ACRA NEWSLETTER

DECEMBER 2018

Australian Cardiovascular Health and Rehabilitation Association

Australian Centre for Heart Health Report

Heart Foundation Report

Research Corner

State reports

AUSTRALIAN CARDIOVASCULAR HEALTH AND REHABILITATION ASSOCIATION

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CHALLENGE...CHANGE...ACHIEVE

EDITOR'S NOTE

While summer has arrived and Christmas is approaching we proudly present the fourth ACRA newsletter of the year 2018. Indeed 'we,' since this editor's note is a duo note by Sue Sanderson and Jeroen Hendriks. Reason for this is that Sue will 'retire' as the Editor of the newsletter. She has been in this role since 2010 and has put great efforts into this role to make it a fantastic newsletter every time. Jeroen Hendriks is the Vice-President for ACRA SA/NT and is currently 'in training' with Sue and will take over from her in the new year.

In this newsletter you'll find an interesting article from Susie Cartledge on the importance of Mentorship and the benefits it can provide, a Research Corner by Robert Zecchin. Also there are some new faces on the National Executive Board who will introduce themselves.

We hope you enjoy this newsletter and wish you Merry Christmas and a Happy New Year!

Sue Sanderson
Editor-in-Chief

Jeroen Hendriks
Editor

WE WELCOME ARTICLES FOR PUBLICATION IN THIS NEWSLETTER

Please send any items to:
jeroen.hendriks@adelaide.edu.au
Author guidelines are available on request

CONTENTS

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PRESIDENT'S REPORT

As the last report for the year, I would like to wish all our members a Merry Christmas and a refreshing summer break if you are having one. Your ACRA executive has recently completed a very hard working week-end in Melbourne, two full days, so that we can plan how to best support our members and a flourishing organisation. Our work over the next 6 months will focus on updating our website so that it is more contemporary, easy to use, secure and includes access to all of our services, including guidelines, mentorship and renewal, with the potential for individual pages for each state. We will also be working on different ways of communicating, including our newsletter and contemporary social media strategies that make it easy to access.

Over the last year I have been working on improving our national and international profile and collaborating with groups leading cardiac rehabilitation. The principle I am working on is that ACRA is present at all key discussions about cardiac rehabilitation and secondary prevention. We had ACRA representatives from every state at the recent National Cardiac Rehabilitation Quality Indicator Think Tank in Adelaide, a project supported by the South Australian Health and Medical Research Institute (SAHMRI). I am cochairing the steering committee with Rachel Foreman (National Heart Foundation) to carry that important work forward.

I also attended the Global Cardiovascular Nurses Forum in Lisbon, Portugal in October, which was an invitation only discussion of how we can move forward the role of cardiac nurses in prevention globally. We now have links to ACRA on the websites of the International Council of Cardiopulmonary Rehabilitation (ICCPR), the British Association of Cardiopulmonary Rehabilitation (BACPR) and Preventive Cardiovascular Nurses Association (PCNA). Please don't hesitate to ask about any of these initiatives and don't forget that your state presidents and representatives can advance any of your ideas nationally. It is very much 'watch this space'. Finally, make sure you are making plans to attend the annual scientific meeting to be held on beautiful Sydney Harbour 5-7 August 2019.

Robyn Gallagher
President

EMC Meeting

Introducing new national executive members

Jeroen Hendriks, RN, PhD, FESC, FCSANZ

Jeroen Hendriks is an Academic Nurse and Health Scientist who received his PhD in 2013 at Maastricht University Medical Centre, Maastricht, the Netherlands. His doctoral studies focused on developing Integrated Care in terms of specialised Arial Fibrillation clinics and proving the role of specialised nurses to manage these clinics.

In 2015 he took up the Derek Frewin Lectureship at the Centre for Heart Rhythm Disorders, University of Adelaide and Royal Adelaide Hospital. His program of research focusses on integrated care management in atrial fibrillation and related cardiovascular disease, as well as preparing and redesigning practices for such an approach. He holds an Early Career Fellowship from the Australian Heart Foundation.

Jeroen is the Vice President of ACRA SA/NT, and is Board Director of the Australasian Cardiovascular Nursing College (ACNC). He is the Past-President of the Dutch Society for Cardiovascular Nurses and the Past Communication Officer and board member of the Council for Cardiovascular Nursing and Allied Professions (CCNAP) within the European Society of Cardiology.

He served on the Task Force Writing Committee to develop the 2016 European Society of Cardiology Guidelines for the management of Atrial Fibrillation, and on the Writing Committee to develop the 2018 Australian Clinical Guidelines for the Diagnosis and Management of Atrial Fibrillation.

He is an Editorial Board member of the European Journal of Cardiovascular Nursing, the International Journal of Care Coordination, and ICT&Health International.

Carmel Bourne

I commenced nursing at the Royal Melbourne Hospital and have worked throughout Australia in ICU and Cardiac units for the past 35 plus years. I started in Cardiac Rehabilitation in 2007 and have worked in both the public and private systems.

I am an RN and other qualifications include Diploma of Personal Management, Bachelor of Nursing, Grad Dip Critical Care (Cardiac) and Master of Cardiac Nursing (Hons).

My current position is an associate nurse unit manager (ANUM) at Bendigo Health Cardiac & Oncology medical unit.

ACRA ASM 2019

The 2019 ACRA ASM organising committee invite you to Sydney for what we hope will be a invigorating and stimulating program.

Theme: Cardiac Rehabilitation – Building Bridges

The conference venue The Kirribilli Club has been booked and the conference dinner will be at the iconic Luna Park under the just as iconic Sydney Harbour Bridge. The conference dinner also comes with two hours of riding the Ferris Wheel or if its raining the Dodgem Cars.

ATTENTION! ATTENTION!

We are pleased to announce our first international speaker at ACRA ASM 2019

Professor Philip Moons from Belgium

More information on speakers to come!

Call for abstracts will be sent out shortly – look for it in your email!

Further updates will be sent via email or twitter accounts @ACRAASM and @ACRA_ACRA

Enquiries re the conference can be sent to:

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dawn.mcivor@hnehealth.nsw.gov.au

AUSTRALIAN CARDIOVASCULAR HEALTH AND REHABILITATION ASSOCIATION (ACRA) MENTORING PROGRAM

Susie and Lis at the ACRA ASM in Perth 2017

Susie

One year, around 2015 at both ACRA and CSANZ conferences, I discovered my own personal cheer squad. I was undertaking my PhD and presenting some of my early research – scary for a nurse and junior researcher. Yet I could feel messages of support for myself and my work flooding in – from the audience and via the digital world of twitter. These messages and good vibes were coming from an experienced nurse researcher and leader in my field, Professor Lis Neubeck. We finally met face to face and got on famously.

I left the conferences thinking "how can I officially get her on my team?" I didn't need another PhD supervisor. I needed a mentor. Someone who could provide some external advice, someone who could look at the big (post PhD) picture. Of course I was too chicken to ask her in person or over the phone, so I sent her an email and asked if she would do the honour of becoming my mentor. She responded swiftly with a resounding yes and we quickly set to work on what our mentor/mentee relationship would look like.

We decided that monthly meetings of 30 minutes duration would be the goal. We would meet over Skype and I would bring questions with me, and in return Lis would keep me in mind for opportunities that might be of benefit. We continue these meetings now, even post PhD and even though we are now on opposite sides of the globe. Through our mentor meetings I have:

- Had the benefit of having an advisor who is separate to my work team
- Given opportunities that I would not have had otherwise (we have written a paper together; Lis has encouraged and supported me to apply for awards and grants)
- Been introduced to new contacts and collaborators
- Had the opportunity to visit Edinburgh Napier University in Scotland
- And, best of all, developed a wonderful friendship, built on common goals and experiences.

These are just some of the benefits that mentoring can provide. If any of these sound helpful to you for your career, I would strongly encourage you to identify and approach a mentor. Don't be afraid to ask someone you admire to fulfil this role for you – chances are they will be chuffed to be asked and happy to share their experience and knowledge with you.

Through the ACRA mentoring program we have done some of the hard work for you already! We have had senior clinicians and researchers volunteer their time and services for our mentoring program. All you have to do is choose one that you think would meet your needs, fill in a form and we can e-introduce you both, then the rest is up to you! And if your chosen mentor is not on our list let us know or be brave, take the leap, and send them an email!

Any questions about the mentoring program can be directed to myself (susie.cartledge@deakin.edu.au), Cate Ferry (cate.ferry@heartfoundation.org.au) or Bridget Abell (bridget.abell@qut.edu.au).

Lis

It has been an honour and an absolute pleasure to support Susie since she first approached me all those years ago. I have seen her grow from a new PhD student to a confident and independent researcher. Over time our relationship has changed from mentor/mentee to one of close colleagues and friends. I hope I can still be of support in the mentor role, but as Susie's work develops she is an equal support and inspiration to me. The mentorship role has been extremely rewarding to both of us, and I highly recommend becoming a mentor.

Australian Centre for Heart Health Report

Professor Alun C Jackson

The Centre continues to operate in a constrained financial environment as I frequently note, but nevertheless, it remains productive and committed to growing our presence as a service provider through the Cardiac Wellbeing Program, in addition to maintaining a high standard of research and training in preventive cardiology.

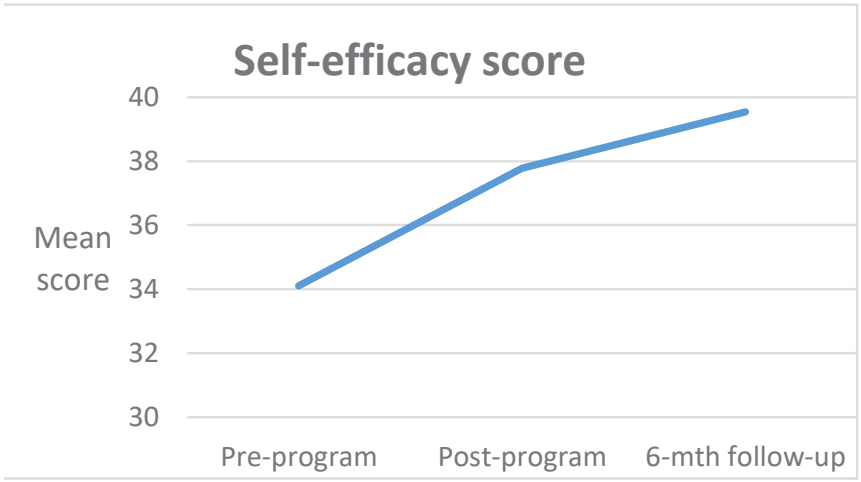
Cardiac Wellbeing Program

We are in negotiation with the **Victorian Department of Health** through Safer Victoria and the Policy and planning Division to provide our full suite of Cardiac Wellbeing programs as a demonstration project in the Western region of Victoria, under the state-wide cardiac care plan, sometime over the next twelve months.

Following our notification to all cardiac rehabilitation services about the Centre's capacity to provide Medicare-approved skype counselling for cardiac patients with mental health issues, enquiries have come from SA, Tasmania, NSW and Queensland. Following contact by the **NSW Health Department**, we are currently negotiating to provide remote counselling services to the Western NSW Health region.

In the New Year the Centre will launch a program to provide **return to work psychological assessments** for those returning to work after cardiac surgery. This follows evidence that although around 90% of people of working age return to work, one-quarter will drop out within the first 12 months. Initially the service would target executive-level employees. Modifiable risk factors associated with detachment from work include high Body Mass Index (BMI), smoking and depression, which can all be addressed by the psycho-education and psycho-cardiology practice of the Cardiac Wellbeing Program.

We have now successfully piloted a manualised **Family Coping Program for parents of children with congenital heart disease** with the write-up of that pilot currently under consideration by *Cardiology in the Young*. The program aimed to give parents greater confidence in their parenting, and as the graph shows, gains made by the end of the program actually **increased** in the six months after the program as parents put into practice the coping skills learned in the program.



We are now developing a proposal to Heart Kids Australia for a jointly badged online delivery of this parenting program.

Following the Centre providing a session at the recent Education Day for Adult CHD, we have now started receiving requests for counselling from younger adults with CHD, and are working on the development of a self-image and self-esteem based intervention for these young adults.

We will also continue to explore the potential for a role for the Centre in transition of young people from paediatric to adult care.

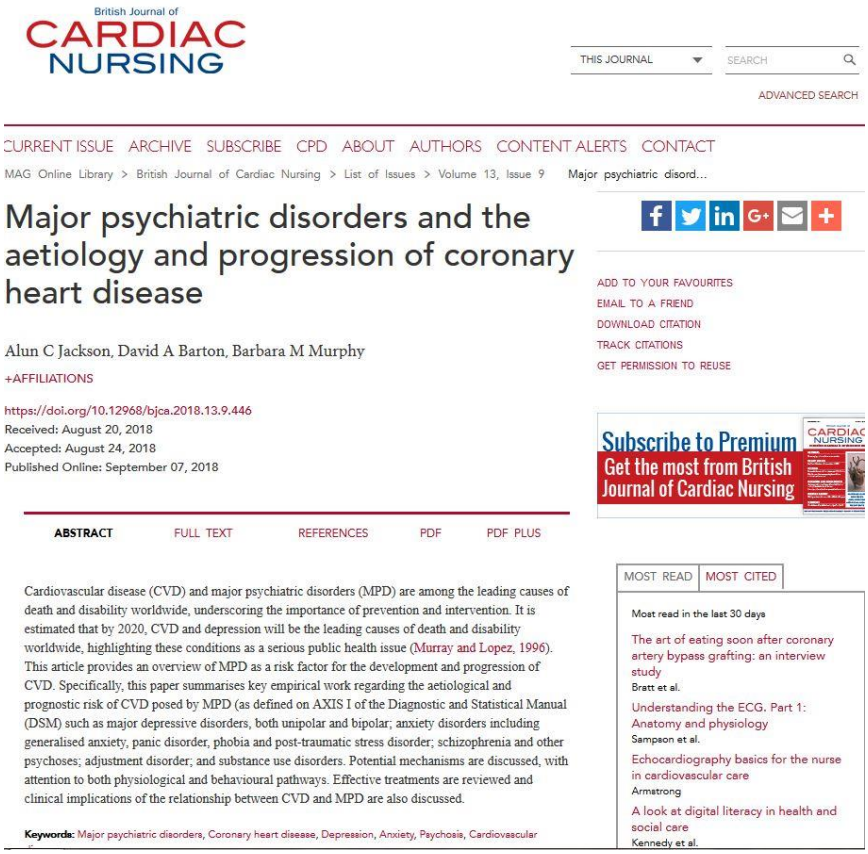
Publication

We completed our four-article psycho-cardiology series for the British Journal of Cardiac Nursing, all of which generated significant interest from clinicians and researchers in Italy, Israel, the US, UK, and Germany .

The four papers were:

Jackson AC, Barton DA, Murphy BM. (2018). Major psychiatric disorders and the aetiology and progression of coronary heart disease, *British Jnl of Cardiac Nursing*,13,9,446-454

Baird D, Jackson AC, Higgins RO, Murphy BM, Tully PJ. (2018). Depression screening, assessment and treatment in chronic heart failure, *British Jnl of Cardiac Nursing*, 13,8,386- 393



British Journal of CARDIAC NURSING

THIS JOURNAL SEARCH

ADVANCED SEARCH

CURRENT ISSUE ARCHIVE SUBSCRIBE CPD ABOUT AUTHORS CONTENT ALERTS CONTACT

MAG Online Library > British Journal of Cardiac Nursing > List of Issues > Volume 13, Issue 9 Major psychiatric disord...

Major psychiatric disorders and the aetiology and progression of coronary heart disease

Alun C Jackson, David A Barton, Barbara M Murphy

+AFFILIATIONS

https://doi.org/10.12968/bjca.2018.13.9.446
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ABSTRACT FULL TEXT REFERENCES PDF PDF PLUS

Cardiovascular disease (CVD) and major psychiatric disorders (MPD) are among the leading causes of death and disability worldwide, underscoring the importance of prevention and intervention. It is estimated that by 2020, CVD and depression will be the leading causes of death and disability worldwide, highlighting these conditions as a serious public health issue (Murray and Lopez, 1996). This article provides an overview of MPD as a risk factor for the development and progression of CVD. Specifically, this paper summarises key empirical work regarding the aetiological and prognostic risk of CVD posed by MPD (as defined on AXIS I of the Diagnostic and Statistical Manual (DSM) such as major depressive disorders, both unipolar and bipolar; anxiety disorders including generalised anxiety, panic disorder, phobia and post-traumatic stress disorder; schizophrenia and other psychoses; adjustment disorder; and substance use disorders. Potential mechanisms are discussed, with attention to both physiological and behavioural pathways. Effective treatments are reviewed and clinical implications of the relationship between CVD and MPD are also discussed.

Keywords: Major psychiatric disorders, Coronary heart disease, Depression, Anxiety, Psychosis, Cardiovascular

MOST READ MOST CITED

Most read in the last 30 days

The art of eating soon after coronary artery bypass grafting: an interview study
Bratt et al.

Understanding the ECG. Part 1: Anatomy and physiology
Sampson et al.

Echocardiography basics for the nurse in cardiovascular care
Armstrong

A look at digital literacy in health and social care
Kennedy et al.

Jackson AC, Ski CF, Murphy BM, Fernandez EP, Alvarenga ME, LeGrande MR, Thompson DR. (2018). What Role Does Personality Play in the Development and Progression of Cardiovascular Disease? *British Jnl of Cardiac Nursing*, 13,7,2-9

Jackson AC, Murphy BM,

Thompson DR, Ski CF, Alvarenga ME, Le Grande MR, Amerena J, Higgins RO, Barton DA. (2018). What is cardiac distress and how should we measure it? *British Jnl of Cardiac Nursing,* 13, 6, 286-293

A number of other papers were published or are currently under review:

Contents lists available at ScienceDirect

Journal of Pediatric Nursing

ELSEVIER

Parent's Perspectives on How They Cope With the Impact on Their Family of a Child With Heart Disease

Alun C. Jackson, PhD [a,b,c,d,*], Rosemary O. Higgins, PhD [a,d,e], Erica Frydenberg, PhD [b], Rachel P.-T. Liang, MEdPsych [a,b], Barbara M. Murphy, PhD [a,d,f]

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ARTICLE INFO

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Parenting

ABSTRACT

Purpose: Studies of familial coping with a child's chronic condition have highlighted psychological distress; family functioning; and quality of life; as issues that demand coping strategies. There are conflicting findings on impact and coping and a paucity of information about the specific coping challenges for parents of a child with heart disease, with few qualitative studies in this area. The purpose of the study was to explore the way parents coped with their child's heart condition as it impacted on different domains of family functioning.
Design and Method: In this qualitative study, interviews were held with 17 parents attending a pediatric hospital-based family support program in 2015. Fifteen of the 17 children's conditions were classified as "major". Domains covered in the interviews included: coping challenges posed at different stages of the illness trajectory, parenting, condition management, transitions, psychological impact, social support and coping strategies. Interview tran-

Jackson, A.C., Higgins, R.O, Frydenberg, E., Liang, R., Murphy, B.M. (2018). Parent's Perspectives on How They Cope with the Impact on Their Family of a Child with Heart Disease, *Journal of Pediatric Nursing*, https://doi.org/10.1016/j.pedn.2018.01.020

Shand L, Higgins RO, Murphy BM, Jackson AC. Development and validation of the Healthcare Provider Patient-Activation Scale, *Patient Education and Counseling* (under review)

Jackson A.C., Frydenberg E., Koey X., Fernandez A., Higgins R.O., Stanley T., Pui-Tak Liang R., Murphy, B.M. Coping with a child's heart condition: Development and pilot of a group program for parents, *Cardiology in the Young* (under review)

Le Grande M, Bunker S, Tucker G, Jackson AC. Validating the SF-12 and the development of disease specific norms in a cohort of Australian private health insurance members, *Australian Jnl of Primary Health* (under review)

LeGrande, Jackson AC, Ski C, Brown A, Thompson D. Depression, cardiovascular disease and Indigenous Australians, for Danto & Zangeneh (Eds) I*ndigenous Mental Health: A Global Perspective* (under review)

Worcester MU, Goble AJ, Elliott PC, Froelicher ES, Murphy BM, Beauchamp AJ, Jelinek MV, Hare DL, Mild depression predicts long term mortality after acute myocardial infarction: a 25-year follow-up, *Heart, Lung & Circulation* (under review)

Publications In preparation arising from new project work are:

Jackson AC, Frydenberg E, Higgins RO, Stanley T, Pui-Tak Liang R, Murphy BM. The Family Coping Program: A co-production case study in paediatric health.

Jackson AC, Le Grande M, Higgins RO, Murphy BM, Ski CF, Alvarenga M, Thompson DR. Psychosocial screening tools in cardiac rehabilitation: A position statement from the Australian Centre for Heart Health.

Murphy BM, LeGrande MR, Higgins RO, Worcester MU, Jackson AC. Training improves health professional's self-efficacy: Evaluation of an intensive training program for health professionals working in cardiac rehabilitation

Current research

Our research continues in the areas of psycho-cardiology, cardiac rehabilitation, congenital heart disease, sleep disorders and CVD, with protocol development for a new study:

Enhancing the uptake and acceptability of cardiac rehabilitation for women: development and implementation of a 'women-only' CR program with a 'women-friendly' exercise component

The **aims** of the study, for which funding is being sought, are to assess:

1. The uptake and completion by female patients attending Monash Health of the women-only CR program and to compare this with uptake and completion by female patients in the mixed-sex program in the previous year;
2. The acceptability of the women-only program by female attendees;
3. Changes in pre/post program exercise self-efficacy in female attendees;
4. Perceptions of cardiology and CR staff involved in the project.

A significant research development is our bid in the current round for a National Health & Medical Research Council Centre of Research Excellence.

The **NHMRC CRE on Psychological, Behavioural and Social Aspects of Heart Disease** brings together Australian and international expertise in psycho-cardiology to pursue

three multidisciplinary research streams and translate findings into evidence-based patient programs and health professional training in psychosocial and behavioural aspects of preventive cardiology. These overlapping research streams investigate the impact of psychosocial and behavioural factors as independent risks for heart disease including repeat events, and examine how programs can address these factors, using randomised controlled trials and other research designs. The psychological stream examines cardiac-related adjustment issues, depression, anxiety, distress, PTSD, cognitive decline, and post-traumatic growth, and the role of personality factors such as trait anger and hostility. The behavioural stream examines traditional behavioural factors such as physical activity and sedentary behaviour, diet, medication adherence, smoking, health literacy, and cardiac rehabilitation program attendance, plus newer areas including sleep disorders. The social stream investigates the role of social isolation, loneliness and socioeconomic status; access and equity issues regarding cardiac service distribution and utilisation and the economic impact of preventive cardiology. Using a matrix design for the Centre's program of research, specific populations – including women, Indigenous Australians, and those with major psychiatric disorders - and conditions – including heart failure and congenital heart disease in both children and adults- will be studied in relation to the primary streams. The Centre has a strong emphasis on translational research: multi-modal patient interventions such as face to face counselling, telehealth, online and avatar-delivered health coaching for patients have been developed and will be further refined, as will face-to-face and online training programs for health professionals.

Health professional education

The Centre's 5-day intensive **Cardiac Rehabilitation** course was delivered in August following the ACRA / CSANZ Conferences.

The **Integrated disease management for patients with chronic heart failure** 3-day intensive course unfortunately had to be cancelled due to lack of numbers. We will now undertake a thorough review of the course design and curriculum.

Our online training modules continue to be accessed with over 500 users so far this year.

The Centre is pleased to be **collaborating with the Heart Foundation** to deliver a Webcast in December:

This follows a successful delivery of 'Cardiac Blues' information to General Practitioners through the Royal Australian College of General Practitioners. As well, the Centre continues its involvement in the **Development of a national 'curriculum' for cardiac rehabilitation (CR) programs.** This project, funded by the Victorian Cardiac Clinical Network (now part of 'Safer Victoria') and undertaken by Deakin University, commissioned the Heart Foundation is **continuing** with Dr Rosemary Higgins, Clinical Consultant to the Centre, representing the interests of the Centre in relation to psycho- cardiology.

Organisational Representation

Centre staff continue their membership of:

- Australian Cardiovascular Alliance
- Executive Committee Membership, Australian Cardiovascular Health & Rehabilitation Association
- Executive Committee ACRA Victoria
- Sleep Research Society
- Australasian Society of Behavioural Health and Medicine
- Council on Epidemiology and Prevention and Council on Quality of Care and Outcomes Research, American Heart Association
- Council on Cardiovascular Nursing and Allied Health Professions, European Society of Cardiology
- Stress and Anxiety Research Society
- Australasian Society of Behavioural Health and Medicine
- Association for Behaviour Analysis International
- Victorian MHPN Psycho-cardiology Network
- International Association for Applied Psychology

Professor Alun C Jackson
Director

November 2018

ACRA Newsletter
Heart Foundation Report December 2018

Cate Ferry

Economic Cost of Acute Coronary Syndrome in Australia

A new series of Heart Foundation reports reveal the total economic cost of acute coronary syndrome (ACS), which includes heart attack and unstable angina, is $6.8 billion in 2017-18. The largest share of this figure is the loss of income for individuals who experience an ACS event, estimated at $3.5 billion. This is followed by the $1.9 billion on healthcare expenditure associated with ACS events, such as hospital stays.

Economic Cost of Acute Coronary Syndrome in Australia: The Cost to Governments

Economic Cost of Acute Coronary Syndrome in Australia: The Cost to Individuals and Their Families

World No Tobacco Day 2018

Tobacco smoke is one of the main risk factors for heart disease and is responsible for 12% of the burden of cardiovascular disease in Australia.

Learn more about the work being done to end tobacco use in Australia

National Action Plan for Heart and Stroke

The Australian Government is working with the Heart Foundation and the Stroke Foundation to develop a National Action Plan for Heart and Stroke. The Action Plan will identify and prioritise actions the Australian Government may implement.

The Action Plan will drive improvements in:

- Prevention and early detection
- Diagnosis and treatment
- Support and care
- Research

An Action Plan is vital to reduce the impact of heart disease and stroke on the individual, the community and the health care system, and achieve better outcomes for Australians affected by heart disease or stroke and their families.

Have your say

Heart Foundation Report Dec 2018 cont.

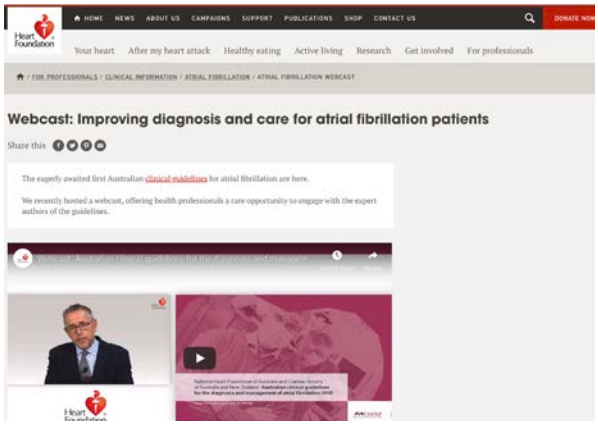
Clinical Guidelines Webcasts

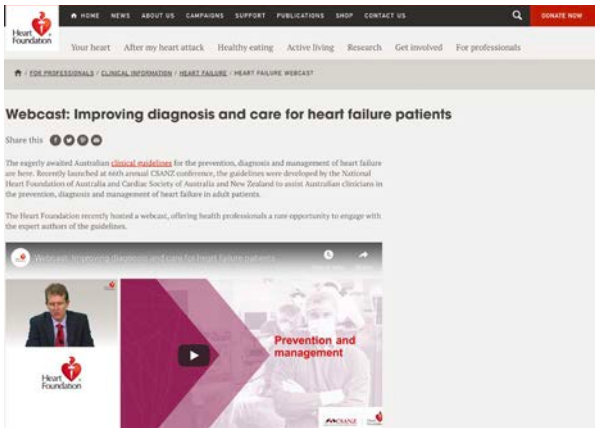
The Australian clinical guidelines for the diagnosis and management of heart failure and atrial fibrillation were launched at the 2018 CSANZ conference. Each guideline was developed by the National Heart Foundation of Australia and Cardiac Society of Australia and New Zealand to assist clinicians prevent, diagnose and manage these common heart conditions.

Clinical guidelines webcasts, chaired by health journalist Dr Norman Swan, have been conducted to provide health professionals with a greater understanding of the guideline and how to apply them in practice. Here are the links to the recordings of the two recent clinical guidelines webcasts.

https://www.heartfoundation.org.au/for-professionals/clinical-information/atrial-fibrillation/atrial-fibrillation-webcast

https://www.heartfoundation.org.au/for-professionals/clinical-information/heart-failure/heart-failure-webinar





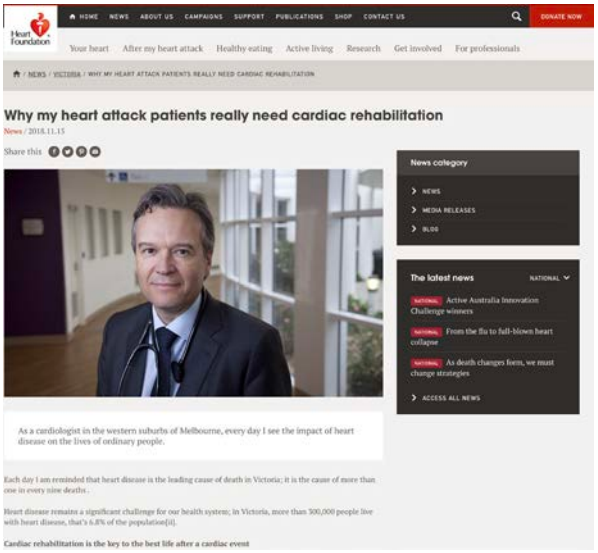
Heart Foundation Advocacy to improve heart health

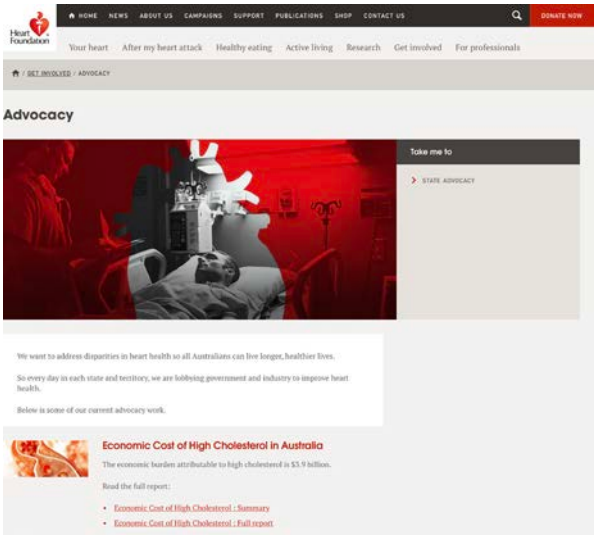
The Heart Foundation wants to address disparities in heart health so all Australians can live longer, healthier lives. So every day in each state and territory, we are lobbying government and industry to improve heart health.

Here are the links to recent advocacy initiatives

https://www.heartfoundation.org.au/news/why-my-heart-attack-patients-really-need-cardiac-rehabilitation

https://www.heartfoundation.org.au/get-involved/advocacy





A CORNER OF RESEARCH FOR AUSTRALIA

By Robert Zecchin RN MN

NB: The title mirrors / reflects ACRA's continuing efforts to provide its members with up to date research, both locally and internationally, to highlight potential best practice and evidence in cardiac rehabilitation.

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. Mental Distress Factors and Exercise Capacity in Patients with Coronary Artery Disease Attending Cardiac Rehabilitation Program.

Kazukauskiene N; Burkauskas J; Macijauskiene J; Duoneliene I; Gelziniene V; Jakumaite V; Brozaitiene J. International Journal of Behavioral Medicine. 25(1):38-48, 2018 02.

PURPOSE: There is still insufficient data on mental distress factors contributing to exercise capacity (EC) improvement before and after cardiac rehabilitation (CR) in patients with coronary artery disease (CAD). The aim of our study was to evaluate the associations between various mental distress factors and EC before and after exercise-based CR (EBCR).

METHODS: Over 12 months, 223 CAD patients (70% men, mean age 58 +/- 9 years) were evaluated for socio-demographic, clinical, and mental distress symptoms as measured by the Hospital Anxiety and Depression scale (HADS), Beck Depression Inventory-II (BDI-II), and Spielberger State-Trait Anxiety Inventory (STAI). Patients were tested for EC at baseline and after EBCR.

RESULTS: In a multivariate linear regression model, EC before EBCR was associated with HADS anxiety subscale (beta = -.186, p = .002) and BDI-II somatic/affective subscale (beta = -.249, p < .001). EC after EBCR was associated with HADS anxiety and depression subscales (beta = -.198, p < .001; beta = -.170, p = .002, respectively) and BDI-II (beta = -.258, p < .001). The BDI-II somatic/affective subscale was the best predictor of reduced EC before and after EBCR.

CONCLUSIONS: Mental distress and somatic/affective symptoms of depression are strongly associated with EC both at the beginning and after EBCR. Analysis of possible mediating or moderating factors was beyond the scope of our study. Future studies should focus on comprehensive evaluation of EC risk factors including other mental distress characteristics, subjectively experienced fatigue, and post-operative CAD symptoms.

The Good News: Don't get me down! Are you monitoring and or screening for depression in your CR Service?

2. Enhancing Participation in Cardiac Rehabilitation: A Question of Proximity and Integration of Outpatient Services.

Ozemek C; Phillips SA; Fernall B; Williams MA; Stamos TD; Bond S; Claeys H; Laddu DR; Arena R. Current Problems in Cardiology. 43(11):424-435, 2018 Nov.

Numerous investigations have established the strong clinical utility of cardiac rehabilitation, while clinical guidelines continually call for a high level of referral and participation. Historically, medical facilities have faced challenges referring eligible patients to cardiac rehabilitation, enrolling only a small portion of those receiving referral. Consequently, less than ~10% of qualifying patients receive any amount of cardiac rehabilitation. This sobering figure has prompted many efforts to identify barriers to referral as well as enrolment and accordingly propose strategies to bolster participation rates. Although reports have highlighted improvements through focused approaches, enrolment rates still lag behind the goal of reaching 70% by 2022, proposed by the Million Hearts Cardiac Rehabilitation Collaborative. An area of inquiry that has received little to no attention in this effort has been the influence of proximity between physician-driven outpatient clinics and cardiac rehabilitation facilities. In this report we outline the development and design of a clinical faculty

practice aimed to maintain close geographical proximity between our physician clinic and the cardiac rehabilitation area. We also propose that our impressive enrolment rates of 57% within our facility and 73% when including patients that started alternative exercise programs were likely due to establishing a close proximity between the respective practices.

The Good News: Plan for co-location of cardiac services to have a positive impact on cardiac rehabilitation referrals and uptake.

3. The role and outcome of cardiac rehabilitation program in patients with atrial fibrillation.

Younis A; Shaviv E; Nof E; Israel A; Berkovitch A; Goldenberg I; Glikson M; Klempfner R; Beinart R. Clinical Cardiology. 41(9):1170-1176, 2018 Sep.

BACKGROUND: Atrial fibrillation (AF) is associated with diminished cardiac function, and exercise tolerance. We sought to investigate the role of cardiac rehabilitation program (CR) in patients with AF.

METHODS: The study included 2165 consecutive patients that participated in our CR program between the years 2009 to 2015. All were evaluated by a standard exercise stress test (EST) at baseline, and upon completion of at least 3 months of training. Participants were dichotomized according to baseline fitness and the degree of functional improvement. The combined primary end point was cardiac related hospitalization or all-cause mortality.

RESULTS: A total of 292 patients had history of AF, with a mean age of 68 +/- 9 years old, 76% of which were males. The median predicted baseline fitness of AF patients was significantly lower compared to non-AF patients (103% vs 122%, P < 0.001, respectively). Prominent improvement was achieved in the majority of the patients in both groups (64% among AF patients and 63% among those without AF). Median improvement in fitness between stress tests was significantly higher in patients with AF (124% vs 110%, P < 0.001, respectively). Among AF patients, high baseline fitness was associated with a lower event rates (HR 0.40; 95%CI 0.23-0.70; P = 0.001). Moreover, prominent improvement during CR showed a protective effect (HR 0.83; 95% CI 0.69-0.99; P = 0.04).

CONCLUSION: In patients with AF participating in CR program, low fitness levels at baseline EST are associated with increased risk of total mortality or cardiovascular hospitalization during long-term follow-up. Improvement on follow-up EST diminishes the risk.

The Good News: Now isn't that irregular – having AFib patients attend cardiac rehabilitation!

4. Referral for cardiac rehabilitation after acute myocardial infarction: Insights from nationwide AMIS Plus registry 2005-2017.

Hermann M; Witassek F; Erne P; Radovanovic D; Rickli H. International Journal of Cardiology. 261:1-5, 2018 06 15.

BACKGROUND: Referral rates for cardiac rehabilitation (CR) after an acute myocardial infarction (AMI) are low despite a Class I recommendation in the present guidelines. Therefore, we aimed to identify predictors for referral and patient characteristics from the national Swiss AMIS Plus registry.

METHODS: Data were extracted from the Swiss AMIS Plus registry between 2005 and 2017, which included patients with ST-elevation myocardial infarction (STEMI) and Non-ST-elevation myocardial infarction (NSTEMI). For 32,416 patient (93.2%) data about destination at discharge were available with 10,940 (33.7%) having a recommendation for CR while 12,282 (37.9%) went home. 9194 (28.4%) were transferred to another hospital after index hospitalisation and were excluded.

RESULTS: Patients referred to CR were younger (62.6 vs. 68.2years) and had a higher prevalence of obesity (22.0% vs. 20.4%). Except for smoking (44.0% vs 34.9%), they had less risk factors such as dyslipidaemia (55.0% vs. 60.1%), hypertension (55.6% vs. 65.3%) and diabetes (16.7% vs. 21.5%). Patients with in-hospital complications were more likely being referred for CR. Furthermore, STEMI (OR 1.61; CI 1.52-1.71), performed PCI (OR 2.65; CI 2.42-2.90) and Killip class >2 (OR 1.58; CI 1.36-1.84) favoured referral for CR, while age>65years, previous myocardial infarction, cerebrovascular disease or peripheral artery disease had a negative impact on referral for CR.

CONCLUSIONS: Our data from 23,222 patients after AMI demonstrate that in Switzerland patients referred for CR are younger, more obese with more STEMI. In-hospital complications were strong predictors for CR recommendation. Unlike anticipated, other risk factors were less present in CR patients.

The Good News: Does this Swiss study relate in your experience or does it have holes like Swiss cheese!

5. Getting to the Heart of the Matter: What is the Landscape of Exercise Rehabilitation for People with Heart Failure in Australia?

Miller S; Mandrusiak A; Adsett J. Heart, Lung & Circulation. 27(11):1350-1356, 2018 Nov.

BACKGROUND: The benefits of exercise rehabilitation for people with heart failure (HF) are well established. In Australia, little is known about how the guidelines around exercise rehabilitation for people with HF are being implemented in clinical practice. Furthermore, it is unknown what organisational barriers are faced in providing exercise rehabilitation programs for this population. The aim of this study is to provide an updated review of exercise rehabilitation services for people with HF in Australia and to identify perceived organisational barriers to providing these services.

METHODS: A cross-sectional survey of cardiac rehabilitation centres in Australia, investigating the number and characteristics of services providing exercise rehabilitation for people with HF.

RESULTS: A total of 334 of 457 identified services responded to the survey. Of these, 251 reported providing a supervised group-based exercise rehabilitation program for people with HF. These services were mapped, showing their distribution across Australia. Services which were unable to provide group-based exercise training for HF patients reported organisational barriers including insufficient funding (60%), staffing (56%) and clinical resources (53%). Of the 78 services that reported patients in their local area were unable to access appropriate exercise guidance, 81% were located in regional or remote areas. We found that reported exercise practices align with current best-practice guidelines with 99% of group based exercise programs reportedly including endurance training and 89% including resistance training.

CONCLUSIONS: In Australia, exercise practices for people with HF align with current best-practice guidelines for this condition. Limited resources, funding and geographic isolation are reported as the major organisational barriers to providing these programs. Future endeavours should include the development of alternative and flexible delivery models such as tele-rehabilitation and other home-based therapies to improve access for these individuals to such services.

The Good News: Some areas that cater for HF should be preserved and enhanced whereas rural/remote CR services who have reduced or no resources should get an noradrenaline shot to its arm!

6. Smoking cessation in European patients with coronary heart disease. Results from the EUROASPIRE IV survey: A registry from the European Society of Cardiology.

Snaterse M; Deckers JW; Lenzen MJ; Jorstad HT; De Bacquer D; Peters RJG; Jennings C; Kotseva K; Scholte Op Reimer WJM; EUROASPIRE Investigators. International Journal of Cardiology. 258:1-6, 2018 05 01.

AB OBJECTIVE: We investigated smoking cessation rates in coronary heart disease (CHD) patients throughout Europe; current and as compared to earlier EUROASPIRE surveys, and we studied characteristics of successful quitters.

OBJECTIVES: To assess the effects of exercise-based CR compared to usual care for adults with stable angina.

METHODS: Analyses were done on 7998 patients from the EUROASPIRE-IV survey admitted for myocardial infarction, unstable angina and coronary revascularisation. Self-reported smoking status was validated by measuring carbon monoxide in exhaled air.

RESULTS: Thirty-one percent of the patients reported being a smoker in the month preceding hospital admission for the recruiting event, varying from 15% in centres from Finland to 57% from centres in Cyprus. Smoking rates at the interview were also highly variable, ranging from 7% to 28%. The proportion of successful quitters was relatively low in centres with a low number of pre- event smokers. Overall, successful smoking cessation was associated with increasing age (OR 1.50; 95% CI 1.09-2.06) and higher levels of education (OR 1.38; 95% CI 1.08-1.75). Successful quitters more frequently reported that they had been advised (56% vs. 47%, p<.001) and to attend (81% vs. 75%, p<.01) a cardiac rehabilitation programme.

CONCLUSION: Our study shows wide variation in cessation rates in a large contemporary European survey of CHD patients. Therefore, smoking cessation rates in patients with a CHD event should be interpreted in the light of pre-event smoking prevalence, and caution is needed when comparing cessation rates across Europe. Furthermore, we found that successful quitters reported more actions to make healthy lifestyle changes, including participating in a cardiac rehabilitation programme, as compared

with persistent smokers. Copyright © 2018 Elsevier B.V. All rights reserved.

The Good News: Cardiac Rehabilitation does have a positive impact on reducing smoking rates!

7. Improving patient adherence to secondary prevention medications 6 months after an acute coronary syndrome: observational cohort study.

Brieger D; Chow C; Gullick J; Hyun K; D'Souza M; Briffa T; CONCORDANCE Investigators. Internal Medicine Journal. 48(5):541-549, 2018 05.

BACKGROUND: Most patients are recommended secondary prevention pharmacotherapies following an acute coronary syndrome (ACS).

AIM: To identify predictors of adherence at 6 months and strategies to improve adherence to these therapies.

METHODS: Patients in the CONCORDANCE registry who were discharged on evidence-based medications were stratified into those receiving >=75% (`adherent') or <75% (`non-adherent') of indicated medications at 6 months. Baseline characteristics, hospital and post-discharge care were compared between groups. Multivariable logistic analysis identified independent predictors of adherence. The relative contribution of each clinical or treatment factor to `adherence' was determined using an adequacy measure method.

RESULTS: Follow-up data were available for 6595 patients, 4492 (68.1%) of whom were `adherent'. Clinical factors predictive of adherence included previous stroke, percutaneous coronary intervention (PCI) and hypertension (odds ratios (OR) 1.36-1.56); factors predictive of non-adherence included discharge diagnosis of non-ST-segment elevation myocardial infarction (vs unstable angina) (OR 0.51) and atrial fibrillation (OR 0.59). Discharge on >=75% of indicated medications was a strong predictor of adherence at 6 months (OR 10.23, 95% confidence interval 7.89-13.27); in-hospital management factors predicting non-adherence were medical management alone (OR 0.34) and coronary artery bypass graft (OR 0.50) (both vs PCI). Post-discharge predictors of adherence included cardiac rehabilitation (OR 1.36) and general practitioner attendance (OR 1.40).

CONCLUSION: Failure to discharge patients on indicated therapies is the most important modifiable predictor of adherence failure 6 months after an ACS. Implementing protocols to automate prescription of indicated discharge therapies, has the potential to reduce non-adherence dramatically in the 6 months following discharge. Copyright © 2018 Royal Australasian College of Physicians.

The Good News: I am in concordance that this study gives further proof that CR increases adherence to prescribed evidence-based ACS medication

8. Does the mode of delivery in Cardiac Rehabilitation determine the extent of psychosocial health outcomes?

Harrison AS; Doherty P. International Journal of Cardiology. 255:136-139, 2018 Mar 15.

BACKGROUND: Cardiac Rehabilitation (CR) is a multicomponent tailored intervention aiming to reduce lifestyle risk factors and promote health in patients post cardiovascular disease. CR is delivered either as supervised or facilitated self-delivered yet little evidence exists evaluating the association between mode of delivery and outcomes.

METHODS: This observational study used data routinely collected from the National Audit of Cardiac Rehabilitation from April 2012-March 2016. The analysis compared the populations receiving supervised and facilitated self-delivered modes for differences in baseline demographics, four psychosocial health measures pre and post CR and changes in anxiety, depression and quality of life following the intervention. The analysis also modelled the relationship between mode and outcomes, accounting for covariates such as age, gender, duration and staffing.

RESULTS: The study contained 120,927 patients (age 65, 26.5 female) with 82.2% supervised and 17.8% self-delivered. The analysis showed greater proportion of females, employed and older patients in the self-delivered group. Following CR, patients in both groups demonstrated positive changes which were of comparable size. The regression model showed no significant association between mode of delivery and outcome in all four psychosocial outcomes when accounting for covariates (p-value>0.0.5).

CONCLUSIONS: Patients benefited from attending both modes of CR showing improved psychosocial health outcomes with 3-76% change from baseline. Over half of CR programmes in the UK do not provide self-delivered CR yet this mode is known to reach older patients, female and employed patients. Facilitated self-delivered CR should be offered and supported as a genuine option, alongside supervised CR, by clinical teams. Copyright © 2017 The Authors. Published by Elsevier B.V. All rights reserved.

The Good News: Does your CR service offer alternative modes of CR delivery?

9. Exercise training in adults with repaired tetralogy of Fallot: A randomized controlled pilot study of continuous versus interval training.

Novakovic M; Prokselj K; Rajkovic U; Vizintin Cuderman T; Jansa Trontelj K; Fras Z; Jug B.

International Journal of Cardiology. 255:37-44, 2018 Mar 15.

INTRODUCTION: Adults with repaired tetralogy of Fallot (ToF) have impaired exercise capacity, vascular and cardiac autonomic function, and quality of life (QoL). Specific effects of high-intensity interval or moderate continuous exercise training on these parameters in adults with repaired ToF remain unknown.

METHODS AND RESULTS: Thirty adults with repaired ToF were randomized to either high-intensity interval, moderate intensity continuous training (36 sessions, 2-3 times a week) or usual care (no supervised exercise). Exercise capacity, flow-mediated vasodilation, pulse wave velocity, NT-proBNP and fibrinogen levels, heart rate variability and recovery, and QoL (SF-36 questionnaire) were determined at baseline and after the intervention period. Twenty-seven patients (mean age 39+/-9years, 63% females, 9 from each group) completed this pilot study. Both training groups improved in at least some parameters of cardiovascular health compared to no exercise. Interval-but not continuous-training improved VO2peak (21.2 to 22.9ml/kg/min, p=0.004), flow-mediated vasodilation (8.4 to 12.9%, p=0.019), pulse wave velocity (5.4 to 4.8m/s, p=0.028), NT-proBNP (202 to 190ng/L, p=0.032) and fibrinogen levels (2.67 to 2.46g/L, p=0.018). Conversely, continuous-but not interval-training improved heart rate variability (low-frequency domain, 0.32 to 0.22, p=0.039), heart rate recovery after 2min post-exercise (40 to 47 beats, p=0.023) and mental domain of SF-36 (87 to 95, p=0.028). CONCLUSION: Both interval and continuous exercise training modalities were safe. Interval training seems more efficacious in improving exercise capacity, vascular function, NT-proBNP and fibrinogen levels, while continuous training seems more efficacious in improving cardiac autonomic function and QoL. (Clinicaltrials.gov, NCT02643810). Copyright © 2018 Elsevier Ireland Ltd. All rights reserved.

The Good News: Does your CR program accept adult congenital heart disease patients? If not, why not!

10. Cardiac rehabilitation and physical activity systematic review and meta-analysis

Dibben GO, Dalal HM, Taylor RS, P Doherty, L Hermann Tang, M Hillsdon. Heart 2018; 104:1394–1402

OBJECTIVE: To undertake a systematic review and meta-analysis to assess the impact of cardiac rehabilitation (CR) on physical activity (PA) levels of patients with heart disease and the methodological quality of these studies.

METHODS: Databases (MEDLINE, EMBASE, CENTRAL, CINAHL, PsycINFO and Sport Discus) were searched without language restriction from inception to January 2017 for randomised controlled trials (RCTs) comparing CR to usual care control in adults with heart failure (HF) or coronary heart disease (CHD) and measuring PA subjectively or objectively. The direction of PA difference between CR and control was summarised using vote counting (ie, counting the positive, negative and non-significant results) and meta-analysis.

RESULTS: Forty RCTs, (6480 patients: 5825 CHD, 655HF) were included with 26% (38/145) PA results showing a statistically significant improvement in PA levels with CR compared with control. This pattern of results appeared consistent regardless of type of CR intervention (comprehensive vs exercise-only) or PA measurement (objective vs subjective). Meta-analysis showed PA increases in the metrics of steps/day (1423, 95% CI 757.07 to 2089.43, p<0.0001) and proportion of patients categorised as physically active (relative risk 1.55, 95% CI 1.19 to 2.02, p=0.001). The included trials were at high risk of bias, and the quality of the PA assessment and reporting was relatively poor.

CONCLUSIONS: Overall, there is moderate evidence of an increase in PA with CR participation compared with control. High-quality trials are required, with robust PA measurement and data analysis methods, to assess if CR definitely leads to important improvements in PA.

The Good News: On your bike - more research is needed!

11. Development of Quality Indicators for Cardiac Rehabilitation in Australia: A Modified Delphi Method and Pilot Test.

Zecchin R, Candelaria D, Ferry C, Ladak LA, McIvor D, Wilcox K, Bennett A, Bowen S, Carr B, Randall S, Gallagher R. Heart Lung Circ. 2018 Sep 7. pii: S1443-9506(18)31857-2. doi: 10.1016/j.hlc.2018.08.004. (Epub ahead of print)

BACKGROUND: International guidelines recommend cardiac rehabilitation (CR) for secondary prevention of cardiovascular disease, however, it is underutilised

A CORNER OF RESEARCH FOR AUSTRALIA CONT.

and the quality of content and delivery varies widely. Quality indicators (QIs) for CR are used internationally to measure clinical practice performance, but are lacking in the Australian context. This study reports the development of QIs for minimum dataset (MDS) for CR and the results of a pilot test for feasibility and applicability in clinical practice in Australia.

METHODS: A modified Delphi method was used to develop initial QIs which involved a consensus approach through a series of face-to-face and teleconference meetings of an expert multidisciplinary panel (n=8), supplemented by an environmental scan of the literature and a multi-site pilot test.

RESULTS: Eight QIs were proposed and sent to CR clinicians (n=250) electronically to rate importance, current data collection status, and feasibility of future collection. The top six of these QIs were selected with an additional two key performance indicators from the New South Wales (NSW) Ministry of Health and two QIs from international registers for a draft MDS. The pilot test in 16 sites (938 patient cases) demonstrated median performance of 93% (IQR 47.1-100%). All 10 QIs were retained and one further QI related to diabetes was added for a final draft MDS.

CONCLUSIONS: The MDS of 11 QIs for CR provides an important foundation for collection of data to promote the quality of CR nationally and the opportunity to participate in international benchmarking.

The Good News: I left the best till last, if I do say myself!

Merry Christmas and Happy New Year - More next year!

STATE PRESIDENTS' REPORTING

SOUTH AUSTRALIA

ACRA SA/NT Inc

President: Jenny Finan

Vice President: Jeroen Hendriks

State Representative: Natalie Simpson

Secretary: Annette Ferguson

Treasurer: Renee Henthorn

Rural Representative: Nicole Dawes

Heart Foundation SA – Sabine Drilling

CATCH Representative: Claudine Clark

Ordinary Members: Louise de Prinse, Sanchia Shute, Celine Gallagher, Michelle Iadanza, Susan Sierp, Rhonda Naffin, Kathryn O'Toole, Sabine Drilling

State representative: **Natalie Simpson**

President: **Jenny Finan**

SA/NT Membership

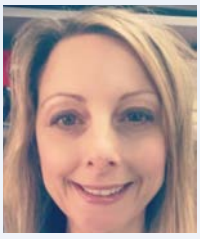
Current members: 68 members

We would like to offer a warm welcome to our new members, and encourage them to attend our education events and member meetings.

Member Profiles

Jeroen Hendriks, RN, PhD, FESC, FCSANZ

Jeroen Hendriks profile is listed on page 4 of this edition.



Nicole Dawes, RN

ACRA SA/NT Rural Representative

Nicole has worked in SA Health for the last 27 years. Nicole spent 19 years working at the Royal Adelaide Hospital with experience in the Emergency Department, Interventional Cardiology & Coronary Care Units. For the last 8 years she has been working for Country Health SA. Her current role is the Adelaide Hills Better Care in the Community Coordinator – Cardiac Services (Cardiac Rehabilitation & Heart Failure).

Nicole has a Bachelor of Nursing and a Graduate Diploma in Nursing Science - Cardiac Nursing. She has an extensive post graduate cardiac and chronic disease education portfolio. Her work interests are cardiac rehabilitation, heart failure and working closely with her patients to develop self-management skills to prevent hospital admissions and avoid emergency department presentations. Nicole is married, has 2 children and lives in the Adelaide Hills.

Nicole has been a member with ACRA since 2011.

Professional Development in 2017-2018

We have been fortunate to have many amazing speakers who have provided their time and expertise to deliver contemporary and interesting talks at our ACRA SA/NT education events.

Education Seminar

A full day seminar was held on 28th April 2018 at the South Australian Health and Medical Research Institute (SAHMRI) Auditorium for members & non-members. We had 41 attendees.

Subjects ranged from patient education & engagement, ways to improve medication adherence, improving outcomes in Aboriginal health, physical activity with CVD, the role of CR for people with AF, screen & diagnosis and treatment for OSA in CVD.

This event was kindly sponsored by Astra Zeneca & Pfizer

Members Only Dinner

Our member's only dinner was held on the 26th September at the Lenzerheide Restaurant, in Hawthorn, SA. We had 29 members attending.

Our invited speaker was **A/Prof Margaret Arstall** (left), Director of Cardiology at the NALHN/ University of Adelaide who spoke on the topic of '**Reducing the Risk of Cardiovascular Disease after Pregnancy Complications**'. Dr Arstall provided information on how to identify women who are at a higher risk of developing premature heart disease. The information provided in this session will be useful for attendees to educate female patients on how to improve their health and reduce their risk of future CVD.

This event was kindly sponsored by Astra Zeneca

Saturday Education Event:

Our recent education event was held on Saturday 20th October 2018 at Flinders Private Hospital.

We had 20 attendees. *This event was kindly sponsored by Boston Scientific.* Our first presenter was **Dr Dylan Jones**. He presented on 'Transapical aortic valve implantation (TAVI)' – 10 years on: diagnosis, criteria for implant/work up and post-operative management. Implant and post implant management has resulted in next day discharge for most people.

STATE PRESIDENTS' REPORTING CONT.

Dr Alicia Chan provided an insightful presentation on '**Cardio-Oncology.**' As the health community is seeing more people diagnosed with cancer and moving into survivorship, is a timely reminder that we have people who may develop early onset cardiovascular disease at a younger age, and are at risk of the development of significant comorbid debility secondary to oncology treatment. Dr Chan's presentation has provided food for thought, and has highlighted potential gaps for collaborative practice.

Ms Karissa Woolfe, from Cancer Council SA, provided a timely update of the Quit Line service. The Quit Line provides evidence based telephone counselling, is a confidential service delivered by trained counsellors to provide motivational support and share up to date knowledge of evidence-based methods to quit smoking and pharmacotherapy. They also explore readiness for change, assist with developing a quit plan, maintenance support and relapse prevention.

For those who were unable to attend: Cost of a local call, the service is culturally appropriate with a dedicated ATSI service, and they offer a free interpreter service & National relay service for the hearing impaired.

Telephone counsellors are available from 8:30am – 8pm weekdays, 2:00pm – 5:00pm Saturdays. Participants can request & schedule call-backs, they can also chat online - www.quitlinesa.org.au

Dr Femke Buisman-Pijlman, Behavioural Neuroscientist, School of Medicine, University of Adelaide provided an insight into behaviours and addiction with her presentation - "The neuroscience of smoking and neuroplasticity - how to build new neural pathways for positive behaviour change." Dr Buisman-Pijlman explored the reasons why people smoke, the biology of addiction and supporting people's choices.

Please watch the video 'Nuggets' which provides a visual explanation of addiction - https://www.youtube.com/watch?v=PKWenbQz5eE&t=0s&list=PLt1E3TJ3F53j-xWdbWZO_YczVk8NiKc_V&index=3

Enrol now in the University of Adelaide's free online course: Managing addiction: a framework for successful treatment – https://www.edx.org/course/managing-addiction-framework-successful-adelaidex-addictionx-0

Mr Adam Jensen, Training Specialist from Boston Scientific, provided an in-depth presentation of their Heart Logic enabled Device. 'HeartLogic,' by Boston Scientific, is a multisensory program, whereby a device can be programed to sense heart sounds, monitor thoracic impedance, respiratory pattern, heart rate, physical activity and sleep incline angle. The aims of these measurements are to aid in the early detection of decompensating heart failure prior to the development of clinic symptoms. This could allow early intervention to improve QOL, reduce distressing symptoms and reduce hospitalisations and ambulance call outs.

Proposed ACRA- SA/NT meeting & education dates 2019 (venues to be confirmed)

27 FEB Ordinary meeting

25 MAY Educational day event and AGM

19 JUNE Ordinary meeting

25 SEPT Members Only Dinner

19 OCT Educational event

27 NOV Ordinary meeting

Please remember: Heart Foundation Education

The SA Heart Foundation 2019 Nurse Ambassador Program (NAP) Application for the 2019 program will open shortly and information will be on the Heart Foundation website. Please go online and review the many benefits of joining the NAP for 2019. *This is a free program, however places are strictly limited. Applications close on the 11th January 2019.* For further information about the program please contact Sabine Drilling (Co-ordinator Heart Health SA) via 8224 2805 or sabine.drilling@heartfoundation.org.au. Please promote the program to your colleagues. https://www.heartfoundation.org.au/programs/south-australia-nurse-ambassador-program/

STATE PRESIDENTS' REPORTING CONT.

Please also don't forget to visit the Heart Foundation's Education portal for Professional education, including the latest updated clinical guidelines (Atrial Fibrillation & Heart Failure) and you can also sign up for the Heart Health Network.

https://www.heartfoundation.org.au/for-professionals/clinical-information

Heart Foundation Webinars:

Live Webcast: The Cardiac Blues and Depression post heart event.

Tuesday 4th December 2:00 to 3:00 pm (AEDST)

'In collaboration with the Australian Centre for Heart Health, the Heart Foundation is hosting a FREE Live Webcast which offers health professionals a rare opportunity to learn more of the psychological and emotional challenges of a heart event and strategies to scree, educate and refer appropriately.'

To view the webcast visit:

https://www.heartfoundation.org.au/for-professionals/clinical-information/psychosocial-health/cardiac-blues-webcast

Webcast: Improving diagnosis and care for heart failure patients

The panel:

Associate Professor John Atherton is a cardiologist and chair of the new heart failure guidelines. He is Director of Cardiology at Royal Brisbane and Women's Hospital, Associate Professor at University of Queensland, Professor at University of Sunshine Coast, Adjunct Professor at Queensland University of Technology, Honorary Fellow at University of Melbourne, Pre-eminent Staff Specialist Queensland Health and an appointed member of the Australian Government Medical Services Advisory Committee

Associate Professor Ralph Audehm is a full-time general practitioner. He is the secretary of the Section of General Practice, at the Australian Medical Association, and is involved in research and teaching at the University of Melbourne, Department of General Practice.

Dr Ingrid Hopper a general physician/clinical pharmacologist and consults in the Alfred Hospital heart failure clinic in Melbourne. Ingrid completed her PhD in heart failure therapeutics. She is a NHMRC early career fellow, senior lecturer, and head of drug and device registries at the School of Public Health and Preventive Medicine, Monash University.

https://www.heartfoundation.org.au/for-professionals/clinical-information/heart-failure/heart-failure-webcast

Webcast: Improving diagnosis and care for atrial fibrillation patients

The panel:

Professor David Brieger, chair of the atrial fibrillation guidelines working group, is a cardiologist. He is head of the coronary care and coronary interventions at Concord Hospital and Professor of Cardiology, University of Sydney.

Ms Cia Connell is a clinical manager at the Heart Foundation and senior clinical pharmacist specialising in cardiology. She also lectures at Monash University and works at the Alfred Hospital.

Professor Nick Zwar is a practising general practitioner. He is also Conjoint Professor of General Practice, UNSW Australia, and has substantial experience in health systems research.

https://www.heartfoundation.org.au/for-professionals/clinical-information/atrial-fibrillation/atrial-fibrillation-webcast

ACRA-SA/NT Grants

This year, the Kathy Reed Grant was awarded to Jeroen Hendriks to assist with his attendance to the 2018 ACRA ASM in Brisbane. Members are strongly encouraged to apply for 2019 ACRA ASM in Sydney.

Rural Report Country Health SA (CHSA)

Nicole Dawes, BCIC Coordinator – Cardiac Services (Adelaide Hills), 26/11/2018

13 health units funded for cardiac rehabilitation through the Better Care in the Community Program (BCIC).

STATE PRESIDENTS' REPORTING CONT.

- Adelaide Hills (Mt Barker), Ceduna, Gawler, Millicent, Mt Gambier, Murray Bridge, Port Augusta, Port Lincoln, Port Pirie, Riverland (Berri), South Coast, Wallaroo and Whyalla.

Programs across all sites are very busy leading up to the Christmas period. There will be no backfill for cardiac rehab coordinator leave over the Christmas period.

Many sites are now offering 2 cardiac rehab programs to accommodate for the increasing demand for service and to reduce wait list times.

The 2018 BCIC Workshop (held in June) for all program coordinators included cardiac education on CATCH updates, Heart Failure and Psychology and the Heart.

Activity across all sites for BCIC Services (Cardiac, Pulmonary, Diabetes):

CATCH Report – 26/09/2018 (Claudine Clark)

Recent work includes:

- CR Service Quality Model – Metro and Country LHN representatives and Heart Foundation representative are meeting to look at accreditation of CR services in SA. Currently in the process of establishing KPIs. Some work identified with Carolyn Astley's project at the SA Translation Centre which ties in with what we are trying to achieve. A workshop was held on October 31st.

- ACS Dashboard – Last CR Coalition meeting involved discussion and demonstration of the SA Health Quality Information & Performance Hub by Rosanna Tavella, in particular the ACS Dashboard and more specifically the CR stream of the dashboard. It looked at the use of the CATCH database as a source for data collection and how this data would meet the SA CR Quality Indicators (as per Carolyn Astley's project). It highlighted the importance of data entry into the CATCH database to accurately reflect the activity of each CR service in the state. Done accurately, this could serve as evidence for additional resources for our services as the dashboard is designed as an organisation-wide reporting tool to provide transparency across all public LHNs.

- I understand that it is difficult to attend meetings such as the Coalition Meetings due to all our conflicting times with CR programs and clinics, so I urge you to email any feedback to Rosy Tirimacco (chair) or myself for any upcoming meetings as your input is the most effective way for meaningful change to occur. Without our voice, there will remain a disconnect between the decision makers and what is relevant to us and what we do at the coalface.

Heart Foundation Report

For ACRA SA/NT 26 September 2018

Changes to Warning Signs Action Plan

The Heart Foundation warning signs action plan advises patients to self-administer a dose of angina medicine (GTN), if they have a current prescription.

Advice to chew 300mg aspirin has been added to the action plan.

Why has aspirin been added to the warning signs material?

Prehospital aspirin therapy for patients with suspected ACS is associated with reduced infarct size, fewer complications and improved short and long-term survival. This forms the basis of the evidence that aspirin is recommended as soon as possible for suspected ACS unless there is clear evidence of allergy. This recommendation has been made after weighing these benefits against potential risks. The risk of bleeding and allergy are minimal compared to the cardiovascular benefits when taken for a suspected ACS. Furthermore, risk of duplication of aspirin dosing in this situation is minimal given the maximum daily dose of aspirin is 1200mg.

The current early warning signs action plan advises patients to self-administer a dose of GTN, if they have a current prescription. Incorporating prehospital aspirin therapy into this advice provides consistency in our recommendation that patients take cardiac medication to improve their chances of survival during an acute coronary syndrome. This recommendation is also consistent with the early warning signs advice provided by the British Heart Foundation.

STATE PRESIDENTS' REPORTING CONT.

What is the evidence to support the addition of aspirin to the warning signs material?

1. A literature review was conducted
2. A benefits/risk analysis was conducted
3. Refer to the following references:

- Freimark, D., et al., *Timing of aspirin administration as a determinant of survival of patients with acute myocardial infarction treated with thrombolysis.* American Journal of Cardiology. **89**(4): p. 381-385.
- Verheugt, F.W.A., et al., *Effects of early intervention with low-dose aspirin (100 mg) on infarct size, reinfarction and mortality in anterior wall acute myocardial infarction.* American Journal of Cardiology. **66**(3): p. 267-270.
- Barbash, I., et al., *Outcome of myocardial infarction in patients treated with aspirin is enhanced by pre-hospital administration.* Cardiology, 2002. **98**(3): p. 141-7.
- National Institute for Health and Clinical Excellence (2010). NICE Guidelines, Chest Pain of Recent Onset: Assessment and Diagnosis, M., 2010.
- Quan, D., et al., *Prehospital Use of Aspirin Rarely Is Associated with Adverse Events.* Prehospital and Disaster Medicine, 2012. **19**(4): p. 362-365.
- Pfaar, O. and L. Klimek, *Aspirin desensitization in aspirin intolerance: update on current standards and recent improvements.* Curr Opin Allergy Clin Immunol, 2006. **6**(3): p. 161-6.

What should health professionals be advising their patients? *Particularly as most patients will be on low dose, enteric-coated aspirin. Should they take this form? How should they take it?*

Aspirin is recommended for anyone having a suspected heart attack – **in this case 300mg should be taken if available (regardless of whether a dose has already been taken that day). This will work best if the tablets are chewed before swallowing (any form of the tablets can be chewed).** In this situation, aspirin is given to reduce the severity of the heart attack, reduce complications, and improve survival.

If 000 operators direct callers to take aspirin, why is the Heart Foundation making this recommendation as, ultimately, consumers who have referred to this action plan are more likely to call 000

Considering the evidence of benefit, the Heart Foundation (with approval of the Heart Foundation's Clinical Committees) has included a recommendation on the warning signs action plan for patients to self-administer a loading dose of 300mg aspirin for a suspected heart attack, prior to the arrival of emergency services. This recommendation ensures that patients receive aspirin as early as possible, while preserving the need for assessment by a health professional to exclude any contraindications. In particular, it recognises the significant proportion of people who present to hospital using private transport who would otherwise miss out on receiving early intervention.

Heart Failure e-learning site update

The site content is currently under review and will be updated to reflect new evidence and recommendations in the National Heart Foundation of Australia and Cardiac Society of Australia and New Zealand: Australian clinical guidelines for the management of heart failure 2018.

My heart my life 6 Steps to cardiac recovery A4 laminated guide and posters are back in stock.

In-service Education

Please contact Brittany Marsh if you would like an in-service at your site. The training currently has a focus on nutrition as National Nutrition Week is coming up. The content can be tailored to your needs.

Contact: brittany.marsh@heartfoundation.org.au or Ph 8224 2862

Country visits

Brittany will be visiting Pt Lincoln and Mt Gambier in October. She will be conducting in services at hospitals, Aboriginal Health Services, and community education about the warning signs of a heart attack.

Heart Foundation 2019 Nurse Ambassador Program

Application for the 2019 program will open shortly and information will be on our website. Please promote the program to your colleagues.

https://www.heartfoundation.org.au/programs/south-australia-nurse-ambassador-program/

Contact: Sabine Drilling, Coordinator Heart Health SA

Sabine.drilling@heartfoundation.org.au or 8224 2805

WA REPORT

Welcome to new members: We extend a friendly welcome to our newest members - Janetta Della-Vadda who joined at our Annual symposium event. 3 new members joined at our November workshop bringing our membership total to 39. We hope you have been able to attend or link into one of our Professional development events: our AGM, Annual Symposium, annual half-day workshop or our monthly series of lectures via videoconference. These are also available to watch online at the links below.

State representative: **Lily Titmus**

President: **Helen McLean**

Monthly TELEHEALTH EVENTS

In response to reaching out to our rural members ACRA-WA, the WACHS Chronic Conditions Strategy Team (CCST),

STATE PRESIDENTS' REPORTING CONT.

the Heart Foundation WA (HF), the Training Centre in Subacute Care (TRACS WA) and ACRA-WA have collaboratively provided monthly telehealth education sessions to our rural and remote CRSP clinicians. The content of these sessions have been made available through the TRACS WA website www.subacutecare.org.au

Session 1 was designed as an **introduction to CRSP** and covered questions such as: what is it, whose job is it and what resources are out there? Content can be viewed at:

https://www.youtube.com/watch?v=fjP1ibPRpSg

Session 2 topic was '**Exercise for Heart Health**' and was run as a community of practice on the 6th September.

https://www.youtube.com/watch?v=UdnmwSTZyPY&feature=youtu.be

Session 3 topic was '**Supporting Your Patients - After Heart Attack**' on the 11th October.

https://www.youtube.com/watch?v=sEmGMpNjpk8&feature=youtu.be

Session 4 incorporated information regarding the **new Heart Failure and Atrial Fibrillation guidelines.** This will be available soon on www.subacutecare.org.au

Additionally, a simplified Cardiopulmonary Guidelines document was drafted for rural and remote practitioners to support the series of videoconferences. This document can be accessed on the TRACS WA website at www.subacutecare.ord.au

4 more sessions have been planned for 2019, details pictured on the left.

ACRA-WA ANNUAL RESEARCH SYMPOSIUM

Tracy Swanson provided us with a fantastic event on WEDNESDAY 18th July 2018 at Hollywood Private Hospital Lecture Theatre in Nedlands from 5pm to 7pm. The presentations were of an excellent standard and gave us much food for thought.

- *Cardiac Rehabilitation Secondary Prevention (CRSP) referral numbers: a retrospective audit and process review.* No matter how well our CRSP program works there can always be room for improvement especially with respect to referrals for maintenance.
- Very interesting to hear about the App being used in conjunction with Cardiology follow-up by video-conference link in *Current status of cardiac rehabilitation and secondary prevention provisions of coronary heart disease patients in a Chinese tertiary hospital: results of a single centre survey.*
- Great diversity of sessions with many practical tips from the *Ventricular assist device implantation with higher levels of physical activity in patients with advance chronic heart failure* session.
- A good reflection into the use of T*otal cardiovascular disease risk scoring assessments: a survey on screening in general practice.* The ongoing work here will see Anita staying in touch to provide further outcomes, and
- Emerging technologies do help in *Telemonitoring of body weight improves quality of life in patients with chronic heart failure.*

Those present thoroughly enjoyed the evening of networking - a mini conference with poster presentations included:

1. *Screening for depression in coronary Care Unit: a translational research approach.*
2. A positive score for depressive symptoms using patient health questionnaire - to what extent is this information used to inform patient care in the community?

STATE PRESIDENTS' REPORTING CONT.

Make a new healthy habit

1. Decide on a goal that you would like to achieve for your health.
2. Choose a simple action that will get you towards your goal which you can do on a daily basis.
3. Plan when and where you will do your chosen action. Be consistent: choose a time and place that you encounter every day of the week.
4. Every time you encounter that time and place, do the action.
5. It will get easier with time, and within 10 weeks you should find you are doing it automatically without even having to think about it.
6. Congratulations, you've made a healthy habit!

My goal (e.g. *'to eat more fruit and vegetables'*)

_____

My plan (e.g. *'after I have lunch at home I will have a piece of fruit'*)
(When and where) _____ I will _____

Some people find it helpful to keep a record while they are forming a new habit. This daily tick-sheet can be used until your new habit becomes automatic. You can rate how automatic it feels at the end of each week, to watch it getting easier.

	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Week 9	Week 10
Monday										
Tuesday										
Wednesday										
Thursday										
Friday										
Saturday										
Sunday										
Done on 5 days or more?										
How automatic does it feel? *Rate from 1 (not at all) to 10 (completely)*										

Ten tips to lose weight and keep it off

1. **Keep to your meal routine**
   Maintain consistent meal times whether you're eating twice a day or five times a day.
2. **Go reduced fat**
   Enjoy small amounts of healthy fats from nuts, avocado and oily fish, instead of fast food and high-fat meats.
3. **Walk off the weight**
   Try to walk 10,000 steps a day. Take the stairs, walk up escalators and get off one bus stop earlier - it all adds up.
4. **Pack a healthy snack**
   If you do snack, go for healthy options like fresh fruit or a small handful of nuts.
5. **Learn the labels**
   Checking food labels helps you pick healthier options that are lower in calories, fat and sugar and higher in fibre.
6. **Caution with your portions**
   Don't overload your plate unless it's with vegetables and think twice before going back for seconds.
7. **Up on your feet**
   Whether you're at work or at home, try to stand for ten minutes every hour.
8. **Think about your drinks**
   Alcohol, juice, fizzy drinks and energy drinks can be high in sugar and calories, so stick with no more than one small glass a day.
9. **Focus on your food**
   Over-eating is all too easy while on the go or in front of the TV. Eating slowly is a surprisingly effective way to eat less.
10. **Don't forget your five a day**
    Having fruit or vegies at every meal makes it easier to get your five- a-day.

Evidence based tips used by Dr Gina Cleo, a dietician with a PhD in habit based weight loss maintenance. Originally developed by Weight Concern, a UK Charity.

Our special congratulations to Paul Camp and his team for providing a fantastic Annual Scientific Meeting. ACRA-WA had a number of representatives and feedback has been highly positive.

OCTOBER celebrations!

In the past the ACRA-WA executive group have organised Christmas celebrations in December – this has meant small attendance numbers as everyone fills up with family, friend and work festive commitments so this year we went out for dinner in October! It was a stormy night with the rain so heavy we couldn't hear each other talk at times! That didn't dampen the fun had by all!

NOVEMBER WORKSHOP

Hazel returned from the ACRA ASM in Brisbane with great enthusiasm to apply some of the Smashing Mindsets and Changing Habits information she had learned. We held a highly interactive event where using a case study approach participant discussed ways to help those we care for break bad habits, activate positive behaviour change and set goals to ensure they successfully reduce risk factors of heart disease and improve the quality of their lives.

SHOWCASING GREAT WORK BEING DONE BY ACRA-WA MEMBERS

ACRA-WA would like to feature some of the great work being down in the West. Please send innovative work your service is currently involved in to me at helen.mclean@health.wa.gov.au for inclusion in future newsletters.

This edition I would like to share our Vice Presidents video.

Hazel Mountford, a Senior Physiotherapist Cardiology, runs the cardiac rehabilitation program at Sir Charles Gairdner Hospital, designed to improve cardiac patient's overall health. The exercise-based sessions are supervised and filled with friendly conversation. Patients are encouraged to join the program following their heart diagnosis. As well as running the cardiac service, Hazel conducts clinical research to help guide development of the service. She has been an active ACRA-WA executive committee member since 2008, and a member since 2006. Check out the 3 minute video at this link https://www.youtube.com/watch?v=fva8GgSXTpA

Again, I must recognise the efforts of all on the ACRA-WA executive and to those on the ACRA national executive who give up there family/personal time to ensure all members receive support and the latest evidence based professional development. Those of you who are new to CRSP – I encourage you to use the mentorship available through the ACRA website. Wishing you all a safe and joyous Christmas time and happy Rehabbing to you!

With much gratitude

Helen Mclean ACRA-WA President

Please don't hesitate to contact me for further information regarding these events or projects – helen.mclean@health.wa.gov.au

STATE PRESIDENTS' REPORTING CONT.

NSW REPORT

Name Change

To align with national partners CRA NSW/ACT will now be known as ACRA NSW/ACT. Our logo has been adapted to reflect this, as per above. We hope you like it!

State representative: **Jane Kerr**

President: **Robert Zecchin**

Progress with ACRA NSW/ACT Cardiac Rehabilitation Minimum Data Set

- A formal Memorandum of Understanding will be signed by the Agency for Clinical Innovation (ACI) and the Heart Foundation on behalf of the NSW Cardiac Rehabilitation (CR) Data Sub Working Group to develop a process for the collection of statewide cardiac rehabilitation data and a reporting system for NSW cardiac rehabilitation services.
- Prof Robyn Gallagher (Sydney Uni) has commenced the data analysis of the repeat cardiac rehab audit (March – May 2017)
- A paper on the development of the of the cardiac rehab minimum dataset and 2016 pilot test entitled, *Development of quality indicators for cardiac rehabilitation in Australia: A modified Delphi method and pilot test,* was published in August in Heart, Lung and Circulation https://doi.org./10.1016/j.hlc.2018.08.004.
- Robert Zecchin (NSW President) is representing ACRA NSW/ACT at the *Improving Cardiac Rehabilitation Measurement in Australia Think Tank,* held in South Australia in September 2018. There was agreement to establish a Taskforce that will meet at least twice before the end of 2018 to progress the development of the above quality indicators.

NSW Cardiac Rehabilitation Framework

Progress has been made on the development of the Cardiac Rehabilitation Framework for NSW cardiac rehabilitation clinicians. Documents supporting the development of the framework include Australian Clinical Guidelines for the Diagnosis and Management of Acute Coronary Syndromes, Heart Failure and Atrial Fibrillation, Australian Cardiovascular Health and Rehabilitation Association Core Components of Cardiovascular Disease Secondary Prevention and Cardiac Rehabilitation and the *Development of quality indicators for cardiac rehabilitation in Australia: A modified Delphi method and pilot test.*

NSW Cardiac Rehabilitation Forum

On the 16 November, the Heart Foundation hosted the annual Cardiac Rehabilitation Forum. NSW Cardiac Rehabilitation Working Group members discussed the progress on the 6-point plan for cardiac rehabilitation action in NSW 2018, communicated examples of good practice and how this can be shared around the state and set several priorities for action in 2019.

ACRA NSW/ACT Annual Scientific Meeting/ Professional Development

This very successful annual meeting was held at the Kirribilli Club, venue for the 2019 ACRA ASM. With 102 registrants the venue coped most adequately with extremely attentive facility hosting and 98% rating of very good to excellent for the venue, facilities and catering. Sessions included:

- Women & heart disease: pregnancy, pre-eclampsia and long-term CVD risk and SCAD
- Updates in HF and AF management
- Sleep & its relationship to CVD
- Cardio-Oncology
- Sitting
- High Intensity Interval Training
- NSW/ACT MDS outcomes
- The St Vincent's Heart Health website
- The environment, pollution as triggers for cardiac events

12 people participated in the Basic Counselling Skills in the pre-conference workshop on 11 October. As a follow up to the workshop, to consolidate their skills, there will be an opportunity for delegates to participate in a 50- minute individual telephone clinical supervision session before the end of December 2018 with the facilitator, Jennifer Fildes.

An art-loving participant also took the opportunity to walk around to Wendy (& Brett) Whitely's much lauded garden which was in full bloom.

Planning is underway to hold an evening forum for cardiac health professionals in February 2019 at RNSH. Also discussion has commenced regarding a series of webinars to particularly support rural clinicians.

NSW/ACT Membership

Great news - ACRA NSW/ACT has increased its membership from 2017 by approximately 20% to 115. The more of your colleagues involved in the Association the stronger we become as a voice and the greater capacity we have to support you to deliver evidence-based care to your patients/clients.

NSW/ACT member feedback has indicated a problem persists with electronic membership renewal processes for some members. This issue is not limited to our state. Steps are now in place to work with our partners to make improvements.

STATE PRESIDENTS' REPORTING CONT.

TACR REPORT

16 financial members and 1 life member as of September.

Several members participated in 2 Queensland Health heart failure webinars with excellent presentations from a wide variety of speakers. We express our sincere thanks to our sunshine state colleagues for allowing us to be involved. For those TACR members who attended the ACRA ASM, this was a great follow-up to the heart failure workshop held in conjunction with that event.

State representative: **John Aitken**

President: **Sue Sanderson**

We received very positive feedback from those who attended ASM regarding the content, social events and the networking opportunities provided – our sincere congratulations to Qld team. Two TACR members received travel grants to attend the ASM.

Any opportunity for a selfie!! North west coast cardiac rehab staff at webinar.

Planning is in progress for the Heart Foundation Clinical Ambassador program scheduled to run in 2019. There has been interest is shown from a wide variety of health professionals. However some early feedback from the acute sector has raised the issue for nurses in this setting who are allowed 5 study days per annum. Running 3-4 workshops for this ambassador program severely impacts on this allowance and opportunities to attend other education days including those provided in-house.

Tassie contingent at ASM with Christine Somerville (NSW)

Following discussions at the recent ACRA EMC we concluded that it is not feasible nor potentially financially viable for ACRA to hold the annual ASM in Tasmania in 2020. Victoria has agreed to take the reins in that year. I understand that many of you were hoping to come to our beautiful state in 2020 but perhaps you can plan to do so after the meeting in Melbourne?

With an increasing number of patients with complex issues being referred to the nurse-led cardiac rehabilitation service in Hobart, we are reviewing the possibilities of gaining support from allied health services. Cardiac rehabilitation in the other state hospitals (there is nothing provided by any of the private hospitals) have multidisciplinary input to their programs. In spite of what might be perceived as limitations in our service, by careful assessment, prioritisation and allocation to group or home based programs, we do not have a waiting list. The majority of our patients are reviewed within 21 days of hospital discharge and assessed. We have a high participation and completion rate.

Sue Sanderson participated in the recent "Improving cardiac rehabilitation measurement in Australia think tank" forum in Adelaide hosted by the SA Academic Health Science and Translation Centre. This was a very informative day with representatives from all states (ACRA), SAHMRI, the Heart Foundation, universities, and the Health Consumers Alliance. "In principle recommendations" were agreed and a committee formed to drive the process forward.

May I take this opportunity to wish my Tasmanian and CR colleagues nationwide the joys of the festive season. I trust the time will be safe and happy as you each indulge **in moderation** the offerings of the season.

Sue Sanderson
President ACRA-Tas

VICTORIA REPORT

Susie Cartledge and Carmel Bourne

The second half of the year has been busy for ACRA Victoria. We have held two successful events, had our AGM and welcomed a new look committee for 2018/2019.

ACRA Vic Membership

We currently have 131 members and welcome three new members; Ashley Barnard, Patricia Booth, Lani Caballero. The committee are keen to reach more Victorian members in the coming year, especially in rural areas and with through acute cardiac and medical units – watch this space!

State representative: **Carmel Bourne**

President: **Susie Cartledge**

STATE PRESIDENTS' REPORTING CONT.

Heart Foundation / ACRA Vic Forum

In conjunction with the Heart Foundation, ACRA Vic was able to co-host a forum for members to have input into the development of an evidence-based Phase II cardiac rehabilitation program content outline. The interactive forum provided a chance for the future end users of this work to provide feedback and input into the project in addition to being able to discuss and share the different aspects of their own program with each other. There was a lot of stimulating discussion during the afternoon and we thank the members that took the time to attend and also provided their invaluable feedback to assist in shaping this work.

ACRA Member and Project team member Emma Thomas facilitating interactive feedback session.

ACRA Vic Education Day

Our latest education day "Holistic Care of the cardiac patient" was held on Friday 12th October. It was well attended by 65 delegates in person and a further 10 who joined via videoconference. In response to member feedback we tried a new venue "Library at the Dock", which is a new City of Melbourne Library. The venue, overlooking the water in the Docklands was a hit and we will consider using it for our smaller events in the future.

The program for the day consisted of multidisciplinary speakers, including a physiotherapist (and PhD candidate), a speech pathologist and a researcher who presented on sleep. The highlight of the program was thought provoking presentation by Dr Michael Wong titled "Arrhythmias and sudden death in chronic kidney disease: a new paradigm shift?" We have had requests for Dr Wong to present for some time, so it was fantastic to be able to welcome him to our event.

We were fortunate to have some great sponsors and for this event had support from Novartis (Gold Sponsor), Edwards Lifescience and Cardihab. Following on from the ACRA ASM Lite 'n Easy generously provided healthy snacks for the day.

Our next event, a Clinical Practice Day entitled "Matters of the Heart and Mind" will be held on the 4th of March and will feature a not to be missed workshop with Chelsea Baird on chronic disease, cognition and self-management. This is a new interactive workshop, so we will look forward to the feedback.

ACRA Vic Education Day – October 2018

Committee Update

During our October AGM, we have had several significant changes at the executive level of the committee with a new incoming President, Susie Cartledge and Carmel Bourne taking on the joint role of Vice President and State Representative. We also welcomed new committee members Jonathan Rawstorn as Treasurer and Katrien Janssen as Secretary.

In addition we were also able to co-opt two new committee members. We welcome Linda Macaulay (Ballarat Health) and Michael Kolarik (Monash Health) onto the committee as co-opted members and look forward to working with them.

Thankfully we will continue to work with immediate past president Emma Boston, our past treasurer Debra Gascard and Vice Treasurer Ailish Commane and past secretary Niamh Dormer. Thank you for all your service to ACRA Vic at an executive level, some roles were undertaken for many years with such dedication. We are thankful to retain your knowledge and expertise as we train up the next generation of the ACRA Vic committee!

We are also fortunate to continue to work with Eugene Lugg as our Heart Foundation Representative and Alun Jackson as our Australian Centre for Heart Health representative.

The committee have engaged in several new initiatives this year. Our main focus has been increasing our communication with our members. We have achieved this using a new platform, "mailchimp", to deliver interactive e-newsletters to members. This platform also provides the committee with invaluable analytics to assess which parts of the newsletter our members are accessing to enable us to guide our future content to ensure we are

STATE PRESIDENTS' REPORTING CONT.

*ACRA Vic Committee from L-R: Eugene Lugg (Heart Foundation representative), Susie Cartledge (President), Jonathan Rawstorn (Treasurer), Emma Boston, Michael Kolarik, Niamh Dormer, Debra Gascard, Carmel Bourne (Vice President/State Rep), Alun Jackson (Australian Centre for Heart Health representative), Katrien Janssen (Secretary), Ailish Commane. *Not pictured Linda Macaulay*

delivering what our members want and are interested in!

We are very proud of what we have achieved in 2018 and look forward to an exciting and challenging 2019 as we endeavour to increase our membership base and deliver quality and engaging education and events to members.

QUEENSLAND REPORT

ACRA Queensland's new State Rep, Michelle Aust, shares her story

In Queensland, we have moved from Christmas in July to Christmas in December. It only seems like yesterday that we packed up the Christmas trees following the Gala Dinner. I trust that those who attended the ACRA ASM in Brisbane enjoyed the conference and the social events organised. I personally would like to say a big thank you to all those who attended and made it a great event and for my fellow conference committee members for a job well done. After last weekend's EMC meeting in Melbourne, I am really looking forward to next year's conference in Sydney. It sounds very exciting!

I am honoured to have been nominated as State Representative for ACRA Qld. I know my size 8 feet will never fit into the shoes of my predecessor, Steve Woodruffe, but I am humbled to be given this opportunity to represent our members in Qld.

ACRAQLD
Australian Cardiovascular Health & Rehabilitation Association – Queensland

State representative: **Michelle Aust**

President: **Bridget Abell**

I thought I would begin my introducing myself. I am currently the Clinical Nurse Consultant coordinating Cardiac Rehabilitation within the Sunshine Coast Hospital and Health Service. I have always been interested in cardiology, working predominantly within Coronary Care Units and Cardiac Rehabilitation throughout my nursing career.

In my early days in the 90's, I was working in Coronary Care in a regional hospital in country Victoria. I was a member of the Victorian Association of Cardiac Rehabilitation (VACR) in the days of the distinguished Alan Goble. It was a pleasure and a great honour to work alongside someone who was the pioneer for cardiac rehabilitation and advocated for the benefits that the multi-disciplinary team played in a patient's recovery. My portfolio within CCU was cardiac rehabilitation. My achievements included developing a patient resource in conjunction with the multidisciplinary team (before the days of My Heart My Life). I also managed to change the referral system from 'physician only' to all health professionals caring for the patient having the ability to refer. This enabled an increase in the number of referrals to Phase II outpatient cardiac rehabilitation. I also provided the

STATE PRESIDENTS' REPORTING CONT.

education in the Phase II program which included cardiovascular disease and risk factors and also a session on CPR.

My move to Qld in 2002 saw me working in CCU in Metro North HHS, until a secondment to Cardiac Rehabilitation in 2007. I was fortunate to gain a permanent position as CN and then was successfully appointed as CNC for the Sunshine Coast HHS in 2010.

During my time there has been many changes, sadly some for the worst due to the political climate. In 2013 we lost our very successful exercise program to facilitate Phase I inpatient education with the introduction of interventional cardiology to the HHS.

I have always held cardiology close to my heart (excuse the pun) and have always taken my nursing role as patient advocate very seriously. Since closure of our exercise program I have been working tirelessly to try and have it reinstated knowing that it is evidence-based practice and provides the best care for our patients.

The Quality Improvement Funding (QIP) offered late 2015 provided me with an opportunity to source funding to re-establish our program. I submitted a business case to recommence an exercise component of our program in conjunction with the University of the Sunshine Coast. We were successful in gaining funding to support increased nursing hours to facilitate patient assessments so we could achieve the performance indicators. However, despite achievements higher than the state average, the red tape was difficult to cut and still, in 2018 we had no exercise program.

Known as the 'squeaky wheel' by my fellow colleagues, I submitted another business case to commence an exercise program utilising current resources. Fortunately, this was granted, and using our cardiology HP5 physio and the gym space at the Sunshine Coast University Hospital, we proudly launched the exercise program in Heart Week this year.

The QIP funding ceased at the end of the last financial year, as did our increase in nursing hours. Despite this we have endeavoured to continue the program, however resources were stretched, doing more with less. Another business case was then submitted and we have just been given approval for a permanent increase in nursing hours which will help facilitate our program. The agreement with the University of the Sunshine Coast is still being considered so watch this space!

My key messages to you all are:

- Never give up, persistence will pay. One of my favourite quotes: "*The key to success is action, and the essential in action is perseverance*" (Sun Yat-sen)
- Never under estimate the value of data collection. Whilst it may seem a timely process, the data is valuable and may assist in any request for an increase in resources. The data recently released by QCOR regarding cardiac rehabilitation is invaluable. You can read the statistics for Cardiac Rehabilitation in Queensland here: https://clinicalexcellence.qld.gov.au/sites/default/files/docs/priority-area/clinical-engagement/networks/cardiac/qcor-cardiac-rehabilitation-report-2017.pdf. I strongly encourage sites who are not yet using the program to get in touch with Samara Phillips (samara.phillips@health.qld.gov.au) for assistance in getting on board.
- Peer support is beneficial. ACRA provides a mentoring program to its members which was launched at the ACRA ASM this year. Benefits of the mentoring program are:
  - Professional and personal development and growth
  - Improved clinical, leadership, management and/or research capabilities
  - Career development

Other benefits of membership include access to the member's lounge on the website, regular state and national newsletters, access to journals, professional development via conferences, seminars and webinars, educational resources and being linked in with like- minded health professionals. In Qld, we are currently seeking expressions of interest for members who would be interested in a peer-to-peer cardiac rehab teleconference session to discuss case studies, professional issues etc. Please forward your EOI to us at qcra@acra.net.au

In the meantime, if you have any questions or feedback regarding membership or cardiac rehabilitation in general, please don't hesitate to contact me via email at michelle.aust@health.qld.gov.au. I look forward to sharing this journey with you all.

Regards

Michelle Aust