Ontario Stroke Evaluation Report 2018: Stroke Quality of Care and Outcomes in Complex Continuing Care and Long-Term Care

The following article describes key findings with respect to recreation therapy and is taken directly taken from the 2018 Ontario Stroke Evaluation Report[1].

In 2018, CorHealth Ontario and ICES released a provincial stroke evaluation report on quality of care and outcomes in Complex Continuing Care (CCC) and Long-Term Care (LTC), using data from 2010 to 2015. The report describes the socio-demographic characteristics and burden of care for stroke survivors admitted to LTC and CCC. The intent of the report is to inform system planning, advocate for system change and identify opportunities for quality initiatives and research.

As you review this information, I ask that you consider how these findings could impact and inform your practice.

According to the report, of the approximately 13,000 Ontarians who survive an acute care hospitalization for stroke or transient ischemic attack (TIA) each year, about 1100 are admitted to CCC and 1300 to LTC within 180 days of discharge from acute care. To date, the care provided to stroke survivors in these settings has been largely unexamined. The report aims to address this knowledge gap by describing the nature and extent of the rehab therapy available to the stroke survivors, selected stroke best practices and outcomes, and their journeys through the health care system.

Table 1 describes the overall characteristics of stroke survivors from 2015.

Characteristics of Stroke Survivors in CCC and LTC		
Characteristic	**CCC (%)**	**LTC (%)**
Over the age of 85	23.8	40.8
Women	50.9	63.2
Diagnosis of Dementia	~40.0	~20.0
At Risk for Depression	18.3	23.8
Limitations in Communication	58.9	55.7
Severe Cognitive Impairment	28.6	20.3
Experienced a Fall	27.8	25.5
Socially Engaged	52.3	38.6
Received Nursing Restorative Care	n/a	11.4 (down from 28.5)
Health Related Quality of Life *(scale from -0.02 to 1.0)*	.32	.37
Discharged to the Community	45.7	10.8

Table 1

[1]Hall RE, Tee A, Khan F, McCormack D, Levi J, Verrilli S, Quant S, Donnelly B, Brown G, Campbell W, Brown P, Cristofaro K, Bayley MT. *Ontario Stroke Evaluation Report 2018: Stroke Care and Outcomes in Complex Continuing Care and Long-Term Care.* Toronto, ON: Institute for Clinical Evaluative Sciences/CorHealth Ontario; 2018.

The report defines Recreation Therapy as "*therapy that provides therapeutic stimulation beyond the general activity program in a facility and is provided by a provincial/territorial licensed or nationally certified therapeutic recreation specialist or therapeutic recreation assistant".*

Recreation Therapy highlights from the report:

- about 30% of stroke survivors in CCC received Recreation Therapy
- stroke survivors receiving Recreation Therapy in LTC dropped from 8.9% to 4.3%
- within both sectors, the time spent in both rehab and recreation therapy per day is minimal
- the median time per day of recreation therapy in CCC was 60 minutes
- the median time per day of recreation therapy in LTC was 45 minutes
- the low degree of social engagement and poor health-related quality of life (HRQL) is concerning
- low health-related quality of life scores may be attributed to limited rehabilitation, nursing restorative care and recreation therapy, in addition to depression and pain

In the discussion section of the report, it was noted that the amount of recreation therapy provided to stroke survivors in CCC and LTC may not be adequate to address physical and cognitive needs, increase social engagement or optimize quality of life. Factors contributing to the poor HRQL among stroke survivors in CCC and LTC may include the limited access to recreation and rehabilitation therapy, the presence of other comorbidities (e.g., dementia, Alzheimer's disease and depression) and limitations in communication abilities. The report also suggests that focused efforts to address the low degree of social engagement and poor HRQL scores for stroke survivors in both CCC and LTC may benefit from a review of resource allocation for nursing restorative care, core rehabilitation therapies (PT, OT, and S-LP) and recreation therapy in CCC and LTC.

When reviewing the limitations to the report, it was noted that the delivery and documentation of recreation therapy and recreation/activity programming varies among facilities.

In conclusion, the time spent in rehab therapy and recreation therapy per day in both CCC and LTC is minimal, and access to physiotherapy and nursing restorative care in LTC has declined over time (access to occupational therapy and speech-language pathology was minimal). Low health-related quality of life scores may be attributed to limited rehab, nursing restorative care and recreation therapy, and to depression and pain.

Thoughts/questions to ponder:

- How can I change my practice to optimize interventions?
- How can I advocate for change in these settings?
- How can I work with the interprofessional team to leverage diverse expertise and the limited available resources?
- How can TRO leverage this report?

If you are interested in further discussing this report and the questions I have posed, please feel free to contact me at any time.

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