THE THEORETICAL AND PRACTICAL PROBLEM OF COORDINATED REHABILITATION OF PATIENTS AFTER STROKE AND THEIR RETURN TO NORMAL LIFE IN THE CZECH REPUBLIC

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Nowadays, the effect of using the possibilities of coordinated rehabilitation (COR) in the context of the return of the patient/client to their normal life, in the form of a long-term rehabilitation plan and follow-up of the patient after discharge from the hospital, is insufficiently researched and described.

Patients after stroke in the home environment are not adequately monitored. Unfortunately, there is no single, standardized method used by all experts, nor is there a unified record of these people (despite the current attempt at the RES-Q (Registry of Stroke Care Quality) database, which, however, shows major shortcomings). It is obvious that due to this, there are economic losses (the client returns after hospitalization in the hospital in an even worse condition than when he was admitted); further losses in the quality of life of discharged patients to the home environment. The assumption is that rehabilitation ambulances or general practitioners could fulfill the coordination role. However, there is no code for health insurance companies that would ensure the reporting of this activity and its de facto implementation. There is no relevant economic analysis (or comparison of treatment costs without monitoring and with monitoring); the reason is the missing data (due to the lack of monitoring), which can only be obtained thanks to research plans or projects (partial, marginal in the sense of small research files and the variety of clinical pictures of patients after stroke) marginally.

Another barrier, which is a practical problem, is the lack of cooperation between the Ministry of Labor and Social Affairs and the Ministry of Health, which must cooperate closely in this area – within the framework of the coordination of social and health services (including setting codes for insurance companies).

According to Vacková [12], coordinated rehabilitation is part of neurorehabilitation and essentially represents a process leading to the rehabilitation of people with neurological consequences that limit their functional abilities. As the author states, the term "coordination" only clarifies its procedural nature and the importance of another profession, which is supposed to organize/coordinate interventions for clients with disabilities and help implement the so-called rehabilitation plan.

The coordination of rehabilitation is based on the UN Convention on the Rights of Persons with Disabilities [11] and imposes on the states that have ratified this Convention the obligation to organize, expand and strengthen the coordination of health care, employment, education, and social services. According to Švestková [12], the basic characteristics/principles of coordinated rehabilitation include timeliness, complexity, continuity, coordination, and cooperation.

As stated by Pfeiffer and Švestková [10], the COR system includes components of medical, pedagogical, work, and social rehabilitation.

Medical rehabilitation deals with restoring the patient's health. It can be provided both

in the form of institutional and outpatient care. As described by Kolář [4], the individual fields of medical rehabilitation include physiotherapy, occupational therapy, rehabilitation engineering, physiatry (physical therapy, balneology, balneotherapy), and myoskeletal medicine.

In pedagogic rehabilitation, the emphasis is placed mainly on striving for the optimal development of persons with disabilities and their maximum integration into society. As Jankovský writes [3] - the main role of pedagogical rehabilitation is education and optimal development of the personality of an individual with a disability, which will further facilitate integration and subsequent active participation in a productive life.

The main goal of occupational rehabilitation is to restore a person's work potential, either for his original job or through retraining to find another suitable job in the labor market.

So far, the main goal of social rehabilitation is to integrate people with disabilities into society to the maximum extent possible. Social rehabilitation smoothly follows medical rehabilitation and is related to other components of coordinated rehabilitation. According to Act No. 108 / 2006 Coll., on social services, social rehabilitation is defined as: "a set of specific activities aimed at achieving the independence, independence and self-sufficiency of persons, namely by developing their specific abilities and skills, strengthening habits and practicing the performance of routine, for the independent life of necessary activities in an alternative way using preserved abilities, potentials, and competences. Social rehabilitation is provided in the form of field and outpatient services, or in the form of residential services provided in centers of social rehabilitation services" [1].

On a theoretical level, it is evident that the role of the coordinator is not conceptually clarified, or rather which profession will be responsible for its implementation. At the same time, there is a lack of financial reimbursement for coordination, which cannot yet be reported as a service or as a code for a health insurance company. The link between the type of disability and the type of profession that will carry out the coordination is also still insufficiently researched and lacking. The legislative deficiency (2 unsuccessful attempts to adopt the law on coordinated rehabilitation) represents a very difficult barrier to overcome in the implementation of coordinated rehabilitation in practice.

Kovářová [6] summarizes that the rehabilitation of patients enables an early return to the home environment, achieving the maximum possibility of self-sufficiency and, if possible, return to work in productive age. According to the author, it is very important for patients to increase their awareness of available services, the possibility of ensuring the safety of the home environment, and the availability of necessary services. The authors summarize the "Set of recommendations for patients and their families," the aim of which is to provide patients and their families with a clear set of information that is important for increasing the self-sufficiency of patients in the home environment.

Today, about the state of the solved problem:

1. We do not have legislatively defined cooperation in the framework of COR hospital-patient-expert.

2. We do not monitor the patient in the home environment by an interprofessional team.

3. The role of the coordinator in relation to the typology of disability is not clarified.

4. There is a lack of clear criteria for COR financing – determination of activities and codes for insurance companies.

These are very closely linked areas – in fact. It is a bit of a vicious circle. The concept of coordinated rehabilitation is well developed in theory. We also have foreign examples of

good practice, but due to the very difficult implementation of COR in Czech practice, there is a lack of comprehensive data that would retrospectively help to create clear criteria for funding and legislative anchoring – and this brings us back to a theoretical problem (including defining the role and profession of the COR coordinator). Rehabilitation of patients after stroke is not coordinated by an accompanying worker according to a long-term rehabilitation plan, i.e., without coordinating the services needed for a gradual return to normal life.

COR represents the cooperation of individual ministries, respectively, the Ministry of Labor and Social Affairs and the Ministry of Health. However, these ministries do not cooperate enough – the reasons may be different (it would be presumptuous to mention them, and de facto, it would be a subjective explanation). Thanks to this, there is no political will to approve the law on coordinated rehabilitation (experts have already tried twice - see the efforts of prof. Pfeiff and prof. Švestková).

The legislative emergency (absence of law) has an effect on financing – i.e., COR is not financed in practice – those who implement it do so because they are able to appreciate its effect (e.g., Arpida in České Budějovice). However, it is unique and voluntary.

Data collection and research investigations that could yield relevant data are very financially demanding due to the longitudinal examination of patients after discharge from the hospital and also due to the diversity of the clinical conditions of people after stroke.

All this will help the patient because we will reduce the degree of dependence and enable a quick return to normal life. The professional public will facilitate the monitoring and recommendation of patient care. They will have legislative support and a universal long-term RHB plan that will be the same for all medical facilities. It will reduce the financial costs of long-term care.

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