Kindred at Home
Our Care Matters

HOME HEALTH

Cardiac Services

Our cardiac clinical delivery model incorporates evidence-based care for patients who are experiencing a new or exacerbated cardiac condition.

Often these patients are at risk of further cardiovascular events such as heart failure or myocardial infarction (MI), and require skilled assessment and education on disease, diet and medications.

Cardiac Symptom Management

- Medication management and adherence to regimen
- Daily weights and education on interventions for fluid retention
- Reduced incidence of exacerbations by educating on lifestyle changes
- Low-sodium diet education

Prevalence

- Nearly 5.7 million people in the United States have heart failure.
- 735,000 Americans have a heart attack each year.
- In the United States, heart disease accounts for one in every three deaths, or 800,000 per year.
- About one in every six healthcare dollars is spent on cardiovascular disease.

Resources:

1. *www.cdc.gov/dhdsp/data_statistics/fact_sheets/docs/fs_heart_failure.pdf*
2. *www.cdc.gov/heartdisease/heart_attack.htm*
3. *millionhearts.hhs.gov/learn-prevent/cost-consequences.html*

Diagnoses We Support

- Heart failure (HF)
- Hypertension
- Angina pectoris
- Acute myocardial infarction (MI or AMI)
- Ischemic heart disease
- Cardiomyopathy
- Tachycardia/atrial fib
- CABG (Coronary Artery Bypass Graft)
- Angioplasty and stent placement

Patient and Caregiver Benefits

- Reduces hospital readmissions
- Improves quality of life
- Improves functional performance

Utilizing a patient-centered, goal-directed approach, an individual treatment plan is established between the patient and physician. It allows optimal recovery in the comfort of home, allowing the patient to regain confidence and independence in managing his or her condition.

For more information, please call

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Cardiac Evidence-Based Practices

Proven Results for Patients and Families

- Ability to better manage their condition
- Positive behavior changes that reduce contributing factors in exacerbations
- Ability to better manage their medications
- Safer at home
- Improved care coordination and access to services
- Lower risk of hospitalization
- Smooth transition to self-care with plan for physician follow up and link to community resources

Every **Patient**, Every Visit

As ordered by the physician

Skilled Nursing

- Comprehensive assessment
- BP, pulse, respirations, lung sounds, blood glucose or pulse oximetry or PT/INR labs, when ordered
- Drug regimen review
- Risk for hospitalization assessed each visit
- Zone Tools for early symptom recognition
- Identify barriers to care

Teaching and Training

- Goal-directed plan of care
- Patient-centered education on disease process, diet, medications and symptom management
- Teach-Back method for improved retention
- Patient engagement to encourage ongoing self-management
- Perform and educate on treatments (e.g., wound care, IVs)

Therapy Services

- Fall prevention, safety in ambulation, ADLs
- Individualized home exercise program (HEP) to increase strength and endurance, thereby improving function
- Energy conservation
- Use of assistive devices
- Cognition evaluation and treatment
- Recommendations for home and leisure modifications

Risk Management and Customized Teaching Plan

- Risk factors drive a clinical care delivery model best suited for each patient
- Patient education and interventions in the home setting are determined by skilled assessments, the individual patient's potential for recovery and physician's orders
- Automatic review and notification of potential medication contraindications or interactions
- The ability to monitor 30-day rehospitalizations

Integrated Discharge Plan and Care Coordination

- Comprehensive discharge plan with appropriate community resources and physician follow up in place
- Fast, safe, efficient transfer between settings
- Follow-up calls post-home health discharge for questions or additional needs