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Chelsea Ratilainen
chelseamcgregor@yahoo.com

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Implementing the WeeFIM Outcome Measure System in Pediatric Rehabilitation

Chelsea Ratilainen, RN, BSN, CRRN, PHN

University of San Francisco

School of Nursing and Health Professions

Outcome measures are important data collection systems that generate information that can be used for continual improvement intervention strategies. Outcome measure data is a key component to reimbursement and provides a mechanism for maintaining standards and consistency. In the physical medicine and rehabilitation (PM&R) department at UCSF Benioff Children's Hospital, Oakland, (UCSFBCCHO) the multidisciplinary team provides comprehensive rehabilitation services for infants, children and adolescents with permanent and temporary disabilities. Through individualized therapy plans, the rehabilitation specialists help patients reach their full potential.

This project will focus on the implementation of a new outcome measure tool in the Outpatient PM&R department at UCSFBCHO. The Functional Improvement Measurement (WeeFIM) system is an 18-item instrument designed to track functional improvement and goal attainment for individuals or groups of children. These outcomes can be compared with national benchmarks and elevate the efficacy and consistency of care (UDSMR.org, 2017). Currently, there are very few outcome measure tools used consistently in the outpatient PM&R department. This project will aim to successfully integrate the WeeFIM system into the daily routine of our rehabilitation specialists, generate verifiable data, improve patient goals and outcomes, and support the Joint Commission and Commission for Accreditation of Rehabilitation Facilities (CARF) accreditation standards.

Clinical Leadership Theme

This project focuses on the CNL curriculum element of *Clinical Outcomes Management*. The CNL role function is Information Manager. As the CNL, I will be directing the training and implementation of the WeeFIM system and serve as a resource to the multidisciplinary team for

this project. Using the newly purchased WeeFIM internet application and clinical training materials, I will integrate the new outcome measure system into the individual care of each patient which will in turn result in more specific goals and potentiate better outcomes.

Statement of the Problem

Pediatric rehabilitation is an individualized process for each client. Generating outcome measure data for a group of clients that are so variably different is an ongoing challenge. With a patient population that range from a spectrum of musculoskeletal, neurological, cognitive and other medical conditions, it has been difficult to generate outcome data using only 1 measurement tool. Before this project, a single tool had not been identified as appropriate for the diverse range of patients. As the department aligns itself for CARF accreditation, it has become apparent that the department does not currently meet the national standard for outcome data collection. The accreditation board uses these benchmarks to measure the program's effectiveness, justify the number of patient visits and evaluate clinician performance and variability. To prepare for accreditation, several outcome measuring tools must be implemented and used constantly over a period of 6 months. For the purposes of this project, 1 outcome measure tool, the Wee FIM System, has been chosen and will be implemented for the accreditation process, the benefit of the patient, and improvement of rehabilitation services rendered.

Project Overview

The primary goal of this project is to familiarize the clinical staff with the WeeFIM tool, how to use it and the importance of using it consistently. It is imperative that each staff member interpret the tool in the same way, for the data to be uniform. The first objective is for the staff to

understand the tool. Individual reading material provided to each staff member that will be involved with using the tool. This material should be covered independently before the staff members training dates. I will work out training dates with each staff member individually. Training will be done through the online training modules. Each staff member will be required to complete the comprehensive training and complete a calibration exam. This can be done during work hours as the schedule of the individual allows. Once the training phase is complete, an in-service will be held as forum for questions and group discussion. Communication throughout this process is imperative. When the team feels comfortable using the tool, the integration will begin. The tool will be built in to the EPIC electronic medical record which will prompt each staff member to answer the WeeFIM questions for each client that they work with. The specific aim of this project is to generate WeeFIM data for 98% of outpatient rehabilitation visits over the 1st month after implementation.

Rational

To identify the unmet criteria for CARF accreditation, a self-evaluation was done. The self-evaluation is based on the CARF application. It is a general review of the application requirements and a comparison to the current practices of the department. Through this evaluation, it was identified that the department does not meet the standard for measuring outcomes. Outcome measuring tools have been implemented in the past but have not worked for several reasons. A root cause analysis (appendix A) was conducted to evaluate the shortcomings of implementations in the past. According to the data analyzed, the outcome measure tools tried in the past have been too clinically specific for the variety of conditions being measured, the interpretation of achievement was inconsistent among staff members and the data was inconsistently documented because it was not integrated in to the EMR note.

A comprehensive list of potential outcome measure tools (appendix B), recommended by CARF, was analyzed through the rehabilitation measures database (rehabmeasures.org, 2017). 40 outcome measure tools were carefully reviewed for appropriateness and relativity to the work performed by the team at UCSFBCHO. 6 measures, deemed appropriate, were reviewed further by the pediatric rehabilitation leadership team, including representatives from physical therapy, occupational therapy, nursing, neurosurgery, orthopedic surgery and neurology. The WeeFim system was determined to be the most inclusive and comprehensive tool for tracking functional outcomes for the spectrum of individual medical conditions. It was also determined by the team to be the most widely respected tool among the PM&R community and met the full accreditation requirements. According to a pilot study conducted by researchers in China, there is often an overlap of the profiles used and a lack of a common 'language' for communicating the aims of the intervention techniques. There is also a lack of a common 'jargon' to assess the objective progress and end-point of the treatment program (Yung et al., 2009). With the objective of providing a common language to the team, the WeeFIM system was chosen as the most useful. An evaluation of WeeFIM strengths and opportunities through SWOT analysis (appendix B) further supported the project.

Purchasing the WeeFIM system cost \$4100.00. The complete program was ordered, which includes inpatient and outpatient tools. The outpatient tool, which is the only portion of the system used in this project, was \$2100.00. There are 6 rehabilitation professionals that have been identified to use the WeeFIM system in the outpatient setting. Training 6 staff members requires about 4 hours of employee time per person with hourly wages ranging from \$48.00-128.00/per hour. Meeting time with multidisciplinary team is projected at \$ 2154.00. The cost of 2 EPIC consultants to build the WeeFIM system into the EMR is \$1290.00. Total training cost is

estimated \$5186.00. The cost to implement the project is projected at \$9286.00. Savings and revenue have been calculated based on patient visits, reimbursement and accreditation projections. Savings and revenue are projected to exceed \$2,566,272.00 per year within the first 3 years after implementation. The complete breakdown of project costs can be reviewed in the budget analysis (appendix D).

Methodology

To begin this project, the comprehensive list of recommended outcome measure tools provided by the Commission of Accreditation of Rehabilitation Facilities (appendix D) was reviewed. There were 40 tools evaluated in depth using the Rehabilitation Measures Database and literature review. I worked independently to comb through the list for the most comprehensive and appropriate tools for our team's needs. While many tools were deemed useful for specific clinical measurement, such as hand therapy or use of a prosthetic, I determined the WeeFIM tool to be ideal for measuring functional outcomes for our entire patient population. According to a study done by Serghiou et al., functional level of independence as measured by the WeeFIM is defined as the child's consistent and usual performance as well as the level of independence defined as the level of assistance needed by the child to perform daily living tasks effectively (Serighiou et al., 2008). This tool allows us to measure functional ability and quality of life by comparing their outcomes to their baseline. This then allows each assessment to be customized and sensitive to detecting the slightest changes in each client's unique condition.

Success in the workplace depends not only on the ability to complete the required job duties, but also to participate in the wide range of communication and social activities that are

seen in the workplace (Storey, 2007). It is critical, when implementing a new practice on a unit, that staff members feel included and well prepared. For a project to be successful, the staff must feel supported, have resources for answering questions and understand the reasoning for the project. In the spirit of communication, this project will be disseminated to the team in a few different modalities. The initialization of this project will begin with a meeting and discussion among staff members involved. This clinical team includes 2 physical therapists, 2 occupational therapists and 2 registered nurses. The 6 team members will sit down to be oriented to WeeFIM and this project. The team will review why the tool is important, how it is used, what will be expected of them and review the timeline for implementation. The forum will meet both before implementation and after training to ensure staff feel completely comfortable and all questions and concerns are addressed. Written reading material will be provided to each team member to review before training. Training will be done through the WeeFIM online application. I will work earnestly to make sure the team knows that I will be a resource throughout this project. For the entire process, I will be available to answer questions.

After completing the training module, a calibration exam is used to determine that each staff member is measuring the outcomes in the same way. The tool is ineffective if the results are too subjective. Once the calibration exam data determines the staff is ready to begin use with the tool, the tool will “go live” in the electronic medical record (EMR). The tool will ask 18 objective measurements on each client’s functional ability at the end of every assessment. Because the tool will be integrated in to the EMR, reports on frequency of use can be easily generated to compare to the projects projected goals.

I am predicating that after 1 month of use, the reports will generate 100% staff compliance of use. The project’s primary goal of 98% compliance, allows room for unusual

occurrences that might result in unmeasurable exam visits. These goals and predications will be compared to the EMR reports.

Kurt Lewin's 'changing as three steps' (unfreezing, changing, refreezing) is regarded by many as the classic or fundamental approach to managing change (Cummings, 2016). This approach to change is simple and straightforward. It can be easily applied to this project as a guide for change. In the unfreezing stage the problem is identified and communicated; outcome measures are not currently used with consistency and uniformity. In the changing phase, the team is trained and communication and feedback are open and fluid. In the refreezing stage, the tool becomes widely accepted and is used as part of the regular routine. This approach is appropriate for this project because it allows me, the project leader, to focus precisely on the objectives of the project and gauge clearly when each stage has been achieved deeming the team ready to move forward.

Literature Review

Choosing the WeeFIM tool required a great deal of research, comparing different outcome measures and analyzing the quality of the tool itself. The literature surrounding the WeeFIM tool generally supports its success as a functional measurement system. The following PICO statement was used to find literature to support this project:

The population is pediatric rehabilitation patients ranging from 6 months to 21 years of age, with short term or chronic conditions that effect their function.

The intervention is the use of outcome measure tool to compare personal baseline to personal developmental outcomes to create and measure goals.

The comparison is not having defined goals. Not comparing outcomes to baseline. Not using outcome measure tool.

Better patient outcomes is the outcome of interest.

Using this PICO statement focused the literature review search and yielded a wealth of information that supported use of the WeeFIM system.

As mentioned, literature review was done in many stages of this process. While choosing the right outcome measure tool, the Canadian Occupational Performance Measure tool was also thoroughly analyzed as a potential candidate. In an article by McIntyre, Nokav, Lannin and Lowe, researchers investigate the relative utility of Canadian Occupational Performance Measure (COPM) (adapted for children) and Goal Attainment Scaling (GAS) as outcome measures for pediatric rehabilitation (Cusick et al, 2006). While the COPM system may still be purchased and implemented in the department, it focuses assessment toward occupational therapy. The WeeFIM system proved to be more well-rounded for the multidisciplinary assessment this project was aiming to achieve. COPM and WeeFIM were the top 2 candidates chosen by the Pediatric Rehabilitation Leadership team.

Once the WeeFIM system was chosen, the literature review became focused on the validity of WeeFIM and the specific population of patients. The American Journal of Physical Medicine and Rehabilitation published a study that compared 134 children with cerebral palsy that were assessed using the WeeFIM system. Reliability was tested by internal consistency, intraclass and interrater correlation coefficients (ICCs), internal construct validity by Rasch analysis, and external construct validity by correlation with the Denver II Development Test (Ayabay et al., 2007). The PM&R department at UCSFBCHO serves a great deal of patients with

cerebral palsy. Through this publication, I was able to validate the use of WeeFIM for a large demographic of our patient population.

Patients suffering from traumatic brain injury (TBI) are another large subcategory of patients served in the rehabilitation department. In the American Journal of Physical Medicine and Rehabilitation, another article was published that evaluated and described functional capability at admission and discharge of children with TBI in rehabilitation settings. Using the WeeFIM tool, researchers were able to uniformly measure the client throughout the process. This article again, validated the use of WeeFIM for our specific demographic.

In an article by Thomas-Stonell et al., researchers assess the relative responsiveness of nine outcome measure scales through evaluation of 33 children and adolescents (aged 4–18 years) who had sustained traumatic brain injuries. Scales were selected to evaluate outcomes from each of the World Health Organization (WHO) International Classification of Functioning, Disability and Health domains (Thomas-Stonell et al., 2006). Reviewing the comparison of different tools supported the choice to use WeeFIM and projected viable outcome measure tools to be implemented in future projects.

A study by Yung et al., supported use of WeeFIM for children with neurodevelopmental disabilities; another subset of the departments client base. In this study, researchers evaluated the use of WeeFIM in monitoring neurorehabilitation programs for children in China (Yung et al., 2009). While our departments benchmarks will be compared to national data, it is important to understand the developments of rehabilitation programs around the world.

Once the WeeFIM tool was chosen for outpatient rehabilitation, it became a question of which system was most appropriate to buy. While the outpatient tool could be purchased

independently, it was important to understand if the tool would benefit the inpatient department as well. Purchasing both systems together offered a handsome discount. The PM&R Journal of Injury published an article that described the sociodemographic characteristics and inpatient rehabilitation outcomes of children with developmental disabilities. Children with developmental disabilities have worse rehabilitation outcomes compared to other children despite longer length of stay. This highlights the need to pay special attention to the inpatient population during rehabilitation planning and anticipate intrinsic barriers to rehabilitation success which the WeeFIM system can help monitor. Through the evidence in this article, it was decided that both systems would be purchased together.

The literature review was enlightening as far as how versatile the WeeFIM system is. By reading studies that used WeeFIM for such a variety of different patients the department serves, it became increasingly obvious that this tool would suit our purposes perfectly.

Timeline

The timeline for this project will span 2 months. While the project does not end in 2 months, this timeframe will include the implementation and first month of use. The project will begin June 1, 2017 and end July 31, 2017. In this time, the outcome measure will be chosen, researched, and approved, the personnel will be trained, all concerns will be addressed and the 1st month of data will be collected and compared to projections and goals. Refer to appendix G for timeline details and calendar.

Expected Results

Outcome measure tools benefit the staff and patients in many ways. I expect this project

to create verifiable data that demonstrates the achievements of individual patients, groups of patients and overall program performance. I expect this data to support Joint Commission and CARF accreditation efforts. I expect compliance from staff and uniform assessment. I expect elevated care delivery by creating measurable goals, identifying individual achievement and collaboration of the multidisciplinary team. Using the WeeFIM tool should also create more reliable expectation for patients and families because the WeeFIM tool can predict the burden of care for families and caregivers. This should help the team determine the family's needs and allow us to connect them to the most appropriate community resources.

Nursing Relevance

Measuring functional abilities at baseline and throughout the rehabilitation process will improve our nursing understanding of each individual and groups of patients. The WeeFIM system helps us understand our clients on an objective level and challenges us to recognize even the slightest changes in their abilities. The WeeFIM system also allows us to compare our patient outcomes to the regional and national data collected by PM&R teams using WeeFIM around the country. While our team does create goals in our current care system, WeeFIM will help us focus and individualize each client's goals to their ability and functional level. Using WeeFIM from beginning to end will create data that validates the number of patient visits and support reimbursement. While I do not intend to standardize care to the point that the individual nurse's contribution is dissolved, I hope that standardizing the way outcomes are documented will improve our continuum of care.

Summary Report

The implementation of the WeeFIM system on the outpatient pediatric rehabilitation unit

at UCSFBCHO started on June 1, 2017 as projected. The first phase of the project, formal staff training and discussion, went according to the projected timeline and was met with overwhelming staff enthusiasm and support. As designed, 6 rehabilitation professionals underwent training and passed the calibration exam. All 6 staff members demonstrated uniform assessments and variability was insignificant.

Building the WeeFIM system in to the EPIC EMR was not possible in the designated timeframe. The hospital put a build freeze on the EMR because of larger projects that took precedence. The WeeFIM system build is rescheduled for January 2018. For the purposes of this project, adjustments were made. The project readjusted to a manual implementation of the WeeFIM system. In addition to EMR charting, participating staff members were asked to submit a handwritten WeeFIM assessment for each client. While this revision created more variability, the goal of 98% staff compliance in the first month remained the same.

On July 1, 2017, the tool was implemented as projected. The 6 staff members have worked diligently for the 1st month and have exceeded the targeted goal of 98% compliance, with a 100% compliance rate. A submission on paper of each outpatient's WeeFIM assessment has been collected and will be used for comparison as their therapy moves forward.

Feedback from the involved staff members has revealed some unanticipated dilemmas for the future of this project. The most concerning problem is that the WeeFIM assessment takes more time than is allotted in an average outpatient visit (about 30 minutes to 1 hour depending on the visit type). In the first month of use, the average assessment took about 20 minutes. While the assessment covers a lot of valuable information, relevant to the visit, it takes time away from the therapy and discussion time for each visit. I project that over time, the assessment will

become more streamlined and move more quickly. 100% of the visits in the 1st month were gathering baseline data, which I project takes longer than subsequent data collection. None the less, this is an issue that must be addressed moving forward.

While the 1st month goals were met, I anticipate compliance to deteriorate somewhat in coming months because this is a handwritten assessment and because of the time constraints on the patient visit. It is important that the quality of time spent with the patient is not compromised by this assessment tool. Reassessment by the multidisciplinary team will be necessary to determine the best way to manage the visit time as well as continue to collect the data required for the CARF accreditation and the improved patient outcomes.

The WeeFIM system is an assessment of 18 categories which include, eating, grooming, bathing, dressing upper body, dressing lower body, toileting, bladder management, bowel management, transfers to chair, transfers to toilet, transfer to tub, locomotion (walk, wheelchair, crawl), locomotion (stairs), comprehension, expression, social interaction, problem solving and memory. Based on the professional assessment of each category by the trained staff member, the client is placed in a WeeFIM “step” (appendix H). The steps are used to identify progress overtime. The current data collected only shows baseline data and therefore client progress cannot be identified until more data points are collected for each patient.

The sustainability of this project in its current form is questionable. Staff members have made a valiant push to comply with the initial data, but moving forward their concerns must be addresses as they are real problems. We must consider extending the visit time, which will limit the number of potential visits per day. We may also need to revisit the other outcome measure tool options to find a tool that can be used in a more efficient time model. It will also be

interesting to see how much time the assessment takes once the baseline data has been collected. Subsequent assessments should take less time. A majority of clients will have baseline data collected after the first quarter. Only new patients should need baseline data after that.

After evaluating the 1st month of implementation, this is still a viable project with potential to be more streamlined. It is still evident that the savings and revenue will be exponential and the benefits far outweigh the project limitations. There is potential for improvement with the assessment built in to the EMR and the continued familiarity of staff members. This project will be moved forward for the coming year.

In conclusion, the implementation of the WeeFIM system in the pediatric rehabilitation unit at UCSFBCHO was successful and the initial goals were met without many barriers. This project will continue to move forward with full support from staff and leadership. As the project director, I have new goals to streamline the process and simplify the charting element in future months. I continue to believe in this project and I look forward to presenting this valuable data to the families we serve and the accrediting bodies.

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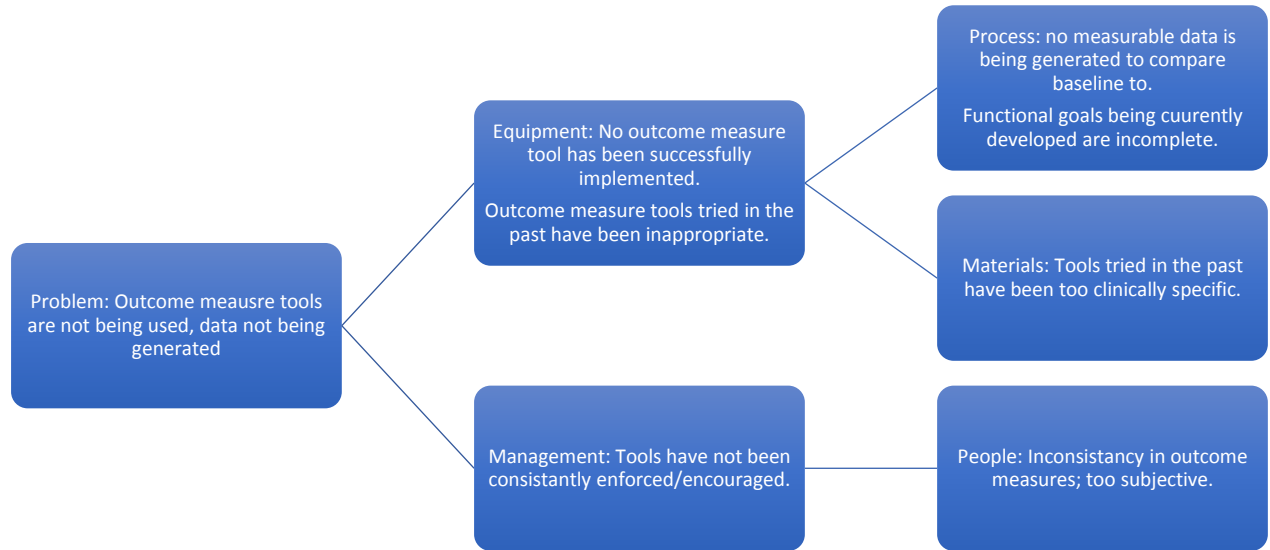
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Appendix A


Root Cause Analysis Fishbone Chart



Appendix B

Outcome measure tools recommended by CARF

INFORMATION AND OUTCOMES MANAGEMENT (IOM)

Identify any outcomes systems used. 

Check all that apply.	Name	Description
<input type="checkbox"/>	Activity Measure-Post Acute Care (AM-PAC)	
<input type="checkbox"/>	eRehabData	
<input type="checkbox"/>	Focus on Therapeutic Outcomes (FOTO)	
<input type="checkbox"/>	IT Healthtrack	
<input type="checkbox"/>	MedTel Outcomes	
<input type="checkbox"/>	National Outcomes Measurement System (NOMS)	
<input type="checkbox"/>	Outpatient Physical Therapy Improvement in Movement Assessment Log (OPTIMAL)	
<input type="checkbox"/>	ProMOS System/RehabCare	
<input type="checkbox"/>	UDS/LifeWare	
<input type="checkbox"/>	UDS-PRO/UDSMR	
<input type="checkbox"/>	Other pooled data system (specify)	
<input type="checkbox"/>	None	

Identify any outcomes tools/measures used. 

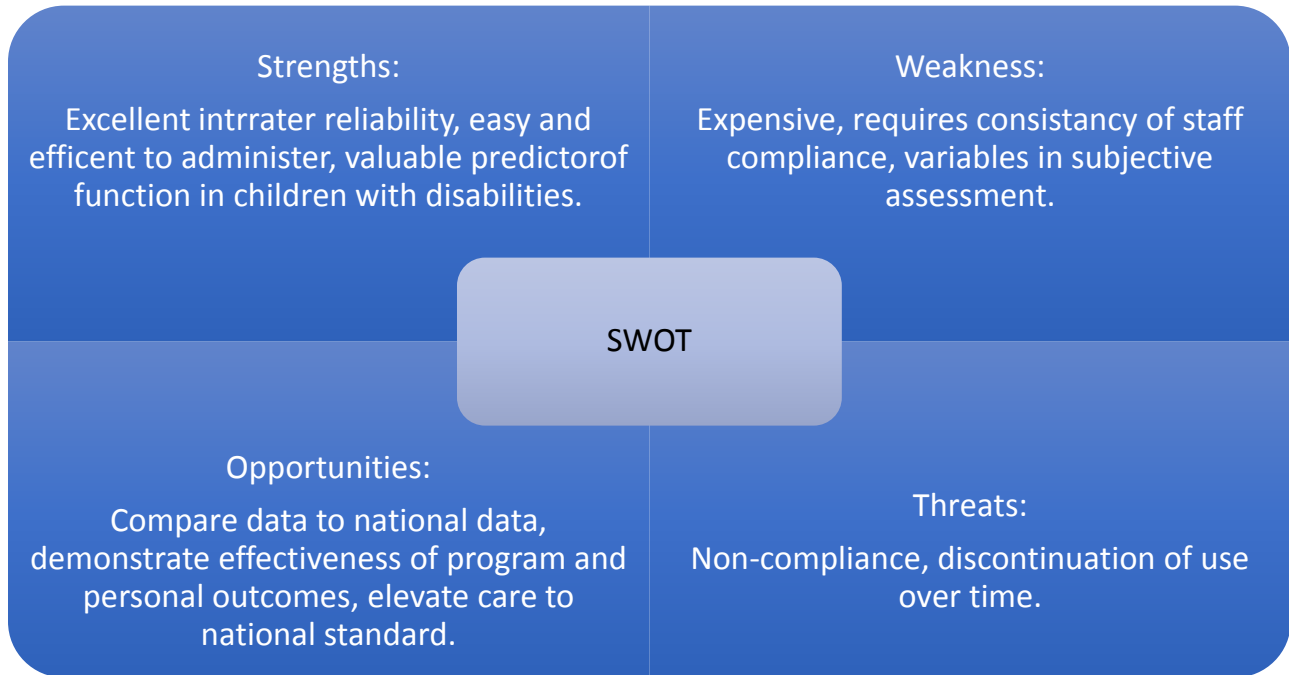
Check all that apply.	Name	Description
<input type="checkbox"/>	Canadian Occupational Performance Measure (COPM)	
<input type="checkbox"/>	Community Integration Questionnaire (CIQ)	
<input type="checkbox"/>	Craig Handicap Assessment Rehab Tool (CHART)	
<input type="checkbox"/>	Diener Satisfaction with Life Survey (SWLS)	
<input type="checkbox"/>	Disabilities of the Arm, Shoulder and Hand (DASH) Outcome Measure	
<input type="checkbox"/>	Disability Rating Scale (DRS)	
<input type="checkbox"/>	Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI)	
<input type="checkbox"/>	Mayo-Portland Adaptability Inventory (MPAI-3, MPAI-4)	
<input type="checkbox"/>	Minimum Data Set (MDS)	
<input type="checkbox"/>	Neck Disability Index (NDI)	
<input type="checkbox"/>	Oswestry Disability Index	
<input type="checkbox"/>	Roland Morris Disability Questionnaire	
<input type="checkbox"/>	SF-12/SF-36	
<input type="checkbox"/>	Supervision Rating Scale (SRS)	
<input type="checkbox"/>	Visual Analog Scale/Pain Rating Scale	
<input type="checkbox"/>	Other published outcome tool (specify)	
<input type="checkbox"/>	Organization-developed/unpublished outcome tool	

Identify any satisfaction tools used. 

Check all that apply.	Name	Description
<input type="checkbox"/>	Avatar Patient Survey	
<input type="checkbox"/>	Gallup Patient Quality System/Patient Satisfaction	
<input type="checkbox"/>	Jackson Group Customer/Patient Satisfaction	
<input type="checkbox"/>	National Research Corp (NRC+Picker) Patient Satisfaction	
<input type="checkbox"/>	Press Ganey Patient/Resident Satisfaction	
<input type="checkbox"/>	Professional Research Consultants (PRC) Patient/Consumer Perception Survey	
<input type="checkbox"/>	uSPEQ Consumer Experience Survey	
<input type="checkbox"/>	uSPEQ Employee Climate Survey	
<input type="checkbox"/>	Other published patient satisfaction (specify)	
<input type="checkbox"/>	Other published stakeholder satisfaction (specify)	
<input type="checkbox"/>	Organization-developed/unpublished satisfaction tool	

Appendix C

SWOT Analysis of WeeFIM System



Appendix D

Budget Analysis**Product**

Inpatient WeeFIM Outcome Measure tool:	\$2100.00
Outpatient WeeFIM Outcome Measure tool:	\$2100.00
Inpatient and outpatient tools purchased together:	\$4100.00

Personnel

Physical Therapists hourly rate:	\$52.00
Occupational Therapists hourly rate:	\$48.00
Nurses hourly rate:	\$78.00
Neurosurgery meeting consultant hourly rate:	\$128.00
Orthopedic surgery meeting consultant hourly rate:	\$111.00
Neurology meeting consultant hourly rate:	\$126.00
EPIC analyst hourly rate:	\$81.00

Personnel Time:

Training and meeting with 2 Physical Therapists for 8 hours:	\$832.00
Training and meeting with 2 Occupational Therapists for 8 hours:	\$768.00
Training and meeting with 2 RNs for 10 hours:	\$1560.00
Meeting with leadership team (1 Neurosurgeon, 1 Orthopedic Surgeon, 1 Neurologist) for 2 hours	\$730.00
Building WeeFIM into EPIC: 2 consultants for 8 hours:	\$1290.00
TOTAL PERSONNEL COST:	\$5186.00
TOTAL WeeFIM PURCHASE COST:	\$4100.00
TOTAL IMPLEMENTATION COST:	\$9286.00

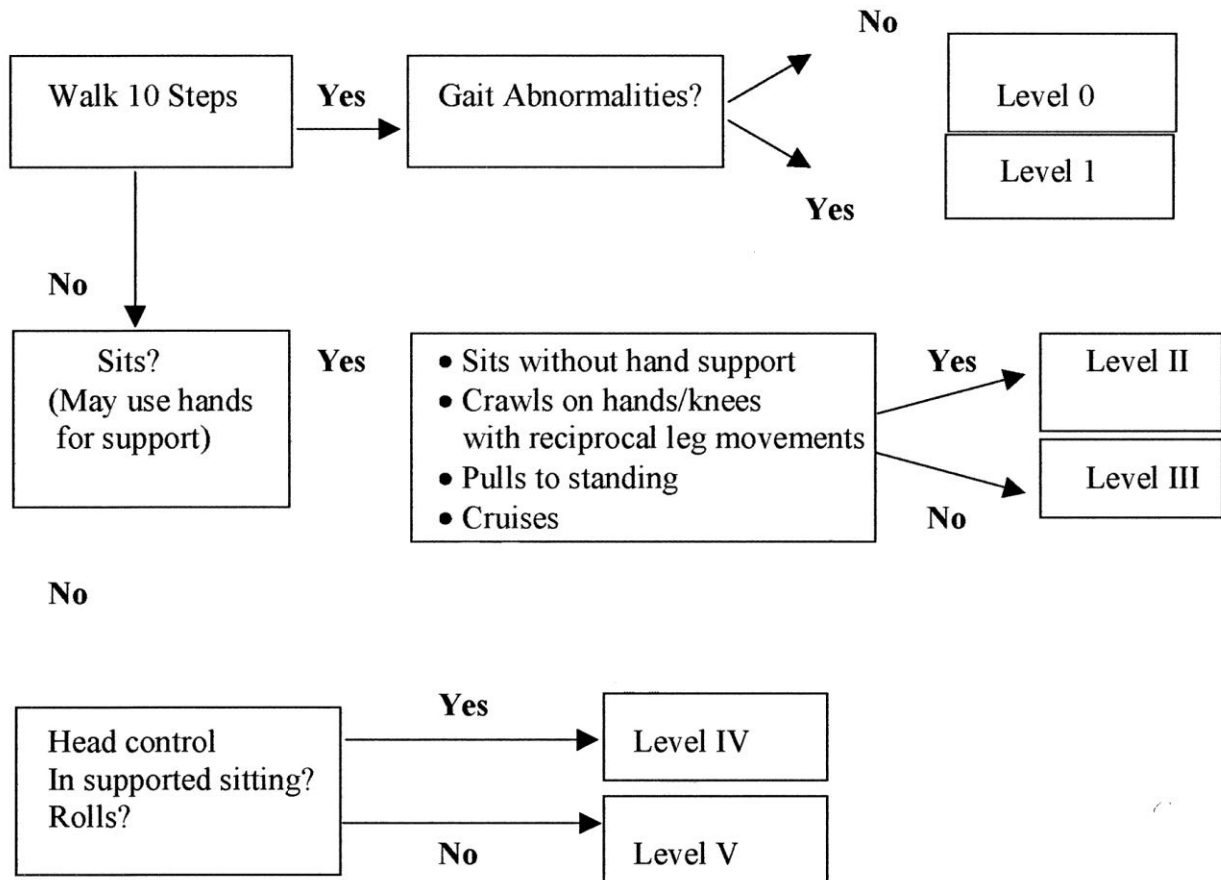
Savings and Revenue

Average number of additional, justifiable visits based on WeeFIM data per client per year: 2	
Projected reimbursement per outpatient visit:	\$489.00
Average number of clients seen per year before CARF accreditation:	1,112
Current number of average visits per client per year:	2
Number of projected referrals after CARF accreditation per year:	200

After implementation of project and achievement of CARF accreditation 1,312 clients are projected to be seen each year, with an average of 4 visits per year. This is a total of 5,248 outpatient visits per year with an average reimbursement rate of \$489.00 per visit. This is a total revenue of \$2,566,272.00 per year. I project that this revenue stream will be achieved yearly within the 1st 3 years after implementation.

Appendix E

GMFCS Flow Chart



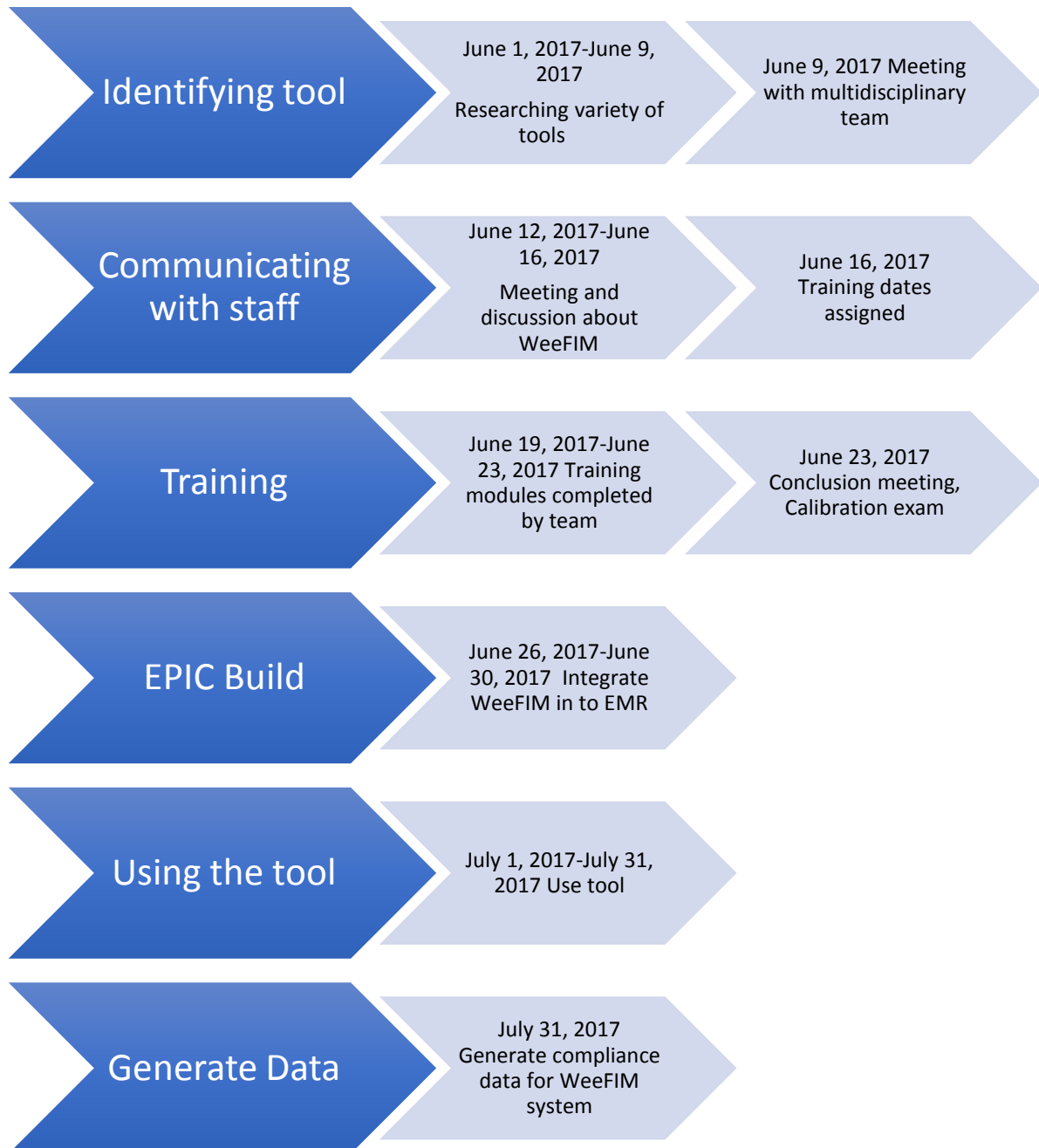
Appendix F

Stakeholder Analysis

<p style="text-align: center;">Protect:</p> <p>The UCSF Benioff Children’s Hospital in Oakland depends on its departments to meet national standards and preform the highest level of patient in care. In doing so, the hospital is marketable, competitive and receives the highest level of reimbursement.</p>	<p style="text-align: center;">Good Relation:</p> <p>Through outcomes measure data the PM&R department can demonstrate verifiable data that validates the program success and justifies continued visits. Implementing WeeFIM will support CARF accreditation which makes the PM&R department marketable and competitive.</p>
<p style="text-align: center;">Low Priority:</p> <p>Other outcome measure tools have been identified and progressive plans have been identified for the future.</p>	<p style="text-align: center;">Monitor:</p> <p>Staff compliance and limited variability will be imperative for the success of the implementation of this project.</p>

Appendix G

Timeline



Appendix H

WeeFIM Steps

WeeFIM® Motor Step Table

		Total # of Steps in WeeFIM® Item																			
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
Total # of Steps Completed by the Child	1	100%	50%	33%	25%	20%	17%	14%	13%	11%	10%	9%	8%	8%	7%	7%	6%	6%	6%	5%	5%
	2		100%	67%	50%	40%	33%	29%	25%	22%	20%	18%	17%	15%	14%	13%	13%	12%	11%	11%	10%
	3			100%	75%	60%	50%	43%	38%	33%	30%	27%	25%	23%	21%	20%	19%	18%	17%	16%	15%
	4				100%	80%	67%	57%	50%	44%	40%	36%	33%	31%	29%	27%	25%	24%	22%	21%	20%
	5					100%	83%	71%	63%	56%	50%	45%	42%	38%	36%	33%	31%	29%	28%	26%	25%
	6						100%	86%	75%	67%	60%	55%	50%	46%	43%	40%	38%	35%	33%	32%	30%
	7							100%	88%	78%	70%	64%	58%	54%	50%	47%	44%	41%	39%	37%	35%
	8								100%	89%	80%	73%	67%	62%	57%	53%	50%	47%	44%	42%	40%
	9									100%	90%	82%	75%	69%	64%	60%	56%	53%	50%	47%	45%
	10										100%	91%	83%	77%	71%	67%	63%	59%	56%	53%	50%
	11											100%	92%	85%	79%	73%	69%	65%	61%	58%	55%
	12												100%	92%	86%	80%	75%	71%	67%	63%	60%
	13													100%	93%	87%	81%	76%	72%	68%	65%
	14														100%	93%	88%	82%	78%	74%	70%
	15															100%	94%	88%	83%	79%	75%
	16																100%	94%	89%	84%	80%
	17																	100%	94%	89%	85%
	18																		100%	95%	90%
	19																			100%	95%
	20																				100%

No Helper

7	Complete Independence: The child completes 100% of the tasks without a helper, without an assistive device, within a reasonable amount of time, and without any safety concerns.
6	Modified Independence: The child completes 100% of the tasks but uses an assistive device or aid, takes more than a reasonable amount of time (three times normal), or does so with safety concerns (risks) for which the child take responsibility.

Helper

5	Supervision/Setup: The child completes 100% of the tasks but requires a helper to provide cueing or coaxing without physical contact. The helper sets up needed items or applies orthoses or assistive/adaptive devices (e.g., TED hose).
4	Minimal Contact Assistance: The child completes 75% or more of the tasks (requires touching assistance).
3	Moderate Assistance: The child completes 50% to 74% of the tasks (requires more than touching assistance).
2	Maximal Assistance: The child completes 25% to 49% of the tasks.
1	Total Assistance: The child completes less than 25% of the tasks; the child requires the assistance of two or more helpers; or the child does not perform the tasks, and a helper does not perform the tasks for the child during the entire assessment time frame.

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