

Overcoming Barriers to Cardiac Rehabilitation Enrollment

A discussion about how the influence of the cardiovascular provider, patient cost, and access affects cardiac rehabilitation program enrollment and ways to improve adherence.

By Terri McDonald, RN, MBA, CPHQ

First approved for coverage by Medicare in 1982, cardiac rehabilitation (CR) has long been recognized as a class I recommendation for secondary prevention and risk reduction in patients diagnosed with acute coronary syndrome, chronic angina and/or peripheral artery disease, coronary revascularization, and clinically stable heart failure.¹ The Million Hearts Cardiac Rehabilitation Collaborative found the associated benefits of CR reduced all-cause mortality by 13% and subsequent all-cause hospitalizations by 31% within 1 year of referral to a program. The benefits in reduced mortality extended throughout the 5-year study.² Three decades of research document benefits beyond the reduced risk of death and rehospitalizations for patients who complete CR, including better symptom control, better medication adherence, improved exercise capacity, improved quality of life and mood, and a reduced occurrence of future cardiac events.³ Given the prevalence of heart disease in the United States, the potential societal benefits of enrolling patients in CR are quite high.

Despite its well-documented benefits as a class I recommendation for secondary prevention in patients with cardiovascular disease, CR is chronically underused. Enrollment rates for eligible patients in the United States have not surpassed 20% to 30% for the past 20 years. In a study assessing Medicare enrollee demographics, 18.9% of eligible women and 28.6% of eligible men enrolled in phase 2 CR. In addition to the gender disparity, the study reflects a disturbing pattern of disparity in access for minority enrollment, with only 13.6% of eligible non-Hispanic Blacks, 13.2% of eligible Hispanics, and 16.3% of eligible Asians enrolled in 2016 to 2017.⁴

MITIGATING BARRIERS TO REFERRAL AND ENROLLMENT

The socioeconomic barriers to patient enrollment in CR programs are well known. Health plan coverage, copay, patients' commitment to follow through, travel, and in 2020, the pandemic—quite possibly the most crushing blow to the traditional CR model. By creating a cultural expectation for patient referral and enrollment, these barriers can be overcome using the same approach we use to push patients forward for other evidence-based therapies.

Leveraging the Influence of the Cardiovascular Provider

Historically, hospital-based CR programs provided phase 1 CR in the inpatient setting. In this model, a member of the CR team met with the patient, provided vital information about his or her event or diagnosis, and often assisted with initiating a walking program prior to discharge. The predischARGE connection was an excellent means to improve the chances of the patient moving forward to phase 2 enrollment in a center-based program. Unfortunately, over time, budget constraints have eliminated the phase 1 program in most hospitals. Disease management education has fallen to the bedside nurse and early ambulation to the physical therapy teams. As lengths of stay have shortened and the nursing and physical rehab teams have become more stretched, the focus on early ambulation and education about a home walking/exercise program has diminished. Today, in a typical day-of-discharge environment, the patient may receive brief education about CR, making meaningful postdischarge connections with

the patient critical to improve the likelihood he/she will enroll in phase 2 CR.

Best Practice

Creating a culture where the use of CR is viewed by the provider and the health care team with the same importance as all other class I interventions we routinely prescribe is the first and most important step in mitigating the barriers to both referral and enrollment.

As a performance measure in the American College of Cardiology's National Cardiovascular Data Registry and Society of Thoracic Surgeons National Database, the percentage of eligible patients referred to CR prior to hospital discharge has gained a lot of attention over the past several years. The same measure may be used for the Merit-Based Incentive Payment System in the ambulatory setting. The percentage of eligible patients referred to CR also plays a role in the criteria requirements for center of excellence designation for some large commercial payer plans. As is often the case, we have responded to a process-based measure by implementing many process-based tools, such as automated orders embedded in postprocedure order sets, discharge order sets, and encounter templates. However, without follow-up coaching and clear direction from the cardiovascular provider, providing anecdotal information about the benefits of CR in the chaos of the discharge process will not likely be enough to push patients toward the option of enrolling in a CR program.

In the postdischarge office visit, a pamphlet given in passing will meet the referral measure, but we still miss the opportunity to influence the patient about the importance of CR in reducing mortality and improving quality of life. A recent survey of more than 2,400 adults revealed that 53% did not feel the additional steps needed to improve their health, such as diet and exercise, were easy to understand after talking with their doctor.⁵ In today's high-volume, low-touch health care model, the greatest predictor of participation in CR is the strength of the recommendation from her/his physician.² Creating a culture where the use of CR is viewed by the provider and the health care team with the same importance as all other class I interventions we routinely prescribe is the first and most important step in mitigating the barriers to both referral and enrollment. This will require attention to follow-up and follow-through with our patients. In doing so, the effort invested in getting patients enrolled in CR will substantially increase the odds of their

compliance with all the secondary prevention measures we prescribe.

Best Practice

The cardiologist should counsel the patient and make a referral to phase 2 CR at the time of procedure or when making a qualifying diagnosis. The hospital team, ambulatory practice team, and CR team should participate in educating the patient about the expectation for CR enrollment and adherence.

Patient Cost

When speaking with physicians, the health care team, and patients, cost and adequate insurance coverage typically come in at or close to the top of the list of barriers to referral and enrollment. Medicare covers CR on a per-session basis for up to 36 traditional sessions or up to 72 intensive cardiac rehabilitation (ICR) sessions. The traditional Medicare copay is applied for each session, making the estimated copay responsibility for Medicare patients in 2021 up to \$835 for 36 traditional CR sessions and up to \$1,670 for 72 ICR sessions. For Medicare patients who have supplemental insurance, some portion of the copay responsibility may be covered, but supplemental coverage for the service and how much may be covered varies widely. Medicare Advantage (MA) plans do provide coverage for CR; however, the coinsurance responsibility varies widely across plans and geographies. Out-of-pocket responsibilities per session may be quite high for some MA plans, making costs to the patient prohibitive.

Private and commercial payers may or may not cover CR, and like MA plans, out-of-pocket responsibilities vary widely and may be particularly high. When covered, non-federal payers typically approve the same indications as those approved by Medicare. Out-of-pocket cost is a barrier for low- and fixed-income patients, and it may deter referral if assisting patients to find access to financial assistance is complex and time-consuming.

Financial Assistance Programs: Creating Solutions Upfront

Enrolling patients in CR makes sense clinically and financially for health care systems. The Million Hearts Cardiac Rehabilitation Collaborative work has quantified potential savings for patients completing 36 1-hour CR sessions as \$4,950 to \$9,200 per year of life.¹ Because CR also helps to reduce readmissions in the cardiovascular population, improving enrollment and completion rates

can have a positive impact on value-based purchasing measures, third-party designations, and publicly reported outcome measures.

Best Practice

Patient financial services play an important role in helping the clinical team mitigate financial barriers to enrollment.

It's crucial to create easy and dignified solutions to address financial barriers to CR enrollment for the patient. An interest-free sliding scale payment plan for the CR program can be an option to assist with out-of-pocket expenses for low-income and underinsured patients. Finding resources for uninsured patients may be more challenging but work with patient financial services to establish self-pay rates and payment plans. Establishing charitable foundation endowments with fundraising is an excellent option to support uninsured patients who will benefit from CR, such as an annual fundraising campaign during heart month.

Assessing the need for assistance with out-of-pocket costs is an important aspect of counseling the patient to move forward with enrolling in CR. Patient education about CR should be designed in a way that provides clear direction about the steps needed to make crucial lifestyle changes. Show how CR is equally important as other interventions to reduce the chance of future events as well as the risk of mortality or disability. Provide assurance during the enrollment process that financial assistance is available and embed this information into the patient education material. When possible, include the necessary forms and documents for financial assistance or payment plans in the admission process to avoid additional appointments with patient financial services.

Access

Work and family commitments, program capacity, location/travel distance, and operational hours complicate access to CR and create barriers to enrollment. A truly patient-centric approach to mitigating these types of barriers to enrollment requires an assessment of the socioeconomic demographics of the patient population served by your program. When possible, use both ambulatory practice data and acute care discharge data to create strategies to increase enrollment. For example, in tertiary programs, partner with smaller community hospital-based programs closer to home for patients to coordinate referral and enroll-

ment. If data reflect a substantial number of patients are working age, expanded hours of operation may be a solution for those patients or modify existing schedules to ensure working patients receive priority for early or late sessions.

Virtual Cardiac Rehabilitation

In-center CR capacity in the United States has been stressed by the COVID-19 pandemic. Approximately 3.3 million sessions were interrupted in 2020.⁶ Although many centers reopened as quickly as practical, physical distancing requirements have forced many centers to reduce the number of patients in centers, creating wait lists. When compared with traditional in-center programs, virtual CR programs that deliver the same comprehensive components as in-center programs have been demonstrated to be equally effective for low-risk patient populations.⁶

There are a growing number of software platforms available to support virtual CR. Allowing low-risk patients to complete CR in a home-based setting may be a future solution to many access-related barriers that were present before the pandemic. The challenge to fully developing a virtual CR model lies in the lack of coverage and reimbursement by Medicare and other major payers. During the pandemic public health emergency (PHE), the Hospitals Without Walls waiver made virtual delivery of CR possible as a provider-based department for the duration of the PHE, albeit under strict, prescriptive requirements.⁷ This was complemented by the 2021 Hospital Outpatient Prospective Payment System final rule allowing virtual direct supervision by a physician through the end of 2021.⁸ Although it is unknown whether the Centers for Medicare & Medicaid Services will issue provisions to support virtual CR beyond the 2020 PHE, this nod to the importance of overcoming barriers to delivery of CR services may be an optimistic indicator for future coverage of virtual models of care.

IMPROVING PATIENT ADHERENCE TO CR

The strength of the physician's recommendation is important to push patients toward enrollment, and optimizing the CR program and infrastructure is important to mitigate potential socioeconomic barriers. Keeping patients enrolled and engaged in CR will be strongly influenced by the CR team. To support patients in maximizing the CR-related benefits, the team can evaluate current and historic program statistics and create strategies to establish an expectation for all patients to complete 36 sessions (72 sessions for ICR). This may be a cultural shift for your program, but designing improvement to achieve new goals for the average number of

sessions completed is important as a parallel to improving enrollment.

Best Practice

To maximize the clinical benefits of CR, set a program expectation for completing 36 sessions (72 sessions for ICR).

NEXT STEPS TO OPTIMIZE CR ACCESS AND ENROLLMENT IN YOUR PROGRAM

The pandemic has been a strange and frightening time in health care, but it has also pushed us into a time of incredible renewed innovation. Using lessons and experiences from this time can help define new goals to improve CR access and enrollment.

As a first step, ask these questions:

- How many of our patients are eligible for CR?
- What are the demographic characteristics of our eligible patient population?
- Are we prescribing CR for those eligible patients?
- How many of our patients are enrolled after referred?

If your program is like most in the United States, the referral and enrollment numbers will be low. Set goals to achieve improvements by hardwiring referral and enrollment.

Next, evaluate the infrastructure of your current CR program to assess whether it is meeting the needs of your eligible patient population. Define specific, actionable strategies to mitigate barriers to referral and enrollment. As you identify and plan program redesign, assess the possibility of virtual resources in the future

to meet patients where they are, or a possible hybrid model.

Finally, define and implement strategies to create a culture where the use of CR is viewed with the same importance as all other class I interventions we routinely prescribe. Communicate current and ongoing performance to the entire team, socialize improvement goals, and involve team members at all levels of the cardiovascular service line in improvement efforts. ■

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