Sustainable Physical Activity Post-Discharge from Community Rehabilitation:

Are we there yet?

G Vyslysel**,** A Carlos, **D Hayden,** A Thomas, A Marler, Westlakes Community Rehabilitation Team, Community and Aged Care Services-Greater Newcastle Cluster, Hunter New England Local Health District, NSW

Background: Westlakes Community Rehabilitation Team (WCRT) provides community rehabilitation to an age-diverse range of people who present with chronic disease and/or injury. Physical activity throughout rehabilitation is essential for recovery as it has been shown to improve function and reduce the risk of falls. Furthermore, ongoing participation in physical activity is required post-discharge to maintain functional gains made during rehabilitation. Despite this understanding, WCRT often received re-referrals from patients soon after discharge. This was not a result of a new onset of illness, but rather due to patient attachment to the program and a failure to effectively transition to alternative physical activity options. In response to this challenge, WCRT made a number of service changes (Table 1).

Table 1: Service changes to improve multifactorial falls prevention program with a focus on sustainable physical activity on discharge

Routine use of patient reported outcome measures: Canadian Occupational Performance Measure.
• Initial assessment establishes patient centred rehabilitation goals and the aim of the program. • Interdisciplinary intake assessment now includes questions about physical activity interests and history so that it is easier to link people in with long term physical activity options post-discharge. *"What exercise or physical activity have you done in the past? Are you interested in getting back to this/trying something new at the end of rehabilitation?"*
Behaviour Change and Self Management strategies: used to gain a better understanding of barriers and facilitators to participation.
• Family and carer engagement in rehabilitation process from admission to discharge. • Exploration of community based physical activity options with patient and family prior to transitioning.
Interdisciplinary community based mobility training: undertaken throughout rehabilitation journey to ensure successful discharge.
• Supported transitions to person centred physical activity options. • Discharge planning throughout care.

Aim: To evaluate the sustainability of a patient's physical activity post-discharge, following changes to WCRT's model of care.

Method: A follow up survey was developed to explore patient engagement with physical activity after discharge and to capture perceived barriers to participation of inactive patients. The survey was sent with a self-addressed postage paid response envelope to all patients who completed physiotherapy as pårt of their WCRT program and had been discharged in the previous 12 months (n=40). Patients were also provided with the option of completing the survey over the phone if this was preferred.

Results: A total of 19 (48% of mail out) responses were received. Of the respondents, 16 (84%) reported that they had remained active or partially active (Figure 1). The description of 'active' varied significantly from *'Fairly active in my home'* to *'Play Tennis x3 per week'.* 94% (n=15) of respondents felt that the plan set with their physiotherapist was suitable. The most popular activities were walking, a home exercise program (including gym use) or participation in local group exercise (Table 2). For those that did not remain active, the most common reported barriers to ongoing physical activity were chronic illness and age (Table 3).

Figure 1: Physical Activity Post Discharge

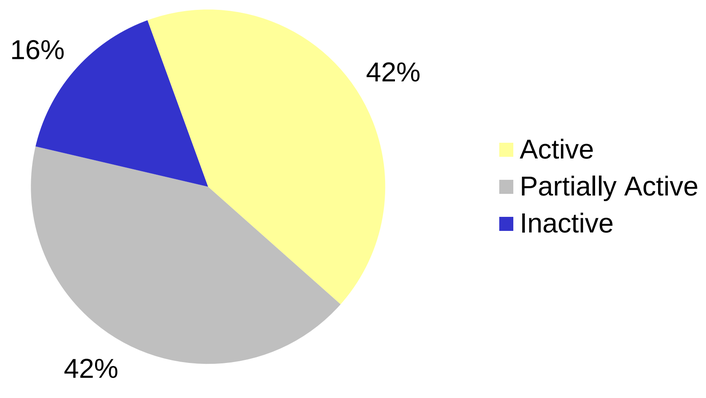


Table 2: Physical Activity Post Discharge

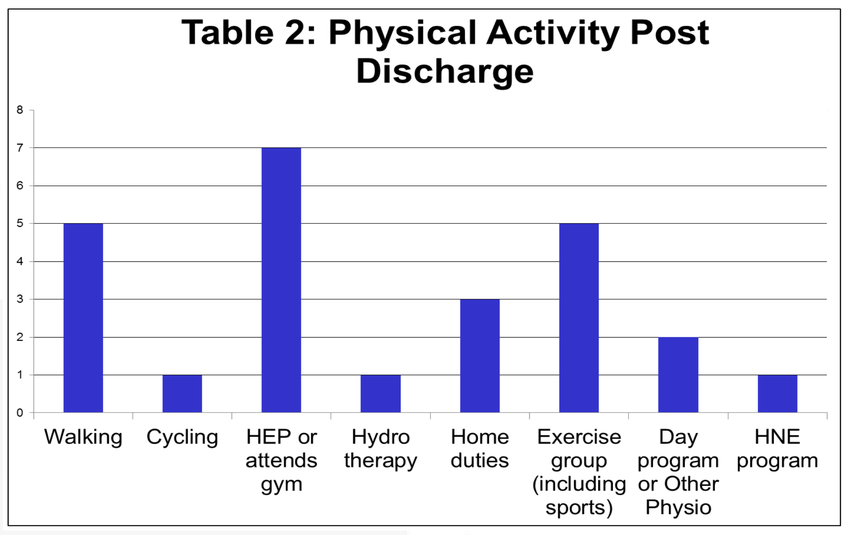
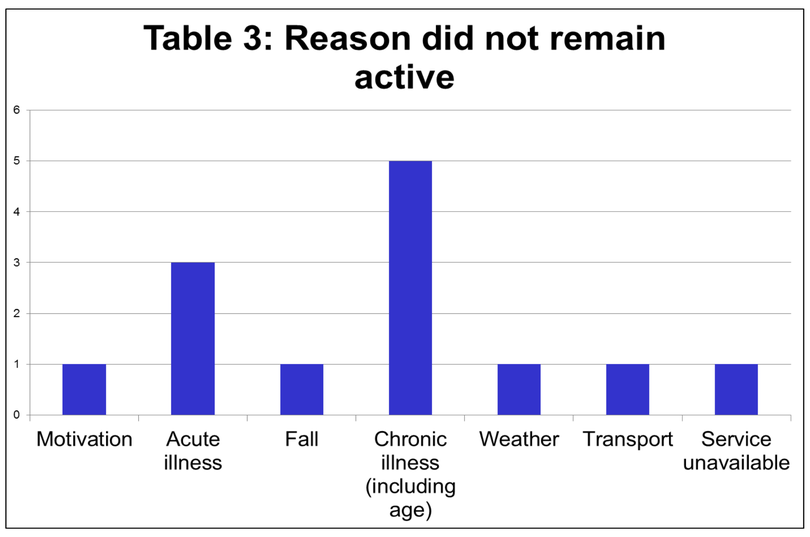
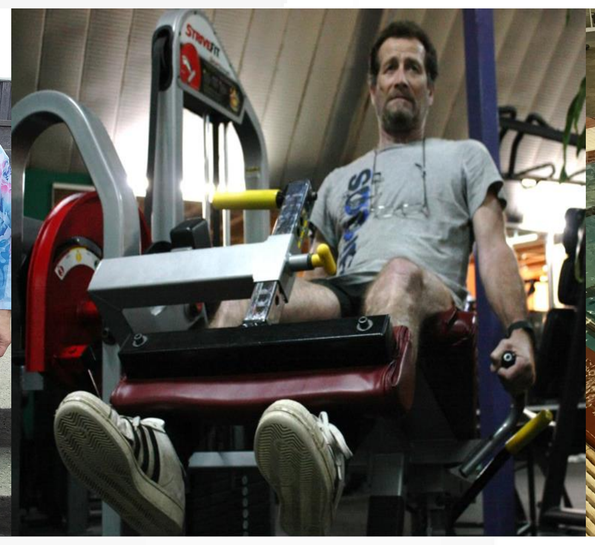


Table 3: Reason did not remain active



Conclusions: Survey results indicate that the new patient-centred care strategies, including goal focused rehabilitation, early identification of physical activity interests, implementation of behaviour change principles, self-management of chronic disease and supported transition to community based exercise are assisting patients to sustain physical activity on discharge. Service re-referral patterns have changed with patients now only returning to the service due to a change in health circumstances, as opposed to the previous triggers of program attachment or inability to transition to other physical activity options. Further work is required to reduce barriers to participation in physical activity, especially beliefs relating to chronic disease and aging.




Acknowledgments: Current and past patients and staff of Westlakes Community Rehabilitation Team.

Contact: Glade.Vyslysel@hnehealth.nsw.gov.au
Team Leader / Occupational Therapist

NSW GOVERNMENT Health
Hunter New England Local Health District