Building Systems for Comprehensive Dementia Care: Opportunities for Public Health to Support Implementation of the CMS GUIDE Model

December 9, 2024

This Public Health Center of Excellence on Dementia Caregiving event is sponsored by:

Welcome from...

Gary Epstein-Lubow, MD

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Associate Professor of Medical Science
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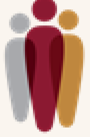
Brown University School of Public Health



The BOLD Public Health Center of Excellence on Dementia Caregiving (PHCOE-DC)

Designed to support state, tribal and local public health agencies nationwide in developing their dementia caregiving-focused programs and initiatives, by…

Improving access to evidence-based programs and best practices.

Facilitating connections and collaboration among public health agencies and a wide range of service organizations.

Providing technical assistance for identifying, selecting implementing effective public health interventions and strategies.

Visit our website!

Reminders for the Presentation Session

- **Submit your questions for the speakers into the Q&A feature.**
- Use the **CHAT to share comments, resources, links, and ideas.**
- The recording, slides and resources will be shared after the event.
- **Please complete the survey at the end of this event** (will pop up in Zoom when you leave this webinar). We greatly appreciate your feedback!

Survey Link:
https://bit.ly/GUIDE_webinar_eval

Poll Question

<u>In what capacity are you attending this event?</u>

- BOLD Public Health Agency
- Non-BOLD Public Health Agency
- Community organization/service provider
- Person living with dementia
- Interested caregiver and/or community member
- Care/clinical professional
- Other

Welcome to our speakers!

Kaleigh Ligus

Social Science Research Analyst,
CMS Innovation Center

Ian Kremer

Executive Director,
LEAD Coalition (Leaders Engaged on Alzheimer's Disease)

Tennessee

Rochelle Roberts

State Dementia Director,
Tennessee Department of Health - Office of Healthy Aging

Liz Hall

Health Systems Director,
Alzheimer's Association,
Tennessee

Shelley Hale

Director of Operations and Programs Administrator, Tennessee Commission on Aging and Disability

Rhode Island

Victoria OConnor

Alzheimer's Disease and Related Disorders Program Manager,
Rhode Island Department of Health

Liz McCarthy

Health Systems Director,
Alzheimer's Association,
Rhode Island

Kelley Hurley

Director of Community Programs,
CareLink

Guiding an Improved Dementia Experience (GUIDE) Model

Center for Medicare and Medicaid Innovation
December 9, 2024

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CMS

Overview | CMS Innovation Center Statute

"The purpose of the [Center] is to test innovative payment and service delivery models to reduce program expenditures…while preserving or enhancing the quality of care furnished to individuals under such titles"

Three scenarios for success:

1. Quality improves; cost neutral
2. Quality neutral; cost reduced
3. Quality improves; cost reduced (best case)

A model that meets one of these three criteria (and other statutory prerequisites), can be expanded in duration and scope through rulemaking.

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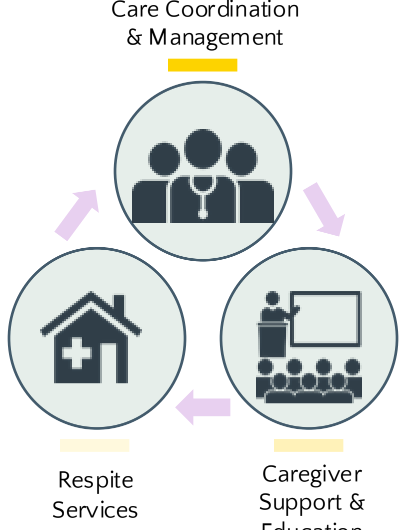
Model Purpose and Overview

The GUIDE Model is testing whether a comprehensive package of care coordination and management, caregiver support and education, and respite services can **improve quality of life for people with dementia and their caregivers** while **delaying avoidable long-term nursing home care** and **enabling more people to remain at home** through end of life.



Care Coordination & Management

Beneficiaries will receive care from an **interdisciplinary team** that will develop and implement a comprehensive, person-centered care plan for **managing the beneficiary's dementia and co-occurring conditions** and provide **ongoing monitoring and support.**

Caregiver Support & Education

GUIDE participants will provide a **caregiver support program**, which must include caregiver skills training, dementia diagnosis education, support groups, and access to a personal care navigator who can help problem solve and connect the caregiver to services and supports.

Respite Services

GUIDE participants will be eligible to receive payment for respite services, up to a cap of **$2,500 per year per beneficiary,** for qualifying beneficiaries. These services may be provided to beneficiaries in a variety of settings, including **their personal home, an adult day center, and facilities that can provide 24-hour care** to give the caregiver a break from caring for the beneficiary.

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Eligible Beneficiaries

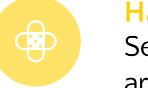
The GUIDE Model is designed for community-dwelling Medicare fee-for-service (FFS) beneficiaries, including beneficiaries dually eligible for Medicare and Medicaid. Eligibility criteria for Model beneficiaries are outlined below:

GUIDE Beneficiary Eligibility Criteria

Dementia Diagnosis
Beneficiary has dementia confirmed by attestation from clinician practicing within a participating GUIDE dementia care program

Enrolled in Medicare Parts A & B
Beneficiary must have Medicare as their primary payer and not enrolled in Medicare Advantage, including Special Needs Plans (SNPs)

Not Residing in Long-Term Nursing Home



Services overlap significantly with the services that are provided under the GUIDE Model

Not Enrolled in PACE
Services overlap significantly with the services that are provided under the GUIDE Model

GUIDE Participants may request a list of potential beneficiaries who may be eligible for voluntary alignment. Additionally, GUIDE participants may have beneficiaries self-referred to them based on letters sent by CMS, or by other provider referrals.

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Care Delivery Requirements

Participants must provide specified services across the domains outlined below. Participants will tailor the exact mix of services based on each beneficiary's individual care plan.

Interdisciplinary Care Team

COMPREHENSIVE ASSESSMENT

Beneficiaries and caregivers receive separate assessments to identify their needs and a home visit to assess the beneficiary's safety.

CARE PLAN

Beneficiaries receive care plans that address their goals, preferences, and needs, which helps them feel certain about next steps.

24/7 ACCESS

Beneficiaries and caregivers have 24/7 access to a member of their care team or help line (may be a 3rd party vendor during off-duty hours).

ONGOING MONITORING & SUPPORT

Care navigators provide long-term help to beneficiaries and caregivers so they can revisit their goals and needs at any time.

REFERRAL & SUPPORT COORDINATION

Beneficiaries' care navigator connects them and their caregivers to community-based services and supports.

CARE COORDINATION & TRANSITION

Beneficiaries receive timely referrals to specialists to address other health issues, such as diabetes, and the care navigators coordinate with specialist.

RESPITE SERVICES

Eligible beneficiaries with caregivers may receive GUIDE respite services.

MEDICATION MANAGEMENT

Clinician reviews and reconciles medication as needed.

CAREGIVER EDUCATION & SUPPORT

Caregivers are given education and support via ad hoc calls and caregiver training.

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Caregiver Support

The model recognizes the critical role that caregivers play in caring for people with dementia by offering caregiver education and support services. Participants must administer a caregiver support program that is based on the caregiver's needs as identified through the comprehensive assessment and is responsive to ongoing changes in need.

Caregiver skills training

Dementia diagnosis information

Support group services

Ad hoc one-on-one support calls

GUIDE Participants provide dementia diagnosis information and ad hoc support calls directly, but may contract with a vendor or a community-based organization to provide caregiver skills training and/or refer caregivers to external support group services.

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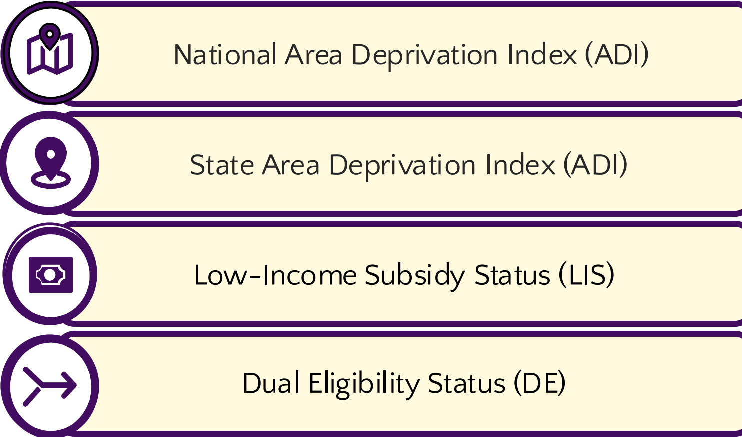
Health Equity Adjustment

The Model's core payment methodology is a per beneficiary per month care management payment, called the Dementia Care Management Payment (DCMP), that is adjusted for health equity and performance on a set of quality metrics.

The Health Equity Adjustment (HEA) is applied to the DCMP based on beneficiary-level health equity scores and is designed to decrease the resource gaps in serving historically underserved communities.

HEA will be based on the following social risk factors:



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Health Equity Plan

The Health Equity Plan will allow each GUIDE participant to identify disparities in outcomes in their patient populations and implement initiatives to measure and reduce these disparities over the course of the model.

Initial Health Equity Plan

FOCUS	**Beneficiary Outreach and Engagement**
GOAL	Encouraged Participants to develop and implement health equity recruitment strategies from model start

- Encouraged GUIDE participants to reach historically underserved eligible beneficiaries
- Questions focused on identification of health disparities within the participant's beneficiary population using reliable data sources and consideration of outreach strategies

Annual Health Equity Plan

FOCUS	**Reducing Disparities in Dementia Care**
GOAL	Encourage Participants to implement initiatives to measure and reduce disparities

- Identify and select evidence-based interventions for addressing health disparities and achieving equitable outcomes
- Set goals and report progress on Health Equity Plans as an element of the model's annual care delivery reporting

Health-Related Social Needs Data Collection

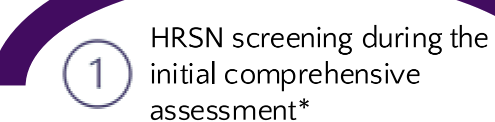
Health-Related Social Needs (HRSN) Data

HRSN collection and referrals are part of the model's broader care delivery requirements for comprehensive assessment and referral for services and supports. Participants will report aggregated data.

Model participants are encouraged to use one of two HRSN screening tools:

- The Accountable Health Communities (AHC) HRSN Screening tool
- The Protocol for Responding to and Assessing Patient Risk (PRAPARE) tool

Required HRSN domains include **food insecurity, transportation, housing, safety, and social isolation.**



1 HRSN screening during the initial comprehensive assessment*

2 Referral and coordination of social services and supports*

3 Report HRSN screening and referral data to CMS to track progress*

All three of these steps are model requirements.

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Referral and Support Coordination

Beneficiaries' care navigator connects them and their caregivers to community-based services and supports, such as home-delivered meals and transportation.

Enter into a written agreement with a local Area Agency on Aging or a Tribal Aging Program to coordinate community-based services and supports

Refer and connect patients and caregivers to services and supports

Maintain, or access, an inventory of community-based resources for services and supports that address the common needs of persons with dementia and their Caregivers (e.g., home-delivered meals, adult day centers, personal care, environmental modification, contractors, food banks, etc.).

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Referral and Support Coordination

Beneficiaries' care navigator connects with beneficiary's Medicaid waiver/HCBS program case manager and connects beneficiaries with resources for the health-related social needs screened as part of the Comprehensive Assessment.

Coordination with Medicaid program case managers on home and community-based services and supports delivery

- Contacts and attempts to coordinate delivery of services
- Shares information about GUIDE Model
- Reviews services the beneficiary receives from the model and Medicaid
- Prevents gaps and/or duplication of services, such as respite

Join or maintain a community referral inventory system

- Referrals to resources for the health-related social needs screened as part of the Comprehensive Assessment
- Connects both the GUIDE Beneficiary and their Caregiver to resources relevant to their needs
- May communicate directly with community services to understand what services were received

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Thank you for Attending this Webinar

We appreciate your time and interest!

Do you have questions? Email your comments and feedback to GUIDEModelTeam@cms.hhs.gov

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