STRATEGIC PLAN 2013 – 2016

The Strategic plan of the National Secondary Prevention Alliance is aimed to guide and help prioritise the work of the Alliance over the next 3 years.

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BACKGROUND

In December 2011 a National Secondary Prevention of Coronary Heart Disease Summit was hosted by The George Institute for Global Health to consider an improved and unified approach to secondary prevention systems in Australia. A consensus of recommendations was established at this Summit resulting in a report published in the Medical Journal of Australia, titled 'Blueprint for Reform' (See appendix: Redfern, Chow, MJA 2013).

One of the key proposals was to establish a National Taskforce that drew together a broad group of national healthcare, consumer, government and non-government organisations to implement the Summit's recommendations. The Taskforce was formally established in May 2013, made up of nineteen national representative organisations. In August 2013, the Taskforce evolved into an Alliance to better reflect the longer term, ongoing vision of the group rather than being defined by a fixed task. The wealth of experience within this Alliance will assist with creating advocacy tools to influence politicians and policy-makers to invest in preventive care services, not only in hospital, but in primary care and community settings.

The Alliance is hosted by The George Institute for Global Health, Sydney, NSW. Associate Professors Clara Chow and Julie Redfern co-chair the Alliance and are supported by a part-time Project Manager, Kate Gall.

WHY A SECONDARY PREVENTION ALLIANCE?

The time has come for a united voice to drive reform and create long-term change in the secondary prevention space. The Alliance will provide a powerful, authoritative, compelling and robust approach in delivering messages and solutions on secondary prevention that are shared by individual groups with a similar agenda. The Alliance can also play a variety of roles including:

- building national advocacy, targeting governments and health professionals
- increase public understanding and awareness
- development and promotion of improved secondary prevention plans/tools and best practice guidelines

The Alliance will also be strongly aligned with global priorities of reducing non-communicable diseases (specifically cardiovascular disease) by 25% by 2025 – and will be actively engaged in the development of a National Action Plan for reducing cardiovascular disease (to be presented at the World Congress of Cardiology in May 2014).

The Alliance is horizontally structured (see list of member organisations and representatives) and consists primarily of representatives from national stakeholder organisations. Communication is predominantly by email with two to three teleconferences and one face to face meeting scheduled per year. A growing Advisory Group of individuals complements the Alliance. The Advisory group can provide direct support and advice to the Alliance and interactive communication is sought and encouraged on a regular basis.

PROBLEM OVERVIEW

The disease burden

Heart disease accounts for greater morbidity in Australia than any other disease state and 20 per cent of all deaths. [1]

Every year about 75 000 Australians have a heart attack. In the year following this, about one in five or 16 000 return with a repeat event.[2]

The number of repeat events is likely to increase by more than 40 per cent by 2020.[3]

Compelling evidence shows that repeat events can be halved by effective Secondary Prevention Care. This includes the use of preventative medicines and lifestyle modification.

However, only 50 per cent of patients take secondary prevention medicines or adhere to lifestyle recommendations, according to Australian surveys. Only one in three people access a prevention program.[4 5 6]

The costs

Heart disease cost Australia $18.3 billion in 2010 – more than any other disease group. Half of this is attributable to *repeat* events, with this cost expected to increase to $11.8 billion by 2020. [2]

26 000 hospitalisations were due to *repeat* coronary events in 2010. This cost Australia $613 million in direct health care costs and $961 million in indirect economic losses – a total of $1.57 billion. [2]

Use of evidence-based secondary prevention care would reduce repeat events by approximately $300 million in indirect health care costs – a total of $600 million each year.

[1] Australian Institute of Health and Welfare (AIHW) 2009. Impact of falling cardiovascular disease death rates: deaths delayed and years of life extended. Bulletin no.70. Cat.no. AUS113. Canberra: AIHW

[2] Deloitte Access Economics. ACS in perspective. The importance of secondary prevention. 2011.

[3] Redfern J, Chow C. Secondary prevention of coronary heart disease in Australia: a blueprint for reform. MJA 2013:198:70-71

[4] Clark AM, Hartling L, Vandermeer B, et al. Meta-Analysis: Secondary Prevention Programs for Patients with Coronary Artery Disease. Ann Intern Med 2005; 143:659-72

[5] Rasmussen JN, Chomng A, Alter DA. Relationship between adherence to evidence-based pharmacotherapy and long-term mortality after acute myocardial infarction. *JAMA* 2007;297(2):177-86

[6] Heeley EL, Peiris DP, Patel AA, Cass A, Weekes A, Morgan C, et al. Cardiovascular risk perception and evidence – practice gaps in Australian general practice (the AusHEART study). Medical Journal of Australia,2010;192(5):254-9.

ALLIANCE VISION

To improve lifelong outcomes for Australians living with heart disease.

ALLIANCE MISSION

The national Secondary Prevention Alliance will provide a collective/ united leadership role in reducing the number of Australians having repeat heart attacks by:

1. Increasing awareness of the chronic nature of heart disease and the need for appropriate lifelong management
2. Improving the delivery of secondary prevention to all Australians living with heart disease
3. Finding innovative solutions to bridge the gap between hospital and primary care
4. Achieving implementation through engagement of key decision makers, including Government

STRATEGIC DIRECTIONS

1. Increase awareness of the need for lifelong care

There is a lack of consumer, general public and professional awareness of the need for lifelong care and management for people living with heart disease. A range of actions are needed to raise public awareness of the need for lifelong management for people living with heart disease.

Actions

1. Promote / operationalize key messages by:

- Working to incorporate them in messaging for Alliance member organisations
- Working messages into any presentations/ talks given by Alliance members
- Create a short video to encapsulate messages and encourage Alliance members to use this tool and distribute

2. Engage ambassadors that appeal to different target audiences

To be considered:

- Build and maintain an interactive website for Alliance members and consumers
- Identify media opportunities

KPIs

1. Alliance agreement on 2-3 key messages
2. Number of reports (stakeholder and academic) that identify the key messages – can be tracked centrally by project manager for annual summary
3. Media reach of the key messages
4. Production and reach of a brief video emphasising the importance of awareness of lifelong care
5. Online consumer survey
6. Engagement from Government to commit/ provide national resource
   (If website established - count number of hits)

2. Improving the delivery of secondary prevention

There is a significant gap between care delivered in-hospital and in the community. A range of national strategies are needed to help close this gap and could include primary care incentives, workforce redesign, consumer engagement and a national registry.

Actions

1. Support the establishment of a national register of cardiac events to enable self-regulation, performance, follow lifelong outcomes of patients and facilitate benchmarking, in alignment with 25 by 25 reduction in CVD (NCDs) goals
2. Utilise and develop incentives for Primary Care to facilitate more regular and ongoing secondary prevention care for Australians living with heart disease
3. Identify a specialised workforce (with specific training and accreditation processes) to provide ongoing care for Australians living with heart disease in the community
4. Develop and implement a standardised secondary prevention resource for all Australians that suffer a heart attack. The resource could also be potentially utilised as a data collection and quality improvement tool.

KPIs

1. Policy influence and outcomes achieved with specific stakeholders
2. Introduction of MBS item number for cardiac care coordinators
3. Introduction of a Primary Care Practice Incentive Payment (PIP)
4. Partner with Heart Foundation to produce National Action Plan
5. Presence on Global Alliance for cardiovascular prevention
6. Revised Access Economics report and complementary business cases for each proposal

3. Working across organisations to find innovative solutions

To be successful, unity and collaboration are key ingredients. These collaborations need to be multilevel and multidisciplinary and include consumers, providers and stakeholders.

Actions

1. Establish working groups to explore implementation of each key strategy
2. Identify and engage with 'champions' within stakeholder organisations including government

KPIs

1. Commencement of funded pilot studies
2. Influence Local, State and Federal Governments to change policy
3. Implementation of an advocacy plan – who, how and when to target
4. Formal partnerships between organisations on policy document

4. Sustainable Funding

A sustainable funding source is needed to maintain the activities of the Secondary Prevention Alliance. Activities include face-to-face and teleconference meetings, development and maintenance of a website as well as employment of staff with appropriate resourcing and infrastructure. Funding could be sourced from a combination of sources including government, stakeholder organisations and philanthropathy. Current funding is minimal and short-term.

Actions

1. To source ongoing financial support for Alliance initiatives/activities

KPIs

1. Committed financial support until 2016
2. Business case for the Alliance produced

CHALLENGES AND OPPORTUNITIES

Challenges

- Other established groups may feel compromised or unwilling to support the Alliance, preferring to advance their own message
- Absence of sustainable funding/ infrastructure
- Alliance's identity/ scope of work underdeveloped

Opportunities

- 'Young' Alliance – can broker introductions, forge new relationships, facilitate progress (no previous track record)
- Align with the WHO/UN call for action to reduce NCDs/CVD by 25% by 2025 globally.
- Establish a new credible voice/identity/ brand to assist in recognising depth of CVD problem
- Collective/ united voice more powerful than individual groups, especially with advocacy
- Capacity for further research to support strategies

GOVERNANCE AND STRUCTURE

Purpose and structure
The broad purpose of the National Secondary Prevention Alliance will be to provide advice and support around the consensus recommendations. The Alliance will be co-chaired by A/Professors Clara Chow and Julie Redfern and will include representatives from approximately 20 Australian stakeholder organisations.

Membership
Membership will be for a period of two to three years in the first instance and will include leading clinical and researcher representatives, key federal government and non-government representatives and consumers.

Functions
- Provide leadership, expert input and advice on consensus recommendations
- Advocate for raising the profile of secondary prevention care in Australia in order to increase the current uptake of secondary prevention treatments and services
- Identify opportunities and barriers when considering the consensus recommendations
- Engage with potential key stakeholders and identify opportunities as they arise
- Develop an action plan to implement recommendations of the 2011 Summit
- Provide expert input and guidance to support the development of other policies

Operations
- The office of the Secondary Prevention Alliance will reside in the Cardiovascular Division of The George Institute for Global Health
- Governance will be managed by the Cardiovascular Division at The George Institute for Global Health (ABN 90 085 953 331)
- The Chairs will be co-directors of the project
- The Alliance will meet approximately 3 times per year, face-to-face (at least once) and by teleconference
- Each member is asked to assist in achieving the functions of the Alliance through active contributions, such as attendance at meetings and comments on project specific documents and activities, as required
- Communications between meetings will occur primarily by email
- A parallel Advisory Group will enable contributions from interested individuals

Responsibilities of representatives
- Members will be expected to be committed towards the vision of the Alliance to improve secondary prevention in Australia
- Members will be expected to actively engage in Alliance operations, contribute to meetings and email discussions

MEMBER ORGANISATIONS AND REPRESENTATIVES

Member Organisation	Representative	Role
Australian Cardiovascular Health and Rehabilitation Association (ACRA)	Steve Woodruffe	President
Australian Commission for Safety and Quality in Healthcare (ACSQH)	Robert Herkes	Clinical Director
Australian Healthcare and Hospitals Association	Annette Schmiede	Council Member
~~Australian Medicare Locals Alliance~~ *Government funding ceased June 2014*	~~Helen Moore~~	~~Principal National Adviser (Immunisation)~~
Australian Primary Health Care Nurses (APNA)	Julianne Badenoch	Vice President
Cardiac Society of Australia and New Zealand (CSANZ)	David Hare	Coordinator CV Research Domain, University of Melbourne
Cardiac Society of Australia and New Zealand Cardiovascular Nursing Council	Lis Neubeck Andrea Driscoll (Shared seat)	Members of CVNC executive committee
Consumer representative	Margaret Kilby	Heart attack survivor/HF Ambassador
Flinders University/ SAHMRI	Derek Chew	Head of Research, School of Medicine. Chair SA Clinical Network
Heart Support Australia	Liz Coker	President
Improvement Foundation (Australia)	Tony Lembke	Clinical Director of APCC
National Aboriginal Community Controlled Health Organisation (NACCHO)	Lisa Briggs	CEO
National Heart Foundation	Robert Grenfell Karen Page Julie-Anne Mitchell Cate Ferry	National Director - Clinical Issues National Manager, Health Equity and Secondary Prevention Director CV Health Programs Clinical Issues Manager
NPS Medicinewise	Karen Kaye	Executive Manager of planning and design
Private Healthcare Australia	Michael Armitage	CEO

Royal Australian College of General Practitioners	Belinda Wozencroft	GP/ Member National Standing Committee for Quality Care
Royal Australasian College of Physicians	David Brieger	Head Coronary Care and Coronary Intervention, Concord Hospital
Centre for Primary Healthcare and Equity, University of New South Wales	Nick Zwar	Professor of General Practice, UNSW
School of Population Health, University of Western Australia	Tom Briffa	Head Cardiovascular Research Group, UWA
The George Institute for Global Health	Julie Redfern Clara Chow David Peiris Kate Gall	Head of CV Health Services & Public Health Program, Cardiovascular Unit Head Cardiac Program, CV Unit Program Head, Primary Health Care Research, Office Chief Scientist, USYD Project Manager

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