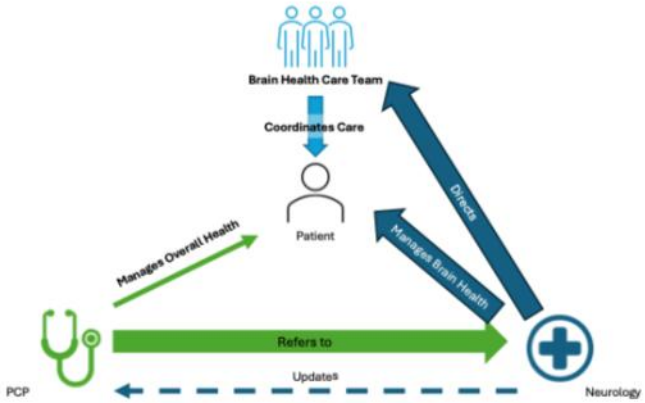
Dementia Navigation Archetypes

Contents

"SPECIALIST MANAGEMENT"

OVERVIEW

Patients with cognitive concerns are referred to Neurology; Neurology performs the diagnostic workup and retains the care of patients who receive a cognitive diagnosis. Patients who do not have a cognitive diagnosis are released back to primary care.



NAVIGATION

Navigation is owned by Neurology, following an "oncology nurse" model. The navigator/care manager is a Neurology resource. Neurology is generally responsible for placing all orders, making referrals, and following up on all abnormal results.

BILLING & REVENUE GENERATION

The most logical billing pathway would be that patients receive PIN pre-diagnosis and PCM post-diagnosis. Patients may also receive CACP performed by Neurology, in addition to any other office visits, diagnostic testing/imaging, etc. Neuropsychological testing may be part of Neurology or upon referral from Neurology.

In these workflows, the biggest obstacle for pre-diagnosis navigation is that the billing provider must have a qualifying initiating visit (QIV) with the patient to bill for navigation or care management. This means until the patient is seen in Neurology, none of the navigation/care management is billable. This is where many sites face challenges.

Sites may be willing to forgo generation of revenue in the pre-diagnosis stage in this model. However, there are workflow options that may allow for compliant billing of services.

OVERCOMING BARRIERS

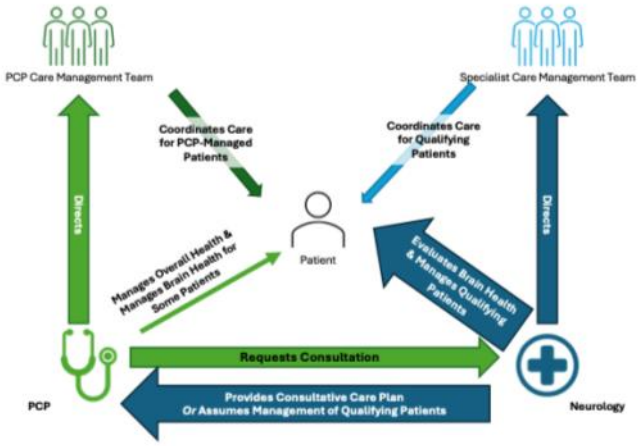
Two common options exist to generate revenue in the pre-diagnosis stage, especially if this stage is prolonged due to the wait time for neurology appointments.

1. Implement early QIVs in Neurology. This can be a 15-minute telehealth appointment with a physician/NPP to review the patient's reason for referral and gain consent for navigation (a Level 3-4 office visit). This allows all the navigation from that point forward to be billable, even if the patient does not have a confirmed diagnosis. Once a diagnosis is confirmed, the patient can be consented to additional services, like PCM. Over time, this workflow reduces Neurology wait times because the initial visit with the neurologist is more valuable, with labs, imaging, etc. being available to the provider at the visit rather than waiting to be ordered and then having to bring patients back to review results.
2. Pre-Neurology navigation with revenue sharing. If Neurology has the embedded resource for navigation/care management, but Primary Care has performed the QIV, Neurology can act as an "outsourced" navigation/care management provider where the PCP retains the overall care of the patient and general supervision of the Neurology navigation staff and bills for services rendered by that staff with a revenue share to Neurology. This is more complex and only valuable if the navigators are performing sufficient billable services before the initial Neurology visit.

"SPECIALIST CONSULTATION"

OVERVIEW

Patients with cognitive concerns are initially evaluated in primary care. If the presentation is confusing, the PCP suspects a complex diagnosis, or the PCP believes the patient may benefit from specialty therapy not offered in primary care, patients are referred to Neurology for confirmatory diagnosis and evaluation, including evaluation for DMT. If the patient is found to have a complex condition (e.g., LBD, frontotemporal dementia) or qualifies for specialty treatment (DMT), the patient's cognitive care is managed by Neurology. Patients with "straightforward" conditions (e.g., vascular dementia) who are not eligible for specialty treatment have a care plan developed by Neurology and are released back to Primary Care to carry out the care plan, with routine follow-up with Neurology in some instances.



This is the most common model when Primary Care and Neurology are not part of the same health system. Therefore, this is the most common model across the nation, although it is not well-reflected in the BHN participant sites.

NAVIGATION

This is the least likely path to have existing navigation, and most variable for where navigation will "sit." Ideally, navigation for patients who remain under the care of Neurology would remain in Neurology, while Primary Care provides navigation to patients pre-referral and after they are released back to Primary Care. This is complicated because it means separate navigation/care management resources must exist in Primary Care and Neurology, and it can be unclear which office is responsible for the navigation/care management in any given month.

BILLING & REVENUE GENERATION

While this is the most common clinical workflow – especially when Primary Care and Neurology are not part of the same health system – it is the most complex billing workflow and the least operationally efficient model.

In this model, either two separate resources are maintained for navigation/care management (one in Primary Care, one in Neurology), or the navigation/care management sits with one department (usually Neurology, but possibly Primary Care if they are big enough). This generally means that before the qualifying initiating visit in Neurology, patients do not receive navigation, and patients who are primarily managed by Primary Care on an ongoing basis do not receive necessary navigation/care management.

This is the model that is least likely to provide and bill all available services. For instance, CACP is often not billed for patients who are managed by Primary Care. If Primary Care provides navigation/care management, it is unlikely to be unreimbursed.

However, patients are eligible to receive PIN, clinical care management (probably PCM) and CACP in this model, the same as they are in other models.

OVERCOMING BARRIERS

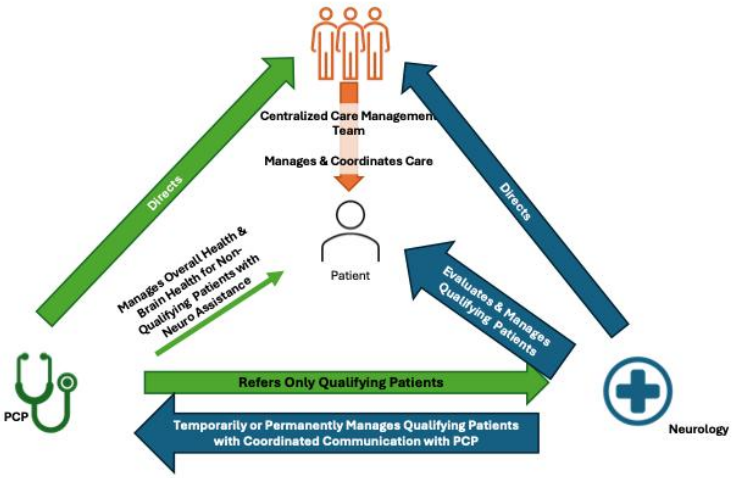
Operational coordination across Primary Care and Neurology is the easiest way to overcome barriers but is unlikely to occur when Primary Care and Neurology are not part of the same health system.
There aren't any "quick fixes" in this model and depending on the relationship between Primary Care and Neurology, and how many Primary Care sites are referring to a Neurology practice, solutions are probably a case-by-case basis. The most common solutions are:

1. Primary Care practices that are large enough can develop a navigation/care management model (likely not specific to brain health, but rather a shared resource across the practice to help patients navigate a variety of conditions.)
2. Neurology can develop a navigation/care management model that provides services after the QIV for all patients during the diagnostic journey, and for patients that remain under their care on an ongoing basis. An early QIV utilizing telehealth would be beneficial to these practices.

"SPECIALIST COLLABORATION"

OVERVIEW

Patients with cognitive concerns are evaluated and diagnosed in primary care using a pre-established/agreed upon care pathway. The care pathway establishes guidelines for involvement of Neurology for complex patient management, but most care is managed within a primary care pathway. If the clinical presentation warrants, patients are rapidly seen in Neurology. Neurology will evaluate the patient and determine the care plan which may include Neurology temporarily or permanently assuming responsibility for the cognitive care of the patient. This model typically relies on a "care manager" to coordinate the collaboration between primary care and neurology and to manage the complex relationship between the patient and the providers who help manage their care.



This model is generally only effective in integrated networks and may rely upon both formal and informal physician consultations.

NAVIGATION

Because this model is typically seen only in integrated networks, navigation is likely a centralized resource (owned at the health system/network level). As the provider who has performed a QIV, the PCP is most likely to be the overseeing provider for pre-diagnosis navigation. Clinical care management service will be overseen by the PCP or neurologist based on who makes the referral to the shared resource.

BILLING & REVENUE GENERATION

Patients receive PIN pre-diagnosis and PCM or other clinically oriented care management services ***and*** ongoing PIN post-diagnosis. Patients may also receive CACP performed by Neurology or Primary Care, based on the patient's presentation and care plan.

OVERCOMING BARRIERS

In this model, the biggest barrier is establishing the centralized resource and/or gaining buy-in to expand the existing centralized resources to provide brain health navigation. If the centralized resources already exist, the financial model is probably already proven with other diseases, and establishing the clinical protocols/workflows will be the biggest obstacle. If the centralized resource does not exist, establishing a program or outsourcing navigation/care management will require Primary Care and Neurology to establish buy-in with leadership/administration.

"NEUROLOGY DESERT"

OVERVIEW

Due to lack of Neurology resources, patients with cognitive concerns are managed in the management, consultation, or collaboration models where the specialist is not Neurology. Typically, this would mean Primary Care works with Psychiatry or Geriatrics for the care of these patients.

Other options (e.g. telehealth, remote care and referrals, virtual specialty care) may also be available for this model.

NAVIGATION

This is the least likely path to have existing navigation and is the most variable for where navigation will "sit," but will be determined based on the model of care selected (management, consultation, collaboration) and how embedded care coordination is in rural community hospitals.

BILLING & REVENUE GENERATION

Billing and revenue generation is per the selected model of care.

ADDITIONAL CONSIDERATIONS

- Navigation and care management for locations that will be GUIDE sites will often be determined by who is "owning" GUIDE care, since the GUIDE program requires much of the same navigation/care management.
- The role of neuropsychological testing is a wildcard, given how little access there is to neuropsychologists in most areas.
- In any model, outsourcing navigation/care management is an option, although easiest in the Collaboration model. Many health systems outsource their care management using a revenue share, and this approach can also be taken for navigation, if appropriate clinical integration is achieved. The issue of the billing provider and who is performing the Qualifying Initiating Visit remains a barrier in the Management and Consultation models.

For more information, please see the BHN Billing Code Resource Guide