Northern Light Health

From the Office of Clinical Informatics

Cerner Millennium
IRF-PAI Report for EMMC & AR Gould

May 29, 2020

On June 15, 2020, the Inpatient Rehab Unit at AR Gould will begin documenting Inpatient Rehab Facility-Patient Assessment Instrument (IRF-PAI) Powerforms and exporting the IRF-PAI report within Cerner Millennium to Uniform Data System (UDS). AR Gould and EMMC will receive tasks for the IRF-PAI forms on the Multipatient Task List. The addition of this functionality is part of the Rehab Optimization efforts aimed at improving workflow efficiencies and decreasing the time spent in the electronic health record (EHR).

IRF-PAI Powerforms

IRF-PAI Powerforms will be tasked on admission to the applicable therapists. Documentation in the IRF-PAI forms will flow to the IRF-PAI Report.

NOTE: **Documentation of admission forms need to be completed within three days of admission. Documentation of discharge forms need to be completed within three days prior to discharge. If the documentation occurs outside that time parameter, the data will not flow to the report.**

- **Forms to be documented upon Admission to the Inpatient Rehab Unit**
  - **IRF-PAI Admission/Discharge Data**
    - The first two sections of this form (**Primary Impairment Group** and **IRF-PAI Admit**) are completed at the time of admission by the **Intake Coordinator** to the Rehab Unit.
    - This person may be a nurse or a Physical Therapist.
  - **IRF-PAI Quality Indicatory Admission**
    - **Sections B, H, J, K**, and **N** are documented by **nursing**.
    - **Speech Therapy** may also document in **section K** if involved with the patient.
    - **GG Sections** are documented by **Physical and Occupational Therapy**.
  - **IRF-PAI Quality Indicators BIMs**
    - **BIM**s is typically documented by the **Intake Coordinator** if a nurse.
    - **BIM**s is documented by a **Speech Therapist** if the Intake Coordinator is a Physical Therapist.
      - If Speech Therapy is not involved with the patient, the form can be documented by an **Occupational Therapist**.
- **Daily Documentation**

- PT/OT/SLP document the number units and the minutes they spend with the patient on their applicable documentation forms in the **Hybrid Time Based Charges** or **Time Spent with Patient** sections.
- The minutes will flow to the **IRF-PAI Report**.

➢ **Forms to be documented prior to Discharge of the patient from the Inpatient Rehab Unit**

- **IRF-PAI Admission/Discharge Data**
  - The last section of this form, **Discharge IRF-PAI** is documented by nursing or a therapist.
  - **Interruptions of service** are documented here.
- **IRF-PAI Quality Indicators Discharge**
  - This form is documented by nursing or the PPS (Prospective Payment System) Coordinator.
- **IRF-PAI Quality Indicators Ongoing Discharge**
  - **Occupational Therapy** documents section **GG: Self Care Functional Abilities**.
  - **Physical Therapy** documents sections **GG: Discharge Mobility Functional Abilities**, and **GG: Mobility Continued**.

Running an Admission or Discharge IRF-PAI Report

➢ The **IRF-PAI Admission Report** should be run within 3 days of Admission to the IRF unit. At EMMC, this report will be run by the PPS Coordinator.

➢ The **IRF-PAI Discharge Report** should be run after the patient has been discharged from the Inpatient Rehab Unit. This report is run by the PPS Coordinator.

STEP 1: Open the patient chart and click **IRF-PAI** in the toolbar. **IRFPAI Export Utility** opens.

STEP 2: Document the **Assessment Start and End Date.**

- Date range is limited to one month and is used to help locate patients.

STEP 3: Select **Admission Report or Discharge Report**.

STEP 4: Select the **Facility** in which the patient is located.

STEP 5: Select the **nursing unit** in which the patient is located.

- If there are more than one Inpatient Rehab Unit in the facility, both can be selected.

STEP 6: Click **Get Patient List.** The Report list opens.

NOTE: **It takes time for the patient list to open initially but subsequent occasions, it is faster.**

- The first column contains the **Patient Name** and **FIN**.
- The second column displays the **Date of Admission**.
- The third column displays the **Date of Discharge** if the patient has been discharged.
- The fourth column displays the **Length of Stay** in calendar days.
- The fifth column displays the **Report Type** that was selected.
- The last column displays the **Admission Assessment** period for the patient based on their date of admission.

STEP 7: Click **Select All** if you wish to generate a report for each of the patient's in the list or click the box(es) next to the desired patient(s).

STEP 8: Click **Generate Report.** In the **Report Type** column, for the selected patients, **Admission Report 2019 or Discharge Report 2019** is now blue and is a link to that patients report.

STEP 9: Click the **report name** in the **Report Type** column for the desired patient. **IRFPAI Export Utility** opens.

- Information in the report tabs pulls from Registration and documentation within the IRF-PAI forms.
- Each section should be reviewed and the **Save** button clicked before moving on to the next tab.
- Clicking **Cancel** will open the Patient List where a different patient can be selected.

STEP 10: In the **Patient Information** tab under Medical Information, enter **Etiologic Diagnosis** in line 22 and **Comorbid conditions** are entered in line 24. Click save after each line is completed. A response must be selected in Line 24A for **Arthritis Condition**.

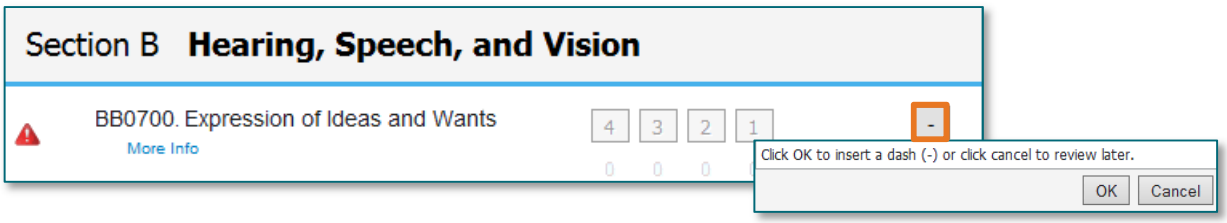
NOTE: **Diagnosis and Comorbid Conditions Codes will not stay if you open the report a second time. It is best to enter these codes last before signing the report to prevent having to enter them multiple times in the event that data is missing from the report and needs to be documented prior to sending the report.**

NOTE: **The Discharge Information tab will populate with data from the IRF-PAI discharge forms. Review this tab if the Discharge Report is being run.**

STEP 11: Review the **Therapy Minutes** tab. This information pulls in from documentation of the PT, OT, or SLP Time Spent with Patient form.

STEP 12: Review **Section B, C**, **Section GG**, and **Section H, I, J.** Boxes with different number values are present. The numbers will appear dark gray when documentation for that assessment has been documented. The number below the boxes indicates how many times that documentation has occurred. After reviewing the data, click **Save** at the bottom of each of these tabs.

- If different Therapy disciplines have documented varying results, more than one box will be dark gray. A **red triangle** will display indicating a choice needs to be made.
- Click More Info to view a description of what each number represents.
- Click the dark gray box to see the documentation for that value, who documented it and when.
- If documentation has not occurred in one of these sections, a box with a dash will display to the far right in the section. Click the box to insert a dash indicating no data or cancel to allow for documentation to occur later.

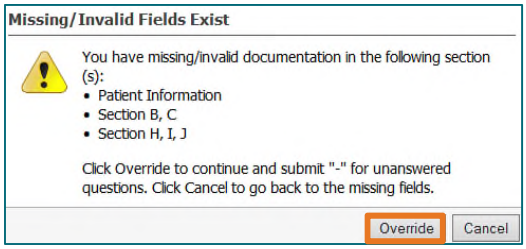


STEP 13: Review **Section K, O.** This section will pull in a diet order from the EHR. Changes can be made if needed. Click **Save**.

STEP 14: Review **Section M**. Skin Conditions will pull in from documentation of Pressure Ulcers in the Incision/Wound/Skin dynamic group.

STEP 15: Review **Section N**. This section pulls in from the Quality Indicator forms. Click **Save**.

STEP 16: The **Incomplete Items** tab will display any missing documentation in the report. This allows time for the information to be documented before signing the report.



- If missing details are present and Sign is clicked, an alert will fire indication which tab(s) have missing data.
- **Override** can be selected, if the report is to be signed without documentation of the missing information.

NOTE: **An attempt should be made to have all missing documentation completed prior to signing the report. Ask the applicable therapist to complete the documentation if needed.**

- Click **Sign**. The Patient List opens, and a blue circle will display next to the patients name in which the report was signed.

STEP 17: Click **Export Report**. The PPS Coordinator will receive a pop-up with two green checkmarks indication successful export of the report to UDS.

NOTE: **If Admission data has been entered into UDS manually, the Discharge data should also be entered manually. Use Cerner to generate and export the IRF-PAI Report on new patients or patients who have not had the Admission IRF-PAI report entered manually.**

For questions regarding process and/or policies, please contact your unit's Clinical Educator or Clinical Informaticist. For any other questions please contact the Customer Support Center at: 207-973-7728 or 1-888-827-7728.