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The Functional Assessment Specialists

The AlphaFIM® Instrument Guide
Version 4.04

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Chapter 1: Introduction to the AlphaFIM® Instrument

Within the field of medical rehabilitation, the FIM® instrument has been widely recognized as a measure of functional status and disability that reflects the minutes of care necessary to support a person with disability in activities of daily living. Widespread endorsement of the FIM® instrument paved the way for consistent, broad, and uniform terminology that communicated effectively about a patient's level of disability. Additionally, the FIM® instrument has been incorporated into the nation's largest repository of data on rehabilitation outcomes: the Uniform Data System for Medical Rehabilitation (UDSMR). UDSMR has used the FIM® instrument as the basis of facility-specific rehabilitation outcomes reports containing national and regional standards of comparison. In 2020, more than a thousand comprehensive medical rehabilitation facilities, subacute rehabilitation units, critical-access hospitals, and long-term acute hospitals in the United States subscribed to UDSMR for outcomes reporting.

Although the FIM® instrument was developed for use in the rehabilitation setting, there remains a recognized need to manage patients in a uniform way across the entire continuum of care. This idea has had much theoretical support but little practical application. The largest obstacle to implementation has been the lack of a consistent method with which to assess patient disability and functional status at all levels of the care continuum.

The AlphaFIM® instrument was designed to help meet this need. Applied in the acute care hospital setting, the AlphaFIM® instrument provides a reliable link back to the FIM® instrument used in the acute and subacute rehabilitation settings of the care continuum. Created specifically for the acute care hospital setting, the AlphaFIM® instrument uses the familiar language and rating system of the FIM® instrument, making it relatively easy for rehabilitation professionals to apply.

The AlphaFIM® instrument is an abbreviated version of the FIM® instrument, which was designed to assess disability and functional status in the acute care setting. The AlphaFIM® instrument has been used by some therapists to track change in patients who received acute care therapy. Over time, however, acute hospital stays have shortened to such a degree that recording change in acute care is less useful. A number of factors may complicate or prevent performance of a full FIM® instrument assessment on patients in such a setting. These factors include:

- Illness severity
- Short stays
- Short contact time with therapeutic staff
- Interruptions for diagnostic evaluations and procedures
- Therapeutic procedures such as intravenous medication running
- Lack of access to clothes to observe dressing
- Lack of space to observe walking 150 feet or stair climbing

For these reasons, the six items used in the AlphaFIM® instrument—four motor items and two cognitive items—were selected from the FIM® instrument for their practicality. The six items depend on the patient's observed walking distance:

Patient A (walks less than 150 feet):	**Patient B (walks 150 feet or more):**
1. Eating	1. Transfers: Bed, Chair
2. Grooming	2. Locomotion: Walk
3. Bowel Management	3. Bowel Management
4. Transfers: Toilet	4. Transfers: Toilet
5. Expression	5. Expression
6. Memory	6. Memory

These items can be assessed conveniently in an acute care hospital setting, yet they provide sufficient information to project a patient's overall functional level. The AlphaFIM® instrument estimates the number of hours per day that a helper would have to spend helping the patient perform basic activities of daily living. For example, a projected burden of care of two hours or less indicates that discharge directly home with appropriate supports may be reasonable, depending on other circumstances; by contrast, a projected burden of care of four to six hours suggests that inpatient rehabilitation might be the best placement, other factors being equal.

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Chapter 2: Uses of the AlphaFIM® Instrument

The AlphaFIM® instrument, an abbreviated version of the FIM® instrument, was designed to assess disability and functional status in the acute care setting. A number of factors, however, may complicate or prevent performance of a full FIM® instrument assessment on patients in such a setting. These factors include:

- Illness severity
- Short stays
- Short contact time with therapeutic staff
- Interruptions for diagnostic evaluations and procedures

For these reasons, the six items used in the AlphaFIM® instrument—four of the thirteen FIM® motor items and two of the five FIM® cognitive items—were selected from the FIM® instrument for their practicality. These items can be assessed conveniently in an acute care hospital setting, yet they provide sufficient information to project the patient's overall functional level.

The AlphaFIM® instrument can be used to accomplish the following:

- **Conduct preadmission screening** for transfer to a rehabilitation program from an acute care hospital unit.
- **Help make decisions regarding discharge** from an acute care hospital setting.
- **Monitor the quality and effectiveness of patient care** during the patient's stay in an acute care hospital setting.

The AlphaFIM® instrument's main purpose is to provide an objective estimate of the patient's burden of care, which is represented as the number of hours a helper would need to spend with the patient on a daily basis. This estimate can be used to gauge the feasibility of likely discharge destinations or admission to the rehabilitation unit. The items that compose the AlphaFIM® instrument were chosen because they can be rated in any acute hospital situation, including the intensive care unit. In summary, the AlphaFIM® instrument is designed to be completed within the first three days of acute admission and used to help make triage decisions with respect to postacute settings. Multiple assessments may be performed throughout the acute hospital stay, and a discharge assessment may be performed so that the facility can monitor the patient's progress and track outcomes.

Information gathered during a preadmission assessment can be used to make decisions about a patient's discharge, using a sorting method known as **triage** to assess the greatest benefit in being discharged to one of several alternative discharge settings. These discharge settings cover a range of treatment intensities, available resources, and costs. Triage decisions based on the AlphaFIM® instrument involve selecting the right treatment setting for the right patient at the right time.

Thus, the clinical care team can use the AlphaFIM® instrument to help make triage decisions regarding the discharge of patients to the most appropriate settings, whether home, another community-based setting, a hospital-based rehabilitation unit, a subacute rehabilitation unit, nursing home, or another destination. A special application of the AlphaFIM® instrument is monitoring whether, over time, the appropriate patients are being transferred to the appropriate postacute care settings. The clinician records the projected site for a postacute discharge; then,

after the patient has been discharged, the actual discharge location is recorded. Periodic comparisons of the projected and actual discharges will aid quality control purposes.

Finally, the AlphaFIM® instrument can be used to monitor the quality and effectiveness of a patient's care while the patient is being treated in the acute care hospital setting. Clinicians can perform multiple assessments for a particular patient and then use that information to measure changes in functional status during the patient's hospital stay.

Triage Ability

The information generated by the AlphaFIM® instrument is meant to serve as a guide. It can help the clinician better understand the functional limitations and therapeutic needs of the patient during the acute hospital stay as the patient is triaged to the most appropriate postacute care setting.

Note that no single source gathered in the acute care hospital setting has the ability to perfectly predict a patient's future needs. This is true for several reasons. First, the AlphaFIM® instrument does not collect all the information that might be used to predict a patient's future course. Second, many AlphaFIM® variables are likely to change between admission and discharge, but the algorithms develop expectancies—burden of care or hours of assistance needed from another person—based on the patient's current functional status. Lastly, the algorithms and prediction models are based on large groups of data. Expected values generated from such models serve well for large groups of patients but may hold limited value when applied to an individual case.

Accordingly, the AlphaFIM® instrument and associated expectancies should be used as intended—as guides. These guides can assist rehabilitation professionals who are interested in a patient's likely future progress upon discharge from the acute hospital setting, as well as those who are screening potential admissions to a rehabilitation unit. The AlphaFIM® instrument and associated algorithms, however, should **not** be used as the sole source of information upon which admission and discharge decisions are made. As always, formalized data collection and predictive algorithms should supplement, rather than replace, good clinical care and medical judgment.

For more information about the overall AlphaFIM® rating and its relationship to the burden of care, see appendix B on page 40.

Chapter 3: Implementation and Rating Overview

The AlphaFIM® instrument consists of six FIM® items. If the patient does not walk 150 feet or more, the instrument consists of the following six items:

1. Eating
2. Grooming
3. Bowel Management
4. Transfers: Toilet
5. Expression
6. Memory

If the patient has been observed to walk 150 feet or more, the six items are:

1. Transfers: Bed, Chair
2. Locomotion: Walk
3. Bowel Management
4. Transfers: Toilet
5. Expression
6. Memory

Such patients usually do not have difficulty eating or grooming, so the items Eating and Grooming are replaced by the items Transfers: Bed, Chair and Locomotion: Walk. For more information, see chapter 4, “Specific Rating Instructions,” on page 9.

In either case, the first four items are FIM® motor items; the last two are FIM® cognitive items. These items are taken directly from the FIM® instrument. They are rated on a seven-level scale that ranges from level 1, Total Assistance, to level 7, Complete Independence. For more information, see chapter 4, “Specific Rating Instructions,” on page 9.

In general, the AlphaFIM® instrument measures disability, not impairment. It is intended to measure what a patient **actually does** rather than what the patient “ought” to do or what the patient “might” do if circumstances were different. When evaluating a particular patient, a clinician may be well aware that the patient can do many things that are not presently being accomplished. Nevertheless, the clinician should base the assessment on what the patient actually does.

There is no provision to consider an item “not applicable.” You must complete **all** six items in order to derive benefit from the measure.

Because it is based on the FIM® instrument, the AlphaFIM® instrument was designed to be a discipline-free system of measurement (i.e., a measure usable by any trained clinician, regardless of discipline). Under certain circumstances, however, a clinician may have difficulty assessing all the necessary activities. In such a case, any relevant clinician with working knowledge of the patient may complete the assessment.

Chapter 4: Specific Rating Instructions

This chapter presents specific instructions for rating each of the eight AlphaFIM® items—the six used for patients who walk less than 150 feet, plus the two additional items used for patients who walk 150 feet or more. The description for each item stipulates that the patient must complete either all of the tasks included in the activity definition or one of several tasks. If the patient must complete **all** of the tasks, the tasks will be connected by the word "and"; if the patient must complete only **one** task, the tasks will be connected by the word "or."

Read the item definitions carefully **before** you begin using the instrument. Commit the activity definitions to memory. Rate the patient **only** with respect to the specific item.

Implicit in all the definitions—and stated in many of them—is a concern that the patient performs the activities with "reasonable safety." With respect to level 6, Modified Independence, ask yourself whether the patient is at risk of injury when performing the task. As always, you should balance the risk that the patient participates in the activity with the corresponding (albeit different) risk that the patient does not.

Use the AlphaFIM® instrument within the first seventy-two hours of the patient's admission to the acute care hospital setting. Base the patient's ratings on activities performed within those first seventy-two hours.

Multiple assessments can be performed throughout the acute care hospital stay. Base these assessments on the activities performed by the patient within the preceding twenty-four hours.

To collect the data, use the preprinted form in appendix A on page 39.

General Rating Rules

Remember these general rating rules:

- **Record actual performance, not capacity.** The AlphaFIM® ratings should reflect what the patient actually does, not what the patient once did or what the patient could do if circumstances were different.
- **Record the lowest rating.** If differences in function occur in different environments or at different times of the day, record the **lowest** (i.e., most dependent) rating. Such differences usually indicate a lack of mastery on the part of the patient or a lack of motivation outside the therapy setting. You may need to discuss a patient's normative behaviors with relevant care staff.
- **Use the best available information.** Base the AlphaFIM® ratings on the best available information. Direct observation of the patient's performance is preferred, but you may gather credible reports about the patient's usual performance from the patient, other staff members, and the patient's family and friends. The patient's medical record also may provide additional information about such factors as bowel accidents and inappropriate behaviors.
- **Do not leave any item blank.** Rate all items. Do not enter "N/A" or leave any item blank.
- **Setup is level 5.** Activities that require setup are uniformly rated level 5 for all items.
- **Risk of injury is level 1.** If the evaluation of a particular activity would place a patient at risk of injury, and that activity does not occur, rate the patient level 1, Total Assistance, for that item.
- **Lack of performance is level 1.** If the patient does not perform an activity, rate the patient level 1, Total Assistance, for that item.
- **Two helpers are level 1.** Whenever a patient requires two helpers to perform an activity, rate the patient level 1, Total Assistance, for that item.

Levels of Function: Descriptions and Ratings

Each AlphaFIM® item is rated according to the following levels of function:

NO HELPER: The patient performs all tasks without assistance from another person.

7 **Complete Independence:** The patient safely performs all tasks without assistance from a helper, without a device, and in a reasonable amount of time.

6 **Modified Independence:** The patient performs all tasks without assistance from a helper, and one or more of the following are true:

- The patient requires an assistive device to perform tasks, and the patient applies the device without assistance.
- The patient requires a prosthesis or an orthosis that is necessary for performing tasks, and the patient applies the prosthesis or orthosis without assistance.
- The patient takes extra time to perform tasks.
- There is a concern for the patient's safety when he performs tasks.

HELPER: The patient requires another person (whether for supervision or physical assistance) to perform tasks, **or** the patient does not perform tasks.

Modified Dependence: The patient performs 50% or more of the tasks.

5 **Supervision/Setup:** The patient performs all tasks but requires supervision (typically standing by, cueing, or coaxing) or setup (for example, setting out necessary items and helping to apply a prosthesis or an orthosis).

4 **Minimal Assistance:** The patient performs 75% or more of the tasks, requiring no more help than touching.

3 **Moderate Assistance:** The patient performs 50% to 74% of the tasks, requiring physical assistance beyond touching.

Complete Dependence: The patient performs less than 50% of the tasks, requiring maximal or total assistance from a helper.

2 **Maximal Assistance:** The patient performs 25% to 49% of the tasks.

1 **Total Assistance:** One or both of the following are true:

- The patient performs less than 25% of the tasks (including nonperformance of tasks).
- The patient requires assistance from two helpers to perform tasks.

Eating

Eating includes using suitable utensils to bring food from a dish to the mouth, where the food is chewed and swallowed; using a cup or glass to bring liquid to the mouth, where it is swallowed; and managing a variety of food consistencies after a meal has been presented in the customary manner on a table or tray.

Rating guidelines:

- Presenting a meal in the customary manner includes delivering the meal tray and removing the cover of the tray.
- If the patient functions at different levels during the day (for example, level 5 in the morning and level 4 in the evening), record the lower rating.
- If the patient eats meals by mouth **and** receives nutrition through tube feedings, consider each time the patient eats and each tube feeding administration as a separate episode. If the patient's functional status varies by episode, record the lower rating.
- If the patient has a feeding tube that is **not** used for hydration or nutrition, and a helper flushes the tube to maintain patency, do **not** consider the feeding tube and the parenteral line when rating this item.

NO HELPER

7 Complete Independence: The patient safely performs all eating tasks without assistance from a helper, without a device, and in a reasonable amount of time.

6 Modified Independence: The patient performs all eating tasks without assistance from a helper, and one or more of the following are true:

- The patient requires an assistive/adaptive device (for example, a long straw, a spork, or a plate guard) to eat and applies the device without assistance from a helper.
- The patient takes extra time to eat.
- The patient requires modified food consistency, modified liquid consistency, or blenderized food, and the food arrives in a modified or blenderized consistency.
- The patient self-administers parenteral or gastrostomy feedings.
- There is a concern for the patient's safety when he eats.

HELPER

5 Supervision/Setup: The patient performs all eating tasks, and one or more of the following are true:

- The patient requires supervision (standing by, cueing, or coaxing) to eat.
- The patient requires setup (including application of orthoses and assistive/adaptive devices necessary for eating) to eat.
- The patient requires a modified food consistency, and a helper modifies the food's consistency, applies Thick-It® powder, etc.
- The patient requires setup of the meal, such as opening containers, cutting meat, buttering bread, and pouring liquids.

4 **Minimal Assistance:** The patient performs 75% or more of the eating tasks.

3 **Moderate Assistance:** The patient performs 50% to 74% of the eating tasks.

2 **Maximal Assistance:** The patient performs 25% to 49% of the eating tasks.

1 **Total Assistance:** One or more of the following are true:

- The patient performs less than 25% of the eating tasks.
- The patient does not eat or drink full meals by mouth, relying instead on other means of alimentation (for example, parenteral and gastrostomy feedings).
- The patient requires assistance from two helpers to eat.
- The patient requires an IV for fluids or hydration (or both) that is administered by a helper.

Grooming

Grooming includes oral care (brushing teeth); hair grooming (combing and brushing hair); washing, rinsing, and drying the hands; washing, rinsing, and drying the face; and shaving or applying makeup.

Rating guidelines:

- Grooming does not include flossing teeth, shampooing hair, or arranging hair in braids, ponytails, and other hairstyles.
- Grooming consists of four or five tasks. If the patient neither shaves nor applies makeup, Grooming includes only the first four tasks, each of which should be rated as 25% of the total. If the patient does not have hair, do not assess hair grooming.
- Grooming includes obtaining articles necessary for grooming (for example, toothbrush, towels, combs, and brushes). It also includes initial setup (for example, applying toothpaste to a toothbrush).
- If the patient uses a wheelchair to complete grooming tasks, the wheelchair is **not** considered an assistive device.

NO HELPER

7 **Complete Independence:** The patient safely performs all grooming tasks without assistance from a helper, without a device, and in a reasonable amount of time.

6 **Modified Independence:** The patient performs all grooming tasks without assistance from a helper, and one or more of the following are true:

- The patient requires an assistive/adaptive device (for example, an orthosis, a prosthesis, a wash mitt, an adapted toothbrush, an adapted comb, or an adapted brush), and the patient applies the device when applicable without assistance from a helper.
- The patient takes extra time to perform grooming tasks.
- There is a concern for the patient's safety when he performs grooming tasks.

HELPER

5 **Supervision/Setup:** The patient performs all grooming tasks but requires supervision (standing by, cueing, or coaxing) or setup (for example, applying an orthosis necessary for grooming, setting out grooming supplies, and assisting with initial preparation, such as applying toothpaste to a toothbrush).

4 **Minimal Assistance:** The patient performs 75% or more of the grooming tasks.

3 **Moderate Assistance:** The patient performs 50% to 74% of the grooming tasks.

2 **Maximal Assistance:** The patient performs 25% to 49% of the grooming tasks.

1 **Total Assistance:** One or both of the following are true:

- The patient performs less than 25% of grooming tasks.
- The patient requires assistance from two helpers to perform grooming tasks.

Bowel Management

Bowel Management includes complete and intentional control of bowel movements and use of any equipment and medication (agents) necessary for bowel control.

Rating guidelines:

- The functional goal of bowel management is to open the anal sphincter only when needed and to keep it closed the rest of the time. This may require a combination of devices, medications (agents), and assistance from a helper.
- When assessing this item, consider the following:
  - Does the patient require an agent or device to maintain control or prevent an accident or incontinent episode?
  - If the patient requires a device to prevent an accident or incontinent episode, how much assistance from a helper is required to manage the device?
  - If the patient has had an accident or incontinent episode, how much assistance from a helper is needed to clean up?
- The assessment time frame for this item is twenty-four hours.
- If the patient does not have a bowel movement during the **entire** twenty-four-hour assessment time frame **and** does not use an assistive device or medication for bowel control, rate the patient level 7, Complete Independence. If the patient does not have a bowel movement during the entire assessment time frame but uses an assistive device or medication for bowel control, rate the patient from level 1 to level 6 depending the device or medication used and the amount of assistance required to maintain it.

Definitions:

Bowel incontinence: The patient is unable to control the anal sphincter, but all stool is contained in a device (e.g., diaper).

Bowel accident: The patient is unable to control the anal sphincter, resulting in soiling of linen or clothing with stool. This includes bedpan spills and ostomy leakage.

NO HELPER

7 Complete Independence: One of the following is true:

- The patient controls his bowels completely and intentionally without assistance from a helper, without a device or medication, and in a reasonable amount of time.
- The patient does not have a bowel movement during the **entire** twenty-four-hour assessment time frame **and** does not use an assistive device or medication for bowel control.

6 Modified Independence: The patient controls his bowels completely and intentionally **or** has an assistive device (such as a colostomy) that has not leaked (soiling linen or clothing), **and** one or more of the following are true:

- The patient requires and retrieves an assistive device such as a bedpan or commode and empties it, or the patient uses an absorbent pad (or diaper) and changes it without assistance.

- The patient requires stool softeners, suppositories, or laxatives (other than natural laxatives such as prunes) and manages all aspects of administration, including preparation and cleanup.
- The patient requires medication (agents) for control.
- The patient maintains a colostomy without assistance, and there have not been any incidences of leakage onto linen or clothing.
- The patient takes extra time to perform bowel management tasks.
- There is a concern for the patient's safety when he performs bowel management tasks.

HELPER

5 **Supervision/Setup:** One or more of the following are true:

- The patient requires supervision or setup of equipment necessary for the patient to maintain a satisfactory excretory pattern or to maintain an ostomy device.
- A helper provides standby cueing or coaxing as the patient uses a device (e.g., self-insertion of suppository, ostomy care).
- A helper obtains and empties a bedpan or commode.
- The patient cleans himself up after an accident or incontinent episode.

4 **Minimal Assistance:** One or both of the following are true:

- The patient performs 75% or more of the bowel management tasks.
- The patient requires minimal assistance to maintain a satisfactory excretory pattern by using suppositories, enemas, or an external device.

3 **Moderate Assistance:** One or both of the following are true:

- The patient performs 50% to 74% of the bowel management tasks.
- The patient requires moderate assistance to maintain a satisfactory excretory pattern by using suppositories, enemas, or an external device.

2 **Maximal Assistance:** The patient performs 25% to 49% of the bowel management tasks.

1 **Total Assistance:** One or more of the following are true:

- The patient performs less than 25% of the bowel management tasks.
- A helper changes the patient's absorbent pad or diaper.
- The patient had an accident, and a helper changed the patient's linen or clothing.
- The patient requires assistance from two helpers to perform bowel management tasks.

Transfers: Toilet

Transfers: Toilet includes all aspects of transferring on and off a toilet. This includes safely approaching, sitting down on, and getting up from the toilet.

Rating guidelines:

- When rating this item, assess the patient's transfers to and from a standard toilet.
- Prostheses and orthoses are considered assistive devices if required for a transfer.

NO HELPER

7 Complete Independence: The patient safely transfers to and from a toilet without assistance from a helper, without a device, and in a reasonable amount of time.

6 Modified Independence: The patient transfers to and from a toilet without assistance from a helper, and one or more of the following are true:

- The patient requires an assistive/adaptive device (for example, a sliding board, a grab bars, or a special seat) to transfer, and the patient sets up the device when applicable without assistance from a helper.
- The patient takes extra time to transfer.
- There is a concern for the patient's safety when he transfers.

HELPER

5 Supervision/Setup: The patient transfers to and from a toilet but requires supervision (for example, standing by, cueing, and coaxing) or setup (for example, positioning a sliding board or moving an armrest).

4 Minimal Assistance: One or both of the following are true:

- The patient performs 75% or more of transferring tasks.
- The patient requires touching, guiding, or contact assistance to complete the transfer.

3 Moderate Assistance: One or both of the following are true:

- The patient performs 50% to 74% of transferring tasks.
- The patient approaches the toilet or commode with no more than contact assistance but requires lifting assistance to either sit down **or** stand up.

2 Maximal Assistance: One or both of the following are true:

- The patient performs 25% to 49% of transferring tasks.
- The patient approaches the toilet or commode with no more than contact assistance but requires lifting assistance to sit down **and** stand up.

1 Total Assistance: One or more of the following are true:

- The patient performs less than 25% of transferring tasks.
- The patient requires assistance from two helpers to transfer.
- The patient requires more than contact assistance to approach the toilet or commode, to sit down, and to stand up.

Transfers: Bed, Chair

Transfers: Bed, Chair includes all aspects of transferring to and from a bed to a chair (or from a chair to a bed), including coming to a standing position.

Rating guidelines:

- Prostheses and orthoses are considered assistive devices if required for a transfer.
- During a bed-to-chair transfer, the patient must begin in a supine position and end in a sitting position. During a chair-to-bed transfer, the patient must begin in a sitting position and end in a supine position.

NO HELPER

7 **Complete Independence:** The patient safely approaches, sits down on, and gets up to a standing position from a regular chair or bed. The patient also safely transfers from bed to chair (or from chair to bed).

6 **Modified Independence:** The patient transfers to and from a chair or bed without assistance from a helper, and one or more of the following are true:

- The patient requires an assistive/adaptive device (for example, a sliding board, a grab bars, or a special seat) to transfer, and the patient sets up the device when applicable without assistance from a helper.
- The patient takes extra time to transfer.
- There is a concern for the patient's safety when he transfers.

HELPER

5 **Supervision/Setup:** The patient transfers to and from a chair or bed but requires supervision (for example, standing by, cueing, or coaxing) or setup (for example, positioning a sliding board or moving an armrest).

4 **Minimal Assistance:** One or both of the following are true:

- The patient performs 75% or more of transferring tasks.
- The patient requires touching, guiding, or contact assistance to complete the transfer.

3 **Moderate Assistance:** One or both of the following are true:

- The patient performs 50% to 74% of transferring tasks.
- The patient approaches the chair or bed with no more than contact assistance but requires lifting assistance to either sit down **or** stand up.

2 **Maximal Assistance:** One or both of the following are true:

- The patient performs 25% to 49% of transferring tasks.
- The patient approaches the chair or bed with no more than contact assistance but requires lifting assistance to sit down **and** stand up.

1 Total Assistance: One or more of the following are true:

- The patient performs less than 25% of transferring tasks.
- The patient requires assistance from two helpers to transfer.
- The patient requires more than contact assistance to approach the chair or bed, sit down, and stand up.

Locomotion: Walk

Locomotion: Walk includes walking on a level surface once in a standing position. The patient must perform the activity safely.

Rating guidelines:

If the patient requires an assistive device (for example, a prosthesis, a walker, a cane, an AFO, or an adapted shoe) to walk, do not rate the patient higher than level 6, Modified Independence.

NO HELPER

7 **Complete Independence:** The patient safely walks a minimum of 150 feet (45 meters) without assistance from a helper and without a device.

6 **Modified Independence:** The patient walks a minimum of 150 feet (45 meters) without assistance from a helper, and one or more of the following are true:

- The patient requires an assistance/adaptive device (for example, a leg brace, special adaptive shoes, a cane, crutches, or a walker) to walk, and the patient applies the device when applicable without assistance from a helper.
- The patient takes more than a reasonable amount of time to walk.
- There is a concern for the patient's safety when he walks.

HELPER

5 **Supervision/Setup:** The patient walks a minimum of 150 feet (45 meters) but requires supervision (for example, standby supervision, cueing, or coaxing).

4 **Minimal Assistance:** The patient walks a minimum of 150 feet (45 meters) and performs 75% or more of the walking effort.

3 **Moderate Assistance:** The patient walks a minimum of 150 feet (45 meters) and performs 50% to 74% of the walking effort.

Expression

Expression includes clear vocal or nonvocal expression of language. It includes either intelligible speech or clear expression of language using writing or a communication device. Evaluate the more usual mode of expression, whether vocal or nonvocal.

Rating guidelines:

- Evaluate the patient's best mode of expression, whether vocal or nonvocal.
- Expression should be based on the patient's usual language, which may be a language other than English. You may need the help of an interpreter to rate the patient for this item. Do not consider the role of an interpreter when rating this item.

Definitions:

Basic needs and ideas: Necessary daily activities, such as hunger, thirst, elimination, hygiene, sleep, fear, pain, and other psychological needs.

Complex or abstract ideas: Current events, religion, relationships with others, etc.

NO HELPER

7 Complete Independence: The patient expresses complex or abstract ideas clearly and fluently without assistance from a helper, without a device, and in a reasonable amount of time.

6 Modified Independence: The patient expresses complex or abstract ideas without assistance from a helper, and one or more of the following are true:

- The patient expresses complex or abstract ideas with mild difficulty.
- The patient requires an augmentative communication device or system to express himself and sets up the device when applicable without assistance from a helper.
- The patient takes extra time to express complex or abstract ideas.

HELPER

5 Standby Prompting: The patient expresses basic needs and ideas clearly more than 90% of the time, requiring prompting (for example, frequent repetition) less than 10% of the time.

4 Minimal Prompting: The patient expresses basic needs and ideas clearly 75% to 90% of the time.

3 Moderate Prompting: The patient expresses basic daily needs and ideas 50% to 74% of the time.

2 Maximal Prompting: The patient uses single words and gestures to express basic daily needs and ideas clearly 25% to 49% of the time, requiring prompting more than 50% of the time.

1 Total Assistance: One or both of the following are true:

- The patient expresses basic needs and ideas clearly less than 25% of the time.
- The patient does not express basic needs appropriately or consistently despite prompting.

Memory

Memory includes skills related to recognizing and remembering while performing daily activities. It includes storing and retrieving information, particularly verbal and visual.

Rating guidelines:

Functional evidence of memory includes recognizing people frequently encountered, remembering daily routines, and executing requests without being reminded.

NO HELPER

7 **Complete Independence:** The patient recognizes people frequently encountered, remembers daily routines, and executes requests without being reminded, and the patient does so without assistance from a helper, without a device, and in a reasonable amount of time.

6 **Modified Independence:** The patient recognizes people frequently encountered, remembers daily routines, and executes requests without being reminded, but one or more of the following are true:

- The patient does so with mild difficulty.
- The patient needs extra time to do so.
- The patient uses an assistive device (for example, a memory book) to do so, and the patient sets up and uses the device when applicable without assistance from a helper.

HELPER

5 **Standby Prompting:** The patient recognizes and remembers more than 90% of the time, requiring prompting (for example, cueing, repetition, or reminders) less than 10% of the time.

4 **Minimal Prompting:** The patient recognizes and remembers 75% to 90% of the time, requiring prompting the rest of the time.

3 **Moderate Prompting:** The patient recognizes and remembers 50% to 74% of the time, requiring prompting the rest of the time.

2 **Maximal Prompting:** The patient recognizes and remembers 25% to 49% of the time, requiring prompting the rest of the time.

1 **Total Assistance:** The patient recognizes and remembers less than 25% of the time.

Chapter 5: AlphaFIM® Calculations

The AlphaFIM® instrument is used primarily to provide an estimate or projection of the patient's likely FIM® ratings on the date that the AlphaFIM® items were assessed. These estimates include:

- FIM-13 raw motor rating
- FIM-13 Rasch motor rating
- FIM-5 Raw cognition rating
- FIM-5 Rasch cognition rating
- FIM® motor range
- FIM® cognition range
- FIM® walking range
- Help needed

These estimates are explained below.

- **FIM-13 Raw Motor Rating:** The FIM-13 raw motor rating is the best approximation of the patient's FIM® motor rating for all thirteen FIM® motor items. It is derived from the four AlphaFIM® motor items.
- **FIM-13 Rasch Motor Rating:** The FIM-13 Rasch motor rating is a number between 0 and 100. It is a transformation of the FIM-13 raw motor rating. This transformation is based on Rasch analysis.
- **FIM-5 Raw Cognition Rating:** The FIM-5 raw cognition rating is the best approximation of the patient's FIM® cognition rating for all five FIM® cognitive items. It is derived from the two AlphaFIM® cognition items.
- **FIM-5 Rasch Cognition Rating:** The FIM-5 Rasch cognition rating is a number between 0 and 100. It is a transformation of the FIM-5 raw cognition rating. This transformation is based on Rasch analysis.
- **FIM® Motor Range:** The FIM® motor range is the best approximation of the patient's overall FIM® motor rating. It is derived from the FIM-13 raw motor rating.
- **FIM® Cognition Range:** The FIM® cognition range is the best approximation of the patient's overall FIM® cognitive rating. It is derived from the FIM-5 raw cognition rating.
- **FIM® Walking Range:** The FIM® walking range represents the best approximation of assistance needed by the patient to walk at least 150 feet.
- **Help Needed:** The Help Needed figure represents the best approximation of the daily number of hours of care that a patient will require from another individual in order to perform typical activities of daily living. This number is based upon several previous research projects in which total FIM® ratings were compared to the number of minutes of personal care.

Chapter 6: Using the AlphaFIM® Website

You can use the AlphaFIM® website to manage your AlphaFIM® patient records. The website takes each patient's AlphaFIM® ratings as input and returns the AlphaFIM® estimates discussed in chapter 5, "AlphaFIM® Calculations." This chapter explains how to access and use the website.

Browser Requirements

Only the latest versions of the following Internet browsers are supported:

- Microsoft® Internet Explorer*
- Microsoft® Edge
- Mozilla® Firefox®
- Google Chrome™
- Apple® Safari®
- Mobile Safari®

* Enterprise Mode is **not** supported.

Logging in to the AlphaFIM® Website

To use the AlphaFIM® instrument, you must first log in to the AlphaFIM® website.

To log in to the website:

1. Click the **Start** button on your desktop.
2. Click the **Programs** button.
3. Open a new browser window.
4. Enter **www.udsmr.org** in the **Address** field. The UDSMR® website will appear.
5. Hover over the **Software Portals** menu to open it.
6. Click the **AlphaFIM® Software** link in the Software Portals menu. The AlphaFIM® Software Logon Information window will appear.
7. Enter your facility code in the **Facility** field.
8. Enter your username in the **Username** field.
9. Enter your password in the **Password** field.
10. Click the **Login** button. The case listing will appear.

The first time a user logs in to the system, a license agreement page will appear. Click the **I Accept** button to dismiss the page and proceed to the case listing.

The AlphaFIM® Website Environment

The AlphaFIM® website environment is shown in figure 1.

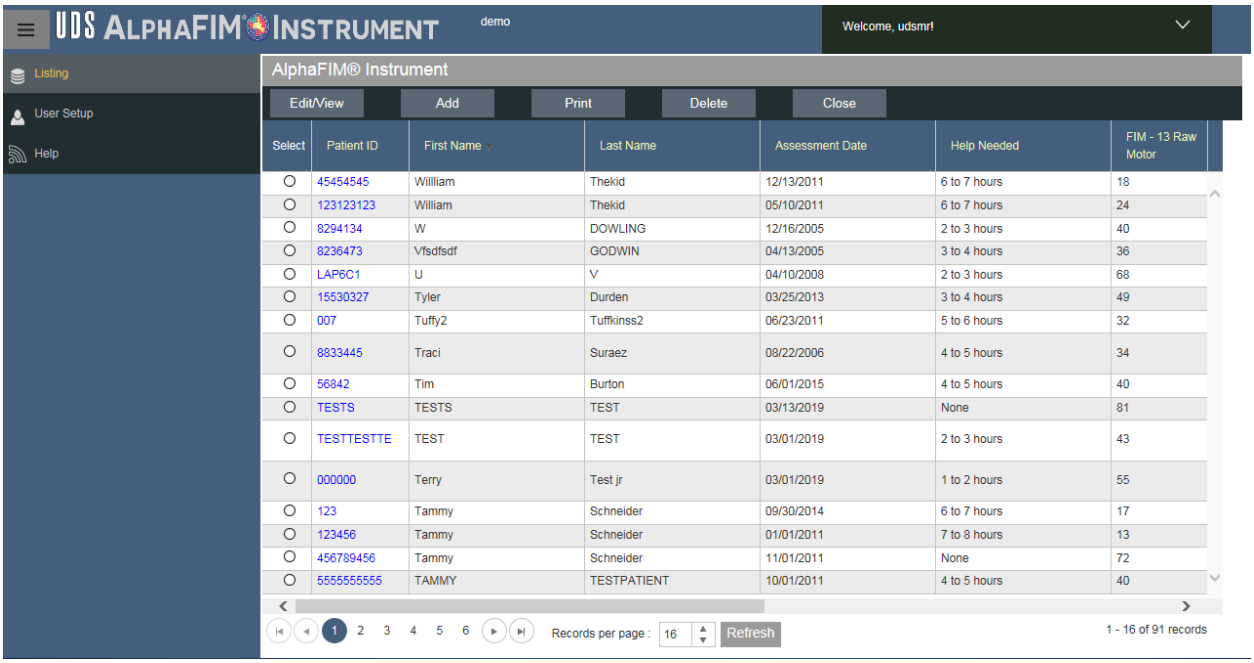

Figure 1. The AlphaFIM® Website Environment

The website environment is divided into two areas: the *navigation area* and the *information area*.

The Navigation Area

The left column of the website environment constitutes the navigation area. The following buttons appear in this area:

- Listing
- User Setup
- Help

You can use these buttons to access other features of the website. These features are explained later in this chapter.

The Information Area

The area to the right of the navigation area is the information area. Clicking buttons in the navigation area will cause new information and options to appear in the information area. You can use these features to perform tasks on the AlphaFIM® website.

The top of the information area also includes a control that displays your username. The name of the user's facility appears in the middle of the top of the page. You can use the control to log out of the website. For more information, see *Logging out of the AlphaFIM® Website* on page 38.

Managing User Accounts

Each AlphaFIM® user must have a user account to access the AlphaFIM® website. A user account consists of a username and a password. User account management consists of adding, editing, inactivating, locking, and deleting user accounts.

When your facility gains access to the AlphaFIM® website, UDSMR will create a master account for your facility. This account is the only account that can manage user accounts.

Adding a User Account

To add a user account:

1. Click the **User Setup** button. The User Setup window will appear, as shown in figure 2.

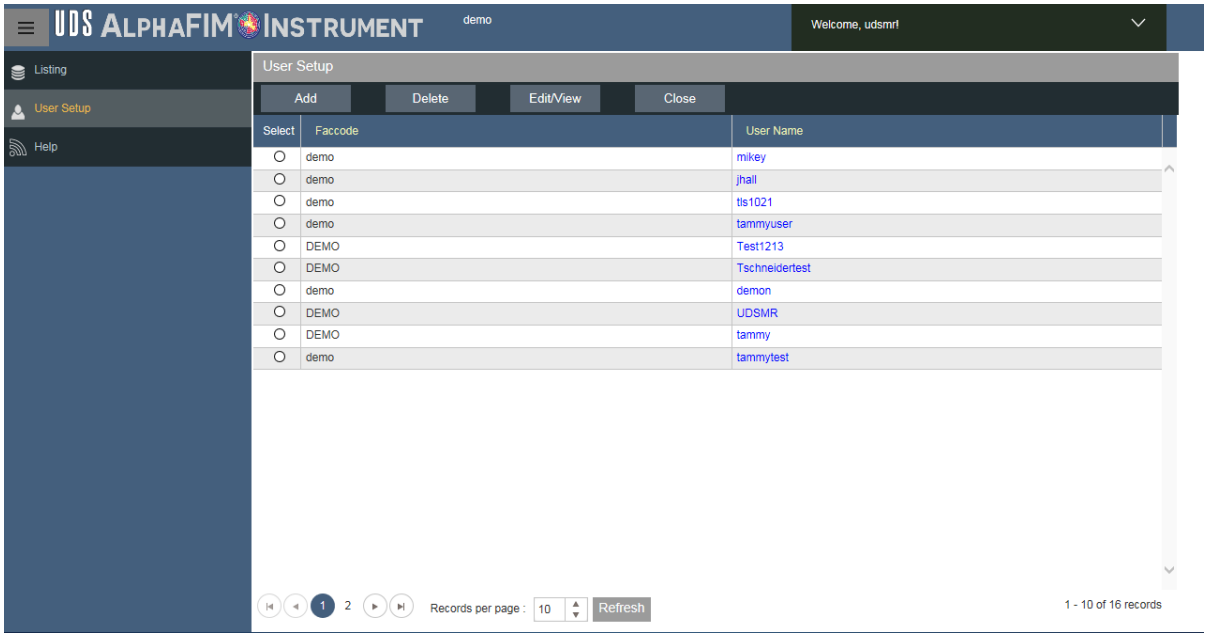

Figure 2. The User Setup Window

2. Click the **Add** button.
3. Enter the facility code of the user's facility in the **Facility Code** field.
4. Enter a username in the **User Name** field.
5. Enter a password in the **New Password** field.
6. Click the **Confirm Password** button. The Confirm Password dialog will appear.
7. Re-enter the password from step 4 in the **Confirm Password** field.
8. Click the **Save** button to confirm the password and close the Confirm Password dialog.
9. Select the **Active** checkbox.
10. Use the options in the Settings area to set the password restrictions you want.
    - To force the user to change the account password each time the user logs in, select the **User should be forced to change password on next login** checkbox.

- To specify the life span of the account password, enter a number in the **Number of days before password will automatically expire** field.
- To ensure that the password never expires, enter **0** in the **Number of days before password will automatically expire** field.
- To give advance warning of an expiring password, enter a number in the **Number of days prior to password expiration** field.
- To avoid giving advance warning of an expiring password, enter **0** in the **Number of days prior to password expiration** field.

9. Set the user's privileges by selecting one of the radio buttons in the **Privileges** area.
10. Click the **Save** button to save the user account.
11. Click the **Close** button. A confirmation dialog will appear.
12. Click the **OK** button to close the confirmation dialog and return to the User Setup window.

Editing a User Account

To edit a user account:

1. Click the **User Setup** button. The User Setup window will appear, as shown in figure 2 on page 28.
2. Click the link in the **User Name** column that corresponds to the account you want to edit.
3. Make any necessary changes to the account.
   - To change the user account's password, enter the new password in the **New Password** field, click the **Confirm Password** button, re-enter the password in the **Confirm Password** field, and then click the **Save** button.
   - To force the user to change the account password each time the user logs in, select the **User should be forced to change password on next login** checkbox.
   - To specify the life span of the account password, enter a number in the **Number of days before password will automatically expire** field.
   - To ensure that the password never expires, enter **0** in the **Number of days before password will automatically expire** field.
   - To give advance warning of an expiring password, enter a number in the **Number of days prior to password expiration** field.
   - To avoid giving advance warning of an expiring password, enter **0** in the **Number of days prior to password expiration** field.
   - To change the user's privileges, select one of the radio buttons in the **Privileges** area.
4. Click the **Save** button to save your changes.
5. Click the **Close** button. A confirmation dialog will appear.
6. Click the **OK** button to close the confirmation dialog and return to the User Setup window.

Inactivating a User Account

You can use the AlphaFIM® website to inactivate user accounts for your facility. An inactivated account cannot be used to log in to the AlphaFIM® website, but it is not deleted.

Inactivation is a live event. If you inactivate a user account currently logged into the AlphaFIM® website, the user will be informed of the inactivation and logged out of the site.

To inactivate a user account:

1. Click the **User Setup** button. The User Setup window will appear, as shown in figure 2 on page 28.
2. Click the link in the **User Name** column that matches the name of the account you want to inactivate.
3. Clear the **Active** checkbox.
4. Click the **Save** button to save your changes. An information dialog will appear.
5. Click the **Close** button. A confirmation dialog will appear.
6. Click the **OK** button to close the confirmation dialog and return to the User Setup window.

To activate a user account, follow these instructions, but select the **Active** checkbox rather than clear it.

Unlocking a User Account

You can use the AlphaFIM® website to unlock the accounts of a user who has been locked out of the website after failing a certain number of login attempts.

To unlock a user account:

1. Click the **User Setup** button. The User Setup window will appear, as shown in figure 2 on page 28.
2. Click the link in the **User Name** column that matches the name of the account you want to unlock.
3. Clear the **Locked** checkbox.
4. Click the **Save** button to save your changes. An information dialog will appear.
5. Click the **Close** button. A confirmation dialog will appear.
6. Click the **OK** button to close the confirmation dialog and return to the User Setup window.

If you want to lock a user out of the system for an extended period, inactivate the account. For instructions, see page 30.

Deleting a User Account

To delete a user account:

1. Click the **User Setup** button. The User Setup window will appear, as shown in figure 2 on page 28.
2. Select the radio button in the **Select** column that corresponds to the account you want to delete.

3. Click the **Delete** button. A confirmation dialog will appear.
4. Click the **Yes** button to confirm your selection and close the confirmation dialog.
5. Click the **Close** button to close the User Setup window.

Viewing the Case Listing

You can use the AlphaFIM® website to build a case listing database, which puts all of your patient information at your fingertips for easy access and editing.

To view the case listing, click the **Listing** button. (See figure 3.)

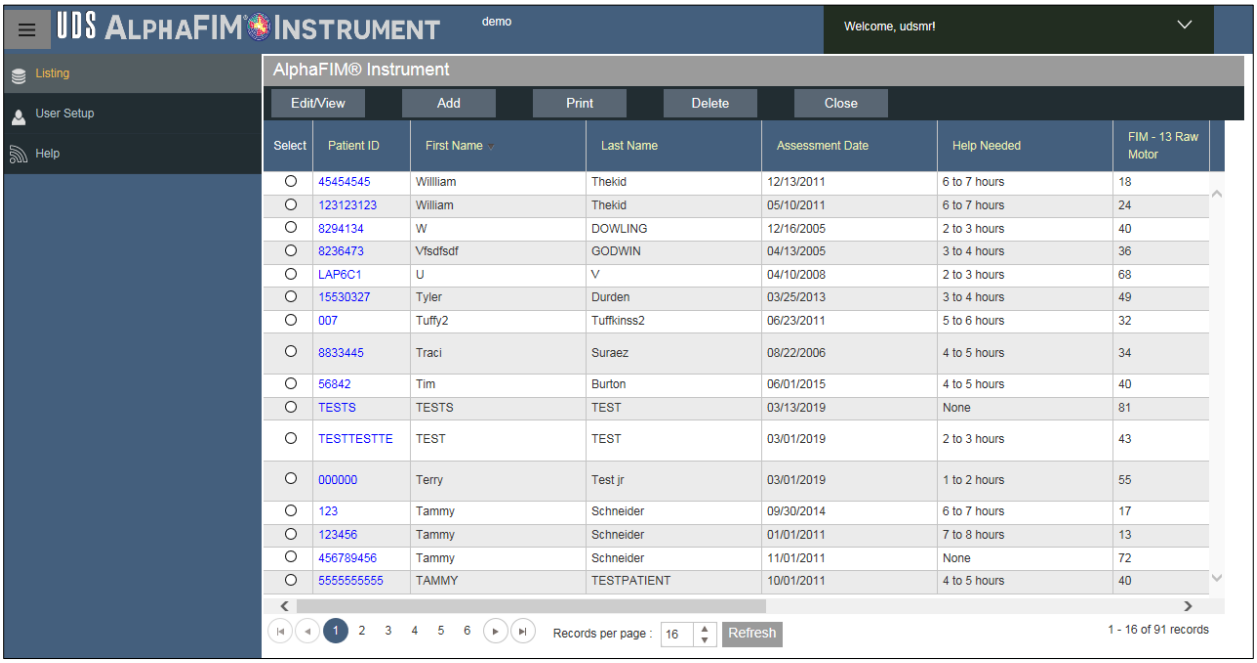

Figure 3. The Case Listing

This window displays a list of all patient records created by users at your facility. The display window contains the following information for each patient record:

- Patient ID (an identifier assigned to the patient by the facility)
- First name
- Last name
- Assessment date (the date on which the patient's AlphaFIM® ratings were assessed)
- FIM-13 raw motor rating
- FIM-13 Rasch motor rating
- FIM-5 raw cognition rating
- FIM-5 Rasch cognition rating
- FIM® motor range
- FIM® cognition range
- FIM® walking range
- Amount of help needed

A record's patient ID and assessment date combine to create a unique identifier for that case. For more information on the rest of these fields, see chapter 5, "AlphaFIM® Calculations," on page 23.

To sort the records by patient ID, first name, last name, or assessment date, click the relevant link; click the link again to sort the list in reverse order.

To print the case listing, click the **Print** button, select your desired printer settings from the Print dialog, and then click the **Print** button to print the document and close the Print dialog.

You can use the buttons in the patient listing to add, edit, and delete the records on display. You also can report on individual patient records. For more information, see *Managing Patient Records* on page 34.

To close the case listing, click the **Close** button.

Managing Patient Records

You can use the AlphaFIM® website to manage patient records for your facility. Patient record management consists of adding, editing, and deleting patient records. You can also report on individual patient records in your database.

To manage case records, click the **Listing** button. The case listing will appear, similar to that shown in figure 3 on page 32. You can use the features of this window to add, edit, and delete patient records, as well as report on them.

Adding a Patient Record

To add a patient record:

1. Click the **Listing** button, and then click the **Add** button. The Add/Edit Patient window will appear, as shown in figure 4.

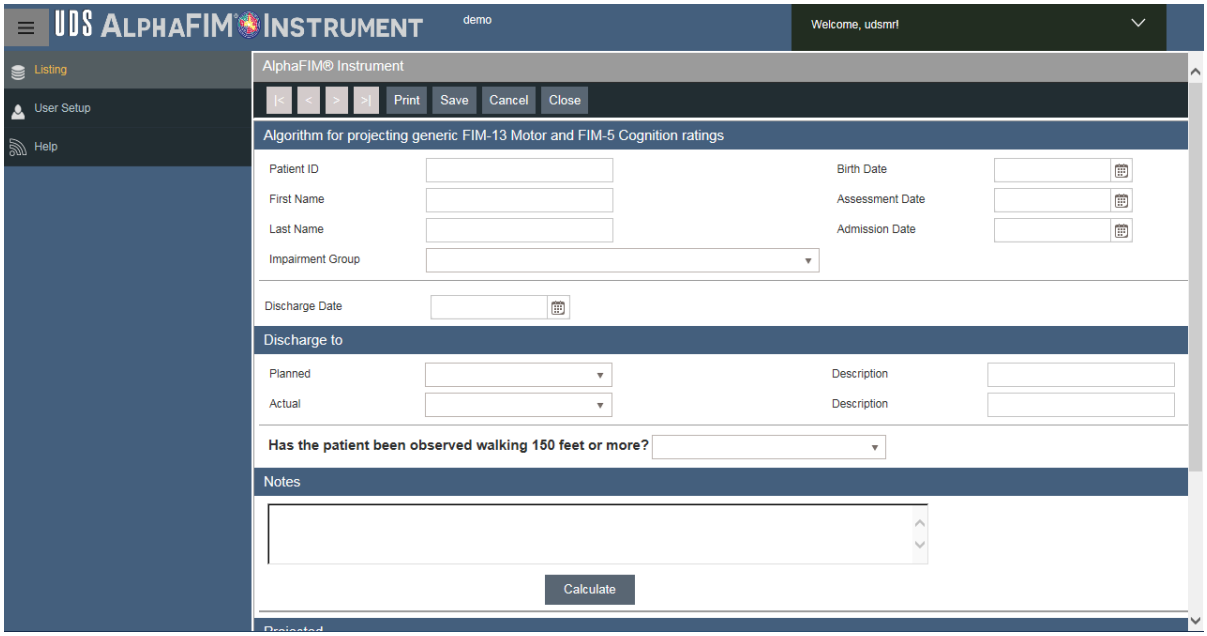

Figure 4. The Add/Edit Patient Window

2. Enter the patient's identification code in the **Patient ID** field. If you have previously entered a record for this patient, use the same ID code for both records.

   Remember that the patient ID and assessment date combine to create a unique identifier for each record.

3. Enter the patient's first name in the **First Name** field.
4. Enter the patient's last name in the **Last Name** field.
5. Enter the patient's date of birth in the **Birth Date** field, or use the calendar icon to select a date.
6. Enter the patient's assessment date in the **Assessment Date** field, or use the calendar icon to select a date.
7. Enter the patient's admission date in the **Admission Date** field, or use the calendar icon to select a date.

8. Select the patient's impairment group from the **Impairment Group** drop-down menu.
9. If you want to track patient discharge planning, open the **Planned** drop-down menu, select the planned discharge destination, and then enter the desired text in the **Description** field that appears to the right of the Planned drop-down menu.
10. If the patient has been discharged, enter the patient's discharge date in the **Discharge Date** field, open the **Actual** drop-down menu, select the discharge destination, and then enter the desired text in the **Description** field that appears to the right of the Planned drop-down menu.
11. Use the **Has the patient been observed walking 150 feet or more?** drop-down menu to indicate whether the patient has been observed walking 150 feet or more. When you make your selection, the software will populate the Add/Edit Patient window with six item fields.
12. Select the patient's AlphaFIM® ratings from the drop-down menus.
13. If you want to add notes to the record, enter the desired text in the **Notes** text box.
14. Click the **Calculate** button to generate the AlphaFIM® estimates for the patient. These estimates will appear in the fields below the Calculate button.
15. Click the **Save** button.
16. Click the **Close** button to close the Add/Edit Patient window and return to the case listing. The newly created record will appear in the case listing.

You can save only one assessment per patient per day.

Editing a Patient Record

To edit a patient record:

1. Click the **Listing** button. The case listing will appear, as shown in figure 3 on page 32.
2. Click once on the patient record you want to edit.
3. Click the link in the **Patient ID** column that corresponds to the record you want to edit, or select the radio button in the **Select** column that corresponds to the record you want to edit and then click the **Edit/View** button. The Add/Edit Patient window will appear, as shown in figure 4 on page 34.
4. Make the desired changes to the fields.
5. If you make changes to the AlphaFIM® items, click the **Calculate** button.
6. Click the **Save** button.
7. Click the **Close** button to close the Add/Edit Patient window and return to the case listing. The edited record will appear in the case listing.

Deleting a Patient Record

To delete a patient record:

1. Click the **Listing** button. The case listing will appear, as shown in figure 3.
2. Select the radio button in the **Select** column that corresponds to the record you want to delete.
3. Click the **Delete** button. A confirmation dialog will appear.

4. Click the **OK** button to confirm your selection and close the confirmation dialog. The deleted record will disappear from the case listing.

Printing a Patient Record

To print a patient record:

1. Click the **Listing** button. The case listing will appear, as shown in figure 3 on page 32.
2. Click the link in the **Patient ID** column that corresponds to the record you want to print, or select the radio button in the **Select** column that corresponds to the record you want to print and then click the **Edit/View** button. The Add/Edit Patient window will appear, as shown in figure 4 on page 34.
3. Click the **Print** button.
4. Configure the desired print settings.
5. Print the record.
6. Click the **Close** button to close the Add/Edit Patient window and return to the case listing.

Additional Information

For help on rating the AlphaFIM® instrument, see chapter 4, “Specific Rating Instructions,” on page 9. For help using the AlphaFIM® website:

- See the other sections in this chapter.
- Click the **Help** button in the navigation area, and then click any of the links.
- Contact UDSMR’s technical support department at 716-817-7834 or techsupport@udsmr.org.

Logging out of the AlphaFIM® Website

The AlphaFIM® website allows you to manage confidential patient records. Closing the program properly will prevent unauthorized people from gaining access to the patient records.

To log out of the website:

1. Click the control in the upper right corner of the web page (the one with your user name). A menu will appear.
2. Click **Sign out**. A confirmation dialog will appear.
3. Click the **OK** button to close the confirmation dialog and log out of the software. The AlphaFIM® Software Logon Information window will appear.
4. Click the **X** in the upper right corner of your browser window to close it.

Appendix A: AlphaFIM® Coding Form

AlphaFIM® Coding Form

Case Identification

1. Patient ID _____
2. First Name _____
3. Last Name _____
4. Birth Date _____
   MM / DD / YYYY

Assessment Information

5. Assessment Date _____
   MM / DD / YYYY
6. Impairment Group _____

AlphaFIM® Instrument

7. Has the pt. been observed to walk 150 feet or more?

❑ Yes (rate item 8A, below)

8A. AlphaFIM® Instrument

Rate the patient for each of the items below.

Motor Items

a. Transfers: Bed, Chair _____
b. Locomotion: Walk _____
c. Bowel Management _____
d. Transfers: Toilet _____

Cognitive Items

e. Expression _____
f. Memory _____

❑ No (rate item 8B, below)

8B. AlphaFIM® Instrument

Rate the patient for each of the items below.

Motor Items

a. Eating _____
b. Grooming _____
c. Bowel Management _____
d. Transfers: Toilet _____

Cognitive Items

e. Expression _____
f. Memory _____

Leave no item blank. If an item is not testable due to risk, enter 1.

AlphaFIM® Instrument Rating Levels

No Helper

7 Complete Independence (no device, timely, safely)
6 Modified Independence (device, not timely, or not safely)

Helper - Modified Dependence

5 Supervision (patient performs 100% of the effort)
4 Minimal Assistance (patient performs 75% or more of the effort)
3 Moderate Assistance (patient performs 50% to 74% of the effort)

Helper - Complete Dependence

2 Maximal Assistance (patient performs 25% to 49% of the effort)
1 Total Assistance or Not Testable (patient performs less than 25% of the effort)

Appendix B: Translating a Patient's Total FIM® Rating into a Daily Burden of Care

Raw FIM® Rating	Rasch Measure	Daily Burden of Care
60	40	Approximately 4 hours of assistance
80	50	Approximately 2 hours of assistance
90	60	Approximately 1 hour of assistance
100	65	Minimal or no assistance
110	70	No assistance