INSTRUCTIONS FOR THE COMPLETION OF THE INDIVIDUAL INDICATOR RATING SCALE

The **INDIVIDUAL INDICATOR RATING SCALE** represents the intermediate step that **must** be completed before determining a level of need. This instrument will assist the rater in objectifying and integrating the data contained in the documents submitted for review through the application of a standard set of procedures.

It is the intent of these instructions to assist the rater in interpreting each section of the **INDIVIDUAL INDICATOR RATING SCALE.** As such, these instructions are guidelines which should help to provide overall consistency in the scoring of each rating scale.

This **INDIVIDUAL INDICATOR RATING SCALE** is not constructed to meet rigorous psychometric principles, either in its design or its application. Its purpose is to provide the Department of Health and Mental Hygiene with a consistent mechanism for measuring individual need that will be used to determine an appropriate level of individual reimbursement.

Ratings should be based solely upon the documentation that is submitted as part of the IIRS packet. Examples of documents that MAY be included in the packet are listed under each section under "Documentation May Include" However, other documents not listed may also be included. Each rating should incorporate services that are recommended as needed by the individual, even though the individual may not currently be receiving those services. It is important to note that, for any score higher than "1", the rater must indicate the specific attached document that substantiates the score. This information must be entered on the "Source/Documentation" line for each section of the **INDIVIDUAL INDICATOR RATING SCALE**.

SECTION I: HEALTH/MEDICAL

A. Raters should indicate routine therapy sessions or health interventions that occur on a regular basis and that are the result of ongoing medical/dental/etc. problems, such as 45-day nursing reviews. Only therapies obtained from licensed professionals may be included. Not included in this section are; routine evaluations, health evaluations and screenings that may be done on an annual

basis, interventions or therapies that are the result of a maladaptive behavior or a psychiatric disability (which are covered in Section I.B), and interventions that were obtained through the support of a family member. Raters should count up the total number of health interventions in a 12 month time period and divide that number by 12 to establish the number of interventions per month.

B. Like Section I.A., raters should indicate routine professional therapy sessions such as individual or group sessions that occur on a regular basis as the result of a maladaptive behavior or a psychiatric disability. Interventions listed in this Section may be provided by a certified professional who is directly employed by the agency or who is an outside consultant. Interventions may include interactions between the certified professional and the staff or between the certified professional and the individual. For example, time spent between the professional and the individual during the development of the behavior plan and time spent training direct care staff in the implementation of a behavior plan may be included. Not included in this Section are interactions between the individual and the direct care staff, as the result of maladaptive behavior or a psychiatric disability.

SECTION II: SUPERVISION/ASSISTANCE

A. Medication/Special Care

Higher levels of assistance are required as scores increase from 1 to 5

Items 1 and 2 refer to medications that are short-term in nature, such as aspirin, cold remedies, antibiotics, etc. In item 1, the individual needs no assistance or supervision in taking the medication, however, in item 2 the individual **does** need supervision or assistance. Items 3, 4, and 5 refer to prescriptive medications. As such, it is assumed that supervision/assistance is needed since a staff person must, at the very least, document that the individual received his medication. Items 3, 4, and 5 are self-explanatory, and reflect a movement towards a greater need for

supervision, and/or more severe consequences should the medication/ treatment not be provided. Items 4 and 5 also include the utilization of specially trained staff for the implementation of a behavior plan or for the provision of specialized medical care. Medications and special medical procedures should be listed on the rating scale under Source/Documentation.

B. Mobility: **Complete Part 1 or Part 2**.

Part 1*:* **For residential or day services only**.

This section is intended to determine an individual's regular need for assistance with mobility. Higher levels of assistance are required as scores increase from items 1 to 5. These questions only consider factors that may inhibit a person's physical ability to be mobile. Note: Issues related to maladaptive behaviors, which result in an increased need for supervision during ambulation are addressed in Section C and should not be addressed here.

Part 2: For supported employment services only.

Higher levels of assistance are required as scores increase from items 1 to 5. The first description relates to the individual's mobility at the work site. The second description identifies transportation needs related to supported employment. You may use **either** criterion when assessing an individual's mobility level in supported employment.

C. Day Program/Residential Program/Supported Employment

Complete the section related to the service for which the individual is being evaluated - **day, residential or supported employment**. The five items noted refer to increased levels of supervision as when moving from item 1 to item 5. This section does not discriminate regarding the reasons for the need for increased supervision (i.e. behavioral problems, medical conditions, etc.), but instead assumes that, regardless of the cause, additional staff supervision is necessary when moving from item 1 to item 5.

INDIVIDUAL INDICATOR RATING SCALE

Individual's Name: **Social Security Number:**
Date:
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CIRCLE the most appropriate response

SECTION I.

A. Health/Medical

. Individual requires health interventions and licensed professional therapies (e.g. OT, PT, S/H, nutritional consultation, medical consultation, 45 Day nursing reviews, nursing consultations, etc.) Does not include annual health evaluations or screenings or therapies resulting from maladaptive behavior. Raters should add the total number of therapies/interventions over a 12 month time period and divide by 12 to determine number of therapies or interventions per month.

1. Individual requires no therapies or interventions.
2. One therapy or intervention per month.
3. Two to four therapies or interventions per month.
4. Five to nine therapies or interventions per month.
5. Ten or more therapies or interventions per month.

Documentation M*ay* Include: 45 Day Nursing Reviews, Nursing Consultation Notes, Physician's Medication Order Form, Medical Appointment Records, Professional Summaries, IP with specific medical services listed.

Source_____
(Specify Exact Citation in Attached Documentation)

INDIVIDUAL INDICATOR RATING SCALE

Individual's Name: **Social Security Number:**
Date:
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B. Behavioral/Psychiatric

Individual exhibits outbursts of anger, violent or seriously maladaptive behavior, an inability to control ritualistic behavior, or has a diagnosed psychiatric disability (e.g. clinical depression, suicidal ideation, etc.) Either because of the frequency of the occurrence and the severity of a maladaptive behavior, or because the individual requires professional therapies as the result of a diagnosed psychiatric disability (psychiatrist, licensed psychologist, master's level psychologist or social worker with experience in managing maladaptive behavior, supervised by a licensed psychologist.) Professional therapies may include interactions between the licensed professional and direct care staff concerning the maladaptive behavior. See instruction I B – total number of professional therapies per month **or** total number of interventions per month.

1. Individual requires no therapies or interventions.
2. 1 to 4 therapies or interventions per month.
3. 5 to 8 therapies or interventions per month.
4. 9 to 11 therapies or interventions per month.
5. 12 or more therapies or interventions per month.

Documentation *May* Include: Behavior Plan, Psychiatric Treatment Plan, Staff Training Record, Professional Therapy Consultation Notes, Medical Appointment Record related to therapy, Behavioral Data.

Source: _____

(Specify Exact Citation in Attached Documentation)

INDIVIDUAL INDICATOR RATING SCALE

Individual's Name: **Social Security Number:**
Date:
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CIRCLE the most appropriate response

SECTION II. SUPERVISION/ASSISTANCE

A. Medication/Special Care

1. Individual requires no medication (other than short-term medication for colds and other non-recurring illnesses). Individual needs no assistance.

2. Individual requires no medication (other than short-term medications for colds and other non-recurring illnesses). Individual is dependent on staff for prompting or supervision.

3. Individual requires prescription medications as needed for chronic/medical condition illness (excludes psychotropic or anti-convulsive medications).

4. Individual either requires medication, including psychotropic or anticonvulsive medications, for chronic behavioral or medical conditions, or individual requires a behavioral plan provided by specially trained staff for a chronic behavior problem, or individual requires special medical assistance/supervision for a medical condition.

5. Individual either has a medical condition requiring special procedures (e.g. insulin injections, tube feeding, colostomy, ileostomy, etc.), or individual requires periodic one-on-one supervision for the implementation of a behavior plan provided by specially trained staff for a chronic behavior problem.

Documentation *May* Include: Physician's Medication Order Form, Medical Reports, Summary of Medications and Medical Conditions, Nursing Care Plan, Behavior Plan.

Source:_____
(Specify Exact Citation in Attached Documentation)

INDIVIDUAL INDICATOR RATING SCALE

Individual's Name: **Social Security Number:**
Date:
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B. Mobility: Complete either Part 1 or Part 2.

Part 1: For Residential or Day services only.

1. No assistance needed.

2. Can walk but needs occasional assistance (i.e. may be elderly, obese, or, because of impaired gait, may need assistance crossing a busy intersection, or occasionally needs a wheelchair for long distances.)

3. Walks with assistive device (e.g. canes, crutches, guide dog, walker, adaptive devices); gait may be unstable; may exhibit scoliosis but is not overly dependent on others for assistance. Uses wheelchair but is self-mobile and can transfer unassisted.

4. Walks with assistive devices and needs assistance; uses wheelchair and is self-mobile but needs assistance with transfers.

5. Non-mobile.

Documentation *May* Include: OT/PT Evaluation, Medical or Nursing Notes, Physician's Orders, Medical Appointment Record, Nursing Evaluation, IP including Staff Ratios.

Source:_____
(Specify Exact Citation in Attached Documentation)

INDIVIDUAL INDICATOR RATING SCALE

Individual's Name: **Social Security Number:**
Date:
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Part 2: For Supported Employment services only. (Rate **either** the individual's mobility at the worksite **or** the individual's transportation needs.**)**

1. No assistance needed **or** is able to access work transportation independently.

2. Can walk but may need occasional assistance **or** needs occasional assistance getting to and from the work site.

3. Walks with assistive device or uses wheelchair but is self-mobile and can transfer unassisted **or** requires transportation to and from the work site with minimal assistance.

4. Walks with assistive devices, needs assistance, or uses wheelchair and is self-mobile but needs assistance with transfers **or** individual requires a wheelchair accessible van, or requires supports to and from work site.

5. Complete assistance needed including total assistance with mobility and transfers **or** requires specialized transportation, private car, etc. **or** requires constant supervision to and from work site.

   Documentation *May* Include: OT/PT Evaluation, Medical or Nursing Notes, Physician's Orders, Medical Appointment Record, Nursing Evaluation, IP including Staff Ratios.

   Source:_____
   (Specify Exact Citation in Attached Documentation)

INDIVIDUAL INDICATOR RATING SCALE

Individual's Name: **Social Security Number:**
Date:
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SUPERVISION

C. Complete the section related to the service for which the individual is being evaluated - **Day, Residential or Supported Employment.** Circle the most appropriate response.

DAY PROGRAM

1. Can function independently within a group setting with only periodic direction. Can be expected to work alone for extended periods of time with little or no direct staff intervention. May need some guidance when initiating new tasks.

2. Needs daily assistance, direction or guidance to function in a group setting. Can be expected to need occasional prompting/cueing in order to stay on task. Direct "hands-on" intervention is rarely needed.

3 . Needs intervention on a daily basis to complete assigned tasks and learn new skills. Can be expected to need direct, "hands-on" intervention on a regular basis either to stay on task or because of physical disabilities. May move off task or become mildly disruptive if left unsupervised (e.g. walk away from work area, become overly loud, take other's possessions, agitate others, etc.)

4 Needs constant supervision/instruction in a group setting because of the severity of medical, behavioral and/or physical conditions. While only one staff member need be present in the individual group, the group cannot be left unsupervised.

5. Needs constant supervision, as part of a small individual group, due to overriding medical, physical, and/or maladaptive behavioral conditions which restrict the individual from performing functional task without direct counselor assistance. Requires at least two staff members be present in the individual group at all times, or requires periodic one to one staffing.

Documentation *May* Include: IP, DDA Application, Adaptive or Functional Evaluation, Behavior Plan, Social History.
Source:_____
(Specify Exact Citation in Attached Documentation)

INDIVIDUAL INDICATOR RATING SCALE

Individual's Name: **Social Security Number:**
Date:
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RESIDENTIAL PROGRAM

1. Needs periodic support on a weekly basis (drop-in assistance), or no more than seven hours of intervention per person per week.

2. Needs programmatic support in order to maintain functional skills. Live-in staff may or may not be required, however, individual may be left unsupervised occasionally, or can go about the neighborhood, back and forth to work, etc., independently.

3. Needs direct care staff assistance because of mental retardation, physical impairments, maladaptive behaviors, and/or sensory impairments in order to perform skills needed to live in the community. Live-in staff is required, and individual cannot be left unsupervised, except within the context of the residential program as defined and allowed for in the IP, at any time.

4. Needs constant supervision/assistance due to the severity of the disabling condition in order to perform functional tasks such as bathing, feeding, etc. Temporary augmentation of staff may be required on occasion due to recurring medical and/or behavioral conditions.

5. Needs periodic, one-to-one supervision while in the home because of overriding medical, behavioral and/or disabling conditions. The individual cannot perform functional tasks without direct counselor assistance, e.g. bathing, feeding, etc. Individual may be a danger to himself or others. May include overnight, awake staff supervision.

   Documentation *May* Include: IP, Behavior Plan, DDA application, Assessment of Skills, Medical Documentation, Physician's Medication Order Form, Staffing Schedule.

   Source:_____
   (Specify Exact Citation in Attached Documentation)

INDIVIDUAL INDICATOR RATING SCALE

Individual's Name: **Social Security Number:**
Date:
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SUPPORTED EMPLOYMENT

1. Individual works independently in competitive or individual work site. Needs provider staff support initiating new job tasks.

2. Individual requires occasional, periodic (but not daily) assistance or prompting from provider staff to stay on task.

3. Individual needs daily intervention and occasional hands on assistance from provider staff to stay on task and/or learn new work skills.

4. Individual requires provider staff present (at less than one-to-one level) at all times for supervision and instruction.

5. Individual needs constant supervision due to overriding medical, physical, and/or maladaptive behavioral conditions which restrict the individual from performing functional/work tasks without direct care staff assistance.

   Documentation *May* Include: Individual Plan, Adaptive or Functional Assessment, School Records, Vocational Assessments/Evaluations.

   Source:_____
   (Specify Exact Citation in Attached Documentation)

INDIVIDUAL INDICATOR RATING SCALE

Individual's Name: **Social Security Number:**
Date:
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SECTION III. DIRECTIONS AND SCORING KEY

1. **HEALTH/MEDICAL**

   Select the highest score in Section I between A and B and enter it on the "Score" line below.

   Score: _____

2. **SUPERVISION/ASSISTANCE**

   Select the highest score in Section II between A and B (i.e. take only one of the scores) and add it to the score for Section II C. Divide that score by 2.

   Higher of A and B: _____

   Plus C: _____

   Sub- Total: _____ **÷ 2 = Score:** _____

3. **SCORING**:

1.0 - 1.49	Mark 1 on Matrix	3.5 – 4.49	Mark 4 on Matrix
1.5 - 2.49	Mark 2 on Matrix	4.5 – above	Mark 5 on Matrix
2.5 - 3.49	Mark 3 on Matrix		

4. **Enter both the HEALTH/MEDICAL AND SUPERVISION/ASSISTANCE scores on the matrix.**

Reviewer's Name: _____ Signature: _____
(Print or type)
Date: _____

Regional Office Reviewer: _____ Signature: _____
(Print or type)
Date: _____

***Place completed scale in individual's record.**