



Long-Term Care (LTC) – Rounds

INSTRUCTIONS

1. Please print clearly, or type in all of the fields below.
2. Please email the completed form to the Alliance LTC Department at LTCHCS@alamedaalliance.org.

For questions, please call the Alliance LTC Department at **1.510.747.4516**.

Facility Name: _____

Date: _____

CENSUS			
Census			
Number of Straight Medi-Cal:		Number of Duals:	
Number of Authorizations Due This Month for Reassessments:			
Room & Board			
Number of Members Receiving Hospice:			
ADMISSION FROM HOSPITAL OR SKILLED NURSING FACILITY (SNF)			
Number of Admissions:			
Name/DOB			
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
MEMBERS READMITTED TO THE HOSPITAL			
Number of Readmissions:			
Name/DOB	Reason for Readmission	Date	Date Returned
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

BED HOLDS/LEAVES OF ABSENCE (LOA)		
Number of Active Bed Holds/LOAs:		Number of Bed Holds/LOAs Pending Authorizations:
Name	Date(s)	
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
DISCHARGES ANTICIPATED		
Number This Week:		Number In Two (2) Weeks:
		Number In One (1) Month:
Name/DOB	Anticipated Discharge Date	Discharge Needs
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
INTERDISCIPLINARY TEAM (IDT) MEETINGS		
Any scheduled meetings in the next two (2) weeks for our members? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Name/DOB	Meeting Date and Time	
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
BILLING CONCERNS		
Unpaid Claims:	Volume:	Type:

QUALITY CONCERNS/POSSIBLE COMPLEX CASE MANAGEMENT (CCM)		
Name	Event	Comments
1.	Choose an item	
2.	Choose an item	
3.	Choose an item	
4.	Choose an item	
5.	Choose an item	
6.	Choose an item	
7.	Choose an item	
8.	Choose an item	
9.	Choose an item	
10.	Choose an item	
QUALITY: CRITICAL INCIDENT REPORTING/CALIFORNIA DEPARTMENT OF PUBLIC HEALTH (CDPH)/OMBUDSMAN		
Event	Explanation	
1. Choose an item		
2. Choose an item		
3. Choose an item		
4. Choose an item		
5. Choose an item		
6. Choose an item		
7. Choose an item		
8. Choose an item		
9. Choose an item		
10. Choose an item		
TRANSPORTATION ISSUES/MISSED APPOINTMENTS		
Name/DOB	Reason (Date, Time, What Happened)	
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
Issues		
Specify:		
STAFFING		
Staffing Shortage? <input type="checkbox"/> Yes <input type="checkbox"/> No		