Alzheimer’s Care Initiative

1. Brief summary of your idea (e.g., problem, goals, intervention, benefits):

**Brief summary:** Alzheimer’s disease (AD) is a neurodegenerative condition with inexorable progression and no disease-modifying therapies, with enormous individual, family, and societal costs due to the nature and length of the illness. A major problem in the current delivery system for AD care is that financial incentives are misaligned, causing monetary constraints to affect ideal patient care. In order to improve the quality and reduce costs of Alzheimer’s care, the American Academy of Neurology (AAN) proposes the following goals and interventions that place patients with Alzheimer’s disease and their caregivers at the center of care:

A. **Goal:** Reduce the rate of hospital admissions and readmissions among patients diagnosed with Alzheimer’s disease.

**Intervention:**

1. Utilize a team of providers for Alzheimer’s related services, with one member of the team serving as a leader

   **Medical clinical staff would include:**
   - **Neurologist:** Make decisions regarding dementia treatment, provide a comprehensive assessment including clinical diagnostic evaluation as well as evaluation of cognitive deterioration over time, and provide follow up visits every 3 to 6 months.
   - **Geriatrician/Primary Care Physician:** Provide ongoing care and regular primary care services for the patient once the diagnosis is reached and the patient is stabilized.
   - **Geriatric Psychiatrist:** Share knowledge and experience in psychopathology and in neuro-psychopharmacology and provide counseling regarding behavioral problems.

   **The non-medical clinical staff would include:**
   - **Neuropsychologist:** Conducts detailed behavioral interviews and in-depth cognitive testing. Interpretation of cognitive test results provides information critical to the differential diagnosis of the dementias during the initial evaluation. Assessments also provide detailed behavioral descriptions that inform rational treatment paradigms and contribute to caregiver understanding and expectations of the natural history of the disease. Repeated examinations help describe and predict the degree and quality of cognitive/behavioral decline over time.
   - **Case Manager (NP, PA, or RN):** Responsible for overall care plan implementation. Facilitate communication among providers and coordination of care. Point of contact for patient between visits. Provide education services to the patient and caregivers, including home safety improvements to prevent falls and how to ensure medication compliance. Also, monitor caregiver physical and mental health and administer cognitive assessment tests.
   - **Social Worker:** Help patients obtain coverage if needed, provide information on support services, legal and financial advice, and shared decision making tools to assist patients and caregivers with common challenges associated with AD.
- **Dietician:** Educate caregivers to ensure adequate nutrition for patients and to customize dietary plan for patients with secondary ischemic heart disease.

- **Pharmacist:** Provide support, information, and access to treatment; counsel patients and caregivers on the proper use of pharmacologic agents and suggest techniques to aid in management of AD, such as memory aids or schedules.

2. Utilize an innovative payment model that would properly reward coordination of care and caregivers’ education: *Per Member per Month Care Coordination Payment (PMPM)* - Facilitate care delivery by providing an up-front per-member-per-month payment of $34 to cover care coordination services for patients with Alzheimer’s. The PMPM fee could provide resources for hiring a nurse to track, assess, and manage Alzheimer’s patients with multiple chronic illnesses and assist with patients’ transition between different healthcare settings (e.g. hospital to home). In addition the PMPM fee would provide resources for implementing health IT infrastructure necessary to support the coordination of care among the team of providers.

3. Utilize an “Enhanced” *Fee-for-Service (FFS)* payment system- CMS should recognize existing CPT® codes describing education and training for patient self-management, team conferences and non-face-to-face care management services such as phone calls and online correspondence by providing separate reimbursement for those activities as part of this pilot project. Codes and assigned RVUs exist for non-face-to-face care coordination services but are not currently separately reimbursed by CMS and therefore likely underreported. Please see attachment 1 for a complete list of codes.

4. Use financial incentives to reward cognitive care and extra time spent with patients and their caregivers. This could be achieved through reimbursing providers for prolonged service evaluation and management (E/M) codes, both with patient contact and without patient contact. Please see attachment 2 for a complete list of codes.

**Benefits:**
- Reduce hospitalization and re-hospitalization rates among patients diagnosed with Alzheimer’s disease.
- Facilitate caregivers’ education about fall prevention, medication compliance, diet requirements and increase caregivers’ role in preventing hospitalization.
- Facilitate communication among the providers and coordination of care during transitions between care settings.
- Facilitate best quality of care by structuring payment in a way that would adequately reimburse for the additional time that providers need to make available to Alzheimer’s patients and their caregivers.

B. **Goal:** Empower patients and their caregivers.

**Intervention:**
1. Educate caregivers about the natural history of the disease, expectations as the disease progresses, their role in care delivery, and provide counseling regarding coping skills. This could be achieved through reimbursing providers for group visits about common challenges caregivers face.
2. Provide patients and caregivers with decision aids, including comprehensive end-of-life counseling and advance care planning, in order to identify the best course of action to manage the disease.

3. Provide information about support networks that would actively engage patients, family members, caregivers and healthcare team members. Cooperate with the local Alzheimer’s community initiatives to connect patients and caregivers with social support groups.

**Benefit:**
- Facilitate shared decision making and effective communication to make decisions that are best for patients.
- Facilitate social support to help patients, caregivers, and family members better deal with the disease that could contribute to lower rates of hospital admission and readmissions, increase patient satisfaction and greater likelihood of adherence to their treatment regimen.

**C. Goal:** Monitor performance and reward outcomes.

**Intervention:**
1. Utilize a *Pay-for-Performance (P4P)* model - Reward physicians for monitoring how well they were able to help Alzheimer’s patients and caregivers taking control of the progressing disorder, specifically for monitoring patient’s ability to perform basic activities of daily living, frequency of patients and caregivers counseling, and adherence to best practices. Utilize the following performance measures from the AAN Dementia Performance Measure Set:
   - *Measure 2 Cognitive Assessment:* Percentage of patients, regardless of age, with a diagnosis of dementia for whom an assessment of cognition is performed and the results reviewed at least within a 12 month period. This would be included as a measure of disease progression/cognitive deterioration over time.
   - *Measure 3 Functional Status Assessment:* Percentage of patients, regardless of age, with a diagnosis of dementia for whom an assessment of functional status is performed and the results reviewed at least once within a 12 month period. This would be included as a measure of the patient’s ability to perform basic activities of daily living.
   - *Measure 7 Counseling Regarding Safety Concerns:* Percentage of patients, regardless of age, with a diagnosis of dementia or their caregiver(s) who were counseled.
   - *Measure 10 Caregiver Education and Support:* Percentage of patients, regardless of age, with a diagnosis of dementia whose caregiver(s) were provided with education on dementia disease management and health behavior changes AND referred to additional resources for support within a 12 month period. Caregivers play a major role in adherence to treatment recommendations for patients with dementia, this would measure adherence to best practices.

2. Mandatory participation in patients’ registry to facilitate performance evaluation.
Benefit:
Monitoring performance will encourage changes in clinical practice that ultimately will result in improved quality of care and lower costs of care.

2. How will your idea lead to reduced Medicare and Medicaid program expenditures while also improving the quality of care and health outcomes for beneficiaries?

   a. The proposed delivery and payment model will reduce Medicare and Medicaid expenditures through care coordination (i.e. team approach) modeled on chronic care models.

   Specifically, this delivery model would reduce expenditures by reducing frequency of hospitalization among patients diagnosed with Alzheimer’s disease. Alzheimer’s disease is the most common type of dementia accounting for 60 to 80 percent of cases. People with Alzheimer’s disease have up to three times higher hospitalization rates than other elderly people. Increased hospitalization rates in dementia patients translate into 3.3 times greater total Medicare expenditures than in non-dementia patients. The main reasons for hospitalization among Alzheimer’s patients are syncope/falls (26 percent), ischemic heart disease (17 percent), and gastrointestinal disease (9 percent). These causes could be significantly reduced by better education of caregivers in terms of fall prevention, medication compliance, and diet. The proposed medical team-based delivery model facilitates caregivers’ education and, therefore, increases caregiver’s role in preventing hospitalization. Consequently, the proposed approach would lead to reduced costs associated with preventable hospital admissions and readmissions.

   Patients with Alzheimer’s disease use multiple medications, which raises the risk of adverse drug reactions and may increase hospital stays and costs. The engagement of a case manager and a pharmacist could reduce the adverse events associated with poly-pharmacy, including hospitalization for hip fracture and syncope.

   In addition, we recommend comprehensive end-of-life counseling and advance care planning. Studies show that advance directives are associated with significantly lower levels of Medicare spending.

   Also, this proposal will reduce expenditures due to utilization of mid-level providers to assist with an ongoing care that do not require the level of expertise of medical clinical staff. Having mid-level providers provide a majority of the ongoing care would be cost-effective and would allow neurologists more time for the initial evaluation, diagnosis, and establishment of treatment protocol.

   Finally, this proposal addresses issues related to caregivers’ healthcare. The Alzheimer’s Association estimates that the physical and emotional impact of caregiving translates into $7.9 billion in increased healthcare costs. Our recommendations regarding caregivers counseling, shared decision making, as well as caregiver education and support, could also reduce Medicare spending.
b. The proposed model would improve the quality by creating stronger incentives to reward patient-centered care.

Specifically, this delivery model would lead to improved quality of care by placing Alzheimer’s patients and their caregivers at the center of care. The ultimate goal of this delivery model is to build a sense of partnership among physicians, patients, and caregivers to ensure that caregivers have the education and support they need to fully participate in the patient’s care. To achieve this goal, we recommended providing patients and caregivers with decision aids that would facilitate effective communication and shared decision making. However, we often hear from physicians that shared decision making requires time and resources for which they are not properly compensated. Specifically, current payments for evaluation and management (E/M) services do not reimburse for additional time that physicians need to make available for Alzheimer’s patients and their caregivers. In fact, CMS has also recognized that E/M services may be undervalued. In order to facilitate shared decision making and patient-centered care, we propose a Per Member per Month Care Coordination Payment, Enhanced Fee-for-Service (FFS) payments, as well as financial incentives to reward cognitive care. These financial incentives will provide adequate compensation for resources and services physicians need to provide in order to improve the quality of care of patients with Alzheimer’s disease and their caregivers.

Finally, this delivery and payment model would improve the quality of care by monitoring performance and rewarding desired outcomes. The development of outcome measures for dementia is particularly challenging given the degenerative nature of the syndrome and the paucity of interventions available to change its course. In fact, there are no existing interventions to halt progression with current pharmacologic interventions showing only modest improvements, or a slower decline, in cognition and function in a substantial minority of patients. In light of these difficulties, performance measures were developed based on processes that will achieve desired outcomes. The desired goals of care management, particularly for those patients with advanced cognitive impairment, are often focused on improving the quality of life for patients and caregivers, maintaining optimal function and providing maximum comfort. In this delivery model, physicians would utilize performance measures to assess how well they were able to help Alzheimer’s patients and caregivers taking control of this progressive disorder, and improving their quality of life.

3. What evidence or successful experience(s) exists for your idea?

Coordination of care based delivery models that utilize a team of providers - including a nurse who tracks, assesses and manages patients - have been successful in improving the quality of care of patients with multiple chronic conditions. For example, Guided Care model for chronically ill patients developed at Johns Hopkins has improved quality of care, reduced total costs and rates of hospital admissions. Although prior cost-evaluations of care coordination models for patients with dementia showed that the use of case managers did not represent a
significant cost offset, these studies showed that utilizing case managers could potentially improve patients’ quality of care.\textsuperscript{12, 13} Another team-based intervention - that included a nurse acting as a care manager - improved the quality of care specifically for older adults with Alzheimer disease and reduced stress levels among their caregivers.\textsuperscript{14} This particular intervention tested application of the current guidelines for the care of Alzheimer’s patients in the primary care setting. We propose similar solutions but our delivery model goes beyond the primary care setting and utilizes a team of healthcare providers to facilitate timely diagnosis, alleviate symptoms, and slow progression of the disease. Ongoing care related to other medical conditions will be provided in a primary care setting.

Savings that would result from this proposal are not directly related to coordination of care or hiring a case manager but rather to the following:

- comprehensive end-of-life planning: for example, studies show that advance directives are associated with significantly lower levels of Medicare spending.\textsuperscript{15}

- enhanced caregivers’ involvement and training: for example, studies show that educating caregivers’ about nutrition could prevent weight loss and slow cognitive decline in patients with Alzheimer’s disease.\textsuperscript{16} Other studies show that instructing and educating caregivers through behavior and non-pharmacologic interventions has been cost effective.\textsuperscript{17, 18}

- enhanced caregivers’ support: for example, studies show that family meetings - run by a professional with an advanced degree in nursing, social work, or psychology – reduced depressive symptoms in caregivers and postponed a decision to place a patient in a nursing institution.\textsuperscript{19} A one-month delay in institutionalization could save as much as $1.12 billion annually, as estimated from data obtained in 1998.\textsuperscript{20}

Finally, because the current payment system is structured in a way that rewards greater volume of services rather than effectiveness of care, we propose restructuring the payment system to pay for services that actually improve the quality and lead to lower costs. This way of restructuring health care financial incentives has been critically important in multiple successful innovative delivery models. For example, a primary care medical home pilot from BlueCross BlueShield (CareFirst) build on traditional Free for Service (FFS) payments with additional incentives, such as PMPM, to facilitate care coordination among various providers\textsuperscript{21}. Similarly, we propose building on an existing FFS structure to facilitate reimbursement for services that are currently not paid for, such as coordination of care, case manager, and education/counseling for caregivers. In addition, we propose mandatory participation in a patients’ registry that will facilitate monitoring and evaluating physicians’ performance. Patient registries that monitor outcomes in a population of patients that have the same diagnosis make it possible “to asses comparative performance at the level of a particular clinic or health system”. In addition, patient registries encourage changes in clinical practice that lead to improved quality of care, as reported in a study of thirteen registries in five countries published recently in Health Affairs.\textsuperscript{22}
4. **What additional specifics about your idea such as the scope, setting, duration, scale or population would you like to share with the Innovation Center?**

   **Setting:** This pilot involves multiple settings  
   **Duration:** 2 to 3 years  
   **Population:** Patients with Alzheimer’s disease and over 65 years of age who still live in the community
**Attachment 1**

Education and Training for Patient Self-Management codes:

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
<th>Medicare Non Facility Payment</th>
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<tbody>
<tr>
<td>98960</td>
<td>Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient</td>
<td>$26.16</td>
</tr>
<tr>
<td>98961</td>
<td>2-4 patients</td>
<td>$12.57</td>
</tr>
<tr>
<td>98962</td>
<td>5-8 patients</td>
<td>$9.51</td>
</tr>
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</table>

Medical team conference E/M codes:

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
<th>Medicare Non Facility Payment</th>
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</thead>
<tbody>
<tr>
<td>99366</td>
<td>Medical team conference with interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more, participation by nonphysician qualified health care professional</td>
<td>$42.13</td>
</tr>
<tr>
<td>99367</td>
<td>Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician</td>
<td>$55.72</td>
</tr>
<tr>
<td>99368</td>
<td>Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by nonphysician qualified health care professional</td>
<td>$36.01</td>
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</table>

Non-face-to-face services for phone and online visit codes:

<table>
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<tr>
<th>Code</th>
<th>Descriptor</th>
<th>Medicare Non Facility Payment</th>
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</thead>
<tbody>
<tr>
<td>99441</td>
<td>Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest</td>
<td>$13.93</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Price</td>
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</tr>
<tr>
<td>99442</td>
<td>5-10 minutes of medical discussion</td>
<td></td>
</tr>
<tr>
<td></td>
<td>11-20 minutes of medical discussion</td>
<td>$26.50</td>
</tr>
<tr>
<td>99443</td>
<td>21-30 minutes of medical discussion</td>
<td>$39.07</td>
</tr>
<tr>
<td>98966</td>
<td>Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion</td>
<td>$13.93</td>
</tr>
<tr>
<td>98967</td>
<td>11-20 minutes of medical discussion</td>
<td>$26.50</td>
</tr>
<tr>
<td>98968</td>
<td>21-30 minutes of medical discussion</td>
<td>$39.07</td>
</tr>
<tr>
<td>98969</td>
<td>Online assessment and management service provided by a qualified nonphysician health care professional to an established patient, guardian, or health care provider not originating from a related assessment and management service provided within the previous 7 days, using the Internet or similar electronic communications network</td>
<td>Carrier Priced</td>
</tr>
<tr>
<td>99444</td>
<td>Online evaluation and management service provided by a physician to an established patient, guardian, or health care provider not originating from a related E/M service provided within the previous 7 days, using the Internet or similar electronic communications network</td>
<td>Carrier Priced</td>
</tr>
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</table>
Under goal A initiative 4, we recommended the use of financial incentives to reward cognitive care and extra time spent with patients and their caregivers. This could be achieved through reimbursing providers for prolonged service evaluation and management (E/M) codes, both with patient contact and without patient contact:

<table>
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<tbody>
<tr>
<td>99354</td>
<td>Prolonged physician service in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service; first hour (List separately in addition to code for office or other outpatient Evaluation and Management service)</td>
<td>$95.47</td>
</tr>
<tr>
<td>99355</td>
<td>Each additional 30 minutes</td>
<td>$94.45</td>
</tr>
<tr>
<td>99358</td>
<td>Prolonged evaluation and management service before and/or after direct (face-to-face) patient care; first hour</td>
<td>$107.71</td>
</tr>
<tr>
<td>99359</td>
<td>Each additional 30 minutes</td>
<td>$51.98.</td>
</tr>
</tbody>
</table>
References

19 Joling KJ, van Hout PJG, Scheltens P, Vernooij-Dassen M, van den Berg B, Bosmans J, Gillissen F, Mittelman M, van Marwijk HWJ. (Cost)-effectiveness of family meetings on indicated prevention of anxiety and depressive symptoms and disorders of primary family caregivers of patients with dementia: design of a randomized controlled trial. BMC Geriatrics. 2008; 8: 2
21 Burell C. Presentation: Primary Care Medical Home. CareFirst BlueCross BlueShield As presented at the AHIP conference on shared accountability on October 18th, 2011.