# BUILDING A BUSINESS CASE FOR A DEMENTIA CARE PROGRAM


ALZHEIMER'S® ASSOCIATION

Dementia Care Navigation Roundtable

## Authors

**R. John Sawyer, Ph.D., ABPP**
Board Certified Clinical Neuropsychologist and Co-Director, Center for Brain Health
Ochsner Neuroscience Institute Michael Brown

**Michael Brown, MBA**
Director on the Future of Aging team, Lead: Alliance to Improve Dementia Care
Milken Institute Health

**Gary Espstein-Lubow, M.D.**
Distinguished Medical Scholar, Education Development Center, Professor of Psychiatry and Human Behavior, Alpert Medical School of Brown University

**Julius Bruch, M.D., Ph.D.**
CEO
Isaac Health

**Jane Carmody, DNP, MBA, RN, FAAN**
Senior Program Officer
The John A. Hartford Foundation

**Leah R. Hanson, Ph.D.**
Senior Director, Neuroscience Research and Senior Investigator
HealthPartners Institute

**Nicole Deaner, MSW**
Strategic Director, Healthcare Leadership
Alzheimer's Association

## Table of Contents

## Abbreviations

- **ACO** – Accountable Care Organization
- **APP** – Advanced Practice Provider
- **CAHPS** – Consumer Assessment of Healthcare Providers and Systems
- **CCM** – Chronic Care Management
- **CMS** – Centers for Medicare & Medicaid Services
- **CPT** – Current Procedural Terminology
- **DiD** – Differences-in-differences
- **ED** – Emergency Department
- **EEG** – Electroencephalogram
- **EHR** – Electronic Health Record
- **FFS** – Fee-for-Service
- **FAQ** – Frequently Asked Questions
- **FTE** – Full-time Equivalent
- **GUIDE** – Guiding an Improved Dementia Experience
- **HCC** – Hierarchical Condition Category
- **HCPCS** – Healthcare Common Procedure Coding System
- **HEDIS** – Healthcare Effectiveness Data and Information Set
- **IHSS** – In Home Support Services
- **IS** – Information Services
- **IT** – Information Technology
- **MA** – Medicare Advantage
- **MGMA** – Medical Group Management Association
- **MSSP** – Medicare Shared Savings Program
- **NPS** – Net Promoter Score
- **NEJM** – New England Journal of Medicine
- **NCQA** – National Committee for Quality Assurance
- **PCM** – Principal Care Management
- **PCP** – Primary Care Providers
- **PIN** – Principal Illness Navigation
- **PMPM** – Per Member Per Month
- **QI** – Quality Improvement
- **RFA** – Request for Application
- **ROI** – Return on Investment
- **RVU** – Relative value units
- **UCLA** – University of California, Los Angeles

## Executive Summary

Health systems are seeking practical approaches to strengthen and sustain dementia care programs at a time when demand is increasing and financing structures continue to evolve. Many programs remain difficult to launch and maintain because traditional fee for service models do not fully account for the interdisciplinary care and support services that are essential for people living with dementia and their caregivers. At the same time, the growing shift toward value-based care and the availability of newer care management codes are creating opportunities to strengthen the business case for dementia care programs. Emerging evidence also shows reductions in avoidable utilization, which can support financial return and long-term program viability.

This paper provides practical guidance for clinical and financial leaders who are working to build or expand dementia care programs and need a clear approach to communicating financial value. The guidance is organized into five modules that outline how to analyze the current state, identify relevant value metrics, review care model options, create a credible program analysis, and apply financial modeling tools in real world settings. Each module includes concrete steps and tools that can be used individually or sequentially depending on organizational priorities.

The purpose of this resource is to help interdisciplinary teams develop a strong and defensible business case for dementia care by aligning clinical goals with financial strategy. By using common language and consistent metrics, teams can better demonstrate how comprehensive dementia care reduces avoidable utilization, improves quality of life, and supports financial sustainability within fee for service, value based, or blended payment environments.

## Introduction

The March 2023 paper, "Making the Business Case for Value-Based Dementia Care," offered actionable guidance for the transformation of dementia care programs and the field as a whole.[1] Published in New England Journal of Medicine (NEJM) Catalyst, the paper outlined tactics for health institutions seeking to transition from traditional fee-for-service payment models to value-based care models. This approach allows for the tracking of financial value metrics, strengthens the financial case for dementia care, and supports overall care improvement.

Since the publication of this paper, the financial and policy landscapes have continued to evolve. Health systems are increasingly adopting alternative payment models, particularly for older adults that reduce unnecessary utilization and cost without sacrificing care quality.[1,2] Value-based care in this context refers broadly to approaches that move away from fee-for-service. These include accountable care organizations (ACOs), bundled payment arrangements, and Medicare Advantage (MA). MA is not identical to value-based care, many MA plans use value-based structures, so both MA and other risk-based models are important when building the business case for dementia care. The Guiding an Improved Dementia Experience (GUIDE) model, launched by Centers for Medicare & Medicaid Services (CMS), is now a closed demonstration. Only enrolled sites can participate in GUIDE, so references in this paper distinguish between considerations for GUIDE participants and options available to non-GUIDE programs.

Newer care management billing codes offer opportunities to reimburse for previously unpaid dementia care work.[1] However, health systems struggle to pilot and adopt alternative payment models and newer billing codes due to a combination of lack of awareness among providers and their administrative counterparts and high administrative burden to understand and operationalize more complex workflows.[2] Additionally, many clinicians within dementia care programs lack the practical tools and strategies needed to engage their leadership to adopt these opportunities to start, sustain, or scale dementia care programs.

Recognizing this need, the Alzheimer's Association sought to provide more practical tools to guide the implementation of value-based dementia care. This paper is intended for use by health system leaders, clinicians, financial officers, policy teams, and national provider organizations (e.g., Medical Group Management Association (MGMA)) seeking to strengthen or establish dementia care programs. This work builds on a related framework to support scaling dementia care, including four steps: identifying leaders and partners, preparing a value proposition, conducting program start-up, and maintaining sustainable implementation.[5] This paper provides detailed guidance to support the value proposition development and program start up, and it consists of five sequential modules, each detailing the key components to building a business case.

## BUILDING A BUSINESS CASE FOR A DEMENTIA CARE PROGRAM

**Module 1: Analyzing Current State**
Assessing the existing dementia care landscape

**Module 2: Identifying and Understanding Key Value Metrics**
Defining the primary sources of financial value important to your institution

**Module 3: Reviewing Care Model Types**
Choosing the right dementia care model

**Module 4: Creating a Credible Program Analysis**
Building a "Program Scorecard" to track metrics

**Module 5: Dementia Care Financial Module**
Learning how to apply modules 1-4 to generate financial data

We know health systems have constant requests to expand various clinical programs. These modules are designed to help clinicians make the best business case despite the financial headwinds constantly challenging clinicians who support dementia patients.

## Current Challenges

Healthcare systems continue to lack adequate dementia care programs despite the rising demand.[1] Many of the models in use today are hard to start and lack long-term sustainability because the primary way health systems initially determine a clinical program's financial value has been unidimensional: Does the revenue generated by providers who bill for their services support the direct and indirect costs of the program?[1]

This traditional fee for service (FFS) financial model and analytic framework presents particular challenges for dementia care. Supporting the care needs of people living with dementia requires an interdisciplinary team. Those team members have had to provide a range of support services without a billing mechanism in the current FFS reimbursement structures.[1] The financing picture is further complicated by a patient population that is disproportionately covered by government payors where reimbursement rates are much lower than private insurance.[1,3,4] In the past few years, Medicare has released various iterations of care management codes that provide reimbursement mechanisms.[1] The lack of widespread adoption, however, is often related to significant complexity and cost to understand and deploy those codes to sustain dementia care programs.[6]

At the same time, many institutions are shifting away from FFS business models and toward value-based care financing models, particularly with older adult patient populations. Valuebased care programs de-emphasize billable services to determine program financial value. Instead, unnecessary utilization, lowering cost of care, reducing hospital length of stay, and improving quality of life are factored into a program's overall financial value or return on investment (ROI). Dementia care programs have an opportunity to better demonstrate their financial return, since there is ample data that they reduce unnecessary utilization, bend the cost curve, and improve quality of life.[1] Since it is challenging to gather and analyze this type of data, these modules aim to give healthcare teams a straightforward approach for financial data analysis.

Finally, to complicate matters more fee-for-service and value-based payment models approach financial sustainability in very different ways. Since most health systems use both FFS and value-based models, this can make it difficult to determine and optimally balance various financial metrics to sustain a dementia care program.

This paper introduces five financial planning modules to help health systems assess, design, and scale comprehensive dementia care. Each module offers practical tools tailored to different stages of program development.

## WHY DEMENTIA CARE PROGRAMS STRUGGLE TO THRIVE

### Rising Need, Stalled Programs

There is growing demand, but limited support:

- Dementia cases keep increasing
- Few health systems offer comprehensive programs
- Existing models lack long-term sustainability

### A Flawed Financial Lens

The old question...

**Does billing revenue** cover the program's costs?

**This narrow view overlooks** the broader value of dementia care.

**Many programs fail** because they're judged by outdated metrics.

## Fee-for-Services (FFS) Barriers

The FFS model doesn't fit dementia care.

### Interdisciplinary Care

No billing codes for many roles

### Medicare/Medicaid

Lower reimbursement rates from government payers

### Care Management Codes

New codes exist but are complex and costly to deploy

**Health systems need a broader financial view** to make dementia care sustainable.

## A New Way to Define Value

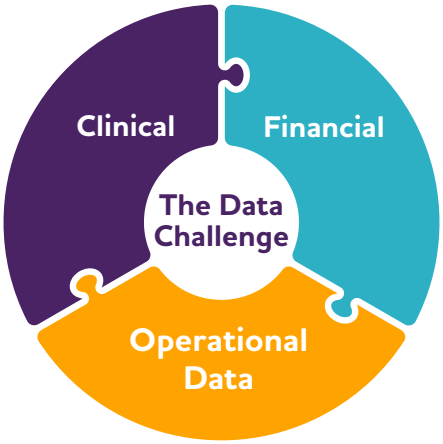
Value-based care measures success through:


- Reduced hospitalizations & ER visits
- Shorter length of stay
- Lower total cost of care
- Better quality of life

Dementia programs already deliver these results — if data can prove it.

## Proving Impact is Hard

Gathering, aligning, and analyzing ROI data is complex. Health systems need simpler, clearer tools.




Different payment models (FFS vs. VBC) track success differently, adding complexity to financial analysis.

## Introducing Five Financial Planning Modules

**1 Analyzing Current State**
Assessing the existing dementia care landscape

**2 Identifying and Understanding Key Value Metrics**
Defining the primary sources of financial value important to your institution

**3 Reviewing Care Model Types**
Choosing the right dementia care model

**4 Creating a Credible Program Analysis**
Building a "Program Scorecard" to track metrics

**5 Dementia Care Financial Model**
Learning how others are applying the modules

**Sustainability and Scalability**
Building the Financial Case for Comprehensive Dementia Care

## How to Use This Guide

This guide translates financial planning concepts into practical steps for dementia care programs. The modules can be completed in order or used individually, depending on your organization's priorities and stage of program development.

It is designed for interdisciplinary teams that include clinicians, financial leaders, data analysts, and administrators who are working together to design, justify, or sustain dementia care programs.

Each module includes a Quick Reference Box with commonly used metrics, partners, and tools, followed by Detailed Guidance for deeper implementation. The final section provides case examples showing how different organizations have applied selected modules.

Start with the information and metrics that are most readily available in your system and expand over time as analytic capacity grows. Your team may be able to complete only some elements within each step at first, but these can be built on progressively. Once initial steps are underway, refer to the complete module content for additional guidance.

# Module 1: Analyzing Current State

## Introduction

### Module Purpose

This module outlines approaches for assessing the existing dementia care landscape at the organizational, regional, or state level, with attention to aligning priorities, avoiding duplication, and identifying partners and leaders, data sources and programs to build on.

### Why It Matters for Financial Planning in Dementia Care

Evaluating the current landscape allows health systems to learn from prior efforts, avoid duplication, and identify local factors that can strengthen the financial case for dementia care.

## Overview

### Quick Start Guide

These abbreviated steps will help you build a credible program proposal.

1. **Define scope and goals:** Clarify why you are assessing the landscape, what decisions it will inform, and how the work aligns with organizational priorities.
2. **Quantify your dementia population:** Determine how many patients have dementia and, as feasible, clinical indicators (type of dementia, severity level), key demographics, insurance type, care utilization at your health system (e.g., primary care, specialty care like neurology), frequency of unnecessary utilization.
3. **Map care delivery and leadership:** Identify where patients are seen (e.g., geriatrics, neurology, primary care) and the clinical/operational leaders at both clinic and serviceline levels. Include access considerations such as wait times for neurology, psychiatry, or geriatrics, which can be barriers.
4. **Inventory data systems and payment contexts:** Identify what data systems are used to monitor clinical and financial metrics (e.g., electronic health record (EHR) data, revenue cycle data systems, population health data systems, dashboards) and determine what percent of dementia patients are in traditional FFS payment models vs value-based arrangements (e.g., ACOs, Medicare Advantage, bundles).
5. **Catalog services, partners, and funding:** Document internal programs and how they measure financial value; list community resources and regional providers; engage key leaders to surface priorities and potential funding sources.

### Quick Reference Box

These are the metrics, roles, and tools you will cite most. Keep them on hand when developing slides or briefs.

| Key Metrics | Partners | Tools/Resources |
|---|---|---|
| Patient volumes, insurance mix, utilization patterns, dementia patient cost and revenue patterns, | Clinical champions, operational leaders, Quality Improvement (QI) teams, finance leaders, community partners. | Internal data systems, QI dashboards, CMS measures, partner engagement frameworks (e.g., IMPACT value proposition guide). |

## Detailed Guidance

### What to Evaluate

Use this checklist to identify key metrics to evaluate. When assessing your organization's current state, keep in mind how shifting program priorities, competing organizational demands, and overlapping value-based care initiatives may influence dementia care planning.

- ☐ **Patient Population:** Assess how many patients with dementia are currently served, along with details such as insurance coverage, demographics, and patterns of service use.
- ☐ **Billing and Diagnostic Codes:** See the **Appendix** for commonly used billing and administrative codes. Organizations should also identify the commonly used dementia-related diagnostic codes in their local context and ensure those codes are consistently applied when estimating the size of the population of people living with dementia.
- ☐ **Points of Care:** Determine the main settings where patients are seen, for example, geriatrics, neurology, primary care, or a combination of sites.
- ☐ **Leadership and Champions:** Identify the clinical and operational leaders responsible for dementia-related services, both locally and at the service-line level.
- ☐ **Organizational Challenges:** Take into account issues your system may already face, such as access challenges to specialists, high readmission rates, unnecessary ED visits, and longer hospital stays.
- ☐ **Quality and Access Data and Metrics:** Review various quality and access metrics for older adults and, if possible, dementia patients. This can help understand where there are quality and access challenges to bolster the program justification.
- ☐ **Participation in Value-Based Care:** Check whether the system is engaged in ACOs, bundled payments, or Medicare Advantage programs, and how those arrangements are performing.
- ☐ **Financial and Service Gaps:** Examine areas where services or financing are incomplete, such as lack of care integration or areas that are heavily reliant on philanthropy, grants, or internal budgets.
- ☐ **Community Resources:** Consider what partnerships already exist with aging services, Alzheimer's organizations, Medicare programs, or other local providers.

**How to Apply It**

Use the list below to convert the framework into action.

- **Engage Partners:** Convene leaders and collaborating departments to identify "win-win" solutions for patients, families, clinicians, and health systems. In particular, population health, technical partners such as information technology (IT), clinical departments, managed care, and care management departments can be key partners. For engagement, strategies can be individualized based on the needs of each partner.[5]
- **Center Patient and Family Needs:** Keep mission alignment with patient and family support needs while balancing financial sustainability.
- **Leverage Quality Improvement Teams:** Connect with existing QI teams that may already track related measures.
- **Explore Funding:** Evaluate opportunities through internal budgets, grants, philanthropic support, and value-based incentives.
- **Facilitate Collaboration:** Start with events or meetings to gain leadership buy-in, then work toward a regularly convening group.

## Common Challenges or Considerations

Anticipate these common challenges to prevent rework and misinterpretation of results.

- **Payment models often change,** which can disrupt program financing.
- **Increasing demand from families** for easier access and rapid support.
- **Dementia and aging care priorities** often need to be elevated as strategic organizational goals.

# Module 2: Identifying and Understanding Value Metrics

## Introduction

### Module Purpose

This module outlines approaches for identifying and defining the primary sources of financial value for dementia care programs, including how different types of value can be measured, aligned with a health system's business model, and influenced by internal and external factors.

### Why It Matters for Financial Planning in Dementia Care

Because dementia care programs vary in design and operate in different economic environments, a clear economic model is essential. It helps demonstrate ROI to leadership, guide resource allocation, and support sustainability. Since payment environments differ, it is important to understand which value metrics apply in each setting.

## Overview

### Quick Start Guide

These abbreviated steps will help you build a credible program analysis quickly and credibly.

1. **Assemble your team:** Finance, clinical, analytics, and operations leaders.
2. **Define how value is determined:** Based on your local context, how is financial value determined for clinical programs? Is it primarily one model (e.g., FFS, value-based, grant supported) or a blend of models (e.g., partially FFS and value-based).
3. **Identify and align metrics with payment context:** Fee-for-service metrics, value-based metrics, some blend of FFS and value-based payment, or external funding (i.e., grants, philanthropy, contracts).
4. **Document challenges and assumptions:** Attribution, payer mix, and data completeness.

### Quick Reference Box

These are the metrics, roles, and tools you will cite most. Keep them on hand when developing slides or briefs.

| Key Metrics | Partners | Tools/Resources |
|---|---|---|
| Relative value units (RVUs), Current Procedural Terminology (CPT)/ Healthcare Common Procedure Coding System (HCPCS), Per Member Per Month (PMPM) costs, Hierarchical Condition Category (HCC), ED/inpatient admits avoided, caregiver satisfaction. | Clinical operations, Revenue Cycle, Finance, Population Health, Billing and Coding, Providers (e.g., neurology, geriatrics, primary care providers (PCPs), psychiatry), Data analytics, IT, EHR teams. | CMS GUIDE, ROI calculators, EHR dashboards, National Committee for Quality Assurance (NCQA)/ Healthcare Effectiveness Data and Information Set (HEDIS) measures, published dementia program evaluations. |

## Detailed Guidance

### What to Evaluate

Use this checklist to select department-level, system-wide, and value-based metrics that fit your payment context.

**Department-Level Metrics:** Assess how the program performs financially within the unit that operates it (neurology, geriatrics, primary care, or home care).

- ☐ **Fee-for-Service Revenue Model:** Consider the effect on billable work RVUs compared with operating costs and note opportunities for reimbursable codes such as Chronic Care Management (CCM), GUIDE, or cognitive assessment. The GUIDE model is a closed demonstration and only sites that enrolled can use GUIDE billing codes. For non-GUIDE programs, codes such as CCM, Principal Care Management (PCM), and Principal Illness Navigation (PIN) remain available options to support dementia care services.
- ☐ **Fixed Grant Revenue Model:** Check whether the program can realistically deliver all required components within the grant budget, including staffing levels and navigator caseloads.

**Health System-Wide Metrics:** Take note of downstream effect on other departments, like imaging, lab testing, specialists, pharmacy/infusion services, and utilization avoidance. Additive value generated from those sources can be factored into your overall financial performance analysis.

- ☐ **Ancillary services revenue impact:** Review changes in use of ancillary services, including imaging, laboratory testing, neuropsychology assessments, and infusion center utilization for disease-modifying therapies.
- ☐ **Care coordination–driven volume shifts:** Track how coordination shifts volumes, for instance, referrals to rehab, home health, or palliative care, and whether post-acute placement patterns change.
- ☐ **Avoidable utilization reductions:** Monitor reductions in emergency department (ED) visits, hospital admissions, duplicate testing, and lengths of stay achieved through proactive management and better discharge planning.

**Value-Based Metrics:** Monitor how the program performs under risk-based arrangements, such as ACO contracts. Dementia care programs, particularly those that include care navigation, can reduce costs. Medicare factors like HCC risk adjustment and quality bonuses may also shape results.

- ☐ **Total cost of care impact:** Track shifts in ED and inpatient admissions, medication spending, nursing home use, referrals to palliative or hospice care, and dementia treatment intensity.
- ☐ **Revenue impact.** Examine Medicare-related factors such as HCC risk adjustment (dementia codes weighted higher in V28) and quality incentives tied to Consumer Assessment of Healthcare Providers and Systems (CAHPS) and HEDIS.
- ☐ **Attribution considerations.** Account for the fact that dementia programs are rarely the only driver of savings; apply risk-adjusted control groups or focus on dementia-attributable costs.

The next section details further considerations for clarifying the scope of your evaluations.

## Economic Model Framework

With targets identified, align them with an economic model to ensure results are comparable and defensible.

| Model | Focus & Examples | Metrics & Notes |
|---|---|---|
| Fee-for-Service | **Key Focus:** Billable activity vs. program cost<br><br>**Examples:** Work RVUs, cognitive assessment codes, CCM, GUIDE | **Direct**<br><br>• **Provider-based billing (M.D., (advanced practice provider (APP), Ph.D.)** – CPT Codes:<br>» Physician and APP Evaluation & Management Codes<br>» Neuropsychological Testing & Evaluation Codes; Cognitive Assessment Codes<br>» Complexity and other add-on codes<br><br>• **Program-based billing** – Care Management Codes:<br>» GUIDE Codes<br>» Principal Care Management Codes<br>» Cognitive Assessment and Care Plan Services (99483 E&M)<br>» Caregiver Training (97550)<br>» Other Care support Codes (PIN, CCM Codes)<br><br>**Indirect**<br><br>• **Downstream or ancillary billing** – CPT Codes:<br>» Lab and Imaging Services (Biomarkers, Brain Scans)<br>» Procedure services (Lumbar Puncture, Electroencephalograms (EEGs))<br>» Pharmacy and Infusion Services<br><br>• **Throughput and access improvement** – Varies: Improved primary care and other specialist access when dementia patients utilize less outpatient visits with dementia care management support<br><br>• **Patient and Caregiver Experience** – Varies: Impact of experience and satisfaction measures |

| Model | Focus & Examples | Metrics & Notes |
|---|---|---|
| Value-based care | **Key Focus:** Program savings vs program cost<br><br>**Examples:** ED and inpatient admissions, nursing home admissions, medication spend | • **Revenue-Enhancing** –<br>HCC Risk Adjustment Score; CPT Codes: :<br>» Risk score of dementia patients in the care management program vs those not in the care management program along with the financial impact of higher/more appropriate risk scores<br>» PIN Codes<br>• **Cost of Care** –<br>Cost of Care Metrics at 6 and 12-Months:<br>» Total Cost of Care compared to typical dementia patients without care management<br>» ED, Inpatient, Outpatient, Ancillary Cost of Care<br>• **Utilization Management**<br>Visit Frequencies:<br>» Total visits compared to typical dementia patients without care management<br>» ED, Inpatient, Outpatient, and Ancillary Visits<br>• **Throughput and access improvement** –<br>Varies: Financial impact of Hospital Length of Stay reductions and improved hospital bed availability<br>• **Patient and Caregiver Experience** –<br>Varies: Impact of experience and satisfaction measures |
| Fixed Grant | **Key Focus:** Delivering components within a set budget<br><br>**Examples:** Staffing levels, caseload per navigator | • **Budget-based:** Tracking whether staffing/caseload commitments are met within allocated funds |

### Organizational Scope of the Analysis

Clarify the boundaries of your economic scope to determine the key financial metrics. Sometimes it may mean tracking all metrics below.

| Economic Scope | Description |
|---|---|
| Program-level billed services only | Is limited to financial billing by providers or team members within the operating unit (e.g., clinical program service revenue like CPT or care management codes. |
| Health system-level billed services | Includes downstream and cross-departmental impacts (e.g., labs, imaging, infusion, home health). |
| Value-based savings | Includes: Cost of care metrics, HCC risk score adjustments, and utilization. |

## How to Apply It

When applying financial models to dementia programs, bring the right team members together and clearly identify the key financial metrics. Use the list below to convert the framework into action.

***Initiating Analysis***

- **Define objectives early:** Clarify whether the goal is to create the business model in the first place, demonstrate ROI, secure funding, meet payer requirements, or support program expansion.
- **Tell a compelling story:** Be ready to explain the growing population of people with dementia, the associated costs, the evidence base for comprehensive dementia care, and the solutions – such as the one you are providing – which can improve care quality and costs (Haggerty, JAGS in press).
- **Establish scope:** Determine whether the economic analysis will be FFS-only, value-based, grant-based, or some combination.
- **Identify data sources:** Determine where the required data will be obtained (e.g., EHR, claims, patient registries, caregiver surveys).
- **Set timeframes:** Establish a baseline period and follow-up intervals to facilitate meaningful comparison.

***Involving Key Partners***

- **Clinical leaders:** Neurology, geriatrics, primary care, and care navigation leads.
- **Finance teams:** Revenue cycle, coding/billing, finance analysts, payer contracting staff, value-based care finance specialists.
- **Operations leaders:** Administrators, care coordinators, scheduling and throughput managers.
- **Data science/analytics:** Data extraction, reporting, and risk adjustment expertise.
- **Payer relations/contracting:** For integration with value-based performance reporting.
- **Quality and compliance:** To ensure alignment with internal and external reporting standards.

### *Collaborating Across Departments and Functions*

- **Set up a cross-functional working group:** Include clinical, finance, operations, and data teams to meet regularly.
- **Establish a shared data set:** Ensure consistency in definitions (e.g., "dementia-attributable costs," "avoidable ED visit").
- **Identify interdependencies:** Identify interdependencies, such as the impact on sub-specialty capacity or other programs claiming total cost of care savings for the same population.

### *Balancing Quick, Practical Insights vs. Analytical Rigor*

- **Start small, then deepen:** Use an initial high-level analysis to identify trends and areas of opportunity.
- **Iterate:** Conduct deeper dives into promising areas, refining methodology as more data becomes available.
- **Align with decision timelines:** Deliver quick wins (e.g., early hospitalization reduction data) to maintain momentum while longer-term analyses mature.
- **Document assumptions:** Keep a transparent record of methods and data limitations, even when working quickly.
- **Integrate into continuous improvement:** Make economic evaluation a recurring activity rather than a one-time project.

## Common Challenges or Considerations

Anticipate these common challenges to prevent rework and misinterpretation of results.

- **Data completeness** is often limited when claims or EHR records have gaps, making analysis harder.
- **Attribution issues** can surface when several programs overlap and affect the same patients.
- **Payer mix variability** means the economics differ across Medicare fee-for-service, Medicare Advantage, and commercial coverage.
- **Conflicting priorities** sometimes develop between finance teams focused on margins and clinicians focused on outcomes.
- **Change management** is harder when staff feel evaluations are being used in a punitive way.

## Module 3: Reviewing Care Model Types

### Introduction

| Module Purpose | Why It Matters for Financial Planning in Dementia Care |
|---|---|
| This module outlines approaches for selecting and designing dementia care models — whether consultant, co-management, or principal care — that are both clinically effective and financially sustainable. | Effective dementia care is time- and resource-intensive. For sites already enrolled, the GUIDE payment model supports structured care, but only if programs are designed with realistic staffing, panel sizes, and service delivery levels. Health systems not in GUIDE will need to use other billing codes, value-based contracts, or grant funding to support similar models. |

### Overview

#### Quick Start Guide

These abbreviated steps will help you build a credible program analysis quickly and credibly. Start with the information and metrics most readily available in your system and add over time as analytic capacity grows. Your team may be able to complete only some elements within each step at first, but you can build on them over time. Once these steps are underway, refer to the complete module content below for deeper guidance.

1. **Select your care model:** Reviewing various evidence-based models and types of care support programs.
2. **Size your panels and staffing:** Estimate patients per tier and align staff full time equivalents (FTEs) and ratios.
3. **Test financial sustainability:** Simulate revenue under GUIDE PMPM rates and tier mix.
4. **Plan for integration:** Map referral pathways and how the model fits within existing practices.
5. **Build support structures:** Engage cross-functional teams, set up tracking dashboards, and document key assumptions.

#### Quick Reference Box

These are the metrics, roles, and tools you will cite most. Keep them on hand when developing slides or briefs.

| Key Metrics | Partners | Tools/Resources |
|---|---|---|
| Patients per tier, staffing ratios, caregiver strain, respite uptake, cost comparisons. | Geriatricians, PCPs, finance, operations, care navigators. | CMS GUIDE Request for Application (RFA) and frequently asked questions (FAQs), staffing/payment models, workflow templates, screening frameworks,[7] on dementia quality measures. |

## Detailed Guidance

### What to Evaluate

Use this checklist to assess core areas, metrics, questions, and risk factors for reviewing care model types.

### Core Areas, Metrics or Questions

- ☐ **Evidence Based Practice:** Review various models of comprehensive dementia care (e.g., Aging Brain Care, Alzheimer's and Dementia Care, Care Ecosystem, etc.) to ground program services in evidence-based practice.[5]
- ☐ **Care Model Type:** Intermittent Consultant, Co-Management, Blend of Intermittent Consultant/Co-Management or Principal Care.
- ☐ **Care model costs:** Account for staffing and panel assumptions, including FTEs per role and expected caseloads, as these drive variation in program costs.
- ☐ **Staffing and Panel Assumptions:** FTEs per role, tier distribution of beneficiaries, and expected patient-to-care navigator or clinician ratios.
- ☐ **Referral and Utilization Metrics:** Respite uptake, transitions to facility care, and caregiver strain measures.
- ☐ **System Integration:** Operation in parallel to, alongside, or within primary care or specialty practices.

### Internal/External Factors Influencing Evaluation

- ☐ **Risk stratification methods:** Identify high-need dementia patients most likely to benefit; many systems can adapt existing stratification processes with dementia-specific overlays.
- ☐ **Analytic expectations:** Track referrals, caregiver outcomes, service intensity, time use, and financial return, requiring robust EHR support.
- ☐ **Attribution considerations:** Separate dementia program outcomes from those attributed to other payment models (e.g., Medicare Shared Savings Program (MSSP), ACOs) that also affect patient cost, quality, and utilization.
- ☐ **Reimbursement issues:** Participation in other CMS APMs does not prevent GUIDE participation, but eligibility rules apply (e.g., MA patients cannot be included, and GUIDE payments cannot overlap with other reimbursements for case management or respite services such as In Home Support Services (IHSS)).

## How to Apply It

Application of these evaluation tools can be broken down into three stages: Choose a model, Plan for Sustainability, and Plan for internal adoption. Use the section below to convert the framework into action.

***Choose a model***

When choosing among these models, also consider staffing needs and whether services will be delivered within the health system or contracted externally.

| Model | Description |
|---|---|
| **Intermittent Consultant** | Low upfront cost but does not follow-up patients at set or prolonged intervals. |
| **Co-Management** | Shared care between dementia specialists and PCPs; enhances care coordination and support. |
| **Principal Care** | Dementia provider assumes lead role; requires full integration but enables maximum control and reimbursement capture. |

***Plan for sustainability***

- Determine how many patients and visits are needed to cover fixed costs (staffing, training, administrative costs).
- Simulate financial impact under chosen model and financial assumptions (e.g., revenue projections based on care management codes or anticipated cost savings).
- Build a staffing matrix based on panel size projections and productivity assumptions.

***Plan for internal adoption***

- Identify cross-functional partners and team members (clinical, finance, analytics, operations).
- Hold care pathway design sessions (e.g., when and how to triage to different model levels).
- Establish caregiver and social services workflows, especially around respite.

Keep in mind cross-team and upstream/downstream dynamics. Ensure smooth collaboration with upstream (screening) and downstream (referrals, respite, hospice) partners.

## Common Challenges or Considerations

Anticipate these common challenges to prevent rework and misinterpretation of results.

### *Outsourcing Dementia Care*

**PROS**

- Rapid deployment and lower initial investment.
- Access to specialized dementia-trained staff.
- Can supplement under-resourced internal teams.
- Standardized protocols and training across contracted teams.

**CONS**

- Reduced care continuity and integration with PCPs.
- Limited ability to manage long-term quality or financial performance.
- May result in lower total revenue capture and missed value opportunities.
- Limited access to EHR for outside contractors.

### *Internal Capacity*

Investing in internal dementia care capacity has many benefits, including:

- Fostering alignment between existing primary care and specialty workflows.
- Enhancing interdisciplinary collaboration.
- Enabling organizations to build sustainable care models with higher long-term financial returns.
- Making data tracking, attribution, and quality reporting more manageable.

### *Analytic Rigor*

- Create clear data standards across roles for documenting services (e.g., time-use logs, caregiver education delivery).
- Build dashboards for tracking referral volumes, service delivery by tier, caregiver strain measures, and unplanned utilization.
- Attribute costs and value per patient or per tier, not just system-wide.

## Module 4: Creating a Credible Program Analysis

### Introduction

| Module Purpose | Why It Matters for Financial Planning in Dementia Care |
|---|---|
| This module outlines approaches for building a "Program Scorecard" that tracks performance, sustainability, and value. | A structured scorecard enables teams to demonstrate the value of dementia care programs to leadership, align program growth with financial sustainability, and build credibility for continued investment. |

### Overview

#### Quick Start Guide

These abbreviated steps will help you build a credible program analysis quickly and credibly.

1. **Define success early:** Agree on program goals and why your system is pursuing this initiative.
2. **Design your scorecard:** Select metrics across revenue, costs, outcomes, and satisfaction—and set realistic targets.
3. **Align with financial context:** Match metrics and reporting cadence to your system's reimbursement model (FFS, value-based, or some blend).
4. **Assemble your team:** Engage finance, analytics, IT, clinical leaders, and operations in planning and ownership.
5. **Plan for rigor and timelines:** Anticipate attribution complexity, level of analytic rigor, delayed ROI, and data lags—build these into expectations and reporting.

#### Quick Reference Box

These are the metrics, roles, and tools you will cite most. Keep them on hand when developing slides or briefs.

| Key Metrics | Partners | Tools/Resources |
|---|---|---|
| GUIDE billing, CCM/PCM codes, HCC scores, PMPM costs, ED visits, satisfaction (patient, caregiver, provider). | P&L owner, program leads, IT, finance, analytics, population health, ancillary care teams. | CMS GUIDE codebook, HCC tools, ROI calculators, prior dementia program case studies, published evidence.[1,7,8,9,10] |

## Detailed Guidance

### What to Evaluate

Use this checklist to assess core areas, internal factors, and external factors for creating a credible program analysis.

#### *Core Areas*

- ☐ Program revenue (provider-based billing, direct GUIDE billing, CCM, PCM).
- ☐ System revenue (downstream service referrals, HCC score changes).
- ☐ System savings (avoidable ED visits, PMPM cost reductions).
- ☐ Program costs (FTEs, operating costs, overhead).
- ☐ Operational quality (referral-to-enrollment time, satisfaction).
- ☐ Market reputation (brand recognition, share).

#### *Factors*

**Internal Factors**

- ☐ Risk stratification capacity
- ☐ Analytic sophistication
- ☐ Leadership priorities

**External Factors**

- ☐ Payer mix
- ☐ Contracting terms
- ☐ Policy changes
- ☐ Lack of benchmarks

#### *Scorecard Example 1*

This scorecard provides a high-level snapshot of program performance. It highlights core measures across operations, revenue, savings, costs, and outcomes, serving as a simple dashboard to track progress and communicate value.

| Score Card Executive Summary | Report Metric | Note |
|---|---|---|
| **Operations** | | |
| Patients Referred for Program Evaluation | XXX | Monthly or Quarterly Referral Volume |
| Patients Enrolled in Program | XX | Monthly or Quarterly Patient Enrollment |
| **Revenue** | | |
| + Direct Program Revenue | +$$$$ | Revenue from Direct Billing of Program |
| + Indirect Systems Revenue | +$$$$ | Revenue from ancillary services i.e. labs, imaging, other specialties |
| **Savings** | | |
| + Systems Savings | +$$$ | Most applicable under Value-Based Models |

| Score Card Executive Summary | Report Metric | Note |
|---|---|---|
| **Costs** | | |
| Direct Operational Costs | -$$ | Direct FTEs, facilities, marketing, and materials needed for the program |
| Indirect Operational Costs | -$$ | Shared overhead attributed to the program |
| Financial Impact | | Quarterly Review |
| Provider Satisfaction Outcomes | Net Promoter Score (NPS) Change | Quarterly |
| Patient Outcomes and Satisfaction | NPS Change | Quarterly |
| Caregiver Outcomes and Satisfaction | NPS Change | Quarterly |
| Health System Brand Recognition and Market Share | %+ Up/Down | Annual |
| **Net Program Impact** | | Positive/Neutral/Negative |

***Scorecard Example Details***

This detailed scorecard expands on the high-level version, showing the specific metrics, definitions, and benchmarks needed for rigorous analysis. Not every measure will apply to every program but reviewing them helps ensure your evaluation is comprehensive.

| Example Metric | How to Measure It | Baseline / Feasibility to Collect | Target | Industry Benchmark | Assessment Frequency |
|---|---|---|---|---|---|
| **Metric Category: Direct Program Revenue** | | | | | |
| GUIDE Code Billing | Count of GUIDE codes filed and reimbursed each month | Current level of GUIDE reimbursement each month | Agreed to by Leadership and Administrators | Use outcome measures from case studies as a reference GUIDE targets 200 enrollees per site | Quarterly |

| Example Metric | How to Measure It | Baseline / Feasibility to Collect | Target | Industry Benchmark | Assessment Frequency |
|---|---|---|---|---|---|
| **Metric Category: Program Revenue** | | | | | |
| PCM and CCM | Total number of billed codes x reimbursement per patient | Is this feasible to collect? How is this audited and verified? | Agreed to by Leadership and Administrators | Use outcome measures from case studies as a reference | Quarterly |
| **Metric Category: System Revenue** | | | | | |
| HCC Score Change | Average Post-Program risk score – average Pre-program risk score | Is this feasible to collect? How is this audited and verified? | Agreed to by Leadership and Administrators | Use outcome measures from case studies as a reference | Quarterly |
| Referrals tied to the program | Labs, Imaging, specialist referrals tied to patients connected to Dementia Navigation | Is this feasible to collect? How is this audited and verified? | Agreed to by Leadership and Administrators | Use outcome measures from case studies as a reference | Quarterly |
| **Metric Category: System Savings** (Value-Based Arrangement) | | | | | |
| Total PMPM Cost | Average per-patient-per-month cost | Is this feasible to collect? How is this audited and verified? | Agreed to by Leadership and Administrators | Use outcome measures from case studies as a reference | Annually – likely requires 2-3 years of program data |
| **Metric Category: System Savings** | | | | | |
| Avoidable ED visits and Hospitalizations | Average # of ED visits and admits pre-program vs. post program | Is this feasible to collect? How is this audited and verified? | Agreed to by Leadership and Administrators | Use outcome measures from case studies as a reference | Annually – likely requires 2-3 years of program data |

| Example Metric | How to Measure It | Baseline / Feasibility to Collect | Target | Industry Benchmark | Assessment Frequency |
|---|---|---|---|---|---|
| **Metric Category: Program Cost** | | | | | |
| Dedicated FTE for program management | # of FTEs x Salary + benefits | Is this feasible to collect? How is this audited and verified? | Agreed to by Leadership and Administrators | Use outcome measures from case studies as a reference | Quarterly |
| Part-time Staff resources supporting the program | Time allocated to Program x (Salary + Benefits) – for each part-time FTE | Is this feasible to collect? How is this audited and verified? | Agreed to by Leadership and Administrators | Use outcome measures from case studies as a reference | Quarterly |
| Direct Program Operating Costs | Equipment, materials, and physical space are needed to administer the program | Consult with the finance team and department heads to determine components of direct program costs | Agreed to by Leadership and Administrators | Use outcome measures from case studies as a reference | Quarterly – will have higher spend at the beginning of the program for one-time start-up costs |
| Indirect Program Operating Costs (Shared Expenses) | Percentage of shared services allocated for program across enterprise – IT, Finance, HR, Facilities, etc. | This may be a standard overhead charge across all programs. Consult with finance team for budgeting | Agreed to by Leadership and Administrators | Use outcome measures from case studies as a reference | Quarterly |
| **Metric Category: Operational Quality** | | | | | |
| Wait time from PCP to Specialists referral | Average days between PCP visit to Specialist visit if applicable | Is this feasible to collect? How is this audited and verified? | Agreed to by Leadership and Administrators | Use outcome measures from case studies as a reference | Quarterly |

| Example Metric | How to Measure It | Baseline / Feasibility to Collect | Target | Industry Benchmark | Assessment Frequency |
|---|---|---|---|---|---|
| Wait time to enroll in Comprehensive Dementia Care Program (GUIDE or GUIDE-Like Model) | Average days between referral to enroll in the program and first visit | Is this feasible to collect? How is this audited and verified? | Agreed to by Leadership and Administrators | Use outcome measures from case studies as a reference | Semi-Annually |
| Provider Satisfaction | Survey response (NPS measure) | Is this feasible to collect? How is this audited and verified? | Agreed to by Leadership and Administrators | Use outcome measures from case studies as a reference | Semi-Annually |
| Caregiver Intensity Score / Confidence / Satisfaction | Pre and Post survey (Zarit Burden Score for example) NPS | Is this feasible to collect? How is this audited and verified? | Agreed to by Leadership and Administrators | Use outcome measures from case studies as a reference | Quarterly |
| Patient Satisfaction | Patient Survey, Patient Reported Outcomes Measures (NPS), Likelihood to recommend | Is this feasible to collect? How is this audited and verified? | Agreed to by Leadership and Administrators | Use outcome measures from case studies as a reference | Quarterly |
| **Metric Category: Market Reputation and Market Share** | | | | | |
| Market Share of Health System<br><br>Overall, Health System Brand Net Promoter Score | Third-party market research firm can evaluate brand reputation and market share | Is this feasible to collect? How is this audited and verified? | Agreed to by Leadership and Administrators | Top Centers of Excellence for Brain Health matched to your system type. Provide examples of<br>• Large Academic<br>• Mid-Sized community<br>• Small community<br>• Rural etc. | Every 3–5 years depending on strategic planning period |

## How to Apply It

Use the section below to convert the framework into action.

- Define success early and why the system agrees to pursue this initiative.
- Use 1-year, 3-year, 5-year, and 10-year framing to take a long-term horizon.
- Align the program goals with financial sustainability, quality of outcomes, and community impact.
- Set realistic targets that are aspirational yet achievable, rather than overly idealistic. The program is likely to evolve, starting slowly and growing as the team gets more comfortable implementing new care pathways.
- Leverage existing tools, such as dashboards, population health data, and case study benchmarks.
- Align around analytic rigor to increase level of certainty and isolate your program's impact

### *Analytic Rigor and Complexity*

Finally, select the method that best matches your data and decision timeline, and use this table to weigh the strengths and trade-offs.

| Model | Description |
|---|---|
| Before–After | Measures changes in metrics pre- and post-enrollment in the program. |
| Fixed Benchmark | Compares cost to established quality or cost targets (e.g., the average cost of a patient with dementia, risk-adjusted for age and severity of the condition). |
| Differences-in-Differences (DiD) | Isolates the program effect by comparing changes over time between intervention and control groups. This helps address the attribution question: "Was this due to your program or other programs in the organization?" |

### Common Challenges or Considerations

Anticipate these common challenges to prevent rework and misinterpretation of results.

- **Agreement on evaluation methodology** requires engagement and participation from diverse team members. Consider including plans for program analysis in early discussions while analyzing the current state and preparing for program development. If an external consultant is engaged, or an internal team member is the health system's point person, be certain that this person is fully informed about the health system's needs for evaluation.
- **Attribution complexity** is inevitable when programs intersect within large health systems. Program analysis must factor in this question: "How do you know it was your dementia care program and not some other program?"
- **Data silos** make financial and operational metrics difficult to retrieve. Involving analytics teams early can help clarify which measures exist, how reliable they are, and how long reporting will take. A shared glossary of field names, definitions, and methods of data capture can also reduce confusion.
- **Delayed financial and success metrics** can be a common challenge in dementia care programs. Claims payments may not arrive for 3-6 months, and population-level improvements usually need large cohorts and several years. Most programs also need to scale before changes such as reduced ED visits or falls per 1,000 can be shown with statistical confidence.

- **Power analysis** is one way to increase confidence in reported results. Statisticians can calculate confidence intervals, check whether sample size and variability are sufficient, and assess effect size. Post hoc analysis can also guide scaling targets, so programs are more likely to achieve savings.
- **Fee-for-service vs. value-based reimbursement** means scorecard revenue, savings, and cost metrics need to align with how the organization budgets and grows under its reimbursement model.
- **Scalability and sustainability** require teams to embrace analytic rigor when evaluating multi-partner dementia care. Programs that can be managed successfully at scale are more likely to endure and to position departments as centers of excellence for this growing population. If implementing an evidence-based comprehensive dementia care model, include measures from that model's evaluation.[5]

## Module 5: Dementia Care Financial Model

### Purpose

A model designed to help teams apply the information presented in modules 1-4 to generate financial data depending on the local context.

- The ***Dementia Care Financial Modeling Tool*** can be overwhelming to review at first glance. It is critical, however, to "get in the weeds" so clinical teams can make the most informed business case for their administrative partners.
- The **Tool** is not intended to address the full implementation of a dementia care program but rather illustrate how the module elements can be applied with financial data.
- Each spreadsheet tab provides a template to guide real-world decision-making and help teams adapt the modules to fit their specific goals, resources, and context.
- We hope teams will implement as many modules as possible, ideally all of them, and provide feedback to help demonstrate the value of comprehensive dementia care.
- The **Tool** has placeholder values for various financial assumptions (e.g., staffing, salaries, visit frequency and types, revenue sources, etc.). These assumptions are designed to be changed depending on your site's model and financial value metrics. The placeholder values are not listed to be indicative of what is recommended or required.
- For example, some programs may have advanced practice providers versus a physician, higher or lower ratios of patient panel sizes, and higher or lower visit frequencies.
- Get started by emailing **dementiacarenavigation@alz.org** to request the free, pre-populated ***Dementia Care Financial Modeling Tool*** Excel file.

## Implementation Considerations and Future Efforts

The following considerations can help teams align stakeholders and integrate the modules into broader strategic planning efforts.

- Building internal alignment: clinical, financial, and key partner and team members
  - » Identify the interdisciplinary teams across the care continuum that will be involved in or affected by the dementia care program.
  - » Define the care pathway to clarify where changes may have upstream or downstream impacts and who should be engaged as a result.
- Integrating modules into strategic planning
  - » Common challenges and strategies.
  - » Discuss attribution complexity early. Determine whether your organization expects the program's impact to be clearly distinguished from other initiatives, and plan accordingly.
  - » Understand what level of analytic rigor is expected within your organization when evaluating new programs – ranging from basic pre-post comparisons to more formal study designs.

Future efforts can expand on the financial framework outlined in this paper. Areas deserving further attention include caregiver cost and quality outcomes. Additional evidence is also needed to determine how telehealth and hybrid approaches can extend the reach and effectiveness of dementia care.

There is also an opportunity to refine the payer case for dementia care by examining how reimbursement models can better capture the value of comprehensive services. Finally, making the business case for community-based navigation will be vital for ensuring long-term program viability and integration across health and community settings.

## References


1. Sawyer RJ, LaRoche A, Sharma S, Pereira-Osorio C. Making the business case for value-based dementia care. NEJM Catalyst Innovations in Care Delivery. 2023;4(3). doi:10.1056/CAT.22.0304
2. Duke-Margolis Center for Health Policy. Strengthening specialist participation in comprehensive care through condition-based payment reforms. Duke University; November 9, 2022. Accessed September 18, 2025. https://healthpolicy.duke.edu/publications/strengthening-specialist-participation-comprehensive-care-through-condition-based
3. Alzheimer's Association. Cost of Alzheimer's to Medicare and Medicaid. Alzheimer's Association; March 2020. Accessed September 18, 2025. https://act.alz.org/site/DocServer/2012_Costs_Fact_Sheet_version_2.pdf?docID=7161
4. White L, Fishman P, Basu A, Crane PK, Larson EB, Coe NB. Medicare expenditures attributable to dementia. Health Serv Res. 2019;54(4):773-781. doi:10.1111/1475-6773.13134
5. Lees Haggerty K, Reuben DB, Stoeckle R, et al. GUIDE and beyond: Strategies for comprehensive dementia care integration. J Am Geriatr Soc. In press. doi:10.1111/jgs.70107
6. Agarwal R, Connolly J, Gupta R, Navathe AS. The impact of bundled payment on health care spending, utilization, and quality: A systematic review. JAMA Intern Med. 2019;179(1):133-139. doi:10.1001/jamainternmed.2018.5823
7. Guterman EL, Kiekhofer RE, Wood AJ, et al. Care Ecosystem Collaborative Model and health care costs in Medicare beneficiaries with dementia. JAMA Internal Medicine. 2023;183(11):1222. doi:10.1001/jamainternmed.2023.4764
8. Chandler J, Ye W, Mi X, Dennehy EB, Atkins AS, Wessels AM. Incremental declines in independence associated with disease progression in early symptomatic Alzheimer's disease (AD). Alzheimer's & Dementia. 2023;19(S24). doi:10.1002/alz.082395
9. Jennings LA, Laffan AM, Schlissel AC, et al. Health care utilization and cost outcomes of a comprehensive dementia care program for Medicare beneficiaries. JAMA Intern Med. 2019;179(2):161-166. doi:10.1001/jamainternmed.2018.5579
10. Jennings LA, Hollands S, Keeler E, Wenger NS, Reuben DB. The effects of Dementia Care Co-Management on Acute Care, Hospice, and Long-Term care utilization. Journal of the American Geriatrics Society. 2020;68(11):2500-2507. doi:10.1111/jgs.16667

## Acknowledgements

**Chairs of the Dementia Care Navigation Roundtable:**

- **David B. Reuben, M.D.**
  Geriatrics Medicine
  UCLA Health
- **David Bass, Ph.D.**
  Senior Vice President of Research & Education,
  Senior Research Scientist Benjamin Rose Institute

**Members of the Dementia Care Navigation Roundtable, Business Case for Navigation Workgroup:**

- **Carolyn Clevenger, NP, DNP**
  Founding dean of the University of Georgia School of Nursing
  Professor at Emory University's Nell Hodgson Woodruff School of Nursing
  Founder and director of Integrated Memory Care at Emory Healthcare
- **Alan B. Stevens, Ph.D., FAPA, FGSA**
  Endowed Vernon D. Holleman-Lewis M. Rampy Centennial Chair in Gerontology at Baylor Scott & White Health and Director of the Center for Applied Health Research, Baylor Scott & White Research Institute
- **Michelle Bentzien-Purrington**
  Sr. Vice President, MLTSS
  Molina Healthcare
- **Dylan Wint, M.D.**
  Medical Director
  Cleveland Clinic Lou Ruvo Center for Brain Health
- **Lisa Weitzman, MSSA, LISW-S, ASW-G, C-ASWCM**
  Director of Strategic Partnerships
  Ben Rose Institute

**Other:**

- **Morgan Daven**
  VP, Healthcare Strategy
  Alzheimer's Association
- **Viviana Bumaschny, M.D., Ph.d.**
  Grupo de Neurociencia de Sistemas, Instituto de Fisiología y Biofísica "Bernardo Houssay" (IFIBIO HOUSSAY) and Facultad de Medicina, Universidad de Buenos Aires, Consejo Nacional de Investigaciones Científicas y Técnicas
- **The Dementia Care Navigation Roundtable**
  Alzheimer's Association

## Appendix

**Common CPT and HCPCS Codes for Dementia Care Programs**

1. Cognitive Assessment and Care Planning:

- 99483 – Cognitive assessment and care plan services, typically 50 minutes of face-to-face time (includes standardized testing, care planning, and caregiver education)

2. Care Management Services:

- 99490 – Chronic care management (CCM), at least 20 minutes of clinical staff time per calendar month, directed by a physician or other qualified health care professional
- 99439 – Each additional 20 minutes of CCM
- 99491 – CCM services, at least 30 minutes of physician or qualified professional time per calendar month
- 99437 – Each additional 30 minutes of physician or qualified professional time per month
- 99487 – Complex CCM, 60 minutes of clinical staff time per month
- 99489 – Each additional 30 minutes of complex CCM
- 99457 – Remote physiologic monitoring treatment management services, first 20 minutes
- 99458 – Each additional 20 minutes

3. Principal Care Management (PCM):

- 99424 – PCM services, 30 minutes of physician or other qualified professional time per month
- 99425 – Each additional 30 minutes
- 99426 – PCM by clinical staff, directed by physician or qualified professional, 30 minutes per month
- 99427 – Each additional 30 minutes

4. Principal Illness Navigation (PIN):

- G0023 – Principal illness navigation services by a qualified health professional, 30 minutes per month
- G0024 – Each additional 30 minutes (by qualified health professional)
- G0140 – Principal illness navigation by clinical staff under general supervision, 30 minutes per month
- G0146 – Each additional 30 minutes (by clinical staff)

5. Community Health Integration (CHI):

- G0019 – Community health integration services by certified or trained personnel, 30 minutes per month
- G0020 – Each additional 30 minutes of CHI services

6. GUIDE Model Codes (for participating sites only):

- G0017 – Dementia care coordination services, per calendar month (comprehensive care under GUIDE)
- G0018 – Each additional 30 minutes (for GUIDE programs)

Note: GUIDE codes are billable only for enrolled demonstration participants.

7. Caregiver Training:

- 97550 – Therapeutic procedure(s), caregiver training, one or more caregivers, each 15 minutes
- 97551 – Each additional 15 minutes

8. Behavioral Health Integration (BHI):

- 99484 – General behavioral health integration (BHI) care management, 20 minutes per month (can apply to cognitive and behavioral symptom tracking in dementia)

9. Evaluation and Management (E/M) Services:

- 99202 – 99215 – Office or other outpatient visit codes for new and established patients
- 99304 – 99310 – Subsequent nursing facility care, per day
- 99318 – Annual nursing facility assessment
- 99324 – 99337 – Domiciliary, rest home, or home visits

10. Diagnostic and Ancillary Services:

- 96116 – 96133 – Neurobehavioral status and neuropsychological testing codes
- 95812 – 95816 – Electroencephalogram (EEG) codes
- 62270 – Lumbar puncture, diagnostic
- 70450 – 70553 – Brain imaging (CT and MRI)
- 80048 – 80053 – Basic and comprehensive metabolic panels
- 80164 – 80165 – Therapeutic drug level monitoring (as applicable)

11. Remote Patient Monitoring (Optional if used for comorbidities):

- 99453 – Initial set-up and patient education for remote monitoring
- 99454 – Supply of device(s) with daily recordings, each 30 days
- 99457 – Monitoring treatment management, first 20 minutes
- 99458 – Each additional 20 minutes

12. Advance Care Planning and Transitional Care:

- 99497 – Advance care planning, first 30 minutes
- 99498 – Each additional 30 minutes
- 99495 – 99496 – Transitional care management services, 14-day and 7-day follow-up respectively

13. Telehealth and Virtual Check-ins:

- G2012 – Virtual check-in by clinician, 5–10 minutes
- G2010 – Remote evaluation of recorded video or image
- 99421 – 99423 – Online digital E/M by physician or qualified professional
- 99441 – 99443 – Telephone E/M services, 5–30 minutes

*Codes beginning with “G” (GUIDE, PIN, CHI) are HCPCS codes and have specific supervision and eligibility requirements. Verify practitioner type and supervision level before billing.