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The Business of Providing Dementia Care in Primary Care

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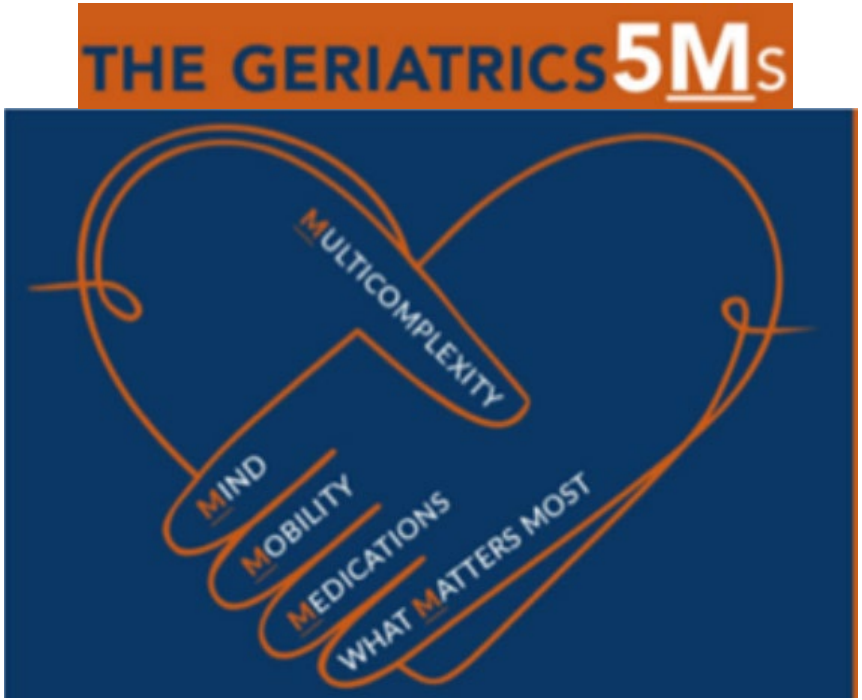
I have no financial disclosures

Diagnosing and treating Dementia in Primary Care

- Diagnosis and Therapeutics
- Alzheimer's disease and Dementia Research
- Cognitive Screening in Primary Care
- ABCs of Biomarker Tests for Primary Care
- Available Treatments in Primary Care
- Caregiver Support
- Integrating this into my primary care practice?

Clinical Workflow

The Practice of Geriatric Medicine



Integrating Dementia Care

The Clinical Team and Partners in Care

- Core Team: Physician, Nurses (including case management), Social worker*, Physician extenders
- Extended Team members: Pharmacist, Neurologist, Geriatric Psychiatrist, Neuropsychologist, Physical/Occupational Therapists, Nutritionist

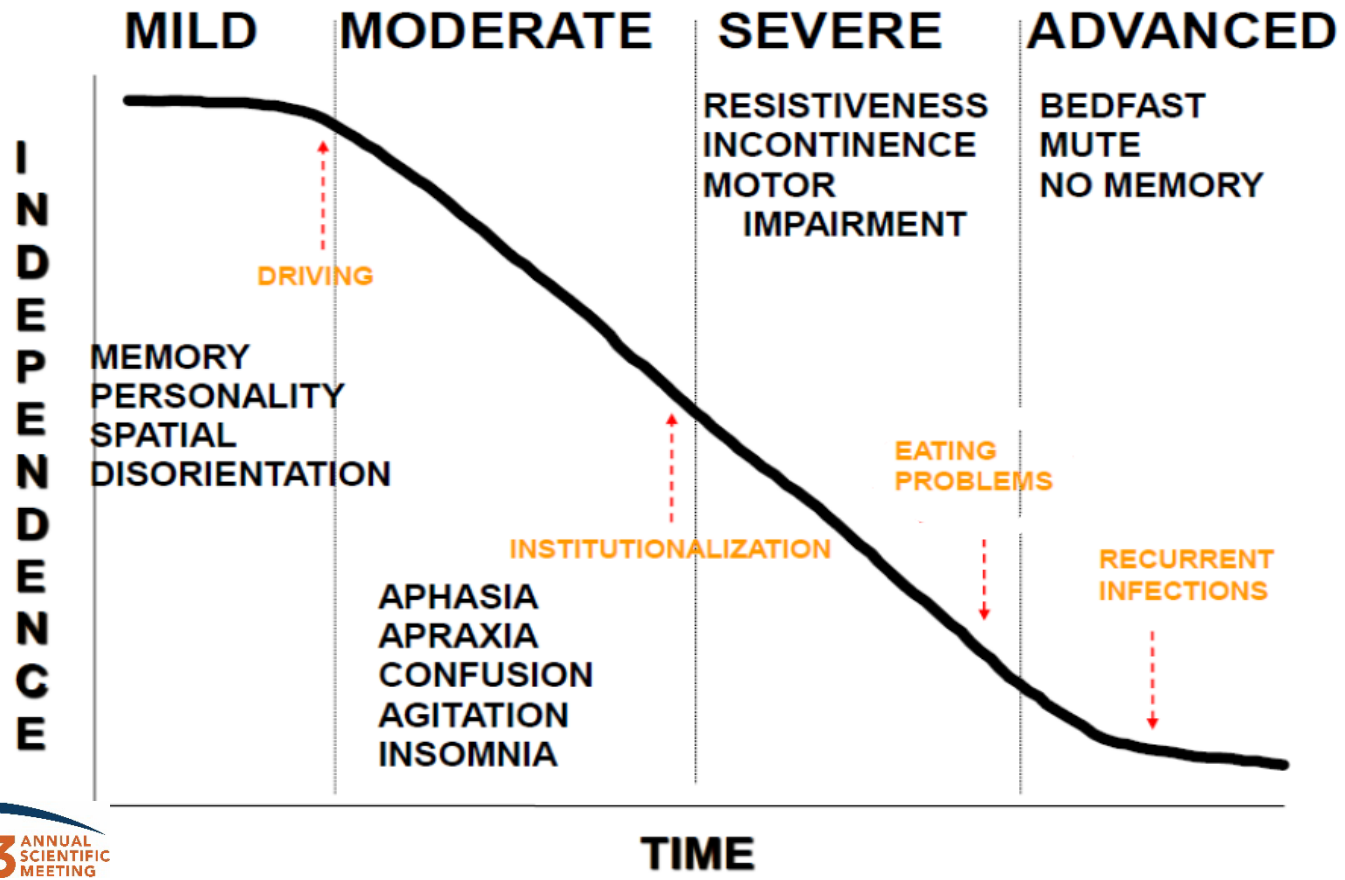
Community Resources

- Community: neighbors & friends, aging & mental health networks, adult day care, respite care, home-health agency
- Organizations: Alzheimer's Association, Area Agencies on Aging, Councils on Aging
- Services: Meals-on-Wheels, senior centers
- Attorney for will, conservatorship, estate planning

Care Team Optimization

- History and Functional report
- Mood assessment PHQ-9, GDS, GAD-7
- Neuroimaging
- Cognitive testing MOCA, SLUMS, MMSE, etc
- Caregiver stress assessment

Dementia care is an ongoing conversation



Quality Improvement in Dementia care

Advanced Care Planning in Dementia Care

- GAP: Provider comfort / time in discussing decline → lack of knowledge of the course of dementia (prognostication) in families
- Risk: inability to capture patient preferences AND identify surrogate decision maker
- Highlights importance of disclosing diagnosis AND conversation AT diagnosis
- Shared decision making in dementia
- Advance directive, Orders for Life Sustaining Treatments

Screening for BPSD and Antipsychotic use

- Signs and symptoms of disturbed perception, thought content, mood, or behavior
- GAP: antipsychotic use is often continued chronically
- Risk: Harm to patient. Black Box Warning since 2005, Increased risk of death: OR 1.6x-1.7x
- Very modest efficacy (but statistically significant)
- QI: Deprescribing, Goal: ↓ medication burden , ↔↑ quality of life
- Deprescribing Guidelines

Follow up Visit re: Dementia

- GAP: time being factor in balancing assessing patient vs hearing caregiver
- RISK: not identifying caregiver stress and burnout → depression, exacerbation of underlying chronic conditions + increased risk of decline with patient
- QI: Concurrent conversations (Role optimization) , Goal: ↑ patient (and caregiver) quality of life
- Dementia Care Models

Dementia Care Models

Dementia Care Core Elements

Comparison of Six Dementia Care Models

Structure and Process	Benjamin Rose Institute Care Consultation	Care Ecosystem	Maximizing Independence at Home	Eskenazi Healthy Aging Brain Center	UCLA Alzheimer's and Dementia Care	Integrated Memory Care Clinic
Key personnel	Non-licensed, SW, RN, MFT	Non-licensed care navigator, CNS, SW, Pharmacist	Non-licensed staff, RN, MD	Non-licensed staff, MD, SW, RN, Psychologist	NP, PA, SW, non-licensed staff, MD	NP, SW, RN
Key personnel base	CBO or health system	Health system or community	Community or managed care organization	Health system	Health system	Health system
Face-to-face visits	No	No	Yes	Yes	Yes	Yes
Access 24/7/365	Optional	No	No	Yes	Yes	Yes
Communication w/ primary care physician	Mail, fax, phone	Fax, phone	Phone, mail, fax	EHR, phone, mail	EHR, phone	N/A
Order writing	No	No	No	Yes	Yes	Yes
Medication management	No	Yes	No	Yes	Yes	Yes
Benefits						
High quality of care	N/A	N/A	N/A	Yes	Yes	Yes
Patient benefit	Yes	Yes	Yes	Yes	Yes	Yes
Caregiver benefit	Yes	Yes	Yes	Yes	Yes	Yes
Cost of the program	+++	++	+++	+++	++++	++++
Cost savings, gross	++	++	+++ (Medicaid)	++	++++	++++

Balancing act in Dementia Care Models

Patient Outcomes	Caregiver Outcomes
Patient behaviors (NPI- Q Severity)	Caregiver strain (MCSI) / (NPI-Q Distress)
ED use/ Hospitalization / Rehab use	Caregiver depression (PHQ-9)
Institutionalization	Caregiver satisfaction with dementia care
Cognition / Functional status	Quality of life
Mortality	
Quality of life	

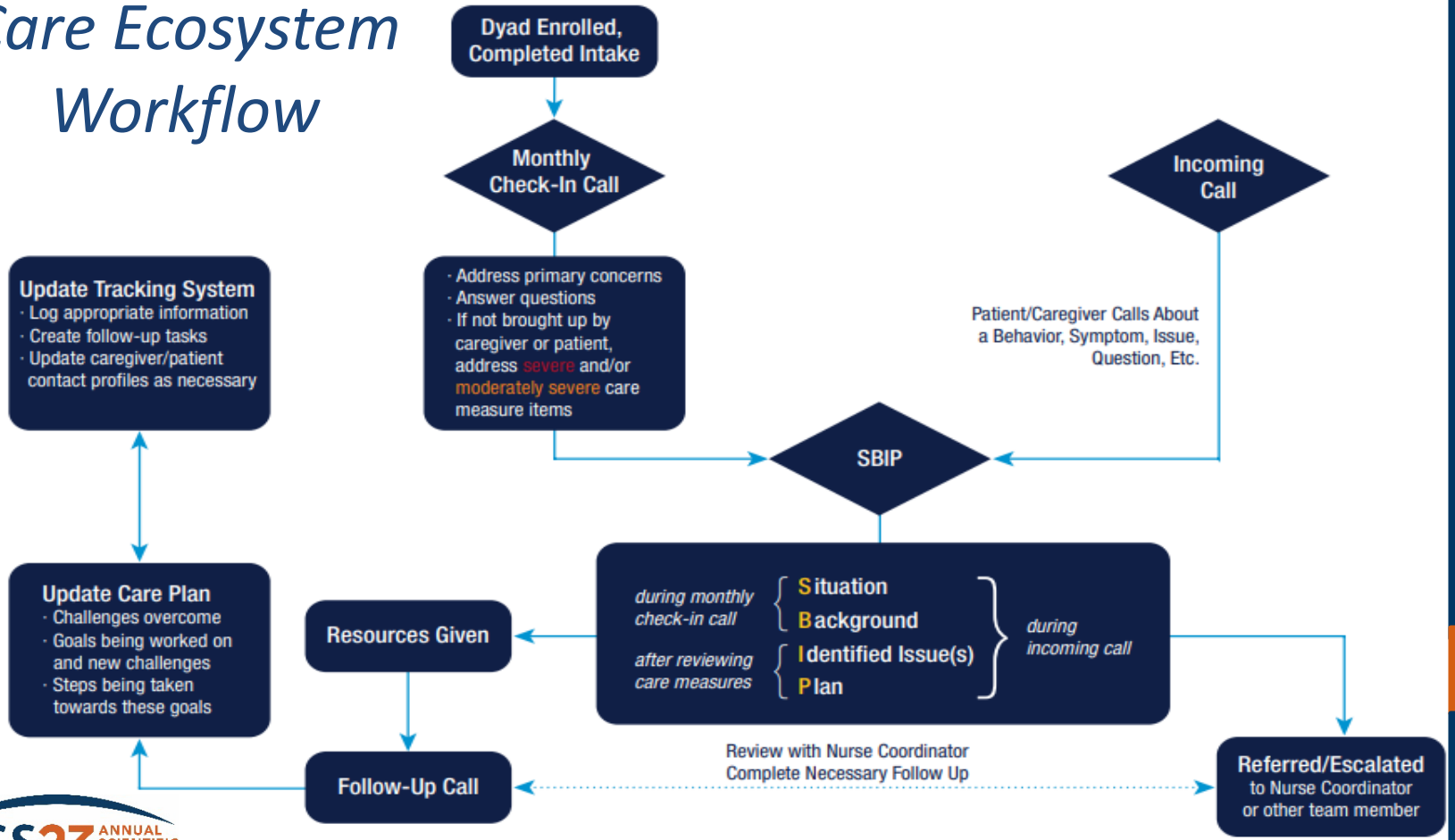
Goal of Dementia care: ↓ costs, ↑ care and outcomes (patient and caregiver)

Care Ecosystem

The Care model includes:

- *nonlicensed* Care team navigators (CTNs)
- Clinicians with dementia expertise (nurse, pharmacist, social worker)
- Care protocols
- outcomes: QOL, ED utilization, caregiver burnout

Care Ecosystem Workflow



The UCLA Alzheimer's and Dementia Care (ADC) Program

The Care model includes:

- NP Dementia Care Managers (DCMs)
- DCMs partnering with PCPs
- Community based organizations
- Involvement with Transitions of Care
- Care protocols

ADC Alzheimer's and Dementia Care PROGRAM

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The Benjamin Rose Institute (BRI) Care Consultation model

The Care model consists of:
Telephone / email based

Trained care consultants (college educated)

Licensed Model vs WeCare

Outcomes: patient and caregiver depression, caregiver stress, isolation

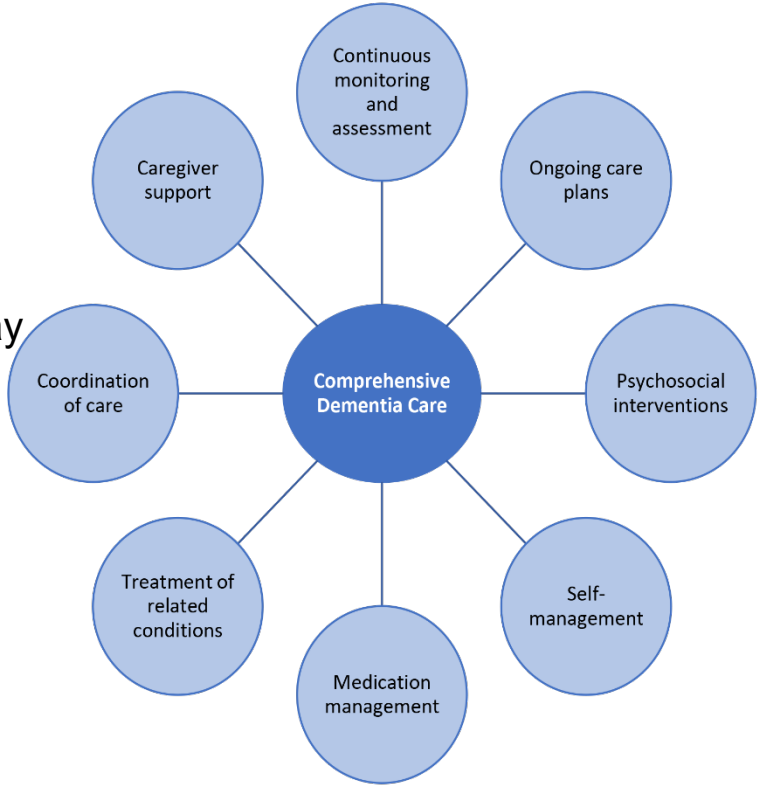
Billing / Coding in Dementia Care

Fractured Dementia Care

Faults of current payment models

- Caregiver needs and other components aren't covered
- Reimbursement doesn't adequately reflect time and resource use
- Newer billing codes are underused and may not align with roles and workflow
- Feasibility of implementing in primary care
- Health care disparities and social determinants of health
- High rates of provider turnover

Goal of healthcare: ↓ costs, ↑ care and outcomes



Initial Evaluation

Type of visit	Length of Visit	Codes
Annual Wellness visit Brief questions to assess whether there is a cognitive complaint	Not specified	Initial G0438 Annual G0439 Can be billed with problem-focused E/M visit, same-day, separate note (99211- 99215 depending on length of visit or complexity of MDM)
Routine Visit w/ unanticipated cognitive complaint Cognitive complaints (or health provider concerns) during visit for other purposes	30 min beyond regular visit	Add-on Code: 99354 Must be billed with another E/M code (can't be used with AWV)
Specific visit to further evaluate significance of cognitive complaint	25 min visit	99214 (or bill for time)

Investigation and Diagnosis

Type of visit	Length of visit	Codes
Cognitive Evaluation Exam (Full HX/Work up) After significant cognitive complaint → a full assessment is needed	New patient: 60min Est. patient: 40min	New patient 99205 (60 mins) Established 99215 (40 mins) Can add prolonged services code if needed Can "bill for time" or complexity of MDM
Diagnosis and Counseling • Disclosing diagnosis with patient and informant (if available) • Education and support • Brief treatment recommendations	25–40min	99214 (25min) 99215 (40min) Can add prolonged services code if needed Can "bill for time" spent counseling patient or for complexity

Further Discussion and Referral

Type of visit	Description	Codes
Follow up by Phone + Referral to specialist	Explain to patient and family about need for additional assessment or need for referral	99358
Follow up IN Person + Referral to specialist	Explain to patient and family about need for additional assessment or need for referral	99214 (25min) 99215 (40min) Can add prolonged services code if needed Can “bill for time” spent counseling patient or for complexity

Care Continuity and Follow Up

Type of visit	Description	Codes
Cognitive evaluation and Care Planning (ACP)	Collecting information needed for ACP • Documenting needs (or lack of need) in all important aspects of care • Discussion/ Instruction with patient and family on care plan	99483 (formerly G0505)
Routine Follow up visit	• Collecting additional information • Following up on outcomes of specific intervention	99214 (25min) 99215 (40min) Can add prolonged services code if needed Can “bill for time” spent counseling patient or for complexity of medical decision making
Palliative Care / Advance Care Planning	• Explanation and discussion of Advance Directives • May include completion of form	99497 (first 30min) 99498 (each additional 30min)

Care Continuity and Follow up

Early Discussions

- Life Care Planning

Difficult Discussions

- Driving
- Finances
- Leaving Home

Diagnosis Corners

- Incontinence (Fecal > Urine)
- Wandering
- Psych/Behaviors
- Recognition of Loved ones
- Speech and Swallowing

**Choosing Wisely: Do not recommend percutaneous feeding tubes in patients with advanced dementia; instead offer oral assisted feeding*.

Care Continuity and Follow up

Type of visit	Description	Length of visit	Codes
Complex Care Management Facilitate implementation of care plan (education, support, safety monitoring, care coordination, linkages to community services	• Monthly follow-up with clinical staff (RN, SW, trained MA) under general supervision of billing provider	20+ minutes of clinical staff time per month plus a minimum of 15min of provider time for general supervision	99490 99487 (60min clinical staff time per month, + at least 15min provider time) Add-on code: 99489, for every 30min of additional clinical staff time (use with 99487)
Transitional Care Management • Permit medication review and reconciliation	• 30-day period of post-discharge care management initiated upon discharge from hospital, skilled nursing, or nursing home facility	Time not specified	99496: High-complexity Face-to-face visit within 7 days of discharge (provider only) 99495: Moderate-complexity face-to-face visit within 14 days of discharge (provider only)

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