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A Letter From the International Council of Cardiovascular Prevention and Rehabilitation

By Sherry Grace, PhD, FCCS, CRFC

AACVPR is a foundational member of the International Council of Cardiovascular Prevention and Rehabilitation (ICCPR), an international organization dedicated to the "promotion of cardiovascular disease prevention and cardiac rehabilitation for all." To learn all about ICCPR, click here.

Dear AACVPR Members:

Did you know years ago there was a "World Council of CR" with your very own Reed Humphrey as "Secretary-General"?

They held their last conference back in 2004 in Dublin, Ireland. The council served an important purpose of bringing together CR professionals around the world.

Unfortunately, the World Council ran out of funds, and the activities were rolled in to the International Committee of the AACVPR. The Committee continues to this day, under the leadership of Francisco Lopez-Jimenez (also a member of ICCPR). I had the pleasure of attending their reception for international delegates at AACVPR's most recent Annual Meeting in Louisville and mingling with the recipients of the international scholarships that support delegates in attending the meeting.

As the current Chair of ICCPR, I am writing on behalf of our Executive to formally introduce ourselves, share with you our history and inform you of our activities. It is only by engaging CR programs that we can all achieve our mission to improve chronic cardiac care and patient outcomes.

History of ICCPR

ICCPR was "born" around 2010, back when Bonnie Sanderson was AACVPR's President. ICCPR hosted a series of meetings with the leads of many of the CR societies globally in Canada (where I am from), to talk about ways to again formally work together and formulate our shared mission. This resulted in our international charter (published in your association journal *JCRP* volume 33 [issue 2] in 2013), which was endorsed by 15 CR or like-minded societies, including AACVPR.

This coalition of associations then went on to become a formal member of the World Heart Federation (WHF). We are a Council comprised of named representatives from the Board of Directors of member associations. For instance, the current AACVPR representative on our Council is Ana Mola, your President-Elect. We are currently 34 association members strong (see figure above), with good coverage across all corners of the globe. AACVPR is a foundational member, which is in recognition of your association's leadership globally. We also recently added a member category of "friends," for those colleagues in countries where CR is burgeoning, yet no CR-type association exists to formally join us. We have 11 such friends as official members.

We meet via web-conference quarterly, and in-person biennially in conjunction with the World Congress of Cardiology. Indeed, we hold a symposium on CR at each World Congress of Cardiology.

You might be interested in perusing our website. There, we collate the resources of all our member associations, including links to AACVPR's guidelines, registry, certification program, competencies, quality indicators/performance measures, standards, as well as the Million Heart CR Change Package. If you know of additional resources with global applicability you feel we have missed, please let us know.

Key ICCPR Projects

ICCPR has led, been involved with, or showcased other, seminal reviews in the CR area. These reviews summarize, for example, CR benefits, registries, national CR delivery, costs and cost-effectiveness, and quality in all countries around the world (see our website).

Our members told us that what they really needed was advocacy for more delivery. Hence, we surveyed all countries to determine what were the CR reimbursement sources around the world, and secured "success stories" from countries with better reimbursement and capacity (including a story from AACVPR's Randal Thomas regarding securing coverage for heart failure, among other successes; see BMC HSR, volume 16, 2016) to circulate along with our advocacy toolkit (http://globalcardiacrehab.com/advocacy/).

We also advocate for CR through our participation in WHF's Global Summits on Circulatory Health (https://www.world-heart-federation.org/global-summit/), and the World Health Organization's Rehab2030 initiative (http://www.who.int/disabilities/care/rehab-2030/en/), where they are developing a package of rehabilitation interventions, inclusive of rehab for ischemic heart disease.

Using the most rigorous of methods, we convened an international panel of experts through our extensive network and developed a consensus statement on CR delivery in low-resource settings. It is available on ECRI's Guideline Clearinghouse (https://guidelines.ecri.org/); in addition to being published in *Heart & Prog in CVD*). In the statement, we put forward recommendations on how to deliver each CR core component in an evidence-based, affordable and feasible manner. We have a companion certification program, where trainees can view a module corresponding to each core component, to increase capacity to deliver CR in low-resource settings.

We also undertook a survey of every CR program around the world! Overall, 112/203 (54.7 percent) countries in the world offer CR, of which we collected data in 93 (N=1,081 programs completed surveys). Results of the study are now

being disseminated (see for example https://www.mdpi.com/2077-0383/7/9/260). For instance, in the United States, we estimated that you have about 547,456 CR "spots" per year (i.e., number of patients you could serve through 36 sessions). When we consider the estimates of annual ischemic heart disease incidence from the Global Burden of Disease study of over 1.34 million patients per year, clearly capacity needs to be augmented substantially. We also learned that US CR programs have a median of 4.5 staff (i.e., some are part-time), and this was quite consistent with other countries globally; staff members were most often nurses, dietitians, cardiologists and exercise specialists. The United States offers a significantly greater number of sessions per program than other countries (median = 24). They also offer very comprehensive programs, but return-to-work counselling was only offered in about half of programs. Finally, we also found very low rates of alternative model delivery, at only about 4 percent of programs offering home-based CR for example, versus a third of programs globally. We only surveyed a random sub-sample of programs in the United States at the time, given you have the most programs of any country in the world. Along with AACVPR, we will be surveying all programs in the near future, and we will be sure to share results with AACVPR members. Please watch your inbox for our survey link!

Finally, our most recent initiative has been around increasing CR utilization; these activities dovetail nicely with your CDC / Million Hearts CR initiative. We have updated the Cochrane review on interventions to increase CR utilization (should be released soon; previous version found here). We found interventions that significantly increase CR enrolment, adherence and completion. Based on the evidence, we have convened an international writing panel (AACVPR represented by Ana Mola, but also Theresa Beckie is serving on the panel) to put forward recommendations based on the findings. We are currently soliciting input and endorsement from key CR societies globally, including AACVPR. We have developed an online course for inpatient cardiac healthcare providers regarding how to promote CR use in their patients to facilitate implementation of statement recommendations, based on our findings. We are evaluating it, and if successful, will be sure to share it broadly.

In closing, we hope you will find ICCPR to be a companion resource to all that AACVPR offers you, bringing you ideas and perspectives from all corners of the globe. If you are ever looking for contacts, resources and more in another part of the world, please do not hesitate to reach out to us.

Sincerely,

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