Learning Objectives

• Leverage tools/training to be comprehensive and efficient during the office visit.

• Identify the management goals and your role for patients with Alzheimer's and other dementias.

• Utilize the visit codes that best reflect your value/time/complex comprehensive care with patient and family.
The Dr. Robert Bree Collaborative
Dementia and Alzheimer’s Disease: Building a Health Care System for All of Us

To align care delivery with existing evidence-based standard of care for diagnosis, treatment, supportive care, and advance care planning within primary care for patients with Alzheimer’s disease or other dementias and their families and caregivers while decreasing variation in quality of treatment across the state of Washington.
http://www.breecollaborative.org/2018/02/26/dementia/

Our Report and Recommendations has six focus areas developed in partnership with the Dementia Action Collaborative:
1. Timely and Accurate Diagnosis with AWV or family/patient concern
2. Ongoing care and support
3. Advance care planning and palliative care
4. Need for increased support and/or higher levels of care
5. Preparing for potential hospitalization
6. Screening for delirium risk
An age-friendly health system (AFHS) will measurably improve the quality of care for older adults and optimize value for health systems across the continuum of care.

AFHS is a health care system in which:
- Older adults get the best care possible;
- Healthcare-related harms to older adults are dramatically reduced;
- Older adults and their families are satisfied with their care;
- Value is optimized for all

Age-friendly health systems will ensure reliable implementation of the “four M’s”:

Providence’s 5Ms for Age-Friendly Health:

WHAT MATTERS
- Know your care preferences and set goals for your health. Establish Advance Directives and Trusted Decision Makers.

MEDICATION
- Manage your medications and understand how they may impact your mobility and cognition.

MENTATION
- Get the emotional and cognitive support you need. Understand, prevent, and seek treatment for dementia, delirium, and depression.

MOBILITY
- Keep active and mobile, preventing injuries and falls. Learn how to safely mobilize as you age.

MALNUTRITION
- Commit to proper nutrition and assess malnutrition risk regularly.
The Problem: Time Lost is Independence Lost

7.2 million people 65+ are projected to have Alzheimer’s dementia by 2025.

Timely detection and comprehensive care

• Growing evidence regarding the importance of early detection and accurate diagnosis –
  - Cardiometabolic risk reduction/improving management of comorbid conditions/reducing polypharmacy/iatrogenic harm
  - Connecting with community resources, programs/services
  - Reducing preventable hospitalizations, inappropriate surgeries, delirium, PHCD/POCD and emergency room visits
  - Identifying goals around what matters, end-of-life care and improving advance care planning
• Approximately **$8 trillion** could be saved in medical and long-term care costs if mechanisms for early detection of AD are employed.¹

• Cost savings can be realized from:
  • Diagnosis during MCI phase, rather than progressive dementia phase
  • Lower medical and long-term care costs for individuals who have diagnosed and well-managed MCI and dementia, compared with individuals with unmanaged MCI and dementia

Hospitalization Rates in Dementia

- Each year 40% of community-dwelling People with dementia (PwD) will visit ED and 30% will be hospitalized at least once.

- Hospital care is 3 times as costly compared to older people w/o dementia

- Acute hospitalization in PwD is associated with increased risk of delirium, falls, cognitive and functional decline, 30 day readmission, longer LOS, long-term care admission and death

- Shepherd et al, BMC Medicine 2019
The Office Visit

• Patient and caregivers should bring in all meds at each visit
• Med reconciliation should occur at each visit
  – Printed copy of adjusted meds AVS
• AD drugs dosed early and effectively
  – Discontinuations based on drug side effects
    • GI, cardiac, sleep (dreams & nightmares)
  – As disease progresses, discontinuation based on benefit vs. risk
• Simplify care at every opportunity/deprescribe
Mitigating the impact of Alzheimer’s Disease

Hallmarks of disease remain memory loss and inability to problem solve
  – Environment needs to change
  – Caregiver needs to learn, receive support and change
  – Pt with dementia has more challenges over time

• Pt and their families can still improve their odds
  – Lower cholesterol and homocysteine levels
  – Lower high blood pressure
  – Control diabetes
  – Exercise regularly
  – Engage in social and intellectually stimulating activities, care partner self-care, education, support.
  – Optimize hearing, diet, sleep, mood
Simplification of the treatment program

• Each therapy needs a justification
• Redundancies and duplication can be eliminated
• Pharmacies can blister pack a week (or a month) worth of medications for easy identification and improved compliance
• Reductions in drug passes may be single biggest opportunity to reduce errors, reduce caregiver burden, save money and limit transitions of care
Medication Safety

• Simplification
  – 3 or 4 x a day reduced to 1 or 2 x a day
  – Elimination of PRN drugs
  – Switch from daily to weekly or from weekly to monthly
  – Consider using an infusion center (and its cost) for once a year rather than monthly or quarterly treatments
    • Osteoporosis
    • Anemia
Goals of Care

• Simplify treatment strategies
• Provide a rationale for each treatment
• **Limit transitions**
  – Home to hospital
  – Hospital to nursing home
  – Assisted living to skilled care
• Provide an environment where a person can function with minimal frustration/failure and maximal use of retained abilities/preserved strengths
Improving HOPE for Alzheimer’s Act

What is CPT® billing code 99483?
- The bipartisan HOPE for Alzheimer’s Act from the 114th Congress would have created a care planning benefit for Medicare beneficiaries with Alzheimer’s and their caregivers.
- By 2016, more than two-thirds of Congress supported the bill. There were 310 co-sponsors in the House of Representatives and 50 in the Senate.
- Since January 1, 2017, the Centers for Medicare and Medicaid Services (CMS) — through CPT® billing code 99483 — allows doctors to be reimbursed for providing a comprehensive set of care planning services to cognitively impaired individuals and their caregivers.

Why is this care planning benefit necessary?
- More than 95% of people with Alzheimer’s and other dementias have one or more other chronic conditions. Alzheimer’s complicates the management of these other conditions — and as a consequence, increases costs.
- For example, a senior with diabetes and Alzheimer’s costs Medicare 81% more than a senior who has diabetes but not Alzheimer’s.
- Individuals receiving dementia-specific care planning have fewer hospitalizations, fewer emergency room visits, and better medication management.

Higher Medicare Costs Due to Alzheimer’s

| Condition        | Cost Increase
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>61%</td>
</tr>
<tr>
<td>Chronic Conditions</td>
<td>64%</td>
</tr>
<tr>
<td>Cancer</td>
<td>60%</td>
</tr>
<tr>
<td>COPD</td>
<td>58%</td>
</tr>
<tr>
<td>Stroke</td>
<td>47%</td>
</tr>
<tr>
<td>Dying Diseases</td>
<td>39%</td>
</tr>
</tbody>
</table>

What about the individual’s quality of life?
- Care planning allows diagnosed individuals and their caregivers to receive counseling and to learn about medical and non-medical treatments, clinical trials, and support services available in the community — all of which result in higher quality of life.
- Participating in planning early in the disease process also allows individuals with Alzheimer’s to create advance directives regarding their care and finances as well as address driving and safety issues so that their wishes can be carried out when they are no longer cognitively able to make such decisions.

How many people have received the care planning benefit?
- In 2017 — the first year the benefit was available — 18,019 fee-for-service (FFS) Medicare beneficiaries received the care planning benefit.
- In seven states (Alaska, Montana, New Hampshire, North Dakota, Rhode Island, South Dakota, and Vermont) and the District of Columbia, not a single FFS Medicare beneficiary received the benefit.
- Even after accounting for individuals in Medicare Advantage plans, fewer than 1% of those with Alzheimer’s and other dementias received the care planning benefit in 2017.

Why has the benefit been so underutilized?
- The low rate of usage of the Medicare care planning benefit in the first year shows that patients and providers are generally not aware of the existence of the benefit.
- However, as more people become aware of the benefit, utilization is likely to increase. In 2017, use of the service increased steadily throughout the year. The rate of use of the care planning benefit was 3 times greater in the fourth quarter of 2017 than in the first quarter.

What Does a Care Planning Visit Consist Of?
- Evaluating concerns
- Assessing function/decision-making capacity
- Reviewing/revising prescription medications
- Measuring behavioral symptoms
- Evaluating safety (including driving ability)
- Identifying and assessing a primary caregiver
- Developing advance directives
- Creating a care plan, including referral to community resources

First Year Code Usage
(Per 1,000,000 FFS Medicare Beneficiaries)
About CPT 99483

Effective January 1, 2018, CPT code 99483 is used to report cognitive assessment and comprehensive care planning services provided face to face to individuals who exhibit symptoms of cognitive impairment.
<table>
<thead>
<tr>
<th>Service Element</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognition-focused evaluation, including a pertinent history and examination of the patient</td>
</tr>
<tr>
<td>Medical decision making of moderate or high complexity (defined by the E/M guidelines)</td>
</tr>
<tr>
<td>Functional assessment (for example, ADLs and IADLs), including decision-making capacity</td>
</tr>
<tr>
<td>Use of standardized instruments for staging of dementia (FAST is often used)</td>
</tr>
<tr>
<td>Medication reconciliation and review for high-risk medications</td>
</tr>
<tr>
<td>Evaluation for neuropsychiatric and behavioral symptoms, including depression and including use of standardized screening instrument(s) (PHQ-9)</td>
</tr>
<tr>
<td>Evaluation of safety (e.g., home), including motor vehicle operation</td>
</tr>
<tr>
<td>Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports and the willingness of caregiver to take on caregiving tasks</td>
</tr>
<tr>
<td>Development, updating or revision, or review, of an Advance Care Plan</td>
</tr>
<tr>
<td>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 (e.g., rehabilitation programs, adult day programs and support groups); shared with the patient and/or caregiver with initial education and support. (Easy to do with Epic’s After Visit Summary)</td>
</tr>
<tr>
<td>Service Element</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Cognition-focused evaluation, including a pertinent history and examination of</td>
</tr>
<tr>
<td>the patient</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Functional assessment, including decision-making capacity</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Use of standardized instruments to stage dementia</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Medication reconciliation and review for high-risk medications, if applicable</td>
</tr>
<tr>
<td>Evaluation for neuropsychiatric and behavioral symptoms, including depression</td>
</tr>
<tr>
<td>and including use of standardized instruments</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Evaluation of safety (for example, home safety), including motor vehicle</td>
</tr>
<tr>
<td>operation, if applicable</td>
</tr>
<tr>
<td>Identification of caregiver(s), caregiver knowledge, caregiver needs, social</td>
</tr>
<tr>
<td>supports and the willingness of caregiver to take on caregiving tasks</td>
</tr>
<tr>
<td>Advance care planning and addressing palliative care needs, if applicable and</td>
</tr>
<tr>
<td>consistent with beneficiary preference</td>
</tr>
</tbody>
</table>
CPT 99483: Who Can Bill Under This Code

- Physicians
- Physician assistants
- Nurse practitioners
- Clinical nurse specialists
- Certified nurse midwives

Every 180 days as appropriate
CPT 99483: Reimbursement

- Reimbursement rates can vary slightly based on the setting in which the service is provided and geographic location.
- Time Based – 50 min
- RVU 3.80
- Estimated revenue $265
References


• https://www.cms.gov/cognitive


• https://www.capc.org/documents/download/921
• https://www.nia.nih.gov/health/alzheimers-dementia-resources-for-professionals

• https://alzimpact.org/media/serve/id/5ab10bc1a3f3c
• https://www.youtube.com/watch?v=NmDjhRVax8E