Cardiac rehabilitation and primary care: Bridging the two solitudes

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In the past two decades, evidence-based medicine has become the basis for standard of care. Rigorously controlled clinical trials in postmyocardial infarction (MI) patients have demonstrated the value of interventions such as lipid-lowering therapy, beta blockade and acetylsalicylic acid in the secondary prevention of coronary artery disease. This has led to comprehensive guidelines for the management of the post-MI patient (1). Included in such management is a recommendation for participation in cardiac rehabilitation. Despite evidence and recommendations, well-documented care gaps continue to exist in post-MI management (2,3). Unfortunately, such reports are sometimes cited to criticize – either explicitly or implicitly – the perceived perpetrators of the care gaps (ie, family physicians). Such criticism does not recognize the practical challenges of following guidelines or the many factors that can influence the day-to-day implementation of recommendations. From purely a time perspective, it has been estimated that if a physician followed care guidelines for only the five top chronic conditions in the United States, 6.7 h per day would be spent solely in this activity (4). Based on the average work hours of a Canadian family physician (5), and presuming similar chronic disease control rates as in an American family practice, this would translate into 65% of a Canadian family physician's workday spent following guidelines for just five chronic diseases. Other factors that determine guideline adherence include those related to the patient, the care team or the system. For example, competing priorities, perceived disability or mental health status can influence a patient's adherence to prescribed medications or lifestyle interventions (6). Physician-related factors such as appointment length or the need to deal with multiple issues in a single visit may also lead to incomplete implementation of recommendations (7). Finally, there are system attributes, such as a lack of planned discharge protocols, that can also influence the implementation of recommendations.

In the present issue of *The Canadian Journal of Cardiology*, Riley et al (8) identify a frequent systemic flaw in our health care system that, although described in relation to cardiac rehabilitation, is not limited to that area. This flaw is the inefficient transfer of information. One principle of managing patients with chronic conditions, the post-MI patient being but one example, is the need for an efficient transfer of information – having the right information in the right place at the right time (9). Post-MI patients are at particularly high risk for subsequent cardiovascular morbidity and mortality; yet, there are effective interventions that can mitigate this risk. Many, if not most, of these interventions are implemented in cardiac rehabilitation programs, which have been shown to improve the prognosis of post-MI patients (10). However, cardiac rehabilitation does not end with a patient's discharge from a formal program. Rather, the rehabilitative and secondary preventative processes need to continue in the community. This continuation necessarily requires transfer of care to, or co-management with, a primary care provider or primary care team. Yet, how can the primary care team effectively assume care of a patient if they do not have access to the necessary information to enable them to assume such care? Necessary information includes details of the exercise prescription, dietary plan and medication list. Similarly, knowing who to contact to obtain further information is critical. Hundreds of

guidelines exist, and it is unreasonable to expect a primary care physician to know the details of each of these guidelines. Even knowing where and how to access up-to-date guidelines for a particular condition can be a daunting task in the busy life of a family physician. Thus, it is incumbent on the health care system to help facilitate the effective management of a variety of patients as they transition from the acute care system to the community. It is all too easy to point a finger at primary care physicians and criticize care gaps. But as the saying goes, "When you point a finger, there are three fingers pointing back at you."

In the current study, Riley et al, with refreshing logic, asked family physicians to identify what information was needed to manage patients leaving cardiac rehabilitation programs and transitioning back to primary care. They then identified care gaps in the current health care system – namely that such required information was rarely provided in completeness. Finally, they proposed a minimum data set to enable effective transfer of care from cardiac rehabilitation programs back to primary care.

While the composition of this minimum data set is still open to refinement, Riley et al should be congratulated for at least starting the discussion. Although their study sample was relatively small, involving interviews with only 50 family physicians, significant precautions were taken to ensure a representative sample. Some of the findings from this study are quite distressing. Less than 50% of family physicians received cardiac rehabilitation program discharge reports, medication lists were frequently not included, dietary and exercise recommendations were often omitted, and the list goes on. It is no wonder that with such discontinuity, care gaps exist in the management of post-MI patients. Perhaps this also contributes to the relatively poor participation of patients in cardiac rehabilitation, even though this sample's participation rate was somewhat higher at 41%. If family physicians were better engaged through complete and timely transfer of information, they might be more proactive in encouraging or facilitating their post-MI patients' attendance in cardiac rehabilitation programs. This, in turn, would be of benefit to patients in terms of health and functional status.

The concept of a minimum data set to be included in a discharge report to a family physician is both logical and appealing. However, involvement of the primary care team during the rehabilitative process may be even more desirable. Regardless of the stage of involvement of the primary care team, timely transfer of information between primary care and specialized services is desirable. Certainly, a rehabilitation program may likewise benefit from knowing key information about patients – information that may reside at the primary care level. Thus, a minimum data set can work both ways – at the onset of the rehabilitative process and at its conclusion. However, the creation of such a data set, and the interdisciplinary interaction that it implies, should not be determined solely by the specialist community. Rather, the end-user, whether it is a family physician or some form of newly evolving primary care team, should be equal partners in the development of such data exchange instruments. Moreover, such documents or templates must take into account implementation challenges at the end-user level. A poorly organized form with excessive data may be

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provided in an attempt to be comprehensive, but ultimately, family physicians will not make use of information that is not user friendly. On the other hand, providing a standard data set also means that standardized data will not only be provided, but will be collected and organized in a standardized manner, opening the door to exciting opportunities for outcomes research.

Sometimes the best solutions are, in retrospect, the most obvious. Providing standardized information on discharge from cardiac rehabilitation programs will help optimize care for the post-MI patient, make life easier for the family physician or primary care team, and ultimately benefit both the patient and the health care system with efficiency and improved outcomes.

Riley et al should be thanked for their efforts to begin building a bridge between the two solitudes.

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