Community Transition and Case Management
Objectives

- Define and discuss case management.
- Define what is a life care plan and its role in the discharge planning process.
- Discuss interdisciplinary team concepts.
- Describe community resources.
- Identify and coordinate discharge planning strategies.
- Utilize a case study to apply the principles of case management.
Rise of Case Management Services

- New directions for managing rising medical costs and improving client care in a rapidly changing health care delivery system
- A way to manage risk and coordinate health care services
Rehabilitation Nursing and Case Management

Historical Perspectives on Case Management (CM)

- 1943 Vocational Rehab Act
- 1960 Workers Comp Law
- 1973 Rehabilitation Act
- 1973: Title V of the Social Security Act and the Older Americans Act
- 1985 Diagnostic Related Groups
Definitions

Association of Rehabilitation Nursing (ARN)

✓ The process of assessing, planning, organizing, coordinating, implementing, monitoring and evaluating the services and resources needed to respond to a person’s healthcare needs (2016)
Case Management Society of America (CMSA)

✓ A collaborative process of assessment, planning, facilitation and advocacy for options and services that meet a person’s health needs through communication and available resources to promote high-quality, cost-effective outcomes
American Nurses Association (ANA)

✓ The framework for case management includes five essential functions: assessment, planning, implementation, evaluation and interaction
Goals of Case Management

- Improve quality
- Meet unexpected outcomes
  - promote optimal functioning
  - independence in the least restrictive
- Prevent complications
- Improve coping with injury, illness or disability
Goals of Case Management

- Help patients or clients assume responsibility for directing their own care, being their own advocates and making informed decisions
- Facilitates successful return to work, school and community
Who Are Case Managers?

Look at the population being served and their needs to determined which discipline is best suited to meet the needs of that population.

Nurses
Social Workers
Therapists
Physicians
Rehabilitation Counselors
Practice Settings
In Almost Any Setting That Provides or Reimburses Health Care - Case Managers Will Be Found

- Institutional care
  - *Acute care (medical and rehab)*
  - *Sub-acute care*
  - *Skilled nursing facilities*

- Public and private insurance companies
  - *Medicare/Medicaid, long term care, disability, auto, managed care*

- Physician groups
- Employer based programs
- Government programs
- Provider agencies
  - *Homecare/hospice*
Models of Case Management

Case Management Services:

- institutional
- residential
- outpatient
- community settings

- Employment (facility or agency based)
- Insurance case managers
- Independent case managers
Case Management Process

Data Collection and Assessment -

- Demographics
- Medical Records
- Neuropsychological Evaluation
- Financial
- Support System
Data Analysis and Problem Identification

- Prior/current living situation
- Primary caregiver
- Educational understanding of client, support system and funding sources
- Transportation issues
Assessment
A Systematic Appraisal of the Individual

- Health status (history, medications, nutritional status, height, weight,)

- Functional skills (ability to perform self care, ability to perform household and outside chores and tasks, cognition, communication, mobility, community involvement)

- Psychosocial status (family/friends, beliefs/values, community support, mood/affect, coping ability, stressors, substance abuse/use, sleep patterns)

- Environment (housing situation, service availability in community, home accessibility/ modifications needed, transportation availability)

- Financial status (income, assets, insurance, ability of family to assist, power of attorney, living will)
Funding Sources

- Primary Insurance
- Secondary sources
  - Medicaid waiver programs
  - victims compensation funds
  - fundraising
- Community resources
  - grants
  - home modification programs
Planning

- Develop and coordinate plan with both patient AND family - both must be assisted in coping with illness and hospitalization and to aide in a successful discharge plan
- Establish mutually agreed upon goals
- Prioritize needs and goals
- Identification of immediate, short term and long term needs of the patient and family
- Set goals and time frames in which aspects of the plan will be achieved
- Determined needed services
Goals and Plan of Care

- Client and Support system
  - realistic
  - safe

- Funding source
  - return to same employment
  - willing to adjust
  - settlement
  - Division Vocational Rehabilitation (DVR)
Resource Identification

- Case managers research financial and community resources available to meet patient and family needs
- Ongoing activity throughout patients stay
Resource Linkage

Link Patient With Resources in the Community

- Nursing services
- Home health care
- Infusion and respiratory care
- Counseling centers
- Durable medical equipment agencies
- Local and national disease specific support groups
- Local Medicaid and Medicare offices
- Skilled nursing facilities and sub-acute facilities
- Transportation resources
- Adult day care
- Meals on wheels
- Respite care
- Diagnosis specific specialty programs
- And many more………
Why Coordinate Care?

- Cost efficient
- Eliminates duplication of services
- Less fragmentation of services
- Save money/increase efficiency
- Avoid re-admissions and complications
Coordination of Services

- Case manager is the pivotal point person for all communication regarding plans - from a clinical perspective and financial perspective.
- Monitors services to be delivered and ensures patient/family cooperation and agreement with plan.
- Case manager continually re-assesses needs based upon patients progress.
- Includes oversight of day to day care, discharge planning. Patient/family education and ensuring appropriate follow up care upon discharge.
Case managers have the opportunity to be creative in developing options to meet patient needs.

Insurance companies look for the most cost effective solution to a problem.

Cost management eliminates duplication and fragmentation of services.
Life Care Planning

- A life care plan was distinguished from a discharge plan by its projection of costs of medical and associated care over a person’s lifetime.
- The life care planner may be a case manager who prepares the dynamic plan.
- The case manager may also be involved in the implementation of the plan.
Description of Life Care Plans

- Consistent with client clinical needs
- Must include healthcare needs and quality of life needs
- Comprehensive plan prepared by assessing medical record and other data
- Medicare set-asides
Life Care Plans

Utilization-

- Identification of costs for attorneys working on personal injury cases
- Identification of potential costs for insurance or reinsurance companies to specify damages resulting from injury
- A guide for families or clients for necessary health care and community resources
Life Care Plans

Utilization:

- A tool for clients and their families to anticipate and self-monitor care.
- A tool for expenditures from group healthcare plans in catastrophic injury or illness.
Implementation

- Identify program type of program
- Meet with patient/family prior to start of program
- Documentation support for recommendation of program
- Scheduling
Monitoring

- Feedback from treatment team
  - monthly conference and progress reports
  - monthly contact with funding source
- Feedback from family
  - spontaneous meetings with caregiver
  - formal meetings with support system
- Feedback from peers
Discharge Planning

- Next Level of rehabilitation
  - community independent living
  - community with assist from caregiver
  - formal assisted living program
  - outpatient clubhouse
  - in community support program
Outcome

- Collaboration and agreement on discharge plan by entire team
- Appropriate referral and acceptance to next level program
- Continued support client/support system
Benefits of a Rehabilitation Team

- Patient-centered environment
- Coordination of care
- Patient treated holistically
- Increased trusting relationship between healthcare practitioners, patient, and family
- Increased lines of communication between all parties involved
- Increased patient/family education
Rehabilitation Team

- Physiatrist and consulting physicians
- Patient/family/caregivers
- Case Manager
- Psychologist/Neuropsychologist
- Rehabilitation Nurse
- Physical Therapist
- Occupational Therapist
- Speech Therapist
- Recreational Therapist
- Dietician
- Peer Support
- Canine Therapy
Rehabilitation Team Members

Rehabilitation Nurses
- Provide necessary follow-through with skills learned in therapy.
- Are an essential component of teaching for patients/families in nursing care skills.

Physical Therapist
- Help patients walk, develop balance, regain muscle tone and strength
- Develop skills using a range of equipment
Rehabilitation Team Members

**Occupational Therapist**
- Improve coordination and strengthen muscles needed for everyday activities, e.g. eating, cooking, dressing, and maintaining personal cleanliness

**Speech/Language Pathologist**
- Evaluate and treat problems in communicating and swallowing

**Recreation Therapist**
- Use leisure activities, e.g. games, painting and gardening to improved physical, social and cognitive skills
- Community skills trips
**Psychologist/Neuropsychologist**

- Evaluate thinking skills, behavior and cognitive abilities.
- Counsel patients for anxiety and depression and provide family support and education.

**Dietitian**

- Evaluate and monitor patient’s diet so that meals provide energy for therapy and healing.
Rehabilitation Team

Goal -

To enable a patient with disabilities to reach and maintain his or her optimal physical, sensory, intellectual, psychological and social functioning levels.
Rehabilitation Team Models

- Medical Model
- Multidisciplinary team
- Interdisciplinary team
- Transdisciplinary team
Medical Model

- A physician-centered model of care in which all care is directed by the physician.
- This model is *not* consistent with rehab philosophy or goals and is uncommon in rehab facilities.
Multidisciplinary Model

- May be seen in rehab, and is one in which the professionals work in parallel
- Each discipline works toward particular client goals, with very little overlap between disciplines
- Communication is more vertical than lateral with the leader controlling team conferences (manager attends team conference)
- This model is effective when team membership is not stable
Interdisciplinary Model

- A matrix like model in which lateral communication is predominant.
- This is an effective model when team members are stable.
- Decisions are determined by the group working directly with the client which means that mutual trust must be established.
- Conflict resolution is an important skill used by team members.
- Team goal setting is important
Transdisciplinary Approach

- A newer team model in which the client has a primary provider from the team who is then guided by the team.
- The primary provider may be a nurse or other member, who then provides PT, ST and OT based on the advice and counsel he/she receives from team members.
- Roles are less clear.
- A good model for situations in which the client is stable and in need of long term services.
Community Reentry and Reintegration

Focus –

- Transition from an acute care environment to the community through gradual acquisition of community skills and training with active participation by family

- Self-care, leisure, and vocational activities, as well as psychosocial integration into the client’s environment

- Nursing services on education, resource management, and advocacy
Community Reentry and Reintegration

Focus –

- On acquiring skills through training and education
- Involves addressing or overcoming community-based barriers
Transition to Community

Rehabilitation Settings -

- Outpatient Rehabilitation Site
- Home Health Care
- Subacute Care
Community Rehabilitation Settings

Outpatient Rehabilitation –

✓ rehabilitation therapies continue at a site in the community that is able to provide the specific therapies needed by the patient to continue the rehabilitation process.
Community Rehabilitation Settings

Home Health Services-

✓ care is provided in the patient’s place of residence.
✓ patient must be confined to their residence or have great difficulty going to an outpatient center (homebound regulation for Medicare services)
✓ care required is intermittent skilled nursing services, and/or physical, occupational and speech therapies.
✓ home Health Aide services may also be covered as well as medical supplies and equipment.
Community Rehabilitation Settings

Sub-Acute/Skilled Nursing Facility -

- a step down from acute rehabilitation care
- patient needs to be medically stable
- care needed must require a skilled, licensed professional
- care must be required on a daily basis
- rehab goals must be achieved in order for patient to remain in sub acute level of care
- care must take place at a Skilled Nursing Facility (SNF) for reasons of patient safety
Transition to Community Living Settings

- Assisted Living
- Group Home
- Residential Living
- Independent Living Facility
- Private Home/Apartment
Transition to Community Living Settings

Assisted Living-
✓ ownership or shared apartment in a facility type setting
✓ able to perform ADL’s with some assistance of an aide if needed
✓ place of residence
✓ setting for a respite stay

Group Home-
✓ home type setting with others of similar disability
✓ assistance with care is available 24/7
✓ place of residence
Transition to Community Living Settings

Residential Living –
✓ home type setting where a group of individuals with disabilities live and share support services

Independent Living Facility –
✓ environment allows a person to maintain his/her own residence while providing support services, e.g. housekeeping, transportation, and recreational opportunities
Transition to Community Living Settings

Private Home/apartment –
✓ live alone, with family/friends or caregiver in their own residence.
Barriers to Community Reentry

- Personal
- Home Care Staff
- Transportation
- Housing
- Financial
Barriers to Community Reentry

Personal -
- Negative attitude
- Poor self-esteem
- Lack of motivation
- Poor self-image
- Feelings of dependence
- Insecurity
- Inability to plan and meet goals
- Unrealistic expectations
Barriers to Community Reentry

Transportation -

- Accessibility to healthcare services
- Ability to pursue vocational interests
- Accessibility to public facilities
- Participation in social and recreational activities
- Pursuit of education
- Ability to achieve independence in high-level self-care skills
Barriers to Community Reentry

Caregiver –

- Need to meet eligibility and income requirements
- Waiting lists for programs
- Services determined to be custodial by payer sources
- Responsibility for hiring, firing, and training is placed on client
- Training can be costly and involve limited staff retention
- If caregiver is unavailable due to illness or personal emergency, a backup plan must be in place
Barriers to Community Reentry

Housing -

- Accessible housing limited
- Architectural barriers
- Long waiting lists
- Poor location
- High cost
Barriers to Community Reentry

Financial -

- Budget restraints in federal and state government
- Limited number of personnel available to train and supervise individuals with disabilities
- Return to work affected by level of disability
- Cost of healthcare
- Loss of or reduced income
Life skills Needed for Independent Living

- Minimizing dependence on others for daily needs
- Ability to manage personal affairs
- Participating in community life
- Fulfilling social roles
- Having options
Return to Community

You can do it!!

- Problem solving
- Planning
- Overcoming barriers (including financial, housing, accessibility, finances, transportation, employment, recreational activity)
Community Living Skills

Home Modifications –

▪ Doorframes and hallways
▪ Kitchens
▪ Bathrooms e.g. curb less shower
▪ Energy supplies e.g. circuitry for ventilators
▪ Ramps

Self Care Activities

✓ Grocery shopping  paying bills  car care
✓ Yard work  housekeeping
✓ Housekeeping  pet care
Adaptive Equipment

Independence Aides -

- Grab bar for tub
- Tub bench
- Door knob turners
- Rolling cart in kitchen
- Reachers
- Adapted phone e.g.. blue tooth
- Computer e.g.. Dragon dictate programs
Case Study

Patient identification-

- “JP” 22 year old male
- Injury due to a motorcycle accident
- C2-3 Asia A ventilator dependent
- Diaphragmatic pacer-not in use
- Stage IV sacral wound
- Mild brain injury
Identification of Care Needs

Ventilator unit -
✓ 24/hour physician management
✓ respiratory support services
✓ rehabilitation nursing
✓ psychology - individual and family

Clinic -
✓ 3 hour therapy program

Education – SCI education series
✓ family training
Case Study

Medical status on admission -

- Respiratory-dependent
- Communication impairment
- Swallow deficit
- Neurogenic bowel
- Neurogenic bladder
- Sacral wound and body
- Abrasions
Case Study

Functional Status -

- Dependant for feeding, grooming and hygiene
- Dependant for all functional transfers
- Dependant for bowel management
- Dependant for bladder management
- Dependant for wheelchair propulsion
Identification of Care Needs

- Patient is a college student
- Apartment is inaccessible
- Parents work full-time
  - live 2 1/2 hour away from rehab hospital
- Supportive friends
The Rehabilitation Team
Partners in the Journey Home

- Patient and Family
- Physiatrist and team physicians
- Rehabilitation nurses
- PT, OT, ST, RT
- Neuropsychology/Clinical Psychology
- Case Management
- Registered Dietician
The Rehabilitation Team
Partners in the Journey Home

- Recreation therapists
- Peer support
- Canine therapy
- Vocational resource counselor
Program Components

- Medical management
- Interdisciplinary team approach
- Well-defined management plan
  - explicit goals
  - measurement of progress
  - evaluation of adjustment to the program
- Community integration
- Family education
Case Management Goals

**Promotion of quality care** -

- Focus on patient - not the system
- Balance patient and family needs
  - accommodations on site
  - local hotel
- Cost-effective use of resources
  - length of stay – exhaustion of rehab benefit
  - intervene with payers for DME reimbursement
- Monitor, evaluate and modify discharge plan
Insurance and Resource Overview

- Commercial insurance
  - defined rehab benefit- 120 days
  - based on medical necessity

- Community resources
  - Medicaid
  - application for Medicaid independence waiver for home care support services
  - NTAF- National Transplant Assistance Fund and Catastrophic Injury Program -fundraising
Transition to the Community

Case Coordination -

- Home evaluation by Kessler staff
- Home mods begin after onsite evaluation
- Meeting with home care agency to coordinate discharge
  - review insurance benefits and coverage
  - letters of medical necessity
  - training of home health staff
- Finalize order for nursing and respiratory supplies
Equipment Overview

Case Management -
- Coordination with rehab team

DME
- Mattress and topper
- Shower/commode chair
- Mechanical patient lift
- Wheelchair
- Environmental control units
- Computer technology
- Respiratory equipment
Barriers to Community Reentry

Caregivers -

- Parents work full-time
- Limited home services provided in traditional commercial plan e.g. no private duty benefit.
- 120 day delay to implement state waiver program
- Mom is anxious- “can I care for my son?”
- Parents consider nursing home placement
Barriers to Community Reentry

Parents residence -

- multi-level home
- 4 step entry through garage will need ramp
- Bathroom small on first floor - no tub or shower
- Large common areas – lack privacy for first floor set-up
“I am not ready for discharge ...I thought I’d be cured.”

Disappointment in the perception of rehabilitation effectiveness often occurs.

**Interventions** –

- Education regarding the goals and limitations of the rehab program.
- Teach the caregiver or family about medical and psychological issues that maybe ongoing.
- Assist the family to recognize and focus on ways they can improve the likelihood of success.
Transition to the Community
Leaving the Nest

“Will we ever be able to manage at home?”

Difficulty remaining patient

Interventions

- Help family members to understand that adjustment to injury occurs over time.
- Advise family that impatience and trying too hard can lead to frustration and anxiety undermining progress.
- It’s a “marathon not a sprint”
The Team Conference

Physician and case manager review plan with team, patient and family -

- Patient and caregiver education
- DME
- Respiratory equipment
- Nursing supplies
- Medication profile
- Physician referrals for the community
- Home services – skilled and private hire
- Notification of community groups e.g. Police, fire, rescue squad
- Transportation
Community Support Services

Case Manager -

Referral for psychosocial needs

- Advocacy and referrals for services in the community
- Encourage social support seeking and networking for caregivers.
- Provide resources for respite care, LTC needs to address caregiver burden.
Home At Last