The Rehabilitation Medicine Model of Care

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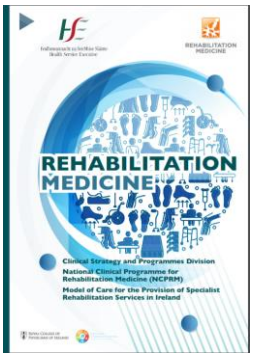

Background

The **Neuro-rehabilitation Strategy** published in 2011 recognised the combined role of rehabilitation medicine and social care (disability) to enable the delivery of the continuum of rehabilitation services. Such services support the timely transition of the person with brain injury from hospital to home, maximise recovery and support re-entry into family and community life.

In this regard, the Health Service Executive established the **National Clinical Programme for Rehabilitation Medicine** (NCPRM) in 2011 and appointed a Consultant in Rehabilitation Medicine as the clinical lead.

The objective of the NCPRM is to describe a framework to ensure that people with complex conditions, such as acquired brain injury (ABI) have access to the rehabilitation they need. (Specialist rehabilitation is the total active care of people with a complex disabling condition by a multi-professional team who have undergone recognised specialist training in rehabilitation). The desired outcomes are improved quality of life, sustainable community independence and improved employability for the person living with ABI and other neurological conditions. The aim is to also reduce length of hospital stay and prevention of unnecessary re-admissions to acute care.

Model of Care

The NCPRM published the **Model of Care for the Provision of Specialist Rehabilitation Services in Ireland** in 2018. The Model of Care recognises the many limitations in services to people across the pathway and therefore it is focused on the development of a framework for the delivery of rehabilitation services. Its successful implementation is predicated on the investment in strategic development, workforce planning and integration of rehabilitation services across the health care continuum. It describes clearly the role of specialist rehabilitation and outlines the brain injury pathways.

The Model of Care refers to three levels of specialist rehabilitation:

1. complex specialist service at national level
2. local/regional specialist rehabilitation and
3. community rehabilitation services.

The Model of Care is based on the following:

- a person-centred approach
- Equitable access to services
- Three levels of service delivery (outlined above)
- the development of appropriately resourced interdisciplinary inpatient, outpatient and community-based specialist rehabilitation teams across Ireland

- Measuring effectiveness and data collection.

The Model of Care sets out in detail the medical in-patient rehabilitation services. This includes a profile of the wide range of clinical inputs and staffing ratios required. It also describes the community neuro-rehabilitation teams and provides a breakdown of the staffing provision required for the teams based on international best practice.

It is worth noting that the Model of Care references two critical components from a brain injury perspective:

1. Case Management
2. Managed Clinical Rehabilitation Network (MCRN)

Case Management

The Model of Care sees the **Case Manager** as a dedicated, distinct role within specialist rehabilitation. Case managers provide a co-ordinated approach to the provision of rehabilitation services. They ensure a seamless transition between the different care settings. They are highly trained experts who support the person with ABI and their family at key stages.

MCRN

A **MCRN** facilitates the re-design, quality improvement, strategy and planning across the rehabilitation pathway. Teams work across department boundaries, units and divisions. The MCRN delivers quality care by enabling clinicians, service managers and people living with the conditions to collaborate and achieve consensus. The network will connect acute and post-acute rehabilitation units, community specialist rehabilitation clinicians and community-based services in a formal way to allow the delivery of co-ordinated rehabilitation services.

The MCRN model is effective in several European countries but a new concept to the Irish healthcare system. In 2018 the HSE set up a MCRN demonstrator project site (in Community Health Organisation Areas 6&7) to assess the feasibility of the project and to apply the learning nationally. The Model of Care recommends 4 MCRNs to be developed in Ireland.

Further information

The full Model of Care document is available to download from:
https://www.hse.ie/eng/about/who/cspd/ncps/rehabilitation-medicine/moc/final-ncprm-moc-web.pdf

The Neuro-rehabilitation Strategy (2011) is available to download at:

https://health.gov.ie/wp-content/uploads/2014/03/NeuroRehab_Services1.pdf

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ABI Ireland is committed to providing accurate and up-to-date information to all our stakeholders on current and emerging policies and legislation that impact on the lives of people with ABI and their families. The briefing papers use a summary, easy to read format.

Comments and feedback on the papers are welcomed. Contact Gráinne McGettrick, Policy and Research Manager
gmcgettrick@abiireland.ie

Acquired Brain Injury Ireland
64 Mulgrave Street, Dun Laoghaire
Co. Dublin TEL: 01 280 4164
abiireland.ie