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ORIGINAL ARTICLE

Secondary Prevention: The Heart Foundation's Experience in Driving Change through Advocacy

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Introduction Heart disease is the leading single cause of death for men and women in Australia. There are 685,000 people living with heart disease, approximately 50% will be experiencing signs and symptoms of heart failure. This article aims to articulate the key advocacy activities required to improve the provision of evidence-based secondary prevention including cardiac rehabilitation and multidisciplinary chronic heart failure management services.

Method The Heart Foundation undertook an extensive consultation process with many experts, policy makers, health and public health professionals through forums, evidence reviews and working groups. A range of actions are required to improve access to secondary prevention, but only those that the Heart Foundation could drive and support have been included.

Results The results identified three synergistic advocacy areas between heart failure and cardiac rehabilitation to drive secondary prevention advocacy. These were data, policy and people.

Discussion The priority actions are discrete and tangible to progress rather than revisit established evidence-based recommendations, and to support uptake and implementation at a national and state/territory level. We must consider the current landscape within which secondary prevention sits and identify the intersecting barriers and enablers that can be influenced. There is no single solution or lever for change.

Conclusion Best-practice management of heart disease can be achieved through a co-ordinated effort to implement system change. Focus should be paid to a multi-faceted approach in the key advocacy areas identified here – data, policy and people – as these will provide benefit across the disease continuum, from secondary prevention and cardiac rehabilitation through to heart failure management.

Keywords Heart failure • Cardiac rehabilitation • Secondary prevention • Health care reform • Health policy • Patient advocacy

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Introduction

Heart disease is the leading single cause of death for men and women in Australia. Every 15 minutes someone experiences a myocardial infarction equating to 55,000 Australians a year [1]; there are 685,000 people living with heart disease, approximately 50% will also be experiencing signs and symptoms of heart failure [2,3]. In 2010, there were 25,773 hospital separations recorded due to repeat acute coronary syndrome (ACS) events and this is expected to rise to 34,519 by 2020 [4]. The direct cost of these repeat events to the Australian health care system is estimated to be $613 million and the indirect costs are estimated at $96 million due to loss of productivity and economic efficiencies [4]. Overall, in Australia, the financial cost of all ACS events in 2010 was estimated to be nearly $5.1 billion, with repeat events accounting for approximately one third of this cost [4].

The majority of individuals experiencing ACS and/or heart failure are eligible for a referral to a secondary prevention program. Examples of evidence-based secondary prevention strategies for heart disease include cardiac rehabilitation services and multidisciplinary CHF management services [5].

These programs can vary in content, delivery mode and setting depending on whether they are addressing risk factor modification following an ACS event or ongoing management of heart failure. However, at an individual and population level the benefits of these programs are well established and include improved quality of life [6], and reductions in morbidity, mortality and hospital admissions [7,8] Despite these well established benefits program attendance is poor. In Australia, participation rates can be as low as 25% [9]; Aboriginal and Torres Strait Islander peoples are less likely to participate than non-Indigenous Australians, despite being twice as likely to die from heart disease [10].

The barriers associated with poor attendance have been extensively documented [11] and across Australia there is growing momentum for system reform. Systematic change is important to achieve consistency of quality service delivery regardless of a patient's status or location. Across ACS and heart failure there are many apparent indicators of non–guideline based management, poor coordination and communication, and recurrent hospital admissions [12]. Reform across secondary prevention to address these gaps remains a pressing concern. In 2009, the Heart Foundation undertook an extensive consultative process to inform a policy paper entitled '*Secondary Prevention of Cardiovascular Disease: a call to action to improve the health of Australians*' [3]. This paper outlined key action areas to improve the provision of secondary prevention. More recently in 2013, The George Institute Summit Blueprint for Reform for secondary prevention [13] and the Heart Foundation's Consensus Statement *A Systematic Approach to Chronic Heart Failure Care: a Consensus Statement* identified similar themes. These policy documents articulate the evidence-based practices necessary to influence system change and improve care delivery.

Advocacy is one of the main tools that the Heart Foundation undertakes to achieve system change at national and local levels. Advocacy can be thought of as ''the pursuit of influencing outcomes – including public policy and resource allocation decisions within political, economic, and social systems and institutions – that directly affect people's lives'' [14]. Sometimes known as 'the art of persuasion', advocacy is simply the process of influencing people to create change. Its lifeblood is good strategic communications, educating people about a need and mobilising them to meet it [15]. The purpose of this paper is to articulate advocacy strategies identified to achieve improvements to the provision of secondary prevention care and care delivery in Australia. This article acknowledges that cardiac rehabilitation and heart failure are separate and different entities on the secondary prevention care continuum. Both of these areas are supported by separate clinical practice guidelines and have many similarities but also unique differences in care and care delivery. Despite these differences, the issues and advocacy activities at a National, State and Territory level share many parallels, which this paper will articulate.

Methods

Complex systems mapping, also referred to as a fishbone analysis, is a form of root cause analysis and is increasingly being used to inform quality initiatives in health [16]. Complex Systems Analysis requires agreement on a problem statement (effect), in this case a lack of system refinement to improve secondary prevention care. The causes of the problem provide the branches and indicate causal relationships. [16]

In 2013, several brainstorming sessions were held with a strategic group of key individuals across the Heart Foundation to undertake a Complex Systems Analysis for secondary prevention which identified the major causes of the problem. The key individuals included the Director of Cardiovascular Health, the Chief Medical Advisor, Secondary Prevention Managers, Government Relations staff, and secondary prevention working group members. As this was an internal piece of work for the Heart Foundation participants were recruited internally from the organisation. All participants were aware of the key secondary prevention documents [13,17]. Participants were then requested to identify advocacy priorities that could assist to address these causes.

Results

The Complex Systems Analysis (Figure 1) undertaken for secondary prevention and heart failure identified three key advocacy areas for quality improvement activities: data, policy and people. The first advocacy area 'access to meaningful data' will allow for measurement and benchmarking of health care activities identifying gaps and strengths to drive quality improvement, while also supporting quality research. The second advocacy area of 'policy' identifies strong need for a national standardised approach to both secondary prevention and heart failure care, coupled with