National Dementia Care Collaborative (NDCC) Autumn Summit

The CMS GUIDE Model: Choices for Implementing Evidence-Based Dementia Care

November 28, 2023

Welcome and Introductions

Rebecca Stoeckle, SVP, EDC

Rani Snyder, VP, The John A. Hartford Foundation

Kristen Clifford, Chief Program Officer, Alzheimer's Association

Agenda

Presentation 1: the CMS GUIDE Model	CMMI
Presentation 2: Determining Financial Benefits	Hollman
Lightning Round: Six Comprehensive Dementia Care Programs	
Presentation 3: Applying Models to GUIDE	Lees Haggerty & Lee
Presentation 4: Health Equity and GUIDE	CMMI
Breakout Session 1	Session Leaders
Concluding Comments	NDCC
Breakout Session 2	Session Leaders
Closure	NDCC

Overview of the Autumn Summit Agenda and the Goals of the NDCC

NDCC

National Dementia Care Collaborative

Cultivating comprehensive dementia care.

- How we got here
- Goals for today
- Future vision

June 28, 2012

- The first US National Plan to Address Alzheimer's Disease published May, 2012
- June 28th Translating Innovation to Impact meeting sought to increase access to proven effective non-pharmacological care practices.
  - See Best Practice Caregiving as one example of structured systematic advances since this meeting.
  - bpc.caregiver.org
- June 28th was also the day the US Supreme Court ruled the Affordable Care Act as constitutional.

TRANSLATING INNOVATION TO IMPACT:

Evidence-based interventions to support people with Alzheimer's disease and their caregivers at home and in the community

A White Paper

September 2012

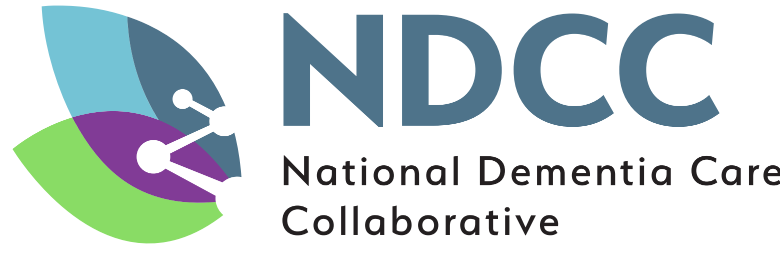
Sponsored by:

MetLife Foundation

Promoting comprehensive dementia care and payment reform

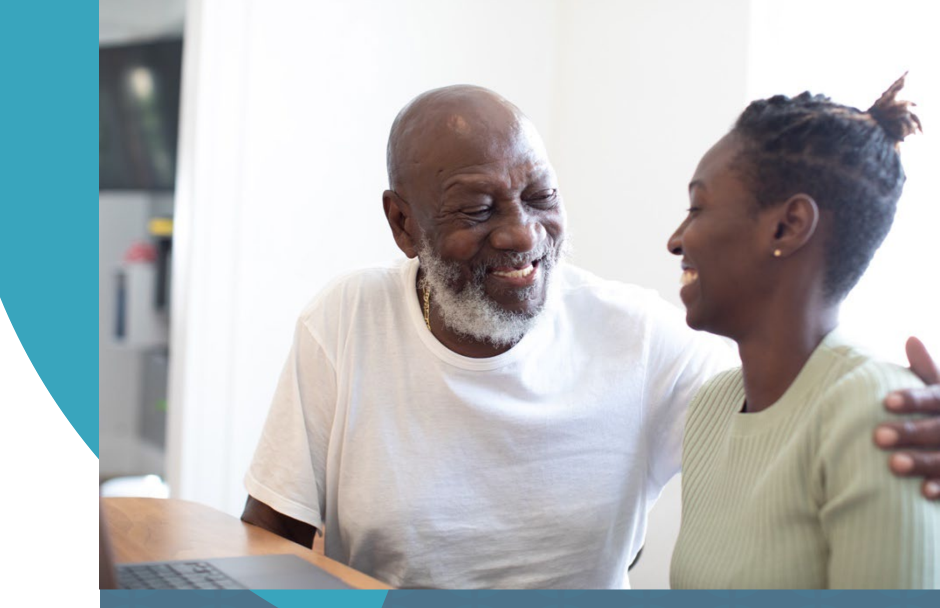
- **Recommendations to Improve Payment Policies for Comprehensive Dementia Care**

  (J Am Geriatrics Soc; Nov 2020)
- Chronic disease management: why dementia care is different (Am J Manag Care; Dec 2022)
- **Payment for Comprehensive Dementia Care** (Health Affairs Forefront; Feb 2023)
- The Other Dementia Breakthrough – Comprehensive Dementia Care (JAMA Neuro; Aug 2023)
- Applying An Evidence-Based Approach To Comprehensive Dementia Care Under the New GUIDE Model (Health Affaires Forefront; Nov 2023)



Elements of Comprehensive Dementia Care

- Continuous Monitoring and Assessment
- Ongoing Care Plans
- Psychosocial Interventions
- Self-Management
- Caregiver Support
- Medication Management
- Treatment of Related Conditions
- Coordination of Care



Lees Haggerty K, Epstein-Lubow G, Spragens LH, Stoeckle RJ, Evertson LC, Jennings LA, Reuben DB. Recommendations to Improve Payment Policies for Comprehensive Dementia Care. J Am Geriatr Soc. 2020 Nov;68(11):2478-2485. doi: 10.1111/jgs.16807. Epub 2020 Sep 25. PMID: 32975812.

The National Dementia Care Collaborative (NDCC) aims to...

1. Improve access to evidence-based comprehensive dementia care.

2. Provide a common platform for health systems and other provider organizations implementing or interested in implementing a proven model of comprehensive dementia care.

NDCC Autumn Summit - Summary Messages:

Use evidence-based comprehensive dementia care programs.

Carefully determine how the GUIDE Model, including its payment structures, can fit your local healthcare environment to promote access to comprehensive dementia care services.

Presentation 1: The CMS Guiding an Improved Dementia Experience (GUIDE) Model

Melissa Trible, CMMI

Lynn Miescier, CMMI

Guiding an Improved Dementia Experience (GUIDE) NDCC Autumn Summit

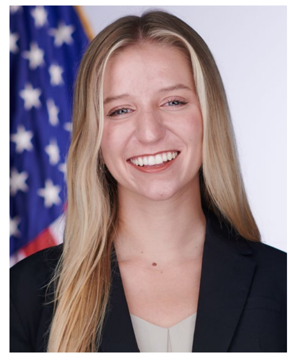
Center for Medicare and Medicaid Innovation
November 28, 2023

Agenda

This webinar provides an overview of the GUIDE Model, including information recently published in the Request for Applications. The following topics will be discussed:

1. Welcome and Introductions
2. Participation and Eligibility Requirements
3. Key Model Components
4. Model Evaluation
5. Application Process and Timeline
6. Closing and Resources

Today’s Presenters



Melissa Trible
GUIDE Model Co-Lead, Division of Healthcare Payment Models

Lynn Miescier
GUIDE Evaluation Lead, Division of Health Systems Research

Participation and Eligibility Requirements

Scope and Duration

GUIDE is an 8-year voluntary model offered in all states, D.C., and U.S. territories. The Model Performance Period will begin on July 1, 2024, and end on June 30, 2032.

Established Program Track and New Program* Track

The purpose of the two tracks is to allow established programs to begin their performance in the model on July 1, 2024, while giving organizations that do not currently offer a comprehensive community-based dementia care program, including safety net organizations, time and support to develop their program.

Model Timeline

	Nov. 15 2023 - Jan. 30 2024	July 2024- June 2025	July '25- June '26	July '26- June '27	July '27- June '28	July '28- June '29	July '29- June '30	July '30- June '31	July '31- June '32
Established Program Track	Application Period	Performance Year (PY) 1	PY 2	PY 3	PY 4	PY 5	PY 6	PY 7	PY 8
New Program Track	Application Period	Pre-Implementation (PI) Period	PY 1	PY 2	PY 3	PY 4	PY 5	PY 6	PY 7

*New program development is intended to help increase beneficiary access to specialty dementia care, particularly in underserved communities.

Eligible Participants

The GUIDE Model eligibility criteria for Participants is described below:

Who is Eligible?

GUIDE Participants will be **Medicare Part B enrolled providers/suppliers**, excluding durable medical equipment (DME) and laboratory suppliers, who are eligible to bill for Medicare Physician Fee Schedule services and agree to meet the care delivery requirements of the Model.

The GUIDE Model is offered to applicants in all states, U.S. territories, and D.C.

Who Can Join?

GUIDE Model Participants must meet the care delivery requirements described in the care delivery section of the RFA but may choose to partner with other organizations, including both Medicare-enrolled providers and suppliers and non-Medicare enrolled entities such as community-based organizations to meet these requirements.

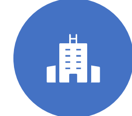
Eligible Beneficiaries

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

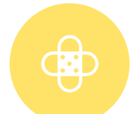
GUIDE Beneficiary Eligibility Criteria

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



Has Not Elected the Medicare Hospice Benefit
Services overlap significantly with the services that will be provided under the GUIDE Model

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

Voluntary Alignment Process
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.

Key Model Components

Model Tiers and Payment Rates

Beneficiaries who align to Model Participants will be assigned to one of five “tiers,” based on a combination of their disease stage and caregiver status. Beneficiary needs, and correspondingly, care intensity and payment, will increase by tier. GUIDE Participants will use a set of new G-Codes created for the GUIDE Model to submit claims for the monthly DCMP.

	Beneficiaries with a Caregiver			**Beneficiaries without a Caregiver**	
	Low Complexity Dyad Tier	Moderate Complexity Dyad Tier	High Complexity Dyad Tier	Low Complexity Individual	Moderate to High Complexity Individual Tier
First 6 months (New Patient Payment Rate)	$150	$275	$360	$230	$390
After first 6 months (Established Patient Payment Rate)	$65	$120	$220	$120	$215

The DCMP rates above represent base payment rates and will be adjusted for geographic variation in costs as well as cost growth over time.

Quality Strategy

The DCMP Performance Based Adjustment (PBA) will increase or decrease participants' monthly DCMPs, depending on how they perform during the previous performance year. Participants will be required to submit quality data annually.

GUIDE Quality Measures	PBA Potential
Use of High-risk Medications in Older Adults (eCQM/CQM)	-0.5 – +1%
Quality of Life Outcome for People with Neurological Conditions (Survey-based)	-1 – +3%
Caregiver Burden (Survey-based)	-1 – +3%
Total Per Capita Cost (Claims-based)	-0.5% – 1.5%
Long-term Nursing Home Stay Rate (Claims-based)	-0.5% – 1.5%
Total	- 3.5% – +10%

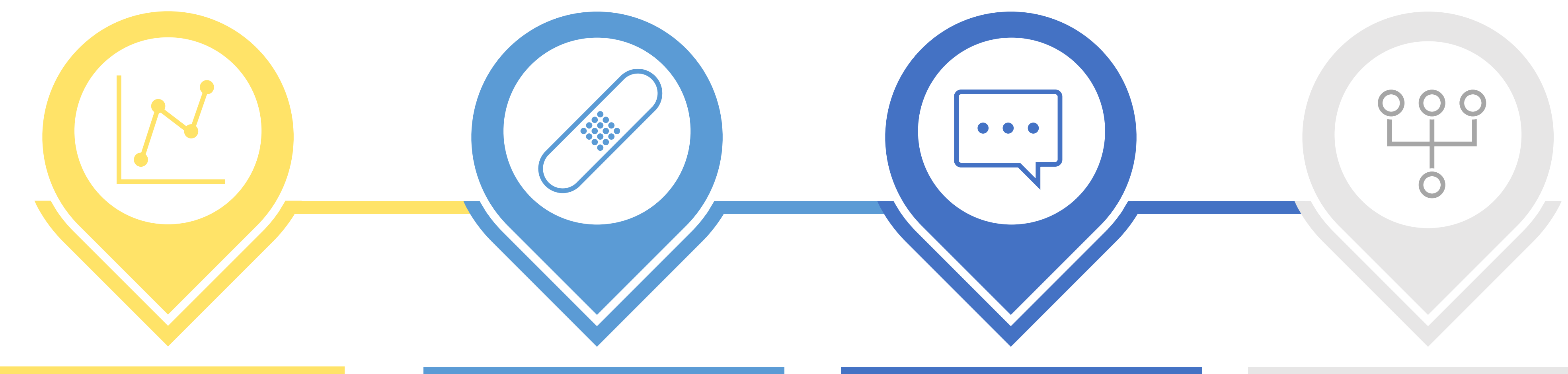
PBA Timing	2024	2025	2026	2027	2028	2029	2030	2031	2032

Established Program Track								
PY 1 7/2024 – 6/2025	**PY 2 7/2025 – 6/2026**	**PY 3 7/2026 – 6/2027**	**PY 4 7/2027 – 6/2028**	**PY 5 7/2028 – 6/2029**	**PY 6 7/2029 – 6/2030**	**PY 7 7/2030 – 6/2031**	**PY 8 7/2031 – 6/2032**	
	PBA 1 1/2026 – 12/2026	**PBA 2 1/2027 – 12/2027**	**PBA 3 1/2028 – 12/2028**	**PBA 4 1/2029 – 12/2029**	**PBA 5 1/2030 – 12/2030**	**PBA 6 1/2031 – 12/2031**	**PBA 7 1/2032 – 12/2032**	

New Program Track								
Pre-Implementation Year	**PY 1 7/2025 – 6/2026**	**PY 2 7/2026 – 6/2027**	**PY 3 7/2027 – 6/2028**	**PY 4 7/2028 – 6/2029**	**PY 5 7/2029 – 6/2030**	**PY 6 7/2030 – 6/2031**	**PY 7 7/2031 – 6/2032**	
		PBA 1 1/2027 – 12/2027	**PBA 2 1/2028 – 12/2028**	**PBA 3 1/2029 – 12/2029**	**PBA 4 1/2030 – 12/2030**	**PBA 5 1/2031 – 12/2031**	**PBA 6 1/2032 – 12/2032**	

GUIDE Data Reporting Requirements

All Innovation Center model participants are required to collect and report data deemed necessary to monitor and evaluate the model, including "protected health information". GUIDE will require participants to report the following:



Quality Data

- Caregiver Burden survey
- Quality of Life survey
- High-risk medication measure

Care Delivery Data

- Care delivery reporting survey

Beneficiary and Caregiver Assessment Data

- Zarit Burden Interview
- Clinical Dementia Rating
- Functional Assessment Staging Tool

Sociodemographic & Health Related Social Needs Data

- Accountable Health Communities HRSN Tool
- Protocol for Responding to and Assessing Patient's Assets, Risks, and Experiences

Model Evaluation

Evaluation Requirements

- Cooperate with an **independent**, **federally-funded evaluation** as required by statute.*

- Activities typically include
  - completion of **surveys**
  - participation in **interviews** and **site visits**
  - other activities deemed necessary to conduct a comprehensive evaluation.

** Section 1115A of the Social Security Act (added by Section 3021 of the Affordable Care Act). The evaluation will inform any decision by the Secretary to expand through rulemaking the duration and scope of the model, as specified under Section 1115A(c).*

Evaluation Purpose

To assess model implementation, the experience of participants and beneficiaries over time, and effects on model outcomes including **3 primary GUIDE objectives**.

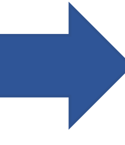
1. Improve the quality of care and **quality of life*** for people with dementia,
2. Reduce **caregiver burden and strain***
3. Help people remain in their homes and communities, while reducing Medicare and Medicaid expenditures.

** Measures for these two outcomes are not available in claims data. Quality data will need to be collected from model participants and non-participants serving as a comparison group.*

Evaluation will use a mixed methods approach

Approach

- Use **claims** to identify aligned beneficiaries and a ***comparison group*** of similar beneficiaries not in the model.
- Collect **quality data** from participants and non-participants.
- Examine trends in quality, long-term nursing home stays, Medicare and Medicaid service use and expenditures
- Conduct interviews and site visits



Potential Effects*

- Improvements in **quality of life** and **caregiver burden**
- Reductions in **long-term nursing home stays**, Medicare and Medicaid service use and expenditures
- Better experience of care for beneficiaries, caregivers, and providers
- Transformation in the delivery of care for people with dementia

**Assuming participant and beneficiary recruitment targets are met and the comparison group submits sufficient quality of life and caregiver burden data to CMS.*

Application Process and Timeline

Model Timeline

The GUIDE Model application period started on November 13, 2023 and the performance period for the established program track and pre-implementation period for the new program track will begin on July 1, 2024.

	Nov. 15, 2023 – Jan. 30, 2024	July '24-June '25	July '25-June '26	July '26-June '27	July '27-June '28	July '28-June '29	July '29-June '30	July '30-June '31	July '31-June '32
ESTABLISHED PROGRAM	Application Period	Performance Year (PY) 1	PY 2	PY 3	PY 4	PY 5	PY 6	PY 7	PY 8
NEW PROGRAM	Application Period	Pre-Implement-ation (PI) Period	PY 1	PY 2	PY 3	PY 4	PY 5	PY 6	PY 7

Application Overview

All GUIDE applications must be submitted through the online application portal by 11:59pm Eastern Daylight Time on January 30, 2024. CMS may request additional information post-application and deny participation based on program integrity review of GUIDE Model applicants.

Interested organizations may prepare to apply to the GUIDE Model considering the timeline* outlined below.

July 31st, 2023
Model Announced

GUIDE Application Period Opens
November 15th, 2023

January 30th, 2024
GUIDE Applications Due

GUIDE Participant Selection
Spring 2024

July 2024
GUIDE Model Starts

Privacy Policy: CMS will safeguard the information provided in accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a). For more information, please see the CMS Privacy Policy at http://www.cms.gov/privacy.

Thank You for Attending this Presentation

We appreciate your time and interest!

Please take the survey following this webinar so we can learn how to make our events better.

Upcoming Events: GUIDE RFA Webinar on November 30th, 2024.

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

Appendix

Medicare Physician Fee Schedule Codes Replaced by DCMP

The DCMP will replace fee-for-service payment for some existing Medicare Physician Fee Schedule (PFS) services, including chronic care management and principal care management, transitional care management, advance care planning, and technology-based check-ins.

Service Type	HCPCS Codes
Advance care planning	99497, 99498
Welcome to Medicare and Annual Wellness Visits	G0402, G0438, G0439
Home Health Care Plan Oversight	G0181
Hospice Care Plan Oversight	G0182
Cognitive Assessment and Planning	99483
Technology-based check-in services	G2012, G2252
Transitional Care Management	99495-99496
Chronic Care Management	99487, 99489-99491, 99437, 99439, G0506
Principal Care Management	99424–99427
Administration of patient-focused health risk assessment (HRA)	96160
Administration of caregiver-focused HRA	96161
Depression screening	G0444
Group Caregiver Behavior Management/ Modification Training Services*	96202, 96203
Caregiver Training Services under a Therapy Plan of Care established by a PT, OT, SLP*	97550, 97551, and 97552
Community Health Integration Services*	G0019, G0022
Principal Illness Navigation Services*	G0023, G0024, G0140, and G0146
Administration of a Standardized, Evidence-based Social Determinants of Health Risk Assessment*	G0136

Presentation 2: Strategies for Determining the Financial Benefits of Participating in the GUIDE Model

Peter Hollman

Chief Medical Officer, Brown Medicine

Strategies for Determining the Financial Benefits of Participation in the GUIDE Model

Peter Hollmann MD

NDCC Autumn Summit

11/28/23

What Are the Questions?

- Why are you thinking about participation?
- How does this compare to present payment?
- Will this help partner organizations?
- Will this help my patients?
- Does this conflict with other CMMI/CMS programs?
- What if “Traditional Medicare” is not the main payer?

BROWN MEDICINE
BROWN PHYSICIANS, INC.

Why

- Goal to provide excellent dementia care
  - Connections within organization and to community
  - Learning collaborative
  - Quality measures
  - Data Sharing
  - More referrals in
  - Retention and Recruitment

Why

- Philosophical
  - FFS is failing
  - Population Health
  - Beneficiary Voluntary Assignment
  - Ability to Shape New Program
  - Equity goals and recognition

The Money

- Get paid for what I do already
- Will fund new activities, quality, training and development
- PBPM is predictable and administratively simple
- MEI Adjusted
- MIPS APM credit
- Telehealth is covered during life of program
- No cost share collection (or non-payment in Medicaid)
- Recognizes safety net providers (+15 PBPM, $75K start up)
- Comparison to FFS
- Additional Expenses, Ramp up/new patient bump

The Money

CODE	DESCR	NF AMT	FACTOR	PBPM EQUIV	NOTE
99483	COG ASSESS AND CP	$273	0.1667	$45	TWICE A YEAR
G0439	AWV	$130	0.0833	$11	ANNUALLY
99490	CCM/PCM	$62	1	$62	MONTHLY (20’)
G0223	PIN	$79	0.25	$20	50% GET EVERY OTHER (60’)
96202	GRP CAREGIV BH TRAINING	$23	0.5	$11	100% GET QOM
99497	ACP	$83	0.08333	$7	ANNUALLY DESPITE CACP
G0136	SDOH ASSESS	$19	0.08333	$2	ANNUALLY
N/A	MISC	$5	1	$5	MONTHLY
TOTAL				$164	COLLECTION 100%
	ESTABL, MOD, DYAD			$120	BEFORE PBA, HEA

Good for my Patients

- No cost share
- Telehealth
- Access to paid respite services
- Possible environmental modifications (if paid by participant)

System/Partners Benefits

- Cost savings in shared savings programs (?)
  - Decreased acute care vs program expense
  - Adverse selection fears
  - MAB therapies (more patients/appropriate use)
  - Revised benchmarks
- Community connections and internal collaboration/coordination
- “Center of Excellence”
- MAB Treatment Center “failures”
- Support of Primary Care

Other Payers and Demos

- Administrative Simplification
- A developed model
- Other VBP/Shared Savings/Quality
- Grant potential
- Assess your mix and how MA plans pay
- Staged roll out vs. same service for all
- Does not conflict with MSSP, REACH, PCF, MCP

Lightning Round Panel:
Six Comprehensive Dementia Care Programs

Moderator: Ian Kremer, LEAD Coalition

Presenters:

- Nicole Fowler, IU
- David Reuben, UCLA
- David Bass, BRI
- Kate Possin, UCSF
- Carolyn Clevenger, Emory
- Halima Amjad, JHU

Aging Brain Care (**ABC**): A Dementia Collaborative Care Model

Indiana University School of Medicine
Indiana University Center for Aging Research

Background of the ABC Program

- The **Aging Brain Care Program** is an evidence-based dementia collaborative care program.

- Developed and tested in **RCT** at Indiana University in 2001-2006

- Implemented in the 3rd largest safety net health system in collaboration with federally qualified **primary care** sites since 2008.

- Developed a scalable, population health version with **CMMI** in 2015.

The Motivation for the ABC Program

- ADRD generates significant financial and emotional stress for *both* the person living the disease and their family caregivers.

- More than half of patients living with ADRD experience behavioral and psychological symptoms of dementia (BPSD), which increase poor outcomes for patients and family members.

- Patients who identify as Black or Hispanic or patients with low socio-economic resources are more likely to be diagnosed late and experience more BPSD.

ABC Program Design Aligns with GUIDE

Caregiver and Patient
Counseling, Education, Skills
& Self-Management Strategies

Brain Health, Memory Care and Mental Health Practitioners
MD, RN, MSW, Psychologists

Access, Coordinate, Deliver & Monitor

Access, Coordinate & Monitor

Dementia Care Coordinator
Community Health Worker, Non-licensed but highly trained

Access, Coordinate & Monitor

Access, Coordinate & Monitor

Home and Community-based Services and Resources
Respite Services, Area Agency on Aging, Alzheimer's Association, Adult Day Services, etc.

Primary Care Physicians
Maintains care of patient

ABC Program Design Aligns with GUIDE

Care Coordination & Management

- Management of dementia and co-occurring conditions delivered by an interdisciplinary care team: Geriatrician or Primary Care Provider, Social worker, and Care Coach

Caregiver Education & Support

- ABC Care Coach receives 40 hours of training
- ABC Care Coach delivers caregiver skills training and education
- ABC Care Coach routinely completes the Healthy Aging Brain Care (HABC) monitor to assess caregiver's stress. Results guide which care protocols should be used.
- ABC Care Coach completes the evidence-based Caregiver Stress Prevention Bundle (CSPB) centered on support group participation, problem solving, and crisis planning

Respite Services

- 8 hours per week of respite for the caregiver

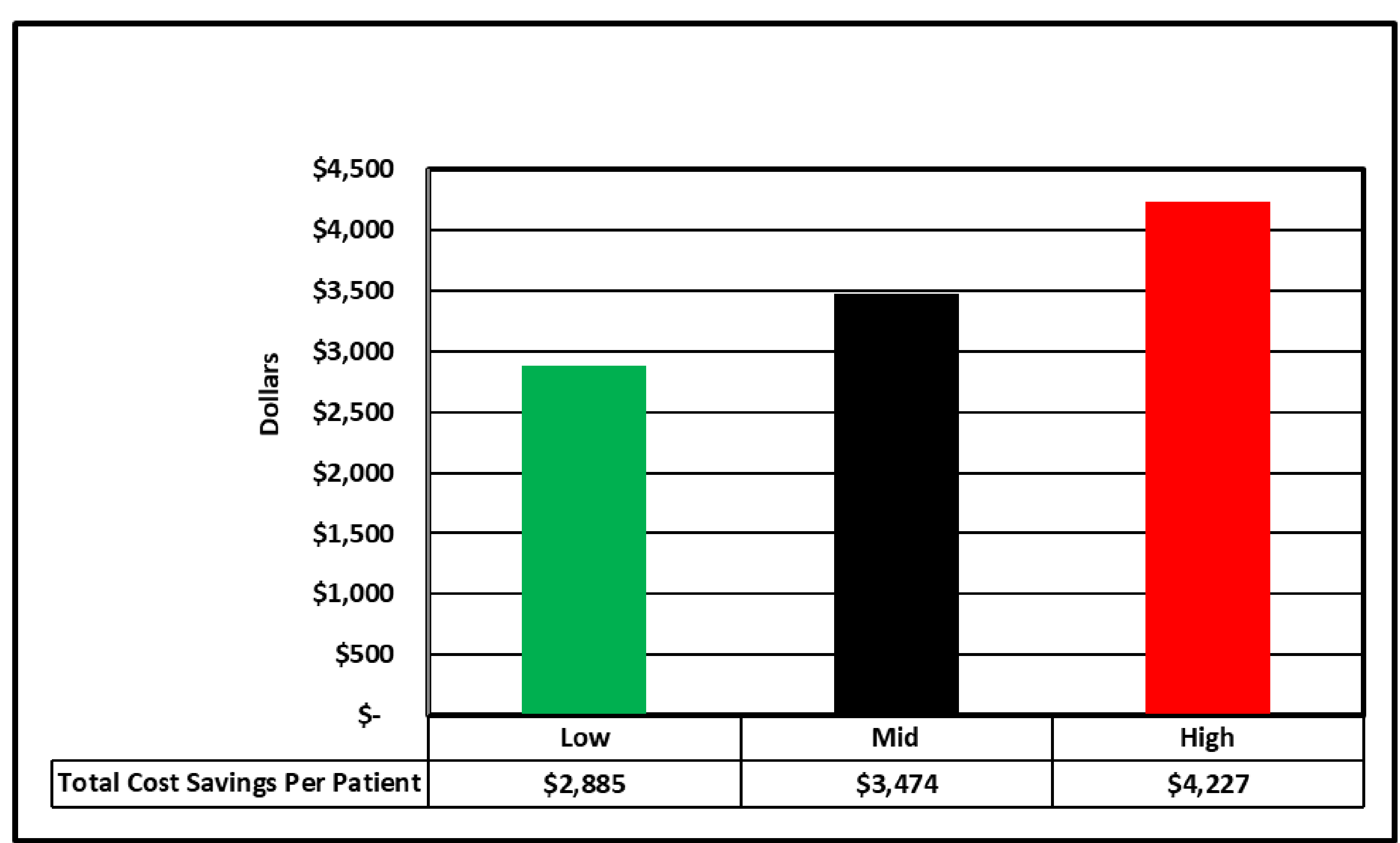
Measures of ABC Success: Patient Outcomes

The Quality of Care Indicator Domain	ABC	PCC
% seen at ER again within one week	14%	15%
% re-hospitalized within 30 days of discharge	11%	20%
% with at least one order of definite anticholinergics	19%	40%
% with at least one order of neuroleptics	5%	5%
% with at least one order of anti-dementia drugs	55%	13%
% with at least one order of antidepressant drugs	68%	48%
% with at least one order of definite anticholinergics and anti-dementia drugs	16%	32%
% with at least one LDL order	82%	72%
% of patients with LDL < 130	45%	23%
% with at least one HbA1c order	78%	62%
% of patients with HbA1c < 8	78%	51%
% with last systolic BP < 160	27%	24%

66% of patients had ≥50% in depressive symptoms.

51% of caregivers had ≥50% in caregiver stress symptoms.

Measures of ABC Success: $



- Average cost saving per year $1076 (95% CI $98-2412)

The Alzheimer's and Dementia Care (ADC) Program

Autumn Summit 2023: Lightning Round

David B. Reuben, MD

November 28, 2023

Overview: The Alzheimer's and Dementia Care (ADC) Program

The Problem: Nobody in health care was taking ownership of patients with dementia

The ADC Solution: Co-management model with APP Dementia Care Specialists

- Provides ongoing longitudinal care and support to persons living with dementia and their loved ones
- Health System-based and partners with Community-Based Organizations (CBOs)
- Improves patient and caregiver outcomes, reduces acute care utilization and long-term nursing home placement, saves money for Medicare

- Since 2012, the UCLA ADC Program has enrolled over 4000 dyads
- **Flexible and adaptable:** implemented at 17 sites; 5 additional sites are in progress

ADC and GUIDE: A Perfect Fit

- Care Delivery Requirements: Provides 9/9 required activities
- Care Team Requirements: APP Care Navigator; Physician Medical Director with dementia proficiency
- Care Navigator Training: 22 on-line didactic modules and experiential training
- Performance Measures:
  - High-risk medication management by APPs
  - Reduced caregiver burden
  - Reduced total per capita cost
  - Reduced rate of entry into long-term nursing homes

Join our Breakout Session to learn more about The ADC Program and the GUIDE Model

BRI Care Consultation™

BRI Care Consultation™ – Background

- Benjamin Rose, 115-year-old, non-profit - leader in aging research and services
- Developed in 1997 as dementia care navigation and care coordination program
- Low cost to deliver (phone, online, mail, email); convenient for patients and family and friend caregivers.
- Establishes ongoing relationship with patients and caregivers
- Delivered by Bachelor or Master-degree Social Workers, Nurses, or others
- Consumer Driven - patient- and family-centered care
- 12 research studies over 25 yrs. – consistent benefits are less burden, better quality of life for patient and caregiver; fewer hospital admissions & ED visits
- Extensive experience delivering program as regular service (not research)
- 60+ licensed healthcare and community organizations delivered program since 2014 - 32 currently (e.g., Benjamin Rose – we have first-hand experience)
- Served over 5,000 patients and caregivers in 2023

BRI Care Consultation & GUIDE Model

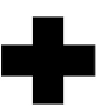
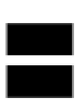
GUIDE Model components delivered by BRI Care Consultation:

Care Navigation and Coordination	Support, Referral and Coordination
Comprehensive Assessment	Ongoing Monitoring
Care Plan	Caregiver Education and Support

Program designed to be flexible and adaptable for different care situations:

- Program can be used by: Patients and caregivers can use program together; Patients without caregivers; Caregivers assisting patients who are too impaired or decline to participate
- Can be adapted for underserved and diverse racial/ethnic/LGBTQ individuals and communities
- Well suited for rural communities because of telephone delivery and focus on mobilizing broad network or family and friends
- Appropriate for all stages of dementia

Two Ways to Add BRI Care Consultation to Your Clinic or Services for GUIDE

Geriatric Clinic/Center Neurology Clinic/Center Primary Care Practice Other Medical Provider		Obtain a License or Contract for BRI Care Consultation		**GUIDE Model**

1. Become a Licensed Site: 1st year license fee $11,220; yearly renewal fee $3,630

- Initial and ongoing training, support, and manuals
- Software platform and Consumer Portal for program delivery, administrative and fidelity monitoring, tracking client information (includes technical support)
- Marketing materials and recruitment toolkit

2. Contract with an Existing Licensed Site or Benjamin Rose's Nationwide Delivery Organization "WeCare…Because You Do"

- Telephone and online delivery minimizes geographic boundaries
- Experienced delivery staff
- No training, staff time, or upfront investments required

NDCC Autumn Summit

Kate Possin, PhD
John Douglas French Foundation Endowed Professor
Professor in Residence
University of California – San Francisco and the Global Brain Health Institute

The Team that Designed the Care Ecosystem in 2013

Jennifer Merrilees
Nurse, caregivers

Bruce Miller
Neurologist

Kirby Lee
Pharmacy

Caroline Prioleau
Content Developer

Sarah Hooper
Elder Law

Winston Chiong
Neuroethicist

Joe Hesse
Strategist

Michael Schaffer
Technology

Steve Bonasera
Geriatrician, rural

Rosalie Gearhart
Nurse Visionary

Sarah Dulaney
Nurse Leader

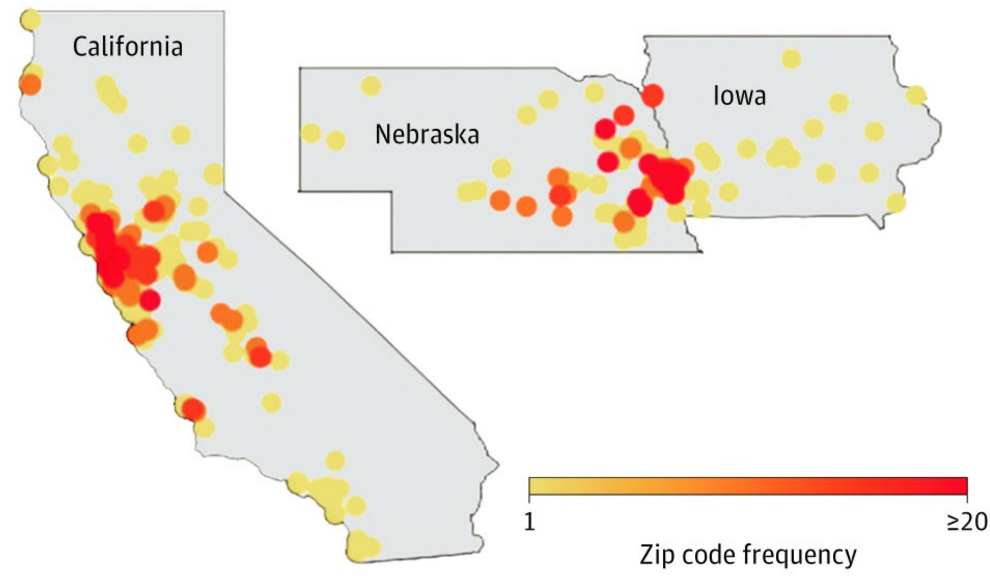
UCSF's Care Ecosystem Model

The Care Team Navigator (CTN) is at the Center

Unique features:

- Telephone-based
- Elevate the navigator role
- All care protocols and trainings are easily accessible on our website

Randomized Clinical Trial: N=780 PLWD-caregiver dyads



- ✓ Improved caregiver well-being
- ✓ Improved patient quality of life
- ✓ Reduced emergency room visits
- ✓ Reduced polypharmacy and potentially inappropriate medication use
- ✓ Reduced total cost of care based on Medicare claims

Possin et al., JAMA IM, 2019; Liu et al., 2022, Alz & Dementia; Guterman et al., 2023, JAMA IM

Randomized Clinical Trial: N=780 PLWD-caregiver dyads

Fun facts!

- The number needed to treat (NNT) to prevent a single ED visit was 5.
- NNT to reduce one potentially inappropriate medication = 3
- NNT to mitigate one moderate to severe depression in caregivers = 12
- Average reduction in costs to Medicare per patient was $500/month
- 97% of Care Ecosystem caregivers would recommend the Care Ecosystem to another caregiver.

Possin et al., JAMA IM, 2019; Liu et al., 2022, Alz & Dementia, Guterman et al., 2023, JAMA IM

The Care Ecosystem Consortium: Locations of Active Programs*

*Some locations represent more than one program

Publications from Care Ecosystem Implementation Sites!

Innovations in Care Delivery

IN DEPTH

Making the Business Case for Value-Based Dementia Care

Robert John Sawyer, PhD, ABPP-CN, Ashley LaRoche, CCRC, Sakshi Sharma, MS, Carolina Pereira-Osorio, MS

Vol. 4 No. 3 | March 2023

DOI: 10.1056/CAT.22.0304

Rosenbloom *et al. BMC Geriatrics* (2023) 23:515
https://doi.org/10.1186/s12877-023-04146-z

BMC Geriatrics

RESEARCH Open Access

Implementation and review of the care ecosystem in an integrated healthcare system

Michael H. Rosenbloom[1,2,3*], Bhavani Kashyap[1,2,3], Ana Diaz-Ochoa[1], Jan Karrmann[1], Aleta Svitak[2,3], Jennifer Finstad[1], Ann Brombach[1], Ann Sprandel[1], Leah Hanson[1,2,3], Sarah Dulaney[4] and Katherine Possin[4]

Mellinger *et al. BMC Geriatrics* (2023) 23:16
https://doi.org/10.1186/s12877-022-03717-w

BMC Geriatrics

RESEARCH Open Access

Impact of dementia care training on nurse care managers' interactions with family caregivers

Taylor J. Mellinger[1,2,3*], Brent P. Forester[1,3,4], Christine Vogeli[1,3,5], Karen Donelan[3,5,6], Joy Gulla[1], Michael Vetter[6], Maryann Vienneau[1] and Christine S. Ritchie[1,3,5]

American Journal of Hospice and Palliative Medicine®
Volume 40, Issue 7, July 2023, Pages 778-783
© The Author(s) 2022, Article Reuse Guidelines
https://doi-org.ucsf.idm.oclc.org/10.1177/10499091221116140

COVID 19

End-of-Life Experiences Within a Dementia Support Program During COVID-19: Context and Circumstances Surrounding Death During the Pandemic

Adreanne Brungardt, MM, MT-BC [1], Jessica Cassidy, LMSW[1], Ashley LaRoche, BS[2], Sarah Dulaney, RN, CNS[3], R. John Sawyer, PhD[2], Katherine L. Possin, PhD[3,4], and Hillary D. Lum, MD, PhD[1]

How can you get support from the Care Ecosystem as you implement GUIDE?

1. Review the Toolkit, Care Protocols, Online Navigator Training
memory.ucsf.edu/care-ecosystem

2. Contact Michelle Barclay, Program Manager, to set up a consultation with one of our program leaders
Michelle.Barclay@ucsf.edu

3. Join our Care Ecosystem Consortium for ongoing collaborative learning via monthly “Implementation Meetings” and other interest meetings (eg, “Care Ecosystem Latino Workgroup”)

Integrated Memory Care

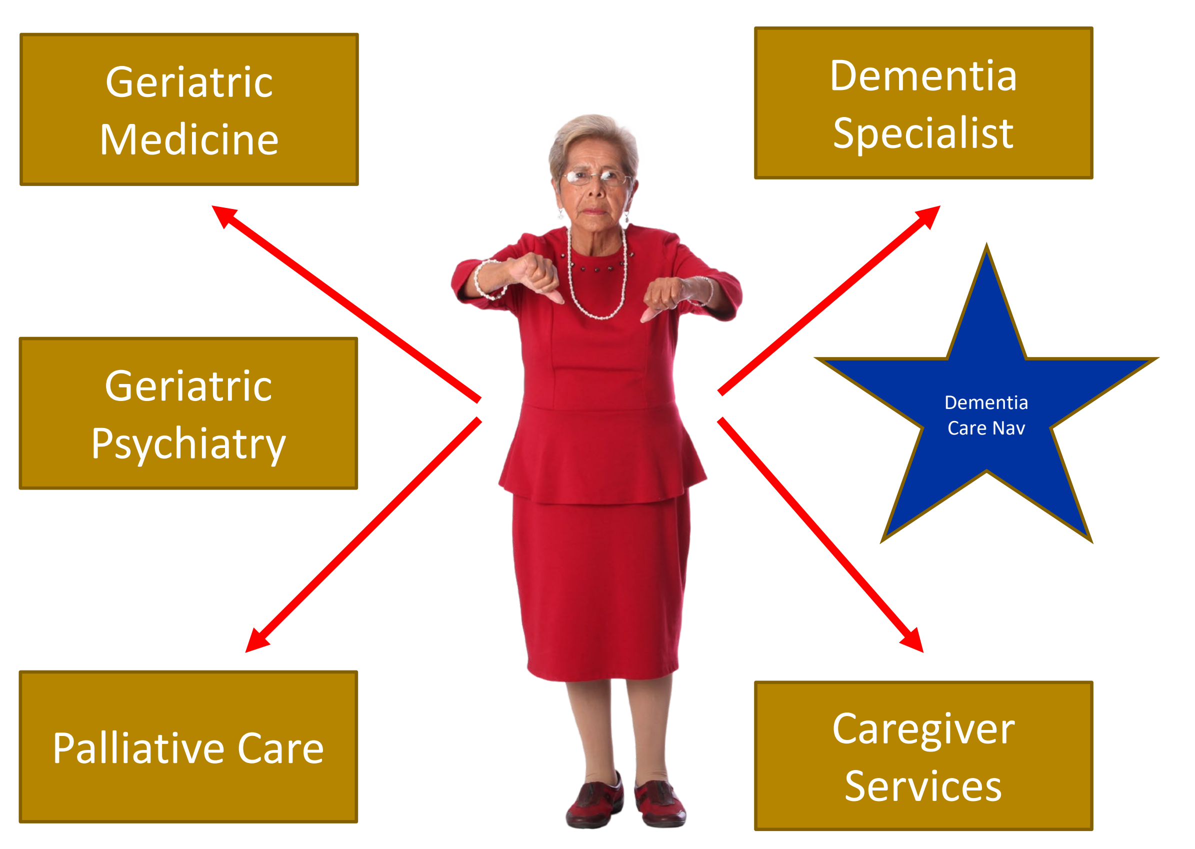
CAROLYN K CLEVENGER, DNP, GNP-BC, AGPCNP-BC, FAANP, FGSA, FAAN

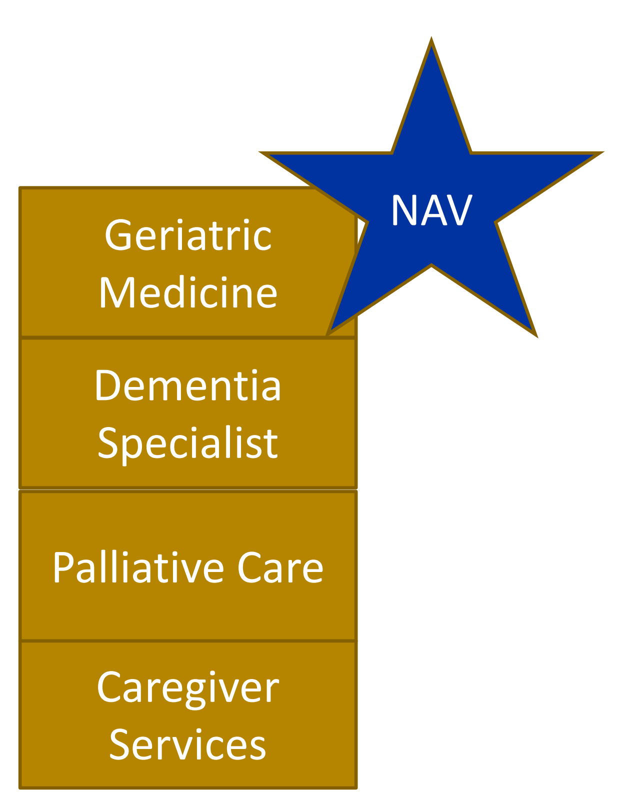
DIRECTOR, INTEGRATED MEMORY CARE

PROFESSOR, NELL HODGSON WOODRUFF SCHOOL OF NURSING

EMORY UNIVERSITY

What's the Big Deal?
Patient/Family Perspective





Caregiver-initiated

Reduce fragmentation to improve quality of life for person living with dementia and their family care partner/caregivers

What is IMC?

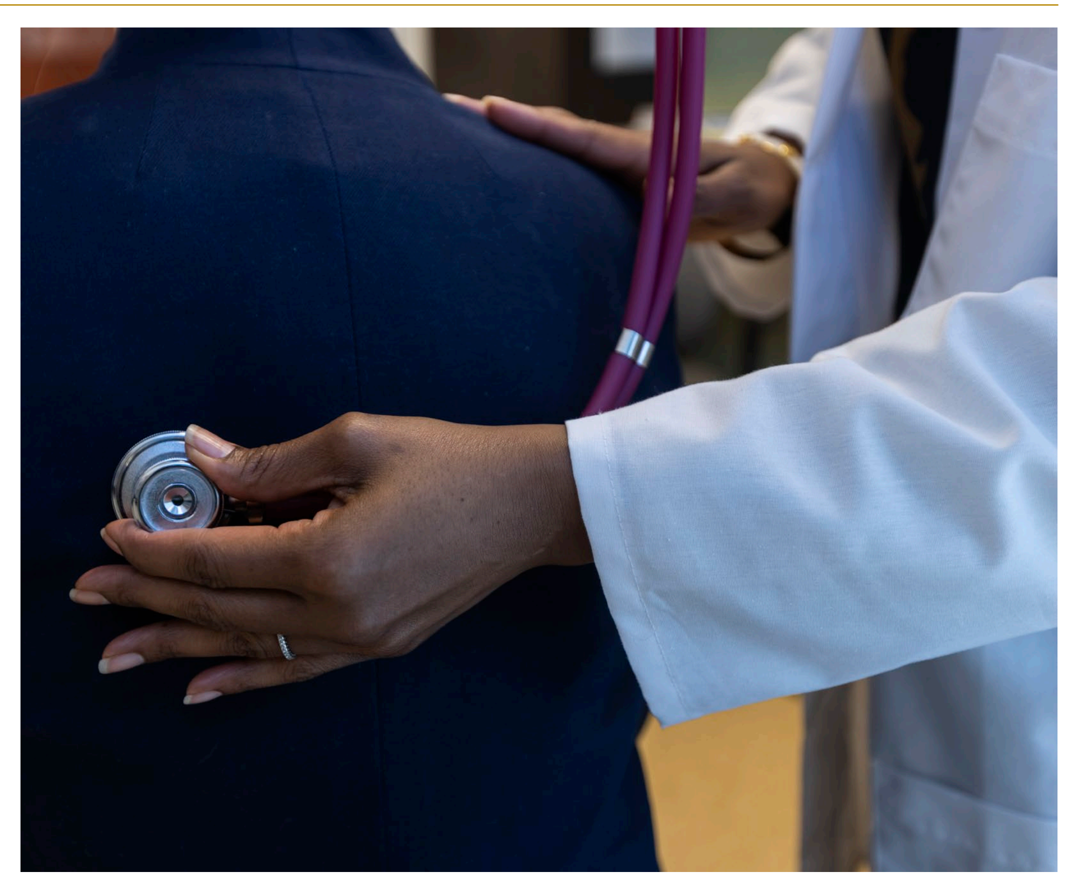
The *single* site solution

Full-scope **primary care** for people living with dementia

Dementia specialty care

Caregiver services, education and supports

In both clinic and senior living communities



IMC Outcomes

Lower Hospitalization Rate

- 2019-21: Compared to being an IMC patient, those seen in primary care had 2.06 odds of hospitalization
- 2019-21: Compared to being an IMC patient, those seen in primary care + cognitive neurology had 1.66 odds of hospitalization

Lower Prescribing of Harmful Drugs

- Odds ratios 10-13X higher in other practices

Fewer Inappropriate Screenings

- TFTC

High Patient and Family Experience

- Reduced caregiver distress

How Does It Work in Other Sites?

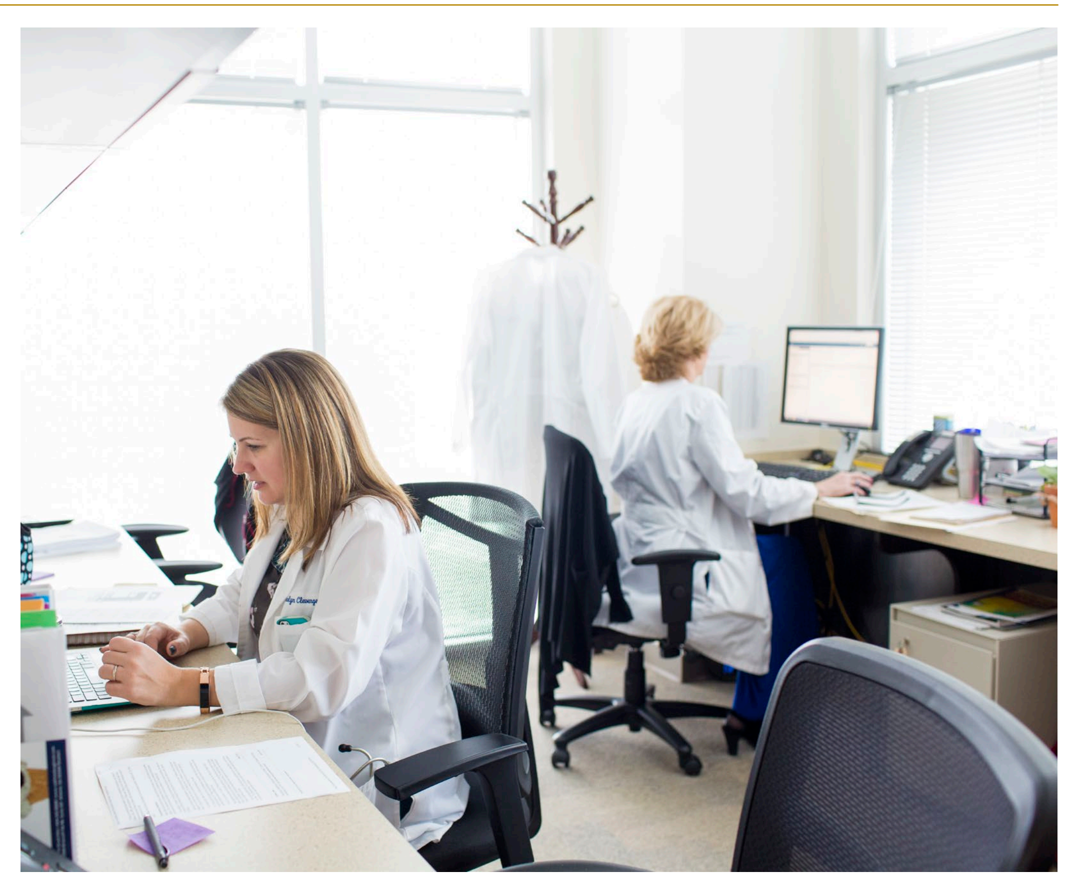
Can base IMC within Neurology practice OR Primary care

Non-negotiables:

- Provide primary care, dementia care, and caregiver services from one team

Central Services:

- Implementation team
- Provider coaching and support
- Caregiver classes and communications
- Documentation, billing and coding support



Contact and More Information

Points of Contact:

Carolyn Clevenger

Carolyn.Clevenger@emory.edu

Laura Medders

Laura.medders@emoryhealthcare.org

Amy Imes *(coming soon)*

MIND at Home

Leading the way.

MIND at Home: Proven, family-centered dementia care navigation

Personalized, family-centered dementia care

Advance Care Planning

Caregiver Support

Medical Care & Financing

Caregiver Health

Home Safety

Caregiver Knowledge & Skills

Function & Daily Activities

Memory & Behavior

↑ Stay Well at Home

↑ Care Quality

↑ Care Experience

↓ Caregiver Burden

↓ Healthcare Costs

Customized, partner-centered implementation

Mission & Goals

Payment Model

Patient Population

Clinical Expertise

Staffing

Outcome Measures

Assessment & Workflow

Regulations

↑ Patient Outcomes

↑ Care Quality

↑ Care Experience

↑ Health Equity

↓ Healthcare Costs

National Dementia Care Collaborative (NDCC)

GUIDE Model/Evidence Based Programs Crosswalk

Kristin Lees Haggerty, PhD
EDC

David R. Lee, MD
UCLA

November 2023

Evidence-Based Programs (EBP): Background

	Aging Brain Care (ABC) Program	Alzheimer's and Dementia Care (ADC) Program	Benjamin Rose Institute (BRI) Care Consultation	Care Ecosystem	The Integrated Memory Care (IMC) program	Maximizing Independence (MIND) at Home
Home Organization	Indiana University	University of California Los Angeles	Cleveland-based Non-Profit	University of California San Francisco	Emory University	Johns Hopkins University
Program Base	Health System	Health System	Community	Community Health System	Health System	Community Health system
Cost per enrollee per month	$	$$	$$	$$	$$	$$
Caseload per Care Navigator	125	250-300 (with assistant)	75-100	75	500	75 (per Community Health Worker)
Number of Dissemination Sites Currently Seeing Patients	7	9	31	15	0	7

GUIDE/EBP Interdisciplinary Team Structure

		GUIDE	Aging Brain Care (ABC) Program	Alzheimer's and Dementia Care (ADC) Program	Benjamin Rose Institute (BRI) Care Consultation	Care Ecosystem	The Integrated Memory Care (IMC) program	Maximizing Independence (MIND) at Home
Care Team Terms		**Care Navigator**	Care Coordinator Assistants	Dementia Care Specialist	Care Consultants	Care Team Navigator	LCSW, RN	Memory Care Coordinator + Memory Care Manager
		Dementia Proficient Clinician	Geriatrics	Program Medical Director	NA	Licensed dementia provider team	Geriatric Specialist NP	Medical director, Director of nursing
Care Navigator Credentials		**None**	Non-licensed	Advanced Practice Provider (NP, PA, Clinical Nurse Specialist w/ prescribing capabilities)	SW/RN	Non-licensed	SW/RN	Non-licensed (e.g., CHW)+ RN, SW, NP, APP

Alignment with GUIDE Program Components

			ABC	ADC Program	BRI CC	Care Ecosystem	IMC	MIND at Home
Care Navigator Training	**GUIDE Required Training Content Areas**		✓	✓	✓	✓	✓	✓
	Program-Specific Training Delivery	Experiential Live (virtual or in-person)	✓	✓	✓	✓	✓	✓
		Asynchronous online	✓	✓		✓	✓	✓
Mode of Care Delivery		In-Person	✓	✓		Site-Specific	✓	✓
		In-Home Visits	✓	Site-Specific		Site-Specific	✓	✓
		Telephone	✓	✓	✓	✓	✓	✓
		Telehealth Video		✓	✓	✓	✓	✓
		Portal/EHR		✓	✓		✓	✓

Alignment with GUIDE Care Delivery Requirements

GUIDE Care Delivery Requirements	ABC	ADC Program	BRI CC	Care Ecosystem	IMC	MIND at Home
1. Comprehensive Assessment Initial comprehensive assessment and reassessments each year.	✓	✓	✓	✓	✓	✓
2. Care Plan Beneficiaries receive care plan	✓	✓	✓	✓	✓	✓
3. 24/7 Access Member of care team or third-party representative	✓	✓	Online Portal Only		✓	Depends on site
4. Ongoing Monitoring and Support Provide long-term help to CG and beneficiaries to revisit goals and needs	✓	✓	✓	✓	✓	✓
5. Care Coordination and Transitional Care Management Coordinate with PCP, coordinate with specialists, support transitions between personal home and care settings	✓	✓	✓	✓	✓	✓
6. Referral and Coordination of Services and Supports Care navigator connects beneficiary and CG to community-based services	✓	✓	✓	✓	✓	✓

GUIDE Care Delivery *Requirements (cont'd)*			ABC	ADC Program	BRI CC	Care Ecosystem	IMC	MIND at Home
7. Caregiver Support	Education provided	Caregiver Skills Training	✓	✓	✓	✓	✓	✓
		Dementia Dx Information	✓	✓	✓	✓	✓	✓
		Support group services	✓	✓	Through Referral	Through Referral	✓	Through Referral
		Ad-hoc 1:1 Support Calls	✓	✓	✓	✓	✓	✓
	Beneficiary receives respite (required in-home), can be outside agency		✓	Through contracts	Through Referral			
8. Medication Management	Clinician reviews and reconciles medication		✓	✓		✓	✓	Site Dependent
	Care Navigator provides tips to maintain schedule		✓	✓	✓	✓	✓	✓
9. Care Coordination and Transition	Beneficiaries receive timely referrals to specialists		✓	✓	✓	✓	✓	✓
	Care Navigators coordinate with specialists		✓	✓	✓	✓	✓	✓

Evidence Related to GUIDE Performance Metrics

Domain		Aging Brain Care (ABC) Program	Alzheimer's and Dementia Care (ADC) Program	Benjamin Rose Institute (BRI) Care Consultation	Care Ecosystem	The Integrated Memory Care (IMC) program	Maximizing Independence (MIND) at Home	GUIDE Proposed Metrics
Care Coordination and Management		✓	✓		✓			High-risk medications (eCQM/CQM)
Beneficiary QOL		✓	✓	✓	✓	✓	✓	Quality of life outcome (Survey-based)
Caregiver Support		✓	✓	✓	✓	✓	✓	Zarit Burden Interview (Survey-based)
Utilization	Per Capita Savings	✓	✓	Cost Neutral	✓		✓	Total per capita cost (Claims based)
	Long-Term Nursing Home		✓				✓	Long-term nursing home stay rate

Presentation 4:
Health Equity Strategies and Addressing Health Disparities in the GUIDE Model

Serena Ho, CMMI

Guiding an Improved Dementia Experience (GUIDE) Health Equity Strategy

Center for Medicare and Medicaid Innovation
November 28, 2023

Agenda

1 CMMI Strategic Objectives: Advance Health Equity

2 Health Equity in the GUIDE Model

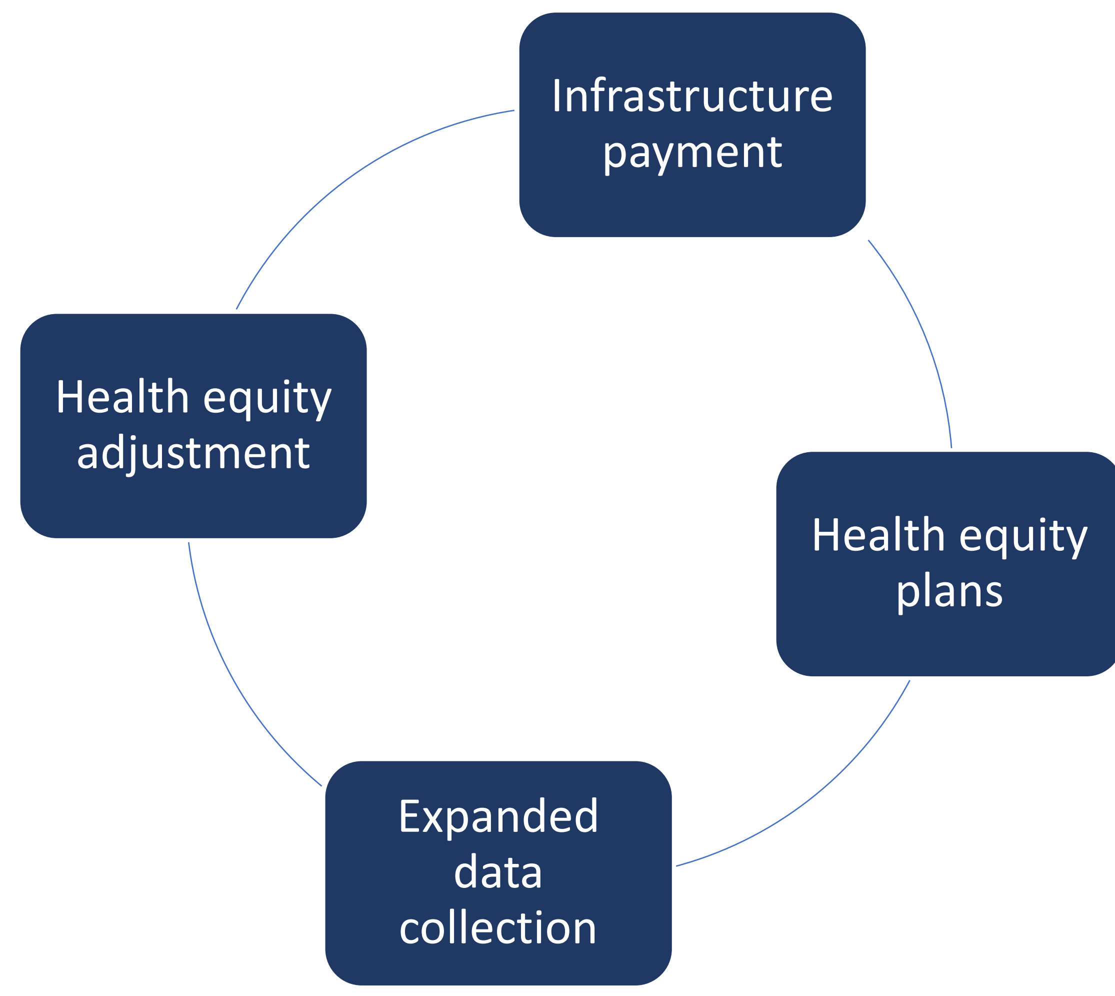
- Health equity adjustment
- Infrastructure payment
- Health equity plans
- Expanded data collection

3 Application Timeline, Process, and Resources

CMMI Strategic Objectives: Advance Health Equity

Aim: *Embed health equity in every aspect of CMS Innovation Center models and increase focus on underserved populations.*

Health Equity in the GUIDE Model



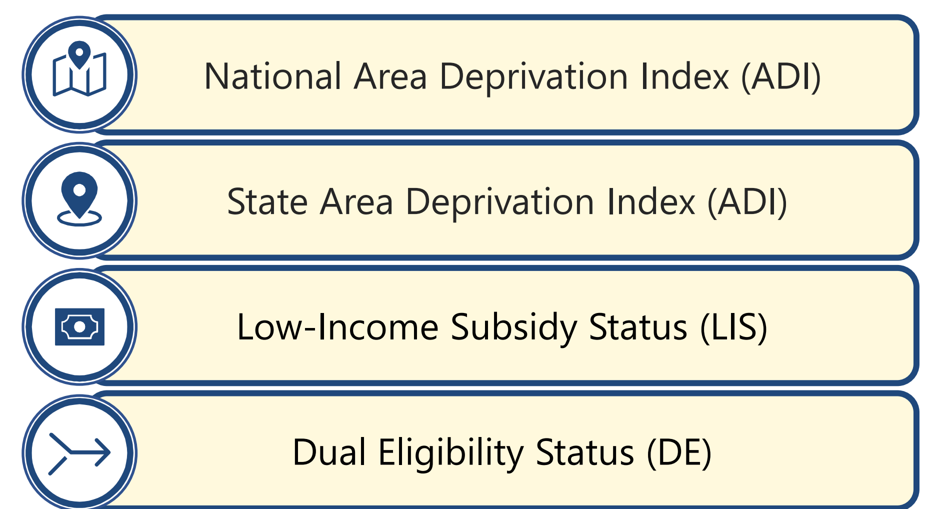
CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE & MEDICAID INNOVATION

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 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:



Health equity score =

0.1 x National ADI + State ADI + 20 x LIS or DE

Where:

- *National ADI = 1-100*
- *State ADI = 1-10*
- *LIS/DE = 1 if yes, 0 if no*

Equity Score Percentile	HEA
$\geq 80^{th}$ percentile of equity scores	**+$15**
51st-79th percentile of equity scores	**$0**
0-50th percentile of equity scores	**-$6**

Infrastructure Payment

Participants in the new program track that are classified as safety net providers will also be eligible to receive an infrastructure payment to cover some of the upfront costs of establishing a new dementia care program.

The infrastructure payment will be a one-time payment of $75,000 made at the beginning of the pre-implementation period (July 2024).

The infrastructure payment is intended to assist GUIDE safety net providers with: 1) hiring, 2) training, 3) developing program workflows, protocols, community partnerships, and materials, 4) community outreach and engagement, and 5) electronic health record technology adaptations.

The payment will be geographically adjusted using the same Physician Fee Schedule geographic adjustment factor that was used to adjust the DCMP.

To qualify, applicants must have a Medicare FFS beneficiary population comprised of at least 36% beneficiaries receiving the Part D LIS or 33.7% of beneficiaries who are dually eligible for Medicare and Medicaid. These thresholds are based on the safety net definition that CMMI has developed to assess and track safety net provider participation in its models.

Health Equity Plan

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

Initial Health Equity Plan (Baseline Care Delivery Reporting Survey)

FOCUS	**Beneficiary Outreach and Engagement**
GOAL	**Encourage Participants to develop and implement equitable recruitment strategies from model start**

- Implement strategies to reach potentially eligible beneficiaries historically underserved
- Identification of underserved groups and outreach strategies

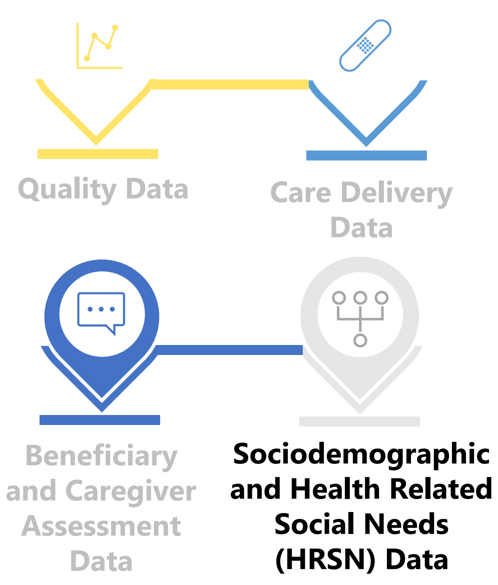
Annual Health Equity Plan (Annual Care Delivery Reporting Survey)

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

- Deploy evidence-based interventions
- Set goals and report progress to achieve equitable outcomes

Expanded Data Collection Efforts

All Innovation Center model participants are required to collect and report data deemed necessary to monitor and evaluate the model. GUIDE will require participants to report the following:



Socio-demographic Data

Participants will be required to report a **core set of sociodemographic measures** for their aligned beneficiaries annually.

The core measures are:

- Race
- Ethnicity
- Sex assigned at birth
- Sexual orientation
- Gender identity
- Disability status
- Preferred language

Health-Related Social Needs (HRSN) Data

HRSN collection and referrals will be part of the model's broader care delivery requirements for comprehensive assessment and referral for services and supports.

Model participants will be 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.

Example HRSN domains include **food insecurity, transportation, housing, utilities, and safety.**

Thank You for Attending this Presentation

We appreciate your time and interest!

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

Breakout Session 1

1: Aging Brain Care (ABC) Program

2: Alzheimer’s and Dementia Care (ADC) Program

3: Benjamin Rose Institute (BRI) Care Consultation

4: Care Ecosystem

5: Integrated Memory Care (IMC)

6: Maximizing Independence (MIND) at Home

7: Choosing a Dementia Care Model: Considerations to Inform Decision-Making, hosted by the National Alzheimer’s Disease Resource Center (NADRC)

8: Act Now: Building Your Dementia Care Model, hosted by Alzheimer’s Association

Concluding Comments and Next Steps

NDCC.edc.org

Breakout Session 2

1: Aging Brain Care (ABC) Program

2: Alzheimer’s and Dementia Care (ADC) Program

3: Benjamin Rose Institute (BRI) Care Consultation

4: Care Ecosystem

5: Integrated Memory Care (IMC)

6: Maximizing Independence (MIND) at Home

7: Choosing a Dementia Care Model: Considerations to Inform Decision-Making, hosted by the National Alzheimer’s Disease Resource Center (NADRC)

8: Act Now: Building Your Dementia Care Model, hosted by Alzheimer’s Association

9: Reflections from Tribal Communities hosted by the Indian Health Service

10: Determining the Financial Benefits of Participation in GUIDE

Thank you!

Contact us!
NDCC.EDC.ORG

Gary Epstein-Lubow
Gepstein-lubow@edc.org

Kristin Lees Haggerty
Klees@edc.org

Summit Funder:

Summit Co-sponsor: