Toronto Rehab Foundation Lunch & Learn

Thursday, December 5, 2019

Discharge Planning and Financial Considerations Following a Traumatic Injury

Leonard Kunka (Moderator)
Partner
Thomson Rogers

Panel:

Stephen Birman
Partner
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Nina McQuigge
Case Manager
Innovative Case Management

Rachel Footman
Occupational Therapist
FunctionAbility

THOMSON ROGERS
LAWYERS

UHN Toronto Rehab Foundation

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Stephen Birman, *Partner*

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AUTO INSURANCE:

Two types of MVA claims (no-fault and tort)

- **Short-term** focus in on no-fault claim and disability claims
- **Longer term** focus in on tort claims
- Auto insurer works on pre-approval basis so get started early (help with OCF-3 and OCF-19)
- Auto insurance kicks in after other available coverage

KEY BENEFITS:

Medical/Rehabilitation (capped at $1,000,000 for catastrophic cases).

Home and Vehicle Modification

Attendant Care

Equipment

HOW YOU CAN HELP:

- Paperwork and Forms
- Document Community Needs and Be Expansive
- Communication with Community Team
- Team Meetings and Discharge Communication
- Leave Contact with Insurers to Counsel

THANK YOU

Please feel free to call or email with questions.

STEPHEN BIRMAN, *Partner*
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Hospital Discharge

The Role of a Case Manager in Discharge

To coordinate treatment, complete referrals as needed, and ensure good communication with everyone involved.

Support in navigating systems including the OHIP / healthcare system, treatment, legal and insurance systems.

Work closely with the Occupational Therapist throughout the discharge process. This can include setting up accounts (ie. Pharmacy, taxi, etc.), making referrals to community providers, ensuring equipment and assessments are completed and the discharge destination will safely accommodate the person.

Bringing the Case Manager and Occupational Therapist into the process prior to discharge as much as possible can help ensure a smooth transition.

Post Discharge and Communication

Following discharge there can often be a lag. Managing aspects that were taken care of in hospital such as treatment schedules, medication, PSW / nursing support is usually very stressful. This in combination with the emotional and physical adjustments following a severe injury can impact overall treatment progress.

Good communication can reduce stress significantly. This can include keeping the hospital informed of what is being set up in the community, and having the hospital provide information on any upcoming medical appointments, changes and lists of medications, and copies of treatment recommendations and assessments as early as possible.

Joint sessions / direct communication, as well as team meetings, are crucial to carry over of information. The hospital team is the expert in the patient's needs at the time of discharge. This is invaluable information for the community treatment teams. Thorough communication allows the community team to pick up where the hospital team left off, which means less falls on the patient to coordinate.

Documentation

There are a number of reports and forms that need to be completed prior to the insurer approving certain funds. This can include a Form 1 for Attendant Care, an OCF3 (Disability Certificate), and OCF19, an application for Catastrophic impairment.

Having the community team members complete assessments prior to discharge can help to ensure treatment is available and ready as soon as the person leaves the hospital. It takes time to get approval from the insurer, so this needs to be coordinated before discharge. The insurer has 10 business days to respond to requests, in addition to the time it takes to draw up the necessary forms and have them signed and submitted. Good coordination is key to avoid lags in treatment.

The hospital team helps set the stage for current and future funding; Adjusters often rely heavily on hospital recommendations in terms of agreeing to pay for services. If possible, refrain from documenting that certain services are NOT needed as Adjusters can use the information to deny future treatment. The hospital is a structured environment, and once clients get home and are challenged in new ways, their treatment needs can change.

Broad Picture

Part of the Case Management role is to look at long term planning to ensure that funding is used appropriately and doesn't run out.

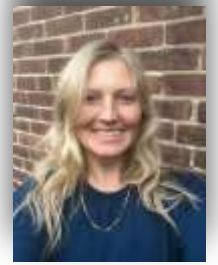
This is especially important following the most recent changes as there is significantly less funding available to someone who has been in an MVA.

Assessing needs and goals can help determine what treatment to prioritize. For example someone who has a significant brain injury may require supervision in the community due to safety concerns (wayfinding, walking into traffic, etc.). Using a Rehabilitation Support Worker would allow more consistent support, with other treating team members providing supervision with less direct treatment. This would conserve funds but still ensure progress in treatment and overall safety.

Determining what treatment to focus on is an ongoing discussion with everyone involved in order to maximize recovery, funding, and a person's goals.

functionability
rehabilitation services

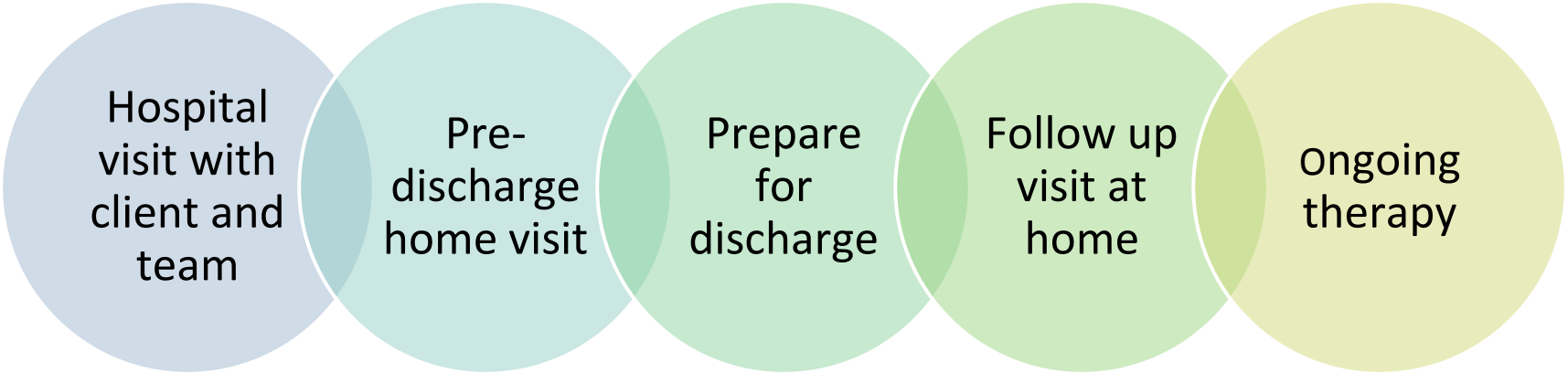
How to support a safe transition from rehab to community. (2019)



- Rachel Footman - Occupational Therapist
- I have worked as an OT for 17 years.
- I had the greatest opportunity to work with the fabulous 1B team at Lyndhurst for 8 years before transitioning to Private Practice last year.

Lyndhurst OT

Private Practice

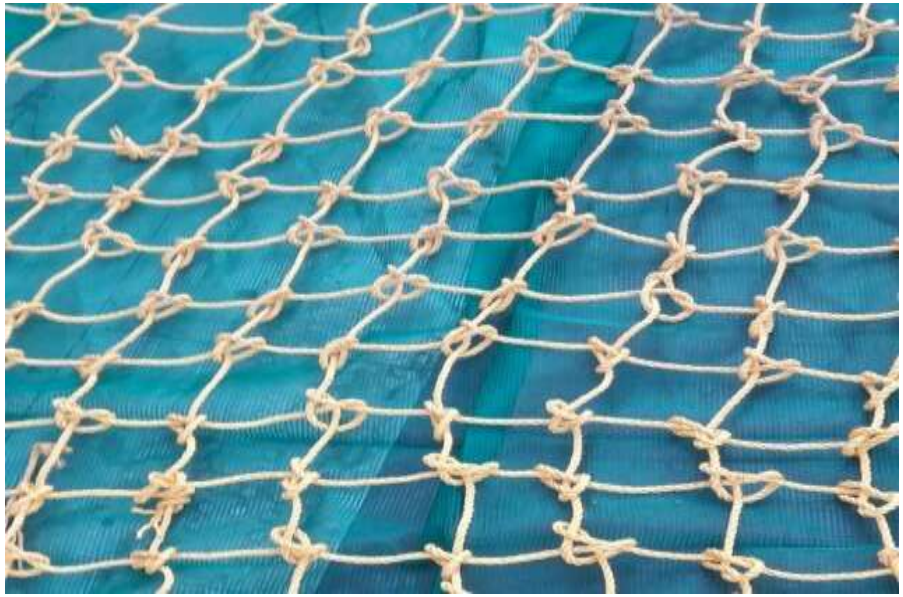

Hospital visit with client and team
Pre-discharge home visit
Prepare for discharge
Follow up visit at home
Ongoing therapy

1) Navigate Funding Systems

- Insurance – Rehabilitation benefits, Equipment
- Public Services – referrals as needs arise
- Extended Health Care (workplace benefits)

2) Discharge Safety Net

- Collaborate with the hospital team, advocate for the client
- Attend Team meetings, assist with discharge planning
- Home visits – proactively deal with barriers to discharge
- Secure funding and follow through on medical recommendations



- Identify clients with motor vehicle collision related injuries
- Start conversation early
- Communicate recommendations to the community team as soon as possible
- Keep communications lines open with the community team

- Transitions can be high risk and stressful and need a strong partnership for the best outcomes for the client
- Responsive and compassionate therapists can make the transition easier
- Post-traumatic growth, resilience and return to meaningful activity is the long term focus

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