

# **Implications of FIM™**

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## **Scoring and Pay for Performance**



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# Introduction and Goals

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⌘ Introduction

⌘ Presentation Goals

- ⌘ Gain an understanding of internal factors that may have a potential impact of on FIM™ ratings and pay-for-performance
- ⌘ Understand how FIM™ scoring may be used to assess clinical quality measures
- ⌘ Provide a tool for assessing risk for possible clinical quality measures related to FIM™ scoring

⌘ Accurate FIM™ today will assure a secure tomorrow

# History of Quality Indicators

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In December 2010 CMS hosted an Open Door Forum to solicit input for consideration of quality measures in response to the Affordable Care Act: Section 3004 which required CMS to establish quality reporting programs for LTCHs, IRFs and hospice programs.

# Affordable Care Act Mandates

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- n Selected measures affecting Annual Payment Update (APU) are to be published by CMS no later than October 1, 2012.
- n Providers to submit data on selected quality measures to receive annual payment update for fiscal year 2014 and subsequent fiscal years.
- n Noncompliance will result in 2 percent reduction in (APU).
- n CMS directed to establish procedures (*no date specified*) to make data available to the public and allow providers to review data prior to publication.

# Quality Measures Focus

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**CMS envisions Quality Measures that are high priority, site-specific, and measurable across all settings and are:**

- ρ Valid, meaningful, feasible to collect
- ρ Address symptom management, patient preferences, and avoidable adverse events
- ρ Can be generated from standards-based CARE data set (Continuity Assessment Record and Evaluation) Tool

# Where We Have Been ?

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## Rehab Reimbursement History

- ⌘ 1965 – 1982 Based on reasonable costs
- ⌘ 1982 – 2002 Based on TEFRA targets
- ⌘ 2002 – 2011 Prospective Payment System

# Where We Have Been?

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## History of FIM™ Scoring

- ⌘ 2002 under PPS, the FIM™ levels were revised to include the “Code 0” to indicate that an activity did not occur when it was intended to occur.

# What Do We Expect?

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## Anticipated Quality Reporting for IRF's FY 2014

- ⌘ Measures for Program Quality

- ⌘ CAUTI – Urinary Catheter

- Associated Urinary Tract Infections

- ⌘ Proposal to collect data on CAUTI events from October through December 2012 and then based on a full calendar year for purposes of calculating the FY 2014 increase factor

- ⌘ Pressure Ulcers that are New or have Worsened

- ⌘ Currently reporting of the Pressure Ulcer quality indicator is optional on the IRF-PAI
    - ⌘ Data elements to be similar to those collected by the Skilled Nursing MDS 3.0



# We aren't done yet

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## Potential Quality Reporting for IRF's

- ⌘ 30-Day Comprehensive All-Case Risk-Standardized Readmission Measure
  - ⌘ Creating setting-specific risk adjusted 30-day all-condition, all cause risk-standardized readmission measures for hospitals, IRF's, long-term care hospitals and nursing homes
  - ⌘ In FY 2013 Rule cycle CMS expects to use claims data submitted by the IRF to calculate this measure

# Where are things going?

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## Quality Reporting – Two Trains of Thought

- ρ Using the FIM™ instrument in the calculation of the LOS Efficiency as a facility-level and patient-level indicator
- ρ Use of the measures that can readily be adopted from NQF



# Who is influencing Quality Measures?

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# Merging Quality Measures with FIM™ Risk

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# Top 5 Problems

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## **FIM™ Training/Knowledge Deficit**

- ρ Team members that have a negative attitude toward FIM™ training
- ρ No “FIM™ Champion” to spearhead FIM™ training
- ρ FIM™ training not provided at the frequency to meet the needs of the program
- ρ FIM™ competency is not required by Medicare, it is recommended in the industry
- ρ Float staff or new employees who are not FIM™ trained, but scoring the FIM™ domains

# Common Problem Areas

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- ⌘ Inaccurate FIM™ scoring for patients on dialysis with no urine output
- ⌘ Staff who don't understand the difference between an accident and an episode of incontinence
- ⌘ Use of the Code "0" more frequently than the state, regional, or national averages for Toilet Transfers

# Weighted Motor Scores



Item:	Weighted
Eating	.6
Grooming	.2
Bathing	.9
Dressing – upper body	.2
Dressing – lower body	1.4
Toileting	1.2
Bladder	.5
Bowel	.2
Transfer Bed, Chair, W/C	2.2
<b>Transfer to Toilet</b>	<b>1.4</b>
Transfer Tub, Shower	Not included as item for CMG
Locomotion	1.6
Stairs	1.6

# FIM™ Accuracy Risk Factors

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## At Risk Processes

- ρ FIM™ scoring is departmentalized
- ρ Inconsistent process for the gathering and verification of admission and discharge FIM™ scores
- ρ Electronic medical record provides “point-and-click” FIM™ scoring and staff do not add annotative descriptions to justify scores
- ρ Lack of follow-up with team members when there are discrepancies within the FIM™ scoring
- ρ Team members are not held accountable for FIM™ scoring
- ρ Team discusses FIM™ scores only at team conference

# What Are Potential Program FIM™ Risk Factors

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## **IRF-PAI Personnel and Processes**

- ρ Turn-over in IRF-PAI Coordinator position in past three months and minimal orientation to the position
- ρ IRF-PAI Coordinator has not written down program specific directions for gathering, assessing, completing and exporting the IRF-PAI and the back-up person has not been actively involved
- ρ Check-and-Balance of IRF-PAI prior to transmission (Does data make sense?)
- ρ The process for gathering admission and discharge FIM™ scores is not consistent with the instructions in the IRF-PAI Training Manual dated 4-1-2004

# What Are Potential Program FIM™ Risk Factors?

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## **IRF-PAI Personnel and Processes Continued**

- ⦿ IRF-PAI, which includes the FIM™, scores is not authenticated prior to sending to medical records
- ⦿ Audit process to verify that the IRF-PAI is in the medical record

# FIM™ Risk Assessment Tool



## FIM™ Risk Assessment

Area to Assess	Yes/No		Needs Attention By Whom and Timeline
	Yes	No	
<b>FIM™ Training or Knowledge Deficit</b>			
Does the rehab team have a negative attitude toward FIM™ training?			
Is there a FIM™ "Champion" to spearhead FIM™ training?			



Color Coded FIM™ Risk Assessment Chart		
NO Risk	100%	
Minimal Risk	80% - 96%	
Moderate Risk	60% - 76%	
High Risk	40% - 56%	

# FIM™ Audit/Tracking Tool



FIM™ Audit/Tracking Tool

Patient Name: \_\_\_\_\_ MR# \_\_\_\_\_



FIM™ Domain	PAS FIM™	Therapy Admit FIM™			Nursing Admit FIM™			IRF-PAI Admit FIM™	POC FIM™		Therapy D/C FIM™			Nursing D/C FIM™			IRF-PAI D/C FIM™	Comments
		1	2	3	1	2	3				1	2	3	1	2	3		
First three days	>>>>>	1	2	3	1	2	3									<<<<<	Insert date or 24 hour period	
Eating																		
Grooming																		
Bathing																		
UE Dressing																		
LE Dressing																		
Toileting																		
		1	2	3	1	2	3				1	2	3	1	2	3		
Bladder																		
Bladder accidents	___																Bladder accidents	
Bowel																		
Bowel accidents	___																Bowel accidents	
		1	2	3	1	2	3				1	2	3	1	2	3		
Bed/Chair Transfer																		
Toilet Transfers																		

# This is what you need to do

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- ρ Start now to assess your FIM™ risk by determining the accuracy of the FIM™ scoring
- ρ Use my tools to identify and isolate problems
- ρ Establish a plan of action
- ρ Take a leadership position and develop a sense of urgency
- ρ Must include FIM™ scoring accuracy as part of your ongoing audit process to assure a secure tomorrow

# Implications of FIM™



## Scoring and Pay for Performance



# Thank You

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