Cardiac Rehab Measures Aim to Boost Referrals

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Medical societies have jointly issued new performance measures for cardiac rehabilitation that are expected to increase the number of patients referred to rehab services. The measures also promote a safe exercise environment for those patients, but stop short of holding cardiac rehabilitation centers responsible for meeting treatment goals.

Published simultaneously in Circulation and the Journal of the American College of Cardiology, the performance measures were developed by the American College of Cardiology, the Association of Cardiovascular and Pulmonary Rehabilitation, and the American Heart Association.

"Research continues to show that cardiac rehabilitation services, although very effective and helpful for people with cardiac disease, are still being vastly underutilized," Dr. Randal J. Thomas said in an interview. Dr. Thomas, director of the Cardiovascular Health Clinic at the Mayo Clinic in Rochester, Minn., chaired the committee that wrote the new cardiac rehabilitation (CR) performance measures.

Despite the fact that CR after cardiac illness has been shown to reduce a patient's mortality risk by 20%-25%, and also to improve physical strength and endurance by 20%-50%, less than 30% of eligible patients participate. There are many reasons for this, but foremost among the correctable causes is that many patients are simply never referred to CR.

Dr. Thomas' committee developed two sets of performance measures. One set is intended to improve the referral of eligible patents to CR, and the other is aimed at improving the services offered by CR programs.

In the first set of measures, the committee specified that all hospitalized patients with eligible conditions should be referred to outpatient CR prior to discharge. In addition, outpatients with a qualifying diagnosis during the prior year should also be referred to CR if they have not yet participated.

The qualifying diagnoses are myocardial infarction, acute coronary syndrome, coronary artery bypass graft surgery, percutaneous coronary artery intervention, cardiac valve surgery, cardiac transplantation, and chronic stable angina. Patients with chronic heart failure and peripheral arterial disease should be considered for CR.

In the second set of measures, the committee specified that all CR programs have a physician medical director, a well-trained emergency response team, and equipment and supplies for emergency resuscitation in the exercise area. All patients should receive individualized assessment of and education about their modifiable cardiovascular risk factors.

The committee chose not to hold CR programs responsible for attainment of treatment goals. Dr. Thomas said that while some committee members suggested that CR programs should demonstrate that their patients are achieving LDL-cholesterol levels below 100 mg/dL or 70 mg/dL (for example), ultimately the committee conceded that this was not entirely under the programs' control. Some CR programs do take charge of their patients' prescriptions, but more commonly it's the patients' personal physicians who choose their regimens.

Dr. Thomas acknowledged that existing CR programs could not accommodate the huge influx of new patients that would result if the performance measures were implemented universally.

"We need to work together to establish new models that will help to provide the care necessary for everybody who's not getting the care," he said. "For example, does everybody need to come into a cardiac rehabilitation center to receive rehabilitation and preventive care? The answer is no. There are a lot of publications showing the benefits of a system where patients would largely carry out their rehabilitation efforts at home or in a local health club, but still under the direction of a nurse and a physician."

Dr. Thomas said that the insurance industry will have an important role to play if the performance measures are to be implemented. "There is an expectation and a hope, anyway, that the insurance carriers will see the value of some of the novel approaches to rehab and start reimbursing for those models of care, which they're not doing generally now."

The full text of the cardiac rehabilitation performance measures is available at www.acc.org/qualityandscience/clinical/pdfs/CardiacRehab_PM_sept20.pdf.■