Capital BlueCross
INPATIENT PHYSICAL REHABILITATION SURVEY

Provider Name: _____
CBC #: _____ **Medicare #:** _____ **Medicaid #:** _____
Accrediting Organization: _____ **Date of most recent accrediting survey:** _____
Person completing survey: _____ **Phone:** _____ **Date:** _____
Contact person (if different than above): _____ **Phone:** _____

Directions: Please complete each line with appropriate information.
Where applicable please indicate with a check mark (☐).

ADMINISTRATION

Number of Beds: _____
Handicap access ☐ Yes ☐No
Average Daily Census: _____
Ages served: _____
Written compliance program ☐ Yes ☐No
Compliance program officer ☐ Yes ☐No
Internal compliance audits ☐ Yes ☐No
Review of the Medicare/Medicaid sanction report ☐ Yes ☐No
Frequency of review: _____
Written policy on patient confidentiality ☐ Yes ☐No
Written policy on medical record confidentiality ☐ Yes ☐No
Written policy for release of medical records ☐ Yes ☐No
Written policy for maintenance/retention of medical records ☐ Yes ☐No
Written patient medical emergency plan ☐ Yes ☐No
Emergency crash carts/supplies available ☐ Yes ☐No
Defibrillator ☐ Yes ☐No
Written policy for checking:
Emergency crash cart/supplies ☐ Yes ☐No
Defibrillator ☐ Yes ☐No
Policy includes frequency of checks ☐ Yes ☐No
Written transfer agreement with acute care ☐ Yes ☐No
If **yes**, list facilities: _____

Written agreement with emergency transportation service ☐ Yes ☐No
Reliance on 911 system ☐ Yes ☐No

Routine Medical Transportation

Facility-owned ☐ Yes ☐No
Contracted ☐ Yes ☐No

QUALITY MANAGEMENT

Quality Activities

Performance Improvement Program ☐ Yes ☐No
Performance Improvement Program includes utilization review ☐ Yes ☐No
Development of improvement activities based on identified issues ☐ Yes ☐No
Performance Improvement Committee ☐ Yes ☐No
Frequency of meetings: _____
List two current Quality Studies:
1. _____
2. _____
Written infection control policies ☐ Yes ☐No

Patient Satisfaction

Patient Satisfaction Surveys utilized ☐ Yes ☐No
Annual return rate for surveys: _____ **%**
Issues identified:
1. _____
2. _____
Results forwarded to PI committee ☐ Yes ☐No
Written patient/family complaint process ☐ Yes ☐No

Clinical Management

Written policy on addressing advance directives ☐ Yes ☐No
Clinical pathways utilized ☐ Yes ☐No
Written plan for team conferences ☐ Yes ☐No
Performed weekly ☐ Yes ☐No
Written admission criteria ☐ Yes ☐No
Written discharge criteria ☐ Yes ☐No
Internal Case Management available ☐ Yes ☐No
Discharge Planning ☐ Yes ☐No

Patient Education

Patient/family education ☐ Yes ☐No
Documented in clinical record ☐ Yes ☐No
Services available for hearing impaired ☐ Yes ☐No
Services available for speech impaired ☐ Yes ☐No
Services available for visually impaired ☐ Yes ☐No

Provider Name:

Bilingual services ☐ Yes ☐No
Bilingual patient education materials ☐ Yes ☐No
Languages offered: _____

Data Collection

Average Length of Stay ☐ Yes ☐No
Program Efficiency per Diagnosis ☐ Yes ☐No
Readmissions ☐ Yes ☐No
Transfers to Acute Care Facility ☐ Yes ☐No
Incident Reports ☐ Yes ☐No
Nosocomial Infection rate ☐ Yes ☐No
FIM Score ☐ Yes ☐No
Community Discharges *(e.g. back to independent lifestyle vs. SNF)* ☐ Yes ☐No

List other data: _____

CLINICAL STAFF

Written policy for clinical competency evaluation ☐ Yes ☐No
- Evaluated during probationary period ☐ Yes ☐No
- Evaluated annually ☐ Yes ☐No

Written policy for verification of all of the following for all clinical staff:
- Certification ☐ Yes ☐No
- Education ☐ Yes ☐No
- License ☐ Yes ☐No

Number of mandatory inservices staff is required to attend annually: _____

Written policy for routine testing of employees for infectious diseases ☐ Yes ☐No

Written policy for credentialing of physicians ☐ Yes ☐No

Written policy for recredentialing of:
- Physicians ☐ Yes ☐No
- Clinical Staff ☐ Yes ☐No
- Frequency: _____

Medical Director ☐ Yes ☐No
Specialty: _____
Board certified ☐ Yes ☐No
All physician staff board certified ☐ Yes ☐No
If physician(s) not board certified, competency established through the facility's credentialing process ☐ Yes ☐No

Medical Staff

_____ Number of Physiatrists
_____ Number Board Certified in Rehabilitation Medicine

Indicate which of the following physician staff is available:
- ☐ Anesthesiologists
- ❑ Cardiologists
- ❑ Cardiovascular Surgeons
- ❑ Family Practitioners
- ❑ Geriatricians
- ❑ Infectious Disease
- ❑ Internists
- ❑ Neurologists
- ❑ Neurosurgeons
- ❑ Oncologists
- ❑ Ophthalmologists
- ❑ Orthopedic Surgeons
- ❑ Pediatricians
- ❑ Podiatrists
- ❑ Psychiatrists
- ❑ Pulmonologists
- ❑ Rheumatologists
- ❑ Urologists

Nursing Staff

	Full Time (Employed 35hr/wk or more)	**Part Time** (Employed less than 35hrs)
RN	_____	_____
LPN	_____	_____
CNA	_____	_____
Clinical Technicians	_____	_____

Written policy for determining appropriate levels of staffing ☐ Yes ☐No

_____ **%** RN overtime per month

_____ **%** Unlicensed staff overtime per month (Nursing Assistants / Clinical Technicians)

Written policy defining staff requiring CPR certification ☐ Yes ☐No

_____ **%** Clinical staff CPR certified

Certified Rehabilitation Nurses ☐ Yes ☐No
Nurses Certified in IV Therapy ☐ Yes ☐No
Enterostomal Nurse Specialists ☐ Yes ☐No
Contracted staff utilized ☐ Yes ☐No
If **yes**, written policy for verification of the following for all contracted staff:
- Certification ☐ Yes ☐No
- Education ☐ Yes ☐No
- License ☐ Yes ☐No

Written policy for evaluating contracted staff's

Provider Name:

performance ☐ Yes ☐No

Other Staff ***(include contracted or employed)***

Behavioral Medicine

_____ Number of Clinical Psychologists
_____ Number of Neuropsychologists
_____ Number of Psychiatric Social Workers

Social Services Staff

_____ Number of Masters of Social Work
_____ Number of Bachelors of Social Work

Support Staff

_____ Number of Developmental Specialists
_____ Number of Licensed Audiologists
_____ Number of Licensed Pharmacists
_____ Number of Pharmacy Aides
_____ Number of Registered Dietitians
_____ Number of Bioengineering Specialists
_____ Number of Vocational Rehabilitation Counselors
_____ Number of Prosthetists
_____ Number of Orthotists
_____ Number of Licensed Physical Therapists
_____ Number of Registered Physical Therapy Assistants
_____ Number of Physical Therapy Aides
_____ Number of Licensed Occupational Therapists
_____ Number of Certified Occupational Therapy Assistants
_____ Number of Registered Recreational Therapists
_____ Number of Certified Respiratory Therapists
_____ Number of Licensed Speech Therapists

SERVICES

Please indicate if the following services are provided:

	Inpt.	Outpt.	Onsite
❑ Aquatic Therapy	❑	❑	❑
❑ Biofeedback	❑	❑	❑
❑ Brain Injury	❑	❑	❑
❑ Burn	❑	❑	❑
❑ Cardiac Rehab	❑	❑	❑
❑ Chronic Pain Mgmt	❑	❑	❑
❑ Day Program	❑	❑	❑
❑ General Rehabilitation	❑	❑	❑
❑ Hand Clinics	❑	❑	❑
❑ Orthopedic	❑	❑	❑
❑ Orthotics	❑	❑	❑
❑ Oncology Rehab	❑	❑	❑
❑ Pediatric Acute	❑	❑	❑
❑ Pediatric Chronic	❑	❑	❑
❑ Prosthetics	❑	❑	❑
❑ Pulmonary Rehab	❑	❑	❑
❑ Spinal Cord Injury	❑	❑	❑
❑ Subacute Care	❑	❑	❑
❑ Ventilator Program	❑	❑	❑
❑ Vocational Rehab	❑	❑	❑
❑ Wellness	❑	❑	❑
❑ Work Hardening Prgm	❑	❑	❑
❑ Wound Therapy	❑	❑	❑
❑ Other (please list)			

(If services not provided Onsite please list service site on Attachment I)

Support Services

Access to:

Laboratory ☐ Yes ☐No
Pharmacy ☐ Yes ☐No
Radiology ☐ Yes ☐No

Clinical Health Care

Indicate which Structured Clinics are part of the Hospital system

(If any clinics are staffed by out of area physicians, please list the clinic and physician name on a separate attachment. For off-site clinics, identify location and services on attachment II)

	On-site	**Off-site**
❑ Adolescent	❑	❑
❑ Amputee	❑	❑
❑ Brain Injury	❑	❑
❑ Diabetic	❑	❑
❑ Geriatric	❑	❑
❑ Hand	❑	❑
❑ Hip & Knee	❑	❑
❑ Medical	❑	❑
❑ Orthopedic	❑	❑
❑ Pain management	❑	❑
❑ Pediatric	❑	❑
❑ Post Polio	❑	❑
❑ Pulmonary	❑	❑
❑ Rheumatology	❑	❑
❑ Spina Bifida	❑	❑
❑ Spinal Cord	❑	❑
❑ Stroke	❑	❑
❑ Wheel chair	❑	❑
❑ Wound Care	❑	❑

Other Clinics: _____

FACILITIES & EQUIPMENT

Provider Name:

Bioengineering specialist ☐ Yes ☐No
If no, person responsible for maintenance of biomedical equipment ☐ Yes ☐No
Written preventive maintenance plan ☐ Yes ☐No
Written plan for equipment failure ☐ Yes ☐No
Written emergency preparedness plan ☐ Yes ☐No
Plan includes:
- Fire ☐ Yes ☐No
- Loss of utilities ☐ Yes ☐No
- Inclement weather ☐ Yes ☐No

Written policy for fire/disaster drills ☐ Yes ☐No
Results of drills documented ☐ Yes ☐No
Written policy for handling biohazardous materials ☐ Yes ☐No

:

As a reminder, please be sure to include

- ***Facility Information Sheet***
- ***Name sheet for branch offices***
- ***Affiliate or owned services***

COMMENTS

Provider Name:

Please complete the following based upon corporate ownership of off-site business initiatives and indicate specific services performed at the office site.

Branch Offices

Name: ______________________
Services Provided: ______________________
Billing Site Only ☐ Yes ☐No
Date of Acquisition or Establishment: __________
Address: ______________________
City: ______________________
Phone: ______________________
Contact Person: ______________________
Counties Served: ______________________

Name: ______________________
Services Provided: ______________________
Billing Site Only ☐ Yes ☐No
Date of Acquisition or Establishment: __________
Address: ______________________
City: ______________________
Phone: ______________________
Contact Person: ______________________
Counties Served: ______________________

Name: ______________________
Services Provided: ______________________
Billing Site Only ☐ Yes ☐No
Date of Acquisition or Establishment: __________
Address: ______________________
City: ______________________
Phone: ______________________
Contact Person: ______________________
Counties Served: ______________________

Name: ______________________
Services Provided: ______________________
Billing Site Only ☐ Yes ☐No
Date of Acquisition or Establishment: __________
Address: ______________________
City: ______________________
Phone: ______________________
Contact Person: ______________________
Counties Served: ______________________

Name: ______________________
Services Provided: ______________________
Billing Site Only ☐ Yes ☐No
Date of Acquisition or Establishment: __________
Address: ______________________
City: ______________________
Phone: ______________________
Contact Person: ______________________
Counties Served: ______________________

Name: ______________________
Services Provided: ______________________
Billing Site Only ☐ Yes ☐No
Date of Acquisition or Establishment: __________
Address: ______________________
City: ______________________
Phone: ______________________
Contact Person: ______________________
Counties Served: ______________________

Name: ______________________
Services Provided: ______________________
Billing Site Only ☐ Yes ☐No
Date of Acquisition or Establishment: __________
Address: ______________________
City: ______________________
Phone: ______________________
Contact Person: ______________________
Counties Served: ______________________

Name: ______________________
Services Provided: ______________________
Billing Site Only ☐ Yes ☐No
Date of Acquisition or Establishment: __________
Address: ______________________
City: ______________________
Phone: ______________________
Contact Person: ______________________
Counties Served: ______________________

Provider Name:

HEALTHCARE FACILITY INFORMATION FORM

Provider Name:_____
Parent:_____
Affiliation:_____
Affiliation:_____

Number of Years in business:_____

Type of Control

- ❑ **Voluntary Nonprofit**
- ❑ **Proprietary** (Identify all individuals, members of partnership, major stockholders, etc. If 'Other' explain.)
  - ❑ Individual _____
  - ❑ Partnership_____
  - ❑ Corporation_____
  - ❑ Other_____
- ❑ **Government**
  - ❑ Federal
  - ❑ State
  - ❑ County
  - ❑ Other, explain:_____

Additional Information Requested

Has the facility, any corporate officer, employee or any agent acting on behalf of the facility been involved in or convicted of healthcare fraud or abuse in the last five (5) years?

- ❑ Yes, explain:_____
- ❑ No

Have you or any of your affiliates, entered into a corporate integrity agreement with any state or federal agency?

- ❑ Yes
- ❑ No

If yes, provide a copy to Capital Blue Cross

Provide copies of the following:

- State Licensure certificate(s)
- List of Board of Directors
- Most recent accreditation letter
- Most recent DOH Report
- Evidence of current malpractice insurance
- Current organizational chart

COMMENTS: _____

Attachment

Provider Name:

Off-site Clinic & out of area Physician

Clinic Site:
Services:

CBC Provider Number:
Date of Acquisition or Establishment:
Address:
City:
Phone:
Contact Person:
Physicians:

Clinic Site:
Services:

CBC Provider Number:
Date of Acquisition or Establishment:
Address:
City:
Phone:
Contact Person:
Physicians:

Clinic Site:
Services:

CBC Provider Number:
Date of Acquisition or Establishment:
Address:
City:
Phone:
Contact Person:
Physicians:

Clinic Site:
Services:

CBC Provider Number:
Date of Acquisition or Establishment:
Address:
City:
Phone:
Contact Person:
Physicians:

Clinic Site:
Services:

CBC Provider Number:
Date of Acquisition or Establishment:
Address:
City:
Phone:
Contact Person:
Physicians:

Clinic Site:
Services:

CBC Provider Number:
Date of Acquisition or Establishment:
Address:
City:
Phone:
Contact Person:
Physicians:

Provider Name:

Please indicate the counties within your service area. If services are limited to only a portion of the county, please identify.

Adams ❑	
Berks ❑	
Centre ❑	
Columbia ❑	
Cumberland ❑	
Dauphin ❑	
Franklin ❑	
Fulton ❑	
Juniata ❑	
Lancaster ❑	
Lebanon ❑	
Lehigh ❑	
Mifflin ❑	
Montour ❑	
Northampton ❑	
Northumberland ❑	
Perry ❑	
Schuylkill ❑	
Snyder ❑	
Union ❑	
York ❑	
Other ❑	