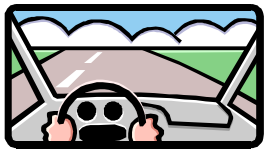
Alzheimer Knowledge Exchange – Online Event
January 24, 2011



A Practical Safe Driving Checklist and a Guide to Dementia Related Billing in Ontario

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Conflict Disclosure Information:

Presenter: Dr. William Dalziel

Title of Presentation:
Alzheimer Knowledge Exchange – Online Event
January 24, 2011. A Practical Safe Driving checklist and A Guide to Dementia Related Billing in
Ontario

None declared.

Learning Objectives

Participants will be able to:

- Describe important issues with respect to dementia and driving.
- Assess patients with dementia for driving safety using a simple 10 minute safe driving assessment.
- Describe appropriate “billing” for dementia care.

A Major Public Health Concern

- Dementia 500,000 now → 1.1 million 2038
- Dramatic increase in senior drivers in the next 20 years.
- When involved in a crash, seniors are over 4 times more likely to be seriously injured and hospitalized than are drivers 16-24 years of age.
- The majority of crash-injured seniors were driving the vehicle.
- Most (3 of 4) crashes involving older drivers are multiple vehicle crashes.

Driving Safety: It is Not Age but Disability

- Medical conditions and medications are the primary cause of decline in driver safety.
  - Can make even the best of drivers unsafe to drive.
  - Can affect drivers of any age: Increasingly likely as age ↑s
- The safety concern is not the presence of diseases/disabilities but the severity and/or instability of conditions (including medication changes.)

Does the diagnosis of dementia automatically mean *no driving* ?

The Take Home Message

The diagnosis of dementia does *not* automatically mean *no driving*

The diagnosis of dementia *does mean*:

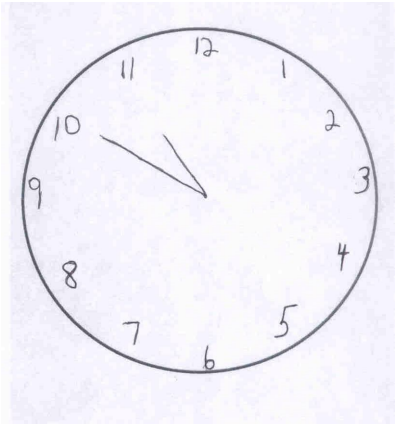
- You must ask if the person is still driving
- You must assess driving safety
- You must document driving assessment and follow your provincial reporting requirements

Just The Facts

- A person with mild dementia has 8 times the crash risk.
- A person with mild dementia has a 50% serious crash risk in the next 2 years.

Mrs. G.: Memory Quick Screen

1. 2/3 recall
2. 12 animals
3. Clock
   - Numbers correct
   - Hands incorrect



Caregiver Interview is Critical

Mr. Green says his wife is forgetful but she still does everything – shopping, cooking, cleaning, finances, driving etc. MMSE 27, MoCA 23 (1/5).

?? Dx _____

Question 6:

Driving Safety? What do you think?

1. Safe _____ 2. Unsafe_____ 3. Unsure _____

Two Years Later

- Mr. Green says that he has noticed that his wife has had some increased forgetfulness and word finding problems and she's easily angered and irritable.
- He has had to take over finances and help a bit with shopping and cooking.

Case History

MMSE 23/30

MOCA 19/30

?? Dx: _____

Question 7:

Driving Safety? What do you think?

1. Safe _____ 2. Unsafe_____ 3. Unsure _____

The 10 Item Dementia and Driving Checklist

A short practical "approach" to decide if senior drivers are

Safe **Uncertain** **Unsafe**

(caveat –no clear evidence based tools exist)

If you were constructing a hierarchic driving and dementia checklist what would you ASSESS at the TOP 10 items (in order of importance)?

THINK OF KILLER BLOWS

The 10 Item Dementia and Driving Checklist

1) Type of Dementia

- FTD unsafe (disinhibition/judgement)
- LBD unsafe (hallucinations/fluctuations)

AD, VAD, Mixed AD/VAD are safer “types of dementia”… (if no visuospatial problems)

The MMSE and Driving Capacity

- There is questionable correlation between driving safety and the MMSE.
- Functional abilities Instrumental Activities of Daily Living (IADLs) are better correlated.

The MMSE and Driving Capacity

- It is critical to emphasize that driving capacity depends on a **GLOBAL CLINICAL PICTURE:**
- The MMSE (when adjusted for age and education) can provide a rough framework for assessing driving safety. Patients scoring under 20 are likely unsafe to drive (if education ≥ Grade 9). (CMAJ Guide says "MMSE <24")

Dementia is cognitive change CAUSING functional change.

The 10 Item Dementia and Driving Checklist

2) Severity Loss of > 1 IADL = Unsafe:

S: Shopping
H: Housework
A: Accounting = finances
F: Food preparation
T: Transportation

Also laundry, hobbies, small machinery and use of telephone, microwave, computer etc.

The 10 Item Dementia and Driving Checklist

3) Family Concerns (? In car lately?):

- Collision, near misses and/or damage to the car
- Getting lost, needing a 'co-pilot'
- Missing stop signs/lights; stopping for a green light
- Right of way problems

Families undercall risk 50%

The 10 Item Dementia and Driving Checklist

Driving “PEARL”

The Granddaughter Question

The 10 Item Dementia and Driving Checklist

4. Significant visuospatial problems: poorly done intersecting pentagons/number placement on clock drawing, etc.

The 10 Item Dementia and Driving Checklist

5) Physical ability to operate a car (if can't be compensated):

- Weakness
- Range of movement (neck)
- Coordination

The 10 Item Dementia and Driving Checklist

6) Visual Acuity and Fields

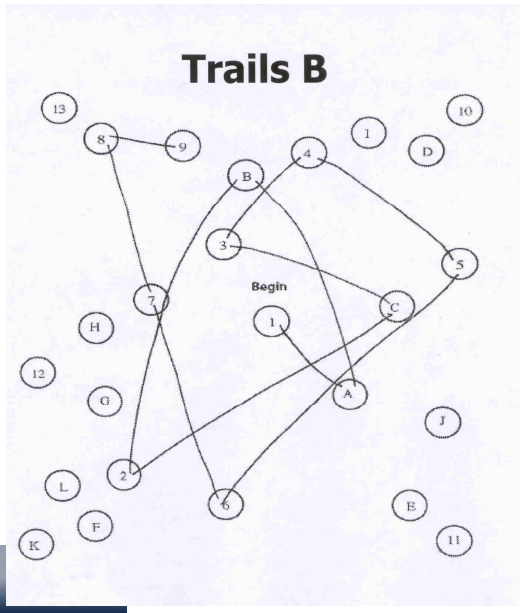
7) Medications that may affect driving (especially high doses or changing doses - if causing drowsiness/inattention etc.)

- alcohol
- benzodiazepines
- antipsychotics
- muscle relaxants
- sedating antidepressants and antihistamines
- anticonvulsants

ANTICHOLERGICS

8) Trails A and B:

tests of visuospatial, executive function, attention and speed of processing (generally failed by failing to understand concept of test or by making errors, not by exceeding time limit)



Trails B

Timing/Errors

1. Less than 2 minutes or errors = GOOD
2. 2-3 min/≤ 2 errors = OK dependent on other observations
3. 3 or more minutes or errors = LIKELY UNSAFE

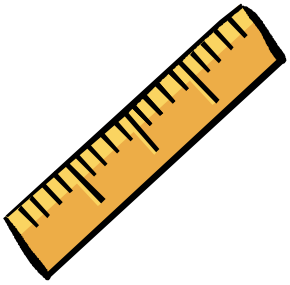
Observations

- Slowness
- Hesitancy
- Self-corrections
- Poor focus

The 10 Item Dementia and Driving Checklist

9) Reaction time:

(dropping a 12” ruler between thumb and index finger – usually caught by maximum of 9” or so, give 2 tries)



The 10 Item Dementia and Driving Checklist

10) Poor judgement/insight:

Judgement and Behaviour:

1. ? What would you do if you were driving along a busy residential street and up ahead of you a ball rolled out on to the road?
2. ? With a condition like dementia/Alzheimer’s Disease, do you ever think it will become necessary for you to ever strop driving?

The 10 Item Dementia and Driving Checklist

10) Behavioural issues

Big Concern

- Disinhibition
- Hallucinations
- Impulsiveness
- Delusions

Less Concern

- Agitation
- Anxiety
- Apathy
- Depression

Physician or Healthcare Professional OFFICE based Dementia and Driving Checklist

Would YOU be willing to get into the car (or would you allow your children/grandchildren in the car) with your patient driving giving the following findings? (NOTE – it is not necessary to complete all 10 items if it is obvious that the patient is unsafe to drive base 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: Shopping, Housework/Hobbies, Accounting, Food, Telephone / Tools)
- R impairment of 1 or more Personal ADLs due to cognition (PADLS = DEATH: Dressing, Eating, Ambulation, Transfers, Hygiene)

Problem

☐ **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 - Unsafe = > 2 minutes or 2 or more errors

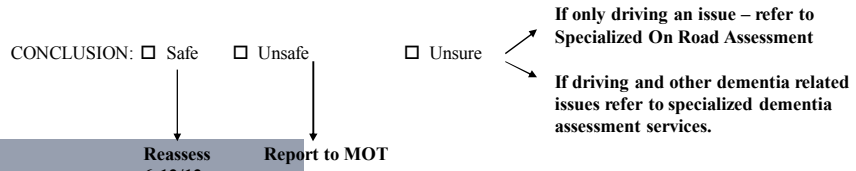
Trailmaking B -Safe = < 2 minutes and < 2 errors (0 or 1 error)

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) and Behaviour:**
    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?



Two Years Later

- Mr. Green says that he has noticed that his wife has had some increased forgetfulness and word finding problems and she's easily angered and irritable.
- He has had to take over finances and help a bit with shopping and cooking.

Case History

MMSE	23/30 (- 1 pentagons)
MOCA	19/30 (2/3 clock)
Dx:	Mixed Alzheimer's AD and Vascular (VAD)

Driving Safety? What do you think?

1. Safe _____ 2. Unsafe_____ 3. Unsure _____

10 Item Dementia and Driving Checklist

1. **Dementia type**: AD, VaD, FTD, LBD (mixed AD/VaD), MMSE 20 MoCA 17 (Circle) Other _____		
2. **Severity** Very mild ☐ Mild ☒ Moderate ☐ Severe ☐ SHAFT: ☐ Shopping, ☐ Housework, ☒ Accounting, ☒ Food, ☐ Telephone/Tools		
	OK	**A problem:**
3. **Family concerns**	☒	☐ _____
4. **Visuospatial ability**	☐	☒ Pentagon ☐ Clock ☐ Other _____
5. **Reaction Time**	☐	☒ slow
6. **Judgment/insight**	☒	☐ _____
7. **Trails A/B**	☐	☒ Trails A 40 sec
	☐	☐ Trails B 180 sec 3 errors
8. **Drugs**	☒	☐ _____
9. **Vision/Hearing**	☒	☐ _____
10. **Other Medical/Physical**	☒	☐ _____

Discussion with Patient and Family

1. "Enlist" family to support stopping driving (pre-meeting if needed)
2. Be firm, "it's the law"
3. Show deficits in testing
4. "You would never want to hurt someone."
5. "Driving a car is $5000/per year".
6. Letter to patient.

Summary

- If dementia (not MCI) is diagnosed
  - Driving must be asked about
  - Driving must be assessed
- Driving assessment must be documented
- Physicians and other HCP's can perform a 10 minute driving safety assessment
- If unsafe – tell pt/family and report (MOT)
- If unsure – specialized on road assessment
- If safe – re-evaluate q6-12 months.

Resources

- Medical Fitness to Drive CMA Guide www.cma.ca
- Driving and Dementia Toolkit www.rgpeo.com
- www.CanDRIVE.ca
- www.rgpeo.ca
- Dementia Newsletter For Physicians: http://www.alzheimer-ottawa-rc.org/graphics/center/newsletter/no1no1folder/dnpv1no1enall.pdf To subscribe to receive future copies of the newsletter for physicians - by email, send address to: info@asorc.org

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

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

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/A967 $33.10 or part of an annual review A003 $71.25
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 $71.25

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	$58.35 per unit (pre-booked)
4) K005	1º mental healthcare (needs to be more focussed on behaviour or neuropsychiatric symptoms)	$58.35 per unit

Second Visit: Neurocognitive Assessment

- If a Folstein MMSE is done, A007/A967 can be billed.
- However, if additional tests are done, 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	$58.35 per unit

Follow up Visits

- 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.
- If primary follow up for behavioural symptoms, K005, counselling (K013)or family interview, conference (K002).
- House call visit , B901 - $43.05
- Palliative care codes if end of life care – G512, etc...

Other Codes to Consider:

K035*** report on driving to Ministry of Transport	$36.25
K070*** CCAC application	$31.75
K071 acute CCAC supervision (advice to CCAC staff) max 1/week x 8 wks follow up CCAC admission	$21.40
K072 chronic CCAC supervision (maximum 2/month starting week 9 post admission to CCAC)	$21.40
K038 LTC application form	$45.15

* **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**

New Code – physician to physician telephone consultation

- This service includes all services rendered by the consultant physician to provide opinion/advice/recommendations on patient care, treatment and management to the referring physician.
- The referring physician initiates the telephone consultation with the intention of continuing the care, treatment and management of the patient. Minimum 10 minutes.

K730 referring physician 27.50
K731 consulting physician 35.50

Medical Record Requirements:

- Physician to Physician Telephone Consultation is only eligible for payment where the following elements are included in the medical record for a physician who submits a claim for the service:
  - patient's name and health number;
  - start and stop times of the discussion;
  - name of the referring and consultant physicians;
  - reason for the consultation; and
  - the opinion and recommendations of the consultant physician

Consultative practice – codes to consider

- A005 – GP consult
- K032 – neurocognitive assessment
- K035 – MTO report
- K005 – primary mental health care
- K002, K013 – counselling codes
- A967 – Focus practice care of the elderly assessment, or other A codes as appropriate
- B901 – house call visits
- K730, K731 – telephone consultation

Questions?