Another Piece of the Puzzle
Wait Times Call for Integrated Patient, Provider, and System Solutions for Cardiac Rehabilitation

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Cardiac rehabilitation (CR) is a multidisciplinary, systematic approach for reducing morbidity and mortality across a spectrum of cardiovascular conditions. Yet, in spite of the class IA recommendations for CR, ≤80% of eligible patients are not referred; many of those referred do not attend; and many participants do not complete the program. A large body of literature over many decades has emphasized the complexity of patient, provider, and healthcare system factors influencing the uptake and adherence to CR. Documented barriers range from cost, access to care and health professional endorsement, and solutions apparent.

Overcoming Barriers and Alternate Models
After decades of documenting barriers to CR, there is a clear signal we have to do things differently. Currently many experts are calling for strategies for repackaging and reframing CR. This approach will likely mean changing our models of service delivery and collaborating with providers across care settings and working differently. There is evidence to suggest that home-based models of CR are equally as effective as facility-based models, and the role of telehealth in supporting health care is increasing. Many of these models have the potential to address the well-documented barriers in accessing and participating in CR. Increasingly, there will be a need to develop accessible, affordable, and acceptable models in communities rather than focusing on service delivery models within acute care settings. It is clear that developing innovative models will require moving beyond considering CR as a unidimensional and definitive strategy to a complex intervention. Considering CR within an integrated disease management model; identifying environmental dimensions, target population, intervention content, intensity, dosing and complexity, delivery personnel; and the importance of both process and outcome assessment in driving service efficiency and optimizing patient outcomes will be important in implementing and refining models of care.

Globally, healthcare systems are striving to achieve efficiencies, increase accessibility, and improve equity. Identifying those at highest risk is an important strategy to maximize the benefits of treatments, and this is likely to be the case in CR. Strategies, such as community health workers and patient navigators, are likely important not just in engaging vulnerable populations, but in delivering elements of secondary prevention. In the United States, the Patient Protection and Affordable Care Act has increased the focus on coordination of health care and the focus on not just individuals but populations. As a consequence, Accountable Care Organizations have been formed which are coalitions of
service groups and healthcare providers, who strive to provide coordinated high-quality care. This is a promising development for CR delivery. Engaging both patients and providers in valuing CR as integral to the care model, rather than as an optional extra, is important in increasing uptake, ensuring persistence, program completion, and adherence with recommendations over time.

The Way Forward

Applying the many valuable lessons of barriers to CR from both experimental studies and registry data demands a comprehensive review of existing practices, models of care, and using information to determine a pathway for the future. Strategies, such as automatic referral and discharge checklists for eligible patients, have been identified as a first step in accessing CR. As shown by Marzolini et al, referral is an important first step, but not sufficient to maximize the benefits of CR. Marzolini et al emphasized that barriers are most apparent in women, the elderly, and those from lower socioeconomic status populations. Ensuring access to CR will require integrated patient, provider, and system solutions. Continuing to document these barriers is no longer viable in the science of CR; we need to develop and test strategies to promote access to this evidence-based approach for improving cardiovascular outcomes.

Disclosures

None.

References


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