CARE/SERVICE COORDINATION

PURPOSE

To ensure the coordination of services for each patient and to minimize the potential for missed, conflicting, or duplicated services.

POLICY

Timely and ongoing communication is the responsibility of each team member and will be appropriate to the needs and abilities of the patient, and relevant to the care/service provided. The clinician/technician will be responsible for facilitating communications about changes in the patient's status among the assigned personnel.

PROCEDURE

1. The program supervisor will assign the patient to a clinician/technician based on the patient's need and level of care required, geographic area, and qualifications of organization personnel needed.

    A. A registered nurse will be assigned to a patient receiving skilled nursing.

    B. A physical therapist or speech therapist will be assigned to a patient receiving physical or speech therapy only.

    C. An occupational therapist may be assigned to a patient after the case has been opened by a registered nurse, physical therapist, or speech therapist.

    D. A respiratory therapist will be assigned to patients in need of clinical respiratory services.

    E. A service technician will be assigned to non-clinical patients receiving home medical equipment services.

2. The assigned clinician/technician will be qualified through education, training, and/or experience and will:

    A. Understand the principles of care/service provided

    B. Know the required qualifications for organization personnel providing care/service and know which organization personnel possess these qualifications

    C. Know the scope of care/service that can be provided by various organization personnel

    D. Understand the nature of the patient population served

3. It will be the responsibility of the primary clinician/technician to facilitate communication about changes in the patient's status among all assigned disciplines.

4. Organization personnel will communicate changes in a timely manner via telephone, one-on-one meetings, case conferences, and home visits. Documentation of all communications will be included in the clinical record on a communication note, case conference summary, or clinical note. Documentation will include:

the date and time of the communication, individuals involved with the communication, information discussed, and the outcome of the communication.

5. When the patient requires more than one (1) service from the organization, the Case Manager will be responsible for cooperative care planning in order to assure that goals, actions, and the interrelationship of services is not duplicated and to minimize the potential for missed or conflicting services.

6. Written evidence of care coordination may be found in the plan of care/service, case conference summary forms, and clinical notes in the patient's clinical record or interdisciplinary group meeting notes.

7. All organization personnel involved in patient care/service, including those providing contracted services, will have access to the plan of care/service and all other relevant patient information to ensure coordination and continuity. All personnel will be knowledgeable regarding patient needs, goals of care, and services.

Contract organization personnel will participate in preparation of the plan of care/service; submit weekly documentation of services provided including clinical notes, schedule of visits, and patient evaluations/assessments; and participate in multidisciplinary (interdisciplinary group) case conferences when a patient in their caseload is being discussed.