ICTUSnet FINAL DISSEMINATION EVENT

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IACS Instituto Aragonés de Ciencias de la Salud

ARS NORTE Administração Regional de Saúde do Norte, I.P.

Institut d'Investigació Sanitària Illes Balears IdISBa

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NAVARRABIOMED BIOMEDICAL RESEARCH CENTRE

Complejo Hospitalario de Navarra

Follow up and Rehabilitation of stroke patients

WP 3

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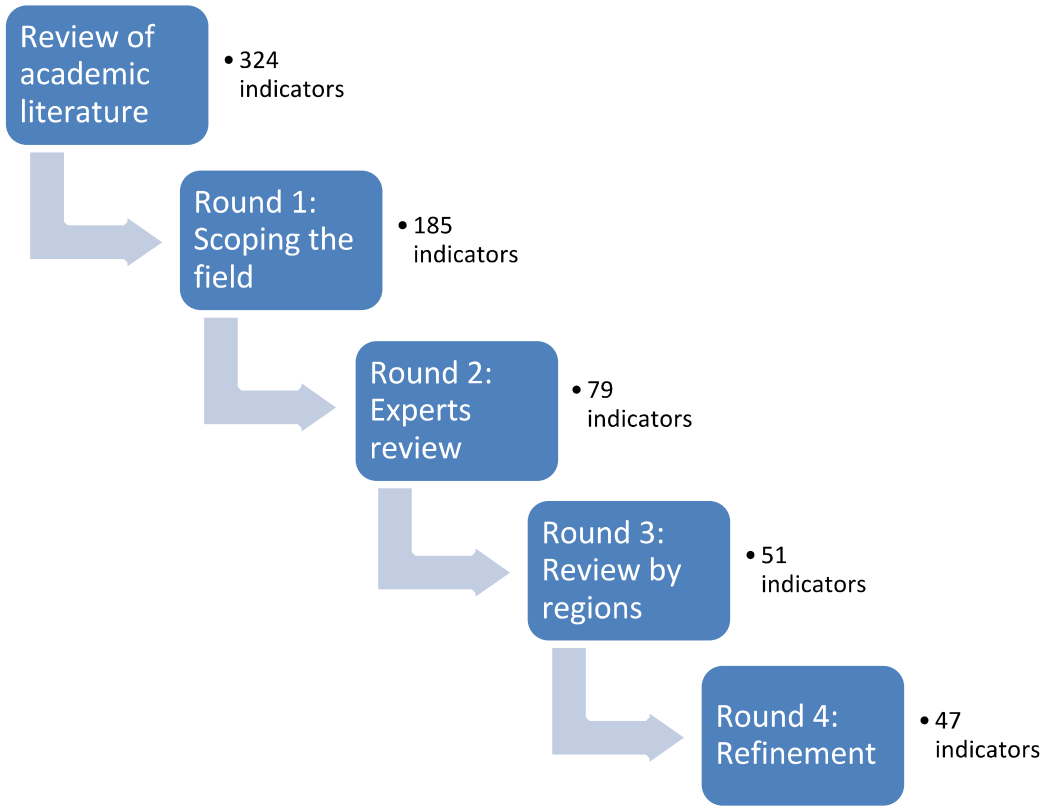
Task leader

Maps the **resources and structure** of stroke rehabilitation in each region. It has been developed with the information from the regional plans and in-depth interviews with the representatives of each region health system.

Countries: France, Portugal, Spain.

Regions: Occitanie, ARS Norte, Aragon, Navarra, Balearic Islands, Catalonia.



Results

WP 3

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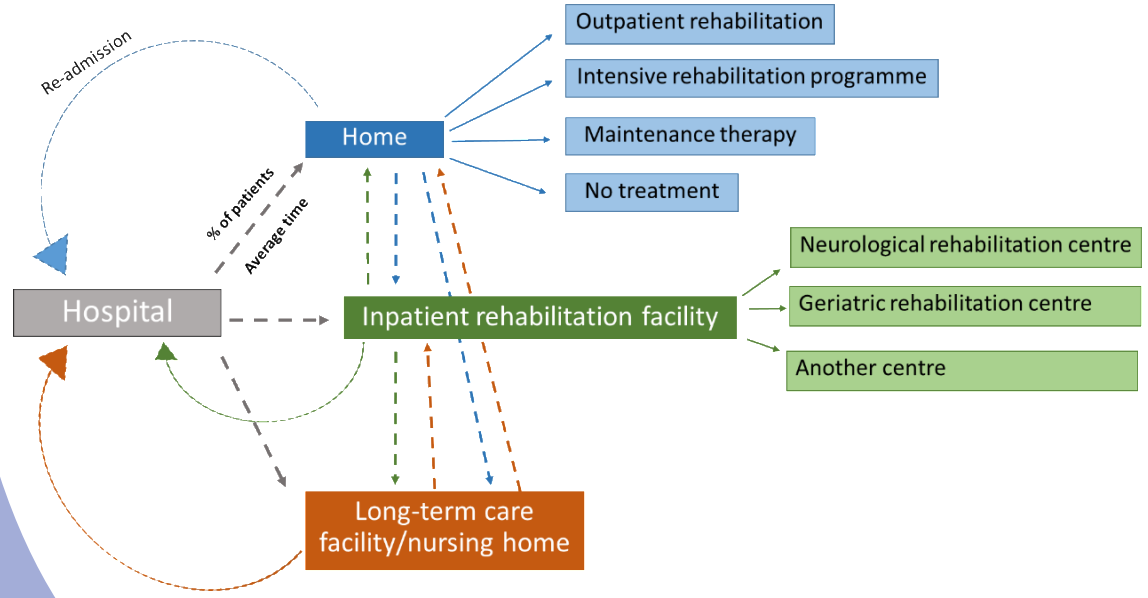
Task leader

Stroke rehabilitation is not easy to monitor, since in general patient records do not include the whole rehabilitation process, and therefore there is no follow up.



Source: Authors elaboration based on Richards et al (2015)

	Aragon	Catalonia	Balearic islands	Navarra	ARS Norte	Occitanie
1. Rehabilitation pathways						
2. Resources for stroke survivors						
2.1 Therapies						
2.2 Quality of life services						
2.3 Services for caregivers						
2.4 Personnel						
3. Follow-up of stroke survivors						
3.1 Assessment						
3.2 Sequelae						
4. Secondary prevention						

Source: Author's elaboration

Conclusions for all stakeholders

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Task leader

- The successful **evaluation** of stroke rehabilitation and secondary prevention would allow for the **improvement of the protocols** that are in place.
- Key to count with **registries that contain the full pathway** of each patient during rehabilitation, **understanding rehabilitation as a whole process** that encompasses the entire chain of care from acute stroke care through to life after stroke.
- Rehabilitation has a key role to **return stroke patients to their lives**.
- Ensure sufficient **resources for rehabilitation**, and also ensure an equitable access to rehabilitation services.

Socio-economic impact

WP 3

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Task leader

Provides a list of dimensions to be taken into account for the evaluation of the social and economic impact of stroke, as well as an overview of the key dimensions that remain more affected for stroke sequelae.

Stage 1. Protocol development
▪ Identify the research questions ▪ Determine search terms and strategy to develop the initial pool of literature and sources to be searched ▪ Define inclusion and exclusion criteria for studies (including time period and geographic area) and basic criteria against which documents will be selected (strength of evidence, relevance and level of academic) ▪ Set up information management processes, including bibliographic software to ensure clear recording of identified literature
Stage 2. Identification and selection of the relevant sources
▪ Develop the initial pool of literature ▪ Review titles and abstracts against inclusion/exclusion criteria ▪ Implement a snowballing approach by reviewing bibliographies of the identified literature for further sources
Stage 3. Data extraction
▪ Review literature, identifying the relevant content, depending from the sub-task that needs to be fed, and assessing these against basic feasibility criteria ▪ Extract, record and collate the relevant measures and associated contextual and background information where available using a standardised reporting tool
Stage 4. Data analysis
▪ Analyse the results to understand themes and trends and inform selection of stakeholders to be involved in primary data collection activities ▪ Synthetise and report the main findings of the review

Source: Author's elaboration

Results

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After a comprehensive review, a list of 55 dimensions to be taken into account when assessing the socioeconomic impact of stroke were identified and grouped in five dimensions:

- **Physical sequelae**, including motor impairment, cognitive impairments or communication problems.
- **Economic consequences**, including impossibility/delay to return to work or need to reduce the working time/responsibilities.
- **Quality of life sequelae**, including patients' mental health-related quality of life, depression or level of social participation.
- **Caregivers sequelae**, including burden, emotional problems or reduction of working hours.
- **Use and cost of rehabilitation services**, including the economic resources invested on sequelae services.

Conclusions for all stakeholders

WP 3

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Task leader

- Stroke is the leading cause of **acquired disability**, the second leading cause of **dementia** and the second leading **cause of death**.
- Only a small percentage of stroke patients are independent in basic activities of daily living (ADL), while a majority will have to **rely on human assistance for ADLs** like feeding, self-care and mobility.
- Stroke sequelae also **impacts caregivers**, representing a relevant amount of time which on average is from 9 to 17 hours per week in the first year after stroke. In addition, the estimated economic burden of informal caregiving per stroke survivor during the first year ranges from €3,100 to €7,600.
- **Healthcare cost of stroke varies considerably**, with 27€ per capita (1,244.8€ million overall) in Spain, 30€ per capita (1,973.2€ million overall) in France and 15€ per capita (159.7€ million overall) in Portugal.
- There is a need to **better measure the socioeconomic burden** of stroke across healthcare systems.