Case Management

Domain III: The Function of the Rehabilitation Team & Transitions of Care

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Objectives:

1. The learner will describe the function of the rehabilitation team.

1. The learner will state the role of the rehabilitation nurse in transitions of care.

Task 1: Collaborate with the interdisciplinary team to achieve patient-centered goals.

Knowledge of:

a. Goal setting & expected outcomes
b. Models of healthcare teams
    i. Interdisciplinary
    ii. Multidisciplinary
    iii. Transdisciplinary
c. Rehabilitation philosophy & definition
d. Role of the rehabilitation nurse and other team members

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Task 1 (continued).

e. Related theories
   i. Change
   ii. Leadership
   iii. Communication
   iv. Team function
   v. Organizational

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Task 1: (continued)

Skill in:

a. Applying appropriate theories
    i. Change
    ii. Leadership
    iii. Communication
    iv. Team function
    v. Organizational
b. Communication & collaborating with the interdisciplinary team
c. Developing & documenting plans of care to attain patient centered goals
d. Appropriate delegation of responsibilities to team members

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Rehabilitation Team Roles in Care Transitions

- The rehabilitation team functions collaboratively to restore optimal patient function, focusing on the physical, emotional & social aspects of recovery.
- Multidisciplinary team
- Effective transitions of care (TOC) ensure continuity as patients move between different levels of care
- This collaboration enhances communication, optimizes resource utilization & fosters holistic treatment plans

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Goal setting & expected outcomes

- Establish SMART objectives: (individualized to each patient)
  - **S**pecific
  - **M**easurable
  - **A**ttainable
  - **R**elevant
  - **T**ime-bound

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Models of Healthcare Teams

- **Interdisciplinary:** collaborate closely, blending expertise to develop cohesive care plans, enhanced communication
- **Multidisciplinary:** teams function independently within their disciplines, sharing information, but not necessarily integrating treatment plans, communicates through meetings
- **Transdisciplinary:** transcends discipline boundaries, integrate knowledge & skills, focus on pt's overall needs not discipline specific goals; shared roles & responsibilities

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Rehabilitation Philosophy and Definition

- Restoring individuals to their highest possible level of function following illness or injury
- Holistic approach
- Integrating physical, emotional, social & vocational aspects
- Working collaboratively with patients & families to set realistic goals

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Role of the Rehabilitation Nurse & Other Team Members

- Nursing
- PT
- OT
- SLP
- SSW

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Knowledge of Related Theories

- Change: transitioning from one state to another, adapting to new health conditions, modifying behaviors/altering environments
- Leadership: guiding, influencing & inspiring a team, communicate effectively, advocate for pts., foster collaborative environment, mentoring, adaptability
- Communication: verbal, non-verbal, written & electronic, strong listening skills; convey complex medical information, foster trust & pt. engagement
- Team function: Collaborative efforts of team working toward common goal of optimizing pt. Recovery & independence, effective communication & respect
- Organizational: coordination of health care, understand hierarchy, P&P, navigate organizational dynamics, manage resources, compliance & quality

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Mastering Theory Application Skills

Utilizing established rehabilitation models & nursing theories to guide patient care.

- Orem’s Self-Care Deficit Nursing Theory: Nursing focus on clients helping themselves; promotion of assistive devices/aids to obtain independence; have the ability to self-care or direct others to provide care
- Roy’s Adaptation Model: Individual is a biopsychosocial adaptive system; effective adaptive response promote integrity of the individual, nursing promotes the patient’s effective coping & progress towards integration

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Change

Lewin’s Change Theory: stages of unfreezing, changing, & refreezing

Rehab nurses facilitate change by:

- assessing patient readiness
- implementing interventions
- evaluating progress

Nurses must:

- Adaptable
- Communicate effectively
- Support pts. Through physical, emotional & psychological transitions

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Leadership

- Guiding & influencing a team toward achieving optimal patient outcomes
- Ability to inspire, motivate & direct others to deliver high-quality care
- Strong communication skills, emotional intelligence, swift decision making
- Advocate for patients' needs & rights; ensure their voice is heard in care planning

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Communication

- Effective communication between nurses, patients, families & interdisciplinary teams to ensure optimal patient outcomes.
- Requires active listening, empathy & cultural sensitivity
- Fosters a supportive environment for recovery

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Team Function

- Each member of the team contributes their expertise to create a comprehensive plan of care
- Communication and mutual respect are key to optimizing outcomes
- Role of nurse is to facilitate communication, advocate for patient & ensure continuity of care

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Organizational

- Structured approach to managing & coordinating healthcare in rehab setting
- Understand the hierarchy, roles and responsibilities within the team ensuring effective communication & collaboration
- Implement P&P that enhance pt. care, streamline operations & improve outcomes.

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Communicating/Collaborating with the Interdisciplinary Team

- Exchange clear, concise information with team members
- Active participation in team meetings & discussions
- Shared decision making
- Integrates diverse expertise & perspectives into plan of care
- Requires active listening, empathy, adaptability & conflict resolution skills

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Patient-Centered Care Planning

- Individualized care plans unique for each patient based on needs, preferences & goals
- Based on assessment of physical, emotional and social conditions/issues
- Collaborate with interdisciplinary teams to set realistic & attainable goals
- Documentation necessary for tracking progress and adjusting interventions
- Ensures for continuity of care, empowers patients leading to improved outcomes

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Delegation

- Assigning tasks to team members based on skill, experience & scope of practice
- Assess/know team members competencies & workload to ensure tasks are delegated appropriately
- Clear communication of expectations, necessary resources & support
- Enhances team efficiency, patient safety & quality of care

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Task 2: Apply the nursing process to promote the patient's community reintegration or transition to the next level of care

Knowledge of:

a. Technology & adaptive equipment
    i. Electronic hand-held devices
    ii. Electrical stimulation
    iii. Service animals
    iv. Equipment to support activities of daily living
b. Community resources
    i. Housing
    ii. Transportation
    iii. Community support systems
    iv. Social services
    v. Recreation
    vi. CPS
    vii. APS

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Task 2: (continued)

c. Personal resources
   i. Financial
   ii. Caregiver support systems
   iii. Caregivers
   iv. Spiritual
   v. Cultural

d. Professional resources
   i. Psychologist
   ii. Neurologist
   iii. Clergy
   iv. Teacher
   v. Case manager
   vi. Vocational rehabilitation counselor
   vii. Home health
   viii. Outpatient therapy

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Task 2: (continued)

e. Teaching & learning strategies for self-advocacy
f. Different levels of care & care continuum
   i. Acute Rehab
   ii. Home Care
   iii. Assisted living

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Task 2: (continued)

Skill in:

a. Accessing community resources
b. Assessing readiness for discharge
c. Assessing barriers to community reintegration
d. Evaluating outcomes & adjusting goals
    i. Interdisciplinary team
    ii. Patient-centered
e. Identifying financial barriers & providing appropriate resources

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Task 2 (continued)

f..Facilitating appropriate referrals
g. Participating in team & patient caregiver conferences
h. Planning discharge
  i. Home visits
  ii. Caregiver teaching
i. Teaching health, wellness & life skills maintenance
j. Using adaptive equipment & technology
  i. Voice activated call systems
  ii. Computer supported prosthetics

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Technology & Adaptive Equipment

- Electronic hand-held devices: smart phones, tablets- support communication, enhance cognitive function & facilitate daily living activities
- Electrical stimulation: modality applies controlled electrical impulses to nerves or muscles facilitating muscle contraction or altering pain perception pathways- aids muscle re-education, prevents atrophy & improves circulation
- Service animals: typically dogs trained to perform specific tasks-assist with ADLs and mobility support-promote autonomy & community reintegration
- ADL support equipment: grab bars, shower chairs, dressing aids and adaptive utensils- enhance independence by compensating for physical limitations

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Knowledge of Community Resources

- Housing: safe, affordable, suitable; consider accessibility & support needed- Independent living, ALF, group homes & transitional housing
- Transportation: vital for access to healthcare, work & social activities- public transit; paratransit services & specialized medical transport
- Community support systems: networks that provide essential services facilitating community reintegration; offer a variety of services such as housing assistance, transportation, vocational training, social services & peer support groups
- Social services: similar to above w/ SSW, also mental health counseling
- Recreation: enhances physical, cognitive & emotional well-being

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Knowledge of Community Resources (cont).

- Child Protective Services (CPS): Govt. agency responsible for welfare of children-offers counseling, parenting classes & rehabilitation
- Adult Protective Services (APS): Govt. agency to safeguard vulnerable adults from abuse, neglect & exploitation–crisis intervention, case management, coordinate with other community resources

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Personal resources

- Financial: monetary assets & funding mechanisms to support pt. care, treatment plans & facility operations, budgeting, cost-effective care strategies and insurance benefits.
- Caregiver support systems: networks/resources may include counseling, respite, support groups & education
- Caregivers: family/friends/professional aides-perform/assist with ADLs, medical needs, monitor symptoms & facilitate communication w/providers
- Spiritual: provide comfort, hope & meaning- assess spiritual needs, facilitate access to spiritual resources & incorporate into plan of care
- Cultural: understand & respect culture, beliefs & practices-enhances trust, improves adherence to plan of care & optimizes outcomes.

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Knowledge of Professional Resources

Involves awareness of and utilization of various tools, organizations & networks necessary for effective rehab nursing practice. Knowledge of best practices, evidence-based guidelines & clinical protocols will enhance patient outcomes.

ARN, CMSA, ANA are examples of professional organizations; all disciplines have a variety of professional organizations/networks that publish journals, hold conferences and offer professional development opportunities. Participation in these is crucial for the rehab nurse to stay abreast of new developments & best practices.

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Professionals:

- Psychologist
- Neurologist
- Clergy
- Teacher
- Case Manager
- Vocational Rehabilitation Counselor
- Home Health
- Outpatient Therapy

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Case Management

ARN: “The process of assessing, planning, organizing, coordinating, implementing, monitoring, and evaluating the services and resources needed to respond to an individual's healthcare needs” (ARN, 2015, para.3).

CMSA: “Case management is a collaborative process, with the case manager acting as an advocate for options and services that will meet a client’s and family’s comprehensive healthcare needs through communication and available resources to promote high-quality, cost-effective outcomes” (CMSA, 2016).

Lutz, B.J., Camicia, M., & Laslo, M.A.(2019). Rehabilitation nursing across the continuum. In S. Vaughn (Ed.), The specialty practice of rehabilitation nursing (pp. 121-140). Chicago: ARN.

Case Management in Rehab Setting

- Coordinate comprehensive care plans
- Facilitate communication amongst interdisciplinary teams
- Responsible for transition of care
- Monitor progress, adjust plan to optimize outcomes
- Promote efficient use of resources
- Advocate for patients
- Identify barriers to recovery
- Navigate insurance/funding

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Teaching Strategies for Self-Advocacy

- Educate patients about their rights
- Teach them effective communication skills & techniques
- How to navigate healthcare systems
- Includes personalized education plans taking into account their learning style
- Interactive/role playing to boost confidence
- Provide feedback

The goal is that they can articulate their needs/preferences in various settings as well as to direct their own care when necessary.

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Care Continuum

- Acute Rehab (IRU, IRF, ARU)
- LTACH
- Transitional Care Unit (TCU, TRU)
- SNF
- ALF
- Home Health
- CORF
- Outpatient

Table 8-1. Postacute Rehabilitation Levels of Care: Inpatient or Facility-Based Care

	Long-Term Care Hospital (LTCH)	Inpatient Rehabilitation Facility (IRF)	Skilled Nursing Facility (SNF)	Long-Term (LT) or Custodial Care
Functional status	Has medically complex needs that cannot be met at a lower level of care Has complex wounds *OR* Failure of 2 or more major organ systems *OR* Failed ventilator weaning after more than 3 weeks at a previous hospitalization	Client has some degree of impairment in ADLs and mobility; cognitively able to participate in therapy; significant practical functional improvement is expected	Client has some degree of impairment in ADLs and mobility or other skilled need; cognitively able to participate in therapy; some functional improvement is expected.	Client has some degree of mobility or ADL impairment and cannot be managed at a lower level of care; Client may or may not have cognitive deficits; Client has not reached independent level to be able to be managed at home; Client is no longer making progress where he or she can benefit from skilled intervention.
Nursing and medical services needed	Needs ongoing acute medical management, including physician oversight and specialty care. Needs 24-hour licensed nursing care	Needs ongoing acute medical management, including physician oversight and specialty care; needs 24-hour rehabilitation nursing care; needs coordinated, interdisciplinary care	Involvement of skilled nursing staff is needed to meet client's medical needs, promote recovery, and ensure medical safety; physician oversight every 30 days	Involvement of nursing staff does not require daily skilled nursing observation or intervention, but staff ensure that the client's medical safety needs are met.
Therapies needed	Needs therapy as an adjunct to medical treatment	Needs two or more therapies, one of which must be physical or occupational therapy	Needs one or more therapies *OR* Client has daily skilled nursing need	May need therapy, but the total must be less than 5 times per week; May benefit from Part B therapy if skilled therapy intervention is needed
Number of therapy hours needed and tolerated	No minimum hours required "Medically complex needs" are sufficient for admission	Tolerates at least 3 hours per day of therapy, 5 days per week	There is no minimum number of tolerated hours required for SNF admission; skilled need is sufficient	N/A
Discharge plan and social support	N/A	Probable discharge to community; Adequate community support resources are available to meet needs based on functional prognosis.	Completed psychosocial needs assessment; transfer to next level of care is completed between SNF and SNF coordinator or SNF physicians; possible discharge to community	Transfer from SNF to LT or custodial care must include LT plan of care; Completed psychosocial needs assessment and discussion with family regarding financial requirements; Application for Medicaid is completed if private funds are not available; Transfer often occurs within the facility from an SNF bed to an LT or custodial care bed and is completed between SNF and SNF coordinator or SNF physicians.

Note. ADLs = activities of daily living; N/A = not applicable.

Table 8-2. Postacute Rehabilitation Levels of Care: Community-Based Care

	Home Health (HH) Rehabilitation Care	Comprehensive Outpatient Rehabilitation Facility	Standard Outpatient Therapy
Functional status	Client is able to be cared for at home. Has some degree of impairment in ADLs and mobility Can benefit from skilled services (nursing and/or therapy)	Client is able to be cared for at home. Needs skilled multidisciplinary intervention with potential to make significant functional improvement in ADLs, mobility, or cognition and language Able to continue exercise or activity program at home	Client has impairments and needs only supervision or minimal assistance with mobility or ADLs. Cognitively able to participate in therapy Able to continue exercise or activity program at home
Nursing and medical services needed	May need home health nursing and assistance with personal care Social work services are also available.	Outpatient rehabilitation nurse, physical medicine and rehabilitation specialist, and social and psychological services are part of the interprofessional team. Prosthetics, orthotics, casts, splints, and durable medical equipment are available as needed.	Referred to outpatient rehabilitation nurse, case manager, and medical social worker if needed
Therapies needed	Needs one or more skilled services including PT, OT, SLT, nursing	Needs one or more therapies	Needs one or more therapies
Eligibility criteria for therapy	Client has a skilled need and a functional goal with good rehabilitation prognosis.	Client has a skilled need and a functional goal with good rehabilitation prognosis.	Client has a skilled need and a functional goal with good rehabilitation prognosis.
Discharge plan and social support	Confined to home Has accessible environment at home and appropriate durable medical equipment HH can assist in obtaining durable medical equipment as needed.	Client must have transportation to therapy location. Has accessible environment at home and appropriate durable medical equipment to meet needs CORF can assist in obtaining durable medical equipment as needed. Has social support to continue exercise or activity program at home	Client must have transportation to therapy location. Has accessible environment at home and appropriate durable medical equipment Has social support to continue exercise or activity program at home

Note. ADLs = activities of daily living; CORF = comprehensive outpatient rehabilitation facility; HH = home health; OT = occupational therapy; PT = physical therapy; SLT = speech-language therapy.

Accessing Community Resources

Understanding available resources to support the patient during community reintegration

- Home health
- Transportation
- Support groups
- Financial assistance programs

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Assessing Readiness for Discharge

Evaluating physical, psychological & social preparedness

Consider:

- Current functional status (mobility, ADLs)
- Support systems
- Understanding of discharge instructions/ongoing care needs

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Barriers to Community Reintegration

Identify the physical, psychological, social & environmental challenges

Consider:

- Mobility
- Cognition
- Emotional readiness
- Support systems
- Accessibility/availability of community resources

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Evaluating Outcomes & Adjusting Goals

- Adaptive approach involving the interdisciplinary team working towards patient-centered goals
- Assessing progress towards goals; adjust as needed
- Critical thinking & clinical judgement
- Identify areas needing improvement; provide reinforcement
- Ensure that goals remain relevant & achievable

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Identifying Financial Barriers & Resources

- Evaluate financial resources:
  - Insurance coverage/benefits
  - Out-of pocket costs/co-insurance
  - Potential funding sources/options
  - Financial assistance programs
  - Sliding scale fees
  - Community services/agencies

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Table 8-4. Anticipated Medical and Living Expenses

Needs[a]	Private Pay	Commercial	Workers' Compensation	Medicaid	Medicare
Medical care	Out-of-pocket expense	Covered; may have copays or restrictions	Covered	Covered	Covered with copay
Durable medical equipment	Out-of-pocket expense	Covered if option chosen	Covered	Covered	Covered with copay
Housing modifications	Out-of-pocket expense	Out-of-pocket expense	May be covered	Out-of-pocket expense	Out-of-pocket expense
Caregiving	Out-of-pocket expense	Out-of-pocket expense	Covered	Covered with limitations	Out-of-pocket expense

[a]*Needs are based on medical necessity, which may be determined by the insurer.*

Case Management Models

Facility/Agency Based Case Manager: A CM employed by a healthcare facility, government or private agency or healthcare provider

Insurance-Based Case Manager: A CM employed by a 3rd party payer

Employer-Based Case Manager: A CM retained by an employer to provide case management services directly to employees

Independent Case Manager: A private CM whose services are retained by a 3rd party payer, facility, agency, attorney, trust fund, individual or family

Life Care Planner: A CM who prepar a dynamic plan that addresses the costs of medical & associated care over a client's lifetime

Facilitating Appropriate Referral Skills

"Identifying & connecting the patient with necessary healthcare services or specialists to optimize their rehabilitation outcomes."

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Team & Patient Caregiver Conference Skills

- Active Listening
- Clear communication
- Collaborative problem-solving
- Empowers caregivers with knowledge for post-discharge management

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Skill in Discharge Planning

- Transition of care home (or to next level of care)
- Involves assessment and coordination with team
- Patient/family education
- Evaluation of functional status, barriers, resources, financial constraints
- Coordination of post-acute services, appointments, referrals
- Medication management

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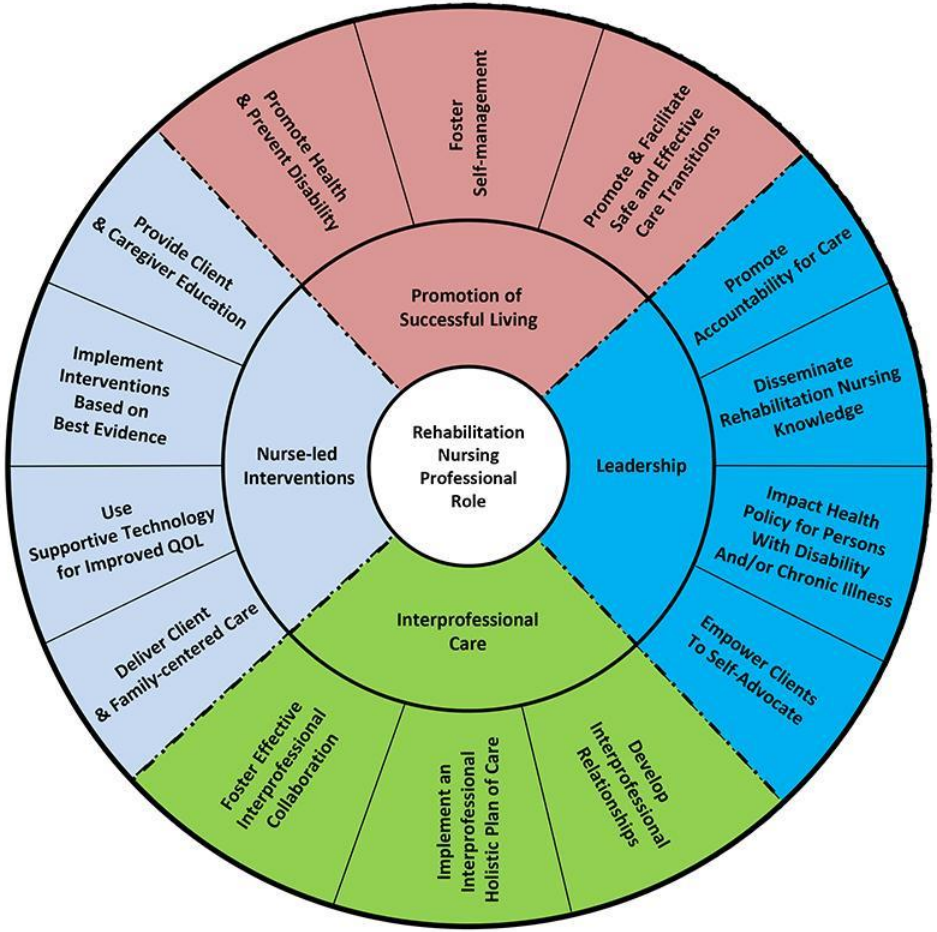
Competency Model

The rehabilitation nuse case manager role touches on all of these domains & competencies!



Additional Skills

- Home visits
- Caregiver teaching
- Teaching health, wellness & life skills
- Mastery of adaptive equipment & technology
- Voice activated call systems (in rehab setting)
- Computer supported prosthetics
  - CAD computer-aided design-digital imaging
  - CAM computer-aided manufacturing-3D printing

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Questions?