Collapsing the Seven Level Scale for Pre-admission Screening

By Dr. Pamela Smith, President and CEO, ITHealthTrack, Inc.

Dr. Pamela Smith

Pre-admission screening is intended to identify patients who are appropriate candidates for inpatient rehabilitation services. One means of determining whether a patient requires hospital level rehabilitation care is to compare pre-admission functioning to current functioning and to make a prediction regarding the patient's potential to achieve significant practical improvement within a reasonable length of stay. Functional recovery is affected by many factors including medical status, motivation, cognition, social support and endurance, just to name a few, but information about previous and current functioning have proven to be very strong indicators of recovery.

One of the most challenging aspects of pre-admission screening is to get reliable information on patients' current functional status. There are several barriers to getting this information. While therapists working in medical/surgical hospitals use common terms such as minimal, moderate and maximal assistance, there are many differences in the way those terms are applied to activities. Therapists working in an inpatient rehabilitation setting use the Functional Independence Measure, which has item definitions. For example, a physical therapist (PT) in the hospital may report that a patient walks 40 feet with minimal assistance, but a PT working in an inpatient rehabilitation facility would report that same patient as needing total assistance because the item definition includes a modifier that factors in distance. Expecting a pre-admission screener to administer a functional assessment is not feasible. Maintaining good relationships with referral sources include keeping the process smooth and convenient. Finally, admission decisions need to be made quickly in a competitive environment. For all of these reasons, collapsing the Functional Independence Measure's seven level scale back to its original four level scale offers a method that may be very useful.

Upcoming revisions to the Medicare Benefit Policy Manual (MBPM) will bring greater attention to the consistency of information gathered at preadmission compared to admission. Wide discrepancies in functional assessment data gathered at these two timeframes will be problematic. One possible solution is to simplify the pre-admission functional assessment by using a four, rather than a seven level scale. Pre-admission screeners would be more likely to classify a patient correctly into major gradations of the scale from information derived from chart review and information reported by the patient or family.

The Functional Independence Measure was developed by a Task Force, beginning in 1984. Through a series of meetings that spanned over two years, the Task Force laid out the data elements, impairment groupings and a simple functional assessment scale. The intent of the Task Force was to develop a data set and functional assessment instrument that would be placed in the public domain and could be used universally. The Functional Independence Measure originally had a four level scale. In the Independent or "No Helper" category, there was Complete Independence scored at level 4 and Modified Independence scored at level 3. In the Dependent or "Requires Helper" category, there was Modified Dependence scored at level 2 and Complete Dependence scored at level 1. Clinicians had the option to make finer distinctions to Modified Dependence (supervision, minimal assistance and moderate assistance). Originally, Complete Dependence included maximal and total assistance. Using the four level scale for pre-admission screening would allow screeners to communicate which activities were limited by residual impairment without having to make finer distinctions which may not coincide with the admission assessment. Once it was determined that a helper was required for an activity to occur, then the screener would only need to decide if the patient provided half or more of the effort versus less than half of the effort (Modified or Complete Dependence).

The seven level scale of the Functional Independence Measure came about because clinicians wanted to be able to document change with greater

precision. According to the four level scale, if a patient was admitted needing total assistance and was discharged needing supervision, then that patient would only have moved from a level one to a level two. This amount of change was not terribly satisfying to clinicians. With a seven level scale, the same patient gains four points, as opposed to one point by moving from a one to a five. Demonstrating change during a rehabilitation program is essential for measuring progress and outcomes. However, at the time of pre-admission screening, there is a different situation. There are two important things to document and different reasons for doing so. It is essential to document: 1) change from pre-morbid status to current status, which in most cases is striking and a four level scale would detect such change and; 2) consistency in pre-admission versus admission status, which is easier to achieve with a four level scale. A pre-admission score of 4 would translate to a 7; a score of 3 would translate to a 6; a score of 2 would translate to a 5, 4 or 3; a score of 1 would translate to a 2 or 1, upon admission. It may be more consistent if the terms Complete Independence (CI), Modified Independence (MI), Modified Dependence (MD) and Complete Dependence (CD) were used. With regard to reliability issues, the most difficult distinctions are between levels five, four and three and levels two and one. Using a four level scale would eliminate the need to make these distinctions.

It would seem to be necessary to assess all 18 items of the Functional Independence Measure when using it for pre-admission screening. Limitations in activity performance in several areas of both the motor and cognitive domains provide strong evidence of the need for interdisciplinary, coordinated services. In order to cross walk information from therapists' notes and patient, family or caregivers' information to a four level scale, pre-admission screeners will need training and testing of their proficiency. Item definitions are of particular importance. In order to classify information to the correct level, screeners will need to know what behaviors or tasks are assigned to a particular level. Knowing item definitions will be crucial for reliable assessment of function. For example, The Functional Independence Measure views a bed to chair transfer as beginning and ending in a supine position. Therefore, screeners will need to consider patients' bed mobility in addition to the activity of sitting to standing and standing to sitting. Therapists who work in the acute hospital will most likely document these activities separately, but screeners would have to gather all of the necessary data.

Admission scoring is accomplished by a team of clinicians who have three calendar days to observe patients' functional performance. Screeners gather information individually and have a very short time to communicate information to a medical director, other physician or admission coordinator for a timely admission decision. Yet, the information they gather is the basis upon which a decision is made whether or not to admit a patient. These decisions are now being scrutinized by Medicare Administrative Contractors (MACs), Recovery Audit Contractors (RACs) and others, after the fact. In addition, revisions to the MBPM will require continuity between data gathered at pre-admission and upon admission. By collapsing the Functional Independence Measure's seven level scale back to its original four level scale, screeners will capture three levels of functioning with the term Modified Dependence and two levels of functioning with the term Complete Dependence, thereby simplifying the assessment process and making it more likely to be consistent with admission scoring.

AMRPA