Secondary Prevention and Cardiac Rehabilitation, Australia Strategy Roundtable

Canberra, Australia

16th October 2019

ACvA Australian Cardiovascular Alliance | ACRA Australian Cardiovascular Health and Rehabilitation Association | Heart Foundation | SPA Secondary Prevention Alliance | The University of Sydney Westmead Applied Research Centre

Agenda

- Welcome and background
- Priorities for implementation
- Priorities for research
- Action planning and next steps

ACvA Australian Cardiovascular Alliance | ACRA Australian Cardiovascular Health and Rehabilitation Association | Heart Foundation | SPA Secondary Prevention Alliance | The University of Sydney – Westmead Applied Research Centre

Purpose

Convene a Roundtable of multidisciplinary experts to identify actionable research and implementation priorities addressing gaps in secondary prevention and cardiac rehabilitation across Australia

Expected outcome

Identification of actionable research and implementation priorities that will be forwarded to the Minister's Office for consideration

The Hon Greg Hunt MP
Minister for Health

The Secondary Prevention Burden

Tom Briffa

CARDIOVASCULAR RESEARCH GROUP
SCHOOL OF POPULATION HEALTH

THE UNIVERSITY OF WESTERN AUSTRALIA

The Burden and Secondary Prevention of Cardiovascular Disease

Tom Briffa[1] on behalf of those assembled today and their constituents

1. School of Population Health, University of Western Australia, Western Australia

CVD Burden

- an ~ 1.2 million (6%) Australian adults had 1+ conditions related to CVD; self-reported

ABS 2017-18 National Health Survey

- More than 4 in 5 cardiovascular hospitalisations occurred in those aged 55+ years
  - CVD hospitalisation rates 30% higher in remote and very remote areas than Major Cities
  - In 2016, an ~ 62,400 people aged 25+ had an acute coronary event (heart attack or unstable angina); 25% have diabetes, and 40% have multiple chronic conditions
- Over 1 million hospitalisations for CVD in 2016-17 (11% of all hospitalisations)
- In 2015, coronary events continue as the No.1 cause of disability adjusted life years
- In 2015-16; an ~ 8.9% ($10.4 billion) of total disease expenditure attributed to CVD

CVD Web Report and Aust Burden Disease Study www.aihw.gov.au; current 30 Aug 2019

Secondary Prevention

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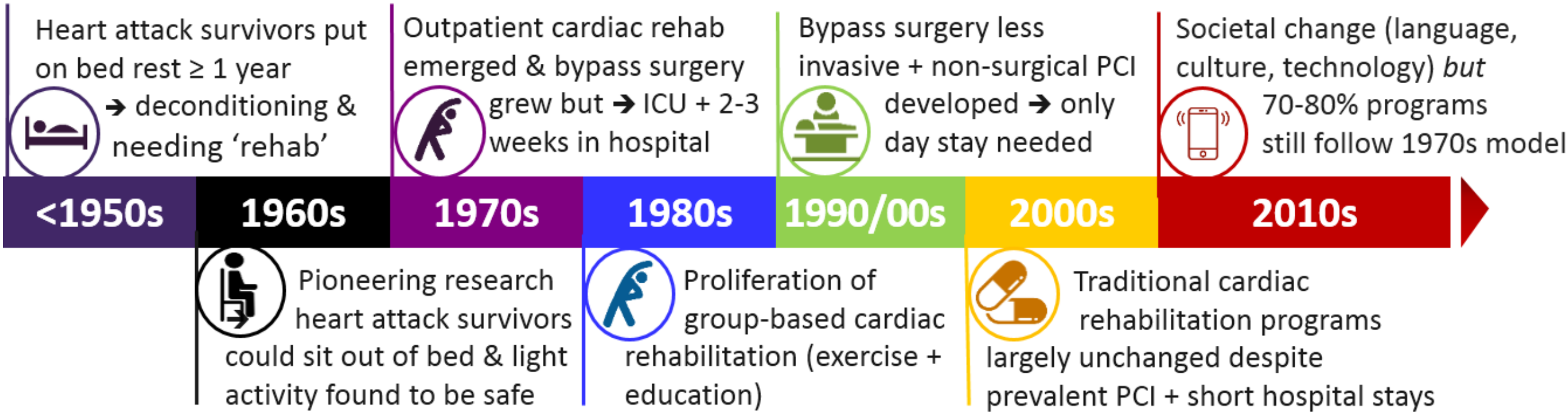
- National SNAPSHOT acute coronary syndrome (ACS) study found *only* 1 in 4 patients receive optimal care (medicines, referral to cardiac rehab and lifestyle advice) at discharge Redfern *Heart* 2014
- Australian registry, audits and population studies of survivors of ACS consistently reveal up to 40% experience a readmission for CVD or death at 2 yrs Chow *Heart Asia* 2019, Atkins *BMC Hlth Ser* 2014; Briffa *Cir CQO* 2011
- Currently, 7 out of 10 Australians each year surviving ACS do not engage in conventional CR and thus are not receiving the beneficial effects of CR on rehospitalisation or death Astley *Heart Lung Circ* 2019
- A recent national audit found >75% (188) of CR in Australia is delivered conventionally (centralised and in groups); a format largely unchanged since the last century Arbell *Open Heart* 2016; Refern *Intern J Cardiol* 2011
- Contrary to guidelines worldwide, the incremental benefit of alternative personalised models of secondary prevention in the context of modern ACS care is unanswered

Where have we come:
Where are we now

Julie Redfern


Heart attack survivors put on bed rest ≥ 1 year ➔ deconditioning & needing 'rehab'
Outpatient cardiac rehab emerged & bypass surgery grew but ➔ ICU + 2-3 weeks in hospital
Bypass surgery less invasive + non-surgical PCI developed ➔ only day stay needed
Societal change (language, culture, technology) *but* 70-80% programs still follow 1970s model
<1950s
1960s
1970s
1980s
1990/00s
2000s
2010s
Pioneering research heart attack survivors could sit out of bed & light activity found to be safe
Proliferation of group-based cardiac rehabilitation (exercise + education)
Traditional cardiac rehabilitation programs largely unchanged despite prevalent PCI + short hospital stays

SNAPSHOT ACS

- Only 46% of patients were referred to cardiac rehabilitation
- Only 26% of patients received a referral to rehab, prescribed evidence-based medicines and at basic lifestyle advice
- In 3 years post-discharge
  - 18% died
  - 21% repeat ACS
  - 14% repeat PCI/CABG

We need to do better

Redfern et al Heart 2014
Redfern et al HLC 2019

The good news

- More people are surviving initial CVD events
- Cardiac rehabilitation is improves outcomes for those who attend
- Flexible models are also effective and can be individualised

The opportunities

- More people are living with CVD
- Improve referral, attendance and completion
- Improve equity, efficiency, scalability and reach
- Improve alignment with contemporary medical care, societal change and technology

Priorities for Implementation

Aim: To discuss and identify implementation priorities for addressing gaps in the secondary prevention and cardiac rehabilitation across Australia

Heart Foundation Priorities in Secondary Prevention and Cardiac Rehabilitaiton

Rachelle Foreman - Director, Support & Care

1. Increase availability, access to and participation in cardiac rehabilitation (CR) and heart failure management programs

- Increase referral
  - As per National Clinical Care standard for ACS

- Increase availability and access
  - Including real world implementation of a variety of evidence-based delivery modes to meet patient risk stratification, patient preferences, access issues and preferred learning style
  - Options and capacity available for a range of patients (e.g. ACS, atrial fibrillation, heart failure, valve etc)

Heart Foundation

2. Measure the quality of interventions delivered

- Develop a set of national quality indicators for CR (Taskforce)
  - To measure processes, impacts and outcomes
  - To enable benchmarking of services
  - To enable quality improvement
  - To improve patient outcomes

- Advocate for registers and minimum datasets to improve the quality and delivery of care
  - Links to National Cardiac Registry
  - Links to National Clinical Quality Registry Strategy

Heart Foundation

3. People living with heart disease receive best practice care from the primary care sector

- As per Heart Foundation guidelines (ACS, CHF, AF) and positions
  - Symptom management
  - Screening for depression
  - Smoking cessation
  - Medication adherence
  - Monitor risk factors – clinical and lifestyle

Heart Foundation

4. Provide quality patient information and support

Heart Foundation My Heart, My Life Program

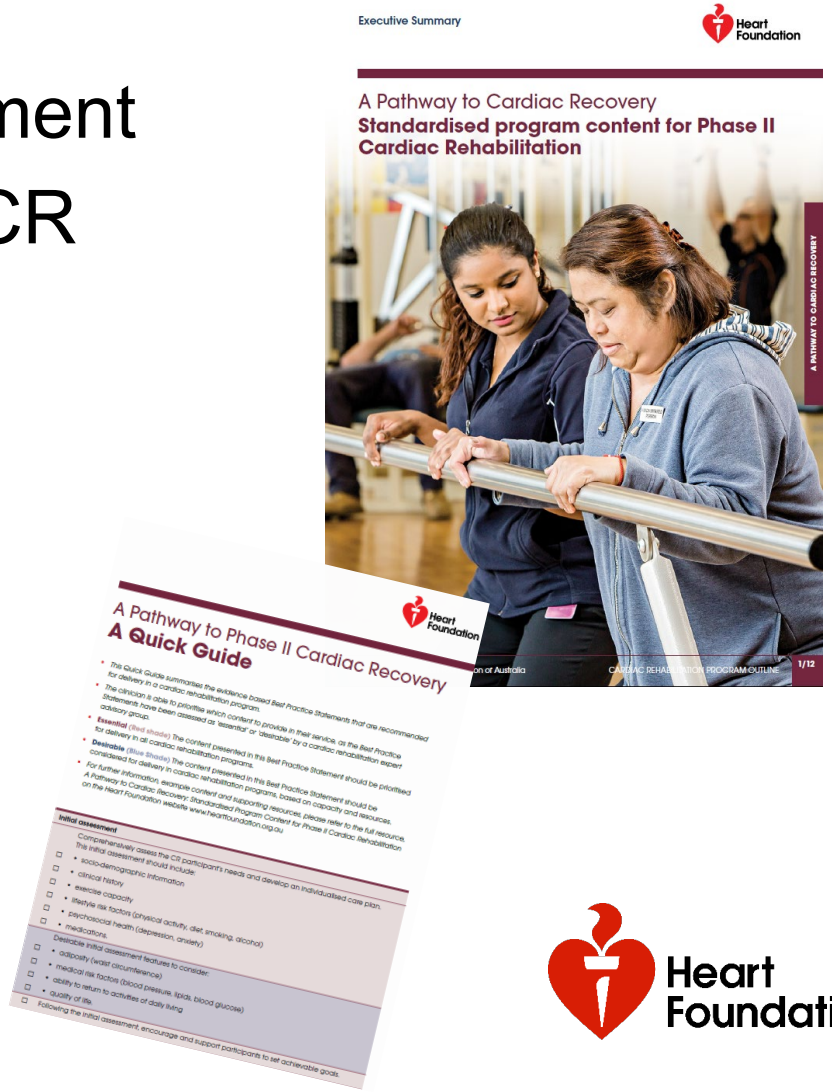
- For patients with ACS
  - Written information
    - Before discharge
    - For recovery
  - Telephone support from our Helpline health professionals
  - Online information and tools (email journey, SMS)
  - Regular updates
  - Mobile phone app

- For patients with heart failure and atrial fibrillation – in development

Heart Foundation

5. Provide quality clinician information and support

- Clinical guidelines around ongoing management
- Standardised program content for Phase II CR
- Core components for CR (ACRA)
- Knowledge translation tools and strategy
  - Guideline App
  - Systems based changes
  - Clinician support and education



Heart Foundation

6. Funding of research into best practice models of care and research translation into the real world

- Heart Foundation
- NHMRC
- ARC
- MRFF

Heart Foundation

Participant Perspectives

- What is it like after hospital discharge - David Gist
- National CR Quality Indicator Taskforce – Robyn Gallagher
- WA cardiac rehabilitation service – Andrew Maiorana
- NSW cardiac rehabilitation service – Rob Zecchin

Actionable implementation strategies

1. Your Task (20 minutes)

- At your table, discuss the 2 allocated priorities identified in the survey
- Identify:
  - What are the feasible solutions to progress the issue?
  - Whose role/s is it to progress?
  - Proposed timeframe (1-2 years, 3-5 years, 5+ years)
  - Likely reach – low, medium, high
  - Scale of the difference it would make from 1-10 (low to high)

2. Report back (4 minutes per table)

3. Agree on priority strategies – group discussion (15 minutes)

4. Summarise priorities (5 minutes)

Heart Foundation

Table	Implementation priorities to identify feasible solutions for
1	• Increase referral, uptake & access to cardiac rehab (including automated referrals) • Address inequity with improved options to manage ethnicity, gender, Indigenous health and access in regional & rural areas
2	• Develop and implement national CR quality indicators – governance, data collection, feedback reports to services • More personalised medicine, patient-tailored, treatment optimization (less didactic)
3	• Implement flexible modes of delivery in the real world to scale (e.g. eHealth, telephone, digital remote rehab, social media) • Wider publicity about programs
4	• Strategies to improve medication adherence • Cater for patients with various conditions - post stroke, TIA, AF, diabetes, obesity
5	• Improved management of risk factors – clinical, lifestyle, psychosocial including action plans and GP follow up • Better education of GPs and Cardiologists about rehab and risk factor targets

Heart Foundation

Priorities for Research

Aim: Discuss and explore research priorities for addressing gaps in the secondary prevention and cardiac rehabilitation in the Australian context

National Cardiac Registry: Process Update

Tom Briffa

National Cardiac Registry (NCR)

Vision

- To harness insights from national cardiac data to drive better outcomes for all Australians

Purpose

- To identify outcome variance and areas for improvement in the quality of cardiac health care across Australia

Objectives

- Utilise a collaborative, federated model for effective engagement, participation and support from stakeholders
- Provide a platform to ingest State and Territory data and measure performance as determined by agreed quality indicators
- Transparently report on clinical, procedural and patient outcomes to hospitals, clinicians, government and community
- Provide national benchmarking of key quality performance measures for cardiac procedures/devices and secondary prevention

NATIONAL CARDIAC REGISTRY

Achievements to date

- Engagement of all States and Territories, agreed federated governance
- Determined scope and priorities of the NCR
- Developed quality indicators and a minimum dataset for PCI
- Undertaken proof of concept exercise with 4 x pPCI STEMI datasets
- Contracted vendor to build data solution
- Identified options for data hosting
- Provided funding to States and Territories to support their participation

NATIONAL CARDIAC REGISTRY

Participant perspectives

- Potential of Big Data - Emily Banks
- Learnings from Primary Care – Jason Agostino
- State Government Perspective – Marianne Gale

Action Planning and Next Steps

Aim: Determine what needs to happen next, funding opportunities, how progress will be co-ordinated and who takes responsibility and timeframes

Role and potential of Advanced Health Research and Translation Centres (AHTRCs)

Garry Jennings

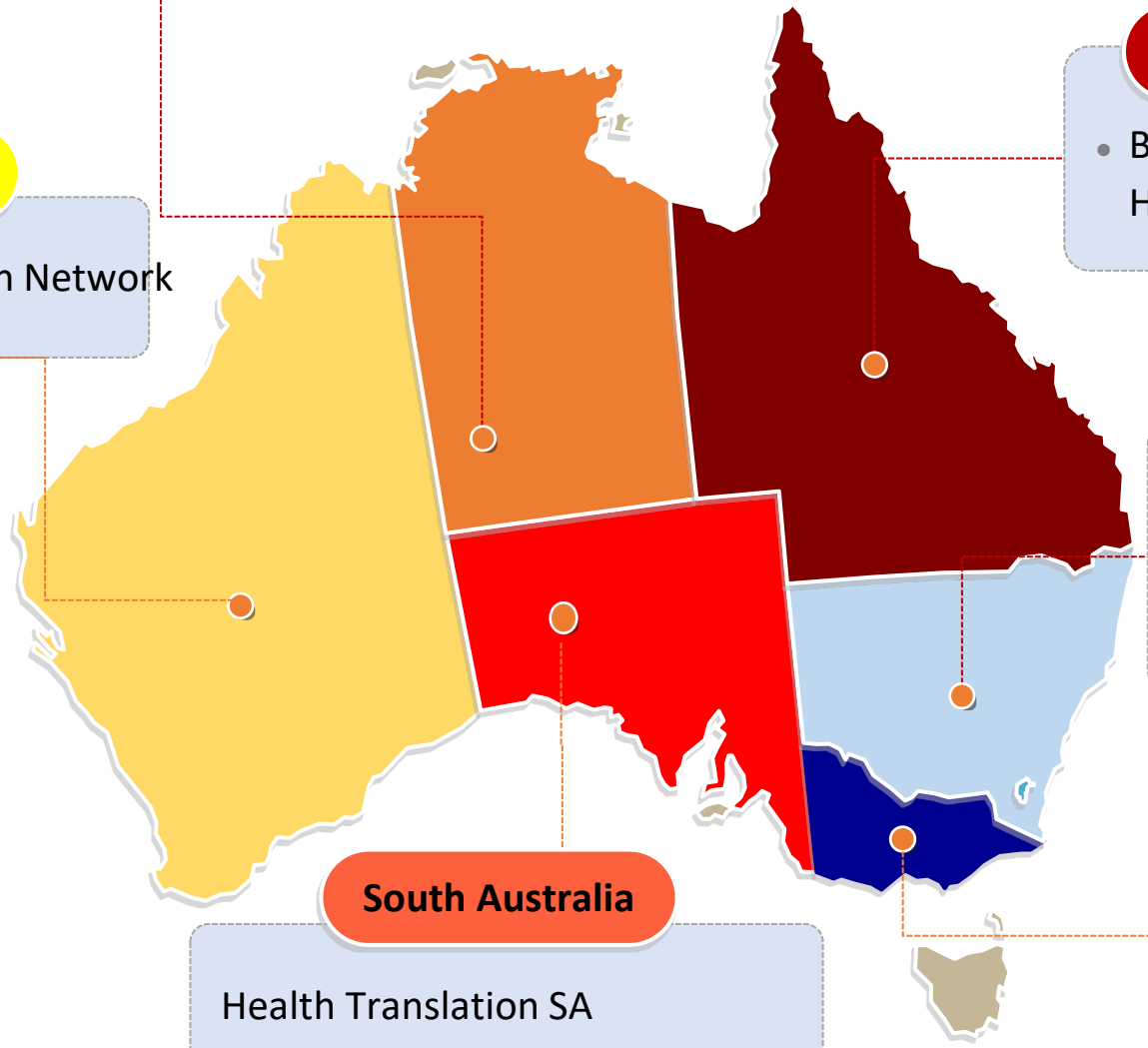
National- AHRA

Central Australia

- Central Australian Academic Health Science Centre

Western Australia

WA Health Translation Network



Queensland

- Brisbane Diamantina Health Partners

New South Wales

- Sydney Health Partners
- Sydney Partnership for Health Research & Enterprise
- NSW Regional Health Partners

Victoria

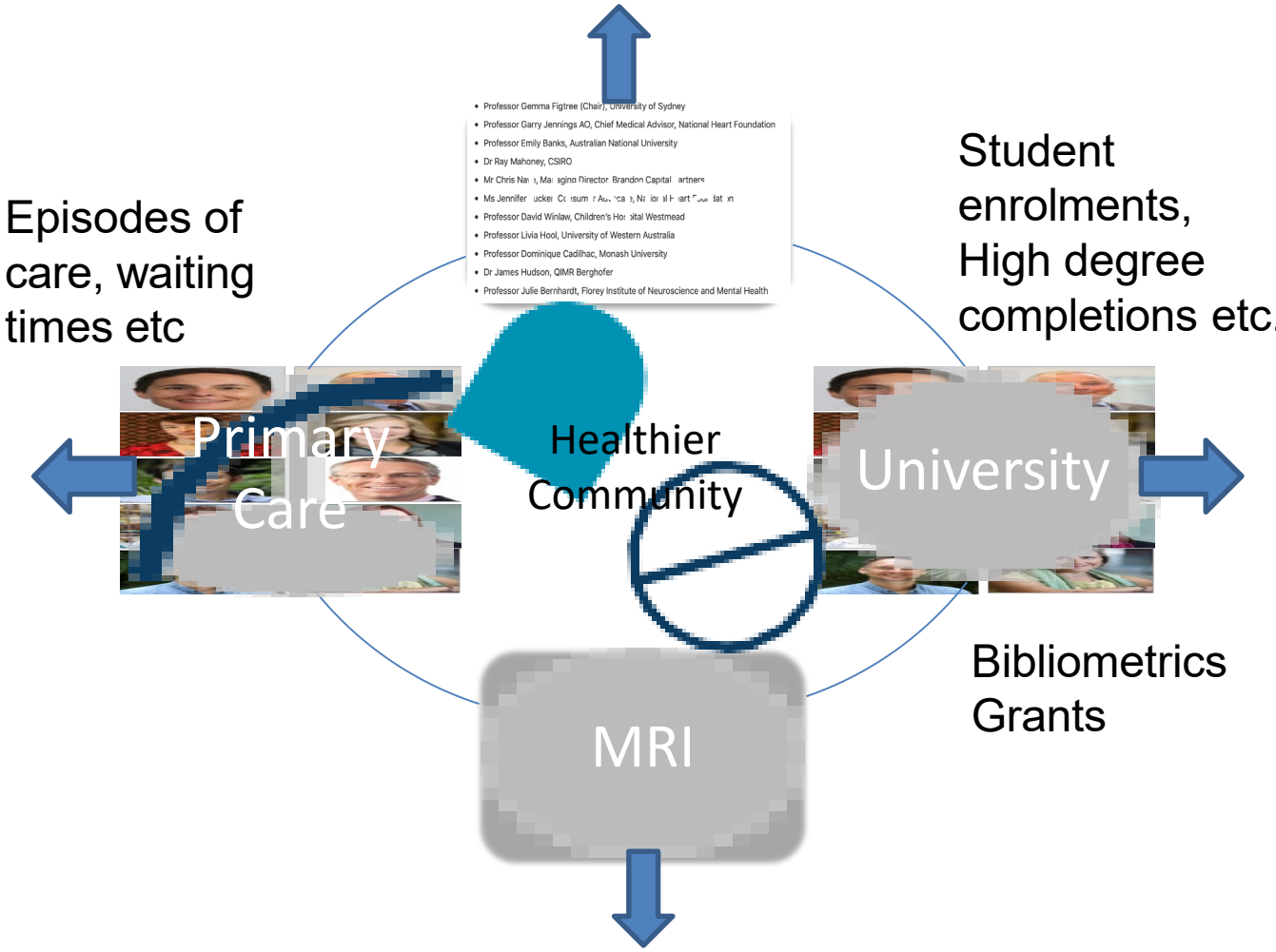
- Melbourne Academic Centre for Health
- Monash Partners

South Australia

Health Translation SA

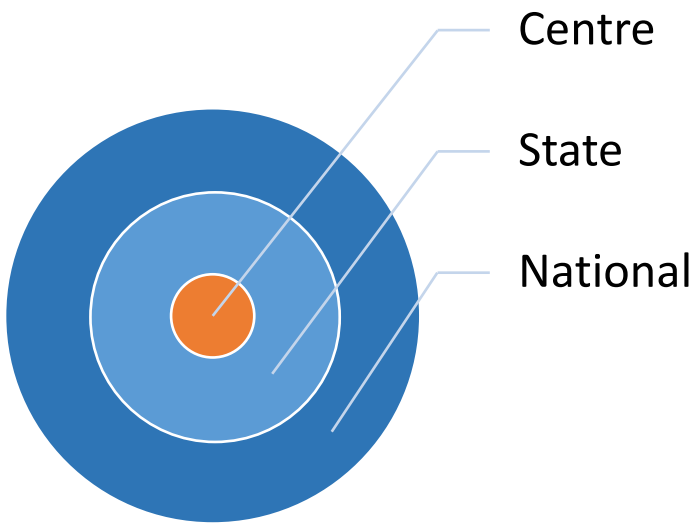
The Centres

Activity



World Rankings

Three Levels of Activity



1. Local Centre- working with health services, Universities and MRIs across the catchment

2. Statewide engagement- working together with 2 other Centres and with Health Departments

3. National collaborations (AHRA)- working with 7 AHRTCs and 2 CIRHs

SHP National Priority Commitments 2018/19
Advanced Health Research Alliance (AHRA) & Medical Research Future Fund (MRFF)

- **Health system improvement** and sustainability Framework
- ***Data driven health care improvements**
- **Indigenous research network**
- *Strengthening **consumer and community involvement** in research
- ****New for 2019**: Aged Care (*Wound Care & Women's Health*)

*SHP is co-leader with AHRA on these priorities
**SHP representatives on these national MRFF initiatives (*wound care & women's* health are Department of Health national priorities)