Abstracts

S361

L. Ladak 4, R. Zecchin 3

indicators (based on pilot) for delivery and outcomes. ± mean age was 66.3 (17.9%) and group (2.5%) programs. Participants (44%), education only (44%), telehealth/phone coaching

diagnoses were ACS (45.8%), cardiac surgery (23.4%) and were culturally and linguistically diverse. Most common

terest (ACT) (n = 1) and provided data on 11 quality

Background: Cardiac rehabilitation (CR) is recommended to promote recovery and secondary prevention following cardiac events, yet the quality of delivery in Australia has not yet been adequately assessed.

Purpose: To conduct a snapshot of CR as a basis for creating a minimal set of national benchmarks for quality.

Methods: CR sites volunteers were selected to represent metropolitan, rural and regional areas across New South Wales (n = 36), Tasmania (n = 2) and Australian Capital Territory (ACT) (n = 1) and provided data on 11 quality indicators (based on pilot) for delivery and outcomes.

Results: Sites delivered centre-based (97%), home-based (44%), education only (44%), telehealth/phone coaching (17.8%) and group (2.5%) programs. Participants (n = 2436) mean age was 66.3 ± 12.5 years, 68.5% were male and 17.1% were culturally and linguistically diverse. Most common diagnoses were ACS (45.8%), cardiac surgery (23.4%) and elective PCI (11%).

CR Delivery: Median waiting time was 15days (IQR 9–25), 59% completed, 75% were referred to GP/specialist and 37% to CR follow-up. Participants had entry and discharge assessment for adiposity (62%, 45%), exercise capacity (59%, 42%), guideline medications (97%, 61%) and entry only for depression (89%) and smoking (97%). Of those screened positive for depression and smoking referral discussion occurred for 77% and 78%.

CR Outcomes. Improvements occurred in waist circumference of 1.16cms (95%CI 1.14–1.18).

Conclusions: This cross-state CR-quality snapshot provides a basis for developing benchmarks for CR delivery and outcomes in Australia.

http://dx.doi.org/10.1016/j.hlc.2019.06.530

S529

Creating National Benchmarks for Cardiac Rehabilitation Quality – New South Wales, Australian Capital Territory and Tasmania Snapshot

R. Gallagher 1, 4, C. Ferry 2, D. Candelaria 1, L. Ladak 4, R. Zecchin 4

1 University Of Sydney, Sydney, Australia
2 National Heart Foundation of Australia, Australia
3 Western Sydney Local Health District, Australia
4 Aga Khan University, Pakistan

Background: Cardiac rehabilitation (CR) is recommended to promote recovery and secondary prevention following cardiac events, yet the quality of delivery in Australia has not yet been adequately assessed.

Purpose: To conduct a snapshot of CR as a basis for creating a minimal set of national benchmarks for quality.

Methods: CR sites volunteers were selected to represent metropolitan, rural and regional areas across New South Wales (NSW) (n = 36), Tasmania (n = 2) and Australian Capital Territory (ACT) (n = 1) and provided data on 11 quality indicators (based on pilot) for delivery and outcomes.

Results: Sites delivered centre-based (97%), home-based (44%), education only (44%), telehealth/phone coaching (17.8%) and group (2.5%) programs. Participants (n = 2436) mean age was 66.3 ± 12.5 years, 68.5% were male and 17.1% were culturally and linguistically diverse. Most common diagnoses were ACS (45.8%), cardiac surgery (23.4%) and elective PCI (11%).

CR Delivery: Median waiting time was 15days (IQR 9–25), 59% completed, 75% were referred to GP/specialist and 37% to CR follow-up. Participants had entry and discharge assessment for adiposity (62%, 45%), exercise capacity (59%, 42%), guideline medications (97%, 61%) and entry only for depression (89%) and smoking (97%). Of those screened positive for depression and smoking referral discussion occurred for 77% and 78%.

CR Outcomes. Improvements occurred in waist circumference of 1.16cms (95%CI 1.14–1.18) and exercise of 2.82, 3.36).

Conclusions: This cross-state CR-quality snapshot provides a basis for developing benchmarks for CR delivery and outcomes in Australia.

http://dx.doi.org/10.1016/j.hlc.2019.06.530

S530

Delivery of Core Components in New Zealand Cardiac Rehabilitation Programs, Compared to other High-income Countries

B. Roxburgh 1, 4, M. Supervia 2

1 University Of Otago, Dunedin, New Zealand
2 Mayo Clinic, Rochester, United States of America

International guidelines state cardiac rehabilitation (CR) programmes should offer specific core components to optimise cardiovascular risk reduction. It is not known how well New Zealand (NZ) programmes conform with these guidelines, nor how they compare with programmes in other high-income countries (HICs) providing CR.

Secondary analysis of a global, cross-sectional survey of CR programmes was undertaken. National CR societies or champions facilitated administration of the survey to each program in their country, via REDCap. American Heart Association-defined core components were considered (total 10). Data from NZ CR programs were compared with the 31 other HICs providing CR (data collected in 28; n = 819 surveys).

24/43 (62.7%) NZ CR programs responded. NZ programmes offered a median 8.5 core components (Q25–75 = 6.5–9.0 vs. 9.0, 8.0–10.0; p < 0.05), with all programmes (n = 24, 100.0%) providing nutrition counselling (vs. other HICs: n = 525, 95.3%; p > 0.05) and most (n = 23, 95.8%) blood pressure management, physical activity counselling and psychosocial management (vs. n = 536, 99.1%; n = 545, 98.6%; n = 529, 96.4%, respectively; all p > 0.05).

Programmes in other HICs were significantly more likely to offer weight management (n = 395, 73.6% vs. n = 12, 50.0%; p < 0.05), diabetes management (n = 442, 82.3% vs. n = 15, 62.5%; p < 0.05) and exercise training (including exercise prescription; n = 528, 96.5% vs. n = 19, 79.2%; p < 0.005), compared to NZ.

NZ CR programmes deliver somewhat fewer core components, in particular weight and diabetes management as well as exercise training with individualised prescription, compared to other HICs. Given evidence of benefit for each component individually and synergistically, programmes must be resourced and staffed to ensure fully comprehensive, evidence-based care is provided.

http://dx.doi.org/10.1016/j.hlc.2019.06.531