



National Secondary Prevention of Coronary Disease Summit

Technical Report July 2012



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TABLE OF CONTENTS

EXECUTIVE SUMMARY 3

BACKGROUND 4

 Cardiovascular disease burden 4

 Evidence-practice gap 4

DISCUSSION SUMMARY – MINIMUM STANDARDS 6

Who should deliver a secondary prevention programme 7

What should be the content of a programme? 7

When should a programme be delivered and for how long? 8

Where should a programme be delivered? 9

How should a programme be delivered? 9

DISCUSSION SUMMARY – ENABLING STRATEGIES 11

 Individual/patient level enabling strategies 12

 Health professional level enabling strategies 12

 Strategies to overcome system level and policy barriers 13

DISCUSSION SUMMARY – EVALUATION 15

 Access to, uptake and completion of a programme 15

 Effectiveness of programme 16

 Satisfaction with a programme 17

FUTURE DIRECTIONS 18

REFERENCES 19

APPENDICIES 20

 Appendix 1: Summit Executive and participants 20

 Appendix 2: List of organisations represented 22

 Appendix 3: National Secondary Prevention of Coronary Disease Summit Program 23

 Appendix 4 – Executive, participants and program development 25

 Appendix 5: Individual session feedback forms 27

Declaration 30

EXECUTIVE SUMMARY

Coronary heart disease (CHD) accounts for greatest morbidity in Australia, more than any other single disease and nearly one fifth of all deaths nationally (AIHW 2009). A recent report estimates that there were about 75,000 acute coronary syndrome (ACS) hospital separations in Australia in 2010 and this figure is expected to be over 100,000 by 2020 (Access Economics 2011). The cost of repeat ACS events in 2010 was over \$8 billion (Access Economics 2011).

Prevention strategies that target individuals at the highest risk (6% of the population that contribute 40-50% of cardiovascular events) with proven treatments are the most effective and efficient means of preventing future cardiovascular events (Briffa et al 2011, Chew et al 2008, Kerr et al 2009). Although essential, effective ongoing disease management after an acute coronary event is infrequently implemented due to challenges around the research evidence its translation and resourcing (Briffa et al 2009, Redfern et al 2010). Policy-makers, health professionals and researchers are confronted by the need for increased services, to improve access and equity, but often with finite and reducing resources. It was in pursuit of translating clinical trial research into effective policy and practice (that can lift the current 30% compliance rate) that a National Summit was convened.

The inaugural National Secondary Prevention of Coronary Disease Summit was hosted by an Executive Committee and The Cardiovascular Division of the George Institute for Global Health in Sydney, Australia on December 2nd 2011. Participants were actively engaged and included key opinion leaders in secondary prevention, policy makers, local and national government representatives, health professionals (including cardiology, general practice, nursing and allied health) and consumers. In total, more than 35 government, health, research and consumer organisations around Australia were represented.

At the Summit there was overwhelming consensus for a patient-centred approach where the chronological journey is defined by patient not by system. It was clear that the divide between hospital and general practice care is incongruent in terms of a definition, patient communication, services provision, funding and data collection. As a result the patient journey is *not* seamless as they transition between tertiary and primary care. The Summit also highlighted a need for flexible and individualised services with the potential for a case manager to enhance co-ordination of patient care. Participants agreed that such services need a simple framework that could be implemented across Australia and have a pragmatic data collection system with an agreed key performance indication.

BACKGROUND

Cardiovascular disease burden

Cardiovascular disease, including coronary heart disease (CHD) and stroke, is the leading cause of death and disease burden globally. CHD accounts for greatest morbidity in Australia more than any other single disease and nearly one fifth of all deaths nationally (AIHW 2009). Despite ongoing clinical management and treatment of patients who initially present with CHD, repeat events often occur.

A recent report estimates that there were about 75,000 acute coronary syndrome (ACS) hospital separations in Australia in 2010 (Access Economics 2011). By 2020, the figure is expected to be over 100,000. About 34% of all ACS events are repeat events, totalling around 35,000, costing over \$8 billion in 2010.

Prevention strategies that target individuals at highest risk (10% of the population that contribute 40-50% of cardiovascular events) with proven treatments are theoretically the most effective and efficient means of preventing future cardiovascular events (Briffa et al 2011, Chew et al 2008, Kerr et al 2009). Effective ongoing disease management after an acute coronary event is essential, but infrequently implemented, due to challenges around the research evidence and its translation (Briffa et al 2009, Redfern et al 2010).

Thus, policy-makers, health professionals and researchers are confronted by the need for increased services, to improve access and equity, but often with finite and reducing resources. There is a clear need to develop innovative ways of delivering ongoing preventive care to the vast and increasing group of people with CHD.

Evidence-practice gap

The benefits of blood pressure-lowering, cholesterol-lowering, antiplatelet medication, exercise therapy and cardiac rehabilitation have been clearly demonstrated in clinical trials and their prescription to those at high cardiovascular risk is universally recommended in treatment guidelines (NHF 2008). The problem lies in poor utilisation of effective preventive drug treatments, cardiac rehabilitation and adherence to lifestyle recommendations (Briffa et al 2009). In a recent George Institute survey of over 5,000 Australian general practice patients, 1548 had clinically-expressed cardiovascular disease (CVD) and only half were following recommended treatments (Heeley et al 2010).

Valid national data on participation in cardiac rehabilitation and exercise therapy are not available, but estimates from local and international reports indicate that less than 30% of eligible patients participate in such programmes (Bethell et al, Scott et al). Compliance with lifestyle change is no better. Recently, we found that amongst 18,809 well-treated clinical trial patients from 41 countries who had suffered ACS only 30% of patients

adhered to diet and exercise recommendations and about two-thirds of smokers had quit smoking six months after their event (Chow et al 2010).

The Australian Cardiovascular Health and Rehabilitation Association strongly recommend multifaceted strategies to promote effective flexible secondary prevention interventions at local, state and national levels (Briffa et al 2009). In parallel, recent National Heart Foundation policy documents have highlighted the need for development of a national framework for secondary prevention, national key performance indicators for secondary prevention services and systems for collection of standardised outcome data (NHFA 2010).

However, it is difficult for a coherent strategy to emerge when the volume of evidence describing and reporting disparate models of delivery continues to expand. There is no lack of models of what might work under the ideal conditions of a clinical trial. The problem is translating the research into everyday clinical practice (Redfern et al 2010). It was in the pursuit of effective policy and practice that can lift the 30% compliance rate to 80 or 90%, that this Summit was convened. The Summit participants, organisations representatives, program, process and participant comment forms are provided in Appendix 1-5.

Summit objectives

1. Identify and agree on the key features that should be included in all coronary disease secondary prevention programs (including cardiac rehabilitation).
2. Identify and agree on a set of realistic and tangible enabling strategies for implementation within existing resources at individual, health service and policy levels.
3. Identify key performance indicators for monitoring and evaluation for hospitals and services community/ primary health services.
4. Agree on next steps for improving implementation of and access to effective secondary prevention strategies

Definition

For the purposes of the Summit, secondary prevention was defined as (NHF 2010):

“Healthcare designed to prevent recurrence of cardiovascular events (e.g. heart attack or stroke) or complications of CVD in patients with diagnosed CVD. It involves medical care, modification of behavioural risk factors, psychosocial care, education and support for self-management (including adherence to prescribed medicines), which can be delivered in various settings”.

PROGRAMME MINIMUM STANDARDS

This session concentrated on the “who”, “what”, “when”, “where” and “how” of programme delivery are summarised in Box 1. Overall, there was overwhelming support that we aim to move in the same direction nationally and there was strong consensus for a patient-centred approach where the chronological journey is defined by patient not by system.

Box 1: Summary of summit outcomes relating to minimum standards
<p>Who should deliver a secondary prevention programme (personnel)</p> <ul style="list-style-type: none"> • Centralised care by a general practitioner (where possible) • Each patient is supported by a designated case manager • Flexibility in terms of specific health qualifications of case manager
<p>What should the content of a programme be (content)</p> <ul style="list-style-type: none"> • Initial assessment including risk factor assessment, health literacy, psychosocial and potential family involvement • Strategies aimed at evidence-based medication use and adherence, risk factor management, psychosocial issues and self management • Ongoing care and support including periodic assessment, reinforcement and potential referral
<p>When should a programme be delivered and for how long (timing)</p> <ul style="list-style-type: none"> • Programmes should commence as early as possible/suitable after diagnosis • Programme duration may vary within and between individuals so programmes should offer a variety of intensities at different times • Ongoing phase should be lifelong and not be time-limited
<p>Where should a programme be delivered (setting)</p> <ul style="list-style-type: none"> • Initial phase can be delivered in a variety of settings (eg, hospital, community, patient’s home) based on patient need, preference and resources • Ongoing care is best delivered in the community
<p>How should a programme be delivered (format)</p> <ul style="list-style-type: none"> • The method of programme delivery should vary between and within individuals and could include face-to-face visits, telephone, internet or web-based systems, video, DVD or written manuals. The format of contact and communication should be flexible based on patient preference, need and available resources.

Who should deliver a secondary prevention programme

Summit participants repeatedly highlighted the need for a case manager or healthcare facilitator for each patient. The qualification/s of specific professionals could vary and be flexible based on local workforce availability and resources. In some areas, the GP would serve as the case manager but elsewhere it may be another health professional similar to a 'Diabetes Educator'. The qualifications for delivering an effective program were noted but not discussed.

It was agreed that the case manager would be responsible for tasks such as (but not limited to):

- i. Tracking of patients to ensure they are engaged and participating in preventive measures
- ii. Checking that patients are receiving optimal care
- iii. Provision of ongoing support and monitoring of progress
- iv. Ensuring and fostering adequate communication between relevant parties (eg, medical, allied health, family)
- v. Ensuring fluidity between the hospital-primary interface

In terms of implementation, participants agreed that the case manager should generally be based in the community (eg, Medicare locals) and perhaps have the capacity to be accredited to come into hospital and meet and greet potential participants/ explain benefits and enroll potential people in need of secondary prevention. The case manager would need to be strongly linked with both general practice and the hospital to ensure such that they have responsibility for the hospital-primary care interface. Participants agreed that the current 'disconnect' between the two was a major problem. Participants highlighted that implementation of such a role would require dedicated funding and/or reorganisation of current workforce.

What should be the content of a programme?

Summit participants commented that a wholistic approach to managing risk was needed. Ideally there needs to be a suite of things for the patient to choose from with both an initial and ongoing care phase. Participants agreed that programmes should be motivating with repeated points and include ongoing efforts to maintain and foster active engagement. It was also agreed that, content should be culturally sensitive, involve family members wherever possible and goals should be set together with the patient and be realistic. The potential importance of involving relatives, family, spouse and/or carers was also highlighted.

The "pillars" of a programme include:

1. *Assessment* - objective measurement of multiple risk factors, assessment of health literacy and other linguistic barriers and psychosocial assessment (depression).

2. *Education* - provision of basic health information (i.e., heart disease - causes, risks and prevention, how to acute episodes etc).
3. *Modification of individual risk* – via availability of a range of potential individually-tailored strategies including any combination of:
 - i. Evidence-based medications use and adherence. These should include medicines such as statins, ACE inhibitors or A2RBs, anti-platelets and b-blockers. Strategies should be employed to ensure patients are being prescribed these medicines and also that they are being taken by patients.
 - ii. Management of biomedical risk factors such as blood cholesterol levels, blood pressure and blood glucose levels.
 - iii. Management of behavioural risk factors including smoking cessation (including nicotine replacement therapy, drug therapy, consideration of a formal program specialist health professional such as a psychologist), physical activity promotion, diet, weight loss.
 - iv. Addressing of psychosocial issues (including depression) and establish availability of support
 - v. Behaviour change education and motivation - Education –life-long, life-saving, Self-management strategies and techniques (goal setting, patient preferences, include families), Self-determination
4. *Periodic reassessment and ongoing support* - this aspect of the programme should be coordinated in the community with clear mechanisms to “dip back” into specialist/intensive services or a facility-based programme. Participants identified that ongoing care should include:
 - i. Continuation of specific strategies that are individually appropriate (e.g., medication taking, physical activity) as well as revision of the risk factor management action plan as appropriate (e.g., addition of smoking cessation, new medication)
 - ii. Planned future follow-up with reinforcement of continuing preventive strategies
 - iii. Formal opportunity for periodic back-referral
 - iv. Routine 6 month or annual review or “status update” with objective measurement of risk factors and review of the risk factor management plan.

When should a programme be delivered and for how long?

There was strong agreement that patients should be seen as early as possible after an event (ideally within 2-4 weeks). During a first contact in hospital (if admitted) participants stated that all patients should be told about and offered secondary prevention services and a referral and initial appointment should be made. Participants also commented that all health professionals involved in contact with the patient should reinforce the

importance of secondary prevention. Where possible, it was agreed that patients should see their GP within 1 week and a cardiologist within 6 weeks of hospital discharge.

In terms of programme duration for the initial phase Summit participants did highlight that at present there is no scientific evidence regarding optimum programme duration. It was generally agreed that length may vary within and between individuals so programmes should offer a variety of intensities at different times during each patient's lifetime. Overall, it was also agreed that programmes should not be time-limited and should provide support for as long as is necessary for individual patients. Such decisions should be made in consultation with each patient's GP.

Where should a programme be delivered?

In terms of programme setting, there was a strong message that the setting should not be restricted to hospitals if access is to be improved. That is the programme could be delivered in variety of settings including hospital, community, general practice or the patient's home. Participants did however identify that initial contact is best made during in-hospital admission (if applicable) and that primary care delivery during this initial phase should involve additional support services (eg, aged care assessment team, case managers).

Participants agreed that the primary care setting was ideal for the long-term aspects of care needed for ongoing CVD prevention and management. The setting for long-term care should vary and could be delivered in the community (eg, community centres) or at patient's own homes in concert with the patients GP.

How should a programme be delivered?

In terms of the format of programme delivery, important concepts identified at the Summit included the need for individualisation and a focus on family involvement, the importance of referral and the need for flexible delivery methods. Summit participants agreed that future programmes should be patient centred and flexible. That is, programmes should be individualised with a range of options where appropriate components are chosen based on patient need and available resources. That is "not everyone needs everything" and that the assessment should "tease out who needs what".

In terms of delivery method, Summit participants identified the need for a face-to-face initial assessment (where possible) after an event and the need for options to vary delivery method (e.g., face-to-face, telephone-based, web-based, DVD, written manuals) between and within individuals.

Discussion regarding programme terminology

There was spirited debate about the meaning of the term 'secondary prevention programme' in relation to CHD and whether it is the same as 'cardiac rehabilitation'. Several participants favoured continuing with the term 'rehabilitation' because it is an international term that consumers understand. However, the majority of participants saw 'secondary prevention programme' as a more inclusive of interventions and strategies that comprise secondary prevention beyond rehabilitation. Alternative terms were also suggested and included "quality care for Australians with heart disease", "cardiovascular relapse prevention", "secondary prevention of heart disease", "cardiovascular secondary prevention", "insuring heart health" and "life beyond heart disease".

Participants highlighted that the term 'cardiac rehabilitation' tended to mean only one specific programme format and one participant stated that "to reach all Australians maybe we need a new term". Another participant highlighted that rehabilitation evokes the idea of a program to help people recover and optimise function whereas the term 'secondary prevention' is broader. A small number of participants felt the term cardiac rehabilitation should continue to be used because it is an international term that consumers understand. Other participants believed the term cardiac rehabilitation was not relevant for the current range of interventions and strategies that comprise secondary prevention. This feeling was particularly strong amongst general practitioners for whom the term cardiac rehabilitation generally did not resonate with non-hospital, life-long preventative care and behaviour change.

ENABLING STRATEGIES

Potential enabling strategies that emerged are presented at individual, health professional and system levels and are summarised in Box 2. Overall, the availability of a service model that has common features but is flexible in its delivery would be ideal. Other suggested strategies included the potential use of incentives for patients and health professionals, the construction of a “map” of available services and funding streams together with education of health professionals and engagement with policy developers and funders.

Box 2: Summary of summit outcomes relating to enabling strategies

Individual/patient level

- To overcome personal factors suggestions included availability of a personalised, individualized, flexible programmes, peer support and family engagement
- To overcome practical barriers suggestions included having availability of pictorial resource, provision of patient peer support groups, provision of telehealth services and utilisation of local and home-based programmes and services
- Strategies identified to overcome financial barriers included flexibility of services, the provision of incentives and utilisation of existing funded services

Health Professional level

- Increasing education and awareness by health professionals included ensuring training in chronic disease management and behaviour changes and the importance of credentialing
- To increase incentives suggestions having secondary prevention key performance indicators, availability of a PIP incentive, a quality improvement module and increasing utilisation of existing funded Medicare programmes
- To reduce time constraints suggestions included engaging with case manager and/or multidisciplinary team, increase awareness of available services locally and the utilisation of electronic tools and systems
- Suggestions to simplify the referral and communication process included linking referrals to funding, ensuring referrals are automated, timely and include evidence-based information and to have systems for improved communication between hospitals and general practice

System and policy level

- Suggestions made for increasing data availability and monitoring included improve benchmarking and collection of hospital-level data, central reporting, utilisation of e-health initiatives and modifying the AIHW definition of avoidable admissions to include stroke and MI
- Suggestions focused on increasing utilisation and/or redesign of existing funding to be activity-based and provided as “packaged care” and increased cross jurisdictional funding
- Suggestions made for potential initiatives that would require new funding included the need for dedicated funding, availability of a practice incentive program programmes, and engagement of mass media.

Individual/patient level enabling strategies

Strategies identified for overcoming personal factors included (but were not limited to):

- i. Availability of a personalised, individualised, flexible program
- ii. Patient support groups, peer-to-peer educators for consumers (especially culturally and linguistically diverse groups)
- iii. Increased public awareness of the value of secondary prevention
- iv. Engagement of family and community and the need for emotional proximity
- v. Availability of varied professionals including Aboriginal health workers

Strategies identified for addressing practical barriers included (but were not limited to):

- i. Availability of pictorial resources and peer engagement where necessary
- ii. Provision of services via telehealth including the telephone, Internet, 'smart phone' technology as the evidence accrues
- iii. Resources identifying local and home-based programmes and services (eg, 'Heart Moves, 'Home Medicines Review')

Strategies identified to overcome financial barriers included (but were not limited to):

- i. Flexibility of services and not a one size fits all approach
- ii. Provision of incentives for involvement, attendance, completion. Could be a package or co-payment if the patient adheres to treatment or a programme where participation/goal achievement is signed off by the GP (eg, government funded immunisation program)
- iii. Utilisation of existing funded services to access allied health professionals and behavior change experts such as psychologists (e.g MBS Primary care items)

Health professional level enabling strategies

Suggested strategies aimed at increasing education and awareness by health professionals included (but were not limited to):

- i. Training in risk management behaviour change strategies (e.g., motivational interviewing, behaviour change therapy) via continuing professional development programs (e.g., offered by specialty colleges and associations) through CPD programs
- ii. Ongoing provision of clinical education about chronic disease management with credentialing
- iii. Consider implementation of automatic email (other electronic) prompts to GPs from hospitals at 6 months to ensure secondary prevention is occurring and ongoing

Suggested strategies aimed at increasing incentive to refer, provide and continue to support patient participation in secondary prevention programmes included (but were not limited to):

- iv. Having secondary prevention key performance indicators in general practice
- v. Availability of a practice incentive program (PIP) around CHD
- vi. Quality indicators and quality improvement module around secondary prevention (eg, RACGP)
- vii. Utilise funded GP programs (eg, for mental and allied health) and private health insurance programmes (where applicable)

Suggested strategies to reduce time constraints included:

- i. Engaging with a proactive case manager to assist with coordination
- ii. Utilisation of Medicare funded General Practice Management Plan (Item 721) and multidisciplinary team and ancillary services such as community pharmacy and the national prescribing services' 'home medicines review'.
- iii. Work with Medicare Locals to develop and increase uptake of secondary prevention "care plans"
- iv. Simple, efficient, standardised and timely referrals between health professionals and services
- v. Increase awareness of available services eg, Heart moves, private health services
- vi. Availability and provision of a 'map' of services and programs including their funding
- vii. Utilisation of electronic tools and systems to identify patients and how well their risk factors are being managed (eg, electronic records, PenCat tool)

Suggestions to simplify the referral and communication process included (but were not limited to):

- i. Activity Based Funding (ABF) link referral/attendance/CPIs to CR funding to provide incentives
- ii. When discharged from hospital after an event – GPs need an evidence-based care-plan
- iii. Automated referrals that ideally reach the GP prior to the patient so that the GP has access to background information before they physically see the patient.

Strategies to overcome system level and policy barriers

Suggestions made for increasing data availability and monitoring included (but were not limited to):

- i. Utilisation of 'My hospital' to improve benchmarking and collection of hospital-level data and potentially allow national audit
- ii. National audit process and central reporting
- iii. Utilisation of e-health to possibility overcome barriers at level of state-federal interface
- iv. Policy around personally controlled health care systems

- v. Include secondary prevention provision and participation in the acute coronary syndrome audit
- vi. Facilitate a new AIHW definition of avoidable admissions to include stroke and MI

Suggestions made where there should be a focus on increasing utilisation and/or redesign of existing funding included (but were not limited to):

- i. Synthesise resources and documentation
- ii. Use of community groups
- iii. Efficiencies with cross –jurisdictional funding and potential activity-based funding
- iv. Services could be designed as a “lifestyle package” (similar to a gym membership) that includes medication and lifestyle options where funding could potentially be managed by the patient themselves or their general practitioner.
- v. Cross jurisdictional funding would facilitate co-operation, communication and uptake
- vi. Investigate the potential of the electronic health records in Primary Care for ongoing national monitoring.

Suggestions made for potential initiatives that would require new funding included (but were not limited to):

- i. Need for dedicated funding for secondary prevention programmes/services
- ii. Payment for performance via national partnerships agreements
- iii. Involvement of non-healthcare professionals
- iv. To activate, would need to prepare a business case around prevention of readmissions (e.g. in NSW Bureau of Health Information data and nationally - AIHW data). Preventing not only CHD but also diabetes, stroke, etc.
- v. Leverage on Australian Commission on Quality & Safety’s consultation paper re goals and appropriate care – secondary prevention for ACS patients.
- vi. Engage mass media to highlight importance of secondary prevention (eg, salt reduction campaigns)
- vii. Availability of a PIP (already available for asthma and diabetes but not CHD).

PROGRAMME EVALUATION

Evaluation of implementation and effectiveness was categorised into the three areas of access and uptake, programme effectiveness and satisfaction and are summarised in Box 3. Participants agreed there was a need to keep reporting simple and achievable measures and utilise existing data wherever possible. However, it was highlighted that reporting requires funding and embedding into everyday practice and that this may require development and utilisation of new technologies such as patients scanning something each time they attend a service and having that data centrally collected. Such initiatives would allow real-time reporting and data collection.

Box 3: Summary of summit outcomes relating to evaluation

Access to and uptake and completion of a programme

- Could be measured via the proportion of eligible patients who are referred to a programme, referred to a GP, the proportion participation in or complete a program.
- Difficult to collect complete data given the variety of secondary prevention alternatives are available and hence would likely require direct communication with all patients

Effectiveness of programme

- Readmission, mortality and possibly revascularisation were considered important and fundamental and could be measured using existing data
- Medication provision and dispensing could be measured using linked data or electronic general practice software systems
- It was agreed that clinical measures were more difficult but could include the proportion of patients achieving key clinical targets (eg, BP, smoking, cholesterol) at specified time points and this data could potentially be obtained using electronic general practice software systems

Satisfaction with programme

- Consumer satisfaction was considered important and information could be collected by a case manager for each patient.
- Consumer understanding in relation to how service was delivered was also highlighted

Access to, uptake and completion of programmes

Participants identified several ways to potentially assess access, uptake and completion. These included:

- Referral to a programme* - could be measured via electronic medical records, a national registry (if available), new ICD-10 code. Participants suggested that this could be reported as the proportion of those who were eligible and who were referred. It was also suggested that an e-health registry could facilitate collection of such data.

- ii. *Referral to a GP* –measured via assessment of discharge report or calculating the number of GP chronic disease management plans.
- iii. *Participation in a program* – measured via calculation of the proportion of patients enrolled compared to those who were referred. It was suggested that this data obtained via contact with service providers, patient self-report via an interview
- iv. *Completion of a program* – measured via calculation of the proportion of patients who completed a program compared to those who are enrolled. Again, it was suggested that data could be obtained via contact with service providers, patient self-report via an interview.
- v. *Service utilization* – measured via proportion of patients with CHD patients with MBS 721 (chronic disease management plan) in the past year (data gathered using GP records eg PEN CAT tool)

Unfortunately, none of these options are exhaustive given the variety of secondary prevention alternatives that are available. For example a person may choose to visit their local gym and manage their medications via their GP and may be missed by hospital programme data collection whereas another may choose to participate in a hospital-based programme and be missed by general practice data collection methods. Hence it was suggested that another alternative would be to conduct brief patient interviews at specific time points (eg, 6, 12, or 24 months). In terms of contacting patients, it was suggested that a system of SMS messages to patients or sending of postcards prompting visits to the GP could be implemented. Alternatively, case managers could conduct brief telephone interviews with all patients however, this would require appropriate resourcing.

Effectiveness of programmes

There was general agreement by Summit participants that re-admission to hospital was a single and useful outcome in terms of effectiveness. Other suggestions included medication adherence and clinical measures. Participants did highlight that it is difficult to obtain accurate and objective data about non-pharmacological measures such as physical activity and smoking quit attempts. Suggested concepts and ideas included the following:

Readmission and mortality

- i. Re-admission (avoidable readmission) to hospital – could be presented as a proportion of those who were eligible and as a proportion of those who attended a program. It was suggested that DRGs could be used to collect the data
- ii. Mortality - could be presented as a proportion of those who were eligible and as a proportion of those who attended a program
- iii. Proportion of people with ACS who have another ACS or revascularization procedure within 12 months (measured via hospital data)

Medication

- i. Medication provision by GPs (GP record and/or at hospital discharge, DMACs or existing system)
- ii. Medication prescription by GPs (GP record and/or at hospital discharge, DMAC or existing)
- iii. Dispensing data measured via PBS
- iv. Proportion of patients with CHD patients on statin and aspirin after 1 year (GP records eg PEN CAT tool)
- v. Proportion of patients on specific medication classes ie, statins, antiplatelet, ACE, b-Blocker (Linked data – PBS, DOHA, AIHW (GRIM books), National Mortality Database, BEACH)

Clinical measures

- i. Proportion of patients achieving key clinical targets (eg, BP, smoking, cholesterol recommended levels) at 6 months, 12 months and yearly (measured by routine review by facilitator Link with GP electronic systems)
- ii. Proportion of patients with BP < 140/90 (GP records eg PEN CAT tool)

Satisfaction with programmes

Several Summit participants suggested that consumer satisfaction was an important measure and that such information could be collected by a case manager for each patient. The concept of consumer understanding in relation to how service was delivered was also discussed briefly and a participant highlighted that an ICD 11 currently being developed opportunity to provide feedback/input.

FUTURE DIRECTIONS

Short, medium and long-term goals resulting from the Summit are summarised in Box 4.

Box 4 – Short, medium and long-term goals	
Short-term goals (0 - 6 months)	Date
1. Production of a full technical report summarising the Summit	March 2012
2. Publication of a position statement summarising the Summit outcomes	May 2012
3. Establish a Summit taskforce with an agreed name, communication plan (i.e., website, email, teleconferences, face-to-face) and goals with a 2 year program of work including a project manager	May 2012
4. Collate information from and liaise with representatives from the National Institute of Clinical Studies (evidence-practice gap reports), Australian Commission for Quality and Safety in Healthcare (currently preparing a Ministerial report), Heart Support Australia (meeting Federal MP's 2011), Australian Institute Health and Welfare and AMEC (cardiac rehabilitation scoping project), Hospital Pricing Authority (to determine the price of secondary prevention services) and Medicare Locals.	May 2012
Medium-term goals (6-12 months)	
5. Produce a map of services (including traditional cardiac rehabilitation, exercise, diet, pharmacy etc including funding e.g., chronic disease management, mental health, home medicines review, private services)	Dec 2012
6. Hold additional face-to-face meeting and consider including all cardiovascular disease groups (e.g., National Stroke Foundation)	Dec 2012
7. Follow up on ICD 11 code development	Dec 2012
8. Facilitate modification of the AIHW definition of avoidable admissions to include stroke and MI	Dec 2012
Long-term goals (2 years and beyond)	
9. Pursue implementation of a system whereby a case manager is allocated to all patients with CHD	Dec 2013
10. Communicate and establish links with the Prevention Task Force who are determining a policy framework for remuneration of services	Dec 2013
11. CHD management to be seen as life-long by health professionals and the public (may require a public health campaign)	Dec 2013
12. Embed health professional training around behaviour change into continuous professional development	Dec 2013
13. Development of a patient-centre model of service delivery that cuts across systems and includes family engagement where appropriate	Dec 2013

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APPENDICIES

Appendix 1: Summit Executive and participants

EXECUTIVE COMMITTEE		
Julie Redfern (Co-chair)	Senior Research Fellow, Clinical Senior Lecturer	The George Institute for Global Health; The University of Sydney
Clara Chow (Co-Chair)	Head, Cardiac Program, Cardiologist	The George Institute for Global Health; Westmead Hospital
David Brieger	Cardiologist	Royal Australian College of Physicians; Concord Hospital
Tom Briffa	Research Associate Professor	School of Population Health, University of Western Australia
Derek Chew	Head of Research, Chair, SA Clinical Network	School of Medicine; Flinders University; SA Clinical Network
Cate Ferry	Clinical Issues Manager	National Heart Foundation
Stephen Leeder	Director, The Menzies Centre for Health Policy	The University of Sydney
David Peiris	Senior Research Fellow	The George Institute for Global Health
Fiona Turnbull	Director, Cardiovascular Division	The George Institute for Global Health
PARTICIPANTS		
Jim Cameron	President	Cardiac Society of Australia and New Zealand
Christine Connors	Program Leader, Chronic Conditions Strategy Unit	NT Department of Health
Brian Dooley	Chief Executive Officer	Heart Support Australia
Rosie Forster	Acting Executive Director	NHMRC National Institute of Clinical Studies
Ben Freedman	Professor of Cardiology	Concord Repatriation General Hospital
Jacque Garton-Smith	Clinical Lead, Cardiovascular Health Network, Hospital Liaison GP	Royal Perth Hospital
Margo Gill	Consumer Nominee	Agency for Clinical Innovation Cardiac Network
Rohan Greenland	National Director, Government Relations	National Heart Foundation
Robert Grenfell	National Director, Clinical Issues Program	National Heart Foundation
Fred Hersch	Resident Medical Officer	Royal North Shore Hospital

Graham Hillis	Director, Cardiovascular Division	The George Institute for Global Health
Sally Inglis	Cardiovascular Nurses Council	University of Technology Sydney
Stephen Jan	Senior Health Economist	The George Institute for Global Health
Shaun Larkin	Managing Director	HCF
Sindy Millington	President, Australian Cardiovascular Health and Rehabilitation Association	University of South Australia
Mark Nelson	Chair of General Practice; School of Medicine	University of Tasmania
Lis Neubeck	NSW Cardiovascular Health and Rehabilitation Association	Concord Hospital
Wilfrid Newman	Consulting Physician, Cardiac Services & ICU	Mackay Base Hospital QLD
Akiko Ono	National Director Research Program	National Heart Foundation
Katie Panaretto	Public Health Medical Officer	Queensland Aboriginal and Islander Health Council
Hella Parker	Program Manager	Cardiac Clinical Network, Victoria Department of Health
Anushka Patel	Senior Director	The George Institute for Global Health
Kazem Rahimi	Cardiologist, researcher	Oxford University
Gary Sinclair	Member, National Standing Committee-Quality Care	Royal Australian College of General Practitioners
Danielle Stowasser	Manager Clinical Advice and Program Design	National Prescribing Service
Janet Struber	CARPA Co-ordinating Editor	Central Australian, Rural Practitioner's Association
Andrew Tonkin	Chair, Cardiovascular Disease Monitoring Advisory Committee	Monash University
Leslie Trainor	Senior Project Officer	Australian Commission on Quality & Safety in Health Care
Nicole Whittaker	Senior Project Officer, Primary Health Community Partnerships Chr Disease	NSW Ministry of Health
Terri Wieczorski	Tasmanian Cardiovascular Health and Rehabilitation Association	Royal Hobart Hospital
Stephen Woodruffe	Exercise Physiologist & President	QLD Cardiovascular Health and Rehabilitation Association
Nick Zwar	Centre for Primary Health Care and Equity	University of NSW

Appendix 2: List of organisations represented

1. Agency for Clinical Innovation Cardiac Network
2. Australian Cardiovascular Health and Rehabilitation Association
3. Australian Commission on Quality and Safety in Health Care
4. Cardiac Clinical Network, Victoria Department of Health
5. Cardiac Society of Australia and New Zealand
6. Cardiovascular Nurses Council
7. Central Australian, Rural Practitioner's Association
8. Concord Repatriation General Hospital
9. Flinders University
10. George Institute for Global Health
11. HCF
12. Heart Support Australia
13. Mackay Base Hospital QLD
14. Menzies Centre for Health Policy
15. Monash University
16. National Heart Foundation
17. National Prescribing Service
18. NHMRC National Institute of Clinical Studies
19. Northern Territory Department of Health
20. NSW Ministry of Health
21. Oxford University, UK
22. Queensland Aboriginal and Islander Health Council
23. Royal Australian College of General Practitioners
24. Royal Australian College of Physicians
25. Royal Hobart Hospital
26. Royal North Shore Hospital
27. Royal Perth Hospital
28. South Australian Clinical Network
29. University of NSW
30. University of South Australia
31. University of Sydney
32. University of Tasmania
33. University of Technology Sydney
34. University of Western Australia
35. Westmead Hospital

Appendix 3: National Secondary Prevention of Coronary Disease Summit Program

OPENING AND INTRODUCTION	
8:30 - 8:35 am	Welcome to Country - Donna Ingram
8:35 - 8:40 am	Welcome to participants - Clara Chow and Julie Redfern
8:40 - 8:45 am	Official Opening - Tony Thirlwell, NSW Heart Foundation
8:45 - 8:55 am	The gap in coronary disease secondary prevention - David Brieger
8:55 - 9:00 am	Structure and format of the Summit - John Ramsay
9:00 - 9:10 am	Participant introductions
SESSION 1 - MINIMUM STANDARDS	
<i>Aim: Identify and agree on the key features that should be included in all coronary disease secondary prevention programs (including cardiac rehabilitation).</i>	
9:10 - 9:20 am	<i>Introduction:</i> Current practice and evidence - Tom Briffa
9:20 - 9:35 am	<i>Participant soundbites:</i> <ul style="list-style-type: none"> • Cardiac rehabilitation model - Sindy Millington • Consumer models of secondary prevention - Brian Dooley • General practice perspective - Nick Zwar
9:35 - 10:10 am	<i>Small group work:</i> Prepare list of minimum/common features appropriate for national implementation
10:10 - 10:30 am	MORNING TEA
10:30 - 11:30 am	<i>Large group discussion:</i> Feedback from tables and preparation of an agreed list of minimum/common features appropriate for national implementation
SESSION 2 – ENABLING STRATEGIES	
<i>Aim: Identify and agree on a set of realistic and tangible enabling strategies for implementation within existing resources at individual, health service and policy levels.</i>	
11:30 – 11:35 am	<i>Introduction:</i> Current evidence barriers and enablers - Julie Redfern

11.35 – 11:50 am	<p><i>Participant soundbites:</i></p> <ul style="list-style-type: none"> • Policy perspective - Stephen Leeder • NT Chronic Disease Management - Christine Connors • e-health and consumer perspectives - Shaun Larkin
11:50 - 12:35 pm	<p><i>Small group work:</i> Identify barriers and enablers at individual, health professional (community and hospital), system and policy levels</p>
12:35 - 1:20 pm	LUNCH
1:20 – 2:20 pm	<p><i>Large group discussion:</i> Feedback from tables and preparation of an agreed and comprehensive list of enabling strategies appropriate for national implementation</p>
SESSION 3 – EVALUATION STRATEGIES	
<i>Aim: Identify key performance indicators for monitoring and evaluation for hospitals and services community/ primary health services.</i>	
2:20 - 2:25 pm	<p><i>Introduction:</i> Monitoring the quality of services - Andrew Tonkin</p>
2:25 - 2:40 pm	<p><i>Participant soundbites:</i></p> <ul style="list-style-type: none"> • Quality improvement in general practice and Aboriginal Health - Katie Panaretto • NHMRC NICS - Rosie Forster • Heart Foundation perspective - Robert Grenfell
2:40 – 3:05 pm	<p><i>Small group work:</i> Develop a list of key performance indicators, measurement strategies and mechanisms for collecting and reporting this information</p>
3:05 – 3:30 pm	AFTERNOON TEA
3:30 – 4:30 pm	<p><i>Large group discussion:</i> Feedback from tables and preparation of an agreed list of key performance indicators and potential mechanisms for collecting and reporting this information</p>
FUTURE DIRECTIONS	
4:30 – 4:40 pm	<p><i>Large group discussion:</i> Next steps - Mr John Ramsay</p>
4:40 - 4:50 pm	Summary of outcomes - Mr John Ramsay
4:50 - 5:00 pm	Closing and thanks - Clara Chow and Julie Redfern

Appendix 4 – Executive, participants and program development

Executive Committee and Participants

A Summit Executive was formed in August 2011 to develop a detailed agenda and identify representatives from institutions across all states and territories of Australia. The Executive comprised nine national experts including three Cardiologists, a general practitioner, a public health physician, an epidemiologist, a policy expert, an allied health professional and a National Heart Foundation representative (Appendix 1). The Executive Committee held one hour weekly teleconference meetings and two longer face-to-face meetings to prepare the Summit. During the meetings an iterative process was followed in order to develop the Summit aims, participant invitation list, program and format as well as speakers.

The Executive Committee developed a participant invitation list based on their expertise and knowledge of national leaders in cardiovascular health and policy. In some cases, the Executive wrote to a senior person within an organisation and requested the nomination of an appropriate representative. The final list of participants (Appendix 1) included a range of clinicians (specialist physicians, general practitioners, nurses, allied health professionals, consumers, government representatives and representatives from a range of stakeholder groups (Appendix 3). The participants also included academics specialising in with health economics and epidemiology.

The Summit proceedings were professionally facilitated. Summit Co-Chairs had three teleconferences and a face-to-face meeting with the facilitator prior to the Summit. During these meetings, the facilitator provided advice about the best format for small group sessions, the size of small groups, optimal program scheduling, documentation and reporting. The role of the facilitator on the day of the Summit was to keep the program on schedule, ensure all participants had the opportunity to contribute and to assist in summarising the discussions. The facilitator was independent of any of the represented organisations.

Program and format

The themes of the four sessions (Appendix 4), each of which was iterative, were minimum standards, enabling strategies, data and monitoring, and future directions. Each session began with a brief overview of current evidence. These presentations aimed to focus the thinking of participants on the objective of the session. The presentations included slides and were for 5-10 minutes duration and Australian experts were nominated to make the various presentations. For each session, the opening presentation was followed by a series of “soundbite” presentations from three pre-selected participants who provided brief examples and experiences from their organisation in three minutes without audiovisual aides.

The small group discussions (30-60 minutes) for each session aimed to allow participants to contribute to the various sessions through back and forth discussion within the groups who were seated at round tables. It was anticipated that small groups allow creative,

flexible interchange of ideas and lively, meaningful discussion where participants could participate freely and actively. For each session, the small group task reflected the larger group agenda and aims of the specific session. There were five small groups, each with approximately eight participants per table. Each small group had a pre-nominated facilitator who endeavoured to ensure all participants at their table had the opportunity to contribute and kept the group on task. Another table participant acted as a scribe to record and summarise the small group's consensus and ideas on butcher's paper.

The large group discussion at the conclusion of each session aimed to allow reflection and drawing together of the small group discussions and develop a group consensus. At the start of each large group discussion, the various table facilitators reported back the consensus and summary from each of the small groups. The Summit facilitator then led an active discussion around the topic. Discussions were recorded by nominated personnel.

For each session where participants felt they had not sufficiently contributed to the small or large group discussion, a comment sheet was available to allow them to make individual written contributions (Appendix 5). At the completion of each session, these individual comment sheets were collected. A total of 32 individual comment sheets were collected throughout the day including 14 for the minimum standards session, 10 for the enablers session and 8 for evaluation session.

Participant feedback

At the Summit's close, attendees were asked to complete a brief survey form. This evaluation included three open-ended questions (asking what participants like, what could be improved and further comments), five statements (asking about organisation, facilitations, communication, venue and satisfaction with the outcome) that participants were to evaluate on a 5-point scale and a single question asking whether they would attend another similar summit in the future.

Of the 15 evaluations returned, 100% said they would attend another similar Summit and 93% reported being satisfied with outcome (one person was neutral because it was "too early to tell"). 100% reported that the overall organisation and facilitator was good or very good. Overall, the feedback forms highlighted that participants particularly like the focussed discussions, the interactive and engaging nature of the Summit, the widespread and diverse range of participants, the brief presentations and contributions from various participants as well as the pre-reading and general facilitation during the Summit. In terms of improvements, participants suggested the availability of session feedback forms and key resources (identified by stakeholders) prior to the meeting.

At the conclusion of the Summit, the reports from each small group, written notes from the large discussions and the individual written contributions were summarised into themes and suggestions for future directions. This summary formed the basis of a full draft report. A feedback and consultation process involving the Executive Committee and all participants was followed to develop the final report.

Appendix 5: Individual session feedback forms

Small Group Discussion – Session 1

Aim: To identify key features that should be included in all coronary disease secondary prevention programs.

Format
1.
2.
3.
Content
1.
2.
3.
Setting
1.
2.
3.
Communication
1.
2.
3.
Timing
1.
2.
3.
Staffing
1.
2.
3.

Small Group Discussion – Session 2

Aim: To identify and agree on a set of barriers as well as realistic and tangible enabling strategies for implementation within existing resources.

BARRIERS	ENABLERS
Individual	
Health Professional	
System	

Small Group Discussion – Session 3

Aim: To identify key performance indicators for monitoring and evaluation for hospital, community and primary health services.

Key Performance Indicator	Measurement strategies/ data collection	Reporting

Declaration

The Summit has been designed by The Cardiovascular division of the George Institute for Global Health, in consultation with an Executive Committee who has complete intellectual and editorial control of the program.

This initiative has received financial support from AstraZeneca to pay for participant attendance (accommodation, travel, parking), venue hire and organizational expenses. Speakers or participants do not receive any direct payments or honoraria.

This initiative has received non-financial support from the Heart Foundation for media and public relations services.