2016 MEDICAL REHABILITATION PROGRAM DESCRIPTIONS

Contents

Comprehensive Integrated Inpatient Rehabilitation Program

A Comprehensive Integrated Inpatient Rehabilitation Program is a program of coordinated and integrated medical and rehabilitation services that is provided 24 hours a day and endorses the active participation and preferences of the person served throughout the entire program. The preadmission assessment of the person served determines the program and setting that will best meet the needs of the person served. The person served, in collaboration with the interdisciplinary team members, identifies and addresses his or her medical and rehabilitation needs. The individual resource needs and predicted outcomes of the person served drive the appropriate use of the rehabilitation continuum of services, the provision of care, the composition of the interdisciplinary team, and discharge to the community of choice.

The scope and intensity of care provided are based on a medical and rehabilitation preadmission assessment of the person served. An integrated interdisciplinary team approach is reflected throughout all activities. To ensure the transparency of information the program provides a disclosure statement to each person served that addresses the scope and intensity of care that will be provided.

A Comprehensive Integrated Inpatient Rehabilitation Program clearly identifies the scope and value of the medical and rehabilitation services provided. Dependent on the medical stability and acuity of the person served, a Comprehensive Integrated Inpatient Rehabilitation Program may be provided in a hospital, skilled nursing facility, long-term care hospital, acute hospital (Canada), or hospital with transitional rehabilitation beds (Canada). Through a written scope of services, each program defines the services provided, intensity of services, frequency of services, variety of services, availability of services, and personnel skills and competencies. Information about the scope of services and outcomes achieved is shared by the program with stakeholders.

Outpatient Medical Rehabilitation Program

An Outpatient Medical Rehabilitation Program is an individualized, coordinated, outcomes-focused program that promotes early intervention and optimizes the activities and participation of the persons served. The program, through its scope statement, defines the characteristics of the persons it serves. An assessment process initiates the individualized treatment approach for each person served, which includes making medical support available based on need. The program includes direct service provision, education, and consultations to achieve the predicted outcomes of the persons served. Information about the scope and value of services is shared with the persons served, the general public, and other relevant stakeholders.

The strategies utilized to achieve the predicted outcomes of each person served determine whether the individual program is single discipline or an interdisciplinary service. A Single Discipline Outpatient Medical Rehabilitation Program focuses on meeting the needs of persons served who require services by a professional with a health-related degree who can address the assessed needs of the person served. An Interdisciplinary Outpatient Medical Rehabilitation Program focuses on meeting the needs of persons served that are most effectively addressed through a coordinated service approach by more than one professional with a health-related

degree who can address the assessed needs of the person served.

The settings for Outpatient Medical Rehabilitation Programs include, but are not limited to, health systems, hospitals, freestanding outpatient rehabilitation centers, day hospitals, private practices, and other community settings.

Home and Community Services

Home and Community Services (HCS) are person centered and foster a culture that supports autonomy, diversity, and individual choice. Individualized services are referred, funded, and/or directed by a variety of sources. In accordance with the choice of the person served, the services provided promote and optimize the activities, function, performance, productivity, participation, and/or quality of life of the person served.

The Home and Community Services may serve persons of any ages, from birth through end of life. Services may be accessed in a variety of settings including, but not limited to, private homes, residential settings, schools, workplaces, community settings, and health settings. Services are provided by a variety of personnel, which may include health professionals, direct support staff, educators, drivers, coaches, and volunteers and are delivered using a variety of approaches, supports, and technology.

Services are dynamic and focus, after a planning process, on the expectations and outcomes identified by both the person served and the service providers. The service providers are knowledgeable of care options and linkages to assist the person served; use resources, including technology, effectively and efficiently; and are aware of regulatory, legislative, and financial implications that may impact service delivery for the person served. The service providers are knowledgeable of their roles in and contribution to the broader health, community, and social services systems.

Home and Community Services must include at least one of the following service delivery areas:

— Services for persons who are in need of specialized services and assistance due to illness, injury, impairment, disability, or a specific age or developmental need.

— Services for persons who need assistance to access and connect with family, friends, or co-workers within their homes and communities.

— Services for persons who need or want help with activities in their homes or other community settings.

— Services for caregivers that may include support, counseling, education, respite, or hospice.

Note: *A service provider seeking accreditation for Home and Community Services is not required to provide all four of the service delivery areas identified in the service description. However, it must include in the site survey all of the service delivery areas it provides that meet the service description.*

Residential Rehabilitation Program

Residential Rehabilitation Programs are provided for persons who need services designed to achieve predicted outcomes focused on home and community integration and engagement in productive activities. Consistent with the needs of the persons served services foster improvement or stability in functional and social performance and health. These programs occur in residential settings and may be transitional or long term in nature. The residences in which the services are provided may be owned or leased directly by the persons served or the organization.

Vocational Services

Vocational Services provides individualized services to persons to achieve their identified vocational outcomes. The services may include:

— Identification of employment opportunities and resources in the local job market.

— Development of realistic employment goals.

— Establishment of service plans to achieve employment outcomes.

— Identification of resources to achieve and maintain employment.

Vocational Services consider:

— The behavioral, cognitive, and medical, physical, and functional issues of the persons served.

— The vocational goals of the persons served.

— The personnel needs of the employers in the local job market.

— The accessibility and accommodations provided by employers.

— The community resources available.

— The trends and economic considerations in the employment sector.

Pediatric Specialty Program

The essence of a Pediatric Specialty Program is family-centered care. Family-centered care is defined as having eight critical components. They are:

— Recognition that the family/support system is the constant in the child's life, while the service systems and personnel within those systems fluctuate.

— Facilitation of family/support system—professional collaboration at all levels of care.

— Sharing of unbiased and complete information with the family/support system about the child's care on an ongoing basis, in an appropriate and supportive manner.

— Implementation of appropriate policies and programs that are comprehensive and provide emotional and financial support to meet the needs of families/support systems.

— Recognition of family/support system strengths and individuality and respect for different methods of coping.

— Understanding and incorporating the developmental needs of infants, children, and adolescents and their families/support systems into healthcare systems.

— Encouragement of parent-to-parent support.

— Assurance that the design of healthcare delivery systems is flexible, accessible, and responsive to family/support system needs. [Adapted from T.L. Shelton, E.S. Jeppson, and B.H. Johnson, *Family-Centered Care for Children with Special Health Care Needs*. (Washington: Association for the Care of Children's Health, 1987).]

Pediatric Specialty Programs are culturally sensitive, interdisciplinary, coordinated, and focused on outcomes. These programs serve children/adolescents who have significant functional limitations as a result of acquired or congenital impairments. The programs use an individualized, developmental, and age-appropriate approach to rehabilitation that ensures that care focuses on preventing further impairment, reducing activity limitations, and minimizing participation restrictions while maximizing growth and development. The programs encompass care that enhances the life of each child/adolescent served within the family, school, and community. A major focus is on providing developmentally appropriate care that acknowledges each child's/adolescent's need to learn and play.

Note: *An organization seeking accreditation for a Pediatric Specialty Program must also meet the program description and standards for at least one of the programs addressed in the Medical Rehabilitation Standards Manual.*

A person served is defined as a child/adolescent if the individual is under the age at which one is legally recognized as an adult in a given state/province. Refer to the Glossary for a definition of child/adolescent.

Emancipated minors are individuals who are under the age at which a state or province would legally recognize them as adults but who have had parental control over them legally terminated. In those states or provinces that recognize emancipated minors, those individuals are considered adults for the purposes of the CARF standards.

Amputation Specialty Program

A person-centered Amputation Specialty Program utilizes a continuum of care with a holistic interdisciplinary team approach. Interventions address the needs and desires of the person served and family/support systems and include, but are not limited to medical, rehabilitation, behavioral, psychosocial, vocational, avocational, and educational needs; prosthetic, orthotic, and pedorthic services; equipment; self-management of healthcare; preventive strategies; identification and use of peer support; and techniques to facilitate empowerment. The program supports and establishes connections to the local and national community that enhance the quality of the person's everyday life. The person served actively participates as a member of the interdisciplinary team to develop and understand the services provided and the impact on his or her functional abilities.

The Amputation Specialty Program focuses on strategies of collaboration to impact perioperative care, prevention, minimizing impairment, maximizing independent function, and maximizing the quality of life of the person served. Through the use of performance indicators, the program measures the effectiveness of services provided across the continuum offered.

An Amputation Specialty Program may be provided in a variety of settings, including hospitals, healthcare systems, outpatient clinics, community-based programs, and residential or long-term residential services.

Brain Injury Specialty Program

A Brain Injury Specialty Program delivers services that focus on the unique medical, physical, cognitive, communication, psychosocial, behavioral, vocational, educational, accessibility, and leisure/recreational needs of persons with acquired brain injury. The program integrates services to:

— Minimize the impact of impairments and secondary complications.

— Reduce activity limitations.

— Maximize participation, including wellness, quality of life, and inclusion in the community.

— Decrease environmental barriers.

— Promote self-advocacy.

A Brain Injury Specialty Program recognizes the individuality, preferences, strengths, and needs of the persons served and their families/support systems. It provides access to information, services, and resources available to enhance the lives of the persons served within their families/support systems, communities, and life roles and supports their efforts to promote personal health and wellness and improve quality of life throughout their life span.

The program demonstrates the commitment, capabilities, and resources to maintain itself as a specialized program for persons with acquired brain injury. A Brain Injury Specialty Program utilizes current research and evidence to provide effective rehabilitation and supports future improvements by advocating for or participating in brain injury research.

A Brain Injury Specialty Program partners with the persons served, families/support systems, and providers from emergency through community-based services to foster an integrated system of services that optimizes recovery, adjustment, inclusion, participation, and prevention. A Brain Injury Specialty Program engages and partners with providers within and outside of rehabilitation to increase access to services by advocating for persons who have sustained a brain injury to regulators, legislators, educational institutions, research funding organizations, payers, and the community at large.

Note: *A program seeking accreditation as a Brain Injury Specialty Program must include in the survey application and the site survey all portions of the program (Comprehensive Integrated Inpatient Rehabilitation Program, Outpatient Medical Rehabilitation Program,*

Home and Community Services, Residential Rehabilitation Program, and Vocational Services) that the organization provides and that meet the program descriptions.

Please refer to the Glossary for the definition of acquired brain injury.

Cancer Rehabilitation Specialty Program

A person-centered cancer rehabilitation specialty program utilizes a holistic interdisciplinary team approach to address the unique rehabilitation needs of persons who have been diagnosed with cancer. A cancer rehabilitation specialty program may be provided in a variety of settings, including hospitals, healthcare systems, outpatient clinics, or community-based programs. Personnel demonstrate competencies and the application of evidence-based practices to deliver services that address the preventive, restorative, supportive, and palliative rehabilitation needs of the persons served.

Cancer rehabilitation is an integral component of quality cancer care. The cancer rehabilitation specialty program focuses on strategies to optimize outcomes from the time of diagnosis through the trajectory of cancer in an effort to prevent or minimize the impact of impairments, reduce activity limitations, and maximize participation for the persons served. The program communicates and collaborates with healthcare providers to deliver coordinated care and promote seamless transitions in care.

The program is guided by the individual preferences, strengths, and needs of the persons served and their families/support systems. A cancer rehabilitation specialty program assists the persons served and their families/support systems to manage their own health, encourages their appropriate use of healthcare systems and services, and supports their efforts to promote personal health and wellness and improve quality of life throughout their life span. The program provides ongoing access to information, services, and resources available to enhance the lives of the persons served within their families/support systems, communities, and life roles.

The program demonstrates the commitment, capabilities, and resources to maintain itself as a specialized program for persons who have been diagnosed with cancer. Through the use of performance indicators the program measures the effectiveness of services across the continuum offered. A cancer rehabilitation specialty program advocates on behalf of persons who have been diagnosed with cancer to regulators, legislators, educational institutions, research funding organizations, payers, and the community at large. A cancer rehabilitation specialty program translates current research evidence to provide effective rehabilitation and supports future improvements in care by advocating for or participating in cancer research.

Spinal Cord System of Care

A Spinal Cord System of Care provides coordinated, case-managed, integrated services for persons with spinal cord dysfunction, whether due to trauma or disease. This system includes at a minimum an inpatient component in an organization licensed as a hospital and an outpatient component. The inpatient component of the Spinal Cord System of Care coordinates and integrates medical and rehabilitation services that are provided 24 hours a day, 7 days a week. The outpatient component of the Spinal Cord System of Care provides a structured, coordinated, comprehensive nonresidential program. The persons served participate on a scheduled basis that is less than 24 hours a day, 7 days a week. The system of care might also include Home and Community Services, a Residential Rehabilitation Program, and/or Vocational Services.

Striving to achieve the most integrated setting for the person served, each component of the Spinal Cord System of Care endorses the active participation and choice of the persons served throughout the entire program.

There is documented evidence that the Spinal Cord System of Care maintains the necessary expertise and capacity to provide services in all components of the continuum it offers. The Spinal Cord System of Care provides or formally links with key components of care that address the life-long needs of the persons served. These key components of care include, but are not limited to, emergent care, acute hospitalization, other inpatient rehabilitation programs, skilled nursing care, home care, other outpatient medical rehabilitation programs, community-based services, residential services, vocational services, primary care, specialty consultants, and long-term care.

The Spinal Cord System of Care is accountable for and serves as a resource to the persons served, their families/support systems, and continuum-of-care providers through its:

— Identification of care options and linkages with services/programs with demonstrated competencies in spinal cord dysfunction.

— Achievement of predicted outcomes.

— Conservation of funding to meet life-long needs.

— Provision and facilitation of medical interventions.

— Facilitation of opportunities for interaction with individuals with similar activity limitations.

— Focus on life-long follow-up that addresses impairment, activity, participation, and quality of life.

— Provision of education and training.

— Identification of regulatory, legislative, and financial implications.

— Participation in research and application of research to clinical practice.

The Spinal Cord System of Care is responsible for developing, facilitating, and ensuring demonstration of competencies that address the unique needs of the persons served. These competencies are established for the persons served, their families/support systems, and personnel.

The Spinal Cord System of Care encompasses care that advocates for full inclusion and enhances the lives of the persons served within their families/support systems, communities, and life roles.

Information about the outcomes achieved is shared with relevant stakeholders.

In addition to the inpatient and outpatient components, an organization seeking accreditation for its Spinal Cord System of Care must include in the survey application and the site survey all portions of the continuum (Home and Community Services, Residential Rehabilitation Program, and Vocational Services) that the organization provides and that meet the program descriptions.

Note: *Spinal cord dysfunction could be caused by trauma, cancer involving the spinal cord, inflammatory conditions such as multiple sclerosis, and nontraumatic etiologies such as tumors.*

Stroke Specialty Program

A stroke specialty program, through application of the research available to clinical practice, delivers services that focus on the unique needs of persons who have sustained a stroke, including:

— Minimizing impairments and secondary complications.

— Reducing activity limitations.

— Maximizing participation and quality of life.

— Decreasing environmental barriers.

— Preventing recurrent stroke.

The program recognizes the individuality, preferences, strengths, and needs of the persons served and their families/support systems. A stroke specialty program assists the persons served and their families/support systems to manage their own health, encourages their appropriate use of healthcare systems and services, and supports their efforts to promote personal health and wellness and improve quality of life throughout their life span. The program provides ongoing access to information, services, and resources available to enhance the lives of the persons served within their families/support systems, communities, and life roles.

A stroke specialty program partners with the persons served, families/support systems, and providers within and outside of rehabilitation throughout phases of care from emergency through community-based services. A stroke specialty program fosters an integrated system of care that optimizes prevention, recovery, adaptation, and participation.

A stroke specialty program contributes to the development of stroke systems of care by partnering with providers within and outside of rehabilitation to increase access to services by advocating for persons who have sustained a stroke to regulators, legislators, educational institutions, research funding organizations, payers, and the community at large. A stroke specialty program utilizes current research and evidence to provide effective rehabilitation and supports future improvements in care by advocating for or participating in stroke research.

Interdisciplinary Pain Rehabilitation Program

An interdisciplinary pain rehabilitation program provides outcomes-focused, coordinated, goal-oriented interdisciplinary team services. The program delivers services that focus on the unique needs of persons who have persistent pain, including:

— Minimizing impairments and secondary complications.

— Reducing activity limitations.

— Maximizing participation and quality of life.

— Decreasing environmental barriers.

An interdisciplinary pain rehabilitation program recognizes the individuality, preferences, strengths, and needs of the persons served, their families/support systems, and stakeholders. The program encourages appropriate use of healthcare systems and services by the persons served and their families/support systems and supports their efforts to promote personal health and wellness and improve quality of life throughout their life span. The program provides ongoing access to information, services, and resources available to enhance the lives of the persons served within their families/support systems, communities, and life roles.

An interdisciplinary pain rehabilitation program fosters an integrated system of care that optimizes prevention, recovery, adaptation, inclusion, and participation. The program utilizes current research and evidence to provide effective rehabilitation and supports future improvements in care by advocating for or participating in pain research.

Note: *A program seeking accreditation as an interdisciplinary pain rehabilitation program must include in the survey application and the site survey all portions of the program (inpatient, outpatient, etc.) that the organization provides and that meet the program description.*

Occupational Rehabilitation Program

An Occupational Rehabilitation Program is individualized, focused on return to work, and designed to minimize risk to and optimize the work capability of the persons served. The services provided are integrative in nature, with the capability of addressing the work, health, and rehabilitation needs of those served. Such a program provides for service coordination and management of those persons served with injuries or illnesses. In view of the multiple stakeholders involved in Occupational Rehabilitation Programs, informed consent to obtain or share information about the persons served is provided by the persons served as required. The program may be provided as a hospital-based program, an outpatient program, or a private

or group practice, and/or it may be provided in a work environment (at the job site).

Note: *For Canadian providers of Occupational Rehabilitation Programs, the concept of* occupation *is broader than a person's employment and might include functional roles such as homemaker, student, volunteer, etc.*

Occupational Rehabilitation Program—Comprehensive Services

Persons admitted to an Occupational Rehabilitation Program—Comprehensive Services tend to have more complex needs due the nature of their injury, illness, or impairment; length of time they have been off work; home or work circumstances; or other reasons. Through the comprehensive assessment and treatment provided by occupational rehabilitation specialists, Occupational Rehabilitation Program—Comprehensive Services directly provide and coordinate services to address the behavioral, functional, medical, physical, psychological, and vocational components of employability and return to work.

Independent Evaluation Services

Independent Evaluation Services coordinate and facilitate objective, unbiased evaluations based on the following:

— Individualized referral questions.

— Effective and efficient use of resources.

— Regulatory, legislative, and financial implications.

— Relevant communication with stakeholders.

In view of the multiple stakeholders involved, the Independent Evaluation Services support transparency and exchange of information.

Independent evaluations may be completed by a variety of professionals who are not involved in the care of the person served for the purpose of clarifying clinical and case issues. The delivery of Independent Evaluation Services may occur in a variety of settings including, but not limited to, a healthcare environment, a private practice, a community-based setting, or a private or group residence.

Case Management

Case Management proactively coordinates, facilitates, and advocates for seamless service delivery for persons with impairments, activity limitations, and participation restrictions based on the following:

— Initial and ongoing assessments.

— Knowledge and awareness of care options and linkages.

— Effective and efficient use of resources.

— Individualized plans based on the needs of the persons served.

— Predicted outcomes.

— Regulatory, legislative, and financial implications.

The delivery of case management may occur in a variety of settings that include, but are not limited to, a healthcare environment, a private practice, in the workplace or in the payer community.