Using the eRehabData®
Pre-Admission Screen Tool

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Pre-Admission Screening

Why do we conduct a pre-admission screening?

- Became a requirement in the 2010 Final Rule.
- To gather information on whether the patient is a good candidate for rehabilitation.
- To determine whether the hospital/unit is equipped to manage the medical and functional needs of the patient.
- To gather preliminary information on the anticipated reason for admission.
- To determine whether the patient will benefit significantly from an inpatient rehabilitation stay.
- MOST IMPORTANTLY—to establish the foundation for the medical necessity of the admission.

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**The Rule**

**Requirements for the Pre-admission Screening**
- CMS believes that a comprehensive pre-admission screening process is the key factor in initially identifying appropriate candidates for IRF care.
- Pre-admission screening is an evaluation of the patient’s condition and need for rehabilitation therapy and medical treatment. The pre-admission screening:
  - is required documentation of the clinical evaluation process that forms the basis of the admission decision.
  - serves as the primary documentation by the IRF clinical staff of the patient's status prior to admission and of the specific reasons that led the IRF clinical staff to conclude that the IRF admission would be reasonable and necessary.
  - must be detailed and comprehensive.

**Pre-admission screening should show:**
- That the patient has the appropriate therapy needs for placement in an IRF
  - The patient is expected to make measurable improvement that will be of practical value in terms of improving the patient's functional capacity or adaptation to impairments.
- That the patient’s condition is sufficiently stable to allow the patient to actively participate in an intensive rehabilitation program
  - The patient is able and willing to participate in an intensive rehabilitation program that is provided through a coordinated interdisciplinary team approach in an inpatient setting.
The Rule

• Pre-admission screening should show:
  ▪ An interdisciplinary team approach to care which requires that treating clinicians interact with each other and the patient to define a set of coordinated goals for the IRF stay, and work together in a cooperative manner to deliver the services necessary to achieve those goals.
  ▪ That the patient requires the intensive services of an inpatient rehabilitation setting
    • The patient “generally requires and is reasonably expected to actively participate in at least 3 hours of therapy per day at least 5 days per week and is expected to make measurable improvement that will be of practical value to improve functional capacity or adaptation to impairments.”

The Rule

• Scope of pre-admission assessment should include:
  ▪ Patient’s prior level of function (prior to the event or condition that led to the patient’s need for intensive rehabilitation therapy)
  ▪ Expected level of improvement
  ▪ Expected length of time needed to reach that level of improvement
  ▪ Evaluation of the patient’s risk for clinical complications
  ▪ Conditions that caused the need for rehabilitation
  ▪ Combination of treatments needed (one of which must be PT or OT)
  ▪ Expected frequency and duration of treatment in the IRF
  ▪ Anticipated discharge destination
  ▪ Any anticipated post-discharge treatments
  ▪ Other information relevant to the care needs of the patient
• Pre-admission screening timeline, approval and retention:
  ▪ Individual elements of the pre-admission screening may be evaluated by any clinician designated by a rehab physician, as long as the clinicians are licensed or certified and qualified to perform the evaluation within their scope of practice and training.
  
  ▪ Each IRF may determine its own process for collecting and compiling the pre-admission screening information. The focus of the review of the screen will be on its completeness, its accuracy, and the extent to which it supports the appropriateness of the admission decision.

• Pre-admission screening timeline, approval and retention:
  ▪ Must be completed within the 48 hours immediately preceding the IRF admission.
  
  ▪ If the patient is not admitted within 48 hours of the screening, an update conducted in person or by telephone no more than 48 hours prior to admission is required to document changes in the patient’s medical and/or functional status.
  
  ▪ A rehabilitation physician must review and document his or her concurrence with the findings and results of the pre-admission screening prior to the IRF admission.
The Rule

- Pre-admission screening timeline, approval and retention:
  - The IRF is responsible for developing a thorough pre-admission screening process for patients admitted to the IRF from home or community-based environments which includes all the required elements described.
  - Pre-admission screenings cannot be done over the telephone; however, updates can be done over the telephone. Pre-admission screenings can be done from faxed patient records.
  - Pre-admission screenings must be retained as a permanent document in the patient's medical record.

PAS Tool Sections

- First section: Demographics
  - Gathers referral information and living status.
  - If the question also appears on the IRF-PAI, the drop down lists are the same and the data are transferred to the IRF-PAI once the patient is admitted.
  - Asks for narrative information on the patient's support system and patient goals.
  - Includes:
    - Patient phone number
    - Race/ethnicity section from the IRF-PAI (carries forward to IRF-PAI upon admission)
    - Marital Status comments box
    - Pre-hospital vocational category and effort fields from the IRF-PAI (carry forward to IRF-PAI upon admission)
    - Education selection
    - Code status section, including Advanced Directives and Power of Attorney
    - Language/communication needs section
    - Religion/cultural considerations section
PAS Tool Sections

• **Second section: Referral/Payer**
  - Gathers information on who initiated the referral.
  - Asks for insurance information with contact names and numbers to expedite follow-up contacts.
  - Referring physician and referral source data will flow into the referral outcomes reports.
  - Referral outcomes reports can be used to track and trend referral patterns.
  - Includes:
    - Referring Source Information notes box
    - Primary/Secondary Insurance Group # fields
    - Insurance notes box

PAS Tool Feature

• **Notify Admissions**
  - This feature allows you to coordinate into your referral process
  - Allows for clinical review to occur while insurance verification occurs
  - Can allow for quicker decision-making
• **Third section: Status**
  - Gathers information on diagnosis, history of present illness, prior rehab or hospitalizations, surgical history, and medications.
  - Asks for information on pain, vitals, diet, infections, acute care therapy involvement, and other safety issues.
  - Codes can be written out as descriptions or entered as ICD-10s.
  - Includes:
    - Free text etiologic diagnosis box to use as alternative to ICD-9 code
    - Vitals measurement system selection option (American Standard or Metric)
    - Vaccinations section including Flu, PPV, Hepatitis B. NOTE that the new vaccination date fields do not require a formatted date, e.g "October 2013" is allowed.
    - Modified diet/supervision options (checkboxes)

• **Fourth section: Review of Systems**
  - Gathers information on allergies and each body system covered in a typical H&P.
  - Several areas include choices and a text box. We will continue to revise the choices based on your feedback and patterns of use.
  - Includes:
    - Vision options (checkboxes)
    - Hearing options (checkboxes)
    - Neuro options (checkboxes)
    - Precautions parameters
    - Oxygen parameters
    - Dialysis parameters
**Fifth section: Labs**
- Lists all lab results that you wish to report and/or consider to be significant.
- Includes:
  - Cultures notes box
  - Studies split out with individual results/notes boxes

**Sixth section: Function**
- Gathers information on bladder, bowel, and functional status.
- The user can record function as per common functional areas or according to the functional independence measures (FIM).
- Pre-morbid status and current status are captured for both types of functional assessment.
- Hide/show button is available to display only the common functional areas or the functional independence measure list.
- Includes:
  - Bladder Device Used field, separate from Incontinence checkbox
  - Foley catheter section
  - Bowel Device Used field, separate from Incontinence checkbox
  - Function Assessment Notes (free text) to elaborate on details describing functional impairments
PAS Tool Sections

**Seventh section: Justification**

- Reports the summary of the findings. Based on the data gathered, the user can recommend admission or denial according to the patient’s needs in several key areas.
- Asks the user to address the patient’s need for close medical supervision. The screening will project the patient’s ongoing medical needs based on the data gathered.
- Asks the user to indicate common nursing tasks that the patient will likely need based on data gathered.
- Also asks for anticipated therapy needs and specific interdisciplinary team interventions.

**Seventh section: Justification (continued)**

- Screening recommendations report the intent to move the patient forward for physician approval and indicates the screening belief that the patient can participate in the therapy program and has a positive prognosis.
- In keeping with the MBPM, you can report the estimated length of stay, anticipated discharge location, and anticipated post-discharge needs.
- The PAS Tool can be signed by the physician to show concurrence with the admission decision. (Notify Physician)
- There is an electronic signature feature for physicians with notifications of when the PAS is ready for review.
- Notified physicians can review and sign the PAS on a mobile device from the link in their notification email.

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• **Justifying the need for close medical supervision:**
  - It is important to be specific about what the patient’s current needs are rather than restating the history and physical (H&P).
  - Indicate what you feel the physicians will likely manage when the patient is in rehabilitation.
  - Include active conditions, potential risks and complications.
  - Remember that the rigors of an intensive rehabilitation program can complicate what was previously a stable comorbidity.

• **Examples:**
  - **Diabetes Management –**
    - Return to oral meds from current sliding scale
  - **Cardiac –**
    - Manage closely due to unstable BP in acute
    - New medication. Watch pressures.
    - Pain issues could impact BP during exercise. Closely manage.
    - Daily weights needed to monitor effectiveness of diuretic.
  - **Medication Management –**
    - Infection control issues.
    - Just completed IV antibiotics. Watch for recurrence of infection.
Close Medical Supervision

• **Examples:**
  - DVT Prophylaxis-
    - On Lovenox. Will require teaching and close management for DVTs.
    - At risk for SVT due to inability to ambulate post-surgery.
  - Pain Management-
    - Pain resulting in increased blood pressure.
    - Pain medication resulting in cognitive and safety issues. May require adjustment.
  - Cognitive issues-
    - Safety needs to be closely watched to avoid further injury.
    - Concerns with ability to focus and follow-through. To be addressed by the rehab physician.

Close Medical Supervision

• **Example:**
  - Wound management-
    - Infection in surgical wound requires close management.
    - Wound vac currently used, but must be discontinued in order to discharge to the community.
    - Close management of surgical sites to avoid infection. Being treated for possible cellulitis.
PAS Tool Features

• Attach Files
  - Allows you to attach scanned documents into the system and associate with this PAS
  - Examples may include:
    • Medication Administration Records
    • Therapy documentation
    • Dialysis run sheets
    • PICC line info

• Re-screen Feature
  - Allows you to create a copy of a PAS tool assessment that you can then edit to update the information that changed since the original or most recent screening. Currently all data entered into the originating PAS tool assessment are transferred to the re-screening except for the following fields on the Justification tab:
    • Date Patient Screened
    • Evaluator
    • Admission Justification: Medically Stable
    • Screening Recommendations: Rehabilitation Admission, Able to Tolerate Rehab, and Rehabilitation Prognosis.
    • Rehabilitation Disposition: Accepted / Anticipated Admission Date
    • Rehabilitation Disposition: Re-screen / Date
    • Rehabilitation Disposition: Denied / Referred to
    • Three associate signatures, positions, and dates signed
    • Physician Signature checkbox, signature, and date signed
**PAS Tool Features**

**Duplicate PAS Tool Assessment**
- Allows you to create a new Pre-Admission Screening Tool assessment based on this assessment's data.
  - As opposed to a re-screen this action will create a **completely new** assessment which is not linked to the current assessment.
- Allows for choice in what is copied, in addition to Patient Identification information:
  - Complete Demographics
  - Referral/Payer
  - Status
  - ROS
  - Labs
  - Function
  - Justification
  - IRF-PAI Notes
  - Facility Custom values
- You may copy this assessment to a different facility. Please select the facility to which the new copy will belong.

**Manage your caseload**
- Forward
  - Send this assessment to another user for additional handling.
- Admit
  - Create an admit assessment for this patient from this pre-admit date
- Deny (or delete) this Pre-Admission assessment.
  - No Bed Available
  - No 40% Bed Available
  - Patient/Family Refused
  - Physician Refused
  - Insurance Denied
  - Too Functional
  - Too Impaired
  - Does Not Meet Medically Necessary Criteria
  - Admitted to Other IRF
  - Insurance Out of Network
  - Admitted to SNF
  - Unable to Accommodate Special Medical Needs
  - No Reliable Discharge Plan
  - Admitted to Other Level of Care (not IRF or SNF)
  - Other
**eRehabData® Features**

- **Configure your home page to the items you prefer to visualize on your work list**
  - Check or un-check (waiting assessments, pre-admit assessments, admit assessments and/or discharge assessments)
  - Using box at bottom of home page, sort/search by:
    - In progress, accepted, filed, denied, etc.
    - For my facility, that I created, my site
    - Decision status
    - Date range
    - Patient name
    - SSN

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**Adjust List Options** to change home screen content

- Name
- Gender
- RIC
- Assessment Status
- PAS Decision
- PAS Date Patient Screened
- PAS Date Physician Signed
- Primary Payer
- 60% Rule Compliant
- Admit Date
- Age at Admission
- CMG Base Pay Weight
- CMG and Tier
- CMS Transmission Date
- Creation Date
- Date of Onset
- Discharge Date
- Discharge Setting
- Expected Reimb. (Facility Adjusted)
- FIM and IGC vs. Diagnosis Warnings
- Final Rule ALOS
- Impairment Group
- Length Of Stay
- Patient ID Number
- Patient Medicare #
- Social Security Number

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PAS Tool Sections

What else?

- No fields are required. The more you record; the better the justification.
- The end product is as good as the information entered.
- The form is printable for filing in the chart. Only the completed fields print out, plus any custom fields configured for pre-admission data gathering.
- We will continue to accept your feedback to enhance the tool.
- Questions? Please email: assistance@eRehabData.com

Questions?

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