

IAF Frequently Asked Questions

GENERAL

1. Are private pays included in ICFs?

Yes, the rater would rate each resident(admitted to the ICF) of a Medicaid certified ICF/IID bed, regardless of payment source or anticipated length of stay, to reflect the resident's condition on the reporting period end date, which is the last day of the calendar quarter. Please note that individuals at an ICF for respite services (ex. funded through a waiver) are not considered residents of the ICF and should NOT be included.

2. Are services provided by all staff able to be counted on the IAF?

Services provided at workshop/day program/school are not to be used to score the IAF, even if the services are provided by residential staff (DSPs, LPNs, RNs, etc). This includes Medication Frequency in which medication is administered to your individuals.

3. What kind of supporting documentation should be used to score the IAF?

Any documentation that your facility uses to outline supports for the individuals and that staff reference to provide those supports. The level of staff assistance/supervision should be consistent among various components of the Individual Plan, such as the Comprehensive Functional Assessment, Behavior Support Plan, Intervention Guidelines, Physicians' Orders, Medication/Treatment Administration Records, etc.

ADAPTIVE SKILLS DOMAIN

1. What is the correct response for the individual who will not begin dressing without being told to do so, but after that initial verbal prompt completes all tasks without further prompts or physical assistance?

This question like all others is designed to report factors that indicate significant differences between individuals in their staff resource needs. To respond to questions where it may be difficult to distinguish between attributes for an individual, think in terms of the staff resources the individual requires.

The adaptive skills of the above individual can best be described as somewhere between the literal definitions of levels 0 and 1. To select the most appropriate response, ask yourself whether this individual is more similar in staff time required to an individual needing verbal prompting, cueing by touch etc., or whether he/she is closer in staff time required to an individual who dresses independently.

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2. 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.

3. If someone needs assistance with all tasks required for oral hygiene (ex. someone with dentures would need a staff member to physically remove the dentures from the mouth, get a glass of water ready for soaking, put cleaning solution in water, brush dentures as needed, then put fixture paste on dentures and put dentures securely back in mouth), how would this be assessed?

The answer would be 3, does not perform the task. Task must be done for the individual. However, if the individual can take the dentures out and put them back in, but staff assist with putting cleaning solution in water and brushing dentures, then the assessor should ask how much time does that take staff and compare that to the amount of staff time needed for the other answers (independently, prompts, hands-on assistance or total assistance) and select the answer that most closely mirrors the amount of staff time needed. For example, if the individual can do everything but open the solution, that might only take staff a few seconds and would most closely mirror the amount of time spent with someone who is independent in oral hygiene.

4. If an individual needs assistance with flossing as part of their oral hygiene how would this be assessed?

If the individual can do everything in regards to oral hygiene except flossing, then the assessor should ask how much time does that take staff and compare that to the amount of staff time needed for the other answers (independently, prompts, hands-on assistance or total assistance) and select the answer that most closely mirrors the amount of staff time needed. Please refer to the above question as it is similar.

5. Does TED Hose fall under dressing and how would it be rated?

TED Hose would be captured under dressing and it would be rated similarly to the response to question#4. For example, if the individual can do everything but put on their TED Hose, that might only take staff a short amount of time and would most closely mirror the amount of time spent with someone who is independent in dressing.

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6. If an Individual has a PT order for ROM consisting of 10 leg lifts 3x a day, how would this be rated?

This would be rated for the amount of times per day (3) the PT was ordered and not the total number of leg lifts (30). Under Turning and Positioning, this would then be rated as a "2" – Two to five times.

7. If an Individual has a PT order for ROM consisting of 10 leg lifts 3x a day and must be positioned 5 times a day for postural drainage, how would this be rated?

This would be rated for the amount of times per day (3) the PT was ordered and the number of times the Individual is positioned (5) In this case this would be 8 times and would be rated as a "3" – Six to twelve times. ROM and the postural drainage are separate occurrences.

8. What consideration been given for staffing of residents who require a 2 person transfer?

This is covered under question #8, Transfer. A score of 2 covers the assistance of 1 or more persons.

9. What is the difference between "Minimal, Moderate, and Continual" for Community Mobility?

Minimal – moves about the neighborhood or community with minimal supervision requiring staff to be available in the setting as a resource for that individual if required (i.e. the individual is aware of staff's presence and can use them as a resource if they need assistance and/or staff is able to assist the Individual as required).

Moderate – moves about the neighborhood or community with moderate supervision requiring staff in the vicinity of the individual (i.e. staff must be within audible and visual range of the individual).

Continual - means staff must be within audible, visual, and physical proximity of the individual.

10. Physical proximity. How close is close enough?

The IAF does not provide a definition for visual, audible, or physical proximity as this is defined and/or determined by an individual's team assessment/evaluation for required level of supervision. However, since physical proximity is the difference between moderate and continual, physical proximity must be closer than visual and/or audible range.

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11. How do you rate an Individual who due to either their cognitive or physical impairments is unable to participate in the activity (i.e. purchasing skills) at all?

They would be rated as a "3" – Does not perform the tasks. Tasks must be done for the Individual.

12. Question 2, Toileting, how would you rate an individual who requires including but not limited to... incontinent garments, attends, depends and/or diapers?

The rater needs to take into consideration if the individual requires including but not limited to... incontinent garments, attends, depends and/or diapers 50% or more of the time then would be rated with a response of 3.

13. Saline flush for a foley catheter. Does this count?

This is considered a part of managing/maintenance for a urinary catheter and would be rated with a response of 4 for question 2, toileting.

14. Does assistance with wearing a hearing aid fall within the scope of question 5, Dressing?

No, this is not applicable to the IAF as this is not a modified article of clothing or prosthesis. A prosthesis by definition is a replacement body part, limb or eye; not a sense.

15. How would you rate for an individual that requires staff in the bathroom during "Bathing/Showering" due to the individual having a history of seizures?

Instructions for attributes under the Adaptive Domain state that the questions are related to the level/utilization of staff assistance/supervision needed for personal care and safety. The rater needs to take into consideration if the individual has current seizure activity for the quarter that would warrant staff to provide one on one supervision (equal to an answer of "2" – requires hands on assistance to initiate or complete the task) to ensure health and welfare during the entire task for bathing/showering. If monitoring is not needed due to the absence of seizure activity or if the individual only has a history of seizures and there is no presence of seizure activity then this would be rated with the response that most closely fits the individual's needs for staff assistance listed for bathing/showering.

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16. Under “Toileting”, how would you rate someone who requires a catheter but is independent with their catheter care and does not require staff assistance with their catheter?

Instructions for attributes under the Adaptive Domain state that the questions are related to the level/utilization of staff assistance/supervision needed for personal care and safety. Since the above individual does not require staff assistance with their catheter, then they would be rated as a “0” – completes all the tasks independently.

17. If an individual needs to be supervised when eating to prevent choking, should he/she be scored a “2” in Eating?

In the score of “2” for the Eating attribute “... requires one on one supervision throughout the entire meal” means that one staff person is assigned to that one individual to provide supervision and/or assistance for the entire meal. That staff person cannot be responsible for providing supervision/assistance to any other individuals during the time that that one individual is eating. So if the staff truly provide one on one supervision throughout the meal, the individual should be scored a “2”. If staff supervise the individual while also supervising/assisting others, the individual should be rated based on the level of assistance typically required.

18. Is providing 1:1 supervision the only way to score a “2” in Eating?

To score a “2” in eating, the individual must require hands on assistance OR need to be hand fed OR need 1:1 supervision throughout the entire meal. So if an individual requires hands on assistance for eating or needs to be hand fed, he/she should be scored a “2”.

19. How do you calculate the number of times a day for Turning & Positioning?

The Turning & Positioning attribute is to be scored based on the number of times a day the service is performed. In order to rate above a “0”, there should be evidence showing that the services were performed at the corresponding frequency for 50% or more of the quarter. (ex: for a score of “4 – More than twelve times”, documentation would need to show that Turning/Positioning was done 13 or more times a day for more than 50% of the quarter.) The documentation needs to clearly show how many times staff provided the services. Services performed while at workshop/day program/school should not be counted toward the frequency.

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BEHAVIORAL DOMAIN

1. How do we handle behaviors that are addressed (with guidelines, not formal plans) but not documented with data collection? 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.

The intent of the IAF is to measure the amount of staff time used to intervene to prevent or react to behaviors. Regardless of where the behavior interventions are outlined (in a formal behavior support plan, guidelines, or incorporated as part of the Individual Plan itself), there needs to be evidence/documentation of interventions that take staff time to support the frequency indicated by the IAF score.

2. Question 21, how would you rate threats of suicide?

This would be determined by what is their condition (mild/cyclical, chronic, acute) stated in their Evaluation and/or Risk Assessment completed by a psychologist or psychiatrist. In addition, what is their defined Level of attention/monitoring required for participation and interruptions for daily activities; placement, planning, and programming due to suicidal behaviors.

3. Stealing, what attribute would this be rated under?

The rater needs to first take into consideration if intervention occurs enough to warrant a plan to be applicable to be rated above a 0. The rater then needs to determine how the stealing behavior is defined within that plan specific to the intent behind the stealing: is it to interfere with activities of others (including staff) or own activities e.g. to pester, tease, and/or gain attention; or is it to steal food to eat that would place that individual at risk due choking hazards. If the intent for stealing is to interfere with the activities of others (including staff) then stealing would fall within the scope of question 19, disruptive behavior. If the intent of stealing involves food to eat and places that individual at risk then this would fall within the scope of question 13, endangering behavior. Stealing includes but not limited to... food, personal belongings, items etc... this could be in their residential setting and or the community. This does not include day programming, community employment, and/or school. The rater should always take into consideration the demand for staff resources/utilization used to minimize and/or extinguish stealing behaviors.

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4. Where would “Insomnia” be rated/captured on the IAF?

Insomnia does not have its own attribute. The rater would need to look at the behaviors that may be caused by the insomnia and see if these behaviors are accounted for on the IAF, account for the amount of staff time/intervention required to meet the definitions for “occasional”, “frequent”, and “continual”, and if the Individual has a plan for the behaviors that is being caused or linked to the insomnia. The plan should state what behaviors the insomnia is linked to in order to properly and accurately rate the Individual on the IAF.

5. How are proactive/preventative supports for behaviors accounted for on the IAF?

Proactive and preventative supports are defined as interventions requiring staff to provide supervision and active interaction with the individual at the same time in which the specific behavior is being addressed as identified in the individual’s plan. For example, if an individual requires staff attention in which there is constant interaction and a need for supervision with the individual in order to implement redirections from engaging in withdrawn behavior then this would be applicable. This is only if it occurred enough to warrant a plan and meets the frequency as defined for occasional, frequent, and continual- 50% or more during the quarter. A proactive support is not applicable if an individual did not require the attention and supervision of staff to be engaged in an activity. For example, if an Individual requires a blue cup for every meal to prevent self injurious behaviors and this requires staff to only place the blue cup on the table for every meal this would not be applicable to be rated as it does not require a significant amount of staff intervention/interaction/attention and supervision.

Behavioral interventions should be clear as to what staff actually do. Words such as “redirect” and “intervene” do not fully explain what staff are to do. There are many actions that are considered redirection and intervention; some take staff time and some do not. Phrases such as “staff may” and “staff should” do not indicate what staff actually did. The intent of the IAF is to measure the amount of staff time used to intervene to prevent and react to behaviors. Interventions that do not take staff time (ex: “speak in a calm voice”) or are unclear as to what staff actually did (ex: “redirect to an activity”), are not ratable.

6. How are 15 minute checks accounted for in the IAF?

The IAF is not used to count the time related to routine protective oversight, monitoring, or bed checks and/or agency driven policies, unless the time involves some direct services that is related to a specific need for the individual (e.g. turning an individual, changing bedding or clothing, providing proactive or reactive behavioral supports). Rating an individual for the IAF is to assess the degree/level of staff interventions/supervision that an individual requires for the severity of their needs.

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Fifteen (15) minute checks can only be accounted for if: the behavioral attribute the rater is trying to rate is in a plan; it is considered a proactive or preventative support; it must occur more than 50% or more of the time in the quarter; and it must be quantified and evidenced when behaviors occur or supports are used to minimize and/or extinguish behaviors. For example: if staff are completing 15 minute checks only to provide routine bed checks, then this would not be able to be rated. However, if staff are using the 15 minute checks to actively engage the individual as a proactive/preventative support (ex. staff must do more than just manage an Individual's preferences or choices that are provided routinely throughout a normal day), and due to this the Individual is aware that if they have a behavior that staff will immediately intervene, then this could be rated according to the responses for the applicable attribute.

7. Can all types of aggression – verbal and physical – be counted under the Aggressive Behaviors attribute?

Only physically aggressive behaviors should be rated under the Aggressive Behaviors attribute. These include but are not limited to physically attacking others, hitting others, kicking others, biting others, throwing objects at others. Self-injurious behaviors, threatening behaviors, and property destruction do not fall within the scope of this attribute. Verbal aggression is not ratable here. Simply "throwing objects" is not ratable here unless it is at others.

8. Are all behaviors in a Behavior Support Plan automatically ratable on the IAF?

Evidence of the occurrence of behaviors should be clear which behaviors actually occurred. If an individual's Behavior Support Plan defines "Aggression" as throwing items at others and knocking over furniture and the documentation just shows the number of times "aggression" occurred, the frequency of Aggressive Behaviors could not be determined as "knocking over furniture" does not fall within the scope of this attribute on the IAF.

Documentation of staff interventions should be clear which interventions staff actually did. If an individual's Behavior Support Plan lists several interventions for a behavior – some that take staff time (such as spending 1:1 time) and some that do not (such as giving the individual quiet time without supervising him/her) – but the documentation just shows the number of times staff intervened to prevent or react to a behavior, the frequency of ratable staff intervention could not be determined as the IAF is to only capture the interventions that take staff time.

Behavioral interventions should be individual specific. General behavioral guidelines that are used agency wide are not ratable for the IAF. The daily schedule of activities available to all residents (ex: game time, arts & crafts, walking, etc.) should not be counted as behavioral interventions.

Behavioral interventions should be tied to a specific behavior. Behavioral interventions and documentation should be clear as to which interventions were used for specific behaviors. If the

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same behavioral intervention is used for multiple attributes, it must be clear which behavior it was used for. The same behavioral intervention episode should not be used for multiple attributes/questions at the same time. Example – a behavior support plan lists spending 1:1 time with an individual to prevent Aggressive and Disruptive Behaviors. If a staff person documents spending 1:1 time, that occurrence can be used in the frequency calculation of ONE of the attributes, not both.

9. If staff have to intervene for a behavior, is that time able to be scored on the IAF?

No behavior conditions should be rated above a “0” unless there is a plan for addressing exhibited behaviors as part of the IPP. Interventions that are being documented should be the interventions that are identified in the IPP. If staff are doing something to prevent/react to a behavior that is not part of an IP, BSP, etc., then it is not ratable on the IAF. Conversely, the interventions that are listed in the plan to be implemented to prevent or react to a behavior should be documented to be ratable on the IAF.

10. Do you have to have a formal behavior support plan for a behavior or can programs be used to address behaviors?

If a training program is used for a specific behavior, the plan should identify the program as a measure to address the behavior. It should be clear in the IPP somewhere that the program is tied to a specific behavior. Example – If an individual participates in an exercise program to lessen the likelihood of Disruptive Behaviors, the plan should state that the intent of the program is to address Disruptive Behaviors.

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MEDICAL DOMAIN

1. If an Individual requires Tracheostomy Care and Suctioning Care, how would this be rated?

This would be rated by adding the total amount of times Tracheostomy Care was completed to the amount of times Suctioning Care was completed that day for the Individual. For example: The Individual requires Tracheostomy Care 2 times a day and Suctioning Care 2 times a day, then this Individual received a total of 4 instances throughout the day in which they required care under Attribute #25. Dependent upon the times of the day the care was completed and the scheduled hours of the DSP's, this would determine how to properly rate this Individual. If the DSP's worked 7am – 7pm and 7pm – 7am and the individual received their Tracheostomy Care once and Suctioning Care once at 8am and each once again at 8pm then this would be rated as a "4" – All shifts. If the DSP's worked 7am – 3pm, 3pm – 11pm, and 11pm -7am and the Individual received their Tracheostomy Care once and Suctioning Care once at 8am and each once again at 8pm then this would be rated as a "3" – Three or more times a day.

2. Where are blood pressure monitoring or glucose checks captured?

These should be included in question 28, if these tasks are for the administration of medication. They are not applicable to question 29, medication frequency.

3. 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.

4. 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.

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5. 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.

6. 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.

7. 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. The documentation should clearly indicate which appointments occurred inside the facility and which were outside the facility at a medical office or hospital.

8. How do you rate med passes that take 2 hours?

This is not applicable. Question 29, medication frequency, is based on the # of medication passes and not the duration of the medication pass. Regardless of the total amount of time a medication pass requires, this is already accounted for within all the resource weights.

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9. Does a CPAP and BIPAP machine count as oxygen?

Yes, only the application can be rated and not the duration of its use.

If an individual uses a CPAP/BIPAP all night and it is only applied once at bedtime, the score would be “1 – Daily”. If staff (DSPs or nurses) have to reapply the CPAP/BIPAP throughout the night, the score would be based on the number of times it was typically applied/reapplied over the quarter. There should be evidence of the number of times it was applied/reapplied.

10. Is a g-tube site and a suprapubic catheter considered a wound? Or is it only considered a wound after they are initially placed?

The site care is considered as a wound; however, that is if there is an actual dressing. Individuals will eventually get to the point that actual ‘wound care’ is not needed and will no longer be able to be rated as the only care required is cleaning with soap/water and patting dry – just like regular bathing to the site.

11. In regards to medications, the IAF lists the following routes – oral, topical, injection, and other way. What qualifies as “other way”?

Other: means prescribed medication include but not limited to...administered via: Tube (G-tube, J-tube, NG tube), Rectal, Inhaled (nebulizer treatments, MultiDose Inhaler), Intrathecal (spinal analgesia for pain management as well as anti-spasmodic therapy).

12. Are Baclofen pumps accounted for on the IAF under Medication Frequency, “other way”?

Administration of baclofen medication via a pump in which the administration is continual and not induced by a nurse does not apply to this attribute as this attribute is to measure the number of times that staff assist individuals with their medications. If the baclofen medication is administered as a pill, this could then be captured under 29a – oral.

13. Nebulizers- do they fall within the scope of question 27, Oxygen and Respiratory Therapy or question 28, Medication Frequency D. Other Way?

This would be rated within the scope of question 29, Medication Frequency D. Other Way only if this is to administer a prescribed medication. Refer to FAQ question 28.

14. Does a humidifier fall within the scope of question 27, Oxygen and Respiratory Therapy?

This depends on the application of the humidifier- if it is a Heat Moisture Exchanger (HME) or Humidification of a Trach Collar then this would fall within the scope of question 25, Tracheostomy Care/ Suctioning Therapy. If it is a humidifier that is an electric appliance that generates water mist or steam and releases it into the room. This is not applicable to the IAF.

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15. Does an individual receiving medical services at day program with residential staff accompanying them fall within the scope of question 31 Utilization of Out of Home Health Care?

This specific attribute is inclusive to account for staff time utilized attending planned/ unplanned hospitalization, physicians, and dentist appointments for routine or specialized medical services. This does not include health care provided on the grounds of the residential facility and/or an adult day program, work, and school. The expert panel believed that Individuals that meet the 30 day(721 hours or more) of staff time are presumed to either have a chronic medical condition requiring frequent routine visits or likely to experience one or more acute episodes of relatively great severity in the course of the year. The 30 day threshold to meet a Chronic Medical classification is set relatively high because it includes transportation time. The decision to include transportation time was based on a desire to make it simple for assessors to calculate resident resource use. By including transportation time, assessors need only know when a resident left and returned to the facility from an out of home visit. Otherwise the assessor would be forced to itemize the time spent by staff with the resident in the hospital, or physician or dentist's office.

While the IAF identifies medically involved residents travelling outside of the facility it does not capture residents who are visited by physician in the facility. The reason for this distinction is based on differences in relative resource use between the two situations. Although the facility staff may accompany or assist doctors during their visits to the ICF, the expert panel did not believe this activity was comparable to accompanying a resident outside of the facility on a regular basis. In the former case, a staff member might interact with a physician during part of this visit while performing other duties during times when the physician is able to act unassisted. In the latter case, the staff member's time is taken up fully the ICF resident, even if it is in the physician or dentist's office waiting room.

The argument that some residents would meet the out of home threshold if their facility did not arrange for in home visits is not persuasive. Facilities should make such a decision based on best medical practices for their resident.

Receiving out of home medical care at a day programming is not applicable for rating within this attribute as this is still an activity that is not comparable to staff accompanying an individual to a medical appointment. This is especially the case if the same provider owns/operates the day program. The intent of this attribute is to capture when an individual is taken to an appointment and there is no option but to have a designated staff that is committed well beyond that time that the individual is with the physician, or dentist or other medical professional. In addition to this, transportation is inclusive to time spent enroute to an appointment when rating this attribute as such there would be no demand for transportation as the presumption would be that transportation would have already occurred as this is part of the individual's routine for attending their day program.

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16. Under “Oxygen and Respiratory Therapy”, how would you rate an individual who requires continual oxygen?

Instructions for attributes under the Medical Domain state that the questions ask for estimates of the number of times staff have provided or assisted in special treatments to address medical conditions. If an Individual is receiving humidified oxygen through the facility oxygen piped system of their room, this would be rated as a “1” – Daily, unless staff need to apply any special treatments related to the oxygen. If this is the case, then the rater would rate based off of the number of times staff provide a special treatment. If the Individual is using an E-cylinder (tank), then the rater would rate based off of the number of times staff replace and/or adjust the E-cylinder. The rater also needs to base their rating off of the physician’s order specific to the treatment for that specific individual. The rater also needs to recognize and be aware that just because the individual receives continual oxygen 24/7, e.g. via nasal cannula, that this does not necessitate an automatic rating with a response for all shifts. This has to be determined by how the oxygen treatment is ordered for administration and what is required by staff to provide this treatment.

17. Does the response “All shifts” apply to a 24 hour period or for only when nursing works and applies treatments?

“All shifts” applies to a 24 hour period. For example: if a provider only has nursing from 12am – 8am and 8am – 4pm (and nursing applies treatments during these 2 shifts), and no nursing from 4pm – 12am, then this does not apply to “All shifts”. The response “All shifts” must account for 24 hours in a 24 hour span in order for a provider to claim this as a response in the Medical Domain. For example: if a provider has nursing from 12am – 8am, 8am – 4pm, and 4pm – 12am and treatments occur on all shifts, then the response, “All shifts” would apply.

18. What types of things fall under Parenteral Therapy? The instructions include “Hickman catheter”. Is this a type of urinary catheter?

Parenteral Therapy refers to the administration of medication, fluids, nutrition, etc. in a manner other than through the digestive tract, such as by intravenous or intramuscular injection. Examples are PICC lines, tunneled central venous catheters, and implanted ports. Urinary catheters do not fall within the scope of this attribute. Please refer to the Medical Domain Information sheet that is included in the IAF Training packet for further information.

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19. When determining Medication Frequency, what counts as a medication pass?

All facilities should develop guidelines for administration of scheduled medications in order to ensure adequate staffing coverage and decrease the likelihood of errors. Guidance under Medicaid Tag W369 allows for the flexibility of administration within a 2 hour period (up to 1 hour before and 1 hour after the scheduled time). We would not expect to see medications administered more often than that 2 hour period unless a physician has specifically indicated to do so and the rationale is available for review. The Department encourages providers to work with physicians to ensure that medication is administered at times and intervals appropriate to the needs of the individual and in a manner that causes the least disruption to the individual's life and ability to participate in activities.

20. Does the use of an Incentive Spirometer fall within the scope of question 27, Oxygen and Respiratory Therapy?

No, an Incentive Spirometer is not applicable to this attribute.