Cardiac Rehabilitation/Secondary Prevention Programs

A Raft for the Rapids: Why Have We Missed the Boat?

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“There are risks and costs to a program of action. But they are far less than the long-range risks and costs of comfortable inaction.”

John Fitzgerald Kennedy

Every year, hundreds of thousands of patients experience a coronary heart disease (CHD) event and enter a period of time that is high risk, life threatening, and life altering—the medical equivalent of a ride down the turbulent and dangerous whitewater-rapids portion of a river. Fortunately, most patients survive these events, thanks in part to the prompt application of life-saving therapies in the home, ambulance, and hospital settings. However, for those patients who leave the hospital after a CHD event, the ride in the whitewater rapids has not ended. They remain at increased risk for future CHD events. Effective secondary prevention therapies are available in the posthospital setting, but unfortunately, some of those therapies, including cardiac rehabilitation/secondary prevention (CRSP) services, are underused. In fact, most patients who survive a CHD event do not receive CRSP services and can be compared with a group of people who are crossing the whitewater rapids of a river without a raft.

The underuse of CRSP services has been documented consistently during the past decade. Published reports also have documented that CRSP improves patient outcomes, in a magnitude similar to the reduction in CHD mortality and morbidity rates obtained from aspirin, β-blocker, and statin therapy, and probably with similar cost-to-benefit ratios. The underuse of CRSP is indeed a problem. The limited use of CRSP services by persons 65 years of age also has been noted, generally showing the highest rates of participation in hospital and community settings, only a minority of patients participated in a CRSP program within the year after their CHD event. Participation was particularly low when ≥1 of the following characteristics was present: older age, female gender, nonwhite racial/ethnic status, lower socioeconomic status, significant comorbid conditions, and long distance from the patient’s home to a CRSP center. Considerable geographical variation in CRSP participation rates also was noted, generally showing the highest rates of participation in the midwestern United States and the lowest in the southern United States. The reason behind this geographic variation is unknown, but at first glance, it appears that CRSP programs in the midwestern United States have already begun implementing effective ways to improve CRSP participation rates. Further investigation is warranted in this area.

The study by Suaya et al gives rise to several important questions about CRSP programs.

Is Underuse of CRSP Really as Big a Problem as It Seems?

The underuse of CRSP services has been documented consistently during the past decade. Published reports also have documented that CRSP improves patient outcomes, in a magnitude similar to the reduction in CHD mortality and morbidity rates obtained from aspirin, β-blocker, and statin therapy, and probably with similar cost-to-benefit ratios. The underuse of CRSP is indeed a problem. The limited use of CRSP services by persons <65 years of age also has been reported and likewise appears to be a significant problem.

Why Is CRSP Underused?

Reasons for the underuse of CRSP are probably multiple and complex but generally center around barriers at the patient, provider, healthcare system, and community levels.

- **Patient barriers.** A significant portion of the barriers to CRSP participation revolve around patients themselves. One study, in fact, found that <50% of patients referred to a CRSP program actually enrolled in the program. Factors behind these barriers are multiple. Patients often...
are unaware of the need for and the benefits of CRSP. Others perceive it negatively as a gymnasium-based group exercise program that is not for them and is too far from home, too expensive, too inconvenient, and too time consuming. Some patients are unsure whether CRSP is covered by their insurance. Still others do not see the incremental value of a CRPS program above and beyond what they can do by themselves or with the help of their healthcare provider. Finally, some patients may not enroll in a CRSP program simply because of the perceived complexity of the referral and enrollment process, a process that can augment the already-formidable complexities of their medical care concerns (eg, patients often have been given a new, life-altering diagnosis, multiple new medications, and numerous anxiety-provoking tests, among other things).

- **Provider barriers.** Current policies specify that for patients to participate in a CRSP program, they must be referred by their healthcare provider. Because of competing demands on their time and attention, many clinicians may not remember to refer their patients to a CRSP program even if they are supportive of CRSP programs in theory. Some clinicians may be unsure which of their patients are eligible or appropriate for CRSP. Still other clinicians may not refer patients to CRSP programs because they do not perceive any incremental benefits of CRSP for their patients above and beyond the benefits their patients receive from the care already provided to them in their office setting.

- **System barriers.** Many leaders in healthcare systems, insurance companies, and policy-making organizations understand the importance of secondary prevention services such as CRSP but have difficulty seeing how they can promote their implementation. Other leaders may fail to see the incremental value of CRSP but rather view it as an added expense with limited short-term results. At the healthcare-system level, competing demands for resources in acute care settings often take priority over resource needs for chronic care and preventive services like CRSP. Last but not least, an important system-oriented barrier to CRSP use is that CRSP programs generally lack a strong “voice” in their support. Although CRSP staff members generally are quite passionate about their work locally, CRSP proponents have generally lagged behind other healthcare organizations in building a strong network of “lobbying” partners at the state and national levels. However, this deficit is gradually improving with the help of leaders in the American Association of Cardiovascular and Pulmonary Rehabilitation, American College of Cardiology, and American Heart Association. Until these efforts become more fruitful and unified with efforts from other healthcare organizations, however, supporters of CRSP will continue to come up short in the competitive push for short- and long-term care.

- **Community barriers.** The perceived need and actual demand for CRSP services can be affected by many influences that run through society, sometimes in conjunction with and sometimes in opposition to each other. Community support for prevention-oriented lifestyles, including infrastructure (walking paths, parks with areas for exercise, etc) and policies (smoking bans, menu labeling, etc), can help exert a positive influence for individuals who are seeking to reduce their CHD risks by improving their lifestyle habits. Help from positive media messaging also can help promote prevention-oriented lifestyle choices. Lack of community support and positive media messaging, however, can produce barriers to prevention-oriented choices, including the choice to participate in a CRSP program.

How Can We Improve the Use of CRSP Services?

To help improve the use and impact of CRSP services, several interrelated steps can be recommended.

1. **Make secondary prevention services a high priority.** Until CRSP services are set as a high-priority item at local, regional, and national levels, they will continue to be underused.
2. **Educate patients and providers.** Educational efforts aimed at the public, providers, healthcare systems, community leaders, and policy makers will help increase the awareness of the importance of CRSP services and thereby help reduce barriers to the use of CRSP services.
3. **Simplify the referral and enrollment process.** Several steps are key to help make this happen.
   - Automatic referral to a CRSP program (eg, standardized orders for all eligible patients) must be provided to all patients who are eligible for CRSP.
   - Automatic enrollment in a CRSP program should be linked to the referral process so that all patients are enrolled in a CRSP program, whether in a center-based, home-based, or community-based setting. Patients should be given a list of CRSP options so that they can choose the CRSP program most convenient and appealing to them.
   - **Effective communication processes are required between referring providers and CRSP programs.** This is essential if the referral and enrollment steps are to join together into one fluid, coordinated step.
4. **Increase resources for CRSP services.** Third-party payers can help stimulate greater use of CRSP services by simplifying coverage policies and increasing CRSP reimbursement strategies for traditional and novel treatment models and for short- and long-term care.
5. **Expect more from CRSP services.** Several factors are emerging that require more effort from CRSP programs.
   - **Capacity and capabilities of CRSP must increase.** Delivery models for CRSP programs must continue to evolve to provide services to all eligible patients. Services must include both traditional and novel approaches to center-based, home-based, and community-based options to help overcome the logistical barriers to CRSP use (eg, geographical, financial, and time-related issues).
   - **If efforts to improve referral to and enrollment in CRSP programs succeed, then CRSP programs will need to expand their capacities, widen their capabilities, or both.** As mentioned by Suaya and coworkers, an additional 93,000 Medicare patients per year.
Suaya and coauthors4 should be congratulated for their efforts to point out our continuing deficiencies in providing CRSP services and related benefits to our patients with CHD. Their study is a wakeup call to all providers of cardiovascular health care to find solutions to this problem to help our patients maneuver more safely through the whitewater rapids of performance measures. The recently published AACVPR/ACC/AHA 2007 Performance Measures on Cardiac Rehabilitation for Referral to and Delivery of Cardiac Rehabilitation/Secondary Prevention Services,21 if fully implemented by clinicians, healthcare systems, cardiac rehabilitation/secondary prevention centers, and third party payors, will stimulate improvement in CRSP service delivery and will also provide a standardized method to measure, track, and report those improvements over time.

Suaya and coauthors4 should be congratulated for their efforts to point out our continuing deficiencies in providing CRSP services and related benefits to our patients with CHD. Their study is a wakeup call to all providers of cardiovascular health care to find solutions to this problem to help our patients maneuver more safely through the whitewater rapids of the rehabilitative and preventive stages of post-CHD event care. We have been missing this boat for too long. It is time for us all to find better ways to help our patients climb aboard.

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References
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