

# Alzheimer's and Dementia Care ECHO Program for Primary Care Clinicians

NAPA Advisory Council on Alzheimer's Research, Care  
and Services  
January 30, 2023



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## 2022 ALZHEIMER'S DISEASE FACTS AND FIGURES



more than  
**6 million**  
Americans are living with  
Alzheimer's



**1 in 3**  
seniors dies with  
Alzheimer's or another  
dementia -  
it kills more than  
**BREAST CANCER**  
+  
**PROSTATE CANCER**  
COMBINED

More than  
**80%**  
of Americans  
know little or are  
not familiar with  
mild cognitive  
impairment  
(MCI) which can  
be an early  
stage of  
Alzheimer's

over  
**11 million**  
Americans  
provide unpaid  
care for people  
with Alzheimer's  
or other  
dementias



These caregivers  
provide an  
estimated 16  
billion hours  
valued at nearly  
**\$272**  
**billion**

Alzheimer's and dementia deaths  
have increased

**17%**  
during the COVID-19 pandemic

between 2000 and 2019,  
deaths from heart disease have

**DECREASED**  
**7.3%**

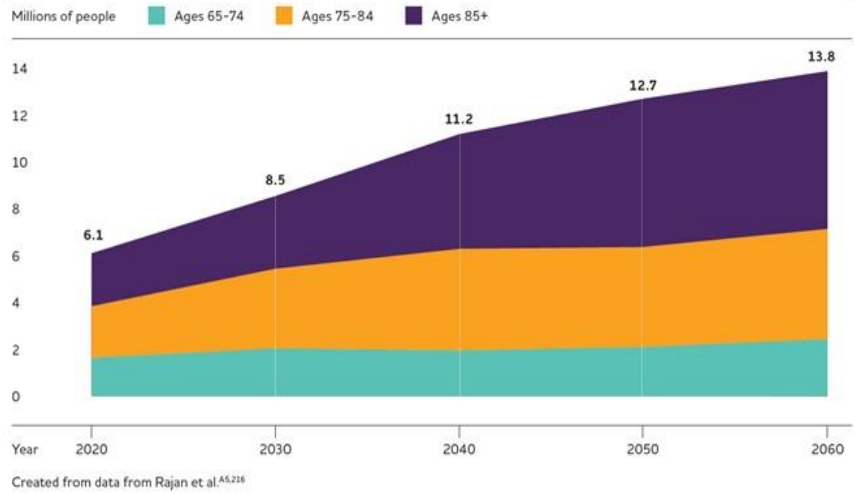
while deaths from  
Alzheimer's disease have

**INCREASED**  
**145%**

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The number of Americans **65+** living with Alzheimer's is expected to nearly double by **2050**.

Projected Number of People Age 65 and Older (Total and by Age) in the U.S. Population with Alzheimer's Dementia, 2020 to 2060



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## Lack of Dementia Care Specialists



- The United States will have to nearly triple the number of geriatricians to effectively care for the number of people projected to have Alzheimer's in 2050
- Few care professionals specialize in geriatrics:
  - 12% of nurse practitioners have special expertise in gerontological care
  - Less than 1% of registered nurses, physician assistants and pharmacists identify themselves as specializing in geriatrics
  - 4% of social workers have formal certification in geriatric social work.
- Efforts to increase recruitment and retention remain slow

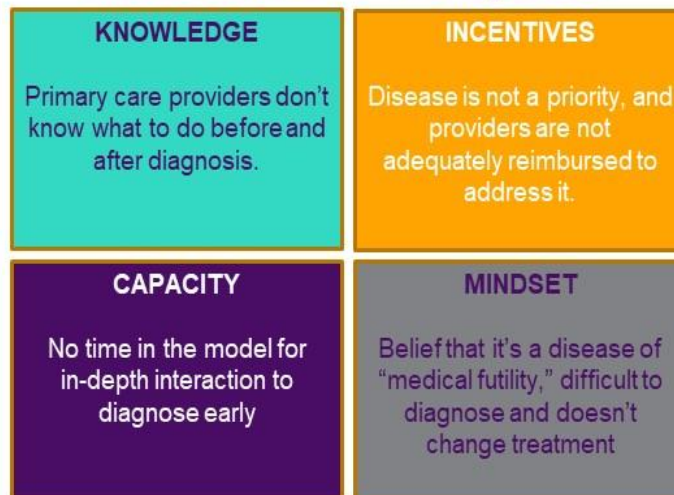
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# Building capacity on the front lines

- **Half** of primary care physicians reported that they do not feel adequately prepared to care for individuals with Alzheimer's and other dementias. More than 25% reported being "only sometimes" or "never" comfortable answering patient questions about Alzheimer's or other dementias.
- **55% of PCPs** caring for people living with Alzheimer's report there are not enough dementia care specialists in their communities.
- PCPs reporting lack of specialists varies by location:
  - **44%** in large cities
  - **54%** in suburbs near large cities
  - **63%** in small city or town
  - **71%** in rural areas

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## PCPs are working within the constraints of the system



Source: Alzheimer's Association health care market research, 2017-2018

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## Traditional CME can be a challenge...

- Limited time away from clinical responsibilities for full day trainings
- Travel often necessary
- Online CME reduce 1:1 instruction and interaction
- Costs

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## WHAT IS PROJECT ECHO®: EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES

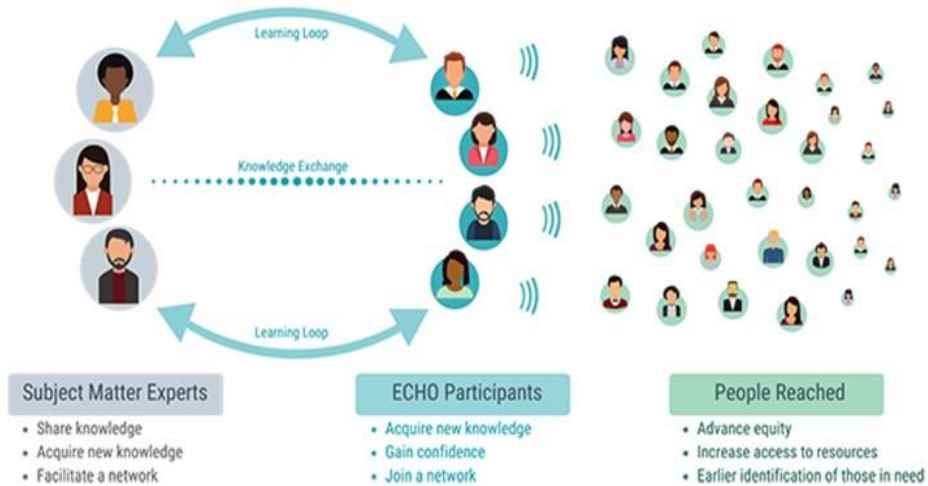
- Developed in 2003 to address barriers to seeking specialist care in New Mexico (long wait times, limited availability) by enhancing primary care capacity (skills-building & confidence) to treat common chronic disease
- Case-based, interactive learning sessions (similar to clinical rounds) delivered via videoconference
- Expert panel (“Hub”) serves as mentors to deliver short didactic lessons on best practice care and group consultation on de-identified patients from community clinics (the “Spokes”)



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# Project ECHO – “All Teach, All Learn”

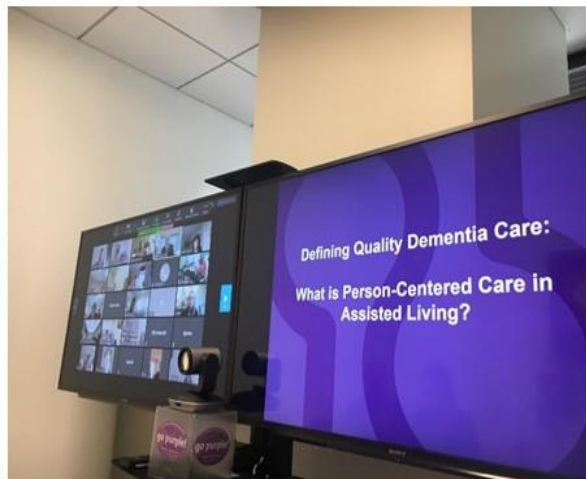
## MOVING KNOWLEDGE, NOT PEOPLE



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## Alzheimer's and Dementia Care ECHO

- Launched in 2018
- Cohort-based / 12 bi-weekly sessions
- Participants are care teams
- Goal: increase access to timely detection and quality care and support
- No cost to join / No cost CME



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## Alzheimer's and Dementia Care ECHO faculty



Eric Tangalos, MD  
Geriatrics  
Mayo Clinic

Glenn Smith, PhD  
Neuropsychology  
University of Florida



Jared Brosch, MD,  
Neurology  
Indiana University

Darby Morhardt, PhD, LCSW  
Social Work  
Northwestern University



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## Curriculum

1. Overview of Program; Diseases Causing Dementia
2. Providing Person-Centered Care: Integration of Family and Caregivers
3. Signs and Symptoms of Cognitive Impairment and Cognitive Assessment Tools
4. Evaluation and Diagnosis in the Primary Care Office
5. Communication of Findings to Patients and Caregivers
6. Referral and Specialty Testing
7. Routine Care Planning
8. Care Management: Addressing Role and Needs of (Informal) Caregivers
9. Care Management: Cognition and Comorbidities
10. Care Management: Behavioral and Psychological Symptoms of Dementia (BPSD)
11. Advance Care Planning
12. Coordination of Care and Transitions of Care

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# Typical Case Study

**GENERAL INFORMATION**

DATE: 8/21 CLINICAL SITE: \_\_\_\_\_  
 PRESENTER: \_\_\_\_\_  
 AGE: 66 GENDER: MALE  FEMALE  TRANSGENDER   
 CHECK ONE: NEW CASE  FOLLOW UP  OCCUPATION: \_\_\_\_\_  
 LIVING ARRANGEMENT: with friend \_\_\_\_\_

What is your main question about this patient?

patient self-determination vs vulnerability

Check all that apply or relate to your main question:

- Specific symptom management (insomnia, wandering, paranoia, hallucinations, etc)
- Dementia specific treatment options
- Issues of Activities of Daily Living (ADLs)
- Issues of Instrumental Activities of Daily Living (IADLs)
- Determining the patient's diagnosis
- Agitation and/or aggression
- Advance care planning
- Inappropriate behavior
- Other(s), decision making capacity especially concerning where she lives

Brief history of present illness:

MS with dementia, lacking insight into her memory deficits and consequences of same, specifically lacking insight into social supports vs vulnerabilities because of memory deficits. APS involved and working with her sister who would like patient to go into a facility. Patient is not interested in this, preferring her current social supports instead.

**Main Question:** How to honor patient's wishes while balancing their vulnerability?

**Brief History:** 66 year old F, dx MS + dementia, lives with friend, lacks insights into current supports. Family would like patient to move into LTC due to concerns about the friend support and motives. APS involved

**Cognitive Findings:** SLUMS 12/30, no neuropsych testing

**Patient Goals of Care:** to stay home

*Other case components:*  
 Medical History & Current Medications  
 Physical Exam Findings  
 Social History  
 Decision making capacity and financial concerns

## Routine Care Planning (Session 7)

### 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.



### Reimbursement

- ✓ Medicare reimbursement rates can vary slightly based on the setting in which the service is provided and geographic location.
- \$ Estimated \$238 reimbursement rate for 99483 reported by a physician in a non-facility setting.
- 📄 Payer policy should be consulted.



### CPT 99483: Cognitive Assessment and Care Plan Services Required Service Elements

- Cognition-focused evaluation, including a pertinent history and examination of the patient
- Medical decision making of moderate or high complexity (defined by the E/M guidelines)
- Functional assessment (for example, ADLs and IADLs), including decision-making capacity
- Use of standardized instruments for staging of dementia (FAST is often used)
- Medication reconciliation and review for high-risk medications
- Evaluation for neuropsychiatric and behavioral symptoms, including depression and including use of standardized screening instrument(s) (PHQ-2)
- Evaluation of safety (e.g., 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, falls (e.g., rehabilitation programs, ) and/or caregiver with initial ed.

### Alzheimer's Association Toolkit for CPT 99483

Service Element	Suggested Tools
Cognition-focused evaluation, including a pertinent history and examination of the patient	<ul style="list-style-type: none"> <li>• Mini-Cog</li> <li>• Short MoCA</li> <li>• Key Elements of Cognition Evaluation</li> </ul>
Functional assessment, including decision-making capacity	<ul style="list-style-type: none"> <li>• Katz Index of Independence in Activities of Daily Living</li> <li>• Lawton-Brody Instrumental Activities of Daily Living Scale</li> <li>• Decision Making Capacity Assessment</li> </ul>
Use of standardized instruments to stage dementia	<ul style="list-style-type: none"> <li>• Questionnaire in Older Adults with Dementia</li> <li>• Dementia Severity Rating Scale (DSRS)</li> </ul>
Medication reconciliation and review for high-risk medications, if applicable	<ul style="list-style-type: none"> <li>• Medication List for Review</li> </ul>
Evaluation for neuropsychiatric and behavioral symptoms, including depression and including use of standardized instruments	<ul style="list-style-type: none"> <li>• NPI-Q</li> <li>• BEHAV'S+</li> <li>• PHQ-2</li> </ul>

## Primary care reach and demand

- New partnerships expanded reach: University of California-San Francisco, University of California-Los Angeles and GWEPs
- Launched seventh nationwide cohort in June 2022
- Georgia, Southern CA, and North Carolina, and DC regional series in 2022
- **Nearly 116 primary care practices and over 333 providers trained (completed series)**



● Primary care practice locations since 2018

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## Benefits of Participation



- Increased skills & expertise in dementia care
- Improved confidence & competence to dx & treat
- Reduced burden on clinicians by optimizing health care team roles
- Reduced role isolation & access to community

- Improved access to timely, accurate diagnosis and high quality care
- Shorter wait times for specialty visits
- Right care, right time

- Retain providers
- Reduced disparities
- Dissemination of best practices
- Patients stay local

- Better quality & safety
- Workforce training
- Improved population health
- Improved patient experiences

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# Impact

Made changes to the way they care for patients

Their quality of care improved



## Nearly all or all have said:

information has been valuable in their work, shared information they learned, positively influenced interactions with families and caregivers

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# Feedback



86% expressed increased job satisfaction after participating in the the Alzheimer's and Dementia Care Primary Care ECHO

*"I learned a great deal and am using the skills and knowledge from this training with caregivers and patients."*



*"The codes were a new thing. I find it very interesting about encouraging early testing and things to look for."*

*"I always have at least 1 if not more really good takeaways, or an "I did not even think about that" moment..."*

*"When the faculty said "run toward the diagnosis"...that really hit home for me and is something we don't typically do. That is changing through education and experience (especially this series)."*



*"The case studies and discussion that followed gave us great insight, inspired us with new solutions and reinforced our belief that cognitive assessment should be treated as a vital sign."*

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# Questions



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