RE: THO North Cardiac Health and Rehabilitation Submission on the Green Paper

The Cardiac Health and Rehabilitation Program is part of the Northern Area Health Services Launceston General Hospitals Cardiology Department and liaises with the Northern Integrated Care Services which includes a range of community based chronic disease focused multidisciplinary teams including Pulmonary Rehab, Cardiac Rehab, Diabetes, Self-Management and Complex Care Coordination.

This Program undertakes a major clinical role via the provision of inpatient liaison and education, community program rehabilitation and expert clinical case management in partnership with primary care providers for people with coronary artery disease and post cardiac surgery across a broad spectrum including those with multiple chronic conditions living in the community who are at risk of deteriorating health that may result in declining quality of life or avoidable hospital admission.

- Heart disease is the leading single cause of death of men and women in Australia and affects 685,000 people.
- Each year around 55,000 Australians suffer a heart attack.
- One Australian dies nearly every 11 minutes and it is the most expensive to treat.
- Heart Disease affects more than 3.4 million Australians, preventing 1.4 million people from living a full life because of disability caused by the disease.
- From 2012 – 2013 PBS spent 1.8 Billion dollars or 21% and of its total outlay on cardiac patients and accounts for 11% of direct health care expenditure.

On discharge from hospital, every patient should be referred to a cardiac rehabilitation program to start them on the road to recovery and ongoing management of their condition (WHO). But this is not happening. Unlike other health priorities there is no national or state funded action plan to drive improvements in prevention, early detection and management of cardiovascular disease.

The issue

Repeat heart attacks are all too common and costly. A third of all heart attacks in Australia are repeat events and in 2010 the cost of these repeat events exceeded $8 billion. Cardiac rehabilitation can save lives and money, with research showing that it leads to improved patient outcomes, including fewer deaths and hospital readmissions.

Cardiac rehabilitation programs are only effective if people attend. With estimated participation rates as low as 10-30% the benefits of cardiac rehabilitation are not being realised. A recent UK modelling study found that increasing cardiac rehabilitation delivery to 65% of eligible patients resulted in a 10% reduction in
emergency readmissions and saved over £30 million. The key challenges to improve the uptake of cardiac rehabilitation are well established and include:
• lack of referral to cardiac rehabilitation programs
• varied belief and support in the value of cardiac rehabilitation by the clinical profession
• emphasis on traditional cardiac rehabilitation models that can present barriers to patients who are younger, work, live remotely, have cultural or language needs or do not wish to attend a group format
• complex and unstable funding arrangements
• lack of data and performance monitoring.
• adequate dedicated workforce

**Cardiac rehabilitation** is the coordinated system of care necessary to help people with CVD (e.g. heart attack, angina, Chronic Heart Failure CHF or heart surgery) return to an active and satisfying life, and helps to prevent the recurrence of cardiac events or new cardiovascular conditions. It includes and complements the care provided by individual medical specialists and general practitioners (GP). Effective cardiac rehabilitation services include the following components (in addition to appropriate specialist medical care):
• individual assessment
• modification of risk factors
• purpose-designed exercise programs
• health education and counselling
• behaviour modification strategies
• support for self-management.

Care across the cardiac rehabilitation continuum should respond to the individual’s needs and can involve education and support to manage medicines; psychosocial assessment and support; assessment and modification of the home environment; referral to ongoing community-based maintenance programs; development of a personalised care plan; and referral to various services as needed.

The cost-effectiveness of cardiac rehabilitation and multidisciplinary Chronic Heart Failure CHF management is well established. An Australian study estimated that, among patients who have experienced an acute coronary syndrome (heart attack or unstable angina), cardiac rehabilitation costs approximately $42,535 per quality-adjusted life year saved (allowing for the effect on survival), compared with standard care. This level of cost-effectiveness is consistent with the levels accepted by decision-making authorities such as the Pharmaceutical Benefits Advisory Committee.

While traditional cardiac rehabilitation has typically been delivered in the hospital outpatient setting, newer delivery models are increasingly being trialled over longer time frames and in a range of community settings, including general practice. Alternative models, such as telehealth, have been shown to be effective.

Despite strong evidence for the benefits of secondary prevention services, these are currently underutilised in Australia. Among people eligible for cardiac rehabilitation:
• referral rates are low
• fewer than one in three people referred actually attend
• even fewer people participate for the full intended period
• people at highest risk of recurrent disease are least likely to participate in cardiac rehabilitation.

Similarly, it remains a challenge to ensure participation in purpose-designed CHF management services for the people who would benefit.

Limited availability of accessible cardiac rehabilitation and CHF management services in our public and private health sectors is partly due to a lack of dedicated funding for these services. A range of barriers to delivery and uptake has also been documented. These include people’s indifferent perceptions of these services, health professionals’ failure to refer people to available services, inefficient administrative processes, lack of commitment by hospital management and staff, lack of flexibility of services to meet individual needs, and the location of secondary prevention services.

Make sure that adequate funding is allocated to secondary prevention services, including cardiac rehabilitation.

Why is this important?
Within a chronic disease management framework, the secondary prevention of CVD represents a significant proportion of client need and costs. However, current funding for secondary prevention services for CVD and cardiac rehabilitation is fragmented, largely discretionary, and fails to guarantee the continuity of existing services. The resulting uncertainty impedes long-term service planning, prevents the implementation of quality improvement initiatives, and restricts health professionals’ capacity to provide good clinical services.

Currently there are no financial incentives for service providers who routinely promote cardiac rehabilitation attendance among their clients. Similarly, there is no incentive for other providers to improve their practice in this area.

What difference will this make?
Adequate funding for secondary prevention services for CVD will:
• enable services to plan for a predetermined volume of patients and deliver adequate services accordingly
• facilitate the implementation of referral pathways and consolidate systems of care
• facilitate planning for an adequate dedicated workforce
• enable ongoing professional development for staff
• enable efficient data collection for research, outcome monitoring and quality assurance.

What must be done?
• Recognise that secondary prevention services for CVD are a major component of chronic disease management programs and there is need to integrate services and budgets accordingly.

• Revise hospital funding mechanisms to recognise and support cardiac rehabilitation as an indispensable component of hospital care for people with CVD related conditions (e.g. via Case mix coding). Implement consistent use of a hospital record code for cardiac rehabilitation (e.g. ICD10 Z50.0).*

• Ensure adequate funding specifically for administrative support within cardiac rehabilitation services, to enable the optimal allocation of clinical staff time to patient care.
• Establish dedicated funding for cardiac rehabilitation services within primary care (e.g. via Medicare Benefits Schedule items for GPs, nurses and allied health professionals). • Establish a system of incentive payments to:
  – increase rates of referral to cardiac rehabilitation services by primary care providers
  – support ongoing secondary prevention in general practice

Provide flexible secondary prevention service options that are:
• tailored to the needs of populations and individuals
• appropriate to various stages of CVD management (acute, subacute and ongoing care)
• readily accessible via all levels of the health system.

Why is this important?
Current secondary prevention services fail to meet the needs of people at highest risk of recurrent cardiac events, including Aboriginal and Torres Strait Islander people. Attendance rates for cardiac rehabilitation are even lower among the Indigenous population than other Australians, despite the fact that Aboriginal and Torres Strait Islander people are twice as likely to die from CHD.

Mainstream cardiac rehabilitation services are also under-attended by women, younger patients, other ethno cultural minorities, people of lower socioeconomic status and people with mental illness. Access to cardiac rehabilitation services is limited for Australians living in rural and remote regions, while access to other secondary prevention services is limited in all regions.

Australian Cardiac Health and Rehabilitation Association (ACRA) recommend the development of flexible secondary prevention services that are tailored to the needs, preferences and circumstances of patients and their careers. It suggests these services need to be culturally competent, while also being appropriate for their clinical status.

In addition to traditional hospital-based delivery models, effective cardiac rehabilitation can be delivered through home visits, telephone support, telemedicine, specifically developed self-education materials, and combinations of these. Cardiac rehabilitation services should be linked with primary care services, community health services and acute care services to ensure access for patients at all stages of care.

What difference will this make?
Offering a range of flexible secondary prevention options that are linked to all health sectors will:
• increase access to cardiac rehabilitation
• increase uptake of cardiac rehabilitation services by at-risk populations, including people in rural and remote communities, Aboriginal and Torres Strait Islander people, and culturally and linguistically diverse communities
• increase health system efficiencies by maximising the use of existing services and structures.

What must be done?
• Allocate dedicated funding to secondary prevention services, including cardiac rehabilitation

• Fund research to identify the most effective delivery models for various patient groups.

• Develop and support a variety of evidence-based cardiac rehabilitation services, including community-based services that deliver cardiac rehabilitation via home visits, telephone, and other methods that suit patient circumstances (e.g. enabling care delivery on a drop-in basis during half-day open sessions in community settings).

• In consultation with local communities, design cardiac rehabilitation services that particularly target population groups that do not participate in services currently offered, including women, younger patients, Aboriginal and Torres Strait Islander people, and culturally and linguistically diverse communities.

• Establish and support effective cardiac rehabilitation outreach services for Aboriginal and Torres Strait Islander people in remote regions.

• Streamline links between acute and primary care sectors to improve collaboration in the ongoing care of patients with CVD and referral rates to existing and new cardiac rehabilitation services. Develop well-defined pre- and post-discharge protocols in acute care services to make sure that patients receive appropriate follow up. Address access barriers by assessing patient needs as early as possible during the hospital stay and identifying an appropriate referral option before discharge.

• Establish strong collaboration and efficient referral pathways between mainstream health services and Aboriginal community-controlled health services.

• When planning secondary prevention services, particularly cardiac rehabilitation services:
  – involve cardiologists and GPs
  – use existing local resources
  – involve Aboriginal and multicultural health workers where appropriate
  – develop women-only groups if appropriate
  – develop patient resources in languages other than English
  – consider practical factors affecting ease of access (e.g. session times, transport and parking).

• Ensure training in cultural competency for all non-Indigenous health professionals who provide cardiac rehabilitation and secondary prevention services for Aboriginal and Torres Strait Islander people.

• Ensure access to language interpreters as required.

• Ensure that people receive culturally appropriate education materials to support self-management.

Integrate secondary prevention into the patient journey for all people with CVD and include cardiac rehabilitation as a standard component of care for everyone with CHD.
Why is this important?
To make sure that all eligible people are referred to suitable cardiac rehabilitation services, these services must be integrated into the patient journey and not seen as extra options outside mainstream healthcare. This involves making sure that patient and their careers are aware of and expect cardiac rehabilitation as a standard service, and that healthcare providers at all levels of the health system collaborate to provide and promote these services routinely.

Effective cardiac rehabilitation must be integrated with ongoing management provided within primary, community and acute healthcare services, all of which must support people to self-manage their chronic disease (e.g. taking medicines, following lifestyle management advice, and monitoring and interpreting symptoms).

What difference will this make?
Making sure that evidence-based cardiac rehabilitation is integrated into all services at the policy level will:
• make cardiac rehabilitation standard practice
• make sure that eligible people are routinely referred to effective cardiac rehabilitation services
• help to promote equal access to services for all eligible people
• help to make sure that services meet or exceed a defined minimum standard of care
• increase community awareness of the benefits of cardiac rehabilitation
• raise people’s expectations of, and demand for, cardiac rehabilitation services.

What must be done?
• Incorporate referral to cardiac rehabilitation services into formal, standardised health service protocols (‘clinical pathways’ or ‘patient pathways’) as a mandatory element of care for all eligible people with CVD. Enable such pathways to be adapted to local needs, including the needs of Aboriginal and Torres Strait Islander people.
• Incorporate referral to cardiac rehabilitation into formal practice standards and quality indicators within all jurisdictions.
• Establish protocols within acute hospital services to make sure that discharge planning occurs early during the patient’s stay. This will enable the healthcare team to identify the most appropriate cardiac rehabilitation option and to work with patients and their primary care providers to encourage attendance.
• Establish a national system of electronic patient records to facilitate efficient communication between healthcare providers and streamline the patient journey.
• At stakeholder level, advocate for the development of a national plan for the implementation of these pathways.
• Develop and implement key performance indicators that effectively monitor the success (e.g. percentage of eligible patients referred to and participating in programs) and outcomes (e.g. program completion rates) of cardiac rehabilitation referral systems.

Develop and fund a framework for comprehensive secondary prevention of CVD within primary care.

Primary care is an important setting for the care of people with chronic and/or complex care needs, including the secondary prevention of CVD. Health
professionals in primary care settings have a pivotal role to play in identifying eligible people, referring people to cardiac rehabilitation, and managing people with CVD according to guideline recommendations.

However, significant management gaps exist in the care of people with CVD in primary care. These gaps are a major contributor to unnecessary morbidity, mortality and cost to the Australian healthcare system. People at high risk of a cardiovascular event, including people with CVD, remain under-treated in Australian general practice. The Heart Foundation’s review of management gaps for the treatment of CHD in general practice found significant disparities between guideline recommendations and actual clinical practice in Australia. For example, preliminary baseline data from the Australian Primary Care Collaborative (APCC) show that, at best, blood pressure is treated to target in only 48% of patients with CHD.

Modelling has shown that improved interventions in general practice for Australians with CHD could reduce coronary events by as much as 15% and coronary deaths by 17%. Modelling also suggests that a comprehensive CHD program has the potential to save between 7,576 and 23,554 disability-adjusted life years, with a relatively modest financial investment. The National heart foundation recommend the implementation of a national comprehensive approach to CVD management in primary care, with appropriate funding arrangements.

In Australia, there has been a substantial shift in the payment system for GPs towards incentives that encourage evidence-based care of patients with chronic diseases in line with a disease management framework that emphasises systematic, coordinated care and self-management. The Australian government’s commitment to a National Primary Health Care Strategy provides an opportunity to establish primary care systems and funding models to enable people who are at high risk of a cardiovascular event (e.g. heart attack or stroke) to be identified early for preventive care. It also supports better care for people with an existing cardiovascular condition.

What difference will this make?
A well-developed primary care framework for the secondary prevention of CVD will:
• increase referral rates to secondary prevention services
• overcome the current problem of discontinuity of care when patients are not followed up after discharge from acute services
• enable some components of cardiac rehabilitation to be delivered by GPs and practice nurses and allied health in primary care
• support GPs and practice nurses in effectively coordinating secondary prevention services delivered by a local multidisciplinary team.

* What must be done?
• Increase rates of referral by general practice to secondary prevention services by:
  – strengthening links between primary care and acute/subacute services involved in delivering secondary prevention services
  – establishing effective referral pathways.

  • Establish a dedicated general practice program for CVD to increase identification rates and improve management. Such a program should:
    – use disease registers to manage patient recall and monitoring
– promote the use of care plans that incorporate lifestyle risk factor management, evidence-based pharmacotherapy, appropriate referral to other providers, and self-management support for patients
– involve financial incentives to improve the quality of care (e.g. practice incentive payments like those applicable to other chronic disease conditions such as diabetes and asthma)
– build on existing chronic disease and quality care initiatives in general practice, including the Australian Primary Care Collaborative Program and Practice Incentives Program
– support and delineate the roles of practice nurses in secondary prevention – be implemented through general practice organisations (divisions of general practice and general practice networks).

• Train and support GPs to make full use of existing Medicare Benefits Schedule chronic disease management items for primary care coordination of multidisciplinary care (general practice management plans and team care arrangements, including GP items and practice nurse and Aboriginal health worker monitoring and support) for secondary prevention of CVD.

• Scope the needs for the delivery of secondary prevention services for CVD through Medicare Locals.

Implement systems to make sure that mental health is assessed in everyone with CVD and that people receive effective mental healthcare.

Why is this important?
Comprehensive secondary prevention of CVD involves identifying people with, or at risk of developing, mental health disorders and providing or arranging referral to effective assessment and management. Health providers caring for people with CVD need to be aware of the following facts.

• Depression is highly prevalent in people with CHD, including people with myocardial infarction (heart attack) and unstable angina, and people undergoing revascularisation procedures or heart valve surgery. Overall, depression is about three times more common in cardiac patients than in the general population, and even higher in people with CHF.

• Approximately 15–20% of people hospitalised with acute myocardial infarction (heart attack) meet formal diagnostic criteria for major depression. An even higher proportion of people show elevated levels of depressive symptoms when they undergo screening using self-report inventories.

• Studies in outpatient and primary care settings show that rates of depression in the community are higher among people living with CHD compared with people without diagnosed CHD.

• Depression often coexists with other mental health disorders, such as anxiety, which may worsen cardiovascular outcomes. These other mental health disorders should be assessed and managed by an appropriately trained mental health professional.
• There is a strong, consistent inverse relationship between the quality of social support and both the development of CHD in initially healthy people and adverse prognostic outcomes in people with existing CHD. Social isolation and lack of social support often co-occur with mental health disorders and are significant risk factors for CVD.

• Despite their high risk for poor outcomes, people with, or at high risk of developing, mental health disorders, such as depression, are less likely to attend cardiac rehabilitation services than other eligible people.

• People with comorbid mental health disorders are less likely than people without mental health disorders to modify their cardiovascular behavioural risk factors, such as smoking, physical inactivity and unhealthy eating, and are less likely to take their medicines as prescribed.

• Healthcare utilisation and costs are higher in people with comorbid mental health disorders.

• Among people with cardiac conditions, the presence of a comorbid mental health disorder is associated with reduced quality of life. People from the following groups may be at particular risk of coexisting CVD and mental health disorders
  • People with severe mental health disorders
  • Aboriginal and Torres Strait Islander people
  • Women
  • People who are socially isolated

What difference will this make?
Systematic identification and management of cardiac patients with, or at high risk of developing, mental health disorders will:

• make sure that unrecognised and previously undiagnosed mental health disorders are not a barrier to attending cardiac rehabilitation and secondary prevention programs • reduce delays in diagnosis and treatment for depression, anxiety and other mental health disorders

• reduce the risk that unrecognised and untreated comorbid mental health disorders adversely impact on the secondary prevention outcomes for cardiac patients. While there is currently no direct evidence that screening for and treatment of depression and anxiety disorders leads to improved CVD morbidity and mortality, comprehensive care involves identification and treatment of these serious and debilitating conditions.

What must be done?
• Develop national clinical practice guidelines for the care of patients with CHD and comorbid mental health disorders (e.g. depression and anxiety) that include recommendations on screening, clinical assessment, diagnosis and treatment (pharmacological and psychological). These guidelines should:
  – take into account health system, provider and patient issues across the patient journey (including acute, subacute and ongoing care settings)
  – be developed through a consultation process involving cardiology, mental health and public health experts
– take into account national health reform initiatives such as the Better Access Initiative (better access to psychiatrists, psychologists and GPs through the MBS)† and the National Primary Health Care Strategy, as well as initiatives for mental health, such as beyondblue‡ and the Cardiac Depression Collaborative Australia.

• Establish clear protocols to make sure that anyone in whom a mental health disorder is identified or suspected during contact with CVD services is referred to appropriate care providers for further assessment and treatment (including psychological, medical and pharmacological management).

• Establish referral and consultation links between acute, subacute and community-based CVD services and specialist mental health professionals (psychiatrists and clinical psychologists) who are trained and experienced in working with people with comorbid cardiovascular conditions.

• Provide adequate training and clinical supervision for cardiology health professionals in all settings to equip them with skills to screen people for mental health disorders and collaborate with mental health providers in caring for people with comorbid mental health disorders and CVD.

Establish a system of professional development and recognition for health professionals delivering secondary prevention services, and support them to perform their role within a flexible workforce model.

Health professionals delivering evidence-based secondary prevention services need specific knowledge and skills in addition to their professional qualification (e.g. degree diploma or certificate of registration) and discipline (e.g. medicine, nursing, Aboriginal health, physiotherapy, occupational therapy, exercise physiology, psychology, social work, pharmacy or dietetics).

Professional development necessary for cardiac rehabilitation and CHF management services staff may include training in adult education, physical activity programs, cultural competence, case management, motivational interviewing and cognitive behaviour therapy. In particular, designated coordinators of multidisciplinary cardiac rehabilitation services4 need to have knowledge of CVD, health promotion, program planning and evaluation, and access to ongoing professional development.

Delivery models for secondary prevention must be flexible to allow for diversity in the workforce and clinical settings, including acute, subacute, primary care and other community-based services. Effective secondary prevention of CVD involves the coordination of a multidisciplinary team, which may be co-located or consist of a network of collaborating providers. For people working in rural and remote regions, who may be the sole trained health professional delivering this ongoing care, secondary prevention may be coordinated through referral and support from specialists at regional health services.

Administrative inefficiencies in the delivery of secondary prevention services can reduce the time available to staff to provide clinical services, and impede the development and implementation of improvements.
What difference will this make?
A system of professional recognition and support for health professionals delivering cardiac rehabilitation services will:
• increase the capacity of existing services
• improve the quality of care
• strengthen the workforce by improving staff retention rates
• increase job satisfaction.

What must be done?
• Establish a system of formal professional recognition for health professionals delivering cardiac rehabilitation services. Such recognition for various disciplines may involve:
  – credentialing
  – agreed minimum standards
  – a system of annually reviewed core competencies, developed and administered by relevant professional associations
  – clearly delineated career pathways in secondary prevention.

• Set up and adequately fund an ongoing and robust system for professional development in secondary prevention of CVD that is:
  – responsive to the demands of evolving secondary prevention services
  – accessible to all disciplines
  – recognised by all relevant professional associations, which would have responsibility for determining, monitoring and reviewing core competencies.

• Clearly delineate the roles and responsibilities of all staff involved in secondary prevention services.

• Establish a framework for quality improvement that involves documenting, monitoring and reporting work processes and protocols that promote best practice.

• Through a system of increasing remuneration, reward staff who acquire and maintain professional qualifications and who work long term in secondary prevention services.

Develop educational resources for patients and carers that:
• are accessible, credible and standardised
• can be provided through various media
• target a range of literacy levels
• can be adapted to meet the needs of ethno culturally diverse communities.

Why is this important?
Current recommendations for the ongoing management of CVD emphasise the importance of self-management, which requires clear and readily accessible information for patients and their careers. Secondary prevention services have adopted disparate self-management information resources for patients. Literacy levels are inconsistent, information is not standardised or regularly updated, and dissemination is often ad hoc. Access to this information is limited for remote communities and Aboriginal and Torres Strait Islander people.
What difference will this make?
Nationwide availability of standardised, credible information resources will:
• lead to better harmonisation between services
• promote more systematic dissemination of information
• benefit people who access multiple services
• better target under-served populations
• reduce duplication costs by avoiding the need for each service to develop its own materials
• ensure currency and accuracy of information.

What must be done?
• Undertake a national audit of information resources currently used by secondary prevention services, evaluating their quality and identifying gaps.

• Determine which formats, media and technologies will enable the most effective communication with each of the various target populations.

• Allocate adequate funding to develop, disseminate and promote standardised information in all states and territories.

• Establish a portal (e.g. a dedicated website) to enable people with CVD, carers and health professionals to access information and download or order resources.

Regards

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