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persons than CKD persons without dialysis (PAD diagnosis based on ABI or TBI: 31% in ESKD persons and 23% in CKD persons; PAD diagnosis based on self-reported history: 17% in ESKD persons and 10% in CKD persons). Older age, Caucasian race, cerebrovascular disease, and haemodialysis were associated with the presence of PAD in ESKD persons.

**Conclusions:** Since there is a considerable proportion of PAD in CKD and ESKD persons particularly in those with ESKD, it is essential to develop an adequate plan to clinically manage CKD patients with PAD and provide evidence of cost-effectiveness and clinical benefit of early detection of PAD in persons with CKD in Australia.

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### Process Evaluation of Patient Self-screening Stations for Atrial Fibrillation in General Practice Waiting Rooms: Preliminary Results

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**Background:** Previous work has identified factors relevant to general practitioner (GP)-led screening for atrial fibrillation in Australian general practices, with GPs indicating significant time constraints. Integrating self-screening stations into practice waiting rooms may increase screening rates, but acceptability from practice staff is unknown.

**Aim:** Determine staff perspectives on opportunistic self-screening in practice waiting rooms, utilising AF SELF SMART (Atrial fibrillation self-screening, management and guideline recommended therapy) self-screening stations.

**Methods:** To date, 11 semi-structured interviews have been conducted with practice staff (GPs, receptionists, and practice managers) across 3 practices participating in the AF SELF SMART pilot, with thematic analysis of results.

**Results:** Several preliminary themes were identified. GPs, receptionists, and practice managers all acknowledged *the importance of screening for AF* in the practice, with GPs indicating high levels of acceptance of self-screening. There were *differential impacts on workflow*, with receptionists but not GPs reporting problems integrating self-screening into their workflow. Receptionists perceived that *our patients need help*, and routinely offered this help before it was requested. Given the increase in workload associated with assisting patients, and as screening was *not receptionists' main priority*, not all patients were offered self-screening during busy periods. *Patient refusal* was also identified as a factor in a number of cases.

**Conclusions:** AF self-screening is supported by GPs and may increase screening rates. Further process improvements are required to streamline workflow and usability of the self-screening station for patients, to reduce impact on reception staff and improve ongoing sustainability at a practice level.

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### Remote Delivery of Cardiac Rehabilitation can Achieve Equivalent Health-related Quality of Life Outcomes to In-person Methods in Patients With Coronary Heart Disease During COVID-19: A Multi-site Study

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**Background:** In-person exercise-based cardiac rehabilitation (CR) has well-established benefits for health-related quality of life (HRQL) for patients with coronary heart disease (CHD). During COVID-19 pandemic restrictions, remote delivery replaced in-person CR but the impact on HRQL is unclear. This study addresses this gap.

**Methods:** Consecutive patients commencing CR at four sites in one Sydney Local Health District were recruited (n=194) December 2019–October 2020. Remote delivery from March 2020 created a natural comparison group to in-person. HRQL was measured at CR entry and completion using SF-12v3 and linear regression used for analyses.

**Results:** Participants were aged mean 65.94 (SD 10.45) years, were 80.9% male and diagnoses included elective PCI (37.9%), CABG (26.7%), and MI (34.9%) either with PCI (23.6%) or alone (11.3%). Participants received remote 103 (53.1%) or in-person 91 (46.9%;  $\geq$  assessment + 2 sessions) CR, with more completions for in-person (75.8% vs 63.1%,  $p=0.03$ ). Remote participants were more likely to be white than ethnic minority (35.2% vs 13.6%,  $p<0.001$ ), however, there were no differences in baseline HRQL for delivery group after adjustment.

HRQL improved from CR entry to outcome regardless of delivery mode (adjusted). Most improvement occurred in physical function (SMD 6.37, 95% CI 4.81, 7.92), role physical (SMD 5.72, 95% CI 4.29, 7.16) and physical component (SMD 5.77, 95% CI 4.43, 7.12) scores. Least improvement occurred in mental component (SMD 1.65, 95% CI 0.53, 2.78).

**Conclusions:** Remotely delivered CR provides comparable HRQL outcomes to in-person delivery, thus providing a promising alternative. Data are needed on cost-effectiveness, staff, and patient preferences.

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