Staffing Rehab Nursing Appropriately Using Patient Daily Acuity

May 16, 2012

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Presentation Agenda

- Webinar Series Overview
- Medicare IRFPPS
- Patient Daily Acuity and Care Demand
- Fine Tuning Care Demand
- Staffing To Meet Care Demand
- Management Insights
Webinar Series Overview: Description of Events

- This Webinar is the 1st in a series of three MediServe Webinars that describe how to appropriately staff rehab nursing using Patient Daily Acuity
  - Presentation of foundational concepts that managers and staff need to understand to successfully implement a rehab nurse staffing system that is based upon Patient Daily Acuity

- The 2nd Webinar in this series will demonstrate a working MediServe software solution that has been designed and built around the concepts presented in the 1st Webinar

- The 3rd Webinar will present various methods to utilize Patient Daily Acuity data to optimize the quality of rehab nursing care, manage rehab nursing cost, and minimize the occurrence of sentinel events
Webinar Series Overview: MediServe

- Founded in 1985
- Headquartered in Chandler, AZ (Phoenix)
- Software solutions that serve post-acute care
  - Inpatient Rehabilitation
  - Respiratory
  - Outpatient Rehabilitation
  - Private Practice Rehab Therapy
- Major focus on Inpatient Rehabilitation Facilities (IRFs)
  - MediLinks IRFPPS first offered in 2002 at inception of IRFPPS
  - Deep knowledge of Medicare IRFPPS program
  - Committed to solving ongoing challenges faced by IRFs
  - Maximize the quality and efficiency of care delivery
  - Optimize revenue cycle management & regulatory compliance
- We measure our success by our clients’ success
Webinar Series Overview:
St. Luke’s Rehabilitation Institute

- Founded in 1994
- Located in Spokane, WA
- Largest freestanding IRF in the Inland Northwest
  - Serves central and eastern Washington, northern Idaho, and western Montana
  - 102 bed inpatient rehabilitation hospital
  - Medical office building and outpatient clinic
  - Comprehensive stroke, spinal cord, brain injury, and orthopedic programs
  - Three outpatient rehabilitation clinics
- Key differentiator is value of care
  - Highest quality of care at lowest possible cost
  - Focused use of technology to streamline operations and improve care coordination
  - Data-driven change management culture
Chief Nurse Executive at St. Luke’s Rehabilitation Institute

25+ years nursing leadership experience
  Â Has held a variety of positions in acute care, long term care, and inpatient rehabilitation
  Â Has been involved in start-ups, program expansion and closures, and turnarounds

Holds a Master’s Degree from Texas Woman’s University

Fellow in the American College of Healthcare Executives (FACHE)
Medicare IRFPPS
Patient Assessment (days 1 – 3)

- Motor FIM® Score
- Cognitive FIM® Score
- Age

Patient IRF-PAI (day 4)

- Case Mix Group (CMG)
- Comorbidities

Medicare Payment & Acuity

- Case Mix Index (CMI) & Payment
Medicare IRFPPS: Patient Assessment

- Nursing and therapy staff perform patient FIM® assessments
  - Days 1 through 3
  - Day 4 until 3rd day before discharge
  - During last 3 days of stay in any contiguous 24 hour period

- FIM® assessments determine ALOS and CMI
  - ALOS (Average Length of Stay) is the “guide post” used to help establish the timeline for each patient’s Plan of Care
  - CMI (Case Mix Index) is a numeric value that describes each patient’s functional impairment

- ALOS and CMI determine treatment and payment
  - Plan of Care (POC) uses ALOS and CMI
  - CMI determines Medicare payment
RIC 1 - STROKE: The Effect of FIM® Scoring On FY 2012 Payment Rate, CMI, and ALOS

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(1) - Tier A = no comorbidities
(2) - Difference calculated from CMG 0107, not CMG 0108
Medicare IRFPPS: Quality and Value

- If you are a clinician that treats patients
  - Thoroughly understand each of the 18 FIM® items
  - Know the difference between a FIM® assessment and a therapeutic intervention
  - Perform FIM® assessments in the proper setting
  - Be objective and accurate when performing assessments

- If you manage clinicians
  - Ensure that clinicians thoroughly understand each of the FIM® items that they routinely assess
  - Ensure that FIM® assessments are completed on-time
  - Continually reinforce proper setting and objectivity
  - Monitor the quality of clinician FIM® assessments

- The Goal: To deliver the highest quality patient care that produces the best possible patient outcome at the lowest possible cost [greatest value]
Medicare IRFPPS: Leveraging IRFPPS Data

- IRFPPS data has important and relevant clinical value
  - RICs categorize a population’s functional impairment
  - Tiers describe the impact of comorbidities on impairment
  - FIM® scores describe caregiver ADL burden of care
  - CMI is a reliable measure of patient acuity

- IRFPPS data can tell us
  - Each patient’s Daily Acuity
  - How much and what type of care each patient needs
  - What effect our care is having on our patients

- IRFPPS data is challenging to use
  - Clinical application of data is not widely understood
  - Data isn’t available; it’s not required over entire stay
  - Most IRFs don’t have skills or time to create software tools
Medicare IRFPPS:
IRFPPS Data Example

Admit CMI: 2.1000
Discharge CMI: 0.9900
CMI Gain: -1.1100

Discharge FIM®: 82.00
Admit FIM®: 44.80
FIM® Gain: 37.20

Patient Progress To Date

Day of Stay

Functional Improvement

Case Mix Index
CMI Trend
Total FIM® Score
How can IRFPPS data be used to inform and guide clinical and business practice?
Patient Daily Acuity and Care Demand
The degree of functional and medical impairment present in the patient as measured at a prescribed time each day
- Fine tuned each shift for every day of their stay

Rehab nursing Patient Daily Acuity is expressed as the Hours Per Patient Day (HPPD) that the patient is dependent upon another person for each of the following types of nursing care:
- ADL care
- Medical/surgical care
- Rehab nursing care
Patient Daily Acuity: Impairment Measurement

- Requires the use of a science-based system that can accurately describe functional impairment across widely varying patient populations
- Must demonstrate repeatable functional impairment measurement accuracy
- Must already be in wide use and accepted by IRFs
- The FIM® assessment instrument, as licensed by Medicare for the IRFPPS, is the measurement tool used to determine rehab nursing Patient Daily Acuity
Care Demand is the total amount of time for each type of nursing care across all in-census patients. To calculate it you must know:

- Each patient’s daily ADL care need
- Each patient’s daily med/surg nursing care need
- Each patient’s daily rehab nursing care need

Care Demand must be allocated by nursing unit to support unit-level staffing requirements

- Nursing units often use a unique combination of nurse types (i.e., RN, LPN, or CNA) that is different from other units
Patient Daily Acuity: Calculating Care Demand

- FIM® scores are used to calculate each patient’s daily ADL Care Demand
  - UDSMR® “Rule of Thumb” Burden of Care (Granger, et al)

- CMI is used to calculate each patient’s daily med/surg Care Demand
  - Modulates average med/surg HPPD to account for each patient’s functional impairment (including comorbidities)

- Each patient’s daily rehab nursing Care Demand is determined by the institution
  - Historical practice
Fine Tuning Care Demand
Each in-census patient must have their “baseline” Care Demand calculated at a prescribed time each day:

- Establishes each patient’s current functional status for the next 24 hours
- Calculation uses the patient’s lowest FIM® scores, looking back 24 hours from each day’s prescribed time, to calculate their baseline Care Demand
- Baseline Care Demand is used as the starting point from which each patient’s Care Demand can be fine tuned for any shift (if needed) during the upcoming 24 hours
Fine Tuning Care Demand: A Complex Process

- Administrative Needs
- Census
- Baseline
- Safety
- Situational Acuity
Fine Tuning Care Demand: Issues

- Many factors that occur after the calculation of patient baseline Care Demand influence the total Care Demand that is used for staffing
  - Ongoing changes in census
  - Patient Situational Acuity
  - Safety (e.g., one-on-one, sitters, et al)
  - Administrative needs

- Care Demand must be fine tuned shift-by-shift to account for the influence of these factors

- Appropriate rehab nurse staffing is dependent upon accurately fine tuning Care Demand
Fine Tuning Care Demand: Changing Census

- Ever-changing census has a dramatic impact on Care Demand
  - Census is the number one factor that causes Care Demand variation
  - Admissions can spike Care Demand while discharges can cause Care Demand to plummet suddenly

- Planned admissions and discharges provide early warning of upcoming changes in Care Demand

- Temporary out-of-census situations affect Care Demand
  - Examples include family visits, doctor appointments, tests, etc.
Fine Tuning Care Demand: Situational Acuity

- Individual patients may require temporary periods of increased care due to Situational Acuity
  - Occurs only for a brief period of time then subsides
  - Examples include UTI, transfusion, bedside dialysis, etc.
- Not included in admission case impairment assessment
- Should only occur infrequently
Fine Tuning Care Demand: Safety

- Patient safety needs (e.g., sitters, one-on-ones, etc.) complicate the calculation of Care Demand
  - The patient’s safety needs may be provided by either a family member or a nurse
  - The patient may need safety services at times that don’t coincide with nursing shifts

- Safety patients require more and different care than regular patients
  - Safety care can significantly increase Care Demand in nurse staffing plans
  - Safety must be accounted for in any nurse staffing plan
Administrative needs may require adjustment of Care Demand

- Low census triggers minimum nursing coverage
- State-mandated nurse-to-patient ratios require a minimum number of nurses that exceed the number of nurses specified by the Care Demand calculation
Patients and their individual Care Demand are organized into units

- Unit assignments are based upon each patient’s actual bed assignment in the hospital admission system
- Enables nurse managers to staff nurses based upon the unique Care Demand “profile” of each unit
- Provides the ability to report nurse staffing activities by unit

Unit Care Demand is aggregated into hospital-wide Care Demand

- Nursing leadership can see the nurse staffing “big picture”
- Staffing decisions can be made at the correct organizational level
Staffing To Meet Care Demand
Staffing Care Demand: Staffing Overview

- The Patient Daily Acuity staffing approach compliments existing rehab nurse scheduling workflow
  - The “long range” nursing schedule (usually covering 4 – 12 weeks into the future) continues to be managed as it has in the past
  - The long range nurse schedule is used as the starting point for the next 24 hour nurse staffing plan
  - Nurse managers fine tune each shift’s staffing plan 2 – 3 hours before shift start to satisfy Care Demand
  - Floats, split shifts, call-ins, and call-offs are taken into account
  - Actual hours worked, by nurse, are documented to identify variance
Staffing Care Demand: Creating The Staffing Plan

- Care Demand provides a staffing target, by unit and shift, based upon Daily Patient Acuity
- Nurse managers fine-tune Care Demand based upon
  - Ongoing changes in census
  - Patient Situational Acuity
  - Safety (e.g., one-on-one, sitters, et al)
  - Administrative needs
- Nurse managers use the adjusted Care Demand target to create a staffing plan for each unit until the Care Demand target is reached
After each shift is complete, the actual hours worked, by nurse, are recorded

- Provides nursing leadership with a plan-vs-actual understanding of each shift’s staffing results
- Identifies those activities that created variance from the staffing plan (e.g., unexpected admissions and discharges, staff illness, etc.)

Nursing management uses variance data to improve nurse staffing function and results
Management Insights
Management Insights: Variance

- Comparison of Plan vs. Actual staffing, by shift, yields an understanding about
  - The true cost of Patient Daily Acuity nursing vs. budget assumptions
  - Opportunities to reduce overtime
  - Adequacy of admission assessment (excessive Situational Acuity)
  - Nurse manager scheduling patterns

- Variance insight is available only if
  - Staff perform FIM® assessments accurately every time a change in patient functional status is observed
  - FIM® assessments are captured electronically and used with nursing standards of practice to calculate Patient Daily Acuity every day
Nursing-sensitive Quality Indicators are directly linked to nurse staffing

- Patient Daily Acuity defines the number and type of nurses that are required to properly care for each shift’s patient population

- Studies show that nursing-related sentinel events are most often attributed to nurse staffing issues

- Patient Daily Acuity provides nursing management with the ability to avoid nurse staffing issues and the associated risk and expense of sentinel events
Wrap-Up
Wrap-Up: What We’ve Learned

- FIM® assessments are very important – for many reasons
- IRFPPS data is valuable but hard to obtain and work with
- Patient Daily Acuity is obtained from IRFPPS data and your institution’s nursing standards of practice
- Calculating Care Demand is a complex process that involves a lot of “moving parts”
- The risk and expense of sentinel events can be minimized using Patient Daily Acuity nurse staffing
Questions
Wrap-Up: Follow-Up

For questions about what you’ve learned during this Webinar please contact the following:

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