
7 Rehabilitation after an acute heart, stroke or vascular event

Goal

To reduce disability and recurrence of acute events by ensuring that all patients have access to a structured rehabilitation program and high quality ongoing care and secondary prevention following an acute heart, stroke or vascular event.

Rationale

Magnitude of the problem

People recovering from heart attacks, cardiac procedures or stroke are not routinely accessing programs and support during their rehabilitation period.

Participation in cardiac rehabilitation is estimated to range between 10–53 per cent, depending on the procedure, and approximately 39 per cent of hospitalised stroke patients are admitted for inpatient rehabilitation (AIHW: Secondary prevention bulletin – from published data from Bunker et al 1999).

In part this is a problem of access – there is a reported deficit of rehabilitation programs and services. However, this is also a problem of uptake. Where services exist patients often are not referred to them or, if referred, are reportedly not taking up or completing rehabilitation programs.

Participation in rehabilitation services is particularly low for Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse backgrounds and people living in rural and remote areas.

A further barrier to optimal rehabilitation and recovery is that insufficient attention is being given by service providers to the social and emotional consequences of heart attacks, cardiac procedures or stroke and the role which psychosocial factors play as a risk factor for further acute episodes.

Needs may vary for different conditions. The needs of people recovering from a stroke are significantly different from those of people recovering after a heart attack or heart surgery and accordingly, the sort of rehabilitation programs and services differ in terms of scope, duration and nature. Most patients have some level of disability as a result of a stroke. Recovery is most rapid in the weeks following stroke, and there is evidence that early rehabilitation plays an essential role in optimal recovery (National Stroke Foundation, 2002). However one year after stroke about half of all survivors are still dependent on others for daily living activities (Hankey et al 2002).

Services need to address support for mobility, communication, social and occupational participation and independence and psychosocial or emotional support. Services also need to support measures for prevention of recurrent stroke through medication management and lifestyle change. The needs of carers for practical and psychosocial support are also often not acknowledged through existing service provision. Rehabilitation for stroke must begin in the acute hospital environment and may continue in a specialised inpatient rehabilitation unit, through hospital outpatient services and should recognise the special needs of young stroke survivors or of people who need to return to the workforce.

In cardiac rehabilitation, the longer term challenges are particularly around ensuring that there is uptake of lifestyle and pharmacological interventions to ensure optimal recovery and prevent a further cardiac event. It is estimated that only a minority of eligible patients participate in cardiac rehabilitation programs even though the World Health Organisation recommends that programs should be available and routinely offered to everyone with cardiovascular disease. Barriers to uptake of services include lack of transport, cost and social isolation. Around one in six people who have experienced acute myocardial infarction become depressed at the time of the event (Hare and Bunker 1999). Depression is associated with increased mortality, recurrent coronary events, angina and rehospitalisation.

The level of social support experienced by patients has been shown to be directly linked to an improved sense of social and emotional well being, yet access to organised support groups is variable across Australia. The expertise of consumers and carers who have direct experience of heart disease or stroke is not being fully utilised through rehabilitation programs and services.

Opportunities

Comprehensive cardiac rehabilitation, incorporating secondary prevention programs, has been shown to reduce death rates by 25 per cent in patients who have had a heart attack. However these benefits are dependent on program participation and long-term concordance with physical activity and other behaviours to reduce cardiovascular risk.

General practitioners are ideally placed to play a coordinating role in patient care through linkages with other services, reinforcement of the importance of maintaining lifestyle changes and ongoing monitoring of medications as part of the maintenance phase of rehabilitation programs.

Local programs carried out in Victoria in secondary prevention have demonstrated improvements for patients in biomedical and lifestyle risk factors and highlight the value of nurse practitioners providing ongoing coordination and care (Vale et al 2002).

There is a need to extend the availability of psychological services in the community dealing with the emotional well-being of stroke survivors, such as counselling services, information and education programs.

Hospital discharge care plans are not always seen by general practitioners which limits their capacity to play an active role in ensuring ongoing care. Many general practitioners do not receive sufficient access to continuing education about long-term consequences of heart attack and stroke, the benefits of rehabilitation and the role of the general practitioner in this process.

There is also an opportunity for the development of care plan templates to meet the needs of people with heart, stroke and vascular disease. Care plans for stroke survivors should acknowledge the longterm nature of recovery.

Local planning authorities can play a key role in improving ongoing quality of life in the post recovery phase of rehabilitation by supporting physical environments, local support groups, community transportation and building regulations and codes to enable access for people of different physical abilities.

Strategies

- Develop, pilot and evaluate multidisciplinary models of heart, stroke and vascular rehabilitation, secondary prevention and step-down services following discharge from hospital after an acute heart or stroke event.
- Ensure that rehabilitation programs are of an appropriate duration with ongoing reviews and monitoring.
- Develop, pilot and evaluate home linkage rehabilitation programs and information delivery using various technologies (multimedia, internet, telephone) to provide information components of rehabilitation programs.
- Explore alternative models of rehabilitation service provision and ongoing prevention and care to meet the diversity of consumer needs and engage groups of consumers who face barriers to participating in rehabilitation programs, including Aboriginals and Torres Strait Islander peoples, people from culturally and linguistically diverse backgrounds and people in rural and remote areas.
- Improve the recognition and treatment of depression and the importance of psychosocial health and support as part of rehabilitation programs, ensuring linkages across programs to address mental health problems as comorbidities.
- Increase the capacity of general practitioners and Divisions of General Practice to provide rehabilitation support and appropriate referrals during the rehabilitation phase.
- Increase the number of practice nurses linked to general practices or Divisions of General Practice programs. Practice nurses can play a pivotal role in case coordination and patient education.
- Improve discharge planning within a community services setting, and ensure that patients receive a written care plan which includes advice and referral on an appropriate rehabilitation program.
- Assign responsibility to individual providers for coordinating and planning care during the rehabilitation phase, to promote continuity of care in the transition between services and to optimise care coordination.
- Increase access to consumer networks to build consumer confidence and the ability to self-manage after an acute heart or stroke event, including access to consumer support networks.
- Develop better support systems to ensure the needs of carers are more consistently met in relation to information provision, psychosocial support and respite care.

Priorities for national action

- *Develop, pilot and evaluate multidisciplinary models of heart, stroke and vascular rehabilitation, together with innovative ways to deliver aspects of rehabilitation programs.*
- *Develop, pilot and evaluate multidisciplinary models of secondary prevention programs.*
- *Address the rehabilitation needs of disadvantaged groups, including Aboriginal and Torres Strait Islander peoples.*
- *Support better recognition and treatment of mental health conditions and the importance of psychosocial health in the context of rehabilitation programs.*