**Department of Veterans Affairs** **VHA HANDBOOK 1170.04**
**Veterans Health Administration** **Transmittal Sheet**
**Washington, DC 20420** **December 30, 2014**

# REHABILITATION CONTINUUM OF CARE

**1. REASON FOR ISSUE:** This Veterans Health Administration (VHA) Handbook describes the rehabilitation paradigm that integrates rehabilitation service procedures for the rehabilitation continuum of care within Department of Veterans Affairs (VA) Community Living Centers (CLC).

**2. SUMMARY OF CONTENT:** This Handbook establishes the processes and procedures for the implementation of interdisciplinary rehabilitation through the continuum of care within VA CLC.

**3. RELATED ISSUES:** VHA Handbook 1170.1.

**4. RESPONSIBLE OFFICE:** The Director, Physical Medicine and Rehabilitation Service (PM&RS) Program Office, and the Director, VHA CLC Programs, are responsible for the contents of this Handbook. Questions may be referred to 202-461-7444.

**5. RESCISSIONS:** None.

**6. RECERTIFICATIONS:** This VHA Handbook is scheduled for recertification on or before the last working day of December 2019.

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# REHABILITATION CONTINUUM OF CARE

**1. PURPOSE:** This Veterans Health Administration (VHA) Handbook specifies the procedures for the implementation of the Rehabilitation Continuum of Care and describes a rehabilitation paradigm that integrates rehabilitative service procedures across the full spectrum of VHA health care services. The Rehabilitation Continuum of Care consists of five distinct levels of intensity of services and resources required to provide the rehabilitation services. Placement into the continuum is based upon a thorough assessment of the participant's medical status, functional status, rehabilitation goals, expectations for improvement, and discharge destination.
**AUTHORITY:** 38 U.S.C. 7301(b).

## 2. BACKGROUND:

a. VHA is committed to providing specialized treatment and comprehensive rehabilitation care to Veterans with disabilities. During World War II, United States (U.S.) military health care professionals pioneered an interdisciplinary team approach to assess and manage complex disabilities associated with battlefield injuries. This approach has remained central to effective rehabilitation. Recent VHA-based outcomes research has further clarified the attributes of effective teams and the influence of organizational culture on these teams.

b. Veterans may have their rehabilitation provided in a variety of environments across the Department of Veterans Affairs (VA) continuum of care, from acute inpatient hospitalization, through a spectrum of inpatient rehabilitation care settings, including Community Living Centers (CLCs), and into the home and community. The provision of rehabilitation services is determined by the Veterans' rehabilitative needs rather than by where the services are delivered or what they are titled. The Algorithm of the Rehabilitation Continuum of Care (see Appendix A) and the Rehabilitation Continuum of Care Chart (see Appendix B) describe the programmatic requirements for specific rehabilitation services across the continuum of care. ***NOTE:*** *Rehabilitation care received as part of the acute medical or surgical hospitalization is not illustrated in this continuum of care algorithm.*

c. To ensure that Veterans receive rehabilitation care in a program appropriate to their needs, performance measures or supporting indicators may be developed that require compliance by individual programs. The latest performance and supporting measure information along with the technical manuals are available at the Office of Quality and Performance Web site at http://vaww.oqsv.med.va.gov/. ***NOTE:*** *This is an internal VA Web site not available to the public.*

## 3. DEFINITIONS:

a. **Activities of Daily Living.** Activities of daily living (ADLs) are fundamental activities related to functions associated with normal daily life. Basic ADLs are tasks that a person does every day to maintain personal independence and include activities that are performed for self-care (e.g., feeding, bathing, dressing, grooming, and personal hygiene), communication, and mobility. Instrumental ADLs (IADLs) are more complex ADL activities or tasks that a person does to maintain independence in the home and community (e.g., home management, money management, shopping, medication management, telephone usage, meal preparation, etc.). The ability to perform ADLs can be utilized as a measure of a person's functional status.

b. **Commission on Accreditation of Rehabilitation Facilities.** The Commission on Accreditation of Rehabilitation Facilities (CARF) serves as the preeminent accreditation body for setting standards and promoting the delivery of quality rehabilitation services for people with disabilities. VHA supports a system-wide collaboration with CARF to achieve and maintain national accreditation for all designated VHA medical rehabilitation programs. This helps ensure that rehabilitation programs meet the unique needs of the Veteran population, provide a catalyst for improving the quality of life of the participants receiving services, are commensurate with international standards established by experts in the field of rehabilitation, and have an ongoing process of quality improvement (see www.carf.org).

c. **Community Living Centers.** CLC replaces the title for the VA Nursing Home Care Units, and reflects the changing mission and philosophy of these units. The VA CLC is a component of the spectrum of long-term care that provides a skilled nursing environment and houses a variety of specialty programs for persons needing short and long stay services. VA CLCs are typically located at or near a VA medical facility, and are VA-owned and operated, but may be free-standing in the community. The provision of services is consistent with the long-term care standards set forth by The Joint Commission. ***NOTE:*** *For legal purposes, CLCs are subject to the laws and policies governing nursing home care in VA nursing homes (see Title 38 United States Code (U.S.C.) Sections 101(28), 1710, 1710A, and 1710B).*

d. **Comprehensive Interdisciplinary Inpatient Rehabilitation Program.** The Comprehensive Interdisciplinary Inpatient Rehabilitation Program (CIIRP) is a highly-specialized level of integrated medical and rehabilitative care that is provided 24 hours a day, and designed to treat medically stable participants who require and are able to tolerate intensive rehabilitation services. An array of rehabilitation specialists make up the rehabilitation interdisciplinary team (IDT) that provides these services. Intensity and duration of therapy is individualized to the needs of the participant, but often include 2 to 3 or more hours of treatment comprised of two or more rehabilitation therapies per day (e.g., physical therapy, occupational therapy, speech language pathology, recreational therapy, etc.). These services are usually provided in a designated CARF-accredited unit. The primary emphasis is to provide rehabilitation services in the early phase, after an acute injury or disease state.

(1) The focus of the CIIRP is on meaningful functional improvement and successful community re-entry. Goals are identified in mobility, ADLs, productive activity, and preparation for home and community.

(2) The treatment program has a specific timeframe and is goal-oriented with a focus on practical life-skills training. Treatment interventions are individualized and cost-effective, incorporating participant and caregiver education and preparation for their transition back into the community.

(3) CIIRPs may be provided in an acute hospital setting, as free-standing rehabilitation units, as part of a skilled nursing, long-term care environment, or CLC. Patients usually remain in the CIIRP until goals are met or maximal functional improvement is achieved.

(4) Within VA, CIIRPs utilize an outcomes management system for ongoing process and quality improvements. The Functional Status and Outcomes Database (FSOD), which uses the

Functional Independence Measure (FIM) as its assessment tool, is the VHA standard outcomes management tool for rehabilitation.

e. **Functional Independence Measure.** FIM is a nationally standardized tool used to track functional improvement, to measure functional gains, and for program evaluation. The FIM instrument is a basic indicator of severity of impairment. The FIM measures eighteen functional activities on a seven-level scale that designates major gradation in behavior, from dependence to independence. Data generated from the FIM is used to track changes and analyze the outcomes in all levels of the rehabilitation continuum except supportive care (see www.udsmr.org).

f. **Functional Related Groups.** Functional related groups (FRG) are a classification system that stratifies patients by severity of impairment and is used for facility planning, research on outcomes, and costs of rehabilitation. FRGs are based on four predictor variables:

(1) Diagnosis leading to disability,

(2) FIM admission motor score,

(3) FIM admission cognitive score, and

(4) Patient age.

g. **Functional Status and Outcome Database.** FSOD is the primary program evaluation database for rehabilitation services in VHA. It incorporates FIM scores, participant demographics, and financial costs. FSOD can be used to monitor agency-wide performance measures for select participant populations.

h. **Geriatric Extended Care Physician.** A geriatric extended care (GEC) physician is skilled in the prevention and management of the unique health concerns associated with older adults and is capable of developing care plans that address the multi-system needs seen in an older population. This physician must possess the knowledge and understanding of the extended care services available through VHA. Board certification in geriatrics is desirable, although not mandatory.

i. **Nursing Hours per Patient Day.** Nursing hours per patient day (HPPD) is a measure of the average amount of time required over 24 hours to meet the nursing care needs of a specified patient population. It includes all levels of direct care nursing staff (e.g., Registered Nurse (RN), Licensed Practical or Vocational Nurse, and Nursing Assistant) providing direct care to the participant.

j. **Physiatrist.** A physiatrist is a physician who is board certified, or trained and board eligible, in Physical Medicine and Rehabilitation. The physiatrist specializes in impairments and disease processes that necessitate admission to rehabilitation programs. The physiatrist further directs a comprehensive rehabilitation team of professionals, that may include: physical therapists, occupational therapists, kinesiotherapists, recreational therapists, rehabilitation nurses, psychologists, social workers, speech-language pathologists, and others working together to manage disorders that alter an individual's functional independence.

k. **Rehabilitation Interdisciplinary Team.** The rehabilitation IDT specializes in the management of the complex needs of patients who would benefit from comprehensive and intensive rehabilitation services. Composition of the IDT is determined by the needs and goals of the patient. The patient and their family are an integral part of the IDT. Disciplines represented on the rehabilitation IDT may include, but are not limited to: physiatry, GEC medical provider, primary care provider and VA patient aligned care team (PACT), rehabilitation nursing, direct care nursing, occupational therapy (OT), physical therapy (PT), kinesiotherapy (KT), recreational therapy (RT), speech language pathology (SLP), psychology, audiology, optometry, ophthalmology, clinical pharmacist, social work, and nutrition. Other disciplines, may be consulted as determined by the patient's needs. An individualized rehabilitation treatment plan is developed with goals and timeframes established, and clinical outcomes are monitored on a routine basis.

l. **Rehabilitation Nurse.** A rehabilitation nurse is an RN who, in addition to possessing traditional patient care skills, also assists individuals affected by chronic illness or physical disability to adapt to their disabilities, achieve their greatest functional potential, and work toward productive, independent lives (see www.rehabnurse.org). The rehabilitation nurse is an integral member of the IDT and participates in the implementation of the treatment plan, developing nursing interventions and goals to reinforce and support the rehabilitative interventions that optimize the participant's functional status and outcomes. The rehabilitation nurse identifies responses to illnesses and disabilities associated with:

(1) Alterations in physical, behavioral, cognitive, perceptual, or mental status;

(2) Ability to perform functional activities;

(3) Emotional stress or crisis of factors such as disability, pain, changes in self-concept, and individual and family developmental stages; and

(4) Adaptation to, and coping with, alterations that result from disability and chronic illness.

***NOTE:*** *A rehabilitation nurse, who has had specialized training and has been certified by the Association of Rehabilitation Nursing, is a Certified Rehabilitation Registered Nurse (CRRN). Certification is recommended.*

m. **Rehabilitation Nursing.** Rehabilitation nursing is based on the principles of rehabilitative and restorative care, and applies an understanding of the concepts that include, but are not limited to: adjustment, adaptation, and coping; growth and development; functional status; and group process and dynamics.

n. **Rehabilitation Point of Contact.** A rehabilitation point of contact (RPOC) is a rehabilitation staff member with specialized expertise in rehabilitation evaluations and assessments, such as a physiatrist or CRRN. The RPOC is actively involved in the rehabilitation referral process, and serves as the primary liaison for consultations requesting rehabilitation services throughout the continuum of care. The RPOC reviews the eligible Veteran's or other eligible participant's medical record, consults with the referring treatment provider, and recommends the most appropriate level of rehabilitation.

o. **Rehabilitation Therapist.** A rehabilitation therapist is a specially trained, licensed, registered or certified professional, who evaluates and provides treatment to individuals to help them meet their functional rehabilitation goals. Rehabilitation therapists are physical therapists, occupational therapists, kinesiotherapists, speech-language pathologists, and recreation therapists.

p. **Resident Assessment Instrument Minimum Data Set.** Resident assessment instrument (RAI) minimum data set (MDS) is a standardized methodology for assessment and treatment planning that was developed by the Centers for Medicare and Medicaid Services (CMS). VHA adopted its use in the year 2000. The MDS is utilized to assess and collect a standardized set of physical, psychological and psychosocial functioning data on all residents in a long term care facility in the U.S., including VHA. The RAI MDS is utilized by VA CLCs surveyed under The Joint Commission's Long-term Care Standards.

q. **Resource Utilization Groups III.** Resource utilization groups (RUGs) are derived from elements in the MDS assessment, and classify CLC residents into one of eight categories that represent the resident's needs for care and resource requirements to meet those needs. The MDS contains extensive information on the resident's ADL impairments, cognitive status, psychosocial needs, and medical and health care issues. This information is used to define groups in RUGs III that form a hierarchy from the greatest to the least degree of impairment and resource needs. Residents with requirements for more specialized nursing, skilled therapies, and those with greater ADL dependency are assigned to higher groups in the RUGs IV hierarchy. The Medicare reimbursement system has recognized that residents in the higher RUGs require more intensive clinical resources, and thus reimburse at a higher level (see Appendix C for RUGs specific to rehabilitation).

r. **Restorative Care.** Restorative care is a program driven by nursing in collaboration with rehabilitation services, consisting of interventions and programs that focus on residents who have become de-conditioned due to acute illness, or chronic debilitating disease, and or prolonged inactivity. A focused program of restorative care involves planned interdisciplinary interventions to improve the Veteran's functional status, and facilitates transition to home or a less restrictive level of care. Restorative care is provided primarily in CLC by nursing staff, in collaboration with therapy services staff who may serve as consultants.

s. **Skilled Therapy.** Skilled therapy involves complex and sophisticated therapy procedures requiring the judgment and/or skill of a qualified rehabilitation therapist. Individuals receiving skilled therapies have individualized goals for functional improvement. Skilled therapy does not include services for skill maintenance or services provided in a restorative nursing care program. A skilled therapist may participate in establishing a plan of care or restorative therapy goal, but does not actually participate in maintenance or restorative care programs.

## 4. SCOPE:

a. Rehabilitation services encompass a broad array of interventions and must be provided as clinically needed across the full spectrum of medical care at various levels of intensity, and in different care settings. Veterans and other participants who are enrolled or otherwise eligible for the care are to have access to the appropriate level of rehabilitative services across the continuum

of care, based on their individualized assessed need. ***NOTE:*** *The phrase "other participants who are enrolled or otherwise eligible" are active duty Servicemembers with a severe injury or illness who needs rehabilitation services to facilitate their recovery and rehabilitation in accordance with 10 U.S.C. 1071.* Providers must monitor the quality of the services and treatment programs through the analysis of individual and aggregate clinical outcomes.

b. Patients across the continuum of care may demonstrate a need for rehabilitation services to improve their functional status, and referrals to rehabilitation services originate from multiple sources throughout the care continuum. Regardless of the origin of the referral for rehabilitation, after a consult to a rehabilitation program is initiated the patient must be screened to determine the intensity and location of care required. The rehabilitation algorithm (see Appendix A) has been designed to facilitate the appropriate rehabilitation placement based on the participant's rehabilitation needs.

**5. LEVELS OF CARE:** The following describes the levels of intensity of services within the Rehabilitation Continuum of Care. The Continuum delineates the staffing resources, medical provider, program oversight, team composition, rehabilitation therapies, and nursing requirements that are typical for each level of care. The recommended level of intensity of rehabilitative services is considered for each case based on an individual assessment, and the HPPD may be used to guide the determination of the intensity level. Nursing staffing levels will be determined using the Office of Nursing Services Nurse Staffing Methodology. The recommended level of intensity for each Veteran and other eligible participant being considered for rehabilitation services is based on individual assessment by the Rehabilitation Point of Contact. ***NOTE:*** *See Appendix B.*

a. **High Intensity Rehabilitation.**

(1) Participation in a high intensity rehabilitation program is recommended whenever there is a new onset of an injury, medical, or surgical condition that requires the services of the rehabilitation IDT and the following level of services:

(a) Daily physician visits.

(b) At least one CRRN to drive the rehabilitation nursing model of care.

(c) Average direct nursing HPPD of 9.4 hours, with a minimum of 7.0 hours.

(d) A combination of at least three rehabilitation therapies, with the ability to tolerate these therapies at a minimum of 3 hours per day, 5 days a week.

(2) The expected length of stay (LOS) is typically less than 30 days, with the range determined by the FRG classification, and the expectation that the participant will return to a setting in the community, such as home.

(3) Diagnostic groups that frequently benefit from this level of rehabilitation services include: polytrauma, traumatic brain injury (TBI), stroke, and complicated medical and surgical conditions.

(4) If the facility is providing high intensity rehabilitation, the Veteran, or other eligible participants, must be cohorted in a designated area. This means physically separated but grouped together with other rehabilitation patients of similar intensity. The physiatrist or physician with extensive rehabilitation experience provides oversight of the care plan. The rehabilitation IDT is integral to implementation of the care plan, and FIM scores are used to measure the rehabilitation outcomes.

(5) A facility offering this level of service to a sufficient volume of participants (occupancy rate of five or more patients) must pursue CARF accreditation, which guides the continuous improvement process.

(6) If High Intensity Rehabilitation is provided in the CLC, completion of the MDS is required, and all of the preceding requirements outlined in paragraph 5.a. (including CARF accreditation) apply.

b. **Moderate Intensity Rehabilitation.**

(1) Participation in a moderate intensity rehabilitation program is recommended when there is a new onset of an injury, medical or surgical condition that requires the following level of services:

(a) At least weekly physician visits.

(b) At least one CRRN to have a direct or consultative role to drive the rehabilitation nursing model of care.

(c) An average overall nursing HPPD of 7.0 hours, with a minimum of 4.8 hours.

(d) A combination of two rehabilitation therapies, with the ability to tolerate a combination of those therapies at a minimum of 2 hours per day, 5 days a week.

(2) The expected LOS is typically less than 30 days, with the range determined by the FRG classification, and the expectation is that the participant will return to the community.

(3) Patient groups that may benefit from this level of care include those with: hip fracture, total joint replacement, amputations, and some individuals with stroke or TBI who may require less intensive treatment or treatment of extended duration.

(4) If the facility is providing moderate intensity rehabilitation, eligible participants must be cohorted in a designated area. The physiatrist or physician with extensive rehabilitation experience provides oversight of the care plan if the participant is admitted to a Physical Medicine and Rehabilitation (PM&R) service, or is consultative for the rehabilitation plan of care if the participant is admitted to the GEC service. The rehabilitation IDT is integral to implementation of the care plan, and FIM is used to measure the rehabilitation outcomes.

(5) A facility offering this level of service to a sufficient volume of participants (occupancy rate of five or more patients) must be CARF accredited, which guides the continuous improvement process.

(6) If Moderate Intensity Rehabilitation is provided in the CLC, completion of the MDS is required, and all the preceding requirements outlined within paragraph 5.b. (including CARF accreditation) apply.

(7) If in a CLC, the RAI MDS generated Quality Measures Report will also guide continuous improvement.

c. **Low Intensity Rehabilitation.**

(1) Inclusion in a low intensity rehabilitation program is recommended when there is a new onset of an injury, medical, or surgical condition that requires limited rehabilitation services in a rehabilitation or restorative environment as described in the following:

(a) At least monthly physician visits.

(b) At least one CRRN is required in a consultative role to the program in order to drive the rehabilitation nursing model of care.

(c) An average overall nursing HPPD of 4.8 hours, with a minimum of 4.1 hours.

(d) Primary interventions are rehabilitation therapies and restorative care, with direct therapies involved for a limited time for the skilled intervention. The participant requires a combination of one or more rehabilitation therapies, and is able to tolerate a combination of those therapies at a minimum of 1 hour per day at least 3 days a week. The care goal is to enhance and optimize function, and prevent regression of that function.

(2) If the facility is providing low intensity rehabilitation, participants may be cohorted in a designated area. It is recommended that a facility offering this level of service to a sufficient volume of participants be CARF accredited. The physiatrist or physician with extensive rehabilitation expertise is consultative to the GEC physician regarding the rehabilitation component of the care plan. The rehabilitation IDT is recommended in the implementation of the care plan. The expected LOS is typically less than 90 days, with the range determined by the FRG classification.

(3) The expectation is that the participant will return to the community. Arrangements to transition care to the out-patient setting are initiated with community or VA primary care providers. For patients receiving primary care at a VA medical facility, this includes involvement of the appropriate PACT.

(4) Patient groups that may benefit from this level of care include those with medical and surgical conditions resulting in severe deconditioning, or with significant debility from chemo or radiation therapy.

(5) FIM scores are used to measure rehabilitation outcomes.

(6) If low intensity rehabilitation is provided in a CLC, the RAI MDS and MDS generated Quality Measure Report must be used to monitor outcomes.

d. **Supportive Rehabilitation.**

(1) Supportive rehabilitation is an array of services provided to optimize functional ability, or maintain or delay further functional loss. These services are provided through restorative care. Restorative care is comprised of different levels of intensity, but follows these guidelines:

(a) Physician visits every 30 days.

(b) An IDT, CRRN, or designated restorative nursing representative in a consultative role to the GEC provider in formulating the rehabilitation component of the care plan.

(c) Combination of nursing HPPD is 4.1 hours, with a minimum of 3.9 hours.

(2) Veterans or other eligible participants identified with supportive rehabilitation needs are often admitted to the CLC for long-stay services. The GEC physicians are responsible for the oversight of the care plan.

(3) The expected LOS may be greater than 90 days. When supportive rehabilitation is provided in a CLC, the RAI MDS and MDS generated Quality Measure Report must be used to monitor outcomes.

e. **Outpatient Rehabilitation.**

(1) Outpatient Rehabilitation must be considered when a participant has functional limitations requiring skilled intervention by rehabilitation therapists, but does not require inpatient care. The expectation is that the participant's condition will improve in a reasonable (and generally predictable) period of time, or the services must be necessary for establishing a safe and effective living environment. Outpatient services may be provided in the outpatient therapy department, the community, or the home. A rehabilitation therapist (PT, KT or OT) is required on every Home Based Primary Care (HBPC) team. All rehabilitation therapists will follow local policy on documentation for CARF, The Joint Commission, and billing requirement compliance. ***NOTE:*** *For additional information see: http://vaww.va.gov/CBO/apps/policyguides/infomap.asp?address=VHA_PG_1601C.03.7.C.5. This is an internal VA Web site not available to the public.*

(2) A plan of care must be developed in conjunction with the patient's medical team providing primary care, either in the community or through the VA PACT. Telerehabilitation can be used to increase access to specialty rehabilitation care on an outpatient basis. This modality allows the provider to be located at the tertiary medical center while the patient is at a Community Based Outpatient Clinic (CBOC) or at home. Veterans with disabilities, especially in rural areas, can greatly benefit from telerehabilitation. Many of these Veterans have mobility issues and/or socioeconomic factors that affect their ability to receive needed care. The results are that this population often have decreased access to care and possibly decreased quality of care. For Veterans with disabilities that need long-term follow-up such as stroke and TBI, telerehabilitation affords clinicians the option to offer enhanced services, thereby assisting in increased functional gains and social re-integration. In circumstances where a Veteran is receiving high intensity or moderate intensity rehabilitation in a CLC and is a candidate for completing treatment in the community, early coordinated discharge planning with the

continuing provider in PACT or HBPC is recommended as the Veteran may benefit from outpatient rehabilitation or telerehabilitation.

**6. ACCESS TO THE REHABILITATION CONTINUUM OF CARE:** Staff can access rehabilitation services for their patients by completing an electronic consult in the computerized patient record system (CPRS), which will alert the designated RPOC. The RPOC assesses the patient and recommends the appropriate level of service. The RPOC uses the guidelines set forth in the algorithm of the Rehabilitation Continuum of Care (see Appendix A) and the Rehabilitation Continuum of Care Chart (see Appendix B) to determine the most appropriate rehabilitation placement. After it is determined that a Veteran is appropriate to receive rehabilitation services and the CLC provides any, or all, of the continuum of rehabilitation services required for the Veteran's needs, the RPOC initiates a GEC Referral Form and the consult proceeds through the CLC admission and screening process as per facility policy and practice for admission to the CLC.

**7. CLINICAL INDICATIONS FOR PARTICIPATION AND DISCHARGE FROM THE INPATIENT REHABILITATION CONTINUUM OF CARE:** The following general indications for participation and discharge from inpatient rehabilitation apply to all levels of the continuum of care. ***NOTE:*** *Individual programs may have additional admission and discharge criteria as well.*

a. **Clinical Indications for Inpatient Rehabilitation Continuum of Care.** Clinical indications for inpatient Rehabilitation Continuum of Care include:

(1) Onset of an injury or a medical or surgical event within the past 90 days resulting in the need for rehabilitation, unless complicating factors exist (i.e., the participant's medical instability had precluded participation in rehabilitation and has shown improvement, referral was delayed due to administrative issues, or the participant's condition has changed from baseline);

(2) The event has resulted in an impairment of functional performance relative to baseline;

(3) The participant has specific functional improvement goals within a projected time frame;

(4) The participant has the ability to actively and safely participate in the rehabilitation program;

(5) The participant agrees to participate in rehabilitation; and

(6) The discharge setting is either to the pre-hospital living setting or alternative living options that have been identified with necessary support systems. Discharge is addressed with the participant prior to admission to the program.

b. **Initial Evaluations.** Each member of the IDT administers discipline-specific evaluations based on the individual medical and surgical diagnoses, impairments, and sequelae. These evaluations assist the IDT to establish the projected achievable goals and timelines for rehabilitation. The results of the evaluations must be completed and documented within the facility's established timelines.

c. **Re-evaluations.** Reevaluations occur as clinical conditions necessitate. In high and moderate rehabilitation, reevaluations usually occur at least weekly, and must not be less often than twice monthly. Close monitoring of all identified problem areas (including medical, physical, functional, cognitive, psychological, and psychosocial), ensures that appropriate adjustments are made to the plan of care, and facilitates discharge planning. The results of reevaluations are documented in the medical record and communicated to the team during the IDT meeting.

d. **Discharge Criteria for Inpatient Rehabilitation Continuum of Care.** The discharge criteria for inpatient Rehabilitation Continuum of Care are:

(1) Treatment goals have been achieved and, if the Veteran is returning to the community, an appropriate referral to home and or community-based care has been initiated.

(2) Care needs require transition to a higher or lower level of care than offered by the program;

(3) The participant is no longer making progress towards goals and no new goals have been identified;

(4) The participant requests discharge from the program;

(5) Documented client non-adherence to program services indicates that continued participation is either not safe or not an appropriate approach to care; or

(6) The participant is unable to actively and safely participate in the rehabilitation program.

(7) If discharge to the home setting is contemplated, appropriate arrangements to transition care to the out-patient primary care team have been initiated, with development of a care plan building upon rehabilitation progress in the in-patient setting.

e. **Discharge Summaries and Evaluations.** All team members are required to complete a discharge summary within the clinical privileges or the scope of practice of each professional. The combined discharge summaries must detail the medical, physical, functional, cognitive, psychological, and psychosocial status of the participant at the time of discharge. The summary must include medications, activity restrictions, adaptive equipment and devices provided, and progress towards rehabilitation goals. Additional discharge information addresses the discharge living setting, written instructions provided to the patient and caregivers, any community contacts, and future appointments to assist the participant with transition back into the community.

***NOTE:*** *Although sometimes challenging, persons with dementia, mental health conditions or other cognitive impairment should not be excluded from receiving rehabilitation because of the dementia or cognitive impairment. Innovative rehabilitation approaches and techniques should be used to assess these patients for any potential for improved function.*

**8. INTERDISCIPLINARY REHABILITATION PLAN OF CARE:**

a. Interdisciplinary treatment plans are a Veteran-centered, coordinated, collaborative plan based on active involvement of the participant, family, or others identified by the participant, and rehabilitation team members.

b. Treatment plans are intended to be dynamic rather than static documents, and are changed in response to the participant's condition and progress toward goals.

c. The physiatrist or physician with extensive rehabilitation experience provides oversight to the rehabilitation plan of care.

d. Each member of the IDT is responsible for recommending participant-specific goals and interventions as a result of their assessments.

e. During team rounds, the IDT reviews progress toward treatment goals, identifies new goals, time frames, treatment interventions, and revises the IDT plan of care accordingly.

**9. COMPLIANCE PROCEDURES:** Procedures recommended for documentation compliance with VHA Chief Business Office guidance are:

a. **Therapy Consult Requirements.** Therapy Consult Requirements include:

(1) Physicians, Physician Assistants (PA), Nurse Practitioners (NP), or other practitioners, based on professional scope of practice and local policy may initiate consults;

(2) The reason for evaluation and treatment is specified;

(3) An initial evaluation, inclusive of plan of care is completed by the therapist; and

(4) The referring provider is identified by the therapist for co-signature for concurrence and certification of the plan of care.

b. **Plan of Care Requirements.** Plan of Care Requirements are:

(1) Short-term and long-term goals with specific target dates for achievement are identified;

(2) Frequency, intensity, and duration of interventions are specified;

(3) Specific therapeutic interventions are delineated;

(4) The referring provider concurs or modifies the plan of care if necessary; and

(5) Certification dates are noted.

c. **Recertification of Plan of Care (Outpatient Setting).** The Recertification Plan of Care must be:

(1) Obtained every 90 days if the participant benefits from ongoing skilled therapeutic intervention;

(2) Inclusive of all the elements previously listed above under plan of care; and

(3) Recertified by the provider who sent the initial consult.

d. **Treatment Visit Notes.** A note for each treatment visit is required identifying procedure and treatment time, treatment objectives, assessment of performance relative to set goals, and response to therapeutic intervention and treatment plan. Treatment minutes must be documented in the RAI MDS as well.

e. **Interdisciplinary Plan of Care Note.** An interdisciplinary plan of care note is required weekly or as indicated by the level of care, and must include:

(1) The presence of primary discipline providers for discussion of goals, achievement, and alterations of the plan; and

(2) The participation of the participant and/or family, either in person or by report.

f. **Discharge Notes.** Discharge notes require a summary of functional gains, goal achievement or reasons for lack of progress, and must include:

(1) A summary of education and training provided to caregivers, family, and participant;

(2) Recommendations for skilled therapeutic interventions or restorative programs; these should include specific recommendations directed to the community provider or VA PACT providing continuous ongoing primary care to the Veteran; and

(3) Specifications regarding the discharge destination.

g. **Restorative Care Orders.** Restorative care orders managed through nursing:

(1) Must specify the type of program, measurable goals, frequency and duration; and

(2) Can be entered by an RN designated as the restorative nurse.

h. **Restorative Care Documentation.** Each restorative intervention provided per the established interdisciplinary plan of care must be documented daily and summarized weekly.

(1) Progress or decline needs to be reviewed and assessed by an RN every 30 days; and

(2) Therapy consultation needs to be considered if skilled therapy is indicated, or if there are needs for consultation about care issues such as positioning or seating, equipment, or conditioning or exercise programs.

i. **Treating Specialty Code.** ***NOTE:*** *A treating specialty code is the numeric code used to identify the bed section or special care area (such as general medicine, orthopedics or psychiatry) on which patients are treated. Each day of inpatient stay has an assigned treating specialty, based on the Patient Treatment File (PTF) treating specialty.* The following Treating Specialty Codes are used to identify inpatient rehabilitation services within the rehabilitation continuum of care.

| Code | Rehabilitation Service |
|---|---|
| 20 | Rehabilitation Medicine |
| 64 | CLC Short Stay Rehabilitation |
| 82 | Physical Medicine and Rehabilitation Transitional Rehabilitation Bed Section (PMRTR) |

(1) Treating Specialty Code 20 is used to identify an admission for rehabilitation services in a PMR bed section that is providing acute rehabilitation services, located in acute hospital beds. These acute inpatient rehabilitation programs provide comprehensive interdisciplinary rehabilitation services and must be accredited by CARF.

(2) Treating Specialty Code 64 is used to identify an admission to a VA CLC when, on admission, the Veteran's expected length of stay is 90 days or less. The admission for short stay rehabilitation is time-limited, goal-directed care for the purpose of returning the Veteran to functioning as independently as possible. These households afford the availability of the full continuum of inpatient rehabilitation services to severely injured Veterans who may require comprehensive rehabilitation services that extend beyond the acute rehabilitation phase and must be accredited by CARF.

(3) Treating Specialty Code 82 is used to identify an admission to an inpatient transitional rehabilitation program that offers a progressive return to independent living through an IDT led structured program that is focused on restoring home, community, leisure, psychosocial and vocational skills in a controlled, therapeutic setting. The transitional rehabilitation program functions to optimize physical abilities through graduated exercise, community and work settings. The transitional rehabilitation program further serves to normalize cognitive, communication, and behavioral abilities by employing these skills in a challenging, "real world" setting, enhancing the likelihood of transfer of the acquired skills to the community setting. A Physical Medicine and Rehabilitation Transitional Rehabilitation program is surveyed by The Joint Commission under acute hospital standards and is required to seek and maintain CARF accreditation under the Medical Rehabilitation standards.

**10. OUTCOME MEASURES PROCEDURES:** Functional outcomes of rehabilitation interventions need to be monitored using the FIM. FIM assessments are to be completed by the IDT, at a minimum, when services are initially ordered and at the end of the course of treatment. They may also be used to track interim progress. This data must be reviewed periodically to evaluate program outcomes for diagnostic groups served. The difference between initial FIM and discharge FIM (FIM change) can be monitored against length of stay, various diagnoses, and rehabilitation interventions. ***NOTE:*** *Polytrauma Transitional Rehabilitation Programs and Restorative Nursing Programs do not use the FIM. These programs are encouraged to establish other outcome measures that meet their specific programmatic needs.*

**11. QUALITY INDICATORS:** Quality indicators suggested by CARF and RAI MDS are used to monitor and measure performance and improvement. ***NOTE:*** *Programs are encouraged to develop other quality measures unique to their settings.*

**12. RESOURCES AND IMPLEMENTATION TOOLS FOR THE CONTINUUM:** A self-assessment tool has been developed to assess level of preparedness for implementation of the Rehabilitation Continuum of Care at a VA medical facility. This readiness tool is designed to provide an inventory of services currently provided, and to be a guide for services requiring further development. The tool can also be used at the completion of program implementation to evaluate and assess the recommended program components. ***NOTE:*** *See Appendix D.*

**13. REFERENCES:**

a. Association of Rehabilitation Nurses, Rehabilitation Nurse Case Manager Role Description and Definition and Scope of Practice, http://www.rehabnurse.org/.

b. CARF. Commission on Accreditation of Rehabilitation Facilities.

c. Centers for Medicare and Medicaid Services, http://www.cms.hhs.gov/InpatientRehabFacPPS/.

d. Nurse Staffing, Models of Care Delivery, and Interventions, Labor Management Institute 15th Annual Survey of Hours, www.lminstitute.com.

e. Office of Quality and Performance home page: http://vaww.oqsv.med.va.gov.

f. Rehabilitation Accreditation Commission (CARF), Medical Rehabilitation Standards Manual. CARF, 4891 East Grant Road, Tucson, AZ 85712; (520) 325-1044; FAX: (520) 318-1129; or at: http://www.carf.org.

g. Smits SJ, Strasser DC, Falconer JA et al., "Patient-focused Rehabilitation Team Cohesiveness in Veterans Administration Hospitals." Arch Phys Med Rehabilitation, 2003. 84(9): p. 1332-8.

h. Strasser DC, Falconer JA, Herrin JS, Bowen SE, Stevens AB, Uomoto J. "Team Functioning and Patient Outcomes in Stroke Rehabilitation," Archives of Physical Medicine and Rehabilitation, 2005. 86(3): o. 403-409.

i. Strasser DC, Falconer JA, Stevens AB, Uomoto JM, Herrin J, Bowen SE, and Burridge AG. "Team Training and Stroke Rehabilitation Outcomes: A Cluster Randomized Trial," Arch Phys Med Rehabilitation, 2007. 88(10): p. e-2.

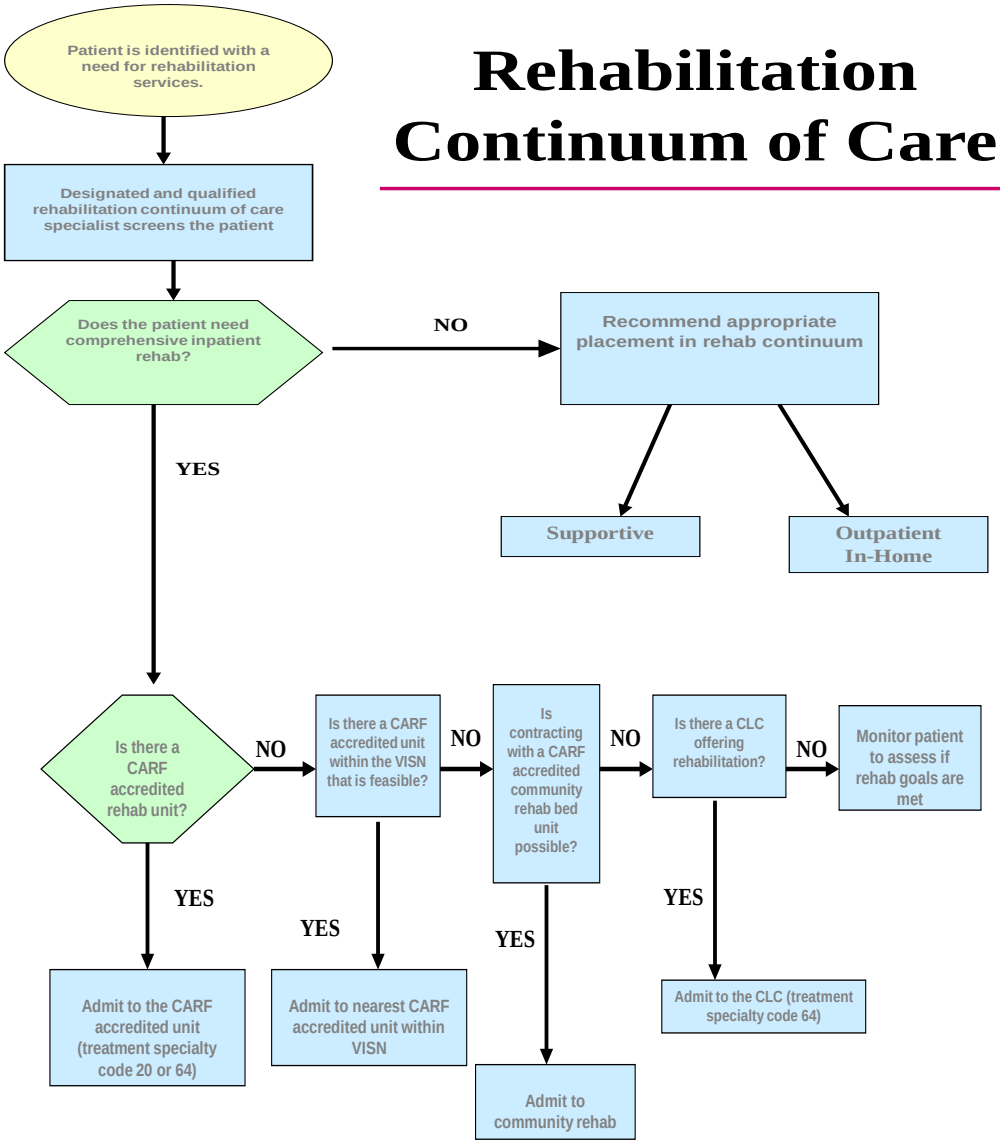
j. Strasser DC, Uomoto JM, and Smits SJ. *The Interdisciplinary Team and Polytrauma Rehabilitation: prescription for partnership* (2007, In Press). *Special Communicatio*n in Arch Phys Med Rehabilitation, 2008. 89(1): p. 179-81.

k. Veterans Health Initiatives: Caring for War Wounded, Hearing Impaired, PTSD, Spinal Cord Injury, Traumatic Amputation, Traumatic Brain Injury, Visual Impairment. http://vaww.va.gov/vhi/.

l. VHA Handbook 1142.01.

m. VHA Handbook 1170.01.

## REHABILITATION ALGORITHM



# REHABILITATATION CONTINUUM OF CARE CHART

| Level of Care | | | | | |
|---|---|---|---|---|---|
| **Inpatient** | | | | | **Outpatient** |
| | **High Intensity** | **Mod Intensity** | **Low Intensity** | **Supportive** | |
| **Responsible Provider** | PM&R | PM&R<br>GEC | PM&R<br>GEC | GEC/<br>Restorative Nursing | Ordering Provider |
| **MD or Licensed Practitioner Visits** | Daily | Weekly | Monthly | Every 30 days | Every 60 days |
| **Rehabilitation Team** | Yes | Yes | Consultative | Consultative | As Indicated |
| **Presence of CRRN or Nurse with Rehabilitation Experience** | Yes, direct | Yes, direct or consultative | Yes, consultative | As clinically indicated | As clinically indicated |
| **Expected LOS (FIM/RUG/FRG)** | Short Stay: Determined by the FRG Classification Typically < 30 days | Short Stay: Determined by the FRG Classification Typically <30 days | Short Stay: Determined by the FRG Classification Typically <90 days | Benchmark Diagnosis; May be >90 days; Rehab Involvement: Limited | Length of treatment determined by benchmark for diagnosis |
| **Nursing HPPD** | 9.4 hrs.<br>(7.0 Minimum) | 7.0 hrs.<br>(4.8 Minimum) | 4.8 hrs.<br>(4.1 Minimum) | 4.1hrs<br>(3.9 Minimum) | Not Applicable |
| **Restorative Care** | Not Applicable | Not Applicable | Restorative Nsg plus rehab therapies<br>> 2 Nsg. Activities | Restorative Nsg. 6 days/wk, 15min/day,<br>> 2 Nsg. Activities | Not Applicable |
| **Therapy Disciplines** | Minimum of 2 | Minimum of 2 | Minimum of 1 | As clinically indicated | As clinically indicated |
| **Therapy HPPD** | Minimum of 3 | Minimum of 2 | Minimum of 1 | As clinically indicated | As clinically indicated |
| **Therapy Days per Week** | Minimum of 5 | Minimum of 5 | Minimum of 3 | As clinically indicated | As clinically indicated |
| **Accreditation Requirements** | CARF and TJC | CARF and TJC | CARF and/or TJC | LTC<br>TJC | Outpatient CARF<br>Outpatient Homecare or<br>TJC |
| **Beds in Designated Area** | Yes | Yes | Not Required | No | NA |
| **Discharge Destination** | Community | Community | Community | Variable | NA |
| **Outcome Measures** | FIM | FIM | FIM | Determined by Program | FIM |
| **Continuous Improvement Measures** | Per CARF Standards and RAI MDS if in CLC | CARF and or RAI/MDS Quality Measures if in CLC | RAI MDS CARF and or Quality Measures | RAI MDS<br>Quality Measures | Per Departmental Policies |

## MDS GENERATED REHABILITATION RESOURCE UTILIZATION GROUPS (RUGs IV)

| CATEGORY | ADL INDEX | END SPLITS | MDS RUG-III CODES |
|---|---|---|---|
| **ULTRA HIGH REHABILITATION PLUS EXTENSIVE SERVICES** | | | |
| Rehabilitation Prescription (Rx) 720 minutes a week minimum and | 16-18 | Not Used | RUX |
| At least one rehabilitation discipline 5 days a week and | 7-15 | Not Used | RUL |
| A second rehabilitation discipline 3 days a week and | | | |
| Intravenous (IV) Feeding in last 7 days or | | | |
| IV medications, suctioning, tracheostomy care, or ventilator or respirator in the last 14 days and | | | |
| Activities of Daily Living (ADL) score of 7 or more | | | |
| **VERY HIGH REHABILITATION PLUS EXTENSIVE SERVICES:** | | | |
| Rehabilitation Rx 500 minutes a week minimum and | 16-18 | Not Used | RVX |
| At least one rehabilitation discipline 5 days a week and | 7-15 | Not Used | RVL |
| IV Feeding in last 7 days OR | | | |
| IV medications, suctioning, tracheostomy care, or ventilator/respirator in the last 14 days and | | | |
| ADL score of 7 or more | | | |
| **HIGH REHABILITATION PLUS EXTENSIVE SERVICES** | | | |
| Rehabilitation Rx 325 minutes a week minimum and | 13-18 | Not Used | RHX |
| At least one rehabilitation discipline 5 days a week; and | 7-12 | Not Used | RHL |
| IV Feeding in last 7 days or | | | |
| IV medications, suctioning, tracheostomy care, or ventilator or respirator in the last 14 days and | | | |
| ADL score of 7 or more | | | |

| CATEGORY | ADL INDEX | END SPLITS | MDS RUG-III CODES |
|---|---|---|---|
| **MEDIUM REHABILITATION PLUS EXTENSIVE SERVICES** | **ADL INDEX** | **END SPLITS** | **MDS RUG-III CODES** |
| Rehabilitation Rx 150 minutes a week minimum; and | 15-18 | Not Used | RMX |
| 5 days any combination of three rehabilitation disciplines; and | 7-14 | Not Used | RML |
| IV Feeding in last 7 days; or | | | |
| IV medications, suctioning, tracheostomy care, or ventilator/respirator in the last 14 days; and | | | |
| ADL score of 7 or more | | | |
| **LOW REHABILITATION PLUS EXTENSIVE SERVICES** | | | |
| Rehabilitation Rx 45 minutes a week minimum; and | 7-18 | Not Used | RLX |
| 3 days any combination of three rehabilitation disciplines; and | | | |
| Nursing rehabilitation 6 days a week, two services (see Reduced Physical Function (below) for nursing rehab services count) and | | | |
| IV Feeding in last 7 days; or | | | |
| IV medications, suctioning, tracheostomy care, or ventilator or respirator in the last 14 days; and | | | |
| ADL score of 7 or more | | | |
| **ULTRA HIGH REHABILITATION** | | | |
| Rehabilitation Rx 720 minutes a week minimum; and | 16-18 | Not Used | RUC |
| At least one rehabilitation discipline 5 days a week; and | 9-15 | Not Used | RUB |
| A second rehabilitation discipline 3 days a week | 4- 8 | Not Used | RUA |
| **VERY HIGH REHABILITATION** | | | |
| Rehabilitation Rx 500 minutes a week minimum; and | 16-18 | Not Used | RVC |
| At least one rehabilitation discipline 5 days a week | 9-15 | Not Used | RVB |
| | 4- 8 | Not Used | RVA |
| **HIGH REHABILITATION** | **ADL INDEX** | **END SPLITS** | **MDS RUG-III CODES** |
| Rehabilitation Rx 325 minutes a week minimum; and | 13-18 | Not Used | RHC |
| At least one rehabilitation discipline 5 days a week | 8-12 | Not Used | RHB |
| | 4- 7 | Not Used | RHA |

| CATEGORY | ADL INDEX | END SPLITS | MDS RUG-III CODES |
|---|---|---|---|
| **MEDIUM REHABILITATION** | | | |
| Rehabilitation Rx 150 minutes a week minimum; and | 15-18 | Not Used | RMC |
| 5 days any combination of three rehabilitation disciplines | 8-14 | Not Used | RMB |
| | 4- 7 | Not Used | RMA |
| **LOW REHABILITATION** | | | |
| Rehabilitation Rx 45 minutes a week minimum; and D | 14-18 | Not Used | RLB |
| 3 days any combination of three rehabilitation disciplines; and | 4-13 | Not Used | RLA |
| Nursing rehabilitation 6 days a week, two services (see Reduced Physical Function (below) for nursing rehab services count)<br><br>*Nursing Rehab Service count:<br>• passive and/or active ROM<br>• amputation/prosthesis care training<br>• splint or brace assistance<br>• dressing or grooming training<br>• eating or swallowing training<br>• transfer training<br>• bed mobility and/or walking training<br>• communication training<br>• scheduled toileting plan and/or bladder retraining program | | | |

## REHABILITATION CONTINUUM OF CARE SELF ASSESSMENT TOOL

| Guideline | Degree of Readiness | | | |
|---|---|---|---|---|
| | Very Well Prepared; no improve-ment needed | Well Prepared; minor improve-ment needed | Not well prepared; major improve-ment needed | Not prepared at all; priority for improve-ment |
| **A. Point of Contact (POC)** | | | | |
| 1. Who is the initial point of contact for new admissions? | | | | |
| Physician | | | | |
| Certified Rehabilitation Nurse | | | | |
| Provider (physician assistant, nurse practitioner) assigned to Rehabilitation service | | | | |
| Nursing professional with extensive rehabilitation experience | | | | |
| Nurse assigned to Extended Care who has little or no rehabilitation experience | | | | |
| | | | | |
| 2. Is there sufficient point-of-contact staffing? | | | | |
| Is there a clear contingency plan should the primary POC be absent? | | | | |
| Is there sufficient staffing to handle a large number of referrals in a short time? | | | | |
| | | | | |
| 3. How many referrals does your facility receive in a typical month? | | | | |
| | | | | |
| **B. Admission Criteria and Processes** | | | | |
| 1. Is there a clear written policy and procedure, specific to the facility, that states specific criteria for admission to **acute rehabilitation (short stay) services**? | | | | |
| 2. Is there a clear written policy and procedure, specific to the facility, that states specific criteria for admission to **CLC (long stay) services**? | | | | |
| 3. Are there clearly established procedures for **physical transfer** of Veteran or other eligible participants from acute care to acute rehabilitation and/orCLC? | | | | |
| 4. Are there clearly established procedures for **administrative transfer** of Veteran or other eligible participants across service lines (i.e., from acute care to acute rehabilitation and/or CLC)? | | | | |

| **Guideline** | **Degree of Readiness** | | | |
|---|---|---|---|---|
| | Very Well Prepared; no improve-ment needed | Well Prepared; minor improve-ment needed | Not well prepared; major improve-ment needed | Not prepared at all; priority for improve-ment |
| 5. Are there clear procedures for arranging alternative placement if the facility is not able to provide needed services on site? | | | | |
| | | | | |
| **C. Commission on Accreditation of Rehabilitation Facilities (CARF) Accreditation** | | | | |
| 1. Is this facility CARF accredited? | | | | |
| 2a. If not accredited, is the facility meeting CARF standards? | | | | |
| 2b. What are the barriers to becoming CARF-accredited? | | | | |
| 3. If not meeting the standards, is the facility familiar with CARF standards? | | | | |

| | | | | |
|---|---|---|---|---|
| **D. Services Offered** | | | | |
| 1. Which of the following services does the facility offer? | | | | |
| a. Physical Therapy | | | | |
| b. Occupational Therapy | | | | |
| c. Speech Therapy | | | | |
| d. Kinesiotherapy | | | | |
| e. Recreation Therapy | | | | |
| f. Rehabilitative Nursing | | | | |
| g. Restorative Nursing | | | | |
| g. Psychological Services | | | | |
| In order to be rated "Very well prepared," the facility should offer rehabilitative nursing along with at least two of the other therapies listed. | | | | |
| 2. Do nursing staff have a solid knowledge base in rehabilitation nursing? | | | | |
| 3. Does the facility's recreational therapy program offer: | | | | |
| a. A rehabilitation focused therapeutic recreation program | | | | |
| b. Diversional activities | | | | |
| c. Both, or | | | | |
| d. Neither? | | | | |
| 4. Is there a well-documented restorative nursing program in place? | | | | |

| Guideline | Degree of Readiness | | | |
|---|---|---|---|---|
| | Very Well Prepared; no improve-ment needed | Well Prepared; minor improve-ment needed | Not well prepared; major improve-ment needed | Not prepared at all; priority for improve-ment |
| **E. Interdisciplinary Team Meetings** | | | | |
| 1. Are all relevant disciplines represented at the care planning meeting? | | | | |
| 2. Is there good communication among different disciplines involved in each resident's care? | | | | |
| 3. Does the facility have regular walking rounds? | | | | |
| 4. Is there a daily morning report at which members of all relevant disciplines are present? | | | | |
| 5. For Veteran or other eligible participants that generate Resource Utilization Group (RUG) that fall into the Rehabilitation category, is the plan of care reviewed at least weekly? | | | | |
| **F. Consults and Orders** | | | | |
| 1. Is there a mechanism in place to facilitate consults to rehabilitation therapies? | | | | |
| 2. Is there a mechanism in place to assure that orders are placed for the therapeutic intervention(s) the Veteran or other eligible participant needs? | | | | |
| | | | | |
| **G. Initial Assessment** | | | | |
| 1. Is there a documented standard operating procedure for performing the initial (post-admission) assessment that conforms to the facility's admission criteria? | | | | |
| 2. If not, is there a designated person who performs standard initial assessments? | | | | |
| | | | | |
| **H. Documentation** | | | | |
| 1. Is local documentation sufficient to meet the need for serving the rehabilitation Veteran or other eligible participant population? | | | | |
| 2. Are therapy minutes clearly documented for each discipline in each Veteran or other eligible participant's medical record and in the MDS if in the CLC? | | | | |
| 3. Does the Minimum Data Set (MDS) assessment place the resident in a RUG appropriate to actual services being provided? | | | | |

| **Guideline** | **Degree of Readiness** | | | |
|---|---|---|---|---|
| | Very Well Prepared; no improve-ment needed | Well Prepared; minor improve-ment needed | Not well prepared; major improve-ment needed | Not prepared at all; priority for improve-ment |
| 4. Does each Veteran or other eligible participant record include an interdisciplinary note with rehabilitation-specific goals stated in measurable terms? | | | | |
| 5. Are specific goals clearly documented in the Veteran's plan of care and accessible to all direct care staff? | | | | |
| | | | | |
| **I. Performance Improvement** | | | | |
| 1. Has this facility set benchmarks for evaluating performance in each area being monitored for quality assurance and improvement? | | | | |
| 2. Has the facility identified specific priorities for improvement in addition to routine performance monitoring? | | | | |
| 3. Is there a data-gathering system in place for monitoring quality of care and progress toward performance improvement objectives? | | | | |
| **J. Outcome Measurement** | | | | |
| 1. Is the Functional Independence Measure (FIM) used as the primary tool for assessing outcomes in **rehabilitation** Veteran or other eligible participants? | | | | |
| 2. Is the MDS used as the primary tool for assessing outcomes in **CLC** residents? | | | | |
| **K. Reimbursement** | | | | |
| 1. Is the facility familiar with the financial impact that rehabilitation services had upon the VERA system? | | | | |
| 2. Is the facility familiar with compliance guidelines for facility reimbursement? | | | | |
| 3. Is documentation in the Veteran or other eligible participant's medical record sufficient to support billable services? | | | | |
| | | | | |
| **L. Rehabilitation in the Community Living Center** | | | | |
| 1. In Your Work Practices: | | | | |

| Guideline | Degree of Readiness | | | |
|---|---|---|---|---|
| | Very Well Prepared; no improve-ment needed | Well Prepared; minor improve-ment needed | Not well prepared; major improve-ment needed | Not prepared at all; priority for improve-ment |
| a. Is nurse staffing such that resident's normal sleep and wake cycles and personal care times reflect resident preferences? | | | | |
| b. Are therapy appointments and rounds at times that respect the resident's personal preferences? | | | | |
| c. Are all members of the interdisciplinary team engaged in every aspect of resident care to the extent possible? | | | | |
| 2. In Your Care Practices: | | | | |
| a. Is the dining environment such that residents can practice eating and or obtaining food as if they were at home? | | | | |
| b. Is food available for residents at all times? | | | | |
| c. Are meals reflective of resident preferences and choice? | | | | |
| d. Is there meaningful activity during waking hours such that it supports what was learned during active therapy? | | | | |
| e. Are residents up and dressed most of the day? | | | | |
| 3. Environment of Care | | | | |
| a. Does the ambiance of the facility foster behaviors that will be carried over into the home? | | | | |
| b. Does the environment reflect safety, comfort, and the ambience of home? | | | | |
| c. Does the environment have sufficient natural lighting, safe flooring, and furnishings that cue the participant about function at home? | | | | |

## ACRONYMN LIST

| | |
|---|---|
| ADL | activities of daily living |
| CARF | Commission on Accreditation of Rehabilitation Facilities |
| CIIRP | comprehensive interdisciplinary inpatient rehabilitation program |
| CLC | Community Living Center |
| CRRN | registered nurse, certified by the Association of Rehabilitation Nursing |
| FIM | functional independence measure |
| FRG | function related groups |
| FSOD | functional status and outcome database |
| GEC | geriatrics and extended care |
| HPPD | hours per patient day |
| IADL | instrumental activities of daily living |
| IDT | interdisciplinary team |
| KT | kinesiotherapist |
| LOS | length of stay |
| MDS | minimum data set |
| NP | nurse practitioner |
| OT | occupational therapist |
| PA | physician assistant |
| PACT | Patient Aligned Care Team |
| PT | physical therapist |
| RAI | resident assessment instrument |
| RPOC | rehabilitation point of contact |
| RT | recreation therapist |
| RUGs | resource utilization groups |
| SLP | speech language pathologist |