**Revisions to IAF Instructions**

**General Comments**

At this point, no additions or changes are being made to the subject areas included in the assessment. The goal for the revisions to the instructions is to clarify the original intent of the subject areas and to provide additional guidance to eliminate the inconsistencies that exist in how current instructions are being interpreted.

**Summary of Revisions**

1. Adaptive Skills Domain
* Instructions/questions now include definitions consistent to updated PLOC and waiver rules for when referencing independent, supervision and assistance.
* The same applies as above for questions 1,2,3,4 with tasks for eating, toileting, oral hygiene, and bathing/showering.
* Question 3 tooth brushing was changed to oral hygiene because of the tremendous feedback from the field to include tasks of caring/cleansing for dentures and cleansing mouth.
* Question 11 community mobility description was revised to include the individual’s assessed capabilities to have unsupervised time or essential supports, and supervision (e.g. audible, visual, and physical proximity) to ensure the provision of health and welfare.
1. Behavioral Domain
* Instructions were revised to help clarify use of proactive and reactive interventions requiring staff utilizations. Also clarified that psychotropic medications to treat and/or manage behaviors do not fall within the scope of this domain. Also references to proactive and reactive interventions to eliminate/extinguish behaviors must be able to be quantified and evidenced.
* Question 13 endanger behaviors description includes the rater to take considerations for the individual’s assessed capabilities to have unsupervised time or essential supports and supervision to ensure the provision of health and welfare.
* Question 19 disruptive behaviors description to include non-compliance/refusals to complete daily tasks and elopement.
* Question 20 withdrawn behaviors’ description is to not include deliberate refusals /non-compliance to complete daily tasks as this is rated under disruptive behaviors.
* Question 21 suicidal behaviors description is specific to the rater on how to rate an individual with this behavior versus just rating them as having a DSM IV diagnosis related to suicide i.e. Depression, Bi-Polar, Eating Disorder etc…
1. Medical Domain
* Question 22 clinical monitoring by a licensed nurse specific that this must be prescribed by a physician and the nurse is onsite. A nurse being on-call is not applicable.
* Question 27 oxygen /respiratory specific not to include PRN inhalers for asthma.
* Question 28 medication administration was written to be consistent with updated PLOC and waiver rules. Need to add orally, topically, by injection or by other means.
* Question 29 medication frequencies written specific for # of med passes and not # of medications administered. Also written to include the utilization of delegated nursing to administer medications would rate a 0.
* Question 30 seizures written specific that medications used to treat/control seizures would not be rated. Also rater should take into consideration staff utilization for specialized treatments and or interventions to treat seizures (e.g. vagus nerve stimulator and Diastat suppository or supervision during and after seizure, etc…)
* Question 31 out of home care written specific that the rater should be able to quantify and evidence through data collection staff hours utilized for out of home health care. Options removed verbiage for days and average and only uses hours per year. Specified period of time to be measured, since question is on a yearly basis.

**Frequently Asked Questions**

* If an individual utilizes oral and non-oral means of nourishment, would this person receive “3” (nourished by other oral means)?
* The assessor should ask themselves what is the resource need to feed the individual by oral means.  If it is similar to the resource need to feed those who require hands-on assistance or to be fed and do not also utilize non-oral means, then the assessor should score it as a 2, since that is the response with the highest resource need.  If they only spend a minor amount of staff time providing assistance with oral nutrition and the majority of nutrition is received through non-oral means, then the assessor should score it as a 3.
* Has consideration been given for staffing of residents who require a 2 person transfer?
	+ Yes – this is covered under question #8, Transfer. A score of 2 covers the assistance of 1 or more persons.
* How do we 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.
	+ This will depend on how much staff interaction/intervention is required for the behavior.  Does staff need to be there for health and welfare?  If there are guidelines, these should be documented (IP) and 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.
* Where are blood pressure monitoring or glucose checks captured?
	+ These should be included in question #28, since these are tasks related to the administration of medication.
* Why is delegated nursing a 0 under medication frequency?
	+ 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.
* If more than 1 staff is needed by the individual to attend out of home health care, are all staff hours reflected in the response?
	+ Yes – all staff time spent with the individual for out of home health should be included
* How should assessors measure Out of Home Health, since this is asked on a yearly basis and not a quarterly basis like most of the other questions?
	+ The rater will use a rolling calendar year (i.e. The individual is being rated on March 31, 2013 therefore the rater will use information going back to March 31, 2012 up to March 31, 2013.) to rate the Individual. If an Individual is admitted and has not been at their current Provider for a year, the rater will use information going back to the date of admission up to the date of the current rating and then pro-rate that amount to project a full year (i.e. The individual has been in the facility for 6 months, the rater should take the amount of time and multiply it by 2). If an Individual is transferred from one ICF/IID to another ICF/IID under the same Provider/Company, the rater will use a rolling calendar year.
* 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.
* Question 31, Out of Home Health Care, 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.). Providers should maintain some documentation that will show how they arrived at their score on this question.