Reimbursement as a Pathway for Quality Dementia Care

Applications from the [GSA KAER Toolkit for Primary Care Teams]()

GSA Momentum Discussions Podcast from The Gerontological Society of America

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Guests:
Carolyn K. Clevenger, DNP, GNP-BC, FAANP, FGSA, FAAN
Professor at the Nell Hodgson Woodruff School of Nursing at Emory University. Clinical Director and a practicing nurse practitioner at the Emory Integrated Memory Care Clinic – a nurse-led primary care practice for people living with dementia

Laura Medders, LCSW
Administrative Director of the Emory Integrated Memory Care Clinic

Host:
Jennifer Pettis, MS, RN, CNE
Director of Strategic Alliances
The Gerontological Society of America

Jen Pettis:

Welcome to this GSA Momentum Discussion podcast addressing how primary care providers can use reimbursement as a pathway for quality dementia care. Momentum discussions highlight topics experiencing great momentum in the field of gerontology. We're grateful to Genentech, Lilly, Otsuka, and Avanir for their support of the GSA KAER toolkit for Brain Health and today's program. My name is Jen Pettis and I'm the director of Strategic Alliances at the Gerontological Society of America, or GSA. I'm delighted to serve as the host for today's momentum discussion.

Please join me in welcoming today's discussants, Dr. Carolyn K. Clevenger, a professor at the Nell Hodgson Woodruff School of Nursing at Emory University, and the Clinical Director as a practicing nurse practitioner at the Emory Integrated Memory Care Clinic, a nurse-led primary care practice for people living with dementia. Dr. Clevenger is joined by her colleague Laura Medders, who is a licensed clinical social worker and the Administrative Director of the Emory Integrated Memory Care Clinic. Dr. Clevenger and Laura, thank you for taking the time out of your busy schedules to share your insights around how providers can achieve appropriate reimbursement for quality dementia care and how they can use the reimbursement as a pathway for this care.

Laura Medders:

Thank you so much for having us.

Jen Pettis:

We have a lot to talk about today so let's dive right in. Dr. Clevenger, let me start with you. In our KAER toolkit for Brain Health, we share information about how providers can be reimbursed for detection, evaluation, and diagnosis of dementia, as well as for care planning and ongoing care of individuals with cognitive impairment in dementia. Particularly for the care planning and ongoing care of these individuals, how can primary care and teams ensure that their billing appropriately reflects the care and services provided by the whole team—not just the primary care provider?

Dr. Clevenger:

First, let me say that I think the ability to use a diverse range of billing types and visit types to provide all of the services that people living with dementia need is best suited in primary care. We certainly need specialists for the specialized knowledge and skills that they add, but people have a relationship with primary care and ideally with the primary care team. But, I think we get overwhelmed in primary care because so many things fall to us. So, when you start talking about quality measures or practice guidelines in dementia, it sounds really overwhelming.

One way to address this is to break things up so that it doesn't have to be done all at once. For example, a classic occurrence in primary care area is that someone has their hand on the doorknob as you're getting ready to finish the visit and this person says, and "Oh, by the way, I'm concerned about my memory or thinking." Or, you have a typical visit where you're addressing all of your other quality metrics, such as trying to make sure their blood pressure is at guideline and they are receiving diabetes education.

Dr. Clevenger:

And while you are doing that, you have a message from someone in their life, such as adult child or a spouse that says, "Hey, while they're there, can you talk to them about this?" So it can feel like a lot.

First, it is important to remember that in those types of ongoing visits, you can do your other care as well. So, for example, your blood pressure does make a difference in cognitive symptoms. And managing the thyroid also makes your cognitive symptoms better. Those activities can be related, and you might consider what it looks like to have a type of visit for someone with multiple chronic conditions, including dementia. For us, and what I recommend often for practices, we don't try to do it all in one visit. So when you do have that end of visit conversation or maybe you've introduced a conversation about memory or thinking or behavior changes that you say, "Why don't we have a separate visit where we do a deep dive into this?"

Dr. Clevenger:

However, if you do try to do it all in one visit, billing based on time has been a really helpful addition to visit types. There was a change in our codes in the CPT catalog recently so that you can have extended visits and bill on the basis of time regardless of complexity. Another visit type that we use is the cognitive assessment in care planning visit. The full list of all the elements that go into that visit is listed in the KAER toolkit, and also available from the Alzheimer's Association. I think that list can feel really overwhelming but there are ways to streamline much of that so that you are using an informant potentially, or a care partner, who can give that information in advance.

Dr. Clevenger:

We'll talk about that in a little bit in terms of our workflows. For example, you may have other folks on your staff who can gather some of that information so that we're maximizing the time of the primary care provider. But the cognitive assessment and care planning visit then does need to result in a care plan, which, I assume, is one of the reasons it has higher reimbursement. I think CMS is clear that it does take longer to do all of these elements, but I assume the higher reimbursement is to motivate practices to do more of things that matter to Medicare beneficiaries. So, taking the time to set up that cognitive assessment visit can be really helpful.

Now, again, there are a lot of elements included; and a lot of information to gather.

Dr. Clevenger:

Sometimes it's helpful to gather that information from an observer. Some of the measures that we want to know are actually validated by an observer rather than from patient report. Of course, patient report is very important, but we've also found that there's often someone else in this person's life who is really anxious to tell you all of the changes they're observing, which the person who is experiencing the changes may not even realize are happening. To gather this information, we use the prolonged non-face-to-face visit, which we sometimes consider to be a supplemental visit in advance of the cognitive assessment visit. This works really well if you expect that you'll need additional time. In any case, it goes especially well when a person in their life, typically an adult child or spouse, wants to tell you things that the person who is having those symptoms may find embarrassing or it may create discord in their relationship to discuss in front of the person.

Dr. Clevenger:

So, think about a visit where you ask about sleep or about basic activities of daily living, and they tell you things like, "Yes, I drove to work" and the adult child or spouse has strategically placed themselves behind the person so they can shake their head to say or gestures with you non-verbally to indicate "no, that's not happening." Or if, they're more assertive, they just interrupt the person while they're sharing their experience.

So, you can schedule that prolonged non-face-to-face time with the informant as a separate call. It should be at least 20 minutes. We typically schedule 30 minutes for those by phone to allow the informant to tell you what they're observing, and where they can say things that they wouldn't say in front of the patient.

Dr. Clevenger:

There are some families that are very open and we talk about things very openly. Then there are some people who never say the A word, meaning Alzheimer's, or never say the D word, meaning dementia.

We all know primary care does a lot of coordination of care outside of scheduled visits. The visit is intense, but lots of other things happen such as community services, or medication management, or maybe a bit of support and coaching of their care partner. And often those services are performed by other staff members. In my case, I'm very fortunate to have registered nurses and social workers and others on staff who may take those calls. We use chronic care management codes, which is an entire catalog of codes including, complex, principal, and chronic.

Dr. Clevenger:

Being able to capture that time with other staff has been very helpful. A lot of things happen between the visits that are really critical, especially if you want do things like avoid unnecessary hospital visits, which we really do.

Finally, we offer one-on-one coaching or actual psychotherapy for the care partner, which has been invaluable. It is one of the best and most effective interventions to empower and train the caregiver for their role. They're doing a very intense job. They, of course, they didn't go to school for this and, many times, they didn't sign up for this, but they find themselves in that role. And in our case, we are very fortunate to have our clinical social workers who are able to provide that level of skilled support and bill for that time as well.

Dr. Clevenger:

So, there is sort of a catalog of things that we do. I find we have a lot of touchpoints with these families. And if you're doing dementia care well, you're going to find that you're having a lot of touchpoints with folks to avoid crises that lead to unnecessary hospitalizations. You certainly want to get reimbursed for the work that you're doing.

Jen Pettis:

Thank you for sharing this great information! I appreciate your team approach and diverse billing strategies. We talk a lot about how team-based care is really necessary to successfully manage patients with dementia in primary care practice. I'd also like to hear from Laura about her experiences.

Dr. Clevenger has described Laura as one of the gurus of chronic care management, or CCM, and capturing that in billing. Laura, I'd love to hear from you about how you support well-coordinated quality dementia care and how you spend time outside of standard visits. Can you share some specific examples of time spent outside of the standard primary care visits, which we generally think of as being short and a bit more structured. How can care outside that visit be a path to appropriate reimbursement?

Laura Medders:

I think Carolyn did a great job of outlining the ways in which we utilize time spent outside of an encounter. We utilize prolonged non-face-to-face visits quite frequently. We use them ahead of new patient visits to gather background information from caregivers, so they can speak candidly. We also use them for gathering information after the initial visit. For example, if medication changes were made, providers will schedule a 30-minute non-face-to-face visit with the caregiver 2 weeks later to see how the patient is responding to those changes. They use those calls to ask, “How is this change going? Have you noticed changes with behavior?” I think that is really important to have that time allotted so that we can follow up on the care goals for our patients and families.

Antiobesity medications (AOMs) We utilize chronic care management codes frequently in our practice to help coordinate care and get reimbursed for the time that our clinical team spends to help patients and families manage this disease process. As much as possible, we try to avoid requiring our patients living with dementia to come in for a visit because it disrupts their day, and we really want to make things easier for the care partners and our patients. For example, we use these codes for the time spent when an assisted living facility calls us to report that one of our patients had a fall or is acting more confused than normal. We spend time outside of face-to-face visits triaging concerns that the facility or the family has about the patient and then implementing a plan to coordinate care on behalf of the patient. We use the chronic care management codes to be reimbursed for that time we spend outside of a visit, which also to makes it easier for our patients and families to do what they need to do at home, and to minimize the disruption to their day.

Jen Pettis:

The work you are doing to be able to care for your patients with a patient-centered, person-centered approach, that minimizes the disruption to patients while allowing you to really get to know them is terrific.

I’ve heard from you both that it is possible to be reimbursed for quality dementia care, and I would imagine that many of our listeners are wondering how to implement this in primary care. In other words, what infrastructure do you need to make it happen? Dr. Clevenger let’s start with you.

Dr. Clevenger:

That’s a great question because I think we spend a lot of time training individuals, particularly primary care providers, about how to provide better and more supportive dementia care. That’s a wonderful thing, but it can also lead to a lot of frustration if they find themselves in a structure that doesn’t support doing the work that they learned about.

In quality work, we start with structure and then we put our process in place. So, there are some really basic things that we can consider in a typical primary care practice to implement this. For example, I've talked about a couple of things that take additional time, and you need to be able to schedule for that.

Dr. Clevenger:

I know there are practices that have expandable slots. Perhaps your typical slot is 20 minutes, but if people meet particular criteria, then your front office staff or your scheduling staff are empowered to expand the slot so that you can have a longer visit. We’ve done a fair amount of work on certain visit types that then automate that process for our schedulers, so they know if we ask for a particular visit type, it gets a longer time. Having that expandable slot can be terrifically helpful. Having the right structure for dementia care also requires staff, and you have to consider the revenue that you need to generate to cover those additional positions.

Dr. Clevenger:

That's part of why it is important that all of our staff members are included in the billing so that they are generating revenue for their time.

We also have to consider our patient population when determining staffing levels. We are a patient-centered medical home, so we look at the population health of our practice. I know lots of primary care practices also carry that designation, but even if you don't, you should consider the characteristics of your patient population. We looked at the characteristics of our population and staffed accordingly. We have a nurse practitioner–driven model of care. Our nurse practitioner does all of the in-person telehealth, and we include a geriatric psychiatry nurse practitioner on the team as a part-time position.

Dr. Clevenger:

That position is like a consultant who is a part of the practice. Again, if you're in a primary care practice with integrated behavioral health, this is probably not new or novel, but something you might consider because you understand that the needs of this population are going to include geriatric psychiatry. We are also staffed with licensed clinical social workers. You've already heard how critical that has been for us, in particular for the caregiver support and to coordinate care for the patient as well. The social workers really have been our care partner point of contact the entire time we've existed.

Dr. Clevenger:

And in dementia care you really need to exist and serve both the care partner and the patient to achieve positive outcomes including improved quality of life and avoiding crises.

And then, of course, we staff with registered nurses. I know that nursing staff levels are always a decision point that you consider in primary care. What is appropriate depends on the level of complexity of the clinical triage that is needed. Our registered nurses also conduct visits including annual wellness visits and they conduct outreach for preventive care and closing care gaps. We also have what we call a patient care coordinator. Other practices might think about that position as a scheduler front desk staff member who is attuned to the model and the needs of this population.

Dr. Clevenger:

It has been very helpful to empower our patient care coordinator and to provide them with some foundational knowledge about cognitive impairment and dementia. Although this person isn't considered clinical, this might be the first person to talk to someone on the phone about cognitive impairment. The patients might not think they need a cognitive assessment visit, but it's our scheduler who knows to call the daughter to say, "Hey, your mom canceled her visit tomorrow, did you want that?" And the daughter says, "Oh no, I still want that visit." So, I think it is important to make sure everyone on your staff is attuned to those needs.

That gets us to then standard processes. However you're staffed, however you're structured, having a clear process and standard flow for patient intakes is important.

Dr. Clevenger:

For new patient visits, as Laura mentioned, it actually involves multiple visits that include a vprolonged non-face-to-face visit with only the care partner or informant. It also includes a cognitive assessment visit. We often schedule multiple providers in a row with the patient so we're really clear when we do the schedule regarding who meets with this person first, second, third, and in our documentation. We have some basic process maps so that we all know where the process begins, which role on the interprofessional team plays which parts, and the order of those steps. We have that standard work or standard processes that we use to facilitate team communication about patients.

Dr. Clevenger:

As a leader of the practice, I think it's my responsibility to create structure for team communication. In our model, we have a structured morning huddle every day for 10 minutes. We've been doing this since we opened seven years ago. That huddle creates a space to know if there are urgent issues that someone needs to address and to share things that we all should know about for the day's work. It's different than things like staff meetings or case conferences. Again, if you're a PCMH, that may be something you're already doing. If you're not, I just can tell you how powerful it has been for both patient care and the team spirit and sense of belonging that we experience with each other to support collaboration and getting through the day.

Dr. Clevenger:

And then finally I would say note templates are an important component of our infrastructure. We have templates for documenting activities such as cognitive assessment and care planning visits, as well as prolonged non-face-to-face encounters. We have those templates embedded in our electronic medical records. We use Epic, which includes a pre-visit check-in template. Some of those tools should get pushed out according to your visit type so that you're capturing that information. And we're all capturing information in a similar manner, using the same tools if we're using a functional assessment for example, or a neuropsych inventory. Then, during the visit, our note templates are quite standardized and similar. This helps keep you as the clinician on the correct path, meaning you're going to check all the elements that you need for billing and compliance. If you as the practice leader are interested in your outcomes or you want to spot check processes, then having the same note template goes a long way because you're pulling out data as it's going in. And then you actually can provide feedback and ongoing continuous quality improvement for the team.

So those are some of the things I would recommend for any practice to put into place. Any one of those, I think, would lead to some improvements in the care of people with dementia. If you can do all of them well, all the better.

Jen Pettis:

Thank you. Laura,

I'm going to turn to you now with this next question. Dr. Clevenger alluded to documentation, and I'd really like to hear from you about documentation that's needed to support billing for quality dementia care, particularly with the complex case management that you mentioned, and the time spent with the care partners and time outside of those standard visits.

Laura Medders:

Of course. Chronic care management requirements have changed over the past seven years, so I'll do my best to recap where we are in that process. There is quite a bit of documentation required to be able to bill, but once you have the process down, it is not cumbersome. The first thing that is required is that the patient or the care partner consents to be enrolled in chronic care management or to be billed for chronic care management. This typically happens at that initial visit with the nurse practitioner in our clinic where they are talking about CCM, getting their consent, and documenting that in the medical record. The next piece that is required before you can bill CCM in a month is that you need a written care plan that has been shared with the patient and the family in some way and is included in the medical records so that other care team members may access it, as well as those outside the practice.

Laura Medders:

You have to have a care plan that should be comprehensive and person-centered. It should talk about the patient's goals and include instructions from the provider about how to meet those patient-centered goals. It should include things such as: What's on the problem list? What are the barriers to meeting these goals? What community support may be necessary? Are there financial limitations to achieving some of these goals? Who are the players that are involved in this person's care?

This is information that you may be collecting in your medical record, so it's a matter of capturing this information in one centralized place so that it's easy to find for the team. Everybody can see the care plan.

There are a couple of other things that are required to bill CCM. You have to have 24/7 access to the medical team.

Laura Medders:

For us, we have an after-hours number on nights and weekends that our patients can call if they have clinical concerns. The after-hours number is really important to us. We think it is critical for keeping our patients out of the hospital when its unnecessary. Caregivers can call and say, "This is new, this is different. Do I need to go to the hospital? Can I wait until Monday morning for triage?" Our providers help them walk through that. It is always somebody on our team that answers the calls from patients and families. Even if it's not their patient, they've often heard about the patients in the morning huddles that Carolyn talked about, so they're really able to give patient-specific advice in this after-hours line.

Additionally, you have to be able to document the medical care that you provide in an electronic medical record.

Laura Medders:

For many people, it needs to be shareable and documented. And then the key piece is being able to document the time spent within a calendar month coordinating the care on behalf of the patient. You have to document what happened, what care you coordinated, what goals were you working towards. It is typically contact-initiated, so it doesn't include time spent doing chart reviews or managing population health needs. It has to be based on a concern, such as the assisted living calling and saying "There's been a fall, there's been a change." Or, there's a caregiver who was calling and saying, "I've never seen this before. I don't know what to do. How do I get through the next 24 hours?" It may be that we are reaching out to say, "Hey, we noticed this,

Laura Medders:

we saw you went to this specialist, we're very concerned. Here's what we think is the plan moving forward."

It is any sort of contact-initiated time that is spent between you and somebody on that patient's care team. It doesn't necessarily have to be calling the patient or calling the patient's care partner to discuss things. Maybe it's time spent with the assisted living facility or the time spent talking to the pharmacy to make sure that the patient's getting the medications that they need. You need to document what you did, and you need to document how long you did it, and by whom. The provider of the service also matters—the enrolling provider. In our case, charges are usually billed under the nurse practitioner. But, for chronic care management, it often includes time spent by the clinical team, including our registered nurses, our social workers, and when we are fully staffed our LPNs, to coordinate care on behalf of our patients.

Jen Pettis:

I will comment that we heard from Dr. Clevenger at our recent annual scientific meeting and when she discussed your work with capturing the CCM, there was a bit of a gasp in the room. I think people didn't really know how that billing is not only possible, but essential. So, Dr. Clevenger, what would you like to add to what Laura shared about documentation? In particular, I'm interested in how you capture high-level visits with your patients?

Dr. Clevenger:

Certainly. Our providers capture the minutes that are devoted to CCM time. In addition, probably the non-traditional time-based visit type that we do most often are the prolonged non-face-to-face encounters because so many things do come up there. That particular code in the past was used only for chart review. You can still use that for chart review as part of intake if you're looking at like specialist notes and those sorts of things like neuropsych testing. But you can also use it for discussion about the patient when the patient is not present. These activities are gathering information from someone else.

Dr. Clevenger:

So just to remind people regarding HIPAA concerns, you are gathering information about the patient, you are not sending information out about the patient. So this is not something that would fall under patient privacy because you are not actually sharing information, you're gathering it.

As a clinician, as you're doing that billable time, you do need to document the visit, including the start time, the visit end time, and the content of what you discussed. It probably is the most free text type of documentation for our practice. We document what kind of information we received, what additional types of assessments we may have asked about, and then the overall impression of what the problem is or the diagnosis that we're addressing, and what is the plan. And then, the other required component is that it relates to either an upcoming visit or it relates to a previous visit that was an actual encounter.

Dr. Clevenger:

So that's important to remember for that documentation.

Now, the other thing that I didn't mention earlier is that sometimes you do have very high-level complex and intricate conversations, in particular around diagnostic disclosure for someone who is newly diagnosed. Or sometimes, when someone is post-diagnosis and, but it is a fresh diagnosis. And so early in those encounters, our conversations are really focused on, "What is your understanding of the diagnosis that you were given?" That's very helpful to understand where they are. And then it really starts to begin the conversation about goal setting.

What we plan for these individuals, by and large, follows a fairly well-known disease trajectory for dementia, whether it's Alzheimer's or Lewy body or vascular or frontotemporal.

Dr. Clevenger:

I start by talking to the person with the diagnosis as much as they're able to engage in the conversation, depending on their stage and their care partner, about what to expect over the next six months. That is advanced care planning. I know we think about advanced care planning as completing a formal advanced directive or a pulse—that's what the life sustaining treatment form is called in our state. That can be part of it, but many times it is also other concerns. For example, I'm concerned that, at this stage, people tend to have more balance issues and falls. At this stage, people tend to need additional care. Are you a family who wants to provide care in the home or would you look to go out of the home? This is the stage where adult day care is really supportive and may delay institutional placement and provide respite. This is the stage where driving cessation might happen. These are the things that we talk about, these are big milestones.

We tend to think about advanced care planning as only end of life care, but there are multiple milestones along this journey and that is certainly advanced care planning. You can obviously include those discussions as part of your visit and be reimbursed for those very valuable and meaningful types of high-level conversations you're having.

Jen Pettis:

Well, we titled this program noting that appropriate billing can serve as a pathway for quality dementia care. So how does that, in fact, serve as such a pathway? Dr. Clevenger, let's start with you.

Dr. Clevenger:

Look at the dementia quality measures that have been published for some time now. They include elements such as: someone with a dementia diagnosis should have a regularly completed assessment of their cognitive, their behavioral, their functional symptoms; their caregiver should be assessed for their own burden and strain; there should be a conversation around safety concerns. So, there are all of these elements in primary care. The concern in general medical care is that we think that all of this care falls to the provider, the nurse practitioner, the physician assistant, the physician. In fact, you really cannot accomplish this, certainly not in an ongoing, sustainable way without the entire team being part of it. Therefore, you don't want the patient and care partner to see you, the provider, as the only source of information.

Dr. Clevenger:

You want them to know that there are other people on the team who may be the best suited to answer their questions and concerns. Sometimes I get into conversations where, really, it's our social worker who is going to be the best person to do a deeper dive. I know about like two layers of depth, and they know ten layers.

Also, in a lot of office practices, we think about our billable providers. As you know, these are the people who need to be in patient encounters generating revenue for their time and everyone else is in a supporting role when, in fact, everyone plays a role. High functioning teams have situational leadership, in which the person who is best suited to lead in that particular circumstance takes the lead. That's high functioning and that's what we aspire to be.

Dr. Clevenger:

Now I do have this nursing lens, that's my background. I'm a nurse practitioner. All of my education, all of my degrees are nursing degrees. I'm unlike the newer folks with more broad-based educational backgrounds. But, I have been told for a long time and I have observed in particular in the hospital, that the work of nursing is invisible. I think social work probably has a similar experience. And because what is visible work is what goes on the billing sheet. But many times, the work of nurses, the work of social workers, makes a huge contribution in avoiding hospitalization, in optimizing quality of life, in better controlling people's chronic conditions, whether it's cognitive or otherwise. But if there isn't a bill attached to that person, it's like it never happened.

Dr. Clevenger:

Everything goes under the billing provider. And honestly, in our private insurance plans, we still have that situation.

So, it has been important to us to not only engage the team, to use every person on the clinical staff at their top of license for clinical activities, but also when we can, identify who is doing the work. Laura mentioned that the person who is doing the work of CCM is captured so that we can credit that person, and can measure their contribution in a quantifiable way, for the bottom line of the practice, and for the outcomes of the patients and caregivers. It's been really important to us. However, these CCM codes are relatively new and uptake is not huge. Cognitive assessment visits are relatively new. It's been important to us to take advantage of those because these patients get more of the care that they need. And it has allowed us to have our clinical staff really step in and lead when appropriate and also recognize the work that they're doing in a more formal way.

Jen Pettis:

Laura, is there anything you'd like to add to what Dr. Clevenger shared?

Laura Medders:

Yes, I agree that the work of social workers in particular is invisible. I feel social workers are the first service line that a lot of healthcare entities say they don't need. There are not as many traditional pathways for reimbursement. So, I think it really is important to be intentional about how we capture our time. We have to look at whether we allow the people on our team to practice at the top of their license so that we can get reimbursed for as much time as possible. That includes utilizing registered nurses to do the annual wellness visit instead of a physician or a nurse practitioner; allowing the clinical social worker to bill for family psychotherapy or individual therapy when possible; and then also capturing other supportive services that they're providing for chronic care management services. I think those practices are really critical to providing high-quality dementia care.

Jen Pettis:

And Laura I'll, ask you this one last question before we wrap up. You have already mentioned how much billing options have changed in the seven years you've been in your practice. We certainly add new resources to our care toolkit as they become available, including around reimbursement. But, we know staying current is a challenge. How do you stay up to date with all of these changes?

Laura Medders:

Carolyn and I have relied heavily on our professional organizations to help us with this. That includes learning from GSA, learning from the American Geriatric Society, the Alzheimer's Association, really being able to rely on their support. That education has been really instrumental in our success in implementing these billing practices locally within our clinic. We've also developed a strong working relationship with our billing partners internally and our coding specialists so that, when we hear about a new code, we can figure out how to apply it appropriately. Partnering with our internal resources to be able to move some of this forward is really critical to make sure that those charges are being applied correctly and we can get reimbursed for the time spent providing this high-quality care.

Jen Pettis:

Great. Well, this has been a terrific discussion and I want to highlight a couple of things I heard. The first is the need to focus on what is best for our patients as we develop pathways of care and ensure that the practice's infrastructure supports guideline-based dementia care to support the best quality outcomes. I also heard about the alignment of guidelines for care reimbursement and quality metrics and really looking at how those align for those better outcomes. And I love the idea of keeping the team from doing invisible work. I also heard a strong message about the importance of team communication and how reassuring this is for patients and care partners, especially if they are teetering on the edge of a crisis in the middle of the night and have someone who they can call. And even though they might not speak with their provider on the phone, they can say, "I talked to Dr. Clevenger, I talked to Laura this morning and she let me know what you guys are facing." That team communication sounds very reassuring for your patients and their care providers.

So those are a couple of real key points that I heard, and I'd also like to hear what you want to leave our audience with. Let's start with you, Laura.

Laura Medders:

I think high-quality dementia care is not accidental. It is something that the practice has to be intentional about figuring out. There are lots of different ways to do this, but how is it going to work for your individual team and what is the structure you need to put in place around it so that you can ensure that this is happening? The other piece for us that's been really important is measuring how well we're doing with outcomes. For example, we think it's really important that our patients receive a cognitive assessment in an annual wellness visit. So, we've been starting to track how well we are doing at meeting those goals.

Jen Pettis:

Dr. Clevenger, how about you? What are some key points you want leave our audience with?

Dr. Clevenger:

I just want to emphasize what you said about how well guidelines and billing and reimbursement and quality measures have aligned. For our clinicians, and our practice leaders who hear this and think "It's so much to keep up with, it's so much to do." Laura said it perfectly, it's been our professional organization that have helped so much with this. And sometimes if you feel overwhelmed, but if you pay attention, these things do line up very well. For example, a lot of the elements required for Patient-Centered Medical Homes set us up very nicely to look at a population of interest. In our case, that's people living with dementia. And then framework let us build a structure and figure out what matters most in terms of measurement. So, all of these things do line up very nicely. It's not like you have to keep up with each thing separately, but when you're paying attention, you start to see where momentum is in terms of offering better and more comprehensive dementia care from all angles, including reimbursement.

Jen Pettis:

Well, I want to thank you both, Laura and Dr. Clevenger. You guys are just terrific. Your patients and families are so lucky to have you. Thanks so much for all the great work that you're doing and thank you for sharing your insights with us at GSA and our listeners. Thanks again.

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