The Social and Functional Consequences of Stroke for Elderly Patients

Rebecca A. Silliman, Edward H. Wagner, and Robert H. Fletcher

Although a great deal is known about the epidemiology of acute stroke, including risk factors for occurrence and subsequent mortality, less is known about the long-term physical, social, and emotional dysfunction that may ensue. Recent studies suggest that between one-fourth and one-third of stroke patients experience persistent dependency in one or more activities of daily living (ADL's) by 6 months after their strokes. Information about social and emotional disabilities is less readily available, but these are probably more prevalent.

Despite conflicting evidence, elderly stroke patients seem to experience greater functional losses than do their younger counterparts, with as many as one-half suffering permanent loss of function. Since the incidence of stroke increases rapidly with age and since the elderly are major consumers of long-term care, it is critically important that we understand patterns of functional disability among this group of stroke patients as well as its effects on their families.

As part of a larger project examining the effects on family caregivers of providing home care for their elders with stroke, we sought to answer questions about the social and functional consequences of this illness: 1) How frequently do patients discharged to home enter nursing homes in the first year after hospital discharge, and conversely, how frequently do patients discharged to nursing homes return home in the first year? 2) What factors predict discharge to home after hospitalization for acute stroke? 3) To what extent does physical dysfunction persist after stroke?

Subjects and Methods

This study sought to answer questions about the social and functional consequences of stroke for elderly patients (≥ 65 years of age). Survivors of acute stroke were retrospectively identified, and hospital records were reviewed. One year after discharge, follow-up interviews were conducted with families of surviving patients. Most patients were discharged to home (82%) and remained there. Independent functional status was the single predictor of discharge to home (p < 0.01). By the time of follow-up, less than half of the surviving patients were functionally independent (42%). Stroke is an important cause of functional dependence among the elderly. Attention should be focused on minimizing the effects of persisting dysfunction on them and their families. (Stroke 1987;18:200–203)

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ports, 5) health and psychosocial impacts of the caregiving experience on caregivers, and 6) perceptions about the caregiving process.

Chi-square analysis and, where necessary because of small cell sizes, Fisher’s exact test were used to test for associations between categorical variables, with \( p < 0.05 \) considered significant. Odds ratios were calculated to determine the strength of associations. Stratified analysis was also employed to examine associations between two variables within a third.

To answer the question about predictors of discharge disposition, we classified patients as independent if they could independently perform all ADL’s. We also used the three-level variable as suggested by Katz et al.\(^1\) Age (< 75 years vs. ≥ 75 years), race (white vs. nonwhite), sex (male vs. female), and stroke severity (mild vs. moderate–severe) were all treated as dichotomous variables in our analyses. Finally, logistic regression was used to develop a best-fitting multivariable model to predict functional status of patients at hospital discharge on the basis of information available at hospital admission.

## Results

Of 147 stroke patients studied, 83 (56%) were men and 64 (44%) were women. Their mean age was 75 years. There were 70 whites (48%) and 77 nonwhites (52%), all of whom were black except 1, a Native American. Seventy-six (52%) were married, while 71 (48%) were widowed, divorced, separated, or never married. Prior to hospital admission the majority had lived with others: 76 (52%) lived with their spouse with or without others, 21 (14%) lived with their children, 12 (8%) lived with other relatives, and 9 (6%) lived with unrelated persons. Only 29 patients (20%) lived alone.

Slightly more than half suffered strokes involving the left cerebral hemisphere (53%). Almost all of the others had strokes in the right hemisphere (42%) although 7 had brainstem infarcts, and 1 suffered a cerebellar hemorrhage. The majority (79%) had no prior history of stroke. Almost all of the remainder (25 of 31) had suffered only one stroke in the past. By the time of hospital discharge, which occurred between 2 and 242 days after admission (mean, 28 days; median, 18 days; SD ± 32.5), more than one-third (36%) were independent in all ADL’s.

Patterns of Discharge Disposition

When discharged from the hospital, 119 of the patients (82%) returned home while only 27 (18%) entered nursing homes or other institutions (1 was transferred to another hospital and subsequently lost to followup). Of the entire group, the majority (86%) were still at their original discharge location at the time of followup. Of those originally discharged to home, 14 subsequently entered nursing homes. Of these, 2 returned home and remained there and 1 returned home, reentered a nursing home, and returned home once again before finally returning to a nursing home to stay. Thus, a total of 12 from the home group entered institutions seemingly permanently. On the other hand, 7 patients originally in institutions returned to their homes and remained there.

Predictors of Discharge Disposition

Based on evidence from the rehabilitation literature,\(^13,14\) we anticipated that patients returning home would be more functionally independent than those discharged to nursing homes. In fact, discharge to home was strongly associated with independence in ADL’s. Only 1 patient completely independent in ADL’s entered a nursing home (he returned home after 1 week), although the majority of those who were dependent were also discharged to home (Table 1). Patient age, race, sex, and marital status were not significantly associated with discharge disposition (Table 2).

Because functional status was such a strong predictor of discharge disposition, the relations between patient characteristics known at admission and predischarge functional status were evaluated. Not surprisingly, in the univariate analysis, stroke severity and functional status were closely related. Patient age and race were also significantly related \((p < 0.01)\). Younger patients and white patients were more often functionally independent.

Logistic modelling was used to determine a best-fitting model for factors related to patient functional status and to evaluate the presence of a significant interaction between stroke severity and a) age and b) race. The best model, which explained 22% of the variance, included only stroke severity and age. None of the other variables (comorbidity, sex, race, and marital status) nor the interaction terms remained in the model.

Lastly, since functional status was such a powerful predictor of disposition, we stratified patients by this variable to explore the roles of other important but less powerful variables. We examined only the functionally dependent group because all but 1 independent patient returned home. In the dependent group there was a nonsignificant trend for both race (nonwhite) and sex (female) to be associated with discharge to home (Table 3).

Because marital status might have been related to the race and sex trends, the data were stratified by marital status, and the relations between sex and disposition and between race and disposition were examined. Among those patients who were married, whites were more apt to enter nursing homes than nonwhites (Table 4). Sex was not an important factor. Converse-

<table>
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<th>Table 1. Relation of Patient Functional Status to Discharge Disposition</th>
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<td><strong>Disposition</strong></td>
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<td>-----------------</td>
</tr>
<tr>
<td>Nursing home</td>
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<tr>
<td>Home</td>
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Fisher’s exact test, \( p < 0.01 \), odds ratio = 20.
ly, among those who were not married, men entered nursing homes more frequently than women (Table 5), and race did not play a role.

**Long-Term Followup**

A total of 20 patients (18%) residing at home died, compared to 11 patients (34%) residing in nursing homes. Of the surviving 115 patients, 94 (82%) were residing at home at the time of followup; 21 (18%) lived in nursing homes. The 3-month total mortality rate was 14%; the 6-month rate, 19%. Of the deaths, 87% occurred by 6 months after the stroke; furthermore, 84% occurred in patients who were dependent in 3 or more ADL's. The cause of death was ascertained from death certificates in 29 of the 31 deaths: 21 were attributed to cerebrovascular or cardiovascular events; 8 to a variety of other conditions such as sepsis or diabetic ketoacidosis.

Since 31 patients had died by the time of followup and another 15 lived too distant or lacked family caregivers, 46 patients and their caregivers were unavailable for further study. Caregivers of the remaining 101 patients were eligible for home interview, and 89 (88%) consented to participate. Thus, more detailed follow-up data for patients are limited to the 89 patients with participating caregivers. Table 6 shows characteristics of the original sample of patients and the follow-up sample. They are remarkably similar.

Caregivers reported that only 36 patients (40%) were functionally independent at followup. Thirty patients (34%) had been independent at hospital discharge. During the follow-up period 12 dependent patients achieved functional independence; 6 declined from independence to dependence.

Additionally at followup, while only about one-third of patients could walk unaided (36%), most could follow directions (74%) and had no difficulty speaking (64%). The health of patients had improved and the amount of care they required had lessened since discharge from the hospital in 52 cases (58%). Following discharge after the stroke 36% had been hospitalized; of these, the majority had been hospitalized only once (65%).

At the time of the interview, 75 patients were living at home and 14 resided in nursing homes. Most (84%) of the 75 community-dwelling patients lived with their family caregivers. Of note, 6 of the 14 in nursing homes had started out at home, but because of increasing debility, institutionalization ensued. Caregivers of stroke victims who had been institutionalized at any time since the stroke said that it was either because they (the caregivers) could not provide care (75%) or because either the physician or other health care personnel felt that this was the correct decision (25%).

When patients living at home were compared with those in institutions, several differences were noted. As expected, nursing home patients functioned poorly, with only 1 of 14 being independent in ADL’s, reflecting differences in functional status at hospital discharge between the institutionalized and noninstitutionalized groups. Although not different in cognitive functioning, the nursing home patients more often had speech impairments.

The majority of caregivers felt that, taking everything into account, the caregiving process was going well for them. For example, almost all (88%) could think of something positive about the experience. Nevertheless, they also reported negative aspects of caregiving that stemmed from changes that caregiving and the stroke had made in their lifestyles; changes that had occurred as a result of changes in the patient’s personality, behavior, and cognitive functioning; or problems that resulted from the patient’s physical limitations. Loss of leisure time activities because of fear, shame, and dysfunction was a central issue.

**Discussion**

Our findings demonstrate that most elderly patients who suffer a stroke return to their homes after a stay in the acute care hospital and remain there. A higher percent of our patients continued to be community-dwelling than has been reported by others. This may...
reflect variations in setting since many previous reports have been from European countries where cultural values, age structure of the populations, and organization of health care delivery systems are different. Our study was conducted in the rural southern United States during a time when the extended family provided extensive support to patients and caregivers.

Although the incidence of stroke is declining, it is still an important clinical and psychosocial problem for the elderly and their families. It may have its greatest effects in this age group because of less physiological resiliency and the greater likelihood of associated debilitating morbidity and functional limitations. On this substrate, even mild deficits from a stroke can have enormous functional consequences. Understanding the social and functional consequences for patients and their families is crucial, particularly since pressures to reduce lengths of hospital stay may mean that patients are discharged from the hospital before much functional recovery has occurred. This may be further compounded by the reluctance of many rehabilitation facilities to accept elderly patients. While the health benefits of rehabilitation therapy following stroke are questionable6,12,13 that time does allow for functional recovery to occur and for the education and mobilization of families.

Similar to findings in the rehabilitation literature,4,14,15 we observed that functional status was the most powerful predictor of discharge disposition following an acute hospital stay. Nevertheless, functional status was not a perfect predictor of disposition. Attitudes of families and desires of patients also undoubtedly influence decision making.

Another key finding of this study was the high prevalence of persisting functional dependence associated with stroke in this elderly population. A challenge to clinicians and researchers is to identify modifiable factors so that appropriate interventions can be developed to promote functional recovery of patients and to minimize the effects of persisting dysfunction on them and their families. Interventions must be targeted at both patient and family caregiver if optimal outcomes for both are to be achieved.

While providing important information about the consequences of stroke for the elderly, several limitations of this study should be considered. First, the data were collected retrospectively from secondary sources: medical records and family interviews. Second, the study was undertaken in the rural south prior to the advent of DRG's (diagnosis-related groups). Nonetheless, since many other studies have been performed in other countries and have not focused on elderly patients, it provides useful information for health care providers and researchers in this country. Further prospective studies that focus on groups of stroke patients in different cultural and social settings are needed. Such investigations will provide the rationale for interventions that maximize functional recovery, both during and following hospitalization for acute stroke.

### Table 6. Characteristics of Initial and Follow-up Samples

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<thead>
<tr>
<th>Characteristic</th>
<th>Initial sample</th>
<th>Follow-up sample</th>
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<tr>
<td><strong>Sex</strong></td>
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</tr>
<tr>
<td>Male</td>
<td>83 (56%)</td>
<td>50 (56%)</td>
</tr>
<tr>
<td>Female</td>
<td>64 (44%)</td>
<td>39 (44%)</td>
</tr>
<tr>
<td><strong>Race</strong></td>
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<td></td>
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<tr>
<td>White</td>
<td>70 (48%)</td>
<td>38 (43%)</td>
</tr>
<tr>
<td>Nonwhite</td>
<td>77 (52%)</td>
<td>51 (57%)</td>
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<tr>
<td><strong>Initial functional status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Independent</td>
<td>53 (36%)</td>
<td>30 (34%)</td>
</tr>
<tr>
<td>Dependent</td>
<td>94 (64%)</td>
<td>59 (66%)</td>
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### References


**Key Words**: stroke • disability • social history
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