MedicalXpress

Helping stroke patients transition from hospital to home

October 14 2014

Stroke patients and their family caregivers often find the transition from hospital to home difficult. However, a new $2 million grant from the Patient-Centered Outcomes Research Institute will help Michigan State University researchers look at ways to improve that experience using a nontraditional approach.

For the 1 million stroke patients who are discharged from hospitals nationwide every year, navigating life after stroke comes with its emotional, social and health challenges. Currently, 20 percent of stroke patients end up back in the hospital within 30 days of discharge because of complications. Many more report high levels of stress and poor quality of life.

In an effort to improve the hospital-to-home transition, Mathew Reeves, a professor in the Department of Epidemiology and Biostatistics at MSU, along with colleagues in the School of Social Work, are using a different method by assigning patients a social worker to assist in taking care of them.

"Social workers have a unique set of skills and training that allows them to assess patients and other family members helping in the home and develop an action plan to help resolve needs and challenges," Reeves said. "While an understanding of the patient's medical care needs is clearly critical, the perspective that a social worker brings to the table is much broader."

Poor communication between health care providers and patients is one of the primary drivers affecting the transition. Other reasons can include too short of a hospital stay, an inability to share health information between multiple people, and simply a patient's and caregiver's lack of knowledge about stroke.

"Social workers are used to working as advocates for people who are under difficult and stressful situations," said Anne Hughes, an assistant professor in social work who is helping lead the study. "By working together with other health care providers, we can make sure all aspects of a patient's needs are being met."

The three-year study will enroll 480 recently discharged, acute stroke patients to be randomly assigned to one of three different intervention scenarios. The first will follow a standard care model with patients receiving the usual discharge instructions and navigating the process on their own. The second will incorporate social workers, or "bridge coordinators," into the home to act as case management liaisons, while the third will include social workers and access to a Virtual Stroke Support Portal that provides additional online communication, information and support services.

"This online portal will further complement the actions of the social worker by helping patients interact with existing community resources as their needs arise," Reeves said. "Ultimately, our goal is to develop an intervention program that helps stroke patients and their caregivers return home with the fewest complications possible."

Provided by Michigan State University

Citation: Helping stroke patients transition from hospital to home (2014, October 14) retrieved 1 May 2024 from https://medicalxpress.com/news/2014-10-patients-transition-hospital-home.html

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