PHYSICIANS' BULLETIN

NOVA SCOTIA MEDICAL SERVICES INSURANCE

April 1, 2011 Volume XLVI - #2

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MEDICAL SERVICE UNIT / ANAESTHESIA UNIT

Effective April 1, 2011, the Medical Service Unit (MSU) value will be increased from $2.28 to $2.30 and the Anaesthesia Unit (AU) value will be increased from $16.31 to $16.47.

WORKERS'S COMPENSATION BOARD MEDICAL SERVICE UNIT / ANAESTHETIC

Effective April 1, 2011 the Workers' Compensation Board MSU Value will increase from $2.53 to $2.56 and the Workers' Compensation Board anaesthetic unit value will increase from $18.12 to $18.30.

PSYCHIATRY FEES

Effective April 1, 2011 the hourly Psychiatry rate for General Practitioners will increase to $105.21 while the hourly rate for Specialists increases to $142.66 as per the tariff agreement.

NEW FEES

Effective January 01, 2011 the following new Health Service Codes are available for billing:

Category	Code	Modifiers	Description	Unit Value	
MASG	49.71E		**Insertion of CRT Pacemaker/Defibrillator Device – composite fee** Development of device pocket, insertion of device and battery pack, insertion of RA, RV and LV leads as required. The fee includes all procedures required to place the LV lead – coronary sinus cannulation, coronary sinus angiogram, fluoroscopy and EP mapping. Interrogation of device and threshold testing. Not billable with electrophysiology studies or cardio version same patient same day. Not billable with ICD insertion team fee.	360	9+T

Category	Code	Modifiers	Description	Unit Value	
MASG	49.71F	RO=FPHN RO=SPHN	**Insertion of CRT Pacemaker/Defibrillator Device – team fee** RO=FPHN Development of device pocket, insertion of device and battery pack, insertion of RA, RV leads as required. RO=SPHN May only be billed in conjunction with CRT device insertion RO=FPHN and not as a stand alone procedure. This fee includes all procedures required to place the LV lead – coronary sinus cannulation, coronary sinus angiogram, fluoroscopy and EP mapping. Interrogation of device and threshold testing. Not billable with electrophysiology studies or cardio version same patient same day.	200 160	9+T
ADON	49.71G		**Defibrillator Testing** Testing of implantable cardiac defibrillator device at the time of insertion as required. Not billable with electrophysiology studies or cardio version same patient same day.	60	9+T
VADT	03.45A		**Remote Follow Up ICD Device** The routine or emergency interrogation of an implantable cardiac defibrillator for the purpose of checking the device function or retrieving information regarding recent ICD therapy or device alerts. Routine interrogation may be billed yearly. May also be billed for unscheduled monitoring for device alerts or after ICD therapy delivery – the reasons for interrogation must be documented in patient's medical record.		15

Physicians holding eligible services must submit their claims from January 1st onward within 90 days of the date for this bulletin. Please include text referring to this bulletin for any service over the 90 day time frame.

Upcoming Fees:

The following venous angioplasty and arterial angioplasty fees have been approved by the Master Agreement Steering Committee (MASG) for inclusion into the fee schedule effective **January 1, 2011.**

Category	Description	Unit Value	
VADT	Venous angioplasty - Axillary vein angioplasty	137.7	8+T
VADT	Venous angioplasty - Dural sinus	183.6	10+T
VADT	Venous angioplasty - femoral	137.7	8+T
VADT	Venous angioplasty - iliac	137.7	10+T
VADT	Venous angioplasty - Popliteal vein angioplasty	137.7	8+T
VADT	Venous angioplasty - Basilic or cephalic vein angioplasty	137.7	8+T
VADT	Venous angioplasty - Brachiocephalic vein angioplasty	137.7	10+T
VADT	Venous angioplasty - Inferior Vena Cava (IVC) angioplasty	137.7	10+T
VADT	Venous angioplasty - Radial or ulnar vein angioplasty	137.7	8+T
VADT	Venous angioplasty - Subclavian vein angioplasty	137.7	10+T
VADT	Venous angioplasty - Superior Vena Cava angioplasty	137.7	10+T
VADT	Venous angioplasty - Visceral vein angioplasty (renal, superior mesenteric, splenic, hepatic, portal)	183.6	10+T
VADT	Percutaneous aorta - infra renal angioplasty	137.7	15+T
VADT	Percutaneous aorta - supra renal angioplasty	200	15+T
VADT	Percutaneous Great vessel (innominate/braciocephalic, left common carotid or left Subclavian artery) angioplasty	183.6	15+T
VADT	Percutaneous Radial or ulnar artery angioplasty	183.6	8+T
VADT	Percutaneous Visceral Arterial angioplasty (celiac, SMA, IMA, splenic, hepatic)	183.6	8+T
VADT	Percutaneous Anterior Tibial, Posterior Tibial or Peroneal Artery Angioplasty	183.6	8+T
VADT	Percutaneous Popliteal Artery Angioplasty	137.7	8+T
ADON (Interim Fee)	Non-cardiac, endovascular stent placement	50	8+T
ADON	Thrombolysis following non cardiac angiography	150	

****Note:** Please hold all eligible service encounters to allow MSI the required time to update the system. Once a new health service code has been assigned it will be published in the MSI Physicians Bulletin.

VASCULAR SURGERY PROCEDURAL CODES

There are a number of instances in which incorrect vascular procedural codes are being submitted to MSI. Physicians billing these codes are reminded of the following:

A procedural code is intended to reimburse physicians for all components of the procedure. It is not permitted to unbundle procedural codes and bill MSI separately for them. For example:

Billing angiograms is not acceptable at the time of a definitive therapeutic vascular procedure. It is expected that diagnostic angiography would have been done prior to the therapeutic procedure. Contrast injections or fluoroscopy required at the time of the therapeutic procedure are included in the procedural fee.

Similarly, billing arteriotomy and/or arterioplasty codes in addition to angioplasty, peripheral vascular stenting procedures or aortic/iliac artery repairs is also not permitted as these are integral parts of the procedure.

REGARDING MINIMALLY INVASIVE VASCULAR PROCEDURES:

If a minimally invasive procedure is performed and there is no specific minimally invasive code in the MSI Physician's Manual the closest open code may be used until such time as until a new fee request is made to the Fee Schedule Advisory Committee. However, if a minimally invasive code does exist, this code should be used. The surgeon cannot choose to bill the open code when in fact he or she performed the minimally invasive procedure.

ENDOVASCULAR ABDOMINAL ANEURYSM REPAIR

The open abdominal aneurysm code may be used until such time as a fee code for endovascular repair has been established. However, it is not permitted to bill an additional code on occasions when the stent descends into the iliac vessels. An alternative would be to use the open aortic bifurcation graft. Angioplasty codes are not appropriate as an aneurysm look-alike and cardiac stent codes should not be added to open aneurysm or bifurcation graft codes.

OPTHALMOLOGY – UPDATED REQUIREMENT

Please be advised that any claims for Health service code 28.73C – intraocular or intravitreal injection of air – now require text indicating the injected substance. Physicians are advised to use HSC 28.73D – intravitreal injection of antibiotics – when injecting a medication such as Lucentis or Avastin. This is an interim fee to be used while a new fee is being considered by the Fee Schedule Advisory Committee.

LONG-TERM CARE CLINICAL GERIATRIC ASSESSMENT (CGA)

Additional new incentive funding is available through the Physicians Master Agreement in 2010/11 to support new programs and/or incentives for family physicians participation in Continuing Care.

Effective January 1, 2011 the following new fee code (billable by general practitioners only) has been approved by the MASG for inclusion in the fee schedule:

Category	Code	Description	MSU
DEFT	CGA1	Long-Term Care Clinical Geriatric Assessment	26.32

Description:

Long-Term Care Clinical Geriatric Assessment (CGA) is an evidence-based clinical process that allows for interdisciplinary input to best assess the complexity of the nursing home resident. The CGA process and form, once completed, gives a point in time assessment of medical, functional and psychosocial needs of the resident which serves as a benchmark to treat to when the clinical condition changes. The physician is directly responsible for completing the medication list, diagnostic categories, cognition, emotional, behaviours and provides the final overall opinion of the frailty level of the resident once the other disciplines have completed their assessments. The frailty level has been determined to be a predictor of the clinical trajectory of the resident, which is helpful in determining what course of care is reasonable, and a reference to use when discussing a resident's care plan with the resident, families and/or staff. The physician has the option to fill out the other fields on the CGA form as well. However the CGA process is best served when all disciplines involved with the resident complete their sections so as to provide accuracy and encourage dialogue among the clinical team.
The other providers who may provide input for the CGA include: nursing, social work, physiotherapy, occupational therapy, pharmacy and/or other health care disciplines consistent with their scope of practice.

The CGA form should be near the front of every nursing home chart and will serve as the lead clinical document that will travel with the resident when a transfer (ER, other facility etc) occurs. In this way accurate clinical information is provided to other caregivers the resident may need to be treated by. This will help ensure accurate communication of the resident's care directives, and all relevant baseline clinical information so any care outside the facility or by any on-call physician can be provided with this vital clinical information that will enhance the quality of the care given.

Billing Guidelines:

- Effective January 1, 2011, family physicians will be remunerated for the completion of the Long-Term Care Clinical Geriatric assessment (CGA) for residents of licensed Nursing Homes and Residential Care Facilities (RCF'S) funded by the Department of Health only.

- The CGA may be billed twice per fiscal year (April 1 – March 31) per resident. The initial CGA is recommended to be completed as soon as possible following Nursing Home or RCF admission, once the physician and clinical team have had time to become familiar with the resident/patient.

- The CGA is normally completed through a collaborative team process involving the family physician and other licensed long-term care healthcare providers. The physician claiming the CGA fee is responsible for the diagnostic section (Cognitive Status, Emotional and Behaviours), the medication section, and providing the final overall opinion of the frailty level of the resident once the other disciplines have completed their assessment. Other sections of the CGA may be completed by the physician or by other licensed healthcare providers.

- The CGA requires one direct service encounter with the resident by the physician on the date of the final completion and signing of the CGA form. This service encounter is included in the CGA fee. The CGA evaluation process may involve additional service encounters (visits) which would be paid separately from the CGA per the Preamble requirements. The dates of all physician service encounters associated with the completion of the CGA must be recorded on the CGA form.

- Prior to claiming the CGA fee, the physician must review, complete and sign the CGA form in the long-term care facility on the date of the final CGA service encounter and place a note in the resident's clinical record (progress notes) corroborating that the CGA has been completed.

- The date of the service is the date when the final CGA service encounter occurs and the CGA form is completed and signed by the physician.

- The CGA fee is billable by eligible fee-for service physicians and by eligible APP contract physicians, based on shadow billings.

It is recommended that the CGA form is attached to any applicable transfer forms, including inter facility transfers whenever possible.

The CGA form is attached to this Bulletin and also on the Doctors Nova Scotia member's website.

Eligible APP Physicians will be required to shadow bill the new fee code in order to receive payment. Eligible claims will be reviewed and paid twice per year in the form of a cheque from MSI. Estimated payment dates for this new fee are June and December of each year, with the first payments beginning in June, 2011.

Physicians holding eligible service encounters can now submit their claims from January 1st onward. Claims must be submitted within 90 days of the date for this bulletin. Please include text referring to this bulletin for any service over the 90 day time frame.

PREMIUM FEES – Reminder

Premium fees may be claimed for certain services provided on an emergency basis during designated time periods. An emergency basis is defined as services, which must be performed without delay because of the medical condition of the patient.

Premium Fees May Be Claimed For:

(a) Consultations, except where a consult is part of the composite fee
(b) Surgical procedures except those performed under local or no anaesthetic
(c) Fractures regardless of whether an anaesthetic is administered
(d) Obstetrical deliveries
(e) Newborn Resuscitation
(f) Selected Diagnostic Imaging Services
(g) Pathology Services

The designated times where premium fees may be claimed and the payment rates are:

Time Period Time Payment Rate
Monday to Friday 17:00 - 23:59 US=PREM (35%)
Tuesday to Saturday 00:00 - 07:59 US=PR50 (50%)
Saturday 08:00 - 16:59 US=PREM (35%)
Saturday to Monday 17:00 - 07:59 US=PR50 (50%)
Recognized Holidays 08:00 - 23:59 US=PR50 (50%)

Premium fees also apply to emergency anaesthesia for a surgical procedure (not a diagnostic or therapeutic) provided by a non-certified anaesthetist at the interruption of his or her regularly scheduled office hours.

Premium fees are paid at 35% or 50% of the appropriate service code but at not less than 18 units for patient-specific services and at not less than 9 units for non-patient-specific diagnostic imaging and pathology services paid through the hospital by special arrangement with MSI.

If a service requires use of an anaesthetic, the anaesthetic start time determines if a premium fee may be claimed.

Premium fees may not be claimed with:

(a) Detention
(b) Critical Care/Intensive Care
(c) Diagnostic and Therapeutic Procedures other than Selected Diagnostic Imaging Services
(d) Surgeons and assistants fees for liver transplants

Physicians are reminded that the above criteria must be satisfied in order for a premium to be billed. It is not appropriate to bill a premium for all services claimed during premium times, for elective procedures or when the physician does not attend the patient without delay.

It is incumbent upon the physician to ensure that the clinical record reflects that the requirements for billing a premium have been satisfied.

PRESCRIPTION RENEWALS and PROVISION OF REQUISITIONS

Physicians are reminded that if a prescription renewal or requisition for a diagnostic or therapeutic service is provided to a patient without an evaluation of the patient then a visit may not be claimed.

VISITS CONDUCTED BY NON-PHYSICIAN HEALTH CARE PROFESSIONALS

In order to meet the requirements of a visit, the physician must personally participate in the visit.

HSC 65.49B – STRANGULATED/INCARCERATED HERNIA WITH RESECTION

Surgeons are advised that this code is only to be billed when a segment of bowel has been resected.

HPF WEB

Physicians whose clinical records are stored on the HPF Web are reminded of the importance of filing patient records on the day the service was provided to the patient and billed to MSI. If the physician's clinical note is filed on a date other than the day the service was provided and billed to MSI the discrepancy may result in an unfavourable audit result. Physicians should ensure that they have completed their clinical note before the record is filed to the HPF Web. MSI staff is not able to access HPF and records obtained from HPF for audit purposes are provided to MSI staff by health records personnel.

EXPLANATORY CODES

The following new explanatory codes have been added to the system:

DE013	Service encounter has been refused as two Long-Term Care Clinical Geriatric Assessments have previously been paid this year.
MJ027	Service encounter has been disallowed as the injected substance has not been indicated.
MJ028	Service encounter has been refused as a claim for the ICD insertion team fee has already been made for this patient.
MJ029	Service encounter has been refused as a claim for the ICD insertion composite fee has already been made for this patient.
NR083	Service encounter has been refused as a substance other than air was injected.
VA035	Service encounter has been refused as you cannot claim electrophysiology studies on the same day as the insertion of CRT pacemaker/defibrillator device.
VT091	Service encounter has been disallowed as this service is included in the CGA1 service that has previously been approved.

UPDATED FILES – AVAILABILITY

Updated files reflecting changes are available for download on Friday, April 1st, 2011. The files to download are health service (SERVICES.DAT), health service description (SERV DSC.DAT), and explanation code (EXPLAIN.DAT).

2010/11 GENERAL PRACTITIONER COLLABORATIVE PRACTICE INCENTIVE PROGRAM

Effective April 1, 2010, funding is provided through the Master Agreement for a new General Practitioner Collaborative Practice Incentive Program (CPIP). The CPIP guidelines for fiscal year 2010/11 have been approved and the program implemented. It is anticipated that this program will be reviewed and evolve in future years.

CPIP incentive payments are intended to support family physicians who are currently participating in collaborative practice models that meet the CPIP program criteria, as well as to encourage other physicians to move towards new models of collaborative care. For the purpose of the CPIP, Collaborative Practice is defined as an inter-professional process of communication and decision making that enables the separate and shared knowledge and skills of different healthcare providers to synergistically influence the client/patient care provided. It occurs when healthcare providers work with people from within their own profession, with people outside of their profession and with patients/clients and their families.

The 2010/11 Collaborative Practice Incentive Program has two funding components:

- Part One: Collaborative Practice Incentive Component
- Part Two: One-Time Education Funding to Off-Set Income Loss Component

CPIP Part One: Collaborative Practice Incentive Component

A payment of $5,000 is available to fee-for-service, APP contract and AFP physicians who meet all of the 2010/11 Collaborative Practice Incentive Component program criteria and submit an application for funding.

2010/11 Eligibility Criteria

1. The physician must have minimum total insured billings/payments of $100,000, including $50,000 of office billings, in the period from February 1, 2010 to January 31, 2011.

2. The physician must participate as a member of a Collaborative Practice consisting of a minimum of three CPIP-eligible general practitioners (GPs) and one full-time equivalent (FTE) “other licensed health care provider”.

3. The physician must have participated in a qualifying Collaborative Practice for a minimum of 6 months between February 1, 2010 and January 31, 2011.

4. “Other licensed healthcare providers” for the CPIP (i.e. other than general practitioners) includes all legislated licensed healthcare providers except specialist physicians.

   Legislated Licensed Healthcare Providers
   Licensed Practical Nurses
   Chiropractor
   Dentists
   Dental Assistant
   Dental Technicians
   Denturists
   Dental Hygienists
   Dietician/Nutritionists
   Physicians
   Occupational Therapists
   Optometrists
   Dispensing Opticians

Pharmacists
Psychologists
Physiotherapists
Registered Nurses (including Nurse Practitioners)
Medical Laboratory Technologists
Medical Radiation Technologists
Midwives
Respiratory Therapists
Paramedics
Social Workers (Department of Community Services Legislation)

5. A 1.0 FTE "other licensed health care provider" works a minimum of 37.5 hours per week and could be filled by 1-3 people in an effort to encourage flexible collaboration and respond to patient needs.

6. The required ratio of eligible general practitioners (GPs) to "other licensed healthcare providers" is (minimum of three GPs required):

Number of Eligible GPs	Required Number of "Other Licensed Healthcare Providers" (FTEs)
3-5 GPs	1
6-10 GPs	2
11-15 GPs	3
16-20 GPs	4

7. Collaborative practice team collaboration must occur at least once per week.

8. Family physicians must engage in **meaningful collaboration** with each other as well as the "other licensed healthcare providers" in the Collaborative Practice. Meaningful collaboration is defined as follows (**all characteristics must be present**):

Characteristic	Accountability Measure
Team members provide care to a common group of patients	➢ Common patient population
Members develop common goals for patient outcomes and work towards those goals	➢ Chart verification of interaction among team members in patient care as appropriate
Appropriate roles and functions are assigned to each member of the team	➢ Job descriptions established and available for each member of the team
The team possesses a mechanism for sharing information about the patient	➢ Common patient record and/or shared EMR
The team possesses a mechanism to oversee the carrying out of plans and to make adjustments as necessary	➢ Set time for formal collaboration (i.e. case conferences, team meetings)

<u>Application Process and Funding</u>

In order to receive a 2010/11 Collaborative Practice Incentive Component payment, eligible physicians are required to complete and submit an application for the funding. **The application, along with more information about the application process and timelines, is being sent out to family physicians through Doctors Nova Scotia on April 4, 2011 by email, if the physician has indicated to Doctors Nova Scotia this is his/her preferred method of communication, or by mail.**

All applications received will be subject to a verification process, facilitated by the Manager of the Physician Master Agreement and in consultation with the District Health Authorities, to ensure all eligibility criteria have been met.

It is expected that the Collaborative Practice Incentive Component payments, in the form of a cheque, will be mailed to qualifying physicians by MSI in June, 2011.

CPIP Part Two: One-Time Education Funding to Off-Set Income Loss Component

Building a Better Tomorrow Together (BBTT) is a series of facilitated continuing education modules for health care professionals and their support staff that enable articipants/teams to acquire new knowledge and develop skills in inter-professional collaboration. A certificate of completion/attendance is awarded at the completion of each three-hour module. The BBTT program is currently being implemented by every District Health Authority (DHA) across Nova Scotia. Family physicians interested in learning about and/or participating in a collaborative practice are encouraged to attend the education sessions offered and complete the BBTT modules. Information about the BBTT modules is attached to this Bulletin as Appendix A.

Through the CPIP, fee-for-service physicians who attend the BBTT education sessions can receive a flat rate payment of $1,000 for each module completed as an off-set for any income loss they may have incurred as a result of the time required to attend the session. The DHAs will track the names of physicians who attend sessions and send this list to the Manager, Physician Master Agreement for processing and payment. Payments will be made on a quarterly basis to all eligible physicians, based on the number of modules completed.

APP and AFP contract physicians are not eligible for these payments.

All family physicians (fee-for-service, APP and AFP), who do not meet the eligibility criteria for the Collaborative Practice Incentive Component payments, are welcome to participate in the BBTT education modules. However, only fee-for-service physicians will be eligible to receive the income loss off-set funding for each completed module.

More information about the Building a Better Tomorrow Together education program is available through the following DHA BBTT contacts:

DHA	Lead	Telephone	Email
South Shore Health- 1	Lisa Joudrey	527-5214	ljoudrey@ssdha.nshealth.ca
South West Nova – 2	Rosanne d'Eon	742-3542 Ext. 683	rdeon@swndha.nshealth.ca
AVDHA - 3	Geoff Piers	365-1705	gpiers@avdha.nshealth.ca
CEHHA – 4	Carolyn Irving	893-5554 Ext. 2581	Carolyn.Irving@cehha.nshealth.ca
CHA – 5	Sharon Griffin	667-5400 Ext. 6493	Sharon.Griffin@cha.nshealth.ca
PCHA - 6	Kim Byrne	752-7600 Ext 4848	Kimberly.byrne@pcha.nshealth.ca
GASHA - 7	Karen MacKinnon	625-1746	Karen.Mackinnon@gasha.nshealth.ca
	Debbie Cotton	867-4500 Ext. 4106	Debbie.Cotton@gasha.nshealth.ca
CBDHA - 8	Kelly MacIsaac	842-0201	macisaack@cbdha.nshealth.ca
CDHA - 9	Kim Peterson	454-8934	Kim.peterson@cdha.nshealth.ca
IWK	Jackie Spiers	470-3930	Jackie.spiers@iwk.nshealth.ca

APPENDIX A

Building a Better Tomorrow Together (BBTT) Education Modules

Building a Better Tomorrow Together (BBTT) is a series of facilitated continuing education modules for health care professionals and their support staff that enable participants/teams to acquire new knowledge and develop skills in interprofessional collaboration. A certificate of completion/attendance will be awarded at the completion of each three-hour module.

Enhancing Collaboration	Interpersonal and Communication Skills	Team Functioning	Roles and Responsibilities	Decision Making and Leadership	Conflict Resolution
• Assessing knowledge/skills in interprofessional collaboration • Characteristics of effective collaborative practice teams • Assessing current collaborative efforts	• Understanding/ respecting different communication styles • Applying communication techniques • Active listening • Communication enhancers/ blockers	• Building an effective team: vision, mission, operating guidelines • Enablers and barriers to team functioning • Conducting interprofessional team meetings • Assessing meetings effectiveness	• Confidence in/knowledge of ones own role • Confidence in/knowledge of others' roles to optimize patient care • Clarifying scopes of practice • Labelling and professional stereotyping • Interprofessionality in teams	• Decision making strategies • Problem solving methodology • Testing for consensus • Leadership roles within teams • The sources and challenges of power in teams	• The nature of the conflict • Recognizing/ managing triggers • Distinguishing constructive and destructive conflict • Understanding/ respecting different conflict resolution styles • Interest based conflict resolution strategies

Understanding Primary Health Care	Generations and Learning Styles at Work	Program Planning and Evaluation	Building Community Partnerships
• History and language of primary health care • The Nova Scotia context • Population health and the social determinants of health • Health promotion	• Assessing learning styles • Appreciating generational differences • Disclosing and providing feedback • Exploring self-awareness	• Program planning (steps 1-3) • Program planning (steps 4-6) • Program evaluation	• The three levels of partnerships • Exploring partnerships based on the social determinants of health • Assessing partnership effectiveness

Long-Term Care
Clinical Geriatric Assessment (CGA)

PATIENT ID

WNL: Within Normal Limits ASST: Assisted
IND: Independent DEP: Dependent

Chief lifelong occupation: _____ Education: (yrs) _____

Cr Cl/eGFR: _____

Infection Control
MRSA _____ Pos _____ Neg
VRE _____ Pos _____ Neg
Flu shot given (d/m/y) _____
Pneumococcal vaccine given (d/m/y) _____
TB test done (d/m/y) _____
Tetanus (d/m/y) _____

Cognitive Status	**Emotional**		**Behaviours**
❒ WNL	❒ WNL	❒ ⇩Mood	❒ Verbal Non-aggressive
❒ Dementia	❒ Depression	❒ Anxiety	❒ Verbal Aggressive
❒ Delirium	❒ Other		❒ Physical Non-aggressive
MMSE _____	❒ Hallucinations/Delusions		❒ Physical Aggressive
Date (d/m/y): _____			

Communication:

Speech	**Hearing**	**Vision**
❒ WNL	❒ WNL	❒ WNL
❒ Impaired	❒ Impaired	❒ Impaired

Foot-care needed ❒ Yes ❒ No
Dental care needed ❒ Yes ❒ No
Skin Integrity Issues ❒ Yes ❒ No

Strength
❒ WNL ❒ Weak
Upper: Proximal Distal R L
Lower: Proximal Distal R L

Mobility	Transfers	❒ IND	❒ ASST	❒ DEP
	Walking	❒ IND Slow	❒ ASST	❒ DEP
	Aid	_____		
Balance	Balance	❒ WNL	❒ Impaired	
	Falls	❒ No ❒ Yes	Frequency	
Elimination	Bowel	❒ Constip	❒ Cont	❒ Incont
	Bladder	❒ Catheter	❒ Cont	❒ Incont
Nutrition	Weight	❒ STABLE	❒ LOSS	❒ GAIN
	Appetite	❒ WNL	❒ FAIR	❒ POOR
ADLs	Feeding	❒ IND	❒ ASST	❒ DEP
	Bathing	❒ IND	❒ ASST	❒ DEP
	Dressing	❒ IND	❒ ASST	❒ DEP
	Toileting	❒ IND	❒ ASST	❒ DEP

Personal Directives ❒ Yes ❒ No
Substitute Decision Maker:
_____
Tel #: _____

Code Status:
❒ Do Not Attempt to Resuscitate
❒ Do Not Hospitalize
❒ Hospitalize
❒ Attempt to Resuscitate

Marital Status	**Family Stress**
❒ Married	❒ None
❒ Divorced	❒ Low
❒ Widowed	❒ Moderate
❒ Single	❒ High

Problems/Past History/Diagnosis	**Medication Adjustment Required**	**Associated Medication**
1.	❒	
2.	❒	
3.	❒	
4.	❒	
5.	❒	
6.	❒	
7.	❒	
8.	❒	
9.	❒	
10.	❒	
11.	❒	
12.	❒	

Current Frailty Score
Scale ❒ 5. Mildly Frail ❒ 6. Moderately Frail ❒ 7. Severely Frail ❒ 8. Very Severely ill ❒ 9. Terminally Ill

Note: Shaded areas to be completed by physician.

Clinical Frailty Scale*

5. Mildly Frail – These people often have **more evident slowing**, and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6. Moderately Frail – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and **need help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7. Severely Frail – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8. Very Severely Frail – Completely dependent, approaching the end of life. Typically, they could not recover from even a minor illness.

9. Terminally Ill – Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frail**.

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging, Revised 2008
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005; 173; 489-495

CGA Associated Visits	
Date	**Comments**

Physician Name (please print): _____ Physician Signature: _____

Signed on (d/m/y): _____ (Visit required on this date)