The Essential Role of the Rehabilitation Nurse in Facilitating Care Transitions

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No off-label use will be discussed.

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Michelle Camicia will not discuss off-label use.
Learning Objectives

1. Demonstrate an understanding of the essential role of the rehabilitation nurse in care coordination
2. Identify ways to optimize the meaning of work as a rehabilitation nurse
3. Explore opportunities to expand the influence of the rehabilitation nurse
ARN Position Statement

Rehabilitation Nursing:

• Is a specialty practice within the profession of nursing and involves the diagnosis and treatment for individuals and groups to actual and potential health problems related to altered functional ability and lifestyle

• Goal is to assist individuals with disability and/or chronic illness in restoring, maintaining and promoting maximal health
Current Issues

• Where is the value in rehabilitation nursing?
• How will we measure rehabilitation nursing value?
• What historical beliefs do we need to challenge?
• How will we determine what intensity of service results in the best value?
Where is the Value?

“In attempting to arrive at the truth, I have applied everywhere for information, but in scarcely an instance have I been able to obtain hospital records fit for any purposes of comparison. If they could be obtained, they would enable us to decide many other questions besides the one alluded to. They would show subscribers how their money was being spent, what amount of good was really being done with it, or whether the money was not doing mischief rather than good...and, if wisely used, these improved statistics would tell us more of the relative value of particular operations and modes of treatment than we have any means of ascertaining at present. They would enable us, besides to ascertain the influence of the hospital with its numerous diseased inmates, its overcrowded and possibly ill-ventilated wards, its bad site, bad drainage, impure water, and want of cleanliness- or the reverse of all of these- upon the general course of operations and diseases passing through its wards; and the truth thus ascertained would enable us to save life and suffering, and to improve the treatment and management of the sick and maimed poor.”

Florence Nightingale (1863)
The value of nursing care coordination: A white paper of the American Nurses Association

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Why “care coordination” and why now? Care coordination has been proposed as a solution to many of the seemingly intractable problems of American health care including high costs, uneven quality, and too frequent disappointing patient outcomes. More resources are devoted to health care per capita in the United States than in any other nation, yet our fragmented system is often characterized by communication failures and nonbeneficial or redundant health care tests and services. This results in an unacceptable

Coordination of care is not a new idea, and it is certainly not new to registered nurses (RNs). In the context of a partnership guided by patients’ and families’ needs and preferences, the RN is integral to patient satisfaction and care quality as well as the efficient use of health care resources. Patient-centered care coordination is a core professional standard and competency for all nursing practice. Registered nurses understand that they are an essential component of the care coordination process to improve patients’ care
Significant Dates in ARN History

1974 The Association of Rehabilitation Nurses (ARN) was formed by Susan Novak with help from Lutheran General Hospital, located in Park Ridge, IL.

1976 ARN was formally recognized as a specialty nursing organization by the American Nurses Association.

1980 The ARN journal, originally established in 1975, was renamed Rehabilitation Nursing.


1984 The Certified Rehabilitation Nurse (CRRN®) exam was first administered.

1986 The Rehabilitation Nursing Institute, originally established in 1977, was restructured and renamed the Rehabilitation Nursing Foundation (RNF).

2007 The landmark study, “Nurse Staffing and Patient Outcomes in Inpatient Rehabilitation Settings,” was published in RNJ.

2014 The ARN White Paper, “The Essential Role of the Rehabilitation Nurse in Facilitating Care Transitions” was published in Rehabilitation Nursing.
The Essential Role of the Rehabilitation Nurse in Facilitating Care Transitions: A White Paper by the Association of Rehabilitation Nurses

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Overriding ARN Assertion

“Successful post-acute care (PAC) transitions for individuals with disabling conditions must be facilitated by nurses with rehabilitation nursing training, knowledge, and experience”.

(Camicia, et al., 2013)
ARN Statements

• ARN is committed to promoting the health and welfare of clients with disabilities.

• The rehabilitation nurse is integral in ensuring that THE PATIENT RECEIVES THE RIGHT CARE AT THE RIGHT TIME BY THE RIGHT PROVIDERS IN THE RIGHT SETTING.
Current PAC Care Transitions

• May be fragmented, disorganized, guided by factors unrelated to quality of care or patient outcomes
• Do not always promote utilization of clinicians skilled in advocating on behalf of the best interests of patients and their families
• Can be confusing for patients and families
• Failure to determine the appropriate site of care leads to higher hospital readmissions
PAC Team Members

- Patient & Family
- PMR MD Physiatrist
- Program Coordinator or Navigator
- Rehab Nurse
- PT
- OT
- Dietitian
- Case Manager
- Pharmacist
- Prosthetics & Orthotics
- Speech & Language Pathologist
- Social Worker
Rehab Nursing Expertise

• Defined by a unique skill set
• Have knowledge and understanding to manage care of patients with acute or chronic disabling conditions
• Can lead teams to develop and implement patient-family-centered interventions
• Can assist in evaluating outcomes
Standards & Scope of Rehabilitation Nursing Practice

- Use the standards of rehabilitation nursing practice
- Modify assessment, management and patient education strategies
- Participate with patients and families in decision making
- Develop a transition plan with patient and family
- Maintain communication

Standards and Scope of Rehabilitation Nursing Practice, 2008
Standards & Scope of Rehabilitation Nursing Practice

• Establish an effective relationship with patient and family
• Collect appropriate assessment data for each rehabilitation patient
• Coordinate and collaborate with the team
• Demonstrate knowledge of the impact of disability and chronic illness
• Employ clinical assessment skills

Standards and Scope of Rehabilitation Nursing Practice, 2008
Standards & Scope of Rehabilitation Nursing Practice

• Apply research findings in practice decisions
• Educate patients, families, payors, healthcare providers and others
• Provide leadership for resource management, program and functional outcomes evaluation

Standards and Scope of Rehabilitation Nursing Practice, 2008
Essential Roles of the Rehab Nurse

1. Caregiver, Expert Practitioner
2. Teacher
3. Coordinator of care
4. Collaborator, liaison
5. Counselor
6. Case manager
7. Researcher
In study of 54 U.S. rehabilitation facilities, Nelson, et al. (2007) found a 1% increase in the number of certified rehabilitation nurses was associated with reduced length of stay for patients.
Case Manager Role

Defined as “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, 2012
Essential Role Components of Rehab Nursing Case Management

• Data collection and assessment
• Data analysis and formulation of nursing diagnosis
• Establishment of goals and plan of care
• Implementation of plan of care
• Collaboration
• Documentation
• Community reintegration
• Evaluation
• Quality Assurance

(Role Descriptions: The Rehabilitation Case Manager, ARN, 2012)
ARN White Paper Recommendations

1. Practice
2. Policy
3. Research
4. Education
PRACTICE

• Care transitions for individuals with disabling conditions **MUST** be facilitated by nurses with rehabilitation nursing training, knowledge & experience.

• It **MUST** be the role of the rehabilitation nurse to educate & inform families on options and services available.

• The Rehab Nurse **MUST** use scientific evidence that can be summarized in a meaningful way so families can make informed decisions about care transitions.
POLICY

- Rehab nurses **MUST** be involved in national policy decisions to ensure that cost-efficient care is being delivered without compromising the quality of patient care in the U.S.

- Rehab nurses **SHOULD** be included on technical expert panels assessing concepts for future care coordination measure development (includes transitional care)– to evaluate the quality of care coordination for those with a disability.
RESEARCH

• There **MUST** be more studies to evaluate the impact of rehab nurses on the healthcare delivery system.

• Federal agencies **SHOULD** fund research that supports comparisons of payments and quality models and evaluation of value-based payment models.
ARN’s Standards and Scope of Rehabilitation Nursing Practice and this white paper SHOULD be foundational documents for discharge planning education related to care transitions for individuals with disabling conditions.
CONCLUSION

The nurse who is dedicated to the care of the patient with a disability **MUST** possess:

- An adequate understanding of rehabilitation/restorative concepts.
- Knowledge of the multitude of resources that exist to help the patient and their family transition to the next level of care.
- A belief that the utmost goal is the return of the individual with a disabling condition back to their home and community as a productive member of society.
Promote & Facilitate Safe & Effective Care Transitions

Beginner

• Assess the client & family regarding cultural values & health literacy as applicable to care transitions
• Participates in the development of an interprofessional plan for care transitions
• Contributes to the development & implementation of the goals for care transitions
• Participates in the care conference that evaluates the care transition plan
Promote & Facilitate Safe & Effective Care Transitions

Intermediate

• Identifies the barriers that could influence the care transitions
• Modifies plan of care based on additional data collection
• Coordinates the resources needed for a seamless care transition
• Contributes to the interprofessional evaluation of the client & family care transition plan
Promote & Facilitate Safe & Effective Care Transitions

Advanced

- Synthesizes client & family data & resources needed for a seamless care transition
- Coordinates the interprofessional plan for care transition
- Facilitates the interprofessional care transition plan
- Collects program data to evaluate the client & family care transition experience for the purpose of program management & improvement
ARN Competency Model for Professional Rehabilitation Nursing

http://www.rehabnurse.org/profresources/content/ARN-Competency-Model-for-Professional-Rehabilitation-Nursing.html
The Fundamental Transformation of the Foundations of Nursing Practice

• “Nurse leaders must now ask a different set of questions regarding the emerging character of the nurse’s role in the coordination, integration, and facilitation of value-based care in an accountable care system.”

• Nurses will accelerate in importance

• Will add considerable value in managing both the partnerships necessary to render truly accountable care

Tim Porter-O’Grady (2014)
Demonstrating Nursing Value

• Documentation of interventions that result in value
• Key quality outcomes
• Quantify and articulate care
• Across the continuum and in the community
• Transition management
Nursing Sensitive Quality Measures

Process Measures
- Maximum utilization of information technology
- POC compliance
- Nursing cost efficiency
- Standard of Care compliance

Outcome Measures
- Falls
- Pressure ulcers
- Functional gain
- Rehospitalization
- LOS
- D/C disposition
Challenge Beliefs

- Staffing
- Role of nurse across settings
- Nursing care part of room and board
- Reimbursement for nursing services
ARN Vision (BHAG)

To **transform** healthcare by integrating rehabilitation nursing concepts into care for all people.

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References


