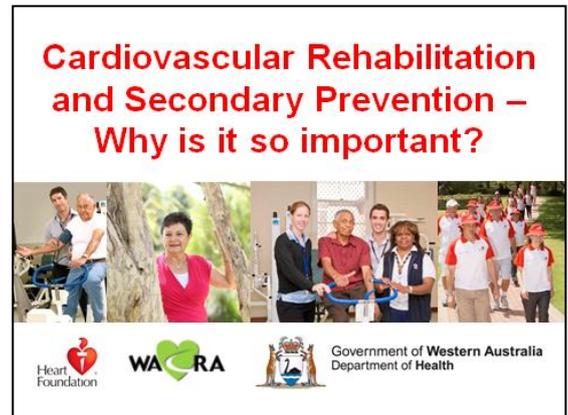


# Background Information for CRSP slide kit

Slide 1



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.

# Background Information for CRSP slide kit

## Slide 2

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



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### Notes:

What are 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"

(National Heart Foundation of Australia. Secondary prevention of cardiovascular disease. Nine key action areas. 2010)

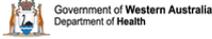
# Background Information for CRSP slide kit

Slide 3

**I'm confused, is it Cardiovascular or Cardiac Rehabilitation or Secondary Prevention?**

- These are all similar terms which are often interchanged.
- Cardiac/Cardiovascular Rehabilitation is often time-limited, 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 what you call it as long as the patient gets referred for it!*

## 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!

### Evidence for Cardiac Rehabilitation and Secondary Prevention

- Improves survival <sup>1,4</sup>
- Improves: functional status, cardiovascular risk profile, quality of life, resulting in fewer psychological disorders and unplanned hospital readmissions <sup>6,7</sup>
- and saves money <sup>4,8</sup>
- People with peripheral arterial disease also benefit<sup>9</sup>



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### Notes:

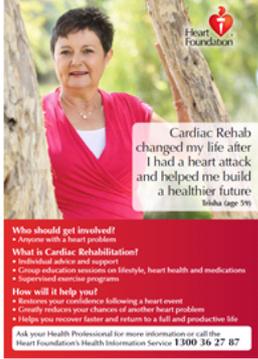
There is a large body of evidence supporting Cardiac Rehabilitation and Secondary Prevention in terms of survival, functional status, cardiovascular risk profile, readmission rate and cost savings. Similar benefit has been seen in people with peripheral vascular disease.

### References:

1. Clark AM, Hartling L, Vandermeer B, McAlister FA. Meta-analysis: secondary prevention programs for patients with coronary artery disease. *Annals of Internal Medicine* 2005;143:659-72.
2. Lawler PR, Filion KB, Eisenberg MJ. Efficacy of exercise-based cardiac rehabilitation post-myocardial infarction: A systematic review and meta-analysis of randomized controlled trials. *American Heart Journal* 2011;162:571-84.
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7. Clark R, Conway A, Puolsen V, Keech W, Tirimacco R, Tideman P. Alternative models of cardiac rehabilitation: a systematic review (published online before print) (online). *European Journal of Preventive Cardiology* 2013 (cited 2013 September 2); 13 August 2013. Available from: <http://cpr.sagepub.com/content/early/2013/08/13/2047487313501093>.
8. Michael Kaiser, Mel Varvel, Patrick Doherty. Making the case for cardiac rehabilitation: modelling potential impact on readmissions. NHS Improvement, Leicester; 2013.
9. Lakshmanan R, Hyde Z, Jamrozik K, Hankey GJ, Norman PE. Population-based observational study of claudication in older men: the Health in Men Study. *Medical Journal of Australia* 2010;192:641-5.

# Background Information for CRSP slide kit

Slide 5



**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

**Who should get involved?**  
• Anyone with a heart problem

**What is Cardiac Rehabilitation?**  
• Individual advice and support  
• Group education sessions on lifestyle, heart health and medications  
• Supervised exercise programs

**How will it help you?**  
• Restores your confidence following a heart event  
• Greatly reduces your chances of another heart problem  
• Helps you recover faster and return to a full and productive life

Ask your Health Professional for more information or call the Heart Foundation's Health Information Service 1 300 36 27 87

Heart Foundation WACRA Government of Western Australia Department of Health

Notes:

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

### What is the problem?

CR programs are effective if people attend... **BUT** participation rates can be as low as 10 - 30%.

### Recent evidence (SNAPSHOT study):

- **27%** acute coronary syndrome patients received optimal in-hospital preventive care.
- 'Optimal care' means receiving lifestyle advice, referral to rehabilitation and prescription of secondary prevention drugs.
- STEMI, NSTEMI, PCI/CABG during admission or history of hypertension were **more** likely to receive optimal preventive care.
- Older patients (>70yrs) or admitted to private hospital = **less** likely to receive optimal care.



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### Notes:

Despite its benefits, referral rates to CR and SP services are suboptimal<sup>1</sup> and participation rates amongst eligible patients are approximately 30%<sup>2</sup>. 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<sup>3</sup> 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<sup>1, 4</sup> 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:

1. Chew DP, French J, Briffa TG, Hammett CJ, Ellis CJ, Ranasunghe I, et al. Acute coronary syndrome care across Australia and New Zealand: the SNAPSHOT ACS study. *Medical Journal Australia* 2013;199 (3):185-91.
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4. Redfern J, Hyun K, Chew DP, Astley C, Chow C, Aliprandi-Costa B, Howell T, Carr B, Lintern K, Ranasinghe I, Nallaiah K, Turnbull F, Ferry C, Hammett C, Ellis CJ, French J, Brieger D and Briffa T. (2014) Prescription of secondary prevention medications, lifestyle advice and referral among acute coronary syndrome inpatients: results from a large prospective audit in Australia and new Zealand, *Heart*, 100(16), 1281-8.

# Background Information for CRSP slide kit

Slide 7

**What policy do we have?**

- [http://www.healthnetworks.health.wa.gov.au/docs/1405\\_CRSP\\_Pathway\\_Principles\\_WA.pdf](http://www.healthnetworks.health.wa.gov.au/docs/1405_CRSP_Pathway_Principles_WA.pdf)

plus

- Quick Reference Guide and Consumer information sheet  
...insert link



Heart Foundation

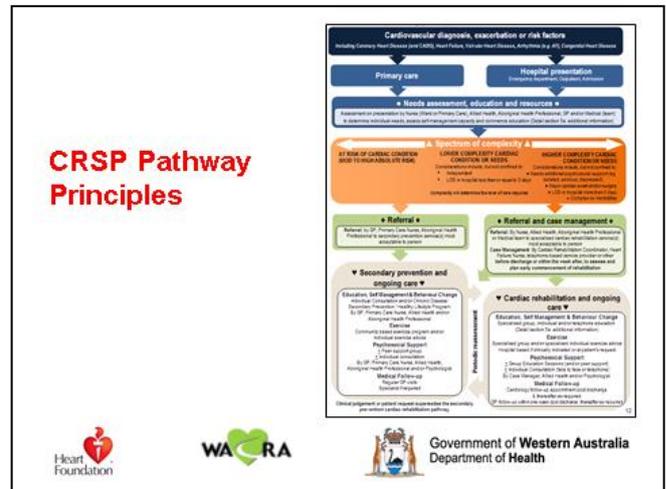
WACRA

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Notes:

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

# Background Information for CRSP slide kit

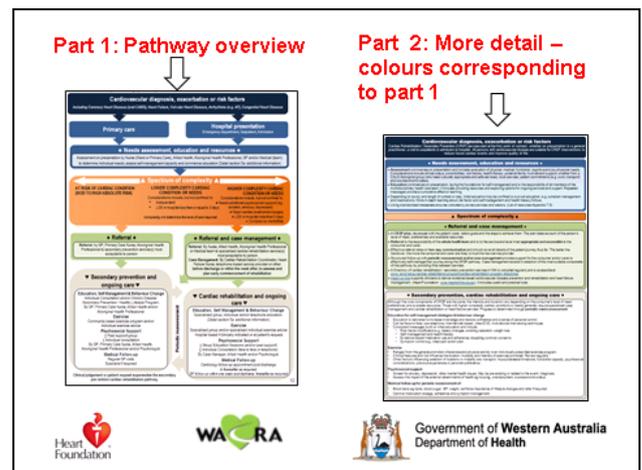


Notes:

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.

# Background Information for CRSP slide kit

Slide 9



Notes:

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

**Who is eligible ?**  
As stated in the pathway....

**Cardiovascular Diagnosis, Exacerbation or Risk Factors**  
Including Coronary Heart Disease (and CABG), Heart Failure, Valvular Heart Disease, Arrhythmia (e.g. AF), Congenital Heart Disease

- All inclusive
- Heart patients and those at risk
- Young and old
- Not just patients with Acute Coronary Syndrome
- For primary care and hospitals

## 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

**• Needs Assessment, Education and Resources •**

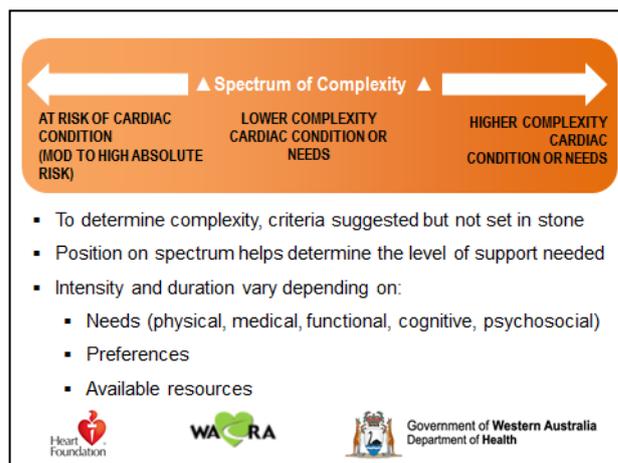
Assessment on presentation by Nurse (Ward or Primary Care), Allied Health, Aboriginal Health Professional, GP and/or Medical (team) to determine individual needs, assess self-management capacity and commence education (Detail section 5a: additional information)

- This is where education starts and resources are provided
- All health professionals have a role to play here
- Reinforcement by many members of health care team is important
- Consider an assessment tool such as CRNAT  
<http://www.heartonline.org.au/SiteCollectionDocuments/Cardiac%20rehab%20needs%20assessment%20tool.pdf>

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Department of Health

### 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.



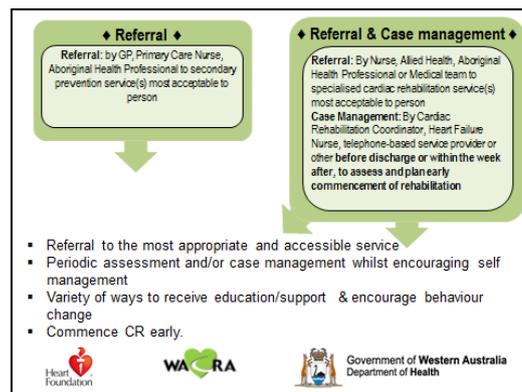
### Notes:

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

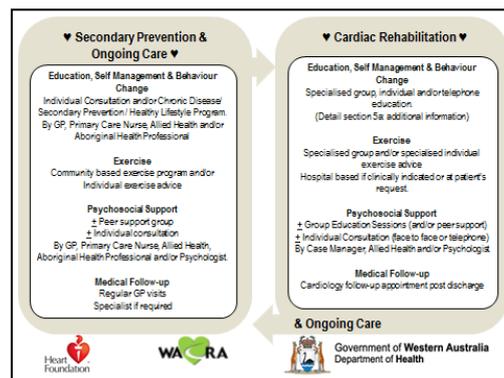
This pathway broadly describes three levels of complexity, however individuals can fall/fit anywhere along the spectrum depending on the level of support they require. This ranges from those who are at high risk of a cardiovascular condition to those with complex cardiac conditions requiring specialised 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.
- A directory of cardiac rehabilitation secondary prevention services in WA is compiled regularly and is accessible at <http://www.acra.net.au/cr-services/cr-directory/>
- 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

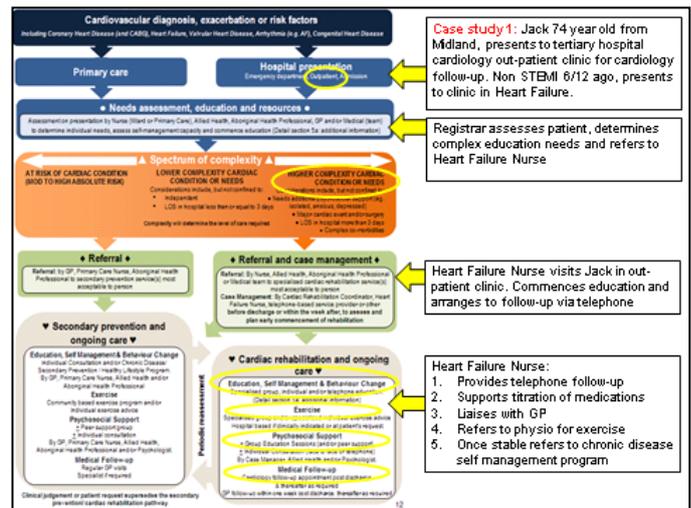
- Screen for anxiety, depression, other mental health issues. May be pre-existing or related to the event / diagnosis.
- Assess the impact of the external determinants of health eg housing, unemployment, socioeconomic status

### 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.

# Background Information for CRSP slide kit

Slide 15



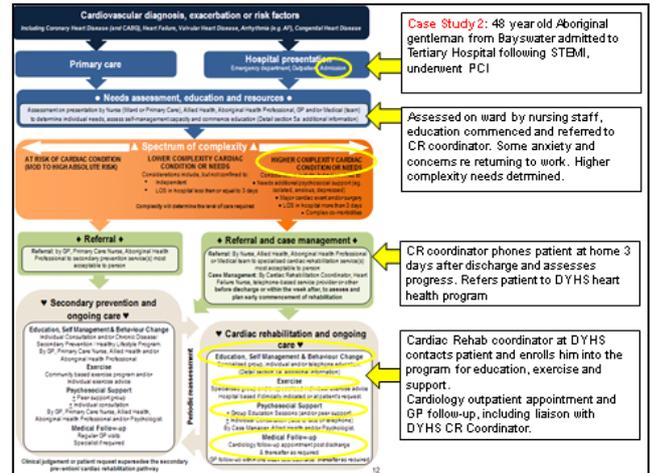
Notes:

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.

# Background Information for CRSP slide kit

Slide 16



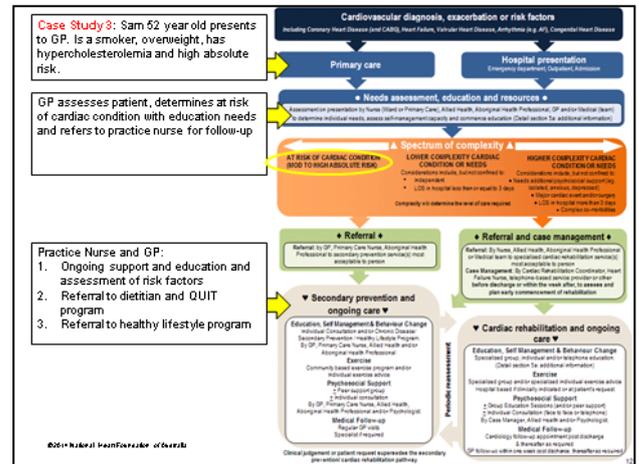
Notes:

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.

# Background Information for CRSP slide kit

Slide 17



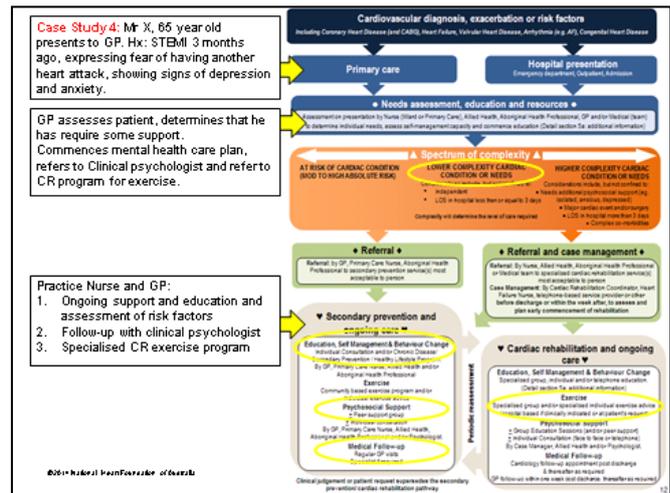
Notes:

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.

# Background Information for CRSP slide kit

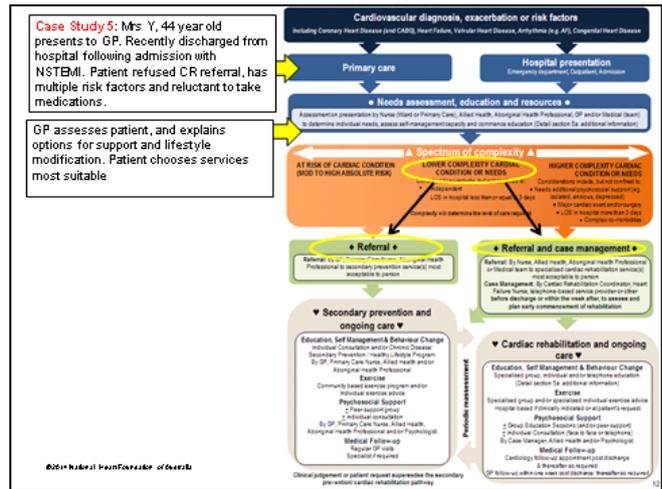
Slide 18



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.

# Background Information for CRSP slide kit

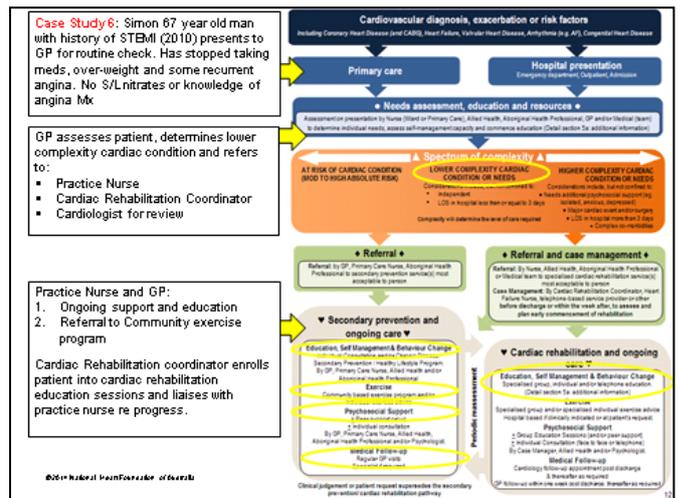


Notes:

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.

# Background Information for CRSP slide kit

Slide 20



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.

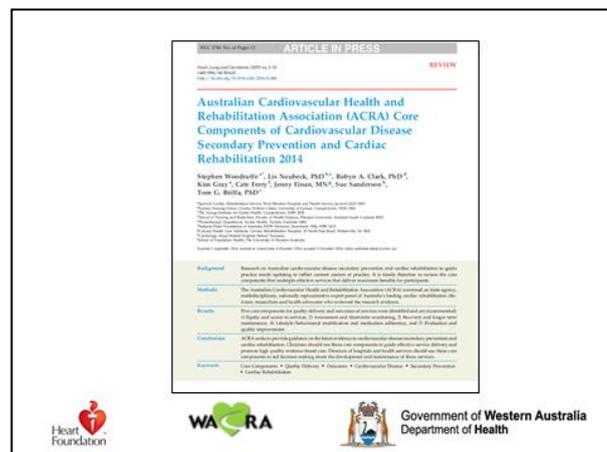
# Background Information for CRSP slide kit

Slide 21



Notes:

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.

Woodruffe, S., Neubeck, L., Clark, R., Gray, K., Ferry, C., Finan, J., Sanderson, S., Briffa T. (2015). Australian Cardiovascular Health and Rehabilitation Association (ACRA) Core Components of Cardiovascular Disease Secondary Prevention and Cardiac Rehabilitation 2014. *Heart, Lung and Circulation* xx, 1–12. <http://dx.doi.org/10.1016/j.hlc.2014.12.008>

# Background Information for CRSP slide kit

Slide 23



Notes:

- 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

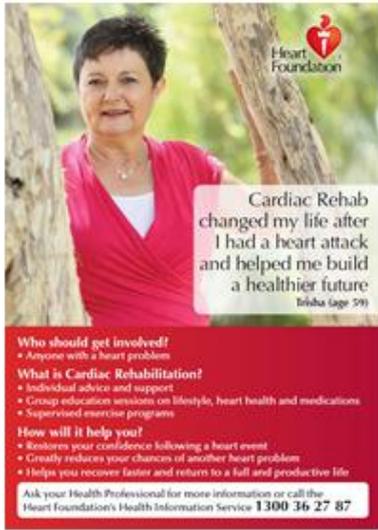
# Background Information for CRSP slide kit

Slide 24



## Notes:

- Additional resources that may be useful
- List of WA CRSP services: [ww.acra.net.au/cardiac-rehabilitation-program/cardiac-rehabilitation-program-directories](http://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.



**Heart Foundation**

Cardiac Rehab changed my life after I had a heart attack and helped me build a healthier future  
Bibha Gage 59

**Who should get involved?**  
• Anyone with a heart problem

**What is Cardiac Rehabilitation?**  
• Individual advice and support  
• Group education sessions on lifestyle, heart health and medications  
• Supervised exercise programs

**How will it help you?**  
• Restores your confidence following a heart event  
• Greatly reduces your chances of another heart problem  
• Helps you recover faster and return to a full and productive life

Ask your Health Professional for more information or call the Heart Foundation's Health Information Service **1300 36 27 87**

**Heart Foundation** **WACRA** **Government of Western Australia Department of Health**

## 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](mailto:healthpolicy@health.wa.gov.au)



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