

# CASE STUDIES

## A Tale of Two Case Managers

### 1 CASE

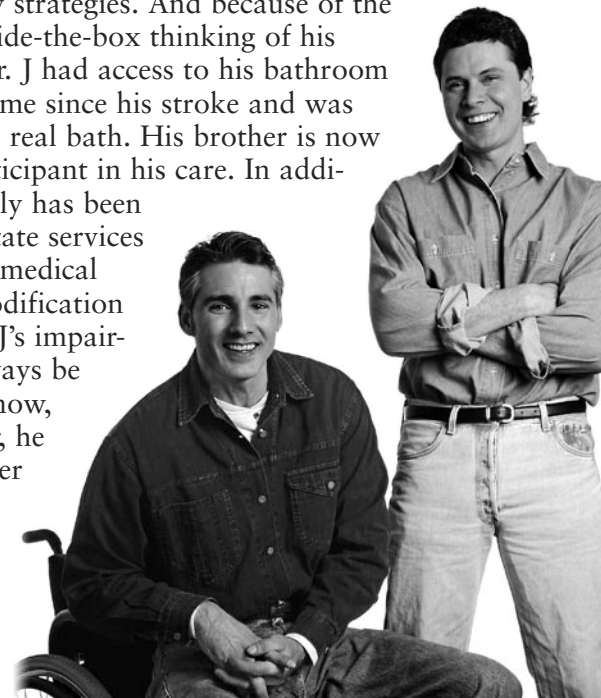
**Background:** Last year, Mr. J\*, a 56-year-old man who lived at home with his partially disabled, unemployed brother, sustained a stroke and was in and out of hospitals due to various complications. Before the stroke, however, Mr. J was his brother's primary caretaker and chief financial support. Now the roles were reversed. This left the homecare company coordinating his services very concerned about the family care he was receiving. On the brink of calling Adult Protective Services, the homecare company referred the case to Rehab Without Walls®.

**Rehabilitation Needs:** When Rehab Without Walls entered the picture, Mr. J was bed-bound, unable to even sit upright without vomiting. He had a Foley catheter and was being tube-fed. Due to architectural barriers in the home, he had not had a bath or shower in six months; his bathing was limited to sponge baths. He also had visual impairments. The brother was unable to drive, and public transportation in the area was very limited, therefore even basic needs such as food and running the household were being neglected.

**The Clinical Coordinator's Role:** The clinical coordinator on this case was also a social worker. After assessing the client's physical needs, she wrote a plan of treatment and coordinated a strong clinical team. Then she devoted her time to helping the family get their more basic needs met. First, she looked at Mr. J's insurance options and worked to get him maximum coverage. Because the family was relying on food banks for food delivery and using their medication dollars to pay for the tube feeding, she worked with the insurance company to cover the formula for the tube feeding. She also quickly learned that the brother responded best to written, not oral, instructions, so she ensured that all of his directions from the team be in writing. She contacted the Lion's Club for free eyeglasses and got a tub transfer bench donated from another source. Transportation proved

to be a little trickier because the local "Handitrans" service only gave rides to and from medical appointments. But when the clinical coordinator learned that Mr. J was a veteran, she was able to arrange for more extensive transport, as well as financial and medical services, through the local VA hospital.

**Outcomes and Results:** "This was a very intensive case because every aspect of this family's life needed assistance," remarks Patricia Runnels, a Rehab Without Walls Director of Clinical Management. "But that's the beauty of the kind of functional, relevant treatment Rehab Without Walls specializes in. We work in the client's home in real world situations." In this case, the clinical coordinator was critical to the process because she could see the bigger picture and had deep resources in the community. Without her interventions and the overall comprehensiveness of the rehabilitation services, the family could have easily fallen through the cracks. As a result of her efforts, Mr. J has become increasingly independent in his mobility and self-care, and can perform basic transfers and compensatory strategies. And because of the creative, outside-the-box thinking of his therapists, Mr. J had access to his bathroom for the first time since his stroke and was able to take a real bath. His brother is now an active participant in his care. In addition, the family has been linked with state services for financial, medical and home modification support. Mr. J's impairment will always be a factor, but now, one year later, he and his brother have an increased quality of life.



**Background:** Steve\* is a 25-year old now living at home with his family after sustaining a traumatic brain injury. He was referred to Rehab Without

Walls® two years after his initial injury via his insurance case manager.

Previously, he had been in almost every type of facility along the continuum—acute care, residential and day treatment—but had made little progress.

## 2 CASE

**Rehabilitation Needs:** At the outset, the Rehab Without Walls clinical coordinator recommended an intensive program of 18 to 23 hours of treatment a week. However, even that proved insufficient and she increased treatment to 24 to 29 hours a week. “To have that intense of a program two years post trauma shows how impaired Steve really was,” notes Runnels. “He had a low level of functioning in every aspect of his life.” The clinical coordinator soon noticed, however, that there was also a level of dysfunction in the family that seemed to be affecting his progress. She felt her best role in the treatment would be to deal with the family’s emotional issues proactively.

**The Clinical Coordinator’s Role:** As she sought to understand the family dynamics, the clinical coordinator realized that the mother was still very angry about what had happened to her son and that the anger was coming out in ways that were having a negative effect on the treatment process. Frequently, the mother would question the various clinician’s intentions and unwittingly sabotage her

son’s progress. She was not open, however, to neuro psyche support or any formal counseling. So instead, the clinical coordinator asked the clinicians to transfer all of the mother’s calls directly to her. This resulted in her speaking with the mother on a daily basis. “In effect, the clinical coordinator took on the role of counselor, educator, clinical coordinator and one-on-one caregiver with the mom,” says Runnels. “She even spent a week going with the mother to various appointments in preparation for discharge.”

This was the turning point in building a trusting relationship with the mother. It also helped her to finally understand the family’s role in the rehabilitation process. Afterward, compliance and follow-through increased and the family became much more involved in the home programs and strategies for Steve’s rehabilitation.

**Outcomes and Results:** “The family had to face the challenges of learning to live with the results of a catastrophic injury. They weren’t in denial, but they were overwhelmed and unable to see the big picture,” explains Runnels. “The clinical coordinator was able to provide this picture, then break down their parts into manageable chunks, while allowing the clinicians to focus on the treatment

that Steve so badly needed. Although Steve still has a ways to go in his recovery process, he now is able to get maximum results from his treatment thanks to family participation and cooperation.”

*\*Names of patients and family members have been changed to protect their privacy.*

