

Rehabilitation Support via Postcard (RSVP): A Randomised Controlled Trial of a Postcard to Promote Uptake of Cardiac Rehabilitation



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Purpose

The aim was to increase cardiac rehabilitation (CR) uptake using a novel intervention, Rehabilitation Support Via Postcard (RSVP), among patients with acute myocardial infarction discharged from two major hospitals in Hunter New England Local Health District (HNELHD), New South Wales, Australia.

Methods

The RSVP trial was evaluated using a two-armed randomised controlled trial design. Participants (N=430) were recruited from the two main hospitals in HNELHD, and enrolled and randomised to either the intervention (n=216) or control (n=214) group over a six-month period. All participants received usual care; however, the intervention group received postcards promoting CR attendance between January and July 2020. The postcard was ostensibly written as an invitation from the patient's admitting medical officer to promote timely and early uptake of CR. The primary outcome was CR attendance at outpatient HNELHD CR services in the 30-days post-discharge.

Results

Fifty-four percent (54%) of participants who received RSVP attended CR, compared to 46% in the control group; however this difference was not statistically significant (odds ratio [OR]=1.4, 95% confidence interval [CI]=0.9–2.0, $p=0.11$). Exploratory *post-hoc* analysis among four sub-groups (i.e., Indigeneity, gender, age and rurality), found that the intervention significantly increased attendance in males (OR=1.6, 95% CI=1.0–2.6, $p=0.03$) but had no significant impact on attendance for other sub-groups.

Conclusions

While not statistically significant, postcards increased overall CR attendance by 8%. This strategy may be useful to increase attendance, particularly in men. Alternative strategies are necessary to increase CR uptake among women, Indigenous people, older people and people from regional and remote locations.

Keywords

Cardiac rehabilitation • Randomised controlled trial • Cardiac rehabilitation uptake

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Introduction

Acute myocardial infarction (AMI) is a common type of cardiovascular disease (CVD), resulting in approximately 153 hospital admissions and 18 deaths in Australia each day [1,2]. In the Hunter New England Local Health District (HNELHD; NSW, Australia) in 2013 there were over 900 AMI incidents, with an overrepresentation of regional compared to metropolitan cases (151 versus 97 per 100,000 population) and Indigenous versus non-Indigenous cases (324 versus 120 per 100,000 population) [3,4]. Following an AMI based on Australian data, the likelihood of recurrence (Risk ratio [RR]=3.1 and 4.5 for males and females, respectively) and mortality (RR=4.1 and 5.6, for males and females, respectively) are increased [5]. As such, the period between an AMI and AMI-recurrence provides an important opportunity for secondary prevention of CVD.

Internationally, cardiac rehabilitation (CR) programs have been shown as highly effective in reducing rehospitalisation (RR=0.82) and mortality (RR=0.74) in patients with CVD, including AMI [6]. Overall, CR programs aim to reduce the psychological and physiological impact of CVD, reduce mortality and improve cardiovascular functioning and quality of life, by improving risk factors for heart disease (i.e., physical activity, diet and smoking) [7]. For patients following AMI specifically, CR attendance can reduce mortality risk by 26% compared to non-attendance [6] and is recommended for all post-AMI patients [8]. Despite the benefits of CR, attendance rates among eligible patients with AMI are low (range from 19% to 28%) [9,10]. At least four factors are known to be associated with poorer attendance at CR: older age [11], female gender [11,12]; Indigenous status [13] and regional or remote residence [13].

Despite the effectiveness of CR following an AMI, the average attendance rate in the HNELHD is 45% [14]. Consistent with evidence regarding some of the known risk factors for poorer CR attendance above, an internal audit found attendance rates in the HNELHD in regional areas (compared to metropolitan areas) and Indigenous populations is considerably lower at 25% and 15%, respectively [14]. This research attempted to address the key problem with CR uptake in the HNELHD overall and explores CR attendance among the four subgroups (identified in the internal audit and/or the literature) known to be at risk of poorer CR attendance.

The effect of studies investigating CR uptake to date have been mixed [15,16]. Pio and colleagues found low-quality evidence of interventions increasing 'enrolment' (defined as attendance at a first visit) (RR=1.27) and that intervention deliverer (nurse or allied health care provider) and delivery format (face-to-face) to be significantly influential in enhancing uptake ($p>0.05$) [16]. One systematic review identified six studies investigating strategies promoting CR uptake, which included letters, telephone calls, pamphlets, home visits and accompaniment to the first CR session, prompts, and encouragement from nurses [17]. While the review identified that all but one study (i.e., 'prompts' for

outpatient CR) reported significantly increased CR uptake, few randomised controlled trials (RCTs) have been conducted (i.e., 3/6 studies were RCTs) and there is a lack of studies targeting underrepresented populations [17]. There is evidence to suggest that physician advice can increase the likelihood of behaviour change in patients [18]. Personally tailored interventions have been effective in a range of other health behaviour change interventions (e.g., mammography screening [19], cancer screening [20] and physical activity and diet [21]), and postcards have been a useful strategy to promote uptake and attendance in other settings, including the promotion of influenza vaccine [22], mammography uptake [23], and dentist attendance in young children [24]. To our knowledge, no studies to date have promoted CR uptake using personally tailored postcards ostensibly written by the patient's admitting medical officer. We hypothesise that postcards may be more appealing for an older population, as they may be more inviting than formal letters and more noticeable than receiving information electronically. As such, this RCT aimed to increase CR uptake in patients following AMI, discharged from the two main hospitals in HNELHD.

Material and Methods

Study Design and Setting

A RCT was undertaken in HNELHD, which has a population of over 960,000 and covers a region of 131,785 square kilometres [25]. The district includes a major metropolitan centre, regional communities and remote and very remote communities serviced by 38 public hospital facilities [25]. Approximately 60,000 Aboriginal and Torres Strait Islander people live in the HNELHD, making up 5% of the population [26]. The design and conduct are reported according to the Consolidated Standards of Reporting Trials (CONSORT) [27] guidelines. Ethics approval was obtained from the Human Research Ethics Committee of the University of Newcastle, Australia (2019/ETH12841).

The Rehabilitation Support Via Postcard (RSVP) intervention prioritised ease of implementation. Developed in conjunction with the clinicians and district managers involved in direct service delivery, RSVP was deliberately designed to be integrated into existing HNELHD systems and be sustainable via automation and use of existing databases. If effective, the intervention will have demonstrated its ability to be implemented across a reasonably large geographic area and potentially be scalable and translatable to other health districts and rehabilitation models e.g., for pulmonary and stroke rehabilitation.

Participants: Eligibility, Recruitment and Randomisation

The Australian Cardiovascular Health and Rehabilitation Association recommend all eligible patients be automatically referred to CR [8]. Between January 2020 and July 2020, all

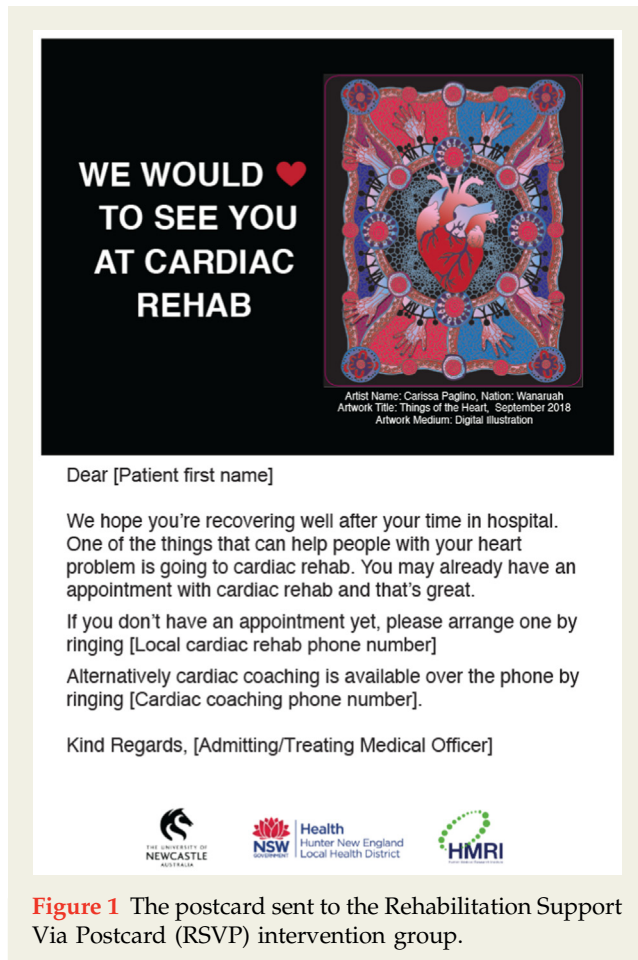


Figure 1 The postcard sent to the Rehabilitation Support Via Postcard (RSVP) intervention group.

patients following AMI with a CR referral from the metropolitan John Hunter Hospital (Newcastle, NSW) and the regional Tamworth Hospital (Tamworth, NSW) were enrolled into the trial. At the time of receiving the CR referral, eligible patients were provided with a participation information statement explaining that participation in the trial was entirely voluntary and participants could withdraw at any time. Lists of eligible patients were sent to a research assistant who applied a randomisation schedule using blocks of eight (created in Stata Version 15 [28]), which allocated patients to either the RSVP intervention or the control group (standard recruitment procedures as described in intervention overview and delivery).

Intervention Overview and Delivery

Participants in the RSVP intervention group received postcards addressed to them individually, which had been automatically signed and sent by their admitting medical officer (Figure 1). Postcards were put into envelopes to ensure confidentiality of participants' medical condition. The postcards included information encouraging CR attendance and reinforced the importance of attending CR to their health (see Figure 1). Additionally, they provided contact details for CR and reminded the participants of a telehealth alternative to attending CR in person. The purpose of sending the

postcard was to facilitate engagement with the CR team, and timely and early uptake with either face-to-face hospital-based CR or telephone-based CR coaching. The text on the postcards was entered into an online readability program (Hemingway Editor, [29]) to ensure it was readable at the 8th school grade.

For maximum ecological validity, the control group was to receive as close to usual practice as possible. Participants in the control group received the standard invitation in whichever way that hospital, ward, and clinician, blinded to allocation, would normally invite patients to CR. Usual practice for referral to CR varies by hospital and can include provision of referral letter while in care or on discharge, letter sent via post and/or additional telephone calls.

Outcomes

The primary outcome was CR referral uptake as measured by at least one attendance to a HNELHD CR program within 30 days of discharge. After the 30 days had expired all participants in the RSVP group received up to two phone calls from a research assistant to ensure the receipt of the postcard.

Statistical Methods and Power Considerations

Initial estimates were that the study would realistically have the ability to recruit 400 patients over a six-month period. Power calculations were then conducted on this sample size based on the assumptions that the rates of CR referral uptake in the control condition remained at 45% (alpha of 0.05 and power of 0.8). While any improvement in CR referral uptake is considered clinically significant, it was calculated that the intervention would need to produce a large improvement of 14% uptake or larger to be detectable with statistical significance.

Data were analysed using Stata Version 15 [28]. Descriptive statistics were reported as frequency (%) or mean (\pm standard deviation [SD]), as appropriate. Logistic regression was used to estimate odds ratios with 95% confidence intervals (95% CI) to determine the difference in rates of CR uptake between the RSVP and control groups. Additional exploratory analyses were conducted to examine the difference between sub-groups of participants (i.e., Indigenous status, sex, rurality and age).

Results

Four hundred and thirty ($n=430$) participants referred to CR were enrolled into the trial, 216 were randomised to receive the RSVP and 214 to the control group (Figure 2). There were no significant differences in Indigenous status, sex, rurality and age between the two groups (Table 1). In the RSVP group, 41% ($n=88$) confirmed receiving the postcard, 35% ($n=76$) were unable to recall if they had received it, and 24% ($n=52$) were uncontactable.

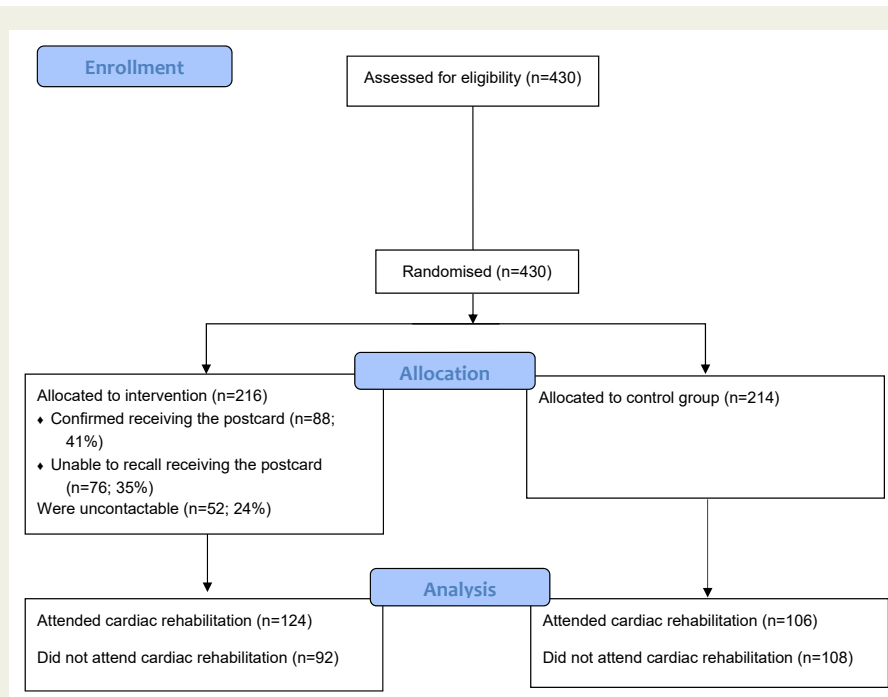


Figure 2 Flow diagram of participants.

Of those who received RSVP, 124 (54%) attended CR compared to 106 (46%) in the control group, which was not significantly different (OR=1.37 95%CI 0.9–2.0 $p=0.11$). Of those that could recall receiving the postcard (41%), there was no significant difference in attendance compared to those who were sent a postcard but could not recall it (OE=1.22 95%CI 0.7–2.1).

Figure 3 presents the CR attendance rates of the RSVP and control groups across four demographic factors—Indigeneity, sex, rurality and age. Logistic regression identified that when comparing males, significantly more men who received RSVP attended CR than controls (Table 2). Conversely, there was no significant difference in CR attendance between RSVP and control groups for females.

This effect of sex also impacted the Indigenous sub-group. There was a higher proportion of females (46% female) in the RSVP intervention group, than in the non-Indigenous sub-group (25% female). The apparent differences in RSVP efficacy between Indigenous and non-Indigenous participants (Figure 3) were non-significant once sex was accounted for.

Discussion

This study investigated the effectiveness of the RSVP intervention on CR attendance in participants with AMI. This appears to be the first study to evaluate whether a scalable postcard intervention can increase CR uptake. It should also be noted that this study took place in the context of the COVID-19 pandemic. Reluctance to attend CR as a result of COVID-19 would have affected RSVP and control conditions

equally and not impacted comparisons between these invitation methods. Further, CR was offered by telehealth to both groups during COVID. However, any differences found should be considered in the greater context of the global pandemic.

Overall, RSVP recipients attended CR at a non-statistically significant rate of 8% greater than controls. Our results are dissimilar to earlier studies that have used written material to promote CR uptake [17]. For example, Wyer and colleagues conducted a two-arm RCT (N=87) where participants received two letters designed to influence participants attitudes towards attending CR, subjective norm, and perceived behavioural control [30]. All participants received an envelope with a nominal letter thanking them for participating and half of these envelopes contained an intervention letter (i.e., randomised to the intervention group). Then a nurse saw all patients for routine assessment and personal invitation to CR programme. Participants in the intervention group who accepted the offer of CR were sent a second letter detailing the benefits of CR. The authors defined ‘attenders’ as those who attended the first week of the CR programme. The study found those in the intervention group were significantly ($p < 0.05$) more likely to accept the invitation to and physically attend CR, compared to controls [30]. It should be noted that other factors may have resulted in the different results compared to Wyer and colleague obtained, including, (i) the use of a theoretical basis for their intervention, (ii) the inclusion of a face-to-face component, and (iii) more than one letter. It is likely that our results may have been affected by the COVID-19 pandemic, given the majority of the intervention period

Table 1 Demographics of included participants.

	Intervention n=216	Control n=214	Total=430
Indigenous	15 (7%)	22 (10%)	37 (9%)
Female	59 (27%)	65 (30%)	124 (29%)
Rural*	73 (34%)	73 (34%)	146 (34%)
Age, mean years (SD)	66 (12)	66 (13)	66 (12)

*Incorporates regional and remote residents.
Abbreviation: SD, standard deviation.

Table 2 Rates and logistic regression of CR attendance patients by sex sub-group.

	Intervention	Control	Odds Ratio	95% CI	P
Males	95 (61%)	72 (48%)	1.6	1.0 to 2.6	0.03
Females	29 (49%)	34 (53%)	0.9	0.4 to 1.7	0.66

Abbreviation: CI, confidence interval.

(i.e., between January to July 2020) occurred during the two-month lockdown in this region (approximately March to April 2020), at which time Australian CR programs underwent substantial structural changes, with periods of closures and reduced services offered in person.

The non-significant difference in the current study may be a result of the power of the sample. Based on the limitations of the recruitment period, the study was powered to find a statistically significant difference of 14%, while overall the benefit in this trial of the RSVP intervention was only 8%. Given that national [8] and international guidelines recommend all patients following AMI attend CR, any improvement in attendance would be considered clinically significant, therefore future investigations of RSVP may be powered to detect smaller differences.

Sub-Group Analysis

Exploratory *post-hoc* analyses examined the CR uptake according to indigenous status, sex, rurality and age. We found a significantly higher uptake of CR in males in the RSVP group, compared to males in the control group. This highlighted the apparent discrepancy of the impact of the RSVP intervention between males and females. Conversely, there was no significant difference for females between the intervention and control group. It is possible that different strategies are needed to promote CR uptake among males and females. A systematic review evaluating barriers and solutions of attending CR for women found that, while there are several demographic, socioeconomic, medical and societal challenges that impede CR uptake for all patients, they were particularly prominent for women [31]. For example, lower education level, family responsibilities, home-related stress, lack of social support, unemployment, an underrepresented minority group, lack of CR awareness, and age (i.e., older than 70 years or younger than 55 years) were all factors associated with lower CR uptake for women [31]. There were

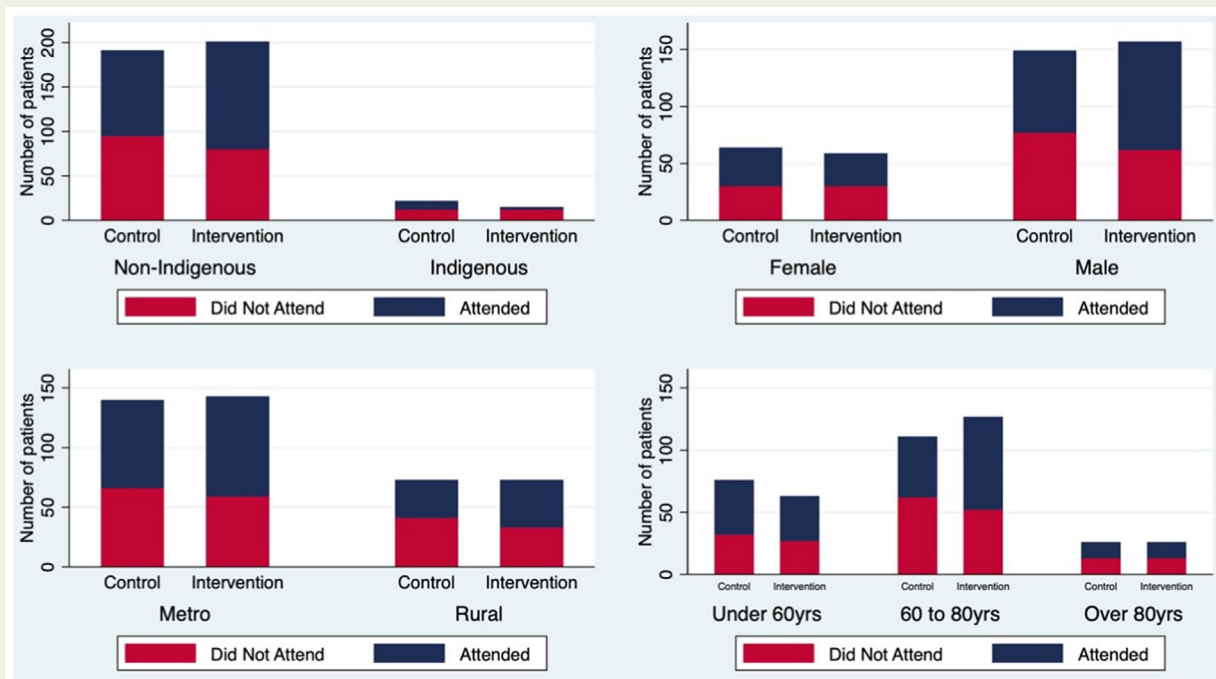


Figure 3 Cardiac rehabilitation attendance rates of RSVP and control groups for Indigenous and Non-Indigenous participants, males and females, rural and non-rural hospitals, and for age category.

no significant differences in CR attendance by Indigenous participants receiving the RSVP intervention, after adjusting for sex. CR attendance by Indigenous patients remained very low overall and requires urgent further study. Regional and remote attendance was not enhanced by the postcard even though it advertised telehealth appointments, highlighting the need for further study among this group. The intervention did not have a statistically significant impact on CR attendance in any of the age groups. Qualitative studies, in consultation with these people from these three subgroups, would help shed light on how CR attendance may be improved.

The RSVP intervention had several strengths, including environmental validity, low cost, designed to be integrated into existing NSW Health systems and sustainability via automation. As such, the intervention would be eminently scalable and translatable to other health districts and rehabilitation models (e.g., for pulmonary and stroke rehabilitation). As mentioned, a limitation of this study was the limited size of the sample that meant that an 8% increase in CR attendance, which clinicians and guidelines (29) consider clinically significant, could not be verified with statistical significance. The trial was also not registered prior to commencement and there were no measures in place to assess to what extent the COVID-19 pandemic may have affected the results. Another limitation is that the postcard itself was not co-designed with CR consumers, which may have reduced the effectiveness of the intervention. Finally, the seemingly high number of participants who were uncontactable in regards to determining if they had received the postcard (24%), and those who were unable to recall if they had received a postcard (35%), are limitations that may have affected the results. Future studies promoting CR uptake using written material (i.e., letters, postcards) should explore reasons for participants' inability to recall receipt.

Conclusions

The current RSVP study provides supporting evidence that postcards ostensibly sent by admitting physicians, promoting CR to participants discharged following AMI, are an effective strategy to increase CR uptake in men, but not to statistically significant levels overall. As such, more research is needed to develop strategies to increase CR uptake among women, Indigenous people, older people and people from rural and remote locations.

Conflicts of Interest

All authors declare no conflicts of interest.

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