



# Cardiac Care

Cardiac Care at Hospital for Special Care (HSC) is provided by an interdisciplinary team with expertise in the treatment of complex cardiac disease. This includes (“acute on chronic”) heart failure patients requiring advanced therapies who have failed traditional methods of treatment. The interdisciplinary approach encompasses the medical team, nursing services, physical, occupational and speech therapy, dietitians, social work, case management, pharmacists, and therapeutic recreational specialists. These team members have advanced cardiac training and encompass a true collaborative approach. Cardiac patients receive specialized programs to meet their individual needs with the goal of optimizing medication management, increasing functional abilities, improving self-management through education, improving quality of life, reducing the cycle of hospital readmissions.

## Who Will Benefit

- Patients who have a diagnosis of heart failure and need IV medications (diuretics, dopamine, milrinone, dobutamine)
- Patients who have had recurrent admissions to an acute-care hospital for management of heart failure
- Patients who need preparation for an LVAD implantation (“pre-hab”) to improve strength prior to surgery and those who have recently received a LVAD, are coming to HSC for treatment, therapy and education prior to returning home

## Therapies

Occupational and Physical Therapies will focus on improving strength and endurance by working on functional activities, exercises and by teaching compensatory skills. Therapeutic Recreation will address leisure interests, adaptations and community reintegration needs. Speech Language Pathology will be available on a consulting basis to address any unique needs related to swallowing or cognition.

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## Pharmacy and Nutritional Education

Pharmacists, as part of the Cardiac Care Team, will review medications with individual patients and their families, and counsel them on what to expect from their medications, including potential adverse effects. The pharmacists will answer the patient's medication related questions, educate them on the importance of medication compliance and discuss other ways to stay healthy. Concurrently, a registered dietitian will also provide nutrition therapy aimed at improving the patient's health and quality of life. A major focus of therapy is to provide the patient with the education and the tools needed to make healthy food choices and sustain a healthy diet and lifestyle for a long-term benefit.

## Transition Planning

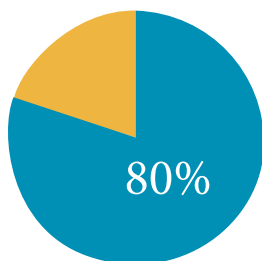
At HSC, our goal is to return patients to the community. Upon admission a transition plan is developed with each patient. Home care services and/or outpatient rehabilitation programs are established for patients prior to their discharge. Some patients may require additional inpatient rehabilitation at a subacute level of care. The discharge plan will be well-coordinated to enable the patient to receive appropriate follow up care in their community.

## Case Management

A Case Manager will oversee the entire experience of both the patient and family from pre-admission activities through inpatient therapies and transition planning. The Case Manager will facilitate communication with the patient's personal cardiologist, ensuring a smooth transition returning home.

## Outcomes

Our Outcome Data for 2015 includes admissions from local Acute Care Hospitals and Emergency Rooms:



Discharged Home

- 92 admissions
- Avg. LOS: 21.9 days
- 6% Heart Failure Readmission rate to referring hospital within 30 days



## Central Location

Located in Central Connecticut, we serve patients across Connecticut, as well as Massachusetts, New York and Rhode Island. Please refer to our website for driving directions and public transportation information.



For more information on accreditations, please visit our website at:  
[hfsc.org/about-us/accreditations](http://hfsc.org/about-us/accreditations)

Hospital for  
Special Care

*We Rebuild Lives.*

