Population and behavioural perspectives on the CR landscape

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Heart Foundation

Population perspective - the aerial view

The terrain…….

- Size of the target population?
- Capacity of current workforce?
- Efficacy of current service?
- Effectiveness of current service (efficacy x reach)
- Cost of providing current service?

- Knowing the denominator, or the size of the whole potential client population.
  - This includes those who make it to CR services, but more importantly knowing those who don't

Recommended for CR

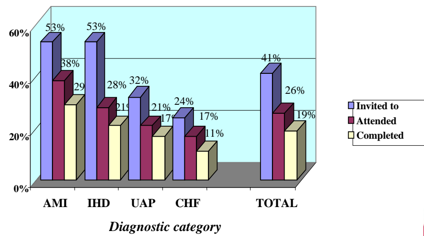
	NSW	VIC	AHCPR
AMI	🗐	🗐	🗐
CABG	🗐	🗐	🗐
PTCA	🗐	🗐	🗐
UAP		🗐	🗐
AP		🗐	🗐
CHF	🗐	🗐	🗐
Other	🗐	🗐	🗐

Hunter, NSW study

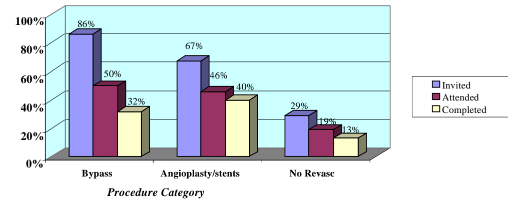
(Johnson, Inder, Nagle, Fisher, Wiggers 2002)

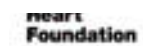
- All patients
  - with an eligible discharge diagnosis in the one year study period (1998-1999)
  - aged 20-86 years
  - resident in the Hunter region
  - alive at recruitment
  - discharged from public hospitals
  - able to be mailed a consent and information letter

The proportion of AMI (n= 285), IHD (n=306), UAP (n=376), CHF (n=209) who were invited, who attended and who completed CR. (Total N=1176)

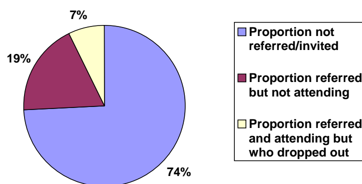


Proportion of CABG (n=172) and PTCA (n=114) who were invited, who attended and who completed CR



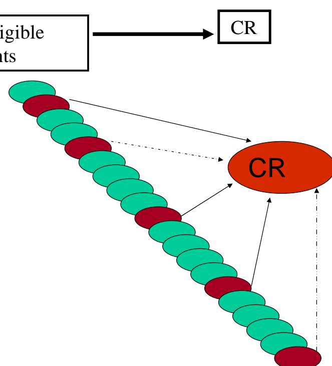


Of those who DID NOT complete CR (n=943) 81%



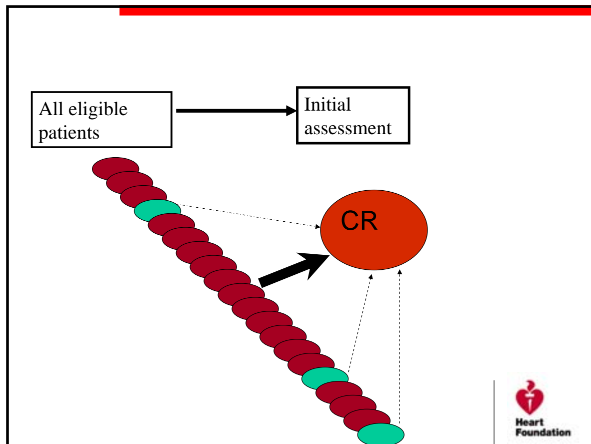
So the denominator is crucial

- Being able to monitor service delivery rates as a proportion of this denominator is crucial for equitable access and service improvement



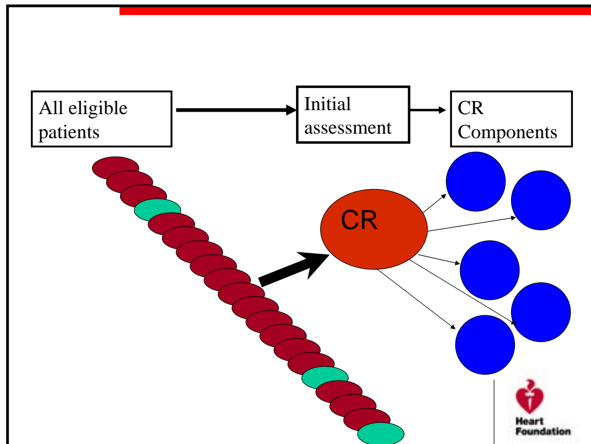
Is a centralised referral system feasible?

- Based on ICD 10 code – stats unit provides names to a centralised booking centre (all eligible for CR)
- Centralised booking system contacts patient for routine appointment with CR assessment clinic
- At assessment CRC + Patient determine how care will be provided



Capacity of workforce

- Approx 120 CR Programs listed on Heart Foundation Directory
- 484 members of ACRA
- Is it feasible that resources for CR will increase three fold to allow current care delivery to meet demand??



Lets assume no new funds/resources …..

Who are our potential partners?

- Private Health Insurance
- General Practice increasingly the focus of secondary prevention funding
- New Commonwealth Care Planning initiatives through Medicare, (engaging practice nurses)
- Private Allied Health Professionals
- Pharmacy (Medication compliance)
- Fitness Industry (Maintenance Exercise)

New Medicare Items

- **General Practitioner Managed Plan**(GPMP)
- **Team Care Arrangement** (TCA)
  - Two other providers
  - 5 Allied Health consults/year
- **Allied Health Group Services Item** (AHGSI)
  - Only for Diabetes at present
- **Home Medicine Review** item

New CDM Items

Name	Item No.	Medicare Fee (100%)	Recomm. Frequency	Minimum Claiming Period
Preparation of a GP Management Plan	721	$120	2 yearly	12 months
Preparation of Team Care Arrangements	723	$95	2 yearly	12 months
Review of a GP Management Plan	725	$60	6 monthly	3 months
Coordination of Review of Team Care Arrangements	727	$60	6 monthly	3 months
Contribution to a multidisciplinary care plan or Team Care Arrangements	729	$41.65	6 monthly	3 months
Contribution to a multidisciplinary care plan by an Aged Care Facility	731	$41.65	6 monthly	3 months

Team Care Arrangements (TCA) MBS Item 723

- Available for patients with a chronic or terminal medical condition *and* complex needs requiring ongoing care from a multidisciplinary team of their GP and at least two other health or care providers.
- TCA involves a GP (can be assisted by Practice Nurse), discussing/agreeing with the patient which providers should be involved, what information can be shared, collaborating with the participating providers on required treatment/services and documenting this in the patient's TCA.
- A TCA can be provided without a GPMP, *but a patient must have both a GPMP and a TCA to access Allied Health and Dental Care.*

What is involved in Team care Arrangements ?

- Assess the patient - identify &/or confirm health care needs, problems and relevant conditions,
- Agree management goals with the patient (changes to be achieved by the treatment and services identified in the plan)
- Identify any actions to be taken by the patient
- Identity required treatment and services, make arrangements for provision of these services and for ongoing management
- Document the patient's needs, goals, patient actions, treatment/services and a review date.

- CURRENT: Catch some, provide all care components for some, and hold some in maintenance
- POTENTIAL: Catch all, manage care components for all, provide some care components for some and release all

Behavioural perspective – the individual's journey

Rehabilitation

- Of the disease?
- Of the patient?

- "…is not what we do to patients it is about what we help patients learn to do to themselves." Philip Ades 2005

Putting behaviours under the microscope

- Each "behaviour" resembles a molecule, comprising even smaller units of behaviour (atoms).
- Units of behaviour within a cluster develop magnetic attractions binding them together.
- We always do what rewards us

Understanding behaviour change

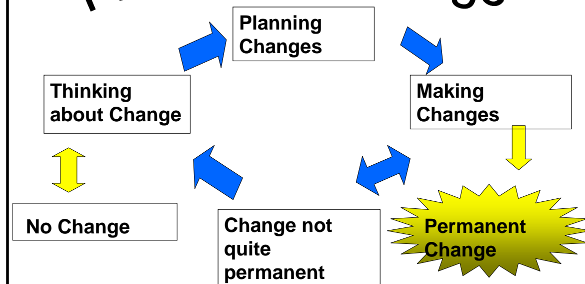
- ……..now it's your turn!!!!!!

Theoretical Models of Behaviour change

Examples:

- Theory of Reasoned Action
- Health Belief Model
- Social Learning Theory
- Transtheoretical Model of Change
- PRECEDE Model

Process of Change



Prochaska and Di Clemente's Transtheoretical Model of Change

Transtheoretical Model

- Describes **different stages** of change
- Behaviour change is a **not a single event**
- **People are the at different stages** of readiness to change
- Movement forward requires energy (motivation)
- Please don't assess stage!!!

But….

- Some models account for individual behaviour but not for the external societal influences
  - Price and availability of exercise programs
  - Access to services and products (transport)
  - Support to make changes
  - Medicare rebates for GPs

PECEDE Model (Larry Green et al)

- **Predisposing** factors
  - which guide a person to behave in a certain way
- **Enabling** factors
  - which encourage or allow a behaviour to occur
- **Reinforcing** factors
  - which reward or punish the behaviour

Example of enabling factor

Example of reinforcing factor

Successful behaviour change requires that patients ...

1. Are aware that change in beneficial and achievable
2. Have an understanding that achieving the final goal involves a long journey and is not a single discrete action
3. Are aware of the final behaviour goal
4. Are aware of their starting level
5. Have set up small incremental steps towards final goal
6. Can manage relapse
7. Have guidance, support or coaching to assist the journey
8. Can identify barriers, impeding progress
9. Feel comfortable managing risk
10. Can enjoy the process and stay in charge

The challenge for us was ...

- **To increase sustained SAFE physical activity among *at risk* individuals, in a community setting**
- **To develop integrated links between GPs health teams (DE, CR, CDM) and the exercise industry**
- **Respond to increasing incentives from government for prevention**
- **Increase collaboration between health teams and exercise industry**

- **Solution → *The Heartmoves Integrated Referral Model***

Clients' Perceived Barriers

- Community perceptions of the fitness industry - "for the young the fit and the beautiful"
- "Lycraphobia" among public
- "Go hard or go home"
- Have to be fit to go to the gym
- Too expensive - locked into long term membership

Exercise Industry's Perceived Barriers

- They would need new marketing strategies
- Put off the existing young clients
- Scared of people with a chronic condition - they might have a heart attack
- Insurance
- New systems for communicating with health professionals

GPs' Perceived Barriers

- GP wariness of prescribing PA for clients with risk factors or with existing CVD (including diabetes)
- Fear of high intensity and fitness industry image ("No pain No gain" "Go hard or Go Home")
- Limited knowledge of training and accreditation standards in the industry
- Query personal liability if event occurs
- Limited knowledge of exercise intensity levels, evidence, referral tools, feedback options or support - no perceived safe, supervised referral programs

Heartmoves leaders

- Deliver :
  - graded goal setting
  - rewards rewards and more rewards
  - social bonds
  - relapse prevention
  - reporting on progress
  - incident reporting
  - feedback to referring HP

Risk management in HEARTMOVES

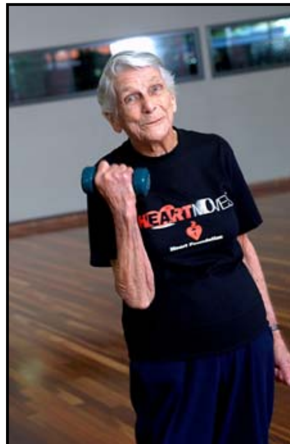
- **Low to moderate intensity** (can talk or sing while exercising, clients taught to use intensity scale)
- **Seated version** of all exercises
- **Monitoring** of exercise intensity and client condition
- **Supervision** of movement, tailoring for limitations
- **Rest and water breaks** assist intensity regulation
- **Warm up and cool down** compulsory (10 min each)
- **Communication with GPs** (Feedback Forms; EPC)
- **Screening and medical clearance**
- **Flexible multi-component programming** - aqua, floor, circuit, weights (resistance) seated, aerobic, Tai Chi, yoga
- **Home based exercise video**
- **GP Referral Resource CD**

HEARTMOVES Leaders

- Are registered exercise professionals with current CPR
- Attend specialised **Heart**moves Short Course -
  - Content approved by NHFA
  - Delivered by a team of health and legal professionals (NHFA and Health Dept)
  - Skills in delivering exercise to at risk populations
  - Accredited with Fitness Australia (15 CEC)
  - Accredited with A PA (54 CPD)
  - Accredited with AAESS (6 CEP)
  - Accredited with ADEA (8 credentialing points)
- Receive a QA audit on their program
- Have Public liability/professional indemnity insurance
- Attend Re-accreditation Workshop (4hrs) biannually

Personal Training & Group programs

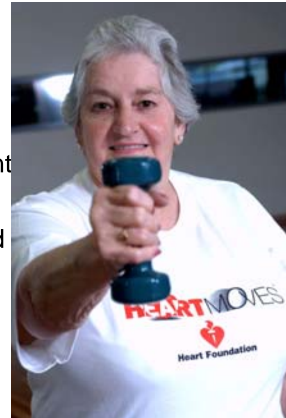
Seated exercises included



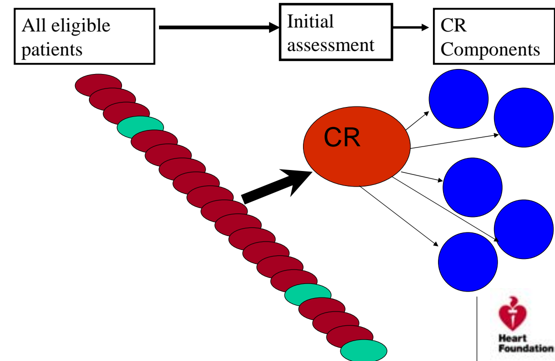
Builds:
- independence
- confidence
- self management skills

Weight Management

(aerobic and resistance training)



Heartmoves Home Based Exercise Video/DVD



5 minutes for smoking

- Assess using smokelyser for (carbon monoxide analysis)
- Specifically describe impact, weight the decision
- Complete and fax a referral to the Quitline (request call back)
- Prescribe NRT and refer to pharmacist
- Record baseline and referrals
- Implement a TCA with GP as consultant.

5 minutes for Exercise

- Raise the urgency of increasing exercise for disease prevention or management
- Provide patient with a written referral:
  - to **Heart**moves and/or
  - to AHP/practice nurse for initial consultation about risk management (eg diabetes) and measurement (eg 6 min walk teat, BMI , Waist), before **Heart**moves
- Use **Heart**moves leader/AHP as “Other Providers” in the Care Plan (Team Care Arrangement)
- Request feedback from **Heart**moves leader and/or AHP (TCA Review Item)

For further information…

- Visit **Heartsite**:
  www.heartfoundation.org.au

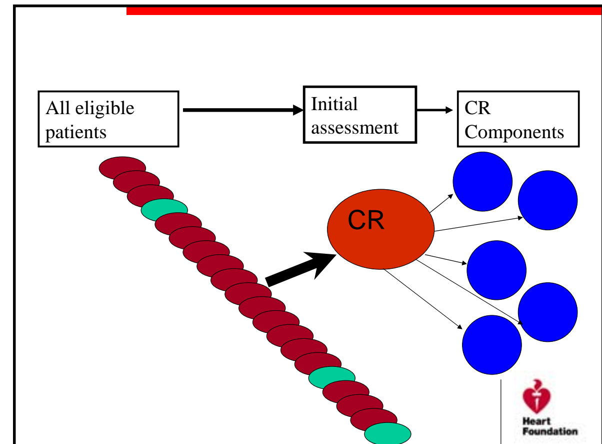
- Call **Heartline** for a free copy of many of the Heart Foundations brochures and leaflets.

  Heartline 1300 36 27 87

Thank You!

Population perspective - the aerial view

Behavioural perspective – the individual's journey



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