

# Gestione Clinica della SCA in Regione Lombardia La Fase della Riabilitazione



Con il patrocinio della  Con il patrocinio di   Regione Lombardia

**MILANO**  
PALAZZO PIRELLI  
SALA PIRELLI  
Via Fabio Filzi, 22  
**7 MAGGIO 2019**

**GESTIONE CLINICA DELLA  
SINDROME CORONARICA  
ACUTA IN REGIONE LOMBARDIA**

2019 MOTORE  
**SANITÀ**  
Cedere è Cambiamento

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Pavia, IT

Past-President Associazione Italiana Cardiologia Clinica Preventiva e  
Riabilitativa (AICPR formerly GICR-IACPR)

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# Key Points

- Cosa è la Riabilitazione o meglio cosa è la Cardiologia Riabilitativa;
- Come deve essere organizzata;
- La Cardiologia Riabilitativa è efficace ?
- Criticità;
- Take-home message.

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# Cosa è la Cardiologia Riabilitativa?

- Assistenza clinica (valutazione/diagnosi, monitoraggio, terapia) volta alla stabilizzazione

La Cardiologia Riabilitativa è un intervento multidisciplinare che non è e non deve essere identificato con il solo «Training Fisico/Attività Fisica»

- Prescrizione di un programma di attività fisica (physical activity o Exercise Training)
- Interventi di mantenimento nel lungo termine (follow-up)

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## Secondary prevention in the clinical management of patients with cardiovascular diseases. Core components, standards and outcome measures for referral and delivery

A Policy Statement from the Cardiac Rehabilitation Section of the European Association for Cardiovascular Prevention & Rehabilitation. Endorsed by the Committee for Practice Guidelines of the European Society of Cardiology

Massimo F Piepoli<sup>1,2</sup>, Ugo Corrà<sup>3</sup>, Stamatis Adamopoulos<sup>4</sup>, Werner Benzer<sup>5</sup>, Birna Bjarnason-Wehrens<sup>6</sup>, Margaret Cupples<sup>7</sup>, Paul Dendale<sup>8</sup>, Patrick Doherty<sup>9</sup>, Dan Gaita<sup>10</sup>, Stefan Höfer<sup>11</sup>, Hannah McGee<sup>12</sup>, Miguel Mendes<sup>13</sup>, Josef Niebauer<sup>14</sup>, Nana Pogossova<sup>15</sup>, Esteban Garcia-Porrero<sup>16</sup>, Bernhard Rauch<sup>17</sup>, Jean Paul Schmid<sup>18</sup> and Pantaleo Giannuzzi<sup>3</sup>

## La Cardiologia Preventiva e Riabilitativa “3.0”: dalle acuzie alla cronicità. Position paper del Gruppo Italiano di Cardiologia Riabilitativa e Preventiva (GICR-IACPR)

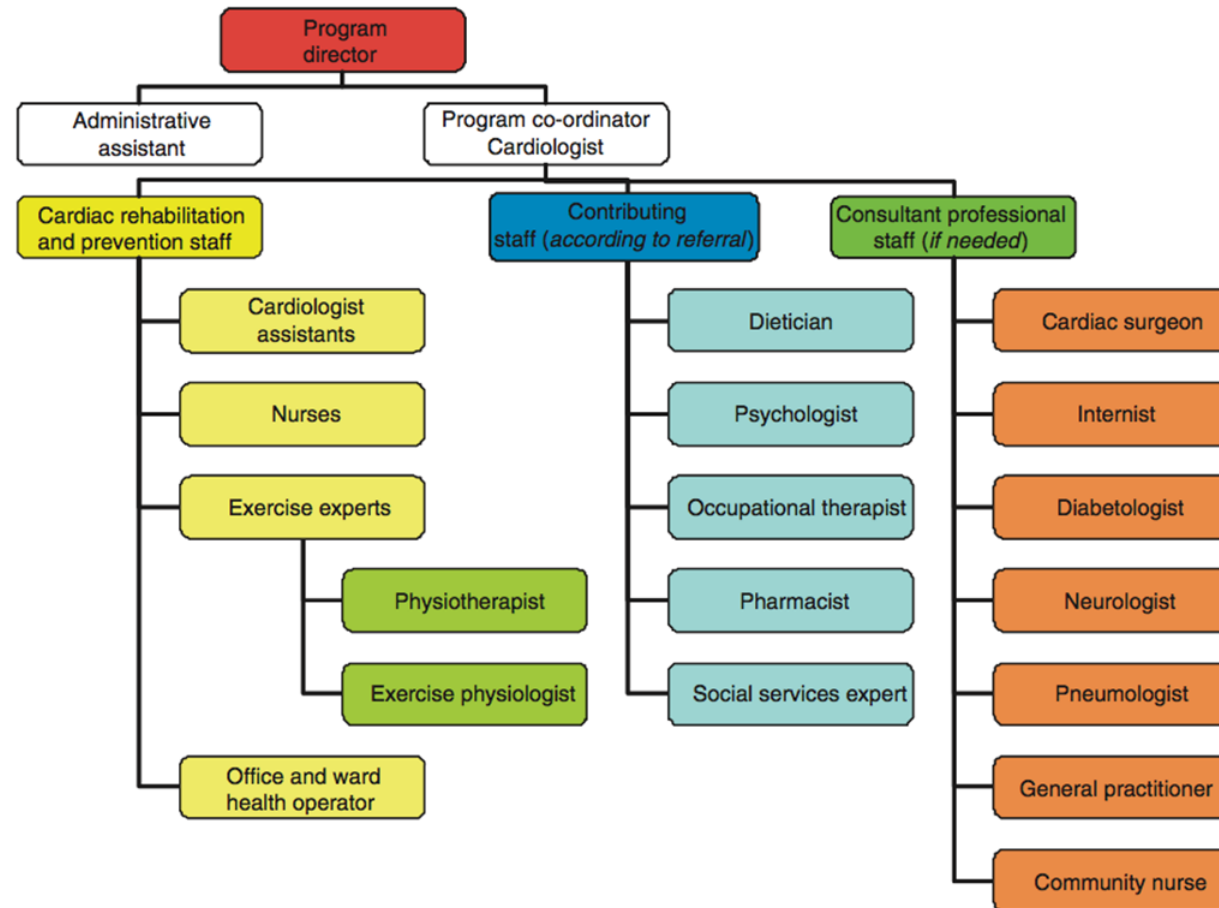
Roberto F.E. Pedretti<sup>1</sup>, Francesco Fattiroli<sup>2</sup>, Raffaele Griffo<sup>3</sup>, Marco Ambrosetti<sup>1</sup>, Elisabetta Angelino<sup>4</sup>, Silvia Brazzo<sup>5</sup>, Ugo Corrà<sup>6</sup>, Nicolò Dasseni<sup>7</sup>, Pompilio Faggiano<sup>7</sup>, Giuseppe Favretto<sup>8</sup>, Oreste Febo<sup>9</sup>, Marina Ferrari<sup>10</sup>, Francesco Giallauria<sup>11</sup>, Cesare Greco<sup>12</sup>, Manuela Iannucci<sup>13</sup>, Maria Teresa La Rovere<sup>10</sup>, Mario Mallardo<sup>14</sup>, Antonio Mazza<sup>1</sup>, Massimo Piepoli<sup>15</sup>, Carmine Riccio<sup>16</sup>, Simonetta Scalvini<sup>17</sup>, Luigi Tavazzi<sup>18</sup>, Pier Luigi Temporelli<sup>6</sup>, Gian Francesco Mureddu<sup>12</sup>

Revisori del Documento

Daniele Bertoli<sup>19</sup>, Andrea Bianco<sup>20</sup>, Pasqualina Calisi<sup>21</sup>, Carlo Ciglia<sup>22</sup>, Furio Colivicchi<sup>23</sup>, Anna Frisinghelli<sup>24</sup>, Michele Gabriele<sup>25</sup>, Giuseppe Ciancamerla<sup>26</sup>, Rocco Lagaioia<sup>27</sup>, Roberto Marini<sup>28</sup>, Bruna Miserrafiti<sup>29</sup>, Salvatore Pirelli<sup>30</sup>, Matteo Ruzzolini<sup>31</sup>, Gianpaolo Scorcu<sup>32</sup>, Franco Tarro Genta<sup>33</sup>, Nidal Tourkmani<sup>34</sup>, Elio Venturini<sup>35</sup>, Marika Werren<sup>36</sup>, Gianni Zobbi<sup>37</sup>

1. *Phase 1* – early intervention during the stay in acute hospital, including early mobilization and prevention of complications secondary to immobilization.
2. *Phase 2* – promotes and delivers preventive and rehabilitative services to patients following an index CVD event with the aim of clinical stabilization, risk stratification and promotion of long term intervention. It may be performed in in-patient as well as in out-patient settings.
3. *Phase 3* – long-term out-patient CR, which seeks to provide sustained delivery of preventive and rehabilitative services in the out-patient setting and/or in the community.

# A Proposal for the Organizational Chart for a Cardiac Rehabilitation/Preventive Cardiology Service



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- Criticità;
- Take-home message.



# Perché la Cardiologia Riabilitativa e Preventiva è in Classe I nelle linee guida ?

Exercise-based rehabilitation for coronary heart disease  
(Review)

Exercise Physiology

Jolliffe J, Rees K, Taylor RRS, Thompson DR, O

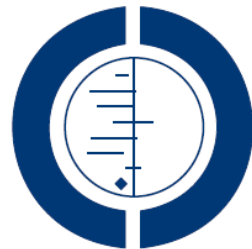
Impact of Cardiac Rehabilitation on Mortality and Cardiovascular Events After Percutaneous Coronary Intervention in the Community

Epidemiology and Prevention

Participation in Cardiac Rehabilitation and Survival After Heart Surgery  
Exercise-based rehabilitation for heart failure (Review)  
CLINICAL RESEARCH STUDY

Taylor RS, Sagar VA, Davies EJ, Briscoe S, Coats AJS, Dalal H, Lough F, Rees K, Singh S

Quin R



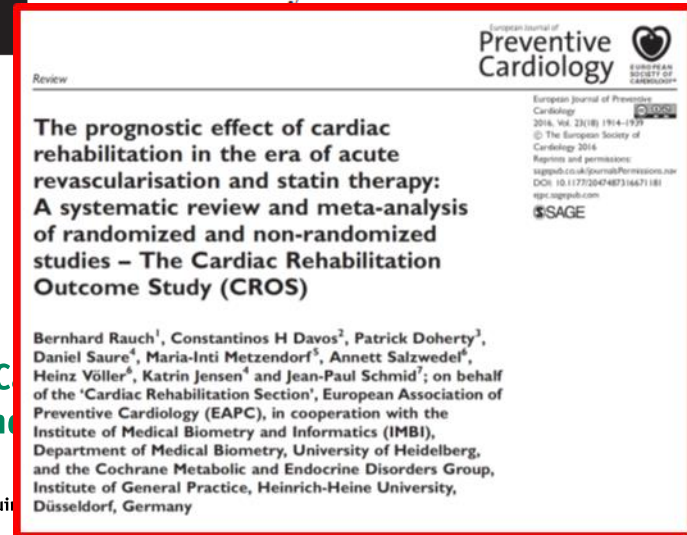
THE COCHRANE COLLABORATION®

r, MS; Kevin L. Greason, MD; D, MSc; Zixin Zhang, MD; IS

Participation in Cardiac Rehabilitation and Survival After Heart Surgery  
Readmissions, and Mortality After Myocardial Infarction


Shannon M. Dunlay, MD, MS,<sup>a,b</sup> Quin R, MD, MPH,<sup>a,b</sup>

<sup>a</sup>Division of Cardiovascular Diseases and <sup>b</sup>Department of Health Sciences Research, Mayo Clinic, Rochester, Minn; <sup>c</sup>Division of Cardiology, Baystate Medical Center, Springfield, Mass.



# Cardiologia Riabilitativa e SCA in Regione Lombardia ...

**Gestione clinica della sindrome coronarica acuta in Lombardia**



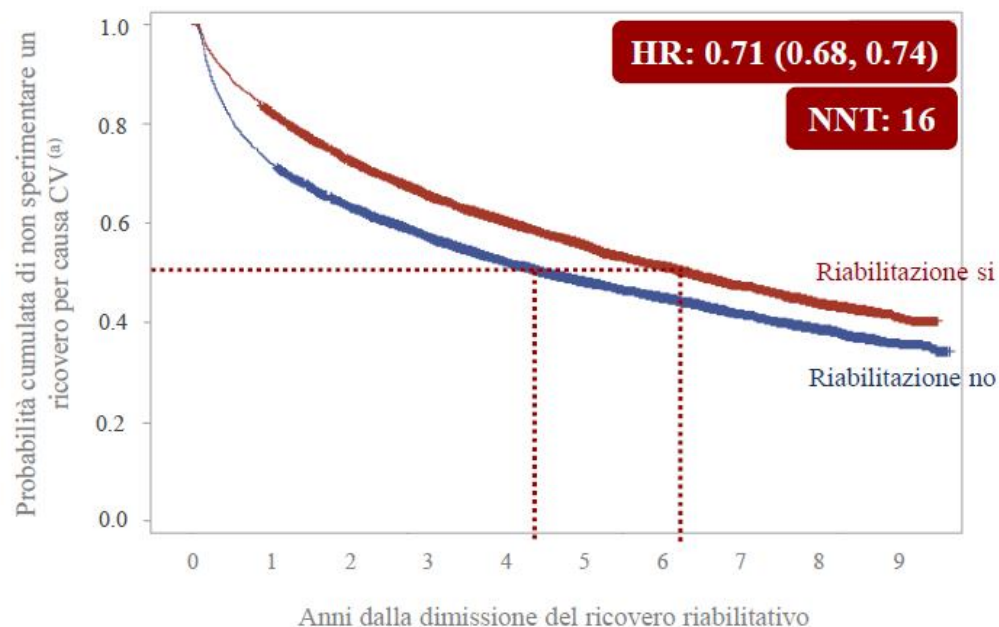
1. Di quali dati stiamo parlando?
2. Quanti pazienti vengono ospedalizzati?
3. Quali caratteristiche hanno?
4. Quanti sperimentano un esito clinico rilevante?
5. A quali terapie/controlli sono sottoposti?
- 6. Quanti esiti potrebbero essere evitati?**

Cosa abbiamo imparato?

**UNIVERSITÀ DEGLI STUDI  
BICOCCA**

**Healthcare Research  
& Pharmacoepidemiology**

## Intervento riabilitativo in degenza ordinaria entro due mesi dalla dimissione indice e probabilità di ricovero per causa CV



<sup>(a)</sup> Stime ottenute con appaiamento 1:1 in base a età e genere al ricovero indice, Multisource Comorbidity Score e High Dimensional Propensity score

| Sindrome coronarica acuta: dati dal mondo reale in Lombardia |  
| Milano 7 maggio 2019 | [giovanni.corrao@unimib.it](mailto:giovanni.corrao@unimib.it) |

# Coronary Artery Disease: 839 Patients With vs 441 Patients Without Out-Hospital Cardiac Rehabilitation

## Impact of ambulatory cardiac rehabilitation on cardiovascular outcomes: a long-term follow-up study

Sara Doimo<sup>1</sup>, Enrico Fabris<sup>1\*</sup>, Massimo Piepoli<sup>2</sup>, Giulia Barbatì<sup>3</sup>, Francesco Antonini-Canterin<sup>4</sup>, Guglielmo Bernardi<sup>5</sup>, Patrizia Maras<sup>1</sup>, and Gianfranco Sinagra<sup>1</sup>

<sup>1</sup>Cardiovascular Department, Azienda Sanitaria Universitaria Integrata, University of Trieste, Via Pietro Valdoni n. 7, 34149 Trieste, Italy; <sup>2</sup>Heart Failure Unit, Cardiac Department, Guglielmo da Saliceto Hospital, Piacenza, Italy; <sup>3</sup>Biostatistics Unit, Department of Medical Sciences, University of Trieste, Italy; <sup>4</sup>Cardiovascular Rehabilitation, Ospedale Riabilitativo di Alta Specializzazione, Motta di Livenza, Italy; and <sup>5</sup>Division of Cardiology, "Santa Maria degli Angeli" Hospital, Pordenone, ASS5, Italy

Received 24 October 2017; revised 3 January 2018; editorial decision 7 June 2018; accepted 20 July 2018

**Aims** To evaluate the long-term clinical impact of the application of cardiac rehabilitation (CR) early after discharge in a real-world population.

**Methods and results** We analysed the 5-year incidence of cardiovascular mortality and hospitalization for cardiovascular causes in two populations, attenders vs. non-attenders to an ambulatory CR program which were consecutively discharged from two tertiary hospitals, after ST-elevation myocardial infarction, non-ST-elevation myocardial infarction, coronary artery bypass graft, or planned percutaneous coronary intervention. A primary analysis using multivariable regression model and a secondary analysis using the propensity score approach were performed. Between 1 January 2009 and 31 December 2010, 839 patients attended a CR program planned at discharged, while 441 patients were discharged from Cardiovascular Department without any program of CR. During follow-up, the incidence of cardiovascular mortality was 6% in both groups ( $P=0.62$ ). The composite outcome of hospitalizations for cardiovascular causes and cardiovascular mortality were lower in CR group compared to no-CR group (18% vs. 30%,  $P<0.001$ ) and was driven by lower hospitalizations for cardiovascular causes (15 vs. 27%,  $P<0.001$ ). At multivariable Cox proportional hazard analysis, CR program was independent predictor of lower occurrence of the composite outcome (hazard ratio 0.58, 95% confidence interval 0.43–0.77;  $P<0.001$ ), while in the propensity-matched analysis CR group experienced also a lower total mortality (10% vs. 19%,  $P=0.002$ ) and cardiovascular mortality (2% vs. 7%,  $P=0.008$ ) compared to no-CR group.

**Conclusion** This study showed, in a real-world population, the positive effects of ambulatory CR program in improving clinical outcomes and highlights the importance of a spread use of CR in order to reduce cardiovascular hospitalizations and cardiovascular mortality during a long-term follow-up.

**Keywords** Coronary artery disease • Cardiac rehabilitation • Cardiovascular mortality • Cardiovascular hospitalization • Propensity score

**Table 2** Cardiovascular outcome

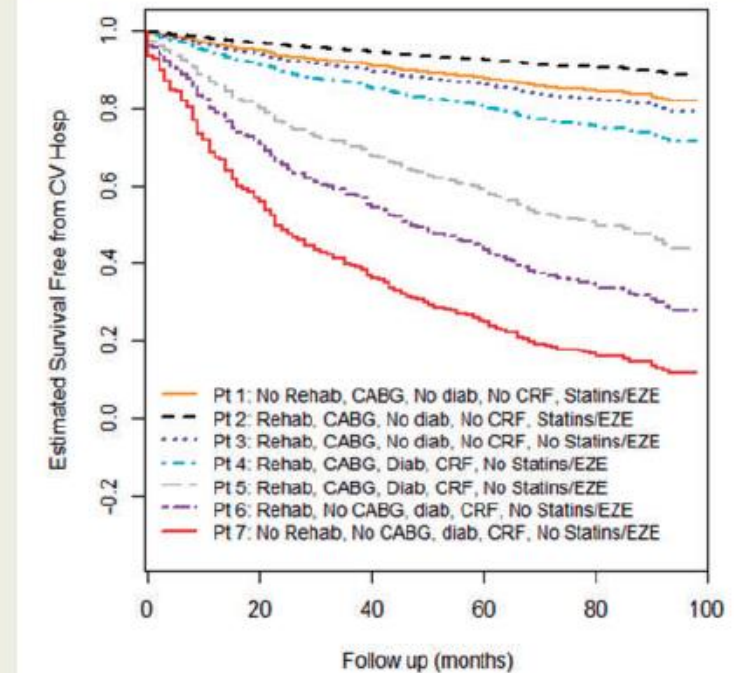
	Non-attenders (441 pts)	Attenders (839 pts)	P-value
Total mortality % (n)	18 (78)	17 (142)	0.861
Cardiovascular mortality % (n)	6 (28)	6 (48)	0.623
Hospitalizations % (n)	27 (119)	15 (122)	<0.001
Hospitalization and cardiovascular mortality % (n)	30 (133)	18 (155)	<0.001

Pts, patients.

**Table 5** Events (propensity-matched analysis)

	Non-attenders	Attenders	P-value
Total mortality, % (n)	19 (69)	10 (38)	<b>0.002</b>
Cardiovascular mortality, % (n)	7 (25)	2 (9)	<b>0.008</b>
Hospitalization, % (n)	25 (94)	11 (42)	<0.001
Hospitalization and cardiovascular mortality, % (n)	29 (106)	13 (48)	<0.001

Seventy-two patients had no left ventricular ejection fraction (LVEF) values and were excluded from the analysis.



**Figure 1** Estimated survival curves from the Cox model. The curves are estimated for patients having the median ejection fraction (56%) of the population. CABG, coronary artery bypass graft; CRF, chronic renal failure; Diab, diabetes; EZE, ezetimibe; Rehab, cardiac rehabilitation.

# In-Hospital Cardiac Rehabilitation Reduces All-Cause Mortality and Rehospitalizations in 140,552 Patients With Incident Acute Heart Failure

**Table 2.** Multivariate predictors of all-cause mortality in the overall study population.

Covariates	HR (95% CI)	SE	P value
Male gender	1.2085 (1.1865; 1.2310)	0.0094	<0.0001
Age	1.0384 (1.0373; 1.0394)	0.0005	<0.0001
Diagnosis groups			
Group 2	0.8050 (0.7748; 0.8352)	0.0154	<0.0001
Group 3	0.9944 (0.9709; 1.0179)	0.0120	NS
Comorbidities (>2)	1.0756 (1.0681; 1.0832)	0.0036	<0.0001
Surgical procedures	1.3387 (1.2611; 1.4189)	0.0300	<0.0001
ACE/ARB (yes/no)	0.8968 (0.8935; 0.9002)	0.0019	<0.0001
Beta-blockers (yes/no)	0.8907 (0.8883; 0.8931)	0.0014	<0.0001
Outpatient care	0.9424 (0.9404; 0.9445)	0.0011	<0.0001
Group B participation	0.5768 (0.5650; 0.5888)	0.0105	<0.0001

HR: hazard ratio; CI: confidence interval; SE: standard error; ACE: angiotensin-converting enzyme; ARB: angiotensin II receptor blocker.

**Table 3.** Multivariate predictors for all-cause readmissions in the overall study population.

Covariates	HR (95%CI)	SE	P value
Intercept	1.3565 (1.2228; 1.5052)	0.0719	<0.0001
Male gender	1.2642 (1.2304; 1.2889)	0.0175	<0.0001
Age	0.9932 (0.9920; 0.9944)	0.0006	<0.0001
Diagnosis groups			
Group 2	1.0165 (0.9780; 1.0550)	0.0196	NS
Group 3	0.7930 (0.7621; 0.8238)	0.0157	<0.0001
Comorbidities (>2)	1.8051 (1.7809; 1.8296)	0.0124	<0.0001
Surgical procedures	1.2508 (1.1832; 1.3225)	0.0355	<0.0001
ACE/ARB (yes/no)	0.9712 (0.9689; 0.9734)	0.0012	<0.0001
Beta-blockers (yes/no)	0.9581 (0.9564; 0.9598)	0.0009	<0.0001
Outpatient care	0.9858 (0.9846; 0.9869)	0.0006	<0.0001
Group B participation	0.7997 (0.7758; 0.8244)	0.0124	<0.0001

HR: hazard ratio; CI: confidence interval; SE: standard error; ACE: angiotensin-converting enzyme; ARB: angiotensin II receptor blocker.



Check for updates

Full research paper

**Impact of in-hospital cardiac rehabilitation on mortality and readmissions in heart failure: A population study in Lombardy, Italy, from 2005 to 2012**

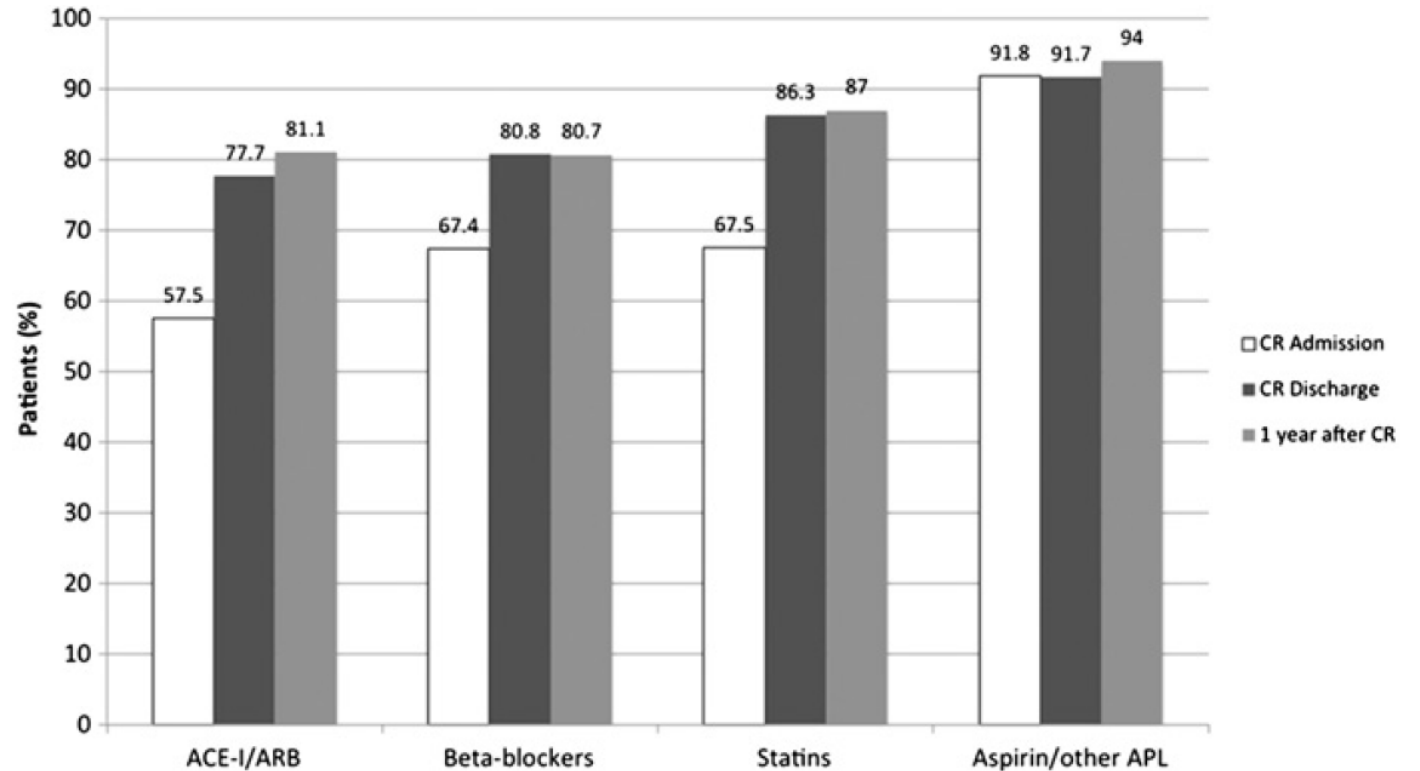
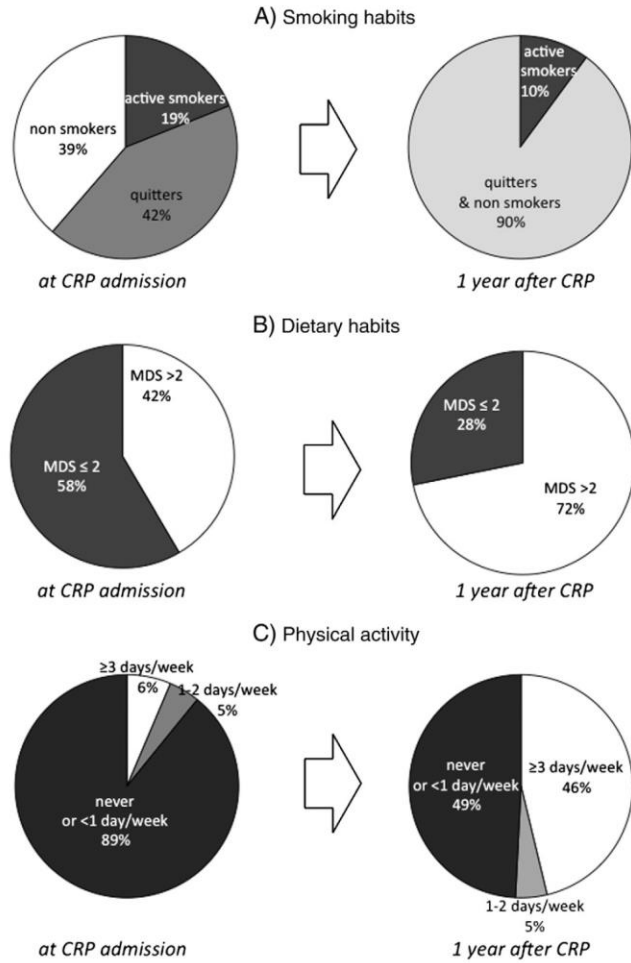
Simonetta Scalvini<sup>1</sup>, Francesco Grossetti<sup>2</sup>, Anna Maria Paganoni<sup>3</sup>, Maria Teresa La Rovere<sup>4</sup>, Roberto FE Pedretti<sup>5</sup> and Maria Frigerio<sup>6</sup>

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# Effective secondary prevention through cardiac rehabilitation after coronary revascularization and predictors of poor adherence to lifestyle modification and medication. Results of the ICAROS Survey

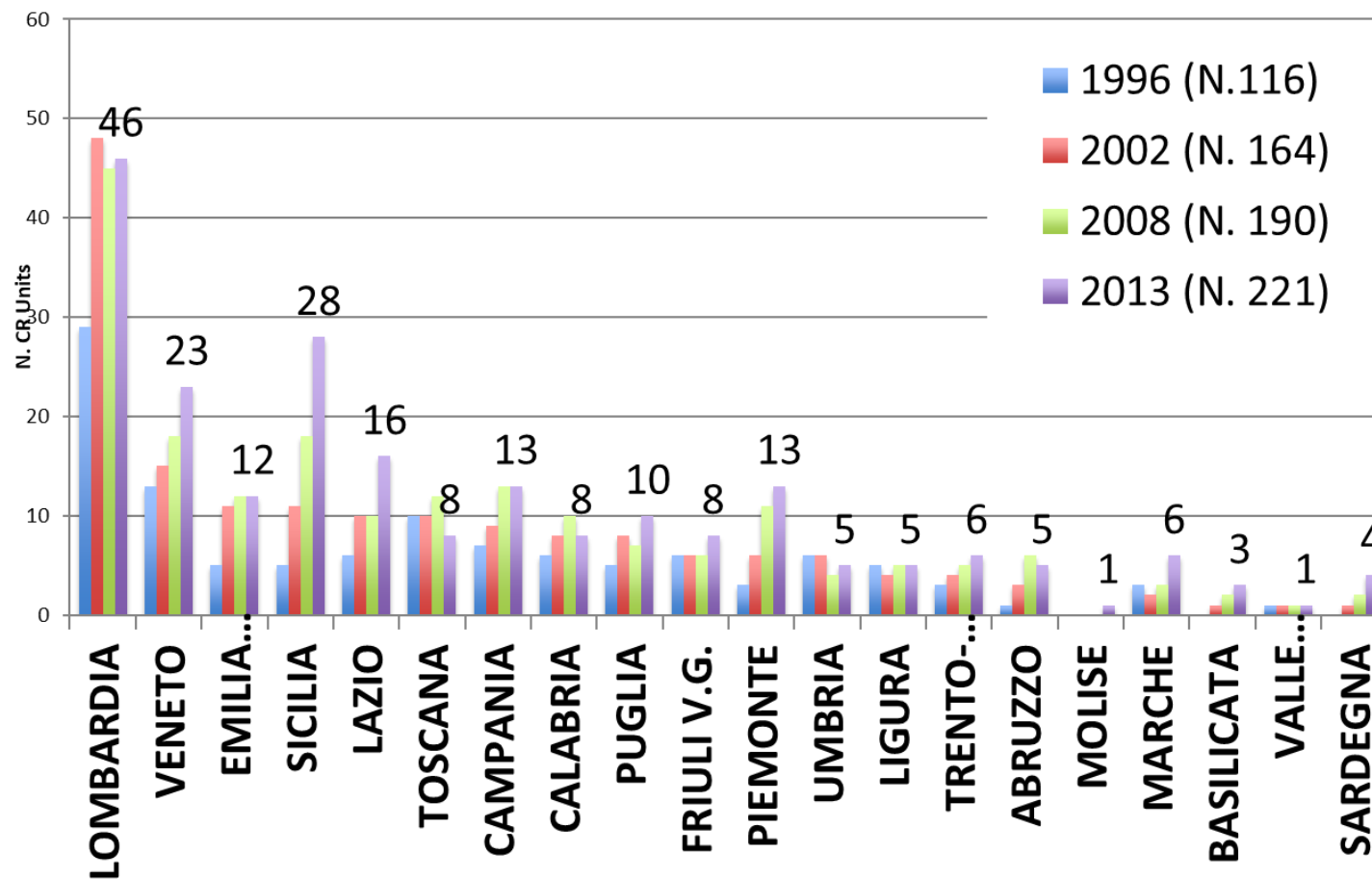


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# Key Points


- Cosa è la Riabilitazione o meglio cosa è la Cardiologia Riabilitativa;
- Come deve essere organizzata;
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- **Criticità;**
- Take-home message.

# Distribuzione regionale delle UU.OO. di Cardiologia Riabilitativa negli ultimi due decenni



# Referral Rate ...


**Gestione clinica della  
sindrome coronarica  
acuta in Lombardia**



1. Di quali dati stiamo parlando?
2. Quanti pazienti vengono ospedalizzati?
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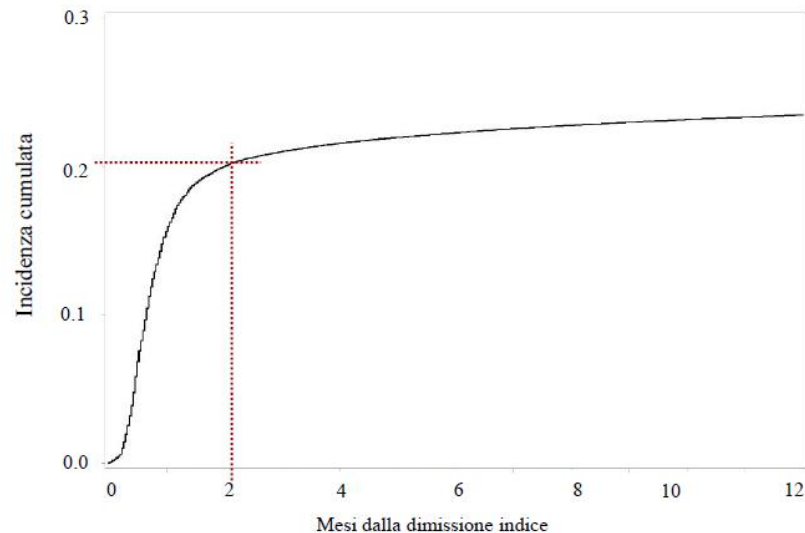
Quanti esiti potrebbero essere evitati?  
Cosa abbiamo imparato?



Healthcare Research  
& Pharmacoepidemiology

**106,104**  
coorte "incidente"  
sopravvivate

## Ricovero riabilitativo in degenza ordinaria entro un anno dalla dimissione indice

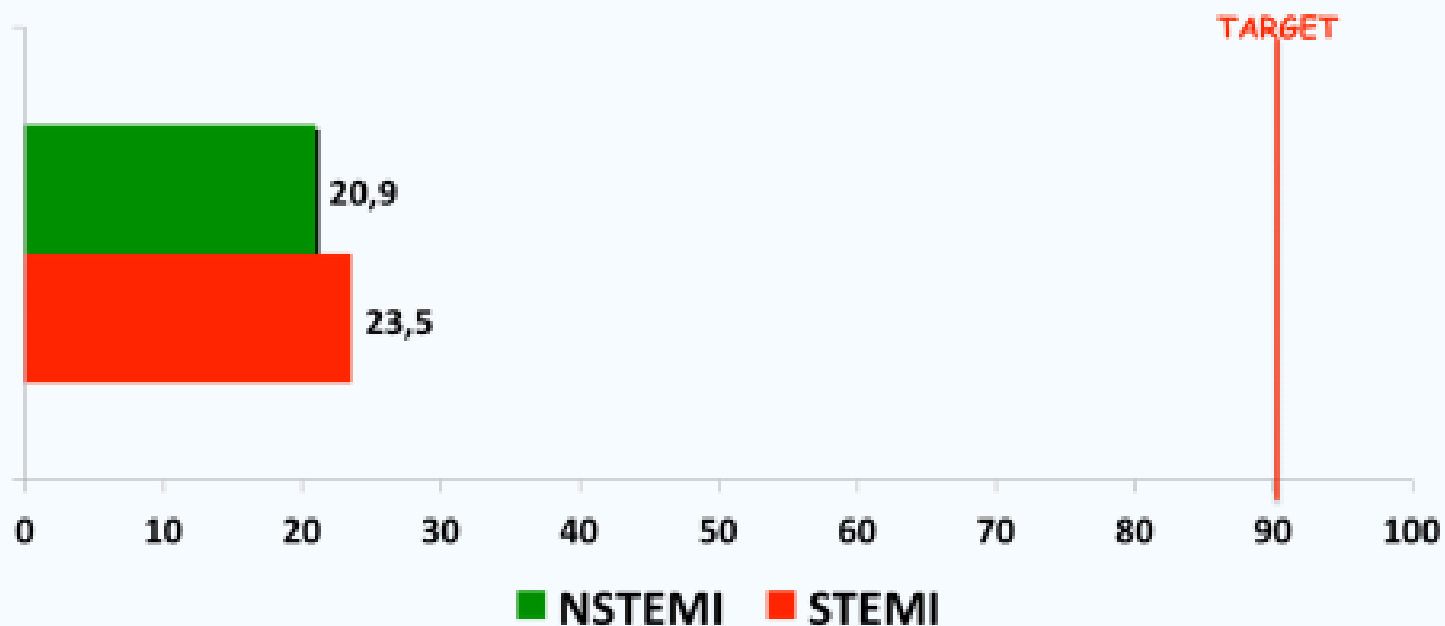


| Sindrome coronarica acuta: dati dal mondo reale in Lombardia |  
| Milano 7 maggio 2019 | [giovanni.corrao@unimib.it](mailto:giovanni.corrao@unimib.it) |





### Eseguito ciclo riabilitativo in pazienti sopravvissuti a 6 mesi con follow up disponibile



# Trends in mortality and heart failure after acute myocardial infarction in Italy from 2001 to 2011

**Table 1**

Trends of index in-hospital mortality rate (I-MR) total in-hospital mortality rate (T-MR) and fatal readmission rate (F-RR) after acute myocardial infarction (AMI). CI = confidence interval.

Discharge year	AMI patients (N)	I-MR (%)	T-MR (%)			AMI patients <sup>a</sup> (N)	F-RR (%)		
			30 days	60 days	1 year		30 days	60 days	1 year
2001	86,107	11.34	12.01	13.12	16.46	76,345	0.67	1.48	4.75
2002	93,275	10.88	11.55	12.74	16.21	83,126	0.67	1.54	4.95
2003	100,031	10.89	11.67	12.84	16.34	89,134	0.78	1.64	5.07
2004	102,567	10.29	11.06	12.29	15.87	92,009	0.77	1.66	5.17
2005	103,847	10.47	11.21	12.41	16.00	92,975	0.74	1.63	5.16
2006	105,219	9.93	10.64	11.86	15.50	94,775	0.72	1.60	5.15
2007	105,813	9.82	10.54	11.80	15.44	95,423	0.72	1.62	5.18
2008	105,210	9.69	10.43	11.69	15.48	95,017	0.74	1.68	5.39
2009	102,094	9.34	10.05	11.26	14.92	92,557	0.71	1.58	5.18
2010	103,196	8.97	9.70	10.93	14.61	93,935	0.73	1.64	5.26
2011	103,463	8.99	9.67	10.93	14.68	94,166	0.69	1.61	5.28
Mean annual change (%)		-0.23	-0.23	-0.22	-0.19		0.00004	0.01	0.04
95% CI of annual change (%)		(-0.27; -0.20)	(-0.27; -0.20)	(-0.25; -0.19)	(-0.23; -0.15)		(-0.001; 0.001)	(-0.004; 0.019)	(0.02; 0.06)
R <sup>2</sup>		0.97	0.96	0.97	0.94		0.00	0.21	0.68
p value for F test		<0.0001	<0.0001	<0.0001	<0.0001		0.9918	0.1547	0.0019

<sup>a</sup> Patients survived at the index admission.

... The percentage of patients who, between 2001 and 2011, were alive at discharge from the index hospitalization but were re-hospitalized and died during the stay, remained unchanged at 30 days (about 0.7%), and increased slightly at 60 days. However, this change of F-RR became larger and statistically significant at 1 year (mean annual change 0.04% [0.02% to 0.06%; p = 0.0019]) ...

\*\*Modificata da R.F.E. Pedretti

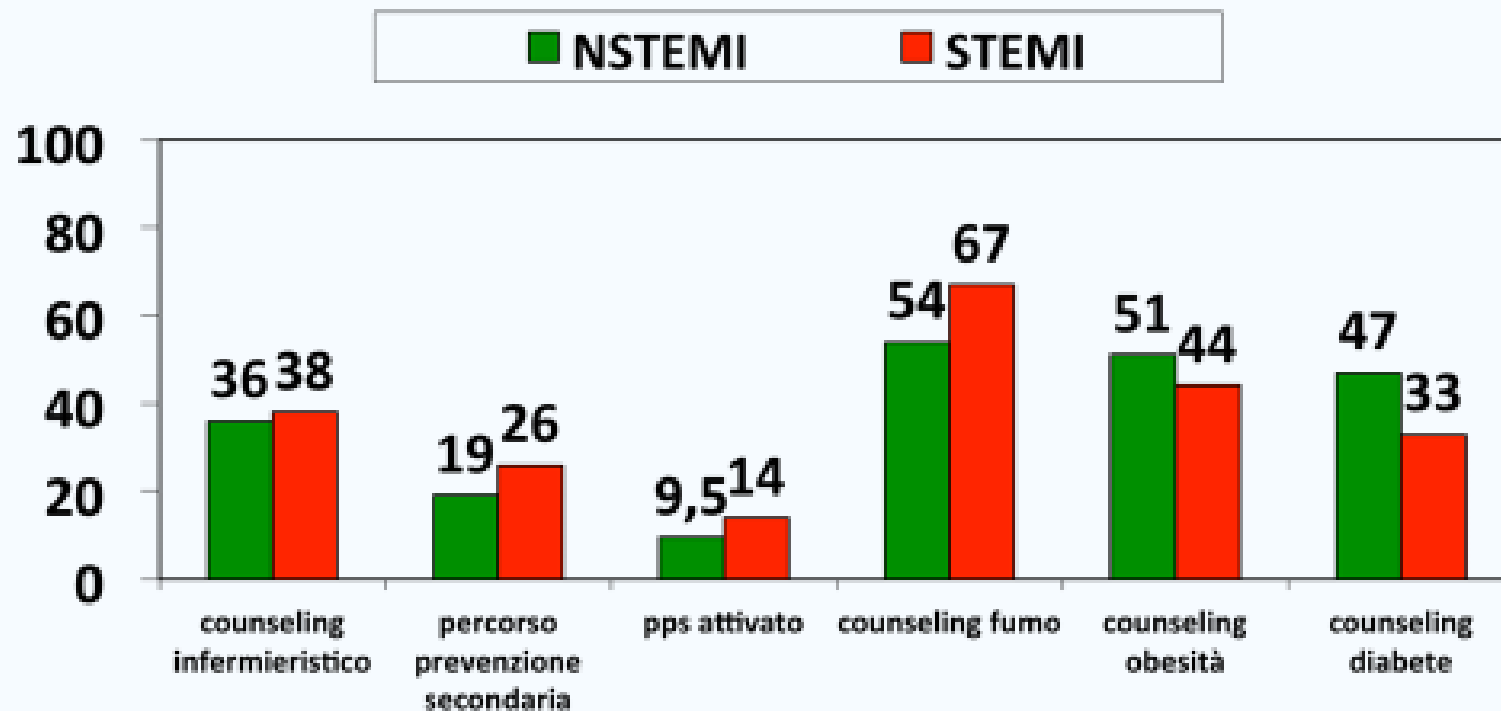
### PERCORSI DI RIABILITAZIONE E PREVENZIONE SECONDARIA IN FUNZIONE DEL PROFILO DI RISCHIO NEL I ANNO

	COUNSELING	CR DEGENZIALE	CR AMBULATORIALE	AMB. CARDIOLOGICI DEDICATI PREV. SEC.	AMB. CARDIOLOGICI MMG
<b>ALTO RISCHIO</b>		<b>+++</b>	<b>+</b>		
<b>RISCHIO TROMBOTICO ELEVATO</b>	<b>+</b>	<b>+***</b>	<b>+++</b>	<b>+</b>	
<b>BASSO RISCHIO</b>	<b>+++</b>				<b>+++</b>



## BLITZ 4 (2009-2010)

163 UTIC ad impronta interventistica





***«Il successo non è mai definitivo, il fallimento non è mai fatale; è il coraggio di continuare che conta»***

***Sir. Winston Churchill***



# Increasing Cardiac Rehabilitation Participation From 20% to 70%: A Road Map From the Million Hearts Cardiac Rehabilitation Collaborative

Philip A. Ades, MD; Steven J. Keteyian, PhD; Janet S. Wright, MD;  
Larry F. Hamm, PhD; Karen Lui, RN, MS; Kimberly Newlin, ANP;  
Donald S. Shepard, PhD; and Randal J. Thomas, MD, MS

**... We also calculate that increasing CR participation from 20% to 70% would save 25,000 lives and prevent 180,000 hospitalizations annually in the United States ...**

## Abstract

The primary aim of the Million Hearts initiative is to prevent 1 million cardiovascular events over 5 years. Concordant with the Million Hearts' focus on achieving more than 70% performance in the "ABCS" of aspirin for those at risk, blood pressure control, cholesterol management, and smoking cessation, we outline the cardiovascular events that would be prevented and a road map to achieve more than 70% participation in cardiac rehabilitation (CR)/secondary prevention programs by the year 2022. Cardiac rehabilitation is a class Ia recommendation of the American Heart Association and the American College of Cardiology after myocardial infarction or coronary revascularization, promotes the ABCS along with lifestyle counseling and exercise, and is associated with decreased total mortality, cardiac mortality, and rehospitalizations. However, current participation rates for CR in the United States generally range from only 20% to 30%. This road map focuses on interventions, such as electronic medical record–based prompts and staffing liaisons that increase referrals of appropriate patients to CR, increase enrollment of appropriate individuals into CR, and increase adherence to longer-term CR. We also calculate that increasing CR participation from 20% to 70% would save 25,000 lives and prevent 180,000 hospitalizations annually in the United States.

© 2016 Mayo Foundation for Medical Education and Research ■ Mayo Clin Proc. 2017;92(2):234-242

PERFORMANCE MEASURES

## 2018 ACC/AHA Clinical Performance and Quality Measures for Cardiac Rehabilitation



A Report of the American College of Cardiology/American Heart Association  
Task Force on Performance Measures

*Developed in Collaboration With the American Association of Cardiovascular and  
Pulmonary Rehabilitation*

*Endorsed by the American College of Sports Medicine, the American Physical Therapy Association,  
the Canadian Association of Cardiovascular Prevention and Rehabilitation, the Clinical Exercise  
Physiology Association, the Heart Failure Society of America, the InterAmerican Heart Foundation,  
the International Council of Cardiovascular Prevention and Rehabilitation, the National Association of  
Clinical Nurse Specialists, and the Preventive Cardiovascular Nurses Association*

CR measures were designed to cover 2 specific aspects of CR services: 1) referral of eligible patients to a CR program and 2) delivery of CR services through multidisciplinary CR programs. The measures also were designed to include all eligible patients who did not have a valid reason for exclusion from the measure. Measure exclusions are those reasons that remove a patient automatically from the denominator. For example, all measures excluded patients who were <18 years of age. In contrast to exclusions, denominator exceptions are those conditions that remove a patient from the denominator only if the numerator criteria are not met. Denominator exceptions are used in select cases to allow for a fairer measurement of quality for those providers with higher risk populations. Exceptions are also used to defer to the clinical judgment of the provider. Exceptions have been listed in several of the measures. For example, in the case of the CR referral from an inpatient setting, a physician who recommends CR referral to an eligible patient is considered to have met performance even if the patient refuses, at the time of referral, because of  $\geq 1$  reasons (e.g., lack of transportation, patient preference). In such a case, the physician would receive credit for the measure. If the patient has told the physician that he/she does not wish to enroll in a CR program, the physician can document in the medical record that he/she has recommended referral but that the patient has refused CR. This is important because, in this scenario, the provider should not be penalized for the lack of a completed CR program referral as long as the CR referral recommendation and the patient refusal are documented. The writing committee closely examined which exceptions should be included for each measure.

# What to Expect From the Evolving Field of Geriatric Cardiology



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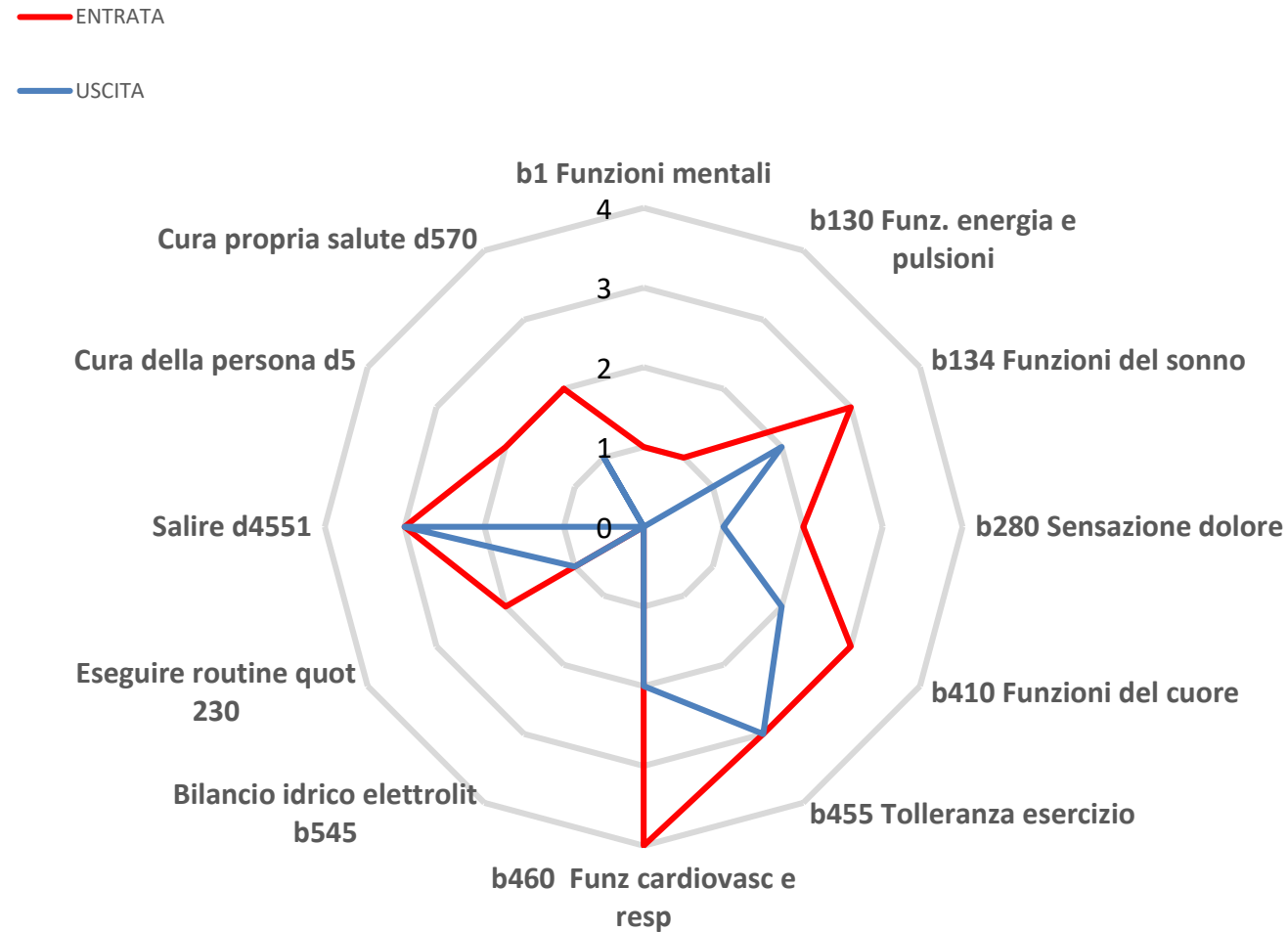
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## ABSTRACT

The population of older adults is expanding rapidly, and aging predisposes to cardiovascular disease. The principle of patient-centered care must respond to the preponderance of cardiac disease that now occurs in combination with the complexities of old age. Geriatric cardiology melds cardiovascular perspectives with multimorbidity, polypharmacy, frailty, cognitive decline, and other clinical, social, financial, and psychological dimensions of aging. Although some assume that a cardiologist may instinctively cultivate some of these skills over the course of a career, we assert that the volume and complexity of older cardiovascular patients in contemporary practice warrants a more direct approach to achieve suitable training and a more reliable process of care. We present a rationale and vision for geriatric cardiology as a melding of primary cardiovascular and geriatrics skills, thereby infusing cardiology practice with expanded proficiencies in diagnosis, risks, care coordination, communications, end-of-life, and other competences required to best manage older cardiovascular patients. (J Am Coll Cardiol 2015;66:1286–99) © 2015 by the American College of Cardiology Foundation.



# Paziente con Scompenso Cardiaco



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# Key Points

- Cosa è la Riabilitazione o meglio cosa è la Cardiologia Riabilitativa;
- Come deve essere organizzata;
- La Cardiologia Riabilitativa è efficace ?
- Criticità;
- **Take-home message.**

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## Take-Home Message

- La Cardiologia Riabilitativa, mediante un approccio multidisciplinare, coniuga la cura (cardiologia clinica) ad un intervento sullo stile di vita, al fine di migliorare la qualità della vita, l'aderenza alle corrette prescrizioni e ridurre morbilità e mortalità.
- La Cardiologia Riabilitativa è disponibile in Lombardia in setting clinici diversi (degenziale/ambulatoriale), da impiegarsi in funzione del livello di rischio e dei bisogni dei pazienti (appropriatezza organizzativa).
- Anche in Lombardia, nonostante l'attenzione dimostrata nel tempo da parte della Regione nei confronti del mondo della riabilitazione, il referral-rate alla Cardiologia Riabilitativa è ancora insufficiente.
- Per i pazienti a rischio più basso, idealmente destinati al territorio, è necessario costruire un percorso efficiente di Prevenzione Secondaria (counselling) già durante la degenza acuta.
- L'appropriatezza organizzativa deve essere migliorata, introducendo il **«referral-rate» come misura di qualità per il mondo dell'acuto** e definendo **«misure di outcome funzionale di riferimento»** per il mondo della Cardiologia Riabilitativa.