Case management is an accepted and even preferred method of managing the many aspects of providing health and social interventions across the continuum of care. Rehabilitation nurses, in particular, have become involved in this systematic approach to caring for patients or consumers. As a result, the Association of Rehabilitation Nurses (ARN) developed this role description of rehabilitation nurse case managers. The purpose of this description is twofold: (1) to identify and clarify the role of rehabilitation nurses participating in the case management process, and (2) to promote a high degree of professionalism in keeping with the established scope and standards of rehabilitation nursing practice (Rehabilitation Nursing: Scope of Practice; Process and Outcome Criteria for Selected Diagnoses and Standards of Rehabilitation Nursing Practice, both publications developed by the Association of Rehabilitation Nurses and the American Nurses Association [ANA]) as well as the Standards of Practice for Case Management as developed by the Case Management Society of America.

Throughout this document, the term individual refers to a person with an injury or illness receiving healthcare services. The term family refers to significant others as well as biological relations.

**Definition of case management**

The Association of Rehabilitation Nurses supports the following definition of case management: the process of assessing, planning, organizing, coordinating, implementing, monitoring and evaluating the services and resources needed to respond to an individual's healthcare needs. This process is most effective when these steps occur:

- timely identification of individuals in need of services, ideally at the onset of an injury or illness;
- referral to a qualified rehabilitation nurse case manager who has a high level of expertise in the area(s) of health and social interventions needed;
- assessment by the case manager to determine the individual's strengths, challenges, prognosis, functional status, goals, and needs for specific services and resources;
- development of a plan that identifies short- and long-term goals, involving the individual, support systems, interprofessional collaboration and use of appropriate resources;
- identification, procurement, and coordination of services and resources to implement the plan;
- provision for ongoing evaluation of the individual's progress on the plan as well as of the effectiveness and appropriateness of the services provided throughout the entire continuum of care;
- advocacy for the most appropriate, cost-effective, evidence-based services to assure quality of care and attainment of appropriate goals; and
- promotion of the individual's self-advocacy skills to achieve maximum self-sufficiency.

**Goal of case management**

The goal of case management is the provision of quality and cost-effective health and social care services. The rehabilitation nurse case manager realizes this goal by organizing rehabilitation and other necessary healthcare services to promote outcomes for the individual that will encourage the highest possible level of independence and quality of life.

**Roles of the rehabilitation nurse case manager**

The rehabilitation nurse case manager can be found in a variety of roles:

- facility- or agency-based case manager- a case manager employed by a healthcare facility, governmental or private agency, or healthcare provider.
- insurance-based case manager- a case manager employed by a third-party payor (e.g., an insurance company).
• employer based case manager- a case manager retained by an employer to provide case management services directly to employees.
• independent case manager- a private case manager whose services are retained by a third-party payor, facility, agency, or an individual or family.
• life care planner- a case manager who prepares a dynamic plan that addresses the costs of medical and associated care over an individual’s life time.

Settings
Case management services are provided in institutional, residential, outpatient and community settings. These settings include, but are not limited to, acute care facilities, rehabilitation facilities, skilled nursing facilities or nursing homes, residential facilities, day care agencies, private residences, or the workplace.

A case manager may provide case management services in any or all of these settings based on short/long-term goals and contractual or employment agreements.

Functions of the rehabilitation nurse case manager
The rehabilitation nurse case manager uses the principles of rehabilitation nursing as defined within the established scope of rehabilitation nursing practice and standards developed by ARN, ANA and CMSA. The functions of the rehabilitation nurse case manager can be divided into several categories, which are outlined below.

Data collection and assessment

1. Obtains all necessary authorizations to contact the individual and family for an initial interview and assessment.
2. Reviews and analyzes referral information in consultation with the individual, health team members, employers, family, legal representative, and claims/insurance personnel as indicated.
3. Reviews and assesses the individual's personal and medical history, current status, diagnosis, prognosis, current treatment plan, and care provider's level of expertise. (For catastrophic injuries or illness, an on-site assessment of the individual and anticipated or actual provider is highly recommended.)
4. Assesses the individual's learning needs related to the medical diagnosis and prognosis, treatment providers, treatment options, financial resources, psychosocial adjustment and coping mechanisms, and vocational rehabilitation requirements and potential.
5. Assesses the family's knowledge base, health status, expectations, and the potential for or actuality of a family member acting as the primary caregiver if necessary.
6. Identifies the team members appropriate for each individual.

Data analysis and formulation of nursing diagnosis

1. Identifies any temporary or permanent alterations in function that have resulted from the injury or illness.
2. Identifies potential challenges or complications of physiological and/or psychosocial function.
3. Identifies potential difficulties in community reintegration where appropriate.
4. Identifies the learning needs of the individual and significant others.
5. Considers vocational history prognosis for re-entering or entering the work force when appropriate.

Establishment of goals and plan of care

1. Establishes realistic goals to achieve optimal outcomes for the individual. This is done in collaboration with the individual and/or family and with the interprofessional team and within available resources.
2. Assists the individual, the family, and team, in identifying the variables that may influence the accomplishment of goals.
3. Develops a comprehensive plan that includes short and long term goals and preventive treatment measures. Identifies alternatives for the individual's treatment when appropriate.
4. Establishes target dates for achievement of goals.

Implementation

1. Uses rehabilitation principles to promote optimal outcomes for the individual.
2. Provides ongoing assessment of the individual, family, and/or caregiver.
3. Coordinates access to accelerated and/or alternative care options when appropriate.
4. Coordinates access to appropriate government and community programs and resources.
5. Coordinates and evaluates in a quality-conscious, cost-effective manner the individual’s and family’s use of medical equipment, supplies, medications, and the full spectrum of services.
6. Provides instruction to the individual and family based on identified learning needs.
7. Coordinates referrals for instruction or counseling as is agreeable to the individual and family, based on identified learning needs.
8. Provides education, guidance, and recommendations to the referral source regarding alternatives for care and services where appropriate.
9. Intervenes promptly when necessary to promote optimal functioning and prevention of complications.
10. Facilitates and collaborates with the healthcare team for timely discharge planning to an alternative level of care or return to the individual’s community when appropriate.
11. Coordinates the discharge plan with the healthcare team and providers.

Collaboration

1. Collaborates with the healthcare team, payors, community agencies, providers, and legal representatives to ensure continuity of the individual’s care through all healthcare settings.
2. Promotes effective communication among healthcare team members, including the individual, family, and payors and employer when appropriate.
3. Participates in team meetings when indicated.
4. Incorporates recommendations and/or services of interprofessional team members in plan of care.
5. Communicates with other case managers along the continuum of care for coordination of the needs of the individual if case management involvement is limited by setting.

Documentation

1. Provides routine verbal and written documentation of the initial assessment and progress of the individual to the referral source and/or appropriate others on a timely, regular basis.
2. Projects costs and needs for the future and provides cost analysis to the referral source as appropriate.
3. Provides a written summary of educational information for the individual, family, or referral source as appropriate.

Community reintegration

1. Assists the individual and family in anticipating needs and making plans for reentry to home or an alternative living site.
   a. When the individual will live at home:
      i. Recommends and coordinates home assessment services before discharge and necessary reassessment after discharge.
      ii. Assists in selecting and arranging for quality-conscious, cost-effective home care, equipment, and services.
      iii. Monitors services for appropriate length of service and/or quality of service.
   b. When the individual will live in an alternative living site:
      i. Assists in determining the most appropriate level of care for the individual.
      ii. Assists in locating and selecting a site.
      iii. Arranges for assessment of the setting, as well as for reasonable adaptation of the site to meet the individual’s needs.
2. Assists the individual and the family in anticipating needs and making plans for reentry into the community environment.
   a. Arranges for special assessment by educational or vocational counselors when indicated.
   b. Assists the individual and family in planning for reentry to the school and/or work environment through collaboration with a vocational counselor (as appropriate) and through contact with school system and/or employer representatives.
   c. If competitive employment is not an option for the client, assists the individual and family with identification of community activities and resources and/or volunteer placement when appropriate.
   d. Ensures that funding is available for services through the referral source or other resources.

**Evaluation**

1. Performs periodic reassessment of the individual's and significant others' response and progress toward treatment goals.
2. Facilitates and participates in conferences that provide ongoing evaluation of interprofessional dynamics, goal attainment, and treatment plan revision.
3. Facilitates case closure based on the individual's response, progress toward treatment goals, and established criteria of the employing facility or agency, or at the request of the third-party payor if appropriate.
4. When appropriate, determines a final cost/benefit analysis for the agency or referral source at close of case.

**Quality assurance**

1. Provides for an evaluation of case management services.
2. Incorporates evaluative data in the provision of ongoing case management services.
3. Adheres to established standards of practice as identified by ARN, ANA and CMSA.

**Qualifications**

Licensure as a registered nurse, preferably with a degree in nursing (BSN) from an accredited school or equivalent work experience.

- A minimum of 2 years of related clinical experience; experience in the rehabilitation of chronically or catastrophically ill or injured individuals is highly recommended.
- Certification in rehabilitation nursing or a related specialty is highly recommended.
- Maintenance of continuing education appropriate to case management and renewal of certification.
- Demonstrated accountability and skills in analysis, problem solving, decision making, time management, and oral and written communications.
- Familiarity with the resources available regarding the regulations and parameters of third-party reimbursement.