhibition	State 3
1100 – 1200	Research Prize Session Chairs: Prof. Rod Jackson and Dr Barbara Murphy	State 1 & 2
1100 – 1115	Does Anhedonia predict cardiac rehabilitation outcomes? <i>Dr Frances Wise*, Dr Darren Harris, Ms Robyn Sheppard, Ms Jennifer Patrick, Professor John Olver</i>	
1115 – 1130	The effect of a cardiac rehabilitation type exercise program on vascular risk and physical fitness in patients diagnosed with a transient ischaemic attack: Implementing cardiac rehabilitation principles to secondary prevention cerebrovascular care <i>Dr James Faulkner*, Dr Danielle Lambrick, Mr Brandon Woolley, Dr Lee Stoner, Mrs Lai-kin Wong, Dr Gerard McGonigal</i>	
1130 – 1145	Health-related quality of life and post-discharge support following primary percutaneous coronary intervention: A comparison by age <i>Ms Soon Yeng Soo Hoo*, Ms Gallagher Robyn, Mr Doug Elliott</i>	
1145 – 1200	High prevalence of modifiable risk factors in patients admitted to hospital with Atrial Fibrillation <i>Ms Leonie Sadler*, Ms Kellie Roach, Associate Professor Robyn Gallagher, Ms Julie Belshaw, Ms Ann Kirkness, Mr Ross Proctor, Ms Ling Zhang, Dr Lis Neubeck</i>	
1200 – 1210	Discussion	



1210 – 1215	Session change		
1215 – 1300	Concurrent Sessions – Mini Oral Presentations		
	New Approaches in Cardiac Rehabilitation State 1 & 2 Chairs: Dr Jan Cameron and Ms Margaret Ryan	Improving Cardiac Rehabilitation Program Attendance and Access Lake 1 & 2 Chairs: Dr Alison Beauchamp and Ms Emma Boston	Psychosocial Issues in Coronary Heart Disease Lake 3 & 4 Chairs: Dr Karen Page and Ms Elizabeth Holloway
1215 – 1222	Improved management of patients with diabetes in phase two cardiac rehabilitation <i>Ms Donella Proud*, Ms Margaret Flaherty, Ms Michelle Lander, Ms Elaine Slater, Dr Denis Wilson</i>	A strategy to improve attendance at Phase II education classes <i>Mrs Sandy McKellar, Mrs Helen Callum*, Mr Matthew Pullen, Mr Gregg McDougall, Miss Jenna Kirchner</i>	The National Heart Foundation of Australia consensus statement on psychosocial risk factors for coronary heart disease <i>Prof. Nick Glozier, Prof. Geoffrey H Tofler, A/Prof. David M. Colquhoun, Dr Stephen J. Bunker*, Prof. David M. Clarke, Prof. David L. Hare, Prof. Ian B. Hickie, Prof. James Tatoulis, Prof. David R Thompson, Ms Alison Wilson, Ms Maree Branagan</i>
1222 – 1229	Promising outcomes at 12 months from a weight loss intervention supplement to cardiac rehabilitation and diabetes education for people who are overweight and obese <i>A/Prof. Robyn Gallagher*, Ms Ann Kirkness, Mr Dan Hollams, Ms Caryn Kneale</i>	Automatic, not automated, referral of all eligible cardiac inpatients to an OCR program <i>Mrs Sandy McKellar*, Mrs Helen Callum, Mrs Yvonne Connolly, Mrs Jan McKenzie, Ms Nicki Butler, Mrs Julanne Hatcher</i>	National Heart Foundation of Australia consensus statement on depression in patients with coronary heart disease: Recommendations for screening, referral and treatment <i>A/Prof. David M Colquhoun, Dr Stephen J Bunker*, Prof. David M. Clarke, Prof. Nick Glozier, Prof. David L. Hare, Prof. Ian B. Hickie, Prof. James Tatoulis, Prof. David R. Thompson, Prof. Geoffrey H. Tofler, Ms Alison Wilson, Ms Maree Branagan</i>
1229 – 1236	Clinical experience gained in the incorporation of a Tai Chi 'warm up' routine within a cardiac rehabilitation program (CRP) <i>Mr Michael Kolarik*, Campbell Newton</i>	Do clients believe that cardiac rehabilitation group content meets their needs? <i>Mrs Lynn Murdoch*, Mrs Maureen Stumke, Mrs Linda Rabbidge*</i>	An integrated secondary prevention group program reduces depression in cardiac patients <i>Dr Rosemary Higgins*, Dr Barbara Murphy, Dr Alyna Turner, Dr Peter Elliott, Mr Michael Le Grande, Dr Alan Goble, Dr Marian Worcester</i>
1236 – 1243	Evidence-based behaviour change 'not negotiables' for consults and cardiac rehab groups <i>Ms Janette Gale*</i>	At last ... an evening group! <i>Mrs Sheryl Gregson*, Miss Ruth Davison, Ms Maree Hextall</i>	Development and validation of a brief cardiac depression scale in a cardiac rehabilitation population <i>Dr Frances Wise*, Dr Darren Harris, Professor John Olver</i>

1243 – 1250	Moving HARP into the private setting—a multi disciplinary and individualised approach to providing an exercise rehabilitation and education program for the heart failure patient <i>Ms Kellie Easton*, Ms Ailish Commane*, Dr Rosemary Higgins, Ms Lauren Barker, Ms Claire Parks, Mr Chris Voiner, Ms Sally Howe</i>	Formal review of cardiac rehabilitation and cardiomyopathy service—roads and roadblocks <i>Ms Kathryn Kelly*, Ms Kerry Poole, Ms Monica Kerlin</i>	Socioeconomic predictors of work–time and leisure–time physical inactivity after an acute cardiac event <i>Dr Michelle Rogerson*, Dr Barbara Murphy, Mr Michael Le Grande, Dr Peter Elliott, Dr Marian Worcester</i>
1250 – 1257	Heart to heart: Enabling conversations for patients and staff <i>Ms Jennifer Fildes*, Dr Nicole Livermore, Ms Cate Ferry, Professor Linda Perry, Mr Nickolas Yu</i>	Discussion	Discussion
1257 – 1300	Discussion		
1300 – 1400	Lunch and Exhibition ACRA AGM		State 3 Lake 1 & 2
1400 – 1425	National Keynote Presentation Chair: Dr Paul MacIntyre		State 1 & 2
	Social deprivation and social determinants of health <i>Dr Rob Grenfell</i>		
1425 – 1430	Session change		
1430 – 1530	Workshops		
	KPIs in Cardiac Rehabilitation State 1 & 2 Facilitator: Dr Rob Grenfell	Improving Cardiac Rehabilitation Program Access Lake 1 & 2 Facilitator: Dr Paul MacIntyre	Cardiac rehabilitation services, past, present and future: Where to from here? Lake 3 & 4 Facilitator: Dr Marcia George
1530 – 1600	Afternoon Tea and Exhibition Moderated Poster Viewing		State 3
1600 – 1730	Disparities in Accessing Cardiac Rehabilitation Invited speakers and panel discussion Chairs: Dr Rob Grenfell and Prof. Rod Jackson		State 1 & 2
1600 – 1620	Regional/rural inequalities <i>A/Prof. Leigh Kinsman</i>		
1620 – 1640	Socioeconomic inequalities <i>Dr Alison Beauchamp</i>		
1640 – 1700	Coalface reality check: Cardiac rehabilitation services in a complex, high-risk, community health care setting <i>Dr Marcia George</i>		
1700 – 1720	Geographic mapping and remote telemonitoring <i>A/Prof. Robyn Clarke</i>		
1720 – 1730	Panel discussion		
1730	Sessions close		
1900 – 2400	Conference Dinner – meet at the front of the hotel for transfers at 6.30 pm AFL Dining Room, Melbourne Cricket Ground		

Wednesday 14 August 2013

0645 – 0745	Walking in Albert Park (meet at the front of the hotel)		
0730	State Presidents' Breakfast (for State Presidents only) Windows Restaurant, Pullman Melbourne Albert Park		
0800	Registration opens		State Lobby
0900 – 1025	Clinical Issues in Cardiac Rehabilitation Chairs: Dr Paul MacIntyre and Dr Frances Wise		State 1 & 2
0900 – 0940	International Keynote Presentation Screening and early diagnosis of heart failure <i>Prof. Tom Marwick</i>		
0940 – 0945	<i>Wake Up</i>		
0945 – 1025	National Keynote Presentation CVD risk factors and primary prevention <i>Prof. Simon Stewart</i>		
1025 – 1100	Morning Tea and Exhibition		State 3
1100 – 1200	Clinical Prize Session Chairs: Prof. Tom Marwick and Dr Jan Cameron		State 1 & 2
1100 – 1115	Determining minimal important change in incremental shuttle walk test results in a cardiac rehabilitation population <i>Ms Lisa Hanson*, Dr Helen McBurney, Dr Nicholas Taylor</i>		
1115 – 1130	Cardiac rehabilitation in the private health sector; catching up with public programs <i>Ms Niamh Dormer*, Ms Deborah Herrick*, Dr. Rosemary Higgins, Mr. Chris Vonier, Ms Lauren Barker, Ms Claire Parks, Ms Sally Howe</i>		
1130 – 1145	Audit of cardiology patients with a history of mental health disorders in a smoking cessation clinic <i>Mr Paul Camp*, Mrs Wendy Senior</i>		
1145 – 1200	Living well with heart failure: The role of the occupational therapist in the management of chronic heart failure <i>Ms Pamela Maryse Arndt*, Mr Glenn Paull</i>		
1200 – 1210	Discussion		
1210 – 1215	Session change		
1215 – 1300	Concurrent Sessions – Mini Oral Presentations		
	Cardiac Rehabilitation for Indigenous and Remote Patients State 1 & 2 Chairs: Ms Vicki Wade and A/Prof. Leigh Kinsman	Outcomes and Issues in Cardiac Rehabilitation Lake 1 & 2 Chairs: Prof. Simon Stewart and Ms Lisa Hanson	Lifestyle Modification after Cardiac Rehabilitation Lake 3 & 4 Chairs: Prof. Patricia Davidson and Dr Lis Neubeck
1215 – 1222	Perceived interrelationships between chronic disease and mental health in the urban Melbourne Aboriginal community context <i>Ms Karmen Jobling*, Dr Rosemary Higgins, Auntie Diane Kerr, Dr Barbara Murphy, Dr Phyllis Lau, Dr Marian Worcester</i>	Is there a significant improvement in heart rate recovery over cardiac rehabilitation programs? <i>Mr Azran Ahmad*</i>	Collaborative approach for the implementation of a 12 month phase three cardiac rehabilitation program in the community <i>Mrs Emma Boston*, Mr Nathan Moorcroft, Ms Zoe Lechte</i>

1222 – 1229	Trialing an outreach model of cardiac rehabilitation (CR) in remote Australia; the Central Australian Heart Protection Study (CAHPS) <i>Mrs Glynis Cacavas*, Mr Steven Warren, Mr Ricky Mentha, Ms Samantha Tongi, Ms Julie Fielke, Professor Alex Brown</i>	Effectiveness of cardiac rehabilitation program in reducing cardiovascular risk factor and improving functional capacity among cardiac patients in kingdom of Bahrain <i>Mrs Thikrayat Nooruddin*, Aziza Matoog, Fatima Mansoor, Zahra Alaswamy, Hawra S. Khalil</i>	Facilitating lifestyle modification via telephone follow-up for post percutaneous coronary intervention (PCI) patients <i>Ms Bi Xia Ngooi*, Ms Shuet Ming Lai, Mr Arunkumar Jeyaveeran, Ms Karen Koh, Dr Raymond Wong</i>
1229 – 1236	Linking ICOP to the hospital <i>Mr Ray Mahoney*</i>	Can participation in 4 weeks phase II Cardiac Rehabilitation Program (CRP) improve fitness and functional capacity? <i>Mr Azran Ahmad*</i>	Piloting of 'HeLP Yourself Online™': An online integrated secondary prevention program for cardiac patients <i>Dr Rosemary Higgins*, Dr Barbara Murphy, Ms Hema Navaratnam, Mr Michael Butler, Ms Lauren Barker, Dr Marian Worcester</i>
1236 – 1243	The wild, wild west: Getting heart attack warning signs messages "out bush" <i>Mrs Julie Smith*, Mrs Shelley McRae, Mrs Lyn Dimer, Mr Trevor Shilton</i>	Attitudes to obesity among rehabilitation health professionals <i>Dr Frances Wise*, Dr Darren Harris, Professor John Olver</i>	Cardiac rehabilitation DVD – 'What is wrong with my heart?' <i>Dr Alistair Begg*, Ms Dianna Lynch</i>
1243 – 1250	Discussion	Heart Education, Assessment and Rehabilitation Toolkit (HEART) online <i>Miss Julie Adsett, Mrs Annabel Hickey*, Mr Robert Mullins</i>	Who is achieving recommended physical activity levels? A 12 month longitudinal study <i>Mr Michael Le Grande*, Dr Barbara Murphy, Dr Michelle Rogerson, Dr Peter Elliott, Dr Marian Worcester</i>
1250 – 1300		Discussion	Discussion
1300 – 1400	Lunch and Exhibition Static Poster viewing		
1400 – 1425	National Keynote Presentation Chair: A/Prof. Robyn Clark		
	Gender inequalities in cardiac rehabilitation <i>Prof. Patricia Davidson</i>		
1425 – 1430	Session change		
1430 – 1530	Workshops		
	Supporting emotional adjustment in cardiac rehabilitation State 1 & 2 Facilitators: Dr Barbara Murphy and Dr Karen Page	Dietary guidelines and their application in cardiac rehabilitation Lake 1 & 2 Facilitators: Ms Beth Thomas and Ms Barbara Eden	Cognitive challenges in cardiac rehabilitation patients Lake 3 & 4 Facilitators: Dr Jan Cameron and Dr Robyn Gallagher
1530 – 1600	Afternoon Tea and Exhibition		
1600 – 1630	National Keynote Presentation Chair: Ms Jennifer Patrick		
	Sedentary behaviour - is sitting the new smoking? <i>Prof. David Dunstan</i>		

1630 – 1700	Conference Closing Chairs: Ms Kim Gray and Ms Sue Sanderson	State 1 & 2
1630 – 1640	Final word from a CR patient—patient reflection <i>Jim Usher</i>	
1640 – 1650	ACRA 2014 Presentation	
1650 – 1700	Conference Close and Announcement of Awards ACRA 2013 Convenors Kim Gray and Sue Sanderson Best Poster Award Best New Research Award – Sponsored by Heart Research Centre Best Clinical Presentation Award Best Exercise and Physical Activity Paper Award – Sponsored by ESSA People's Choice Award	 

Posters

Board # Poster Title

Moderated Posters

The moderated poster session will take place during the Welcome Reception on Monday 12 August. The viewing session will take place during afternoon tea on Tuesday 13 August.

- | | |
|----|---|
| 01 | My heart health journey—a person centred pathway
<i>Ms Margaret Ahern*, Mrs Helen O'Regan-Tabart</i> |
| 02 | Is ultrasound a reliable measure of sternal micromotion in patients following cardiac surgery?
<i>Ms Sulakshana Balachandran*, Dr Annemarie Lee, Ms Maeve O'Reilly, Prof. Alistair Royse, A/Prof. Linda Denehy, Dr Doa El-Ansary</i> |
| 03 | Journey to become smoke free—St John of God Health Care Frankston Rehabilitation Hospital's (SJOGHC – FRH) experience
<i>Mrs Emma Boston*, Mrs Sally Faulkner, Ms Claire Ferguson</i> |
| 04 | Carers' experiences of patient engagement in heart failure self-care
<i>Ms Kerry Rhodes, Dr Jan Cameron*, A/Prof. Chantal Ski, Prof. David Thompson</i> |
| 05 | A mother's heart beats for two: Exploring current continuum of care for women with cardiac disease during pregnancy
<i>Mrs Sandra (Sindy) Millington*, Dr Judy Magarey, Dr Robyn Clark</i> |

Static Posters

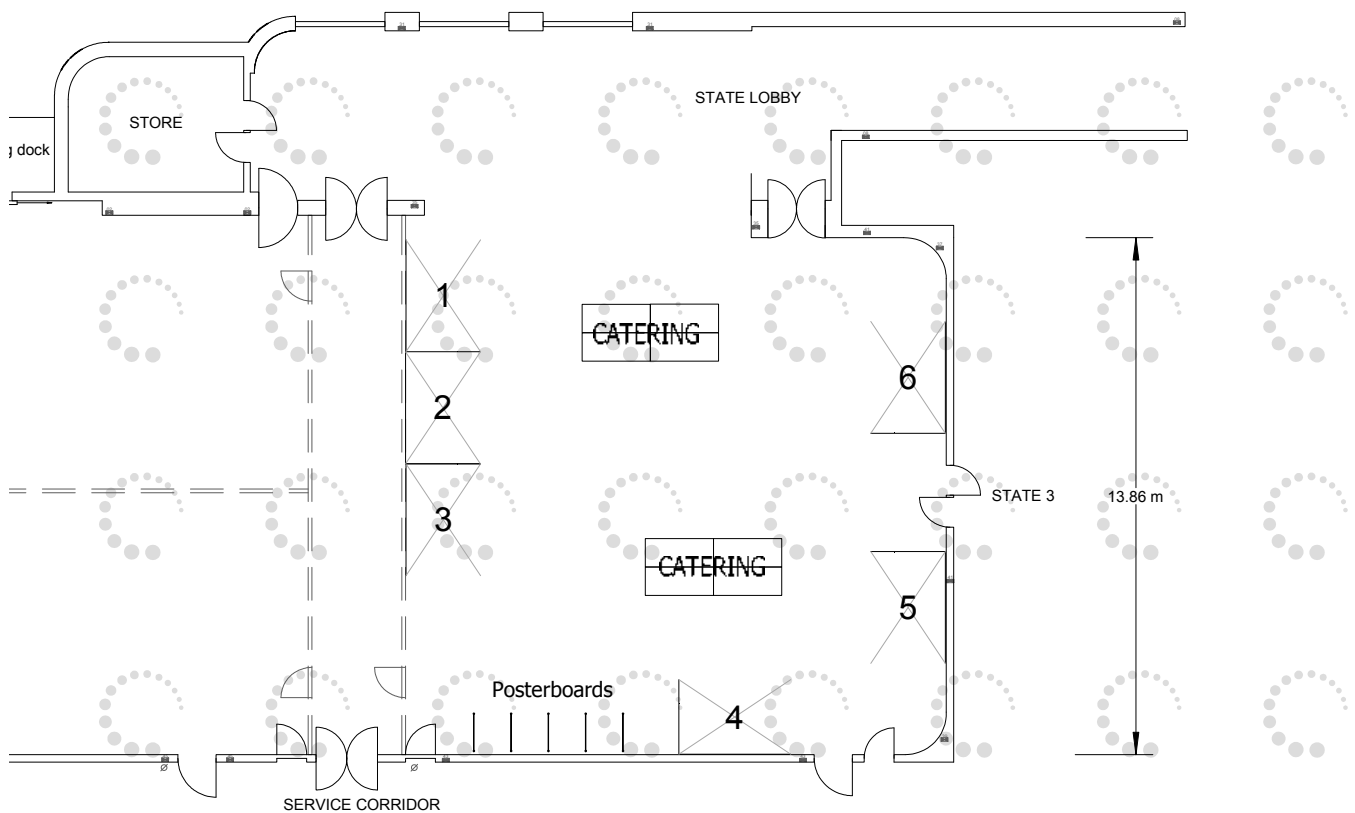
The static poster viewing session will take place during lunch on Wednesday 14 August.

- | | |
|----|---|
| 06 | Supporting SCAD survivors
<i>Mrs Carolyn Brand*, Mrs Fiona Sherri</i> |
| 07 | Improving health literacy in cardiac rehabilitation—an alternative BORG scale
<i>Mrs Carolyn Conway*, Mrs Carolyn Brand*</i> |
| 08 | Improved quality of life after biventricular pacemaker insertion
<i>Mrs Adrienne Caulfield, Mrs Michelle Dove*, Mrs Philippa Ashworth</i> |
| 09 | 'Cardiac blues™': An overview of a project for patients and health professionals
<i>Elizabeth Holloway*, Dr Barbara Murphy, Dr Rosemary Higgins, Dr Karen Page</i> |
| 10 | Health-related quality of life of people undergoing valve replacement surgery for rheumatic heart disease in Fiji
<i>Ms Linda Thomson Mangnall*, A/Prof. Robyn Gallagher, Prof. David Sibbritt, Prof. Margaret Fry</i> |

Exhibition Floor Plan



Site	Company
01	Aspen Australia
02	Menarini
03	Healthdirect Australia
04	Servier
05	Heart Foundation
06	Health Change Australia





General Information

Accommodation Accounts

All accommodation accounts must be settled on check-out.

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The registration desk will be located in the Lake Lobby on Monday and the State Lobby on Tuesday and Wednesday. The registration desk will be open at the following times:

Monday 12 August	1300 – 1930
Tuesday 13 August	0745 – 1730
Wednesday 14 August	0800 – 1700

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The conference and social functions are non-smoking.

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Police – General Assistance 637 Flinders Street	(03) 9247 6666
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Taxi – Melbourne Cabs	1300 635 222
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Airport Transfers	(03) 9600 1711
Qantas	131 313
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ACRA 2013

Abstracts



This workshop is being run by Health Change Australia



How to increase patient attendance and build behaviour change support into cardiac rehab groups

Janette Gale, MAPS CHP

Janette Gale is a Health Psychologist, consultant behaviour change specialist and founder and CEO of Health Change Australia.

Janette is a leading authority on applied health behaviour change and has authored two text books on this subject. She works with corporate and public health organisations in Australia and Canada to provide consultancy and training programs to embed behaviour change support into clinical practice and health services in a broad range of contexts.

Workshop Content

This workshop provides a practical framework for clinicians to systematically build behaviour change support into cardiac rehabilitation group-based programs. It includes program design principles as well as tips, techniques and tools specifically designed for this purpose. Additionally, it provides strategies to increase patient uptake of cardiac rehab referrals and patient retention for the duration of their programs.

Why don't Aboriginal and Torres Strait Islander peoples access cardiac rehabilitation: Trials and tribulations

Ms Vicki Wade

Heart Foundation, Australia

It is well documented that Aboriginal and Torres Strait Islander peoples have much poorer health than all other Australians. The life expectancy gap of over 10 years is well described in the literature. Cardiovascular health contributes to much of the health differentials. If Aboriginal and Torres Strait Islander peoples achieved the same level of cardiovascular care as other Australians the gap could be closed by 6.5 years.

It is less understood the reasons behind the gap, we know they are deep-seated and complex and impact on access and quality of cardiac care. The Heart Foundation has been looking at disparities of care for Aboriginal and Torres Strait Islander peoples experiencing a heart attack. I will share some of these findings.

In order to achieve equality by 2030 as set out in the Close the Gap Statement of Intent (SOI) there requires ongoing commitment, long term investment, continuous engagement with a number of partners including the Aboriginal and Torres Strait Islander community.

As co-signatory to the SOI, the Heart Foundation has been fulfilling its commitment in a number of ways; as the Leader of the National Aboriginal Health Unit (NAHU) I have provided leadership and guidance to the organisation to facilitate this commitment. This presentation will look at the work the NAHU is undertaking in improving access to cardiac care for Aboriginal and Torres Strait Islander peoples.

The **V**ascular **I**nformatics using **E**pidemiology and the **W**eb (VIEW) programme: A major programme of research to reduce evidence–practice gaps and disparities in CVD burden in New Zealand

Professor Rod Jackson

University of Auckland, Auckland, NZ

Cardiovascular diseases (CVDs) are common, readily preventable chronic diseases and there are major disparities between population groups. About 10-15% of adults in countries like New Zealand and Australia probably account for over half the premature CVD events, but we are currently unable to identify them accurately to target preventive treatment effectively. Moreover available treatments can halve CVD risk but there are significant treatment disparities including under- and over-treatment.

The VIEW program is designed to:

- develop better risk prediction tools to identify these high-risk patients;
- quantify and map gaps and disparities in appropriate treatment;
- model the impact of treatment disparities on CVD burden.

To achieve this we are linking encrypted personal data on over two million New Zealanders from routine national health databases and from web-based decision support systems. The decision support systems are currently used by several thousand GPs to help them manage CVD risk and a secondary care version is being rolled out to coronary care units across the country to support quality improvement activities and research.

This presentation will cover the mid-term results of this long-term research program including: new risk prediction tools in primary and secondary prevention; the magnitude of disparities in CVD risk burden by ethnicity and socioeconomic status; and levels of preventive medication use post ACS using maps and other figures.

Providing accurate risk prediction algorithms, interactive atlases of treatment disparities, and evidence of the impact of disparities, will be directly relevant to practice and policy.

Does Anhedonia predict cardiac rehabilitation outcomes?

Dr Frances Wise^{1,2}, Dr Darren Harris³, Ms Robyn Sheppard¹, Ms Jennifer Patrick¹, Prof. John Olver²

¹ Cardiac Rehabilitation Unit, Caulfield Hospital, VIC

² Epworth Monash Rehabilitation Medicine Unit, Epworth Hospital, VIC

³ Aspex Consulting, Melbourne, VIC

Objective

Depression is recognised as a determinant of cardiovascular morbidity. More recently, Anhedonia, defined as lowered ability to experience physical or social pleasure, or lack of positive affect, has been cited as a predictor of clinical events and mortality in cardiac patients. The aim of this study was to determine whether Anhedonia predicts objective and subjective cardiac rehabilitation outcomes.

Methods

The Cardiac Depression Scale (CDS) was administered to 1451 consecutive ambulatory adult cardiac patients on admission to an outpatient Cardiac Rehabilitation program. Anhedonia was defined as a score ≥ 28 (i.e. greater than or equal to the 75th percentile of the score distribution) on an Anhedonia subscale of the CDS. Rehabilitation outcomes included quality of life and exercise capacity measured on discharge from cardiac rehabilitation.

Results

The prevalence of Anhedonia was 24.8%, and more severely depressed mood was 25.4%. Higher levels of Anhedonia were detected in more chronic cardiac diagnoses, and in female subjects. Anhedonia failed to predict cardiac rehabilitation attendance. Depression was significantly associated with more discharge Quality of Life dimensions than was Anhedonia, and also correlated with admission Body Mass Index and 6 Minute Walk distance. Where depression (as opposed to Anhedonia) was an independent predictor of cardiac rehabilitation outcomes, greater amounts of variance were accounted for.

Conclusion

Although Anhedonia independently predicted energy levels and the extent to which physical or emotional problems interfere with work or other daily activities, this study encourages the continued use of depression, rather than Anhedonia alone, as a predictor of rehabilitation outcomes in cardiac patients.

The effect of a cardiac rehabilitation type exercise program on vascular risk and physical fitness in patients diagnosed with a transient ischaemic attack: Implementing cardiac rehabilitation principles to secondary prevention cerebrovascular care

J. Faulkner¹, D. Lambrick¹, B. Woolley¹, L. Stoner¹, L. Wong², G. McGonigal³

¹ Massey University, Wellington, New Zealand

² Clinical Nurse Specialist, Wellington Hospital, Wellington, New Zealand

³ York Teaching Hospitals, NHS Foundation Trust, York, UK

Introduction

Exercise-based cardiac rehabilitation (CR) is used to improve modifiable risk factors among coronary artery disease patients. Many people who present with a Transient Ischaemic Attack (TIA) have similar predisposing modifiable vascular risk factors (hypertension, hyperlipidaemia, obesity etc) as cardiac patients. As such, this randomised, parallel-group clinical trial assessed the efficacy of a CR type program on vascular risk factors and aerobic fitness in patients who had recently experienced a TIA.

Methods

Sixty TIA patients completed a baseline [BL] vascular risk (blood pressure, blood lipid profile etc) and aerobic fitness examination (cycle test) within two weeks of symptom onset. Subjects were then randomised to either an 8-week, twice weekly CR programme or to a usual-care control group. Post-intervention assessments were completed immediately after the intervention [PI] and at a 3-month follow-up [3PI].

Results

A greater reduction in systolic blood pressure (-10.4 ± 9.2 mmHg) and total cholesterol (-0.53 ± 0.90 mmol/L) were observed between BL and PI assessments for the exercise group compared to the control group (-1.9 ± 15.4 mmHg & -0.08 ± 0.59 mmol/L, respectively) ($P < .05$). These improvements were maintained between PI and 3PI ($P > .05$). Significant improvements in aerobic fitness were also observed and maintained at 3PI for those randomised to the exercise group ($P < .05$).

Conclusion

The early engagement in a CR type exercise program resulted in significant improvements in vascular risk factors and fitness in those diagnosed with TIA. As these beneficial effects were maintained up to 3 months after completing the exercise program, a CR type exercise program should be considered a useful additive treatment strategy for newly diagnosed TIA patients.

Health-related quality of life and post-discharge support following primary percutaneous coronary intervention: A comparison by age

Soo Hoo Soon Yeng, Robyn Gallagher, Doug Elliott

University of Technology Sydney, Ultimo, NSW

Introduction

Older people are more often undergoing primary PCI for STEMI, but the effect on health-related quality of life (HRQOL) or use of post-discharge support is not well described.

Methods

A descriptive comparative design evaluated HRQOL (Seattle Angina Questionnaire (SAQ) and the SF-12) and post-discharge support for people <60 vs ≥60 years at 1 and 6 months post primary PCI for STEMI at Royal North Shore Hospital (n=246).

Results

Mean age was 64 years ± 13.16. At 1 month older people experienced less impact on HRQOL from angina frequency (SAQ 95.2 vs 87.4, p=0.026) but worse overall physical function (SF-12 PCS subscale 40.1 vs 43.7, p=0.057). At 6 months older people had better overall HRQOL (SAQ 90.5 vs 85.5, p=.011) and mental health (SF-12 MCS 55.7 vs 52.6, p=.008) but worse physical function (SAQ 93.2 vs 96.2, p=.004).

Older and younger people had similar use of acute post-acute care (APAC) and cardiac rehabilitation (CR). Younger people were more likely to see their GP early (98.9% vs 89.8%, p=.001) and to rate APAC and CR (25.8% vs 14.4% and 7.8% vs 3.9%, p=0.027) as helpful.

Conclusion

While HRQOL was similar between ages, differences occurred for angina frequency, physical function, mental health and post-discharge support, identifying areas for intervention.

High prevalence of modifiable risk factors in patients admitted to hospital with Atrial Fibrillation

Robyn Gallagher¹, Kellie Roach², Leonie Sadler³, Julie Belshaw⁴, Ann Kirkness⁵, Ross Proctor⁶, Ling Zhang⁷, Lis Neubeck⁸

¹ University of Technology Sydney, Ultimo, NSW

² Royal North Shore and Ryde Hospitals, Eastwood, NSW

³ Manly Hospital, Manly, NSW

⁴ Hornsby Hospital, Hornsby, NSW

⁵ Royal North Shore and Ryde Hospitals, St Leonards, NSW

⁶ Royal North Shore and Ryde Hospitals, St Leonards, NSW

⁷ University of Technology Sydney, Ultimo, NSW

⁸ The George Institute for Global Health, Camperdown, NSW

Introduction

Atrial Fibrillation (AF) is common, with a lifetime risk of 1:4 for adults worldwide. AF increases the risk of stroke 5-7 fold, and strokes as a result of AF are generally severe or fatal. Reduction of modifiable cardiovascular disease (CVD) risk factors has strong potential to decrease AF and sequelae such as stroke; however, prevalence of these risk factors in this population has received little attention.

Methods

We aimed to describe the presence of modifiable CVD risk factors in patients admitted with AF by auditing the medical records in all cardiac wards of Northern Sydney Area Health Service from January to March 2013.

Results

89 patients were admitted to hospital with AF; 54% were male; the mean age was 75 years (SD 13.96), and 40% also had CVD. Most had been admitted through emergency departments with AF (89%). More patients were identified as having paroxysmal AF (43%) than permanent AF (33%). Poor documentation of CVD risk factors was common (Table 1), despite this, modifiable CVD risk factors were prevalent and cumulative, with 60% having ≥ 2 risk factors.

Table 1: Prevalence and documentation of modifiable risk factors

Risk Factor	Prevalence		Not documented	
	n	(%)	n	(%)
Hypercholesterolaemia	48	(54%)	12	(14%)
Hypertension	55	(62%)	7	(8%)
Smoking	13	(15%)	17	(19%)
Overweight	28	(32%)	21	(24%)
Diabetes	13	(15%)		

Conclusion

AF patients need improved assessment of modifiable CVD risk. Support to modify multiple CVD risk factors is indicated and may reduce preventable complications of AF.

Improved management of patients with diabetes in phase two cardiac rehabilitation

Donella Proud, Margaret Flaherty, Michelle Lander, Elaine Slater, Dr Denis Wilson

The Canberra Hospital, Cardiology Department, Woden, ACT

What clinical practice guideline or initiative/s did you put into day-to-day practice?

- Developed formal guidelines for staff managing patients with diabetes mellitus in phase two cardiac rehabilitation
- Developed self management guidelines for patients with diabetes mellitus in the form of a poster and handout

List the healthcare professionals or consumer groups you worked with or tried to influence.

- Registered Nurses
- Exercise Physiologists, Physiotherapists
- Diabetes Educator, Dietitian
- Endocrine Registrar, Endocrine Specialist
- General Practitioners
- Multimedia Professionals
- Patients in Cardiac Rehabilitation Program

Why was it important to put this guideline/initiative into practice?

- To reduce the incidence and frequency of patients experiencing hypoglycemia whilst exercising, thereby facilitating a more effective exercise program
- Reduce the time managing and treating patients having hypoglycemia in the gym
- Encourage and facilitate better patient self management of diabetes mellitus
- Ensure evidence base practice guidelines followed by all staff

What strategies did you use to get this guideline/initiative taken up?

- Consultation with Diabetes Educator and Endocrinologist
- Utilised evidence based research from Diabetes Australia, National Evidenced Based Guidelines for the Management of Type 2 Diabetes Mellitus 2006 (NHMRC), and the Royal Prince Alfred Hospital Sydney, Diabetes Centre
- Consultation with Multimedia service to facilitate a consumer friendly poster
- Developed an evaluation form for patients to assess the effectiveness of the information on the poster
- Regular communication meetings with stakeholders

What did you measure and how?

- An evaluation form using the Lickert scale was developed to assess the effectiveness of the poster/ handout information
- 12 patients responded to the evaluation form
- Blood Glucose levels were monitored and recorded pre and post exercise in the gym and appropriate intervention taken as per guideline

What did you achieve? Not achieve?

The evaluation results indicated that the majority of patients strongly agreed or agreed:

- that the information was clear and concise
- more aware of BGL monitoring before exercise
- aware of HBA1C information
- importance of Diabetes follow up and improved self management

A decrease in hypoglycemia events occurred in gym.

What was the biggest challenge to getting the guideline/initiative taken up?

- Time during working hours to research and develop information
- Researching patient appropriate material for poster

What was the thing that most helped in getting the guideline/initiative/s taken up?

- Consultation and collaboration with the Diabetes Educator and the Cardiac Rehabilitation Nurses
- Consultation with multimedia services
- Patients’ verbal and written responses

How did you get the time/money/other resources you needed?

- The printing costs funded through the Cardiac Rehabilitation unit
- Time allocated at work
- Worked on project in own time

What is your key message to share with other groups about getting guidelines or initiatives used?

- Collaboration with Allied Health professionals is essential for quality improvement and development of Cardiac Rehabilitation Programs
- Evidence-based guidelines have improved patient care and safety in the gym
- Facilitated the improved self management of patients with Diabetes
- Diabetes Educators and medical team involvement improved the patients’ BGL control and the ability to exercise

Promising outcomes at 12 months from a weight loss intervention supplement to cardiac rehabilitation and diabetes education for people who are overweight and obese

Robyn Gallagher¹, Ann Kirkness², Dan Hollams², Caryn Kneale³

¹ University of Technology Sydney, Ultimo, NSW

² North Shore Cardiovascular Education Centre, Royal North Shore Hospital, St Leonards, NSW

³ Diabetes Education Service, Royal North Shore Hospital, St Leonards, NSW

Introduction

Achieving and sustaining a healthy weight is important for people with coronary heart disease and/or type 2 diabetes. The Healthy Eating and Exercise Lifestyle Program (HEELP), has proven short-term benefits for weight, body mass index (BMI), waist circumference and exercise outcomes at 4 months but long term results have not yet been reported.

Methods

Patients with BMI 27-39 kg/m² were recruited following CR and DE and undertook the HEELP active phase (16-weeks of group-based exercise, diet and behaviour change sessions) and maintenance phase (36-weeks of 1 group session and 3 follow-up telephone calls). Participants (n= 94, 70% retention) who completed did not differ from non completers.

Results

The sample was aged 63.66 years (SD 8.5) and 62% male. At the end of the active phase there were significant reductions in weight, BMI and waist and significant gains in exercise participation which despite slight regains were sustained at 12 months. (Table 1)

Clinically significant weight loss occurred for 22% at 4 months and 25% at 12 months.

Table 1. Weight, BMI, waist and exercise participation outcomes over time.

characteristic	Baseline		Post active phase 4 months		Post maintenance phase 12 months		F	p
	Mean	SD	Mean	SD	Mean	SD		
Weight	87.93	14.17	85.47	13.92	86.31	14.7	15.87	<.001
BMI	30.9	3.0	30.04	3.09	30.27	3.26	17.63	<.001
Waist	107.31	9.21	104.39	9.57	105.23	9.66	27.38	<.001
Exercise frequency	4.24	2.49	5.33	2.51	4.69	2.67	4.79	.01
Exercise duration	193.51	151.95	323.43	225	265.45	196.64	10.61	<.001

Conclusion

HEELP is an effective supplement to CR and DR for achieving and sustaining weight for overweight and obese people.

Clinical experience gained in the incorporation of a Tai Chi ‘warm up’ routine within a cardiac rehabilitation program (CRP)

Michael Kolarik, Campbell Newton

¹ Monash Health, Clayton CRC, Clayton, VIC

What clinical practice guideline or initiative/s did you put into day-to-day practice?

- To introduce a ten-minute Tai Chi ‘warm up’ within a CRP outpatient program
- Commenced in October 2011
- The initiative was evidence based^{1a} and also surveyed client preferences over conventional ‘warm up’^{1b}

List the healthcare professionals or consumer groups you worked with or tried to influence.

- Clients and carers, Nursing, PT, AHA and students, had the opportunity to learn and practice Tai Chi based on Shibashi² facilitated by ‘trained up’ CRP staff
- Practice of Tai Chi can calm the mind, relax the body, slows the heart rate and lowers blood pressure³

Why was it important to put this guideline/initiative into practice?

- The 2010 Quality Improvement Project demonstrated that all clients preferred Tai Chi to conventional ‘warm up’ exercise^{1b}
- Tai Chi is consistent with exercise guidelines for cardiac rehabilitation and it increases exercise capacity³
- Tai Chi stimulated interest in some clients, their ongoing participation and at home on discharge

The standard Tai Chi ‘warm up’ session developed since introduction to CRP in 10/11. (What strategies did you use to get this guideline/initiative taken up?)

The practice space required is no different to regular ‘warm up’. A quiet environment and ambient music is appropriate.

Clients are given a diagram of the shortened ‘Cardiac Chi’ set⁵. This can then be practiced in the group or alone at home. A resource folder is available for detailed instructions and for local Tai Chi schools.

Staff instruct clients during the ‘Cardiac Chi’. They stand quietly, focus on their breathing, then complete a short ‘head to toe’ warm up to improve circulation and general mobility.

Thereafter the ‘Cardiac Chi’ set involves eight movements. Each one is repeated five times and then ‘flows’ into the other until the closing movement. Clients then continue on to the physical exercise component.

What did you measure and how?

The Quality Improvement Survey completed in 2011 measured client satisfaction and preference of Tai Chi vs conventional ‘warm up’. Clients were able to practice both types of ‘warm up’ equally during their CRP.

At completion of the CRP (n=21) they completed a five question survey using a strongly agree to disagree response measure.

What did you achieve? Not achieve?

We affirmed that Tai Chi is a suitable preparation before physical exercise. It’s safe and well accepted by most participants. No adverse effects have been reported since introduction.

We refined a ‘warm up’ set based on Shibashi in which clients could readily participate in and complete.

This project has been presented at the 4th APCCRC and VACRA Conferences^{4,6}.

What was the biggest challenge to getting the guideline/initiative taken up?

Our participants are of varying ages, physical capacity and cultural backgrounds. Thus modifying the Shibashi from 18 movements into the ‘Cardiac Chi’ set of eight movements that our clients could effectively practice was the main challenge.

What was the thing that most helped in getting the guideline/initiative/s taken up?

In Australia Tai Chi is an accepted exercise that is also utilised in management of several chronic diseases.

Our staff and manager were enthusiastic about the concept of incorporating variety into a well-established CRP.

The project was ‘driven’ by the RN/CRP Co ordinator.

How did you get the time/money/other resources you needed?

We initiated and were encouraged to complete the Quality Improvement Project and thereafter incorporation of Tai Chi into our program by the CRC manager. This was a small and very inexpensive project, which was easily integrated into the existing CRP infrastructure.

What is your key message to share with other groups about getting guidelines or initiatives used?

Get together with interested clinicians, define your initiatives clearly, scrutinise the available evidence, substantiate the findings and have a final outcome. Define the potential benefits to your clients-program and use available means of support to incorporate the initiative. Finally review and refine the initiative periodically.

References:

- 1a. A systematic review of 'Tai chi exercise for patients with CVS conditions and risk factors' was published by G.Y.Yeh et al. (J Cardiopul Rehabil Prev. 2009;29:152-160)It concluded that preliminary evidence suggests that tai chi may be a beneficial adjunctive therapy for some patients with CVD and CVDRF.
- 1b. Southern health Quality Improvement Report and client survey (n=21) 'Tai Chi for cardiac rehab program warm up' completed September 2011.Clayton CRC staff.
- 2 Shibashi or 18 movement Taichi-Qigong (meaning literally 'breath work)', li is a stationary form of Tai Chi exercise founded by Dr Lim Hou Shen of China. Various references are available.
- 3 'Tai chi exercise for patients with CVS conditions and risk factors' by G.Y.Yeh et al. (J Cardiopul Rehabil Prev. 2009;29:152-160)*See details in reference section; numbers 4, 8,&10, 30,31,32 and 33
- 4 VACRA conference poster presentations:
2009, 'Cardiac Chi ' as an alternative cardiac warm up for phase 2 CRP participants. What are the benefits of Tai Chi? (References 1, 2 and 3). Author's Carolyn Brand, CHN and Lieng Lay, Physiotherapist, ISIS Primary Care, Wyndham Victoria.
2011,'Tai chi as an alternative cardiac rehabilitation exercise'. Author Michael Kolarik RN and Campbell Newton PT, Southern Health Clayton CRC, Melbourne Victoria.
- 5 Diagram of shortened 'Cardiac Chi' form adapted by Michael Kolarik for clients from Shibashi exercise.
- 6 4th Asian Preventative Cardiology & Cardiac Rehabilitation Conference, December 1-2 2012 in Hong Kong.
'Tai Chi as an alternative cardiac rehabilitation 'warm up' exercise is published in the Journal of Hong Kong College of Cardiology(Vol20/ Sup 2)Dec 2012.
- 7 Tai Chi Qi Gong, Shibashi Instruction Manual (with diagrams) by Master Wing Cheung 2010. (Free download at www.taichi18.com)
Poster, video and Shibashi training is available. I completed the level 1 instructors accreditation in 2012.

Evidence-based behaviour change 'not negotiables' for consults and cardiac rehab groups

Ms Janette Gale

Health Change Australia, Kangaroo Valley, NSW

The behaviour change evidence base is a complex body of literature to read through and digest. However, there are clear messages regarding the main factors that are required for clinicians to support behaviour change so that patients have the greatest chance of meeting clinical targets and attaining the best outcomes.

This presentation provides a summary of key learnings from the health behaviour change literature that informs best practice for clinicians. It provides insights regarding three critical factors for clinicians to understand and consider in all patient interactions. Some practical tips to operationalise these factors are included so that clinicians can benchmark themselves in relation to clinical best practice.

Moving HARP into the private setting—a multidisciplinary and individualised approach to providing an exercise rehabilitation and education program for the heart failure patient

K. Easton¹, A. Commane¹, R. Higgins², L. Barker¹, C. Parks¹, C. Vonier¹

¹ Cabrini Health, Malvern, VIC

² Cabrini Health & Heart Research Centre, Melbourne, VIC

What clinical practice guideline or initiative/s did you put into day-to-day practice?

Provide a comprehensive, multidisciplinary program based on the successful Hospital Admission Risk Program (HARP) to Chronic Heart Failure (CHF) patients. Such programs are rare or non-existent in private hospitals.

List the healthcare professionals or consumer groups you worked with or tried to influence.

Hospital management, Private Health Funds, Cardiologists, Physicians, Cardiac Nurses, Clinical Nurse Consultant(CNC), Health Psychologist, Physiotherapist, Dietician, Pharmacist, Social worker, Occupational therapist, General Practitioners, Pastoral Care Workers, Palliative Care staff, CHF patients, spouses and caregivers.

Why was it important to put this guideline/initiative into practice?

All patients with CHF should be offered evidence-based care. Contrary to guidelines, there was a lack of a multidisciplinary approach to management of CHF in the private setting. This required the development of a new model of care incorporating a self-management approach for privately insured patients with CHF.

What strategies did you use to get this guideline/initiative taken up?

- Negotiations between management and private health insurer to fund development of a new model of chronic disease rehabilitation funding
- Ongoing discussions with cardiologists resulted in a collaborative approach to patient care alongside the multidisciplinary team
- Appointment of CNC and expert multi-disciplinary team to develop and staff program
- Training of all program staff in chronic disease self-management
- Development of evaluation plan to measure program outcomes
- Submission of ethics application for program evaluation

Services established

Inpatient—education, self-management support and allied health referral

Home Visits—individualised to patient needs

Group Program—individualised group exercise and education program for appropriate patients

What did you measure and how?

Thirty-eight patients were recruited to the Pilot.

- Data collected at three time points: program entry, completion and 12 months. Outcome measures included Six Minute Walk Test, SF 36, Minnesota LWHFQ, Kessler10, Jenkins Self-Efficacy Scale, Health behaviours
- Presentations to Emergency Department and Hospital Readmissions were compared with pre-program data

What did you achieve? Not achieve?

- A new model of care for private patients

Outcomes included:

- 44% reduction in total acute hospital readmissions and 68% reduction in total acute days in the six months following program entry
- Substantial economic savings for the health fund
- Improved self-efficacy in patients
- Significant improvement in SF36 mental component score

What was the biggest challenge to getting the guideline/initiative taken up?

- Slow referral process
- Sufficient staffing hours to accommodate the workload
- Cultural change
- Resistance to program involvement from some medical staff
- Patient parking issues for rehabilitation

What was the thing that most helped in getting the guideline/initiative/s taken up?

- Funding from Health Fund
- Commitment from the organisation – Cabrini Health
- Support and commitment from medical staff, the Heart Failure Rehabilitation Team and the members of the multidisciplinary/allied health team

How did you get the time/money/other resources you needed?

- Health fund
- Cabrini Health
- Cardiologists offered their time to provide education to the outpatient exercise rehabilitation program

What is your key message to share with other groups about getting guidelines or initiatives used?

- Development of a Heart Failure program using Best Practice Guidelines, with a multidisciplinary team, to provide best patient outcomes, is possible in the Private setting, with the support of management and Health funds.

Heart to heart: Enabling conversations for patients and staff

J. Fildes¹, N. Livermore², C. Ferry³, L. Perry¹, N. Yu¹

¹ The Prince of Wales Hospital, Randwick, NSW

² Eastern Suburbs Mental Health Services, C/O Prince of Wales Hospital, Randwick, NSW

³ National Heart Foundation of Australia (NSW Division)

Introduction

A multidisciplinary health coaching approach to patient education can facilitate self management around lifestyle choices and therefore decrease cardiac morbidity and mortality risks. However staff may not feel competent or confident in this aspect of their clinical care.

Methods

The QI project gained ethics approval to explore staff patient engagement around the use of a heart health resource. Activities comprised staff and patient surveys and retrospective audits of patient notes. What started out as an initiative to increase dissemination of a heart health resource emerged over three years into a self generated community of practice (CoP).

Results

Results showed significant improvement in clinical practice i.e. more staff using and patients receiving the resource. The CoP subsequently developed multidisciplinary forums with nursing, allied health and medical participation which the majority have rated as "Excellent".

Conclusion

It became apparent that supporting staff to have meaningful conversations with patients about heart health rather than just giving out resources was a central priority. The Forums have explored staff patient perceptions with topics such as "Let's talk about sex", "Who gets to treat: Why?" and "Advance care planning: Opportunity or threat?".

A strategy to improve attendance at Phase II education classes

Helen Callum, Sandy McKellar, Matthew Pullen, Gregg McDougall, Jenna Kirchner

The Wesley Hospital, Toowong, QLD

What clinical practice guideline or initiative/s did you put into day-to-day practice?

Providing a comprehensive education program for Phase II cardiac rehabilitation attendees

1. NHF & ACRA Recommended Framework for Cardiac Rehabilitation '04
2. NHF. Secondary prevention of cardiovascular disease. 2010.
3. Private health insurance contracts

List the healthcare professionals or consumer groups you worked with or tried to influence.

- This initiative was influenced by the Q'health MDS collection process.
- Cardiac Nurses, Exercise Physiologists
- Phase 2 clients and their families

Why was it important to put this guideline/initiative into practice?

A review of Phase II education attendance showed that we tracked attendance individually but did not know how our attendance rates for sessions compared globally. Did all patients attend all sessions and were they being targeted appropriately? Investigation revealed on average clients attended only 60% of the education sessions provided.

What strategies did you use to get this guideline/initiative taken up?

Grouped education topics according to NHF risk factor guidelines.

- Included groups on participant outpatient chart.
- Ticked & dated the boxes for every session the patient attended.
- Scheduled education sessions before, between or after exercise sessions.
- Actively marketed education benefits; encouraged and escorted participants to the education room.
- Set improved uptake as a monthly department goal (reportable as part of our organisations Living Values program).

Percent ranked individual "expert sessions" done by the extended team for inclusion in their ISO information

What did you measure and how?

- Patient attendance at Phase II education classes following implementation of a new marketing and recording strategy
- Recorded percentages attendances for each category; each individual and each globally for each month

What did you achieve? Not achieve?

- Improved attendance rates by up to 26%
- Added extra "expert sessions" with the assistance and consensus of the members of the extended multidisciplinary team effectively doubling patient access to and attendance at these classes

What was the biggest challenge to getting the guideline/initiative taken up?

- Time to re-develop our patient pathway to include the revised education topics

What was the thing that most helped in getting the guideline/initiative/s taken up?

- It was a team effort
- It became a marker of monthly achievement for our Living Values program
- It has proved an easy way of tracking performance towards goals

How did you get the time/money/other resources you needed?

We prioritised the time necessary to achieve this goal. We certainly didn't get or need any funding or other resources to undertake the project.

What is your key message to share with other groups about getting guidelines or initiatives used?

Don't let time be your enemy. If you know you have a delivery model issue in your program and want to find a solution, generate a think tank with your team—managers and staff; then work together to construct a common strategy that you can prioritise and work together to achieve.

Automatic, not automated, referral of all eligible cardiac inpatients to an OCR program

Helen Callum, Sandy McKellar, Yvonne Connolly, Jan McKenzie, Nicki Butler, Julianne Hatcher

The Wesley Hospital, Toowong, QLD

What clinical practice guideline or initiative/s did you put into day-to-day practice?

- Referral of inpatients to Phase II cardiac rehab
- NHF & ACRA Recommended Framework for Cardiac Rehabilitation '04
- NHF. Secondary prevention of cardiovascular disease. 2010

List the healthcare professionals or consumer groups you worked with or tried to influence.

Cardiac Clinical Nurses, cardiac ward and coronary care ward staff

Why was it important to put this guideline/initiative into practice?

On average, only 23% of cardiac inpatients at The Wesley Hospital live in the catchment area of The Wesley's OCR program, leaving 77% (approx. 750 annually) of our cardiac inpatients to be referred elsewhere. We needed a simple referral strategy for us and other cardiac rehab services.

What strategies did you use to get this guideline/initiative taken up?

- We are unable to generate an electronic automated referral system in our organisation
- Using OCR state directory we produced a one page flyer with contact information for every program we routinely refer to in Queensland
- Reviewed and revised inpatient information currently collected to reflect the new information we wanted to collect

What did you measure and how?

- Numbers of inpatients seen annually by collating patient demographic info and referral patterns which is recorded on a database monthly
- Reasons for non-referral

What did you achieve? Not achieve?

- Accurate referral data for major referral centres
- A system that worked seamlessly for us to refer and collate data
- A system that provided relevant information to the client being referred

What was the biggest challenge to getting the guideline/initiative taken up?

Deciding on the data relevant to include; minimum requirements were clear using MDS guidelines however limiting the amount required for a one page referral form and data collection was a hurdle.

What was the thing that most helped in getting the guideline/initiative/s taken up?

- Enthusiasm by the team to find a system that worked

How did you get the time/money/other resources you needed?

- Part of role
- No extra time required
- The staff believed that this process review would actually create efficiencies for us

What is your key message to share with other groups about getting guidelines or initiatives used?

Whatever you believe needs doing—Just do it! There will never be the perfect time. Perfection is the greatest enemy of good!

Do clients believe that cardiac rehabilitation group content meets their needs?

Lynn Murdoch, Maureen Stumke, Lin Rabbidge

Community Health, Integrated Health Centre, Peninsula Health, Frankston, VIC

What clinical practice guideline or initiative/s did you put into day-to-day practice?

- Evaluation of client satisfaction with cardiac rehabilitation group component of program to assess relevance of content and value to participants, both clients and carers

List the healthcare professionals or consumer groups you worked with or tried to influence.

- Three cardiac rehabilitation groups at two sites across Peninsula Health, comprising 86 participants
- Three registered nurses working in Community Health

Why was it important to put this guideline/initiative into practice?

- To determine whether the groups met the client/carer needs during early phase adjustment to new health status and beginning period of behavior change

What strategies did you use to get this guideline/initiative taken up?

- Devised in-house questionnaire
- Discussed rationale for survey between key clinicians working at groups
- Promoted participation to clients and carers who attended at least 5 sessions of 7
- Gave clients survey to take home and return via reply paid envelope anonymously
- Made participation optional

What did you measure and how?

- Participant expectations
- Usefulness and applicability
- Confidence of participants in health professional supervision and support
- Most and least beneficial components of groups from participant perspective
- Suggestions and comments for quality improvement

What did you achieve? Not achieve?

- Quality responses detailing feedback which was useful for group alteration or maintenance of positive components
- Quality feedback regarding value of attendance for clients and carers
- Additional data to support other evaluation data such as attendance and completion rates following a comprehensive review and update of the program

What was the biggest challenge to getting the guideline/initiative taken up?

- Finding the time to devise the survey and implement the data collection and collation

What was the thing that most helped in getting the guideline/initiative/s taken up?

- Quality rapport with clients and carers gained during the seven week attendance
- This was in conjunction with strong peer rapport at groups facilitated through an active client focused dynamic.

How did you get the time/money/other resources you needed?

- No money allocated
- Quality improvement focus by program coordinator for best client outcomes and satisfaction
- Good time management and efficient work practice

What is your key message to share with other groups about getting guidelines or initiatives used?

Clients and carers are the source of overt and covert feedback about service quality. Clinicians must gain insight into this to ensure that risk reduction needs are met in the early phase of recovery. This may then have a strong positive influence on outcomes for long term behavior change.

At last ... an evening group!

Sheryl Gregson, Ruth Davison, Maree Hextall

Canterbury District Health Board, Christchurch, New Zealand

What clinical practice guideline or initiative/s did you put into day-to-day practice?

- The establishment of an evening Cardiac Rehabilitation Program for patients and supporters who were unable to attend our existing daytime program through work, family or transport difficulties.

List the healthcare professionals or consumer groups you worked with or tried to influence

- Patient group
- Multidisciplinary team members
- Cardiologists
- Service managers

Why was it important to put this guideline/initiative into practice?

- To provide timely, appropriate cardiac rehabilitation for a patient cohort who were struggling to attend our conventional program
- Decreased attendances from this group attributed to shorter lengths of hospital stay, early return to work, compounded by earthquakes and economic downturn
- Engagement and education of young patients early in heart journey

What strategies did you use to get this guideline/initiative taken up?

- We canvassed and consulted with our patients regarding their preferred options
- Reviewed evening groups currently running in NZ; based on information gained we developed a program suited to our population
- Assessed willingness of other multi-disciplinary team members to participate outside 'normal' work hours
- Researched appropriate venue – availability, cost, parking
- Discussed with stakeholders – content, time, length and frequency of sessions and impact on existing service provision
- Proposal for support initially to our Service Manager then sought support from Service Managers in Allied Health
- Program had to be cost neutral

What did you measure and how?

- Measured attendance and patient demographics
- Measured Patient and Supporter satisfaction
- Developed questionnaire and collated data
- Monitored impact on core daytime program
- Monitored impact on overall service delivery
- Retrospective Patient and Supporter survey being developed currently

What did you achieve? Not achieve?

- We have been able to provide a condensed and effective education program and support for a patient group previously lost to cardiac rehabilitation with minimal impact to our core service.
- We are not able to offer exercise within the program but do provide discussion and advice on same

What was the biggest challenge to getting the guideline/initiative taken up?

- Managing to sustain uncompromised service with increased workload and no increase in FTE
- Ensuring expert speaker availability
- Venue – obtaining appropriate dates and times due to demand on facilities post earthquake

What was the thing that most helped in getting the guideline/initiative/s taken up?

All MDT members had long recognised a need for this program and offered willingness and commitment to provide the best opportunity to engage this particular patient cohort in cardiac rehabilitation.

How did you get the time/money/other resources you needed?

We used existing staff resources and worked flexi-hours as required. We were able to utilise and adapt our existing resources to meet our needs.

With no extra cost to our service apart from hall hire we were able to negotiate with our manager to let us 'give it a go'.

What is your key message to share with other groups about getting guidelines or initiatives used?

Our evening group has increased accessibility to cardiac rehabilitation for a patient cohort who have struggled to attend. We have attracted a diverse group of patients previously difficult to engage in our program.

With commitment and goodwill an effective program can be presented at very little increased financial cost.

Formal review of cardiac rehabilitation and cardiomyopathy service—roads and roadblocks

K. Kelly, K. Poole, M. Kerlin

The Royal Melbourne Hospital, Parkville, VIC

What clinical practice guideline or initiative/s did you put into day-to-day practice?

The Royal Melbourne Hospital (RMH) has undertaken an extensive review of its Cardiac Rehabilitation (CR) and Cardiomyopathy (CM) service in 2011/12. As a result, a number of changes were implemented, leading to a more streamlined and enhanced service.

List the healthcare professionals or consumer groups you worked with or tried to influence.

This comprehensive service review involved benchmarking against National Heart Foundation Recommendations and similar Health Services. All aspects of the CR and CM service were reviewed, with input from consumers, Allied Health team members and the hospital's business/financial advisors.

Why was it important to put this guideline/initiative into practice?

No formal review of the two services had taken place since their beginning/inception 10+ years ago.

What strategies did you use to get this guideline/initiative taken up?

A reviewer was appointed and together with the key stakeholders, Terms of Reference were formulated.

Regular stakeholder meetings were held, and key areas reviewed such as the patient journey, CR coordinator journey, referral processes etc.

What did you achieve? Not achieve?

Roads—many benefits came from the Review: a new streamlined CR referral process for inpatients was implemented, an offsite venue for CR was secured, dedicated clerical support was allocated to the service, and the program delivery and content was revamped and revitalised.

What was the biggest challenge to getting the guideline/initiative taken up?

Roadblocks—negotiating space which is a premium, access to CR for culturally and linguistically diverse (CALD) in tight economic times, and having hospital financial controllers appreciate the health benefits of the service.

What is your key message to share with other groups about getting guidelines or initiatives used?

While the Review, requested by Hospital Management was initially daunting and was a mammoth task, it provided an opportunity to reflect, review and reinvigorate the service. The CR and CM service at RMH is now more efficient, patient-focused and has a 21st century application, benefitting the patients, hospital, and the wider community.

The National Heart Foundation of Australia consensus statement on psychosocial risk factors for coronary heart disease

Nick Glozier¹, Geoffrey H Tofler², David M Colquhoun³, Stephen J Bunker⁴, David M Clarke⁵, David L Hare⁶, Ian B Hickie¹, James Tatoulis⁷, David R Thompson⁸, Alison Wilson⁷, Maree G Branagan⁷

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Introduction

New evidence has emerged around psychosocial risk factors and CHD necessitating an update to the 2003 National Heart Foundation position statement on stress and CHD, to guide health professionals in acute and primary care in Australia.

Methods

An expert working group reviewed new evidence around psychosocial stressors including acute individual stressors, acute population stressors, and chronic stressors (in particular workplace stress). Depression is discussed in a separate paper.

Results

- An acute emotional stress may trigger myocardial infarction (MI) and Tako Tsubo (“stress”) cardiomyopathy, although the absolute increase in transient risk due to an individual stressor is low.
- Awareness of the potential for increased cardiovascular risk among populations exposed to natural disasters and other conditions of extreme stress may be useful for emergency services response planning.
- Public access defibrillators should be available where large populations gather and as part of a response to natural and unnatural disasters.
- Perceived chronic job stress and shiftwork are associated with a small increased risk for the subsequent development of CHD.
- Workplace programs aimed at weight loss, exercise and other standard risk factors may have positive outcomes on these risk factors but no evidence is available with respect to the effect of such programs on the development of CHD.
- Social isolation is associated with a poor prognosis post MI. Attempts to reduce social isolation are likely to produce positive psychosocial effects, although there is no evidence of an improvement in CHD outcomes after a cardiac event.

Conclusion

Psychosocial stressors have an impact on CHD however clinical significance and prevention require further study.

National Heart Foundation of Australia consensus statement on depression in patients with coronary heart disease: Recommendations for screening, referral and treatment

David M Colquhoun¹, Stephen J Bunker², David M Clarke³, Nick Glozier⁴, David L Hare⁵, Ian B Hickie⁴, James Tatoulis⁶, David R Thompson⁷, Geoffrey H Tofler⁸, Alison Wilson⁶, Maree G Branagan⁶

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⁷ Cardiovascular Research Centre, Australian Catholic University, Melbourne, VIC

⁸ Royal North Shore Hospital, University of Sydney, Sydney, NSW

Introduction

New evidence has emerged around depression and CHD necessitating an update to the 2003 National Heart Foundation position statement on stress and CHD, to guide health professionals in acute and primary care in Australia.

Methods

An expert working group reviewed new evidence in this area. Recommendations were made for screening, referral and treatment based on this evidence.

Results

- The prevalence of depression is high in patients with CHD. Depression has a significant impact on the patient's quality of life, adherence to therapy, and has an independent effect on prognosis.
- A simple tool for initial screening, such as the Patient Health Questionnaire-2 (PHQ-2)*, can be incorporated into usual clinical practice with minimum interference, and may increase uptake of screening.
- If screening is followed by comprehensive care, depression outcomes are likely to be improved.
- Depression in CHD patients responds similarly to collaborative care, cognitive behavioural therapy, exercise, and some drug therapies as it does in other patients with depression in the general population.
- Many patients with mild depression and CHD respond well to regular exercise and cardiac rehabilitation (exercise based).
- Exercise may also improve CHD outcomes in patients with CHD.

Conclusion

The benefits of treating depression include improved quality of life, improved adherence to other therapies and potentially improved CHD outcomes.

An integrated secondary prevention group program reduces depression in cardiac patients

Rosemary Higgins, Barbara Murphy, Alyna Turner, Peter Elliott, Michael Le Grande, Alan Goble, Marian Worcester

Heart Research Centre, Melbourne, VIC

Introduction

Depression is common following an acute cardiac event and can occur at a time when behaviour change is strongly recommended to reduce the risk of further cardiovascular events. The 'Beating Heart Problems' program was designed to support cardiac patients in behaviour change and mood management.

Methods

The program was based on cognitive behaviour therapy and motivational interviewing. A randomised controlled trial (RCT) comparing the 8-week group program with usual care was undertaken between 2007 and 2010. All patients attended a clinic for assessment of physiological risk factors at baseline (6 weeks after their acute event), and at 4- and 12-month follow up. Psychological indicators were assessed by self-report questionnaires. Of the 275 patients enrolled into the RCT, 42 (15%) had Beck Depression Inventory-II scores >13 at baseline. Treatment and control group comparisons were undertaken for this subgroup, using growth curve modelling and testing for group differences over time in psychological measures.

Results

Significantly greater improvements ($p<0.01$) in depression symptoms and self-rated health were reported for the intervention group, as well as significantly larger gains in confidence in managing depression ($p<0.05$) and anger ($p<0.01$). Trends ($0.05<p<0.10$) for larger treatment group improvements were also seen for anxiety symptoms and confidence in managing anxiety.

Conclusion

Improvements in depression scores were consistent with depression focused interventions. A group secondary-prevention programme that integrates behavioural and mood management strategies leads to decreased depression, increased confidence, and improved health perceptions in depressed cardiac patients.

Development and validation of a brief cardiac depression scale in a cardiac rehabilitation population

Dr Frances Wise^{1,2}, Dr Darren Harris³, Prof. John Olver²

¹ Cardiac Rehabilitation Unit, Caulfield Hospital, VIC

² Epworth Monash Rehabilitation Medicine Unit, Epworth Hospital, VIC

³ Aspex Consulting, Melbourne, VIC

Objective

The current study was undertaken to provide evidence supporting the reliability and validity of the Brief version of the Cardiac Depression Scale (B-CDS) in a population of cardiac rehabilitation patients.

Methods

The CDS was administered to 1479 consecutive ambulatory adult patients attending an outpatient Cardiac Rehabilitation program. From the CDS, a Brief form (B-CDS) consisting of ten items was developed using factor analysis with maximum likelihood extraction and oblique (oblimin) rotation. The B-CDS was then evaluated on a separate, representative cohort of 150 cardiac rehabilitation patients, to explore its predictive value with cardiac rehabilitation outcomes.

Results

The B-CDS proved to be additive with high internal consistency (Cronbach's $\alpha = .84$) and convergent validity with the full CDS ($r = .94$). Receiver Operating Characteristic (ROC) curves suggested a B-CDS cut-off score of 39 to detect more severe depression, with good sensitivity (86%), specificity (92%) and overall accuracy (90%). The B-CDS was significantly associated with patients' exercise capacity, and independently predicted subsequent rehabilitation attendance and Health-Related Quality of Life. This new brief version takes no more than two minutes to complete.

Conclusion

These findings support the use of the Brief CDS as a screening tool for depressed mood in cardiac rehabilitation patients, which may prove helpful in busy clinical settings where longer instruments prove burdensome.

Socioeconomic predictors of work–time and leisure–time physical inactivity after an acute cardiac event

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⁵ Director, Heart Research Centre, Royal Melbourne Hospital, VIC

Introduction

Physical inactivity has been identified as a distinct health risk. However, little is known about how this can vary at work and leisure in cardiac patients. The aim of the current study was to examine the predictors of inactivity during work and leisure in the 12 months following a cardiac event, with particular attention to sociodemographic factors.

Methods

A series of 346 patients consecutively admitted to hospital with acute coronary syndrome or to undergo coronary artery bypass graft surgery were interviewed in hospital, and 4 and 12 months later. Work and leisure physical activity was measured using the Stanford Brief Activity Survey. Socio-demographic, psychosocial and medical data were also collected. Logistic regression was used to identify predictors of work-time and leisure-time physical activity at 12 months.

Results

Approximately 50% of participants were physically inactive in their work, regardless of whether this was measured before or after the cardiac event. Leisure-time physical inactivity declined over time, with 52% inactive pre-event and 29% inactive at 12 months. The significant predictors of work-time physical inactivity at 12 months were white collar occupation and prior physical inactivity at work. The significant predictors of leisure-time physical inactivity at 12 months were non-home ownership and prior physical inactivity at leisure.

Conclusions

Socioeconomic indicators predicted both leisure and work inactivity after an acute cardiac event, together with pre-event physical inactivity. Sociodemographic factors need to be taken into account when designing interventions for increasing physical activity in work-based and leisure-based settings.

Social deprivation and social determinants of health

Dr Rob Grenfell

Heart Foundation

By international standards Australians enjoy good health. But for too many people, good health—and life's chances—are compromised by virtue of their social position. Despite declining rates of cardiovascular disease mortality in recent years, people from lower socioeconomic groups continue to experience a disproportionate burden of cardiovascular disease (1). The most disadvantaged groups in Australia are almost twice as likely to die from cardiovascular disease as those from the least disadvantaged groups (2).

This inequity is not randomly assigned; it is shaped by deeper social structures (3). Factors that contribute to differences in health between people include income, education, social status, control over life choices, discrimination, stress, social isolation; access to health and other services; social, political, economic and physical environments; and individual health related behaviour (3, 4). These factors are referred to as the social determinants of health.

The WHO Closing the Gap in a Generation report urges the health sector to adopt a broader social determinants of health approach in its prevention, policies, service delivery and programs (3). The WHO calls for social determinant approaches to be explicitly identified and addressed in treatment guidelines, policy documents, training modules and implementation research related to CVD (5). The Heart Foundation is responding to this imperative with its new strategic focus on health equity.

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KPIs in Cardiac Rehabilitation

Dr Robert Grenfell

Heart Foundation

Introduction

Each year in Australia, coronary heart disease (CHD) accounts for about 100,000 hospital separations and a high proportion of events occur in those with known CHD. This places a significant burden on the health system with the cost of repeat ACS events in 2010 estimated at over \$8 billion. Contemporary secondary prevention strategies, such as cardiac rehabilitation, have been shown to improve recovery and management of CHD while reducing recurrent cardiac events. Despite the known benefits of these strategies, uptake and completion is consistently low and the reasons for which are many.

Workshop overview

The workshop aims to discuss and define the future directions for cardiac rehabilitation in Australia to improve referral, uptake and completion. This will be informed by the recent release of the Secondary prevention of coronary heart disease in Australia: a blueprint for reform.

Firstly, the current landscape for cardiac rehabilitation will be presented. This will include:

- an overview of the 'state of play' of cardiac rehabilitation at the state, territory and national level, and
- identification of key system and policy gaps and opportunities.

With this in mind, future directions for cardiac rehabilitation will then be discussed with particular consideration given to:

- the role of each of the key stakeholders of influence – patients, health professionals, health services and government;
- alternative models of care;
- the patient journey from event back into community – positioning cardiac rehabilitation within broader secondary prevention reform; and
- meeting the needs of vulnerable populations.

Improving Cardiac Rehabilitation Program Access

Dr Paul MacIntyre

Royal Hobart Hospital, Hobart, TAS

This workshop will revisit eligibility for cardiac rehabilitation and will consider coding issues for those eligible for cardiac rehabilitation in the Australian Health Care System. The workshop will be interactive. It will focus on barriers for referral, uptake and completion of cardiac rehabilitation programs. Dr MacIntyre will engage with the audience to develop strategies overcoming barriers in cardiac rehabilitation.

Cardiac rehabilitation services, past, present and future: Where to from here?

Dr Marcia George

ISIS Primary Care Limited, Williamstown, VIC

The purpose of this workshop is to bring the collective viewpoints and experiences of like-minded professionals together, in a collaborative and interactive forum to discuss and debate the role of cardiac rehabilitation services (CRS) in today's contemporary health care environment.

The theme underpinning this workshop is 'one size does not fit all' in CRS. It is with this assertion in mind that the workshop will explore the following questions: 'Are CRS effective in: (a) responding to the enormous changes taking place in cardiac medicine? and (b) responding to the changing needs of an increasingly diverse and complex community?'

Utilising case study vignettes, the workshop will discuss the role of CRS within the broader context of the cardiac services continuum of care. The challenges confronting phase 3 CRS in a high-risk, multicultural community health care environment, and the significance of the traditionally acknowledged levels of CRS, otherwise known as phase 1, phase 2 and phase 3 CRS, will be explored.

Finally, by highlighting some of the gaps that currently exist in CRS, this workshop also aims to identify potential new pathways from which gaps in CRS can be overcome with the support of more streamlined and more flexible approaches to the way in which CRS are now delivered.

Regional/rural inequalities

Associate Professor Leigh Kinsman

Monash University, Melbourne, VIC

The disadvantage experienced by rural Australians for cardiovascular disease prevalence and death is unacceptable for a developed nation. Australians living outside of major cities are 20% more likely to develop cardiovascular disease than those in major cities, while those living in remote areas are 38% more likely to die of cardiovascular disease than their city counterparts. In fact, cardiovascular disease prevalence and death rates in rural Australia compare poorly with other developed nations.

This inequity can be explained by three factors:

- Worse lifestyle and risk factor profiles for rural Australians
- Lower socio-economic status for rural Australians
- Poorer access to appropriate health services in rural areas

There is potential for the rural/urban gap to be significantly reduced through improved cardiovascular disease prevention across primary care services. More appropriate, accessible rural and remote primary care services combined with greater emphasis on lifestyle advice, screening, health promotion and risk factor management will save lives. Unfortunately, rural primary care practitioners report that cost, lack of motivation (patients and health professionals) and insufficient time combine with a funding system that rewards disease management to hinder primary care-based health promotion.

Recent primary care research suggests that targeted education and quality improvement initiatives are associated with improved cardiovascular disease prevention activities both in rural Australia and Europe. Unsurprisingly, these studies also demonstrated that there was a positive association between the quality of cardiovascular disease prevention activities and the proportion of primary care staff that were health professionals (usually GPs and nurses).

The deplorable inequity regarding cardiovascular disease between rural and city-based Australians is unacceptable, yet can be readily reduced through primary care models that encourage primary and secondary prevention through a combination of incentives, education and quality improvement.

Socioeconomic inequalities

Dr Alison Beauchamp

Deakin University, Burwood, VIC

By any measure of socioeconomic position (SEP) people who are more disadvantaged have both a greater risk of cardiovascular disease (CVD) and are more likely to experience poorer outcomes following a cardiac event. Many studies report a social gradient in CVD from the most to the least disadvantaged, implying that the burden of disease is greatest among those groups with fewer resources to manage their condition. While there is a strong evidence-base of recommended interventions for the management of CVD, it is vital that such interventions are shown to be equitable. If interventions are taken up more readily by higher SEP groups, they may lead to widening inequalities. Yet little is known about the impact on socioeconomic inequalities in CVD of current 'best-practice' strategies such as cardiac rehabilitation. Further, because the mechanisms underlying the social gradient are not clearly understood, it is difficult to identify key areas for intervention. For example, it is known that social disadvantage is associated with a greater prevalence of cardiovascular risk factors. However, these risk factors are thought to account for only about 50% of CVD inequalities and so interventions that target risk factors alone may not effectively reduce the social gradient.

Low health literacy may be an important mechanism between SEP and health outcomes. Health literacy is defined as a person's motivation and ability to find, understand and use health information and services effectively. Low health literacy is associated with poorer health outcomes, inappropriate use of health services, and socioeconomic disadvantage. Few studies have examined the relationship between health literacy and cardiac rehabilitation. Preliminary results from a study that uses a new questionnaire to identify health literacy-related predictors of attendance at cardiac rehabilitation will be presented.

Coalface reality check: Cardiac rehabilitation services in a complex, high-risk, community health care setting

Dr Marcia George

ISIS Primary Care Limited, Williamstown, VIC

This case study presentation explores some of the challenges that have confronted phase 3 cardiac rehabilitation services (CRS) in a high-risk, low sociodemographic, multicultural, and multi-ethnic community. Adding to social and cultural challenges were complexities such as: diversity in patients' diagnostic mix, low attendance rates, burgeoning waiting lists and ambiguous referral systems. These issues contributed to the multiplicity of challenges confronting these CRS. They also served as the catalyst for change leading to the eventual restructuring of these CRS.

The premise underpinning this restructuring process was 'one size does not fit all' in CRS. As such, it was argued that to remain relevant and responsive to the changing needs of the community, CRS were in need of greater levels of flexibility in their structure, content, and timeframes. It was this hypothesis that spearheaded and sustained the subsequent climate of CRS change.

Especially significant however, was the development of a simple, triage and clinical stratification framework. This framework offers a clearly defined pathway, from which the complexity and diversity of patients' needs can be aligned with that of a corresponding level of CRS. In other words, enabling CRS to more effectively respond to the CRS needs of patients; rather than patients being expected to comply with the inflexible constraints of CRS. This simple triage and clinical stratification framework has since become the conduit from which these CRS have continued to survive in this challenging, community health care setting.

Attendance rate data, key performance indicators, and details outlining this restructuring process are discussed further in the presentation of this paper.

Geographic mapping and remote telemonitoring

Associate Professor Robyn A Clark

Flinders University, Bedford Park, SA

Background/Aims

Timely access to appropriate cardiac care is critical for optimising outcomes of a cardiac event. In Australia the overall attendance at cardiac rehabilitation remains less than optimal (ranging 10%-30%). Our aim was to derive an objective, comparable, geographic measure, the Cardiac Accessibility and Remoteness Index of Australia (Cardiac ARIA), reflecting access to cardiac services for all 20,387 population locations after a cardiac event.

Methods

An expert panel defined a single patient care pathway. Using geographic information systems (GIS) the numeric/alpha index was modelled. The aftercare phase was modelled into 5 alphabetic categories: A (Access to general practitioner, pharmacy, cardiac rehabilitation, pathology \leq 1 hour) to E (no services available within 1 hour).

Results

Approximately 96% or 19 million people lived within 1 hour of the four basic services to support cardiac rehabilitation and secondary prevention, including 96% of older Australians and 75% of the indigenous population. Conversely, 14% (64,000) indigenous people resided in population locations that had no access to any service to support cardiac rehabilitation.

Conclusion

Results demonstrated that the majority of Australians had excellent "geographic" access to services to support cardiac rehabilitation and secondary prevention. Therefore, it appears that it is not the distance to services that affects attendance. Innovative clinical practice such as telehealth is needed to improve uptake of this important aspect of cardiac care.

Screening and early diagnosis of heart failure

Professor Tom Marwick

Menzies Research Institute Tasmania, Hobart, TAS

Heart failure (HF) has reached epidemic proportions, with a lifetime risk of >30% in people between 50 and 80 years old. The problem is likely to grow further with the ageing of the population. Despite much effort and many advances, HF remains an expensive and morbid diagnosis. Part of the cause of this is that presentations with symptoms and signs (Stages C or D) of HF occur when much damage has occurred—to the extent that the situation is difficult to reverse with medical therapy.

The solution which has been widely canvassed is to identify and treat patients with the early phases of HF—either preclinical LV dysfunction (Stage B) or risk factors (Stage A). The rationale of this step is that the initiation of therapy before substantial LV damage is more likely to prevent further damage, and change the trajectory of the disease. A number of new echocardiographic tools have become available that puts the ability to identify this early disease in the hands of clinicians in the community.

The problem with screening strategies for all diseases is that the correct identification of the disease is dependent not only on the reliability of the imaging test but also the prevalence of the disease in the population being screened. Therefore the initial clinical evaluation of patients using HF risk scores is an important 1st step. The subsequent steps may involve either blood tests for type B natriuretic peptide, echocardiography or both. The recognition and treatment responses to Stage B heart failure should be familiar to all clinicians if the seemingly irresistible progression to HF is to be reversed.

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CVD risk factors and primary prevention

Professor Simon Stewart

Baker IDI Heart and Diabetes Institute, Melbourne, VIC

Australia and the wider international community face an evolving epidemic of cardiovascular disease driven by a combination of inevitable population dynamics and modifiable ways in which people choose to live their lives (and place themselves at increased risk of premature disease, disability and death). As part of our response to a challenging health care environment (with finite resources) there is a critical need to understand who are most vulnerable to developing cardiovascular disease and how we might apply innovative primary care prevention strategies to mitigate future risk in vulnerable individuals and communities. This presentation will review current trends in cardiovascular risk with a particular focus on regional and Indigenous communities. It will also review the potential application of innovative prevention strategies under the auspices of a national/international collaboration—The National Health and Medical Research Council of Australia (NHMRC) Centre of Research Excellence to Reduce Inequality in Heart Disease led by the Baker IDI Heart and Diabetes Institute.

Determining minimal important change in incremental shuttle walk test results in a cardiac rehabilitation population

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Cardiac rehabilitation programs use field walking tests such as the Incremental Shuttle Walk Test (ISWT) as a method of participant assessment and measure of program outcome. In order for clinicians and researchers to interpret test results, it is important to not only understand the statistical significance of results but also the clinical importance of results. The minimal important change (MIC) is the smallest meaningful change in test score. We aimed to determine the MIC in ISWT results as perceived by patients attending a cardiac rehabilitation program.

Fifty-two patients referred for cardiac rehabilitation completed two ISWTs (ISWT1 and ISWT2) on admission and two ISWTs on completion (ISWT3 and ISWT4) of a cardiac rehabilitation program. Upon completion, patients also rated their perceived change in health status using a five-point ordinal global rating of change scale.

The MIC was determined using an anchor-based minimal important change distribution method. The global rating of change was used as an anchor, with patients categorised as deteriorated, unchanged, or improved, and the measure of change was determined by the difference in distance walked between ISWT4 and ISWT2.

The group mean change scores for patients reporting an improvement in global rating of change was 146m (\pm 57). The MIC was determined to be 85m based on the receiver operator characteristics (ROC) cut-off. The MIC improves clinician and researcher understanding of the ISWT in cardiac rehabilitation.

Cardiac rehabilitation in the private health sector; catching up with public programs

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¹ Cabrini Health, Malvern, VIC

² Heart Research Centre, Melbourne, VIC

What clinical practice guideline or initiative/s did you put into day-to-day practice?

Guidelines recommend a comprehensive, multidisciplinary cardiac rehabilitation (CR) program to support self-management. We were funded by a private insurer to develop and pilot a 12-session best practice CR program.

List the healthcare professionals or consumer groups you worked with or tried to influence.

The private health fund was invited to fund this new program to improve service for their members. The pilot program was developed collaboratively by a multidisciplinary team comprising Cardiac Nurses, Physiotherapist, Health Psychologist, Dietitian, Pharmacist, Social Worker, Occupational Therapist and Pastoral Care. Learning goals and key outcomes were identified.

Why was it important to put this guideline/initiative into practice?

The existing CR program did not meet best practice guidelines. This pilot program will collect evidence to support the provision of this comprehensive model of care to all privately insured cardiac patients. Other health funds will then be approached to fund the provision of this comprehensive program to their members.

What strategies did you use to get this guideline/initiative taken up?

Negotiations between management and the private health insurer to fund the development of a new model of chronic disease rehabilitation

- Appointment of highly expert multi-disciplinary team to develop and staff program
- Training of all program staff in chronic disease self-management including motivational interviewing
- Appointment of psychologist to support program
- Development of pilot program protocol in line with best practice guidelines
- Development of evaluation plan to measure program outcomes
- Submission of ethics application for program evaluation
- Measurement of outcomes in usual care quasi-control group comprising patients not funded by the specific insurance fund
- Regular team meetings to guide progress

What did you measure and how?

Entry assessments were conducted on 99 cardiac patients in the first 12 months of the program. The assessment was repeated on program exit (n=65) and will be repeated again 12 months after program entry.

Measures used included the Kessler 10, Six Minute Walk Test, SF36 and Jenkins Self-Efficacy Scale.

What did you achieve? Not achieve?

84 (84%) of patients completed the program, demonstrating high acceptability. Significant improvements were observed in functional capacity ($t(60)=4.25, p<.001$), and overall self-efficacy ($t(56)=4.71, p<.001$) along with other measures. It is anticipated that the private health fund will continue to fund the program and that other health funds will also participate.

What was the biggest challenge to getting the guideline/initiative taken up?

The common change-management challenges were experienced. In particular, attitude changes were required to facilitate the adoption of a patient-centred, individualised, self-management approach which included comprehensive assessment of patient needs.

What was the thing that most helped in getting the guideline/initiative/s taken up?

Cross-fertilisation between the public and private sector created opportunities to challenge and change existing cardiac rehabilitation practices. Management was committed to the development of this new private model of care.

How did you get the time/money/other resources you needed?

Provided by Cabrini Health (staff and equipment) and the private health fund.

What is your key message to share with other groups about getting guidelines or initiatives used?

All programs should follow evidence-based practice whether in a public or private setting. Private health funds need to be provided with evidence to prove that this model is effective, both in the interest of the patient and cost.

Audit of cardiology patients with a history of mental health disorders in a smoking cessation clinic

Paul Camp, Wendy Senior

Mater Adult Hospital, Brisbane, QLD

Introduction

Smoking remains a major driver of health inequity and cardiovascular disease amongst those with mental health disorders. At the same time, this group experience higher levels of nicotine dependence, often requiring more intensive support to quit smoking. A hospital based nurse-led smoking cessation clinic was commenced to offer intensive support for cardiology patients who smoked. An audit of the clinic examined gaps in how those with a history of a mental health disorder used this service.

Methods

Patients with coronary artery disease, heart failure, atrial fibrillation or those seen under a chest pain assessment service and who smoked, were offered up to 10 outpatient visits over 3 months to the 'Cardiac Patients Smokers Clinic'. The clinic provided face-to-face counselling, ongoing evidenced-based behavioral support, advice on smoking cessation pharmacotherapy and validation using carbon monoxide monitoring. An audit evaluated levels of nicotine dependence, clinic attendance rates, use of smoking cessation pharmacotherapy and abstinence rates, as well mental health history.

Results

The audit of clinic patients (n=66) showed that those with a history of mental health disorders, experienced higher levels of nicotine dependence ($p=0.046$). Even so, these patients were no less likely to attend clinic appointments, use smoking cessation pharmacotherapy or achieve abstinence, as those without a history of a mental health disorders.

Conclusion

Results from this audit suggest that cardiology patients with a history of mental health disorders are just as likely to use a smoking cessation clinic and achieve abstinence, even despite having higher levels of nicotine dependence.

Living well with heart failure: The role of the occupational therapist in the management of chronic heart failure

Pamela Maryse Arndt, Glenn Paull

St George Hospital, Kogarah, NSW

Introduction

Multidisciplinary Heart Failure (HF) programs are recommended as standard care for Chronic Heart Failure (CHF) patients presenting with unique needs and physical symptoms of shortness of breath, fatigue, activity restriction and deteriorating cognitive function. Characterised by acute exacerbations and often poor quality of life, HF patients have an ongoing and dynamic requirement for support, evaluation and advice.

Methods

To explore the views of HF patients regarding the content of Occupational Therapy education sessions a sample (n=40) of adults who attended Occupational Therapy groups in a 12-week HF rehabilitation program completed a written survey about gaining new knowledge, levels of comfort sharing concerns in a group, and the most and least useful information. Responses were analysed using descriptive statistics.

Results

Analysis of data revealed favourable evaluation of the Occupational Therapy sessions with 70% reporting gaining new knowledge. Only a minority (8%) expressed discomfort in speaking up in the group situation. Factors identified as most useful in meeting patient's needs were: practical strategies (40%), social support (37%), information on the condition (13%), and understanding of fluctuating symptoms (13%). Information on sleep was identified as the least useful information provided.

Conclusion

CHF is a physical disease producing physical symptoms presenting challenges to clinicians when facilitating self-management strategies. This presentation will focus on Occupational Therapy interventions for CHF management and discuss development of tailored lifestyle strategies to facilitate functional improvements and provide support to this vulnerable population.

Perceived interrelationships between chronic disease and mental health in the urban Melbourne Aboriginal community context

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⁶ Director, Heart Research Centre, Royal Melbourne Hospital, VIC

Introduction

The unique contributions of both chronic disease and mental health disorders to the life expectancy gap between Aboriginal and Torres Strait Islander (A&TSI) community and non-A&TSI community are widely recognised. Limited qualitative investigation has occurred concerning the interrelationship between chronic disease and mental health, and the associated burden such co-morbidities have on affected community members. A qualitative investigation was undertaken in partnership with the Traditional Custodians of Melbourne, as represented by the Wurundjeri Tribe Land Compensation Cultural Heritage Council (TLCCHC) Inc, the Heart Research Centre (HRC) and the General Practice and Primary Health Care Academic Centre, University of Melbourne. The study explored the perceived interrelationships, as identified by service providers, between chronic disease (i.e., heart, kidney, liver and lung disease, diabetes, cancer, lupus and arthritis) and mental health, in the urban Melbourne A&TSI community. The views of service providers on how services could be improved for this population were also explored.

Methods

Semi-structured interviews were conducted in seventeen health and allied health organisations in urban Melbourne. Participants comprised twenty-five service providers from both A&TSI and non-A&TSI organisations. The audio-recorded interviews were transcribed and a qualitative thematic analysis was performed using a constant comparative method.

Results

Urban Melbourne A&TSI community presenting to services in the context of their chronic disease, were reported as experiencing high prevalence of depression and anxiety, trauma (including trans-generational trauma) and grief, as well as experiencing significant social isolation. Participants reported a need for integrated and coordinated care that encompasses culturally sensitive and holistic approaches to improve services for this population. Concerns about the transient nature of some of the current health initiatives were also identified.

Conclusion

It should be recognised that A&TSI community presenting to services in the context of a chronic disease are likely to be experiencing significant co-morbidities. Organisations or service providers unfamiliar with working with A&TSI community are encouraged to adopt a culturally sensitive and holistic approach to service provision. Sustainable integrated and coordinated care should be the long-term goal for this population.

Trialing an outreach model of cardiac rehabilitation (CR) in remote Australia; the Central Australian Heart Protection Study (CAHPS)

Glynis Cacavas¹, Steven Warren¹, Ricky Mentha¹, Samantha Tongi¹, Julie Fielke¹, Professor Alex Brown on behalf of CAHPS investigators²

¹ Baker IDI Central Australia, Alice Springs, NT

² South Australian Health and Medical Research Institute, Adelaide, SA

What clinical practice guideline or initiative/s did you put into day-to-day practice?

This study tests an outreach model of care providing secondary prevention, CR based on recommendations following an acute coronary event, responding to the significant burden of CVD in Central Australia.

List the healthcare professionals or consumer groups you worked with or tried to influence

The Central Australia (CA) context is characterised by geographically dispersed, small communities and regional centres, serviced by multiple health care providers. This study works with Indigenous & non-Indigenous CA residents, community controlled and government primary care providers, tertiary care providers and related social service providers.

Why was it important to put this guideline/initiative into practice?

There is limited access to CR in the remote setting of CA, with multiple providers involved in primary and tertiary health care. The model of care trialled aims to enhance clinical management, education and ongoing communication between health service providers.

What strategies did you use to get this guideline/initiative taken up?

CAHPS is a randomised controlled trial involving 360 participants, randomised to intervention or usual care. Inclusion criteria are residents of CA, who are ≥ 18 years and have a confirmed diagnosis of acute coronary syndrome (ACS) and/or being treated for exacerbation of heart failure secondary to coronary artery disease (CAD). A culturally sensitive DVD was produced in four local Aboriginal languages to assist with the informed consent process. An extensive stakeholder engagement strategy commenced following ethics approval and is ongoing, ensuring integration with primary care providers. Pre-existing relationships with Alice Springs Hospital have been expanded to medical, nursing and allied health professionals.

What did you measure and how?

Data is collected at scheduled and follow-up visits relating to clinical status, pathology, lifestyle factors and psychosocial status. Customised, comprehensive cardiac education is provided to the participants and family members. This includes participant identified goal setting and management priorities. This data is provided to the participant's primary care providers.

What did you achieve? Not achieve?

To date we have been able to implement this model of care with anecdotal evidence that people have better understanding of their cardiac condition, prescribed medications and importance of lifestyle modifications. The model is also improving linkages between primary and tertiary care and advocacy for participants and their family members.

What was the biggest challenge to getting the guideline/initiative taken up?

Establishing and maintaining good working relationships with all stakeholders to ensure the participant and their family is able to navigate the complex levels of care within a remote context.

What was the thing that most helped in getting the guideline/initiative/s taken up?

The diversity of experience within the CAHPS team, of four registered nurses (RN) and an Aboriginal health worker (AHW), has assisted in building trust through ongoing communication, support and mentorship.

How did you get the time/money/other resources you needed?

Baker IDI is committed to research that makes a difference in health service delivery. A NHMRC project grant was secured (2011-2015) to implement the study. This allowed for the employment of staff, funds to support travel to remote communities and establish comprehensive education kits for CR/education.

What is your key message to share with other groups about getting guidelines or initiatives used?

CAHPS seeks to understand and test effectiveness of a nurse-led, family-based CVD secondary prevention self-management program by reducing major adverse cardiac events by including the following key components; Learning About Your Heart, Looking After Your Heart, Keeping a Healthy Heart and Engaging Family in the management and prevention of CVD.

Linking ICOP to the hospital

Ray Mahoney

CSANZ Indigenous Scholarship in CVD Health, Research Fellow, Indigenous Health, School of Public Health and Social Work, Faculty of Health, Queensland University of Technology, Kelvin Grove, QLD

Introduction

Measuring and reporting accurately on the severity of CVD for Aboriginal and Torres Strait Islander people has been an issue for many years because of the lack of consistent national data about hospital treatment of Aboriginal and Torres Strait Islander people.

Methods

The Indigenous Cardiac Outreach Program (ICOP) is a specialist cardiac outreach service delivering point-of-care, diagnostic and consultation in CVD screening to a broad range of marginalised & disadvantaged communities whom reside across rural and remote Queensland Using an action based research approach that involved extensive community consultation and data gathering, ICOP developed an innovative and successful model of care for providing tertiary level Cardiac Outreach Speciality Services

Results

ICOP has established a database containing patient information collected outside of the hospital. Information is from 784 patients who were treated between February 2007 and November 2010. Partnering with Queensland University of Technology (QUT), ICOP has analysed this database, focusing on diagnosis, treatment and the prevalence of CVD risk factors. Patients presenting to ICOP and treated at TPCH have been linked, with a focus on investigating diagnosis and treatment consistent with recommended evidence-based care for the management of CVD.

Conclusion

Preliminary results will be available at the time of this conference that will inform and build upon the limited evidence available that connects the treatment of Aboriginal and Torres Strait Islander people that reside in rural and remote community with hospital care, especially for this unique population with CVD.

The wild, wild west: Getting heart attack warning signs messages “out bush”

J. Smith, S. McRae, L. Dimer¹, T. Shilton

Heart Foundation, Subiaco, WA

Introduction

People in remote locations have 10-30% higher risk of death from coronary heart disease than residents in major cities. The Heart Foundation’s remote campaign aims to raise awareness in remote areas of the warning signs of heart attack and the importance of getting help fast.

Method

A literature review and survey helped determine current practices and barriers to accessing emergency services in rural and remote locations.

A social marketing campaign was used as one strategy. Six posters were developed with community and health practitioner consultation to ensure images and language communicated messages that resonated with Aboriginal, mining and farming communities. Ten remote WA local government areas were identified for a convenience advertising campaign and posters were placed in the toilets of licensed venues, airports etc. Community and venue management provided feedback.

To circulate further, a poster order form was emailed to statewide contacts and placed on Australian Indigenous HealthInfoNet.

Results

Seventy-eight posters were installed in the ten selected areas with an estimated reach of 12,500 patrons. Overwhelming support was registered.

The email marketing enabled state-wide penetration for minimal cost; over 2,200 posters distributed, including to very remote locations and new contacts in non-health settings (e.g. Department of Fisheries, Port Authorities, Main Roads). Anecdotal feedback indicated appreciation for these culturally relevant and tailored resources.

Conclusion

Warning signs posters developed for rural and remote areas were developed and disseminated widely using convenience advertising and viral email. Other strategies are being explored to enable system and behavior change to reduce lives lost.

Is there a significant improvement in heart rate recovery over cardiac rehabilitation programs?

Azran Ahmad

Physiotherapy & Rehabilitation Department National Heart Institute, Kuala Lumpur, Malaysia

Introduction

Physical exercise is an important component of the standard therapy for patients after a cardiac event. Data from clinical trials demonstrated significant reductions in all-cause and cardiovascular mortality for patients with coronary artery disease who are enrolled in exercise-based cardiac rehabilitation programs. The decrement in heart rate immediately after exercise has been suggested as an important predictor of mortality. A delayed decrease in heart rate defined as a reduction of 12 beats/minute or less from the heart rate at peak exercise was associated a relative risk of death. The rise in heart rate during exercise in this program is considered to be due to the combination of parasympathetic withdrawal and sympathetic activation. The fall in heart rate (heart rate recovery) immediately after exercise is a marker of vagal tone that findings have shown to be a powerful predictor of all-cause mortality. Heart rate recovery should be evaluated before and after completion of cardiac rehabilitation program. The purpose of this study aimed to evaluate the effect of exercise-based cardiac rehabilitation on heart rate recovery.

Methods

A retrospective study was performed. Each individual entering the Phase II cardiac rehabilitation program undertakes a pre-assessment which includes: physical assessment, current cardiac status, lifestyle assessment, agreed goals, 6-minute walk test and 3-minute step test.

In all of our pre- and post-assessment the step test is used as our measure of cardiovascular fitness, prognostic marker mortality and the patient's perceived workload. For this abstract the step test result will be presented as a measure of each patient's progress throughout Phase II. The step test requires stepping up and down onto an 8-inch step for three minutes. The heart rate is then taken for 60 seconds to show signs of recovery and the patient's Borg rating perceived exertion (RPE) is assessed. The analyses of the results are presented by comparing the pre- and post-assessment step test heart rate and results.

Results

48 patients who completed Phase II of the cardiac rehabilitation program from Jan to April 2012 were analysed. The sample consisted of 48 patients; (24 cardiology cases vs. 24 cardiothoracic cases) age range 29 years – 77 years (Mean: 56.33 ± 10.02 years). 39 (92%) of the patients showed an improvement as measured by heart rate recovery and RPE. Of the remaining patients, 9 (21.4%) showed no improvement within both group after 4 weeks cardiac rehabilitation program demonstrates significant change in heart rate recovery. Among this two group, cardiology patients showed a significant improvement 14 (58.3%) before enrolling for cardiac rehabilitation program increased to 23 (95.8%) after completed the program.

Conclusion

Regular structured exercise in Cardiac Rehabilitation Program increases functional capacity. A simple functional exercise assessment (steps test) is a valuable way to audit Phase II cardiac rehabilitation. It is also a good way of providing objective feedback to the patient and provides additional prognostic information to the established Cardiac Rehabilitation Program. However, this study has several limitations. It was small sample, and it is not known if the heart rate recovery is a modifiable risk factor.

Effectiveness of cardiac rehabilitation program in reducing cardiovascular risk factor and improving functional capacity among cardiac patients in kingdom of Bahrain

Thikrayat Nooruddin¹, Aziza Matoq², Fatima Mansoor³, Zahra Alaswamy⁴, Hawra S. Khalil⁵

Ministry of Health (SMC), Kingdom of Bahrain

Introduction

Cardiovascular diseases (CVD) are one of the main leading causes of death in the world and is considered a global burden. In Bahrain, cardiovascular death accounts for about 19.5% annually (Fadhil et al, 2011). Cardiac rehabilitation program (CR) specifically phase III (exercise training) has demonstrated substantial benefits in various cardiovascular diseases (CVD) and its risk factors, in addition, improvement in functional capacity. The aim of the study was to measure the differences in (CVD) risk factors and 6 minute walk test (6MWT) pre and post (CR).

Methods

Descriptive retrospective study done on n=36 patients post cardiac events who underwent a comprehensive phase III CR program, cardiovascular assessment for some risk factor pre and post (CR), in addition to (6MWT) to measure the functional capacity pre and post (CR).

Results

The patients demonstrated overall significant reduction, in systemic blood pressure (systolic from mean 125.8 ± 13.2 to 118.1 ± 10.8 , $P= 0.00$), (diastolic from mean 73.9 ± 10.1 to 70.8 ± 7.7 , $P= 0.08$), cholesterol (from mean 4.7 ± 1.4 to 4.2 ± 1.0 , $P= 0.019$), triglyceride (from mean 1.9 ± 1.5 to 1.5 ± 0.6 , $P= 0.022$), weight (from mean 85.1 ± 20.4 to 83.6 ± 19.8 , $P= 0.000$). Moreover, 6MWT showed significant improvement in distance covered (from mean 493.1 meter ± 77.6 to 519.8 meters ± 59.9 , $P= 0.015$).

Conclusion

Cardiac rehabilitation is associated with significant improvement in reducing cardiovascular risk factors and improvement of functional capacity, the improvement of any farther explain the reduction in morbidity and mortality noted after formal cardiac rehabilitation and exercise training program (Am Heart J 2002,143:977-83).

Can participation in 4 weeks phase II Cardiac Rehabilitation Program (CRP) improve fitness and functional capacity?

Azran Ahmad

Physiotherapy & Rehabilitation Department, National Heart Institute, Kuala Lumpur, Malaysia

Introduction

The positive effect of physical activity on coronary artery disease has long been shown, as has the positive effect of participation in 4 weeks Phase II Cardiac Rehabilitation Program (CRP). The aim of this study was to ascertain the level of improvement of fitness over Phase II CRP and to see what type of patients from a fitness point of view benefited most from participation in CRP.

Methods

The aim of this study was to ascertain the level of improvement of fitness over Phase II CRP and to see what type of patients from a fitness point of view benefited most from participation in CRP.

Results

Retrospective descriptive study of patients who participated in a 4 weeks Phase II CRP. Each patient undertakes a pre-assessment which includes: physical assessment, current cardiac status, lifestyle assessment, agreed goals and 6-minute walk test (6-MWT). The 6-MWT was used in the program for both pre and post Phase II CRP. During the program, the Maximum Heart Rate method was used to calculate target heart rate and exercise prescription was set a maximum of $\leq 75\%$. The results of the 6-MWT were converted to estimated MET's for analysis.

Conclusion

Distance from 6-MWT increased significantly as a consequence of 4 weeks Phase II CRP with greater changes occurring in post cardiology and cardiothoracic patients. However there are still a substantial number of patients classified as sedentary (MET's ≥ 10 ACSM 2001) from a fitness point of view post Phase II CRP. Is this improvement enough to reduce risk? Is the program sufficient enough or should the setting of exercise prescription goals set higher than the current guidelines? In conclusion 6-MWT is one of the predictive markers for exercise prescription would improve the validity and reliability level of 6-MWT. 6-MWT is simple, safe and useful objective outcome measurement of functional capacity and guideline for exercise prescription in clinical practice as well as in Phase II CRP. Besides, it may replace the exercise stress test as a functional capacity indicator among the population who cannot perform exercise stress test.

Attitudes to obesity among rehabilitation health professionals

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Objective

Negative attitudes toward obese individuals can affect the quality of their healthcare and their health outcomes. The current study was undertaken to identify the attitudes and beliefs of rehabilitation health professionals (including Cardiac Rehabilitation professionals) toward overweight/obese patients. In addition, the role of potential predictors of anti-fat attitudes (or "fat phobia") was examined.

Methods

A cross-sectional, anonymous, self-report survey of rehabilitation health professionals employed in both public and private health sectors was performed. Measures included demographic information, attitudes toward obese patients, beliefs regarding the causes of obesity and levels of empathy. Results were compared with previous similar studies, and associations between demographic variables, attitudes and beliefs were examined by using multivariate regression analysis.

Results

Overall mean scores on the Fat Phobia Scale (3.5; SD 0.46) indicated average levels of fat phobia, with only 4% of respondents exhibiting high levels of anti-fat attitudes. Younger rehabilitation professionals had significantly higher levels of negative attitudes than did older staff ($p < .001$). Sex, levels of empathy, type of professional (when controlled for age), or area of clinical practice (e.g. Cardiac Rehabilitation) did not correlate with attitudes. Fat phobia was predicted by respondent age and beliefs about the causes of obesity, with 20% of variance in attitudes to obesity being accounted for.

Conclusion

Rehabilitation health professionals demonstrate average levels of negative attitudes to obese individuals. These attitudes are not affected by sex, professional group, area of practice or the weight of the respondents, but are predicted by causal beliefs and the age of the health professional. These findings have implications for reducing fat phobia and improving patient outcomes by education of health professionals regarding the nature and causes of obesity.

Heart Education Assessment and Rehabilitation Toolkit (HEART) online

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¹ State-wide Heart Failure Co-ordinator, The Prince Charles Hospital, QLD

² Heart Failure Service, Royal Brisbane and Women's Hospital, QLD

³ School of Exercise and Nutrition Sciences, Queensland University of Technology, QLD

Introduction

HEART Online's mission is to be the leading web resource for health professionals seeking evidence-based information and tools that support delivery of quality cardiovascular disease prevention and rehabilitation and heart failure management services.

Methods

The web format, developed by 26 national key stakeholders in October 2011, was designed to reflect flexible models of care. Content leads coordinated input and wrote the relevant sections. Six experts independently reviewed content and revisions were made based on their feedback.

As the first content to be completed was relevant to exercise professionals, initial user evaluation invited physiotherapists and exercise physiologists to review the site and to complete a survey.

Results

Response rate was 82% with 31 completing the survey. Average age was 36 with 11 years since degree completion. Clinicians rated site features on a 5 point scale (5 being a positive strongly agree). Mean responses on 9 questions ranged from 3.45 to 4.61 suggesting that the site is meeting the needs of users in regards to clarity and accuracy of content and usability. Open feedback relating to improvements was analysed and categorised as technical or content errors, content refinement, or as ideas for future development. Comments about usefulness were made by 74% and ranged from interactive resources through to specific content.

Conclusion

Improvement and refinement will be ongoing but the initial evaluation suggests that the site will meet the needs of exercise specialists. Other professional groups will be invited to evaluate the site once relevant content is available.

Acknowledgements: HEART Online is supported by the Queensland Government and the National Heart Foundation of Australia.

Collaborative approach for the implementation of a 12 month phase three cardiac rehabilitation program in the community

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¹ St John of God Health Care, Frankston Rehabilitation Hospital, Frankston, VIC

² PACE Exercise Physiology Practice, Frankston, VIC

What clinical practice guideline or initiative/s did you put into day-to-day practice?

Implementation of a 12 month Phase Three Cardiac Maintenance program in the community that provides ongoing contact with a trained professional for patients who had successfully completed Phase Two Cardiac Rehabilitation at SJOGHC – FRH.

List the healthcare professionals or consumer groups you worked with or tried to influence.

- Jo McLaren Pulmonary Coordinator SJOGHC – FRH
- Simone Weremijenko Physiotherapist SJOGHC – FRH
- Claire Ferguson Director Allied Health SJOGHC – FRH
- Jim Curtain Director of Mission SJOGHC – FRH
- Dr Nathan Johns Medical Director SJOGHC – FRH

Why was it important to put this guideline/initiative into practice?

Audit of the previous maintenance program raised concerns regarding the functional status of the individuals. Initial program had filled a gap in service delivery however new option provided the necessary expertise and resources to truly integrate patients into the community.

What strategies did you use to get this guideline/initiative taken up?

- Working party formed with CRC, DOM and PRC
- Discernment of the Mission and Values of SJOGHC – FRH
- Investigated external options.
- Audit results presented to key stakeholders including all current hospital Phase Three participants in an open forum
- SJOGHC health professional and Cardiac Volunteer appointed to exercise at a PACE Exercise Physiology Practice with the group weekly initially to demonstrate a physical connection between the two organisations
- Letters sent to each participant and phone calls encouraging them to attend a PACE Exercise Physiology Practice

What did you measure and how?

- 6MWT
- QOL London Handicap Scale
- Attendance numbers measured weekly
- Compared costs of the two programs
- Discernment framework applied from the Mission and Values of SJOGHC – FRH

What did you achieve? Not achieve?

- Successful transition to off-site management meant improved organisational stewardship
- Improved patient car parking access
- Flexibility of time, day and location of gym was now available
- Some participants did not embrace the change as they were required to contribute part of the financial cost of attending

What was the biggest challenge to getting the guideline/initiative taken up?

- Degree of reluctance of some long-term attendees to adapt to change
- Lack of patient's ability to comprehend importance of fostering independence outside of the hospital

What was the thing that most helped in getting the guideline/initiative/s taken up?

Collaboration between key stakeholders and a robust discernment framework of SJOGHC - FRH

How did you get the time/money/other resources you needed?

Discernment and stewardship of existing resources

What is your key message to share with other groups about getting guidelines or initiatives used?

It is possible to work collaboratively and be successful with external organisations.

Facilitating lifestyle modification via telephone follow-up for post percutaneous coronary intervention (PCI) patients

Bi Xia Ngooi, Shuet Ming LAI, Arunkumar Jeyaveeran, Karen Koh, Raymond Wong

National University Hospital, Singapore

Introduction

Telephone follow-up has been used in a variety of settings as a means of supporting patients post-discharge. We report a single-center experience of an accelerated cardiac lifestyle modification program and explore the effects of telephone follow-up on patients' post-discharge recovery.

Methods

A retrospective study with 19 patients who had undergone uncomplicated revascularization (17 male: 2 female, average age 51 + 9 years) was conducted. The program commenced with a face-to-face session with a cardiac advanced practice nurse (APN), physiotherapist (PT) and occupational therapist (OT). Each patient's problems are identified, lifestyle modification goals set, 6-minute walk test (6MWT) and body mass index (BMI) measured as outcome measures. Telephone calls were made after 2 weeks and 6 weeks by an OT. Thematic analysis of the barriers and facilitators reported by the patients was done. The above outcome measures were obtained at 8th week.

Results

The types of lifestyle modification goals set by patients were on improving physical activity levels (100%), diet (68%) and stress management (58%). Primary barriers reported were lack of 1) family support 2) healthier food options in workplace 3) time. Main facilitators were 1) family and friends' support 2) packing home cooked food 3) presence of nearby exercise facilities.

Self-reported progress by participants: 68% met all goals, 21% met partial goals, and 11% did not meet any goals at all. 63% has a decrease in BMI (mean change -0.3, p=0.4), while 74% has significant improvements in 6MWT (mean -31 metres, p=0.02).

Conclusion

We found the potential benefits of including telephone follow-up in facilitating lifestyle modification among post-PCI patients, in particular improvement in physical tolerance. Future studies can include comparisons of traditional supervised programs versus telephone follow-up.

Piloting of 'HeLP Yourself Online'TM: An online integrated secondary prevention program for cardiac patients

Rosemary Higgins¹, Barbara Murphy², Hema Navaratnam², Mr Michael Butler³, Ms Lauren Barker,³ Marian Worcester²

¹ Research Centre & Cabrini Health Melbourne, VIC

² Heart Research Centre, Melbourne, VIC

³ Cabrini Health, Malvern, VIC

Introduction

The development of a flexible online secondary prevention program for cardiac patients will increase the flexibility of services for patients after an acute cardiac event. The purpose of the present project was to develop a flexible online package 'HeLP Yourself Online' Health and Lifestyle Planning for cardiac patients' self-management based on existing self-management resources developed previously by the Heart Research Centre

Methods

Fifty three patients admitted to Cabrini Health for a cardiac event were recruited to trial the program. Of these, 23 (44%) patients actually trialled the online program. The program was evaluated using both qualitative and quantitative methods.

Results

Quantitative evaluation with 21 patients showed that patients were generally happy with the program and believed that the program would assist them in their self-management. Qualitative evaluation, using focus group and interview methods with 15 patients, showed that, while patients were generally satisfied with the program they would have liked to access the program soon after their cardiac event. Further revisions were required prior to broader trialling of this program.

Conclusion

The major revisions required are to provide the program earlier in the patients' recovery process and to streamline the intervention content. This includes the provision of clearer instructions within modules and reduction of patient burden currently associated with the pre and post program evaluation questionnaires. These modifications will address patient concerns regarding the program. A broader RCT of the program is planned.

Cardiac rehabilitation DVD – 'What is wrong with my heart?'

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¹ SA Heart/MSD, Ashford, SA

² Ashford Hospital/MSD, Ashford, SA

Cardiac Rehabilitation (CR) has been shown to improve long term cardiovascular outcomes, yet is only attended by about 30% of suitable candidates. We aimed to improve access to the Cardiac Rehabilitation program at our hospital (Ashford Private Hospital) by designing a DVD to incorporate the messages that we felt were important from our program.

We enlisted a professional production team to work with us to design and implement a DVD style format to incorporate the major elements of our CR program. The DVD is formatted in a question/answer style and includes patient vignettes of common scenarios, along with interviews with experts in the fields of cardiac surgery, cardiology, pharmacy, physiotherapy, nursing, and dietetics. The project was primarily directed at patients coming through our hospital CR programme, and their families, friends, and carers. However the information is generally relevant to all those with a cardiovascular problem and those interested in preventing such a problem.

So far we have had positive feedback from professionals in the CR field along with CR patients.

We plan to obtain feedback from independent reviewers to provide a market-based CR program that will aid many CR programs around the country, in particular in remote and rural areas that have limited resources and access to a range of allied health professionals.

We received funding from an independent grant from Merck, along with assistance from Ashford Private Hospital, and SA Heart.

Who is achieving recommended physical activity levels? A 12 month longitudinal study

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Introduction

Little is known about the type and intensity of physical activity (PA) reported by cardiac patients during the first year after hospitalisation. Are patients meeting the PA guidelines of 30 minutes or more of moderate-intensity physical activity (PA) on most days of the week? Additionally, little is known concerning the determinants of PA guideline attainment over the course of recovery. Are the same variables which predict PA guideline attainment early in recovery, equally as important 12 months after hospitalisation?

Methods

136 patients consecutively admitted to two Victorian hospitals after acute myocardial infarction (31%), or to undergo bypass surgery (29%) or percutaneous coronary intervention (40%) were interviewed in hospital and four and 12 months later. PA at each time point was assessed by the Active Australia PA Survey. Medical data were obtained from hospital records. Sociodemographic data, self-reported anxiety and depression and cardiac rehabilitation attendance status were also recorded. Logistic regression was used to identify predictors of PA guideline attainment at each of the three time points.

Results

At all three time points walking was regularly performed by over 95% of patients, while moderate and vigorous PA only reached 40% and 59% participation by 12 months respectively. Significant predictors of PA guideline attainment in hospital were physical functioning, waist girth, depression, occupational status and gender. As hypothesised different predictors were found for 4 months (living arrangements, history of diabetes, history of depression) and 12 months (body mass index, marital status, smoking status and socioeconomic status).

Conclusion

The study demonstrated the importance of walking for cardiac patients and highlighted the dynamic nature of variables influencing PA at various stages of recovery.

Gender inequalities in cardiac rehabilitation

Professor Patricia M Davidson

University of Technology Sydney, St Vincent's Hospital, Sydney, NSW

More than one in every three Australian women die from cardiovascular disease and globally this is an important health issue. Perhaps most importantly cardiovascular disorders are a major cause of disability and reduced quality of life in women and are the second most expensive diseases in terms of health expenditure. This emphasises the importance of secondary prevention strategies, particularly cardiac rehabilitation, in improving health outcomes and facilitating effective transitions following an acute cardiac event. Although participation rates in cardiac rehabilitation remain challenging across all population groups amongst women these are most pronounced. A range of patient, provider and health care system issues contribute to lower rates of participation of women and each of these dimensions requires specific strategies. In order to improve the participation of women in cardiac rehabilitation it is important to consider both sex and gender based differences and how cardiovascular services respond to these needs. Emerging data suggests that the tailoring and targeting of models of intervention are important to address the needs of women. This presentation will discuss the important role of cardiac rehabilitation in promoting effective transitions for women who experience an acute cardiovascular event and provide strategies for increasing participation in evidence-based cardiac rehabilitation models.

Supporting emotional adjustment in cardiac rehabilitation

Dr Barbara Murphy¹, Dr Karen Page²

¹ Heart Research Centre, Melbourne, VIC

² Heart Foundation Australia

Patients experience a range of emotions at the time of a cardiac event. While some patients are at risk of ongoing depression, many adjust to the event through normalisation of their experiences and appropriate support during cardiac rehabilitation. This workshop will draw on current research and clinical knowledge to provide participants with information and skills relating to the normalisation of emotional adjustment and the management of depression within the cardiac rehabilitation setting.

Dietary guidelines and their application in cardiac rehabilitation

Beth Thomas¹, Barbara Eden²

¹ National Policy Officer, Heart Foundation, Australia

² Senior Food Supply Manager, Heart Foundation, Australia

Good nutrition is the cornerstone of good health. The importance of this is underscored at a time when more than half of all Australians are an unhealthy weight, only 5% eat enough fruit and vegetables, cardiovascular disease is the leading cause of disease burden and coronary heart disease the leading cause of death.

In 2013, after 5 years and some 50,000 papers reviewed, the eat for health Australian Dietary Guidelines were released. These guidelines provide evidence-based recommendations for good food for good health.

The Heart Foundation, a not-for-profit organisation and charity, promotes good nutrition as an essential part of heart health. In this workshop, the Heart Foundation's food & nutrition experts will provide the key nutrition recommendations for heart health and answer the question – what do the new Australian Dietary Guidelines mean for cardiac rehab?

Participants will be encouraged to take part in small group activities to apply the key nutrition recommendations to relevant situations. The workshop will also be an opportunity for participants to contribute to the work of the Heart Foundation's in supporting evidence based nutrition recommendations in cardiac rehabilitation.

Cognitive challenges in cardiac rehabilitation patients

Dr Jan Cameron¹, Dr Robyn Gallagher²

¹ Cardiovascular Research Centre, ACU, East Melbourne, VIC

² Faculty of Health, University of Technology Sydney, NSW

Aims

To provide practical tips and examples of cognitive screening measures that can be incorporated into clinical practice. To discuss strategies that can be applied in clinical practice to address the delivery of individualised care for patients with mild cognitive challenges.

Methods

A brief overview of cognitive functions will be given by presenters and examples of 2–4 cognitive screening measures will be provided. Working in small groups delegates will discuss the differing cognitive screening measures and discuss practical strategies that can be applied to address any cognitive gaps identified and ensure the effective uptake of key health messages and behaviours. Examples of research papers will be provided to the groups. Each group will present a summary of their discussion points to the overall group.

Sedentary behaviour—is sitting the new smoking?

Professor David Dunstan

Baker IDI Heart and Diabetes Institute, Melbourne, VIC

In contemporary society, prolonged sitting has been engineered into our lives across many settings, including transportation, the workplace, and the home. There is new evidence that too much sitting (also known as sedentary behavior—which involves very low energy expenditure, such as television viewing and desk-bound work) is adversely associated with health outcomes, including cardio-metabolic risk biomarkers, type 2 diabetes, some cancers and premature mortality. In addition to the decreased energy expenditure induced through sitting, sedentary time may also be harmful because of the prolonged absence of muscle contractile activity in the lower limbs. Importantly, these detrimental associations remain even after accounting for time spent in leisure time physical activity—which within adult populations is infrequent and very low volume. This presentation will provide an overview of recent evidence from epidemiological and experimental studies. This new evidence is beginning to make a strong case that too much sitting should now be considered as a potential new element of physical activity and health recommendations—particularly for reducing the risk of type 2 diabetes and cardiovascular disease.

My heart health journey—a person centred pathway

Margaret Ahern, Helen O'Regan-Tabart

Bellarine Community Health Ltd, Point Lonsdale, VIC

What clinical practice guideline or initiative/s did you put into day-to-day practice?

- Guidelines for Best Practice: Goble & Worchester 1999,
- Home & Community Care (HACC) Active Service Model (ASM) 2009,
- Victorian Public Health & Well Being Plan 2011-15

These frameworks support the development of the “My Heart Health Journey” tool.

List the healthcare professionals or consumer groups you worked with or tried to influence.

Previous 12 months attendees totalled 104; this included consumers that required surgical, interventional and medical heart disease management.

BCH management and Cardiac Rehab team recognise that clients attending Integrated Chronic Disease programs such as cardiac rehabilitation will benefit from a self determined and self management maintenance program.

Why was it important to put this guideline/initiative into practice?

Heart research center Higgins et al 2009 that Cardiac Rehabilitation should focus on equipping clients with skills to adopt and maintain behavior change that promotes ongoing health and wellbeing. Health Change Australia (2011) state to make change readiness, importance, confidence, knowledge and timing is required. The pathway is important because it puts these recommendations into practice.

What strategies did you use to get this guideline/initiative taken up?

We applied change management theory discussed in peer review and collaborative planning with the Cardiac Rehab team. Providers felt that on exit/discharge clients having the opportunity to reflect back on their journey would impact on their self efficacy. The client's confidence and importance was derived from their personal reflections of their recent past. This would be applied to have the client to then look forward to plan their ongoing health and wellbeing.

To implement this exit/discharge process a post-program appointment is negotiated in a time, place setting that suits the provider and client. This may be a home, café or health setting.

What did you measure and how?

- 3 month goal set at exit/discharge recorded through Excel sheet
- Phone call for 3 month follow up and 1:1 health coaching offered if wished by client
- Follow up to then be at 6 months
- A focus group of 2013 clients that followed this process will be conducted in October 2013
- Currently the Pathway is in trial phase

What did you achieve? Not achieve?

Achieved:

- Implementation of person centered tool to pilot
- Supermarket tours if so desired by clients
- GP feedback form to support options made by client

Not achieved:

- Statistical data to support efficacy of tool which aims to prevent early representation

What was the biggest challenge to getting the guideline/initiative taken up?

- Health Providers with part time EFT and competing demands having the capacity to do formalised exit/discharge interviews 1:1 with clients and partners

What was the thing that most helped in getting the guideline/initiative/s taken up?

- Enthusiasm of Cardiac Rehabilitation team
- Support from BCH Families & Community manager
- The tool was driven by client's positive feedback to the regular goal setting during program

How did you get the time/money/other resources you needed?

Home and Community Care funding encourages client contact and Executive Management and the organisation is committed to the Active Service Model philosophy of care that requires a person centered approach.

What is your key message to share with other groups about getting guidelines or initiatives used?

If the tool is client centered, they own it and see the process as assisting them to maintain ongoing health and wellbeing. Then change will be made and sustained as Higgins et al 2009 encourage.

Is ultrasound a reliable measure of sternal micromotion in patients following cardiac surgery?

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³ Department of Surgery, Royal Melbourne Hospital, Parkville, VIC

Introduction

Upper limb restrictions are usually recommended as a precautionary measure following cardiac surgery via median sternotomy to prevent sternal complications. However, there is a paucity of evidence to support this clinical practice and the effects of upper limb movements on sternal healing remain unclear. Ultrasound is a reliable measurement tool of sternal micromotion in patients with chronic instability. The purpose of this study was to determine the reliability of ultrasound measures of sternal micromotion in acute patients following cardiac surgery.

Methods

20 participants who had undergone cardiac surgery participated in this study. Ultrasound measures were taken at rest and during 5 tasks, including deep inspiration, cough, upper limb elevation (unilateral and bilateral) and sit to stand. Ultrasound images were captured using a Sonosite M-Turbo 3 to 7 days post-surgery. Two independent raters, blinded to participant and task, used the device proprietary software to measure sternal micromotion. Intra and inter-rater reliability of the mean ultrasound measures for each task was calculated using intra-class correlation coefficients (ICC).

Results

The intra-rater reliability of the ultrasound measures of all tasks ranged from ICC (3,1) 0.95 to 0.99. The inter-rater reliability ranged from ICC (2,1) 0.90 to 0.97.

Conclusion

Ultrasound demonstrates excellent intra and inter-rater reliability of real-time assessment of sternal micromotion in acute patients following cardiac surgery via a median sternotomy. Further research regarding the clinical application of this method is warranted.

Journey to become smoke free—St John of God Health Care Frankston Rehabilitation Hospital's (SJOGHC-FRH) experience

Emma Boston, Sally Faulkner, Claire Ferguson³

St John of God Health Care, Frankston Rehabilitation Hospital, Frankston, VIC

What clinical practice guideline or initiative/s did you put into day-to-day practice?

Development, implementation and delivery of a smoke free cessation program for inpatients, outpatients and staff at SJOGHC-FRH with the view to establishing a smoke free environment.

List the healthcare professionals or consumer groups you worked with or tried to influence.

- SJOGHC-FRH patients, visitors, staff, CEO/DON and OH&S Manager
- Smokefree Working Party SJOGHC-FRH
- Adrienne James, The Alfred, Lung Health Promotion Unit
- Quit Victoria
- Frankston & Mornington Peninsula Smokefree Charter

Why was it important to put this guideline/initiative into practice?

Clean air and environment is a basic human right. Drift smoke entered the building exposing non-smokers to fumes. Healthcare workers have a duty of care to promote smoke free environments with education, positive health promotion and prevention.

Recognition that smoking is a chronic debilitating condition affecting the health of an individual and deserves to be treated like any other chronic medical condition.

What strategies did you use to get this guideline/initiative taken up?

Formed staff working party engaging non-active and active smokers.

Conducted "wellness" information sessions. Engaged with other hospital based committees e.g. OH&S, Hospital Governance and Executive.

A health professional undertook smoking cessation training and became the on-site facilitator for staff, patients and visitors. The approach was non-confrontational, low-key with a no blame philosophy.

Free NRT starter packs provided at no cost to hospital with written information including Quit and external support services.

Pilot program was run and an educational brochure for all patients implemented.

Designed and implemented one exclusive, secure, external smoking area with seating, But Bin, Duress Alarm, CCTV monitoring, security door and gate for all smokers.

What did you measure and how?

Monitored referrals, engaged smokers and successful completers for harm reduction and abstinence rates of smokers enrolled in pilot.

Smoking breaches identified and recorded on hospital incident management system.

What did you achieve? Not achieve?

Rates of harm reduction and abstinence rates achieved were equal to or better than benchmark standards.

Established and provided access to a smoking cessation program not previously available.

Greater awareness of smoking issues.

Anecdotally, smoking breach rates noticeably declined or ceased completely.

Hospital campus yet to be declared completely smoke free.

Yet to purchase a biochemical marker for carbon monoxide.

What was the biggest challenge to getting the guideline/initiative taken up?

Misconception amongst clinical staff that rehabilitation patients would be less likely to address their smoking and could cause safety issues through breaches.

Access to formalised funding stream for this health promotion activity meant redirection of monies away from other uses.

What was the thing that most helped in getting the guideline/initiative/s taken up?

Sticking to a ...“no blame”... policy and recognition that the smoker is marginalised socially, economically and physically due to a chronic health condition.

Support from the SJOGHC-FRH CEO/DON and OH&S Manager.

How did you get the time/money/other resources you needed?

Initially an interested health professional self-funded their own smoking cessation education and pilot proposal. With the appointment of a new CEO/DON discernment prioritised the program as important.

NRT samples, written information where possible sourced free from pharmaceutical or government organisations.

What is your key message to share with other groups about getting guidelines or initiatives used?

One cannot underestimate the value of sound discernment, communication, education, engagement and resourcefulness.

Carers' experiences of patient engagement in heart failure self-care

Kerryn Rhodes, Jan Cameron, Chantal F Ski, David R Thompson

Cardiovascular Research Centre, ACU, East Melbourne, VIC

Background

Effective engagement in self-care behaviours is necessary to improve health outcomes in the significant number of people with chronic heart failure (CHF). Yet engagement in self-care is hindered on many levels. Informal carers have developed experiential insights into the management of CHF symptoms and are well placed to add to the existing body of knowledge surrounding facilitators and barriers to CHF self-care.

Objectives

- 1) To gain knowledge from the carer perspective on factors that support or hinder patient engagement in CHF self-care.
- 2) To validate the domains assessed in the Heart-Failure Screening Tool (Heart-FaST) as a measure of self-care capacity.

Methods

Grounded theory was used with semi-structured interviews conducted on participants who identified themselves as providing informal care to a person diagnosed with CHF. Thematic analysis of the interviews was performed by two nurses and two psychologists.

Findings

Data saturation was reached after 12 carers were interviewed. Four main themes were identified by carers as critical to patient engagement with recommended CHF self-care behaviours. Symptom severity, emotional functioning and cognitive decline were identified as factors that hindered self-care. Roles and relationships, social support/community engagement, and carer perceived competency were identified as factors that facilitated self-care. The themes and sub-themes identified also provided further validation of the three Heart-FaST dimensions of cognitive, emotional and physical functioning as predictors of self-care capacity.

Conclusion

Knowledge gained from this study provides unique insights from the carer's perspective on factors that hinder and facilitate effective engagement in CHF self-care behaviours.

A mother's heart beats for two: Exploring current continuum of care for women with cardiac disease during pregnancy

Sindy Millington¹, Dr Judy Magarey¹, Dr Robyn Clark²

¹ School of Nursing, University of Adelaide, Adelaide, SA

² School of Nursing, Flinders University, Adelaide, SA

Introduction

Although cardiac disease complicates approximately 1% to 3% of pregnancies, it is responsible for 10% to 15% of maternal mortality. This rate is expected to increase in the current environment of elderly primigravida and increased obesity and diabetes in pregnancy. This study focused on the continuum of care and guidelines for women with pre-existent or newly acquired cardiac disease during pregnancy.

Methods

A review of the literature was conducted to identify current clinical practice guidelines and significant issues related to the management of women with cardiac disease in pregnancy.

Results

Improved treatment of women with pre-existing congenital disease has led to more women reaching childbearing age and becoming pregnant. Although acute myocardial infarction (AMI) in pregnancy has traditionally been considered a rare occurrence, statistics indicate high mortality rates, with a maternal death rate of up to 37%. Nursing and medical care in pregnancy is a very complex issue. Pre-existent risk factors such as stress, smoking, obesity, high cholesterol and family history of heart disease contribute to the increased risk of AMI in pregnancy.

Conclusion

Limited literature is available to provide a basis for evidence-based education and clinical guidelines for nurses caring for these women. This study has identified the need for research to provide evidence for improved clinical care for mothers with heart disease and their babies.

Supporting SCAD survivors

Carolyn Brand, Fiona Sherri

ISIS Primary Care, Hoppers Crossing, VIC

What clinical practice guideline or initiative/s did you put into day-to-day practice?

Fiona's story:

"I only found out a week ago about SCAD and was very happy to put a name to what had happened to me"

List the healthcare professionals or consumer groups you worked with or tried to influence.

This clinical initiative was developed in partnership with Fiona, a cardiac rehabilitation participant who experienced a Spontaneous Coronary Artery Dissection and wanted to tell her story to inform health professionals and SCAD survivors of the condition and how to access support.

Why was it important to put this guideline/initiative into practice?

SCAD is a rare condition that can be fatal. It can cause a sudden tear in the coronary artery and potentially a heart attack. Approximately 80% of cases affect women. Can relate to female hormone levels and often seen in post partum women. Many health professionals have had minimal experience with SCAD.

What strategies did you use to get this guideline/initiative taken up?

Fiona had recently experienced SCAD and was frustrated at the lack of information and support available. She told her story on an online support group for SCAD survivors and from there, together with the CHN has developed a poster to address the gaps she found in getting help and support. These include advice on issues faced by SCAD survivors such as breast feeding, coping with stress, social networking, exercise guidelines and support groups.

What did you achieve? Not achieve?

Fiona feels more in control of her condition. Women are accustomed to caring for others, rather than focusing on their own health care needs. She wants to inform health professionals and empower women to take control of their own recovery.

What is your key message to share with other groups about getting guidelines or initiatives used?

Often it is our cardiac rehabilitation participants who inspire us to learn more about their condition and together find the best pathways to their recovery.

References:

www.inspire.com/groups/womenheart/discussion

www.mayoclinic.com/health/spontaneous_coronary_artery_dissection

Improving health literacy in cardiac rehabilitation—an alternative BORG scale

Carolyn Conway¹, Carolyn Brand²

¹ Plenty Valley Community Health, Whittlesea, VIC

² ISIS Primary Care, Hoppers Crossing, VIC

What clinical practice guideline or initiative/s did you put into day-to-day practice?

An alternative BORG Scale was developed for cardiac clients with low health literacy. This tool is more visual, replaces numbers with colours and uses recognisable emoticons and simple words.

List the healthcare professionals or consumer groups you worked with or tried to influence.

Cardiac Rehabilitation coordinators from Plenty Valley CH & ISIS Primary Care developed the tool. It has been utilised by staff and clients at these services for two years. Requests from other Victorian programs has seen it utilised by them over the last twelve months.

Why was it important to put this guideline/initiative into practice?

Many of our clients have demonstrated low levels of health literacy. Health literacy can have a significant impact regarding information provided, written handouts and use of tools e.g., perceived exertion scales (BORG Scale). People who do not understand basic health information have been found to have poorer health outcomes.

What strategies did you use to get this guideline/initiative taken up?

Literature had shown that significant numbers of cardiac rehabilitation clients fell into the low health literacy risk category being elderly, lower education levels, CALD backgrounds including newly arrived refugees. These clients had difficulty in understanding and utilising numerical tools e.g., BORG scale. This demonstrated need led us to develop an alternative tool that they could use effectively and accurately in a clinical setting. Following development of the tool it was trialled by our programs for one year prior to being shown at a VACR conference and made available for other cardiac rehabilitation programs to trial. Clients also use tool for home exercise program.

What did you measure and how?

This was development of a clinically appropriate tool for use in a clinical cardiac rehabilitation setting. The tool is used in the exercise sessions of cardiac rehabilitation. Most feedback has been anecdotal with high satisfaction rating. Our next step is to measure the reliability and validity of the tool in the clinical setting.

What did you achieve? Not achieve?

Use of the alternative BORG Scale in our Cardiac Rehabilitation programs has improved our clients' knowledge and understanding of their perceived exertion levels. The BORG scale is a valuable tool as the standard for measuring perceived exertion but has some limitations for clients with low health literacy.

What was the biggest challenge to getting the guideline/initiative taken up?

Evaluating the reliability and validity of the tool in the clinical setting to prove/disprove what is seen locally with use of the tool. This is very difficult within community health setting.

What was the thing that most helped in getting the guideline/initiative/s taken up?

A demonstrated need that was recognised by cardiac rehabilitation program coordinators with a passion to continually improve the quality and relevance of their programs for their clients.

How did you get the time/money/other resources you needed?

Project was developed mostly within usual work time (some personal time was involved) with no extra budget or funding. Local management of our health services were supportive when the project was presented to them.

What is your key message to share with other groups about getting guidelines or initiatives used?

If you have a demonstrated need, then try to develop what you think is appropriate to meet that need. It can seem to be something small, but you may be surprised that it has not been thought of before and how many other people are looking for something similar.

References:

"Low Health Literacy May Mean Worse Health"

Amy Norton, Annals of Internal Medicine, July 19, 2010

Improved quality of life after biventricular pacemaker insertion

Adrienne Caulfield, Michelle Dove, Philippa Ashworth

Peninsula Private Hospital, Frankston, VIC

Introduction

Biventricular pacemakers are becoming a common treatment for clients with heart failure. Clients experience varying levels of functional and/or measurable change after biventricular pacemaker insertion. Our study aimed to measure the recipient's own subjective perception of physical and/or emotional improvement post pacemaker insertion.

Methods

Over a three year period all patients who had a biventricular pacemaker inserted by Dr Arun at Peninsula Private hospital were asked to complete the *Minnesota Living with heart failure questionnaire. The questionnaire was given pre insertion of the pacemaker, 3 months post insertion and 6 months post insertion. The aim was to determine did patients perceive a change in their quality of life, whether it be improvement or deterioration after having a biventricular pacemaker inserted.

Results

Results showed improvement in every area measured. Three categories were identified, those being significant improvement across the 6 month period, those with moderate improvement and those with minimal improvement as determined by clients' subjective ratings of the impact of their physical symptoms and emotional and psychological wellbeing.

Conclusion

No clients who completed the six month survey reported a decline in quality of life. All recipients felt some improvement in their quality of life, some noting it to be significant.

'Cardiac blues™': An overview of a project for patients and health professionals

Elizabeth Holloway¹, Dr Barbara Murphy¹, Dr Rosemary Higgins¹, Dr Karen Page²

¹ Heart Research Centre, North Melbourne, VIC

² Heart Foundation

Introduction

Many patients experience a strong emotional reaction at the time of or soon after an acute cardiac event. Yet patients and health professionals are commonly unaware that these symptoms can usually be considered a part of normal adjustment after an acute event.

The aim of this project is to develop a written resource for patients and an online training package for health professionals to support patients' emotional adjustment.

Methods

The quantitative component will involve assessment of a range of indicators of program acceptability (both patient and health professional arms), and a pre-post program evaluation of change in self-efficacy (health professional arm only). The qualitative component will involve focus group discussions (both patient and health professional arms) to illuminate the quantitative findings and provide more detailed attitudinal data on both the patient and health professional resources.

Results

The resource will be made available to patients in public acute care settings and on discharge from hospital and during cardiac rehabilitation programs. The health professional training will be promoted widely to those working with cardiac patients.

Conclusion

The overall objective is to support patients' emotional adjustment after an acute cardiac event. Previous studies point to the need for timely resources to inform both patients and health professionals about the process of emotional adjustment at the time of an acute cardiac event. The present study is designed to address this need.

Health-related quality of life of people undergoing valve replacement surgery for rheumatic heart disease in Fiji

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Introduction

Rheumatic Heart Disease (RHD) is a significant cause of mortality and morbidity in developing countries, particularly in the South Pacific. Degenerative changes to the cardiac valves often necessitate valve replacement (VR) surgery, but the effect of this surgery on health related quality of life (HRQOL) has not yet been reported.

Aims

To evaluate the impact of VR surgery for RHD on HRQOL.

Methods

Recipients of VR surgery by Operation Open Heart in Fiji were surveyed prospectively (pre and post operatively) 2010-2013 and retrospectively only 1991-2009 using the Short-Form-36 (SF36) and additional items specific to VR and RHD health self-care.

Results

The sample had a mean age of 26 years (SD=11.71), the majority were female (63%) and ethnic Fijian (65.8%). Surgery included the mitral valve (52%), aortic valve (19%), both (16%) and both with tricuspid-ring annuloplasty (13%). HRQOL was substantially reduced preoperatively but improved significantly in all domains at 1 year with nonsignificant reductions over time (Table 1).

Table 1. SF36 HRQOL Over time

	Preop n=51	1-year * n=35	2-years * n=20	6 years* n=50
Physical Function	51.20	95.42	85.25	87.90
Role-Physical	47.30	89.06	75.63	79.75
Bodily Pain	69.01	88.50	79.60	78.44
General Health	38.63	87.88	82.50	72.70
Vitality	52.20	75.26	72.50	67.87
Social Function	59.07	89.58	85.63	82.50
Role-Emotional	64.70	94.10	80.00	79.33
Mental Health	64.61	73.75	75.25	71.40

*change from preop baseline $p < 0.05$

Conclusion

This first-ever study of the impact of RHD and VR on HRQOL indicates the benefits of surgery and identifies areas where patients require support.

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Survey of the ACRA 2013 Conference

The committee can only make the conference more valuable through your input. Information gained from the following survey will be used to assess the Melbourne conference and to plan for the 2014 conference.

Please return the evaluation by dropping it in the designated box on the Registration Desk, email to georgia@conferencedesign.com.au, or fax to 03 6231 1522.

Registration Type

Did you attend as a: Delegate Exhibitor Committee Speaker

Other

Pre-Conference

How did you hear about the conference?

Email Committee Member Colleague Association website Conference website

Other website Postcard or flyer Journal advert Attended the last conference

Other

Please rate the following (circle the appropriate value)

Below expectation = 1, Appropriate = 2, Above expectation = 5

- | | | | | | |
|---|---|---|---|-----|----|
| 1. Quality of general information online: | 1 | 2 | 3 | 4 | 5 |
| 2. Quality of the program information online: | 1 | 2 | 3 | 4 | 5 |
| 3. The registration process: | 1 | 2 | 3 | 4 | 5 |
| 4. Did you use the online registration? | | | | Yes | No |
| 5. Registration cost: | 1 | 2 | 3 | 4 | 5 |

During the Conference

Please rate the following (circle the appropriate value)

Below expectation = 1, Appropriate = 2, Above expectation = 5

- | | | | | | |
|---|---|---|---|---|---|
| 6. Quality of the plenary sessions: | 1 | 2 | 3 | 4 | 5 |
| 7. Quality of the mini oral presentations | 1 | 2 | 3 | 4 | 5 |
| 8. Quality of the moderated poster session: | 1 | 2 | 3 | 4 | 5 |
| 9. Quality of the pre-conference workshop: | 1 | 2 | 3 | 4 | 5 |
| 10. Quality of the workshops: | 1 | 2 | 3 | 4 | 5 |
| 11. Relevance of presentations to you: | 1 | 2 | 3 | 4 | 5 |
| 12. Organisation at the conference: | 1 | 2 | 3 | 4 | 5 |
| 13. Suitability of the conference venue: | 1 | 2 | 3 | 4 | 5 |
| 14. Social functions: | 1 | 2 | 3 | 4 | 5 |
| 15. Catering at the social functions: | 1 | 2 | 3 | 4 | 5 |
| 16. Catering at the conference: | 1 | 2 | 3 | 4 | 5 |
| 17. Did you find the conference relevant? | 1 | 2 | 3 | 4 | 5 |

Do you think (please circle)...

- | | | | |
|--|------|------|------|
| 18. There should be more or less plenary sessions: | More | Same | Less |
| 19. There should be more or less concurrent sessions: | More | Same | Less |
| 20. There should be more or less posters: | More | Same | Less |
| 21. There should be more or less discussion time/panels: | More | Same | Less |
| 22. There should be more or less free time: | More | Same | Less |
| 23. There should be more or less workshops: | More | Same | Less |
| 24. There should be more or less mini presentations: | More | Same | Less |

Overall

- | | | | | | | |
|---|--------|--------|--------|--------|-----|---|
| 25. Did the conference represent value for money? | Yes | No | | | | |
| 26. Based on this year's conference would you attend the next conference? | Yes | No | | | | |
| 27. How often do you think the conference should be held (in years)? | 1 | 2 | | | | |
| 28. How satisfied were you with the conference (out of 5)? | 1 | 2 | 3 | 4 | 5 | |
| 29. How many conferences have you attended? | 1 | 2 | 3 | 5+ | 10+ | |
| 30. Ideally, how many months before the conference do you think a full program should be available? | 1 | 2 | 3 | 4 | 5 | 6 |
| 31. What is your preferred level and type of accommodation? | 3 star | 4 star | 5 star | | | |
| 32. How much do you prefer to pay for accommodation (per room)? | <\$150 | <\$175 | <\$200 | <\$250 | | |

General Comments

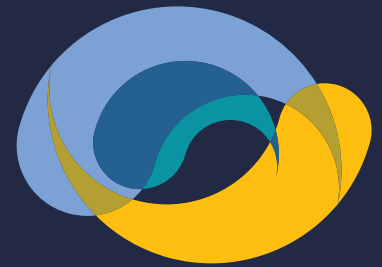
What was your favourite part of the conference?

What was your least favourite part of the conference?

Do you have any suggestions to improve future conferences?



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24TH ANNUAL SCIENTIFIC MEETING

NOVOTEL SYDNEY BRIGHTON BEACH, NSW
21 - 23 AUGUST 2014

The 24th Annual Scientific Meeting of the Australian Cardiovascular Health and Rehabilitation Association (ACRA 2014), will be the only major national cardiovascular conference in 2014.

It is the 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. The emphasis of the 2014 meeting is on "Sex, Drugs and Rock n Roll". These themes will be echoed throughout the conference as we look at what is challenging, new and different in cardiovascular disease.

CONFIRMED KEYNOTE SPEAKERS: DR ROSIE KING & PROFESSOR CHRIS SEMSARIAN

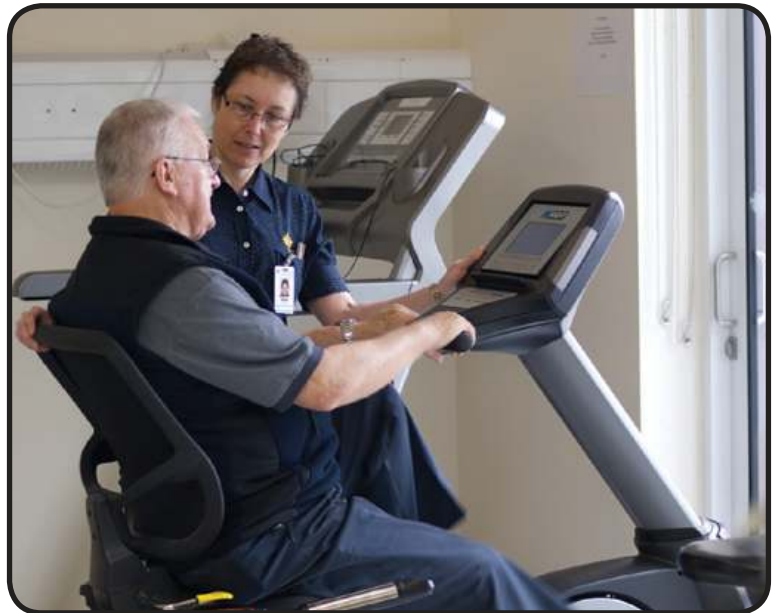
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St John of God Frankston Rehabilitation Hospital is a stand-alone 69 bed Rehabilitation Hospital. We offer neurological, orthopaedic, cardiac and reconditioning programs to more than 1,500 inpatients and over 35,000 outpatients each year.

Our co-ordinated Cardiac Rehabilitation Programs are evidenced based with a tailored multi-disciplinary patient centred approach, designed for people who have experienced a cardiac event such as Acute Coronary Syndrome or Heart Failure, revascularisation procedures such as Percutaneous Coronary Intervention, Coronary Artery Bypass Grafting or Heart Valvular Surgery, or the insertion of Permanent Pace Makers or Internal Cardiac Defibrillators.

The Cardiac Rehabilitation Programs are designed in alignment with The National Heart Foundation recommendations and guidelines, to slow or reverse progression of CVD and help prevent recurrence of cardiac events by maximising the physical, psychological and social wellbeing with people recovering from an acute cardiac event.



The Phase Two Cardiac Rehabilitation for outpatients is a rolling five week program incorporating twice weekly sessions of exercise combined with education.

Whilst the average age of our participants varies between 41-92 years, the 6 Minute Walk Test results consistently demonstrate an improvement average of 78 meters and the Health Education Impact Questionnaire (HeIQ) customer satisfaction results of equal to or greater than comparable Cardiac Rehabilitation Programs.

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