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## **The Essential Role of the Rehabilitation Nurse in Facilitating Care Transitions: A White Paper by the Association of Rehabilitation Nurses**

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The current process of care transitions for individuals with disabling conditions is both ineffective and inefficient. There is a need for clinicians with the necessary knowledge and skills to advocate and facilitate transitions that result in the greatest value to the patients, their families, and the healthcare delivery system. A review of the literature reveals significant problems with transitions to postacute care (PAC) settings. Care is fragmented, disorganized, and guided by factors unrelated to the quality of care or patient outcomes. Studies have demonstrated that the selection of a PAC setting for patients is influenced by multiple factors (Sandel et al., 2009; Gage, 2009).

Patients' clinically assessed needs often do not match the level of care determined by decision makers because optimal patient outcomes may not be the primary factor considered. Competing factors include proximity of providers, relationships between providers of care, payer source, and variation in the interpretations of regulations regarding PAC. Decision makers may include the patient, family members, discharge planners, physicians, insurance company representatives, social workers, and other healthcare providers. Many times, these decision makers lack adequate information to make the best decision during care transition planning. Consequently, care transitions remain a confusing time for patients and their families and can

result in both overuse and underuse of PAC services and sub-optimal quality of care and clinical outcomes. Families involved in PAC transitions often feel overwhelmed and dissatisfied (Lutz, Young, Cox, Martz, & Creasy, 2011). PAC is a significant part of the overall care of many Medicare patients. Up to 35% of Medicare patients are discharged each year to a PAC setting (Gage, 2009). Of those Medicare patients discharged, almost one-fourth of Medicare beneficiaries discharged from the hospital to a skilled nursing facility were readmitted to the hospital within 30 days (Mor, Intrator, Feng, & Grabowski, 2010).

PAC is provided in various settings, including skilled nursing facilities, inpatient rehabilitation facilities, long-term care hospitals, in the home by home healthcare agencies, and outpatient centers. PAC is provided by a wide array of specialized clinicians from physical therapists, occupational therapists, physicians, speech-language pathologists, neuropsychologists, social workers, discharge planners, and nurses with and without rehabilitation expertise. Rehabilitation is a key component of the care provided in each of these settings. About 30%–60% of the older patients develop new dependence in activities of daily living (ADL) during an acute care hospital stay, which can result in progressive disability after discharge (Huang, Chang, Liu, Lin, & Chen, 2013).

Determining the best setting for the patient requires a thorough understanding of rehabilitation services and evidenced-based outcomes to evaluate appropriateness of care for the patient. Pilot studies have demonstrated that when a nurse with an understanding of care transitions is integrated into the process, unplanned 30-day hospital readmission rates decline and outcomes are improved (Congressional Research Service [CRS], 2010).

The current case management model has failed to promote the utilization of clinicians skilled in advocating on behalf of the best interests of patients and their families (American Nurses Association [ANA] 2012). The clinician involved in PAC transitions for people with chronic disease and disabling conditions must be client centered, goal oriented, and outcome based. They must understand the available levels of PAC and roles of other professionals and how each role impacts long-term success in the patient's care. Rehabilitation nurses are defined by a unique skill set, which entails the knowledge and understanding of chronic illnesses and conditions that cause disability and a focus on helping patients recover as much function as possible through the formulation and implementation of interventions and evaluating outcomes. Rehabilitation nurses possess a comprehensive understanding of the resources available at each level of PAC. It is this skill set and strong value for advocating for the provision of appropriate services based on the patient and family's needs that makes them uniquely able to guide families in successful PAC transitions. Furthermore, greater use of rehabilitation nurses in policy making would serve to balance cost efficiency and healthcare quality.

Care coordination promotes greater quality, safety, and efficiency in care, resulting in improved healthcare outcomes and is consistent with nursing's holistic, patient-centered framework of care (ANA, 2012). A nurse with rehabilitation nursing training, knowledge, and experience is the healthcare professional who is best able to coordinate, support, and facilitate the discharge transition process to promote quality outcomes and cost-effective care for individuals with disabling conditions. To this end, the Association of Rehabilitation Nurses (ARN) recommends that nurses with this specialty training are utilized to facilitate care transitions for individuals with disabling conditions, to educate and inform families about options and services available, and be involved in national policy decisions to ensure that cost-efficient care is being delivered without compromising the quality of patient care in the United States. PAC is changing and we lack research on many issues. Studies are needed to evaluate the impact of rehabilitation nurses on the healthcare delivery system, including transitional care. Additionally, the Standards and Scope of Rehabilitation Practice (ARN, 2008) and The Essential Role of the Rehabilitation Nurse in Facilitating Care Transitions (ARN, 2014), should be foundational documents for discharge planning education related to care transitions for individuals with disabling conditions.

The ARN remains committed to promoting the health and welfare of clients with disabilities and ensuring that the patient receives the right care at the right time by the right providers. Appropriate care transitions promote the greatest value and the most effective and efficient care for clients with disabilities. It is integral that people involved with healthcare policy decision making, educators, payers, and other stakeholders in health care understand the value of the rehabilitation nurse's essential role in facilitating in care transitions.

## Background

The Affordable Care Act (ACA) seeks to instill more quality into the U.S. healthcare system. Following the passage of the ACA, the U.S. Department of Health and Human Services in 2012 submitted to Congress the National Quality Strategy Report, which presents three aims for the healthcare system:

- **Better care:** Improve the overall quality of care by making health care more patient centered, reliable, accessible, and safe.
- **Healthy people and communities:** Improve the health of the U.S. population by supporting proven interventions to address behavioral, social, and environmental determinants of health in addition to delivering higher quality care.
- **Affordable care:** Reduce the cost of quality health care for individuals, families, employers, and government.

To help achieve these aims, the strategy also established six priorities to help focus efforts by public and private partners:

1. Making care safer by reducing harm caused in the delivery of care.
2. Ensuring that each person and family is engaged as partners in their care.
3. Promoting effective communication and coordination of care.
4. Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.
5. Working with communities to promote wide use of best practices to enable healthy living.
6. Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new healthcare delivery models.

The National Quality Strategy report embraces a focus on quality as measured by clinical and patient-reported outcomes. As part of patient-reported outcomes, the

report recommends evaluation of care transitions and change in functional status (U.S. Department of Health & Human Services [HHS], 2012), which are integral to PAC. To ensure high-quality health care, it is necessary to focus on PAC transitions to ensure the coordination of the patient's care as he/she moves from one site of care to another.

Ensuring proper care coordination from a hospital to a PAC provider has increased in recent years as patients are spending less time as a hospital inpatient. The average hospital length of stay (ALOS) for patients has steadily declined since 1983 with the advent of the inpatient prospective payment system and the diagnosis-related groups (DRG) system. The average inpatient rehabilitation facility (IRF) LOS of stroke patients nationwide decreased from 19.6 to 16.5 days between 2001 and 2008 (Granger, Markello, Graham, Deutsch & Ottenbacher, 2009). According to the American Hospital Association, (2011), the ALOS from 1991 to 2011 declined from 7.2 days to 5.4 days, a decrease of 25 percent.

Although patients are spending less time as hospital inpatients, the use of PAC services has increased. The Centers for Medicare and Medicaid Services (CMS, 2010) contracted with RTI International to examine PAC costs and outcomes in 206 PAC settings from 2008 to 2010. According to this study, up to 35 percent of Medicare patients are discharged from acute care to a PAC setting (Gage, 2009). Utilization patterns of the various PAC settings appear to be influenced by the payment system (Medicare Payment Advisory Commission [MedPAC], 2013). The Institute of Medicine Committee on Geographic Variation in Health Care Spending and Promotion of High-Value Care identified geographic variation in spending and utilization. This variation in spending across geographic areas is driven largely by variation in the utilization of PAC services. The committee also identified an inconsistent relationship between spending and quality of health care (Institute of Medicine, 2013).

The reduction in inpatient length of stay, growth in vulnerable populations with disabilities, and increased utilization of PAC settings has made care transitions a critical component of favorable patient outcomes. Every year, more than 10 million Medicare beneficiaries are admitted to a PAC setting (Grobowski, Huckfeldt, Sood, Escarce & Newhouse, 2012). These beneficiaries are some of the frailest and most vulnerable individuals. Medicare's spending on them has increased significantly in the past decade, more than doubling from \$26.6 billion in 2001 to \$58 billion in 2010 (MedPAC, 2011).

Unfortunately, poorly coordinated care transitions have led to disparities in care based on geographic proximities to providers and other factors unrelated to evidenced-based practice (Sandel et al., 2009). This study of more than 11,000 stroke patients found that patients who experienced a stroke were more likely to go to a skilled nursing facility (SNF) if they were female and older. If the patients were Asian, black, from a higher socioeconomic class, or within a close proximity to an IRF, they were more likely to receive PAC at an inpatient rehabilitation facility.

The National Quality Forum recognizes that readmission measures can serve as an indicator of whether care coordination has been optimized. According to the Medicare Payment Advisory Commission, unplanned readmissions to the hospital within 30 days of a patient's discharge cost the Medicare program approximately \$15 million annually. Included in the ACA is the calculation of hospital readmission rates from claims data. Hospitals with above-average readmissions rates face a financial penalty. Since the hospital readmissions reduction program began in fiscal year (FY) 2013, policymakers have considered expanding the readmissions reduction program to include other providers. For example, as part of the FY 2014 rehabilitation facility prospective payment system final rule, the Centers for Medicare & Medicaid Services (CMS, 2012) adopted an all-cause unplanned readmission measure for 30 days post discharge from inpatient rehabilitation facilities. CMS also finalized an all-cause unplanned readmission measure for 30 days post discharge for long-term care hospitals (LTCHs) in the inpatient prospective payment system and LTCH prospective payment system final rule.

In March 2013, CMS released the Guidance for Discharge Planning Conditions of Participation (CoP) for hospitals. The report notes that unplanned hospital readmissions may result from a variety of factors, including poor care transitions. One attribute to hospital readmission is the discharge from the hospital to an inappropriate setting or if the patient does not receive adequate information or resources to ensure a continued progression of services. According to the report, "system factors such as poorly coordinated care and incomplete communication and information exchanged between inpatient and community-based providers may also lead to unplanned readmissions" (CMS, 2013a; p. 6). Given this, CMS presented the revised CoP. This includes the requirement that hospitals evaluate "the likelihood of a patient needing post-hospital services and the availability of services" and "the likelihood of a patient's capacity for

self-care or the possibility of the patient being cared for in the environment from which he or she entered the hospital” (CMS, 2013a, p. 11). The hospital is expected to be aware of the capabilities and limitations of postacute facilities to avoid readmissions.

Also, insurance company contracts, often following the precedent of CMS Fiscal Intermediaries, create additional guidelines for approval of patients to various settings. These guidelines often are created to serve the interest of the insurance companies in the short term, without addressing the long-term outcomes or total costs of care incurred by the family. For example, an insurance company may find that a lower level of care is less expensive under their coverage guidelines, but if the outcome leads to long-term care for the patient, this cost is often incurred by another payer source, usually the patient and family. The resulting consequence for the patient of not achieving their optimal functional goal and returning to a community setting is also not factored into the decision-making process.

Historically, very little guidance has been provided to key decision makers in choosing the PAC setting that delivers effective and efficient care and results in optimal patient outcomes. In determining where to discharge patients, a myriad of factors (e.g., availability of PAC services, geography, financial considerations, etc.) are considered. Nurses have a key role in guiding this decision making as described in the ANA white paper, *The Value of Nursing Care Coordination* (2012). Although CMS suggests that certain disciplines may perform transitional care management services (CMS, 2013b) nurses who possess experience with the specialty practice of rehabilitation nursing, including nurse practitioners and advanced practice registered nurses, possess the optimal skills to provide care coordination for patients requiring rehabilitation services due to injury or illness causing disability.

In addition to the most recent MedPAC report, Medicare paid for care in SNFs for 1.7 million beneficiaries. An estimated 3.4 million Medicare beneficiaries received home health care. IRFs treated 371,000 beneficiaries and 123,000 Medicare beneficiaries received care in LTCHs (MedPAC, 2013). Yet, usage patterns alone are insufficient to determine whether a patient is receiving care in the setting most appropriate for their needs.

### Definition of Rehabilitation

Although PAC occurs in a variety of settings, rehabilitation services are often a significant part of the care provided. Rehabilitation is a philosophy of practice and an

attitude toward caring for people with disabilities and chronic health problems (Larsen, 2011). The goal of rehabilitation is to restore mental and/or physical abilities lost to disease, to function in a normal or near-normal way (National Cancer Institute [NCI], 2013).

Underlying the concept of rehabilitation is the specialty of rehabilitation nursing. Rehabilitation nursing is defined as “the diagnosis and treatment of human responses of individuals and groups to actual or potential health problems related to altered functional ability and lifestyle” (ARN, 2008; p. 13). Various levels and settings for rehabilitation services are available, including SNFs, IRFs, LTCHs, outpatient therapy (OP), or home health (HH). Rehabilitation in each of these settings seeks to maximize the function of the individual impacted by the injury of disease. Each of these sites of care will be further described in greater detail with regard to the amount and type of rehabilitation services offered in these settings and associated outcomes based on the complexity of the patient and the appropriateness of services provided to meet the patient’s needs.

### Care Transitions

The concept of care transitions and the utilization of PAC services is complex. The determination of postacute level of care is often driven by factors unrelated to producing the best possible outcome of care. As mentioned previously, the study by Sandel et al. (2009) demonstrated that discharge to PAC was correlated with gender, race, age socioeconomic background, and geographic proximity to a PAC provider. In another study by Gage (2009), hospital relationship with a PAC provider had a higher correlation with discharge to a PAC setting. Gage found that if a hospital had a formal relationship with an IRF, SNF, or HH provider, patients were more likely to be discharged to one of those settings.

Throughout the decades following the advent of DRGs, acute care hospitals have implemented care coordination under the guidance of care management. Regrettably, the move to expand the use of care coordination under the purview of care management (CM) has resulted in limited improvement in the quality of patient care. Much of the early efforts of care management were focused on utilization management, which focuses more on resource utilization, rather than care or transition management. The Agency for Healthcare Research and Quality (AHRQ) found when studying traditional models, “CM had limited impact on patient-centered outcomes, quality of care,

and resource utilization among patients with chronic medical illness” (2013, p. vii).

Failure to determine the individual patient’s appropriate site of care for PAC services has contributed to an unacceptable level of hospital readmissions. The Congressional Research Services (CRS) found that patients are readmitted to the acute care provider from the PAC setting often because they either lack the ability to provide the appropriate level of care, or lack sufficient information to provide for the Medicare beneficiary’s needs (2010). It is suggested that with improved care coordination, 30-day hospital readmissions would be reduced, with a subsequent reduction in costs and negative patient outcomes. In pilot studies conducted at an integrated healthcare network, coordinated care transitions resulted in significantly lower hospital readmission rates (CRS, 2010). This illustrates the benefits of matching the patient’s needs with the appropriate level of PAC and associated healthcare resources.

### Rehabilitation Levels of Postacute Care

Rehabilitation is a process, practice, and philosophy, not a care setting. The determination of the right level of PAC for an individual must be based on the individual’s biopsychosocial ecological assessment. There are many factors that must be considered, including systems factors, biological factors, social factors, financial resources, and environmental factors. Systems factors include the components of care and services, the intensity of services, and the structure and process of the program. Biological factors include an individual’s medical needs, preinjury or illness level of function, and tolerance of rehabilitation. Social factors include psychological and community supports, both formal and informal. Financial resources and stressors and the physical environment of the community living setting are also important considerations. The PAC setting must be matched to the patients’ needs. Tables 1 and 2 briefly describe various levels of PAC.

### Studies on Postacute Settings and Outcomes

Each level of PAC serves as a valuable component of the care continuum. Unfortunately, external pressures from payers have led to selection of settings based on cost containment, without concern for maximizing outcomes. For example, Congress imposed upon IRFs a “75 percent rule” which mandated that 75 percent of the patients treated at an IRF must have specified medical diagnoses in order for an IRF to maintain certification. In 2004, Congress lowered

the threshold to 60 percent and also removed lower extremity joint replacement from the list of diagnoses. The result has been a decrease in joint replacement patients discharged to IRFs for PAC (MedPAC, 2012).

In another example, a study by Mallinson et al. (2011) demonstrated that joint replacement patients discharged from SNF settings had a lower ability to perform self-care tasks compared with postjoint replacement patients discharged from an IRF setting. This same study showed that patients who were less dependent at admission were less dependent on discharge from home health services than either IRF or SNF patients. The finding suggests that acuity of the patients and functional level are better determinants of successful outcomes than excluding one setting versus another (Mallinson et al., 2011). The appropriate level of care with the associated intensity of services and resources tailored to the individual’s needs is achieved through effective care coordination during transitions.

Other studies have looked at the effectiveness of care in stroke patients in various settings. A study including over 58,000 patients compared clinical outcomes for stroke patients in both IRF and SNF settings. A comparison was made for stroke patients with minimal motor disabilities who received PAC in IRFs versus SNFs. For patients with minimal motor disabilities, there was no statistically significant difference in likelihood of discharge to a community setting whether they received their rehabilitation at an IRF or SNF. The likelihood of being discharged to a community setting was also not statistically different for stroke patients with significant cognitive disabilities. However, patients with mild cognitive disabilities and mild to significant motor disabilities had a greater likelihood of returning to a community setting if they received care in an IRF rather than an SNF setting (Deutsch et al., 2006). The study clearly demonstrates that motor and cognitive function should be used as determinants for PAC, rather than medical diagnosis alone.

The timing of care transitions is also critical. In a study of the effect of onset days on the functional outcomes of stroke patients receiving IRF treatment, Wang, Camicia, Terdiman, Hung and Sandel (2011) illustrated that a shorter time from stroke onset to inpatient rehabilitation hospital (IRH) admission was significantly associated with greater functional gain of stroke patients during IRH stay. Patients with both moderate and severe functional impairments had a higher total Functional Independence Measure gain when admitted to IRH within 21 days of stroke. Earlier transition of stroke patients to an IRH may lead to better functional improvement after stroke.

**Table 1** Postacute rehabilitation levels of inpatient care

	Long-Term Care Hospital (LTCH)	Inpatient Rehabilitation Facility (IRF)	Skilled Nursing Facility (SNF)	Long-Term/Custodial Care
Functional status	Medically complex needs that cannot be met at a lower level of care Have complex wounds OR Failure of two or more major organ systems OR Failed ventilator weaning after more than 3 weeks at a prior hospitalization	Patient has some degree of ADL and mobility impairment Cognitively able to participate in therapy Significant practical functional improvement is expected	Patient has some degree of ADL and mobility impairment or other skilled need Some functional improvement is expected	Patient has some degree of mobility or ADL impairment and cannot be managed at a lower level of care Patient may or may not have cognitive deficits Patient has not reached independent level to be able to be managed at-home setting Patient is no longer making progress where they can benefit from skilled intervention
Nursing & medical services required	Requires ongoing acute medical management Requires 24-hour licensed nursing care	Requires ongoing acute medical management Requires 24-hour rehabilitation nursing care Need for coordinated, interdisciplinary care	Involvement of skilled nursing staff is required to meet individual's medical needs, promote recovery, and ensure medical safety	Involvement of nursing staff does not require daily skilled nursing observation or intervention, but staff ensure that the patient's medical safety needs are met
Therapies required	Therapy as an adjunct to medical treatment	Requires two or more therapies, one of which must be PT or OT	Requires one or more therapies OR Patient has daily skilled nursing need	May require therapy, but the total must be less than 5x per week May benefit from Part B therapy if requires skilled therapy intervention N/A
Number of therapy hours required and tolerated	No minimum hours required. "Medically complex needs" is sufficient of admission	Tolerates at least 3 hour per day of therapy, 5 days per week	*There is no minimum number of tolerated hours required for SNF admission; skilled need is sufficient	
Discharge plan & social support		Probable discharge to community Adequate community support resources are available to meet needs based on functional prognosis	Completed psychosocial needs assessment - Warm handoff completed between SNF and SNF Coordinator/SNF MDs Possible discharge to community	SNF transfer must include long-term plan of care Completed psychosocial needs assessment and discussion with family regarding financial requirements Warm handoff completed between SNF and SNF Coordinator/SNF MDs

**Table 2** Postacute rehabilitation levels of care – home-based care

	Integrated Outpatient Therapy/Day Treatment	Home Health	Standard Outpatient Therapy
Functional status	Patient is able to be cared for at home Requires skilled multidisciplinary intervention with potential to make significant functional improvement in ADLs, mobility, or cognition/ language Able to do a home exercise/activity program	Patient is homebound due to some degree of ADL and mobility impairment Completed cognitive evaluation	Patient has impairments and requires only supervision or minimal assistance with mobility or ADLs Cognitively able to participate in therapy
Nursing & medical services required	Outpatient rehab RN, PM&R, case manager, and medical social worker are part of the multidisciplinary team as need	May require home health nursing	Referred to outpatient rehab RN, case manager, and medical social worker if needed
Therapies required	Requires at least two therapies	Requires one or more therapies with a nurse or social worker	Requires one or more therapies
Number of therapy hours required and tolerated	Tolerates at least 1 hour per day <i>OR</i> Patient has a skilled need and a functional goal with good rehab prognosis	Tolerates at least 0.5 hour per visit <i>OR</i> Patient has a skilled need and a functional goal with good rehab prognosis	Tolerates at least 0.5 hour per day either in the clinic or doing at-home exercises <i>OR</i> Patient has a skilled need and a functional goal with good rehab prognosis
Discharge plan & social support	Patient must have transportation to therapy location Has accessible environment at home and appropriate durable medical equipment to meet needs Has support to continue exercise/activity program at home	Confined to home Has accessible environment at home and appropriate durable medical	Patient must be able to get to/from therapy visits Has accessible environment at home and appropriate durable medical Has social support to continue exercise/activity program at home

Functional outcomes are affected by PAC services. A study conducted on stroke patients between 2008 and 2010 compared the functional level of patients 6 months after they received PAC care in various settings. Patients who received PAC care at an IRF had significant functional improvement 6 months after their stroke versus patients who received PAC care at any of the other settings (SNF, OP, or HH) (Chan et al., 2013; Deutsch, 2013).

Looking at survival rates, a study was conducted that compared 60-day and 1-year survival rates for poststroke patients after discharge from various PAC settings. The results revealed that 1-year survival rates were better for patients who received care at an IRF versus patients who were treated initially by HH, but no difference was noted when IRF patients were compared with patients treated in OP. The authors of the study recognize that differences in

survival may in fact be attributed to PAC follow-up or referral patterns rather than the PAC settings themselves. More study on survival rates is recommended (Chan et al., 2013).

As previously noted, there are great variances in the amount of therapy a patient may receive in various settings. Patients may expect to receive as little as 1 hour per day, 3 days per week in outpatient, or as much as 3 hours per day, 5 or more days per week in an IRF. The amount of care provided is dictated by financial constraints and rules that govern the requirements for licensure. To maintain licensure, an IRF must provide 3 hours per day of therapy 5 days per week (or 15 hours over 7 days) to each patient. This requirement begs the question of whether or not the costs associated with providing this level of care are consistent with expected benefits. In a study involving 360 stroke patients, it was determined that patients who received 3 hours per day of therapy, 5 days per week had significant functional gain as opposed to patients who received less than 3 hours per day of therapy. No additional benefit was noted with greater than 3 hours per day of therapy (Wang et al., 2013).

Research has also been conducted to evaluate the outcomes of ventilator-dependent LTCH patients with the goal of weaning off the ventilator and returning the patient to a community setting or lower level of care. The costs savings for transferring a patient to an LTCH was shown to be over \$20,000 per patient. Added to this is the fact that patients transferred to an LTCH had a longer mean survival time than patients who did not receive transitional care in an LTCH (Seneff, Wagner, Thompson, Honeycutt, & Michael, 2000).

### Rehabilitation Nursing

Utilization of appropriate resources is critical in the healthcare delivery system. The Certified Registered Rehabilitation Nurse (CRRN) is a rehabilitation or restorative nurse who has demonstrated a combination of experience and knowledge in this specialty practice area. The value of the CRRN was illustrated in a multisite study by Audrey Nelson (2007), which showed an inverse relationship between the number of CRRNs and LOS in inpatient rehabilitation facilities. Nelson's study showed a 6% decrease in LOS for a 1% increase in CRRNs.

Rehabilitation nurses work in a variety of roles across the continuum of health care. To assist patients in achieving optimal outcomes, rehabilitation nurses act as case managers and use their expertise in effective com-

munication between patient and family, and rehabilitation team and patient, as well as family education, to maximize rehabilitation process and minimize disability. They support the optimum utilization of therapies and community resources. In a case manager role, the rehabilitation nurse integrates psychosocial factors using disease management concepts. They maintain perspective of the trajectory of illness and recovery for complex medical issues and the care continuum over the life span and associated healthcare resources (ARN, 2006). The rehabilitation nurse assists clients in adapting to an altered lifestyle, while providing a therapeutic environment for clients and their families. The rehabilitation nurse designs and implements treatment strategies that are based on scientific nursing theory related to self-care, and that promote physical, psychosocial, and spiritual health. The nurse is a teacher, caregiver, collaborator, and advocate.

The rehabilitation staff nurse provides direct care and education on medication administration, sleep, nutrition, safety, and skin, bowel, and bladder care. The rehabilitation nurse performs activities that maintain and restore function and prevent complications. They direct carryover of skills taught and practiced during therapy. The nurse acts as a patient and family advocate.

### Members of the Rehabilitation Team

Rehabilitation nurses are key contributors to the care of individuals with chronic conditions and disability. Rehabilitation is provided by additional professionals who collaborate with each other and the patient and family to develop goals and objectives. This team approach values all members of the team, with the patient and family in the center of the team. The roles and responsibilities of team members are further defined.

#### Patient

- Communicate with other members of the team
- Learn about his/her illness or injury
- Participate in therapies
- Participate in decisions and preparations for next level of care

#### Patient Family/Caregiver/Significant Other

- Learn about the patient's injury or illness
- Investigate community resources

- Discuss concerns with team members as needed
- Provide information about the home environment

#### Physician

- Establish a medical diagnosis
- Guide the rehabilitation program
- Inform the patient and family members regarding goals and prognosis
- Order tests, DME, and postdischarge care
- Determine physical restrictions and impairment ratings

#### Rehabilitation Nurse

- Assist the client in adapting to an altered lifestyle
- Design and implementing treatment strategies to promote overall health
- Provide a therapeutic environment

#### Advanced Practice Nurse

- Conduct a comprehensive assessment
- Synthesize data to formulate decisions and plans that optimize health
- Collaborate with nursing peers and interdisciplinary team

#### Physical Therapist

- Promote mobility and function
- Diagnose and treating conditions that limit the body's ability to move
- Carry out a treatment plan that improves and restores strength, flexibility, endurance, balance, and coordination
- Teach the patient and family compensatory strategies
- Assist with the acquisition of assistive mobility devices

#### Occupational Therapist

- Utilize treatment modalities to restore ability to perform activities of daily living
- Educate the patient and family on adapting the environment, modifying tasks, or utilizing equipment to perform activities of daily living
- Develop exercise programs to improve upper extremity function

#### Speech-Language Pathologist

- Provide information regarding communication problems
- Evaluate and treating cognitive problems
- Assess for the possible use of augmentative communication devices
- Evaluate and treating swallow disorders

#### Neuropsychologist

- Assess cognitive, behavioral, and emotional aspects of the client
- Assist the team in understanding and intervening in behavioral issues
- Educate the patient and family on neurological conditions
- Provide the family with coping strategies for challenging behaviors

#### Social Worker

- Support the patient and caregiver throughout the process
- Assess the patient's social situation and its impact on recovery
- Facilitate communication between the family and rehabilitation team
- Assess and acquiring recommended resources

#### Care Coordinator

- Assist the patient with transitions between healthcare settings
- Ensure communication between patient/family and healthcare team
- Assist the family/patient understand healthcare benefits
- Identify skills and expectations of patients/families with regard to the rehabilitation process.

#### Recreational Therapist/Activity Therapist

- Promote social skills and constructive use of leisure time
- Develop educational leisure programs
- Provide information on community resources to assist with community reentry

The composition of the rehabilitation team is dependent on the needs of the individual and the treatment setting. It is critical that individuals with chronic and disabling conditions are served in the PAC setting that includes the provision of services to optimize health outcomes and quality of life. Not every rehabilitation team will consist of representatives of each of these professions.

### **The Role of the Patient and Family: Postacute Care Transitions**

Transitions across care settings represent a time of “heightened vulnerability” (Chugh, Williams, Grigsby, & Coleman, 2009; p. 11) for patients, and confusion and uncertainty for family members. The key points of transition are between acute care and postacute levels of care and the transition to home. Transitions home can be particularly overwhelming and have been defined as a time of crisis for family caregivers, especially those who are new to the caregiver role (Lutz et al., 2011). Transitioning patients who qualify for rehabilitation services to the appropriate setting throughout the continuum of care is important to achieving the best possible patient outcomes (Chan et al., 2013).

Acute care hospitalizations are often a time of crisis for patients and their families, making cognitive decision making difficult. The acute hospital ALOS is often short (5 days), requiring quick decisions about the next level of care. Families often believe that the patients’ healthcare providers are the most appropriate people to make the decision about the next level of care. This is heightened if the family is overwhelmed, in crisis, or lacks the knowledge to make such decisions. If the patient or family places a high value on the expertise of healthcare providers’ knowledge about appropriate levels of care, they will rely heavily on that expertise. In many cases, when given a choice, they will defer to the healthcare provider to make a recommendation of the appropriate level of care. However, many healthcare providers do not have the necessary information to make decisions about the PAC. Furthermore, in many instances, families are often not included in the decision-making process.

Engagement of the patient and family in this decision making is essential, although the degree to which patients and families are involved is variable. Health literacy is an important consideration that is often overlooked. According to Dossa et al., (2012), discharge information needs to be legible, in large type, and provide accurate information to patients regarding contact information for questions.

Discharge education and instruction need to be thoroughly reviewed by both patients and their caregivers.

Patient and family engagement in decisions regarding care has been defined as “essential to improving quality” (Nursing Alliance for Quality of Care [NAQC], 2013; p. 2) of care and is key to providing patient-centered care (NAQC, 2013). Rehabilitation professionals have identified the importance of including the patient and his or her family members in the decision-making process regarding the most appropriate location for PAC. Patients and family members are often overwhelmed because of the illness and defer to healthcare providers, friends, or other support mechanisms to assist them in making the PAC transition decision.

Often, the healthcare provider (physician, nurse, social worker, or case manager) makes the decision about the next level of care and the facility to which the patient transitions. This may depend on which facilities have space available or on the healthcare provider’s opinion on what the appropriate level of care is. Families and patients often indicate that they were not informed about their options or were not included in the decision-making process. When choices are provided, they are not explained in sufficient detail for families and patients to make an informed choice (Lutz et al., 2011).

### **Discussion**

The current process of care transitions for individuals with disabling conditions is both ineffective and inefficient. The patient and family are unable to process information and often are not provided with necessary information and support to participate in decisions regarding care transitions. Furthermore, clinicians involved in PAC decisions are guided more by geographic proximity or relationship with their own setting, rather than achieving optimal, cost-effective outcomes for the patient and families involved.

The current case management model has failed to promote the utilization of clinicians skilled in advocating on behalf of the best interests of patients and their families. The clinician involved in PAC transitions for people with chronic disease and disabling conditions must be client centered, goal oriented, and outcome based. They must understand the available levels of PAC and roles of other professionals and how each role impacts the long-term success in the patient’s care. The nurse, who either through specialty certification (CRRN) or experience in rehabilitation nursing, possesses this knowledge and skill. It is the role of the nurse to advocate on behalf of the

patient, understand the scientific basis for healthcare decisions, and balance the various ethical needs of the patient. Rehabilitation nursing provides the foundation needed to practice the art and science of case management for patients with complex medical and psychosocial conditions. The nurse–patient relationship is unique within the healthcare environment and, because nurses are central to the healing process, their role on the rehabilitation team is vital. Rehabilitation nurses use assessment skills in a holistic manner that is inclusive of physical, behavioral, spiritual, and psychosocial factors (ARN, 2006).

## Conclusion

A nurse with rehabilitation nursing training, knowledge, and experience is the healthcare professional who is best able to coordinate, support, and oversee the discharge transition process to promote quality outcomes and cost-effective care for individuals with disabling conditions. To this end, ARN makes the following recommendations:

### Practice

- Care transitions for individuals with disabling conditions must be facilitated by nurses with rehabilitation nursing training, knowledge, and experience.
- It must be the role of the rehabilitation nurse to educate and inform families on options and services available, taking scientific evidence and summarizing in meaningful ways, so that families can make informed decisions about care transitions.

### Policy

- Nurses with training, knowledge, and experience in rehabilitation nursing 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 United States.
- Rehabilitation nurses should be included on technical expert panels assessing concepts for future care coordination measure development, including transitional care, as a tool to evaluate the quality of care coordination for individuals with disabilities.

### Research

- Studies are needed to evaluate the impact of rehabilitation nurses on the healthcare delivery system.

## Key Practice Points

- Post acute care (PAC) options are often complex and confusing to patients and their families.
- Rehabilitation nurses must be involved in facilitating transitions of care.
- The rehabilitation nurse must be involved in research and public policy initiatives in order to educate and advocate for the patient.

- Federal agencies should fund research that supports comparisons of payments and quality models and evaluation of value-based payment models.

### Education

- ARN's Standards and Scope of Rehabilitation Practice and the ARN white paper, *The Essential Role of the Rehabilitation Nurse in Facilitating Care Transitions*, should be foundational documents for discharge planning education related to care transitions for individuals with disabling conditions.

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