Dementia Assessment Guide

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Dementia Interview Guide: Dr. W. Dalziel Geriatrician, University of Ottawa

This Dementia Interview Guide can be used in conjunction with the 1st ODN Newsletter article http://physicians/champlaindementianetwork.org/ "A Guide to Scheduling and Billing". This Guide illustrates how assessments can be divided into several appointments of 10-20 minutes (billing friendly).

Dementia Interview Guide: Residential Homes

Developed by: Dr. W. B. Dalziel, Geriatrician, Ottawa, ON

Patient: _____ Age:_____ Gender: ____ Education: _____

Living Arrangements? ❑ Alone ❑ With Someone _____

Family/Primary Caregiver Name: _____ Relationship: _____

Reason for Assessment:

History of Cognitive Problems: How Long? _____ Progression: ❑ Slow ❑ Stepwise ❑ Sudden Change

Description: _____

_____

SIGNS OF DEMENTIA: THE 4 A'S PLUS EXECUTIVE DYSFUNCTION

1. A Amnesia ❑ No ❑ Yes _____
2. A Apraxia ❑ No ❑ Yes _____
   (difficulty doing a motor task (dressing) despite intact motor/sensory function)
3. A Agnosia ❑ No ❑ Yes _____
   (difficulty identifying objects/recognizing people despite intact sensory function)
4. A Aphasia (language) ❑ No ❑ Yes _____
5. Executive dysfunction ❑ No ❑ Yes _____
   (Trouble with SOAP – Strategizing, Organizing, Arranging, Planning)

ABC Complaints: From patient AND family/caregiver

	OK	A problem
ADLs	❑	❑ Shopping ❑ Housekeeping ❑ Finances ❑ Cooking ❑ Grooming/hygiene ❑ Dressing ❑ Taking Medication ❑ Driving ❑Hobbies/Leisure ❑ Tools/Appliances ❑ Other _____
Behaviour	❑	❑ Apathy/↓ initiative ❑ Anxiety ❑ Depression ❑ Hallucinations ❑ ↓ Alertness/"tuned in" ❑ Wandering ❑ Agitation/Anger ❑ Aggression ❑ Other _____
Cognition	❑	❑ Repetition ❑ Word Finding ❑ Forgetfulness ❑ Orientation ❑ Meds compliance ❑ ↓ Focus/"following" ❑ ↓ Reading/TV ❑ Other _____

Past Medical Diseases: _____

_____

Past History: serious head injury/delirium with illness/surgery? _____

Past History: depression/anxiety disorder/psychosis? _____

Past Neuroimaging (CT/MRI scan)? _____

Vascular Risk Factors:

- ❑ high blood pressure/hypertension
- ❑ stroke/TIA (transient ischemic attack)
- ❑ diabetes
- ❑ angina/heart attack (coronary artery disease)
- ❑ atrial fibrillation
- ❑ currently smoking
- ❑ high cholesterol/hyperlipidemia
- ❑ obesity

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Any suggestion of depression? In the last 2 weeks have you felt sad or depressed?

❑ No ❑ Yes (give details) _____

_____

If any suggestion of depression, see Appendix 1.

Any suggestion of delirium?

❑ No ❑ Yes (give details) _____

_____

If any suggestion of delirium, suggest doing CAM (Confusion Assessment Method) (See Appendix 2)

Any Confounding Features to Cognitive Performance?

	No	Yes		No	Yes
Patient refusing	❑	❑	Irritability	❑	❑
Patient not trying	❑	❑	Anxiety	❑	❑
Hearing/vision	❑	❑	Depression	❑	❑
Language	❑	❑	Drowsy/Sedated	❑	❑
Aphasia	❑	❑	Family Interference	❑	❑

List of Drugs, including OTC/herbal (give details if started or stopped in the last 4 weeks)

❑ Check if possible connection to decreased cognition.

Drugs	Concerns
❑ _____	_____
❑ _____	_____
❑ _____	_____
❑ _____	_____
❑ _____	_____
❑ _____	_____
❑ _____	_____
❑ _____	_____
❑ _____	_____

Has patient ever been on a Cholinesterase inhibitor or Memantine/Ebixa?

❑ No ❑ Yes (give details) _____

_____

If yes, please indicate:

❑ Aricept/Donepezil

❑ Exelon/Rivastigmine

❑ Reminyl/Galantamine

❑ Ebixa/Memantine

Safety Concerns – person and/or caregiver/family

	No	Yes	Details
Cooking	❑	❑	_____
Getting lost going out	❑	❑	_____
Malnutrition	❑	❑	_____
Driving	❑	❑	_____
Medication Errors	❑	❑	_____
Using appliances/tools	❑	❑	_____
Smoking/fires	❑	❑	_____
Alcohol	❑	❑	_____
Falls	❑	❑	_____
Handing an Emergency	❑	❑	_____
Dealing with Finances/abuse	❑	❑	_____

Financial/Legal:

Is there a power of attorney for financial affairs? ❑ No ❑ Yes

If "yes", who? _____

Is there a power of attorney for personal care/decision-making? ❑ No ❑ Yes

If "yes", who? _____

Is there a will? ❑ No ❑ Yes

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Red Flags

Clinical Features which, if present, should make you consider a diagnosis other than Alzheimer's (AD).

	Think of:
❑ Cognitive complaints/change but NO functional change/loss ❑ Intact ADLs/functional abilities	MCI (Mild Cognitive Impairment)
❑ Cognitive decline within 3 months of CVA/TIA ❑ Focal neurological symptoms ❑ Focal neurological signs ❑ Abrupt onset/stepwise decline ❑ Previous CVA or TIA	- Vascular Dementia (VAD) - Mixed AD/VAD
❑ Visual hallucinations – (detailed/recurrent) ❑ Pronounced fluctuation in cognition over hours/days ❑ Parkinsonism (especially rigidity) / bradykinesia ❑ Executive function worse than memory ❑ Neuroleptic sensitivity ❑ Unexplained falls / loss of consciousness	Lewy Body Dementia
❑ Behavioural changes: disinhibition / apathy ❑ Impulsivity / poor judgment ❑ Self-neglect / socially inappropriate ❑ Executive function worse than memory	Frontotemporal Dementia
❑ Abnormal gait ❑ Incontinence early in course of dementia ❑ Rapidly progressing dementia	Normal Pressure Hydrocephalus (NPH)

Impression:

_____

_____

_____

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Summary of Assessment

Cognitive Testing Results:	
MMSE	_____/30 (serial 7's) _____/30 (world) _____
MOCA	_____/30
Clock	#s: Normal _____ Abnormal _____ Hands: Normal _____ Abnormal _____
Animal Naming in 1 Minute	

Rule Out (check if any present)

- ❑ Alcohol
- ❑ Drug side effect/concerns: (see drug checklist) _____
- ❑ Delirium (see CAM)
- ❑ Depression
- ❑ Unstable medical illness

Red Flags:

- ❑ Negative (likely Alzheimer's)
- ❑ Positive for:
  - ❑ Vascular
  - ❑ Mixed/vascular
  - ❑ Lewy Body
  - ❑ Frontotemporal
  - ❑ NPH

Still Driving? ❑ No ❑ Yes (see Trails A and B) (Also can do Appendix 3: Driving Checklist)

Trails A – errors	❑ Normal ❑ Abnormal – errors	❑ Time ❑ Seconds Observation: _____	
Trails B - errors	❑ Normal ❑ Abnormal – errors	❑ Time ❑ Seconds Observation: _____	

Conclusion:	Possible Diagnostic Impression:			
	Other issues:			
	1.			
	2.			
	3.			
	4.			
Action Items:	What:		Who:	
	What:		Who:	
	What:		Who:	
	What:		Who:	

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APPENDIX 1

DEPRESSION: SUPPLEMENTARY OPTION ITEMS

Symptoms of Depression (Optional)

A major depressive episode is defined in the DSM IV TR* as ≥ weeks of low mood or anhedonia plus 4 of the following:

M	Mood persistent not fluctuating low mood/affect
M	Mood Anhedonic (loss of enjoyment in previously pleasurable activities)
S	Change in **S**leep pattern especially early morning awakening (not due to medical cause)
I	Lack of **I**nterest in usual activities
G	Feelings of excessive **G**uilt or regret or negative ruminations
E	Lack of **E**nergy
C	Loss of **C**oncentration
A	Change in **A**ppetite
P	**P**sychomotor change ❑ agitation ❑ retardation
P	**P**sychosomatic complaints (Somatize)
S	**S**uicidal ideation

SIG = Prescription
E = Energy
CAPS = Capsule

"Prescription for Energy Capsules:

*Adapted from American Psychiatric Association. American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (4th ed. Text version), Washington, DC; 2000.

Geriatric Depression Scale (GDS) (Optional)

1. Are you basically satisfied with your life? YES/**NO**
2. Have you dropped many of your activities and interests? **YES**/NO
3. Do you feel that your life is empty? **YES**/NO
4. Do you often get bored? **YES**/NO
5. Are you in good spirits most of the time? YES/**NO**
6. Are you afraid that something bad is going to happen to you? **YES**/NO
7. Do you feel happy most of the time? YES/**NO**
8. Do you often feel helpless? **YES**/NO
9. Do you prefer to stay at home, rather than going out and doing new things? **YES**/NO
10. Do you feel you have more problems with memory than most? **YES**/NO
11. Do you think it is wonderful to be alive now? YES/**NO**
12. Do you feel pretty worthless the way you are now? **YES**/NO
13. Do you feel full of energy? YES/**NO**
14. Do you feel that your situation is hopeless? **YES**/NO
15. Do you think that most people are better off than you are? **YES**/NO

Source: Courtesy of Jerome A. Yesavage, MD. For more information, see http://www.stanford.edu/~yesaverage/GDS.english.short.html

Score 1 point for each BOLD answer. Cut-off: normal = 0.5; above 5 suggests depression

APPENDIX 2

CAM – Confusion Assessment Method

- Sensitivity (94 to 100%), specificity (90 to 95%)

Requirement for delirium = 1, 2 AND either 3 OR 4

1. **Acute onset and fluctuating course**
   - Is there evidence of an acute change in cognition from the patient's baseline?
   - Does the abnormal fluctuate during the day (i.e., tend to come and go, or increase and decrease in severity?)
2. **Inattention**
   - Does the patient have difficulty focusing his/her attention (i.e., easily distractible or has difficulty keeping track of what is being said)?

AND

3. **Disorganized thinking**
   - Is the patient's thinking disorganized or incoherent (i.e., rambling or irrelevant conversation, unclear or illogical flow from ideas, or unpredictable switching from subject to subject?

OR

4. **Altered level of consciousness**
   - Is the patient's mental status anything besides alert (i.e. vigilant or hyperalert, lethargic or drowsy, easily aroused, stuporous or difficult to arouse, comatose or unarousble)?

Inouye S. Ann Int Med 1990:113:941

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APPENDIX 3

Physician or Healthcare Professional OFFICE based
Dementia and Driving Checklist
(Based on Clinical Opinion and Experience not Evidence)

Would YOU be willing to get into the car (or would you allow your children / grandchildren in the car) with your patient driving given the following findings?
(NOTE – it is not necessary to complete all 10 items if it is obvious that the patient is unsafe to drive based on early items)

PROBLEM

☐ **1. Dementia Type:**
Generally Lewy Body dementia (fluctuations, hallucinations, visuospatial problems) and Frontotemporal dementias (if associated behaviour or judgment issues) are unsafe.

☐ 2. **FUNCTIONAL IMPACT of the Dementia** - According to *CMA guidelines* **Unsafe** if:
- impairment of more than 1 Instrumental ADLs due to cognition
(IADLs = **SHAFT**: **S**hopping, **H**ousework/**H**obbies, **A**ccounting, **F**ood, **T**elephone / **T**ools)

☐ - **OR** impairment of 1 or more Personal ADLs due to cognition
(PADLS = **DEATH**: **D**ressing, **E**ating, **A**mbulation, **T**ransfers, **H**ygiene)

3. Family Concerns: (ask in a room separate from the person)

☐ Family feels safe/unsafe (make sure family has recently been in the car with the person driving)

☐ * The grand daughter question - Would you feel it was safe if a 5 year old grand daughter was in the car alone with the person driving (often a different response from family)

☐ Generally if the family feels the person is unsafe they are unsafe. If the family feels the person is safe, the person may still be unsafe as family may be unaware or may be protecting patient.

4. Visuospatial: (intersecting pentagons/clock drawing: the numbers)

☐ If major abnormalities – likely unsafe

5. Physical inability to operate a car (often a "physical" reason is better accepted):

☐ Medical/Physical concerns such as musculoskeletal problems, weakness/multiple medical conditions (neck turn, problems in the use of steering wheel/pedals), cardiac/neurologic (episodic "spells")

6. Vision/Visual Fields:

Significant problems including visual acuity, field of vision.

7. Drugs: (if associated with side effects: drowsiness, slow reaction time, lack of focus)

Alcohol/Benzodiazepines/Narcotics/Neuroleptics/Sedatives

Anticholinergic – antiparkinsonian/muscle relaxants/tricyclics/antihistamine (OTC)/antiemetics/ antipruritics/antispasmodics/ others

8. Trailmaking A&B: (available on www.rgpeo website)

Trailmaking A -

Trailmaking B -

- Unsafe = > 2 minutes or 2 or more errors
- Safe = < 2 minutes and < 2 errors (0 or 1 error)
- Unsure = 2-3 minutes or 2 errors: (consider qualitative dynamic information regarding HOW the test was performed: slowness/hesitation/corrections/ anxiety or panic attacks/impulsive or perseverative behaviour /unfocussed/multiple corrections/forgetting instructions/inability to understand test etc.)
- Unsafe = > 3 minutes or 3 or more errors

9. Ruler Drop Reaction Time test (Accident Analysis & Prevention 2007; 39(5): 1056 – 1063)**:**

The bottom end of a 12" ruler is placed between thumb and index finger (1/2" apart) → let go and person tries to catch ruler (normal = 6-9"/abnormal = 2 failed trials)

10. Judgment/Insight (Ask the person):

What would you do if you were driving and saw a ball roll out on the street ahead of you?

With your diagnosis of Dementia, do you think at some time you will need to stop driving?

CONCLUSION: ☐ Safe → Reassess 6-12/12 ☐ Unsafe → Report to MOT ☐ Unsure → ☐ If only driving an issue – refer to Specialized On Road Assessment ☐ If driving and other dementia related issues refer to specialized dementia assessment services.

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

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

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).

3rd 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.

Other Codes to Consider:

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