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PAS Tool - Best Practices with Pre-Admission Screening

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Better outcomes for everyone.

- **Why did we create it?**

- § To provide a comprehensive tool.

- § To allow providers easy access to a tool that could be moved through the review process conveniently.

- § To introduce uniformity in justifying the admission.

- **Why do we conduct a pre-admission screening?**
 - § To gather information on whether the patient is a good candidate for rehabilitation
 - § To determine whether the 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

• **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.

- **Preadmission 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.

- **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.”

- **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.

- **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 in the patient's record.

- **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.

- § Coming to the Demographics section:

- Pre-Hospital Vocational Category
- Areas for education, communication and cultural needs
- Additional check boxes and text areas for Pre-Hospital Activity Status and Pre-Hospital Living Setting.
- Areas for DNR status and living will information

- **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.
- § Coming to the Referral/Payer section:
 - Area for general notes
 - Expanded insurance information
 - Patient room number

- **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-9s.

- § Coming to the Status section:

- Expanded selections for infections
- Expanded selections for diet
- Expanded selections for therapies ordered in acute to include psychology/psychiatry
- Additional notes fields
- Metric/standard height/weight unit of measure option
- Immunizations information

- **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.
- § Several additions are slated for the special considerations section to allow the user to record precautions, oxygen and dialysis parameters.
- § Coming to the ROS section:
 - Additional hearing, vision, endocrine, skin options
 - Expanded neuro section
 - Expanded special considerations section

- **Fifth section: Labs**

- § Lists all lab results that you wish to report and/or consider to be significant.

- § Coming to the Labs section:

- Expanded studies section, including dates and individual notes fields
- Calendar feature on date fields
- GFR value and date
- Urinalysis notes
- Cultures section

- **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.
- § 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.
- § Coming to the Function section:
 - Expanded bladder/bowel device used sections
 - Dates and notes to current therapy evaluations
 - Bathing selections for non-FIM functional assessment area
 - Shortcut to set all pre-morbid values to Independent

- **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 and report what the patient need medical supervision for. 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.
- § Coming to the Justification section:
 - Quick start list of potential complications/risks
 - Customizable evaluator list
 - Configurable physician attestation language
 - Time fields for all signatures
 - Additional "Position" options for signatures
 - Shortcut to denial reasons when Denied is selected
 - Electronic signature functionality for Signatures section

- **Re-screening**

§ There are 2 methods for re-screening:

- Complete re-screen to be used when a patient has made considerable changes in status.
 - 4 The original PAS Tool will be copied into a new document.
 - 4 The user can update the status without having to re-enter information that is static.
- Updates can be reported in the text box on the justification tab.

- **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



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Questions?

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