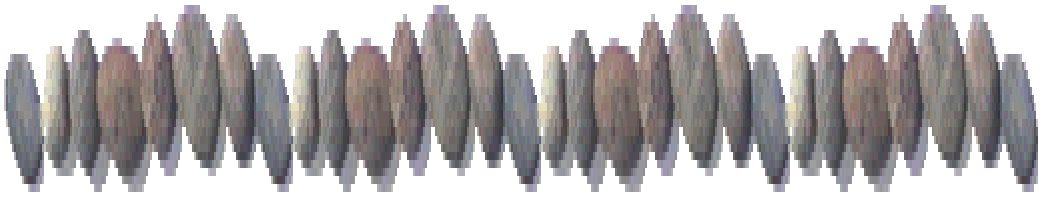
Center for Improvement
CIHQ
in Healthcare Quality

CENTER
OF EXCELLENCE
IN
REHABILITATION SERVICES

Policies
Standards
Survey Process

Effective January 2018



INTRODUCTION

The CIHQ "Center of Excellence in Rehabilitation Services" (CERS) program recognizes specialized inpatient rehabilitation facilities or units that demonstrate compliance to standards designed to assure desired outcomes in patient safety and quality.

The standards and survey procedures contained herein are based on the following:

- Regulations promulgated by the Center for Medicare Services (CMS)
- Practice guidelines established by the Agency for Healthcare Research & Quality (AHRQ)
- Recommendations from the American Academy of Physical Medicine & Rehabilitation (AAPMR)
- Guidelines established by the National Healthcare Safety Network

CENTER OF EXCELLENCE IN REHABILITATION SERVICES POLICIES

ELIGIBILITY REQUIREMENTS

In order to obtain/maintain CERS designation, an organization must:

- Be accredited in good standing by a CMS approved deeming authority for acute care hospitals, or directly certified by CMS
- Be in full compliance with CIHQ CERS policies
- Be in full compliance with CIHQ CERS standards or have developed and implemented an acceptable plan of correction to come into compliance in areas of deficient practice.
- Have provided inpatient long-term acute care, treatment, and service for at least one year prior to an initial CERS survey.
- Have provided inpatient care to at least 30 patients within the 12 months prior to an initial CERS survey; and at least 90 patients during the prior period for re-designation. Patients must be representative of a population that requires long term acute care services.
- Pay CERS fees in a timely manner
- Permit the CERS survey to occur

CIHQ reserves the right to withdraw/deny CERS status to an organization that does not meet/maintain eligibility requirements.

APPLICATION FOR CERS DESIGNATION

An organization must submit a formal application to CIHQ requesting CERS designation. The application must be complete and accepted by CIHQ before a survey is considered. Once designated, the organization is responsible for assuring that information contained in the application is current. Organizations must notify CIHQ of any substantive changes to information contained in their application in a timely manner. At a minimum, the organization must inform CIHQ within 30 days of any of the following:

- A change in ownership
- Opening of a new physical location where care and treatment will be rendered
- Establishment of a new clinical program or service
- Closure of a physical location where care and treatment is rendered or closure of a clinical program or service.

BUSINESS ASSOCIATE AGREEMENT

If an organization requires CIHQ to sign a business associate agreement for HIPAA compliance, the agreement must be provided to CIHQ at the time the application is filed.

PERMISSION TO SURVEY

Any organization wishing to obtain or maintain CERS designation must agree to allow CIHQ surveyors complete and unfettered access to their facility(s), documents, medical records, staff, patients, and other sources of information necessary to determine the organization's compliance. CIHQ reserves the right to immediately deny or withdraw an organization's designation for failure to do so

DURATION OF CERS AWARD

CERS designation is awarded to an organization for a maximum of 36 months. Prior to the 36 month, the organization must undergo another full survey to maintain its status. For initial surveys, the date of designation will be the date that a submitted plan of correction has been accepted by CIHQ to address any identified deficiencies.

USE OF CIHQ SURVEYORS AS CONSULTANTS

CIHQ surveyors are not permitted to independently serve as consultants. Organizations may not employ, retain, contract with, or otherwise utilize CIHQ surveyors for any of the following:

- Provide consulting services or standards interpretation to prepare the organization for a survey. This does not apply to accessing CIHQ central office staff for official standards interpretation.
- Providing tools or documents to assist in accreditation compliance. This does not apply to organizations that utilize CIHQ officially approved documents obtained directly from CIHQ.
- Provide education programs on CIHQ standards. This does not apply to attendance at CIHQ officially sponsored education programs and activities
- Assist with developing and/or reviewing appeals or corrective action plans for deficiencies identified during a CIHQ survey.
- Conduct mock surveys

RELATIONSHIP BETWEEN CIHQ STAFF / SURVEYORS & APPLICANT ORGANIZATIONS

Surveyors may not survey a hospital with which the surveyor has a professional or financial interest. CIHQ surveyors or staff may not be involved in CERS decisions for a hospital with which the surveyor / staff person has a professional or financial interest. A surveyor / staff person is considered to have a professional or financial interest in an organization under any of the following conditions:

- The surveyor / staff person is currently employed or has been employed within the past five years by the organization
- The surveyor / staff person is currently, or has been in the past five years, on the medical staff of the organization and/or granted privileges to practice in the organization
- The surveyor / staff person has an ownership interest in, or receives monies or other compensation from the organization
- The surveyor / staff person serves on the Board of the organization or in another professional capacity.

Surveyors / staff persons are required to disclose to CIHQ any professional or financial interest they have in an applicant / accredited organization that they may be scheduled to survey or participate in an accreditation decision so that reassignment can occur.

FALSIFICATION & MISREPRESENTATION

Honesty and the provision of truthful and accurate information, is at the heart of the CERS designation process. Organizations are expected to engage in all activities in an honest and truthful manner. Information presented to CIHQ in any manner, for any reason, at any time must be accurate.

If an organization's leadership or staff intentionally misrepresents their compliance to CERS standards and/or policies, lies, falsifies documents or medical records, or is otherwise dishonest or untruthful, CIHQ reserves the right to immediately withdraw/deny designation.

NOTIFYING ORGANIZATIONS OF CHANGES TO CERS STANDARDS, REQUIREMENTS, & POLICIES

All changes to CIHQ CERS standards, requirements, and policies will be communicated to organizations in writing. The notification will include the effective date of implementation. In addition, all notifications will be posted on the CIHQ website and permanently archived for review.

CIHQ may from time to time issue official interpretation of existing CERS standards, requirements, and policies. These interpretations will be posted on the CIHQ website and are accessible to organizations. It is the organization's responsibility to access this information.

Organizations may request official interpretation of an existing CERS standard, requirement, or policy. Requests must be made in writing. Information on submitting a written request is available on the CIHQ website. CIHQ will provide a written response to each request within 5 business days of submittal.

AFFECT OF ACCREDITATION / CERTIFICATION STATUS ON CERS DESIGNATION

CERS designation is tied to an organization's accreditation / certification status. If an organization voluntarily withdraws its accreditation / certification; or their accreditation / certification is withdrawn/denied, then the CERS designation is withdrawn/denied as well.

CERS SURVEYS

For CIHQ accredited hospitals, CERS is not a separate and distinct survey activity. Rather, it is integrated into the organization's initial or triennial accreditation survey. In some cases, the overall length of the survey and/or the number of surveyors may be expanded in order to accomplish this function. If an organization wishes to apply for CERS designation, outside of its initial or triennial accreditation survey, then CIHQ will work with the organization to develop a specific agenda and survey. Please contact CIHQ for details.

For non-CIHQ accredited hospitals, the CERS is a separate and distinct survey apart from that of the organization's accreditor. The survey is one or two days in length – depending on the size of the organization. The survey is conducted by a single surveyor. The survey is announced and scheduled in coordination with the organization

SAMPLE SURVEY SCHEDULE

0830 – 0845 – Welcome & Opening Conference

0845 – 1000 – Review of Requested Documents – See Attachment A

1000 – 1200 – Tour of Patient Care Areas

1200 – 1300 – Lunch

1300 – 1500 – Medical Record Review

1500 – 1600 – Staff Training & Education Review

1600 – 1630 – Surveyor Preparation Time

1630 – Exit Conference

ISSUANCE OF A SURVEY REPORT

Following the conclusion of the survey, a preliminary report be produced. The preliminary report will then be reviewed by either the Executive Director of Survey Operations or the Chief Executive Officer of CIHQ. The purpose of the review is to assure the following:

- There is sufficient information in a finding to appropriately assign a deficiency
- The deficiency has been assigned to the appropriate CIHQ standard

The survey report will be modified as necessary as a result of the review process. Following this review the report will be considered final.

CITATION OF DEFICIENCIES

Non-compliance to CERS standards results in a cited deficiency. Non-compliance is cited on a per occurrence basis – meaning there are no percentages or thresholds of compliance.

DETERMINATION OF A CERS DESIGNATION DECISION

Based on the number of deficient standard requirements contained in the final report, a designation decision will be rendered. In order for an organization to achieve CERS designation, each standard must be implemented, and the organization must be in compliance with at least 85% of standard requirements at the time of the survey. In addition, an acceptable plan of correction for any deficiencies is required.

NOTIFICATION TO THE ORGANIZATION

Upon completion of the review, the final report and designation decision will be communicated in writing in electronic form to the contact person listed on the organization's accreditation profile. Unless there are extenuating circumstances, final report and accreditation decision will be provided within 10 business days following completion of the survey.

REQUIREMENTS FOR A CORRECTIVE ACTION PLAN

The organization is required to submit an acceptable corrective action plan (CAP) to CIHQ within 20 business days following receipt of their CERS survey report for any deficiencies identified.

A CAP must be developed and submitted for each deficiency identified. In order for the CAP to be accepted, it must address at least the following:

- The specific steps that the organization has taken (or will take) to correct the deficiency. The plan must address both the specific finding and the processes that led to the deficiency.
- A description of how the CAP was (or will be) implemented
- The monitoring process that has been (or will be) put in place to assure ongoing implementation of the CAP. Documentation must include the frequency and duration of monitoring, sample size, and target thresholds.

- The title of the person responsible for implementing the CAP; and
- The date the CAP was (or will be) implemented.

The CAP should be implemented as quickly as possible. The expectation is that – whenever possible – corrective action has already occurred by the time the CAP is submitted. Due dates for completion of corrective actions should not exceed 45 days. If specific actions require a longer timeframe, please notify CIHQ for assistance and direction.

REVIEW / ACCEPTANCE OF CORRECTIVE ACTION PLANS

Upon submission, the CAP will be reviewed by senior CIHQ staff. If a determination is made that the corrective action plan is acceptable, the organization will be notified in writing and no further action on the part of the organization will be required.

- If a determination is made that the CAP is unacceptable, the organization will be notified in writing of the reason(s) for declination, and the specific modifications necessary for the plan to be accepted. The organization will then be required to submit a second CAP within 10 calendar days.
- If the second corrective action plan is unacceptable, the organization will be notified in writing of the reasons for declination and the specific modifications necessary for the plan to be accepted. The organization will then be required to submit a third and final CAP within 5 calendar days.
- If the third and final corrective action plan is unacceptable, then the organization's CERS designation will be denied / withdrawn

Request for Extension of the Corrective Action Plan

If an organization is unable to implement a corrective action(s) within the time frame submitted/accepted, it must request a one-time extension from CIHQ prior to the action(s) due date. The request must include the reason why the original date of completion cannot be met, as well as any supporting evidence justifying the request. Granting of an extension is at the sole discretion of CIHQ.

Failure to Implement a Corrective Action Plan

Failure to implement a corrective action plan within the time frame submitted/accepted, may result in withdrawal / denial of a CERS designation

Validation of the Corrective Action Plan

CIHQ may, at its sole discretion, require an organization to submit evidence that the accepted CAP has actually been implemented. If requested, the organization is required to submit the evidence within the requested time frame. Failure to submit evidence that a CAP has been implemented will result in a withdrawal / denial of CERS designation.

APPEAL PROCESS

CIHQ has established an appeals process for organizations wishing to contest a deficiency and/or designation decision. If an organization wishes to appeal a finding, it must notify CIHQ in writing within 10 calendar days following receipt of the report. The appeal is to be submitted on-line. Senior staff will review the appeal, contact the organization for any questions, discussion, further information, etc. and issue a determination in writing of the organization's compliance to the standard/requirement in question. The decision by CIHQ senior staff is final

If an organization wishes to appeal a CERS designation decision, it must notify CIHQ in writing within 10 business days following issuance of the decision. There is no specific format for the appeal. The content must specifically address the following:

- The basis for appealing the accreditation decision
- Why the organization believes that the accreditation decision was incorrectly rendered
- The specific relief being requested

The written request must be submitted to:
Center for Improvement in Healthcare Quality
ATTN: Chief Executive Officer
P.O. Box 3620
McKinney, TX 75070
rcurtis@cihq.org

Senior staff at CIHQ will make the decision with respect to any appeal submitted. In making this decision, the following will be carefully considered:

- Information that led to the accreditation decision
- The position and any information provided by the organization as part of the appeal
- Input and feedback from the surveyor

The decision by CIHQ senior staff is final

AFFECT OF THE APPEAL PROCESS ON SUBMISSION OF A CORRECTIVE ACTION PLAN

Initiating the appeal process does not obviate the organization from submitting an acceptable plan of correction within required time frames. The organization should submit due dates for completion on deficiencies they wish to appeal with enough lead time to allow the appeal process to occur and still implement corrective actions in a timely manner should the appeal be denied. The organization should contact CIHQ for assistance in this regard.

INFORMATION THAT IS PUBLICLY SHARED BY CIHQ

CIHQ will make the following information available to the public:

- Verification that the organization is CERS designated or is seeking designation
- The organization's current CERS status
- The dates of the organization's initial or last CERS survey
- The expiration date of the organization's current CERS designation

CERS FEES

Fees are billed on an annual or quarterly basis as preferred by the organization. Fees include surveys and surveyor travel expenses. Fees are as follows:

- CIHQ accredited hospital = $2,500 annually
- Non-CIHQ accredited hospital = $4,500 annually

Fees are non-refundable and due within 30 days of invoice

INDEMNIFICATION

Organizations agree that CERS designation does not constitute a warranty of compliance standards, and further that designation is not a substitute for self-monitoring and assessment of the services and the quality and safety of care provided by the organization.

The organization agrees to indemnify and hold harmless the CIHQ, its commissioners, officers, agents, employees, and member organizations from any and all professional liability claims of other parties against CIHQ, its commissioners, officers, agents, employees, or member organizations arising from its CERS designation program, process, policies, and survey activities, including all judgments, settlements, costs, expenses, and reasonable attorneys' fees, unless and until any such judgments, settlements, costs, expenses and attorneys' fees are found by a final judgment of a court of competent jurisdiction to have resulted solely from negligence or wrongdoing on the part of the CIHQ.

This indemnification and hold harmless provision shall apply only to professional liability claims, i.e., claims based on the CIHQ' performance of its professional services, and not to general liability claims for bodily injury or property damage arising out of the CIHQ' negligence or intentional misconduct.

The organization agrees that in the event of any error or omission in connection with or as a result of CIHQ' performance of CERS designation services including, but not limited to, the scheduling and conduct of any survey, the processing of the results of any survey, and the disclosure of any survey results, the CIHQ' liability to the organization for any loss or damage arising therefrom, shall be limited to the total fees paid or payable for any CERS services provided.

This limitation of liability shall apply to the fullest extent permitted by law regardless of whether the organization's claim for loss or damage is based upon contract, tort, strict liability, or otherwise, and shall constitute CIHQ' sole liability to the organization and the organization's exclusive remedy against the CIHQ in the event of any such error or omission.

CENTER OF EXCELLENCE IN REHABILITATION SERVICES
STANDARDS

ORGANIZATIONAL STANDARDS

ERS-1: Defining the Scope of Services Provided by the Rehabilitation Services Program

The organization has a written document that defines the scope of services provided by the program.

A. The organization defines the patient populations served by the program
B. The organization describes the current scope of services provided. At a minimum, the following services must be provided:
    - Rehabilitative Nursing Services
    - Physical Therapy Services
    - Occupational Therapy Services
    - Speech Language & Pathology Services
    - Recreational Therapy Services
    - Vocational Rehabilitation & Counseling Services
    - Prosthetic / Orthotic Services (if providing care to that patient population)
    - Social Work Services / Case Management Services
C. For each service, the organization identifies at least the following:
    - Whether the service is provided directly by the organization or provided through contractual arrangements
    - The "hours of operation"
    - The minimum number and qualifications of staff that provide care.
    - The normative staffing levels (e.g. routine staffing for normal operation)
    - How staffing levels are adjusted to account for changes in patient census / acuity.

ERS-2: Administrative Leadership of the Rehabilitation Services Program

The organization provides for effective administrative leadership of the program

A. The organization identifies a physician leader for the program who by education, training, and experience is qualified to provide medical direction to the program. The physician leader should be board-certified by the American Board of Physical Medicine & Rehabilitation (ABPMR). If the physician leader is not ABPMR certified then the organization must demonstrate that the physician leader has comparable qualification.
B. The organization identifies an administrative leader to oversee the program. There is a written document that defines the minimum qualifications, duties, and responsibilities of the administrative leader.

ERS-3: Clinical Leadership of the Rehabilitation Services Program

The organization provides for effective clinical leadership of the program

A. The organization identifies an individual(s) who will serve as a clinical leader for the staff of each of the following disciplines:
    - Rehabilitative Nursing
    - Physical Therapy
    - Occupational Therapy
    - Speech Language & Pathology
    - Recreational Therapy
    - Vocational Rehabilitation & Counseling Services
    - Prosthetic / Orthotic Services (if providing care to that patient population)
    - Social Work Services / Case Management Services
B. For each of the clinical services listed above, the organization assures that the clinical leader has the minimum education, training, and experience necessary to effectively lead their service. The clinical leader should be certified in their specialty by a nationally recognized certification body. If the clinical leader is not certified in their specialty, the organization must demonstrate that the individual(s) has comparable knowledge, experience, and expertise.
C. The clinical leader provides overall direction to staff within their specialty on the clinical care and management of the rehabilitation patient.

ERS-4: Education and Professional Development of Rehabilitation Services Staff

The organization supports the ongoing education and professional development of its staff.

A. The organization makes current knowledge-based resources readily available to its staff. This information includes, but is not limited to, evidence-based practices, research, clinical practice guidelines, professional journals, texts, and reference materials, and access to information promulgated by their respective professional organizations.
B. The organization encourages its staff to obtain professional certification in their specialty by a nationally recognized body.
C. Clinical staff must receive at least eight hours of continuing education annually appropriate to their clinical discipline in caring for the rehabilitation patient.

ERS-5: Performance Monitoring & Improvement

The organization establishes, implements, and maintains an ongoing performance monitoring and improvement program pertinent to the care needs of the rehabilitation patient.

A. The organization collects, aggregates, analyzes, and takes appropriate action on at least the following metrics:
    - The incidence of catheter associated urinary tract infections (CAUTI)
    - The incidence of facility-wide post-admission Methicillin-resistant staphylococcus aureus (MRSA)
    - The incidence of facility-wide post-admission Clostridium Difficile (C. Difficile)
    - The incidence of patients experiencing one or more falls with major injury during hospitalization
    - The incidence of pressure ulcers (both those that are newly acquired as well as those present on admission but worsened during hospitalization)
    - The incidence of unplanned readmissions within 30 days of discharge
    - The percent of patients who were assessed and appropriately given seasonal influenza vaccine
    - The percent of staff that received seasonal influenza vaccination
    - Percent of patients with an admission and discharge functional assessment and a care plan that addresses function
    - Patient satisfaction with the care, treatment, and services rendered
    - Functional outcome measures for rehabilitation patients:
        - Change in self-care score
        - Change in mobility score
        - Discharge self-care score
        - Discharge mobility-score
B. For each performance metric noted above, the organization measures its performance against benchmarks established by an industry accepted external database (i.e. CMS IRF Quality Reporting Measures). If no external database exists, then the organization establishes its own internal benchmark (based on historical performance) and measures its performance against this benchmark over time.
C. For each performance metric noted above, the organization maintains its performance level at or above the established benchmark. If a performance metric fall below the established benchmark, the organization undertakes demonstrable efforts to improve its performance in that area.
D. On an annual basis, the organization undertakes at least one project designed to improve the care provided to the rehabilitation patient population.

ERS-6: Allocation of Resources to Support the Rehabilitation Service Program

The organization assures that adequate resources are provided to effectively provide rehabilitative services

A. On at least an annual basis, the organization solicits input from physicians and representatives of each clinical service on the operational and capital resources needed to provide safe and effective care.
B. Based on the results of said input, the organization determines if there are adequate resources allocated to the rehabilitative service program
C. When it is determined that additional resources are necessary, the organization develops a plan to provide those resources within a reasonable period of time.

GENERAL PATIENT CARE STANDARDS

ERS-7: Criteria for Admission to the Rehabilitation Services Program

The organization establishes written criteria that guide admission to the rehabilitation services program.

A. Criteria are designed to assure that only patients who will benefit from intensive rehabilitation services are admitted. These criteria must include the following:
    - The patient must require the active and ongoing therapeutic intervention of multiple therapy disciplines (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics), one of which must be physical or occupational therapy.
    - The patient must generally require an intensive rehabilitation therapy program, consisting of at least 3 hours of therapy per day at least 5 days per week. In certain well-documented cases, this intensive rehabilitation therapy program might instead consist of at least 15 hours of intensive rehabilitation therapy within a 7 consecutive day period, beginning with the date of admission.
    - The patient must reasonably be expected to actively participate in, and benefit significantly from, the intensive rehabilitation therapy program at the time of admission.
    - The patient must require physician supervision by a rehabilitation physician, defined as a licensed physician with specialized training and experience in inpatient rehabilitation
    - The patient must require an intensive and coordinated interdisciplinary approach to providing rehabilitation

ERS-8: Preadmission Screening Process

The organization establishes and implements a preadmission screening process that assures appropriate patients are admitted to the rehabilitation facility

A. A preadmission screening (evaluation) of the patient's condition and need for rehabilitation therapy and medical treatment must be conducted by a licensed or certified clinician(s) within the 48 hours immediately preceding admission.
B. Criteria developed by the organization guide the preadmission screening process. (See ERS-6)
C. The preadmission screening process must include a review of the patient's medical record from the referring hospital. If the patient is being admitted from a community setting, then a review of the patient's medical record from the most recent hospitalization in only required if pertinent to the patient's situation.
D. The preadmission screening must document:
    - The patient's prior level of function (prior to the event or condition that led to the patient's need for intensive rehabilitation therapy),
    - Expected level of improvement, and the expected length of time necessary to achieve that level of improvement.
    - An evaluation of the patient's risk for clinical complications, the conditions that caused the need for rehabilitation, the treatments needed (i.e., physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics),
    - The expected frequency and duration of treatment in the facility,
    - The anticipated discharge destination,
    - Any anticipated post-discharge treatments, and other information relevant to the care needs of the patient.
E. All findings of the preadmission screening must be conveyed to a rehabilitation physician prior to admission. In addition, the rehabilitation physician must document that he or she has reviewed and concurs with the findings and results of the preadmission screening prior to admission.

ERS-9: Post-Admission Physician Evaluation

A post-admission physician evaluation of the patient must be performed by a rehabilitation physician.

A. The post-admission physician evaluation must be completed within the first 24 hours of admission, and must support the medical necessity of admission.
B. The post-admission physician evaluation must identify any relevant changes that may have occurred since the pre-admission screening and must include a documented history and physical exam, as well as a review of the patient's prior and current medical and functional conditions and comorbidities.
C. The post-admission must be documented in the medical record.

ERS-10: Physician Supervision of Rehabilitative Care

The organization assures that patients receive appropriate supervision and direction by a qualified physician for their rehabilitative care.

A. Each patient's care shall be supervised by a rehabilitation physician. A rehabilitation physician is defined as a licensed physician with specialized training and experience in inpatient rehabilitation.
B. A rehabilitation physician must be available 24 hours per day / 7 days per week to provide supervision and direction.
C. The rehabilitation physician must conduct face-to-face visits with the patient at least 3 days per week throughout the patient's hospitalization to assess the patient both medically and functionally, as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process.
D. The organization assures the timely availability of consulting physicians to treat continuing, unstable, or complex medical conditions.

ERS-11: Initial Assessment to Determine Patient Care Needs

The organization assures that each patient receives a timely comprehensive assessment to determine their rehabilitative care needs.

A. Each clinical service defines the scope of its initial assessment and the time frame in which the assessment must be performed.
B. Each clinical service performs its assessments within established time frames
C. At a minimum, the combined results each disciplines initial assessment activities must document the following parameters in the patient's medical record:
    - Admitting diagnosis
    - Past medical history – including comorbidities
    - Psycho-social history
    - Vocational history
    - Recreational history
    - Cardiorespiratory status
    - Mental / Neurologic status
    - Nutritional / Hydration status
    - Integumentary status
    - Musculoskeletal status
    - Bladder function
    - Bowel function
    - Reproductive / sexual function
    - Swallowing function
    - Ability to engage in activities of daily living, locomotion, and self-care

ERS-12: Ongoing Assessments to Determine Patient Care Needs

The organization assures that each patient receives timely ongoing assessments to determine their rehabilitative care needs.

A. Each clinical service defines the scope of its ongoing assessments and the maximum time frame between routine reassessment activities.
B. The frequency of reassessment is appropriate to assure that each patient's ongoing care needs are addressed.
C. Each clinical service performs its ongoing assessments within established time frames

ERS-13: Development of a Patient-Specific Treatment Plan

The organization assure that there is a treatment plan developed for each patient that addresses his/her rehabilitative care needs identified as a result of the pre-admission screening, post-admission physician evaluation, and clinical service assessment activities

A. Each clinical service develops a written treatment plan that addresses the rehabilitative care needs identified as the result of assessment activities. There may be a single interdisciplinary treatment plan, or each clinical service may retain a separate treatment plan. If each clinical service maintains a separate treatment plan, then there must be a process in place that assures members of other clinical disciplines can access that information.
B. The treatment plan developed by each clinical service addresses at least the following:
    - The specific care need (problem) that is being addressed
    - Identification of both short and long-term goals written in patient terms (i.e. from the view of the patient)
    - Strategies (interventions) to assist the patient in meeting their short and long-term goals.
    - How it will be determined if the patient is progressing towards or meeting their short and long-term care goals
C. Overall treatment planning determines the measurable, practical improvement in the patient's functional condition can be accomplished within a predetermined and reasonable period of time.
D. Overall treatment planning indicates both the nature and degree of expected improvement and the expected length of time to achieve the improvement.
E. Overall treatment planning details the patient's medical prognosis and anticipated rehabilitative interventions required during the hospital stay, including:
    - Expected intensity (number of hours per day),
    - Expected frequency (number of days per week), and
    - Expected duration (number of total days during hospitalization);
    - Detail functional outcomes; and
    - Detail discharge destination from the hospital.
F. Overall treatment planning must be completed within four days of the patient's admission
G. The patient is involved in the establishment and ongoing development of his/her treatment plan.

ERS-14: Multidisciplinary and Coordinated Approach to Care

The organization establishes a multidisciplinary and coordinated approach to meeting a patient's rehabilitative care needs.

A. Interdisciplinary services are those provided by a treatment team in which all of its members participate in a coordinated effort to benefit the patient and the patient's significant others and caregivers.
B. At a minimum, the interdisciplinary team must document participation by professionals from each of the following disciplines (each of whom must have current knowledge of the patient)
    - A physician with specialized training and experience in rehabilitation services;
    - A registered nurse with specialized training or experience in rehabilitation;
    - A social worker or a case manager (or both); and
    - A licensed or certified therapist from each therapy discipline involved in treating the patient.
    - The interdisciplinary team must be led by a rehabilitation physician who is responsible for making the final decisions regarding the patient's treatment. This physician must document concurrence with all decisions made by the interdisciplinary team at each meeting.
C. The periodic team conferences must focus on:
    - Assessing the individual's progress towards the rehabilitation goals;
    - Considering possible resolutions to any problems that could impede progress towards the goals;
    - Reassessing the validity of the rehabilitation goals previously established; and
    - Monitoring and revising the treatment plan, as needed.
D. The periodic team conferences are initiated by the 8th day of admission and are held on a weekly basis therafter
E. Documentation of each team conference must include the names and professional designations of the participants in the team conference.
F. The occurrence of the team conferences and the decisions made during such conferences, such as those concerning discharge planning and the need for any adjustment in goals or in the prescribed treatment program, must be recorded in the patient's medical record

ERS-15: Providing Rehabilitative Services

Based upon the identified needs of the patient, the organization assures that rehabilitative care and service is provided in a timely and effective manner

A. The patient's medical record must document that the required rehabilitative therapies and treatments began within 36 hours from midnight of the day of admission. Therapy evaluations done in the hospital constitute initiation of the required therapy services.
B. Patients receive one-on-one rehabilitative therapy and treatment. Group therapy is acceptable, but must be well-documented and may not constitute the majority of therapy provided to the patient.
C. The specific reasons for a break in the provision of rehabilitative therapy and treatment must be documented in the patient's medical record

ERS-16: Education of the Patient / Family to Meet Rehabilitative Care Needs

The organization assures that patients / families / caregivers receive the education, training, and information necessary to effectively participate in the patient's rehabilitative care.

A. The organization identifies the specific rehabilitative education needs – as appropriate – of the patient / family / caregiver necessary to maximize the patient's functional potential and to prepare the patient to return to the pre-hospitalization environment.
B. The organization identifies cognitive, functional, or other barriers that may impede the ability of the patient / family / caregiver to receive education in a manner that he or she can comprehend.
C. Education is provided to address specific rehabilitative needs within time frames that assure the patient / family / caregiver are adequately prepared to effectively participate in the patient's care.
D. When barriers to receiving education are identified, the organization demonstrates that education is provided to the individual in a manner that accommodates said barriers.

ERS-17: Transition to the Post-Hospitalization Setting

The organization provides for effective transition of the rehabilitative patient to the post-hospitalization setting

A. As part of its discharge planning process, the organization identifies patient-specific factors facilitating discharge, as well as potential complications, barriers, or other issues affecting the ability of the patient to transition to his/her anticipated post-hospitalization setting.
B. When appropriate, the organization works collaboratively with home health agencies, DME providers, and community agencies to assure that post-hospitalization rehabilitation services are coordinated and provided in a timely manner.
C. When post-hospitalization needs require the patient / family / caregiver to operate equipment, use assistive devices, or otherwise provide rehabilitative supportive care; the ability of the patient / family / caregiver to safely perform these activities is confirmed prior to the patient's discharge.
D. If patients temporarily leave the hospital to engage in activities of daily living, the organization assures the following:
    - The activity is determined to be necessary for the patient to successfully transition to his/her intended post-hospitalization setting
    - The patient is transported to and from the site of the activity in a safe and appropriate manner
    - The patient is accompanied by a staff member qualified to recognize and respond to a basic medical emergency

PATIENT POPULATION SPECIFIC CARE STANDARDS

ERS-18: Care of the Patient with a Loss (Amputation) of an Extremity

The organization provides safe, effective, and quality care to the patient who has experienced the partial or full loss of an extremity.

A. The patient receives a specialized assessment on admission that identifies at least the following:
   - Risk factors and co-morbidities that could lead to further loss of an extremity
   - Potential or actual complications related to the lost extremity
   - The physical condition of the remaining portion of the extremity including wound care needs
   - Impact of extremity loss on the patient's psychological well-being
   - Impact of extremity loss on the patient's lifestyle, work, finances, social structure, mobility, and activities of daily living
   - The patient's support systems, including family involvement in the patient's care and rehabilitative needs
   - The patient's goals for functional independence
   - The education needs of the patient related to loss of an extremity
   - The need for prosthetic and/or orthotic services
   - Post-discharge needs specific to patients who have loss of an extremity
B. A plan of care is developed and implemented to address the patient's care needs identified as a result of the admission assessment
C. The organization develops and implements evidence-based practice guidelines for the clinical management of the remaining portion of the lost extremity. The guidelines are approved by the medical staff.
D. Staff receive training and education on an annual basis on caring for patients with extremity loss
E. For patients receiving prosthetic and/or orthotic services, the organization does the following:
   - Arranges for the services of a prosthetist and/or orthotist as part of the patient's care team
   - Assures proper size and fit of the prosthetic and/or orthotic device
   - Educates the patient on at least the following:
     - Use of the prosthetic and/or orthotic device and attendant care needs
     - Potential necessity for adjustments to the prosthetic and/or orthotic device over time
     - Potential complications related to the prosthetic and/or orthotic device use, malfunction, wear and tear, and failure.
     - Community resources available to assist the patient
     - Any follow-up care required post-discharge

ERS-19: Care of the Patient at Risk for Development of a Pressure Ulcer

Patients identified as being at risk for developing a pressure ulcer receive safe quality care

A. The organization uses a standardized evidence-based skin assessment tool to identify those patients at risk for developing a pressure ulcer.
B. Appropriate healthcare personnel are given periodic in-service training regarding use of the skin assessment tool
C. All patients are assessed upon admission and at least weekly thereafter to determine if they are at risk for developing a pressure ulcer. If a patient has been identified as being at risk, skin assessments are performed at least once each day
D. For patients identified as being at risk for developing a pressure ulcer, staff take the following actions (as appropriate to specific patient care needs):
   - Controlling the amount of moisture (wetness) on the skin (e.g. incontinence)
   - Use of proper lifting and transfer techniques to reduce shearing and friction on the skin
   - Use of positioning devices
   - Relieving pressure on bony prominences
   - Monitoring the patient's nutritional intake and status to identify potential malnutrition

ERS-20: Care of the Patient with a Wound

Patients with a wound receive safe quality care

A. The organization develops and implements evidence-based clinical practice guidelines for wound care. The guidelines are approved by the medical staff.
B. The clinical practice guidelines address at least the following:
    - Assessment of wounds – including minimum frequency of assessments
    - Appropriate staging of wounds and identifying characteristics of wounds
    - Treatment and interventions appropriate to the type and nature of the wound
    - Tracking the improvement or worsening of wounds over time
C. Appropriate healthcare personnel are given periodic in-service training regarding use of the guidelines.
D. Wound assessments and care are documented in the patient's medical record
E. Staff have access to a certified wound care nurse or authoritative resources to assist in wound assessment and care activities
F. The patient's nutritional intake and status is monitored to identify potential malnutrition

ERS-21: Care of the Patient with a Neurological Impairment due to Stroke or Brain Injury

The organization provides safe, effective, and quality care to the patient who has experienced a neurological impairment due to stroke or brain injury

A. The patient receives a specialized assessment on admission that identifies at least the following:
    - The scope and severity of the patient's neurological impairment
    - Risk factors and co-morbidities that could lead to further neurological impairment
    - Potential or actual complications related to the patient's current neurological impairment
    - Impact of the neurological impairment on the patient's ability to communicate
    - Impact of the neurological impairment on the patient's cognitive functioning
    - Impact of the neurological impairment on the patient's psychological well-being
    - Impact of the neurological impairment on the patient's ability to prevent self-injury or harm
    - Impact of the neurological impairment on the patient's lifestyle, work, finances, social structure, mobility, and activities of daily living
    - The patient's support systems, including family involvement in the patient's care and rehabilitative needs
    - The patient's goals for functional independence
    - The education needs of the patient related to the neurological impairment
    - The need for adaptive and assistive and communication equipment
    - Post-discharge needs specific to patients with a neurological impairment
B. A plan of care is developed and implemented to address the patient's care needs identified as a result of the admission assessment
C. The organization uses an evidence-based tool to assess the patient's neurological status on admission and on an as needed basis throughout the patient's hospitalization. Staff is trained on use of the assessment tool.
D. The organization develops and implements evidence-based practice guidelines for the clinical management of the patient's neurological impairment. The guidelines are approved by the medical staff.
E. The organization assures that there are appropriate tools and resources to meet the communication and assistive needs of patients with a neurological impairment
F. Staff receive training and education on an annual basis on caring for patients with neurological impairments due to stroke or brain injury

ERS-22: Care of the Patient with a Spinal Cord Injury

The organization provides safe, effective, and quality care to the patient who has experienced a spinal cord injury

A. The patient receives a specialized assessment on admission that identifies at least the following:
    - The cause of the spinal cord injury
    - The level(s) and completeness of the spinal cord injury
    - Risk factors and co-morbidities that could lead to spinal cord injury
    - Potential or actual complications related to the patient's spinal cord injury
    - Impact of the spinal cord injury on the patient's ability to communicate
    - Impact of the spinal cord injury on the patient's psychological well-being
    - Impact of the spinal cord injury on the patient's ability to prevent self-injury or harm
    - Impact of the spinal cord on the patient's lifestyle, work, finances, social structure, mobility, and activities of daily living
    - The patient's support systems, including family involvement in the patient's care and rehabilitative needs
    - The patient's goals for functional independence
    - The education needs of the patient related to the spinal cord injury
    - The need for adaptive and assistive equipment and technology
    - Post-discharge needs specific to patients with a spinal cord injury
B. A plan of care is developed and implemented to address the patient's care needs identified as a result of the admission assessment
C. The organization assures that there are appropriate tools and resources to meet the communication and assistive needs of patients with a spinal cord injury
D. The organization develops and implements evidence-based practice guidelines for the clinical management of the patient's spinal cord injury. The guidelines are approved by the medical staff.
E. The organization assures that a physician specifically trained in the care of patients with a spinal cord injury is available on at least a consulting basis to assist the patient's primary physician in providing medical care and direction.
F. Staff receive training and education on an annual basis on caring for patients with spinal cord injury

ERS-23: Care of the Ventilated Patient

Patients requiring mechanical ventilation receive safe quality care

A. The organization assures that only qualified and competent staff cares for the ventilated patient – including specific competencies to operate and manage the ventilator and attendant respiratory care services.
B. A manual resuscitator and appropriate size mask are available at the bedside and functional
C. The patient is continuously monitored via cardiopulmonary monitor and pulse oximetry.
D. There is access to emergency power for the ventilator in the case of a power failure
E. Ventilator circuitry and/or manual resuscitation equipment is changed according to policy or as needed when visibly soiled or leaky
F. Changes to the ventilator parameters are documented at the time of change
G. Airway care maneuvers (including suctioning) are documented at the time they are performed
H. Transport parameters, adverse events, weaning parameters, care plan information, and patient assessment findings are documented to promote continuity of care.
I. The organization develops and implements appropriate measures designed to prevent ventilation assisted pneumonia. These measures include but are not limited to:
    - Proper elevation of the head of the bed
    - Prophylactic treatment to prevent peptic ulcer disease
    - Regular oral care
J. The organization develops and implements appropriate prophylactic measures to prevent deep venous thrombosis
K. The patient's nutritional intake and status is monitored to identify potential malnutrition

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ATTACHMENT A

List of Documents to be Available during the Document Review Session

DOCUMENT REQUESTED	REFERENCE
Evidence that the organization has a written document that defines the scope of services provided by the program.	ERS-1
Evidence that the organization identifies a physician leader for the program who by education, training, and experience is qualified to provide medical direction to the program. The physician leader should be board-certified by the American Board of Physical Medicine & Rehabilitation (ABPMR). If the physician leader is not ABPMR certified then the organization must demonstrate that the physician leader has comparable qualification.	ERS-2
Evidence that the organization identifies an administrative leader to oversee the program. There is a written document that defines the minimum qualifications, duties, and responsibilities of the administrative leader.	ERS-2
Evidence that the organization identifies an individual(s) who will serve as a clinical leader for the staff of each of the following disciplines: • Rehabilitative Nursing • Physical Therapy • Occupational Therapy • Speech Language & Pathology • Recreational Therapy • Vocational Rehabilitation & Counseling Services • Prosthetic / Orthotic Services (if providing care to that patient population) • Social Work Services / Case Management Services Evidence that for each of the clinical services listed above, the organization assures that the clinical leader has the minimum education, training, and experience necessary to effectively lead their service. The clinical leader should be certified in their specialty by a nationally recognized certification body. If the clinical leader is not certified in their specialty, the organization must demonstrate that the individual(s) has comparable knowledge, experience, and expertise.	ERS-3
Evidence that the organization collects, aggregates, analyzes, and takes appropriate action on at least the following metrics: • The degree or percent of change in the functional status of patients from admission to discharge using an industry accepted evaluation tool. • The incidence of catheter associated urinary tract infections (CAUTI)\The incidence of patient falls during hospitalization • The incidence of pressure ulcers (both those that are newly acquired as well as those present on admission but worsened during hospitalization) • The incidence of potentially preventable readmissions from the organization to a short-stay or long-term acute care hospital within 30 days of discharge • Percent of patients who were assessed and appropriately given the seasonal influenza vaccine • Influenza vaccination coverage among healthcare personnel • Patient satisfaction with the care, treatment, and services rendered	ERS-5
Evidence that on an annual basis, the organization undertakes at least one project designed to improve the care provided to the rehabilitation patient population.	ERS-5
Evidence that on at least an annual basis, the organization solicits input from physicians and representatives of each clinical service on the operational and capital resources needed to provide safe and effective care.	ERS-6