Clinician's Commentary on DePaul et al.¹

What becomes of stroke patients after we have seen them at our particular point in their continuum of care? What have we done well to prepare them to face their futures? What could we have done better? What could we help them with now, if only we could provide services to them again? Most, if not all, clinicians working in stroke rehabilitation have asked these questions at some point in their career. Unfortunately, the extent to which we receive feedback of this type after our patients leave our care is often very limited, as is our ability to see patients for ongoing therapy again 6 months or a year after they leave our care.

DePaul and colleagues' article¹ is valuable to all clinicians working with stroke patients because it begins to answer some of these questions. While other studies have examined post-stroke patient needs,² this one is unique in aiming to provide more physiotherapy-relevant detail to help guide clinicians' decisions. It also aims to determine how patient needs change with time and whether different sub-groups of stroke survivors have different perceived needs.

A broad spectrum of mobility-related needs is documented in this article, from basic mobility needs such as bed mobility and toilet transfers to higher-level needs such as negotiating crowds and walking outdoors. Today's health care environment focuses on getting stroke patients out of hospital and back into the community more quickly and efficiently; decreasing lengths of stay can lead to an emphasis on meeting basic mobility requirements. While this is an important prerequisite for relatively safe initial return to the community, two caveats should be noted. First, as DePaul and colleagues' work shows,¹ even these more basic needs are not always perceived to be met through a patient's hospital stay; and, second, basic mobility needs are not the only needs and barriers reported by patients. As DePaul and colleagues note, it is important that we not restrict access to ongoing physiotherapy after basic mobility milestones have been met; physiotherapists can continue to play a role in helping patients to effectively re-integrate into the community with therapies targeting high-level balance, outdoor and community mobility, and/or strategies to compensate for more severe impairments.

It is also interesting to note that fatigue was one of the issues most commonly reported on the survey and was equally frequent in both mild and more severe acute presentations. While fatigue is likely multidimensional, study participants also perceived a need to improve their fitness levels, and at discharge 33% reported needing a suitable place to exercise. This very interesting finding raises the question of how we can help our patients find suitable places to exercise. There is a wealth of evidence that reduced exercise capacity is amenable to treatment;^{3,4} therapists must endeavour to assist patients in finding ways to continue with exercise after discharge from hospital, taking into account many factors such as motor control issues, transportation, accessible locations, and patient self-efficacy and self-management principles. While post-rehab exercise

plans, patient self-efficacy, and self-management strategies can be examined and promoted in physiotherapy interactions during active rehabilitation, "tune-up" sessions after formal discharge may also be beneficial in promoting physical fitness activities. This is an avenue in need of further research and further safe community-based exercise opportunities.

DePaul and colleagues found that perceived needs did not decrease over time.¹ While, as they state, it is difficult to determine the reason for this lack of change, it is important to note that stroke is considered a chronic health condition. Chronic conditions have been defined in many ways; according to Nolte and McKee (2008), the common theme of these definitions is that chronic conditions "require a complex response over an extended time period that involves coordinated inputs from a wide range of health professionals and access to essential medicines and monitoring systems, all of which need to be optimally embedded within a system that promotes patient empowerment."^{5(p.1)} Physiotherapists should be among the health professionals whose input is required, especially in light of patients' consistently reported physiotherapy needs. More research needs to focus on the value of community-based physiotherapy-related services during, at a minimum, the first year after stroke. As well as benefiting individual patients, such health maintenance/health promotion could yield overall cost savings for Canadian health care systems.

DePaul and colleagues ask whether different sub-groups of patients, as defined by FIM scores, have different needs after discharge. Stroke affects different people in very different ways, and people with stroke are not a homogeneous group; I applaud research that seeks to divide people with stroke into different categories and so better examine this heterogeneous group. The FIM provides an estimate of burden of care,⁶ which is often used to describe different functional levels. I wonder whether other, more physiotherapy- or impairment-specific classifications might also illuminate different needs of different "categories" of people with stroke.

The article by DePaul and colleagues is an excellent step toward answering some of the burning questions that most therapists must ask themselves at some point in their career. I look forward to more investigations along these lines to help us, as therapists, assist our clients and prepare them for life after discharge and to critically evaluate whether our current systems for managing a chronic condition are adequate.

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