Doi: 10.32481/djph.2023.08.009

The Social Worker in The Care of The Stroke Patient

Annamarie McDermott, LMSW, ACM-SW

Director, Care Management and Social Work, Saint Francis Hospital

Abstract

As a leading cause of death and long-term disability, stroke care is a complex endeavor, requiring a coalition of healthcare professionals. As part of a multi-disciplinary team, social workers help the patient to reach individual goals and facilitate their return to and stability in their community at their highest possible functional, social, and economic level.

Stroke is one of the most stressful, life changing experiences for a person. No one plans for them. They are always an emergency that in some way upends life as it was. Given that stroke is a leading cause of both death and disability in the United States, providing care to a person with a stroke is a complex endeavor, requiring a coalition of healthcare professionals. The social worker is an active member of a stroke patient's care team, helping the patient to reach individual goals and facilitate the patient's return to and stability in their community at their highest possible functional, social, and economic level.

To understand the contributions of a social worker to the stroke recovery care team, it is important to have a brief overview of who social workers are and what they do. The National Association of Social Workers characterizes social work as a helping profession focused on helping individuals, families, and groups restore or enhance their capacities for social functioning and work to foster a supportive community.[1] The practice of social work requires knowledge of human development and behavior; of social, economic, and cultural institutions; and of the interaction of all these factors. They work in every area of community life - schools, hospitals, mental health clinics, senior centers, elected office, private practices, prisons, military, corporations, and in numerous other public and private agencies that serve individuals and families.

Social workers, both at the bachelor's and master's level licensures, are required to continue their education. Since social workers are in a diversity of settings, they must seek opportunities to educate themselves on the particulars of that setting. To effectively listen, communicate, and advocate as a stroke care social worker, an essential knowledge of stroke is imperative. Both the American Stroke Association (ASA) and the American Heart Association (AHA) have an extensive education library specifically for professionals.[2] More locally, the Medical Society of Delaware and the Delaware Stroke Initiative offers numerous education opportunities.[3] Of note, the John Scholz Stroke Education Conference has been held annually with speakers and topics from the multiple disciplines who care for stroke patients, with 2022 forum presentations available online as of this writing.[4]

Interventions

Social workers offer a broad scope of interventions that can assist the multi-disciplinary team in best care for the stroke patient. Below are some key roles and responsibilities of social workers on a stroke team, applicable at all levels of care.

Doi: 10.32481/djph.2023.08.009

Emotional Support

Stroke can have a profound impact on a patient's well-being, their lifestyle, their ability to manage responsibilities like work, finances, and even seemingly mundane tasks like housework and meal preparation. Social workers offer emotional support to stroke survivors and their families, to help navigate the complex emotions of fear, grief and worry that may arise after a stroke. For a stroke survivor with pervasive deficits, or even one debilitating deficit, adjustment to living with disability often involves going through a grief process. Caregivers of stroke survivors are at risk for developing burnout, a condition that can cause physical and mental exhaustion, anxiety, and depression. While every discipline on a stroke care team is attuned to these issues, the role of the social worker is suited to create time for purposeful engagement with their patient and families on the emotional experiences and reactions to stroke.

Mental Health Referrals

As a stroke interrupts the blood supply to the brain, this "brain attack" can cause emotional and behavioral changes, depending on which part of the brain is affected and the extensiveness of injury. Forgetfulness, carelessness, confusion, as well as anxiety, anger, or depression can be experienced. Post-stroke depression can affect approximately one third of stroke survivors, increasing risk for suboptimal recovery, recurrent vascular events, poor quality of life, and mortality.[5] When parts of the brain that control emotions are injured by a stroke, some people experience pseudobulbar affect (PBA), also called emotional lability or reflex crying.[6] Uncontrollable laughter and sudden mood shifts are also symptomatic of PBA. It is imperative that a social worker caring for a stroke survivor be attuned to that person's mental health needs. Social workers can provide psychosocial support and, importantly, facilitate communication to the stroke survivor's medical team and make appropriate referrals.

Care Coordination

Social workers help coordinate various aspect of a stroke patient's care, including planning for discharge from 24-hour care facilities to lower levels of care, and facilitating communication among health care professionals. Social workers use their advocacy skills to assist patients in accessing healthcare resources, insurance coverage, and financial assistance programs. They are often tasked with ensuring a stroke survivor has appropriate durable medical equipment, such as a walker or hospital bed. Another important task is ensuring medication assess. Stroke survivors may be prescribed medications to manage medical conditions that contributed to the stroke and, vitally, reduce risk of stroke recurrence. Some of these medications, like brand name anti-coagulants, can be quite expensive. Ensuring financial coverage, which may include managing prior authorizations, is essential.

Community Resources

Whereas care coordination is a more structured process, usually involving coordination with health care providers and with the patient's insurance, social workers also connect patients and their families with support groups, educational resources, and social assistance programs to promote a successful transition back to their community. The Delaware Stroke Initiative has employed both in person and remote support groups.[7] To help address needs like housing, food, transportation, and other such essential requirements, Delaware's 2-1-1 is a free confidential

Doi: 10.32481/djph.2023.08.009

service that connects people in the State of Delaware with health and human services to support individuals and families in need.[8]

Social Determinants of Health

As the guide for national health promotion and disease prevention under the U.S. Department of Health and Social Services, Healthy People 2030 promotes a society in which all people can achieve their full potential for health and well-being across the lifespan.[9] A powerful tool in building this vision is identifying and addressing the Social Determinants of Health, conditions where people are born, live, learn, work, play, and age that affect a wide range of health, functioning, and quality of life outcomes and risks.[10] Inherent in the role and function of a social worker, as charged by the principles of service and social justice in the National Association of Social Worker's Code of Ethics, the social worker – as member of a stroke survivor's care team – must identify the impact of non-medical issues on a stroke patient's progression of care. Factors like housing, transportation, access to nutritious foods and exercise, as well as a plethora of non-medical factors may contribute to causing a primary or recurrent stroke. While an intimidating task seemingly beyond the abilities of one medical social worker in a healthcare setting, Healthy People 2030 has a strong emphasis on data driven research and collaborative partnerships. Both acute care and the outpatient setting have medical codes specific to social determinants of health. As part of the care team, social workers should be purposeful not only in addressing patient specific issues to the best of their professional abilities, but also in ensuring accurate documentation of these determinants.

Vulnerable Populations

In healthcare, the designation of vulnerable population is simultaneously broad and specific. Broadly, it refers to individuals who have poor access to healthcare and experience poor outcomes as the result of factors such as age, geographic location, language, gender or sexual orientation, chronic illness or disability, race, and economic status. Sometimes, depending on a host of interplaying factors, specific populations are more vulnerable than others, such as persons in congregate care settings during the COVID pandemic.

Due to the elevated risk of disability and mortality, particularly among individuals with a history of stroke, social workers have a crucial responsibility to diligently identify individuals at risk of not receiving preventive care. One of the most vulnerable populations is the uninsured. Assessment and stabilization of all persons in an emergency medical situation, regardless of insurance coverage or ability to pay, is safeguarded by the federal Emergency Medical Treatment & Labor Act (EMTALA). For many stroke patients, stabilization is just the beginning. An uninsured person may not have access to much needed post hospital care, like medications and rehabilitative services. A well-informed social worker should readily be aware of healthcare clinics and financial assistance programs, and facilitate completion of applications and making referrals.

Another vulnerable population is the socially isolated. As recently articulated by the U.S. Surgeon General, loneliness is associated with a greater risk of cardiovascular disease, dementia, stroke, depression, anxiety, and premature death.[11] The AHA provides a sharper focus of the impact of loneliness on stroke, reporting that socially isolated adults with three or fewer social contacts per month may have a 40% increased risk of recurrent stroke or heart attack.[12] Discharge planning back to the community – particularly if the person is impacted by stroke

deficits – can be challenging. Loneliness and social isolation can be well hidden, so a purposeful conversation is worthwhile. For a formal assessment, the Lubben Social Network Scale is a brief instrument that gauges social isolation in older adults by measuring perceived social support received by family and friends.[13]

Of note, technological literacy has become a recent stressor for patients in managing their health. Technologies supporting care coordination and patient engagement can serve as a bridge, rather than a barrier, only when barriers are directly remedied. Issues include lack of internet access, lack of a phone, lack of an appropriate device, cost concerns, lack of training for the individuals and their family members on how to use the tools, and language barrier issues.

Stroke care is not only best provided by a multidisciplinary team, but also across a continuum of care. Stroke care usually begins in the community with 911 and first responders and ideally ends in the community, as the stroke survivor transitions back to their home.

Social Work During Acute Hospital Care of a Stroke Patient

This phase of care, beginning with the arrival of the ambulance and proceeding through the Emergency Department and continued hospitalization, is the busiest, most stressful, and uncertain phase for a stroke patient and their loved ones. The medical team is focused on accurate diagnosis, treatment, and stabilization. During this stabilize and treat phase, the hospital social worker focuses on family engagement, coordinating family meetings with the medical team, and addressing needs and concerns as brought up by the patient and their families.

The discharge planning process happens concurrent to stabilize and treat. While “discharge planning starts at the door” is a standard for hospitals, it is an overwhelming thought for a patient and their family to even think about during such a crisis. The hospital social worker, sometimes with a nurse care management partner, is tasked with educating patients and their families on its necessity. Discharge plans for life changing conditions like stroke often take time as they have a multitude of variables.

From the hospital, the ASA strongly recommends the Inpatient Rehabilitation Facility (IRF) level of care for stroke survivors who can manage three hours of therapy daily.[14] Other options for care include skilled nursing facilities (SNFs), appropriate for those whose nursing needs are more significant than rehabilitation needs and patients can only tolerate an hour daily of therapies. Long term acute care (LTAC) is specifically for stroke survivors with serious medical conditions that require ongoing care but no longer require intensive care or extensive diagnostic procedures.

For stroke survivors leaving acute care with minimal to no deficits, homecare is an option, which can provide skilled nursing, physical, occupational and speech therapies, and social work. Some stroke survivors can be managed safely with outpatient follow up. In these cases, it is imperative that the discharge planner, often a social worker, ensure follow up appointments as recommended by the care team, usually neurology, cardiology, and primary care. Of equal importance is ensuring the stroke survivor has access to prescribed medications.

Social Work During Post-Acute Facility Care of a Stroke Patient

Stroke deficits can be pervasive, impacting a multitude of functions: gross motor skills, fine motor skills, speech and language, cognition, vision, and emotions. Appropriate, quality

Doi: 10.32481/djph.2023.08.009

rehabilitation with specially trained therapists is necessary for the best possible recovery. Rehab therapies usually begin in the hospital setting once physicians have cleared the patient medically. It is vital that a stroke survivor with deficits transition to the next level of rehabilitative care as soon as possible. As hospital level of care is ideally brief and focused on medical stabilization, hospital therapy sessions are comparatively brief and focused on assessment of the stroke survivor's deficits and subsequent discharge needs.

The ASA estimates that 10% of people fully recover from a stroke, 25% have only minor impairments and 40% have moderate impairments that are manageable with some special care. The sooner a stroke survivor starts a therapy program, the more likely they are to regain impacted abilities and skills.[14]

In the IRF level of care, therapists in collaboration with a physician specially trained in rehabilitative medicine provide comprehensive interventions. A stroke survivor's IRF care team is focused on the prevention of secondary complications, treatment to reduce neurological deficits, and compensation to adapt to disabilities that may continue over an indefinite time. The IRF social worker's role and function is similar to the acute hospital social worker, with heightened focus on return to the community and post-facility adjustment. The IRF care team relies heavily on social work to facilitate a safe discharge to home, the preferred discharge goal after extensive rehabilitation is completed.

Stroke survivors who step down from the hospital to a SNF usually have skilled nursing needs that take precedence over rehabilitation needs. Likely, they are unable to tolerate three hours of daily therapy, which is often related to previous level of functioning, extensiveness of the stroke, or the interplay of the stroke with comorbidities. Social workers in the SNF level of care carry a breadth of responsibilities. They facilitate the admission process, assist in creating a comprehensive plan of care, perform needs assessments, and plan for discharge. A SNF social worker will manage discharge plans to IRF, to the home, or transition a patient to long term care in a nursing home.

Stroke survivors who discharge from the hospital to the LTAC setting have serious medical conditions that require ongoing care, but no longer require intensive care or extensive diagnostic procedures. They may then transition to IRF, SNF or even home.

The focus of stroke care and medical care in general is to restore a person's health and wellbeing. Some strokes are so profound that they cause irreparable damage. Hospice can be the right support for certain stroke patients. The hospital social worker can facilitate goals of care conversations and ensure referrals are made to the agency that can best care for a patient and their family at this most critical point. Hospice social workers then continue to offer support, whether it is counseling or resource finding.

Discharge Planning from Facility Level of Care

As levels of medical care that treat stroke, hospitals, IRFs, SNFs and LTACs have the common thread of being 24-hour care facilities with medical supervision and access to highly trained healthcare professionals. Discharge planning from each level of care, whether it is to another 24-hour care facility or to home, mandates effective needs assessments. Discharge planning tools guide the discharge planner and their team in well-informed decision making about the stroke survivor's needs, and how to provide the most appropriate care possible.

Doi: 10.32481/djph.2023.08.009

There are several discharge planning models to guide social workers and their fellow clinicians, all with the shared goal of transitioning the patient out of facility care safely and effectively. IDEAL (Include, Discuss, Educate, Assess, Listen) focuses on engaging patients and family members. RED (Re-Engineered Discharge) focuses on actions the hospital undertakes during and after the hospital stay to ensure a smooth and effective transition at discharge, making follow up appointments, identifying discharge medications and planning how patients can obtain them. The Agency for the Healthcare Research and Quality, under the U.S. Department of Health and Human Services, has toolkits for both initiatives.[15,16] Better Outcomes for Older Adults through Safe Transitions (BOOST), emphasizes teach back and capturing discharge information on a readable one-page document.[17] An integrated and pragmatic approach that is informed by research and evidence from sources like the above three approaches can help guide a comprehensive discharge plan individualized to the patient.

Social Work During the Outpatient Phase of Stroke Patients

At this point in the recovery process, social workers are focused on the stroke survivor's adjustment back to their home and community, arguably the most important transition. Depending on the severity of the stroke, pervasiveness of any deficits, and impact of medical comorbidities, it could last weeks to months after a stroke survivor arrives home. For others, it can be a couple of days, as may be case with a TIA. In the initial three months after a stroke, the risk of stroke is 15 times higher than the general population. Furthermore, the ASA estimates that 23% of strokes are recurrent. Clearly, attention to this transition is crucial.

In the outpatient setting, the stroke survivor may access a social worker through a home care agency who is also providing skilled nursing and therapy services. Social work may also be available if the primary care physician or other involved provider is part of an accountable care organization (ACO). An ACO care coordinator will reach out to a stroke survivor to ensure they are aware of the supports offered by the ACO team. Social work is also available if the patient is undergoing cancer treatment or getting hemodialysis.

Generally, the outpatient social worker will build on the successful discharge planning from previous levels of care. If there are issues with availability of prescribed medications, durable medical equipment, or expected healthcare services, a social worker is helpful in navigating these issues to resolution. Social workers will provide both education and counselling for the patient and their families to assist them in processing the realities of the stroke event and its aftermath. The social worker can also focus on social supports such as finding social self-help groups within the community. The outpatient social worker uses their own critical thinking, input from the medical care team, and feedback from the stroke survivor to identify and address, as best possible, barriers to the stroke survivor's stability within their own community. Of perhaps even greater value is the work an outpatient social worker does that contributes to stroke prevention – access to medications, screenings, and medical transportation, to name a few.

Conclusion

Strokes are one of the most stressful, life changing things a person will ever experience. No one plans for them. Compassionate patient centered care goes a long way to alleviate that stress and get the patient on their road to recovery. Social workers can be helpful at all stages of patient stroke recovery and are a vital resource to the care team and to the patient.

Ms. McDermott may be contacted at amcdermott@che-east.org.

References

1. National Association of Social Workers. (n.d.). About social workers. https://www.socialworkers.org/News/Facts/Social-Workers
2. American Stroke Association. (n.d.). Professionals. [REMOVED HYPERLINK FIELD]https://www.stroke.org/en/professionals
3. Delaware Stroke Resources. (n.d.). Stroke education. https://delawarestrokeresources.org/?page_id=398
4. Delaware Academy of Medicine/Delaware Public Health Association. (2022). 2022 Scholz stroke education conference. https://delamed.org/education/educational-series/conferences/2022-scholz-stroke-education-conference/
5. Towfighi, A., Ovbiagele, B., El Husseini, N., Hackett, M. L., Jorge, R. E., Kissela, B. M., . . . Williams, L. S. (2017, February). Poststroke depression: A scientific statement for healthcare professionals from the American Heart Association/American Stroke Association. *Stroke*, *48*(2), e30–e43. https://doi.org/10.1161/STR.0000000000000113 PubMed
6. American Stroke Association. (2018, Nov). Pseudobulbar affect (PBA). https://www.stroke.org/en/about-stroke/effects-of-stroke/emotional-effects-of-stroke/pseudobulbar-affect
7. Delaware Stroke Resources. (n.d.). Delaware support groups. https://delawarestrokeresources.org/?page_id=337
8. 2-1-1 Delaware. (n.d.). Help starts here. https://delaware211.org/
9. United States Department of Health and Human Services. (n.d.). Healthy people 2030: Building a healthier future for all. https://health.gov/healthypeople
10. United States Department of Health and Human Services. (n.d.). Social determinants of health. https://health.gov/healthypeople/priority-areas/social-determinants-health
11. Office of the U.S. Surgeon General. (2023). Our epidemic of loneliness and isolation: The U.S. Surgeon General's Advisory on the healing effects of social connection and community. https://www.hhs.gov/sites/default/files/surgeon-general-social-connection-advisory.pdf
12. Cené, C. W., Beckie, T. M., Sims, M., Suglia, S. F., Aggarwal, B., Moise, N., . . . McCullough, L. D. (2022, August 16). Effects of objective and perceived social isolation on cardiovascular and brain health: A scientific statement from the American Heart Association. *Journal of the American Heart Association*, *11*(16), e026493. https://doi.org/10.1161/JAHA.122.026493 PubMed
13. Brandeis University. (n.d.). Lubben social network scale. https://www.brandeis.edu/roybal/docs/LSNS_website_PDF.pdf
14. Winstein, C. J., Stein, J., Arena, R., Bates, B., Cherney, L. R., Cramer, S. C., . . . Zorowitz, R. D. (2016, June). Guidelines for adult stroke rehabilitation and recovery: A guideline for

healthcare professionals from the American Heart Association/American Stroke Association. *Stroke*, *47*(6), e98–e169. https://doi.org/10.1161/STR.0000000000000098 PubMed

15. Agency for Healthcare Research and Quality. (2017, Dec). Care transitions from hospital to home: IDEAL discharge planning. https://www.ahrq.gov/patient-safety/patients-families/engagingfamilies/strategy4/index.html
16. Agency for Healthcare Research and Quality. (2023, Apr). Re-engineered discharge (RED) toolkit. https://www.ahrq.gov/patient-safety/settings/hospital/red/toolkit/index.html
17. Coffey, C., Greenwald, J., Budnitz, T., & Williams, M. V. (2013). Project BOOST implementation guide, 2nd Ed. Society of Hospital Medicine. https://www.hospitalmedicine.org/globalassets/professional-development/professional-dev-pdf/boost-guide-second-edition.pdf