The purpose of this presentation is to highlight the importance of cardiac rehabilitation and secondary prevention and provide an overview of the evidence and policies that help guide the care that all West Australian should have access to.
What is Cardiac/Cardiovascular Rehabilitation (CR) and Secondary Prevention (SP)?

“Cardiac Rehabilitation describes all measures used to help people with heart disease return to an active and satisfying life and to prevent the recurrence of cardiac events”

(Recommended framework for Cardiac Rehabilitation 2004, National Heart Foundation of Australia and Australian Cardiac Rehabilitation Association)

“…..it involves medical care, control of biomedical and behavioural risk factors, psychosocial care, education and support for self-management”

Notes:

There terms Cardiovascular or Cardiac Rehabilitation or Secondary Prevention can cause some confusion but basically they are similar terms which are often interchanged.

Cardiac/Cardiovascular Rehabilitation is often time-limited and is a component of the Secondary Prevention continuum that is lifelong.

Cardiovascular is often used instead of Cardiac as a more encompassing term for Rehabilitation that is offered to people at high risk of cardiovascular disease or who have peripheral vascular disease.

It doesn’t matter so much which words you use as long as the patient is referred to the services!
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Evidence for Cardiac Rehabilitation and Secondary Prevention
- Improves survival
- Improves functional status, cardiovascular risk profile, quality of life, resulting in fewer psychological disorders and unplanned hospital readmissions
- and saves money
- People with peripheral arterial disease also benefit

Notes:

There is a large body of evidence supporting Cardiac Rehabilitation and Secondary Prevention in terms of survival, functional status, cardiovascular risk profile, readmission rate and cost savings. Similar benefit has been seen in people with peripheral vascular disease.

References:

Important messages:

- CR and SP is part of usual care
- It's everyone's job to help ensure that all patients have access to CR and SP
- CR and SP are as important as medication or surgery
- Must be flexible and accessible
Despite its benefits, referral rates to CR and SP services are suboptimal\(^1\) and participation rates amongst eligible patients are approximately 30\(^2\). Factors influencing access to or attendance at CR and SP services have been identified as transport difficulties, work and social commitments, lack of perceived need, functional impairment\(^3\) and service availability. Some patients are less likely to be referred, such as older patients or those admitted to private hospitals, even though they will generally still benefit from CR or SP.

Recent evidence from the ACS SNAPSHOT study\(^1,\,4\) showed that:

- 27\% acute coronary syndromes patients received optimal in-hospital preventive care.
- ‘Optimal care’ means receiving lifestyle advice, referral to rehabilitation and prescription of secondary prevention drugs.
- People with STEMI (ST elevation myocardial infarction), NSTEMI (non ST elevation myocardial infarction), PCI (percutaneous coronary intervention) /CABG (Coronary artery bypass graft) during admission or history of hypertension were more likely to receive optimal preventive care.
- Older patients (>70yrs) or those admitted to private hospital were less likely to receive optimal care.

References:

Notes:

The recommendations made about CRSP align with WA Health policy, the Cardiovascular and Secondary Prevention Pathway Principles released in May 2014.
Notes:

A significant element of the Pathway Principles was the development of an algorithm to guide assessment and referral to ensure that each person gets the right level of CRSP. Practitioners have fed back that this is a useful resource in the workplace and so it has been developed into a Quick Reference Guide which is also available on-line.
Notes:

On the second page further information and key resources are listed in boxes corresponding to the colour coding on the algorithm.
Notes:

Who is eligible? In the pathway it states those with cardiovascular diagnosis, exacerbation or risk factors, including coronary heart disease (and CABG), valvular heart disease, arrhythmia (e.g. atrial fibrillation), congenital heart disease. As mentioned previously this also includes those with peripheral arterial disease.

Eligibility is all inclusive and meant for:

- Heart patients and those at risk
- Young and old
- Not just patients with acute coronary syndromes
- For primary care and hospitals
Notes:

- **Assessment** commences on presentation and includes evaluation of physical, medical, functional, cognitive and psychosocial needs. Considerations include:
  - clinical status, comorbidities, risk factors, health literacy, potential family involvement/support, whether from a culturally and linguistically diverse (CALD) or Aboriginal group (who require culturally appropriate and safe services), local services, patient commitments (e.g. work, transport) and socioeconomic status.

- **Education** commences on presentation, laying the foundations for self management and is the responsibility of all members of the multidisciplinary health care team. It includes providing resources and exploring options for ongoing services and support. Repeated messages provide a cumulative effect on learning.

- Depending on acuity and length of contact or stay, initial education may be confined to survival education, e.g. symptom management and medications. More in-depth learning about risk factor and self management follows.

- Using standardised **resources** ensures consistency across services and sectors. There is a list of those resources in the Appendix of the CRSP Pathway Principles document.

- Consider using the Cardiac Rehabilitation Needs Assessment Tool (CRNAT), adapted from a tool designed by the team at Royal Perth Hospital as part of the CR redesign research project to engage patients. See web link to Heartonline.
Once a needs assessment has been conducted the level of complexity can be determined. The position on the spectrum helps determine the level of support needed. The intensity and duration of support will vary depending on:

- Needs (physical, medical, functional, cognitive, psychosocial)
- Preferences
- Available resources

This pathway broadly describes three levels of complexity, however individuals can fall/fit anywhere along the spectrum depending on the level of support they require. This ranges from those who are at high risk of a cardiovascular condition to those with complex cardiac conditions requiring specialised support and care. A few criteria have been included to help determine complexity.

- Criteria for lower complexity cardiac condition or needs, include but are not confined to: Length of stay (LOS) in hospital less than or equal to 3 days

- Criteria for higher complexity cardiac condition or needs, include but are not confined to:
  - The need for additional psychosocial support (eg. Isolated, anxious or depressed)
  - Major cardiac event (eg a more complicated ACS, heart failure or arrest) and/or surgery
  - LOS in hospital more than 3 days
  - Complex comorbidities
Notes:

- **A CRSP plan**, developed with the patient/carer, tailors goals and the steps to achieve them. The plan takes account of the person’s level of need, preferences and available resources.

- Referral is the responsibility of the **whole health team** and should be to the service and level most appropriate and accessible to the consumer and carer.

- Effective referral relies on **two-way communication** and should cover all details of the patient journey thus far. The better the handover, the more the consumer and carer are likely to trust the new service provider.

- Structured follow-up with **periodic reassessment and/or case management** provides support for the consumer and/or carer to effectively self–manage their journey along the CRSP pathway. Case management assists in selection of the most suitable components of the pathway by providing links between services.


- Heart-on-line supports clinicians to deliver evidence-based cardiovascular disease prevention and rehabilitation and heart failure management. (Heart Foundation: [www.heartonline.org.au](http://www.heartonline.org.au)). It includes useful and practical tools.
Notes:
Although the core components of CRSP are the same, the intensity and duration vary depending on the consumer’s level of need, preferences and available resources. Those with higher complexity cardiac conditions or needs generally require specialised case management and cardiac rehabilitation or heart failure services. Progress is determined through periodic needs assessment.

Education for self-management strategies & behaviour change
- Education is delivered to increase knowledge and restore confidence and a sense of personal control. Can be face-to-face, by telephone, internet/web, video/DVD. Motivational interviewing techniques are effective. Consistent messages build on initial education and include:
  - Risk factor modification e.g. dietary changes, smoking cessation, weight loss
  - Self-management and health literacy
  - Evidence-based medication use and adherence, dispelling common concerns
  - Symptom control e.g. chest pain action plan.

Exercise
- Ranges from the general promotion of exercise and physical activity to an individually prescribed exercise program.
- Clinical features and risk influence the location, modality and intensity of exercise promoted. Review regularly.
- Other factors influencing selection of locations or modality are: transport, musculoskeletal limitations, functional capacity, psychosocial considerations, previous experiences or personal preference.

Psychosocial support
- Screen for anxiety, depression, other mental health issues. May be pre-existing or related to the event / diagnosis.
- Assess the impact of the external determinants of health eg housing, unemployment, socioeconomic status

Medical follow-up for periodic reassessment of:
- Blood tests eg lipids, blood sugar. BP, weight, reinforce the importance of lifestyle changes and refer if required.
- Optimal medication dosage, adherence and symptom management.
Notes:

This is an example of an outpatient case although Jack could equally be presenting at his GP or to emergency.

Regardless of where he presents, his condition sits at the high complexity end of the spectrum and he would benefit from more intensive support, ideally from a designated cardiac/cardiovascular rehabilitation service in liaison with his GP.
Notes:

This gentleman is assessed as being higher complexity as an inpatient after a STEMI and PCI due to his anxiety and the need for psychosocial support to help him return to work.

In this instance as he is Aboriginal he is eligible for Derbarl Yerrigan Heart Health which he agrees is the best service for him.
Notes:

The only difference between Sam and someone who has proven cardiovascular disease may be that he just hasn’t had an event yet. He will benefit from intervention before it is too late and his GP can help him find the right services in the community.

Although in this example he is presenting to the GP, if he turns up in an outpatient clinic or hospital ward for an unrelated problem, it would be helpful to ask him to go back to his GP to address his cardiovascular risk.
Notes:

In this case Mr X presents to his GP and although he has had a STEMI several months ago, the GP is able to refer him for psychological support under Medicare using a Mental Health plan. This is a good example of a situation where most of his needs can be met in the community; however he did need to be linked into the exercise program of a Cardiac Rehab service.
Notes:

Even though CR/SP is offered after a NSTEMI, some people may not be ready and this patient was initially reluctant to accept CR. This illustrates how the GP is able to help Mrs Y access care after the event.
Notes:

In this case again, the patient has slipped through the net but the GP would have instantly seen that Simon remains at high risk for another cardiac event, was able to assess him and link him back into services, both in the community and from a CR service, even some years after his original STEMI.
Heartonline is an online toolkit designed to support health professionals deliver evidence based care in cardiovascular disease prevention & rehabilitation and heart failure management.
Notes:

The Australian Cardiovascular Health and Rehabilitation Association (ACRA) brought together an expert panel of Australia’s leading cardiac rehabilitation clinicians, researchers and health advocates to review the research evidence. 5 core components for quality delivery and outcomes were identified and are recommended:

1. Equity and access to services,
2. Assessment and short-term monitoring
3. Recovery and longer term maintenance,
4. Lifestyle/behavioural modification and medication adherence
5. Evaluation and quality improvement.

Clinicians should use these core components to guide service delivery and care. Directors of health services should use these core components to aid decision-making about the development and maintenance of these services.

• Heart Foundation website has useful patient resources as well as health professional resources.

• Includes a toolkit developed in Queensland to support health professionals with an action plan of how to improve services and 2 facts sheets outlining evidence and benefits of CR and HF services

• Staff at the Heart Foundation in WA are also available to provide advice 9388 3343
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Notes:

- Additional resources that may be useful
- List of WA CRSP services: ww.acra.net.au/cardiac-rehabilitation-program/cardiac-rehabilitation-program-directories
- Coming soon on the Heart Foundation website - a web-based national directory to find local cardiac rehabilitation or heart failure programs by entering a postcode.
Important messages

- CR and SP is part of usual care
- It’s everyone’s job to help ensure that all patients have access to CR and SP
- CR and SP is as important as medications or surgery
- Must be flexible and accessible
Thankyou

If you have feedback or any concerns, about the content of this presentation or supporting materials please email the Cardiovascular Health Network on healthpolicy@health.wa.gov.au