June 2024

INDEPENDENT LIVING ASSESSMENT (ILA) MANUAL INSTRUCTIONS

Health Review Section

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Health Review

Purpose

This section can be completed by the case manager and/or an agency nurse (LPN/RN) and intended to a review of the individual's health, mental health and memory/cognition/behaviors as reported by the individual and/or with the use of other supporting documentation or verbal reports **within the last 30 days**. The intention of this review is to identify if the individual's health has remained the same or has changed (declined or improved) since the initial clinical assessment or since the last annual reassessment. Any change in health may also affect the individuals' functional abilities and the plan of care that is in place. It may also affect the individual goals identified in the person-centered plan.

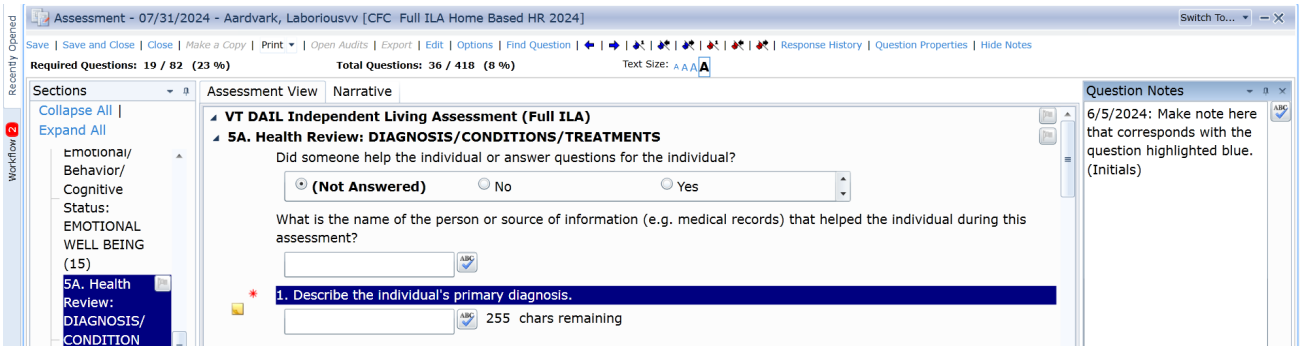
It is important to note that certain questions and the responses to those questions may trigger the need for further evaluation and/or follow-up by the individual's primary care, mental health, or specialty care providers.

Documentation Best Practices

Listen, Observe, Document! The expectation for documentation is to make detailed notes that correspond with individual questions based on what you hear the individual and/or support people report and what you observe the individual doing. The documentation should be descriptive. E.g. Mobility: The individual reports that she can walk independently, and it was observed that she is independent, but needs to hold onto the railing in the hall for support and guidance due to balance issues when walking from the living room to the bathroom.

To do this, the "show notes" box needs to be open, and the notes need to correspond with the currently highlighted question.

Example:



Diagnosis/Conditions/Treatments

Diagnosis: List the primary diagnosis for which the individual is receiving long term care services/supports (reason for Choices for Care clinical eligibility). The diagnosis listed here should also relate to the individuals' functional abilities. **Note:** The "primary" diagnosis may be different than the diagnosis being used for the purpose of billing Medicare, Medicaid, or other insurance.

> **Example:** An individual may have Type II Diabetes, High Blood Pressure (Hypertension) and a right side above the knee amputation. For Choices for Care, right side above the knee amputation would be the primary diagnosis affecting functional abilities.

ICD-10 Code: All Choices for Care (CFC) High/Highest participants must have a billable ICD-10 diagnosis code that relates to their need for long term services and supports.

At the time of clinical assessment, the DAIL LTCCC Nurse shall assign the ICD-10 code after obtaining and reviewing the health information provided for Choices for Care in the Home Based, Adult Family Care and Enhanced Residential Care setting. This diagnosis code will be copied from the clinical assessment onto the ILA form and will be in the Health Review section of the ILA. Upon utilization review (UR), the DAIL LTCCC Nurse will update the ICD10 Code as needed. The ICD10 Code will be in the service plan section of the UR ILA form.

Other Conditions Diagnosis: Check <u>all</u> the current conditions/diagnoses that have a relationship to the <u>current</u> ADL status, cognitive status, mood and behavior status, medical treatments, nursing monitoring, or risk of death. In this section, please note any history of medical conditions that may not be receiving current treatment. If none, check "NONE OF THE ABOVE". If there are others that do not appear on the list, check "OTHER" and write in the specific disease diagnosis.

Comments: Use this space for comments on the diagnosis, any referrals or follow up being done for any of the diagnosis or conditions.

Medications are often a significant aspect of an individual's health and wellbeing. Gathering information on medications gives a more wholistic picture of the individual's health and will help the case manager identify if the individual needs any support in this area. The list of medications will be copied from the clinical assessment onto the ILA for an initial assessment. During the annual reassessment or during a significant change assessment, the case manager should ask about any changes in medication use and make the changes to the medication list. If an individual is reporting any issues with medications e.g. side effects, accessing meds (refills), the number of medications (polypharmacy), a referral should be made to their primary care provider, pharmacist, or agency Nurse for follow- up.

List the names of all prescription medications (if available).

The LTCCC will obtain a list of prescription medications during the clinical assessment. The list will only include the names of the prescription medications. The list will be copied over from the clinical assessment into this section of the ILA. Please review the list of prescription medications with the individual and update the list in a note. Dosage and frequency are not expected, but can be noted if available. If you can obtain a copy of the individual's medication list, this can be attached in the DAIL- ASD database in the individuals record.

List the names of all over the counter (OTC) medications (if available).

The LTCCC will obtain a list of OTC medications during the clinical assessment. The list will only include the names of the OTC medications. These will be copied over from the clinical assessment into this section of the ILA. Please review the list of OTC medications with the individual and update the list in a note.

For all prescription and OTC medications dosage and frequency are not expected, but can be noted if available. If you can obtain a copy of the individual's medication list, this can be attached in the DAIL-ASD database in the individuals record. Please make a note that the list has been attached.

Rationale for Medication Lists: It is going to be rare that you work with an individual who is not taking any medications. In fact, it is more likely that you will be working with individuals who take multiple medications, for multiple conditions, prescribed by multiple providers. You may not know what all the medications are for, but you can ask the individual if they know. If they do not know and you do not know, that is okay. This can

lead to looking up medications together on a phone/computer (if there is service) and open discussion about the medications.

Additional Prompting Questions could be:

- Is the individual remembering to take their medications?
- What kind of system do they use e.g. pill box, bubble packs, do they need a system, or do they need help with their current system?
- Can they access their electronic medical record to get a list of their medications?
- Are any of their medications causing side effects?
- Are they having trouble getting their medications?

It is the role of the case manager to ensure that the individual is referred to the Primary Care provider, pharmacist, or agency nurse for if the individual is reporting any issues with their medications. The individual may need medication reconciliation which is when the provider compares medication orders to all the medications that the individual has been taking to ensure all the medications are compatible. The person leading the reconciliation can work with the individual and other providers to make any necessary adjustments.

What is the name of the individuals Primary Care Provider?

Write in the name of the individuals Primary Care Provider. If the individual does not have a primary care provider, document this and what is being done to connect the individual with a provider. If you need assistance to find a provider in the area where the individual resides, *see the Appendix page for the Medicaid Provider Search function.*

What is the phone number of the individuals Primary Care Provider?

Write the phone number of the individuals Primary Care Provider, if they have one.

Select all that apply with regards to the client's oral and dental status.

Ask the individual the question and read them the options for the responses. Check all responses that apply or check none of the above. If the individual reports a response that indicates dental/oral issues, then the next question is an opportunity to ask about frequency of dental visits and referral for follow up if they have a dentist or support the individual with referrals to establish a dental home, if they do not have a dentist. *See the Appendix page for the Medicaid Provider Search function.*

How often does the individual see a Dentist? Document in a note.

Ask the individual how often they go to the dentist and document the response in a note, along with any follow-up that may be needed regarding oral/dental status based on responses to the question about oral/dental status.

Health Related Questions

Please list all hospital events in the last 30 days. – Ask the individual this question. If they are unable to answer, you may get this information from other sources, such as family, caregivers, or medical records if available. Hospital events include visits to the Emergency Department (ED), admissions for "observation" or inpatient admissions. This question will give the case manager an idea of the individual's current health and risk of future hospital events. It is also considered by the DAIL LTCCC Nurse when determining ongoing "nursing home level of care" for CFC clinical eligibility related to being medically unstable. Along with the hospital event, please note timeframe and when the individual was discharged, if this information is available.

In the past year, how many times have you stayed overnight in a hospital? Overnight hospital stays include those for "observation" or inpatient stays and expands the timeframe of the prior question related to 30 days. This expanded timeframe helps to identify any trends in health conditions. E.g. has the individual been admitted for an inpatient stay multiple times in the last year for the same condition or has a new condition developed/been diagnosed?

Have you stayed in a nursing home in the last year? – Ask the individual the question. This question includes any stays at a nursing home for rehabilitation to have therapies such as Physical and Occupational therapy (short- term) or long term stays. If they are unable to answer, you may get this information from other sources, such as family or caregivers.

If you are doing this review as part of discharge planning while an individual is in a nursing home or is considered complex care and "stuck" at a hospital, then the individual may be referred to Money Follows the Person (MFP) to see if they may be eligible for funding to support a transition from the nursing home or hospital back to the community. See this link for more information including how to make a referral: Money Follows the Person Program | Adult Services Division (vermont.gov)

Emotional/Behavior/Cognitive Status: Cognitive Status

(See Cognitive Chart at end of instruction manual)

Cognition is how a person thinks (judgment), remembers, and makes decisions about their daily lives. Cognition is one of the hardest areas to assess. Consider that many things have an impact on an individual's cognition- e.g. new environments, medications, time of day, infections. Having a conversation with the individual, observing them in their environment and listening to their responses to questions will give you clues on how they think (process information to make judgments) if they understand their strengths and weaknesses (insight) and whether they are repetitive (memory). Keep in mind that questions about cognitive function and memory can be sensitive issues. Some individuals may become defensive, agitated or very emotional which is a common reaction to performance anxiety. Letting the individual know that you ask all individuals about memory and cognition may help to "normalize" this section of the health review. Asking this information in a private area and using a nonjudgmental approach will help develop a sense of trust between the you and the individual. If possible, gather information from caregivers and/or family members, as well.

The following questions may be awkward or sensitive for some individuals. The reviewer should gently introduce the questions by assuring the individual that the questions are asked of everyone, and they simply help provide a little bit of information about memory and decision making. Ask each question directly to the individual. It is OK if the individual uses a calendar or other tool to help them answer one or more of the questions. Make sure you reflect any tools or "clues" used in a documented note. If the individual is not able to answer the question correctly or is not able to independently use a calendar or other tool to help them with the answer, then the answer is "incorrect answer". The reviewer must use their judgment to determine whether the individual has a challenge with memory requiring follow-up. If the individual is not able to respond, the answer is "no response".

"What year is it?"

Ask the question directly to the individual. If they are unable to response, check "No response".

What month is it?

Ask the question directly to the individual. If they are unable to response, check "No response".

What day of the week is it?
Ask the question directly to the individual. If they are unable to response, check "No response".

The answers to the questions in the following section must be obtained from the reviewer's observations of the individual, in addition to the report of any caregivers and/or health professionals who are involved with the individual. In all cases code the cognitive items with answers that reflect your best judgement and document in a corresponding note, why the answer was chosen.

Memory and use of information – Check one answer that best fits the individual's memory and use of information.

Global confusion – Check one answer that best fits the individual's global confusion.

Verbal communication – Check one answer that best fits the individual's verbal communication status.

Cognitive skills for daily decision –making
An individual with Alzheimer's, dementia or other neuro-cognitive conditions usually goes through different phases of memory and cognitive loss impacting the ability to make different kinds of decisions.

Memory Responses:

Early Stage: The individual may experience mild forgetfulness (short term memory) or mild disorientation. Usually the long term memory is fully intact. There may be mild challenges with problem solving, but the individual is still independent with most daily activities, however, may need occasional cueing (1-3 times/day). The individual can still make most decisions, but may need some assistance with more complex decisions e.g. around finances or managing finances.
Coding: Minimal Difficulty Remembering (Memory) and Modified Independence (Cognition).

Middle Stage: The individual will have noticeable memory loss, usually significant short term memory loss and mild long term memory loss (will remember way back). The individual requires more frequent queuing (4+ times/day) throughout the day to complete household tasks and personal care. The individual can still make decisions, but they are simpler ones such as choosing what activity they would like to do. Complex tasks are no longer possible, and they may no longer participate in prior "usual" activities. **Coding: Difficulty Remembering (Memory) and Moderately Impaired (Cognition).**

Late Stage: The individual will have no short term memory and profound long term memory loss (may only remember from childhood). Spoken language may be limited or lost. The individual needs continuous prompts or cueing to get through daily activities. The individual will still have preferences and be able to make extremely simple decisions e.g. do they want a banana or apple sauce? **Coding: Cannot Remember (Memory) and Severely Impaired (Cognition).**

Examples of Daily Decision Making: Choosing items of clothing; knowing when to make and eat meals; knowing how to schedule and follow-through with appointments; using environmental cues to organize and plan (e.g., clocks, calendars, posted listings of upcoming events); in the absence of environmental cues, seeking information appropriately (i.e., not repetitively) from others in order to plan the day; using awareness of one's own strengths and limitations in regulating the day's events (e.g., asks for help when necessary); making the correct decision concerning how to get to appointments and using transportation.

Cognition Responses:

Check one answer that best fits the individual's cognitive skills for daily decision-making and document in a note describing the individual's function and reason for that choice. *Refer to additional examples above and charts.*

> **Independent-** the individual's decisions in organizing daily routine and making decisions were consistent, reasonable, and organized reflecting lifestyle, culture, and values.
>
> **Modified Independence**- The individual organizes their daily routine and makes safe decisions in familiar situations and surroundings but experiences some difficulty in decision-making when faced with new tasks, situations, or surroundings.
>
> **Moderately Impaired** - The individual makes decisions that put his/her health and safety at risk due to memory/cognitive decline. The individual requires reminders, cues, and supervision in planning, organizing, and correcting daily routines. The individual needs assistance with complex decisions.
>
> **Severely Impaired** – The individual's decision making is severely impaired. The individual rarely or never makes decisions, however may still be able to make simple decisions e.g. what food to eat if offered a choice.

Assessor Action: write a note to indicate any reviewer action and comments regarding the individual's emotional well-being and/or cognitive status, as well as any planned follow up (e.g. with PCP, Memory Clinic).

Behavioral Status
(See Behavioral chart at end of instruction manual)

The answers to the following section must be obtained from the reviewer observations, in addition to any caregivers and/or health professionals who are involved with the individual. Each behavior is measured by its frequency in the last 30 days and how easily the behavior was altered. Document in a note a description of the behavior if it exists. *See Behavior Charts for additional information.*

How often does the individual get lost or wander? – Wandering is defined as "locomotion with no rational purpose, seemingly oblivious to needs or safety." A wandering individual may be unaware of their physical or safety needs. Wandering behavior should be differentiated from purposeful movement (e.g. a hungry person moving about the home in search of food). Wandering may be manifested by walking or by wheelchair. Wandering may also be triggered by anxiety.
Responses: "Never", "Less than daily", or "Daily".
Examples:

- Trying or wanting to "go home" even when at home.
- Becoming restless, pacing, or making repetitive movements
- Having difficulty locating familiar places such as the bathroom
- Acting as if doing a hobby or chore, but nothing gets done.
- Appearing lost in a new or changed environment.

In the last 30 days, was the wandering alterable? – Answer "Behavior was not present OR was easily altered" or "Behavior was NOT easily altered". For example, if the individual does not respond to redirection or is aggressive when attempts are made to redirect unsafe wandering, then the behavior was "NOT easily altered".

How often is the individual verbally abusive to others? – Verbal abuse is defined as "Others were threatened, screamed at, cursed at."
Responses: "Never", "Less than daily", or "Daily".
Examples:

- Yelling and name-calling
- Direct threats of physical harm
- Threats against people or things that are important to the other person as a way of instilling fear or gaining power and control.

In the last 30 days, was the verbal abuse alterable? – Answer "Behavior was not present OR was easily altered" or "Behavior was NOT easily altered". For example, if the individual does not respond to distraction or redirection or becomes aggressive when attempts are made to stop verbal abuse, then the behavior was "NOT easily altered".

How often is the individual physically abusive to others? – Physical abuse is defined as "Others were hit, shoved, scratched, sexually abused."
Responses: "Never", "Less than daily", or "Daily".
Examples:

- Hit
- Shoved
- Kicked
- Bit or scratched
- Choked

In the last 30 days, was the physical abuse alterable? – Answer "Behavior was not present OR was easily altered" or "Behavior was NOT easily altered". For example, if the individual does not respond to distraction, physical intervention or becomes more aggressive when attempts are made to stop physical abuse, then the behavior was "NOT easily altered".

How often does the individual exhibit socially inappropriate/disruptive behavior? – Socially inappropriate/disruptive behavior is defined as "Makes disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public, smeared or threw food/feces, hoarding, rummaged through other's belongings."
Responses: "Never", "Less than daily", or "Daily".
Examples: Same as above.

In the last 30 days, was the socially inappropriate/disruptive behavior alterable? – Answer "Behavior was not present OR was easily altered" or "Behavior was NOT easily altered". For example, if the individual does not respond to distraction, physical intervention or becomes aggressive when attempts are made to stop the behavior, then the behavior was "NOT easily altered".

How often did the individual display symptoms of resisting care? – Resisting care is defined as "Resists taking medications/injections, ADL assistance or eating." *This does not include instances where the resident has made an informed choice not to follow a course of care.* Signs of resistance may be verbal and/or physical.
Responses: "Never", "Less than daily", or "Daily".
Examples:

- Physically pulling away from caregiver or tightening limbs/stiffening body.
- Deliberately ceasing to bear weight during care.
- Waving arms and legs.
- Verbally objecting to care using words or sounds

In the last 30 days, was the resisting care behavior alterable? – Answer "Behavior was not present OR was easily altered" or "Behavior was NOT easily altered". For example, if the individual does not respond to redirection or becomes aggressive when attempts are made to provide care, then the behavior was "NOT easily altered".

Comments – Document if there is a plan in place for caregivers to manage behaviors and if the plan is having a positive impact or if the plan may need to be adjusted. Describe the impact behavioral challenges may have on ADL/IADL's and the individuals' functional abilities.

General Health Questions

Infections – Check all the infections that apply. If none, check "NONE OF THE ABOVE". If there are others that do not appear on the list, check "OTHER" and write in the specific infection. Document in a note what the treatment is for any reported infections.

Additional prompting questions could be:

- Is home health coming to the home and giving treatment? If so, how often and what is being done?
- Is the caregiver doing treatment? If so, how often and what is being done?
- If this is a newly reported issue, has the individual followed up with the primary care provider? Has a referral been made? This should be documented in the note.

Problem Conditions – Check all of the problems that have been present *in the last 30 days.* Document in a note any current treatments for the problem conditions reported and/or any referrals made.

Additional prompting questions could be:

- Is home health coming to the home and giving treatment? If so, how often and what is being done?
- Is the caregiver doing treatment? If so, how often and what is being done?
- If this is a newly reported issue, has the individual followed up with the primary care provider? Has a referral been made? This should be documented in the note.

Medical Treatments – Check all of the treatments that have been received *in the last 30 days.* Document in a note any current treatments for the problem conditions reported and/or any referrals made.

Additional prompting questions could be:

- Is home health coming to the home and giving treatment? If so, how often and what is being done?
- Is the caregiver doing treatment? If so, how often and what is being done?
- If this is a newly reported issue, has the individual followed up with the primary care provider? Has a referral been made? This should be documented in the note.

Check all nutritional approaches in the last 30 days – Check all of the nutritional issues that have applied to the individual *in the last 30 days*. If none, check "None of the Above". Document in a note if the individual is following any of the nutritional approaches and the reason it is needed.

Is the individual currently receiving in home or outpatient OT/PT/SLP/RT from a licensed professional? Check the therapies that the individual has received in the last 30 days.

Additional prompting question:

- Are therapies taking place in the home or outpatient?

Requires specialized physical therapy for range of motion activities as part of an active treatment plan specific to a disease state resulting in restriction of mobility. Check "Yes" or "No". If the individual has received specialized physical therapy (PT) in the last 30 days, check "Yes". "Yes", should only be checked if the individual has a "prescribed program" by the licensed physical therapist versus a general home exercise program. The PT may teach the caregiver how to carry out the therapeutic program at home. If this teaching has been done and is carried out by the caregiver document the details in a note.

Explain the effect, if any, these treatments/therapies have on the client's level of care: E.g. has the treatment/therapy improved the individual's range of motion in the arms, legs or has it improved the individual's mobility or ability to transfer or get in/out of bed (PT)? If so, how? If the individual is having a therapy other than PT, how has it impacted the individuals daily activities?

Describe the assistance required to help the individual follow through with treatment/therapies. Document if the therapist has trained the in-home caregiver to carry out ongoing therapy activities with the individual and what the plan looks like- how many days/week, how many times each day etc. If additional time is needed for this, please make the variance request for additional time under the ADL or IADL (most impacted by the therapy) in the ADL/IADL section of the ILA. Please reach out to your local DAIL LTCCC Nurse if you are unsure where to make the request.

Example: If the caregiver is working with an individual to carry out a prescribed physical therapy program that needs to be done 3 times/week for gait/balance training and takes 15 minutes each time, a variance can be requested for this additional time in the ADL for mobility.

Residential Stability: Check off the response that best applies to the individuals current (in past 30 days) residential stability. Housing instability can be a precursor to other issues which include poor physical and mental health. If housing is noted to be unstable, document in a note any follow up or referrals that were made to support stable housing.

High risk factors characterizing this individual: Check off all that apply to the individual (within the last 30 days). Document in a note any follow up or referrals made based on the individual's response.

Indicate which of the following skin problems the individual has that requires treatment: Check off all that apply to the individual (within the last 30 days). Document in a note any follow up or referrals made based on the individual's response.

Additional prompting questions could be:

- Is the individual receiving home health services (frequency of visits) for any in home care related to skin issues?
- Is the individual going somewhere for outpatient for their reported skin problems?

Indicate the individual's frequency of pain interfering with activity or movement: Check off the response that applies (within the last 30 days).

If the individual experiences pain, does its intensity disrupt their usual activities? (e.g. sleep, eating, energy level). Check off "Yes" or "No" based on the individual's response. Document in a note how the pain is affecting the individual and any daily functional abilities if the response is "Yes".

Elimination Status

For the Health Review of the ILA, an individual is only incontinent if urine or stool **leaks beyond** the underpants, brief or other "appliance" used to attempt to contain the contents. The response in this section determines if additional time may be necessary (beyond normal toileting time) to assist with clean-up of the individual, clothing, bedding or other linens where the contents leak beyond the underpants, brief or pad etc. Document in a note the description of the clean-up that is needed if the individual is leaking beyond the brief or appliance.

What is the current state of the individual's bladder incontinence (in last 30 days)? – There are many reasons an individual may have urinary incontinence. A medical evaluation may be necessary to determine if the incontinence is reversible. Check the appropriate response "Yes "incontinent- if urine soaks through underpants or appliance, "No incontinence and no urinary catheter", or "No incontinence, individual has urinary catheter". *Note that when an individual uses a urinary catheter, they are not considered "incontinent". If accidents occur related to a malfunction or misuse of the individual's catheter, refer the problem to the individual's physician or nurse for follow-up.*

What is the frequency of the individual's urinary incontinence? – Individuals vary greatly in the frequency of urinary incontinence that occurs. Check the answer that best describes the individual's frequency of urinary incontinence.

When does urinary incontinence occur? – Check the answer that best describes when the individual usually has urinary incontinence, "during the day only", "during the night only", or "during the day and night".

What is the current state of the individual's bowel incontinence (in the last 30 days)? – There are many reasons an individual may have bowel incontinence. A medical evaluation is often necessary to determine if the incontinence is reversible.

Check the appropriate response "Yes"- incontinent- volume of stool soaks through underpants or appliance, "No incontinence and no ostomy", or "No incontinence, individual has an ostomy". *Note that when an individual uses an ostomy, they are not considered "incontinent". If accidents occur related to a malfunction or misuse of the individual's ostomy, refer the problem to the individual's physician or nurse for follow-up.*

What is the frequency of bowel incontinence? – Individuals vary greatly in the frequency of bowel incontinence that occurs. Check the answer that best describes the individual's frequency of bowel incontinence.

When does bowel incontinence occur? – Check the answer that best describes when the individual usually has bowel incontinence, "during the day only", "during the night only", or "during the day and night".

Has the individual experienced recurring bouts of diarrhea in the last 30 days? Frequent diarrhea can be an indication of other significant health problems. If the answer is “Yes”, recommend the individual follow-up with their primary care provider.

Has the individual experienced recurring bouts of constipation in the last 7 days? Frequent constipation can be an indication of other significant health problems. If the answer is “Yes”, recommend the individual follow-up with their primary care provider.

Comments: Please do not use this spot for comments. Ensure the “show notes” box is open and make notes with the correct corresponding question.

COGNITIVE STATUS

ILA Question: 4B.4 Select the choice that most accurately describes the client 's memory and use of information. (M)

ILA Question: 4B.7 What is the client's ability to make decisions regarding tasks of daily life? (C)

Cognition is how a person thinks **(judgement)**, remembers **(memory)**, and makes decisions about their daily lives ***(executive functions)**. Cognition is difficult to assess. Having a conversation with the individual and listening to how the individual responds will give you clues on how the individual thinks (judgement) if they understand their strengths and weakness **(insight)** and whether the individual is repetitive (memory).

Independent Living Assessment (ILA) Rating for Memory/Cognition

Level of Need ILA Coding Memory= (M) Cognition= (C)	Example	Cognition/Memory and Functional Level	Typical Cognitive Scores
No Difficulty Remembering (M) **Independent (C)**	An individual has no challenges with organizing a daily routine. Decisions are consistent, reasonable, and organized reflecting lifestyle, culture, and values. ** May continue to drive.	No Cognitive Impairment: • Normal memory and cognition • Independent Function • Competent in home, work, and hobbies	MMSE: >27/30 MOCA:>26/30
Minimal Difficulty Remembering (Cueing 1-3 times/day) (M) **Modified Independence (C)** *(Mild Cognitive/Memory Impairment)*	Individual can perform most of her daily tasks, but on some days, feels easily confused and forgets when and if tasks have been done. Individual develops a schedule and checklist to assist on those days. The schedule covers times for completing certain daily activities, such as showering and dressing, walking her dog, picking up mail from the mailbox and taking medication. The individual can follow this schedule. (Occasional reminders/cueing needed) **Consider OT driving assessment.	A mild but noticeable decline in cognition/memory: • Mild forgetfulness • Mild disorientation • Mild impairment in problem solving. • Independent in most activities • May struggle with complex tasks	MMSE:24-27/30 MOCA:18-26/30 *(mild cog. Impairment)* MOCA:11-17/30 *(mild dementia)*

Independent Living Assessment (ILA) Memory/Cognition/Behaviors Supplemental Reference Guide

Level of Need ILA Coding Memory= (M) Cognition= (C)	Example	Cognition/Memory and Functional Level	Typical Cognitive Scores
Difficulty Remembering (Cueing 4+ times/day) (M) **Moderately Impaired (C)**	Individual can dress independently but needs staff to organize outfits and provide cues. Caregivers remind the individual to do things such as when to eat and when to bathe, as the individual easily loses track of time and forgets what the next step is while in the middle of a task. The individual can decide on what activities to do, but someone must stay with the individual due to being confused and getting off task. (Frequent reminders/cueing needed) **Must stop driving.	Definite cognitive/memory decline and impairment: • Moderate to marked memory loss. • Impaired problem solving • Requires prompts/supervision to complete household tasks & personal care. • Complex tasks no longer possible • Social interaction may be preserved or may start to see challenges with social engagement. • May be disoriented to time and place. • May require supervision when leaving the home. • May no longer have the ability to participate in usual activities	MMSE:10-18/30 MOCA:6-10/30
Cannot Remember (M) **Severely Impaired (C)**	The individual requires someone to wake up in the morning, pick out an outfit, and help dress. If the individual is not prompted and assisted, the individual will sit on the bed and not remember to eat, bathe, or use the toilet. The individual is not able to plan most aspects of the day, although is able to tell others preferences when asked (e.g., what to eat). Often unable to recognize family members. May exhibit behavior or psychiatric complications. (Constant reminders/cueing needed) **Must stop driving.	Profound impairment of cognition/memory/function: • Severe memory impairment/disorientation • Spoken language limited or lost. • Incontinence • No ability to make judgements/decisions. • High dependency on others for personal care • Not able to do household chores.	MMSE:<10/30 MOCA:<6/30

Examples of Daily Decision Making:

- Choosing items of clothing.
- Knowing when to make and eat meals.
- Knowing how to schedule and follow-through with appointments.
- Using environmental cues to organize and plan (e.g., clocks, calendars, posted listings of upcoming events)
- In the absence of environmental cues, seeking information appropriately (i.e., not repetitively) from others to plan the day.
- Using awareness of one's own strengths and limitations in regulating the day's events (e.g., asks for help when necessary).
- Making decisions concerning how to get to appointments and using transportation.

***Executive Functioning:** This is a set of cognitive skills that help individuals get things done. These skills help individuals stay on task, keep organized and regulate emotions. They are essential for life in general:

Planning	Time Management	Task Initiation	Organization
Problem Solving	Flexibility	Emotional Control	Impulse Control
Attention Control	Self- Monitoring		

Cognitive Tests:

MOCA- Montreal Cognitive Assessment: https://mocacognition.com

MMSE- Mini Mental State Exam: Microsoft Word - Mini-Mental State Examination.doc (bmc.org)

Mini-Cognitive Test: Mini-Cog© – Quick Screening for Early Dementia Detection

Driving Assessment:

Fanny Allen Driver Rehab (UVM Health Network):

Driver Rehabilitation (uvmhealth.org)

BEHAVIORS

ILA Question 4.C Emotional/Behavior/Cognitive Status: BEHAVIORS

*Behaviors need to have occurred within the **7 days prior** to the ILA assessment being completed.*

Are these behaviors occurring **daily or less than daily** in the last 7 days?

Are they **easily altered** (can the individual be easily redirected?)

Behavior	Definition	ILA Definition	Examples
Wandering	Individuals lose their ability to recognize familiar places and faces. Individuals may become lost or confused about where they are in their environment.	Locomotion with no rational purpose, oblivious to needs or safety.	• Trying or wanting to "go home" even when at home. • Becoming restless, pacing, or making repetitive movements • Having difficulty locating familiar places such as the bathroom • Acting as if doing a hobby or chore, but nothing gets done. • Appearing lost in a new or changed environment.
Aggression ***Verbal***	Aggressive behaviors may be verbal or physical. They occur suddenly for no apparent reason and/or result from a frustrating situation. Aggression is not done on purpose. It is a reaction to something that an individual is not able to express in any other way. May be caused by Physical discomfort (Pain), Environmental Factors, Poor Communication.	Others are threatened, screamed at, cursed at.	• Yelling and name-calling • Direct threats of physical harm • Threats against people or things that are important to the other person as a way of instilling fear or gaining power and control.

Behavior	Definition	ILA Definition	Examples
Aggression ***Physical***		Others were hit, shoved, scratched, touched inappropriately/abused.	• Hit • Shoved • Kicked • Bit or scratched • Choked
Socially Inappropriate/ Disruptive Behavior	May be due to impaired judgement, social skills, or impulsivity. Unacceptable behavior may involve actions, words or physical gestures that could be perceived to be the cause of another individual's distress or discomfort.	Makes disruptive sounds, noises, screaming, self-abusive acts, sexual behavior or disrobing in public, smeared, or thrown food/feces, hoarding, rummaged through other's belongings (being intrusive).	See ILA Definition
Resisting Care	Individuals may lack insight into the need for care, may not want to admit the care is needed and may refuse to accept it. Resistance to care is often related to the desire to remain in control of what the individual has capacity to control based on the stage of cognitive/memory decline.	Resists taking medications/injections, ADL assistance or eating. This does not include instances where the individual has made an informed choice not to follow a course of care.	• Physically pulling away from caregiver or tightening limbs/stiffening body. • Deliberately ceasing to bear weight during care. • Waving arms and legs. • Verbally objecting to care using words or sounds.

**Behavior support plans are not a requirement of the Choices for Care and Brain Injury programs; however, is recommended as a best practice to ensure person -centered and consistent care by all caregivers.

Appendix
Training/Resources
5.2024

Find a Provider (Primary Care Provider, Specialist, Dentist etc.)

Provider Network Info | Department of Vermont Health Access

Medical Diagnosis

How To Find Reliable Health Information Online | National Institute on Aging (nih.gov)
Medical Encyclopedia: MedlinePlus
Medical Dictionary of Health Terms: A-C - Harvard Health

Common medical terms/Abbreviations

Appendix B: Some Common Abbreviations: MedlinePlus

Medications & Management

Keeping Track of your Medications: https://www.youtube.com/watch?v=YLsHPlx4188

Creating a Basic Medication List: https://www.youtube.com/watch?v=flCtiLrX8dk

Dementia Caregiver Support

Dementia Family Caregiver Center Dementia Family Caregiver Center | The University of Vermont Health Network (uvmhealth.org)

Alzheimer's Association VT Chapter: Vermont Chapter (alz.org)

Brain Injury Support

Brain Injury Alliance of Vermont: Brain Injury Alliance of Vermont (biavt.org)

General Caregiver Support

Veteran's Administration Caregiver Support VA Caregiver Support Program Home

VT Area Agencies on Aging **Helpline 1-800-642-5119**

Brain Injury Alliance of VT Brain Injury Alliance of Vermont (biavt.org)

Older Adult Driver Resources

VT Dept. of Health Older Adult Drivers | Vermont Department of Health (healthvermont.gov)

Appendix
Training/Resources
5.2024

Substance Use and Older Adults

Substance Use and Older Adults | Vermont Department of Health (healthvermont.gov)

Assistive Technology

VT Assistive Technology Program**:** Home Page | Assistive Technology Program (vermont.gov)

Nurse Resources

- If your agency does not have a nurse, with the individual's permission, the case manager can reach out to the primary care provider's office to speak with the office nurse if there is something related to the health and safety needs of the individual.
- If your agency has a nurse, with the individual's permission, the case manager can reach out to the agency nurse to review health and safety needs of the individual.
- Nurses may still complete the health review section of the ILA.
- The case manager can consult with the DAIL LTCCC Nurse if there are health and safety concerns that arise from conducting an ILA reassessment or change assessment.

Medically Complex Individuals

- The case manager should review these individuals with their supervisor for guidance.

Follow up (how to relay information to a Primary Care Provider or Pharmacist)

- Examples of when to follow up have been noted in the Health Review Section ILA Manual instructions.
- Case managers can consult with their supervisor and/or the DAIL LTCCC Nurse, as well.