HSS Rehabilitation National Network

Standards and Requirements

The HSS Rehabilitation Network (hereafter referred to as the "Network") has established a guide to quality standards and requirements. Practices must adhere to these standards, state practice laws, the APTA and AOTA Code of Ethics, and any other obligations specified in the Membership Agreement.

The HSS Rehabilitation National Network Advisory Board (hereafter referred to as the "Board") functions as the Network's governing body in collaboration with the Network and hospital administration. The Board meets regularly and addresses various issues affecting the Network, including policy and decisions on prospective new and ongoing members. The Board comprises elected owner-members, including one from each geographic area representing the Network. It may include a "member-at-large" and two "rotating" advisory seats. It also consists of the Network's executive management team and hospital representatives. Except for rotating advisors who serve for 18 months, Board member terms are for three years.

Organizational Criteria:

- Must be an independent therapist-owned practice without physician (including Chiropractic) ownership or association; in operation for at least 12 months, with the following exceptions:
    - *At HSS' discretion, a hospital-owned, corporate-operated, or private equity-backed facility may be considered if the situation warrants; Network policy on corporate ownership will apply in the latter two circumstances.*
    - *New facilities of an existing member will be eligible for membership after six continuous months of operation. In addition, the Advisory Board may consider a facility for membership before 12 months of operation if the staff possess advanced credentials and/or expertise deemed beneficial to the Network.*
- Practices may not lease any part of their treatment space directly to or from a physician. If an applying or existing member clinic leases any part of its space to another non-physician practitioner, they must reveal that lease relationship to the Network. Whether or not to approve new or ongoing membership of a facility that leases out part of its space is at the discretion of the Network Advisory Board, per the Network's space lease policy.
- At least one practice owner must be involved full-time in the operations of all practice locations, applying for membership and on-site regularly, preferably in a part-time clinical role. When an owner has a part-time presence in the facility, a full-time senior clinician on-site must be designated clinic director. In this situation, the clinic director will be subject to any/all obligations otherwise required of the owner.

- At least one owner must also be licensed in the state where the practice is located, have at least three years of clinical experience in their therapy field, and be a member of their respective professional organization.
- Each rehabilitation facility must have a qualified clinical director on-site full-time, who has administrative responsibility for the delivery of patient care and the supervision of the service(s), who is fully licensed in their state(s) of practice and has a minimum of three years of clinical experience in their field.
- The administrative direction of each rehabilitation service offered at the applying facility must be provided by a qualified individual, fully licensed in their state(s) of practice, with a minimum of three years of clinical experience.
- The practice location and scope of service meet Network demand/patient needs as determined by the Board.
- All Network member practices must have an up-to-date operational Policy and Procedure (P&P) manual specific to each facility. Although it may contain some of the same documentation, an employee handbook or manual will **NOT** be accepted as a facility's P&P manual. **Required components of the Policy and Procedure Manual are listed in that section heading. The required elements must be submitted in advance to HSS and be available for review at the clinic's site visit.**
- The practice must be engaged in physical rehabilitation on a full-time basis.
- All practices must be open full-time. (Full-time is defined as at least a part-time day, four days/week, for a minimum of 40 total hours).
- All practices must be wheelchair accessible.
- All care must be rendered free of discrimination as to race, religion, ethnicity, or gender and as otherwise guaranteed by law.
- Patient volume may not exceed three patients per hour per therapist or therapy assistant.

Personnel and Operational Criteria:

- All staff members must be hired and employed in compliance with all applicable laws within the state/local area where the practice does business.
- All individuals who provide rehabilitation must have been deemed competent to provide such services as determined by education, training, experience, and demonstrated adherence to current standards of care.
- Patient volume may not exceed three patients per hour per therapist or therapy assistant.
- All clinical staff must possess appropriate valid licensure/registration in the respective state of operation, with documentation posted in the facility as required by law.
- The ratio of a therapist to PTA/COTA must not exceed 1:4.
- The ratio of therapist to aide must not exceed 1:2.

- Reception coverage must be provided at least 50% of facility operating hours and/or equivalent coverage by a remote method.
- Patient evaluations may only be performed by a licensed Physical or Occupational therapist.
- Physical Therapy Assistants (PTAs) and Certified Occupational Therapy Assistants (COTAs) may not evaluate, re-evaluate, or independently progress a patient's program. They may, however, collaborate with the therapist on the patient's treatment and progression within the boundaries set by the state's laws in which the facility is located and as per APTA/AOTA guidelines/standards. Certified Athletic Trainers (ATCs) or other unlicensed staff may not provide any part of actual therapy treatment unless expressly permitted by law in the state of practice.
- Treatments are always provided by or under the supervision of a qualified and fully licensed therapist following appropriate state law.
- Each practice must provide evidence of a Quality Assurance Plan with demonstrable outcomes.
- Clinician staff claiming an area of clinical specialty or designation must submit proof of certification or credentialing.
- All Medicare participants must submit their provider number for all facilities applying for Network membership and display an appropriate mechanism for updating Medicare plans of care.
- All electro-modality devices used in treating patients [except those in use less than 12 months] must be appropriately calibrated/or professionally inspected annually by a certified vendor. Proof of inspection must be available on-site.
- Sufficient space, equipment, and facilities must be available to support the facility's clinical, educational, and administrative functions.

General Liability & Malpractice Insurance:

- There must be evidence of malpractice insurance for the practice, which covers each clinician who treats within the practice, with a minimum coverage of $1,000,000 / $3,000,000 aggregate in all cases.
- There must be evidence of general liability coverage for the practice, with a minimum coverage of $1,000,000 / $2,000,000 aggregate.
- Practices must maintain worker's compensation insurance coverage per the following:
    - With the law for the state(s) in which they operate and Employer's Liability insurance
    - With limits of not less than $1,000,000 per incident.
- **Hospital for Special Surgery must be listed as an additional insured on the practice's malpractice and general liability policies.**

Changes in Ownership, Facility, or Business Name

Network membership does not automatically transfer in the event of an ownership or address change and may also be affected by significant structural changes to an existing facility.

- The Network must be notified immediately if a member site plans to move, undergoes change or addition to ownership, or change the practice name.
- If there is a significant change in the ownership or management of a Network member facility, membership may be suspended while the new ownership's structure is reviewed. If more than 50% of the facility's ownership/management changes, the new ownership entity must submit a change of ownership form.
- Any new ownership entity will be evaluated for membership eligibility. If eligible, the new owners' entity must submit all Network agreements in effect at the time of acquisition on their behalf.
- A new application is unnecessary if a member facility changes location; however, ongoing membership in the new site is not guaranteed. The new site of an existing member must be inspected within three months of opening to verify compliance with Network standards.
- If a member facility undergoes significant structural renovation/or expansion, the Network must be notified upon completion of the work and site inspection conducted within three months to verify continued compliance with Network standards.

Continuing Education

As part of the Network's commitment to quality and professional growth, all professional staff must attend at least six hours of continuing education per year to include at least one clinically based course every 24 months unless a graduate of an accredited program within the last twelve months. To assist in meeting that requirement, therapists employed by Network practices are eligible for discounts to HSS Rehabilitation-sponsored continuing education courses and a host of free web-based learning opportunities on the eAcademy. In addition, a minimum of two in-services in the clinic must be presented annually.

Documentation / The Medical Record

An audit of documentation will be a component of every site visit.

- A minimum **average score of 80%** on the Documentation Scorecard is required.
- The medical record of the patient receiving rehabilitation services must include, at minimum, the following information:
    - A valid written prescription (unless exempt due to Direct Access). Verbal orders must be documented and followed up by a written order from the physician.

- An initial evaluation, including subjective findings, objective findings, patient goals and therapy goals with achievement time frames, and a treatment plan, including frequency and duration.
- The objective exam reflects an appropriate quadrant scan, contralateral, proximal/distal to the region of concern.
- Objective exam to include special tests.
- Treatment and progress records include documentation of daily treatment sessions, appropriate re-assessments, and updating patient/therapy goals and treatment plans.
- Functional outcome measures are collected and recorded in a timely manner and repeated as appropriate.
- The treatment program demonstrates appropriate progression.
- Pain score recorded **weekly.**
- At least one objective and/or functional measure is documented in **every follow-up visit**.
- Home exercise program (HEP) copied or referenced and progressed as indicated.
- Goals must be updated, as appropriate, in objective or functional terms by the target achievement date.
- There must be a note in the medical record documenting the treatment given and the patient's progress and response to treatment for each visit.
- Sufficient detail should be established to replicate the treatment from the notes.
- There must be evidence that Medicare referrals and plans of care are certified and/or updated following current CMS rules.

Advanced Orthopedic Triage Certification:

As we look to raise the bar for proving the quality assurance and clinical excellence of the HSS Rehabilitation National Network, we aspire to have at least one clinician from each Network location practice take and pass the HSS Advanced Orthopedic Triage Certification (AOTC).

As clinicians achieve this certification, we will recognize the accomplishment on their clinic's listing on the Network's website. Having at least one AOTC clinician on staff will be a requirement for renewal as of 2025. Beginning in 2024, any new applicants to the Network will be required to meet the AOTC requirement within the first six months of membership.

For more information regarding the AOTC, you may access the certification information through the membership portal or our access to the HSS eAcademy.

Click here for more information.

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Policy & Procedure Manual Requirements

It is a requirement for Network Membership that all practices have an up-to-date Policy and Procedure (P&P) manual specific to each facility. At a minimum, there must be a written statement, policy, and/or procedure (as appropriate) for each subject listed below. The list is not intended to exclude policies or procedures not specifically addressed. Blank copies of supporting documents should also be included whenever possible (i.e., incident report form). While the items listed below will be reviewed before the actual site visit inspection, the existence of the complete P&P will be verified at the time of the visit. Although it may contain some of the same documentation - **An Employee Handbook/Manual will not be accepted as a facility's P&P manual.**

General:

- Mission Statement
- Description of Services
- Hours of Operation

Safety:

- Safety issues must be addressed, including performance requirements and quality control for all equipment that provides patient care services.
- Exits must be marked, and each facility must have an appropriate number and type of fire extinguishers accessible on the premises, even if a sprinkler system is in place. Extinguishers must be maintained/inspected and tagged annually by a certified vendor (or replaced annually). Emergency phone numbers must be prominently posted by each outgoing telephone, even if only "911".
- Basic emergency supplies must be readily accessible on the premises, including, at minimum, a blood pressure cuff, stethoscope, and self-contained basic first aid kit.
- Each facility must be prepared for emergencies. In addition to being in the manual, they must post the following conspicuously within the facility:
    - Phone numbers for emergency first responders, the local police department/precinct and fire station providing coverage in their area, and the nearest hospital or doctor available to provide emergency care.
    - A map of the facility, picturing all exits and exit paths, must be posted for easy viewing by patients and staff.
- Emergency Plans must be established and documented for:
    - Fire
    - Medical
    - Disaster
    - Utility Failure (including elevator alternatives for facilities not on the ground floor)

  - The above plans and the procedure to be followed for any other event where patient safety is an issue or evacuation of the premises is required must include appropriate specific actions to be taken by staff.

- If the facility has an isolated treatment area [i.e., therapeutic pool], there must be a method by which staff can signal for assistance in an emergency. In the case of therapeutic pools, there must be a specific procedure for pool emergencies.
- Emergency Closing
  - Plan/procedure followed if the facility closes due to emergency (i.e., inclement weather, fire)
  - Must include a description of the procedure for contacting patients to cancel and/or reschedule.
  - Plan/procedure for referring patients to other providers if the office must be closed for an extended period.

<u>Infection Control and Cleaning Procedures:</u>

- General infection control guidelines must be developed and enforced to protect patients, staff, and equipment.
  - Regarding illness and/or skin disorders in patients and staff
  - Basic office cleaning procedures
- Specific cleaning policies and procedures must be developed and implemented for each type of equipment, including laundry, treatment tables, exercise equipment, and modality devices.
  - Frequency of cleaning
  - Person(s) responsible for the task
  - Method/products used.
- Temperature and chemical levels must be regulated per local governing board standards for facilities with therapeutic pools. These levels must be checked and recorded, with results kept on file on the premises and available for inspection. Cleaning procedures should be described as part of the cleaning policy described above.

<u>Incident Reporting</u>

- There must be a procedure for reporting incidents that might occur during standard treatment.
  - Outline of steps to be taken by staff in the event of an incident
  - Standard form for reporting the incident.
- **Any incidents involving patients recommended by the Hospital for Special Surgery or the Rehabilitation Network must be reported to the Network office within 24 hours of occurrence.**

Payment Policy:

- There must be a written policy delineating the billing process used by the practice, including a written explanation of fees and billing given to patients.
    - Include a copy of patient information and an authorization form.
    - Should note specifics for co-payments and limitations on coverage for patients insured by Medicare.

Equipment:

- List of all therapy equipment used by the practice.
- References re: indications and contraindications of all modalities and categories of exercise equipment (i.e., cardiovascular, PRE, etc.) used in the facility must be available on-site.
- There must be a process for and evidence of staff education and competency on all equipment.

Personnel:

- Job descriptions and performance requirements for ALL employee types (clinical and non-clinical)
- Staff initial training procedures
- Continuing education policy
- Performance appraisals: These appraisals should be performed at least once a year. There should be a formal mechanism for these appraisals, and a copy of the form used for doing so should be kept on file.
- Clinical and support staff coverage
    - The procedure that is used to maintain coverage levels during planned and unexpected absences.
- Mechanism for communicating important information to covering staff.

Scheduling Procedure

- Standard procedure for scheduling, re: volume, patient contact, insurance verification, etc.
- A policy must be in place for the treatment and/or referral of patients for use in the event a member facility must close. * Within this mechanism must be a provision for emergency treatment of patients when a facility is temporarily unavailable, regardless of the closure length. ***** It is preferred that patients of Network members be recommended to other practices within the Network.
- Provision must be made to allow the practice to be contacted when clerical/reception staff are unavailable, i.e., during lunch after hours.

HIPAA/Privacy

- HIPAA form for privacy notification

Coverage Plan

- Each practice must have a written policy in place to ensure appropriate coverage for all staff members * (both clinical and support staff) for expected and unanticipated absences and be able to demonstrate evidence of that coverage.

Closing the Office

- It is preferred that member practices of the Hospital for Special Surgery Rehabilitation Network do not close at any time other than recognized holidays. However, if an office temporarily closes, it may only do so for up to one week at a time or more than two weeks a year unless the facility is deemed unsafe or otherwise unusable due to physical/structural damage or another emergency.
- If a Network member facility does close, whether temporarily or permanently, the practice must inform the Network Coordinator immediately to update alternate referrals and Network listings.

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Financials

Processing Fee

To cover the cost of the review procedure, applicants must submit a one-time $600 fee to cover application processing and the site visit, which must be included with their application and is non-refundable. If an owner wishes to apply for multiple locations, each location is considered its own entity, and a separate application and fee must be submitted for each site seeking membership. **No owner/ownership group will be permitted to represent more than 15%* of the facilities in the Network at any time.** Applications are valid for six months from the date they are received. All required information must be provided, and a site visit must be completed within these six months unless specifically authorized in writing by the Network. Checks should be payable to HSS Rehab Network and sent to the Network at the hospital address, attention Connie Stallone.
*(*as of the beginning of the Network year in which the latest application is submitted)*

Membership Fee

The annual fee for membership in the HSS Rehabilitation National Network is $4995 for the 1st practice and $4500 for subsequent practices each calendar year. The membership fee covers the Network's operating expenses, educational programming, web-based activities, other marketing initiatives, and all other administrative costs related to the Network's function. This fee must be paid before the deadline stated in enrollment information for new members or the date specified in the renewal documents sent to existing members. All memberships renew on February 1st. New members in the Network for less than 11 months at the time of their first renewal will have their renewal membership fee prorated as appropriate. If a practice applies for multiple sites and has more than one accepted into the Network, the "first" site will be billed the full fee; each additional office will be discounted 10% of the annual fee for initial membership and renewals.

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Application Submission - Phase I

Once a practice's application is received, it will undergo initial review by the Network office. This review will ensure that the application is filled out and that all required documentation has been submitted. In addition, all credentials and claims made in the application will be verified to the fullest extent possible. All staff information (as applicable) must be submitted, and all mailing and email addresses, fax, and telephone numbers must be provided as requested. In the event of any missing information, the Network office will notify the practice of what additional information must be provided to permit the application to be considered. Applications are valid only for six months from the date they are first received.

The following are required for submission of your application:

1. Proof of license for all therapists, assistants, and athletic trainers (or registration for NY state).
2. Proof of APTA/AOTA or other appropriate professional membership for owners and therapists (preferred).
3. CEU certificates for the past year for all owners.
4. Proof of facility general insurance coverage, showing expiration date
5. Proof of malpractice coverage and amount of premium paid
6. Evidence of Medicare certification (if participating)
7. Resumes for all treating Staff members.
8. A copy of all required Policies/Procedures
   Please submit only the required policies, not your entire manual.
9. **$600 non-refundable application and site visit fee**

All owners of the facility in question must sign the application statement. If a practice is not independently owned, a partner, high-level administrator, or the clinical director of the applying facility may be designated as the proxy for the ownership group. Once selected, that individual will be responsible for all items/activities required in the application process and any subsequent membership on-boarding unless and until the Network is notified of a change in proxy or/or the representative is no longer eligible to serve in that capacity under Network policy. Ownership ensures the application is signed by an individual authorized to act on their behalf. Once received by the Network, application fees are non-refundable.

Initial Site Visit

Following the processing of a complete application, a site visit will be arranged. The visit will entail:

- Facility walk-through for safety, cleanliness and compliance
- Review of components in the Policy and Procedure Manual

- Documentation audit

Site Re-Visit

Every 18 – 24 months, existing members will undergo a re-visit which will entail:

- Facility walk-through for safety, cleanliness and compliance
- Documentation audit
- Updated QA review:
  - Continuing Education of staff
  - Quality Assurance projects

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Application & Site Visit Approval Process

The decision on whether to accept a new member's location or to approve an existing member for ongoing membership is solely at the discretion of the Board. Factors for acceptance include but are not limited to community need, clinical excellence, and quality assurance measures. Additionally, specialty services and accessibility are also considered.

Practices will be notified in writing on any deficiencies identified and their impact on eligibility for membership.

Practices approved for membership have satisfied the Network's strict standards and requirements. In doing so, members are recognized by the HSS community as providing an outstanding level of care and practice management. Members are included in all Network print and digital information and marketing materials, facilitating high visibility and ease of access. The Network does not guarantee that patients will choose a Network practice due to membership.