Alden

Rehabilitation & Health Care Centers

Post-Acute Collaborative Care Process

Pre-Admission Screening

- Medical Track (Congestive Heart Failure, Acute Myocardial Infarction, Pneumonia, Sepsis – protocols for the prevention of unneccesary returns to the hospital)
- Therapy Track (Optimal Rehabilitation, Rapid Rehabilitation)
- Referral Sources determined (Home Health, Outpatient Therapy, Hospice, etc)
- Return to Hospital Risk Assessment

Patient Commitment Agreement (enrollment and participation in the program)

My Therapy/Heart Notebook

Daily Weight Log and Monitoring (Cardiac)

Diuretic Flow Sheet if change in orders (Cardiac)

Diet and Health Lifestyle change (Education)

Patient Satisfaction/Delight Survey (initial and final – 3 days prior to leaving)

Optimal Interdisciplinary Team Rounds (at bedside)

- Initial Rounds - Within 24 hours (Nurse, Therapist, Discharge Planner/Ambassador)
- Hourly Clinical Rounds (Medical Track)
- Weekly Rounds (Physician or Advanced Practice Nurse, Nurse, Therapist, Discharge Planner)

Patient Self-Assessment

Return to Hospital Risk Assessment

Patient Education Log

Weekly Updates

- To Hospital
- To Surgeon
- To Primary Care Physician (in community) upon admission and prior to transition to next level of care

Return to Hospital Analysis

- Review/analysis of all Return to Hospital statistics conducted by the facility and jointly with the hospital on a monthly basis

Transition Summary/Recapitulation

Post Acute Transition Review Checklist

Post Acute Follow Up Tracking Process (24 hours, 72 hours, 7 days, 15 days, 30 days)

Metrics: Return to Hospital, Successful Transitions, Therapy Length of Stay, Therapy Goals Met, Alden Length of Stay, Patient Satisfaction, Physician Satisfaction, Hospital Satisfaction

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