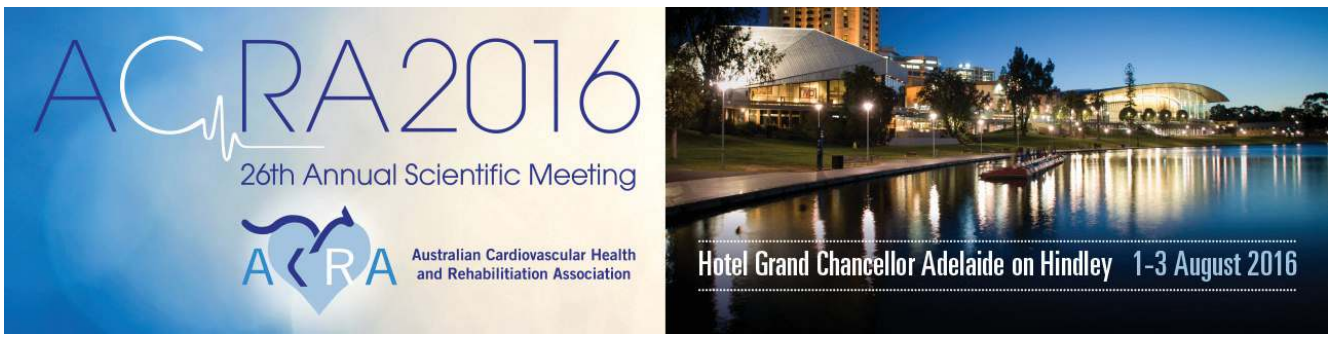
ACRA NEWSLETTER

MARCH 2016

Australian Cardiovascular Health and Rehabilitation Association

THIS EDITION



AUSTRALIAN CARDIOVASCULAR HEALTH AND REHABILITATION ASSOCIATION

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CHALLENGE...CHANGE...ACHIEVE

EDITOR'S NOTE

I hope you enjoy the autumn edition of your newsletter. There is a great report from VACR regarding their recent CPD day. Congratulations on another successful event. Robert Zecchin regularly trawls journals and websites to get some great research reviews for the newsletter and once again he has come up with a range of the latest research to whet your appetites.

The Heart Foundation theme for Heart week, May 1st-7th, is Cardiac Rehabilitation. Heart Week which puts the spotlight on heart health nationally, is this year promoting the benefits of ca diac rehabilitation after a heart attack and how it can save lives. We know this, but do you actively spread the word with all your patients?

People who are referred to cardiac rehab are 40% less likely to be readmitted to hospital, but less than 1 in 3 heart attack survivors receive a referral. The Heart Foundation has a "Campaign page" that is now live and will be updated with downloadable kits for health professionals at the beginning of April.

"You can save a life with just one conversation" (Foundation website). Do your colleagues support you in the workplace to promote the benefits? Visit the Heart Foundation website for more information and resources to advertise your service during Heart Week. You could take your cardiac rehab group for a walk in the park and/or have a healthy morning tea as part of your program activities during the week. It would be great to see some reports and photos of your specific Hea t Week activities in the next newsletter.

It's that time again to consider who will be the next president of the Association. While Lis has yet to complete her fi st year in the role, the next incumbent needs to be elected and serve alongside her in the V-P role. Nomination forms are available on the website. The position needs a nominator and a seconder and acceptance by the nominee. Any member can nominate another member for the position. Ideally the nominee will be well known within the Association and have a proven 'track record' as an advocate for cardiovascular health management championing cardiac rehabilitation and secondary prevention. They may be a clinician, a researcher, an academic.

The call is also out for the next recipient of the Dr Alan Goble Distinguished Service Award. Again, nomination forms are available on the website. Previous winners include, but not limited to, Tom Briffa, Kerry Inder, Suzie Hooper, Helen McBurney, and David Hare. Again a nominator and seconder but the nominee should not be informed of the nomination. A sub-committee from within the EMC membership will review nominations and determine the outcome of those nominations, taking into account the criteria outlined on the nomination form.

Merit awards are also available and again the nomination forms are on the website. Each of the above awards have criteria and these too are on the website. Check it out and consider nominating a colleague.

Happy re-habbing
Sue Sanderson

WE WELCOME ARTICLES FOR PUBLICATION IN THIS NEWSLETTER

Please send any items to:
sue.sanderson@dhhs.tas.gov.au
Author guidelines are available on request

CONTENTS

PRESIDENT'S REPORT

We continue to grow and develop our ACRA resources. Our working groups are hard at work on our key focus areas; membership services, professional development, advocacy and research. I was particularly pleased to be invited to talk about these activities at the Australasian Cardiovascular Nursing College (ACNC) conference held in Melbourne on the 4-5th March in Sydney. ACRA and ACNC also partnered to deliver a pre-conference workshop on atrial fib illation. The workshop was very well-attended and evaluations indicate that it was interesting and relevant. We look forward to bringing this to ACRA in August 2016. ACRA was well represented at the ACNC conference with ACRA stars winning awards: Susie Cartledge, won the best research paper prize, and Kellie Roach, was awarded the Clinical Excellence Award. We send our warmest congratulations to Susie and Kellie.

In this newsletter, you will notice that it is now time to consider nominating a new ACRA President Elect. The President Elect will work with the current ACRA executive for one year, and then start his/her term as President from August 2017. As I mentioned in my previous report, we will vote at this meeting to change our constitution, so that for future our President Elect will start at the same time as the new President, to facilitate a greater corporate knowledge and ensure that we have active involvement from our incoming President in ensuring the vision of ACRA is continued.

On a personal note, it is with very mixed feelings that I let you know that I have accepted the post of Professor of Long Term Conditions in the School of Nursing Midwifery and Social Care at Edinburgh Napier University, which I will start in August of this year. The decision to move to Scotland was motivated by a desire to be closer to my family, but the opportunity to work in such a fantastic post came a little earlier than anticipated! As part of my negotiations with the University, they have very generously agreed to pay for me to return to attend all the ACRA executive face-to-face meetings, so that I could continue all my commitments to my role as ACRA president. I contacted the ACRA executive personally to let them know of this, and they have very kindly supported me to continue as ACRA president for the duration of my term. Please be assured that the continued growth and prosperity of ACRA remains my top priority.

Very best wishes,

Lis Neubeck lis.neubeck@sydney.edu.au

ACRA President 2015-2017

Exercise Training and Heart Failure Workshop

Supported by Statewide Heart Failure Services

Thursday
23rd June, 2016
9.00 am - 4.00 pm

Russell Armstrong Auditorium, Princess Alexandra Hospital

This one day course offers exercise specialists clinical and evidenced based information on current practices relating to exercise training and heart failure. Topics include the evidence for rehabilitation models for patients with heart failure, considerations for exercise intensity, resistance training and aquatic exercise; the physiological basis for abnormal ventilation in these patients; and finally the pproaches to determining risk and appropriateness for patients returning to sport.

Enquiries - email qldheartfailure@health.qld.gov.au

VACR CLINICAL PRACTICE DAY 2016

Nurse Practitioner Margaret Ryan started the day with a session on cardiac clinical assessment. This involved a "hands on" clinical examination demonstration from Dr John Counsel utilizing a real patient. This generated lots of interest and a huge amount of appreciation and respect from the audience. We were indebted to both Dr Counsel and the gentlemen patient (who wishes to remain anonymous) for their very generous time and expertise which was given so freely.

Continuing with a clinical theme physiotherapist Katrien Janssen presented how to exercise the frail elderly cardiac patient. Katrien had some great tips and photos for simple and effective ways to exercise. This included strategies for balance and falls prevention which is so commonly a co-morbidity with this tricky cohort.

The wide variety of health professional roles involved in the management of cardiac rehabilitation was well represented on the day. This theme continued with Psychiatrist Dr Jeremy Stone's informative and entertaining presentation on the complexity of treating heart conditions and associated psychiatric conditions; how cardiac problems and drug therapies can mimic psychiatric illness stimulated some tricky audience questions.

Rivka George, Occupational Therapist delved into the variety of ways occupational tools and therapies can be used to assist the cardiac patient to get back home.

VACR was very pleased to have well known Heart Failure Cardiologist Professor David Kaye who spoke eloquently on assessing and managing breathlessness. Professor Kaye was on a very tight timeline. However he was very generous of his time and expertise; and that was appreciated very much by the audience.

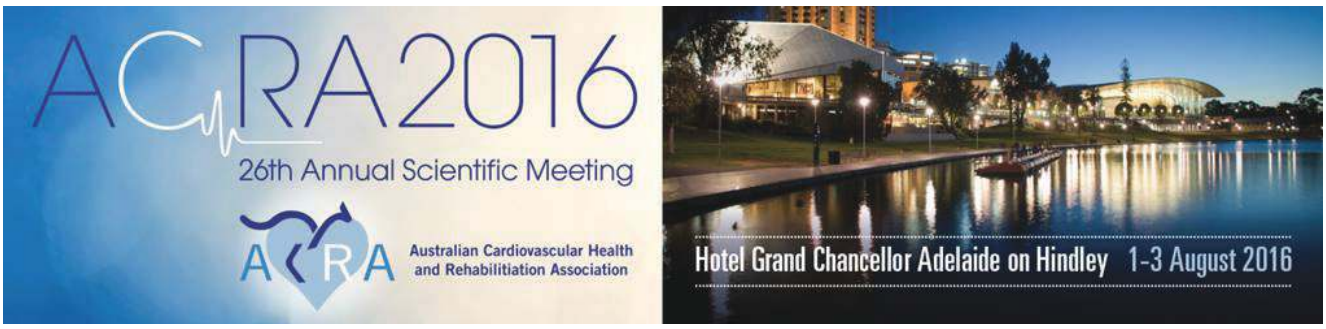
VACR is also indebted to Country cardiologist Dr Joris Mekel who travelled all the way down from Bendigo during his busy schedule for his session on the cardiology issues that present to the geographically challenged areas of Victoria.

Moving onto a different theme Kate Keighran, Clinical Nurse Consultant Wound Care, demonstrated the devastating impacts that seemingly unrelated pressure area problems can cause with her patient scenario. The photos of the wound progression were dramatic further enhancing Kate's message. At the end of Kate's presentation the audience demonstrated through lots of questions that wound care is an area that a lot of health professionals would like more information on.

Despite Anna Torres and Verity scoring the last session of the day they had the audience engaged and eating out of their hands with a simple and practical mindful technique using chocolate. Their brilliant session ended the day as it started on a very high note.

The VACR CPD day was a great success on many fronts. This was due largely to the great variety and calibre of presenters covering a broad range of topics, an enthusiastic and engaging audience, sponsorship support from Epworth Health Care Brighton-Camberwell, NicheMedical and St John of God Frankston Rehabilitation, and a hard working VACR Committee. Thank you one and all.

Emma Boston



ACRA 26th Annual Conference Report: March 2016

South Australia it is our turn to sparkle!

Registrations are open for this year's ACRA Annual Conference.

We here in South Australia have been working feverishly to plan the most exciting conference yet!! (Or so we like to think). Like good cardiac nurses, we have listened to feedback from last year's conference and we will be including more exercise opportunities, better food options (especially after the Gala night), more streamlined prize sessions and a well-balanced program.

To make this conference successful we are still in need of sponsorship of any size so if you have any contacts you may think would be helpful please forward to: Vanessa@theassociationspecialists.com.au

Convenors:

Dianna Lynch (SA) & Helen McLean (WA)

The emphasis of the 2016 Meeting will focus on "Transforming into the Future". A theme that will be echoed throughout the meeting as we explore what is challenging, new and different in cardiovascular disease.

Scientific Committee:

Prof Robyn Clark – (Chair), Caroline Astley, Louise Deprinse, Sabine Drilling, Doa El-Ansary, Jenny Finan, Jeroen Hendriks, Vanessa Poulson & Natalie Simpson

We have a magnificent line up of local, national and international speakers to present on many topics ranging from a:

- Pre-conference workshop on atrial fib illation sponsored by Boehringer Ingleheim (Gold Sponsor) on the fi st day of the conference, a number of patient stories, our poster and prize sessions.
- The Welcome Ceremony will again be sponsored by Dr Alistair Begg, SA Heart – 'What's Wrong with my Heart?'
- The ever popular breakfast seminar will be kindly sponsored by the SA Heart Foundation. This session will be robust and divisive as we investigate whether we as clinicians or patients are failing cardiac rehab.

We are also excited to be introducing the inaugural Alan Goble Oration at this year's conference. This will be presented by one of our keynote speakers.

We have tried to pique everyone's interest with fresh topics not discussed in recent conferences. Please visit the ACRA Website for further information and registration information.

Abstract Submissions:

Please consider applying to have a poster at this year's conference. There are two different abstract categories available – research and clinical.

Please submit abstracts online by close of business **Wednesday 30th March, 2016** via the conference website at: www.acra.net.au/acra-2016-asm/

In order to submit your abstract, you will fi st be required to create a profile via *Currinda*. This process should only take a few minutes.

Categories for prizes include: Poster, Clinical, Research, People's Choice, Sponsors Passport Prize, Lucky Feedback Prize and Survey Prize.

Looking forward to seeing you there!

NB: If you encounter any issues accessing registration of membership or conference registration you may consider using your home PC as some of the workplace IT fi ewalls systems may prevent accessing and processing. As Currinda can be a bit temperamental when viewing on internet explorer, it definitely works better on Google chrome or Firefox.

News From Across The Nation

Boosting aftercare for heart patients will save lives and reduce health costs

Greater uptake of cardiac rehabilitation will save lives and reduce costs to the health system by $86.7 million, according to new research published by the Heart Foundation in *Heart, Lung and Circulation* journal's February 2016 edition.

The analysis conducted by the Heart Foundation and Ernest and Young investigated the social and economic impact of increasing participation in cardiac rehabilitation in Victoria using cost benefi analysis.

The analysis has provided additional insights into the wider, longer-term impacts of cardiac rehabilitation and shows that greater participation in cardiac rehabilitation can reduce the burden of disease by improving outcomes for patients after a heart attack or other cardiac event. This directly translates to a reduction of costs in the healthcare system and wider economy, which more than offsets the costs associated with the increase in participation.

The evidence demonstrates that cardiac rehabilitation is a program that helps patients return to normal life and reduces their risk of having a repeat heart attack or cardiac event, yet only 30% of patients currently attend programs in Australia.

This analysis shows that if uptake was increased to 65% over a ten year period:

- The healthcare system would save up to $86.7 million
- The social and economic benefits ould increase by $227.2 million
- Hospitals would see 5,133 fewer readmissions
- The years of healthy life lost would be reduced by 37,565.

The results of this analysis highlight why there is a need for more effective patient education and routine referral in our hospitals, as well as reforms to boost uptake of cardiac rehabilitation.

The article 'Economic and Social Impact of Increasing Uptake of Cardiac Rehabilitation Services – A Cost Benefit Analysis' can be found online at **http://dx.doi.org/10.1016/j.hlc.2015.08.007** I recommend accessing and reading this document

Heart Week 2016

Heart Week, Sunday 1 May until 7 May 2016, shines a spotlight on the problem of heart disease and helps improve the heart health of all Australians.

In 2016 the theme will focus on cardiac rehabilitation, and how it can help people get back on their feet, return to living an active and satisfying life and prevent another heart event.

While the benefits a e clear, many people aren't referred to or don't attend their cardiac rehabilitation, leaving them at real risk of having another heart attack.

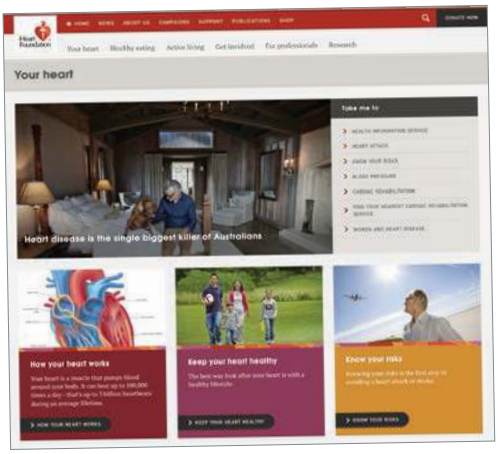
The physical activity after a heart attack resources are accessible via **http://heartfoundation.org.au/your-heart/living-with-heart-disease/cardiac-rehabilitation** Additional resources will be available to download from Heart Foundation website.

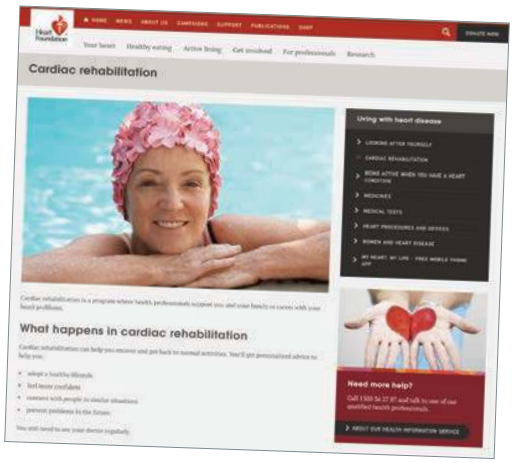
As a nurse, doctor, pharmacist or health professional you can help save lives by taking part in Heart Week. **Join our Heart Health Network for updates.**

Enhancements to Cardiac Rehabilitation Services Directory Project and temporary access to previous Directory information

The Heart Foundation has setup an interim solution to access the old national CR Services Directory information while the revised solution is being developed.

The directory information can be accessed via the Your heart webpage (**http://heartfoundation.org.au/your-heart**) by clicking the 'Find your nearest cardiac rehabilitation service' link (**http://heartservicesdirectory.heartfoundation.org.au/Pages/default.aspx**) on the take me to panel, or the Cardiac Rehabilitation webpage (**http://heartfoundation.org.au/your-heart/living-with-heart-disease/cardiac-rehabilitation**) by clicking





the 'Find a cardiac rehabilitation service' link (**http://heartservicesdirectory.heartfoundation.org.au/Pages/default.aspx**).

The proposed enhancements include Services having the ability to update their own information, consistent information collected from Services across the country and more detailed and practical search functionality. The project is progressing well. It is anticipated it may be finalised in early May, ahead of the estimated completion date of 30 June 2016.

Researchers shine spotlight on failing hearts

A vulnerable group of patients may be missing out on best-practice care, according to the fi st detailed snapshot of heart failure across NSW and ACT, published on 15 February 2016 in the Medical Journal of Australia. The NSW Heart Failure (HF) Snapshot Study, comprised a prospective audit of consecutive patients admitted to 24 participating hospitals in New South Wales and the Australian Capital Territory with a diagnosis of acute HF. It was conducted over one mid-winter month in 2013.

The results identified a dis ppointing under-use of the prescription medications typically used to manage heart failure.

This snapshot is the fi st time comprehensive data on heart failure admissions and management has been collected on a state-wide basis. None exists nationally.

The NSW Heart Failure Snapshot Study was funded by a research development grant provided by the NSW Cardiovascular Research Network of the National Heart Foundation.

The researchers anticipate that the results of the HF Snapshot will inform the development of strategies for improving the uptake of evidence-based therapies, and hence outcomes, for HF patients.

The article 'Acute heart failure admissions in New South Wales and Australian Capital Territory: the NSW HF Snapshot Study' can be found online at

https://www.mja.com.au/system/files/issues/20403/10.5694mja15.00801.pdf

A CORNER OF RESEARCH FOR AUSTRALIA

The following are excerpts of recent research articles which may:

a. encourage further research in your department

b. make you reflect on your daily practice

c. enable potential change in your program

d. All of the above

1. Acute heart failure admissions in New South Wales and the Australian Capital Territory: the NSW HF Snapshot Study.

Phillip J Newton, Patricia M Davidson, Christopher M Reid, Henry Krum, Christopher Hayward, David W Sibbritt, Emily Banks, Peter S MacDonald. MJA 204 (3) 15 February 2016.

Objective: AThe primary aim of the NSW Heart Failure (HF) Snapshot was to obtain a representative cross-sectional view of patients with acute HF and their management in New South Wales and Australian Capital Territory hospitals.

Design and setting: A prospective audit of consecutive patients admitted to 24 participating hospitals in NSW and the ACT with a diagnosis of acute HF was conducted from 8 July 2013 to 8 August 2013.

Results: A total of 811 participants were recruited (mean age, 77 years; 58% were men; 42% had a left ventricular ejection fraction <50%). The median Charlson Comorbidity Index score was 3, with ischaemic heart disease (56%), renal disease (55%), diabetes (38%) and chronic lung disease (32%) the most frequent comorbidities; 71% of patients were assessed as frail. Inter-current infection (22%), non-adherence to prescribed medication (5%) or to dietary or fluid estrictions (16%), and atrial fib illation/flutter (15%) ere the most commonly identified p ecipitants of HF. Initial treatment included intravenous diuretics (81%), oxygen therapy (87%), and bimodal positive airways pressure or continuous positive airways pressure ventilation (17%). During the index admission, 6% of patients died. The median length of stay in hospital was 6 days, but ranged between 3 and 12 days at different hospitals. Just over half the patients (59%) were referred to a multidisciplinary HF service. Discharge medications included angiotensin-converting enzyme inhibitors/ angiotensin receptor blockers (59%), b-blockers (66%) and loop diuretics (88%).

Conclusions: Patients admitted to hospital with acute HF in NSW and the ACT were generally elderly and frail, with multiple comorbidities. Evidence-based therapies were underused, and there was substantial inter-hospital variation in the length of stay. We anticipate that the results of the HF Snapshot will inform the development of strategies for improving the uptake of evidence- based therapies, and hence outcomes, for HF patients.

The Good News: "Just over half the patients (59%) were referred to a multidisciplinary HF service" is the good news but can if more patients with HF were referred it would be great news.

2. Effect of cardiac rehabilitation on functional and emotional status in patients after transcatheter aortic-valve implantation.

Voller H; Salzwedel A; Nitardy A; Buhlert H; Treszl A; Wegscheider K. European Journal of Preventive Cardiology. 22(5):568-74, 2015 May.

Background: Transcatheter aortic-valve implantation (TAVI) is an established alternative therapy in patients with severe aortic stenosis and a high surgical risk. Despite a rapid growth in its use, very few data exist about the effica y of cardiac rehabilitation (CR) in these patients. We assessed the hypothesis that patients after TAVI benefit f om CR, compared to patients after surgical aortic-valve replacement (sAVR).

Methods: From September 2009 to August 2011, 442 consecutive patients after TAVI (n=76) or sAVR (n=366) were referred to a 3-week CR program. Data regarding patient characteristics as well as changes of functional (6-min walk test (6-MWT)), bicycle exercise test, and emotional status (Hospital Anxiety and Depression Scale) were retrospectively evaluated and compared between groups after propensity score adjustment.

Results: Patients after TAVI were significantly older (p<0.001), more female (p<0.001), and had more often coronary artery disease (p=0.027), renal failure (p=0.012) and a pacemaker (p=0.032). During CR, distance in 6-MWT (both groups p<0.001) and exercise capacity (sAVR p<0.001, TAVI p<0.05) significantly increased in both groups. Only patients after sAVR demonstrated a significant eduction in anxiety and depression (p<0.001). After propensity scores adjustment, changes were not significantly di erent between sAVR and TAVI, with the exception of 6-MWT (p=0.004).

Conclusions: Patients after TAVI benefit f om cardiac rehabilitation despite their older age and comorbidities. CR is a helpful tool to maintain independency for daily life activities and participation in socio-cultural life.

The Good News: With an increasing TAVI population, expect increased referrals to your program. Get Ready!

3. Depressive symptoms at discharge from rehabilitation predict future cardiovascular-related hospitalizations.

Meyer FA; Hugentobler E; Stauber S; Wilhelm M; Znoj H; von Kanel R. Cardiology. 131(2):80-5, 2015.

Objectives: Depression is associated with poor prognosis in patients with cardiovascular disease (CVD). We hypothesized that depressive symptoms at discharge from a cardiac rehabilitation program are associated with an increased risk of future CVD-related hospitalizations.

Methods: We examined 486 CVD patients (mean age=59.8+/-11.2) who enrolled in a comprehensive 3-month rehabilitation program and completed the depression subscale of the Hospital Anxiety and Depression Scale (HADS-D). At follow-up we evaluated the predictive value of depressive symptoms for CVD-related hospitalizations, controlling for socio-demographic factors, cardiovascular risk factors, and disease severity.

Results: During a mean follow-up of 41.5+/-15.6 months, 63 patients experienced a CVD-related hospitalization. The percentage of depressive patients (HADS-D>8) decreased from 16.9% at rehabilitation entry to 10.7% at discharge. Depressive symptoms at discharge from rehabilitation were a significant p edictor of outcome (HR 1.32, 95% CI 1.09-1.60; p=0.004). Patients with clinically relevant depressive symptoms at discharge had a 2.5-fold increased relative risk of poor cardiac prognosis compared to patients without clinically relevant depressive symptoms independently of other prognostic variables.

Conclusion: In patients with CVD, depressive symptoms at discharge from rehabilitation indicated a poor cardiac prognosis.

The Good News: Do you measure depression in your clinic? If not, why not!

4. Home-based versus centre-based cardiac rehabilitation.

Taylor RS; Dalal H; Jolly K; Zawada A; Dean SG; Cowie A; Norton RJ. Cochrane Database of Systematic Reviews. 8:CD007130, 2015.

Background: Cardiovascular disease is the most common cause of death globally. Traditionally, centre-based cardiac rehabilitation programmes are offered to individuals after cardiac events to aid recovery and prevent further cardiac illness. Home-based cardiac rehabilitation programmes have been introduced in an attempt to widen access and participation. This is an update of a review originally published in 2009.

Objectives: To compare the effect of home-based and supervised centre-based cardiac rehabilitation on mortality and morbidity, health-related quality of life, and modifi ble cardiac risk factors in patients with heart disease.

Search Methods: To update searches from the previous Cochrane review, we searched the Cochrane Central Register of Controlled Trials (CENTRAL, The Cochrane Library, Issue 9, 2014), MEDLINE (Ovid, 1946 to October week 1 2014), EMBASE (Ovid, 1980 to 2014 week 41), PsycINFO (Ovid, 1806 to October week 2 2014), and CINAHL (EBSCO, to October 2014). We checked reference lists of included trials and recent systematic reviews. No language restrictions were applied.

Selection Criteria: Randomised controlled trials (RCTs) that compared centre-based cardiac rehabilitation (e.g. hospital, gymnasium, sports centre) with home-based programmes in adults with myocardial infarction (MI), angina, heart failure or who had undergone revascularisation.

Data Collection and Analysis: Two authors independently assessed the eligibility of the identified trials and data were extracted by a single author and checked by a second. Authors were contacted where possible to obtain missing information.

Main Results: Seventeen trials included a total of 2172 participants undergoing cardiac rehabilitation following an acute MI or revascularisation, or with heart failure. This update included an additional fi e trials on 345 patients with heart failure. Authors of a number of included trials failed to give sufficient detail to assess their potential risk of bias, and details of generation and concealment of random allocation sequence were particularly poorly reported. In the main, no difference was seen between home- and centre-based cardiac rehabilitation in outcomes up to 12 months of follow up: mortality (relative risk (RR) = 0.79, 95% confidence inte val (CI) 0.43 to 1.47, P = 0.46, fixed-e fect), cardiac events (data not poolable), exercise capacity (standardised mean difference (SMD) = -0.10, 95% CI -0.29 to 0.08, P = 0.29, random-effects), modifi ble risk factors (total cholesterol: mean difference (MD) = 0.07 mmol/L, 95% CI -0.24 to 0.11, P = 0.47, random-effects; low density lipoprotein cholesterol: MD = -0.06 mmol/L, 95% CI -0.27 to 0.15, P = 0.55, random-effects; systolic blood pressure: mean difference (MD) = 0.19 mmHg, 95% CI -3.37 to 3.75, P = 0.92, random-effects; proportion of smokers at follow up (RR = 0.98, 95% CI 0.79 to 1.21, P = 0.83, fixed effect), or health-related quality of life (not poolable). Small outcome differences in favour of centre-based participants were seen in high density lipoprotein cholesterol (MD = -0.07 mmol/L, 95% CI -0.11 to -0.03, P = 0.001, fixed-e fect), and triglycerides (MD = -0.18 mmol/L, 95% CI -0.34 to -0.02, P = 0.03, fixed-e fect, diastolic blood pressure (MD = -1.86 mmHg; 95% CI -0.76 to -2.95, P = 0.0009, fixed-e fect). In contrast, in home-based participants, there was evidence of a marginally higher levels of programme completion (RR = 1.04, 95% CI 1.01 to 1.07, P = 0.009, fixed-e fect) and adherence to the programme (not poolable). No consistent difference was seen in healthcare costs between the two forms of cardiac rehabilitation.

Conclusions: This updated review supports the conclusions of the previous version of this review that home- and centre-based forms of cardiac rehabilitation seem to be equally effective for improving the clinical and health-related quality of life outcomes in low risk patients after MI or revascularisation, or with heart failure. This finding together with the absence of evidence of important differences in healthcare costs between the two approaches, supports the continued expansion of evidence-based, home-based cardiac rehabilitation programmes. The choice of participating in a more traditional and supervised centre-based programme or a home-based programme should reflect the preference of the individual patient. Further data are needed to determine whether the effects of home- and centre-based cardiac rehabilitation reported in these short-term trials can be confi med in the longer term. A number of studies failed to give sufficient detail to assess their risk of bias.

The Good News: Both models of CR work – are you flexible in our program design to offer both according patient needs and/or preference?

5. Provider Type and Quality of Outpatient Cardiovascular Disease Care: Insights From the NCDR PINNACLE Registry.

Virani SS; Maddox TM; Chan PS; Tang F; Akeroyd JM; Risch SA; Oetgen WJ; Deswal A; Bozkurt B; Ballantyne CM; Petersen LA. Journal of the American College of Cardiology. 66(16):1803-12, 2015 Oct 20.

Background: The current number of physicians will not be sufficient to accommodate 30 to 40 million Americans expected to secure health coverage with Affordable Care Act implementation. One proposed solution is to use advanced practice providers (APPs) (nurse practitioners and physician assistants).

Objectives: This study sought to determine whether there were clinically meaningful differences in the quality of care delivered by APPs versus physicians in a national sample of cardiology practices.

Methods: Within the American College of Cardiology's PINNACLE Registry, we compared quality of coronary artery disease (CAD), heart failure, and atrial fib illation care delivered by physicians and APPs for outpatient visits between January 1, 2012, and December 31, 2012. We performed hierarchical regression adjusting for provider sex; panel size; duration of participation in registry; and patient's age, sex, insurance, number of outpatient visits, history of hypertension, diabetes, myocardial infarction, and percutaneous coronary intervention or coronary artery bypass grafting in the preceding 12 months.

Results: We included 883 providers (716 physicians and 167 APPs) in 41 practices who cared for 459,669 patients.

Mean number of patients seen by APPs (260.7) was lower compared with that seen by physicians (581.2). Compliance with most CAD, heart failure, and atrial fib illation measures was comparable, except for a higher rate of smoking cessation screening and intervention (adjusted rate ratio: 1.14; 95% confidence interval: 1.03 to 1.26) and cardiac rehabilitation referral (rate ratio: 1.40; 95% confidence inte val: 1.16 to 1.70) among CAD patients receiving care from APPs. Compliance with all eligible CAD measures was low for both (12.1% and 12.2% for APPs and physicians, respectively) with no significant di ference. Results were consistent when comparing practices with both physicians and APPs (n = 41) and physician-only practices (n = 49).

Conclusions: Apart from minor differences, a collaborative care delivery model, using both physicians and APPs, may deliver an overall comparable quality of outpatient cardiovascular care compared with a physician-only model.

The Good News: Advanced practice providers (APPs) which include nurse practitioners and physician assistants are CR referral champions – now we have to work on the Doctors!

6. Participation Rates, Process Monitoring, and Quality Improvement Among Cardiac Rehabilitation Programs in the United States: A NATIONAL SURVEY.

Pack QR; Squires RW; Lopez-Jimenez F; Lichtman SW; Rodriguez-Escudero JP; Lindenauer PK; Thomas RJ. Journal of Cardiopulmonary Rehabilitation & Prevention. 35(3):173-80, 2015 May-Jun.

Purpose: Although strategies exist for improving cardiac rehabilitation (CR) participation rates, it is unclear how frequently these strategies are used and what efforts are being made by CR programs to improve participation rates.

Methods: We surveyed all CR program directors in the American Association of Cardiovascular and Pulmonary Rehabilitation's database. Data collection included program characteristics, the use of specific referral and recruitment strategies, and self-reported program participation rates.

Results: Between 2007 and 2012, 49% of programs measured referral of inpatients from the hospital, 21% measured outpatient referral from office clinic, 71% measured program enrolment, and 74% measured program completion rates. Program-reported participation rates (interquartile range) were 68% (32-90) for hospital referral, 35% (15-60) for office/clinic eferral, 70% (46-80) for enrolment, and 75% (62-82) for program completion. The majority of programs utilized a hospital-based systematic referral, liaison-facilitated referral, or inpatient CR program referral (64%, 68%, and 60% of the time, respectively). Early appointments (<2 weeks) were utilized by 35%, and consistent phone call appointment reminders were utilized by 50% of programs. Quality improvement (QI) projects were performed by about half of CR programs. Measurement of participation rates was highly correlated with performing QI projects (P < .0001.)

Conclusions: Although programs are aware of participation rate gaps, the monitoring of participation rates is suboptimal, QI initiatives are infrequent, and proven strategies for increasing patient participation are inconsistently utilized. These issues likely contribute to the national CR participation gap and may prove to be useful targets for national QI initiatives.

The Good News: Collecting meaningful data will help drive quality improvement and the attainment of best practice in CR!

7. Motivational processes and well-being in cardiac rehabilitation: a self-determination theory perspective.

Rahman RJ; Hudson J; Thogersen-Ntoumani C; Doust JH. Psychology Health & Medicine. 20(5):518-29, 2015.

This research examined the processes underpinning changes in psychological well-being and behavioural regulation in cardiac rehabilitation (CR) patients using self-determination theory (SDT). A repeated measures design was used to identify the longitudinal relationships between SDT variables, psychological well-being and exercise behaviour during and following a structured CR programme. Participants were 389 cardiac patients (aged 36-84 years; M (age) = 64 +/- 9 years; 34.3% female) referred to a 12-week-supervised CR programme. Psychological need satisfaction, behavioural regulation, health-related quality of life, physical self-worth, anxiety and depression were measured at programme entry, exit and six month post-programme. During

the programme, increases in autonomy satisfaction predicted positive changes in behavioural regulation, and improvements in competence and relatedness satisfaction predicted improvements in behavioural regulation and well-being. Competence satisfaction also positively predicted habitual physical activity. Decreases in external regulation and increases in intrinsic motivation predicted improvements in physical self-worth and physical well-being, respectively. Significant longitudinal elationships were identified hereby changes during the programme predicted changes in habitual physical activity and the mental quality of life from exit to six month follow-up. Findings provide insight into the factors explaining psychological changes seen during CR. They highlight the importance of increasing patients' perceptions of psychological need satisfaction and self-determined motivation to improve well-being during the structured component of a CR programme and longer term physical activity.

The Good News: Thought provoking study!

8. Remission of recently diagnosed type 2 diabetes mellitus with weight loss and exercise.

Ades PA; Savage PD; Marney AM; Harvey J; Evans KA. Journal of Cardiopulmonary Rehabilitation & Prevention. 35(3):193-7, 2015 May-Jun.

Purpose: To determine the rate of remission of recently diagnosed (<1 year) type 2 diabetes mellitus (T2DM) in overweight/obese individuals, with a 6-month program of weight loss and exercise.

Methods: Subjects (N = 12) were overweight/obese (body mass index = 35.8 +/- 4.3 kg/m), sedentary, and unfit ((Equation is included in full-text a ticle.) O2peak = 20.7 +/- 4.7 mL.kg.min) and recently (<1 year) diagnosed with T2DM. They were willing to participate in a lifestyle program of behavioural weight loss counseling and supervised exercise located at a cardiac rehabilitation program prior to consideration of diabetes medications. Glycated haemoglobin (HbA1c) level before and after the study intervention was the primary study outcome, along with secondary metabolic, fitnes , and body composition variables.

Results: Subjects had a baseline HbA1c of 6.5% to 8.0% (mean 6.8 +/- 0.2). Subjects lost 9.7 +/- 0.2 kg body weight (9%) and improved peak aerobic capacity by 18%. Two subjects withdrew for medical reasons unrelated to the lifestyle program. Eight of 10 completers (80%) went into partial T2DM remission, with the mean HbA1c decreasing from 6.8 +/- 0.2% to 6.2 +/- 0.3% (P < .001).

Conclusions: For individuals with recently diagnosed T2DM willing to undertake a formal lifestyle program, 80% of study completers and 67% of our total population achieved at least a partial T2DM remission at 6 months. Further study of this intervention at the time of diagnosis of T2DM with randomized controls and longer-term follow-up is warranted.

The Good News: Interesting and promising study in a small population.

9. Effect of High Interval Training in Acute Myocardial Infarction Patients with Drug-Eluting Stent.

Kim C; Choi HE; Lim MH. American Journal of Physical Medicine & Rehabilitation. 94(10 Suppl 1):879-86, 2015 Oct.

Objective: Peak oxygen uptake (VO2peak) is a strong predictor of survival in cardiac patients. The aims of this study were to compare the effects of high interval training (HIT) to moderate continuous training (MCT) on VO2peak and to identify the safety of HIT in acute myocardial infarction patients with drug-eluting stent.

Design: Twenty-eight acute myocardial infarction patients with drug-eluting stent were randomized to either HIT at 85%-95 % of heart rate reserve or MCT at 70%-85% of heart rate reserve, 3 days a week for 6 wks at a cardiac rehabilitation clinic. Primary outcome was VO2peak at baseline and after cardiac rehabilitation.

Results: Both HIT and MCT groups showed significant increases in VO2peak and heart rate recovery after 6 wks of training. The 22.16% improvement in VO2peak in the HIT group was significantly g eater than the 8.48% improvement in the MCT group (P = 0.021). There were no cardiovascular events related to both HIT and MCT.

Conclusions: HIT is more effective than MCT for improving VO2peak in acute myocardial infarction patients with drug-eluting stent. These findings ay have important implications for more effective exercise training in cardiac rehabilitation program.

The Good News: What exercise modality do you use in your program?

A CORNER OF RESEARCH FOR AUSTRALIA CONT.

10. Cardiac Rehabilitation after Percutaneous Coronary Intervention in a Multiethnic Asian Country: Enrolment and Barriers.

Poh R; Ng HN; Loo G; Ooi LS; Yeo TJ; Wong R; Lee CH. Archives of Physical Medicine & Rehabilitation. 96(9):1733-8, 2015 Sep.

OBJECTIVE: To determine the enrolment or barriers to cardiac rehabilitation (CR) among Asian patients who have undergone percutaneous coronary intervention (PCI). DESIGN: Prospective observational study. SETTING: Department of cardiology at a university hospital. PARTICIPANTS: Patients (N=795) who underwent PCI between January 2012 and December 2013 at a tertiary medical institution.

MAIN OUTCOME MEASURES: Data on enrolment in phase 2 CR and its barriers were collected by dedicated CR nurses.

RESULTS: Of 795 patients, 351 patients (44.2%) were ineligible for CR because of residual coronary stenosis, while 30 patients (3.8%) were not screened because of either early discharge or death. Of the remaining 416 patients (90.8% men; mean age, 55 y), 365 (87.7%) declined CR participation and 51 (12.3%) agreed to participate. Of these 51 patients, 20 (39%) did not proceed to enrol and 4 (8%) dropped out, leaving 27 patients (53%) who completed at least 6 sessions of the CR program. The top 3 reasons provided by patients who declined to participate in CR were (1) busy work schedules (37.5%), (2) no specific eason (26.7%), and (3) preference for self-exercise (20.1%). Non-smokers were more likely to participate in CR (P=.001).

CONCLUSIONS: CR participation of Asian patients after PCI was found to be lower than that reported in Western countries. The exclusion criteria used in the institution under study differed from those provided by international associations. A busy work schedule was the most common reason for declining CR after PCI.

The Good News: "A busy work schedule was the most common reason for declining CR after PCI" - Sounds familiar!

More next time!

By Robert Zecchin RN MN

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The Heart Research Centre is now the Australian Centre for Heart Health

The Australian Centre for Heart Health (ACHH) was the next logical step in the evolution of the HRC. Very importantly, it brings together the internationally recognised research of the HRC and its highly successful cardiac rehabilitation workforce development program with a new program, the **Cardiac Wellbeing Clinic.**

heart RESEARCH CENTRE → Australian Centre for Heart Health

What services will the Cardiac Wellbeing Clinic offer?

All the programs offered in the *Cardiac Wellbeing Clinic*® are evidence-based and have been extensively evaluated. The programs draw on the principles of cognitive behaviour therapy (CBT) underpinned by a framework of self-regulation theory, both of which have been shown to be highly efficacious or cardiac patients and particularly effective in supporting behaviour change. These programs have been developed by our team of registered health psychologists and behaviour change experts, who are highly experienced in the development and delivery of support programs for cardiac patients and their families.

The **Beating Heart Problems** program is an 8-week group program for people who have had a cardiac event. The program addresses the key health behaviours – healthy eating, physical activity, and smoking cessation – and provides support in managing mood difficultie . The program is facilitated by one of our trained registered psychologists.

Teleheart is an 8-session telephone-delivered program for people who have had a cardiac event. It addresses the same behavioural and psychosocial issues as in the Beating Heart Problems program but is available to patients in the comfort of their own home. It is delivered by trained registered psychologists. This program provides an evidence-based personalised behaviour change and maintenance program where patients are supported by self-designed SMS messages. The program places a strong emphasis on self-regulation.

Help Yourself Online is a 6-session internet-delivered program for people who have had a cardiac event. Again it addresses the same behavioural and psychosocial issues, but is available to patients 24-hours a day, thus can be accessed at a time that best suits patients. Again the program incorporates techniques from CBT and self-regulation theory.

Cardiac Blues Online is a 3-session internet-delivered program to support patients experiencing the cardiac blues, anxiety, anger and/or depression after their cardiac event. Patients can undertake the program in the comfort of their own home, with modules providing information, education and support for patients in managing their mental health.

Cardiac Connect is an online community for people who have had a cardiac event. It is designed to provide follow-up support for patients who have undertaken our individual programs. Cardiac Connect is facilitated by a trained registered health psychologist, and assists patients in maintaining a healthy body and mind. It is based on evidence that social support aids physical and emotional recovery of people with heart disease.

The Cardiac Blues Resources support patients' emotional recovery. The resources include an 8-page Cardiac Blues brochure and a single-page Cardiac Blues postcard for patients, both of which are currently available through all hospitals across Australia.

Cognitive Behaviour Therapy for Insomnia (CBT-I) will be provided for cardiac patients experiencing insomnia. There is a high prevalence of sleep disturbances such as obstructive sleep apnoea (OSA) and insomnia in cardiac patients. The CBT-I program will be facilitated by a trained, registered psychologist and will be offered either individually or in groups.

The **Cardiac Partner Program** is a group-based support program for partners of cardiac patients, designed to run alongside our Beating Heart Problems program or traditional cardiac rehabilitation programs for cardiac patients.

The Heart Research Centre is now the Australian Centre for Heart Health CONT

Our research shows that many partners of cardiac patients experience more anxiety than the patients themselves. The Cardiac Partner Program supports partners in the management of their own body and mind. The program will be facilitated by a trained, registered psychologist.

Cardiac Partner Connect is an online community for partners of cardiac patients. Cardiac Partner Connect will be facilitated by a trained registered health psychologist, and will assist partners in maintaining a healthy body and mind whilst they support the cardiac patient.

The **HeartChild Family Coping** program is an 8-module program delivered over fi e weeks, designed to assist parents of children with congenital heart disease. The program, which is facilitated by a registered psychologist, will be delivered either individually or in groups. The program is resilience-based and aims to enhance families' capacity to deal with the challenges and stresses they encounter as parents of special needs children. The program will be facilitated by trained psychologists and HeartKids Family Support Workers.

We will provide **individual counselling** sessions for patients, partners, parents and other family members. These sessions will focus on helping patients and family members make healthy lifestyle changes and manage symptoms of depression and anxiety. Group counselling sessions will also be offered.

Web-based counselling will be offered to patients and families, using appointment-based synchronous communications (instant messaging and chat) and non-appointment asynchronous communications (email), both of which deliver a range of counselling, information, education and support options. Online sessions can lead to improved wellbeing and reduced distress.

Australasian Cardiovascular Nursing College Annual Conference 2016

Reported by Emma Boston.

Held at the Melbourne Convention Centre March 4th-5th this conference was attended by several ACRA members. Incoming ACNC President Maria Sheehan acknowledged ACRA's collaboration during her opening welcome address reporting on the very successful AF session held the previous evening.

ACRA National President Lis Neubeck was, as always, an excellent ambassador for ACRA working hard also as a session chair during the conference. Lis further excelled with her presentation on the Core Components of Cardiac Rehabilitation and National Action on Secondary Prevention of CHD.

Congratulations also go to two of our ACRA Members Kellie Roach and Susie Cartledge. Kellie was awarded the ACNC Clinical Excellence award. Susie won the Best Research paper for her presentation on …"Factors associated with ambulance use for acute coronary syndrome in Victoria"...

Well done Lis, Kellie and Susie!

STATE PRESIDENTS' REPORTING

TASMANIA

State representative:
John Aitken

President:
Sue Sanderson

The holiday season saw each program 'closing down' for 3-4 weeks from an out-patient group perspective. Patients continued to cross our thresholds and in-patient education was maintained. All back in 'full swing' now and it is hard to believe Christmas was almost 3 months ago.

From an Association view point we have been very quiet. However, at a meeting held in early March planning started in earnest for our annual education seminar and AGM to be held April 15th in Launceston. We are hoping to broaden the appeal of our seminar by dividing the day into 2 blocks – the morning for members and non-members to gain more information about heart failure and patient assessment, device therapy and monitoring of devices, and exercise prescription. Following the AGM the afternoon block the focus will shift to data collection specifically or the cardiac rehabilitation clinicians in the state. We are fortunate in having Prof Leigh Kinsman at the UTAS campus in Launceston and we will engage him in facilitating this session.

Speakers for the morning talks include technician Colin Woodfield and p ysiotherapist Caroline Hanley. The cardiologist is yet to be confi med. As always, we encourage and invite members from other states to come along.

I am now working part time at the Heart Foundation in Tasmania as Clinical Engagement Coordinator. I am still employed at the RHH part time as nurse practitioner in the heart failure service and the remaining hours of the position have been converted to a CNC and Jude Enright has been successful in gaining that role. We will work jointly in the heart failure service and she will manage a community based cardiac rehabilitation program as well as maintaining some hours in the RHH program. I have also been assisting Gillian Mangan, CV Health Director, on the statewide Cardiac Services Plan which we anticipate will be the blueprint for cardiology and cardiothoracic services for the state, endorsed by the Cardiology Advisory Group and adopted by and for the recently established Tasmanian Health Service.

Tom Shepherd, physiotherapist at the LGH, has started a cardiopulmonary rehabilitation program at St Helens on the east coast through funding acquired by a private physiotherapy practice on the coast. We hope that this can be sustainable as distance from the LGH otherwise precludes patients in this region from accessing a program.

Congratulations to Anna Storen who has been appointed to the cardiac rehabilitation position at the North West Regional Hospital in Burnie. Previously she had been temporary in the position following the retirement of Erica Summers. Best wishes Anna.

Sue Sanderson
TACR President

NEW SOUTH WALES / ACT

State representative:
Robyn Gallagher

President:
Dawn McIvor

Post state AGM only
Report from AGM

CRA NSW ACT AGM 24th October, 2016.

Upcoming events

1) CRA NSW ACT state conference will be held on the Monday 24th October 2016 at University of Sydney
2) State webinar held on the 4th May during Heart week. Topic: Core components in Clinical Practise by Steve Woodruffe
   Time: TBA
3) NHF celebrating Heart Week 1-7th of May. The topic for 2016 is Cardiac Rehabilitation with focus on the health professional

State network reports

NSW Cardiac Rehabilitation (CR) State working party in conjunction with their Data Sub Working Group have commence a pilot program over up to 28 sites across NSW.

The pilot data collection will commence on 1 March 2016 and conclude on 30 May 2016. From there will await feedback about any improvements required and/or suggestions and correlate this data to the State CR working party.

Jo Leonard
NSW/ACT President

STATE PRESIDENTS' REPORTING CONT.

QUEENSLAND

Professional Development Opportunities

State representative: **Jessica Auer**

President: **Paul Camp**

QCRA is looking to host a number of professional development events for its members in 2016. Being planned are a webinar/videoconference to celebrate Heart Week (1-7th May) and a dinner-workshop (video-conferenced/ videorecorded) in June/July. Excitingly we can announce our QCRA-Heart Foundation state conference will take place on Friday October 28th. This conference will provide a space where QCRA members can feel comfortable sharing 'what's new and innovative' about their own practice. It will be held at the Royal Brisbane and Women's Hospital and videoconferenced across the state. QCRA continues to look for other opportunities to offer our members professional development opportunities.

Possible Name Change

As discussed locally and at the QCRA AGM, we are considering a name change similar to that of other states e.g. 'ACRA-State Name'. QCRA members were asked to feedback on the possible name change to 'ACRA-Queensland' by January 31st. The overwhelming majority of feedback we received was in favour of this move. The next step will be to take this proposed name change to the next AGM (October 28th) as a special resolution for a formal member vote.

Using Data to Advance CR

The Statewide Cardiac Clinical Network - Cardiac Rehab Working Group (SCCN CRWG) has been working to facilitate the implementation of a statewide data set. Ultimately this data set would be used to highlight the benefits of CR and be a p werful tool in promoting these services in Queensland. QCRA will keep you informed of these developments as they are announced. The SCCN CRWG is made up of CR clinicians dedicated to supporting and advancing this service within Queensland.

QIP Improving Cardiac Rehab Referrals

The Quality Improvement Payment (QIP) announced by the Queensland Government in December to enhance referrals to Cardiac Rehab, continues to be very well supported. This important initiative by Government, the Heart Foundation and the SCCN is improving referrals to secondary prevention programs across the state. Important to the success of the QIP has been good data entry for tracking of referrals. QCRA encourages all participating in the QIP to keep up this careful data entry, as well as keep us informed of changes to their program contact details at qcra@acra.net.au

Paul Camp
QCRA President

SOUTH AUSTRALIA

State representative: **Natalie Simpson**

President: **Dianna Lynch**

Welcome members to the year that will showcase our state especially for cardiac health and health in general.

We have an exciting year ahead with the 26th Annual ACRA conference being held here in Adelaide at the Grand Chancellor Hotel in Hindley St, from the 1st-3rd August. This conference will be so exciting and as a convenor, and working alongside the magnificent scientifi committee we have had most of our wish lists realised with many different topics that should pique the interest of all attendees. We can't wait for you to see the program, and by the time you read this newsletter, registrations will be open.

The ACRA conference this year will precede CSANZ which will also be held here in Adelaide. More details will follow as they are released.

We will welcome the opening of the " New RAH" (Royal Adelaide Hospital), and our health care services are still in the midst of " transforming " into different models, and significant changes a e inevitably still evolving. This will translate into the evolution of many of our own ways in which we practice, however it is encouraging to see our members embracing the changes and also to seeing the different strategies being used to provide quality cardiac care and support

Executive News:

This year will see a change in the way we will renew our membership. In the past we have paid on the anniversary of our joining, however we will be moving to an annual renewal date, much like our AHPRA registration. If your annual renewal is coming up you will notice that your remittance will be scaled until the 30th June followed by a second invoice that will be for the full year.

We would like to thank and recognise Chris Walton who has stepped down as our Rural Representative, Chris has worked with CATCH and was integral in the introduction of the centralised referral service for not

STATE PRESIDENTS' REPORTING CONT.

only country patients but also for the utilisation by all metro sites including public and private hospitals. Chris has now moved to Boston Scientific to begin his technical training. Chris has expressed his thanks for all your support and he plans on keeping his membership and keeping in touch with us.

Natalie Simpson our State Representative has now expanded her role to include Acting National Treasurer, replacing the long-serving Craig Cheetham. This is a large undertaking and we are very glad to have her step into this role.

Natalie Simpson (State Representative) and Di Lynch (President) will be attending the bi-annual EMC meeting in May and we will continue to provide a voice for our state.

Please note that our AGM is coming up and we will require nominations for the role of Rural Representative and Secretary.

Education Seminar:

At our last ordinary meeting the members voted and decided that due to the conference this year we will reduce our education seminars to just two for the year.

Our fi st education seminar will be held on Saturday 9th April at GP Plus, Smart Road Modbury, followed by our AGM. We will be having a workshop presented by Deb Wright who will demonstrate chest pain clinical assessment skills, and we are awaiting confi mation on the other speaker/s.

Members News:

Kath O'Toole, one of our Nurse Practitioners has designed and implemented a pilot **Women's Health & Wellness Program (WHWP).**

Cardiovascular disease (CVD) is the number one killer of Australian Women. The National Heart Foundation of Australia (NHF) recognizes that one in three women are unaware of this fact and has identified 90% of women have at least one risk factor and over half at least two. CVD is the single biggest killer of women in Australia, taking the lives of 24 women each day. Three times as many Australian women die of heart disease as they do breast cancer.

The Women's Ischemia Syndrome Evaluation (WISE) study and numerous other studies of CVD in women have identified a number of ala ming differences in the presentation, diagnosis and treatments of CVD between men and women (Pastore et al 2012).

Therefore nurse practitioners in the community setting are in a key position to address CVD prevention and cardiac rehabilitation and close the gap in the preventable care and management of CVD in women.

Kath's Women's Health & Wellness Program (WHWP) is a pilot program aiming to provide primary and secondary prevention for women in the primary care setting that will monitor and address issues specific to women's health care requirements. This is delivered using is a comprehensive assessment, management and lifestyle and education program for women with existing CVD or those at risk of CVD, which encompasses and identifies isk factors and offering a collaborative approach to implementing treatment and management action plans which are essential in promoting CVD prevention.

The WHWP offers:

- Small group sessions
- Relaxed atmosphere in a safe and comfortable setting
- Education on topics related to women's heart health and chronic disease management
- One to one consultation with a nurse practitioner
- Opportunity for conversations with other women in the program with similar health concerns.

Susan Sierp: Becoming a Nurse Practitioner

When asked to compile a 'paragraph' of my journey to becoming a Nurse Practitioner (NP) my initial thoughts were centred on the reasons for this decision in regards to where this would take me this late in my career.

My early decision process was fraught with self-doubt and procrastination (my middle name) as to whether I could cope or even manage a higher level of tertiary education after so many years of 'no structured study' and working full time. Therefore I went through a 'pros' and 'cons' process with focus on the cons fi st of course!

Cons – absence of NP candidacy position however a 'support in principle' via my organisation (meaning very little); work / life balance; no previous tertiary degrees (only hospital based equivalents); absence of 'protected time' in regards to a nominated team support for assessments and feedback; no guarantee of a NP position at the completion of the Masters Degree.

Pros – Advanced Practice Nurse (APN) for many years with already extensive skills in cardiology assessment and planning; good rapport embedded within the cardiology team; existing patient satisfaction that could potentially be enhanced as a NP for complete episode of care.

As it was obvious the 'cons' outweighed the 'pros' my observations and admiration of my NP colleagues who had successfully embedded their scope of practice is what ultimately influenced me The ability to offer complete holistic episodes of care appealed to me with obvious client satisfaction as an extra bonus. Without going into absolute detail my next issue was, "what is my scope of practice" that will differ and value add to my existing practice?

STATE PRESIDENTS' REPORTING CONT.

This was a major challenge as according to my university lecturers I was working beyond my current scope with nowhere to move. Thankfully the head of the cardiology department Dr Margaret Arstall had a plan for me (at the 11th hour) that was coming to fruition. Cardiovascular Prevention and Rehabilitation (CP&R) would be moving into new territory for South Australia at Lyell McEwin Hospital (LMH).

A systematic review of findings in 2014 suggested a strong association of pregnancy complications (25% of 1st pregnancies) with latent and future cardiovascular (CV) disease which ordinarily are much less appreciated at the time of birth with emphasis of the complications implicated on the babies lifelong health. However, most cardiovascular adaptations to normal pregnancy resolve in the post-partum period.

Pregnancy can be likened to a physiological / metabolic stress test that can identify women at risk of further coronary artery disease (CAD). The evidence suggests an increase in mortality and morbidity of CAD risk due to recurrent miscarriages and complications of Pre-Eclampsia, Intrauterine Growth Restriction (IUGR), Small gestational age (SGA), Idiopathic Pre-term delivery and Gestational Diabetes Mellitus (GDM) or Impaired Glucose Tolerance (IGT). Other CV risks indicators include smoking, excess weight gain during pregnancy, weight retention and gain post-partum.

These adverse outcomes linked to the underlying vasculo-endothelial mechanisms are thought to include hyperlipidaemia, endothelial dysfunction and increased lipid deposition in blood vessel walls.

Therefore a major gap was identified t ansitioning to Primary Health Care (PHC) and reliance on GP's to follow up on these women with many postpartum complications and a potential to be missed. Based on a model of care (MOC) of the 'Postpartum Maternal Health Clinic' in Canada, a clinic at the Lyell McEwin Hospital in collaboration with Obstetrics, Endocrinology and Cardiology is in the process of development to address these clients with potential CV risk 6 months postpartum.

The objective and purpose of the NP led clinic will include an opportunity to address primordial and primary prevention measures in regards to CV risk and health and reducing care inequities for women in general and specifically ounger women. To identify lifestyle and health behaviours with possible impact of socio-economic circumstances and provide support and education in the postpartum phase and reduce incidence of CAD later in life. Engagement with stakeholders including GP's, families, Allied Health (Dietetics, EP, and Social Work), Midwives, DNE's, Mental Health and community links will be a part of the NP role.

We will also be following up on clients from a previous 10 year observational study, 'Screening for Pregnancy Endpoints' (SCOPE) to conduct a further interventional versus usual care approach on CV risk. Therefore the clinic will be a combined academic and clinical focus with potential for ongoing research opportunities for PhD candidates and me in the future.

So a lot of work ahead of me and within this process I need to authorise my NP status and formulary with the Nurses Board and my organisation – another daunting task. However I am very excited with this new pathway and perhaps the fi st for Australia, so watch this space!

Sue Sierp
Clinical Practice Consultant (soon to be NP)

LYELL McEWIN HOSPITAL S.A.

Dianna Lynch: Promotion opportunity for primary and secondary prevention and cardiac rehabilitation.

The South Australian Safety Summit hosted by the Safety Institute of Australia approached Dianna Lynch and Natalie Simpson to present at their conference in May. This opportunity was discussed with the members who attended the SACRA meeting in February and it was agreed that this was an ideal opportunity to raise more awareness around cardiovascular disease and the effects cardiovascular disease has on the workforce. This will provide a great platform to showcase cardiac rehabilitation and its importance for employers to be aware of how this may affect their employees and how best to embrace their return to work. Dianna has confi med that she will present at this conference.

Heart Foundation Update for SACRA 17 February 2016

Guidelines:

- ACS: hoping to have finished or CSANZ conference in August 2016
- Hypertension: we are in the final stages of updating the Guidelines for the diagnosis and management of hypertension. We are aware of and currently reviewing the recent body of literature on blood pressure thresholds. The updated guideline will be released in 2016.

Google Maps for Cardiac Rehabilitation and Heart Failure Programs

The Heart Foundation recently upgraded their website. As a result we will be developing new google maps to assist with people searching for a cardiac rehab program close to them. The maps will allow people to search via postcode/suburb. They will also have geolocation technology where the system will know where the person is located (via their computer)

STATE PRESIDENTS' REPORTING CONT.

and automatically provide them their nearest program. We will be sending out an email soon asking you to verify your details and let us know of any updates required. The system will allow you to update your own program details in the future. The current list of programs can be found on the website here (see `find our nearest cardiac rehabilitation service' link):

http://heartfoundation.org.au/your-heart/living-with-heart-disease/cardiac-rehabilitation

Save the Dates:

- **16th March** - Ordinary Meeting 5-630pm sharp Heart Foundation Hutt St Adelaide
- **9th April** – Clinical Workshop Education Seminar **followed by AGM**
- GP Plus Smart Rd Modbury
- **1-7th May – Heart Week**
- **6th May Heart Foundation Seminar TBA**
- **1-3rd August – ACRA National Conference Grand Chancellor Hotel – Hindley St Adelaide**
- **21st September –** Ordinary Meeting 5-7pm sharp Heart Foundation Hutt St Adelaide
- **2nd November –** SACRA Annual Dinner/ Christmas Dinner/ Education Session Ayres House. Time & Topic TBA

WESTERN AUSTRALIAN

As I write this report I am busily packing attendance lists, certificates and other documents or our professional Development meeting and AGM ...thank goodness for multi-tasking!

State representative: **Helen McLean**

Our professional development sees A/ Professor Bu Yeap, an endocrinologist based at Fiona Stanley Hospital and in the School of Medicine and Pharmacology of the University of Western Australia present his research: **Testosterone and Cardiovascular Health.**

President: **Craig Cheetham**

A/Professor Yeap is involved in many research projects, in clinical service, and with supervision of junior staff and endocrine advanced trainees, and teaching. He has a major research interest in the influence of testoste one on health during male ageing. He has over 100 peer reviewed publications and has been awarded over $6 million in research funding. He has been an international invited speaker on the topic of hormones and health outcomes in men, and he received the US Endocrine Society's International Award for Publishing Excellence in 2013.

In 2015 Prof Yeap received a Heart Foundation Research grant to examine whether testosterone and exercise training will improve the function of blood vessels and the heart more than either alone, in middle aged or older men who are overweight. These results will help inform us whether such treatments might reduce the risk of heart disease in men.

Special thanks to one of our ECM members, Lily Titmus, who has made this happen by securing a sponsor. It will be a beautiful balmy evening with fine wine and cuisine!

We had 30 registered members and non-members registered, it was also our AGM so we had reports from our President, Craig Cheetham, our treasurer, Heart Foundation representative and ACRA state Rep, all positions were declared vacant and we hoped we would see our faithful few return and also engage new blood for our Executive Committee.

2017 sees Perth's turn to hold the ACRA conference. We already have interested parties and are meeting soon to organise a fun, innovative event showcasing not only WA and all the changes we have had to our now vibrant city but also display the wealth of knowledge of our WA Cardiac rehab expert clinicians.

Morning after!...our AGM and education that is!

What a great evening we all had, the 35 present were engaged and enthusiastic, feedback was that those present thoroughly enjoyed the evening.

Prof Bu Yeap was informative, engaging and left us with a new perspective of checking Testosterone levels...watch this space!

We have now formed our new Executive committee: Many thanks to those who have stepped down, stepped up and our new committee members. We look forward to working together and will hold our fi st meeting in 2 week's time.

The following WACRA executive committee nominations were received and accepted:

- Craig Cheetham: President
- Helen McLean: State Rep
- Carol De Groot: Secretary
- Joanna Clarke: Treasurer
- Sandy Hamilton: Rural rep
- Shelley McRae, Julie Smith: Heart Foundation Reps
- Anita Dinsdale, Lily Titmus, Narelle Wilson, Hazel Mountford, Julie Prout, Trisha Jones, Tracy Swanson, Paul Crabtree

STATE PRESIDENTS' REPORTING CONT.

WACRA will be busy with our next professional development event in May and then we will hold our annual Symposium prior to the ACRA conference (1-3 August) so we will run our symposium late in July to allow all those presenting at ACRA a practice opportunity! We will also hold our half-study day in November. Happy days!

Craig and myself would like to thank Shelley McRae who has been a tremendous support to us in her secretary role for the past 2 years, Shelley works tirelessly in all her WACRA roles and will now be mentoring Carol De Groot into the secretary role. Shelley's focus for WACRA will be leading the scientific committee for the Perth conference. Thanks Shelley.

Helen Mclean
WACRA State Representative
WACRA representative on the Cardiovascular Health Network's Group.

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

VICTORIA

VACR
VICTORIAN ASSOCIATION OF CARDIAC REHABILITATION

State representative:
Kim Gray

President:
Emma Boston

The VACR Annual Clinical Practice day was held in February at The Oaks on Collins, Melbourne. The committee chose the venue as it had a different set up with seating which the Committee hoped would address some of the delegate feedback from the previous CPD day in 2015. Fortuitously the venue had the capacity to increase the room size as VACR was inundated with registrations for this event.

VACR Committee has reverted back to the old process of operating the CPD event registration site ourselves. This operationally was a much smoother process compared with the last VACR event for the Committee; and we seem to have had very few Member issues. Again this change was brought about from our Members keeping us very well informed.

However some Members are still reporting issues with emails from the VACR site. The VACR site is also receiving a lot of undelivered emails that is possibly due to employer IT fi ewall systems. It has been suggested that if a member is having concerns and in particular feel that they are not receiving VACR communications that they could try using a personal email address to resolve this issue. Please feel free to contact the VACR Committee if you have any concerns.

Happily the great news from the CPD is that is appears to have been an extremely satisfying event for both the participants from an educational and professional perspective; as well as event operational point. There were 127 registrants on the day.

Interestingly 46 people attended the event as non-members and happily 9 of those joined VACR/ACRA on the day. This means that the VACR membership stands at 132 fully financial membe s. A very warm welcome is extended from the Committee to those new members!

Analysis of the CPD day 2016 participant feedback surveys is underway and the results will be passed on to VACR Members when they become available. This will continue to assist the Committee in planning more VACR professional development events for 2016. We will keep you informed as the information comes to hand.

A more detailed report on the CPD event can be found in this ACRA newsletter.

A special note of thanks to our sponsors Cathryn Furby from NicheMedical , Suzie Hooper from Epworth Healthcare Brighton - Camberwell, and Sally Faulkner from St John of God Healthcare Frankston Rehabilitation for the delegate satchels. These individuals and their organisations have been very generous with their support of VACR. On behalf of the VACR Committee and Members I sincerely thank them and appreciate that the Committee would not have been able to provide the participants with such a great event and at such a reasonable cost without this crucial support.

On behalf of the VACR Committee I wish you a wonderful Easter and very pleasant Autumn.

Emma Boston
President VACR