Care Coordination as Part of the Discharge Plan to Support Community Reintegration of Individuals with Stroke Living in Appalachian Rural Communities

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PURPOSE

Studies indicate a high incidence of readmission within the first 12 months post-discharge home following stroke. In addition, there is a limited awareness of healthcare services, community resources, and lack of access to information in rural communities. Previous work from our group has demonstrated the need for community-based navigational support during community reintegration for survivors of stroke. The purpose of this study was to determine the effectiveness of providing community health navigation to facilitate continued communications with healthcare providers and linkages to services and community resources for survivors of stroke in Appalachian rural communities.

SUBJECTS

15 individuals (4 males and 11 females) discharged from acute care following stroke and their caregivers were enrolled in this study. Ages ranged from 43 to 89 years of age. Three of these individuals required their placement in long-term care facilities so were no longer included in the study. One person stopped participating after the 1st week. This left 11 individuals in this study.

METHODS

A specially trained community-based stroke navigator coordinated patient transitions and linkages with healthcare and community resources for 6 months post discharge home. Quality of life (QoL) was assessed with the Stroke Impact Scale and Caregiver Burden Scale. Other outcomes measured included: 1) documented medical problems, 2) type of education provided and frequency, and 3) types of resources accessed including enrolling in healthcare plans, accessing durable medical equipment (DME), medications, outpatient rehabilitation, community resources.

RESULTS

1. Overall, the number of known risk factors for stroke (e.g. diabetes, hypertension, history of heart attach or heart disease, smoker, high BMI) were significant in this group.
2. There were no stroke-related 30 day emergency department or hospital readmissions.

RESULTS

3. Required care coordination included: 1) enrolling in a proper insurance plan, 2)supporting gaps in health care due to lack of coverage, 3) obtaining medication coverage, 4) obtaining DME coverage, and 5) obtaining additional therapy.
4. Overall there was an improvement in participant and caregiver QoL.
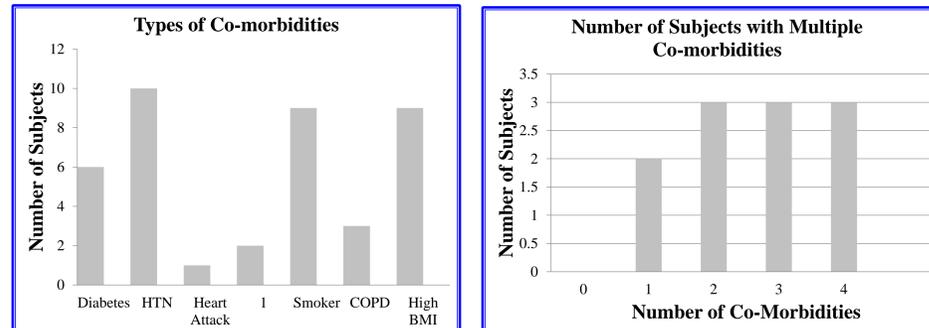

Figure 1: Results demonstrate the high level of co-morbidities in our population (left graph). 55% of these individuals had 3 or 4 co-morbidities (right graph).
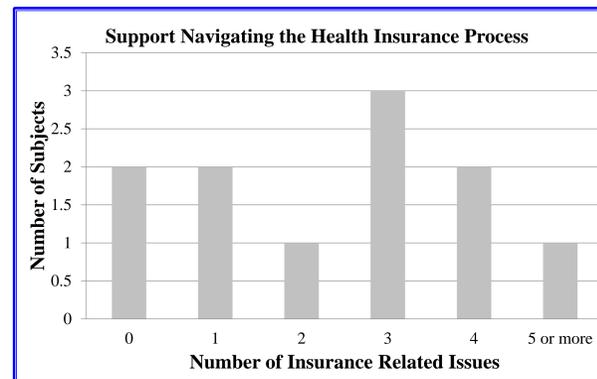

Figure 2: Demonstrates the number of Health Insurance related issues the participants needed support with. These issues included obtaining medical equipment, medications, additional therapy visits, and overall healthcare enrollment.
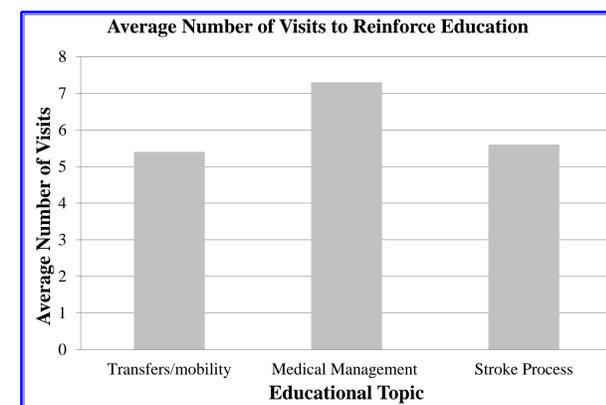

Figure 3: Demonstrates the average number of visits needed to reinforce the education provided upon discharged back home in order for the participants to be independent with their home care.
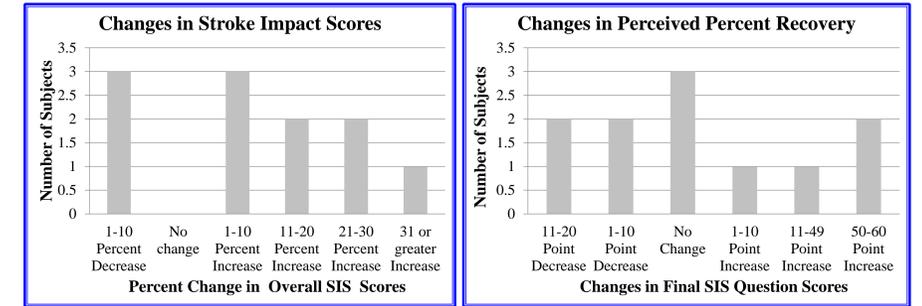

Figure 4: Stroke Impact Scores (SIS) taken at 1-month and 6-months post-discharge to home. The majority of subjects expressed an increase in perceived function at the 6 month follow-up (left figure). However, 36% of the subjects reported a decreased perceived level of recovery at 6 months post-discharge to home (right figure). This suggests the need for continued support past 6-month.
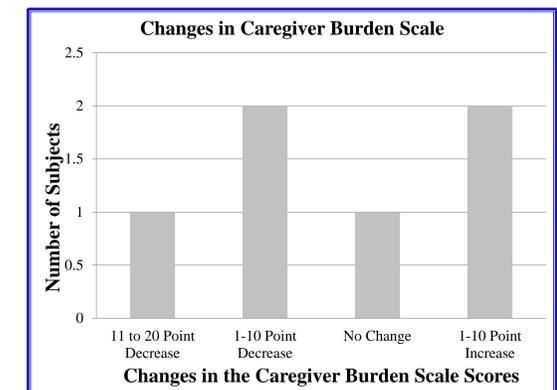

Figure 5: Changes in the Caregiver Burden Scale from 1-month to 6-months post-discharge to home. Overall there was no change or a decrease in the perceived level of burden in 4 of the 6 caregivers sampled. However, multiple caregivers indicated the need for additional training/education to care for their loved ones as well as the need for a stroke survivor and caregiver support group.

CONCLUSION

Results of this study demonstrate the need for a community-based navigator to support: 1) navigating the insurance process, 2) follow-up education, and 3) development of a stroke survivor an caregiver support group to support QoL. In addition, the need for navigator support is long-term (i.e. goes beyond 6 months post-discharge home).