Government of **Western Australia**
Department of **Health**

Cardiovascular rehabilitation and secondary prevention

Quick reference guide for health professionals

Important Messages:

- Cardiovascular rehabilitation and secondary prevention (CRSP) saves lives, improves quality of life and reduces unplanned hospital admissions.
- CRSP must be considered part of usual care.
- All healthcare professionals have a role to play in ensuring that patients have access to CRSP.
- CRSP involves:
  - Education, self-management and behaviour change
  - Exercise
  - Psychosocial support
  - Medical follow-up.

Resources for Health Professionals:

(See back page for resources for consumers and their families.)

- Heart online (**H**eart **E**ducation **A**ssessment **R**ehabilitation **T**oolkit for health professionals): www.heartonline.org.au
- Heart Foundation WA Cardiac Rehabilitation Secondary Prevention Services Directory: www.acra.net.au/cr-services/cr-directory
- Peak health professional body, The Australian Cardiovascular Health and Rehabilitation Association: www.acra.net.au
- Core components of CRSP – new release: www.sciencedirect.com/science/article/pii/S1443950614008221
- Heart Foundation: www.heartfoundation.org.au

Information for this quick reference guide is taken from the *Cardiovascular Rehabilitation and Secondary Prevention Pathway Principles for Western Australia.* For the full document (and other supporting/useful information) go to: www.healthnetworks.health.wa.gov.au/docs/1405_CRSP_Pathway_Principles_WA.pdf

Have your say. We would welcome your feedback on the CRSP Quick Reference Guide and supporting resources by emailing Health Networks on healthpolicy@health.wa.gov.au. Feedback will be reviewed by an expert working group.

Cardiovascular Rehabilitation and Secondary Prevention Pathway Principles

Cardiovascular Diagnosis, Exacerbation or Risk Factors

Including Coronary Heart Disease (and Coronary Artery Bypass Graft), Heart Failure, Valvular Heart Disease, Arrhythmia (e.g. AF), Congenital Heart Disease.

Primary Care

Hospital Presentation
Emergency Department, Outpatient, Admission

● Needs Assessment, Education and Resources ●

Assessment on presentation by Nurse (Ward or Primary Care), Allied Health, Aboriginal Health Professional, GP and/or Medical team to determine individual needs, assess self-management capacity and commence education (see section 5a of the full document for additional information).

▲ Spectrum of Complexity ▲

At risk of cardiac condition (Moderate to high absolute risk)

Lower complexity cardiac condition or needs

Considerations include, but not confined to:

- Independent
- Length of stay in hospital less than or equal to three days.

Higher complexity cardiac condition or needs

Considerations include, but not confined to:

- Needs additional psychosocial support (e.g. isolated, anxious, depressed)
- Major cardiac event and/or surgery
- Length of stay in hospital more than three days
- Complex co-morbidities.

◆ Referral ◆

Referral: by GP, Primary Care Nurse, Aboriginal Health Professional to secondary prevention service(s) most acceptable to the person.

♥ Secondary Prevention and Ongoing Care ♥

Education, Self-management and Behaviour Change

Individual Consultation and/or Chronic Disease/ Secondary Prevention / Healthy Lifestyle Program by GP, Primary Care Nurse, Allied Health and/or Aboriginal Health Professional.

Exercise

Community-based exercise program and/or Individual exercise advice

Psychosocial Support

- Peer support group
- Individual consultation

By GP, Primary Care Nurse, Allied Health, Aboriginal Health Professional and/or Psychologist.

Medical Follow-up

Regular GP visits.

◆ Referral and Case management ◆

Referral: by Nurse, Allied Health, Aboriginal Health Professional or Medical team to specialised cardiac rehabilitation service(s) most acceptable to the person.

Case Management: by Cardiac Rehabilitation Coordinator, Heart Failure Nurse, telephone-based service provider or other **before discharge or within the week after, to assess and plan early commencement of rehabilitation.**

♥ Cardiac Rehabilitation and Ongoing Care ♥

Education, Self-management and Behaviour Change

Specialised group, individual and/or telephone education.

Exercise

Specialised group and/or specialised individual exercise advice. Hospital-based if clinically indicated or at patient's request.

Psychosocial Support

- Group Education Sessions (and/or peer support)
- Individual Consultation (face-to-face or telephone)

By Case Manager, Allied Health and/or Psychologist.

Medical Follow-up

Cardiology follow-up appointment post discharge and thereafter as required. GP follow-up within one week post discharge, thereafter as required.

Periodic reassessment

Clinical judgement or patient request supersedes the secondary prevention/ cardiac rehabilitation pathway.

Cardiovascular Diagnosis, Exacerbation or Risk Factors

Cardiac Rehabilitation Secondary Prevention (CRSP) services start at the first point of contact, whether on presentation to a General Practitioner, a visit to outpatients or admission to hospital. All persons with cardiovascular disease are suitable for CRSP interventions to reduce future cardiac events and improve quality of life.

● Needs Assessment, Education and Resources ●

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

▲ Spectrum of Complexity ▲

◆ Referral and Case Management ◆

- A **CRSP plan**, developed with the patient/carer, tailors goals and the steps to achieve them. The plan takes into account the person's level of need, preferences and available resources.
- **Referral** is the responsibility of the **whole health team** and is 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 re-assessment 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.
- A directory of cardiac rehabilitation secondary prevention services in Western Australia is compiled regularly and is accessible at www.acra.net.au/cr-services/cr-directory
- Heart-on-line (www.heartonline.org.au) supports clinicians to deliver evidence-based cardiovascular disease prevention and rehabilitation and heart failure management. It includes useful and practical tools.

♥ Secondary Prevention and Cardiac Rehabilitation and Ongoing Care ♥

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 and behaviour change

- Education is delivered to increase knowledge and restore confidence and a sense of personal control.
- Can be face-to-face, use telephone, internet/web-based, video/DVD, motivational interviewing techniques.
- 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 e.g. housing, unemployment, socioeconomic status.

Medical follow-up for periodic reassessment of:

- Blood tests e.g. lipids, blood sugar, BP, weight. Reinforce importance of lifestyle changes and refer if required.
- Optimal medication dosage, adherence and symptom management.

Cardiovascular rehabilitation and secondary prevention: Contacts and resources for carers, consumers and their families

Healthy living in Western Australia

- Your gateway to health services and information in WA: www.healthywa.wa.gov.au
- Heart Foundation's Health Information Service provides free personalised information and support on heart health, healthy eating, and active living: www.heartfoundation.org.au or call 1300 36 27 87.
- Smoking cessation support: www.quit.org.au

Eating well

- The Australian Dietary Guidelines: www.eatforhealth.gov.au
- Healthy eating and cardiovascular health: www.heartfoundation.org.au/healthy-eating

Achieving and maintaining a healthy weight and active lifestyle

- Taking small steps to improve your health: www.livelighter.com.au
- Keeping active with a heart condition: www.heartmoves.org.au
- Heart disease and diabetes: www.diabeteswa.com.au
- Aboriginal health and diabetes: www.aboriginalhealthdiabeteswa.com.au
- Heart Foundation Walking groups: http://walking.heartfoundation.org.au
- My Healthy Balance – a free, interactive, online healthy lifestyle program: www.myhealthybalance.com.au
- Get on Track Challenge – a free, online, team-based challenge to help you increase your daily physical activity and fruit and vegetable intake: www.getontrackchallenge.com.au

Staying happy and connected to others

- Social and emotional wellbeing: www.actbelongcommit.org.au
- Talk it through when things get tough: www.beyondblue.org.au
- Adjusting after a cardiac event: The Cardiac Blues Project – www.heartresearchcentre.org/research/the-cardiac-blues-project

Managing your medication

- Medication advice: www.nps.org.au
- Anti-platelet medication advice card: www.healthnetworks.health.wa.gov.au/projects/medication_card.cfm

Find your local support network

- Cardiac rehabilitation support: www.heartfoundation.org.au
- Exercise physiologist: www.exerciseright.com.au/find-us
- Heart Support Australia: www.heartnet.org.au
- Dietitian: www.daa.asn.au/for-the-public/find-an-apd
- Physiotherapist: www.physiotherapy.asn.au/apawcm/controls/findaphysio.aspx

This document can be made available in alternative formats on request for a person with a disability.

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