**Comparing Models of Care Delivery:** New models of providing services will continue to emerge, as health care services continues to evolve and change. Often rehabilitation nursing leaders or managers will not use one single model. Instead, they will develop a service model in which many models will coexist to develop effective framework to meet the goals of a more diverse population it aims to service & to help address the staffing challenges in the industry. The rehabilitation nursing philosophy can be infused into any healthcare setting. Collaboration between team members and the individual, family and community is a vital aspect of rehabilitation.

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| **Models of Care Delivery** | **General Description** | **Focus** | **Advantage/Disadvantages** |
| Client-centered care | Serve a specialized population such as individuals with mental illness | The focus can be on a specific developmental stage such as older adult or geriatric or a type of impairment such as traumatic head injury | With a targeted population, providers target the resources and gain extensive expertise |
| Setting-centered care | Focuses on the setting such as acute care, long-term care, home care and community care are traditional models | Each focus on where or the setting in which care is provided | The trend away from inpatient care has accelerated in recent years, because of changing funding practices |
| Provider-centered care | There are many models that reflect how healthcare providers decide to organize the provision of care. Such as task model; team nursing or primary care nursing which was popular in the 1980’s | Goal is often to maximizing the use of human resources. | There are a wide variety of provider-centered models utilized to delegate care task to providers at various skill levels. This model is more expert driven and often still utilized in most Long-Term Care settings. |
| Person-centered care | Individuals become active participants in their own care | Services are designed to focus on their individual needs and preference. A partnership to ensure that decisions respect clients wants, needs and preferences | This model is at the core of national and local efforts to improve quality of care. There is a commitment to enhance quality and safety to ensure clients/families make informed decisions about their health |
| Case Management | Coordinate a spectrum of care through client transitions and across multiple practitioners and practice settings. The role of a case manager is broader than health care. The CM address social determinants of health and utilizes a collaborative process of assessment and planning | Collaborative assessment, coordination, advocacy for options and services to meet an individual’s health needs through communication and available resources to promote quality of care. Monitors services for individuals to move from illness/injury along a continuum towards wellness. | Provides early identification and referral of client needs of comprehensive services.  Ensure appropriate care to each client; improve continuity of care; increases client satisfaction; reduces duplication of services; decrease cost and improve team morale |