



# DEMENTIA NEWSLETTER *for* PHYSICIANS

Sault Ste. Marie and Algoma District

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## Vocally Disruptive Behaviours

*Louse Carriere, FRCP, Geriatric Psychiatry Community  
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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, "help me, help me...." most of her waking hours. This has the negative effect of agitating other residents such as Mrs. Y who slapped her to shut her up on the weekend. What should you do?

Vocally disruptive behaviours are unfortunately a common experience with moderate to severe dementia, occurring in 10 to 40% of nursing home residents. These behaviours are challenging and difficult to treat.

Vocally disruptive behaviours 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 residents and care givers leading to avoidance or retaliation. Vocally disruptive behaviours, as all behaviours, should be seen as a means 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 multi disciplinary and multi modal approach is a must. Triggers are sought through careful observation (mapping of behaviours). A medical assessment with targeted laboratory is needed to reveal any potential biological or psychiatric etiologies and pre-morbid 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 patients so an empirical trial using analgesics may be considered. The effectiveness of psychotropics is disappointingly low at 44%. Antidepressants such as citalopram, paroxetine and trazodone have been used on the rationale that low serotonin levels increase impulsivity. Atypical antipsychotics such as risperidone and olanzapine, 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 can sometimes be considered in a medication resistant patient. Remember that medication alone is relatively ineffective.

Psychological interventions are a key element in the treatment of vocally disruptive behaviours. Reframing vocally disruptive behaviours 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-etre strategies include common sense approaches, improving

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## Vocally Disruptive Behaviours *(...continued from page 1)*

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 care givers' 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. Vocally disruptive behaviours are challenging but small successes can be greatly rewarding. Therapeutic approaches involve multiple interventions from a multi-disciplinary. For most, the goal is to reduce the vocally disruptive behaviours and alleviate the patient's suffering.

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

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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, focused billing friendly visits can facilitate the process.

### The first "visit" is usually one of three 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)	<b>Memory Quick Screen</b> <ul style="list-style-type: none"> <li>• 3 item recall</li> <li>• Animal naming in 1 minute (&lt;15)</li> <li>• Clock drawing</li> </ul>	<b>A007 \$31.95</b> Or part of an annual review <b>A003 \$61.00</b>
2) Scenario 2 – memory complaint by family or patient (R/O depression) Or Scenario 3—red flag symptoms	<b>Full review of ABC symptoms with patient &amp; caregiver</b> A = activities of daily living B = behaviour C = cognition <ul style="list-style-type: none"> <li>• Physical exam, order lab and CT head (if appropriate)</li> </ul>	<b>A003 \$61.00</b>

### ***Katherine Punch Resource Library***

*For current information on Alzheimer's disease and related dementias, refer your patients to the free resources at the Alzheimer Society. Books and videos on topics such as the progression of Alzheimer's disease, communication techniques, coping strategies, making the long term care decision and research are just a few of the issues covered. For more information call the Alzheimer Society at 942-2195*

## 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	<b>\$51.70 per unit</b>
4) K005	1° mental healthcare (needs to be more focused on behaviour or neuropsychiatric symptoms)	<b>\$51.70 per unit</b>

## 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, visiospatial and executive function). The MoCA (Montreal Cognitive Assessment [www.mocatest.org](http://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	<b>\$51.70 per unit</b>
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## 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) codes as appropriate.

K035*** report on driving to Ministry of Transportation	\$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 = 1/2 hour or major part thereof (minimum 20 minutes)

\*\* Must be prebooked

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

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# First Link®

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

The First Link® program, initially piloted by the Alzheimer Society of Ottawa and Renfrew County (2002) has now rolled 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
- 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: [cathierandell@alzheimeralgoma.org](mailto:cathierandell@alzheimeralgoma.org) or contact Cathie Randell - First Link Coordinator at 942-2195.

## **WE NEED YOUR HELP TO ENSURE THIS NEWSLETTER MEETS YOUR NEEDS.**

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Yes                       No

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**Please return to fax # 705-256-6777**

## **Did You Know That...**

You can download all previous editions of the Dementia Newsletter for Physicians at the Dementia Network Algoma website at: [www.dementiaalgoma.org](http://www.dementiaalgoma.org)

## ***THANK YOU***

**The Dementia Care Network Algoma would like to thank  
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