

Dimensions for an International Classification System for Service Organization in Health-related Rehabilitation (*ICSO-R*)

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Overview

- Background
- Conceptual description of rehabilitation services
- The development of the ICSO-R
- The ICSO-R dimensions
- Results of *(preliminary)* ICSO-R testing
- Proposals for a new version (*ICSO-R 2.0*)
- Outlook: rehabilitation service assessment (*tools and application*)

Background

Global Disability Action Plan (2014-2021)

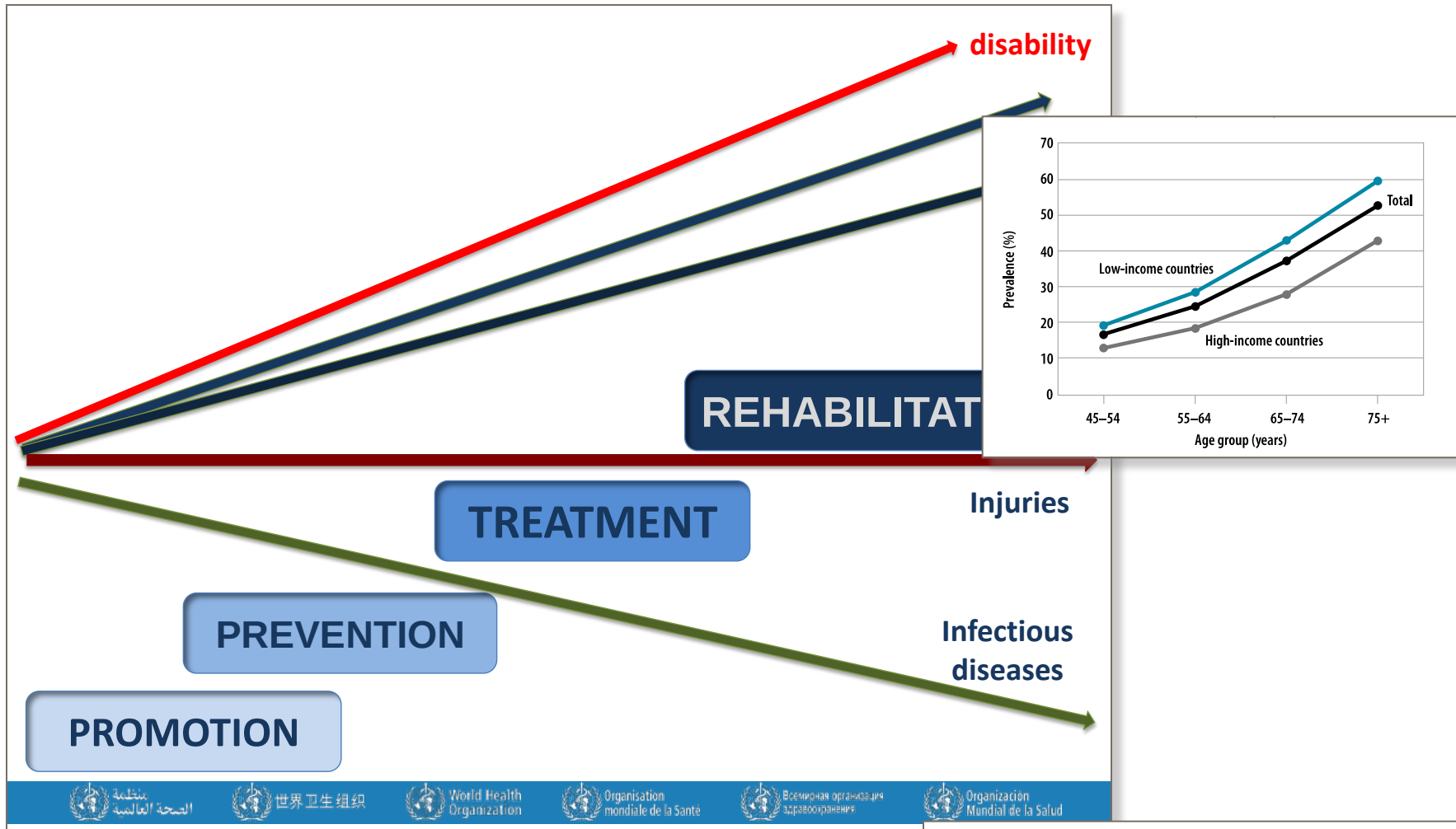


- Objectives:

- (1) to remove barriers and improve access to health services and programmes
- (2) to **strengthen and extend rehabilitation, habilitation, assistive technology, assistance and support services**, and community-based rehabilitation
- (3) to strengthen **collection of relevant and internationally comparable data** on disability and **support research on disability and related services**

www.who.int/disabilities/actionplan/en/

Public Health Challenges *(Alarcos Cieza)*



<http://www.who.int/disabilities/care/rehab-2030/en/>

Health accounts vs. strategies

No	Dimensions of ICHA-HC (OECD)	Health Care Strategies (Stucki et al.)
1	HC.1: Services of curative care	Curative care (<i>curative strategy</i>)
2	HC.2: Services of rehabilitative care	Rehabilitative care (<i>rehabilitative strategy</i>)
3	HC.3: Services of long-term nursing care	Maintenance care (<i>supportive strategy</i>)
4	HC.4: Ancillary services to health care	
5	HC.5: Medical goods dispensed to out-patients	
6	HC.6: Prevention and public health services	Prevention (<i>preventive strategy</i>)
7	HC.7: Health administration and health insurance	

Rehabilitation: the health strategy of the 21st century

J Rehabil Med 2017; 49: xx-xx

SPECIAL REPORT

REHABILITATION: THE HEALTH STRATEGY OF THE 21ST CENTURY

Gerold STUCKI, MD, MS^{1-3*}, Jerome BICKENBACH, LLB, PhD^{1-3*}, Christoph GUTENBRUNNER, MD⁴ and John MELVIN, MD^{2,5}

*From the ¹Department of Health Sciences and Health Policy, Faculty of Humanities and Social Sciences, University of Lucerne, Lucerne, ²Swiss Paraplegic Research (SPF), Nottwil, ³ICF Research Branch, a cooperation partner within the World Health Organization Collaborating Centre for the Family of International Classifications in Germany (at DIMDI), Nottwil, Switzerland, ⁴Department of Rehabilitation Medicine, Hanover Medical School, Hanover, Germany, ⁵Sidney Kimmel Medical College, Thomas Jefferson University, Philadelphia, PA, USA. *Both of these authors contributed equally to this paper.*

There is strong evidence that population ageing and the epidemiological transition to a higher incidence of chronic, non-communicable diseases will continue to profoundly impact societies worldwide, putting more pressure on healthcare systems to respond to the needs of the people they serve. These trends argue for the need to address what matters to people about their health: limitations in their functioning that affect their day-to-day actions and goals in life. From its inception, rehabilitation, 1 of the 4 health strategies identified in the Declaration of Alma Ata in 1978, has had functioning as its outcome of interest. Its practitioners are from fields that include physical

The objectives of this paper are to assemble the best demographic and epidemiological evidence about future trends, in order to build on the current conceptualization of the health strategy of rehabilitation, compared with other health strategies, and, utilizing the powerful notion of functioning as a health indicator, set out the best case for the proposition that rehabilitation is the key health strategy for the 21st century.

WORLDWIDE POPULATION AGEING

Both the absolute number and proportion of the po-

Rehabilitation 2030: a call for action

- Background:

- Rehabilitation (*in WHO*) mainly has been described from the perspective of disability (*politically leading to a minority perspective*)
- Rehabilitation must be seen from a majority perspective (*universal health coverage*)

- Meeting:

- Held in Geneva, February 2017
- Participation: WHO departments, governments, NGO's
- Working groups: e.g. Professional organizations, professional working in academic institutions

Rehabilitation 2030: a call for action

Rehabilitation: key for health in the 21st century

Key messages

- Rehabilitation is essential, along with prevention, promotion, treatment and support, in addressing the full scope of health needs of a population and achieving Sustainable Development Goal 3: Ensure healthy lives and promote well-being for all at all ages.
- Rehabilitation plays an important role among older populations, reducing the risk of falls and hospital admissions, and keeping people independent for longer.
- More people than ever are living with noncommunicable diseases and other chronic conditions. Health systems need to be equipped to provide services that optimize functioning in light of impairments, injuries or health conditions, acute or chronic.
- The benefits of rehabilitation are realized beyond the health sector. Rehabilitation can reduce care costs and enable participation in education and gainful employment.
- Rehabilitation must be integrated into national health plans and budgets. Current epidemiological trends, demographic shifts and expanded access to health care make scaling up rehabilitation services imperative for health systems in the 21st century.
- Coordinated and concerted action is needed to scale up rehabilitation services and address the profound unmet needs that exist.



<http://www.who.int/disabilities/care/rehab-2030/en/>

Rehabilitation 2030: a call for action



- 1 Creating strong leadership and political support for rehabilitation at sub-national, national and global levels.
- 2 Strengthening rehabilitation planning and implementation at national and sub-national levels.
- 3 Improving integration of rehabilitation into the health sector to effectively and efficiently meet population needs.
- 4 Incorporating rehabilitation in Universal Health Coverage.
- 5 Building comprehensive rehabilitation service delivery models to progressively achieve equitable access to quality services, including assistive products, for all the population.
- 6 Developing a strong multidisciplinary rehabilitation workforce that is suitable for country context, and promoting rehabilitation concepts across all health workforce education.
- 7 Expanding financing for rehabilitation through appropriate mechanisms.
- 8 Collecting information relevant to rehabilitation to enhance health information systems including system level rehabilitation data and information on functioning utilizing the International Classification of Functioning, Disability and Health (ICF).
- 9 Building research capacity and expanding the availability of robust evidence for rehabilitation.
- 10 Establishing and strengthening networks and partnerships in rehabilitation, particularly between low-, middle- and high-income countries.

Strengthening Rehabilitation in Health Systems

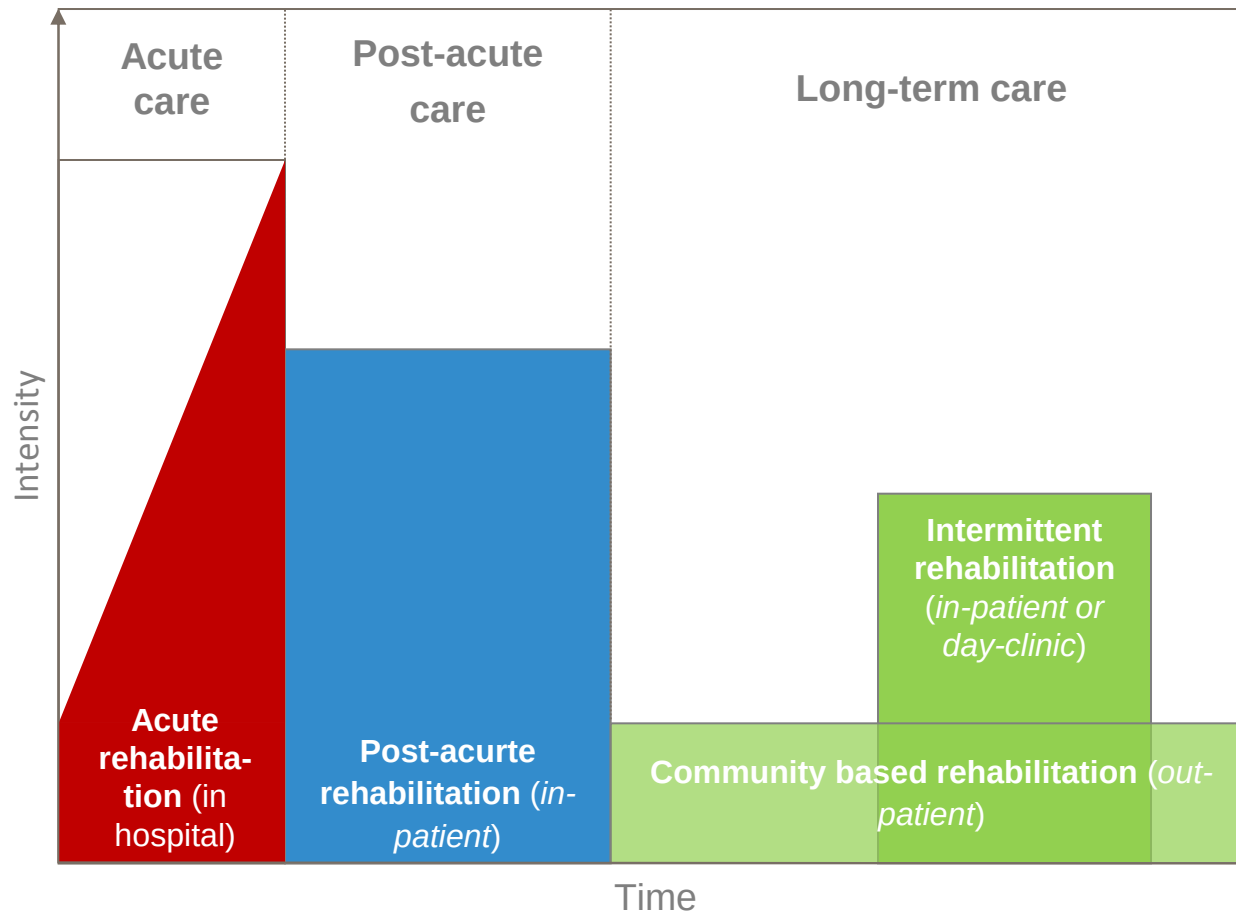


http://www.who.int/disabilities/rehabilitation_health_systems/en/

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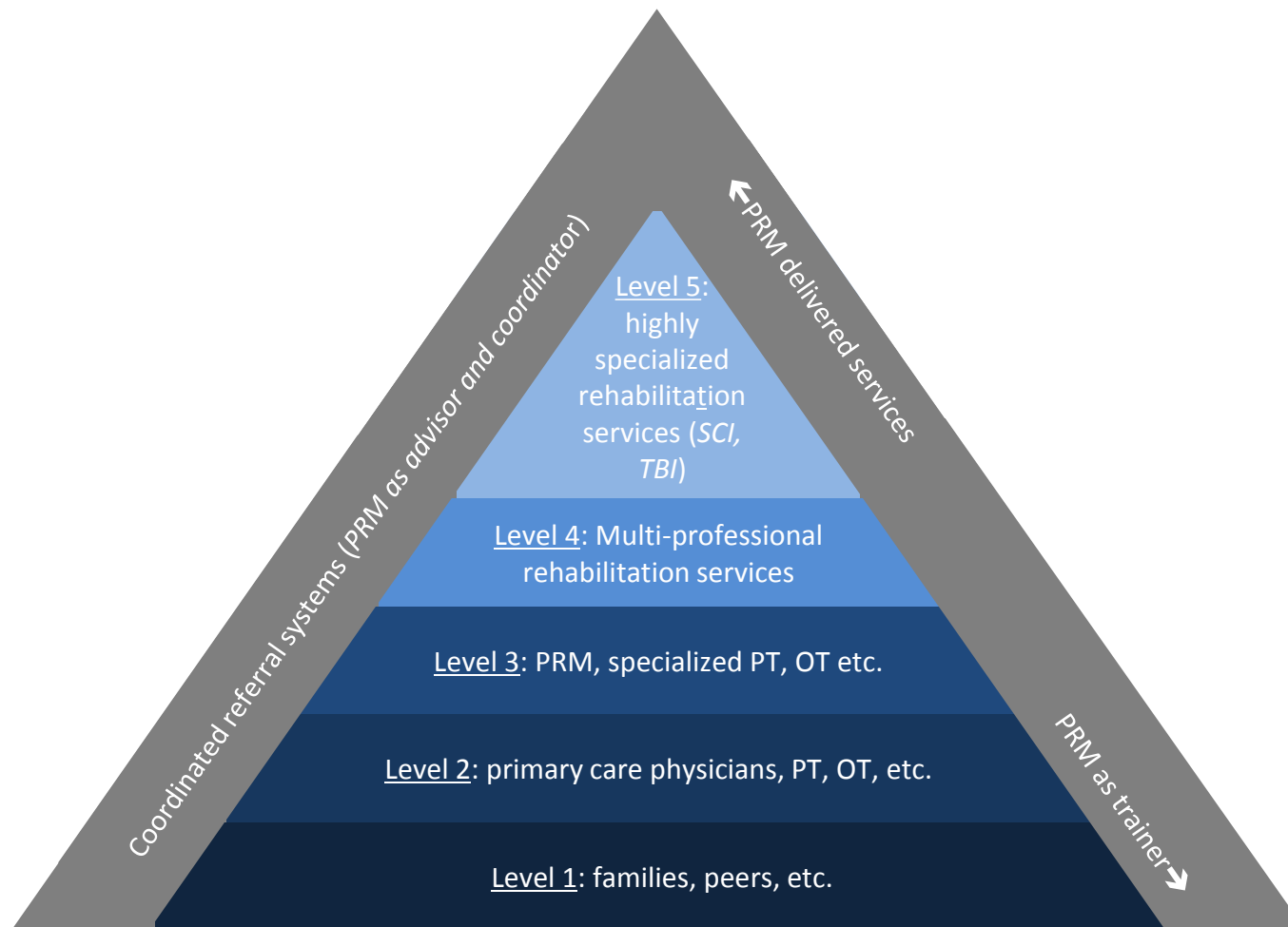
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Integrative phase model of rehab care



Gutenbrunner C, Meyer T, Stucki G: Am J Phys Med Rehabil 2011; 90: 521-525

Levels of specialization



Conclusion (1)

- The need of rehabilitation is growing
- Rehabilitation services must be part of universal health coverage
- Rehabilitation services should be implemented at all levels of health care and in all phases of care provision
- Rehabilitation can be seen as the health strategy of the 21st century
- Systematic approaches for rehabilitation service provision analysis and implementation have to be developed

Conceptual description of rehabilitation services

Conceptual description: Rehab strategy

Rehabilitation is the health strategy which

based on **WHO's integrative model of functioning, disability and health**
applies and integrates

- ⇒ approaches to **assess functioning** in light of **health conditions**
- ⇒ approaches to **optimize a person's capacity**
- ⇒ approaches that build on and **strengthen the resources of the person**
- ⇒ approaches that provide **a facilitative environment**
- ⇒ approaches that develop **a person's performance**
- ⇒ approaches that enhance a person's quality of life in light of health conditions

in partnership between person and provider and in appreciation of the person's perception of his or her position in life

over the course of a **health condition**;

for all age-groups;

along and across the continuum of care,

- ⇒ including hospitals, rehabilitation facilities and the community;

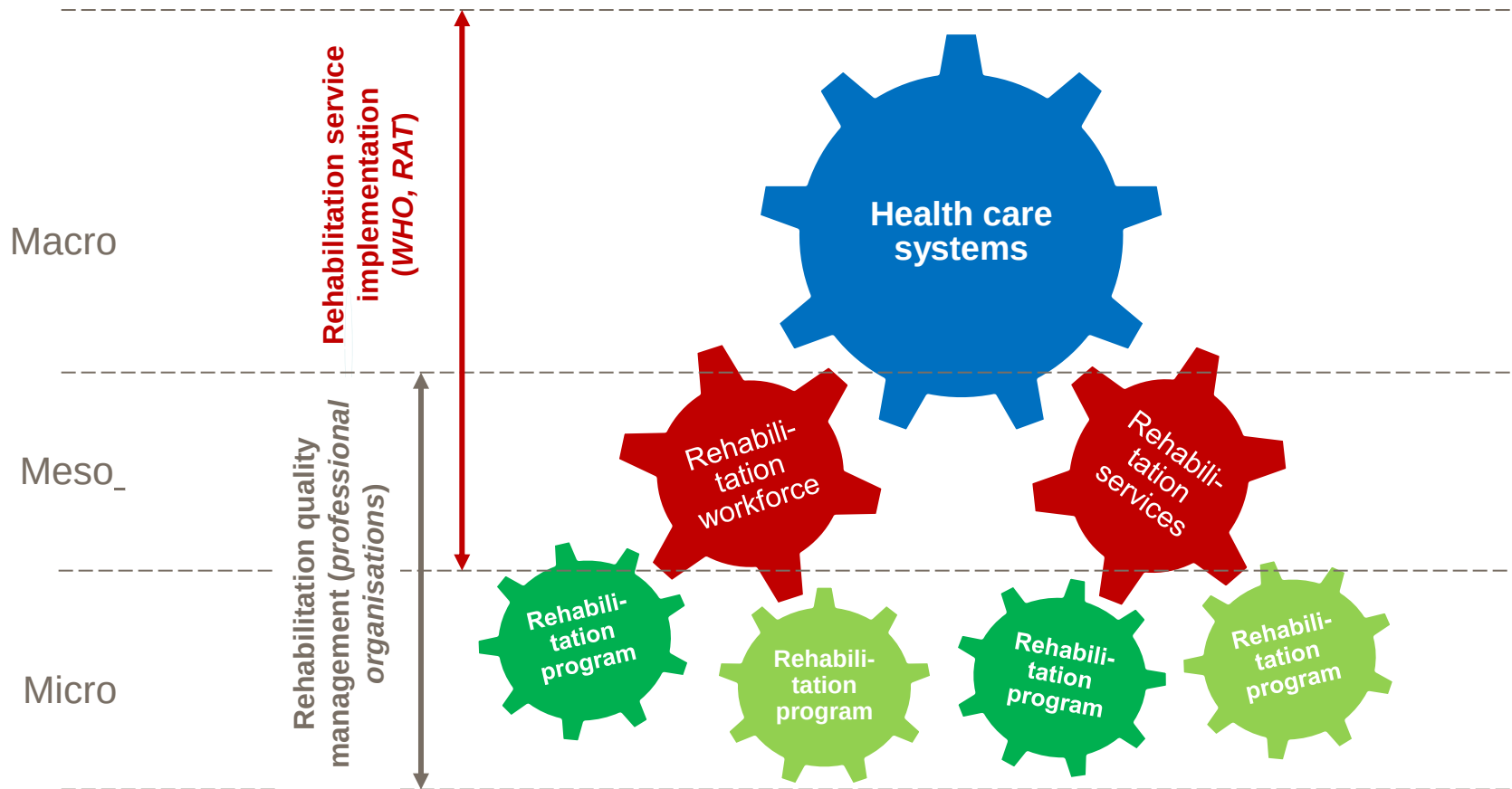
and across sectors

- ⇒ including health, education, labor and social affairs

with the goal

- ⇒ to enable persons with **health conditions** experiencing or likely to experience **disability** to achieve and maintain optimal **functioning** in interaction with the **environment**

Health system levels



Conceptual description: Rehab service

Rehabilitation services,

are **personal and non-personal intangible products**

offered to persons with a health condition experiencing

or likely to experience disability or to their informal

care-givers **within an organisational setting**

in interaction between provider and person

addressing individual functioning needs

that **aim at enabling persons to achieve and maintain**

optimal functioning

considering the integration of other services addressing the

individual's needs

including health, social, labour and educational services and **delivered**

by rehabilitation professionals, other health

professionals, or appropriately trained community-

based workers

Conclusion (2)

- Rehabilitation can be described conceptually based on the ICF as a health strategy aiming at optimizing functioning
- Rehabilitation services must be described at the meso-level of health systems (*with interfaces with micro- and macro-levels*)
- A conceptual description of rehabilitation services is also available
- There are (*up to now*) no tool or parameters to systematically describe rehabilitation services

The development of the ICSO-R

ICSO-R: International
Classification of Service
Organization in Rehabilitation

Dimensions for Service Organization in Rehabilitation (ICSO-R)
Christoph Gutenbrunner
CHARM Workshop on Classification Systems for (Re-) Habilitation Services
Oslo, Norway, April 25, 2017



Hannover Medical School

The problem

- There is a need to develop and strengthen rehabilitation services (*and programs*)
- Besides the analysis of the need for rehabilitation (*in individuals and populations*) it is crucial to analyse existing services
- To plan the establishment of rehabilitation services it is necessary to identify gaps between existing services and the needs
- A set of internationally accepted parameters for such analysis are indispensable (*but not existing up to date*)

The ICSO-R Approach (*ISPRM-WHO-LC*)

- Develop a conceptual description of rehabilitation services (*based on the conceptual description of rehabilitation as a health strategy*)
- Analyse existing classifications and frameworks
- Develop a framework
- Develop (*and propose*) dimensions
- Describe use cases and check applicability and feasibility

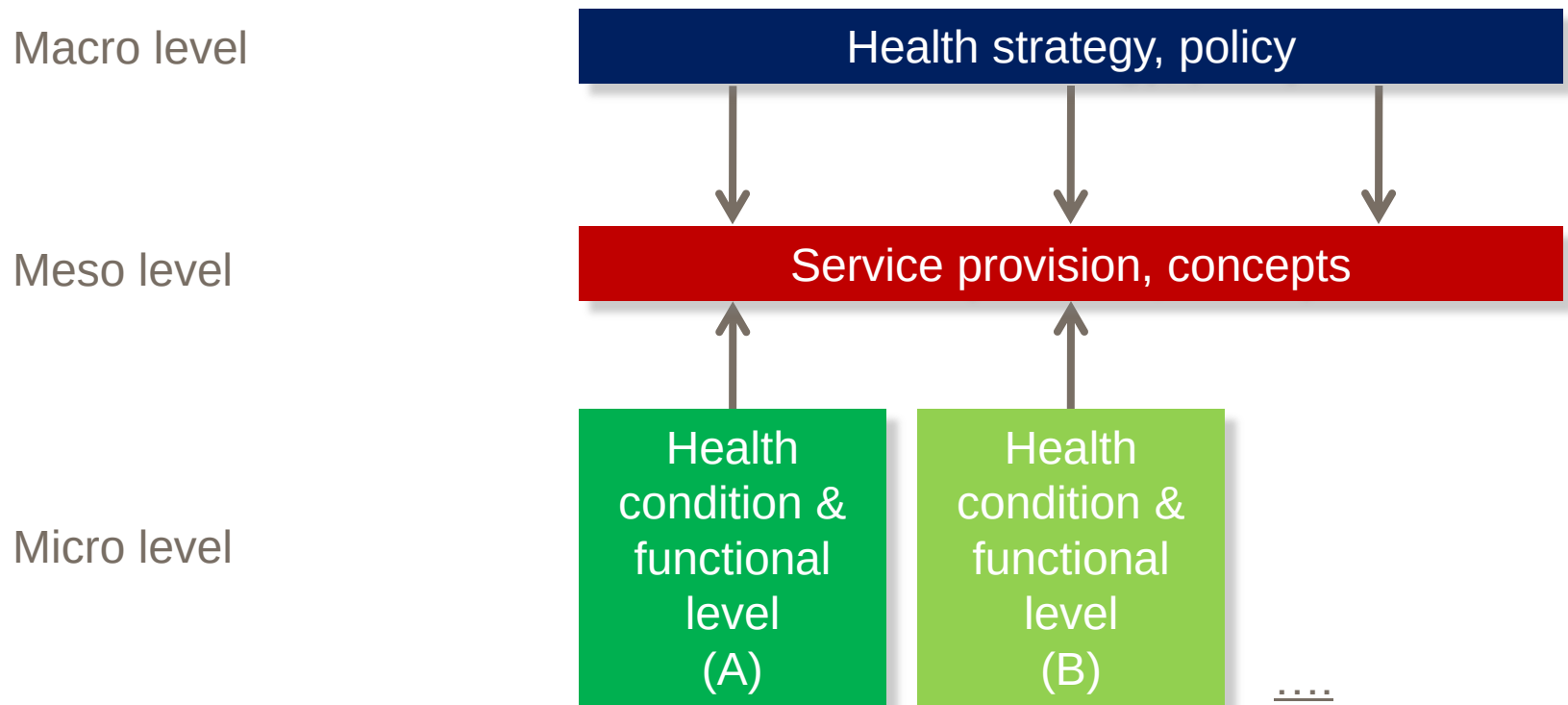
ICSO-R: goals and development

- The aim (...) is to develop a list of dimensions and categories to describe the organisation of health-related rehabilitation services
- The classification starts from the (...) conceptual description of a rehabilitation service (*Meyer et al. 2013*)
- The classification is based on expert workshops including members from the “Strengthening Medical Rehabilitation Subcommittee” within the WHO-Liaison-Committee of the ISPRM

ICSO-R: cornerstones

- In order to make the classification **feasible for use** it should be as short as possible
- The dimensions and categories should be clearly **defined and easy to understand**
- The categories should be **distinctive**, however, some dimensions might be associated with others (*e.g. long-term services will be more often associated with maintenance as main health strategy and multi-professional team structure will be more often associated with higher intensity of care interventions*). However, the selection of dimensions and categories aimed to avoid overlaps
- Conceptually, a **three-level classification** was aimed at. It should include dimensions, categories, and value sets

Levels to describe rehabilitation



ICSO-R: discussion paper

J Rehabil Med 2015; 47: 809–815

SPECIAL REPORT

ISPRM DISCUSSION PAPER: PROPOSING DIMENSIONS FOR AN INTERNATIONAL CLASSIFICATION SYSTEM FOR SERVICE ORGANIZATION IN HEALTH-RELATED REHABILITATION

Christoph Gutenbrunner, MD, PhD¹, Jerome Bickenbach, LLB, PhD^{2,3}, Charlotte Kiekens, MD⁴, Thorsten Meyer, PhD⁵, Dimitrios Skempes, PT, MPH^{2,3}, Boya Nugraha, MS, PhD¹, Matthias Bethge, MS, PhD⁶ and Gerold Stucki, MD, PhD^{2,3}

From the ¹Department of Rehabilitation Medicine, Hannover Medical School, Hannover, Germany, ²Swiss Paraplegic Research, Nottwil, ³Department of Health Sciences and Health Policy, University of Lucerne, Lucerne, Switzerland, ⁴Physical and Rehabilitation Medicine, University Hospitals Leuven, Leuven, Belgium, ⁵Integrative Rehabilitation Research Unit, Institute for Epidemiology, Social Medicine and Health Systems Research, Hannover Medical School and ⁶Institute of Social Medicine and Epidemiology, University of Lübeck, Lübeck, Germany

Objective: Rehabilitation is one of 4 main health strategies. The World Report on Disability identifies deficits in rehabilitation care for people with disabilities as an important barrier to full inclusion in society or to achieve optimal functioning. In order to overcome such deficits, to close gaps in national and/or regional rehabilitation systems, and to develop appropriate rehabilitation services, it is crucial to define uniform criteria and a widely accepted language to describe and classify rehabilitation services. The aim of this paper was therefore to develop a list of dimensions and categories to describe the organization of health-related rehabilitation services.

Methods: The classification is based on a series of expert workshops including members of the International and Eu-

to achieve optimal functioning (4). Thus, it is one of the most important tools for overcoming disability in persons with health conditions, such as congenital deformities, chronic diseases or trauma (5). In this context, disability may be defined as the result of an interaction between the person with a health condition and his or her environment (5, 6). Thus rehabilitation must aim both at empowering persons experiencing disability to enhance their level of activity and participation, and at removing barriers from the environment (4). Physical and Rehabilitation Medicine integrates medical interventions to improve body functions and activities and actions to overcome environmental barriers, e.g. providing assistive technology or advising employers to create a supportive work environment (7).

The ICSO-R dimensions

ICSO-R dimensions

- Service provider:
 - The main questions behind are **where** and **in which context** the service is delivered
- Funding of the service:
 - The question behind is **what are the principles** of financial resources
- Service delivery:
 - It focuses on the question **how** the services are delivered to the user

ICSO-R categories

1. Provider

- 1.1. Location
- 1.2. Organisation
- 1.3. Context
- 1.4. Facility
- 1.5. Human resources
- 1.6. Technical resources and equipment
- 1.7. Quality assurance
- 1.8. Profit-orientation
- 1.9. Other categories of provider

2. Funding

- 2.1. Source of money
- 2.2. Criteria of cost refund
- 2.3. Other criteria of funding

3. Service delivery

- 3.1. Strategy
- 3.2. Target groups
- 3.3. Service goals
- 3.4. Aspects of time
- 3.5. Intensity
- 3.6. Team structure
- 3.7. Mode of production
- 3.8. other categories of service delivery

ICSO-R: value sets (*provider*)

1. *Provider*

- 1.1 Location (centralized vs. decentralized service, situated in rural area vs. urban area, accessibility (transport systems and others) and other dimensions of location).
- 1.2 Organization (independent organization, affiliation, or other dimensions of organization).
- 1.3 Context (single practise, community-based service, institutional care, such as nursing home or hospital-based service, home-based or other dimensions of context).
- 1.4 Facility (building, hotel service and other aspects of facility).
- 1.5 Human resources (health professionals, administrative staff, technical staff, and other personnel).
- 1.6 Technical resources and equipment (diagnostic devices, therapeutic devices and treatment modalities, data procession and communication, and other technical resources).
- 1.7 Quality assurance (total quality assurance system, single quality assurance measures and other methods of quality assurance).
- 1.8 Profit-orientation (profit-oriented, non-profit organization as charity organization and others, and other aspects of profit-orientation).
- 1.9 Other categories of provider.

Value sets have not been developed yet, however, descriptions, inclusions and exclusions are under development

ICSO-R: value sets (*service delivery*)

3. *Service delivery*

- 3.1 Strategy (prevention (preventive strategy), therapy (curative strategy), rehabilitation (rehabilitation strategy), maintenance (supportive strategy), or other health strategies).
- 3.2 Target groups (e.g. patients with defined health conditions, persons with specific deficits in body functions, activities and participation, case mix index and other target groups).
- 3.3 Service goals (restitutio ad integrum, improvement of health status, improvement of self-care, return to normal life, return-to-work, or other service goals).
- 3.4 Aspects of time (phase of disease (acute phase, post-acute phase, long-term phase), time-frame of intervention (short-term intervention, long-term intervention, intermittent interventions), number and duration of treatment time per day, and other aspects of time).
- 3.5 Intensity (high, medium or low intensity or other dimensions of intensity).
- 3.6 Team structure (involved professions, team organization (e.g. multidisciplinary team, interdisciplinary team), or other dimensions of team structure).
- 3.7 Mode of production (hospitalization, inpatient service, day clinic, outpatient service or other modes of production).
- 3.8 Other categories of service delivery.

Value sets have not been developed yet, however, descriptions, inclusions and exclusions are under development

ICSO-R: examples

No.	<u>Dimension</u> and category	Rehabilitation service A	Rehabilitation service B	Rehabilitation service C	Rehabilitation service D
Type		University department	Inpatient and outpatient rehabilitation service	Inpatient and outpatient rehabilitation service	Community based rehabilitation service
Name, place		Department for Rehabilitation Medicine, Hannover Medical School, Hannover, Germany	Department for Rehabilitation Medicine, Fatmawati, Jakarta, Indonesia	Saint Joseph Children and Adult Home, Mambu, Bafut, NWR, Cameroon	Functional rehabilitation program for achieving independence and autonomy in the community, Medellin, Colombia
1.	<u>Provider</u>				
1.1.	Location	City	City	Village	Poor neighborhoods in a city
1.2.	Organisation	Public	Public/government hospital	Private	Nongovernmental
1.3.	Context	University hospital	General hospital	Rehabilitation centre	City neighbourhoods
1.4.	Facility	Rehabilitation department	Rehabilitation department for out patient and In-patient ward, orthotic and prosthetic workshop and wheel chair workshop	Rehabilitation department with vocational training, orthopaedic workshop, Infirmary, shoe making works, embroidery workshop, cane workshop, bakery and the resource room for the visually impaired	Community centers and homes.
1.5.	Human resources	Multiprofessional Team (Physicians, PT's, OT's, Dysphagia Therapists, Sport Therapist, researchers)	Multiprofesional team (physicians PMR, PT's, OT's, Speech Therapist, P&O, Social Workers, Nurse , psychologists)	Physical therapists, orthopaedic technicians, prosthetic technicians, special education teachers, technical workers.	Interdisciplinary Team (Physiotherapy, Psychology, Social Work, Special Education, sign language interpreter, sign language teacher (hearing impaired))

Conclusion (3)

- ICSO-R is an approach to systematically describe rehabilitation services or at least to provide dimensions to do so
- Its dimensions are
 - service provider
 - financing
 - service delivery
- The ICSO-R is going to be tested and modified based on the testing results

Results of (preliminary) ICSO-R testing (and proposals for a new version)



ORIGINAL ARTICLE

European initiative for the application of the International Classification of Service Organization in Health-related Rehabilitation (ICSO-R)

Charlotte KIEKENS ^{1*}, Thorsten MEYER ², Francesca GIMIGLIANO ³, Cristiana BAFFONE ⁴,
Christoph M. W. GUTENBRUNNER ^{5, 6}, UEMS PRM ICF workshop moderators and rapporteurs

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EUROPEAN JOURNAL OF OCCUPATIONAL REHABILITATION

European Journal of Occupational and Rehabilitation Medicine 2012, 2(2)

ORIGINAL ARTICLE

**European initiative for the application
of the International Classification
of Service Organization
in Health-related Rehabilitation (ICSO-R)**

**Cristiana KIEKENS^a, Thomasa MEYER^b, Francesco GEMELLIANO^c, Cristina BARTONE^d,
Chantal M. P. GUTTENBERG^e, UMS-PM-ICF working partners and co-partners**

^aDepartment of Rehabilitation Sciences, University of Leuven, Leuven, Belgium; ^bDepartment of Rehabilitation Sciences, University of Leuven, Leuven, Belgium; ^cDepartment of Rehabilitation Sciences, University of Leuven, Leuven, Belgium; ^dDepartment of Rehabilitation Sciences, University of Leuven, Leuven, Belgium; ^eDepartment of Rehabilitation Sciences, University of Leuven, Leuven, Belgium

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- Dimensions for Service Organization in Rehabilitation (ICSO-R)
Christoph Gutenbrunner
CHARM Workshop on Classification Systems for (Re-) Habilitation Services
Oslo, Norway, April 25, 2017

Kiekens C, et al.: European initiative for the application of the International Classification of Service Organization in Health-related Rehabilitation (ICSO-R). Eur J Phys Rehabil Med 2016

Narrative descriptions



TABLE II.—*Description of a highly specialized post-acute rehabilitation service for spinal cord injury (Group 4).*

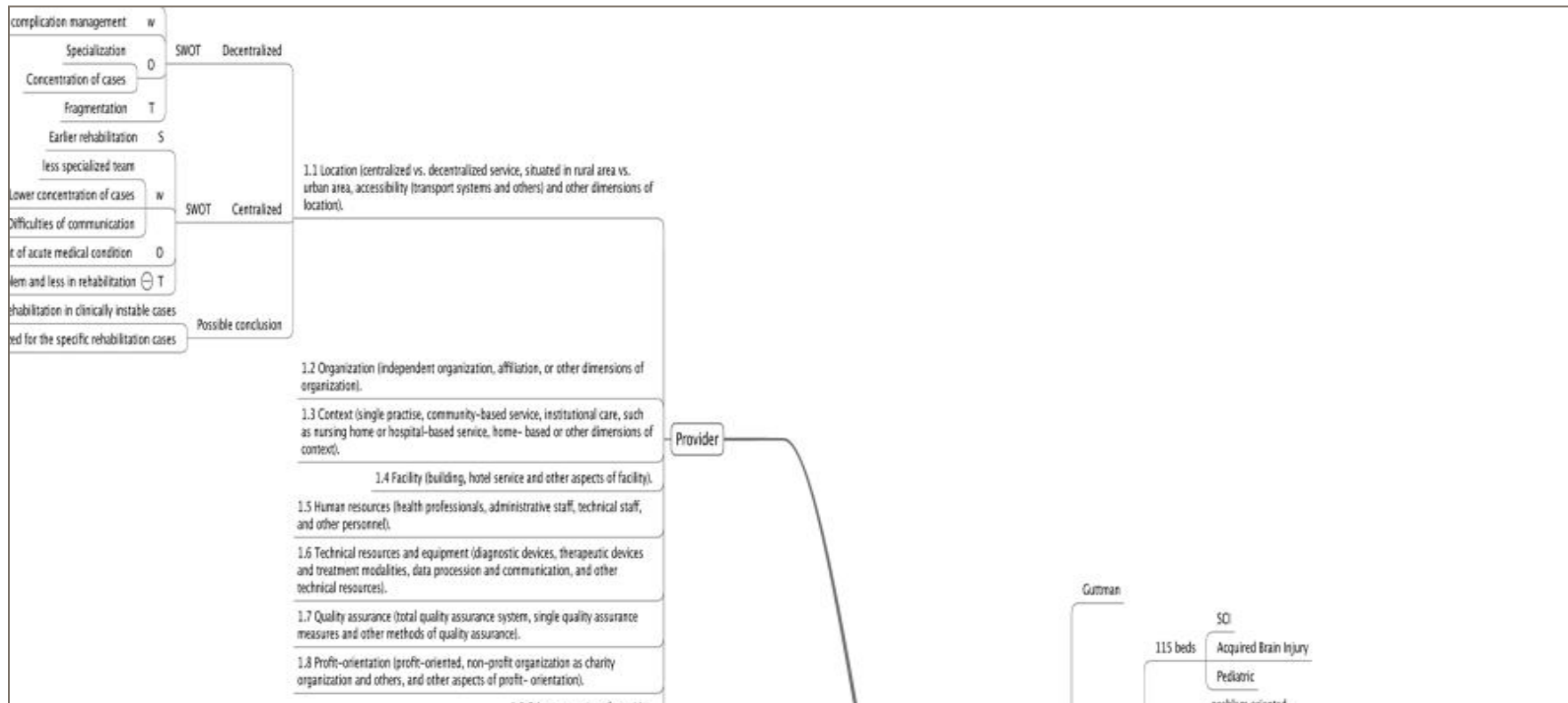
Slide 1: Patients with newly acquired spinal cord injury (SCI) need complex and comprehensive rehabilitation including specific diagnostics after the acute phase:

- to stabilize the health condition and prevent early and long term complications
- to achieve best functioning, participation in society and quality of life according to the expected outcome.

Slide 2: To set this into practice it is necessary to provide a specialized inpatient rehabilitation service including:

- a multidisciplinary rehabilitation team skilled in SCI, integrated in an interdisciplinary setup (e.g. orthopedic surgeon, urologist, radiologist)
- a team highly experienced in SCI specific patient centered goal setting process to choose the right interventions in the early phase only in an inpatient setting and perhaps in an outpatient setting such as day clinics in later phases.
- therefore it necessary to organize these services in highly specialized centers with specific infrastructure and equipment in a national centralized organization with an adequate patient load.

Mind map approach



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ICSO-R table



TABLE III.—*Application of the dimensions and categories of the 2-level classification in six rehabilitation services.*

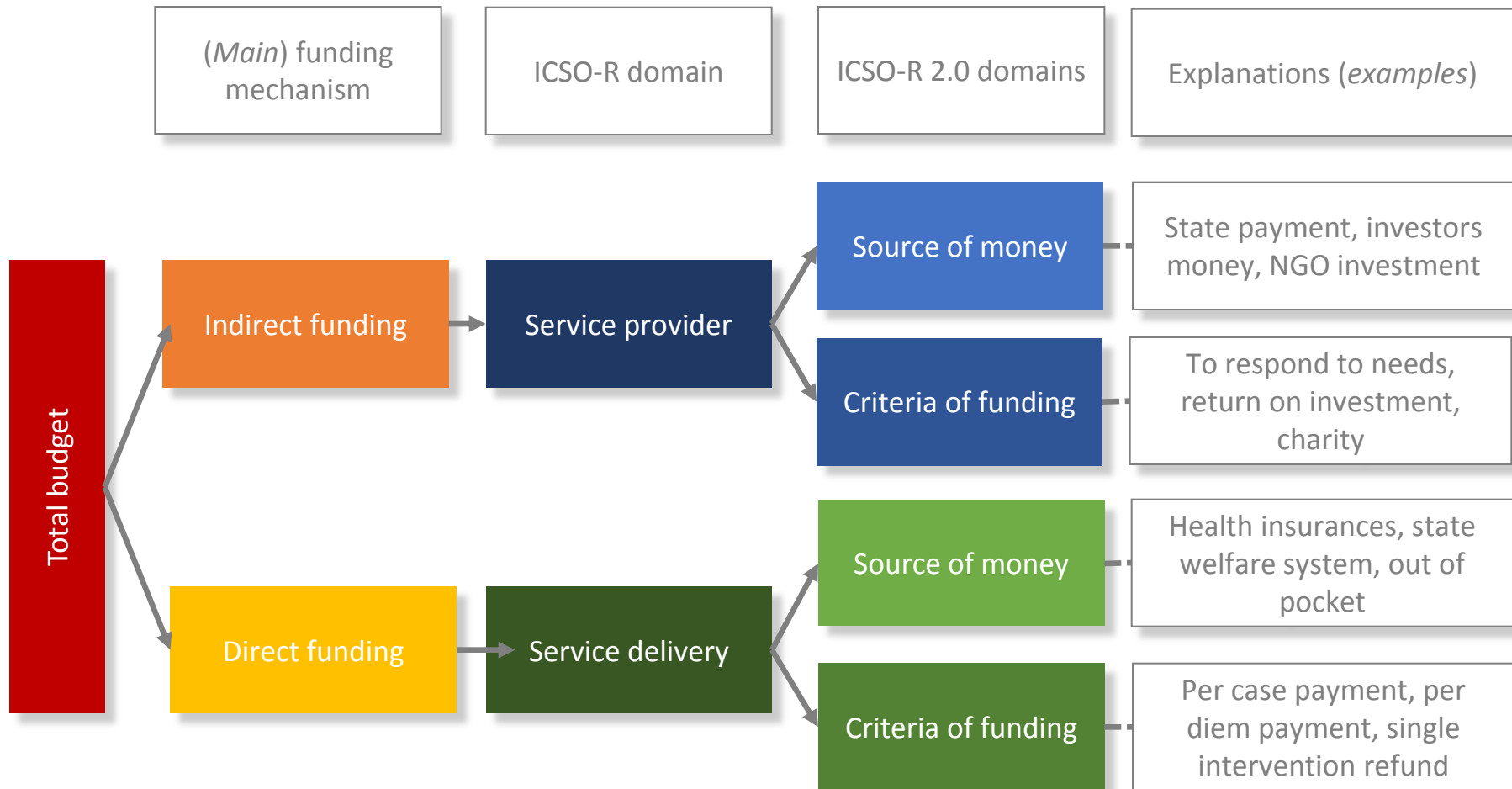
Number	Dimensions and category	Acute I Mobile	Post-acute I Polyvalent	Post-acute II Neurorehabilitation	Post-acute III SCI	Long term I Day Clinic	Long term II Rehab in Community
2	Funding						
2.1.	Source of money	Health insurance and government (ministry of health)	Public, through the social security system	Social security, Insurances and Private	Health insurance, Accident insurance, Pension insurance, Public or private sources	The same principles apply as for inpatient rehabilitation	Depends on the welfare system
2.2.	Criteria of cost refund	DRGs or budget based	Health insurance reimbursed by government and private patients	Case-mix oriented to results (Social Security) and Per day (insurance and private)	Patient classification system and compensation on a daily basis	Refund must be the multi-professional rehabilitation not for single therapies	Based on the health care needs
2.3.	Other categories	Not applicable	Donations	Charity grants	Not specified	Not specified	Not specified

Conclusion (4)

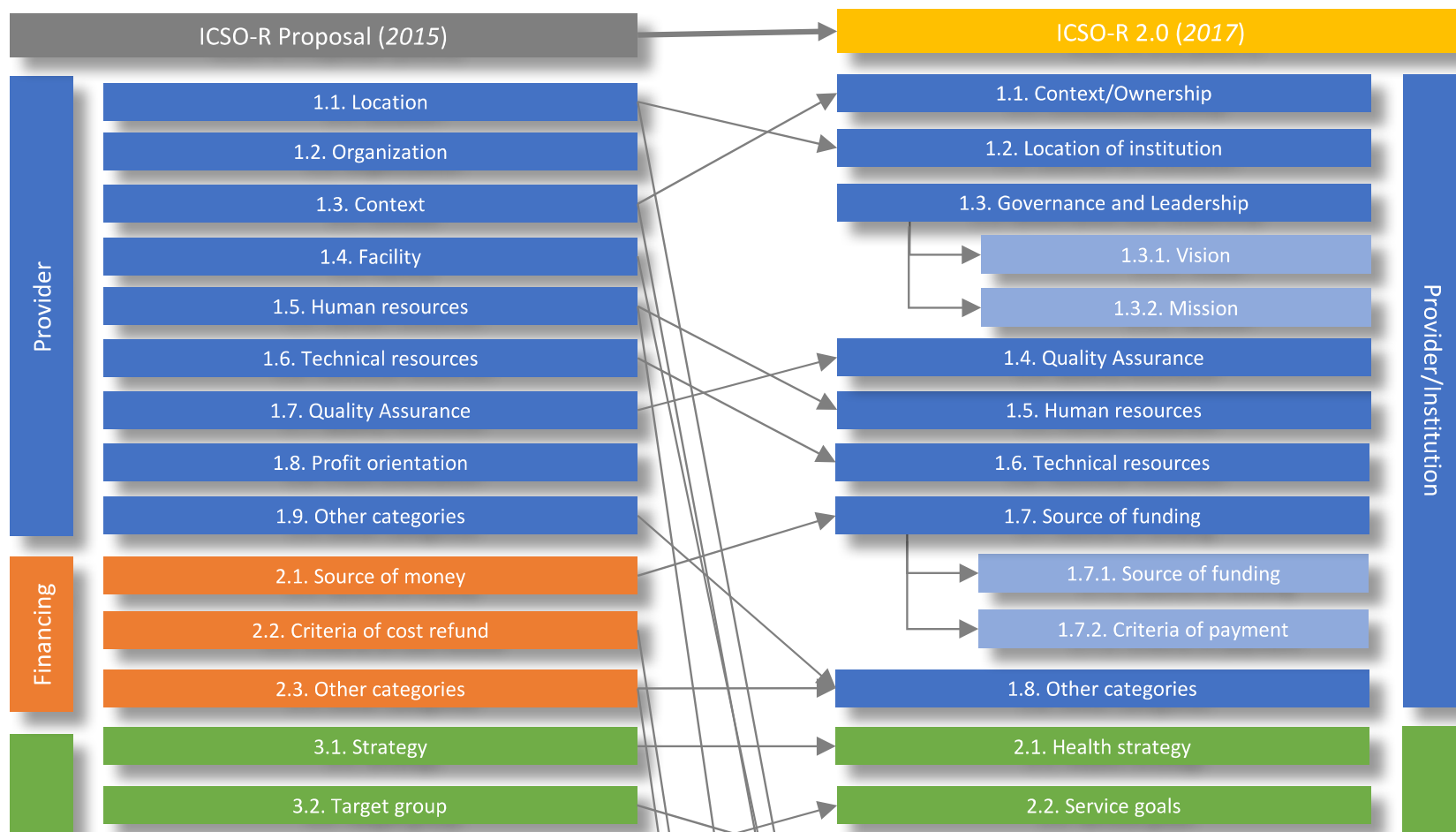
- The ICSO-R is a feasible instrument to describe rehabilitation services
- Its application leads to more comparable descriptions as compared to narrative description
- Some issues for understanding of ICSO-R occurred, e.g.
 - One institution can provide more than one type of service
 - Financing of institution and of service delivery may differ
- The ICSO-R working group took the following
 - Thinking on a new version (*based on testing results*)
 - Thinking about describing prototype services (*incl. matrix*)

Proposals for a new version (ICSO-R 2.0)

Financing



Clarifications & subcategories



Inclusions and exclusions

!	Dimensions! and category!	Descriptions!	Inclusions!	Exclusions!	Explanations!
2.11.!	Aspects of time'	Time schedule of service provision and interventions'	⇄ Length of stay or treatment period ⇄ Intermittent vs. continuous treatments ⇄ Duration of single treatments (minutes) ⇄ Total duration of treatment (per day) ⇄ Service hours (per day, per week)	Any aspects of time related to service organisation such as ⇄ years since founding of the organisation	Ranges and/or averages may be reported
2.12.!	Rehabilitation Team'	Professions and competencies of rehabilitation team members; team structure and method of team communication'	⇄ Health and health related profession: delivering services to the users (patients), such as diagnostics, treatments, and others ⇄ Team organisation (multiprofessional, interprofessional etc.) and team supervision, counseling etc.	Administrative staff, technical and maintenance staff (exception: rehabilitation engineers), cleaning staff"	'

Conclusion (5)

- The ICSO-R working group is coming up with a proposal for a version 2.0
- Main changes will be
 - integrating the financing part into both domains (*“provider/institution” and “service provision”*)
 - adding some missing (*useful*) dimensions (*such as “governance and leadership” and “access to service”*) and some subcategories (*for clarification in case of multi-dimensional categories*)
 - including inclusions and exclusions
- ICSO-R 1.0 and ICSO-R 2.0 will be compatible (*a linking table will be provided*)

Outlook: rehabilitation service assessment *(tools and application)*

ISPRM-WHO-collaboration plan (2014-2017)

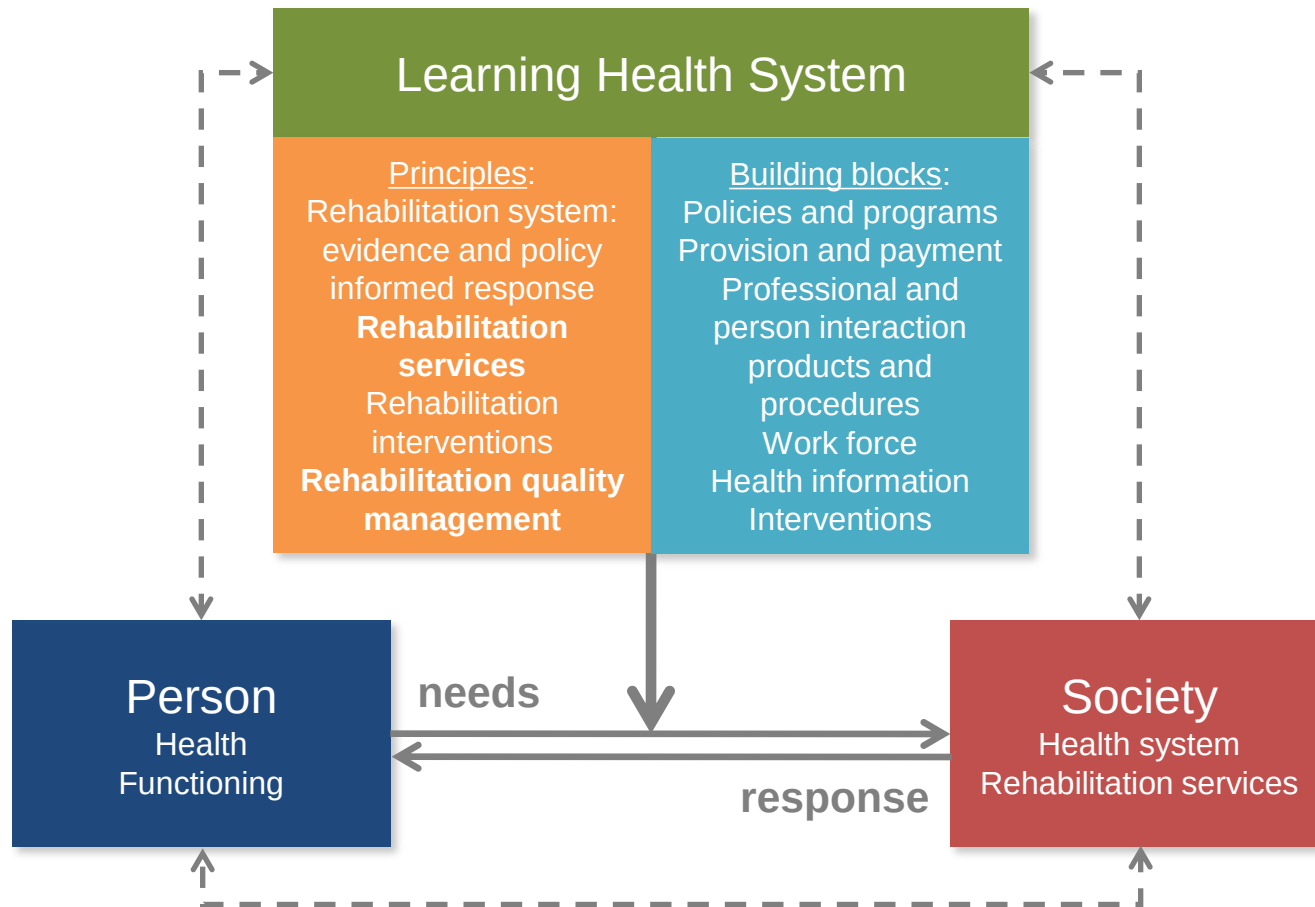
- General Collaboration area: Contribution to WHO meetings and projects and information to ISPRM
- Collaboration project 1: **Learning Health Systems** for Spinal Cord Injury, an initiative incl. international spinal cord injury survey (*in co-leadership with ISCoS*)
- Collaboration project 2: **Fast Response Teams** on strategies and plans of rehabilitation and related services
- Collaboration project 3: **ICF based routine data collection** in national health information systems

Collaboration Project 2



- To **carry out consultations with countries** on request and suggested by the DTO aiming at strengthening rehabilitation services and building capacity of the rehabilitation workforce
 - To **provide matrix and checklists** to analyse existing rehabilitation services as well as to identify gaps in service provision
 - To establish **Rehabilitation Services Advisory Teams** of experts with global and regional health systems understanding that can provide guidance to governments
 - (...) This includes **Rehabilitation Service Advisory Meetings** and **Stakeholder Dialogues**

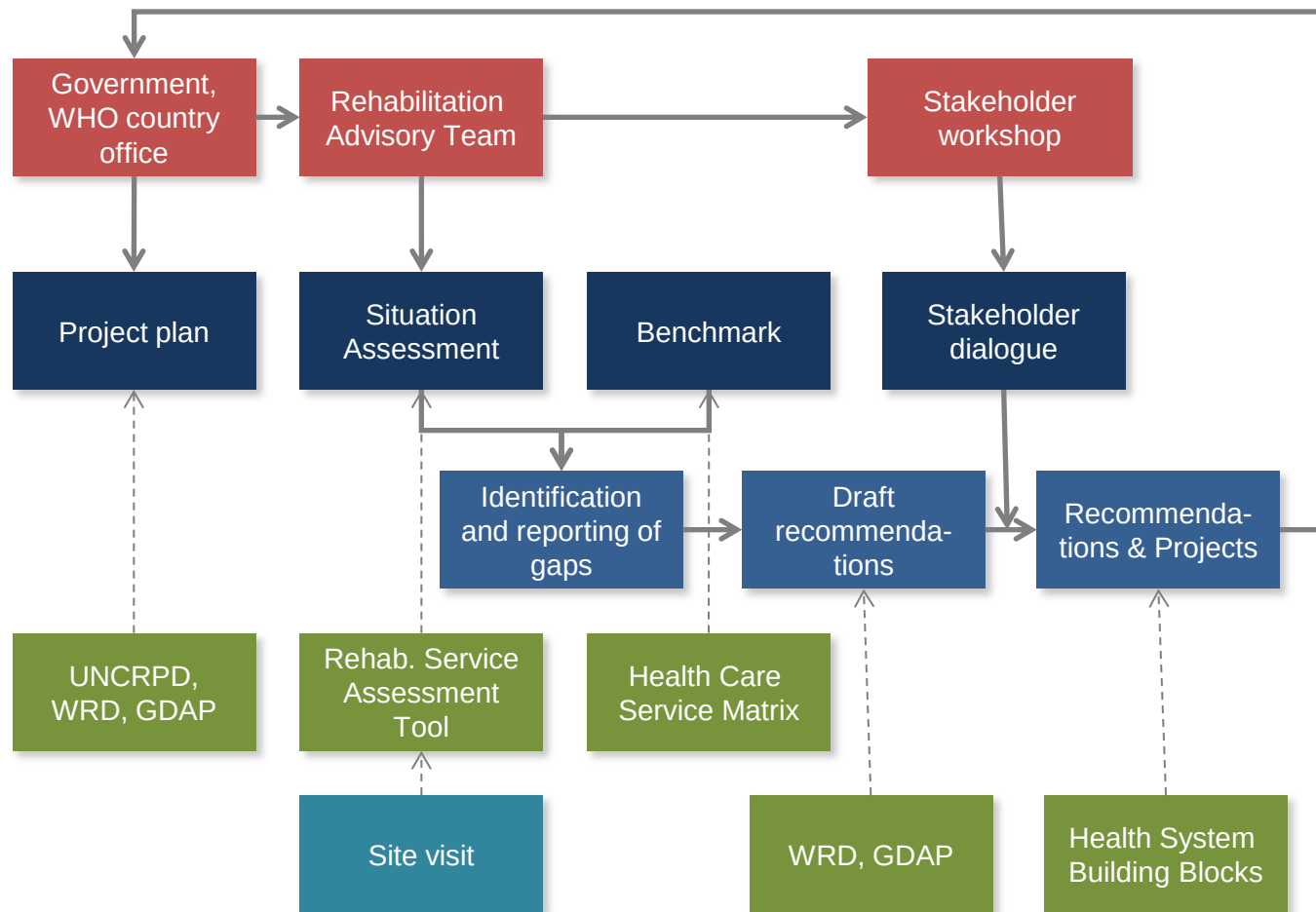
Learning health systems (Stucki et al.)



Rehabilitation Service Implementation

- Guiding principles:
 - Assessment of existing services (*incl. workforce*)
 - Development of recommendations & projects
 - Stakeholder dialogues
- Tools (*some are still under development*):
 - Rehabilitation Service Assessment Tool (*RSAT*)
 - International Classification of Service Organization in Rehabilitation (*ICSO-R*)
 - Rehabilitation Service Implementation Framework (*RSIF*)
 - WHO Health Systems Building Blocks
- Recommendations:
 - According to WRD or GDAP

ISPRM Rehabilitation Advisory Teams



Spectrum and types of services

	A. Acute care	B. Post-acute care	C. Long-term-care
Tertiary level of health care	A.1: Acute rehabilitation wards A.2: Mobile acute rehabilitation teams	<i>B.1: In-patient post acute rehabilitation unit</i>	--
Secondary level of health care	A.2: Mobile acute rehabilitation teams	B.1: In-patient post acute rehabilitation unit B.2: Out-patient post acute rehabilitation unit <i>B.3: Mono-professional post-acute services</i>	C.1: Intermittent in-patient rehabilitation service
Primary level of health care	--	<i>B.2: Out-patient post acute rehabilitation unit</i> B.3: Mono-professional post-acute services	C.2: Primary care rehabilitation centres C.3: Mono-professional long-term services C.4: Community Based Rehabilitation Service

Prototypes: narrative descriptions

Box 1. Short narrative descriptions of the most relevant types of health-related rehabilitation services (11)

- *Acute rehabilitation services delivered in hospitals at the secondary and tertiary levels.* The target group are patients with severe disease or injury who are likely to develop long-term disability. Acute rehabilitation services should start even during intensive care and should be performed in medicine (PRM), nursing, physiotherapy (PT), occupational therapy (OT), and other services may include mobile acute rehabilitation services.
- *Post-acute rehabilitation services delivered immediately or shortly after discharge from acute care hospitals.* The target groups are patients with persisting impairment activity limitations and participation restrictions after acute care or trauma. Post-acute rehabilitation services improve functioning (including participation) and can contribute to earlier discharge from hospital. For more severe cases (with limitations in mobility and activities of daily living) post-acute rehabilitation should be carried out in inpatient post-acute rehabilitation units. Patients with fewer restrictions can be referred to outpatient post-acute rehabilitation units. For patients with minor deficits mono-professional services may be sufficient. Post-acute rehabilitation services should be specialized for the specific disease or trauma and be delivered by a multi-professional rehabilitation team.

Conclusion (6)

- From the perspective of rehabilitation service analysis and implementation a broader approach is necessary
- Tools may be
 - Rehabilitation service assessment tool (*RSAT*)
 - Rehabilitation service implementation framework (*RSIF*)
 - Rehabilitation advisory team missions (*including stakeholder dialogues*)
- ICSO-R should be used in service assessment and implementation projects
- As mentioned before, description of prototype services are needed too (*normative approach*)



Thank you for your attention!

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