

Thursday December 1, 2022

Clinical Conversation: Breaking down the barriers to cardiac rehab

Facilitated by Roschelle Brown, SCV Subject Matter Expert – Cardiac Rehab Pilot Project Safer Care Victoria

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Acknowledgement of Country

I acknowledge the Traditional Custodians who have lived and loved this country through the vastness of time.

I honour the Wathaurong People, whose country I stand on today and I wish to acknowledge them as Traditional owners.

I would also like to pay my respects to their elders past and present, and Aboriginal Elders of other communities who may be here today.

For this land always was, and always will be, Aboriginal Land.



Artwork by Anmatyerr woman, Tradara Briscoe



Before we begin

This session will be recorded and made available on the SCV website and sent to Network members



Meet our panel



Dr Susie Cartledge

Heart Foundation and Senior Research Fellow at Monash University



Sheree Burgess

Exercise Physiologist



Dr Joshua Collingwood

Rehabilitation Medicine Physician



Roschelle Brown

Cardiac Rehab Coordinator Critical Care Registered Nurse

Rationale behind this Clinical Conversation

Coronary heart disease (CHD) is the leading cause of death in Australia CHD is largely preventable, as many of its risk factors are modifiable Attending CR after a cardiac event decreases morbidity, mortality and improves quality of life Australian registry data reveals only a third of eligible patients are referred to a CR program, and only 28% of patients attend

Objectives:

- Provide an overview of the evidence regarding barriers to cardiac rehabilitation
- •Utilise case studies to explore common barriers faced by consumers of cardiac rehab and aid clinicians in navigating complex patient scenarios

Barriers to cardiac rehabilitation

Dr Susie Cartledge

BN(Hons), PhD, FESC, FCSANZ

Heart Foundation Postdoctoral Fellow, Senior Research Fellow

Honorary Senior Research Fellow, University of Sydney

Immediate Past President, ACRA Victoria



Referral and attendance barriers

System factors	Patient factors
Poor referral – time, processes	Location / Transport / Timing of program
Poor recommendation	Return to work
Lack of awareness from HCPs	Perceptions / Knowledge of CR
Lack of delivery of Phase I CR	Cost
Siloed and fragmented care	Older age, gender, socioeconomic status
	Language other than English
	Depression
	Multiple comorbidities

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Pio S, et al. 2019. Cochrane Database of Systematic Reviews. No CD007131. Neubeck L, et al. 2012. EJPC: 19(3); 494-503





Digital divide

Consumers that have resources, motivations and skills to access digital technologies Groups that do not: may be accentuated by: demographics, education, resources, access and opportunity

Photo by Will Francis on Unsplash

Australian CR and Telehealth research

National ACRA COVID Impact survey

- Overall impact Cartledge S, Thomas E, et al. HLC; under review
- Use of telehealth Thomas E, Cartledge S, et al. in preparation.

Qualitative studies

- Victoria November 2020 Cartledge S,... Jackson A. EJCN; 2021: 21(6), 548-558
- Queensland July 2021 Thomas E, ... Cartledge S. EJCN; Accepted

ACRA COVID Impact Research



Victorian experience: November 2020



Sustainability: Victoria

		Simple	Straightfor	ward, predictable, few components
		Complicated	Multiple int	teracting components or issues
NAS	SS Framework	Complex	Dynamic, ι	unpredictable, not easily disaggregated
	Domain			
1	The condition or illness	S		Simple, complicated
2	The technology			Simple
3	The value proposition			Simple
4	The adopter system			Complicated, complex
5	The organisation			Complicated, complex
6	The wider context			Complicated
7	Embedding and adapt	ion over tin	ne	Simple

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Cartledge S,... Jackson A. EJCN; 2021: 21(6), 548-558

Recommendations: Queensland

NASSS Framework

Domain

1	The condition or illness	Share learnings	
2	The technology	Platforms & access	(
3	The value proposition	Manage risk & share experiences	
4	The adopter system	Increase training & support	
5	The organisation	Share resources Program structure & funding	
6	The wider context	Shared models of care	
7	Embedding and adaption over time	Refine over time	

RECOMMENDATIONS

for cardiac and pulmonary rehabilitation services to enable further integration of telehealth



Thomas E, ... Cartledge S. EJCN; Accepted

ACRA COVID Impact Research



Figure 3 Barriers of telehealth use. The size of the bubble relates to the number of respondents that reported each factor.

Figure 4 Enablers of telehealth use. The size of the bubble relates to the number of respondents that reported each factor.

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Thomas E, Cartledge S, et al. in preparation.

Case study 1

Shane

56-year-old male living in large regional Victorian town.

Lives with partner, working full time as pharmacist, prior to cardiac event considered highly active – gym, running, rowing.

Past History: Family history of heart disease

Presenting History: Ambulance called by partner due to collapse, CPR commenced, on ambulance arrival found to be in VF - DCR x 4, STEMI call with direct transfer to cardiac catheter lab. Angiogram demonstrated severe TVD – proceeded to inpatient CABGS.

TTE - moderate to severe left ventricular dysfunction

Uncomplicated hospital stay. Discharged home five days post-surgery.

Discharge Plan: GP review 1/52 post discharge. Cardiology follow up 8/52. Surgical follow up telehealth at 6 /52. Repeat TTE 3/12. No driving for 6 months post cardiac arrest.

Brief inpatient discussion about cardiac rehabilitation – however not referred as deemed to have high health literacy and able to manage exercise independently.

Discharge Progress: Main concern for Shane reported to be anxiety and breathlessness. Compliant with medications. Following Heart Foundations walking guidelines.

Referral to cardiac rehabilitation by GP after multiple reviews discussing uncertainty regarding exercise and anxiety around event and long-term prognosis.

Case study 1 - Shane

Barriers:

- · Lack of inpatient promotion of the benefits of cardiac rehabilitation
- Delayed referral
- Driving restrictions post cardiac arrest
- Motivation to attend
- Anxiety and mood

Overcoming Barriers – Questions

- How does cardiac rehabilitation benefit those with minimal cardiac risk factors and high health literacy?
- How do we promote cardiac rehabilitation exercise to those with a high level of fitness?

Case study 2

Rebecca

45-year-old female living in a small rural town.

At home with husband and 3 children aged 9,11 & 14. Employed part time at local supermarket.

Born in Fiji, moved to Australia 15 years ago.

Past History: Gestational diabetes, ischaemic heart disease - stent to RCA 3 years ago, hypertension, increased BMI, hypercholesterolemia, physical inactivity, T2DM, previous non-compliance with medication.

Presenting History: Presented to emergency with chest pain for 2 days – diagnosed late presentation NSTEMI. Angiogram demonstrated 80% LCx – stent inserted. Moderate disease in other coronary arteries for medical management.

Case study 2 – Rebecca

Discharge Plan: GP review within a week of discharge, Cardiology review in 6 weeks. Cardiac rehabilitation for aggressive risk factor modification.

Discharged Progress: Post discharge one presentation back to emergency with chest pain. Since discharge feeling lethargic, keen to return to work due to financial concerns.

Contacted by cardiac rehabilitation service - reluctant to attend due to distance to service as well as work and caring responsibilities.

Rebecca also reporting that cardiac rehabilitation may not be helpful as heart condition has been treated and that exercise is not something she finds enjoyable.

Case study 2 – Rebecca

Barriers:

- Caring responsibilities
- Distance to cardiac rehabilitation service
- Return to work
- Health literacy

Overcoming Barriers – Questions

- Will providing flexible cardiac rehabilitation options allow Rebecca to participate in meaningful cardiac rehabilitation?
- What strategies can be implemented to promote the benefits of rehabilitation for risk factor modification and long-term health?

SCV Digital Cardiac Rehabilitation Pilot Project

- SCV has partnered with five regional health services for 18 months
- SCV provided participating sites with licenses to a digital cardiac rehab platform to provide the core components of cardiac rehab
- Consumers are offered flexible cardiac rehab options to improve attendance – traditional group program, remote digital program or a combination of both (hybrid)

Project aim and data collection

The following objectives apply to cardiac rehab at the five pilot health services:

- 1. Increase attendance
- 2. Increase completion rates
- 3. Reduce waiting times
- 4. Assess consumer satisfaction

The following data is collected by the five participating health services:

- Timelines referral received, initial
 assessment and program commencement
- Declined service and non-completion rationale
- Engagement and completion rates
- Quality of life measures
- Exercise measures
- Work status

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Hospital readmissions

Preliminary consumer feedback

- Somewhere to add blood pressure and heart rate and monitor these each day
- I was very apprehensive about doing exercise in case
 something went wrong, but the staff were great answered all my questions
- ✓ Keeping up with medication and daily exercise
- Initially transport to get to the centre was hard. So I was introduced to the remote option
- When I returned to work staff called regularly to check in and also answered my many questions
- Portability. I was travelling during my time involved. The mental safety net of a weekly check on gave me confidence to undertake my travels.
- It was easy to follow the program and the staff made contact with you all the time to make sure you are going ok

Let's take a poll

Further information

If you have any questions regarding Safer Care Victoria's Digital Cardiac Rehab Pilot Project, please address them to:

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