

Section 2: Service Provision

This section provides generic information on planning and implementing a new CR service and developing and monitoring an existing service.

Planning a New Service

A service plan forms the basis of developing a quality CR service. Once developed, the service plan can be used to measure and review CR service achievements. Priorities and aims of the CR service need to be defined and the method of achieving these aims detailed.

Identifying the goals and objectives of the CR service and focusing on these during planning is essential to the successful establishment of the service and ultimately to the successful rehabilitation of those participating.

Developing a CR service plan should involve representatives from those groups who will be directly or indirectly involved with the service, referred to as key stakeholders. A key to the success of the service will be the allocation of an 'executive sponsor'. Executive sponsors ensure the service plan is addressed at executive level of the health service or organisation. Other key stakeholders may include but are not limited to a range of health professionals including medical specialists and general practitioners, people with existing heart disease, community members, health service administrators and managers, representatives from funding agencies, as relevant to the local community. The health professionals involved should include those who may refer to the CR service in addition to those who will actively participate in providing the service.

It will be useful initially to hold a stakeholder meeting where all interested parties are invited to discuss planning and development of the CR service and following this to form a steering committee that meets regularly to direct and monitor service development. As part of the planning process the following needs to be considered:

- The location/s of the service;
- Equipment required for components of the services including exercise, education, self-management.
- Consumables required such as information pamphlets, refreshments etc...
- Staffing required to coordinate, participate, manage and administer the service;

- Referral arrangements – such as who will be eligible, how eligible clients are identified, who makes the referral, referral pathways, what constitutes participation/utilisation/completion. Tools may need to be developed to support and enable these processes.
- Funding arrangements including details of how the staffing, equipment, consumables and venue costs will be met. Some costs will be initial establishment costs and others will be ongoing costs.

Funding arrangements are likely to place limitations on the location, staffing, equipment and consumables. Access to the location of the service is an important consideration, including transport options and parking.

A detailed CR service planning document would cover the following areas:

1. A needs assessment

- Characteristics of potential clients in the local community, for example, people with existing heart disease, people at high risk of heart disease, other chronic disease;
- A description of existing cardiac rehabilitation and secondary prevention services;
- Evidence of key stakeholder and community consultation;
- Priority needs identified by community and key stakeholders;
- Supporting evidence for a new cardiac rehabilitation and secondary prevention service

2. Description of the proposed service

- Service/s to be provided
- Benefits to participants
- Effect on existing services

3. Management and Integration

- Organisational chart
- Senior management team
- Ongoing community involvement
- Links with existing services

- Quality improvement
4. Financial Planning and Resource Map
 - Current and additional funds required
 - Projected income from fees or charges, if relevant
 - Evidence for cost effectiveness
 5. Key Results
 - Objectives
 - Performance Indicators

(Modified from the Australia Government, Department of Health and Aging¹)

Characteristics of the local population who will access the service will help to define what the service needs to provide. To access this information seek advice and support from local health service administration, disease registers, universities. Useful information may be available from local government population data and the Australian Bureau of Statistics. Information including the number and type of heart-related hospitalisations, the age range and median age of the cardiac population, the proportion of males and females, the ethnicity, socioeconomic class and education level will all help to tailor the service better. The proportion of people with CHD who have an unplanned readmission within a three to six month period following an acute event and the reasons for this may help refine content of the service however, access to this type of local data will vary and may require considerable expertise and time to obtain.

Describe what is known about existing local CR services or alternative services that may have an impact on the new service, including details about access and availability. Identify the needs this service caters for and who accesses it.

Provide details of how key personnel have been engaged in the planning process and the depth and breadth of community consultation. Community consultation, including the involvement of people with existing heart disease and specific population groups such as Indigenous communities and culturally and linguistically diverse communities, is an important step to help identify any unique requirements within a local community. This can be a time consuming process to organise but has a number of benefits for both the community and the service. It provides the community with greater control over their health needs, an opportunity to voice concerns and to understand health issues and service delivery. For the

new service it offers the opportunity to adapt to changing community needs, a higher profile and better acceptance of the service and ideally will lead to a more efficient use of resources and improved health of the community. It may be important to hold a public meeting, particularly in smaller communities.

Effective community consultation occurs when the community is invited to have input and involvement from the beginning and when there is general acceptance of the community's right to be involved. This includes from the time of concept through to implementation and ongoing monitoring. Community leaders should be approached and involved where possible and well researched and clear information should be provided. Importantly community concerns need to be listened to and responded to. Community participation promotes innovation in service delivery and is vital to the success of the service. If planning to provide a service in Indigenous communities or culturally diverse communities, there needs to be considerable consultation with Indigenous leaders, groups and organisations. Practical and detailed information to enhance this process is available from the NHMRC document *Strengthening Cardiac Rehabilitation and Secondary Prevention for Aboriginal and Torres Strait Islander Peoples*².

Assessing the needs of potential participants in the service is an important part of planning as the consideration of local factors is paramount and should include issues such as transport, parking and general physical access. Focus groups may be a useful way of identifying priority needs of community or key stakeholders.

It is important to clearly document why the new service is needed, the evidence available to support this and the benefits it will provide. Be specific about the content and structure of the service and the anticipated benefits to those who participate and their families. When describing the benefits also look at this from the perspective of the acute health service, primary health care services and the community in general. Provide some information on the anticipated effect the new service may have on existing services.

Clearly identify the person who will have overall responsibility of the service, the management structure and how this fits into the organization where the service is provided. Describe how the community will continue to be involved in implementation, development and evaluation of the service. Outline the potential links to existing services including details about specific client groups who may be referred to these existing services. Describe any

routine quality improvement activities or ways in which the service will be monitored or audited.

Describe in detail financial resources including those provided in kind. Define any fees that will be payable or donations that may be made by clients attending the service, if applicable. Estimate establishment costs, ongoing costs, including maintenance of equipment and insurance. Outline any areas of potential cost savings.

Be clear about the objectives of the service you are providing. The objectives should be measurable. Be mindful of the cost in terms of time and resources of measuring your objectives. Include key performance indicators so that health professionals working in the service are aware and focused on the key areas of importance and so management can determine the success of the service. Performance indicators need to be tailored to the service provided and in some situations success may be measured by community engagement rather than specific clinical indicators.

Service implementation

Once the service plan has been finalised it needs to be forwarded to the appropriate person within the organisation for approval. Within the public health system, look for opportunities to seek enhancement funding or funding through quality improvement initiatives. In the private sector there may be opportunity for sponsorship and arrangements with private medical insurance companies.

Implementation of a new cardiac rehabilitation service may be best undertaken as a pilot and after a specified period of time, such as three months, allow an opportunity to review the process and make any necessary adjustments or changes. It will not be possible to foresee all potential problems.

Regular team meetings with those people actively involved in the implementation of the service is one of the keys to ongoing success of a CR service. The meetings need to be brief, relevant and allow multi-professional issues to be addressed. For optimal participation the meetings would be scheduled in advance so people can plan to attend with an agenda and previous minutes circulated in advance of the meeting.

Policy and procedures need to be developed by key stakeholders, according to their role in the service, to guide implementation. All key stakeholders should have the opportunity to review

and contribute to the policy and procedure documents developed. Seek policy and procedure from other established CR services in addition to reviewing published literature in development of these guiding documents. Policy and procedures should be revised following the pilot and at regular intervals (yearly or second yearly) and as required. A policy and procedure manual should be readily accessible to all health professionals involved in the service, including those who are employed on a temporary or casual basis. An orientation, education and training strategy should be developed to enable policy and procedures to be implemented.

Development of an Existing Service

Cardiac rehabilitation services will develop over time due to changes in the experience and skills of the health professionals involved, changes in expectations of people with heart disease and their families and changes to knowledge, evidence, treatment and disease management. Services should be reviewed against the service plan on a regular basis. Cardiac rehabilitation and secondary prevention services would benefit from a comprehensive review every two or three years due to the rapid development of new evidence and technology in cardiovascular disease management. All opportunities to conduct quality improvement activities should be taken to ensure the ‘quality cycle’ is a live concept. Examples include when an activity or component of the service is questioned and the answer cannot be determined from published evidence.

Service planning is a useful process that can be undertaken in a modified way by an established service. Many existing CR services developed from a perceived need identified by nursing, medical or other professionals or from community pressure. A detailed plan may not have been part of this process or the plan used may now be less relevant. A revised service plan may allow components of a service to develop further or change direction.

Generic versus Disease-Specific Services

An important issue facing many CR services in recent times is the decision to provide a generic service applicable to a range of chronic diseases, including heart disease, or providing a specific service ‘restricted’ to people with heart disease. This decision is partly dependent on the number of people who are likely to access the service. If there are a small number of

people likely to access a disease specific service then it makes sense to provide a service to a range of diseases with similarities in management to make the service provision feasible.

In generic services the needs of specific disease groups may become less important than other aspects that are relevant to the group as a whole. It is important that people with a specific disease have access to someone who is familiar with their disease and its management. For area health services with an area CR coordinator, this position is an ideal advocate for heart disease if a generic service is provided.

In rural and remote areas a combined service may be more easily justified. In metropolitan areas disease specific services should be encouraged with justification required for running generic services.

Continuous Improvement and Evaluation

Cardiac Rehabilitation services need to be high quality and safe for participants, family and staff. Service evaluation is the process that allows providers and practitioners to monitor actual performance against projected performance. It can be very useful for monitoring quality and making improvements. Practitioners can use the results of an evaluation to make adjustments to the service provided and as evidence for ongoing or enhanced funding.

Evaluation is necessary to provide a quality service and should be considered as an integral part of the planning process. In this way it can be more easily resourced appropriately. The service objectives provide the basis for questions that guide an evaluation. To conduct an effective evaluation, the goals and objectives should be well-defined, with good service planning prior to implementation. Once implemented, evaluation should be an ongoing process that occurs continually. Evaluation that is considered once the service is developed can become costly and time consuming.

There are a number of reasons why services need to be evaluated. Evaluation can address the following aspects by answering the corresponding questions³:

- Effectiveness: What is the right service to run?
- Appropriateness: Did we do the right thing?
- Performance: Did we do the right thing right?
- Outcome: Did it have the right result?

- Equity: Was the right result observed in the right people?

Other reasons to evaluate services include:

- to assess the extent to which service goals and objectives have been achieved
- to enable the continued development and refinement of content and structure
- to identify problems and barriers to service delivery
- to determine whether implementation is consistent with the service plan
- to identify unexpected outcomes of the service
- to optimise the use of resources
- to provide feedback for key stakeholders

Consultation should occur with stakeholders in the planning of any evaluation. However, there may not be the time, resources or organisational capability to address all the issues raised by these stakeholders. Prioritising the most important questions for the sake of the effectiveness of the evaluation is one method of working with limited resources. When reporting a service evaluation it is important that consideration is given to the perspective and position of the person to whom the report will be detailed. Managers and administrators and funding bodies may be interested in different outcomes compared to members of the CR multi-professional team, medical practitioners who refer to the service or the community.

The three commonly agreed types of evaluation are process, impact and outcome evaluation. Process evaluation measures the activities and quality of the service and who it is reaching. It is therefore related to the strategies of the services. Impact evaluation measures the immediate effect of the service and asks the question 'Does the service meet the objectives set?' This type of evaluation is often associated with measurement of individual characteristics such as knowledge, attitudes, behaviour or physical characteristics (including weight, blood pressure and cardiovascular fitness). Outcome evaluation measures the long term effects of the service and asks the question 'Does the service meet the goals set?'

Formative evaluation is a very useful type of evaluation to employ in the early stages of service development as its purpose is to identify aspects of performance that need to improve and offers suggestions for improvement. It is undertaken as the service is being implemented.

Team work, coordination and collaboration

The success of a cardiac rehabilitation service is dependent upon many things including effective processes and the skills and expertise of a team of health practitioners. It is important to be aware of, acknowledge and utilise the skills and expertise of all team members and staff involved the service.

The expertise required of health practitioners will be influenced by the nature, format and content of the CR service, structure and resources. This in turn will determine whether the service should include staff with significant cardiac experience at acute care and rehabilitation levels. This may vary depending upon the model of CR service being implemented. No matter the model of care and service type chosen all staff involved in the provision of cardiac rehabilitation will have basic life support skills and awareness and experience with the principles of adult education and behaviour change theory.

The philosophies of self management support will be utilised by all team members. This does not refer to a particular model of care but rather the way participants and their carers or family are approached in the decision-making regarding their individual care plan and goals, that is, as true partners in the healthcare journey.

Practitioners working in more isolated situations may benefit from access to health professionals (by telephone, email, video link) willing to provide assistance and advice from a more specialised or experienced perspective as required. Clinical guidelines should be utilised (and may need to be developed) to support health care providers working in isolated areas. All cardiac rehabilitation and secondary prevention services should have access to a medical advisor.

Where available teams will be multi-professional in nature consisting of a range of health professionals including, but not limited to, nurses, physiotherapists, occupational therapists, pharmacists, dietitians, psychiatrists, social workers, Indigenous Health Workers, exercise physiologists and medical practitioners from general or specialised practice. General Practice nurses are a potential partner that in addition to providing support for people with cardiac disease, help to strengthen the link between general practice and acute services or community services.

The people involved in the team will vary according to the components of the service provided, the location of the service (community, hospital based, rural, remote) and

availability of health professionals. General Practitioners and GP practice nurses may be important and Indigenous Health Workers are essential in assisting to encourage Aboriginal and/or Torres Strait Islander clients to access the CR service.

Where possible all members of the team should be encouraged to become members of their state cardiac rehabilitation association which automatically includes membership of the national association, the owners of this Guideline (ACRA). Membership fosters collaboration with other cardiac rehabilitation practitioners including those who work with specific population groups such as people with heart failure. Other tangible benefits include receipt of several newsletters with information from across Australia and beyond, access to educational opportunities, special members access to information kept on the ACRA website.

¹ Australian Government Department of Health and Ageing – Developing a Service Plan. http://www.health.gov.au/internet/wcms/Publishing.nsf/Content/ruralhealth-services-mps-service_plan.htm Website accessed June 2007page last modified September 2004.

² National Health and Medical Research Council. Strengthening Cardiac Rehabilitation and Secondary Prevention for Aboriginal and Torres Strait Islander Peoples – A guide for health professionals. Australian Government September 2005

³ Irwig L. An approach to evaluation of health outcomes. NSW Public Health Bulletin 1993; 4:135-136.