**OPRA**

**IAF Instructions Feedback**

**ADAPTIVE SKILLS DOMAIN**

DODD has added the following definition: “need” means the inability of an individual to complete a “necessary” and applicable task independently, safely, and consistently. They go on to say that if the individual is not willing to complete the task, this is not a “need”. When measuring staff time, it does not matter if the staff has to complete the “necessary” task because the individual refuses or if they simply cannot perform. Arguably it would take longer due to refusal because we would be spending additional time encouraging them to complete it.

We appreciate this feedback. Originally, we thought it would be a good idea to include this definition to be consistent with the level of care language. However, after receiving a few comments on this, we will be removing this definition. We do agree that since this is a resource tool and not a level of care tool, it may not be as applicable and in fact, refusal may lead to the need for additional resources.

Questions 11 and 13 seem to define unsupervised time as (audible, visual, and physical proximity of staff) to ensure health and welfare? Unsupervised means the consumer is alone, with no need for any staff to be available or in the proximity. I believe the phrase you are referring to is “an individual’s assessed capabilities to have unsupervised time **or** essential supports and supervision (e.g. audible, visual and physical proximity of staff) to ensure the provision of health and welfare.” These examples are referring to the supervision required, not unsupervised time.

References to “occasional” mean less than weekly but more than monthly. Should it read "…but no more than monthly" or simply "less than weekly"?
These are the original definitions included in the tool. At this point, we are not changing the tool, but just clarifying the original intent of the questions.

**BEHAVIOR DOMAIN**

Question 21: Everyone would need to make sure the assessments/evaluations are current and up to date with these criteria explicitly spelled out!

How should a provider handle behaviors that are addressed (with guidelines, not formal plans) but not documented? This happens frequently with stereotypic behaviors and behaviors that are addressed via ignoring. When an individual has Behavioral Guidelines and not an actual BSP…Guidelines are not typically documented on and often require substantial staff time. So to get credit for the interventions that occur…it appears it would be necessary to change Guidelines to a Formal Program.

This will depend on how much staff interaction/intervention is required for the behavior. If these occur frequently and require substantial amounts of staff time, then they should be documented in the IP and be specific to what the staff should be doing in relation to the exhibited behavior.  An example would be offering replacement behaviors by redirecting/maintaining the individual is actively absorbed in recreation and/or functional activities.

 How should a provider handle behaviors that exist but are not exhibited due to the presence of staff? This depends on how the staff is being used. Remember that the behavioral domain asks assessors to rate the seriousness of behavioral challenges in terms of the degree of staff intervention/supervision typically required over the quarter. If the presence of staff is just normal staffing ratios, then that would not be included. However, if additional staff are needed to prevent behaviors from occurring then that would be included, based on how often additional staff are needed. For example, if an individual needs 1-on-1 staff time 3 times a week to prevent behaviors from occurring, then that would be scored as frequent.

We do have some concerns that the current IAF does not effectively capture the impact of multiple maladaptive behaviors and how they impact staffing needs, but I assume we will be able to broach that topic after the Department determines if the IAF is a useful tool.

Yes – as mentioned previously, we are not changing the tool at this point, just clarifying the intent of the questions to gain consistency in application across providers. We may need to look at this in the future.

**MEDICAL DOMAIN**

Questions 22 and 29 contain changes in definitions that could impact scores and rebasing of IAF. We don’t believe that these are changes to the definitions, just clarification of the original intent of the question. During our conversations with providers, we found that there was a wide range in how questions were being interpreted, so these changes to the instructions are to clarify the intent and to try to minimize the room for interpretation, which leads to inconsistency in application.

Question 31 will require specific documentation or will be disallowed. What is needed and what is the process? The requirement is just that the response be evidenced. We are not requiring providers to use a specific format to do this, but believe that they should have documentation already existing in multiple places (nursing notes, medical records, staffing schedules, transportation logs, etc.). We do not believe that it is unreasonable to require that providers maintain some documentation that will show how they arrived to their score on this question.

 Has consideration been given for staffing of residents who require a 2 person transfer? This is already captured under question #8, Transfer; answer #2 is “needs direction and/or physical help from one or more persons when transferring”.

 Has there been any consideration of prep time for medication administration? It can take quite a bit of time to set up for residents who require multiple medications. This is already captured under question #28, Medication Administration. It includes all tasks associated with taking medications, which would include prep time.

 Some residents are able to manage their diabetes with education (thus insulin injections are discontinued). The education component takes more time than the injection. There does not seem to be any question that reflects this.

If this refers to education to increase the individual’s level of independence with the administration of insulin via injection or oral medication, then it would fall within the scope of question #28 (Medication Administration).  However, if it refers to education needed to manage diabetes by diet alone, then you are correct that this may not be covered under the questions on the IAF.  However, dietitian services are not included in the direct care cost center, but under the indirect cost center, which is not impacted by the IAF results.

Has there been any consideration of staff time spent at hospitals? Many hospitals rely on ICF staff for assistance at meals, to reduce restraints, for companionship and family communication, to monitor IV’s so they don’t get pulled out, discharge planning, etc.

This would be covered under the “Out of Home Health Care” question #31.  Staff time spent out of the home for hospitalizations is included.  However, providers should be able to evidence the time spent with some sort of documentation of actual staff hours spent with the individual out of the home.

      Is there consideration for blood sugar checks? This is included in question #28, Medication Administration.  Since checking blood sugar is a task related to the administration of medication, it should be captured in question #28.

 Question 27 says: “Special measures to improve respiratory functions, including blow bottles…” We suggest it say: “…including, but not limited to...” This is a good suggestion; we will update the instructions with this. We are wondering if such things as elevating a person’s head so they do not aspirate or changing a person’s position so they are able to breathe is supported in this domain? No. These would be captured under question #6, Turning & Positioning.

Why is delegation in question 29 a 0? This does take staff time and training. When the IAF was originally created, there was no delegated nursing and nursing staff were required to administer medications.  Since the original intent of this question was to measure the amount of nursing time needed to administer medications, delegated nursing would not fit within the scope of the question.

In regards to Question 29, all medications should be combined together. Topical medications, injections, oral Meds, and other way are all medications and we are curious as to why they are listed in different categories. Also the number of medication passes is not a good indicator of time spent by a nurse. If someone has 15 medications to take at one time and another individual has 1 medication taken at one time, the time on the part of the nurse is vastly different. We feel number of medications should matter. It is possible (hopefully not) that some agencies could change the medication administration times to every hour or every two hours which would increase errors and disrupt client lives. Finally to rate Nursing Delegation as a zero does not make sense. Someone still has to administer the medication (if the person is unable to self-medicate), staff still must be trained, and there is still a nurse on call. This actually is penalizing individuals who live in a smaller setting. At this point, we are not changing the questions; we are just clarifying the original intent of the question to gain consistency in application. As mentioned above, even though staff time is required for delegated nursing situations, this question was originally intended to measure the amount of nursing staff time required. Costs associated with 24 hour nursing staff are much higher than costs associated with 24 hour direct care staff with nursing supervision. Capturing the difference in costs based on the resource needs of each individual is the purpose of this tool.

 **General Comments**

First we think the IAF scoring system is flawed. There are only a number of items on it that actually trigger a score that truly counts. In this sense it does not give an accurate reflection of the entire picture of a person and the amount of time that goes into providing care for an individual.

Supervision Levels matter. There are clients who have constant Supervision or Line of Sight Supervision or other Supervision Levels that are not documented on but occur throughout the day, all day. Supervision Levels are quite time-consuming but are not really addressed.

In regards to Question 31: The question asks information about one quarter but is based upon the entire year. Why not just base the question on each quarter.

Overall the changes are not too bad but actually the IAF is not a great assessment tool. It is supposed to rate the amount of staff time or staff intervention with clients but it does not really do that. It really only truly rates the amount of intervention needed on several items and ignores the other parts of an individual’s daily life.

Thank you for your feedback. As mentioned above, at this point, we are not making any changes to the IAF tool; we are just clarifying the intent of the questions so that they can be consistently applied across providers. Once we have confidence that the tool is being completed consistently, we may need to review the actual questions/subject areas. I would remind folks that the tool is not meant to capture all variances in resource needs from individual to individual, but rather to capture the major differences in resource needs. The original workgroup consisted of industry experts, both state and national, who worked to determine which areas would be assessed and utilized time study results and wage information to validate which measures had major impacts on facility costs. I hope this will help to put perspective on the current efforts and assist providers in understanding our iterative approach to the review of the IAF.