Applying for GUIDE Model in California

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UCLA Health ADC Alzheimer's and Dementia Care PROGRAM DHCS

Introduction

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Housekeeping

We will leave 10-15 minutes at the end of this session for Q&A. Throughout the webinar, you can put your questions into the Q&A/chat functions and some may be answered in real time.

We will share instructions for claiming Continuing Education (CE) credit at the end of this webinar and via email within 48 hours.

You will receive the recording of this webinar via email within 48 hours

You can also access the webinar slides and recording from the Dementia Care Aware website and YouTube channel.

Learning Objectives

- Describe what is required to participate in the GUIDE Model.
- List 2 examples of a successful partnership in California that follows the GUIDE Model.
- Identify 2 resources to help California applicants apply for the GUIDE Model.

Now We Would like to Share This Video with You!

https://docs.google.com/presentation/d/1HfqAKkLPvVd06AAH_pcCXYggFhPuPrYQs41rTpfzvNA/edit?pli=1#slide=id.p

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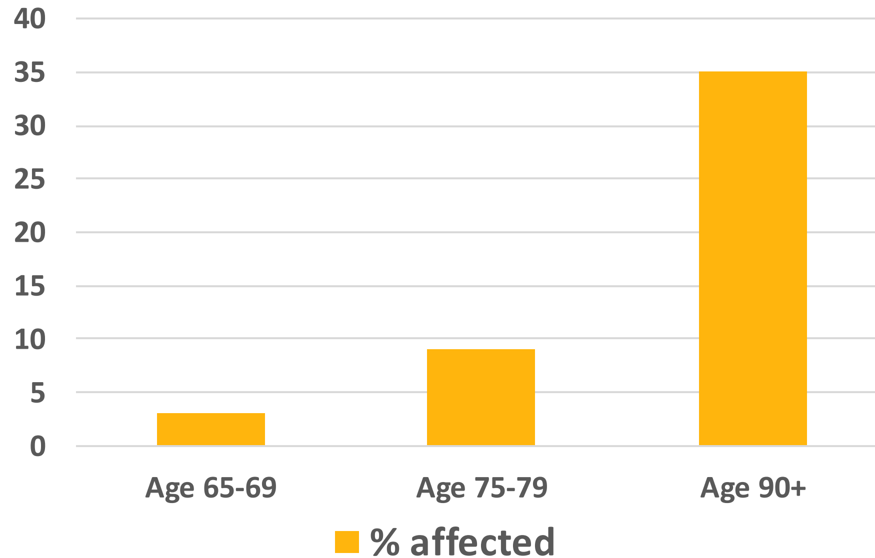
The Worst Fear of Aging, and with Good Reason.



6.5 million Americans have Alzheimer's disease

By 2025, it will be **7.2 million**

Higher prevalence in African Americans (OR 1.8) and < high school education (OR 1.6)

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The Dementia Quality Problem

- Poor quality of care: 38-44% of Assessing Care of Vulnerable Elders (ACOVE) Quality Indicators met
  - Cognitive evaluation if positive screen (25%)
  - Checking medications (9%)
  - Caregiver support (29%)
  - Monitoring for behavioral/psychological symptoms (45%)

- Poor linkages to community-based resources

The Consequences

- $345 billion in health care for persons with dementia (2023).
- 3 x hospital stays: higher provider, nursing home, home health, and drug costs.
- >11 million caregivers provided 17 billion hours of care worth $340 billion (2022).
- Cost per person per year with and without dementia (2022):

Cost	Dementia	Without dementia
Medicare	$21,873	$7,882
Medicaid	$6,739	$303
Out of pocket	$10,241	$2,518
Total	$43,444	$14,593

Comprehensive Dementia Care

- **Focuses on patient and caregiver and includes:**
  - Continuous monitoring and assessment
  - Ongoing care plans
  - Psychosocial interventions
    - Aimed at person living with dementia
    - Aimed at caregivers
  - Self-management
  - Medication management (some community-based programs don't)
  - Treatment of related conditions
  - Coordination of care

Boustani M, et al. An Alternative Payment Model To Support Widespread Use Of Collaborative Dementia Care Models. Health Aff (Millwood). 2019 Jan;38(1):54-59. PMID: 30615525.

Evidenced-based dementia care navigation programs

- Benjamin Rose Institute (BRI) Care Consultation
- Care Ecosystem
- Eskenazi Healthy Aging Brain Center
- Integrated Memory Care
- Maximizing Independence (MIND) at Home
- UCLA Alzheimer's and Dementia Care Program

How Comprehensive Care Models Differ

- Staffing
- Base of operations
- Scope of services
- Intensity
- Cost
- Efficacy/Effectiveness (pragmatism)
- Potential Return On Investment
- Level of evidence

Comparison of Six Dementia Care Models

Structure and Process	BRI – CC	Care Ecosystem	MIND	HABC	UCLA ADC	IMCC
Key personnel	Non-licensed, SW, RN, MFT	Non-licensed care navigator, CNS, SW, Pharmacist	Non-licensed staff, RN, MD	Non-licensed staff, MD, SW, RN, Psychologist	NP, PA, SW, non-licensed staff, MD	NP, SW, RN
Key personnel base	CBO or Health system	Health System or Community	Community or Managed Care Organization	Health system	Health system	Health system
Face-to-face visits	No	No	Yes	Yes	Yes	Yes
Access 24/7/365	Optional	No	No	Yes	Yes	Yes
Communication w/ PCP	Mail, fax, phone	Fax, phone	Phone, mail, fax	EHR, phone, mail	EHR, phone	N/A
Order writing	No	No	No	Yes	Yes	Yes
Medication management	No	Yes	No	Yes	Yes	Yes
Benefits						
High quality of care	N/A	N/A	N/A	Yes	Yes	Yes
Patient benefit	Yes	Yes	Yes	Yes	Yes	Yes
Caregiver benefit	Yes	Yes	Yes	Yes	Yes	Yes
Costs of the program	+++	++	+++	+++	++++	++++
Costs savings, gross	++	++++	+++ (Medicaid)	++	++++	++++

The Alzheimer's and Dementia Care (ADC) Program

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The ADC Program Model

Approaches the Person Living With Dementia and caregiver as a dyad; both need support

Provides comprehensive care based in the health system that reaches into the community

Recognizes that this care is a long journey.

Uses a co-management model with Adanced Practice Providers as Dementia Care Specialists (DCS) who do not assume primary care of the Person Living With Dementia

The ADC Program

- **Mission:** To partner with families, physicians, and community organizations to:
  - maximize person living with dementia function, independence, and dignity,
  - while minimizing caregiver strain and burnout.

The ADC Program Model

- Multidisciplinary care team
- Works with primary care and specialty physicians to care for patients by
  - Conducting in-person needs assessments
  - Developing and implementing individualized dementia care plans
  - Monitoring response and revising as needed
  - Providing access 24 hours/day, 365 days a year
- Partners with community-based organizations (CBO) to provide direct services (e.g., adult day care) and caregiver training

Dementia Care Specialist (DCS) and Assistants (DCA)

- DCS: Advance Practice Provider (Nurse Practitioner, Physician Assistant, Clinical Nurse Specialist with prescribing authority)
  - Health care system-based, outpatient clinic setting
  - Dementia care co-management along with the individual's medical team
  - Each DCS follows 250 patients
- DCA: Non-licensed or Licensed (Registered Nurse, Social Worker, PharmD)
  - Reach out to lower acuity People With Dementia-caregiver dyads and offer resource
  - Identify dyads in crisis
  - Allow DCS to work at the top of their license

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Services Provided by Partner Community-Based Organizations (CBOs)

- Services for patients:
  - Adult day care services
  - Programs for brain health (for early-stage memory loss)
- Services for families/caregivers:
  - Education (workshops, classes, informational sessions, handouts)
  - Counseling and peer-to-peer support
  - Case management
  - Legal and financial counseling
  - Support groups
- Voucher system funded by philanthropy
  - Selected, short-term services, authorized by Dementia Care Specialist (DCS) (i.e., counseling, case management, respite care)

Overall Dementia Quality of Care (ACOVE-3 and PCPI QIs)*

Community-based physicians	38%
Community-based physicians & NP	60%
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*Based on medical record abstraction of first 797 patients

Jennings LA, et al. J Am Geriatr Soc, Jun 2016. PMID: 27355394

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ADC 1- Year Outcomes for PLWD and Caregivers

Outcome	PLWD	Caregiver
Cognition (MMSE)	Worse	
Functional status (FAQ)	Worse	
Behavioral symptoms (NPI-Q)	Improved	
Distress because of behavioral symptoms		Improved
Caregiver strain		Improved
Caregiver depression (PHQ-9)		Improved

ADC Utilization and Costs

Type of Care	Impact
Hospitalizations	▼ 12%
ED visits	▼ 20%*
ICU stays	▼ 21%
Hospital days	▼ 26%*
Nursing home placement	▼ 40%*
Hospice in last 6 months	▲ 60%*

Total Medicare costs of care:
▼ $2,404/year *

* $p<.05$
Based on NORC external evaluation of CMMI Award using fee-for-service claims data and UCLA ACO data September 2015- September 2017

Guiding an Improved Dementia Experience (GUIDE) Model

- On July 31, 2023, the Centers for Medicare & Medicaid Services (CMS) announced the new voluntary nationwide GUIDE model that aims to:
  - Improve the quality of life for people living with dementia,
  - Reduce burden and strain on unpaid caregivers of people living with dementia.
  - Prevent or delay long-term nursing home care.

GUIDE Model: Design

1. **Defining a standardized approach to dementia care delivery**
2. **Providing an alternative payment methodology** – CMS will provide a monthly per-beneficiary payment to support a team-based collaborative care approach
3. **Addressing unpaid caregiver needs** – by caregiver training and support services, including 24/7 access to a support line, as well as connections to community-based providers.
4. **Respite services** – Payment for respite services, which are temporary services provided to a beneficiary in their home, at an adult day center, or at a facility that can provide 24-hour care
5. **Screening for Health-Related Social Needs** – and help navigate them to CBOs to address

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GUIDE Model: Patient Eligibility

- Diagnosis of dementia
- Medicare is their primary payer
- Enrolled in Medicare Part A and B (not in MA, including SNPs and PACE)
- Not enrolled in hospice
- Not residing in long-term nursing home

Patient Navigators and Dementia Care Navigation

Patient Navigators are trained personnel whose role is to partner with patients to help them identify their needs and goals and then overcome modifiable patient-, provider-, and system-level barriers.

They are nurses, social workers, lay health workers, or peers working individually or in various team and supervisor arrangements.

Dementia Care Navigation is a program that provides tailored, strengths-based support to persons living with dementia and their care partners across the illness continuum and settings to mitigate the impact of dementia through collaborative problem-solving and coaching.

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GUIDE Model: Care Delivery Approach

- Standardized set of services in 9 domains
- Interdisciplinary care team
- Training requirement for care navigators
- Person-centered care plan
- Care coordination
- Caregiver services

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Dementia Care Specialist (DCS)

- Advance Practice Provider
  - Nurse Practitioner, Physician Assistant, Clinical Nurse Specialist (with prescribing authority),
- Health care system-based, outpatient clinic setting
- Dementia care co-management along with the individual's medical team (e.g., primary care, neurologist, psychiatrist)
- Each DCS follows 250 patients

What's so different about the program is that now we involve the families and they're so grateful.

- Adopting Site DCS

It's extremely rewarding work, to be honest.

- Adopting Site DCS

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Dementia Care Specialist Training

- **Online curriculum (GAPNA distribution)**
  - 22 online modules + 4 asynchronous videos
- **Zoom live intensive training**
  - 8-hour role and model training
  - 1:1 weekly training with a DCS expert trainer
    - Brings together information learned in the online training to the real-world environment
    - Case-based scenarios
    - Networking
  - Available office hours each week

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GUIDE Required Care Delivery Activities by Domain and how ADC meets them

Domain	Required Activities	ADC Program Core Components
Comprehensive Assessment	Clinical, behavioral and psychosocial, and ACP domains, as well as caregiver needs and capabilities and home visit	In-person initial assessments
Care plan	Comprehensive person-centered care plan that addresses all assessment domains	Care plan based on assessment and shared with patient and caregivers
24/7 Access	24/7 access to an interdisciplinary care team member or help line	Coverage by geriatrics, palliative care, or other practice
Ongoing Monitoring and Support	DCN is primary point of contact Minimum contact by model tier	APP DCN is main point of contact Frequency of contact is based on needs
Care Coordination and Transitional Care Management	Coordinate with the beneficiary's primary care provider Support transitions	Initial and annual care plan sent and reviewed by Primary Care Physician (PCP)

GUIDE Required Care Delivery Activities by Domain and how ADC meets them

Domain	Required Activities	ADC Program Core Components
Referral and Coordination of Services and Supports	Inventory of and referral to local/community services	Identify CBO partners and establish menu of services and contracting relationships; Voucher system to pay for services
Medication Management and Reconciliation	Clinician with prescribing authority must review, and changes must be shared with PCP	APP DCN has prescribing authority PCPs are notified of all medication changes
Caregiver Education and Support	Caregiver skills training, dementia diagnosis information, support group services, ad-hoc 1:1 calls	Skill training, diagnosis information, and ad-hoc calls by APP DCN ADC-sponsored and CBO support groups
Respite	In-home respite care, adult day centers, facility-based respite providers	Contracts with home care agencies and CBOs Voucher system to pay for services

Other GUIDE-required elements and how ADC meets them

- Care Team Requirements: Care Navigator (APP); clinician with dementia proficiency (Physician Medical Director)
- Care Navigator Training: 22 online didactic modules and experiential training
- Performance Measures (can increase payment up to 10% or decrease to 3.5%)
  - High-risk medication management by APPs
  - Person with dementia quality of life
  - Reduced caregiver burden
  - Reduced total per capita cost
  - Reduced rate of entry into long-term nursing homes

Cons and Pros of Using ADC as the Model for GUIDE

Cons

- More expensive
- Higher level of Care Navigator (APP vs CHW)
- Team is larger than required minimum
- Requires space and support for clinicians

Pros

- Covers everything GUIDE requires
- Strong evidence that it will achieve CMMI's goals for GUIDE
- Care navigators enjoy their work
- Helps PCPs
- Tried and true; it works

Guide Model: Payment

- Per-beneficiary-per-month payment
- Amount per beneficiary by tier (5 categories) based on:
    - Whether beneficiaries have a caregiver
    - Severity of dementia (mild, moderate, or severe)
- Payment adjustments based on health equity and performance
- Respite care payment for moderate or severe patients up to an annual cap of $2,500
- Infrastructure payment for safety net providers: One-time lump sum for program development

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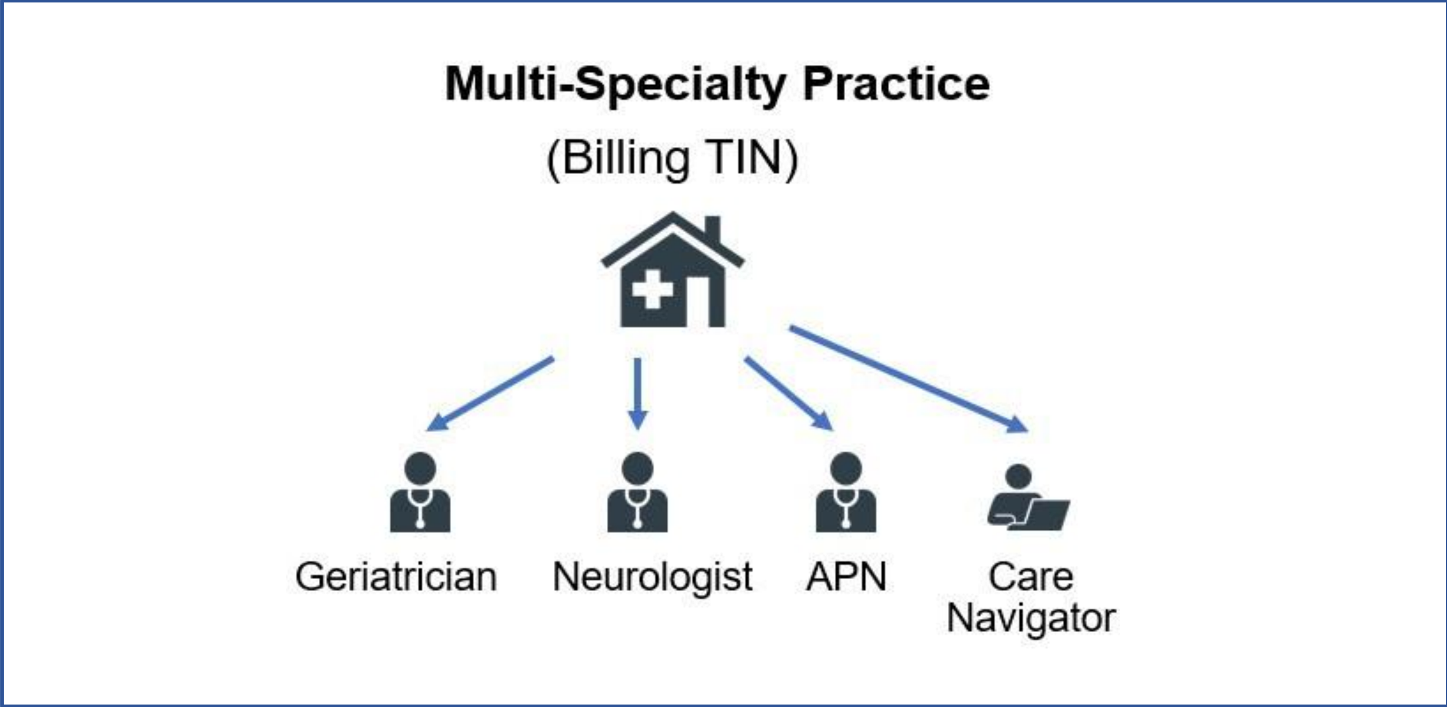
Guide Model: Getting In

- Medicare Part B enrolled providers and suppliers

- Interdisciplinary care team including
  - Care navigator who has received training
  - Clinician with dementia proficiency (e.g., specialty designation in neurology, psychiatry, geriatrics, geriatric psychiatry, behavioral neurology, or geriatric neurology)

- Two tracks
  - Established program if already providing comprehensive dementia care in at least 6 of 9 care delivery domains for at least 12 months prior to submission date (start July 1, 2024)
  - New program: One-year pre-implementation period (beginning on July 1, 2024)

How to Structure GUIDE: Example 1: Single Provider



No partner organization; all requirements, including in-home visit and in-home respite services must be provided by the participant

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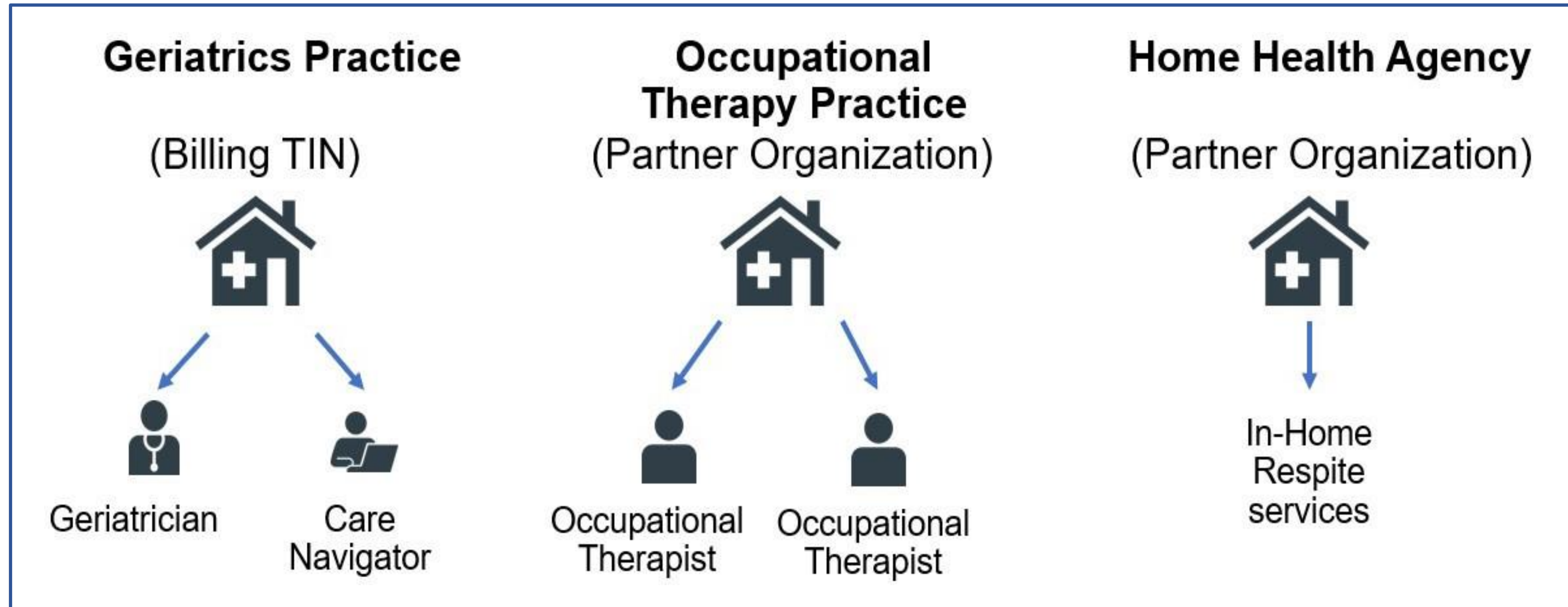
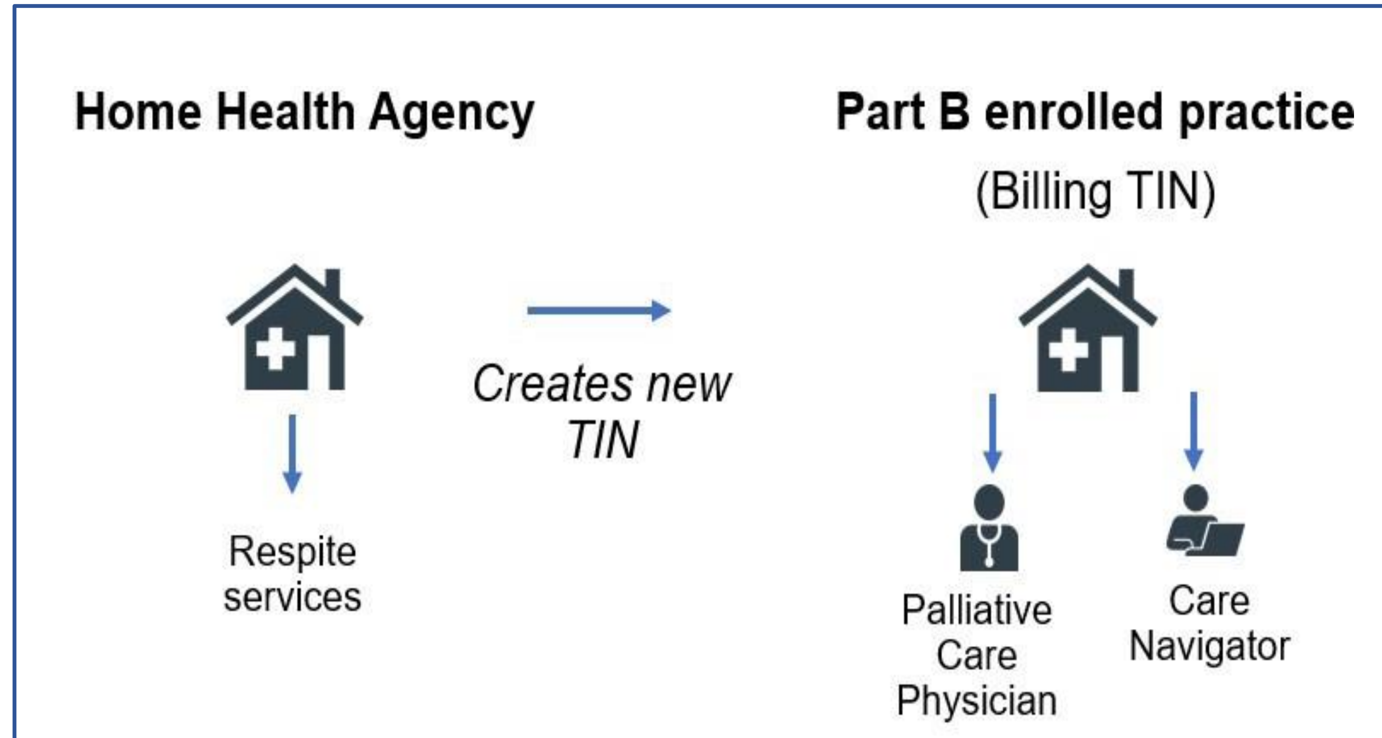
How to Structure GUIDE: Example 2: Provider and Partners



Practice is the GUIDE participant and bills all services; all practitioners must reassign their billing rights to this TIN.

How to Structure GUIDE: Example 3: Provider Establishes New Part B enrolled TIN to form a Dementia Care Program



Home health agency establishes new Part B practice to become a GUIDE participant.

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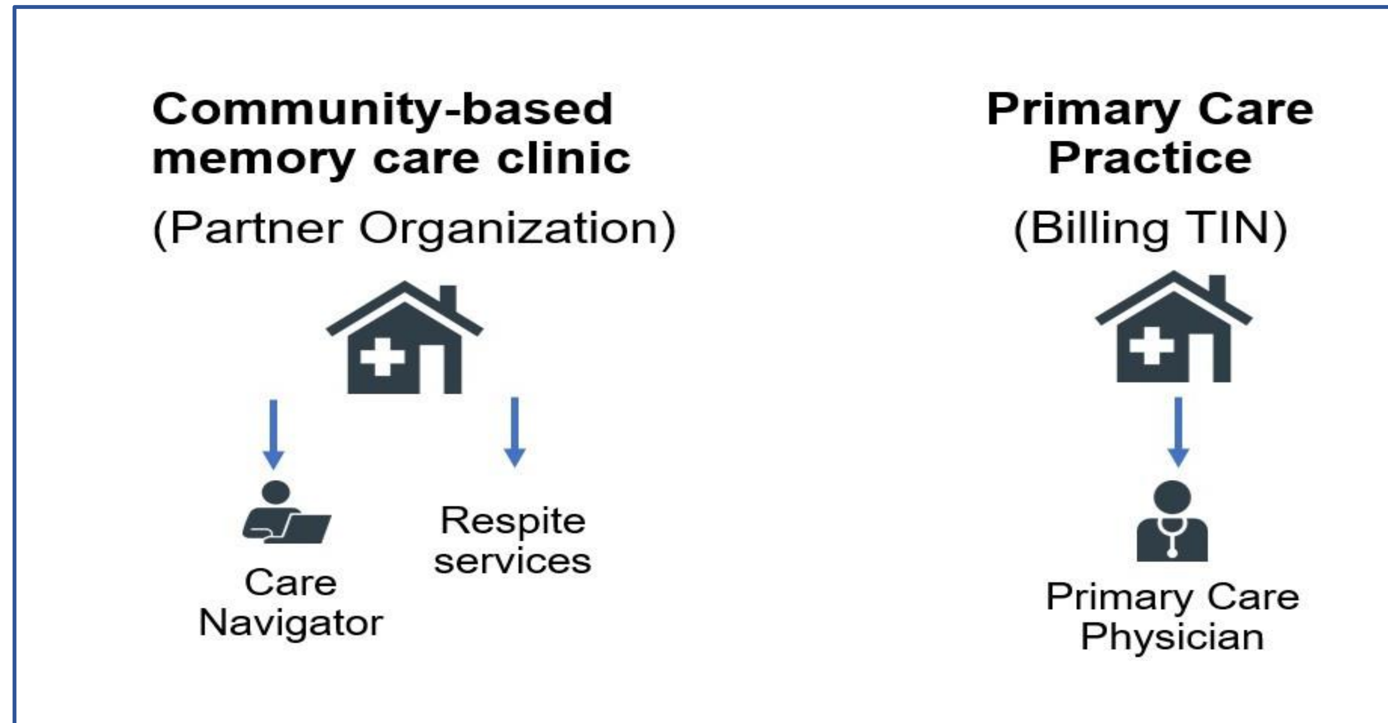
How to Structure GUIDE: Example 4: CBO Partners with Primary Care Practice to Form a Dementia Care Program



CBO without Part B provider partners with Primary Care Practice; the Primary Care Practice is the GUIDE participant, and services are billed under its TIN

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GUIDE Model Timeline

- Eight-year model
  - Letters of Interest (optional, non-binding) due September 15, 2023
  - Request for Applications issued November 15, 2023
  - Applications due January 30, 2024
  - Launch July 1, 2024
    - Established program: start care and payment on July 1, 2024
    - New program: One-year pre-implementation period beginning on July 1, 2024; start care and payment on July 1, 2025

How ADC Can Help You Become a GUIDE Participant

For sites contemplating using ADC model for GUIDE

- Weekly office hours to answer questions about adapting ADC to your institution and meet GUIDE requirements

For sites who have signed Letters of Agreement to adopt ADC

- 1-on-1 meetings with UCLA ADC staff
- Language about ADC that can be inserted into GUIDE application
- Review, if requested, of draft elements of application

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How to claim Continuing Medical Education (CME) credit

Step 1. Please complete our evaluation survey using the link provided in the chat and a post-webinar email. Please select the correct link based on the credit type you are claiming.

- For this activity, we provide **CME credits** for MDs, NPs, APPs and PAs including **AAFP** (for family physicians)
- **ABIM MOC** (for internal medicine physicians).
- We also provide **CAMFT credits**, which in the state of California is approved, for Licensed Clinical Social worker, Licensed Professional Clinical Counselor, Marriage and Family Therapist, and Licensed Educational Psychologist

Step 2. Upon completing the evaluation survey, please scan a QR code or link to claim credit directly on the UCSF continuing education portal. :

- Use your phone camera to scan a QR code and tap the notification to open the link associated with the CME portal.
- Enter your first name, last name, profession, and claim **1 CE credit** for the webinar.

Thank You