(A) Policy Statement

Services rendered to patients will be coordinated to promote continuity of care.

(B) Purpose of Policy

To facilitate continuity of care among community agencies, facilities, and disciplines, to ensure a coordinated and integrated approach to treatment, family instruction/counseling, and discharge planning.

(C) Procedure

1. Referral information will be obtained prior to treatment of the patient.

2. The care coordination staff will facilitate communication between UTMC and community resources.

3. Representatives of each rehabilitation service shall attend the team conference, trauma rounds etc. as appropriate, based upon their location of service. Information and disbursing recommendations will be communicated to the primary clinician (if other than themselves).

4. Effort shall be made when indicated to meet with the nursing staff and communicate information regarding positioning, transferring, communication, and ADL techniques, including swallowing precautions, to meet the needs of the patient.

5. The Rehabilitation Services Department shall, upon request, provide formal inservice education for the nursing staff, other disciplines, other facilities, and community referral sources.

6. Documentation of coordination efforts/team conferences will be made on Team Conference forms, or in the discipline progress notes.

7. Documentation of recommendations between services shall be recorded in the appropriate service record of the patient.

8. Each individual staff therapist is responsible for arranging continuity of care for his/her patients.
It is the responsibility of the reader to verify with the responsible agent that this is the most current version of the policy.