Cardiac rehabilitation factsheet

Evidence to support your case for improved cardiac rehabilitation

We need to help Queenslanders to stay productive and out of hospital after they have had a heart attack. It is important people with heart disease understand they are living with a chronic condition that needs to be actively managed to improve their health and wellbeing and reduce their risk of another heart attack.

There is overwhelming evidence that cardiac rehabilitation is an important part of recovery after a heart attack and benefits people of all ages. However, such programs are only effective if they are accessible and suitable to people's needs and people participate in them.

What is the issue?

- In Australia, the number of hospitalisations for heart attack increased by 80% from 1993-94 to 2007-08 and by 33% for unstable angina[1]. More than 30 per cent of hospital admissions for heart attack are repeat events[2].
- The total economic cost of just one heart attack is $281,000 including the direct and in-direct health care system costs, individual's productivity losses, private costs associated with treatments, medication and rehabilitation[3].
- Repeat heart attacks are costing Queensland $1.6 billion[3].
- Repeat heart attacks are projected to increase by over 40% by 2020 which will require an extra 4000 hospital beds and cause an extra 1400 deaths each year[3].

What are the benefits?

Health and clinical benefits of cardiac rehabilitation[5]

- better knowledge of risk factors
- accelerated recovery
- improved clinical outcomes (e.g. improved cholesterol, blood pressure)
- improved behavioural outcomes (e.g. exercise tolerance, smoking cessation)
- reduced repeat cardiovascular events and hospital readmissions
- strengthened adherence to medication
- enhanced mental health and overall quality of life
- improved symptom management
- increased 5 year survival and reduced all cause mortality

Economic benefits

The United Kingdom modelled the potential impact of significantly increasing uptake of cardiac rehabilitation from 25% to 65% on unplanned cardiac readmissions. The result was delivering a potential reduction in emergency cardiac admissions of 30%, equating to potential savings of nearly AUD $55 million (taking into account the increased costs to deliver a complete service to 65% of patients)[6]. Of concern, 25% of their cardiac readmissions occurred within the first 30 days following discharge.

What do the guidelines recommend?

The Guidelines for the Management of Acute Coronary Syndromes 2006, and 2011 Addendum to the National Heart Foundation of Australia/Cardiac Society of Australia and New Zealand Guidelines for the Management of Acute Coronary Syndromes (ACS) 2006[4] state:

- Patients should be given advice on lifestyle changes that will reduce the risk of further coronary heart disease events, including smoking cessation, good nutrition, moderate alcohol intake, regular physical activity and weight management, as appropriate.
- All patients should have access, and be actively referred, to comprehensive ongoing prevention and cardiac rehabilitation services.
- All patients should be provided with a written action plan for chest pain.

How are we doing?

Despite all of our best efforts to improve access to cardiac rehabilitation, patients are simply not getting the support they need following discharge. Some of the reasons include non-systematic referral, not enough services, and failure of services to remain contemporary to meet patient needs and preferences, especially people at the highest risk of cardiac events (e.g. Aboriginal and Torres Strait Islander, and people living in rural, regional and remote areas)[7].

Referral and attendance rates in Queensland are low

- More than half of patients are leaving hospital without a referral to cardiac rehabilitation or access to quality self-management tools to support their lifestyle changes, medication compliance, cardiac rehabilitation process, and a chest pain action plan[8].
- The two-week Acute Coronary Syndrome (ACS) Snapshot audit in 2012 showed that the proportion of patients referred to cardiac rehabilitation in Queensland varied significantly - 85% for ST elevation myocardial infarction (STEMI), 72% for non-STEMI and 43% for unstable angina patients[9].
- In 2003, 70% of eligible patients in Queensland did not attend cardiac rehabilitation and this has not improved over time[5,9].
- The recent Heart Foundation Heart Attack Survivor Survey (2013) confirmed that patients aren't receiving the support they need after a heart attack[10]:
  - Two in three heart attack survivors were not advised by medical staff to attend cardiac rehabilitation. If advised they were significantly more likely to attend.
  - As a result, only two in five attended cardiac rehabilitation.

Clinical and behavioural outcomes

- The Heart Attack Survivor Survey (2013)[10] confirmed that:
  - One in four patients had not been able to return back to the workforce.
  - More than half continued to smoke after their event.
  - One in six were not regularly taking their medication.
- 29% of patients who have previously had a heart attack have unmanaged or uncontrolled high blood pressure.
- More than 30% of hospital admissions for heart attack are repeat events[2].
- There is high prevalence of depression in patients with heart disease (~15%) which impacts on their adherence to medication and lifestyle management strategies, quality of life and prognosis[11]. Despite this, there are poor levels of screening to help recognise depression and refer patients for further evaluation within the health system. To download and print a copy of a screening tool (PHQ-2) for depression in patients with CHD go to: www.heartfoundation.org.au.

Heart Foundation®

For heart health information

1300 36 27 87

www.heartfoundation.org.au

References

1. AIHW (2011). Monitoring acute coronary syndrome using national hospital data: An information paper on trends and issues. Cat. no. CVD 57. Canberra: AIHW. http://www.aihw.gov.au/publication-detail/?id=10737420977. (accessed 4 January 2012).
2. Deloitte Access Economics (2011) ACS in perspective: The importance of secondary prevention.
3. Access Economics (2009) The economic costs of heart attack and chest pain (Acute Coronary Syndrome).
4. The Guidelines for the Management of Acute Coronary Syndromes 2006, and 2011 Addendum to the National Heart Foundation of Australia/Cardiac Society of Australia and New Zealand Guidelines for the Management of Acute Coronary Syndromes (ACS) 2006.
5. Briffa T et al (2009). An integrated and coordinated approach to preventing disease events in Australia. Policy statement from the Australian Cardiovascular Health and Rehabilitation Association, Med J Aust 2009; 190:683-6.
6. NHS Improvement Heart (2013) Making the case for cardiac rehabilitation: modelling potential impact on readmissions.
7. National Health and Medical Research Council (2005). Strengthening Cardiac Rehabilitation and secondary prevention for Aboriginal and Torres Strait Islander Peoples. Australian Government.
8. Standards of care (2012): a report on Queensland acute and day hospital self-assessed compliance with healthcare standards, Health Quality and Complaints Commission.
9. ACS Snapshot (2012). Queensland Department of Health 2013.
10. Heart Foundation (2013) Heart Attack Survivor Survey 2013.
11. David M Colquohoun et al (2013) Screening, referral and treatment for depression in patients with coronary heart disease: A consensus statement from the National Heart Foundation of Australia, Med J Aust 2013 198(9) 483-487.