Benefits of a Subacute Interdisciplinary Cardiac Rehabilitation Program
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Introduction

There is limited research and education noted in subacute rehabilitation facilities and programs to assist those with congestive heart disease. The changes implemented by managed care plans have impacted the length of stay as well as pressures from bundled/episodic payment models. As a result of these changes, it was, and continues to be, important to introduce and maintain a structured evidence program. Such a program not only positively impacts healthcare workers, it also helps the patients and their families. A noted benefit of a structured congestive heart failure (CHF) program on patients diagnosed with CHF in a subacute facility has demonstrated through an increase in functional abilities from admission to discharge.

The purpose of the study is to continually examine the benefits of a structured cardiac rehabilitation team. Specifically, reduce re-hospitalizations, improve interdisciplinary patient education, and increase the functional abilities upon discharge compared to admission.

Methods: Program Design

1. Identification & admittance of post-acute rehabilitation patients who have a primary or active secondary diagnosis of Heart Failure.
2. Assess patient’s medical history and support service needs
3. Medical Team places an order for the CHF Program.
4. Develop a comprehensive individualized care plan for the patient’s post-acute stay
5. Nurse provides an educational booklet explaining the Heart Failure Program as well as education about their disease process.
6. Involve family/caregivers in process
7. Rehabilitation evaluation includes a mobility and self-care assessment based on a 6 point scale called the CARE tool.
8. Patients placed on a telemetry program during therapy program for extended monitoring.
9. Interdisciplinary education provided on an ongoing basis.

Results

Do patients show a functional improvement from Admission to Discharge?

Q1 data for 2017 shows the improvements made for mobility and self-care for the Heart Failure patients. Improvement in these areas correlate to a safe discharge home.

Table 1. Functional Improvements.

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of Patients</th>
<th>% Improve Mobility</th>
<th>% Improve Self Care</th>
<th>Overall Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan-17</td>
<td>30</td>
<td>156.77%</td>
<td>63.72%</td>
<td>50.00%</td>
</tr>
<tr>
<td>Feb-17</td>
<td>20</td>
<td>200.00%</td>
<td>64.00%</td>
<td>50.00%</td>
</tr>
<tr>
<td>Mar-17</td>
<td>30</td>
<td>202.00%</td>
<td>69.00%</td>
<td>50.00%</td>
</tr>
</tbody>
</table>

Are patients receiving the appropriate education through the Interdisciplinary Team?

Q1 data for 2017 shows the improvements in teaching by the interdisciplinary team, when utilizing a team developed education booklet.

Table 2. Patient Education.

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of Patients</th>
<th>% of Patients receiving Education</th>
<th>Overall Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan-17</td>
<td>30</td>
<td>0.00%</td>
<td>100.00%</td>
</tr>
<tr>
<td>Feb-17</td>
<td>20</td>
<td>26.00%</td>
<td>100.00%</td>
</tr>
<tr>
<td>Mar-17</td>
<td>30</td>
<td>54.00%</td>
<td>100.00%</td>
</tr>
</tbody>
</table>

Discussion

In conclusion, having a dedicated position of Director of Cardiopulmonary Rehabilitation, increasing education of staff with competencies have positively affected the overall patient care for individuals with congestive heart failure.

By increasing staffs education, patient education has increased with good carryover of medications, importance of daily weights and exercise has positively affected the reduced re-hospitalization rate.

Telemetry based occupational and physical therapy, encompassing both exercise, Jintronix and functional based rehabilitation interventions, have facilitated overall functional improvements, decrease in re-hospitalization and greater carryover of education upon discharge to home.

References


