Heart Foundation®

A toolkit for health professionals: Improving cardiac rehabilitation and heart failure services

Improving cardiac rehabilitation and heart failure services

Health professionals can strengthen patient voices

As a health professional you are in an influential position to be the voice of your patients and steer system change to improve services. This toolkit is designed to support health professionals to take steps to improve cardiac rehabilitation and heart failure services so that Queenslanders receive the best possible cardiovascular care.

Cardiac rehabilitation and heart failure management programs need to be able to demonstrate not only whether patients are receiving care in accordance with national guidelines, but that service provision is efficient, timely and accessible.

Cardiovascular disease is the most costly disease group. Hospital admitted patient services in Australia make up 59% of these costs and this is growing.

The average cost of one hospital visit for cardiovascular disease is $9,982 for males and $8,634 for females[1]. Real system savings can be made by better prevention and management of cardiovascular disease.

Not enough patients are being referred to cardiac rehabilitation after a heart attack. Even if referred, they are often not accessing the service. Heart failure patients are often not being identified, referred or managed effectively. These are lost opportunities in the system, leading to many unnecessary hospital readmissions and costly interventions.

Solutions to delivering quality cardiac rehabilitation

How you can help improve care coordination

- Ensure your health service is providing high quality information for patients and their families to support sound decision making, for example the Heart Foundation's evidence-based patient resource *My heart, my life* and app.
- Ensure that every eligible patient is routinely referred to cardiac rehabilitation.
- Ensure there are discharge care pathways in place and being utilised.
- Ensure all patients are screened for depression and appropriately referred to psychosocial support services with proactive followup with their GP.
- Ensure your health service coordinates with primary care services so ongoing maintenance programs are made available to cardiac patients to support lifestyle changes including hospital, community and phone based programs.

How you can help improve data and evaluation

- Advocate for a routine referral system at discharge so that all eligible patients are referred to rehabilitation programs and services with active followup as a quality performance measure.
- Explore early rehabilitation interventions which may impact favorably on patient outcomes and readmissions in the first 30 days after discharge from hospital.
- Look to broaden the scope of programs offered to ensure they are contemporary and meet patient needs and preferences. Patient feedback surveys can inform this.
- Ensure you evaluate your program. Check if your HHS or hospital collects data to capture:
  - identification of eligible patients and referral to cardiac rehabilitation
  - evidenced based in-patient education
  - uptake and completion of cardiac rehabilitation
  - readmission rates.

A guide to performance evaluation can be found on the HEART Online website www.heartonline.org.au/CDPR/performance-evaluation

References

1. AIHW 2014. Health care expenditure on cardiovascular diseases 2008-09. Cat. no. CVD 65. Canberra: AIHW.
2. National Heart Foundation of Australia. A systematic approach to chronic heart failure care: a consensus statement. Melbourne: National Heart Foundation of Australia, 2013.

Solutions to delivering quality heart failure management

How you can help improve care coordination

- Ensure your health service is providing evidence - based patient resources for example, the Heart Foundation's *Living well with chronic heart failure* and *Living every day with my heart failure*.
- Ensure that every eligible patient is routinely referred to heart failure services.
- Ensure your health service coordinates with primary care services to support ongoing management of chronic heart failure (e.g. symptom and medication management, lifestyle support and palliative care).
- Ensure all patients are screened for depression and appropriately referred to psychosocial support services with proactive follow up with their GP.

How you can help improve program evaluation

- Ensure you evaluate your program to demonstrate your outcomes. A guide to performance evaluation is on the HEART Online website at www.heartonline.org.au/HFM/Performance-Evaluation.

How you can help improve the uptake of chronic heart failure models of care

- Ensure your models of care meet the needs of your patients especially if you work with high risk populations such as Aboriginal and Torres Strait Islander peoples, those from regional areas, lower socio-economic backgrounds, and culturally and linguistically diverse populations.
- Advocate for intensive case management interventions (particularly for frailer patients), led by a specialised heart failure team.

How you can help improve the collection of clinical performance and outcome data

Advocate for improved data collection such as:

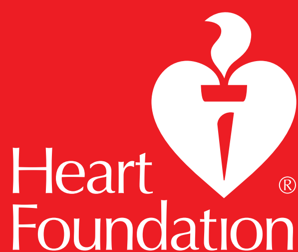
- proportion of patients reviewed within 2 weeks of referral.
- proportion of patients assessed for left ventricular function within the last 2 years.
- proportion of eligible patients prescribed evidence-based medications on discharge, at first clinical review and reviewed at 6 months.
- readmission rates and length of stay.
- twelve-month event-free survival including emergency presentations, hospitalisations and premature death[2].

Your Action Plan to improve patient services

1. Identify what cardiac rehabilitation and/or heart failure services are available for your patients. See the cardiac rehabilitation directory on - www.acra.net.au.
2. Request information from your local manager/administrator to provide an audit on current services in your Hospital and Health Service, private hospitals and in the community.
3. Identify gaps in these services such as referral processes, available services and patient followup.
4. Refer to the solutions in this toolkit to provide guidance to fill the gaps in local services and develop a business case to address these.
5. Identify and meet colleagues and decision makers who will support you such as your direct manager, administrators, clinicians and local MPs.
6. Identify patients who are willing to share their stories to provide a patient's perspective and promote the value of these programs.
7. Seek confidential support and advice by contacting the Clinical Manager of the Heart Foundation on 07 3872 2500 or qld@heartfoundation.org.au
8. To guide your meetings, be familiar with the policy documents that underpin the current health system including:

   Blueprint for Better Health Care in Queensland - www.health.qld.gov.au/blueprint/

   Department of Health Strategic Plan 2012-2016 - www.health.qld.gov.au/about_qhealth/strat_plan/12-16
9. Map how your service aligns with your Health Service Agreements. Activity, outcome or process information can be reported and should be summarised. (e.g. www.health.qld.gov.au/hhsserviceagreement)
10. Use factsheets in this toolkit as evidence to support your services and programs.



For heart health information

1300 36 27 87

www.heartfoundation.org.au

Real patient stories are your best evidence

Ashley's story: Plenty of life after a heart attack

I survived six stents in one artery, 60% blockage in two, 40% damage to my heart muscle. I manage to survive a heart attack every day!

My heart attack was a moment of such clarity about healthy choices that make a difference. However it's not easy sticking with lifestyle changes. There are a lot of uncertainties you experience after suffering a heart attack.

Cardiac rehab provided me with essential education like the importance of taking my medications, eating healthily, staying physically active, how to look after my mental health and return to work safely.

Managing the emotional side after a heart attack requires support from family and qualified health professionals. The staff at my cardiac rehab were committed to guiding me through the recovery. They helped answer all my health questions and worked through issues that I couldn't discuss with my GP or cardiologist.

Cardiac rehab got me back to my usual routine and most importantly will reduce my chances of having to go back to hospital.

Leon's story: Living well with heart failure

Leon is 69 years old. A year ago he had a heart attack while playing golf. Since then he has experienced increasing breathlessness and swelling of his ankles. He no longer accompanies Ella, his wife, on their shopping trips and has found himself increasingly reluctant to leave their house.

Leon and Ella visited their GP, who referred to the cardiologist for further investigations. It was established that Leon had significant heart failure, requiring a new medication regime, insertion of a pacemaker and education to help him manage his heart failure.

Leon was referred to a heart failure rehabilitation program, and Ella was encouraged to attend with him. During this program they received physiotherapy-guided exercise; nurse-led education; vital medication information from the pharmacist; and a psychologist's support to manage their anxieties. Leon's GP received a discharge summary from the cardiology team clearly identifying his care requirements and the need for titrating his medication.

The discharge summary also included information on how to contact the heart failure nurse consultant. Leon now weighs himself daily and maintains a stable weight. He knows to contact his heart failure nurse if he experiences an increase in weight or becomes breathless. Leon has returned to playing 18 holes of golf at least once each week.