IMPROVING CARDIAC REHABILITATION MEASUREMENT IN AUSTRALIA THINK TANK

COMMUNIQUE

On 26 September 2018 the SA Academic Health Science and Translation Centre (the SA Translation Centre) Cardiac Rehabilitation Priority Project jointly hosted a national forum in Adelaide – The National Improving Cardiac Rehabilitation Measurement Think Tank.

The purpose of the forum was to:

- share state-based activities on measuring the effectiveness of Cardiac Rehabilitation (CR) services;
- progress the development of a minimum dataset of national quality indicators; and
- determine the next steps to progress the measurement of CR across Australia.

This Think Tank was supported through funding from the Medical Research Future Fund Rapid Applied Research Translation Program and was a partnership between the SA Translation Centre, the Australian Cardiovascular Health and Rehabilitation Association (ACRA) and the National Heart Foundation of Australia (NHFA). It included consumer, clinician, research, data, health and policy promotion leaders representing Northern Territory, Western Australia, South Australia, Tasmania, Queensland, Victoria and New South Wales.

Why measure cardiac rehabilitation and secondary prevention in Australia?

In 2014-15, nearly 625,000 Australians (2.7%) reported having long term heart disease, causing 160,000 hospitalisations and costing $1.5 billion of the annual health budget.[1,2,3] Survivors of a heart attack or threatened heart attack have > 20% risk of a repeat event within 2 years, some of which are fatal.[4] Cardiac rehabilitation services are proven to assist patients to reduce their risk factors (high blood pressure and /or cholesterol, smoking, diabetes and depression) and can prevent another heart event. National, expert guidelines recommend referral to CR.[5,6]

Despite the evidence, referral rates in Australia remain poor (approx.45%) and once referred, attendance and completion rates remain low (approx. 20-60%).[7,8,9] Barriers include a combination of psychological, social and system factors.[10] **Importantly contemporary Australian data on referral, attendance and completion rates are lacking.** CR services also vary widely in terms of program content, structure and delivery.[9]

Measuring the quality of CR services can improve patient experience and outcomes.[9] Further, aggregated data from multiple health services can support comparisons and identify areas for improvement. High quality data are needed to monitor service effectiveness. Consequently, clinicians and decision makers are informed of the evidence and value proposition of CR services.[10]

What happened at the Think Tank?

Following presentations on the current evidence on global CR registries and a national environmental scan, services from each state provided a status update on their service measurement activities. Of note New South Wales, Queensland, South Australia and Victoria are already progressing significant bodies of work to measure CR services. A workshop was facilitated to conceptualise and determine the way forward.

Consumer members spoke to the importance of focusing on the measurement of patient experiences and outcomes. There was support for pre- and post-patient assessments as the best way of measuring program effectiveness, highlighted by an improvement in risk factors and quality of life. The Think Tank was an example of how collaboration can be harnessed to progress an initiative across the country.

IN-PRINCIPLE RECOMMENDATIONS

- Progress the establishment of a national set of quality indicators for CR service measurement which state/territories can use where feasible.
- Use the common quality indicators for CR that have been identified in SA, QLD and NSW to form the basis of a national minimum set of indicators. These include:
    - Referral to cardiac rehabilitation
    - Wait times to commence a service
    - Guideline medications at discharge and on service completion
    - Completion of a CR service
    - Pre and post assessments to measure change in risk factors including; depression, smoking, HbA1C, cholesterol, blood pressure, physical activity and waist circumference and quality of life.

By the end of the day there was agreement to:

- Establish a Taskforce that will meet at least twice before the end of 2018 to progress the development of the above quality indicators.
- The Taskforce will develop the detail on each indicator and work towards compiling a data dictionary.
- Barriers and enablers to collecting data should be outlined against each quality indicator.
- Where states have already progressed this work, information outlining the processes, barriers and enablers could be collated, written up and published with the aim of sharing learnings with others.

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