DEMENTIA NEWS LETTER FOR PHYSICIANS

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A Publication of the Champlain Dementia Network

In This Issue...

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Vocally Disruptive Behaviours

Louise Carrier, MD, FRCP (C) , Geriatric Psychiatry Community Services of Ottawa

You receive a call from the nurse of your local nursing home pleading for you to do something about Mrs. X. She is either singing bad opera or screaming for help, "help me, help me…" most of her waking hours. This has the negative effect of agitating other residents such as Mr. Y who slapped her to shut her up on the weekend. What should you do? Vocally disruptive behaviours (VDB) are unfortunately a common condition in people with moderate-severe dementia, occurring in 10-40% of nursing home residents. These behaviours are challenging and difficult to treat.

VDB can take many forms from screaming, shouting, yelling to repeated phrases, noises or nonsense talking, to verbal aggression, threats, cursing or profane language. These can be goal-directed or purposeless, occasional or constant. They are disruptive to other patients and caregivers, leading to avoidance or retaliation. VDB, as all behaviours, should be seen as a mean of communication. The challenge is to decode the meaning: unmet needs such as hunger, thirst, pain or discomfort, need to interact and communicate with another human being, too much or too little stimulation, a response to auditory hallucination or a need to self stimulate in a patient with sensory deprivation. Understanding the message is the key to success. A multidisciplinary and multimodal approach is a must. Triggers are sought through careful observation (mapping of behaviours). A medical assessment with targeted laboratory testing is needed to reveal any potential biological or psychiatric etiologies and premorbid personality and functioning history can be revealing. Only after a comprehensive assessment is completed and a working hypothesis is developed, can treatment begin.

Unless a specific etiology has been found, treatment most often consist of trial and error. The treatment plan should include a bio-psycho-social approach. Pain is often under diagnosed and under treated in dementia patient so an empirical trial using analgesics may be considered. The effectiveness of psychotropics is disappointingly low at 44%. Antidepressants such as citalopram, paroxetineand trazodonehave been used based on the rationale that low serotonin levels increase impulsivity. Atypical antipsychotics such as risperidone andolanzapine, have been found helpful in some. Other medications such as benzodiazepines, mood stabilizers, psychostimulants, acetylcholinesterase inhibitors and memantine have been used but little data as to their efficacy exists. Electro-convulsive therapy (ECT) can sometimes be considered in a medication-resistant patient. Remember that medication alone is relatively ineffective.

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Vocally Disruptive Behaviours

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Psychosocial interventions are a key element in the treatment of VDB. Reframing VDB as a communication effort in a mentally impaired patient is a first step. This leads to a more positive attitude to the problem and towards the patient. Savoir-être strategies include commonsense approaches, improving communication, remaining calm, presenting a non-hurried and non-demanding attitude, using touching or diversion. Specific care and environmental interventions engages the patient in activities such as exercise, music, sensory stimulation and chores. Spa bathing in the evening may have a calming effect. Reinforcement strategies are based on the principle of ignoring the behaviours. Rewards items may include foods, contact with animals, children, family or staff members. Finally indirect interventions focus on the caregivers' needs. There is a need for education and emotional support to the nursing staff, helping them come to terms with their own emotional reactions and reminding them that behaviours are not to be taken personally. Good leadership and supervision of the treatment plan is essential. DB are challenging but small successes can be greatly rewarding. Therapeutic approaches involve multiple interventions from a multidisciplinary team. For most, the goal is to reduce the VDB and alleviate the patient's suffering.

Office Assessment of Dementia: A Guide to Scheduling and Billing for Family Physicians

Dr. Leslie Anne Bailliu, B.Sc.P.T., CCFP(CoE), Medical Director, Geriatric Rehabilitation Services, Hôpital Elizabeth Bruyère, Bruyère Continuing Care.
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The appropriate assessment of dementia can be a complex and time intensive activity in the fee for service office environment. However, dividing the assessment into multiple, shorter, focussed, billing friendly visits can facilitate the process.

The first "visit" is usually 1 of 3 scenarios:

1- screening high risk but asymptomatic elderly
2- assessing a "complaint" (usually by family) of a "memory" problem
3- you or your staff "noticing" a red flag problem (self neglect, non-compliance, "confusion",vagueness etc).

First Visit

1) Scenario 1 - Screening (high risk by age/vascular risk factors)	**Memory Quickscreen** • 3 item recall or 1/3 • animal naming in 1 minute (<15) • clock drawing	**A007 $31.95** or part of an annual review **A003 $61.00**
2) Scenario 2 - memory complaint by family or patient (R/O depression) or Scenario 3 - red flag symptoms	**Full review of ABC symptoms with patient and caregiver** A = Activities of Daily Living B = Behaviour C = Cognition • physical exam, order lab and CT head (if appropriate)	**A003 $61.00**

First Visit

Could also consider, depending on circumstances:

3) K002**	Interview with relatives to obtain history/make decision on treatment on behalf of a patient who can't because of illness, incompetence	$51.70 per unit
4) K005	1° mental healthcare (needs to be more focussed on behaviour or neuropsychiatric symptoms)	$51.70 per unit

Second Visit Neurocognitive Assessment

If a Folstein MMSE plus other cognitive tests are done, A007 can be billed. However, it is recommended that you consider the neurocognitive assessment code K032*** (minimum 20 minutes: tests of memory, attention, language, visuospatial and executive function). The MoCA (Montreal Cognitive Assessment www.mocatest.org) plus animal naming, trails A & B (useful for driving) is suggested. If another problem is assessed at the same visit, another code can be billed (eg A007).

Third Visit Diagnostic Disclosure/Family Conference

K013**	Counselling (education, discussion re diagnosis, prognosis, treatment, driving, safety etc.) (3 units/year afterwards bill K033*** 31.95/unit	$51.70 per unit

Follow up Visit

If a patient is started on a cholinesterase inhibitor/memantine, the follow up visit at 3 months to determine benefit can also utilize the K032 (no limit), A007 codes as appropriate.

K035*** report on driving to Ministry of Transport	$34.85
K070*** CCAC application	$25.65
K071 acute CCAC supervision (advice to CCAC staff) max 1/week x 8 wks follow up CCAC admission	$17.75
K072 chronic CCAC supervision (maximum 2/month starting week 9 post admission to CCAC)	$17.75
K038 LTC application form	$41.00

* Unit = ½ hour or major part thereof (minimum 20 minutes)

** Must be pre-booked

*** Outside of the "basket" for FHT/FHO/FHN = full amount paid even for rostered patients

DEMENTIA NEWS LETTER

First Link®

Your partner in caring for patients affected by Alzheimer's disease and other related dementias.

The First Link® program, initially a piloted by the Alzheimer Society of Ottawa and Renfrew County (2002) is now rolling out in 25 Alzheimer Society Chapters in Ontario. The Canadian Consensus Guidelines on Dementia (Hogan et. al., 2007), developed by 45 medical experts, recommend that primary care providers utilize First Link® as a support to persons and families affected by dementia.

A First Link® referral will save you valuable time and energy.

It's simple – just fax a referral form and First Link® will take it from there.

Your patients will then receive:

- Telephone contact offering information and support
- A package of information about Alzheimer's disease and related dementias
- Opportunities to register for a progressive Learning Series
- Linkages to appropriate community services and
- Ongoing follow up support through out the continuum of the disease.

Once the First Link® is made, you will notice your patients and families will be more knowledgeable and prepared with enhanced coping skills.

To obtain the First Link® referral form contact: krobinson@asorc.org

For more information: www.alzheimer-ottawa-rc.org or **phone 613-523-4004**

A Guide to Scheduling and Billing for Family Physicians

You can download all previous editions of the Dementia Newsletter for Physicians at the Champlain Dementia Network website at:
www.champlaindementianetwork.org

WE NEED YOUR HELP TO ENSURE THIS NEWSLETTER MEETS YOUR NEEDS. PLEASE PROVIDE YOUR FEEDBACK.

Do you like the information in this edition of the Physician's Newsletter?

❍ Yes ❍ No

Would you prefer this newsletter is:

❍ Faxed
❍ Emailed
❍ Mailed (Canada Post)

Please return to fax number: 613-523-8522

THANK YOU

The Champlain Dementia Network would like to thank Janssen-Ortho, Lundbeck, Novartis and Pfizer for supporting this edition of the Dementia Newsletter for Physicians.

Pfizer NOVARTIS JANSSEN-ORTHO Lundbeck

NEWS LETTER DEMENTIA

CHAMPLAIN DEMENTIA NETWORK

DEMENTIA EDUCATION PROGRAM for FAMILY PHYSICIANS

This program meets the accreditation criteria of The College of Family Physicians of Canada and has been accredited for Mainpro-MI credits and up to 1.0 Mainpro-C credits.

Scheduling of sessions: Sessions are individualized, one-on-one or group sessions, 40 - 60 minutes in length, tailored to your needs. A small group sponsored Breakfast or Lunch and Learn session, with one teacher for four to six learners, can be provided in your office.

Physician educators will include:
Dr. Anna Byszewski, Dr. Bill Dalziel, Dr. Barbara Power, Dr. Inge Loy-English, Dr. Andrew Frank, and Dr. Louise Carrier

Please rank (1 – 4) your top 4 areas of interest for your sessions

1._____ Early identification/screening for cognitive impairment

2._____ Differing Mild Cognitive Impairment (MCI) from normal aging and from dementia

3._____ Practical office based assessment of dementia in 3 – 5 visits (a Dementia Toolkit)

4._____ Diagnosis of more unusual dementias: Lewy Body Dementia/Fronto Temporal Dementia

5._____ Approach to Vascular Dementia, Mixed Alzheimer's/Vascular Dementia and treatment of "risk factors"

6._____ Nuts and bolts of starting Cholinesterase Inhibitors

7._____ How to monitor patient response to Cholinesterase Inhibitors

8._____ Switching strategies: dealing with patients who don't tolerate or respond to the first Cholinesterase Inhibitor

9._____ Assessing driving safety (a Driving and Dementia Toolkit)

10._____ Behaviours and psychological symptoms of dementia

11._____ Diagnosis disclosure

12._____ Severe dementia

13._____ Other

SCHEDULING and CONTACT INFORMATION

Scheduling of sessions: ❍ One-on-one visit ❍ Small Group Session

Preferred start times (Please list 2 or 3 days/dates of the week including start times)

Name:

Address: **Postal code:**

Phone: **Fax:** **Email:**

Please fax this form to Alzheimer Society of Ottawa and Renfrew County: 613-523-8522

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