Medicare AWV
Physician Practice Guide

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What is the Annual Wellness Visit?

Medicare's Annual Wellness Visit (AWV) is not a typical physical exam, rather it is an opportunity for patients and providers to:

- Focus on specific issues important to older adults
- Consider issues that may be overlooked in a typical physical exam
- Engage with patients on a regular (annual) basis and detect emerging health and safety risks
- Review the patient's complete medication list and identify any potential adverse drug events
- Review current providers and suppliers of medical care and check for alignment with patient goals

One of the most valuable elements of the AWV is the creation of a long-term preventive care plan based on the information a patient shares with their provider including a:

- Health Risk Assessment (HRA)
- Family history
- Current list of medical providers and medications
- Screening for cognition, depression, alcohol misuse, hearing, functional status, and fall risk

There are three types of visits covered by Medicare that align with the practices AWV program:

IPPE

Initial Preventive Physical Examination

- Medicare pays for one per lifetime
- Must be done in first 12 mos. of Part B coverage
- Also known as "Welcome to Medicare Visit"

Initial AWV

Initial Annual Wellness Visit

- Applies the first time a beneficiary receives AWV
- Done after first 12 mos. of Part B coverage
- No IPPE or AWV within the past 12 months

Subsequent AWV

Subsequent Annual Wellness Visit

- Applies to all AWVs after a beneficiary's first AWV
- No IPPE or AWV within the past 12 months

Reference- Annual Wellness Visit Toolkit healthinsight.org

Why Wellness Care?

Summary of Benefits for Your Practice and Your Patients

If implemented effectively, it is anticipated a solid AWV program will introduce the following benefits to your practice and your patients:

Provider/Practice Benefits

- Opportunity to build a complete medical history for chronically ill patients
- Strengthen the provider/patient partnership
- Increases patient engagement through outreach and education
- Provide proactive care to patients
- Increase quality metrics
- Create a new and sustainable revenue stream for the practice

BETTER FOR...

THE CLINIC TODAY

More and more clinics are finding that they can use wellness care services and revenues to strengthen their infrastructure for providing comprehensive and coordinated care.

THE PATIENT

The Medicare Annual Wellness Visit (AWV) is designed to encourage and support individuals in taking an active role in accurately assessing and managing their health, and improving their well-being and quality of life.

THE CLINIC TOMORROW

Changes in payment models, like CMS' Medicare Access and CHIP Reauthorization Act (MACRA) – also known as the Quality Payment Program or QPP, make it imperative for primary care providers and geriatricians to be proactive identifying, documenting, and managing their patients' health risk.**

CONTROL YOUR FUTURE

While it requires some effort to implement and refine processes to deliver AWV effectively and efficiently, with help and guidance, we expect that almost every clinic will be able to find a way that works for them.

Reference- Annual Wellness Visit Toolkit healthinsight.org

Patient Benefits

- No co-pay - Medicare covers the cost of the beneficiary's AWV. The beneficiary pays zero out-of-pocket expenses and Medicare pays the provider the full amount.
- Annual, comprehensive evaluation focused on overall wellness and prevention
- Early disease detection and prevention
- Maximize wellness
- Prevent accidents at home
- Keep patients out of the hospital
- Delay long-term care

Alignment with Other Key Initiatives or Reporting Requirements

Medicare's QPP

An effective AWV program implementation may also support much of QPP's reporting and improvement requirements for both the Merit-based Incentive Payment System (MIPS) and the Advanced Alternative Payment Models (AAPMs) pathways. Here are just a few specific examples:

- ***Quality***
  - Preventive care such as immunizations, BMI, high blood pressure screenings and tobacco cessation intervention
  - Medication documentation in medical records and risk assessments (e.g. risk for falls)
  - Improvement Activities
  - Evidenced-based techniques to promote self-management into usual care
  - Implementation of fall screening and assessment programs
- ***Improvement Activities***
  - Evidenced-based techniques to promote self-management into usual care
  - Implementation of fall screening and assessment programs
- ***Promoting Interoperability***
  - Patient-specific education
  - Immunization registry reporting
  - Clinical information reconciliation
- ***Cost***
  - AWV is an effective way to engage in preventative health while containing or decreasing overall costs.
  - Coordinating care with specialty providers to reduce duplication and unnecessary care
  - Patient engagement and patient attribution

What is included in the Medicare AWV?

CMS Guidelines for Wellness Visits

Section	Initial AWV Components	Subsequent AWV Components
Acquire Beneficiary Information	- Administer HRA - Establish a list of current providers and suppliers - Establish the beneficiary's medical/family history - Review the beneficiary's potential risk factors for depression - Review the beneficiary's functional ability and level of safety.	- Update HRA - Update the list of current providers and suppliers - Update the beneficiary's medical/family history
Begin Assessment	- Obtain patient measurements (4 required) - Detect any cognitive impairment	- Obtain patient measurements (2 required) - Detect any cognitive impairment
Counsel Beneficiary	- Establish a written screening schedule - Establish a list of risk factors and conditions for which interventions are recommended or underway - Furnish personalized health advice and appropriate referrals - Furnish, at the discretion of the beneficiary, advance care planning services.	- Update the written screening schedule - Update the list of risk factors and conditions for which interventions are recommended or underway - Furnish personalized health advice and appropriate referrals - Furnish, at the discretion of the beneficiary, advance care planning services
Eligibility Requirements	Medicare covers patients who are - NOT within 12 months of their Medicare Part B benefits eligibility date - Did NOT receive an IPPE (G0402) or AWV (G0438) within the past 12 months	Medicare covers patients who are - NOT within 12 months after an initial AWV (G0438) was performed/billed.
	This is a once-in-a-lifetime service.	

There is no patient co-pay or deductible for these services.
These services are not routine physical exams. Medicare does not cover routine physical exams.

Documentation Requirements: Initial AWV

Code	Descriptor
G0438	Annual Wellness visit; include a personalized prevention plan of service (PPS), initial visit
RVU	2.60 (Updated 4/25/23)

To code/bill for this service the provider must:

- Perform a Health Risk Assessment (HRA)
- Establish the patient's medical and family history.
- Establish a list of patients' current medical care providers and suppliers
- Measure height, weight, BMI, BP, and other routine measurements deemed appropriate.
- Assess cognitive function
- Perform screening on depression risk factors
- Review patient's functional ability and safety
- Include a written plan of care to the patient detailing any follow-up screening or preventive services that the patient should receive.
- Establish a list of patient risk factors with interventions
- Provider personalized health advice and preventative counseling services.
- Provide advance care planning if needed.
- Review current opioid prescriptions and potential risk factors for substance use disorders.

Health Risk Assessment (HRA)

HRA can be self-reported information or completed by clinical staff.

At a minimum, information should include:

- Demographic data
- Health status self-assessment
- Psychosocial risks including but not limited to depression/life satisfaction, stress, anger, loneliness/social isolation, pain, and fatigue
- Behavioral risks including but not limited to tobacco use, physical activity, nutrition and oral health, alcohol consumption, sexual health, motor vehicle (for example, seat belt use), and home safety
  - Activities of Daily Living (ADLs) including dressing, feeding, toileting, grooming, and physical ambulation including balance/risk of falls and bathing; and Instrumental ADLs (IADLs), including using the phone, housekeeping, laundry, mode of transportation, shopping, managing medications and handling finances.

List of Current Providers and Suppliers

Include current patient providers and suppliers that regularly provide medical care, including behavioral health care.

- ➢ Include provider name and specialty
- ➢ If the patient has no other current providers or suppliers include this in the documentation

Example: *"Patient has no current providers/suppliers."*

Medical and Family History (Initial AWV)

Review of the beneficiary's medical and family history with attention to modifiable risk factors for disease.

- **Medical History** is defined to include, at a minimum, the following:
  - **(1)** Past medical and surgical history, including experiences with illnesses, hospital stays, operations, allergies, injuries, and treatments
  - **(2)** Use of, or exposure to, medications and supplements, including calcium and vitamins.

- **Family History** is defined to include, at a minimum, the following:
  - **(1)** Medical events of the patient's parents, siblings, and children including hereditary conditions that place them at increased risk

Exam

An examination to include the following measurements:

- ✓ Height
- ✓ Weight
- ✓ Body Mass Index
- ✓ Blood Pressure

As well as other factors as deemed appropriate, based on the beneficiary's medical and family history, and current clinical standards.

Cognitive Impairment

Assess Cognitive function by direct observation, considering information from the patient, family, friends, caregivers, and others.

- **We use the Mini-Cog Tool: Quick Screening for Early Dementia Detection**

Potential (Risk Factors) for Depression

Review of the beneficiary's potential (risk, factors) for depression, including current or past experiences with depression or other mood disorders, based on the use of an appropriate screening instrument for persons without a current diagnosis of depression, which the physician or other qualified non-physician. **We use the PHQ-9, which is built into the HRA and in EPIC.**

NOTE: The depression screening must be performed on the day of the Initial AWV. Depression screenings performed prior to the visit (i.e. earlier in the year) cannot be used to satisfy this requirement.

Functional Ability and Level of Safety

Review of the beneficiary's functional ability, and level of safety based on the use of appropriate screening questions or a screening questionnaire, which the physician or other qualified non-physician practitioner may select from various available screening questions or standardized questionnaires designed for this purpose and recognized by national professional medical organizations.

- **This information must include, at a minimum, a review of the following areas**:
  - (1) Hearing impairment
  - (2) Activities of daily living
  - (3) Falls risk
  - (4) Home Safety

Written Screening Schedule

The written screening or checklist should include screening for the next 5-10 years.

Base written screening schedule on the:

- Patient's HRA, health status and screening history, and age-appropriate preventive services Medicare Covers

Reminder: Written preventive screening schedule must be scanned into the patient's medical record.

List of Patient Risk Factors and Interventions

Documentation should include:

- Mental health conditions including depression, substance use disorder(s), and cognitive impairment
- Treatment options and associated risks and benefits

Education, Counseling and Referral

Education, counseling, and referral as deemed appropriate by the physician or qualified non-physician practitioner, based on the results of the review and evaluation services.

- Community-based lifestyle interventions to reduce health risks and promote self-management and wellness, including:
  - Fall Prevention
  - Nutrition
  - Physical Activity
  - Tobacco-use cessation
  - Weight loss
  - Cognition

Advanced Care Planning (optional, additional reimbursement)

Advance Care Planning ***upon agreement with the patient*** includes:

(1) Their preparation of an advance directive in case an injury or illness prevents them from asking about health care decisions
(2) Future care decisions they might need to make
(3) How they can let others know about care preferences
(4) Caregiver identification
(5) Explanation of advance directives, which may involve completing standard forms

Review of Current Opioid Prescriptions

A review of any **current** opioid prescriptions means, with respect to the individual determined to have a **current prescription for opioids,** all of the following should be documented:

(1) A review of the potential risk factors to the individual for opioid use disorder;
(2) An evaluation of the individual's severity of pain and current treatment plan;
(3) The provision of information on non-opioid treatment options; and
(4) A referral to a specialist, as appropriate.

Screening for Potential Substance Use Disorders

Screening for potential substance use disorders- including review of the individual's potential risk factors for substance use disorder and referral for treatment as appropriate.

Documentation Requirements: Subsequent AWV

Code	Descriptor
G0439	Annual Wellness visit; include a personalized prevention plan of service (PPS), initial visit
RVU	1.92 (last updated 4/24/23)

To code/bill for this service the provider must:

- ***Review and Update*** Health Risk Assessment (HRA)
- ***Update*** medical and family history.
- ***Update*** list of current providers and suppliers.
- Measure weight, BP, and other routine measurements deemed appropriate.
- Assess cognitive function
- ***Update*** written screening schedule.
- ***Update*** list of patient risk factors with interventions.
- ***Provide or update*** personalized health advice and preventative counseling services.
- Provide Advance Care planning if needed.
- ***Review*** current opioid prescriptions and potential risk factors for substance use disorders

Health Risk Assessment (HRA)

Review and update:

HRA can be self-reported information or completed by clinical staff.

At a minimum, information should include:

- Demographic data
- Health status self-assessment
- Psychosocial risks including but not limited to depression/life satisfaction, stress, anger, loneliness/social isolation, pain, and fatigue
- Behavioral risks including but not limited to tobacco use, physical activity, nutrition and oral health, alcohol consumption, sexual health, motor vehicle (for example, seat belt use), and home safety
- Activities of Daily Living (ADLs) including dressing, feeding, toileting, grooming, and physical ambulation including balance/risk of falls and bathing; and Instrumental ADLs (IADLs), including using the phone, housekeeping, laundry, mode of transportation, shopping, managing medications and handling finances.

*****PCH HRA form on page *****

List of Current Providers and Suppliers

Update:

Current patient providers and suppliers that regularly provide medical care, including behavioral health care.

- Include provider name and specialty
- If patient has no other current providers or suppliers include this in the documentation

Example: *"Patient has no current providers/suppliers."*

Medical and Family History

Update

Beneficiary's medical and family history with attention to modifiable risk factors for disease.

- **Medical History** is defined to include, at a minimum, the following:
  - **(1)** Past medical and surgical history, including experiences with illnesses, hospital stays, operations, allergies, injuries, and treatments.
  - **(2)** Use of, or exposure to, medications and supplements, including calcium and vitamins
- **Family History** is defined to include, at a minimum, the following:
  - **(1)** Medical events of the patient's parents, siblings, and children including hereditary conditions that place them at increased risk.

Exam

An examination to include the following measurements:

- ✓ Weight
- ✓ Blood Pressure

As well as other factors as deemed appropriate, based on the beneficiary's medical and family history, and current clinical standards.

Cognitive Impairment

Assess cognitive function by direct observation, considering information from patient, family, friends, caregivers, and others.

Written Screening Schedule

Update:

Written screening or checklist should include screenings for the next 5-10 years.

Base written screenings schedule on the:

- Patient's HRA, health status and screening history, and age- appropriate preventive services Medicare covers.

Reminder: Written preventive screening schedule must be scanned into the patient's medical record.

List of Patient Risk Factors and Interventions

Update:

List of risk factors:

- Mental health conditions including depression, substance use disorder(s), and cognitive impairment
- Risk factors or conditions identified
- Treatment options and associated risks and benefits.

Education, Counseling and Referral

Update:

Education, counseling, and referral as deemed appropriate by the physician or qualified non-physician practitioner, based on the results of the review and evaluation services.

- Community-based lifestyle interventions to reduce health risks and promote self-management and wellness, including:
  - Fall Prevention
  - Nutrition
  - Physical activity
  - Tobacco-use cessation
  - Weight loss
  - Cognition

Advance Care Planning (optional, additional revenue)

Advance Care Planning *upon agreement with the patient* includes:

(1) Their preparation of an advance directive in case an injury or illness prevents them from asking about health care decisions
(2) Future care decisions they might need to make
(3) How they can let others know about care preferences
(4) Caregiver identification
(5) Explanation of advance directives, which may involve completing standard forms.

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(1) A review of the potential risk factors to the individual for opioid use disorder;
(2) An evaluation of the individual's severity of pain and current treatment plan;
(3) The provision of information on non-opioid treatment options; and
(4) A referral to a specialist, as appropriate.

Screening for Potential Substance Use Disorders

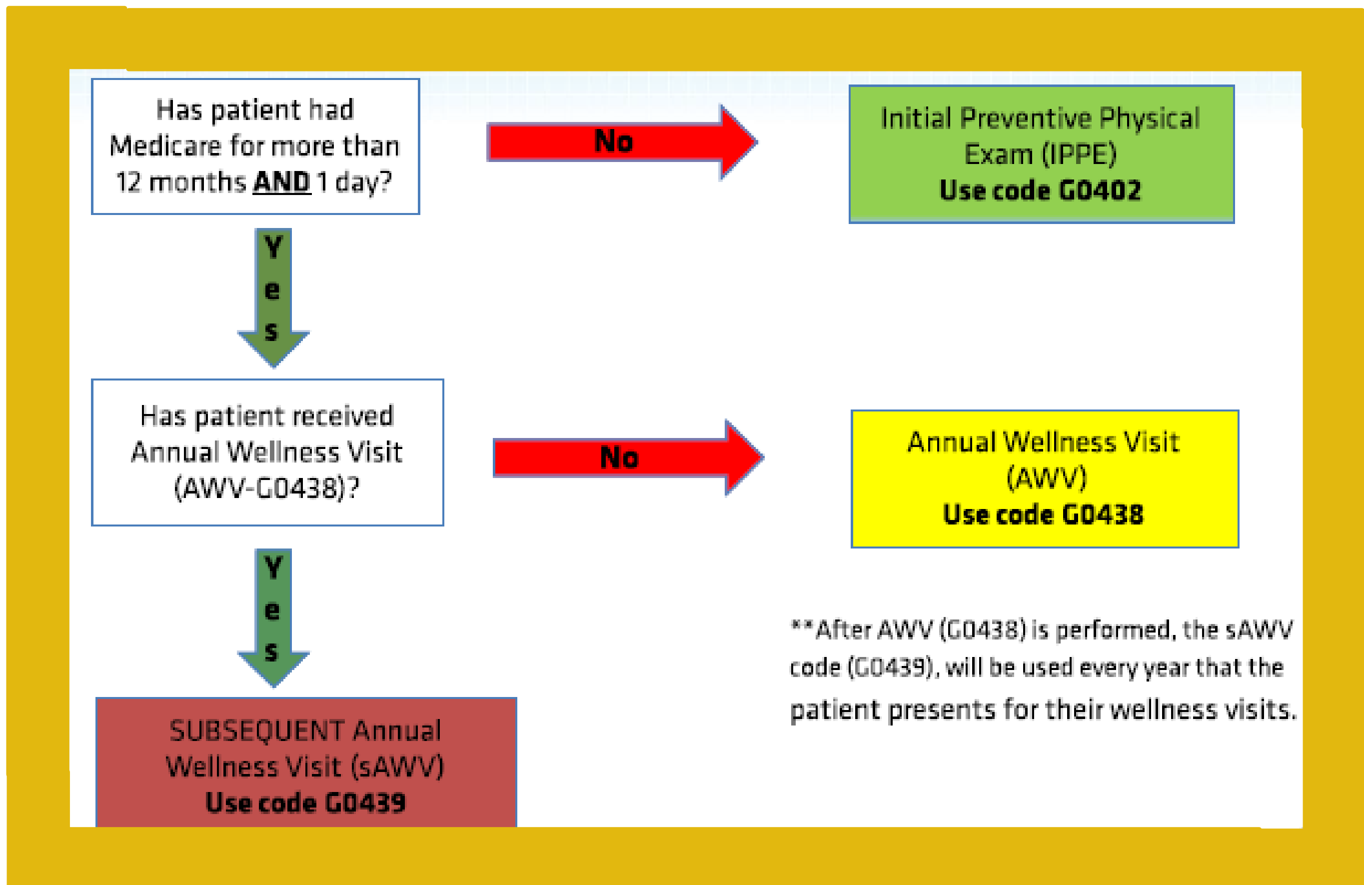
Screening for potential substance use disorders including a review of the individual's potential risk factors for substance use disorder and referral for treatment as appropriate.

Checking Eligibility

Scheduling IPPE vs Medicare AWV

IPPE, known as the "welcome to Medicare" preventive visit, is covered once in a lifetime not later than the first 12 months after the patient's Medicare Part B benefits eligibility date. IPPE is not included in the nurse wellness program**. If a patient wants their IPPE, this must be scheduled with a provider and NOT with the wellness nurse.**

Use the Eligibility Guide Below to determine what visit is most appropriate



Reference: Bill Dunbar & Associates

Checking Insurance Coverage using EPIC RTE

In EPIC, you can get instant eligibility for Medicare Wellness visits using the Real Time Eligibility (RTE). Run eligibility through the patient's registration to determine what type of appointment to schedule. For Medicare patients, their AWV information should show up under "Query Status" and will show what type of appointment they are due for.

In the below example, the patient just started Medicare on 5/1/22 so he is still eligible for his IPPE. Once May 1st has passed, we can schedule him for his initial AWV.

This only works with TRADITIONAL MEDICARE

Registration | Patient Guarantors and Coverages | E-MEDICARE | RH - E-MEDICARE

CS

Male, 65 y.o.,

MRN:

CSN:

ergies: Molds Extract, Pollen tracts

VID-19 Vaccine: Vaccinated

HIPAA

tive Rosters: None

Taylor, Sara E, PA-C

PCP - General

IT COVERAGE & FINANCIAL INFO

MEDICARE/MEDICARE PART A B (+1)

arantor: P/F - Self

lf-Pay Bal Due: $0.00

LECTED VISIT

atus: Completed

Response History

Current Patient Only | File Response

Sent	Received	Sent By
04/20/2023 11:37 AM	04/20/2023 11:37 AM	
03/08/2023 10:25 AM	03/08/2023 10:25 AM	

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Query Status
Highlights
Adjunctive Dental Services
Alcoholism
Alternate Method Dialysis
Blood Charges
Cardiac Rehabilitation
Chiropractic
Consultation
Dental Accident
Dental Crowns
Diagnostic Dental
Diagnostic Medical
Dialysis
Drug Addiction
Durable Medical Equipment
Emergency Services
Endodontics
Gynecological
Health Benefit Plan Coverage
Home Health Care
Hospice
Hospital - Ambulatory Surgical
Hospital - Emergency Accident

Coverage status: Active Coverage
Service: Immunizations
Insurance Type: Medicare Part B
Eligibility Dates:
Status: 4/20/2023

Benefit Information: Other Source of Data
Description: EXPERIAN HEALTH ALERTS
Note:
NEBO0010 Patient has Medicare AB
NEBO0522 Patient is in SNF
NEBO0524 Medicare Part A Effective Date: 05/01/2022
NEBO0525 Medicare Part B Effective Date: 05/01/2022
NEBO0526 Life Time Reserve Days remaining: 60
NEBO0532 Co-Pay Days Remaining: 30
NEBO0533 Full Days Remaining: 60
NEBO0541 Skilled Nursing Care. Begin Date: 20230101, End Date: 20231231
NEBO0544 Initial Annual Wellness Visit is in the future: 05/01/2023
NEBO0545 Subsequent Annual Wellness Visit is in the future: 05/01/2023

Benefit Information: Other Source of Data
Description: EXPERIAN HEALTH ALERTS
Note:
NEBO0551 Initial Annual Wellness Visit Benefit Begin Date: 05/01/2023
NEBO0552 Subsequent Annual Wellness Visit Benefit Begin Date: 05/01/2023
NEBO0555 SNF Full Days Remaining: 20
NEBO0556 SNF Co-Pay Days Remaining: 80

Checking Insurance Coverage For Advantage Plans

Check the Medicare portal for their part B coverage, it will be listed out. Some insurances you can check on their eligibility portal, both places should be checked.

Chart Prep

Use the chart prep guide- check each item as you work through the chart and taking notes on this paper as needed

Patient Name: ______________________________ DOB: ______________ APPT DATE: ___________

Risk Screenings

- Alcohol Use
- Illicit drug use
- Tobacco use
- Sexual Activity
- Caffeine use
- Dental Check
- Annual Eye Exam

Labs

- **Lipds(80061)** ____
  - *(Every 5 years cholesterol(82465), lipid(83718), and triglyceride levels(84478)*
  - *(NO PREVIOUS HISTORY OF DX)*
- **PSA(G0103)** *(annually)*
- **PAP** (Every 5 years)____***(no screening for women over 65 if prior tests are normal)***
- **Glucose (82947)** *(annually)*_____
  - *(NO PREVIOUS HISTORY OF DX)*
- **FOB(82270)** *(annually if symptomatic)* _____
  - Or Colonoscopy *(10 years if family hx or personal hx of polyps)*
  - Or Cologuard(81528) *(every 2 years)*

Procedures/Screening Exams

- **Mammo(77080)** *(Every 2 years)*
- **Bone Density Study** _____
  - *Menopausal women only; if male appears at risk complete male screening form and scan to visit)*
- **Cardiac Calcium Score**_____
  - *Discuss if indicated*
- **Low Dose Lung CT(G0297)***(annually)* ____
  - *Discuss if indicated(G0296)*
    - *Age 55-77, asymptomatic, tobacco smoking hx of at least 30 pack-years (one pack year=smoking one pack per day for one year, 1 pack=20 cigarettes), or current smoker or one who quit smoking within the last 15 years*
- **AAA screening(76706)** ____ (1x in lifetime)
  - *Family hx of AAA OR*
  - *Male age 65-75 and smoked 100 cigas or more in lifetime*

Immunizations

- **Covid**____*(All Adults)*
- **Prevnar(90670)**____ *(x1 after 65)(once)*
- **Pneumovax(907362)**____ *(1x after 65)(once after age 65)*
- **Influenza**_____ *(Once every flu season)*
- **Tetanus** _____ *(1x every 10 years, do Tdap 1x to boost pertussis)(Covered at pharmacy)*
- **Zoster** *(vaccine after 50-55)(Covered at Pharmacy)*
- **Hep B**____*(high risk pt's only-iv drug use, multiple sexual partners, direct contact with infected)*

Care Team/ Suppliers

- **Cardiologist**
- **Oncologist**
- **Endocrinologist**
- **ENT**
- **Eye Specialist**
- **GI**
- **Home health**
- **OB/GYN**
- **Neurologist**
- **Pain Management**
- **Podiatrist**
- **Pulmonologist**
- **Rheumatologist**
- **Urologist**
- **Nephrologist**
- **DME company**
- **Nursing Home**
-

Update:	Recommendations:

After checking eligibility to determine what type of AWV is due, you can start you chart prep. A full chart prep consists of the following pieces as well as documentation on the chart prep tool to guide you through the appointment.

- **Updating the Chart**
  - **Step 1: Research the chart**
    - Check to see if they have had a visit yet in EPIC, if not pull the information from Allscripts.
    - **Uncheck Default filter to load in all records*
    - Print out Health any HM information not in EHR currently and scan in
    - Check demographic information to see what screenings they are due for.
  - **Step 2: Check Health Maintenance Tab**
    - During chart check you will see what you can take off from old chart, or if they are due for others

< Check the Snapshot for Health Maintenance and update/pull info.

<Most items are addressed during a wellness visit.

  - **Step 3: Update Immunizations**
    - Pull a CHIRP and update as needed
  - **Step 4: Clean up Medical History/Problem List (Reviewed during the appointment)**
    - Patients medical history is often full of old diagnoses, but some of them are chronic that need to be added to the problem list. You can do this by going too snapshot >medical history> clicking + sign to add any pertinent diagnosis that are current. This will add it to the patient's problem list.

Past Medical History

Diagnosis	Date	PL
Actinic keratoses		+
Acute pain of left knee		+
Arrhythmia	2010	+
Benign hypertension	07/22/2005	+
BMI 34.0-34.9,adult		+
Body mass index (BMI) 32.0-32.9, adult		+
Carcinoma of cervix (CMS/HCC)	1992	+
Chest pain, atypical		
Closed extra-articular fracture of distal end of left radius with routine healing		

During the Appointment- Vaccines and Immunizations

Vaccines Covered During AWV

Medicare Part D covers most vaccines and immunizations. However, there are certain vaccinations that are always covered by Part B:

- ✓ Influenza (flu) shots, including both the seasonal flu vaccine and the H1N1 vaccine
- ✓ Pneumococcal (pneumonia) shots
- ✓ Hepatitis B Shots
- ✓ COVID-19 vaccine

Vaccines at the Pharmacy

Starting in 2023, the Inflation Reduction Act **eliminated all out-of-pocket costs for vaccines** that the CDC's Advisory Committee on Immunization Practices recommends for adults, whether you have drug coverage from Part D or from a Medicare Advantage plan. That includes the shingles vaccine.

To avoid billing issues, it is usually best to send patients to the pharmacy. We cannot bill Part D in a doctor's office.

- ✓ Shingles (Herpes Zoster)
- ✓ D-Tap (Tetanus-Diphtheria-whooping cough vaccine)

During the Appointment- Covered Lab Tests

	Diagnosis Codes	Lab Test	Eligibility Requirements (only for Part B Medicare Patients)	Frequency	Patient Shares Cost	NO Cost Sharing
G0103	Z12.5	Prostate Cancer Screening (PSA)	- Male - Age 50 or older	Annually		✓
G0472	Z72.89 **or** Z19.20	Hepatitis C Antibody screening	Part B patients must meet at least 1 of these criteria:	Once		✓
			High Risk for HCV infection	**Annually** only for high-risk patients with continued illicit injection drug use		✓
			Born 1945-1965	Once		✓
			Had a blood transfusion before 1992	One initial screening, regardless of birth year, for high-risk patients.		✓
80061	Z13.6	Lipid Panel	Patients without apparent cardiovascular disease signs or symptoms	Once every 5 years		✓
G0499	Z11.59 **and** N18.6	Hepatitis B Screening	High-risk, asymptomatic, non-pregnant adolescents and adults	-Once for asymptomatic screening who meet the high-risk definition -Annually for patients with continued high risk who don't get HBV		✓
G0475	**Increased risk factors NOT <u>reported</u>** Z11.4 ___________ **Increased risk factors <u>reported:</u>** Z11.4 **and** Z72.51, Z72.52, Z72.53, or Z72.89	HIV Screening ***HIV Consent is required. Print from chart, have patient sign and scan form to the encounter.***	Certain patients without regard to perceived risk or at increased HIV risk, including anyone who asks for the test	Annually for patients older than 65 at increased HIV risk		✓

During the Appointment- Cognitive Screening

Mini-Cog

Step by Step Instructions:

1. Make sure you have the person's attention.

- Instruct the person to listen carefully to and remember three unrelated words and then to repeat the words back to you so then you will know they heard the words correctly.
- You may want to say something like, "What we're going to do next will take some concentration. Ready?"

2. Ask the person to repeat the words to ensure understanding.

- Once you are sure the person is paying attention, say, "I am going to say three words that I want you to remember now and later. The words are banana, sunrise, chair (or the word set you have chosen). Please say them now."
- Give the person three tries to repeat the words. You may repeat the words to them for each try.
- If they are unable to repeat the words back to you after three tries, go directly to the clock drawing.

3. Ask person to draw a clock.

- Provide the person with page 2 of the Standardized Mini-Cog© Instrument.
- Say all the following phrases in the order indicated below:

1. "Please draw a clock in the circle." It is acceptable to provide a sheet of paper with the circle already drawn for the person, as depicted on the standardized Mini-Cog® (insert hyperlink to the Mini-Cog® Tool page)
2. "Put all the numbers in the circle"
3. When #2 is completed, say, "Now set the hands to show ten past eleven."

- If the person has not finished the clock drawing in 3 minutes, discontinue and ask for the word recall items.

4. Ask person to recall the 3 words.

- You will be asking the person to recall the set of 3 words you gave them at the beginning of the test.
- Say, "What were the three words I asked you to remember?"
- Administer this portion of the test even if the person did not accurately repeat the 3 words earlier in #2 above.

****Scan Form to patients Encounter****

Reference: https://mini-cog.com/

Scoring the Mini-Cog

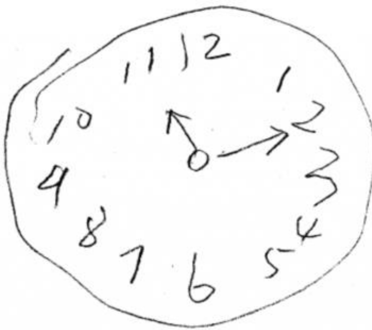
Recall Score (Total Possible Score: 0-3)

- 1 point for each word correctly recalled without prompt

Clock Drawing Score (Total Possible Score: 0-2)

- 2 points for a normal clock or 0 (zero) points for an abnormal clock drawing.
- A normal clock must include all numbers (1-12), each only once, in the correct order and direction (clockwise).
- There must also be two hands present, one pointing to the 11 and one pointing to 2.
- Hand length is not scored in the Mini-Cog Algorithm. ***

Normal Clock



Abnormal Clock

(abnormal hands)

Abnormal Clock

(missing number)

Interpreting the Mini-Cog Score (Total Possible Score: 0-5)

Instructions:

- **Add the 3-item recall and clock drawing scores together. That's it!**

Clinical Interpretation:

Total score of 0-2	Total score of 3-5
Indicates higher likelihood of clinically important cognitive impairment. **Referral/follow-up required*	Indicates lower likelihood of dementia but does not rule out some degree of cognitive impairment

Note: *If a person has a normal Mini-Cog score but reports concern about memory or thinking, this should ALWAYS be taken seriously and followed up with more detailed assessment.*

Reference: https://mini-cog.com/

During the Appointment- Fall Prevention Screening

Get Up and Go (TUG)

ASSESSMENT

Timed Up & Go (TUG)

Purpose: To assess mobility

Equipment: A stopwatch

Directions: Patients wear their regular footwear and can use a walking aid, if needed. Begin by having the patient sit back in a standard arm chair and identify a line 3 meters, or 10 feet away, on the floor.

NOTE: Always stay by the patient for safety.

① **Instruct the patient:**

When I say "Go," I want you to:

1. Stand up from the chair.
2. Walk to the line on the floor at your normal pace.
3. Turn.
4. Walk back to the chair at your normal pace.
5. Sit down again.

② **On the word "Go," begin timing.**

③ **Stop timing after patient sits back down.**

④ **Record time.**

Time in Seconds: ______________________

An older adult who takes ≥12 seconds to complete the TUG is at risk for falling.

Patient ______________________

Date ______________________

Time ______________________ ☐ AM ☐ PM

OBSERVATIONS

Observe the patient's postural stability, gait, stride length, and sway.

Check all that apply:

- ☐ Slow tentative pace
- ☐ Loss of balance
- ☐ Short strides
- ☐ Little or no arm swing
- ☐ Steadying self on walls
- ☐ Shuffling
- ☐ En bloc turning
- ☐ Not using assistive device properly

These changes may signify neurological problems that require further evaluation.

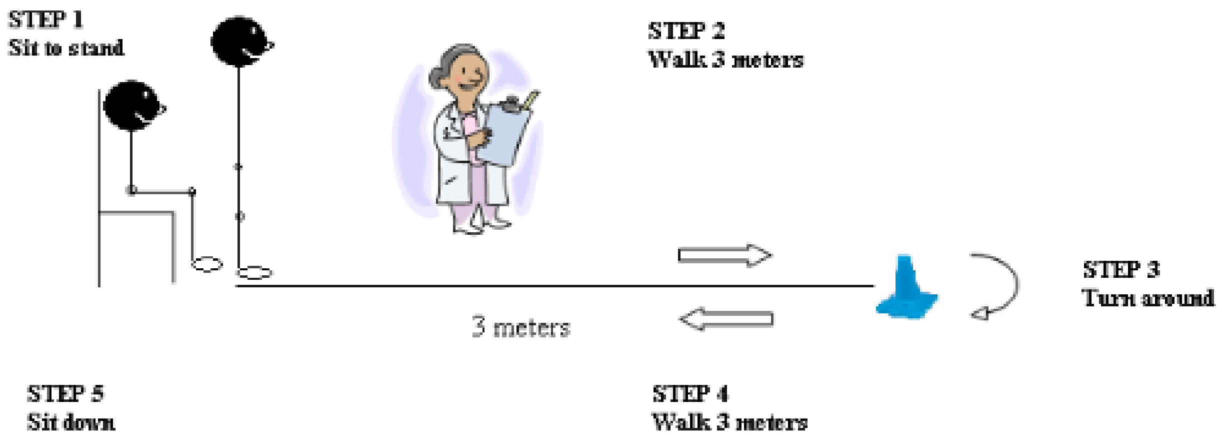
CDC's STEADI tools and resources can help you screen, assess, and intervene to reduce your patient's fall risk. For more information, visit www.cdc.gov/steadi

Scan form to patients encounter

Interpreting the TUG test

Instructions:

The individual must stand up from a chair (which should not be leaned up against a wall), walk a distance of 3 meters, turn around, walk back to the chair, and sit down- all performed at a comfortable and safe pace (Figure 1). One practice trial is permitted to allow the individual to familiarize him/herself with the task. Timing commences with the verbal instruction "go" and stops when the client returns to seated position. The individual wears their regular footwear and is permitted to use their walking aid (cane/walker) with its use indicated on the data collection form. No physical assistance is given.



Interpretation:

Scoring and interpretation of the TUG

Score	Interpretation
< 10s	**Completely independent** With or without walking aid for ambulation and transfers
< 20s	**Independent for main transfers** With or without walking aid, independent for basic tub or shower transfers and able to climb most stairs and go outside alone
> 30s	**Requires assistance** Dependent in most activities

Reference: cdc.gov/steadi/materials.html

During the Appointment- Advanced Care Planning

Benefits of ACP

Patients, family members, staff, and medical providers all benefit from advance care planning. It reduces family and healthcare provider stress and anxiety, and it increases patient and family satisfaction with care. In prospective studies and randomized trials, advance care planning has significantly improved multiple outcomes, particularly for patients with serious illness. These include:

- ACP honors a patient's right to self-determination and helps ensure that patients receive care that is consistent with their preferences and the requirements of the Patient Self-Determination Act of 1990.
- ACP is associated with higher patient satisfaction with the quality of healthcare.
- ACP improves communication between patient, loved ones, and clinicians resulting in shared decision-making.
- ACP reduces moral distress among health care providers.
- ACP increases likelihood that clinicians and families understand and comply with a patient's wishes.
- ACP lowers risk of stress, anxiety, and depression in surviving relatives of deceased persons.
- ACP provides guidance to family members and reduces their decisional burden about whether they are following their loved ones' preferences. Family members feel better prepared to make decisions for their loved one. Family is better prepared about what to expect during the dying process.
- ACP helps healthcare surrogates by providing a framework that they may utilize to inform decision-making, keeping in mind the patient's goals, values, and beliefs, as well as their treatment preferences.
- ACP is associated with higher rates of completion of advance directives, a reduction in hospitalizations at the end of life, fewer invasive treatments at the end of life, and increased utilization of hospice and palliative care services.
- ACP increases the likelihood that a patient will die in his/her preferred environment.
- Emerging data indicates advance care planning reduces cost of end of life care, without increasing mortality.

Source:
Advance Care Planning and Advance Directives. Karen Detering, MD, Maria J. Silveira, MD, MA, MPH. In UpToDate

Resources

For all Hospice, Palliative Care, and Advanced Care Planning resources go to the below website. We also have Elaine Peck at epeck@pchosp.org for any questions, vital medical files, or ACP Planning folders.

https://pchpca.org/

Having the Conversation at Three Life Stages: A Guide for Providers

	No Serious Illness	Serious Illness	Advanced Serious Illness
Sample Case Progression	Ms. Smith is a 68-year-old woman with hypertension, hyperlipidemia, and history of smoking. She was recently diagnosed with emphysema/COPD. She's coming in for a routine follow-up for her hypertension with her daughter.	At age 71, Ms. Smith developed a COPD exacerbation, which turned into a pneumonia with significant shortness of breath. She was admitted to the hospital. She was sick enough to require BIPAP and was in the ICU. Eventually, she recovered and was discharged home. She is now in your office for routine follow-up.	Now 75 years old, Ms. Smith has had a couple admissions for less severe COPD exacerbations. She was eventually placed on home oxygen, and then about 2 months ago her illness seemed to progress. You talk more, and it becomes clear that she doesn't want to have to go back to the hospital if it isn't necessary. She really prefers to stay at home.
Conversation Goals	• Build trusting and respectful relationships • Learn about the patient as a person • Establish a surrogate decision maker • Promote patient-surrogate-family conversations	• Continue to build trusting, respectful relationships • Continue to learn more about the patient as a person • Ensure a good understanding of diagnosis, prognosis, and treatment options • Anticipate emergencies and make a plan when appropriate • Promote patient-surrogate-family conversations	• Rely on the trusting, respectful relationships that were built • Keep the focus on the patient as a person • Ensure a good understanding of diagnosis, prognosis, and treatment options before introducing hospice • Continue to hope for the best, but prepare for when things don't go well
Examples of What to Say	• Normalize the conversation • Try starting it after family history *"Have you ever thought who would speak for you if you couldn't speak for yourself? Is it ok if we talk about that?"* • If they already have an advance directive (AD): *"May I see it? What does it say?"* • If they do not have an AD: *"Can I offer you some tools to start thinking about it?"*	• Talk about "what matters most" *"Can you tell me your understanding of what happened in the hospital?"* *"What was that like for you?"* *"How are you doing now?"* *"If surrogate decision making was needed, how was that?"* • Identify the values that guided decision making, i.e., "what mattered most"	*"You have been in and out of the hospital quite a bit. How has that been?"* *"How do you feel about your quality of life?"* *"Given everything that has happened, what are you hoping for?"* *"Unfortunately, we don't have any more treatments to help your lungs get better."* *"It seems to me what matters most to you is to [stay out of the hospital, control your symptoms at home, and make the most of each day OR stay out of the hospital but continue to receive treatment] and I think [hospice OR home care] is the best way of doing that."*

Billing Details	New Codes from CMS • Use 99497 if you meet or exceed 16 minutes	• Use 99497 + 99498 if you meet or exceed 46 minutes
	Documentation Requirements • Total time in minutes • Patient/surrogate/family "given opportunity to decline" • Details of content • Attending MDs and DOs, as well as NPs and PAs (i.e., those who are authorized to independently bill Medicare for CPT services), are the only providers who can use these codes.	• If medical management billing is based on medical decision making, then you can bill as you normally would in that scenario. On top of that, you should also bill based on time spent for ACP. • If instead you are billing for the medical management based on time, you should be sure you do not double count the time spent on the advance care planning conversation.

Want more information? Visit ihi.org/CMSpayment

The information contained in this document is based on our best understanding of the new reimbursement codes. It is your responsibility to check with your local billing expert before using the new codes. Please review our full disclaimer of warranties and liability at [illegible]

SPEAKING UP FOR YOUR CARE

WHO WE ARE

PUTNAM COUNTY HOSPICE AND PALLIATIVE CARE ASSOCIATION

History. The Association started in 2016 as a partnership between the Putnam County Community Foundation and the Putnam County Hospital. The Community Foundation provides an annual grant for our work. The Hospital serves as our fiscal sponsor. The Association is a 501 (c) 3 non-profit, public charity, by virtue of the Hospital's fiscal sponsorship.

Mission statement. The Putnam County Hospice and Palliative Care Association seeks to enhance the quality of life for terminally ill persons, their loved ones, and their caretakers, by providing education and resources about the benefits of hospice care, palliative care, and advance care planning.

- We do not provide legal or medical advice.
- We do not recommend particular companies or organizations.
- We DO provide educational opportunities, information, tools, and resources to the general public and to Putnam County healthcare providers and systems, and we are always seeking new ways to be of greater support.

TOOLS AND RESOURCES FOR HEALTHCARE PROVIDERS AND SYSTEMS:

Free information and resources on our website: www.pchpca.org; Facebook and Instagram

Free awareness-raising materials and services:

- Free Advance Care Planning posters, table tents, pamphlets, banners, etc.
- Free Vital Medical Information File signs, table tents, etc.
- Free speakers for meetings and events

Free patient resources:

- Free patient packets: Vital Medical Information Files (for persons 60 + and seriously ill)
- Free patient packets: My Advance Directives folders (for all adults)
- Free patient packets: Hospice and Palliative Care Information folders

Coming soon:

- Free fliers for staff: Is it time to introduce hospice?

Free educational opportunities:

- Free remote advance care planning workshops: Second Wednesday of each month at noon—via zoom—to register, send email to contact.us@pchpca.org
- Free remote Indiana Physician Orders Scope of Treatment (POST) training—via zoom

SCAN ME
to visit our website

CONTACT INFORMATION

- **Elaine Peck, Director: 765.301.7614; epeck@pchosp.org**
- **Tammy Hunter, President: 765.301.7626; thunter@pchosp.org**

CONTACT US. Office: **765.301.7614** Email: **contact.us@pchpca.org** Website: **www.pchpca.org**

FREE
ADVANCE HEALTHCARE PLANNING LUNCH AND LEARN OPPORTUNITIES

Learn about advance healthcare planning in the comfort and convenience of your office or home.

Second Wednesday of Every Month
Noon to 1 PM - Zoom

Advance Healthcare Planning Lunch and Learns are highly individualized according to the needs and interests of attendees, and provide time for answering questions.

POSSIBLE TOPICS INCLUDE:

- What do I need to know about advance healthcare planning?
- How to introduce advance healthcare planning conversations to your loved ones.
- How to choose and be a Healthcare Representative (HCR).
- How to complete a Statement of Healthcare Preferences (Living Will).
- How to ensure comfort-care and allow a natural death with a Physician Orders for Scope of Treatment (POST) form.

REGISTERING IS EASY!

- Just send an email to contact.us@pchpca.org with your interests and questions.
- Register no later than 5 PM the night before the ACP Lunch and Learn.
- A Zoom meeting invitation will emailed to you on the morning of the Lunch and Learn and will include instructions to join the session.

CONTACT US. Office: **765.301.7614** Email: **contact.us@pchpca.org** Website: **www.pchpca.org**

Choosing a HEALTHCARE REPRESENTATIVE *is important for* ALL ADULTS at ALL STAGES of life and health.

WHAT IS A HEALTHCARE REPRESENTATIVE?

A healthcare representative may also be called an agent, a proxy, a surrogate, or an attorney-in-fact for healthcare.

A healthcare representative is the person you choose to make healthcare decisions for you if you become unable to speak or make decisions for yourself.

Being a representative is not for everyone. The representative may have to make tough, quick decisions on your behalf—including decisions about medical treatments, procedures, even life-support.

Your representative doesn't need to be a medical expert, but he/she should be someone who can apply your general values to specific medical circumstances and make decisions that are consistent with your expressed wishes.

CONTACT US

FOR FREE ASSISTANCE & INFORMATION, & CHECK OUT OUR WEBSITE.

SPEAKING UP FOR YOUR CARE

1542 S. Bloomington Street
Greencastle, IN 46135
T: 765.301.7614
contact.us@pchpca.org
www.pchpca.org

IDEAL QUALITIES OF A HEALTHCARE REPRESENTATIVE

- Lives close by or could travel to be at your side if needed.
- Able to make decisions on your behalf that are in line with your wishes and values and to separate his/her own feelings from yours.
- Can be a strong advocate and comfortable asking questions of doctors and other busy providers and standing up for you and your wishes if necessary.
- Able to make decisions in changing circumstances.
- Able to communicate your wishes and handle conflicting opinions between family members, friends, and medical personnel.
- Will talk with you now about sensitive issues and listen to your wishes.

FREQUENTLY ASKED QUESTIONS

What if I want to choose more than one person to be my representative? Usually it is best to name one person to serve at a time, with at least one successor, or back-up person in case your primary representative is unable to serve.

Are there laws about who CANNOT be my representative? Yes. State rules governing who may be a representative vary, but the most common groups disqualified are these:

- Anyone under age 18.
- Your healthcare providers, including the owner or operator of a health or residential facility serving you (unless the person is a close relative).
- An employee of your health care providers (unless the person is a close relative).

ADDITIONAL INFORMATION

How to Select Your Healthcare Agent or Proxy
https://pchpca.org/images/pdf/acp-for-trusted-advisors/ABA_Select_Healthcare_agent_or_proxy.pdf

Guide for Healthcare Proxies
https://pchpca.org/images/pdf/acp-for-trusted-advisors/ABA_Guide_for_Healthcare_proxies.pdf

You have been chosen to be a loved one's HEALTHCARE REPRESENTATIVE.

It is an HONOR to be asked to do something so important.

WHAT IS A HEALTHCARE REPRESENTATIVE?

A healthcare representative may also be called an agent, a proxy, a surrogate, or an attorney-in-fact for healthcare.

A healthcare representative is a person chosen by a loved one to make healthcare decisions, including end-of-life decisions in the event the person becomes unable to make his or her own decisions. In most states, a doctor determines when and if the person is unable to make his or her own decisions.

This is a very important role. The person who has chosen you is expecting that you will make the decisions that he or she would make if able. He or she values you and trusts you to do the right thing.

CONTACT US

FOR FREE ASSISTANCE & INFORMATION, & CHECK OUT OUR WEBSITE.

SPEAKING UP FOR YOUR CARE

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DUTIES OF A HEALTHCARE REPRESENTATIVE

TALK TO YOUR LOVED ONE. If you are going to be someone's healthcare representative, the most important thing you can do is talk to that person while there's still time. The decisions that you'll make should be based on what the other person would want, even if that is different from what you would want for yourself.

YOUR DUTIES as a healthcare representative depend upon what the person's advance directive says and upon state law. Your duties begin when the person loses the ability to make healthcare decisions on his or her own. In general, you will have the authority to make any and all decisions a patient would make for him or herself, if able. This includes:

1. Conferring with the medical team, receiving the same information the individual would receive, and reviewing the medical chart.
2. Asking questions and getting explanations.
3. Discussing treatment options.
4. Requesting consultations and second opinions.
5. Consenting to or refusing medical tests or treatments, including life-sustaining treatment.
6. Authorizing a transfer to another physician or facility.

HOW TO MAKE MEDICAL DECISIONS FOR SOMEONE ELSE

1. Find out the person's complete medical situation.
2. Find out the treatment options, including benefits and risks of each option.
3. Do your best to figure out how your loved one would decide if they knew all the facts and options.

The toughest decisions may involve starting or stopping life-sustaining treatments.

MANY PEOPLE say they do not want to die slowly hooked up to machines.

WHAT DOES YOUR LOVED ONE WISH?

INDIANA HEALTH CARE REPRESENTATIVE:
A Health Care Representative is a person chosen by you to make healthcare decisions, including end-of-life decisions, if you are unable to make your own. It is a good idea to talk with this person about your preferences ahead of time. A doctor will determine if you are unable to make your own decisions.

My name (Full Legal Name – also known as "declarant") Date of Birth (MM/DD/YYYY)

____ ___________________________

My Health Care Representative can make decisions for me if I cannot make and share my own health care decisions. My Health Care Representative must follow my wishes and values. My values include my ideas about dignity and quality of life. If my Health Care Representative does not know my wishes, my Health Care Representative must act in good faith and make decisions in my best interests. These decisions include but are not limited to:

- Agreeing to medical treatment
- Refusing medical treatment
- Stopping medical treatment
- Arranging comfort care

I want the following person to be my Health Care Representative (HCR):

HCR Name HCR Phone Number

____ ___________________________

If my primary HCR named above is not able or available to act for me, I want the following person to be my backup Health Care Representative:

Backup HCR Name Backup HCR Phone Number

____ ___________________________

OPTIONAL STATEMENT OF PREFERENCES:
I would like to provide some additional guidance for my Health Care Representative on my end of life preferences. (Please select only one option below).

☐ The ***quality of my life*** is more important than the length of my life. If I am unable to make my own decisions and my attending physician believes that I will not recover, I do not want treatments to prolong my life or delay my death. Instead, I would want treatment or care to make me comfortable and to relieve me of pain.

☐ ***Staying alive*** is more important to me, no matter how sick I am or how unlikely my chances for recovery are. I want my life to be prolonged to the greatest extent possible, in accordance with reasonable medical standards.

☐ I choose to NOT complete this section at this time.

p. 1 of 2

Declarant Name: ___________________________

REQUIRED SIGNATURES:
By signing this form, I cancel and revoke every health care power of attorney I signed in the past.

____ ____________________________
Signature (Declarant) Date

____
Printed Name (Declarant)

This form must be either signed by 2 adult witnesses (below left) or notarized (below right) to be legally valid.

SIGNATURE OF 2 ADULT WITNESSES

Each of the undersigned Witnesses confirms that he or she has received satisfactory proof of the identity of the Declarant and is satisfied that the Declarant is of sound mind and has the capacity to sign the above Advance Directive. **At least one of the undersigned Witnesses is not a spouse or other relative of the Declarant.**

____
Signature of Adult Witness 1

____
Printed Name of Adult Witness 1

____
Date

____
Signature of Adult Witness 2

____
Printed Name of Adult Witness 2

____
Date

__________ Initial here if the Witnesses participated by phone.

This advance directive was created by the Indiana Patient Preferences Coalition and is freely available. See www.INadvancedirectives.org for more information.

NOTARIZATION

STATE OF INDIANA)
) SS:
COUNTY OF _______________)

Before me, a Notary Public, personally appeared _________________________________ [*name of signing Declarant*], who acknowledged the execution of the foregoing Advance Directive as his or her voluntary act, and who, having been duly sworn, stated that any representations therein are true.

Witness my hand and Notarial Seal on this _______ day of ___________________, 20____.

____
Signature of Notary Public

____
Notary's Printed Name *(if not on seal)*

____
Commission Number *(if not on seal)*

____
Commission Expires *(if not on seal)*

____
Notary's County of Residence

p. 2 of 2

Indiana Code (05/09/2023)

https://iga.in.gov/legislative/laws/2022/ic/titles/016#16-36-1-5

IC 16 **Title 16 – HEALTH**
IC 16-36 **Article 36 – MEDICAL CONSENT**

IC 16-36-1-5 Persons authorized to consent for incapable parties; minors

Sec. 5. (a) If an adult incapable of consenting under section 4 of this chapter has not appointed a health care representative under section 7 of this chapter or the health care representative appointed under section 7 of this chapter is not reasonably available or declines to act, except as provided in sections 9 and 9.5 of this chapter, consent to health care may be given in the following order of priority:

(1) A judicially appointed guardian of the person or a representative appointed under section 8 of this chapter.
(2) A spouse.
(3) An adult child.
(4) A parent.
(5) An adult sibling.
(6) A grandparent.
(7) An adult grandchild.
(8) The nearest other adult relative in the next degree of kinship who is not listed in subdivisions (2) through (7).
(9) A friend who:
(A) is an adult;
(B) has maintained regular contact with the individual; and
(C) is familiar with the individual's activities, health, and religious or moral beliefs.
(10) The individual's religious superior, if the individual is a member of a religious order.

(b) Consent to health care for a minor not authorized to consent under section 3 of this chapter may be given by any of the following:

(1) A judicially appointed guardian of the person or a representative appointed under section 8 of this chapter.
(2) A parent or an individual in loco parentis if:
(A) there is no guardian or other representative described in subdivision (1);
(B) the guardian or other representative is not reasonably available or declines to act; or
(C) the existence of the guardian or other representative is unknown to the health care provider.
(3) An adult sibling of the minor if:
(A) there is no guardian or other representative described in subdivision (1);
(B) a parent or an individual in loco parentis is not reasonably available or declines to act; or
(C) the existence of the parent or individual in loco parentis is unknown to the health care provider after reasonable efforts are made by the health care provider to determine whether the minor has a parent or an individual in loco parentis who is able to consent to the treatment of the minor.
(4) A grandparent of the minor if:
(A) there is no guardian or other representative described in subdivision (1);
(B) a parent, an individual in loco parentis, or an adult sibling is not reasonably available or declines to act; or
(C) the existence of the parent, individual in loco parentis, or adult sibling is unknown to the health care provider after reasonable efforts are made by the health care provider to determine whether the minor has a parent, an individual in loco parentis, or an adult sibling who is able to consent to the treatment of the minor.

(c) A representative delegated authority to consent under section 6 of this chapter has the same authority and responsibility as the individual delegating the authority.

(d) An individual authorized to consent for another under this section shall act in good faith and in the best interest of the individual incapable of consenting.

(e) If there are multiple individuals at the same priority level under this section, those individuals shall make a reasonable effort to reach a consensus as to the health care decisions on behalf of the individual who is unable to provide health care consent. If the individuals at the same priority level disagree as to the health care decisions on behalf of the individual who is unable to provide health care consent, a majority of the available individuals at the same priority level controls. [Pre-1993 Recodification Citation: 16-8-12-4.]

As added by P.L.2-1993, SEC.19. Amended by P.L.81-2015, SEC.6; P.L.54-2017, SEC.1; P.L.67-2018, SEC.3.

STATE OF INDIANA
OUT OF HOSPITAL DO NOT RESUSCITATE DECLARATION AND ORDER
State Form 49559 (R / 9-11)

This declaration and order is effective on the date of execution and remains in effect until the death of the declarant or revocation.

OUT OF HOSPITAL DO NOT RESUSCITATE DECLARATION

Declaration made this ____________ day of ______________________________, ___________, being of sound mind and at least eighteen (18) years of age, willfully and voluntarily make known my desires that my dying shall not be artificially prolonged under the circumstances set forth below.

I declare:
My attending physician has certified that I am a qualified person, meaning that I have a terminal condition or a medical condition such that, if I suffer cardiac or pulmonary failure, resuscitation would be unsuccessful or within a short period I would experience repeated cardiac or pulmonary failure resulting in death.

I direct that, if I experience cardiac or pulmonary failure in a location other than an acute care hospital, cardiopulmonary resuscitation procedures be withheld or withdrawn and that I be permitted to die naturally. My medical care may include any medical procedure necessary to provide me with comfort care or to alleviate pain.

I understand that I may revoke this Out of Hospital Do Not Resuscitate Declaration at any time by a signed and dated writing, by destroying or canceling this document, or by communicating to health care providers at the scene the desire to revoke this declaration.

I understand the full import of this declaration

Signature of declarant
Printed name of declarant
City and state of residence

The declarant is personally known to me, and I believe the declarant to be of sound mind. I did not sign the declarant's signature above, for, or at the direction of, the declarant. I am not a parent, spouse, or child of the declarant. I am not entitled to any part of the declarant's estate or directly financially responsible for the declarant's medical care. I am competent and at least eighteen (18) years of age.

Signature of witness	Printed name	Date *(month, day, year)*
Signature of witness	Printed name	Date *(month, day, year)*

OUT OF HOSPITAL DO NOT RESUSCITATE ORDER

I, ______________________________, the attending physician of ____________________________, have certified the declarant as a qualified person to make an Out Of Hospital Do Not Resuscitate Declaration, and I order health care providers having actual notice of this Out Of Hospital Do Not Resuscitate Declaration and Order not to initiate or continue cardiopulmonary resuscitation procedures on behalf of the declarant, unless the Out Of Hospital Do Not Resuscitate Declaration is revoked.

Signature of attending physician		
Printed name of attending physician	Medical license number	Date *(month, day, year)*

INDIANA PHYSICIAN ORDERS FOR SCOPE OF TREATMENT (POST)

State Form 55317 (R3 / 5-18)
Indiana State Department of Health – IC 16-36-6

INSTRUCTIONS: This form is a physician's order for scope of treatment based on the patient's current medical condition and preferences. The POST should be reviewed whenever the patient's condition changes. A POST form is voluntary. A patient is not required to complete a POST form. A patient with capacity or their legal representative may void a POST form at any time by communicating that intent to the health care provider. Any section not completed does not invalidate the form and implies full treatment for that section. HIPAA permits disclosure to health care professionals as necessary for treatment. The original form is personal property of the patient. A facsimile, paper, or electronic copy of this form is a valid form.

Patient Last Name	Patient First Name	Middle Initial
Birth Date *(mm/dd/yyyy)*	Medical Record Number	Date Prepared *(mm/dd/yyyy)*

	DESIGNATION OF PATIENT'S PREFERENCES: The following sections (A through D) are the patient's current preferences for scope of treatment.
A *Check One*	**CARDIOPULMONARY RESUSCITATION (CPR):** Patient has no pulse AND is not breathing. ☐ Attempt Resuscitation / CPR ☐ Do Not Attempt Resuscitation / DNR When not in cardiopulmonary arrest, follow orders in B, C and D.
B *Check One*	**MEDICAL INTERVENTIONS:** If patient has pulse AND is breathing OR has pulse and is NOT breathing. ☐ Comfort Measures (Allow Natural Death): Treatment Goal: Maximize comfort through symptom management. Relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Patient prefers no transfer to hospital for life-sustaining treatments. Transfer to hospital only if comfort needs cannot be met in current location. ☐ Limited Additional Interventions: Treatment Goal: Stabilization of medical condition. In addition to care described in Comfort Measures above, use medical treatment for stabilization, IV fluids (hydration) and cardiac monitor as indicated to stabilize medical condition. May use basic airway management techniques and non-invasive positive-airway pressure. Do not intubate. Transfer to hospital if indicated to manage medical needs or comfort. Avoid intensive care if possible. ☐ Full Intervention: Treatment Goal: Full interventions including life support measures in the intensive care unit. In addition to care described in Comfort Measures and Limited Additional Interventions above, use intubation, advanced airway interventions, and mechanical ventilation as indicated. Transfer to hospital and/or intensive care unit if indicated to meet medical needs.
C *Check One*	**ANTIBIOTICS:** ☐ Use antibiotics for infection only if comfort cannot be achieved fully through other means. ☐ Use antibiotics consistent with treatment goals.
D *Check One*	**ARTIFICIALLY ADMINISTERED NUTRITION:** Always offer food and fluid by mouth if feasible. ☐ No artificial nutrition. ☐ Defined trial period of artificial nutrition by tube. (Length of trial: ________ Goal: ______________________) ☐ Long-term artificial nutrition.
	OPTIONAL ADDITIONAL ORDERS:
	SIGNATURE PAGE: This form consists of two (2) pages. Both pages must be present. The following page includes signatures required for the POST form to be effective.

Page 1 of 2

Patient Name:______________________ Date of Birth *(mm/dd/yyyy)*:______________________

Signature of Patient or Legally Appointed Representative: In order for the POST form to be effective, the patient or legally appointed representative must sign and date the form below.

E

Signature of Patient or Legally Appointed Representative

My signature below indicates that my physician or physician's designee discussed with me the above orders and the selected orders correctly represent my wishes.

Signature *(required by statute)*	Print Name *(required by statute)*	Date *(required by statute)* *(mm/dd/yyyy)*

F

Contact Information for Legally Appointed Representative in Section E (*if applicable*):

If the signature above is other than patient's, add contact information for the representative.

Relationship of representative identified in Section E if patient does not have capacity *(required by statute)*	Address *(number and street, city, state, and ZIP code)*	Telephone Number

Physician Order:

A POST form may be executed only by an individual's treating physician, advanced practice registered nurse, or physician assistant, and only if:

(1) the treating physician, advanced practice registered nurse, or physician assistant has determined that:
- (A) the individual is a qualified person; and
- (B) the medical orders contained in the individual's POST form are reasonable and medically appropriate for the individual; and

(2) the qualified person or representative has signed and dated the POST form

A qualified person is an individual who has at least one (1) of the following:

(1) An advanced chronic progressive illness.

(2) An advanced chronic progressive frailty.

(3) A condition caused by injury, disease, or illness from which, to a reasonable degree of medical certainty:
- (A) there can be no recovery; and
- (B) death will occur from the condition within a short period without the provision of life prolonging procures.

(4) A medical condition that, if the person were to suffer cardiac or pulmonary failure, resuscitation would be unsuccessful or within a short period the person would experience repeated cardiac or pulmonary failure resulting in death.

G

Documentation of Discussion: Orders discussed with *(check one)*:

☐ Patient (patient has capacity) ☐ Health Care Representative ☐ Legal Guardian
☐ Parent of Minor ☐ Health Care Power of Attorney

H

Signature of Treating Physician / Advanced Practice Registered Nurse / Physician Assistant

My signature below indicates that I or my designee have discussed with the patient or patient's representative the patient's goals and treatment options available to the patient based on the patient's health. My signature below indicates to the best of my knowledge that these orders are consistent with the patient's current medical condition and preferences.

Signature of Treating Physician / APRN / PA *(required by statute)*	Print Treating Physician / APRN / PA Name *(required by statute)*	Date *(required by statute)* *(mm/dd/yyyy)*

Physician / APRN / PA office telephone number *(required by statute)*	Physician / APRN / PA License Number *(required by statute)*	Health Care Professional preparing form if other than the physician / APRN / PA

I

Appointment of Health Care Representative: As patient you have the option to appoint an individual to serve as your health care representative pursuant to IC 16-36-1-7. You are not required to designate a health care representative for this POST form to be effective. You are encouraged to consult with your attorney or other qualified individual about advance directives that are available to you. Forms and additional information about advance directives may be found on the ISDH web site at http://www.in.gov/isdh/25880.htm.

Page 2 of 2

After the Appointment

Coding/Billing

Initial AWV

- **G0438**
- **G0444** ***Depression Screening- included in cost***
- **99497** ***Advanced Care Planning, if applicable (extra revenue)***

Subsequent AWV

- **G0439**
- **G0444** ***Depression Screening (extra revenue)***
- **99497 Advanced Care Planning, if applicable (extra revenue)**

Code	National Average Fee (Depends on RHC AIR rate)	RVU
G0438	$181.78	2.6
G0439	$142.16	1.92
G0444	$20.36	0.18
99497	$82.56	1.5

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G0444
Medicare Annual Depression Screening

G0444 - Annual depression screening, 5 to 15 minutes

Coverage Criteria:

- Must be eligible for Medicare
- Screening only, does not apply to:
  - Depression treatment
  - Chronic condition caused by depression
- Allowed annually
  - 11 full months must pass following month screening occurred
  - Example: Service date 07/12/22, next available – 07/01/23

Documentation should include the following:

- Tool used
- Time in minutes to:
  - Administer screening
  - Document and interpret results
- Use of the results by the healthcare professional
  - Plan of care
  - Follow up
  - Referral

- Must be performed in a Primary Care Setting, Outpatient Hospital, Independent Clinic, Telehealth, State or Local Public Health Clinic.
  - Emergency departments, inpatient hospital settings, ambulatory surgical centers (ASCs), independent diagnostic testing facilities, skilled nursing facilities (SNFs), inpatient rehabilitation facilities, and hospice are not considered primary care settings under this definition.

- Coverage is limited to <u>screening services</u> and does not include treatment options for depression or any diseases, complications, or chronic conditions resulting from depression, nor does it address therapeutic interventions such as pharmacotherapy and/or combination therapy (counseling and medications).

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*Source: CMS.gov, 2023 HCPCS, WPS Learning Center

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Coding Advisor
Evaluation and Management

Advance Care Planning (cont'd)

CMS Documentation Requirements

- Voluntary nature of the visit
- The explanation of advance directives
- Who was present
- Time spent discussing ACP during the face-to-face encounter
- Any change in health status or health care wishes if the patient becomes unable to make their own decisions

CMS Additional Information and Resources

Are there limits on how often I can bill CPT codes 99497 and 99498?

Per CPT, there are no limits on the number of times ACP can be reported for a given beneficiary in a given time period. Likewise, the Centers for Medicare & Medicaid Services has not established any frequency limits. When the service is billed multiple times for a given beneficiary, we would expect to see a documented change in the beneficiary's health status and/or wishes regarding his or her end-of-life care.

Does the beneficiary/practice have to complete an advance directive to bill the service?

No, the CPT code descriptors indicate "when performed," so completion of an advance directive is not a requirement for billing the service.

CMS ACP Example: *A 68-year-old person takes multiple medications for heart failure and diabetes. They see their physician for the E/M of these 2 diseases, and the physician adjusts their medications.*

While discussing short-term treatment options, the patient also wants to address long-term treatment concerns. They talk about a possible heart transplant if the heart failure worsens. They also discuss ACP, including the patient's desire for care and treatment if they have a health event that adversely affects their decision-making abilities, and the physician helps the patient complete a legal advance directive form from their state attorney general's office.

According to CPT reporting instructions, the physician may report the ACP codes in addition to the E/M visit code describing the active management of the heart failure and diabetes, as long as the ACP time doesn't overlap with active management of those conditions.

Resources:

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AdvanceCarePlanning.pdf

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-Advance-Care-Planning.pdf

Documentation must support and justify the medical necessity of the service(s) and procedure(s) provided and the code(s) utilized. Please check with individual payers for their policy.

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G0444
Medicare Annual Depression Screening (cont'd)

Bundling of Depression Screening into Other Services

Common services performed with G0444 and their bundling status:

- Initial Preventive Physical Exam (IPPE) G0402
  - G0444 bundles as a component of G0402
  - No modifier overrides this edit
- Annual Wellness Visit (AWV), initial G0438
  - G0444 bundles as a component of G0438
  - No modifier overrides this edit
- Annual Wellness Visit, subsequent G0439
  - G0444 is separately billable from G0439
  - No edit is active, no required modifier
- Evaluation and Management (E/M) Services
  - G0444 bundles as a component of the E/M
  - When documentation supports it, use a modifier to show a separately billable service

Resources:
https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?NCDId=346&ncdver=1&DocID=210.9&bc=gAAAAAgAAAAA&
https://www.cms.gov/medicare-coverage-database/view/ncacal-decision-memo.aspx?proposed=N&NCAId=251

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*Source: CMS.gov, 2023 HCPCS, WPS Learning Center

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Coding Advisor
Evaluation and Management

Advance Care Planning

99497 Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional: first 30 minutes, face-to face with the patient, family member(s), and/or surrogate

+99498 each additional 30 minutes (List separately in addition to code for primary procedure)

A unit of time is attained when the mid-point is passed.

Time Spent	Code
Less than 16 min.	Do not code
16 min. – 45 min.	99497
46 min. – 60 min.	99497 and 99498 X 1

Advance care planning codes are used to report the face-to-face service between a physician or other qualified health care professional and a patient, family member, or surrogate in counseling and discussing advance directives, with or without completing relevant legal forms.

An advance directive is a document appointing an agent and/or recording the wishes of a patient pertaining to his/her medical treatment at a future time should he/she lack decisional capability at that time.

Examples of written advance directives include, but are not limited to:

- Health Care Proxy
- Durable Power of Attorney for Health Care
- Living Will
- Medical Orders for Life-Sustaining Treatment (MOLST)
- Psychiatric advance directives

Because the purpose of the visit is the discussion, no active management of the problem(s) is undertaken during <u>the time period reported</u>.

The dialogue often includes topics such as:

- The purpose of the Advanced Care Planning
- Planning for the unexpected
- How to discuss the choices with loved ones
- The selection of a surrogate decision maker
- The technical components of completing, distributing, and maintaining written plans.

<u>Coding Guidelines</u>

- There is no limitation on how many times advance care planning can be billed
- An E/M may be reported separately on the same day <u>except</u> for the following services:
  - Critical Care (99291, 99292)
  - Inpatient Neonatal and Pediatric Critical Care (99468-99476)
  - Initial and Continuing Intensive Care Services (99477-99480)
  - Cognitive Assessment and Care Plan Services (99483)
- If Advance Care Planning is provided with an Annual Wellness Visit, **<u>Modifier 33</u>** should be appended to the Advance Care Planning Code <u>so that the copay and deductible will be waived</u>.

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*Source: CPT Code Book 2023 (AMA), CPT Assistant, Dec. 2014

Abnormal Screenings: Follow up

Abnormal Depression Screen

Clinical Depression Screening Codes and Documentation

G8431: Screening for clinical depression is documented as being positive and a follow-up plan is documented.
G8510: Screening for clinical depression is documented as negative. A follow-up plan is not required as the patient is not eligible/appropriate for follow-up.

Documenting the Follow-Up Plan
The follow-up plan is the proposed outline of treatment to be conducted as a result of clinical depression screening. Follow-up for positive depression screening must include one (1) or more of the following:
- Additional evaluation
- Suicide risk assessment
- Referral to a practitioner who is qualified to diagnose and treat depression
- Pharmacological interventions
- Other interventions or follow-ups for the diagnosis of depression

The documented follow-up plan must be related to positive depression screening, for example:
"***Patient referred for psychiatric evaluation due to positive depression screening.***"

Abnormal Cognitive Assessment

Memory & Aging Progress Note Templates

Progress Note: Screen abnormal (Mini-Cog <4), schedule follow-up
- Patient screened today for cognitive changes characterized by *** (e.g., forgetfulness, repeating self, misplacing things, confusion, inability to carry out daily routine). Evaluation with the Mini-Cog yielded an abnormal score of ***/5. A follow-up evaluation is indicated to assess for possible cognitive disorder/dementia. The patient will return in *** weeks to complete work up.

Progress Note: Screen normal (Mini-Cog 4-5), schedule follow-up
- Patient screened today for cognitive changes characterized by 888 (e.g., forgetfulness, repeating self, misplacing things, confusion, inability to carry out daily routine). Evaluation with the Mini-Cog yielded a normal score of ***/5. However, the patient/family expressed concern regarding deteriorating cognition and it appears that follow-up is warranted. The patient will return in *** weeks to complete cognitive disorder/dementia work-up.

Code

99483 payment- $272.79 RVU- 3.84

EMR DECISION SUPPORT TOOLS FOR ALZHEIMER'S AND RELATED DEMENTIAS

The **ACT on Alzheimer's® Electronic Medical Record (EMR) Decision Support Tools** provide an evidence-based template to assist clinicians in implementing a standardized approach to all aspects of dementia care within the health record: screening, diagnosis and treatment/management (see samples of each tool below).

1. Screening Tool

Automated Patient Instructions

- ☑ Patient instructions for coping with memory loss / brain health / healthy aging.
- ☑ Please bring all over the counter and prescription medications to the next appointment.
- ☑ Please bring a family member or friend (care partner) to the next appointment.

Memory & Aging Progress Note Templates

- ☐ **Progress Note: Screen abnormal (Mini-Cog < 4), schedule follow-up**
  Patient screened today for cognitive changes characterized by *** (e.g., forgetfulness, repeating self, misplacing things, confusion, inability to carry out daily routine). Evaluation with the Mini-Cog yielded an abnormal score of ***/5. A follow-up evaluation is indicated to assess for possible cognitive disorder/dementia. Patient will return in *** weeks to complete work-up.
- ☐ **Progress Note: Screen normal (Mini-Cog 4-5), schedule follow-up**
  Patient screened today for cognitive changes characterized by *** (e.g., forgetfulness, repeating self, misplacing things, confusion, inability to carry out daily routine). Evaluation with the Mini-Cog yielded a normal score of ***/5. However, patient/family express concern regarding deteriorating cognition and it appears that follow-up is warranted. Patient will return in *** weeks to complete cognitive disorder/dementia work-up.
- ☐ **Create your own note**

2. Diagnostic Tool

History

History questions to be asked in the presence of a caregiver.

Family Questionnaire
Functional Assessment Staging of AD (FAST)
Instrumental Activities of Daily Living (IADL)
Activities of Daily Living (ADL)
High Yield History Questions

Cognitive Screening

Montreal Cognitive Assessment (MoCA)
St. Louis University Mental Status Exam (SLUMS)

3. Treatment/ Management Tool

Consults, Referrals, Education & Support

Indication: Safety/Driving

A formal driving evaluation is recommended for newly diagnosed dementia patients who drive.

- ☐ OCCUPATIONAL THERAPY – Driving evaluation
- ☐ OCCUPATIONAL THERAPY – Home safety and medication compliance (e.g., medication management, home safety evaluation)
- ☐ OCCUPATIONAL THERAPY – Fall risk assessment

Patient and Care Partner Instructions

- ☐ Read *At the Crossroads: Family Conversations about Alzheimer's & Driving.*
- ☐ Visit the Alzheimer's Association Online Dementia & Driving Resource Center.

1. Screening Tool

Criteria For When to Use:

As a general cognitive screening tool or as part of an annual exam (Medicare Annual Wellness Visit).

How to Use:

This is the first Decision Support Tool (DST) of three that helps guide you through evidence-based assessment and care for your patients with cognitive impairment. The second is a guide to evaluation for memory loss / dementia, and the third DST is designated for the post-diagnostic follow-up visit.

Evidence Based Practice Resources:

American Academy of Neurology:
www.aan.com/Guidelines/Home/ByTopic?topicId=15

ACT on Alzheimer's Clinical Provider Practice Tool:
www.actonalz.org/provider-practice-tools

Screening Tool:

Conduct brief objective cognitive screen with the Mini-Cog (www.mini-cog.com). If score is < 4* or patient/ family express concern regarding deteriorating cognitive function, proceed with workup for possible cognitive disorder/dementia.

*A cut point of <3 on the Mini-Cog has been validated for dementia screening, but many individuals with clinically meaningful cognitive impairment will score higher. When greater sensitivity is desired, a cut point of <4 is recommended as it may indicate a need for further evaluation of cognitive status.

Contents:

1.1 - Documentation
1.2 - Orders
Labs
- Routine Dementia Screening Labs
- Contingent Labs
1.3 - Imaging
1.4 - Specialty Consult
1.5 - Patient Instructions

References

Borson, S., Scanlan, J.M., Chen, P., & Ganguli, M. (2003). The Mini-Cog as a screen for dementia: Validation in a population-based sample. JAGS, 51(10), 1451-1454.

Borson S, Scanlan JM, Watanabe J et al. Improving identification of cognitive impairment in primary care. Int J Geriatr Psychiatry 2006; 21: 349–355.

Ismail Z, Rajii TK, Shulman KI. Brief cognitive screening instruments: an update. Int J Geriatr Psychiatry. Feb 2010; 25(2):111-20.

Larner, AJ. Screening utility of the Montreal Cognitive Assessment (MoCA): in place of – or as well as – the MMSE? Int Psychogeriatr. Mar 2012;24(3):391-6.

Lessig M, Scanlan J et al. Time that tells: Critical clock-drawing errors for dementia screening. Int Psychogeriatr. 2008 June; 20(3): 459–470.

McCarten J, Anderson P et al. Screening for cognitive impairment in an elderly veteran population: Acceptability and results using different versions of the Mini-Cog. J Am Geriatr Soc 2011; 59: 309-213.

McCarten J, Anderson P et al. Finding dementia in primary care: The results of a clinical demonstration project. J Am Geriatr Soc 2012; 60: 210-217.

Nasreddine ZS, Phillips NA, Bedirian V, et al. The Montreal Cognitive Assessment, MoCA: a brief screening tool for mild

cognitive impairment. J Am Geriatr Soc. Apr 2005;53(4):695-699.

Scanlan J & Borson S. The Mini-Cog: Receiver operating characteristics with the expert and naive raters. Int J Geriatr Psychiatry 2001; 16: 216-222.

Tariq SH, Tumosa N, Chibnall JT, et al. Comparison of the Saint Louis University mental status examination and the mini-mental state examination for detecting dementia and mild neurocognitive disorder-a pilot study. Am J Geriatr Psychiatry. Nov 2006;14(11):900-10.

Tsoi K, Chan J et al. Cognitive tests to detect dementia: A systematic review and meta-analysis. JAMA Intern Med. 2015; E1-E9.

1.1 - Documentation

☐ **Progress Note: Screen abnormal (Mini-Cog < 4*), schedule follow-up**
Patient screened today for cognitive changes characterized by *** (e.g., forgetfulness, repeating self, misplacing things, confusion, inability to carry out daily routine, etc.). Evaluation with the Mini-Cog yielded an abnormal score of ***/5. A follow-up evaluation is indicated to assess for possible cognitive disorder/dementia. Patient will return in *** weeks to complete work-up.

☐ **Progress Note: Screen normal (Mini-Cog 4-5*), schedule follow-up**
Patient screened today for cognitive changes characterized by *** (e.g., forgetfulness, repeating self, misplacing things, confusion, inability to carry out daily routine, etc.). Evaluation with the Mini-Cog yielded a normal score of ***/5. However, patient/family express concern regarding deteriorating cognition and it appears that follow-up is warranted. Patient will return in *** weeks to complete cognitive disorder/dementia work-up.

☐ **Progress Note: Screen normal (Mini-Cog 4-5*), no follow-up**
Patient completed cognitive screening today with the Mini-Cog and obtained a normal score of ***/5. Routine screening will be conducted again during the next annual wellness visit.

☐ **Create your own note**

1.2 - Orders

If proceeding with a work-up, diagnostics can be ordered now or at the time of follow-up.

Labs
All of the following should be obtained in any memory loss evaluation based on American Academy of Neurology (AAN) recommendations. Repeat labs unnecessary if prior results obtained following onset of presenting memory loss.

Routine Dementia Screening Labs:
☐ BASIC METABOLIC PANEL
☐ CBC (HEMOGRAM/PLTS)
☐ LIVER PANEL (HEPATIC FUNCTION PANEL)
☐ B12 ONLY
☐ TSH, SENSITIVE

Contingent Labs (per patient history):
☐ RPR (SYPHILIS SCREEN) – The American Academy of Neurology (AAN) does not recommend routine screening for syphilis in dementia except in specific populations where the disease may be suspected.
☐ HEAVY METALS
☐ LYME TITER
☐ HIV

1.3 - Imaging

According to the American Academy of Neurology (AAN), either a Head CT or Brain MRI are considered appropriate imaging tools in evaluating memory loss.

Repeat imaging unnecessary if prior head CT or brain MRI obtained following onset of presenting memory loss. Consider MRI in cases where patient has focal neurological findings, rapidly progressive dementia, atypical presentation for Alzheimer's disease, and early onset dementia at age < 65.

☐ CT HEAD WITHOUT CONTRAST
☐ MR BRAIN/STEM WITH/WITHOUT CONTRAST

1.4 - Specialty Consult

Indication: diagnostic uncertainty, early onset dementia, atypical dementia, dementia medication management, management of moderate-severe dementia with psychosocial factors or management of behavioral symptoms of dementia

☐ MEMORY SPECIALTY CENTER / DIAGNOSTIC CENTER
☐ NEUROLOGY CONSULT-ADULTS

☐ NEUROPSYCHOLOGY CONSULT-ADULTS — Neuropsychological evaluation is typically most helpful for differential diagnosis, determining nature and severity of cognitive functioning, and the development of an appropriate treatment plan. Testing is typically maximally beneficial in the following score ranges: SLUMS = 18-27, MoCA = 19-27, Kokmen STMS = 19-33, MMSE/MMSE-2 = 18-28

☐ PSYCHIATRY CONSULT-ADULTS
☐ OCCUPATIONAL THERAPY (cognitive, functional eval)
☐ MEDICATION REVIEW (e.g., PharmD Consult)
☐ SLEEP STUDY / SLEEP MEDICINE
☐ HEALTH CARE HOME REFERRAL
☐ COMPLEX CARE MANAGEMENT REFERRAL

1.5 - Patient Instructions

☐ Patient instructions for coping with memory loss / brain health / healthy aging.

☐ Please bring all over the counter and prescription medications to the next appointment.

☐ Please bring a family member or friend (care partner) to the next appointment.

2. Diagnostic Tool

Criteria For When to Use:

During the initial work-up for patients with new onset memory loss OR following abnormal performance on cognitive screening (e.g., Mini-Cog score < 4*).

An Initial Evaluation Includes:

- A thorough history addressing memory loss and cognitive dysfunction
- Objective cognitive screening / assessment
- Dementia-related laboratory studies
- Neuroimaging

How to Use:

This is the second Decision Smart Tool (DST) in a set of three that helps guide you through evidence-based assessment and care for your patients with cognitive impairment. The first is a guide to cognitive screening and the third DST is designated for the post-diagnostic follow-up visit.

Evidence Based Practice Resources:

American Academy of Neurology:
www.aan.com/Guidelines/Home/ByTopic?topicId=15

ACT on Alzheimer's Clinical Provider Practice Tool:
www.actonalz.org/provider-practice-tools

NOTE: Consider distributing a release of information form (ROI) to all family members during the rooming process.

Contents:

2.1 - History
2.2 - Cognitive Screening
    Montreal Cognitive Assessment
    St. Louis University Mental Status Exam
2.3 - Documentation/HPI
2.4 - Orders
    Labs
    - Routine Dementia Screening Labs
    - Contingent Labs
2.5 - Imaging
2.6 - Specialty Consult
2.7 - Diagnosis
2.8 - Patient Instructions

2.1 - History

Select from the tools below:
Family Questionnaire: www.actonalz.org/pdf/Family-Questionnaire.pdf
Functional Assessment Staging of Alzheimer's Disease (FAST): http://geriatrics.uthscsa.edu/tools/FAST.pdf
Instrumental Activities of Daily Living (IADL): http://consultgeri.org/try-this/dementia/issue-d13.pdf
Activities of Daily Living (ADL): http://consultgeri.org/try-this/general-assessment/issue-2.pdf
High Yield Clinical Questions: www.alz.org/documents/mndak/high_yield_clinical_questions_for_history.pdf

2.2 - Cognitive Screening

Montreal Cognitive Assessment

The Montreal Cognitive Assessment (MoCA) is preferred as a cognitive screen over the MMSE, offering a more extensive evaluation with sensitivity of 90% for mild cognitive impairment (vs MMSE 18%) and 100% for dementia (vs MMSE 78%). Estimated administration time is 15 minutes.

Conduct MoCA (www.mocatest.org):

- MoCA is available in 30+ languages
- Instructions for administering MoCA
- 30 points is the maximum score
- Abnormal score is less than 26

St. Louis University Mental Status Exam

The St. Louis University Mental Status Exam (SLUMS) is preferred as a cognitive screen over the MMSE, offering a more reliable evaluation with sensitivity of 92% for mild cognitive impairment (vs MMSE 18%) and 100% for dementia (vs MMSE 78%). Estimated administration time is 10 minutes.

Conduct SLUMS (http://medschool.slu.edu/agingsuccessfully/pdfsurveys/slumsexam_05.pdf):

- Instructions for administering SLUMS (www.elderguru.com/downloads/SLUMS_instructions.pdf)
- 30 points is the maximum score
- Abnormal score is less than 27 (HS education) or less than 25 (< HS)

2.3 - Documentation/HPI

☐ **Progress Note: Cognitive Impairment Workup**

Patient evaluated today for cognitive changes characterized by *** (e.g., Mini-Cog score < 4, forgetfulness, repeating self, misplacing things, confusion, inability to carry out daily routine, etc.). Evaluation with the *** (e.g., MoCA/SLUMS) yielded a score of ***/30. Will review current medication list and order routine dementia labs and neuroimaging to rule out common medical causes of cognitive impairment. A follow-up visit will be scheduled for *** weeks to review diagnosis and discuss treatment recommendations.

☐ **Create your own note**

2.4 - Orders

If proceeding with a work-up, diagnostics can be ordered now or at the time of follow-up.

Labs

All of the following should be obtained in any memory loss evaluation based on American Academy of Neurology (AAN) recommendations. Repeat labs unnecessary if prior results obtained following onset of presenting memory loss.

Routine Dementia Screening Labs:

- ☐ BASIC METABOLIC PANEL
- ☐ CBC (HEMOGRAM/PLTS)
- ☐ LIVER PANEL (HEPATIC FUNCTION PANEL)
- ☐ B12 ONLY
- ☐ TSH, SENSITIVE

Contingent Labs (per patient history):

- ☐ RPR (SYPHILIS SCREEN) – The American Academy of Neurology (AAN) does not recommend routine screening for syphilis in dementia except in specific populations where the disease may be suspected.
- ☐ HEAVY METALS
- ☐ LYME TITER
- ☐ HIV

2.5 - Imaging

According to the American Academy of Neurology (AAN), either a Head CT or Brain MRI are considered appropriate imaging tools in evaluating memory loss.

Repeat imaging unnecessary if prior head CT or brain MRI obtained following onset of presenting memory loss. Consider MRI in cases where patient has focal neurological findings, rapidly progressive dementia, atypical presentation for Alzheimer's disease, and early onset dementia at age < 65.

- ☐ CT HEAD WITHOUT CONTRAST
- ☐ MR BRAIN/STEM WITH/WITHOUT CONTRAST

2.6 - Specialty Consult

Indication: diagnostic uncertainty, early onset dementia, atypical dementia, dementia medication management, management of moderate-severe dementia with psychosocial factors or management of behavioral symptoms of dementia

- ☐ MEMORY SPECIALTY CENTER / DIAGNOSTIC CENTER
- ☐ NEUROLOGY CONSULT-ADULTS

- ☐ NEUROPSYCHOLOGY CONSULT-ADULTS — Neuropsychological evaluation is typically most helpful for differential diagnosis, determining nature and severity of cognitive functioning, and the development of an appropriate treatment plan. Testing is typically maximally beneficial in the following score ranges: SLUMS = 18-27, MoCA = 19-27, Kokmen STMS = 19-33, MMSE/MMSE-2 = 18-28

- ☐ PSYCHIATRY CONSULT-ADULTS
- ☐ OCCUPATIONAL THERAPY (cognitive, functional eval)
- ☐ MEDICATION REVIEW (e.g., PharmD Consult)
- ☐ SLEEP STUDY / SLEEP MEDICINE
- ☐ HEALTH CARE HOME REFERRAL
- ☐ COMPLEX CARE MANAGEMENT REFERRAL

2.7 - Diagnosis*

Working Diagnosis

- ☐ **Memory loss (R41.1 – anterograde amnesia, R41.2 – retrograde amnesia, R41.3 – other amnesia)**
  Patients presenting with memory loss who have not completed an evaluation to enable a diagnosis can be classified as having "memory loss."

- ☐ **Mild cognitive impairment (MCI) (G31.84)**
  Mild deficits in 1 (or more) cognitive function(s): memory, executive, visuospatial, language, attention, intact ADLs and IADLs; does not meet criteria for dementia

- ☐ **Unspecified dementia without behavioral disturbance (F03.90)**
  Cause of dementia is unknown. No behavioral symptoms are present.

- ☐ **Unspecified dementia with behavioral disturbance (F03.91)**
  Cause of dementia is unknown. Behavioral symptoms are present.

continued on next page

** The latest DSM-5 manual uses the term "Major Neurocognitive Disorder" for dementia and "Mild Neurocognitive Disorder" for mild cognitive impairment. This ACT on Alzheimer's resource uses the more familiar terminology, as the new terms have yet to be universally adopted.*

2.7 - Diagnosis (cont.)

- [ ] **Delirium (R41.82 – altered mental status, R41.0 – disorientation unspecified, R41.9 – unspecified signs involving awareness and cognitive functions, F05 – delirium due to known physiological condition, R40.0 – somnolence, R40.1 – stupor)**
  Acute onset confusion and fluctuating consciousness/alertness. Markedly reduced responsiveness to environmental stimuli. Presence of dementia unknown.

2.8 - Patient Instructions

- [ ] Patient instructions for coping with memory loss / brain health / healthy aging.
- [ ] Please bring a family member or friend (care partner) to the next appointment.
- [ ] Contact the Senior LinkAge Line®, A One Stop Shop for Minnesota Seniors to locate and plan for community resources such as chore/homemaker services, home-delivered meals, transportation, caregiver supports and assistance with paying for prescription drugs. You can contact the Senior LinkAge Line® by phone or online: 1-800-333-2433 or www.MinnesotaHelp.info®

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3. Treatment/Management Tool

Criteria For When to Use:

During the follow-up visit for patients with new onset memory loss, Mini-Cog score less than 4, MoCA test score less than 26, or SLUMS less than 27 (HS education) or less than 25 (less than HS education).

How to Use:

This is the third Decision Support Tool (DST) of three that helps guide you through evidence-based care for your patients with memory loss / dementia. The first is a guide to cognitive screening and the second DST is designated for the initial evaluation visit.

Evidence Based Practice Resources:

American Academy of Neurology:
www.aan.com/Guidelines/Home/ByTopic?topicId=15

ACT on Alzheimer's Clinical Provider Practice Tool:
www.actonalz.org/provider-practice-tools

NOTE: Consider distributing a release of information form (ROI) to all family members during the rooming process.

Content:

3.1 - Documentation
3.2 - Diagnosis
3.3 - Coordination of Care
3.4 - End of Life Planning
3.5 - Report Suspected Abuse
3.6 - Consults/Referrals
- Indication: Diagnostic Uncertainty
- Indication: Safety/Driving
- Indication: Polypharmacy Contributing to Cognitive Disorder
- Indication: Counseling, Education and Support Systems
- Indication: Cognitive Stimulation, Rehabilitation, and Healthy Lifestyle
- Indication: Newly Diagnosed Dementia Resulting in Difficulty Coping with Diagnosis For Both Patient and Care Partners
- Indication: Behavioral Interventions
- Indication: Sleep Disturbance

3.7 - Medication Treatment
- Indication: Mild-Moderate Alzheimer's Disease
- Indication: Moderate-Severe Alzheimer's Disease
- Indication: Depression/Anxiety
- Indication: Insomnia
- Indication: Agitation / Psychosis

3.8 - Patient Instructions

3.1 - Documentation

☐ **Progress Note: Follow-up Memory Loss/Dementia**

Patient seen today in follow-up for symptoms of memory loss/cognitive impairment. A recent work-up included *** (e.g., labs, neuroimaging, cognitive/functional testing). Neurological exam was *** (e.g., nonfocal; suggestive of parkinsonism; notable for abnormal cognitive screening with the MoCA). The broader work-up was remarkable for *** (e.g., cerebral atrophy; small vessel ischemic disease; vitamin B12 deficiency). My impression is the patient is suffering from *** (e.g., Alzheimer's disease, Lewy Body dementia). We discussed treatment options today and the patient is agreeable to *** (e.g., starting Aricept 5mg qd). His/her care partner has been identified as *** (e.g., name of spouse, adult child, close friend) and will plan to accompany the patient to all medical appointments. For disease education and support, I have referred the patient/family to ***(e.g., Alzheimer's Association; local support group; care coordination). A follow-up appointment will be made in *** weeks to monitor progress.

☐ **Create your own note**

3.2 - Diagnosis*

☐ **Mild cognitive impairment (MCI) (G31.84)**

- Mild deficits in 1 (or more) cognitive function(s): memory, executive, visuospatial, language, attention
- Intact ADLs and IADLs
- Does not meet criteria for dementia

☐ **Alzheimer's disease (G30.0 – Alzheimer's disease with early onset, G30.1 – Alzheimer's disease with late onset, G30.8 – other Alzheimer's disease, G30.9 – Alzheimer's disease, unspecificed)**

- Most common type of dementia (60%-80% of cases)
- Memory loss, confusion, disorientation, dysnomia, impaired judgment/behavior, apathy, depression

☐ **Dementia with Lewy bodies (G31.83)**

- Second most common type of dementia
- Hallmark symptoms include visual hallucinations, parkinsonism and fluctuations in cognition

☐ **Frontotemporal dementia (G31.09)**

- Third most common type of dementia affecting individuals in their 50s and 60s
- EITHER marked changes in behavior/personality OR language (difficulty with speech production or word meaning) with relative sparing of episodic memory

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** The latest DSM-5 manual uses the term "Major Neurocognitive Disorder" for dementia and "Mild Neurocognitive Disorder" for mild cognitive impairment. This ACT on Alzheimer's resource uses the more familiar terminology, as the new terms have yet to be universally adopted.*

3.2 - Diagnosis (cont.)

- ☐ **Vascular dementia (F01.50 – vascular dementia without behavioral disturbance, F01.51 – vascular dementia with behavioral disturbance)**
  - Relatively rare in pure form (6%-10% of cases)
  - Symptoms often overlap with AD: there is sparing of recognition memory

Other:

- ☐ Delirium (R41.82 – altered mental status, R41.0 – disorientation unspecified, R41.9 – unspecified signs involving awareness and cognitive functions, F05 – delirium due to known physiological condition, R40.0 – somnolence, R40.1 – stupor)
  - Refer to Delirium protocol
- ☐ Normal pressure hydrocephalus (G91.2 – idiopathic)
- ☐ Primary progressive aphasia (G31.01)
- ☐ Corticobasal degeneration (G31.85)
- ☐ Posterior cortical atrophy (G31.9 – degenerative disease of nervous system)
- ☐ CJD (Creutzfeldt-Jakob disease) (A81.00 – unspecified, A81.09 – other)
- ☐ Unspecified dementia (F03.90 – without behavioral disturbance; F03.91 – with behavioral disturbance)
- ☐ Memory loss (R41.1 – anterograde amnesia, R41.2 – retrograde amnesia, R41.3 – other amnesia)

3.3 - Coordination of Care

- ☐ Complete or update Health Care Directive and Financial Surrogacy documents.
- ☐ Care coordination referral.
- ☐ Instructions for check-out staff: Patient to fill out ROI for care partner.
- ☐ Instructions for check-out staff: Enter care partner name and contact information into EMR patient demographics.

3.4 - End of Life Planning

- ☐ Discuss role of palliative care and hospice.
- ☐ Complete POLST.

3.5 - Report Suspected Abuse

- ☐ In compliance with Minnesota statutes, report suspected abuse, neglect (including self-neglect), or financial exploitation.

3.6 - Consults/Referrals

Indication: diagnostic uncertainty, early onset dementia, atypical dementia, dementia medication management, management of moderate-severe dementia with psychosocial factors or management of behavioral symptoms of dementia.

☐ MEMORY SPECIALTY CENTER / DIAGNOSTIC CENTER
☐ NEUROLOGY CONSULT-ADULTS

☐ NEUROPSYCHOLOGY CONSULT-ADULTS — Neuropsychological evaluation is typically most helpful for differential diagnosis, determining nature and severity of cognitive functioning, and the development of an appropriate treatment plan. Testing is typically maximally beneficial in the following score ranges: SLUMS = 18-27, MoCA = 19-27, Kokmen STMS = 19-33, MMSE/MMSE-2 = 18-28.

Indication: Safety/Driving

A formal driving evaluation is recommended for newly diagnosed dementia patients who drive.

☐ OCCUPATIONAL THERAPY DRIVING EVALUTION
☐ OCCUPATIONAL THERAPY – Home Safety and Medication Compliance (e.g., medication management, home safety evaluation)
☐ OCCUPATIONAL THERAPY / PHYSICAL THERAPY – Fall risk assessment, maximize function

Patient and Care Partner Instructions:
Read "At the Crossroads: Family Conversations about Alzheimer's & Driving"
http://www.thehartford.com/mature-market-excellence/publications-on-aging

Visit Alzheimer's Association Dementia & Driving Resource Center
http://www.alz.org/care/alzheimers-dementia-and-driving.asp

Indication: Polypharmacy Contributing to Cognitive Disorder

☐ MEDICATION REVIEW (e.g., PharmD, MTM Consult)

Indication: Counseling, Education and Support Systems

☐ COMPLEX CARE MANAGEMENT REFERRAL
☐ HEALTH CARE HOME REFERRAL

Patient and Care Partner Instructions:
For disease education, counseling support and dementia-specific resources, contact:
Alzheimer's Association 24/7 Helpline – Call 800-272-3900 or visit www.alz.org
Senior LinkAge Line® – Call 800-333-2433 or visit www.MinnesotaHelp.info®

Indication: Cognitive Stimulation, Rehabilitation, and Healthy Lifestyle

Patient and Care Partner Instructions:
Read the "Living Well Workbook"
http://www.actonalz.org/pdf/Living-Well.pdf

3.6 - Consults/Referrals (cont.)

Indication: Newly Diagnosed Dementia Resulting in Difficulty Coping with Diagnosis For Both Patient and Care Partners

☐ REFERRAL TO BEHAVIORAL HEALTH

Indication: Behavioral Interventions

Each link opens patient education handouts provided by the Alzheimer's Association. The handouts can be printed and given to the patient or care partner.

Screening, Identifying and Managing Behavioral Symptoms in Patients With Dementia:
www.actonalz.org/pdf/Figure1.pdf

Potential Nonpharmacologic Strategies:
www.actonalz.org/pdf/Table1.pdf

General Nonpharmacologic Strategies:
www.actonalz.org/pdf/Table2.pdf

Behaviors:
www.alz.org/national/documents/brochure_behaviors.pdf

Communication:
www.alz.org/national/documents/brochure_communication.pdf

Agitation:
www.alz.org/documents/mndak/emr_agitation_link.pdf

Tips to Minimize Unwanted Actions in Persons with Dementia:
www.alz.org/documents/mndak/emr_unwanted_actions_link.pdf

Communicating Using a Therapeutic Response/Emotional Truth:
www.alz.org/documents/mndak/emr_therapeutic_response_link.pdf

Indication: Behavioral Interventions (cont.)

☐ REFERRAL TO BEHAVIORAL HEALTH
☐ REFERRAL TO GERIATRIC PSYCHIATRY

Indication: Sleep Disturbance

☐ REFERRAL FOR SLEEP STUDY / SLEEP MEDICINE

3.7 - Medication Treatment

Patients with mild cognitive impairment or dementia should be followed every 1-3 months in the setting of newly initiated medications. Patients with stable symptoms and medication dosing may be followed at 6 month to 1 year intervals at which time cognitive, behavioral and functional status should be reassessed.

Contraindicated Medications:
The use of anticholinergics (e.g., diphenhydramine, oxybutynin, Tylenol PM), benzodiazepines (e.g., lorazepam, alprazolam, zoldipem), mood stabilizers (e.g., valproic acid), and narcotics (e.g., oxycontin, methadone, morphine) should be avoided in dementia.

Indication: Mild-Moderate Alzheimer's Disease

- Alzheimer's Medications (description): Medications in Alzheimer's disease provide symptomatic benefit, but do not impact disease course.
- Cholinesterase Inhibitors: Decrease to maximally tolerated dose if patient experiences cholinesterase-related side effects of GI intolerance, insomnia, weight loss, dizziness, etc.
- Consider baseline EKG in patient with history of bradyarrhythmia as these medications may result in sinus arrhythmia or AV block.

☐ donepezil (ARICEPT) 10 MG tablet (5 mg for one month, increase to 10 mg after first month)
☐ galantamine (RAZADYNE) 8 MG tablet (8 mg for one month, increase to 16 mg after first month)

- Suggest using Rivastigmine (EXELON) patch in instances of oral cholinesterase inhibitor intolerance. Prescribe 4.6 mg patch q24 hours x 1 month; increase to 9.5 mg after 1 month.

☐ rivastigmine (EXELON) 4.6 MG/24HR patch
☐ rivastigmine (EXELON) 9.5MG/24HR patch

☐ ECG 12-LEAD ROUTINE (EKG)

Indication: Moderate-Severe Alzheimer's Disease

- NMDA Antagonists:

☐ memantine (NAMENDA) 5 MG tablet

Indication: Depression/Anxiety

☐ sertraline (ZOLOFT) 25 MG tablet PO qAM x 1 week, then 50 mg qAM. May increase by 50 mg increments to maximum dose of 200mg/day as needed and if tolerated
☐ escitalopram oxalate (LEXAPRO) 10 MG tablet (for Depression with Predominant Anxiety Component)
☐ mirtazapine (REMERON) 15 MG PO qhs. May increase by 15 mg increments to maximum dose of 45 mg PO qhs if needed and tolderated

Indication: Insomnia

☐ trazodone (DESYREL) 50 MG tablet (start at 25-50 mg, increase to 75-100 mg within 1 month if desired effect is not obtained)

3.7 - Medication Treatment (cont.)

Indication: Agitation / Psychosis

- Neuroleptics: Recommend starting neuroleptic as PRN medications with gradual transition to standing medication if patient has continued behavioral problems. Suggest obtaining baseline EKG due to impact upon QT interval.

☐ ECG 12-LEAD ROUTINE (EKG)

- Atypical antipsychotics: Atypical antipsychotics may result in increased mortality in the elderly and have not shown to be any more effective than behavioral interventions within the geriatric population (see NEJM article). If behavioral interventions are insufficient, quetiapine and risperidone are recommended.

☐ quetiapine (SEROQUEL) 12.5 MG tablet PO qd as needed
☐ risperidone (RISPERDAL) 0.25 MG tablet PO qd as needed

3.8 - Patient Instructions

☐ Patient instructions for coping with memory loss and behavior challenges.
☐ Please bring a family member or friend (care partner) to the next appointment.
☐ Contact the Senior LinkAge Line®, A One Stop Shop for Minnesota Seniors to locate and plan for community resources such as chore/homemaker services, home-delivered meals, transportation, caregiver supports and assistance with paying for prescription drugs. You can contact the Senior LinkAge Line® by phone or online: 1-800-333-2433 or www.MinnesotaHelp.info®.

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DEMENTIA-SPECIFIC PRACTICE TOOLS AND RESOURCES FOR PROVIDERS

Use these ACT on Alzheimer's® provider practice tools and resources with patients who have memory concerns and to support their care partners. These best practice tools incorporate recognized care standards as well as input from community stakeholders and people with dementia.

Clinical Provider Practice Tool

Provides physicians a streamlined protocol for managing cognitive impairment and guiding decisions for cognitive assessment, diagnosis and disease management.

www.actonalz.org/provider-practice-tools

View tutorial videos and webinars on administering and scoring cognitive assessment instruments (MiniCog, SLUMS, MoCA) and communicating assessment results at: www.actonalz.org/video-tutorials

Delivering the Diagnosis [Video]

Portrays an actual physician-to-patient interaction for delivering an Alzheimer's diagnosis during a medical visit.

www.actonalz.org/videos

After a Diagnosis

Gives action steps and tips that medical and community provider professionals can share with a person and care partner when Alzheimer's or dementia is diagnosed. Includes support and resource information.

www.actonalz.org/provider-practice-tools

Managing Dementia Across the Continuum

Provides physicians a streamlined protocol for treating, managing and supporting persons with mid- to late-stage dementia, including information on non-pharmacological approaches to managing behavioral symptoms.

www.actonalz.org/provider-practice-tools

Abnormal TUG

STEADI Algorithm for Fall Risk Screening, Assessment, and Intervention among Community-Dwelling Adults 65 years and older

START HERE

1 SCREEN for fall risk yearly, or any time patient presents with an acute fall.

Available Fall Risk Screening Tools:

- **Stay Independent: a 12-question tool** [at risk if score ≥ 4]
  - **Important:** If score < 4, ask if patient fell in the past year (If **YES** → patient is at risk)
- **Three key questions** for patients [at risk if **YES** to any question]
  - Feels unsteady when standing or walking?
  - Worries about falling?
  - Has fallen in past year?
    - » If **YES** ask, "How many times?" "Were you injured?"

SCREENED NOT AT RISK

PREVENT future risk by recommending effective prevention strategies.

- Educate patient on fall prevention
- Assess vitamin D intake
  - If deficient, recommend daily vitamin D supplement
- Refer to community exercise or fall prevention program
- Reassess yearly, or any time patient presents with an acute fall

SCREENED AT RISK

2 ASSESS patient's modifiable risk factors and fall history.

Common ways to assess fall risk factors are listed below:

- **Evaluate gait, strength, & balance**
  Common assessments:
  - Timed Up & Go
  - 30-Second Chair Stand
  - 4-Stage Balance Test
- **Identify medications that increase fall risk**
  (e.g., Beers Criteria)
- **Ask about potential home hazards**
  (e.g., throw rugs, slippery tub floor)
- **Measure orthostatic blood pressure**
  (Lying and standing positions)
- **Check visual acuity**
  Common assessment tool:
  - Snellen eye test
- **Assess feet/footwear**
- **Assess vitamin D intake**
- **Identify comorbidities**
  (e.g., depression, osteoporosis)

3 INTERVENE to reduce identified risk factors using effective strategies.

Reduce identified fall risk

- Discuss patient and provider health goals
- Develop an individualized patient care plan (see below)

Below are common interventions used to reduce fall risk:

Poor gait, strength, & balance observed

- Refer for physical therapy
- Refer to evidence-based exercise or fall prevention program (e.g., Tai Chi)

Medication(s) likely to increase fall risk

- Optimize medications by stopping, switching, or reducing dosage of medications that increase fall risk

Home hazards likely

- Refer to occupational therapist to evaluate home safety

Orthostatic hypotension observed

- Stop, switch, or reduce the dose of medications that increase fall risk
- Educate about importance of exercises (e.g., foot pumps)
- Establish appropriate blood pressure goal
- Encourage adequate hydration
- Consider compression stockings

Visual impairment observed

- Refer to ophthalmologist/optometrist
- Stop, switch, or reduce the dose of medication affecting vision (e.g., anticholinergics)
- Consider benefits of cataract surgery
- Provide education on depth perception and single vs. multifocal lenses

Feet/footwear issues identified

- Provide education on shoe fit, traction, insoles, and heel height
- Refer to podiatrist

Vitamin D deficiency observed or likely

- Recommend daily vitamin D supplement

Comorbidities documented

- Optimize treatment of conditions identified
- Be mindful of medications that increase fall risk

FOLLOW UP with patient in 30-90 days.

Discuss ways to improve patient receptiveness to the care plan and address barrier(s)

Centers for Disease Control and Prevention
National Center for Injury Prevention and Control