SERVICE REQUIREMENTS FOR COMMUNITY REHABILITATION SERVICE

COMMUNITY REHABILITATION SERVICES

1. Introduction

1.1 This document states the requirements for the Contractor receiving Government subsidies or is authorized for Medisave use for the provision of community rehabilitation services that shall be provided by the Contractor.

1.2 The Contractor is to note that the Authority retains the right to review and update this document, by providing not less than fourteen (14) days' written notice of the revision to the Contractor.

2. Programme Objectives

2.1 Individuals affected by a variety of medical conditions may require rehabilitation in order to complement or complete their medical care. The aim of rehabilitation is to improve the individual's functional status to the maximum level medically possible, and hence allow them to remain active in the community[1].

2.2 Medical conditions which may require rehabilitation include, but are not limited to, stroke, Parkinson's disease, orthopaedic conditions such as fractures, post-amputations etc., as well as de-conditioning due to other medical conditions. The process of rehabilitation consists of assessment, target setting, therapy, and evaluation of outcomes.

2.3 Rehabilitation shall be provided by the Contractor within the context of "*care for the whole person*" to ensure that the community rehabilitation services and overall care provision in the centre is holistic.

3. Access to Care

3.1 Criteria and Referrals for Admission

3.1.1 AIC is the central co-ordinating body for the placement of patients to ILTC services. All patients receiving Government subsidies for community rehabilitation services at the centre must be referred through AIC. In addition, all patients who wish to utilise Medisave for community rehabilitation services must also be referred through AIC. The AIC referral forms can be downloaded from the AIC website at: www.aic.sg.

[1] This is distinct from maintenance exercises to maintain functionality and independence. The aim of maintenance exercises is to prevent deterioration of physical and mental functions.

3.1.2 Subsidies and Medisave. For patients who wish to receive Government subsidies and/or utilise Medisave for community rehabilitation services, the Contractor shall assess the patients' eligibility and suitability for the community rehabilitation programme. In addition, all patients who wish to receive Government subsidies and/or make Medisave claims must be referred by a Singapore Medical Council-registered medical practitioner who shall certify that the patient is suitable and can benefit from rehabilitation to improve his/her functional status. The Contractor shall work with AIC and the referral source and/or the Singapore Medical Council-registered medical practitioner to ensure that the necessary forms documenting the patient's medical condition and co-morbidities are available during referral, including medical diagnosis, certification for rehabilitation, information on their home environment and information of the patient's caregivers. A six (6)-monthly review and re-certification of the needs and suitability of the patient for community rehabilitation services are required to determine the necessity for the patient to continue the community rehabilitation programme (See clause 4.6).

3.1.3 Additional Criteria for Medisave Use for Rehabilitation. For the avoidance of doubt, Medisave may not be utilised for day care or maintenance programmes at the centre. Medisave may be used only for patients who require community rehabilitation services to recover functional ability, after an acute medical illness, injury, surgery or chronic disuse (e.g. Hip fracture, Stroke, Traumatic Brain Injury, De-conditioning). Medisave is not claimable for rehabilitation carried out to address sports injuries, acute musculoskeletal injuries, congenital disabilities or chronic degenerative conditions without potential for significant functional recovery.

3.1.4 Referral Processes: The Contractor shall maintain a documented process for the management of incoming patient referrals, which shall include specifying the referral source(s) for Non-Subsidised Patients in the centre who are not referred through AIC. The Contractor shall request the referral source(s) to complete a written referral form to be submitted to the Contractor, and shall contain the following components as far as possible:

(i) Reason for referral (i.e. type of service required);
(ii) Patient's personal particulars;
(iii) Patient's social information / history;
(iv) Patient's medical information / history, including diagnosis, medical conditions, investigations, management to-date, medications and drug allergies;
(v) Results of any screening conducted for the patient (i.e. for any infectious disease, special precautions);
(vi) Patient's current functional status (i.e. physical and cognitive abilities);

(vii) Patient's personal references (if any, for example in terms of diet and activities); and

(viii) Particulars of referral sources(s).

3.1.5 The Contractor shall inform the patient/patient's caregiver on the necessary documents that will be required for initial assessment/screening and means-testing. The Contractor shall be responsible for administering means-testing and providing financial counselling to every potential patient.

3.1.6 Transfers. For Subsidised Patients in the centre who are transferring from the centre to another centre, the Contractor shall raise the AIC referral form and submit all the required supporting documents (including information obtained from the original referral source) through AIC. Subsidised patients who have not been re-certified by a Singapore Medical Council-registered medical practitioner in the last six (6) months prior to the transfer shall obtain an updated certification for suitability and eligibility for rehabilitation.

3.1.7 Admissions: For all patients, admission to the centre shall be contingent upon the approval by the Contractor's team of Care Staff and healthcare professionals ("care team"). However, patients shall not be denied admission to community rehabilitation services based on the medical conditions listed in Table 1, unless deemed by a Singapore Medical Council-registered medical practitioner not to be able to benefit or who may cause disruption to the rehabilitation/ care of other patients.

Table 1: Admissions for patients with Medical Conditions

Multi-drug Resistant Organism (MDRO) (Colonised)	Accept
Psychiatric / Dementia	Accept stable psychiatric / dementia patients
Parkinson Disease	Accept stable Parkinson disease patients
Cardiac / Respiratory conditions	Accept patients with stable cardiac / respiratory conditions who are certified to be suitable for rehabilitation
Pulmonary Tuberculosis (PTB)	Accept treated and existing PTB patients who are not infectious
Cancer (prognosis of more than one year)	Accept
HIV positive	Accept
Hepatitis	Accept
Nasogastric / Gastrostomy feeding	Accept
Urinary catheter / Supra-pubic catheter care	Accept

Colostomy care	Accept

3.1.8 The Contractor shall be open to all patients who require their services, regardless of race, language or religion.

3.2 Outcomes of Referrals

3.2.1 The Contractor shall inform AIC the referral outcome for all patients referred through AIC. The Contractor shall also inform patient/patient's caregiver on the patient's referral outcome.

3.2.2 Acceptance by Contractor. If the potential patient is accepted by the Contractor for community rehabilitation services, the Contractor shall inform the patient/patient's caregivers and AIC of the expected admission date into the centre's community rehabilitation programme. The Contractor shall provide this information to AIC and to the patient/patient's caregiver within ten (10) working days from the day the patient is referred to the Contractor.

3.2.3 Refusal / Rejection by Contractor. If the potential patient is not accepted by the Contractor for community rehabilitation services, the Contractor shall inform the patient/ patient's caregiver and AIC, indicating the reason for rejection. The Contractor shall provide this information to AIC and to the patient/patient's Caregiver within ten (10) working days from the day the patient is referred to the Contractor. AIC will then coordinate with the referral source to arrange for alternative care arrangements for the patient.

3.2.4 Withdrawals by patient or patient's caregivers: If the potential patient/patient's caregiver rejects the referral for community rehabilitation services before admission to the centre, the Contractor shall inform AIC the reason for the rejection or withdrawal within three (3) working days after receiving the rejection or withdrawal request from the patient/patient's caregiver, in the event that the Contractor is informed of the reason. AIC will then coordinate with the referral source and patient/patient's caregiver for alternative care arrangements to be made for the patient.

3.2.5 Temporary Exclusion (applicable only after admission into the centre's community rehabilitation programme). If a patient exhibits disruptive or unmanageable behaviour, or there is a significant change in his medical condition and/or if the patient is experiencing an acute medical illness, he/she shall be temporarily excluded from the community rehabilitation programme. The Contractor shall screen all patients who are returning to the community rehabilitation programme after temporary exclusion, to ensure that the patients are still eligible for admission. Patients who have been temporarily excluded for more than two (2) months shall be deemed by the Authority as 'discharged' and

will require a re-assessment by the Contractor and/or a new referral to be raised to the community rehabilitation programme again.

3.3 Admission and Service Contract

3.3.1 Once a patient has been accepted by the Contractor and the patient/patient's caregiver has agreed to receive community rehabilitation services at the centre, a written service contract shall be entered into between the Contractor and the patient/patient's caregiver, before the patient receives the community rehabilitation services at the centre.

3.3.2 The Contractor shall ensure that it has explained the terms and conditions of the service contract to the patient/patient's caregiver before he/she signs the service contract accepting the said terms and conditions, which shall include (but shall not be limited to):

- Service hours;
- Scope of the services to be provided;
- Transport arrangement (including cost of transport);
- Expected frequency of services;
- Date of commencement of the community rehabilitation programme;
- Indemnity clauses (including medical, medication indemnity etc);
- Fees/Charges and payment scheme (including the amount of Government subsidy);
- Rules and regulations of the centre;
- Discharge criteria (so that the patient/patient's caregivers understand that the community rehabilitation programme may not continue indefinitely);
- Contact information of the patient and the patient's caregiver; and
- Emergency procedures – Incident reporting procedures, such as in the event of incidents such as falls, injury, changes in the patient's condition, and medical emergencies.

4. Appropriate Care

4.1 Approach to Care

4.1.1 Multi-Disciplinary Approach: In addition to a holistic, person-centred approach, it is expected that the care approach shall be multi-disciplinary, where necessary, for holistic care of the patient. The Contractor's physiotherapist(s) and occupational therapist(s) (i.e. "therapists", who shall be registered with the Allied Health Professions Council) shall have regular case discussions with other healthcare professionals on the medical and rehabilitation needs of the patients. This shall be conducted through telephone, written memos or on-site discussions. The Contractor shall also communicate and coordinate with registered medical

practitioners or other healthcare professionals like speech therapists, dieticians, orthotics and prosthetic specialists, podiatrists etc, to provide holistic rehabilitative services. The Contractor shall also link the patients and their caregivers with other relevant agencies/organisations for additional areas of needs such as social work, case management, meals-on-wheels and home help services, as appropriate.

4.2 Initial Assessment

4.2.1 During the patient's first attendance at the centre, the therapists shall conduct a comprehensive initial assessment of the patient which shall include an evaluation of the patient's rehabilitation needs based on the assessment findings and the information provided by the referral source(s). Upon completion of the initial assessment, an individualised care plan (ICP) shall be developed.

4.3 Individualised Care Planning and Documentation

4.3.1 Throughout care delivery, the Contractor shall respect and promote the patient's autonomy, independence and dignity. Whenever possible, the preferences and views of the patient and his/her caregiver shall be respected and incorporated into care planning.

Care plans shall be individualised to each patient. The Contractor shall maintain a case file for each patient, containing his/her rehabilitation care plans and intervention records. These plans and records shall be regularly updated by the Contractor's registered therapists to document the progress of the patient and the interventions provided. The Examples of standardised assessment tools that may be used in the design of care plans for the patients, are listed below. Staff conducting the assessment tools shall be trained in the use of these assessment tools:

(i) Template - Modified Barthel Index (MBI) (Schedule A-1);
(ii) Template - Timed Up and Go (TUG) (Schedule A-2);
(iii) Template - Zarit Burden Interview 4 (ZBI-4) (Schedule A-3);

4.3.2 Individualised Care Plans (ICPs): Once a patient's rehabilitation needs are identified from the initial assessment, an individualised, person-centric care plan must be developed by the Contractor. An ICP shall include, but shall not be limited to the following:

(i) The patient's identified care needs, strengths, limitations and potential;

(ii) Specific intervention plans with respect to the patient's needs and goals; taking into consideration where possible, the preferences and views of the patient and his/her caregiver;

(iii) Specific, measurable, attainable outcomes, with time frame for reviews and outcome measurements stated;

(iv) Specific roles and guidance for the care team with respect to the patient's intervention plan, and following any reviews/outcome measurements;

(v) Specific roles of the patient, his/her caregiver and volunteers (if any) with respect to the patient's intervention plan;

(vi) Discharge and transition plans, including specific criteria for discharge or transfer.

4.3.3 The Contractor shall be secular in its approach and be respectfully mindful of the religious background of each patient in the provision of care. The Contractor shall have documented policies and procedures regarding the prohibition of proselytising by staff and volunteers of the Contractor at the centre.

4.3.4 Communication. The aim and approach to care, the patient's care plans and goals, the role to be played by patients' and caregivers, shall be explained by the Contractor to the patient and his/her caregiver. Information and health education shall be provided to help the patient and his/her caregiver to manage the patient's care.

4.3.5 The Contractor shall respect the privacy and confidentiality of all patient-related information.

4.4 Programmes & Services

4.4.1 The Contractor providing community rehabilitation services shall provide session-based rehabilitation services that shall include physiotherapy and occupational therapy. The list of physiotherapy and occupational therapy services that shall be provided by the Contractor shall include, but shall not be limited to:

i. Physiotherapy

(i) Physiotherapy services shall be provided to restore or maximise the patient's physical functions which have been limited by illnesses or disabilities.

(ii) The physiotherapist shall assess the patient's mobility status, physical strength, joint motion, cardiopulmonary endurance, balance, fall risk and pain level.

(iii) Physiotherapy services to be provided by the Contractor shall include, but shall not be limited to:

- Functional mobility training and gait training;
- Active and passive exercises to improve or restore range of motion, physical strength, flexibility, co-ordination, balance and endurance;
- Treatment to relieve pain (e.g. through electro-physical agents);
- Advice on the use of assistive ambulatory devices such as walking aids and prosthetic devices;
- Caregiver training and patient education; and
- Community integration activities.

ii. Occupational Therapy

(i) The occupational therapist shall assess the patient's Activities of Daily Living (ADL), Instrumental ADL (IADL), leisure abilities, functional status, cognition, perception and psychosocial status.

(ii) Occupational therapy services to be provided by the Contractor shall include, but shall not be limited to:

- Re-training in ADL and IADL;
- Exercises and graded activities to improve strength and range of motion, particularly in the upper extremities;
- Co-ordination and dexterity activities;
- Advice on the use of orthosis, prosthesis or assistive / adaptive devices to maintain or improve ADL performances;
- Pre-vocational and vocational training;
- Advice on occupational ergonomics;
- Home assessment and recommendations on home modification;
- Leisure and recreational therapy;
- Caregiver training and patient education;
- Wheelchair and seating assessment; and
- Community integration activities.

4.4.2 A list of appropriate rehabilitative equipment for the centre is set out in Schedule A-4.

4.5 Staffing and Qualifications

4.5.1 The Contractor shall have sufficient therapists who shall be registered with the Allied Health Professionals Council as well as support care staff (i.e. therapy assistants) to meet the rehabilitation needs of all patients at all times in the centre.

4.5.2 The therapists are key to improving the patient's functional status. Therefore, the physiotherapy and occupational therapy programme for each patient shall be under the charge of the therapists. The community rehabilitation services shall be provided by the therapists and a team of therapy assistants under their supervision.

4.5.3 The Contractor shall use alternative modes of employment (e.g. part-time, contract or temporary) or any other arrangement as required by the Contractor to maintain a staff complement required to meet the needs of the patients receiving community rehabilitation services at the centre.

4.5.4 During each rehabilitation session, the community rehabilitation services shall be carried out by the therapist, with the assistance of the Contractor's support care staff. The therapist shall provide adequate direct contact time with the patient depending on his/her rehabilitation needs, (i.e. for assessment of the patient and provision of community rehabilitation services). The patient's caregiver may assist during the rehabilitation exercises or practice as part of caregiver training, but shall be supervised by the therapist.

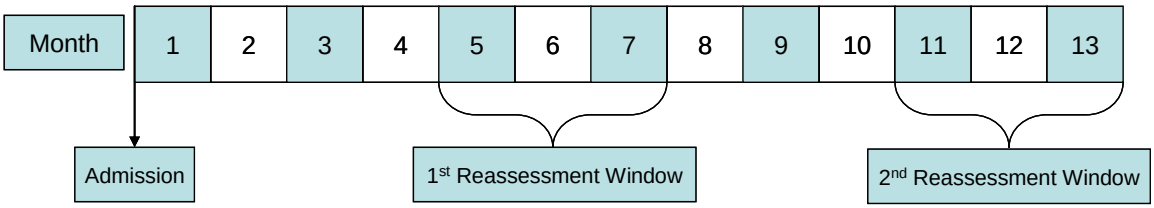
4.6 Care Outcomes and Reviews

4.6.1 The Contractor shall monitor each patient's rehabilitation outcomes using the MBI. Assessment using the MBI shall be completed by the therapist and repeated at least once every three (3) months or when the patient's status changes, whichever is sooner. The MBI scores of all patients receiving Government subsidies and/or utilising Medisave for community rehabilitation services shall be reported to the Authority every quarter.

4.6.2 Review and re-certification of the needs and suitability of a patient for rehabilitation shall be required to determine the necessity for the patient to continue rehabilitation. Details of the reassessment schedule can be found in Figure 3-1 below. This re-certification shall be done by the therapist and supported by a Singapore Medical Council-registered medical practitioner. The form to be used by the Contractor for the six (6)-monthly review (*Template – Rehabilitation Programme Review Form*) is set out in Schedule A-5. The Contractor shall refer the patient back to his primary care physician or the referring physician or to a Singapore Medical Council-registered medical practitioner if neither of the former two is available. In addition, the Contractor

shall also refer the patient to either of these physicians in the event the patient exhibits any at-risk signs or symptoms that may deem the patient potentially unfit to continue undergoing the community rehabilitation programme at the centre, even if the patient is not yet due for his/her six (6)-monthly review.

Figure 3-1: Reassessment schedule for patients under the community rehabilitation programme at the centre



4.7 Discharge

4.7.1 The patient shall be discharged from the community rehabilitation programme under any one of the following conditions:

(i) The patient has achieved his/her rehabilitation goals;

(ii) The patient has been certified by a Singapore Medical Council-registered medical practitioner that continuous rehabilitation will not lead to further significant functional improvement for the patient; and/or

(iii) The patient has defaulted attendance or not been able to attend the community rehabilitation programme for more than two (2) months. If the patient wishes to return to the community rehabilitation programme, he/she shall be considered as a new admission and shall seek a re-certification[2] or a new referral from a Singapore Medical Council-registered medical practitioner.

4.7.2 The Contractor shall explain to the patient/patient's caregiver the reasons for the recommendation to be discharged from the community rehabilitation programme. As appropriate, the Contractor shall offer alternative programmes for the patient at the centre and discuss with the patient/patient's caregiver on the most appropriate programmes.

4.7.3 The Contractor shall conduct discharge planning for the patient and as necessary, follow up with the discharged patient up to one month post discharge.

[2] The patient shall return to the centre for screening and assessment before going to the Singapore Medical Council-registered medical practitioner with the review form for endorsement.

4.7.4 Procedures for discharge shall include the development of a discharge or transition plan by the Contractor, including:

- A discharge summary stating the reason(s) for discharge, place to be discharged to and recommendations for continuing care. A copy of the discharge summary shall be made available to the patient/patient's caregiver by the Contractor, for onward transmission to his/her primary care physician or referral source, where appropriate.
- Referral to an appropriate service or agency if the patient is unsuitable for the community rehabilitation programme at the centre. Arrangements shall be made by the Contractor to transfer the patient's records to the service or agency that is receiving the said patient to ensure continuity of care.

4.7.5 The Contractor shall inform AIC on all discharges of patients from the community rehabilitation programme including any transfer of a patient to the Contractor's other programmes or services provided in the centre.

4.8 Transport

4.8.1 The Contractor shall provide one or two-way transport (as required by the patient) using a specialised transport vehicle between the patient's home to the centre. Door-to-door service, escort and the use of stair crawl for patients living in non-lift-landing apartments shall be provided when necessary. The transportation services shall be safe, accessible, and properly equipped (e.g. hydraulic lift) to meet the needs of the patients.

4.8.2 The Contractor shall work with the patient/patient's caregiver on the timing and arrangements for two-way transport from the patient's home to the centre.

4.8.3 The Contractor shall ensure that all transportation personnel (employees and approved sub-contractors) must be adequately trained in managing the special needs of patients and handling emergency situations in a manner that is safe and appropriate. Relevant changes in a patient's ICP relating to areas such as the patient's functional status and medical conditions shall be communicated to the transportation personnel by the Contractor.

5. Safe Care

5.1 Policies and Procedures for Key Safety Areas

5.1.1 The Contractor shall ensure that there are policies or procedures in place to provide safe care to the patients and to protect the patients against adverse

outcomes. The Contractor shall monitor occurrences/lapses in safety and take appropriate remedial action.

5.1.2 Key safety areas shall include falls, injury prevention, proper infection control (see clause 5.2 below) and medication safety (see clause 5.3 below).

5.1.3 The Contractor shall ensure infection control through standard contact precautions and good hand hygiene practices.

5.1.4 The Contractor shall ensure that the patients are not subject to physical, emotional, psychological or sexual abuse, or neglect at the centre. Incidents of abuse of the patients shall be reported to the management team of the centre, who shall thoroughly investigate such incidents and put in place the necessary prevention measures.

5.1.5 The Contractor shall ensure that the centre meets the following safety requirements:

- Be equipped, and maintained to provide for the physical safety of patients, personnel, and visitors.

- Ensure a safe, sanitary, functional, accessible, and comfortable environment for the delivery of services that protects the dignity and privacy of the patients.

- Include sufficient suitable space and equipment to cater for care team meetings, treatment, therapeutic recreation, restorative therapies, socialisation, personal care, and dining.

5.2 Infection Control

5.2.1 The Contractor shall establish, implement, and maintain a documented infection control plan that meets the following requirements:

- Ensures a safe and sanitary environment; and
- Prevents and controls the transmission of disease and infection.

5.2.2 The infection control plan shall include, but shall not be limited to the following:

- Procedures to identify, investigate, control, and prevent infections;
- Procedures to record any incidents of infection; and

5.2.3 Procedures to analyze the incidents of infection to identify trends and develop corrective actions related to the reduction of future incidents.

5.3 Administration of Medication

5.3.1 The provision of medication to patients who require help with medications during his/her rehabilitation sessions at the centre shall be seen as providing care within the context of the whole patient.

5.3.2 The Contractor shall ensure that written medication safety policies and procedures are in place and relevant care staff are aware of these policies and procedures. The Contractor shall monitor the safety of their medication administration processes. The Contractor's medication safety policies, procedures or processes shall minimally include the following:

5.3.3 Storage of medication:

(i) Medication shall be stored in accordance with the manufacturer's recommendations.

(ii) All medication shall be stored safely and shall be locked up in a designated area not accessible to patients or member of the public.

(iii) All medication shall be arranged in a systematic manner and shall be clearly labelled with identifiers to prevent mix-ups.

5.3.4 Documentation and administration of medication:

(i) There shall be a written record of medication received from or returned to the patient/patient's caregiver.

(ii) A written medication record shall be maintained for the administration of medication in relation to each patient in the community rehabilitation programme. The record shall include (a) the name of the patient; (b) the names of the medication prescribed; (c) the dosage of medication prescribed; (d) the name of the person who administered the medication; (e) the time and date of administration of medication; and (f) the route of administration of medication, if any. If the patient has any drug allergy, it shall also be recorded in the medication record.

(iii) All medication received from the patient/patient's caregiver shall be prescribed by a Singapore Medical Council-registered medical practitioner, or in accordance with the written instructions of the patient/patient's caregiver.

(iv) Only the Contractor's designated staff shall be responsible for the administration of medication to the patients.

(v) The designated staff shall check the 5 "Rights" when administering medication, i.e. right person, right medication, right dose, right time, right route to prevent medication errors.

(vi) The designated staff shall refer to the medication record when preparing medication for administration and shall bring along the medication record when administering medication to ensure that the medication is administered to the right patient.

(vii) The designated staff shall sign on the medication record as soon as the medication is administered to the patient. The date and time that the medication is administered to the patient shall also be documented.

(viii) If for any reason, the patient fails/ refuses to consume the medication that he/ she is served with, the Contractor must notify the patient's caregiver.

5.4 Use of Restraints

5.4.1 The use of restraints on a patient is not desirable. Research has shown that the imposition of restraints on the patient is harmful to the patient's physical and emotional health. Prolonged immobility can lead to constipation, muscle wastage, balance problems and pressure sores. Restraints also cause fear, frustration, unhappiness, loss of dignity, depression, increased agitation and skill loss in the patient.

5.4.2 The use of restraints is discouraged and the Contractor shall provide restraint-free care as far as possible. The Contractor may consider the use of restraints only as a temporary solution if a patient poses an immediate safety risk to self or others, and only as a last resort after non-restrictive methods have been unsuccessful. The Contractor shall have clear written policies stating the situations under which restraints are necessary and how constraints shall be used if they have to be deployed (e.g. stating the frequency, the duration, etc.). The Contractor shall document the use of restraints on patients and the reasons behind the decision to do so, and shall inform the patient's caregiver(s) when restraints are used and shall review the use of restraints.

5.4.3 The Contractor shall use the following principles in setting its policies on the use of restraints within the community dementia care programme:

- The least possible use of restraint;
- Involvement of the patient, his/her caregiver and the care team in the decision making process;
- Physical restraint assessment undertaken and documentation of approved devices;
- Specification of a review period;

- Checking of devices before and during use for safety and appropriateness; and
- Full documentation of the purpose of restraint.

5.5 Quality Assurance

5.5.1 Adverse Events & Incidents*:* The Contractor shall have the necessary structures, processes and procedures to detect and review of significant adverse events and incidents in the centre. Findings and recommendations of reviews shall be implemented by the Contractor in order to prevent future events and incidents from affecting care quality provided to patients in the centre.

5.5.2 In addition to evaluating its quality of care, the Contractor shall also regularly evaluate other aspects of its operations, including effectiveness of its community rehabilitation programme, and the adequacy of financial, volunteer, and human resource management etc.

5.6 Public Health and Emergency Preparedness

5.6.1 The Contractor shall put in place appropriate plans in the event of infectious disease outbreaks and/or emergencies. Standard Operating Procedures (SOPs) shall include procedures for persons with disabilities, and those needing assistance such as patients with dementia and persons on wheelchairs.

5.7 Feedback/Complaint Management

5.7.1 The Contractor shall have a process to actively receive, handle and respond to feedback and complaints. The Contractor shall ensure that the feedback and complaints are fully investigated and handled in a fair and prompt manner with anonymity (if possible/necessary).

5.7.2 The Contractor shall document all feedback and complaints received, and take appropriate measures to prevent recurrences, improve the centre's processes/services and notify its management and/or the relevant authorities when necessary.

6. Physical Environment and Amenities

6.1 The physical environment of the centre shall be barrier-free and safe for individuals with physical disabilities. For example, there shall be adequate ramps, hand-rails, grab-bars, and slip-resistance floors. Doors and walkways in the centre shall be

sufficiently wide to allow a wheelchair, a patient using a mobility aide, or two people assisting a patient to pass through.

6.2 Equipment Maintenance And Records

6.2.1 The Contractor shall ensure that all equipment in the centre is in a good state of repair at all times.

6.2.2 The Contractor shall establish, implement and maintain a written plan to ensure that all equipment used is maintained in accordance with the manufacturer's recommendations.

6.2.3 The Contractor shall perform the manufacturer's recommended maintenance on all equipment.

6.2.4 The Contractor shall ensure that equipment that is faulty shall be clearly marked out, removed from use and be scheduled for repair if appropriate.

6.2.5 For therapeutic equipment/appliances that require licensing, the Contractor shall ensure that all licensing requirements are fulfilled (e.g. license for ultrasound machines).

7. Operating Hours

7.1 The operation hours of the centre shall take into consideration the patients' and their caregivers' needs. For example, working caregivers may require the patients to attend the programme from 7 am to 7 pm due to their working schedules. The centre shall be open at least from Mondays to Fridays (excluding gazetted public holidays).

8. Administrative Policies and Procedures

8.1 Attendance Roster

8.1.1 The Contractor shall maintain an attendance roster for patients receiving the community rehabilitation services.

8.2 Fee Schedule and Charging

8.2.1 The Contractor shall maintain a written policy on fee charging that includes:

(i) Administration procedures;
(ii) Fee schedule;

(iii) Management of programme fees; and
(iv) Approval and endorsement by its centre manager.

8.3 Means-Testing

8.3.1 The Contractor shall carry out means-testing to ascertain a patient's eligibility for Government subsidies, based on the prevailing means-testing criteria for non-residential step-down care to determine the subsidy rate.

8.3.2 A social report shall be provided for patients who require a fee waiver or deviation from the means tested subsidy rate.

8.3.3 The Contractor is required to monitor the financial status of all Subsidised Patients in the centre and review their financial status at least once every two (2) years.

8.3.4 The Contractor shall provide financial counselling to all patients. The patients must acknowledge in writing that they have been informed of the fees and charges, deposits and any other charges to be paid.

8.3.5 The Contractor shall provide itemised billing for all patients and the bill shall indicate the programme fee, the amount of subsidy provided, the amount of patient co-payment required and the actual fee paid by the patient. A sample of the bill format that the Contractor intends to use shall be submitted by the Contractor to the Authority for prior approval.

8.3.6 The Contractor shall retain the patient records for a period of three (3) years after the close of the Authority's financial year (i.e. 31 March of each year) in which the record was made.

8.3.7 The Contractor shall submit audited annual financial statements of accounts within three (3) months after the close of the Authority's financial year (i.e. by 30 June of each year).

9. Reporting and Audits

9.1 Submission of Data on Performance and Service Indicators

9.1.1 The Contractor shall submit a quarterly return to the Authority. An indicative list of data items to be submitted and the respective frequency for submission is set out at Annex B.

9.1.2 The Contractor shall submit any other information as and when required by the Authority in accordance with the stipulated format, manner of submission and timeline. The Authority shall provide not less than fourteen (14) days' written notice of the information required to the Contractor.

9.2 Service Audits

9.2.1 The Authority may conduct service audits at the centre to evaluate the care and services provided by the Contractor under the community rehabilitation programme.

9.2.2 Documents bearing the care team's assessment of the patient shall be required by the Authority as part of the service audits. In addition, the Contractor shall submit any other information relating to the service audits as and when required by the Authority in accordance with the stipulated format, manner of submission and timeline. The Authority shall provide not less than fourteen (14) days' written notice of the information required to the Contractor.

9.3 Financial Audits

9.3.1 Regular financial audits may be conducted by the Authority to ensure that the Contractor is in compliance with the Authority's means-testing framework and subvention claims. Documentation relating to both subvention claims and means-testing shall be submitted by the Contractor to the Authority at the Authority's request. The Contractor shall ensure that these documents are properly maintained.

9.3.2 The Contractor shall submit any other information relating to the financial audits as and when required by the Authority in accordance with the stipulated format, manner of submission and timeline. The Authority shall provide not less than fourteen (14) days' written notice of the information required to the Contractor.

9.4 Medisave Audits

9.4.1 Medisave Audits are made up of two (2) parts: (i) Professional audits undertaken by the Authority; and (ii) Operational audits undertaken by the Central Provident Fund (CPF) Board.

9.4.2 Professional audits by the Authority: This shall ensure that Medisave claims meet the conditions for Medisave use. The documents which the Contractor shall submit to the Authority include:

- Payment records showing the itemised breakdown of the bill submitted for the patient's Medisave claim;
- Hardcopies of the Universal Claim Form (UCF);
- Patient's ICP; and
- Certification/recertification of the patient's rehabilitation needs from a Singapore Medical Council-registered medical practitioner.

9.4.3 Operational audits by the CPF Board: This shall ensure that Medisave claims meet the conditions of use. The processes which the Contractor shall comply with include:

- The Contractor's external auditors shall submit an *Audit Report of Medisave Claims* to the CPF Board (see Schedule A-6) for each financial year within three (3) months after the closing of the Authority's financial year (i.e. by 30 June of each year).

- The CPF Board shall conduct regular audits or surprise inspections of the Contractor's records. For the purposes of these audits and/or inspections, the Contractor shall submit the following documents to the CPF Board shall include:
    - ❖ Hardcopies of the Universal Claim Form (UCF);
    - ❖ Medisave Authorisation Form(s);
    - ❖ Patient's bills;
    - ❖ Photocopies of the patient's identification papers (where necessary); and
    - ❖ Such other documents as requested by the CPF Board.

**

SCHEDULE A-1

TEMPLATE - MODIFIED BARTHEL INDEX (MBI)
(SHAH, VANCLAY & COOPER, 1989)

FUNCTIONAL ITEM DESCRIPTION **DATE**				**REMARKS**
FEEDING				
Dependent in all aspects and needs to be fed	0	0	0	
Can manipulate an eating device, usually a spoon, but someone must provide active assistance during the meal	2	2	2	
Able to feed self with supervision. Assistance is required with associated tasks such as putting milk/sugar to drink, salt, pepper, spreading butter, turning a plate or other "set up" activities	5	5	5	
Independence in feeding with prepared tray except with cutting meat, opening drink carton, jar lid etc. Presence of another person is not required	8	8	8	
The person can feed self from a tray or table when food is within reach. The person must put on an assistance device if needed, cut the food, and use salt and pepper, spread butter etc. if desired	10	10	10	
PERSONAL HYGIENE (GROOMING)				
Unable to attend to personal hygiene and is dependent in all aspects	0	0	0	
Asst. is required in all aspects of personal hygiene, but able to make some contributions.	1	1	1	
Some assistance is required in one or more steps of personal hygiene	3	3	3	
The person is able to conduct personal hygiene but requires min. asst. before and/or after the operation.	4	4	4	
The person can wash own hands and face, comb hair, clean teeth & shave. Males must be able to use any kind of razor but must insert the blade, or plug in the razor without asst. as well as retrieve it from the drawer/cabinet. Females must apply own makeup, but need not braid or style her hair.	5	5	5	
DRESSING				
The person is dependent in all aspects if dressing and is unable to participate in the activity	0	0	0	
The person is able to participate to some degree, but is dependent in all aspects of dressing	2	2	2	

FUNCTIONAL ITEM DESCRIPTION **DATE**				**REMARKS**
Assistance is needed in putting on, and/or removing any clothing	5	5	5	
Min. asst. is required with fastening clothing eg buttons, zips, bra, shoes, etc	8	8	8	
The person is able to put on, remove and fasten clothing, tie shoelaces or put on, fasten, remove corset/braces, as prescribed.	10	10	10	
BATHING				
Total dependence in bathing self	0	0	0	
Asst. is required on all aspects of bathing, but the person is able to make some contribution.	1	1	1	
Asst. is required with either transfer to shower/bath or with washing or drying: including inability to complete a task because of condition or disease etc.	3	3	3	
Supervision is required for safety in adjusting water temperature, or in the transfer.	4	4	4	
The person may use a bathtub, a shower, or take a complete sponge bath as well as to do all steps of whichever method is employed without another person present	5	5	5	
Total **SCORE** for this page				
FUNCTIONAL ITEM DESCRIPTION **DATE**				**REMARKS**
BOWEL CONTROL				
The person is bowel incontinent	0	0	0	
The person needs help to assume appropriate position and with bowel movement facilitatory techniques.	2	2	2	
The person can assume appropriate position, but cannot use facilitatory techniques or clean self without asst. and has frequent accidents.	5	5	5	
The person may require supervision with the use of suppository or enema and has occasional accidents.	8	8	8	
The person can control bowels and has no problem. Can use suppository or take an enema when necessary.	10	10	10	
BLADDER CONTROL				
Dependent in bladder management, is incontinent, or has indwelling catheter.	0	0	0	
The person is incontinent but is able to assist with the application of an internal or external device.	2	2	2	

FUNCTIONAL ITEM DESCRIPTION **DATE**				**REMARKS**
The person is generally dry by day, but not by night, and needs asst. with the devices.	5	5	5	
The person is generally dry by day and night but may have an occasional accident, or needs minimal assistance with internal or external devices.	8	8	8	
The person is able to control bladder by day and night and or is independent with internal or external devices.	10	10	10	
TOILET TRANSFER				
Fully dependent in toileting	0	0	0	
Assistance is require in all aspects of toileting	2	2	2	
Asst. is required in management of clothing, transferring or washing hands.	5	5	5	
Supervision may be required for safety with normal toilet. A commode may be used at night but assistance is required for emptying and cleaning.	8	8	8	
Able to get on and off toilet independently.	10	10	10	
CHAIR / BED TRANSFER				
Unable to participate in transfer, 2 attendants required to transfer the person with/without a mechanical device	0	0	0	
Able to participate but max assistance of an attendant is required in all aspects of the transfer	3	3	3	
Requires another person. The assistance may be in any aspects of the transfer.	8	8	8	
An attendant is required, either as a confidence measure or to provide supervision of safety.	12	12	12	
Independent	15	15	15	
AMBULATION				
Dependent in ambulation	0	0	0	
Constant presence of one or more assist is required during ambulation.	3	3	3	
Assistance is required with reaching aids and / or their manipulation. One person is required to offer assistance.	8	8	8	
Person is independent in ambulation but unable to walk 50m without help, or supervision is needed for confidence or safety in hazardous situations.	12	12	12	
The person must be able to wear braces/prosthesis, lock and unlock it, assume standing, sit down, and place the necessary aids into position for use. The person must be able to use walking aids and walk 50m without asst.	15	15	15	
Total **SCORE** for this page				

FUNCTIONAL ITEM DESCRIPTION **DATE**				**REMARKS**
AMBULATION – WHEELCHAIR If unable to walk, use this item only if person is rated "0" for AMBULATION & then only if person has been trained in wheelchair management				
Dependent in wheelchair ambulation.	0	0	0	
Able to propel self over short distances on flat surface but asst. is required for all other areas of wheelchair manoeuvring.	1	1	1	
Presence of one person is necessary and constant asst. is required to position the wheelchair to table, bed, etc.	3	3	3	
The person can propel self for a reasonable duration over regularly encountered terrain, minimal asst. may still be required in "tight corners"	4	4	4	
The person is independent if able to propel self at least 50 m, go around corners, turn around and manoeuvre the wheelchair to a table, bed, toilet, etc.	5	5	5	
STAIR CLIMBING				
The person is unable to climb stairs	0	0	0	
Assistance is required in all aspects of stair climbing	2	2	2	
The person is unable to ascend / descend but is unable to carry walking aids and needs supervision and assistance	5	5	5	
Generally no assistance is required. At times supervision is required for safety due to morning stiffness, shortness of breath, etc.	8	8	8	
The person is able to use handrails, cane or crutches when needed and is able to carry these devices while ascending or descending.	10	10	10	
Total SCORE (including page 1& 2)				

Assessment Schedule:

1st assessment: within 3 working days of admission

Reassessment:: 6 monthly & as & when required if condition deteriorates

Total Dependency = 0-24 Severe Dependency =25-49 Moderate Dependency = 50-74
Mild Dependency =75-90 Minimal Dependency = 91-99 Independent = 100

Name & Signature of Therapist : _____

Date of Review : _____

Name of the centre : _____

**

SCHEDULE A-2

TEMPLATE - TIMED UP AND GO (TUG) TEST

Patient Name & NRIC: _____

Equipment: Stopwatch

Directions: Patients wear their regular footwear and can use a walking aid if needed. Begin by having the patient sit back in a standard arm chair and identify a line 3 meters or 10 feet away on the floor.

Instructions to Patient:

When I say "Go," I want you to:

1. Stand up from the chair
2. Walk to the line on the floor at your normal pace
3. Turn
4. Walk back to the chair at your normal pace
5. Sit down again

On the word "Go" begin timing. Stop timing after patient has sat back down and record.

Time: _____ seconds

An older adult who takes ⩾12 seconds to complete the TUG is at high risk for falling.

Observe the patient's postural stability, gait, stride length, and sway. Circle all that apply:
Slow tentative pace / Loss of balance / Short strides / Little or no arm swing / Steadying self on walls / Shuffling / En-bloc turning / Not using assistive device properly

Notes:

_____	_____	_____
Assessed by (name & signature)	Date Assessed	Time Assessed

Source: Centres for Disease Control and Prevention
**

TEMPLATE - ZARIT BURDEN INTERVIEW 4

a. **Zarit Screen Measure of Caregiver Burden**

Gerontologic health scientific literature identifies a number of scales to measure caregiver burden. The Zarit Scale of Caregiver Burden or the Zarit Burden Interview is the most widely used instrument.

Originally designed and tested in 1980 containing 29 items, it was reduced to 22 questions. Subsequent adaptation of the scale made it particularly attractive. The research reported in The Gerontologist (2001, Vol 41, No. 5, 652-657) that a short 12-item version and 4-item screening version were found to correlate well with the full 22-item version. The short and simpler 4-item screen, proven to be valid and reliable for its designated use, is self-administered by the caregive. A score of 8 indicates high burden, and intervention may be indicated. The screen has proven to be a helpful resource tool for caregivers and their families.

To be completed by caregiver.

Indicate how often you experience the feelings listed by circling the number that best corresponds to the frequency of these feelings.

1. Do you feel that because of your relative that you don't have enough time for yourself?

" Never	" Rarely	" Sometimes	" Quite Frequently	" Nearly Always
0	1	2	3	4

2. Do you feel stressed between caring for your relative and trying to meet other responsibilities (work, home)?

" Never	" Rarely	" Sometimes	" Quite Frequently	" Nearly Always
0	1	2	3	4

3. Do you feel strained when you are around your relative?

" Never	" Rarely	" Sometimes	" Quite Frequently	" Nearly Always
0	1	2	3	4

4. Do you feel uncertain about what to do about your relative?

" Never	" Rarely	" Sometimes	" Quite Frequently	" Nearly Always
0	1	2	3	4

A score of 8 indicates high burden, and assistance may be indicated.

**

SCHEDULE A-4

LIST OF REHABILITATIVE EQUIPMENT AND FURNITURE

S/N	Major Rehabilitative Equipment & Furniture	Recommended Quantity (1-4 patients / session)
Clinical Furniture		
1	Electric height adjustable beds and wooden plinths	1
2	Electric Tilt Table +/- Standing Frame (electric)	1
3	Training staircase & ramp	1
4	Parallel bars	1
5	Wall bars / grab bars	2
6	Stationary bike (reclining)	1
7	Work tables	2
8	Arm chairs &/or High chairs	4
9	Therapy stools	1
Mobility Aids		
1	Quadsticks (narrow & broadbase)	2
2	Pointstick	1
3	Walking frame	1
4	Forearm support rollator frame / walker	1
5	Wheelchairs (standard & reclining)	1
Therapy Items		
1	Knee Gaitors	2
2	Elbow Gaitors	2
3	Ankle Foot Orthosis	2
4	Ankle weights (various weights)	12
5	Therabands /Theratubes (various grades)	5
6	Positioning aids : Foam wedges / rolls / cushions	5
7	Pedal exercisers (with footplates)	2
8	Step boards (various heights)	6
ADL, Upper Extremity & Cognitive Training Items		
1	Bean bags	varies
2	Hand strengthening exercise items (e.g. pinch / grip exerciser)	2
3	Peg boards & stacking cones (various)	3
4	Shoulder exercise ladder / Climbing board / Inclined board	3
5	Upper limb ergometer	1

S/N	Major Rehabilitative Equipment & Furniture	Recommended Quantity (1-4 patients / session)
6	Forearm skate board	1
7	Fine dexterity & manipulation training items	1 set
8	ADL assistive devices (various training items): cutlery, dressing/grooming/showering aids	1 set
9	Games, puzzles & crafts	1 set
10	Therapy Putty (various grades)	5
Others		
1	BP & HR monitor (e.g. Dynamap)	1
2	TENS &/or Electrical Muscle Stimulator	1
3	Test Tubes	6
4	Heat therapy modality e.g. Hot pack (microwaveable)	3
5	Goniometer	1
6	Dynamometer	1

**

SCHEDULE A-5

TEMPLATE - REHABILITATION PROGRAMME REVIEW FORM

PART 1 – PATIENT INFORMATION

Name of Patient : _____

NRIC : _____

Date of Admission to centre : _____

Name of centre : _____

PART 2 - SELF-ASSESSMENT QUESTIONS:

(These are questions related to functional status of the patient in the past 3 months – to be completed by patient with help from the therapist)

	Yes	No
a) Have you fallen recently or had a near fall?	☐	☐
b) Have you been unable to perform any one (1) of the following Activities of Daily Living (ADLs) which you were previously able to do independently or at your previous functional level: bathing, dressing, eating, and transferring from bed/chair?	☐	☐
c) Have you been unable to perform any one (1) of the following Instrumental Activities of Daily Living (IADLs) which you were previously able to do independently or at your previous functional level: using the telephone, taking medications, accessing public transport, managing money or your finances, cooking and doing laundry?	☐	☐
d) Do you think that your ability to manage your daily activities is worse than before in the last three (3) months?	☐	☐
e) Do you feel that you have lost energy or interest in things that you usually enjoy?	☐	☐

PART 3 – CLINICIAN ASSESSMENT:
(To be completed by physiotherapist / occupational therapist or registered nurse - please check boxes that apply to the patient.)

I.STOP! Permanent Exclusion	II.WAIT! Temporary Exclusion	III. Go! Exercise Recommended
If any boxes in this column are checked, the patient is ineligible for the community rehabilitation programme. a. □ End-stage congestive heart failure b. □ Permanent bed-bound status c. □ Severe cognitive impairment or behavioural disturbance d. □ Unstable abdominal, thoracic or cerebral aneurysm e. □ Untreated severe aortic stenosis f. □ Other, pls specify_____	**If any boxes in this column are checked, follow the protocols for further evaluation of these concerns with medical staff prior to re-evaluating for appropriateness/modification of the community rehabilitation programme.** a. □ Acute change in mental status or delirium b. □ Cerebral haemorrhage within the past 3 months c. □ Exacerbation of chronic inflammatory joint disease or osteoarthritis d. □ Eye surgery within the past 6 weeks e. □ Fracture in healing stage_____ f. □ Hernia, symptomatic (abdominal or inguinal) g. □ Myocardial infarction or cardiac surgery within past 3 months h. □ Other acute illness or change in symptoms_____ i. □ Proliferative diabetic retinopathy or severe non-proliferative retinopathy j. □ Pulmonary embolism or deep venous thrombosis within 3 months	**If only boxes in this column are checked, patient is suitable for the community rehabilitation programme without additional evaluation by medical staff at this time.** a. □ Arthritis b. □ Chronic obstructive pulmonary disease, asthma c. □ Congestive heart failure d. □ Coronary artery disease e. □ Chronic renal failure f. □ Cancer (history or current) g. □ Chronic liver disease h. □ Chronic venous stasis i. □ Dementia j. □ Depression, anxiety, low morale k. □ Diabetes l. □ Drugs causing muscle wasting (steroids) m. □ Frailty n. □ Falls, history of hip fracture o. □ Gait and balance disorders, mobility impairment p. □ Hypertension q. □ HIV infection r. □ Hyperlipidemia s. □ Malnutrition, poor appetite t. □ Neuromuscular disease

I.**STOP! Permanent Exclusion**	**II.WAIT! Temporary Exclusion**	**III. Go! Exercise Recommended**
	k. □ Soft tissue injury, healing _____ l. □ Systemic infection_____ m. □ Uncontrolled blood pressure (>180/100 mmHg) n. □ Uncontrolled diabetes mellitus (FBS>6.5mmol/L) o. □ Uncontrolled malignant cardiac arrhythmia (ventricular tachycardia, complete heart block, atrial flutter, symptomatic bradycardia) p. □ Unstable angina (at rest or crescendo pattern, ECG changes) q. □ Other, pls specific_____	u. □ Obesity v. □ Osteoporosis w. □ Parkinson's disease x. □ Peripheral vascular disease y. □ Stroke

Part 3 is adapted from 'Resident Medical Screening Form' with permission from Fiatarone Singh M.

PART 4 – PHYSIOTHERAPIST/OCCUPATIONAL THERAPIST ASSESSMENT (Shah Modified Barthel Index and Abbreviated Mental Test):
(To be completed by physiotherapist or occupational therapist)

Shah Modified Barthel Index:	Score at the previous review (Date:_____)	Score at current review	Max Score
Personal Hygiene			5
Bathing Self			5
Feeding			10
Toileting			10
Stairs Climbing			10
Dressing			10
Bowel Control			10
Bladder Control			10
Ambulation			15
*Wheelchair (to score if Ambulation is zero)			5
Chair/Bed Transfer			15
Total Score			100
*Abbreviated Mental Test (optional)			10
1) Patient's goals :			
2) Therapy goals			
3) Goals of therapy achieved			
4) Patient's future goals Further goals of therapy and treatment plans for the next rehabilitation period			

Name & Signature of Therapist : _____

Date of Review : _____

Name of the centre : _____

PART 5 – MEDICAL PRACTITIONER ASSESSMENT *(To be completed by a Singapore Medical Council-registered Medical Practitioner)*

I have reviewed the physiotherapist/occupational therapist assessment (as in Part 4 above) and certify that:
*(*Please tick ✓)*

Yes, the above-named patient is fit to undergo and can benefit from further rehabilitation to improve his/her functional status.	□	Remarks
No, the above-named patient has achieved his/her rehabilitation goals, and/or further rehabilitation is unlikely to result in significant functional improvement.	□	Remarks:

Additional points on patient's condition, co-morbidities and medications to highlight to the physiotherapist/ occupational therapist (optional)

Name & Signature of Singapore Medical Council-registered Medical Practitioner : _____

MCR Number : _____

Date of Review : _____

Name & Address of Clinic : _____

Note: Certification is valid for six (6) months from the date of assessment by a Singapore Medical Council-registered medical practitioner. Reassessment and re-certification is required if patient requires community rehabilitation beyond six (6) months.

**

SCHEDULE A-6

TEMPLATE - AUDIT REPORT OF MEDISAVE CLAIMS

Central Provident Fund Board
79 Robinson Road
CPF Building
Singapore 068897

Dear Sirs

AUDITOR'S REPORT ON

_____ FOR THE FINANCIAL YEAR _____
name of centre

1 We have examined the claims made by the above hospital to the CPF Board during the year ending _____ on the Medisave accounts of CPF members'/ the CPF members' dependants' rehabilitation and care expenses. Our examination was carried out in accordance with Statements of Auditing Guideline and, accordingly, included such tests of the accounting records and such other auditing procedures as we considered appropriate in the circumstances.

2 In our opinion:

a) The Centre has complied with the terms and conditions laid down in the Deed of Indemnity and the "Manual for Providers of Community Rehabilitation Services offering Medisave Scheme".

b) The claims were made in accordance with the Central Provident Fund (Medisave Account Withdrawals) Regulations and with the terms and conditions laid down by the CPF Board in its "Manual for Providers of Community Rehabilitation Services offering Medisave Scheme".

Authorised Signature
Name of Company
Singapore
Date

**

ANNEX B

QUARTERLY RETURNS AND REPORT ON INDICATORS FOR COMMUNITY REHABILITATION

The Approved Provider shall submit the manpower, clinical, financial and utilisation information related to the community rehabilitation services provided and such other relevant patient, institution and staff data, in such form and at such times as the Authority[3] may determine to;

The ILTC Desk Head
Health Information Operations Branch, Health Information Division
Healthcare Performance Group
Fax : 63259137 or E-mail : MOH_SDCS@moh.gov.sg

The tentative list of indicators to be collected for community rehabilitation services is listed in Table B below. This list of indicators may be updated by the Authority from time to time with prior written notice of not less than fourteen (14) days provided to the Approved Provider of any change.

Table B: List of Indicators for Community Rehabilitation

Number of Patients		**Frequency**
1.a	Number of patients in community rehabilitation programme as at end of the previous quarter (i.e. Balance brought forward)	Quarterly
1.b	Total number of patients in community rehabilitation programme as at the end of the quarter	Quarterly
1.c	Number of patients served in community rehabilitation programme during the quarter (i.e. including new and existing patients)	Quarterly
1.d	Number of and percentage of patients successfully admitted into community rehabilitation	Quarterly
1.e	Number of and percentage of patients appropriately discharged from community rehabilitation and reasons for discharge	Quarterly
1.f	Number of and percentage of patients with minimum length of stay less than seven (7) days from admission to discharge, and reasons for discharge	Quarterly
1.g	Proportion of "Total Admissions" divided by "Total Discharges", over the reporting period of three months, unless otherwise directed by the Authority	Quarterly
Attendance		
2.a	Number of service days in the quarter	Quarterly
2.b	Number of attendances for community rehabilitation programme in the quarter	Quarterly

[3] This list of indicators and the method of data submission to the Authority is subject to updates. Prevailing guidelines and instructions for the submission of data will be communicated by the ILTC Desk Head, Health Information Division, Healthcare Performance Group.

2.c	Average daily attendance for community rehabilitation programme in the quarter	Quarterly
2.d	Maximum daily capacity for community rehabilitation programme in the quarter	Quarterly
2.e	Average daily utilisation rate for community rehabilitation programme in the quarter	Quarterly
2.f	Total number of patients seen by (i) a physiotherapist and (ii) an occupational therapist (listed separately) for community rehabilitation programme during the quarter	Quarterly
2.g	Total number of therapy hours by i) a physiotherapist and (ii) an occupational therapist (listed separately) for community rehabilitation programme during the quarter	Quarterly
2.h	Percentage of "Total Daily Attendance" divided by Approved Capacity" over the reporting period of three months, unless otherwise directed by the Authority	Quarterly
Application Rejection Rate		
3.a	Number of new patient referrals for community rehabilitation programme rejected in the quarter	Quarterly
3.b	Number of new patient referrals for community rehabilitation programme in the quarter	Quarterly
3.c	Number of withdrawals for community rehabilitation programme in the quarter	Quarterly
3.d	Number of and percentage of referrals to community rehabilitation programme that the Contractor rejected for admission and reasons for rejection	Quarterly
3.e	Number of and percentage of patients and their caregivers who withdrew their referral and reasons for the withdrawal of referral	Quarterly
3.f	Percentage of "Total Number Of Referrals Admitted" divided by "Total Number Of Referrals Received" over the reporting period of three months, unless otherwise directed by the Authority	Quarterly
Application Waiting Time		
4.a	Total waiting time for patients before admission into the centre for community rehabilitation programme in the quarter	Quarterly
4.b	Number of individuals on the waiting list for community rehabilitation programme at the end of the quarter	Quarterly
Average Length of Stay		
5.a	Total length of stay in community rehabilitation programme in the centre	Quarterly
5.b	Total number of discharges from community rehabilitation programme in the centre	Quarterly
5.c	Average length of stay in community rehabilitation programme in the centre	Quarterly
Clinical Outcome		
6.a	Scores of MBI (Shah Modified Barthel Index)	Quarterly
6.b	Scores of TUG (Timed Up and Go)	Annually with quarter update option
6.c	Average MBI scores at admission and upon discharge into the community rehabilitation programme	Every 6 months

6.d	Average MBI score improvement for patients in the community rehabilitation programme from the point of admission to discharge	Every 6 months
6.e	Number of patients with MBI improvement (<=0, 1-10, 20-30,>30)	Every 6 months
Patient and Caregiver Satisfaction		
7.a	Zarit Burden Interview (ZBI-4) scores of caregivers	Annually with quarter update option
7.b	Number and percentage of caregivers with ZBI-4 scores of less than eight (8)	Every 6 months
7.c	Client and Caregiver satisfaction survey scores	Annually with quarter update option
7.d	Number and percentage of caregivers and community rehabilitation Patients satisfied with community rehabilitation Services	Every 6 months
Staffing		
8.a	Number of local and foreign staff (including healthcare professionals) in the centre by type of occupation(i.e. established, filled and vacant posts)	Quarterly
8.b	Number of local and foreign staff (including healthcare professionals) leaving the centre by type of occupation	Quarterly
8.c	Educational qualifications of staff (including healthcare professionals)	Quarterly
8.d.	Residence status (i.e. Singaporean, Permanent Resident or Non-Resident) and nationality of staff (including healthcare professionals)	Quarterly
8.e	Employment type of staff (including healthcare professional) (i.e. employee, locum, purchased service, volunteer, others)	Quarterly
8.f	Working hours of staff (including healthcare professionals) (direct care and non-direct care)	Quarterly
8.g	Training programmes attended by staff (including healthcare professionals)	Quarterly
Others		
9.a	Characteristics of patients for profiling and for analysing clinical outcome: diagnosis, residence status (i.e., Singaporean, PR, non-resident), nationality, age, gender, ethnicity, religion, occupation (current or last held), language and dialect spoken, highest education attained, mobility status, presence/ absence of caregiver, and financing details	Quarterly

**