COGNITIVE IMPAIRMENT CARE PLANNING TOOLKIT

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Cognitive Assessment and Care Planning Services:
Alzheimer's Association Expert Task Force Recommendations and Tools for Implementation

1. Background and introduction to CPT® code 99483

The Alzheimer's Association® has long advocated for Medicare reimbursement for services aimed at improving detection, diagnosis, and care planning and coordination for patients with Alzheimer's disease and related dementias (ADRD) and their caregivers (Attea, Johns, 2010). These efforts, embodied in the Health Outcomes, Planning, and Education for Alzheimer's (HOPE) Act and aided by support from physician groups involved in developing new Current Procedural Terminology (CPT) codes, culminated in approval of a Medicare procedure code, G0505, which took effect January 1, 2017. In January 2018, G0505 was replaced by CPT code 99483. Code 99483 provides reimbursement to physicians and other eligible billing practitioners for a comprehensive clinical visit that results in a written care plan. Code 99483 requires an independent historian; a multidimensional assessment that includes cognition, function, and safety; evaluation of neuropsychiatric and behavioral symptoms; review and reconciliation of medications; and assessment of the needs of the patient's caregiver. (See the CPT 2018 manual for full details.) These components are central to informing, designing and delivering a care plan suitable for patients with cognitive impairment (Anonymous. Fed Register 2016).

The Alzheimer's Association Expert Task Force provided information and suggestions on the content and use of Code G0505 (now 99483) to the Centers for Medicare & Medicaid (CMS) during the comment phase (Alzheimer's Association Task Force, 2016), and reconvened in November 2016 to make recommendations about how to conduct the required assessments. Its recommendations derive from a broad consensus about good clinical practice, informed by intervention trials and emphasizing validated assessment tools that can be implemented in routine clinical care across the United States. The multidisciplinary task force was comprised of geographically dispersed experts in the United States who provide ongoing clinical care for individuals with ADRD and/or have published recognized works in the field.

2. Who is eligible to receive this comprehensive care planning service?

Cognitive assessment and care plan services are provided when a comprehensive evaluation of a new or existing patient, who exhibits signs and/or symptoms of cognitive impairment, is required to establish or confirm a diagnosis, etiology and severity for the condition.

Do not report cognitive assessment and care plan services if any of the required elements are not performed or are deemed unnecessary for the patient's condition. For these services, see the appropriate evaluation and management (E/M) code. (American Medical Association, CPT 2018).

3. Who can provide this service?

Any practitioner eligible to report E/M services can provide this service. Eligible providers include physicians (MD and DO), nurse practitioners, clinical nurse specialists, and physician assistants. Eligible practitioners must provide documentation that supports a moderate-to-high level of complexity in medical decision making, as defined by E/M guidelines (with application as appropriate of the usual "incident-to" rules, consistent with other E/M services) (Anonymous. Fed Register 2016). The provider must also document the detailed care plan developed as a result of each required element covered by 99483.

4. What must the clinician do to meet the required elements for code 99483?

Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home, domiciliary or rest home setting with all of the following required elements:

- Cognition-focused evaluation including a pertinent history and examination;
- Medical decision making of moderate or high complexity;
- Functional assessment (eg, basic and instrumental activities of daily living), including decision-making capacity;
- Use of standardized instruments for staging of dementia (eg, functional assessment staging test [FAST], clinical dementia rating [CDR]);
- Medication reconciliation and review for high-risk medications;
- Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized screening instrument(s);
- Evaluation of safety (eg, home), including motor vehicle operation;
- Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks;
- Development, updating or revision, or review of an Advance Care Plan;
- Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neurocognitive symptoms, functional limitations, and referral to community resources as needed (eg, rehabilitation services, adult day programs, support groups) shared with the patient and/or caregiver with initial education and support.

Typically, 50 minutes are spent face to face with the patient and/or family or caregiver.

See the 2018 CPT manual for the full description and detailed instructions for code 99483.

5. When, where and by whom can the required elements be assessed?

The nine assessment elements of 99483 can be evaluated within the care planning visit or in one or more visits that precede it, using appropriate billing codes (most often an E/M code). Patients with complex medical, behavioral, psychosocial and/or caregiving needs may require a series of assessment visits, while those with well-defined or less complex problems may be fully assessed during the care plan visit. Results of assessments conducted prior to the care plan visit are allowed in care planning documentation provided they remain valid or are updated with any changes at the time of care planning.

A single physician or other qualified health care professional should not report 99483 more than once every 180 days.

Many of the required assessment elements can be completed by appropriately trained members of the clinical team working with the eligible provider. Assessments that require the direct participation of a knowledgeable care partner or caregiver, such as a structured assessment of the patient's functioning at home or a caregiver stress measure, may be completed prior to the clinical visit and provided to the clinician for inclusion in care planning. Care planning visits can be conducted in the office or other outpatient, home, domiciliary or rest home settings.

6. What measurement tools should be used to support the care planning process and its documentation?

Standardized, validated tools are preferred whenever possible and are required for some elements (see Table 1 for suggested tools). Such tools offer a basic framework on which to build a nuanced clinical understanding of care needs through ongoing clinical contact with the patient and caregiver. Though all required elements must be represented, the choice of assessment tools should be customized for differing clinician styles and practice composition, workflows and overall clinical goals. For example, primary care providers and dementia specialists may prefer different tools.

For several domains of care planning, simple, validated tools do not yet exist, and where they do, not all have been formally tested for validity and uptake in actual primary care practices. In the table below, those that have been tested in primary care are marked with an asterisk; those untested in primary care have either high face validity (e.g., Safety Assessment checklist) or published validation data that support further use. Ideally, tools should be:

- **Practical:** Time and effort to complete them fit the primary care clinical setting.
- **Parsimonious:** Provide enough information to support a meaningful care plan.
- **Scorable:** Results depicted in a single number.
- **Retrievable:** Easily incorporated into electronic health record fields and searchable at the point of care.

Table 1: Suggested Measures to Support the Care-Planning Process
The table below provides examples of simpler and more complex tools acceptable for assessing each domain. In some settings, a simple tool might be sufficient; in others, it could be used to trigger a more complex assessment or be replaced by a more detailed measure.

Domain	Suggested measures	Comments
Cognition	Mini-Cog	≤ 3 min, validated in primary care
	GPCOG	Patient/informant components
	Short MoCA	~ 5 min, needs testing in primary care
Function	Katz (ADL), Lawton-Brody (IADL)	Caregiver rated
Stage of cognitive impairment	Dementia Severity Rating Scale	Caregiver rated, correlates with Clinical Dementia Rating
Decision-making	3-level rating: able to make own decisions, not able, uncertain/needs more evaluation	Global clinician judgment
Neuropsychiatric symptoms	NPI-Q	10 items
Depression	BEHAVE 5+	6 high-impact items
	PHQ-2	Depression identification
Medication review and reconciliation	Med list + name of person overseeing home meds	Identify/reconsider high-risk meds; assess for reliable administration by self or other
Safety	Safety Assessment Guide	7 questions (patient/caregiver)
Caregiver identification and needs assessment	Caregiver Profile Checklist	Ability/willingness to care, needs for information, education, and support
	Single-Item Stress Thermometer	Rapid identification of stress
	PHQ-2	Depression
Advance care planning	End-of-Life Checklist	Screen for preferences and legal needs

7. The written care plan

Preparing the plan

The care plan should reflect a synthesis of the information acquired as part of the assessment. It should be written in language that is easily understood, indicate who has responsibility for carrying out each recommended action step and specify an initial follow-up schedule.

Some clinicians find it useful to organize the care plan into broad components, such as:

- Specific characteristics of the cognitive disorder (e.g., type and severity of cognitive impairment; special hazards such as falls or orthostatic hypotension in Lewy body dementia; or referral to a dementia specialist for further diagnostic assessment or complex management).
- Management of any neuropsychiatric symptoms, including referrals for caregiver stress and behavior management training or psychiatric care for the patient as indicated.
- Comorbid medical conditions and safety management, including any changes needed to accommodate the effects of cognitive impairment.
- Caregiver stress and support needs, including primary care counseling and, as indicated, referrals to community-based education and support, specialized individual or family counseling, or in-home care, legal or financial assistance.

Documenting and sharing the plan

Though not required by 99483, a standardized care plan template customized to the provider or health care system simplifies communication and tracking of patient care and outcomes over time. The written plan must be discussed with and given to the patient and and/or family or caregiver; this face-to-face conversation must be documented in the clinical note for all encounters reported using 99483. The care plan must be filed in the patient's medical record where it can be easily retrieved and updated. Sharing the plan with other providers caring for the patient, including clinicians, care managers, caseworkers, and others who assist the patient and caregiver, both within and outside the primary care environment will help ensure continuity and coordination of care. When such sharing requires explicit consent of the patient, family caregiver or legally designated decision-maker (DPOA holder), that permission should be sought and documented.

8. How often can 99483 be used?

Qualified health care professionals may report 99483 as frequently as once per 180 days, per CPT. However, payer policy may say otherwise and should be consulted. Care plans should be revised at intervals and whenever there is a change in the patient's clinical or caregiving status. Medicare intermediaries may audit the frequency of use.

9. How does 99483 relate to Chronic Care Management (CPT 99490)?

CPT code 99490 is an appropriate service to use for monthly care management of a patient with dementia plus at least one other chronic condition, after a cognitive impairment care plan has been developed and documented.

10. Identifying proper coding

CPT code 99483 was developed to provide reimbursement for comprehensive evaluation of a new or existing patient, who exhibits signs and/or symptoms of cognitive impairment, is required to establish or confirm a diagnosis, etiology and severity for the condition. This service includes a thorough evaluation of medical and psychosocial factors, potentially contributing to increased morbidity. Do not report cognitive assessment and care plan services if any of the required elements are not performed or are deemed unnecessary for the patient's condition. For these services, see the appropriate evaluation and management code.

Table 2: Commonly used ICD-10 codes for dementia and mild cognitive impairment

Code	Description
G300	Dementia Alzheimer's disease with early-onset
G301	Dementia Alzheimer's disease with late-onset
G309	Dementia Alzheimer's disease, unspecified
F01.50	Vascular dementia without behavioral disturbance
F01.51	Vascular dementia with behavioral disturbance
F02.80	Dementia in other diseases classified elsewhere without behavioral disturbance
F02.81	Dementia in other diseases classified elsewhere with behavioral disturbance
F03.90	Unspecified dementia without behavioral disturbance
F03.91	Unspecified dementia with behavioral disturbance
G31.01	Pick's disease
G31.09	Other frontotemporal dementia
G31.85	Corticobasal degeneration
G31.83	Dementia with Lewy bodies
G31.84	Mild cognitive impairment, so stated

Table 3: CPT codes that cannot be reported in conjunction with 99483

Because many 99483 elements overlap with other CPT codes, CMS provides specific guidelines on which CPT codes cannot be reported together with 99483 on the same date of service. It is important to note that Medicare Advantage Plans and Accountable Care Organizations may have different reimbursement criteria. Payer policy should be consulted.

Code	Description
90785	Psychotherapy complex interactive
90791	Psychiatric diagnostic evaluation
90792	Psychiatric diagnostic evaluation with medical services
96103	Psychological testing administered by a computer
96120	Neuropsychological testing administered with a computer
96127	Brief emotional/behavioral assessment
96160-96161	Health risk assessment administration
99201 – 99215	Office/outpatient visits new
99241-99245	New or established patient office or outpatient consultation services
99324 – 99337	Domicile/rest home visits new patient
99341 – 99350	Home visits new patient
99366 – 99368	Team conference with patient by healthcare professional
99497	Advanced care plan 30 min
99498	Advanced care plan additional 30 min
99605-99607	Medication therapy management services
G0506	Comprehensive assessment of and care planning by the billing practitioner for patients requiring CCM services
G0181, G0182	Home health care and hospice supervision

Table 4: CPT codes that can be reported with 99483 on the same date of service
CMS does not believe the services described in 99483 would significantly overlap with the following codes.

Code	Description
99358, 99359	Non-face-to-face prolonged services
99487, 99489, 99490	Chronic care management (CCM) services
99495, 99496	Transitional care management (TCM) services

References (partial)

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Mini-Cog™

Instructions for Administration & Scoring

ID: _____ Date: _____

Step 1: Three Word Registration

Look directly at person and say, "Please listen carefully. I am going to say three words that I want you to repeat back to me now and try to remember. The words are [select a list of words from the versions below]. Please say them for me now." If the person is unable to repeat the words after three attempts, move on to Step 2 (clock drawing).

The following and other word lists have been used in one or more clinical studies.[1-3] For repeated administrations, use of an alternative word list is recommended.

Version 1	**Version 2**	**Version 3**	**Version 4**	**Version 5**	**Version 6**
Banana	Leader	Village	River	Captain	Daughter
Sunrise	Season	Kitchen	Nation	Garden	Heaven
Chair	Table	Baby	Finger	Picture	Mountain

Step 2: Clock Drawing

Say: "Next, I want you to draw a clock for me. First, put in all of the numbers where they go." When that is completed, say: "Now, set the hands to 10 past 11."

Use preprinted circle (see next page) for this exercise. Repeat instructions as needed as this is not a memory test. Move to Step 3 if the clock is not complete within three minutes.

Step 3: Three Word Recall

Ask the person to recall the three words you stated in Step 1. Say: "What were the three words I asked you to remember?" Record the word list version number and the person's answers below.

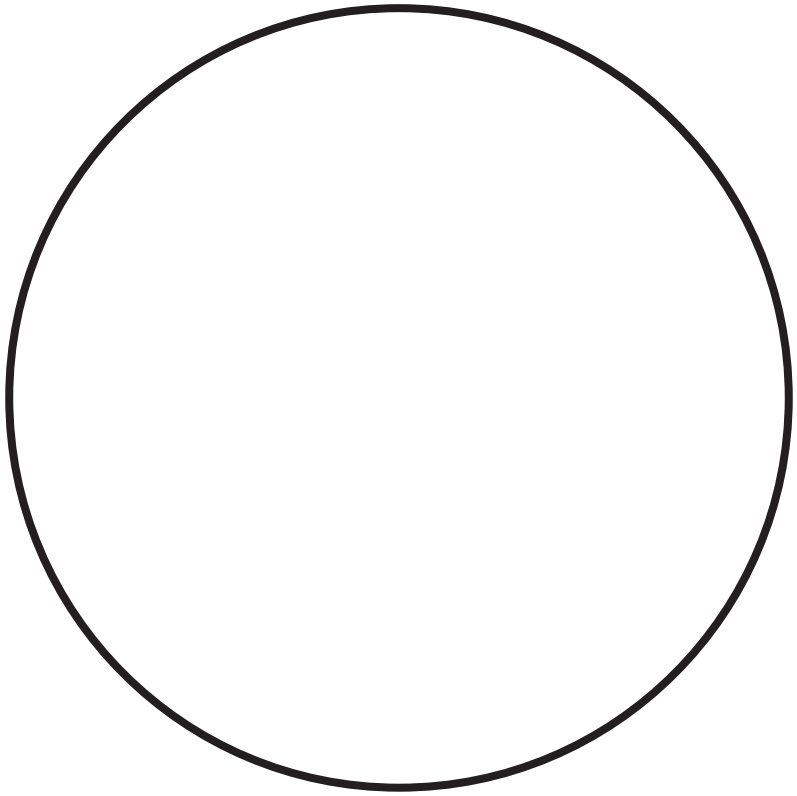
Word List Version: _____ Person's Answers: _____ _____ _____

Scoring

Word Recall: _____ (0-3 points)	1 point for each word spontaneously recalled without cueing.
Clock Draw: _____ (0 or 2 points)	Normal clock = 2 points. A normal clock has all numbers placed in the correct sequence and approximately correct position (e.g., 12, 3, 6 and 9 are in anchor positions) with no missing or duplicate numbers. Hands are pointing to the 11 and 2 (11:10). Hand length is not scored. Inability or refusal to draw a clock (abnormal) = 0 points.
Total Score: _____ (0-5 points)	Total score = Word Recall score + Clock Draw score. 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.

Clock Drawing

ID: _____ Date: _____



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2. Borson S, Scanlan JM, Watanabe J et al. Improving identification of cognitive impairment in primary care. Int J Geriatr Psychiatry 2006;21: 349–355.
3. Lessig M, Scanlan J et al. Time that tells: Critical clock-drawing errors for dementia screening. Int Psychogeriatr. 2008 June; 20(3): 459–470.
4. Tsoi K, Chan J et al. Cognitive tests to detect dementia: A systematic review and meta-analysis. JAMA Intern Med. 2015; E1-E9.
5. 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.
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Patient name:_____ **Date:** _____

GPCOG Screening Test

Step 1: Patient Examination

Unless specified, each question should only be asked once

Name and Address for subsequent recall test

1. "*I am going to give you a name and address. After I have said it, I want you to repeat it. Remember this name and address because I am going to ask you to tell it to me again in a few minutes: John Brown, 42 West Street, Kensington.*" (Allow a maximum of 4 attempts).

Time Orientation	**Correct**	**Incorrect**
2. *What is the date?* (exact only)	☐	☐

Clock Drawing – use blank page

3. *Please mark in all the numbers to indicate the hours of a clock* (correct spacing required)	☐	☐
4. *Please mark in hands to show 10 minutes past eleven o'clock* (11.10)	☐	☐

Information

5. *Can you tell me something that happened in the news recently?* (Recently = in the last week. If a general answer is given, eg "war", "lot of rain", ask for details. Only specific answer scores).	☐	☐

Recall

6. *What was the name and address I asked you to remember*

John	☐	☐
Brown	☐	☐
42	☐	☐
West (St)	☐	☐
Kensington	☐	☐

(*To get a total score, add the number of items answered correctly*
Total correct (score out of 9) **/9**

If patient scores 9, no significant cognitive impairment and further testing not necessary.
If patient scores 5-8, more information required. Proceed with Step 2, informant section.
If patient scores 0-4, cognitive impairment is indicated. Conduct standard investigations.

Brodaty et al, *JAGS* 2002; 50:530-534

Informant Interview

Date: _____

Informant's name: _____

Informant's relationship to patient, i.e. informant is the patient's: _____

These six questions ask how the patient is compared to when s/he was well, say 5 – 10 years ago

Compared to a few years ago:

	Yes	No	Don't Know	N/A
▪ Does the patient have more trouble remembering things that have happened recently than s/he used to?	☐	☐	☐	
▪ Does he or she have more trouble recalling conversations a few days later?	☐	☐	☐	
▪ When speaking, does the patient have more difficulty in finding the right word or tend to use the wrong words more often?	☐	☐	☐	
▪ Is the patient less able to manage money and financial affairs (e.g. paying bills, budgeting)?	☐	☐	☐	☐
▪ Is the patient less able to manage his or her medication independently?	☐	☐	☐	☐
▪ Does the patient need more assistance with transport (either private or public)? (If the patient has difficulties due only to physical problems, e.g bad leg, tick 'no')	☐	☐	☐	☐

(*To get a total score, add the number of items answered 'no', 'don't know' or 'N/A')*

Total score (out of 6) ☐

If patient scores 0-3, cognitive impairment is indicated. Conduct standard investigations.

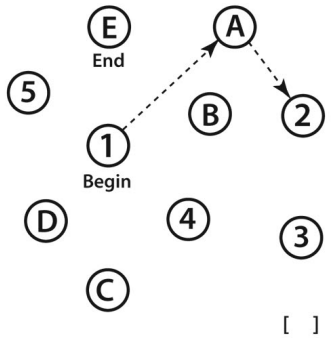
Brodaty et al, *JAGS* 2002; 50:530-534

Appendix Figure 1. The s-MoCA with instructions. Test items have *not* been modified from the original MoCA (Nasreddine et al., 2005). The order of the items has been altered to preserve the duration between word list presentation and delayed recall. The MoCA is freely available (http://www.mocatest.org/). All images and instructions were reproduced with permission from MoCA©.

MEMORY Read list of words, subject must repeat them. Do 2 trials, even if 1st trial is successful. Do a recall after 5 minutes.

	FACE	VELVET	CHURCH	DAISY	RED
1st trial					
2nd trial					

VISUOSPATIAL / EXECUTIVE



[ ]

Draw CLOCK (Ten past eleven)
(3 points)

[ ] Contour [ ] Numbers [ ] Hands

__/4

ATTENTION

Serial 7 subtraction starting at 100 [ ] 93 [ ] 86 [ ] 79 [ ] 72 [ ] 65

4 or 5 correct subtractions: **3 pts**, 2 or 3 correct: **2 pts**, 1 correct: **1 pt**, 0 correct: **0 pt**

__/3

ABSTRACTION Similarity between e.g. banana - orange = fruit [ ] watch - ruler

__/1

LANGUAGE

Fluency / Name maximum number of words in one minute that begin with the letter F [ ] _____ (N ≥ 11 words)

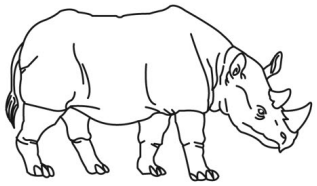
__/1

ORIENTATION

[ ] Place

__/1

NAMING



[ ]

__/1

DELAYED RECALL

	Has to recall words **WITH NO CUE**	FACE [ ]	VELVET [ ]	CHURCH [ ]	DAISY [ ]	RED [ ]	Points for UNCUED recall only
Optional	Category cue						
	Multiple choice cue						

__/5

Total Score: ___/16

s-MoCA Instructions (8-items)

*These instructions have not been modified from the original MoCA (Nasreddine et al., 2005), however the order of presentation has been changed in order to preserve and adequate delay interval between the word list presentation and recall.

Memory:

Administration: The examiner reads a list of 5 words at a rate of one per second, giving the following instructions:

"This is a memory test. I am going to read a list of words that you will have to remember now and later on. Listen carefully. When I am through, tell me as many words as you can remember. It doesn't matter in what order you say them".

Mark a check in the allocated space for each word the subject produces on this first trial. When the subject indicates that (s)he has finished (has recalled all words), or can recall no more words, read the list a second time with the following instructions:

"I am going to read the same list for a second time. Try to remember and tell me as many words as you can, including words you said the first time."

Put a check in the allocated space for each word the subject recalls after the second trial. At the end of the second trial, inform the subject that (s)he will be asked to recall these words again by saying,

"I will ask you to recall those words again at the end of the test."

Scoring: No points are given for Trials One and Two.

Alternating Trail Making:

Administration: The examiner instructs the subject:

"Please draw a line, going from a number to a letter in ascending order. Begin here [point to (1)] **and draw a line from 1 then to A then to 2 and so on. End here** [point to (E)]."

Scoring: Allocate one point if the subject successfully draws the following pattern:
1 −A- 2- B- 3- C- 4- D- 5- E, without drawing any lines that cross. Any error that is not immediately self-corrected earns a score of 0.

Visuoconstructional Skills (Clock):

Administration: Indicate the right third of the space and give the following instructions:

"Draw a clock. Put in all the numbers and set the time to 10 after 11".

Scoring: One point is allocated for each of the following three criteria:

- Contour (1 pt.): the clock face must be a circle with only minor distortion acceptable (e.g., slight imperfection on closing the circle);

- Numbers (1 pt.): all clock numbers must be present with no additional numbers; numbers must be in the correct order and placed in the approximate quadrants on the clock face; Roman numerals are acceptable; numbers can be placed outside the circle contour;
- Hands (1 pt.): there must be two hands jointly indicating the correct time; the hour hand must be clearly shorter than the minute hand; hands must be centred within the clock face with their junction close to the clock centre.

A point is not assigned for a given element if any of the above-criteria are not met.

Serial 7s:

Administration: The examiner gives the following instruction:

"Now, I will ask you to count by subtracting seven from 100, and then, keep subtracting seven from your answer until I tell you to stop."

Give this instruction twice if necessary.

Scoring: This item is scored out of 3 points. Give no (0) points for no correct subtractions, 1 point for one correction subtraction, 2 points for two-to-three correct subtractions, and 3 points if the participant successfully makes four or five correct subtractions. Count each correct subtraction of 7 beginning at 100. Each subtraction is evaluated independently; that is, if the participant responds with an incorrect number but continues to correctly subtract 7 from it, give a point for each correct subtraction. For example, a participant may respond "92 – 85 – 78 – 71 – 64" where the "92" is incorrect, but all subsequent numbers are subtracted correctly. This is one error and the item would be given a score of 3.

Abstraction:

Administration: The examiner asks the subject to explain what each pair of words has in common, starting with the example:

"Tell me how an orange and a banana are alike".

If the subject answers in a concrete manner, then say only one additional time:

"Tell me another way in which those items are alike".

If the subject does not give the appropriate response (fruit), say,

"Yes, and they are also both fruit."

Do not give any additional instructions or clarification.
After the practice trial, say:

"Now tell me how a ruler and a watch are alike".

Do not give any additional instructions or prompts.

Scoring: Only the last item pair is scored. Give 1 point to the item pair if it is correctly answered. The following responses are acceptable:

Ruler-watch = measuring instruments, used to measure.
The following responses are not acceptable: Ruler-watch = they have numbers.

Verbal fluency:

Administration: The examiner gives the following instruction:

"Tell me as many words as you can think of that begin with a certain letter of the alphabet that I will tell you in a moment. You can say any kind of word you want, except for proper nouns (like Bob or Boston), numbers, or words that begin with the same sound but have a different suffix, for example, love, lover, loving. I will tell you to stop after one minute. Are you ready? [Pause] **Now, tell me as many words as you can think of that begin with the letter F.** [time for 60 sec]. **Stop.**"

Scoring: Allocate one point if the subject generates 11 words or more in 60 sec. Record the subject's response in the bottom or side margins.

Orientation:

Administration: The examiner gives the following instructions:

"Tell me the name of this place, and which city it is in."

Scoring: Give one point for each item correctly answered. The subject must tell the exact place (name of hospital, clinic, office).

Naming:

Administration: Point to the figure and say:

"Tell me the name of this animal".

Scoring: One point each is given for the following responses: rhinoceros or rhino.

Delayed recall:

Administration: The examiner gives the following instruction:

"I read some words to you earlier, which I asked you to remember. Tell me as many of those words as you can remember."

Make a check mark () for each of the words correctly recalled spontaneously without any cues, in the allocated space.

Scoring: Allocate 1 point for each word recalled freely without any cues.

Patient Name:_____ Date:_____
Patient ID #_____

Katz Index of Independence in Activities of Daily Living

Activities Points (1 or 0)	**Independence** (1 Point) **NO** supervision, direction or personal assistance.	**Dependence** (0 Points) **WITH** supervision, direction, personal assistance or total care.
BATHING Points: _____	**(1 POINT)** Bathes self completely or needs help in bathing only a single part of the body such as the back, genital area or disabled extremity.	**(0 POINTS)** Need help with bathing more than one part of the body, getting in or out of the tub or shower. Requires total bathing
DRESSING Points: _____	**(1 POINT)** Get clothes from closets and drawers and puts on clothes and outer garments complete with fasteners. May have help tying shoes.	**(0 POINTS)** Needs help with dressing self or needs to be completely dressed.
TOILETING Points: _____	**(1 POINT)** Goes to toilet, gets on and off, arranges clothes, cleans genital area without help.	**(0 POINTS)** Needs help transferring to the toilet, cleaning self or uses bedpan or commode.
TRANSFERRING Points: _____	**(1 POINT)** Moves in and out of bed or chair unassisted. Mechanical transfer aids are acceptable	**(0 POINTS)** Needs help in moving from bed to chair or requires a complete transfer.
CONTINENCE Points: _____	**(1 POINT)** Exercises complete self control over urination and defecation.	**(0 POINTS)** Is partially or totally incontinent of bowel or bladder
FEEDING Points: _____	**(1 POINT)** Gets food from plate into mouth without help. Preparation of food may be done by another person.	**(0 POINTS)** Needs partial or total help with feeding or requires parenteral feeding.

TOTAL POINTS: _____ **SCORING:** 6 = High (*patient independent*) 0 = Low (*patient very dependent*

Source:
try this: Best Practices in Nursing Care to Older Adults, The Hartford Institute for Geriatric Nursing, New York University, College of Nursing, www.hartfordign.org.

general assessment series 17

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Best Practices in Nursing Care to Older Adults

From The Hartford Institute for Geriatric Nursing, New York University, College of Nursing

Issue Number 2, Revised 2007

Series Editor: Marie Boltz, PhD, GNP-BC
Series Co-Editor: Sherry A. Greenberg, MSN, GNP-BC
New York University College of Nursing

Katz Index of Independence in Activities of Daily Living (ADL)

By: Meredith Wallace, PhD, APRN, BC, Fairfield University School of Nursing, and Mary Shelkey, PhD, ARNP, Virginia Mason Medical Center

WHY: Normal aging changes and health problems frequently show themselves as declines in the functional status of older adults. Decline may place the older adult on a spiral of iatrogenesis leading to further health problems. One of the best ways to evaluate the health status of older adults is through functional assessment which provides objective data that may indicate future decline or improvement in health status, allowing the nurse to intervene appropriately.

BEST TOOL: The Katz Index of Independence in Activities of Daily Living, commonly referred to as the Katz ADL, is the most appropriate instrument to assess functional status as a measurement of the client's ability to perform activities of daily living independently. Clinicians typically use the tool to detect problems in performing activities of daily living and to plan care accordingly. The Index ranks adequacy of performance in the six functions of *bathing, dressing, toileting, transferring, continence, and feeding*. Clients are scored yes/no for independence in each of the six functions. A score of 6 indicates full function, 4 indicates moderate impairment, and 2 or less indicates severe functional impairment.

TARGET POPULATION: The instrument is most effectively used among older adults in a variety of care settings, when baseline measurements, taken when the client is well, are compared to periodic or subsequent measures.

VALIDITY AND RELIABILITY: In the thirty-five years since the instrument has been developed, it has been modified and simplified and different approaches to scoring have been used. However, it has consistently demonstrated its utility in evaluating functional status in the elderly population. Although no formal reliability and validity reports could be found in the literature, the tool is used extensively as a flag signaling functional capabilities of older adults in clinical and home environments.

STRENGTHS AND LIMITATIONS: The Katz ADL Index assesses basic activities of daily living. It does not assess more advanced activities of daily living. Katz developed another scale for instrumental activities of daily living such as heavy housework, shopping, managing finances and telephoning. Although the Katz ADL Index is sensitive to changes in declining health status, it is limited in its ability to measure small increments of change seen in the rehabilitation of older adults. A full comprehensive geriatric assessment should follow when appropriate. The Katz ADL Index is very useful in creating a common language about patient function for all practitioners involved in overall care planning and discharge planning.

MORE ON THE TOPIC:

Best practice information on care of older adults: www.ConsultGeriRN.org.

Graf, C. (2006). Functional decline in hospitalized older adults. *AJN*, *106*(1), 58-67.

Katz, S., Down, T.D., Cash, H.R., & Grotz, R.C. (1970) Progress in the development of the index of ADL. *The Gerontologist*, *10*(1), 20-30.

Katz, S. (1983). Assessing self-maintenance: Activities of daily living, mobility and instrumental activities of daily living. *JAGS*, *31*(12), 721-726.

Kresevic, D.M., & Mezey, M. (2003). Assessment of function. In M. Mezey, T. Fulmer, I. Abraham (Eds.), D. Zwicker (Managing Ed.), *Geriatric nursing protocols for best practice* (2nd ed., pp 31-46). NY: Springer Publishing Co., Inc.

Mick, D.J., & Ackerman, M.H. (2004, Sept). Critical care nursing for older adults: Pathophysiological and functional considerations. *Nursing Clinics of North America*, *39*(3), 473-93.

Patient Name:_____ Date:_____
Patient ID #_____

LAWTON - BRODY
INSTRUMENTAL ACTIVITIES OF DAILY LIVING SCALE (I.A.D.L.)

Scoring: For each category, circle the item description that most closely resembles the client's highest functional level (either 0 or 1).

A. Ability to Use Telephone		**E. Laundry**	
1. Operates telephone on own initiative-looks up and dials numbers, etc.	1	1. Does personal laundry completely	1
		2. Launders small items-rinses stockings, etc.	1
2. Dials a few well-known numbers	1	3. All laundry must be done by others	0
3. Answers telephone but does not dial	1		
4. Does not use telephone at all	0		
B. Shopping		**F. Mode of Transportation**	
1. Takes care of all shopping needs independently	1	1. Travels independently on public transportation or drives own car	1
2. Shops independently for small purchases	0	2. Arranges own travel via taxi, but does not otherwise use public transportation	1
3. Needs to be accompanied on any shopping trip	0	3. Travels on public transportation when accompanied by another	1
4. Completely unable to shop	0	4. Travel limited to taxi or automobile with assistance of another	0
		5. Does not travel at all	0
C. Food Preparation		**G. Responsibility for Own Medications**	
1. Plans, prepares and serves adequate meals independently	1	1. Is responsible for taking medication in correct dosages at correct time	1
2. Prepares adequate meals if supplied with ingredients	0	2. Takes responsibility if medication is prepared in advance in separate dosage	0
3. Heats, serves and prepares meals, or prepares meals, or prepares meals but does not maintain adequate diet	0	3. Is not capable of dispensing own medication	0
4. Needs to have meals prepared and served	0		
D. Housekeeping		**H. Ability to Handle Finances**	
1. Maintains house alone or with occasional assistance (e.g. "heavy work domestic help")	1	1. Manages financial matters independently (budgets, writes checks, pays rent, bills, goes to bank), collects and keeps track of income	1
2. Performs light daily tasks such as dish washing, bed making	1	2. Manages day-to-day purchases, but needs help with banking, major purchases, etc.	1
3. Performs light daily tasks but cannot maintain acceptable level of cleanliness	1	3. Incapable of handling money	0
4. Needs help with all home maintenance tasks	1		
5. Does not participate in any housekeeping tasks	0		
Score		**Score**	
		Total score_____	

A summary score ranges from 0 (low function, dependent) to 8 (high function, independent) for women and 0 through 5 for men to avoid potential gender bias.

Source: *try this:* Best Practices in Nursing Care to Older Adults, The Hartford Institute for Geriatric Nursing, New York University, College of Nursing, www.hartfordign.org.

try this: Best Practices in Nursing Care to Older Adults
from The Hartford Institute for Geriatric Nursing
New York University, College of Nursing

Issue Number 23, Revised 2007

Series Editor: Marie Boltz, PhD, APRN, BC, GNP
Managing Editor: Sherry A. Greenberg, MSN, APRN, BC, GNP
New York University College of Nursing

The Lawton Instrumental Activities of Daily Living (IADL) Scale

By: Carla Graf, MS, APRN, BC, University of California, San Francisco

WHY: The assessment of functional status is critical when caring for older adults. Normal aging changes, acute illness, worsening chronic illness, and hospitalization can contribute to a decline in the ability to perform tasks necessary to live independently in the community. The information from a functional assessment can provide objective data to assist with targeting individualized rehabilitation needs or to plan for specific in home services such as meal preparation, nursing care, home-maker services, personal care, or continuous supervision. A functional assessment can also assist the clinician to focus on the person's baseline capabilities, facilitating early recognition of changes that may signify a need either for additional resources or for a medical work-up (Gallo, 2006).

BEST TOOL: The Lawton Instrumental Activities of Daily Living Scale (IADL) is an appropriate instrument to assess independent living skills (Lawton & Brody, 1969). These skills are considered more complex than the basic activities of daily living as measured by the Katz Index of ADLs (See *Try this*: Katz Index of ADLs). The instrument is most useful for identifying how a person is functioning at the present time, and to identify improvement or deterioration over time. There are eight domains of function measured with the Lawton IADL scale. Women are scored on all 8 areas of function; historically, for men, the areas of food preparation, housekeeping, laundering are excluded. Clients are scored according to their highest level of functioning in that category. A summary score ranges from 0 (low function, dependent) to 8 (high function, independent) for women, and 0 through 5 for men.

TARGET POPULATION: This instrument is intended to be used among older adults, and can be used in community or hospital settings. The instrument is not useful for institutionalized older adults. It can be used as a baseline assessment tool and to compare baseline function to periodic assessments.

VALIDITY AND RELIABILITY: Few studies have been performed to test the Lawton IADL scale psychometric properties. The Lawton IADL Scale was originally tested concurrently with the Physical Self-Maintenance Scale (PSMS). Reliability was established with twelve subjects interviewed by one interviewer with the second rater present but not participating in the interview process. Inter-rater reliability was established at .85. The validity of the Lawton IADL was tested by determining the correlation of the Lawton IADL with four scales that measured domains of functional status, the Physical Classification (6-point rating of physical health), Mental Status Questionnaire (10-point test of orientation and memory), Behavior and Adjustment rating scales (4-6-point measure of intellectual, person, behavioral and social adjustment), and the PSMS (6-item ADLs). A total of 180 research subjects participated in the study, however, few received all five evaluations. All correlations were significant at the .01 or .05 level. To avoid potential gender bias at the time the instrument was developed, specific items were omitted for men. This assessment instrument is widely used both in research and in clinical practice.

STRENGTHS AND LIMITATIONS: The Lawton IADL is an easy to administer assessment instrument that provides self-reported information about functional skills necessary to live in the community. Administration time is 10-15 minutes. Specific deficits identified can assist nurses and other disciplines in planning for safe discharge.
Limitations of the instrument can include the self-report or surrogate report method of administration rather than a demonstration of the functional task. This may lead either to over-estimation or under-estimation of ability. In addition, the instrument may not be sensitive to small, incremental changes in function.

FOLLOW-UP: The identification of new disabilities in these functional domains warrants intervention and further assessment to prevent ongoing decline and to promote safe living conditions for older adults. If using the Lawton IADL tool with an acute hospitalization, nurses should communicate any deficits to the physicians and social workers/case managers for appropriate discharge planning.

MORE ON THE TOPIC:

Best practice information on care of older adults: www.ConsultGeriRN.org.
Gallo, J.J., & Paveza, G.J. (2006). Activities of daily living and instrumental activities of daily living assessment. In J.J. Gallo, H.R. Bogner, T. Fulmer, & G.J. Paveza (Eds.), *Handbook of Geriatric Assessment* (4th ed., pp. 193-240). MA: Jones and Bartlett Publishers.
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Pearson, V. (2000). Assessment of function. In R. Kane, & R. Kane (Eds.), *Assessing Older Persons. Measures, Meaning and Practical Applications* (pp. 17-48). New York: Oxford University Press.

DEMENTIA SEVERITY RATING SCALE (DSRS)

PARTICIPANT'S NAME:_____ DATE:_____

PERSON COMPLETING FORM:_____

Please circle the most appropriate answer.

Do you live with the participant? No Yes

How much contact do you have with the participant? Less than 1 day per week 1 day/week 2 days/week 3-4 days/week

5 or more days per week

Relationship to participant

Self Spouse Sibling Child Other Family Friend Other _____

In each section, please circle the number that **most closely applies** to the participant. This is a general form, so no one description may be exactly right -- please circle the answer that seems to apply most of the time.

Please circle only one number per section, and be sure to answer all questions.

MEMORY

0 Normal memory.

1 Occasionally forgets things that they were told recently. Does not cause many problems.

2 Mild consistent forgetfulness. Remembers recent events but often forgets parts.

3 Moderate memory loss. Worse for recent events. May not remember something you just told them. Causes problems with everyday activities.

4 Substantial memory loss. Quickly forgets recent or newly-learned things. Can only remember things that they have known for a long time.

5 Does not remember basic facts like the day of the week, when last meal was eaten or what the next meal will be.

6 Does not remember even the most basic things.

DEMENTIA SEVERITY RATING SCALE (DSRS)

SPEECH AND LANGUAGE

0 Normal ability to talk and to understand others.

1 Sometimes cannot find a word, but able to carry on conversations.

2 Often forgets words. May use the wrong word in its place. Some trouble expressing thoughts and giving answers.

3 Usually answers questions using sentences but rarely starts a conversation.

4 Answers questions, but responses are often hard to understand or don't make sense. Usually able to follow simple instructions.

5 Speech often does not make sense. Can not answer questions or follow instructions.

6 Does not respond most of the time.

RECOGNITION OF FAMILY MEMBERS

0 Normal - recognizes people and generally knows who they are.

1 Usually recognizes grandchildren, cousins or relatives who are **not** seen frequently but may not recall how they are related.

2 Usually does not recognize family members who are not seen frequently. Is often confused about how family members such as grandchildren, nieces, or nephews are related to them.

3 Sometimes does not recognize close family members or others who they see frequently. May not recognize their children, brothers, or sisters who are not seen on a regular basis.

4 Frequently does not recognize spouse or caregiver.

5 No recognition or awareness of the presence of others.

ORIENTATION TO TIME

0 Normal awareness of time of day and day of week.

1 Some confusion about what time it is or what day of the week, but not severe enough to interfere with everyday activities.

2 Frequently confused about time of day.

3 Almost always confused about the time of day.

4 Seems completely unaware of time.

DEMENTIA SEVERITY RATING SCALE (DSRS)

ORIENTATION TO PLACE

0 Normal awareness of where they are even in new places.

1 Sometimes disoriented in new places.

2 Frequently disoriented in new places.

3 Usually disoriented, even in familiar places. May forget that they are already at home.

4 Almost always confused about place.

ABILITY TO MAKE DECISIONS

0 Normal - as able to make decisions as before.

1 Only some difficulty making decisions that arise in day-to-day life.

2 Moderate difficulty. Gets confused when things get complicated or plans change.

3 Rarely makes any important decisions. Gets confused easily.

4 Not able to understand what is happening most of the time.

SOCIAL AND COMMUNITY ACTIVITY

0 Normal - acts the same with people as before

1 Only mild problems that are not really important, but clearly acts differently from previous years.

2 Can still take part in community activities without help. May appear normal to people who don't know them.

3 Often has trouble dealing with people outside the home without help from caregiver. Usually can participate in quiet home activities with friends. The problem is clear to anyone who sees them.

4 No longer takes part in any real way in activities at home involving other people. Can only deal with the primary caregiver.

5 Little or no response even to primary caregiver.

DEMENTIA SEVERITY RATING SCALE (DSRS)

HOME ACTIVITIES AND RESPONSIBILITIES

0 Normal. No decline in ability to do things around the house.

1 Some problems with home activities. May have more trouble with money management (paying bills) and fixing things. Can still go to a store, cook or clean. Still watches TV or reads a newspaper with interest and understanding.

2 Makes mistakes with easy tasks like going to a store, cooking or cleaning. Losing interest in the newspaper, TV or radio. Often can't follow a long conversation on a single topic.

3 Not able to shop, cook or clean without a lot of help. Does not understand the newspaper or the TV. Cannot follow a conversation.

4 No longer does any home-based activities.

PERSONAL CARE - CLEANLINESS

0 Normal. Takes care of self as well as they used to.

1 Sometimes forgets to wash, shave, comb hair, or may dress in wrong type of clothes. Not as neat as they used to be.

2 Requires help with dressing, washing and personal grooming.

3 Totally dependent on help for personal care.

EATING

0 Normal, does not need help in eating food that is served to them.

1 May need help cutting food or have trouble with some foods, but basically able to eat by themselves.

2 Generally able to feed themselves but may require some help. May lose interest during the meal.

3 Needs to be fed. May have trouble swallowing.

DEMENTIA SEVERITY RATING SCALE (DSRS)

CONTROL OF URINATION AND BOWELS

0 Normal - does not have problems controlling urination or bowels except for physical problems.

1 Rarely fails to control urination (generally less than one accident per month).

2 Occasional failure to control urination (about once a week or less).

3 Frequently fails to control urination (more than once a week).

4 Generally fails to control urination and frequently can not control bowels.

ABILITY TO GET FROM PLACE TO PLACE

0 Normal, able to get around on their own. (May have physical problems that require a cane or walker).

1 Sometimes gets confused when driving or taking public transportation, especially in new places. Able to walk places alone.

2 Cannot drive or take public transportation alone, even in familiar places. Can walk alone outside for short distances. Might get lost if walking too far from home.

3 Cannot be left outside alone. Can get around the house without getting lost or confused.

4 Gets confused and needs help finding their way around the house.

5 Almost always in a bed or chair. May be able to walk a few steps with help, but lacks sense of direction.

6 Always in bed. Unable to sit or stand.

INTERPRETATION
Add up the points for all sections.

Score
0-18 --- Mild
19-36 -- Moderate
37-54 -- Severe

Author:

Dr. Christopher M Clark, Alzheimer's Disease Core Center
Department of Neurology, University of Pennsylvania, Philadelphia, Pennsylvania, USA

Decision making capacity assessment

At the time of the visit, it is my opinion that the patient is:

Able to make his/her own medical decisions	☐
Not able make his/her own medical decisions	☐
Uncertain – May require additional testing	☐

npiTEST

The Neuropsychiatric Inventory Questionnaire:

Background and Administration

By Jeffrey L. Cummings, MD

The Neuropsychiatric Inventory–Questionnaire: Background and Administration

The Neuropsychiatric Inventory–Questionnaire (NPI-Q) was developed and cross-validated with the standard NPI to provide a brief assessment of neuropsychiatric symptomatology in routine clinical practice settings (Kaufer et al, J Neuropsychiatry Clin Neurosci 2000, 12:233-239). The NPI-Q is adapted from the NPI (Cummings et al, Neurology 1994; 44:2308-2314), a validated informant-based interview that assesses neuropsychiatric symptoms over the previous month. The original NPI included 10 neuropsychiatric domains; two others, Nighttime Behavioral Disturbances and Appetite/Eating Changes, have subsequently been added. Another recent modification of the original NPI is the addition of a Caregiver Distress Scale for evaluating the psychological impact of neuropsychiatric symptoms reported to be present (Kaufer et al, JAGS, 1998;46:210-215). The NPI-Q includes both of these additions.

The NPI-Q is designed to be a self-administered questionnaire completed by informants about patients for whom they care. Each of the 12 NPI-Q domains contains a survey question that reflects cardinal symptoms of that domain. Initial responses to each domain question are "Yes" (present) or "No" (absent). If the response to the domain question is "No", the informant goes to the next question. If "Yes", the informant then rates both the Severity of the symptoms present within the last month on a 3-point scale and the associated impact of the symptom manifestations on them (i.e. Caregiver Distress) using a 5-point scale. The NPI-Q provides symptom Severity and Distress ratings for each symptom reported, and total Severity and Distress scores reflecting the sum of individual domain scores.

Most informants will be able to complete the NPI-Q in 5 minutes or less. It is recommended that responses to the NPI-Q be reviewed for completeness by a clinician and for clarifying uncertainties after each administration. The first time an informant completes the NPI-Q, it may be useful to verbally review the instructions. In some instances, it may be necessary to conduct the NPI-Q in part or entirely as an interview.

For inquiries regarding the NPI-Q, contact:

Jeffrey L. Cummings, MD
Mary S. Easton Center for Alzheimer's Disease Research
10911 Weyburn Ave; #200
Los Angeles, CA 90095
jcummings@mednet.ucla.edu

The NPI-Q can be found at:
www.NPItest.net

Please answer the following questions based on changes that have occurred since the patient first began to experience memory problems.

Circle "Yes" only if the symptom(s) has been present in the last month. Otherwise, circle "No". For each item marked "Yes":

a) Rate the SEVERITY of the symptom (how it affects the patient):

1 = Mild (noticeable, but not a significant change)
2 = Moderate (significant, but not a dramatic change)
3 = Severe (very marked or prominent, a dramatic change)

b) Rate the DISTRESS you experience due to that symptom (how it affects you):

0 = Not distressing at all
1 = Minimal (slightly distressing, not a problem to cope with)
2 = Mild (not very distressing, generally easy to cope with)
3 = Moderate (fairly distressing, not always easy to cope with)
4 = Severe (very distressing, difficult to cope with)
5 = Extreme or Very Severe (extremely distressing, unable to cope with)

Please answer each question carefully. Ask for assistance if you have any questions.

Delusions Does the patient have false beliefs, such as thinking that others are stealing from him/her or planning to harm him/her in some way?

Yes No **SEVERITY: 1 2 3** **DISTRESS: 0 1 2 3 4 5**

Hallucinations Does the patient have hallucinations such as false visions or voices? Does he or she seem to hear or see things that are not present?

Yes No **SEVERITY: 1 2 3** **DISTRESS: 0 1 2 3 4 5**

Agitation/Aggression Is the patient resistive to help from others at times, or hard to handle?

Yes No **SEVERITY: 1 2 3** **DISTRESS: 0 1 2 3 4 5**

Depression/Dysphoria Does the patient seem sad or say that he /she is depressed?

Yes No **SEVERITY: 1 2 3** **DISTRESS: 0 1 2 3 4 5**

Anxiety Does the patient become upset when separated from you? Doeshe/she have any other signs of nervousness such as shortness of breath, sighing, being unable to relax, or feeling excessively tense?

Yes No **SEVERITY: 1 2 3** **DISTRESS: 0 1 2 3 4 5**

Elation/Euphoria Does the patient appear to feel too good or act excessively happy?

Yes No **SEVERITY: 1 2 3** **DISTRESS: 0 1 2 3 4 5**

Apathy/Indifference Does the patient seem less interested in his/her usual activities or in the activities and plans of others?

Yes No **SEVERITY: 1 2 3** **DISTRESS: 0 1 2 3 4 5**

Disinhibition Does the patient seem to act impulsively, for example, talking to strangers as if he/she knows them, or saying things that may hurt people's feelings?

Yes No **SEVERITY: 1 2 3** **DISTRESS: 0 1 2 3 4 5**

Irritability/Lability Is the patient impatient and cranky? Does he/she have difficulty coping with delays or waiting for planned activities?

Yes No **SEVERITY: 1 2 3** **DISTRESS: 0 1 2 3 4 5**

Motor Disturbance Does the patient engage in repetitive activities such as pacing around the house, handling buttons, wrapping string, or doing other things repeatedly?

Yes No **SEVERITY: 1 2 3** **DISTRESS: 0 1 2 3 4 5**

Nightime Behaviors Does the patient awaken you during the night, rise too early in the morning, or take excessive naps during the day?

Yes No **SEVERITY: 1 2 3** **DISTRESS: 0 1 2 3 4 5**

Appetite/Eating Has the patient lost or gained weight, or had a change in the type of food he/she likes?

Yes No **SEVERITY: 1 2 3** **DISTRESS: 0 1 2 3 4 5**

NPI-Q SUMMARY

	No	Severity	Caregiver Distress
Delusions	0	1 2 3	0 1 2 3 4 5
Hallucinations	0	1 2 3	0 1 2 3 4 5
Agitation/Aggression	0	1 2 3	0 1 2 3 4 5
Dysphoria/Depression	0	1 2 3	0 1 2 3 4 5
Anxiety	0	1 2 3	0 1 2 3 4 5
Euphoria/Elation	0	1 2 3	0 1 2 3 4 5
Apathy/Indifference	0	1 2 3	0 1 2 3 4 5
Disinhibition	0	1 2 3	0 1 2 3 4 5
Irritability/Lability	0	1 2 3	0 1 2 3 4 5
Aberrant Motor	0	1 2 3	0 1 2 3 4 5
Nighttime Behavior	0	1 2 3	0 1 2 3 4 5
Appetite/Eating	0	1 2 3	0 1 2 3 4 5
TOTAL			

BEHAV5+

Please check yes for the behaviors that **you have observed** in your **care recipient** in the **past month.**

1. AGITATION/AGGRESSION Does your care recipient get angry or hostile? Resist care from others?	☐Yes ☐No
2. HALLUCINATIONS Does your care recipient see and/or hear things that no one else can see or hear?	☐Yes ☐No
3. IRRITABILITY/ FREQUENTLY CHANGING MOOD Does your care recipient act impatient and cranky? Does his or her mood frequently change for no apparent reason?	☐Yes ☐No
4. SUSPICIOUSNESS/PARANOIA Does your care recipient act suspicious without good reason (example: believes that others are stealing from him or her, or planning to harm him or her in some way)?	☐Yes ☐No
5. INDIFFERENCE/SOCIAL WITHDRAWAL Does your care recipient seem less interested in his or her usual activities or in the activities and plans of others?	☐Yes ☐No
6. SLEEP PROBLEMS Does your care recipient have trouble sleeping at night?	☐Yes ☐No

NIDA Clinical Trials Network

Patient Health Questionnaire-2 (PHQ-2)

Instructions:

Please respond to each question.

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Give answers as 0 to 3, using this scale:

0=Not at all; 1=Several days; 2=More than half the days; 3=Nearly every day

1. **Little interest or pleasure in doing things**

☐0 ☐1 ☐2 ☐3

2. **Feeling down, depressed, or hopeless**

☐0 ☐1 ☐2 ☐3

Instructions

Clinic personnel will follow standard scoring to calculate score based on responses.

Total score: _ _

Medication List for Review

List all current medications.

Medications	Dosage	Review date

Name of caregiver who assists with or oversees medication management:

Safety Assessment Checklist

If the patient or caregiver answers yes to questions 1 and 3–7 or no to question 2, refer to the Safety Assessment Guide for further evaluation. When working with patients living with dementia, it is recommended that you also consult with a family member, friend or caregiver, as the patient's judgment, memory and decreased cognitive skills may impact insight into the illness and the ability to provide accurate reporting.

Questions	Yes	No
1. Is the patient still driving?		
2. Is the patient taking medications as prescribed?		
3. Are there concerns about safety in the home?		
4. Has the patient gotten lost in familiar places or wandered?		
5. Are firearms present in the home?		
6. Has the patient experienced unsteadiness or sustained falls?		
7. Does the patient live alone?		

Driving

A patient's functional ability — not age or diagnosis — should dictate when it's time to retire from driving. Look for changes from his or her baseline.

Questions to ask patient	Questions to ask family/caregiver	Considerations	Resources
Are you still driving? How have your driving behaviors or in-traffic skills changed? Have you had any traffic accidents? Have you considered making a plan for when you are no longer able to drive?	Is the patient still driving? Is the patient a good driver? Has the patient been involved in any recent accidents, including fender benders, or been issued any tickets? Do you have any concerns about a passenger riding with the patient?	These questions should be asked during every visit for as long as the patient is still driving. Driving requires the ability to multitask. High-risk driving is increasingly linked to impairment of higher-order ADLs. Both the person with dementia and the family need to be aware that functional abilities will change over time, making driving no longer possible. Plans should be made for when that time comes. Driving represents independence and the loss of the ability to drive can be very difficult to accept. Acknowledging this loss of independence with the patient can be helpful, along with discussing other available transportation options. There may come a time when the person doesn't understand why he or she can no longer drive safely. Once other measures to prevent the person from driving have been exhausted, counsel the family or caregiver about removing the person's access to the car, disabling the vehicle or taking away the keys. Sometimes it can be helpful to write out a "retire from driving" prescription.	**Alzheimer's Association Dementia and Driving Resource Center** alz.org/driving **American Occupational Therapy Association** myaota.aota.org/driver_search **Car Safety Guides** thehartford.com/resources/mature-market-excellence/publications-on-aging **Aging Life Care Association** aginglifecare.org/ALCA/About_Aging_Life_Care/Find_an_Aging_Life_Care_Expert/ALCA/About_Aging_Life_Care/Search/Find_an_Expert.aspx?hkey=78a6cb03-e912-4993-9b68-df1573e9d8af

Managing Medications

Self-managing medications is a common difficulty for patients with cognitive impairment and/or those taking multiple medications, and thus requires assistance, even when the person is in the early stage.

Questions to ask patient	Questions to ask family/caregiver	Considerations	Resources
It's not uncommon for older adults to sometimes forget to take their medications. Does that ever happen to you? What do you do to help remember to take your medications? How do you tell your medications apart? Do you use pill boxes? Who fills your pill boxes? How do you refill your prescriptions?	How is the patient doing with his or her medications? How confident are you that he or she is taking them as directed? Do you ever notice that there are too many or not enough pills at the end of the month?	We cannot rely on self-management of conditions for patients with dementia. Tools like pill boxes, a reminder call from a family member or special bottles with caps that count how many times the bottle has been opened may be helpful in managing medications. Family members or caregivers can provide assistance by asking the pharmacist to distribute medication in a pill box and by setting alarms on a phone or watch as medication reminders.	**Medication Management: A Family Caregiver's Guide** nextstepincare.org/uploads/File/Guides/Medication/Medication_Management_Guide/Medication_Management.pdf **Medication Safety** alz.org/care/dementia-medication-drug-safety.asp **Medi-Cog** pharmacy.umaryland.edu/practice/medmanagement/assisted_living/Tools-to-Assess-Self-Administration-of-Medication/

Home Safety

It is important to educate the family/caregiver about safety in the home early in the process so they can make appropriate modifications to the home and learn how to continually assess safety as the disease progresses.

Questions to ask patient	Questions to ask family/caregiver	Considerations	Resources
Have you had any safety-related incidents at home? Do you feel safe in your home? Do you use the stove to cook? Is it becoming more difficult for you to complete chores? Do you ever smoke while alone in your home?	Do you feel comfortable leaving the person home alone? Have you noticed any burned pans or other signs of issues with the stove or other appliances? Do you have any concerns about the person's cooking or eating habits? Are there working smoke detectors and fire extinguishers in the home? Are there any concerns about the patient harming themselves or others?	There will come a time when the person should not be left alone. However, he or she may still be able to participate in some chores with supervision. Keep an eye on the person's ability to conduct typical household tasks, such as cooking and using appliances and tools. Adjust as necessary. A speech and/or occupational therapist specializing in dementia can provide additional customized strategies to support the person with dementia and the family/caregiver.	**Alzheimer's Association Safety Center** alz.org/safety **Simple Solutions: Practical Ideas and Products to Enhance Independent Living** thehartford.com/resources/mature-market-excellence/publications-on-aging

Wandering and getting lost

Getting lost can occur at any stage of the disease; however, wandering behavior often occurs during the middle stage. It's important to educate the person with dementia and their family/caregiver about the possibility of wandering and getting lost, and how to be prepared.

Questions to ask patient	Questions to ask family/caregiver	Considerations	Resources
Have you ever gotten lost in places that are familiar to you?	Has the patient ever come home much later than expected without an explanation? Does the patient ever try to leave the house or ask to "go home" when he or she is already at home?	For the person who is still independently active in the community: • Make sure the person has an In Case of Emergency (ICE) contact in his or her phone. • Enroll in the MedicAlert® + Alzheimer's Association Safe Return® program. • Consider using technology such as the Find My Phone mobile app or other GPS apps or devices. For the person who is at risk for wandering: • Set up structured and engaging activities throughout the day to help discourage wandering behavior. Include exercise, if possible. • Disguise the exits with wall hangings. • Put an alarm on the door so you are aware when it is opened.	**Tips on wandering/getting lost** **alz.org/care/alzheimers-dementia-wandering.asp**

Firearms

Due to the disease, there may come a time when the patient may not recognize family members or friends. It is not uncommon for a person with dementia to believe that a stranger has entered his or her home when it is, in fact, a relative or caregiver. If firearms are accessible, this can become a dangerous situation.

Questions to ask patient	Questions to ask family/caregiver	Considerations	Resources
Do you have firearms in your home?	Are there firearms in the home?	If possible, remove all firearms from the home. If that isn't an option, keep ammunition stored separately from the weapon and ensure that both are kept in a locked cabinet or gun safe. If the patient is reluctant to remove the firearms, encourage him or her to consider "gifting" the firearms to another family member or friend. If necessary, ask local law enforcement for assistance in removing the firearms from the home. The family may receive compensation from a gun buy-back program.	**Alzheimer's Association *Staying Safe* brochure** **alz.org/national/documents/brochure_stayingsafe.pdf**

Falling

Patients with dementia can be at risk for falls due to the changes they experience in vision and mobility.

Questions to ask patient	Questions to ask family/caregiver	Considerations	Resources
Do you ever feel unsteady on your feet? Have you fallen recently? Are you limiting outings or travel due to fear of falling?	Does the patient seem unsteady on his or her feet? Has the patient fallen recently?	Order an evaluation with a physical therapist to assess for fall risk. Refer the caregiver to education about proper transfer techniques. Remove throw rugs in the home.	**Steadi Materials for Health Care Providers** **cdc.gov/steadi/materials.html**

Living Alone

Individuals with dementia who live alone present unique challenges. Because of the disease, they may not accurately report information. It can be helpful to have a conversation with the person to help you assess whether their level of cognitive decline is impacting their ability to live alone. Keep in mind that many people who live alone also already have a family member, friend or neighbor who provides assistance in the home.

Questions to ask patient	Questions to ask family/caregiver	Considerations	Resources
Do you live alone? Tell me about a good day. What works well for you in your routine and what are your challenges? It is not uncommon for older adults to need some assistance to remember to take their medications. How do you manage that? Do you ever feel lonely, isolated or scared? Are you having any challenges getting to appointments, visiting friends or running errands? Have you noticed any changes in your eating habits? Have you had any trouble paying your bills or balancing your checkbook? *If the patient came to the appointment alone*: There is a lot for us to go over during these appointments. It may be helpful to bring a friend or family member with you to help you keep track of everything we discuss. Is there someone who can join you for your next appointment?	Have you thought about when it will no longer be safe for the patient to live alone? Do you have any concerns about the patient's ability to live alone? Are you confident that the patient is: • Eating regularly? • Getting to appointments? • Managing finances? • Able to shop, clean and prepare meals?	Patients who exhibit any of the following behaviors can no longer safely live alone. Plans should be made for more appropriate housing: • Delusional or paranoid behavior or thinking. • Serious fall risk (or has fallen). • Unable to remember to take medications, posing a dangerous risk to his or her health. • Forgetting to eat and/or drink regularly. A diagnosis of dementia and the resulting changes in function and/or social withdrawal may cause a person to feel increased loneliness or isolation. This may in turn impact mood, function and self-care.	**Alzheimer's Association** **alz.org/i-have-alz/if-you-live-alone.asp**

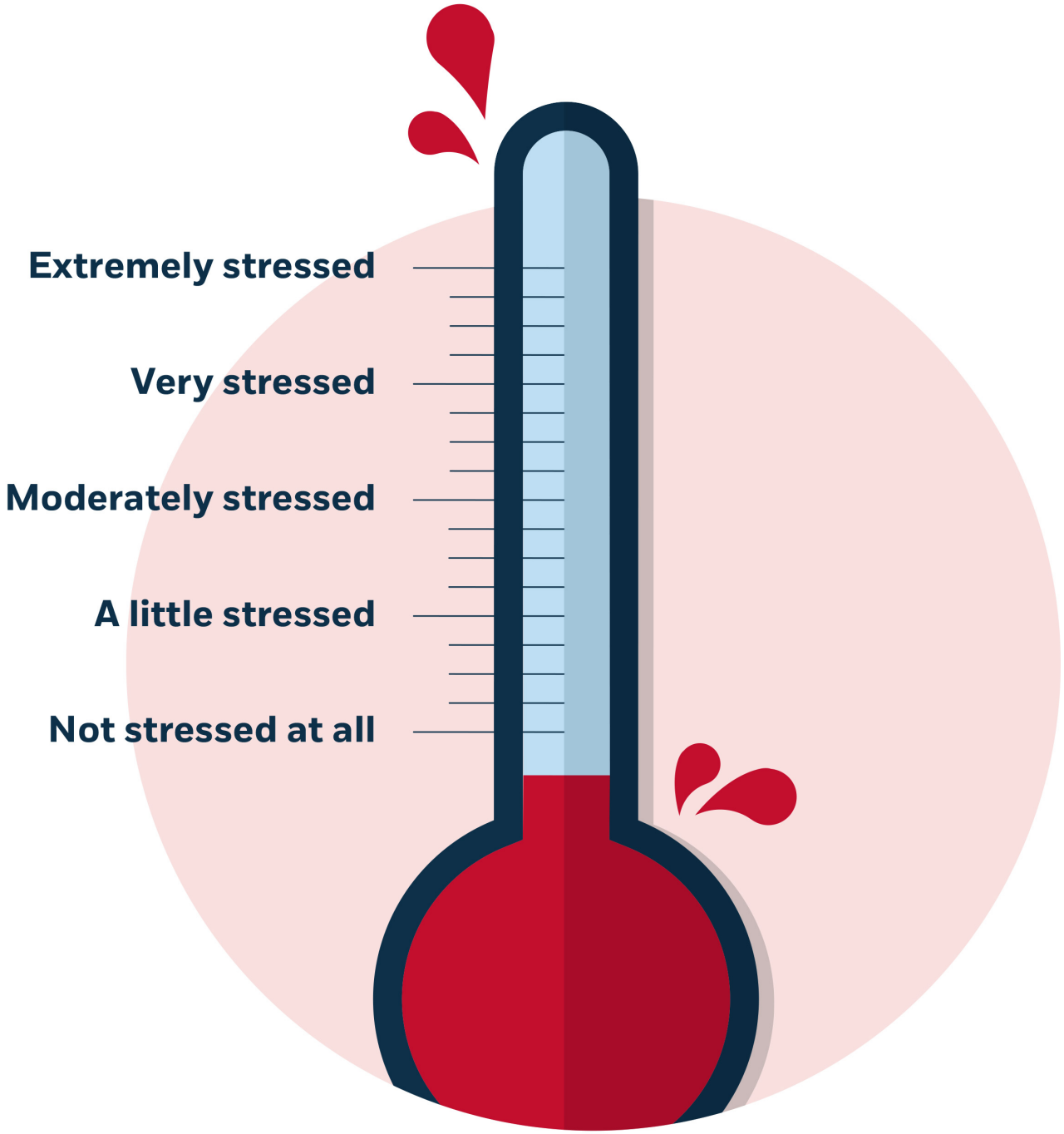
Questions to ask the individuals who will provide care and assistance to the patient with dementia

Questions	Yes	No	Resources
Do you understand Alzheimer's disease and other dementias?			**Alzheimer's Association®** **alz.org®** **800.272.3900** Provides disease education, support groups, and personalized care consultation in person, online and through a free 24/7 Helpline. **Alzheimer's Disease Education and Referral (ADEAR)** **nia.nih.gov/alzheimers** **800.438.4380** Offers disease information online or by phone for individuals with Alzheimer's or other dementias and their families. **Administration on Community Living** **alzheimers.gov** Supports individuals living with Alzheimer's or other dementias and their caregivers by increasing access to community resources.
Do you know where you can obtain additional information about the disease?			
Are you able and willing to provide care and/or assistance?			**Alzheimer's Association** **alz.org** **800.282.3900** Care consultants are available to talk all day, every day via the 24/7 Helpline, and support groups take place in communities nationwide. **ALZConnected®** **alzconnected.org** Online community that connects individuals facing the disease and provides online support. **Community Resource Finder** **alz.org/CRF** Find local programs, resources and support services. **Aging Life Care Association** **aginglifecare.org** Locate a geriatric care manager. **Family Caregiver Alliance** **caregiver.org** Offers support for family and friends providing long-term, in-home care. **Eldercare Locator** **eldercare.gov** Connects older adults and their caregivers with local services and provides resource referrals and contact information for state and local agencies on aging.
Do you know where you can receive support as a caregiver?			

My Stress Thermometer

*STRESS: Feeling tense, nervous, anxious, restless, or unable to sleep because your mind is troubled all the time.**

Please mark your current stress level on the thermometer:



1 ID:_____ Date:_____

 | *Reference: Elo A-L, Leppänen A, Jahkola A. Scand J Work Environ Health 2003;29(6):444–451.

Questions	Yes	No	Resources
Have wishes or desires for end-of-life care been discussed?			**Aging with Dignity Five Wishes** **agingwithdignity.org** Provides resources for end-of-life planning. **The Conversation Project** **theconversationproject.org** Offers a guide for how to talk about the end of life.
Is a power of attorney in place for financial needs?			**Alzheimer's Association®** **alz.org/care/alzheimers-dementia-common-costs.asp** Provides information on costs to expect and tips for financial planning.
Is a power of attorney in place for health care decisions?			**National Association for Elder Law Attorneys** **naela.org** Offers a directory of elder law attorneys.
Is palliative or hospice care appropriate for the patient?			**National Hospice and Palliative Care Organization** **nhpco.org/find-hospice** Provides information about hospice and palliative care and local hospice and palliative care organizations.

Caregiving

Administration on Community Living
alzheimers.gov
Supports individuals living with Alzheimer's disease or other dementias and their caregivers by increasing access to community resources.

Aging Life Care Association
aginglifecare.org
Locate a geriatric care manager.

ALZConnected®
alzconnected.org
Online community that connects individuals facing the disease and provides online support.

Alzheimer's Association®
alz.org
800.272.3900
Provides disease education, support groups, and personalized care consultation in person, online and through a free 24/7 Helpline.

Alzheimer's Disease Education and Referral (ADEAR)
nia.nih.gov/alzheimers
800.438.4380
Offers disease information online or by phone for individuals with Alzheimer's or other dementias and their families.

Community Resource Finder
alz.org/CRF
Find local programs, resources and support services.

Family Caregiver Alliance
caregiver.org
Offers support for family and friends providing long-term, in-home care.

Eldercare Locator
eldercare.gov
Connects older adults and their caregivers with local services and provides resource referrals and contact information for state and local agencies on aging.

Safety

Aging Life Care Association
aginglifecare.org/ALCA/About_Aging_Life_Care/Find_an_Aging_Life_Care_Expert/ALCA/About_Aging_Life_Care/Search/Find_an_Expert.aspx?hkey=78a6cb03-e912-4993-9b68-df1573e9d8af

Alzheimer's Association Dementia and Driving Resource Center
alz.org/driving

Alzheimer's Association Safety Center
alz.org/safety

American Occupational Therapy Association
myaota.aota.org/driver_search

Car Safety Guides
thehartford.com/resources/mature-market-excellence/publications-on-aging

If You Live Alone
alz.org/i-have-alz/if-you-live-alone.asp

Medication Management: A Family Caregiver's Guide
nextstepincare.org/uploads/File/Guides/Medication/Medication_Management_Guide/Medication_Management.pdf

Medication Safety
alz.org/care/dementia-medication-drug-safety.asp

Medi-Cog
pharmacy.umaryland.edu/practice/medmanagement/assisted_living/Tools-to-Assess-Self-Administration-of-Medication/

Simple Solutions: Practical Ideas and Products to Enhance Independent Living
thehartford.com/resources/mature-market-excellence/publications-on-aging

***Staying Safe* brochure**
alz.org/national/documents/brochure_stayingsafe.pdf

Steadi Materials for Health Care Providers
cdc.gov/steadi/materials.html

Wandering and Getting Lost
alz.org/care/alzheimers-dementia-wandering.asp

End-of-Life

Aging with Dignity Five Wishes
agingwithdignity.org
Resources for end-of-life planning.

Alzheimer's Association
alz.org/care/alzheimers-dementia-common-costs.asp
Provides information on costs to expect and tips for financial planning.

The Conversation Project
theconversationproject.org
Offers a guide for how to talk about the end of life.

National Association for Elder Law Attorneys
naela.org
Offers a directory of elder law attorneys.

National Hospice and Palliative Care Organization
nhpco.org/find-hospice
Provides information about hospice and palliative care and local hospice and palliative care organizations.