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

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.

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

2. 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).

3. 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.

4. The Rehabilitation Services Department shall, upon request, provide formal in-service education for the nursing staff, other disciplines, other facilities, and community referral sources.

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

6. 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.