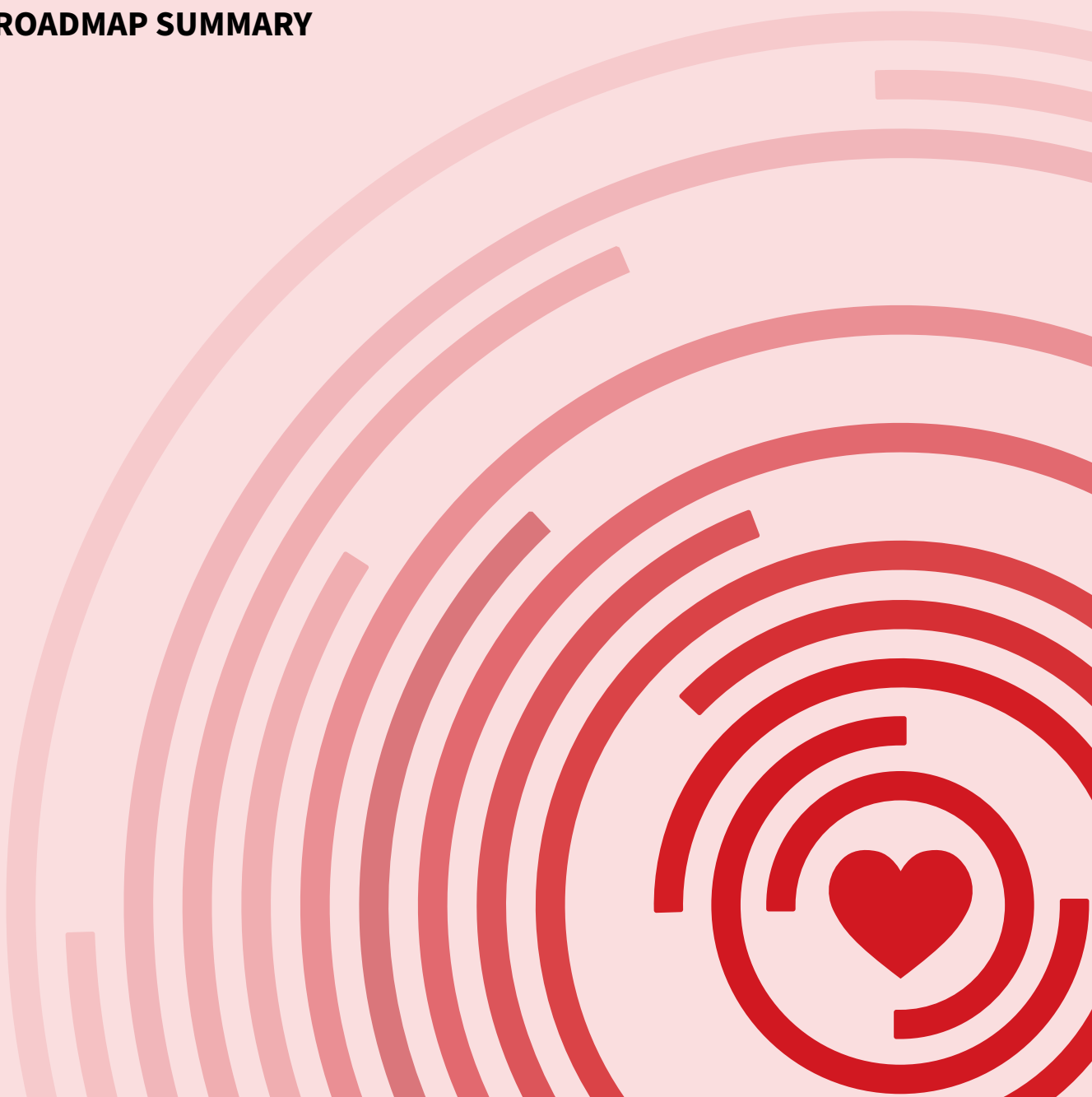


WORLD HEART FEDERATION **CARDIAC REHABILITATION** **ROADMAP SUMMARY**

**A PATHWAY TO ACHIEVING LIFELONG CARDIOVASCULAR
HEALTH ROADMAP SUMMARY**



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A PATHWAY TO ACHIEVING LIFELONG CARDIOVASCULAR HEALTH

Cardiovascular disease (CVD) remains the leading cause of death worldwide, accounting for approximately 20.5 million deaths in 2021.¹ Over the past century, considerable advancements have transformed the management of people with CVD with improved diagnostics, arterial revascularization techniques, protective pharmacotherapies, and multidisciplinary care.^{2,3}

These advancements have led to more people surviving initial episodes of care and shortened hospital stays.⁴ However, with aging populations and persistence of unhealthy lifestyle behaviors, healthcare systems are now challenged by a growing number of people living longer with CVD and its sequelae.³

Cardiac rehabilitation programs have been the cornerstone for providing structured care integral to comprehensive secondary prevention.⁵ These programs originated as group-based exercise and education sessions and have been expanded in scope encompassing all aspects of secondary prevention. Substantial scientific research has highlighted the benefits of cardiac rehabilitation for those who attend, including enhanced functional capacity, quality of life, adherence to preventive medications, reduced risk of reinfarction and hospital admissions and favorable cost benefits.⁶

Programs vary somewhat in terms of comprehensiveness, dose and delivery model all likely impacted by multiple factors, including funding models within a given health care system.⁷ Unfortunately, while major international guidelines strongly recommend cardiac rehabilitation for people with CVD,^{8,9} research consistently shows that survivors may have unacceptably poor rates of referral (30% of eligible),¹⁰ attendance (9% of eligible) and completion (less than 5% of all eligible).¹¹ Further, the use of evidence-based medications and lifestyle improvements typically decline within six months of an acute event, particularly in the coronary vasculature, and are rarely sustained.¹² Moreover, programs are frequently under-resourced and lack universal agreed

standards and quality measures, and disparities between countries, regions and populations.¹³

The evolution of programs from being exercise-based to encompass all aspects of secondary prevention and including peripheral and cerebrovascular disease as well as cardiac disease has resulted in the name cardiovascular rehabilitation (CVR) being used throughout this document to reflect the ultimate objective of achieving cardiovascular health for all people who are eligible.¹⁴ This Roadmap aims to present a united and forward-looking vision to consolidate efforts that enhance equitable access, improve patient outcomes, and ensure value-based healthcare. Proposed solutions form part of the WHF commitment to improving global cardiovascular health and contribute to the United Nations Sustainable Development Goals.¹⁵

KEY POINTS

- Healthcare systems are now challenged by a growing number of people living longer with CVD and its sequelae.
- The evolution of CVR, from exercise based to encompassing all aspects of secondary prevention, has led to the ultimate objective of achieving cardiovascular health for all people who are eligible.
- This Roadmap presents a united and forward-looking vision to consolidate efforts that enhance equitable access, improve patient outcomes, and ensure value-based healthcare.
- The interconnected solutions are founded on unity, patient centeredness and having a future-focus and address five key roadblocks by having a more lifelong approach to cardiovascular health, better engagement in programs, implementation of new and more flexible models of care, workforce strengthening and enhanced advocacy and policy. (Figure 1).
- Next steps are to facilitate local/regional implementation plans and an evaluation framework. A shift to systems, policy and advocacy thinking is critical for the sector, with a view to long-term investment to meet growing demands.



This is a summary document of the soon to be published World Heart Federation Cardiac Rehabilitation Roadmap.

A pathway to achieving lifelong cardiovascular health was developed based on a three-stage iterative process encompassing; a global survey, a global forum, and formation and preparation of the Roadmap by an international expert writing group. The target population is people with all manifestations, or at high risk, of CVD.

The global survey* in June 2024 gathered input from 327 Cardiac

Rehabilitation professionals and stakeholders across all WHO regions, highlighting diverse challenges and enablers to improving programme reach and uptake.

Building on these findings, the **Global Cardiac Prevention and Rehabilitation Forum** was held in London on 29 August 2024, bringing together 52 experts and emerging leaders from more than 40 organisations and 20 countries.

Organised by ICCPR and SOLVE-CHD with input from a global advisory group, the Forum aimed to strengthen international collaboration, improve quality and outcomes in cardiovascular rehabilitation, and identify practical, cross-cutting strategies for collective action.

The combined findings from the survey and the Forum were need for:

1. Development, dissemination and implementation of global standards to support best practice
2. Establishment of recognised accreditation or certification processes and systems to support quality and standards
3. Creation of a global database to enable benchmarking, research and quality improvement
4. Clinician training and education programs especially in low-resource settings
5. Better integration of timely referrals and digital technologies to enhance accessibility and monitoring
6. Increased awareness and advocacy for importance of multidisciplinary team capacity building and promotion of benefits of CVR among patients, providers, and policymakers.

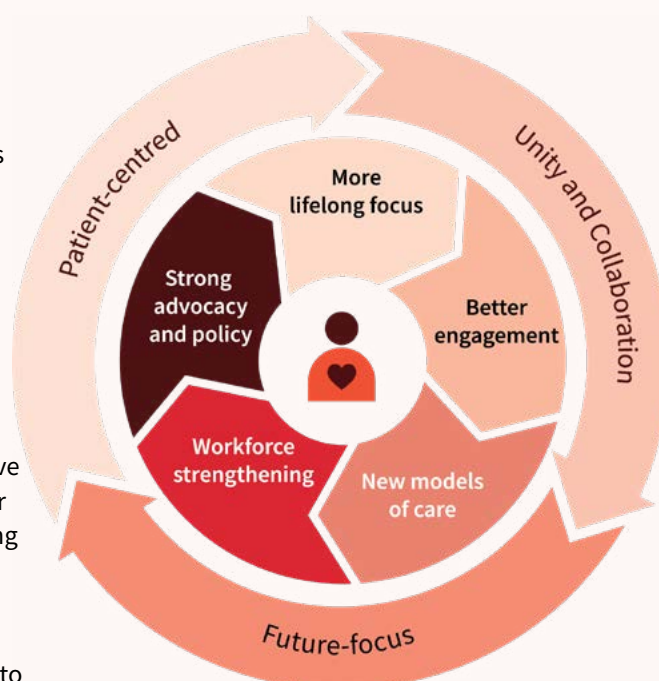
*Targeting clinicians, researchers, allied health professionals, and consumers, the survey was distributed through ICCPR and SOLVE-CHD networks and social media. A total of 327 responses were received from across all WHO regions, with over half of respondents having more than 11 years' experience. Participants represented a range of settings, including hospitals (51%), public/private practice (45%), and community organisations (19%).

ROADBLOCKS AND SOLUTIONS

Five interconnected roadblocks were identified via synthesis of results and input from the global survey, Global Forum and consensus discussions of the Writing Group. Solutions are intended to be patient-centered, founded on unity and collaboration, and future-focused (Figure 1). The Roadmap includes a series of practical solutions that consider patient, provider and systems-levels for improved health. They are intended to be diverse and adaptable to varying contextual, geographical, and resource circumstances. The proposed solutions are intended to (1) have a lifelong focus, (2) improve engagement, (3) emphasize new models of care, (4) consider strategies for workforce strengthening, and (5) support strong advocacy and policy (Figure 1).

Solutions include reframing terminology to broaden the scope and place greater emphasis on each person's journey to lifelong cardiovascular health as follows:

Figure 1. Schematic overview of proposed solutions to the 5 interconnected roadblocks



“Cardiovascular rehabilitation (CVR) is the systematic provision of ongoing care and support for people with, or at elevated risk of, CVD, and in combination with all aspects of evidence-based prevention will lead to lifelong cardiovascular well-being. Care should be person-centred and encompass all aspects of lifestyle optimisation, clinical management of risk factors, psychosocial support, and adherence to guideline-directed medical therapy.”

**APPROX 20.5M
DEATHS IN 2021**

**FROM A CARDIOVASCULAR
DISEASE (CVD)**

Roadblock 1	Solutions
Short-term focus with lack of emphasis on lifelong cardiovascular health	1. Reframe CVR as an entry point to lifelong cardiovascular health • Reframe CVR to '<i>cardiovascular rehabilitation</i>' for lifelong wellbeing. • Reframing can be used as an opportunity to expand awareness and promotion of programs beyond a short period of 'rehabilitation' • Promotion by stakeholders³⁷ including patient-led groups. 2. Integrate CVR into chronic disease management • Build bridges for sustainable community initiatives. • Implement patient-centred and family-based approach. 3. Applying principles from marketing to CVR • Develop co-designed marketing toolkits with local contextualization.

CASE STUDY

COMBINING HOSPITAL- AND HOME/COMMUNITY-BASED CVR USING A TRAIN-THE-TRAINER APPROACH, MALAWI

Malawi began setting up CVR in 2020 with a combined hospital- and home-based program. With minimal resources, informal caregivers were trained to deliver exercise using sandbags, resistance bands, and stepping boxes or similar; and lifestyle advice on healthy eating, being active and less sedentary. Patients accessed hospital-based exercise sessions once-weekly coupled with 2 home-based sessions for 12-weeks.

Following its initial success:

- Ministry of Health Malawi has since trained and continues to support nearly 60 more health care workers (physiotherapists, clinicians, nurses, and social workers) nationwide on this model of CVR delivering over 15 new programs.
- CVR programs are free for all people in these state-run hospitals; however, out-of-pocket, transport cost to attend is a barrier.
- Advocacy and championing of CVR is ongoing in Malawi by Ministry-employed Health Surveillance Assistants who serve as community-based facilitators. The goal is to better integrate hospital- and home-based components, allowing patients to attend occasional hospital visits for assessment and treatment review, while fostering peer support and regular engagement within their own communities.



Roadblock 2	Solutions
Missed opportunities to identify, refer, and engage eligible patients	1. Implementation of automated referral systems and pathways - Structured clinical pathways, including leveraging automated processes via electronic health records.¹⁶ - Inclusion of referral and enrollment rates as quality metrics.¹⁷ 2. Activating nursing and allied health staff to initiate CVR - Task-shifting to non-physician staff (including general nurses) to deliver patient education and ensure CVR referral before discharge. - Strengthening interdisciplinary links, engagement and communication between hospital staff and outpatient programs. 3. Clinician awareness building - Continuous education of physicians, staff and students about the importance of cardiovascular health and rehabilitation beyond the in-patient admission.¹⁸ - Incorporating cardiovascular health and rehabilitation education into local and national professional guidelines and the undergraduate curriculum. 4. Patient awareness building - Raising awareness about cardiovascular health and rehabilitation benefits leveraging community volunteers and previous participants could be efficient and have broad reach. - Public messaging should be contextualized to target varied cultural and potentially disadvantaged groups.¹⁹

CASE STUDY

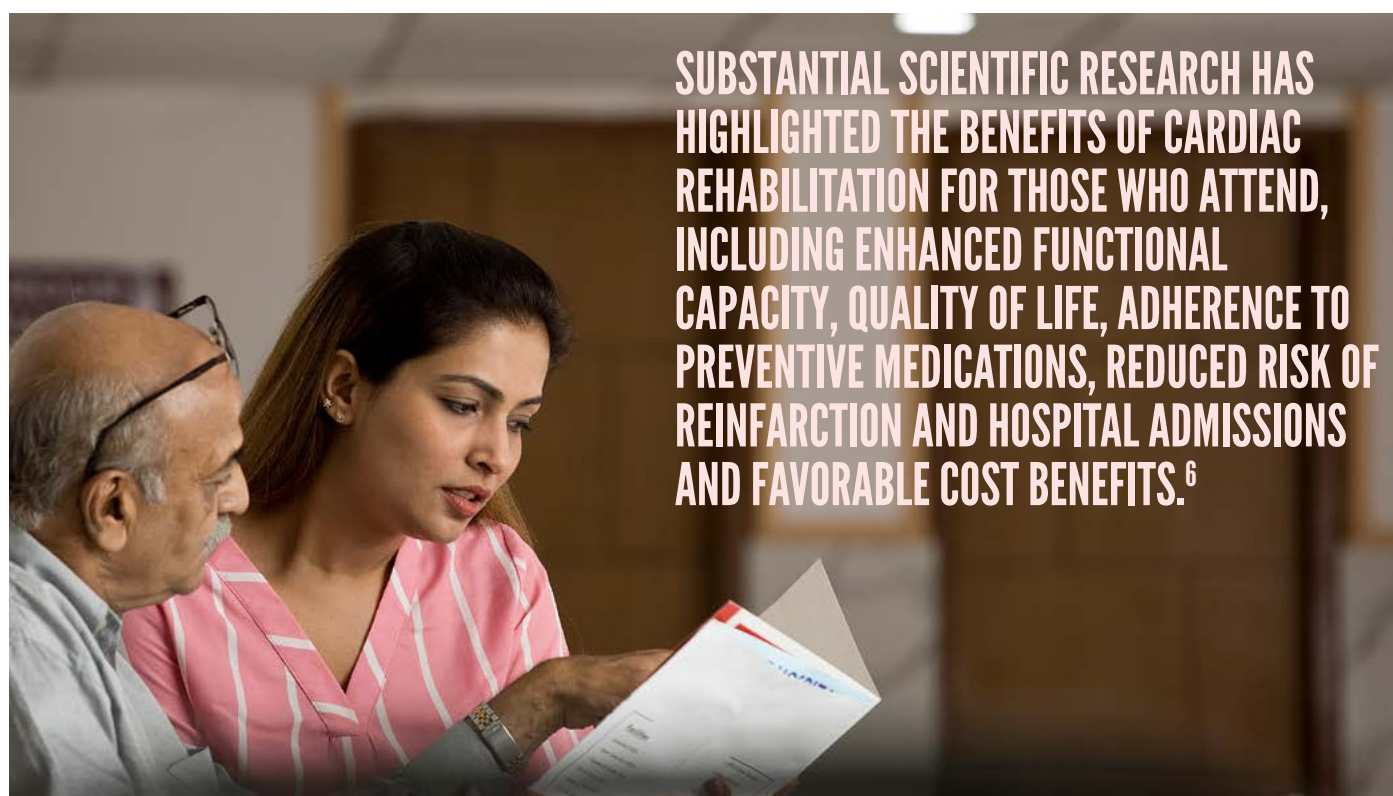
INTRODUCING A 'MANAGEMENT ALGORITHM', INDIA²⁰

In 2017, the Cardiology Society of India created management algorithms for patients with ST elevation myocardial infarction as part of the national guidelines to enhance cardiovascular care.

Following its initial success:

- The clinical algorithm supports referral to CVR, with a sequential progression of care during the inpatient stage of acute care was proposed. This algorithm ends with important functional assessments and risk-stratification to be performed.
- The algorithm also includes an option for home-based CVR or a supervised out-patient program.
- The algorithm was found to be feasible to implement and to achieve functional goals safely at a tertiary care teaching hospital with 24 hour access to cardiovascular care.²¹ The treatment algorithm did not place an undue burden of time on the treating healthcare professional (such as the physiotherapist) with good acceptance among low-moderate risk of patients undergoing percutaneous coronary intervention.

Roadblock 3	Solutions
Failure to evolve traditional exercise-based programs to models that incorporate all aspects of prevention with embedded flexibility and personalization	1. Delivering early personalized CVR • Adopt a case-management approach to ensure a patient-centered approach to cardiovascular health²² that incorporates a multidisciplinary team²³ and patient choice in how, when and where people can engage with personalized care planning.²⁴ • Ensuring cultural appropriateness and relevance for all people.²⁵ • Contextual adaption is also valuable. e.g., exercise sessions delivered with yoga or dance.²⁶ • Early inpatient liaison with inclusion of family members or caregivers, where appropriate, could further support personalization. • Collection and utilization of patient-reported outcome measures (PROMs) and experience measures (PREMs) can align care plans with each individual's life context, health literacy, and cultural background; enhance shared decision-making; and improving overall quality of care.^{3,27} 2. Accelerating new cardiovascular health and rehabilitation models of care • Offering telerehabilitation, digital and home-based models of CVR, or a combination of (hybrid) that combines in-person and digital components to enhance flexibility and engagement.^{24,28,29} • Implement national policy that supports personalization and flexible models of care that are tailored to each patient's values, personal preferences and circumstances.^{3,30-32} 3. Establish certified centres in cardiovascular health and rehabilitation ('hub and spoke' model) • Within each country or region these certified centres could provide specialised training and clinical placements for staff and students needing further expertise. • Specialised centres could also establish satellite centres in lower resource settings nearby, acting as a hub for training and support (hub and spoke model). Also, the spoke centres could be supported through telerehabilitation models. 4. Develop and implement contextually relevant quality indicators and reporting systems • Ensure availability of simple and accessible data capture systems and processes. • Robust research (including multi-centre trials and longitudinal studies) should be conducted to understand the value and benefit of use of data to understand practice gaps, evaluate reach, program quality, cost and support data sharing.³³



SUBSTANTIAL SCIENTIFIC RESEARCH HAS HIGHLIGHTED THE BENEFITS OF CARDIAC REHABILITATION FOR THOSE WHO ATTEND, INCLUDING ENHANCED FUNCTIONAL CAPACITY, QUALITY OF LIFE, ADHERENCE TO PREVENTIVE MEDICATIONS, REDUCED RISK OF REINFARCTION AND HOSPITAL ADMISSIONS AND FAVORABLE COST BENEFITS.⁶



Roadblock 4	Solutions
Inadequate workforce standardisation, training, and diversified expertise	1. Ensure access and availability of training and education related to CVR • For clinicians already working in CVR, there are processes to certify clinicians are trained to offer personalized and culturally competent care that is likely to facilitate greater engagement.^{34,35} • Training and education for providers and students at all levels should include education relating to importance of personalization, lifelong cardiovascular health, telehealth and digital options and other solutions. 2. Implement at least the minimum composition and expertise of staff required to deliver cardiovascular health and rehabilitation • Low-resource settings programs should include at least a general practitioner and nurse with training in cardiovascular and health rehabilitation.³⁶ • Expanding cardiovascular health and rehabilitation capacity to include non-physician/ nurse health workers such as trained community health assistants or peer mentors can help bridge gaps in follow-up care and build sustainable local solutions.³⁶ 3. Facilitate learning and skill building through success stories, networking opportunities • Establish regular regional workshops to discuss issues, provide case study success stories and celebrate successes. • Promote the benefits of interdisciplinary teamwork for staff.²³ • Consider people with a lived experience and lay health workers, who with some screening and supervision, can provide additional support and share unique experiences.³



Roadblock 5	Solutions
Inadequate advocacy and policy	1. Importance of a united ‘voice’ to promote collective advocacy • United voice that is aligned to existing global priorities.³⁷ For example, positioning CVR as a strategy to support implementation and achievement of the United Nations Sustainable Development Goals of a 33% reduction in CVD mortality by the year 2030;¹⁵ and the World Rehabilitation Alliance, a WHO global network, Rehabilitation 2030 Initiative.³⁸ • Engage people with lived experience to support advocacy. • Seek endorsement, engagement and advocacy from National Societies of Cardiology, CVR Associations, Foundations and other professional organisations and stakeholders. 2. Integration of lifelong cardiovascular health CVR into guidelines • Guidelines offer important advocacy tools to support the prioritization and implementation of programs and guide resource allocation at national level. • Guidelines highlight the importance of individualized care planning, cultural (including language spoken) adaptation and availability of varied models of care. 3. Lobbying government for resourcing and investment • Clear vision, advocacy and marketing strategies highlighting value for society and health systems. • Flexible, patient-centered care require formal inclusion in health policies and reimbursement frameworks to ensure scalability and sustainability.

CONCLUSION AND NEXT STEPS:

- **Ongoing support and advocacy from WHF and WHO to encourage local and global championing especially if the reach and quality of CVR and the goal of lifelong cardiovascular health are to be optimized.**
- **Local/regional implementation plans with an evaluation framework to measure implementation.**
- **A shift to systems, policy and advocacy thinking important for the sector with a view to long-term investment to meet growing demands.**
- **Importance of patient involvement, interdisciplinary, unity and collaboration also fundamental.**

WORLD HEART FEDERATION ROADMAPS

CVDs and related conditions can often be prevented, or, through early detection, can be treated cost-effectively to prevent hospitalizations and death.

Successfully tackling CVDs requires coordinated national policy and health systems responses built around evidence-based strategies. Health resources are limited meaning cost-effective interventions for the prevention, detection and management of CVD must be prioritized to plan effective health systems responses.



WHAT ARE ROADMAPS?

WHF Roadmaps are a global framework that can be adapted and used at national or regional level. Their goal is to trigger effective action that can measurably reduce premature deaths and the associated global economic burden caused by CVD.



WHF ROADMAPS AIM TO SPUR ACTION THROUGH:

1. Summarizing current recommendations that are proven, practical and cost effective to reduce the burden of CVD.
2. Highlighting obstacles to implementing these recommendations.
3. Proposing potential solutions for overcoming these obstacles.
4. Providing tools and strategies to adapt solutions to local needs.

HOW DO THEY WORK?

WHF Roadmaps offer a global framework, tools and solutions that can then be used and adapted, through stakeholder collaboration, to meet the specific needs of individual regions and nations. This requires:

- A situation analysis of the current health system based on tools such as WHF CVD Scorecards
- Roundtables with multiple stakeholders to discuss obstacles, solutions and appropriate strategies
- A plan to implement and evaluate the proposed strategies

WHO ARE THEY FOR?

Roadmaps empower WHF Members, including CVD foundations, societies and patient associations, to lead country-specific, action-oriented initiatives, including Roundtables.

These involve diverse stakeholders, such as:

- Governments and policy makers
- NGOs, health activists and advocates
- Healthcare professionals
- Corporate entities
- Academic and research institutions
- Patients and patient groups

TO ACCESS ALL WHF ROADMAPS PLEASE VISIT – [WORLD-HEART-FEDERATION.ORG/CVD-ROADMAPS](https://www.world-heart-federation.org/cvd-roadmaps)

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