Secondary prevention of coronary heart disease in Australia: a blueprint for reform

An integrated national approach represents the greatest opportunity to further reduce cardiovascular disease burden

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In Australia, coronary heart disease (CHD) accounts for about 100 000 hospital separations annually. In 2010, the total cost of acute coronary events was over $5 billion.[1] A high proportion of coronary events occur in those with known CHD,[2,3] and there is strong evidence that secondary prevention reduces hospital readmission and death within the first year after a coronary event by as much as 45% and 25%, respectively.[4,5] However, despite abundant evidence and guideline recommendations,[6] fewer than half of eligible patients take appropriate preventive medicines or adhere to lifestyle recommendations, and only about a third of those who are eligible attend a prevention program.[7,8] A nationally orientated and coordinated approach that underscores the value of secondary prevention, defines the available resources, and monitors uptake and outcomes will be essential in closing these gaps.[9]

Consensus recommendations

1. Develop and implement a national approach that is inherently adaptable to available resources and individual patient needs and values, and includes structured initial assessment, risk factor modification, follow-up and reassessment.
2. Bridge the gap between hospital and primary health care and provide connected care by using a case-management approach, improved communication, and greater provider education relating to secondary prevention, behaviour change techniques and self-management strategies.
3. Increase awareness, cohesion and utilisation of existing services (by patients) through creation of a national inventory or "map" of secondary prevention initiatives.
4. Develop a system for monitoring and maintaining performance in secondary prevention.
5. Implement a communication strategy that links and engages state and federal government, Medicare Locals, consumers and private health funders to facilitate sustainability.
6. Establish a national secondary prevention task force to implement the recommendations resulting from the secondary prevention consensus meeting. ◆

A national consensus meeting to consider an improved approach to secondary prevention was held in December 2011.[10] The Summit was attended by 40 representatives from relevant stakeholder groups including government and non-government agencies, consumers and health professionals. Organisations that were represented included the Australian Commission on Safety and Quality in Health Care, the Australian Cardiovascular Health and Rehabilitation Association, the Cardiac Society of Australia and New Zealand, the National Heart Foundation of Australia, Private Healthcare Australia and the Royal Australian College of General Practitioners, among others. We aimed to appraise the essential components of an effective CHD secondary prevention program, performance measures, and barriers and enablers to implementation. The aims are detailed in the full report.[10] Six interdependent recommendations emerged (Box) that highlighted the connection between tertiary, secondary and primary care as an area of paramount concern. A series of practical strategies to improve CHD secondary prevention are outlined below.

National task force

Establishment of a cohesive and multidisciplinary secondary prevention task force (linking state governments, federal governments and stakeholders, as achieved by

the Summit) is essential for raising the profile of the problem and providing leadership. Moreover, a task force should develop a nationwide scheme of secondary prevention and provide a platform to raise the profile of the problem. Such a national scheme could be modelled on a program like the National Diabetes Services Scheme — a government-funded initiative, administered by Diabetes Australia, that provides diabetes information and support and includes an interactive website giving access to resources, health professional advice and online registration.

Focus on better coordinated secondary prevention care

Patients with CHD need lifelong management; however, few cardiac rehabilitation programs and primary health care services are organised to provide this. A patient-centred approach is needed, perhaps using care coordinators, in the way diabetes management plans use diabetes educators to collaborate with the person with diabetes and other team members to achieve clinical targets. Importantly, diabetes educators are located in hospitals, community health centres, general practice or private practice and, if credentialled, their services are recognised by Medicare. A similar model would also be likely to work for CHD secondary prevention.

Better integration and utilisation of existing services

An immediate mechanism for improving secondary prevention of CHD is through more comprehensive use of existing services. Many health providers and patients are unaware of all the relevant services. A web-based and updateable inventory of resources (including information about costs) would improve this situation. The inventory would need to include a range of programs and schemes, including, among others: cardiac rehabilitation; Heart Foundation programs such as *Heartmoves* and *Walking*; schemes that give access to allied health and psychology services via chronic disease management plans and home medicines reviews, and which attract a Medicare rebate; Quitline; and Aboriginal and Torres Strait Islander services. The maintenance of the inventory might become an activity of the Australian Commission for Quality and Safety in Health Care in collaboration with state governments, Medicare Locals or a non-government organisation (eg, the Heart Foundation).

Maintaining quality

A central function of a national task force would be to establish performance measures to facilitate clinical practice improvement. Measures such as access and timeliness could be used to assess service delivery, and measures such as hospital readmissions and death from CHD could be used to assess end health outcomes. Eventually, measurement and review of clinical practice improvement may be made routine, given that evaluation of service delivery is already possible through linkage of administrative and clinical datasets in New South Wales (eg, the Centre for Health Record Linkage), Western Australia (WA Data Linkage Branch) and rural Victoria (eg, Generic Health Network Information Technology for the Enterprise). This potential should increase with the growing use of electronic medical records.

Narrowing the evidence–practice gap in secondary prevention for CHD is an obvious strategy that will directly reduce Australia's CHD burden. Raising this issue as a national priority, increasing the use of existing schemes and developing similar strategies to those effectively implemented for management of other chronic diseases in Australia are strategies that offer excellent prospects for progress.

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