NIA IMPACT COLLABORATORY
TRANSFORMING DEMENTIA CARE

The Guiding and Improved Dementia Experience (GUIDE) Model: A CMS payment model test to support people living with dementia and their family caregivers

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Housekeeping

- All participants will be muted
- Enter **all questions** in the Zoom **Q&A/chat box** and send to Everyone
- Moderator will review questions and ask them at the end
- Want to continue the discussion? Associated podcast released about 2 weeks after Grand Rounds
- Visit impactcollaboratory.org
- Follow us on Twitter & LinkedIN:

@IMPACTcollab1

https://www.linkedin.com/company/65346172

Learning Objectives

Upon completion of this presentation, you should be able to:

- Review the historical context of the CMS GUIDE Model and its potential for transforming the delivery, quality and outcomes of dementia care in the United States.
- Learn the requirements for participating health systems regarding care delivery and outcomes reporting.
- Understand how the GUIDE Model requirements align with evidence-based comprehensive dementia care, including new opportunities and challenges for pragmatic evaluation of dementia service delivery related to GUIDE-participating health systems.

NIA IMPACT Collaboratory

- Mission: “To build the nation’s capacity to conduct pragmatic clinical trials of interventions embedded within health care systems for people living with dementia and their care partners.”

- Vision: “To transform the delivery, quality, and outcomes of care provided to Americans living with dementia and their care partners by accelerating the testing and adoption of evidence-based interventions within health care systems.”

National Alzheimer's Project Act (NAPA)

- Signed into law January 2011
- Public / Private **Advisory Council on Alzheimer's Research, Care and Services**
- **National Plan** to Address Alzheimer's disease:
  - Prevent and Effectively Treat AD/ADRD by 2025.
  - Enhance Care Quality and Efficiency.
  - Expand Supports for People with AD/ADRD and Their Families.
  - Enhance Public Awareness and Engagement.
  - Improve Data to Track Progress.
  - Accelerate Action to Promote Healthy Aging and Reduce Risk Factors for AD/ADRD.

https://aspe.hhs.gov/collaborations-committees-advisory-groups/napa

Federal Programs and Initiatives

- Administration for Community Living (ACL)
- Centers for Disease Control and Prevention (CDC)
- Health Resources and Services Administration (HRSA)
- Veterans Health Administration (VHA)
- National Institute on Aging (NIA)
  - National Research Summit(s) on Care, Services and Supports for People Living with Dementia and their Care Partners / Caregivers
  - National Academies of Sciences, Engineering and Medicine (NASEM) reports
- Centers for Medicare and Medicaid Services

Recommendations to Improve Payment Policies for Comprehensive Dementia Care

- One-day convening at Education Development Center in Washington, DC
- Over 50 national experts in dementia care from diverse perspectives
- Recommendations:
  - Payments for services to family caregivers
  - New research to determine success metrics
  - Education for consumers, providers and policymakers
  - Advance a population health model approach to tier coverage based on risk and need within a health system

Lees Haggarty, Epstein-Lubow et al; J Am Geriatr Soc; 25 Sept 2020

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

Comprehensive Care for Alzheimer's Act

- Senate 626 in the 118th Congress (2023-24)
- "This bill allows the Center for Medicare and Medicaid Innovation (CMMI) to test a Dementia Care Management Model that provides comprehensive care to Medicare beneficiaries with Alzheimer's disease or a related dementia."
- "Under the model, participating health care providers receive payment under Medicare for comprehensive care management services that are provided to individuals with diagnosed dementia, excluding Medicare Advantage enrollees, hospice care recipients, and nursing home residents. **Required services include medication management, care coordination, and health, financial, and environmental monitoring, as well as trainings and other support services for unpaid caregivers**. Providers must furnish services through interdisciplinary teams and must ensure access to a team member or primary care provider 24-7. The CMMI must set payments and determine quality measures for the model in accordance with specified requirements."
- "The bill also allows the CMMI to design a similar model under Medicaid."

https://www.congress.gov/bill/118th-congress/senate-bill/626

Payment for Comprehensive Dementia Care: Five Key Recommendations

1. The payment model should cover comprehensive dementia care that meets quality outcomes measures.
2. The payment model should address both beneficiary and caregiver needs.
3. To be eligible, beneficiaries must have a diagnosis of dementia.
4. Comprehensive dementia care programs should be widely available to Medicare beneficiaries, especially those living in rural and underserved communities who have traditionally had difficulty accessing health care systems.
5. The payment model should be capitated based on the severity of symptoms and available resources.

Super et al; Health Affairs Forefront, Feb 7, 2023

Biden-Harris Administration April 2023 Executive Order 14095: Increase Access to High-Quality Care

- "Make child care and long-term care more accessible and affordable for families."
- Support for family caregivers
- Included a direction to HHS to:
  - "consider whether to select for testing by the Center for Medicare and Medicaid Innovation an innovative new health care payment and service delivery model focused on dementia care that would include family caregiver supports such as respite care."

The Guiding an Improved Dementia Experience (GUIDE) Model

- Announced July 31, 2023 by the Centers for Medicare & Medicaid Services
- To support the GUIDE Model and other innovations:
  - National Dementia Care Collaborative (NDCC)
  - NDCC “Autumn Summit: CMS GUIDE Model: Choices for Implementing Evidence-based Dementia Care”
    - 3-hour virtual event
    - November 28, 2023
    - Archived at NDCC.edc.org

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

- Improve access to evidence-based comprehensive dementia care.

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

NDCC
National Dementia Care Collaborative

Comprehensive Dementia Care Models

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

Indiana University School of Medicine
Indiana University Center for Aging Research

The Alzheimer's and Dementia Care (ADC) Program

Providing comprehensive, coordinated, dementia care for Persons Living with Dementia and their loved ones

UCLA Health

BENJAMIN ROSE
Let's rethink aging.

BRI Care Consultation™

Care Ecosystem
Navigating Patients and Families Through Stages of Care

University of California – San Francisco

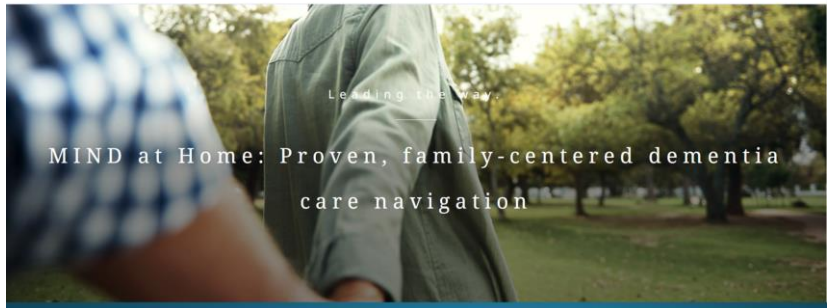
UCSF

imc
Where Dementia is Primary

Integrated Memory Care
Emory University

Johns Hopkins School of Medicine

MIND at Home



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

Evaluating Results and Advancing Best Practices

CMMI uses **independent evaluators** to routinely and rigorously assess the impact of each model on quality of care and program expenditures

CMMI seeks to advance models that generate net savings and represent **high-value investments of taxpayer dollars** while maintaining or improving quality of care

The Secretary of Health & Human Services has the authority[1] **to expand the duration and scope of a model** being tested… including implementation on a nationwide basis[2].

[1]Under Section 1115A(c) of the Social Security Act
[2]pending model expansion determinations performed by CMS under section 1115A(b)(4).

CMMI Strategy | 2021 Strategic Refresh: A Vision for the Next Decade

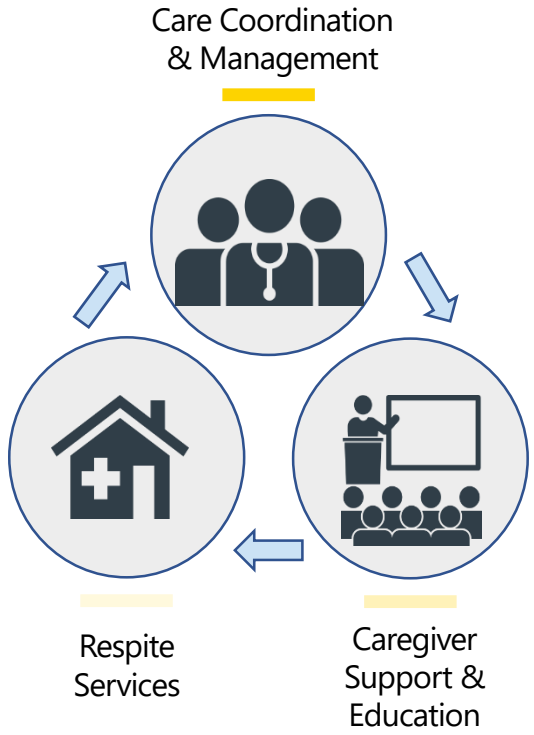
CMS Has Run Five Previous Dementia Care Projects

Project	Focus	Setting	Workforce	Intensity	Duration[#]
HCIA[*] Dementia Care Ecosystem (Ecosystem) 2015-2017	Care planning, support	Telehealth ^	Non-clinical navigators; IDT	Varied by disease acuity, monthly phone contact or every 3-4 months	12 months
HCIA[*] Maximizing Independence (MIND) at Home 2015-2017	Barriers to care, navigation	Home	Non-clinical memory care coordinators; IDT	Home visit every 2 months, weekly phone contact	18 months
HCIA[*] Alzheimer's and Dementia Care (ADC) 2012-2015	Partnership with community-based services	Clinic	Nurse practitioners; IDT	Annual clinic visit, quarterly phone contact	25 months[X]
HCIA[*] Aging Brain Care (ABC) 2012-2015	Barriers to care, navigation	Home	Lay health workers; IDT	Quarterly home visit, monthly phone contact	32 months[X]
Medicare Alzheimer's Disease Demonstration and Evaluation (MADDE)[+] 1989-1994	Direct payments to beneficiaries to help cover care needs	Home	Nurse case managers; IDT	In-home assessment, updated every 6 months by phone	36 months

[#] Exposure to the intervention and evaluation follow-up period. [X] Average number of months enrolled in the project.
^ Care team navigators primarily engaged beneficiaries and caregivers by telephone and occasionally in person.
IDT = Interdisciplinary care team, consisting of a program director (e.g., geriatrician/neurologist), nurses, occupational therapists, social workers, pharmacists.

Model Purpose and Overview

The GUIDE Model will test 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

A subset of beneficiaries in the model will be eligible to receive payment for respite services with no cost sharing, up to a cap of **$2,500 per year**. 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.

Scope and Duration

The GUIDE Model 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

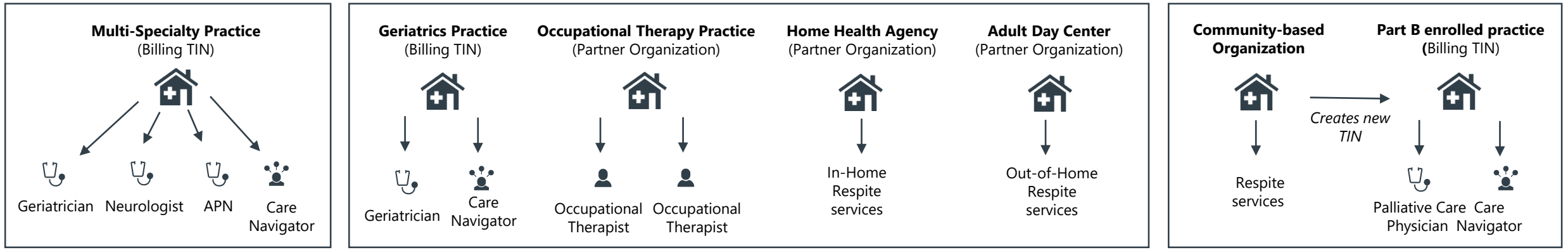
	Nov. 15 2023 - Jan. 30 2024	July 2024- June 2025	July '25- June '26	July '26- June '27	July '27- June '28	July '28- June '29	July '29- June '30	July '30- June '31	July '31- June '32
Established Program Track	Application Period	Performance Year (PY) 1	PY 2	PY 3	PY 4	PY 5	PY 6	PY 7	PY 8
New Program Track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

Who is Eligible to Participate in GUIDE?

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 service and agree to meet the care delivery requirements of the model. If the GUIDE participant can't meet the GUIDE care delivery requirements alone, they have the ability to contract with "Partner Organizations," which may be other Medicare providers/suppliers or non-Medicare enrolled organizations, to meet the care delivery requirements

Example Dementia Care Program provider and supplier arrangements:



A single Medicare provider with multiple suppliers forms a GUIDE DCP

Several Medicare providers and multiple suppliers form a DCP

Medicare-enrolled provider establishes a new Part B enrolled TIN to form a GUIDE DCP

GUIDE is an 8-year voluntary model offered in all states, D.C., and the U.S. territories.

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

The GUIDE Model will use a voluntary alignment process. Participants must document that a beneficiary (or their legal representative if applicable) consents to align to the Participant.

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

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.

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 can call a member of their care team or a third-party representative using a 24/7 helpline.

ONGOING MONITORING & SUPPORT
Care navigators provide long-term help to beneficiaries and caregivers so they can revisit their goals and needs at any time and are not left alone in the process.

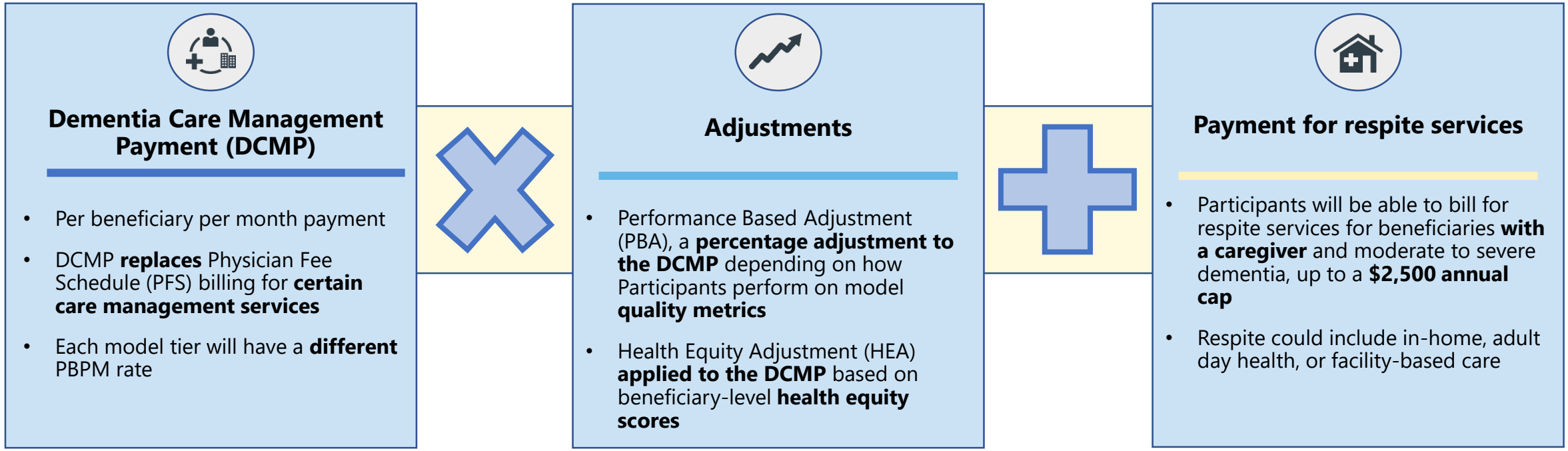
REFERRAL & SUPPORT COORDINATION
Beneficiaries' care navigator connects them and their caregivers to community-based services and supports, such as home-delivered meals and transportation.

CAREGIVER SUPPORT
Caregivers take educational classes and beneficiaries receive respite services, which helps relieve the burden of caregiving duties.

MEDICATION MANAGEMENT
Clinician reviews and reconciles medication as needed; care navigators provide tips for beneficiaries to maintain the correct medication schedule.

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

Payment Methodology



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. Safety net provider status will be defined based on the share of a provider's patient population that receives the Medicare Part D Low Income Subsidy or is dually eligible for Medicare and Medicaid.

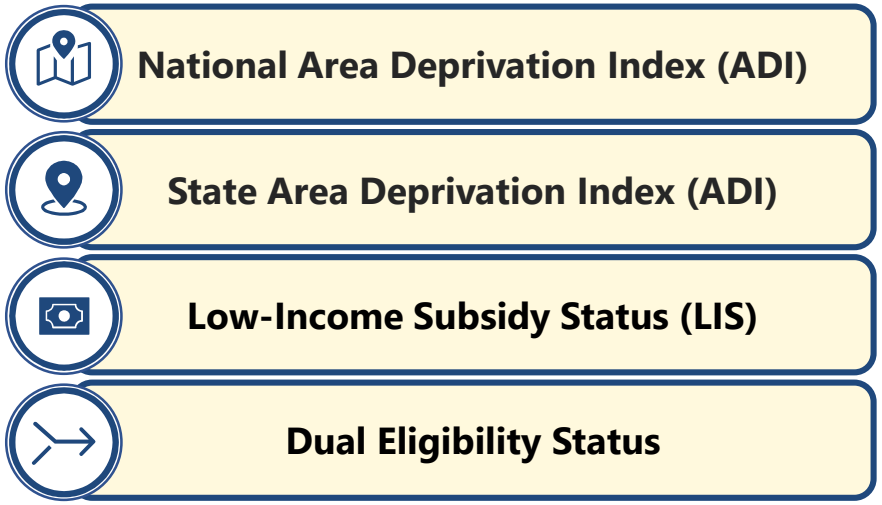
Payment Adjustments

When participants bill the per beneficiary per month Dementia Care Management Payment (DCMP), the DCMP will be adjusted by a Performance-Based Adjustment (PBA), as well as a Health Equity Adjustment (HEA).

The Health Equity Adjustment (HEA) is designed to decrease the resource gaps in serving historically disadvantaged communities.

The Performance Based Adjustment (PBA) will increase or decrease participants' monthly DCMPs, depending on how they perform during the previous performance year.

HEA will be based on certain social risk factors, which include:



PBA will range from -3.5% to +10% and calculated from five model performance metrics across four domains that include:

DOMAIN	METRICS
Care Coordination and Management	High-risk medications (eCQM/CQM) (MIPS #238)
Beneficiary quality of life	Quality of life outcome (Survey-based) (MIPS #AAN22)
Caregiver Support	Caregiver Strain (Survey-based)
Utilization	Total Per Capita Cost (Claims-based)
	Long-term nursing home stay rate (Claims-based)

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 *or* 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

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 will use a mixed methods approach

Approach

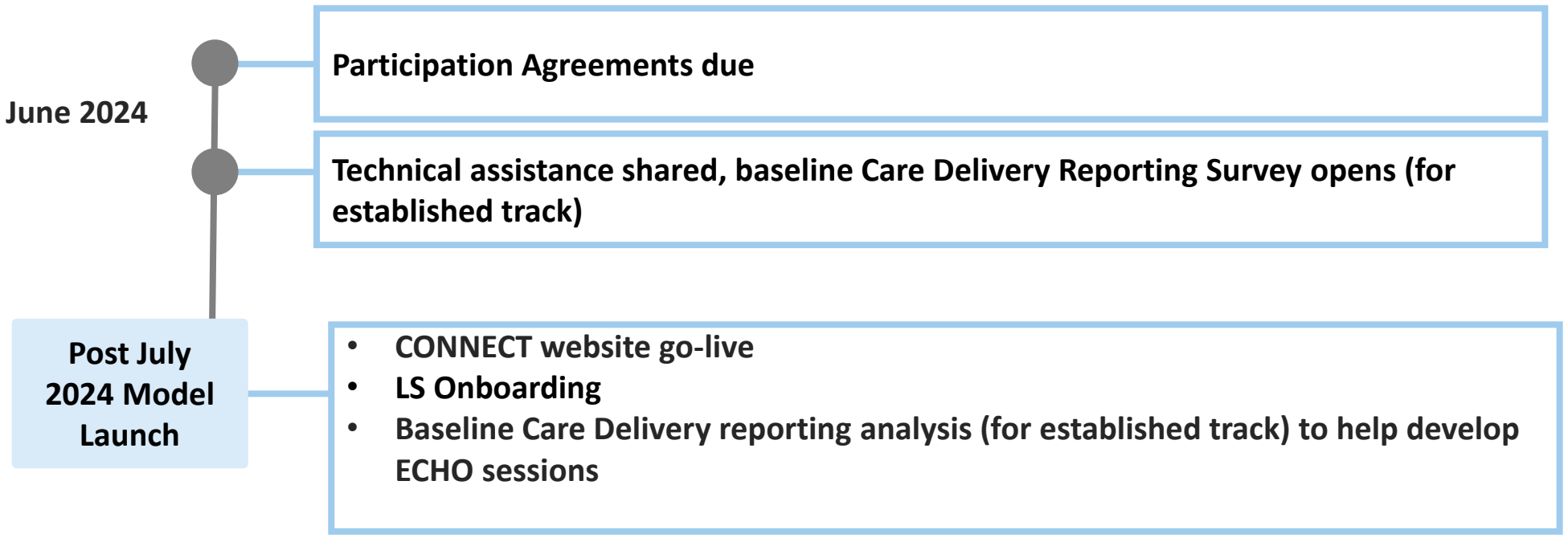
- Use **claims** to identify aligned beneficiaries and a ***comparison group*** of similar beneficiaries not in the model.
- Collect **quality data** from participants and non-participants.
- Examine trends in quality, long-term nursing home stays, Medicare and Medicaid service use and expenditures
-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

GUIDE Learning System Activities through September 2024



CONNECT site

1. **Bi-directional Feedback & Insights**

   CMS will understand, track, and respond to participant priorities.

2. **Peer-to-Peer Learning**

   Participants engage with each other, share strategies, and create a network.

3. **Content Library**

   Platform to host event calendar and resources, so participants can access learning materials.

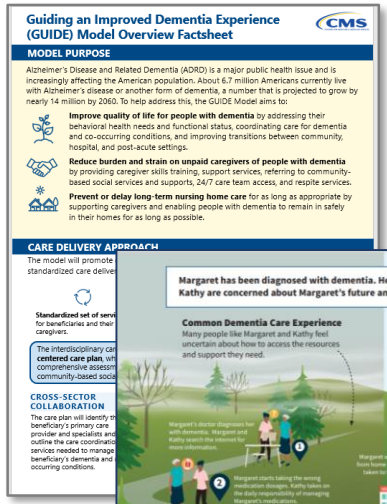
Model Resources

The GUIDE Model team has a host of resources to support interested organizations. To see the latest resources, visit the Model's website at https://innovation.cms.gov/innovation-models/guide.

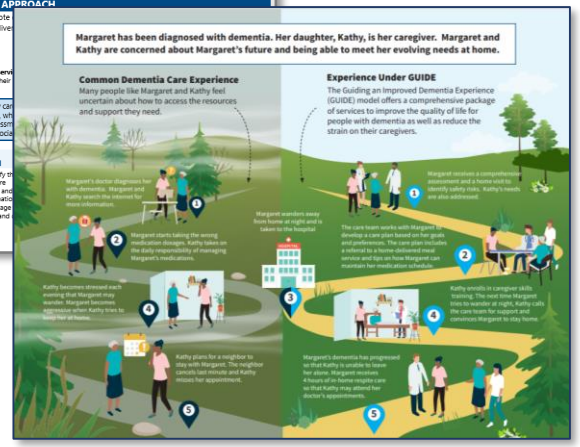
Frequently Asked Questions
Please reference the list of FAQs on the Model's website for answers to common questions.

Model Factsheets
Model Overview Factsheet, Dementia Pathways Infographic, Strength in Partnerships Factsheet, and Participant Incentives Factsheet may be found on the Model's website.

Helpdesk
If you have questions for the GUIDE Model team, please reach out to us via email at GUIDEModelTeam@cms.hhs.gov.



Model Overview Factsheet



Dementia Pathways Infographic

Applying an Evidence-Based Approach to Comprehensive Dementia Care Under the New GUIDE Model

- The CMS GUIDE Model offers a unique opportunity
- Evidence-based models are available for implementation
- GUIDE helps make comprehensive dementia care financially viable
- The National Dementia Care Collaborative (NDCC) is working to:
  - Promote and aid adoption of evidence-based comprehensive dementia care
  - Ensure that the pool of participants in GUIDE is enriched by inclusion of sufficient numbers of health systems relying with fidelity on one or more evidence-based programs as core components of the healthcare delivery

Lees Haggerty et al; Health Affairs Forefront, Nov 22, 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

IMPACT Collaboratory: Mission & Vision

- Vision: “To transform the delivery, quality, and outcomes of care….”
  - The GUIDE Model provides a large opportunity to improve services
  - Potential to extend GUIDE as a general service to all beneficiaries

- Mission: “To build the nation’s capacity to conduct pragmatic clinical trials of interventions embedded within health care systems…”
  - GUIDE participating health systems may become “non-environments” for the conduct of ePCTs?

Health System Environments

- Included in the GUIDE Model:
  - Established Programs
  - New Programs
  - Extended new programs from “non-local” or “convener” TIN GUIDE participants
- Not included in the GUIDE Model
  - GUIDE Model applicants, not awarded participation
  - GUIDE Model applicants, awarded participation but not selecting participation
  - Ineligible for GUIDE: PACE, Hospice, Medicare Advantage, VHA, residential

Implications of GUIDE for ePCTs - 1

- Understand how the GUIDE Model requirements align with evidence-based comprehensive dementia care
  - Health systems where Established or New GUIDE sites exist will be adjusting services delivery to align with GUIDE requirements
  - ePCTs occurring now within these health systems will experience context change

Implications of GUIDE for ePCTs - 2

- Address new **challenges** and opportunities for pragmatic evaluation of dementia service delivery related to GUIDE-participating health systems
- Challenges:
  - Consider not starting new dementia ePCTs within GUIDE participants
  - If planning to conduct a dementia ePCT within a GUIDE participant, carefully determine how the intervention is additive to and not duplicative of GUIDE Model requirements.

Implications of GUIDE for ePCTs - 3

- Address new challenges and **opportunities** for pragmatic evaluation of dementia service delivery related to GUIDE-participating health systems
- Opportunities:
  - Consider specific “add-on” trials within GUIDE participating health systems
    - Social Isolation
    - Beneficiary without a caregiver
    - Cultural adaptations of evidence-based programs
  - Distinct from the CMS contracted evaluation of overall GUIDE, CMS does not have any prohibition against investigators conducting ePCTs related to aspects of the GUIDE intervention

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Questions?