IMPACT Grand Rounds 47 – The GUIDE Model

Jill Harrison, PhD:

Hi, this is Jill Harrison, executive director of the National Institute on Aging (NIA) IMPACT Collaboratory at Brown University. Welcome to the IMPACT Collaboratory Grand Rounds podcast. We're here to give you some extra time with our speakers and ask them the interesting questions that you want to hear most. If you haven't already, we hope you'll watch the full grand rounds webinar recording to learn more. All of the companion grand rounds content can be found at impactcollaboratory.org. Thanks for joining.

Vince Mor, PhD:

Good day. This is Vince Mor. I'm one of the principal investigators of the IMPACT Collaboratory funded by the National Institute on Aging, designed to study the impact of non-pharmacological interventions on the lives and experiences of persons living with dementia and their care partners and caregivers. And this is done to try to get things that work, when researchers do them, interventions that work for these patients, to see whether or not they'll work when they're implemented in a real healthcare system.

And today, we have a great discussion to talk about the new GUIDE initiative articulated and initiated by the Centers for Medicare and Medicaid Innovation out of CMS Medicare. And we have with us today Tonya Saffer from CMMI, the Medicare & Medicaid Innovation Center, and Kristin Lees-Haggerty and Gary Epstein-Lubow, who have been involved with IMPACT from the very beginning. So I have a series of questions. I want to thank you all very much for your engagement. And why don't I just open it up, so we have a little discussion? I know that the grand rounds was on, where we have a full explanation of what the GUIDE program is, but maybe very succinctly, could one of you please give me a quick summary of what GUIDE is?

Tonya Saffer, MPH:

Sure, Vince. I'm happy to do that. This is Tonya Saffer with the CMS Innovation Center. GUIDE is a model test. And what we are looking to test is if delivering a comprehensive package of coordinated care and care management services, including support for caregivers, will improve outcomes for beneficiaries in their quality of life, reduce caregiver strain, and essentially, reduce long-term nursing home placement.

Vince Mor, PhD:

Great, thank you very much. GUIDE is sort of an amalgamation of a number of different kind of programs focused on caring for persons who are living with dementia, but what are you hoping that these new comprehensive programs and their variation across the selected sites might tell you, you might learn from?

Tonya Saffer, MPH:

For the CMS Innovation Center, what we are ultimately hoping to do and why we cast a wide net in inviting participation into the models is to essentially have a model test that can succeed in improving quality of care and outcomes for patients, while also reducing costs to the Medicare program. And we have to have results that are generalizable, in order to succeed in those goals. And ultimately, when we have one of these tests is we want to be able to make it a permanent part of the Medicare program, if it's successful.

Gary Epstein-Lubow, MD:

I'll add, Vince, Gary Epstein-Lubow. As Tonya explained really well in the grand rounds, the requirements for participants in GUIDE were based on studies that CMS ran of evidence-based comprehensive dementia care programs that had been developed over time and tested in controlled trials and then run through earlier CMS demonstration projects. And what's occurring now is an amalgamation where the requirements for health systems to participate need to meet the elements articulated by GUIDE, but do not need to align with any specific comprehensive dementia care model. CMS is not able, under their authority, to require that health systems do it in any particular way, whereas they can require that they meet the elements of GUIDE. So some of the work that Kristin showed in the grand rounds is how several of these comprehensive dementia care models do already align with the requirements of GUIDE. And we are hopeful that the majority or at least very many of the participants in GUIDE are aligned with those already tested and shown comprehensive programs.

Vince Mor, PhD:

Great. Thanks. Kristin?

Kristin Lees-Haggerty, PhD:

I was thinking exactly what Gary said and would add that the National Dementia Care Collaborative, ndcc.edc.org, can help interested sites see how the models align with the GUIDE requirements and, for people from clinical settings, how they align with the needs of that clinical setting. So that's a nice resource for people to be aware of.

Vince Mor, PhD:

Great. So in other words, there are these various components, most of which have been shown to work in comprehensive or clinical trials, and then, it's up to each of the individual providers or the participants, participating organizations or consortia, to pick which components they would actually put together in implementing their program?

Tonya Saffer, MPH:

That's exactly right, Vince.

Vince Mor, PhD:

Thank you. Could you describe the patient eligibility determination process? Can patients be referred for participation in the GUIDE program in their local area without a formal diagnosis of dementia, but if there's a suspicion that they might have a dementia?

Tonya Saffer, MPH:

Yes, absolutely. We want to see beneficiaries that have been suspected to have dementia to benefit from a formal assessment and getting connected to care. And so, if a clinician suspects that one of their patients may have dementia, but has not gone through the assessment process to establish a formal diagnosis, or maybe somebody has gone in the hospital and the hospital suspects that the person might have dementia, we do want to see those types of referrals happen. And essentially, once they are assessed by a dementia care program, then we would expect to see the diagnosis.

Vince Mor, PhD:

Yeah, a formal diagnosis. So the GUIDE approaches beneficiaries, but there's a caregiver component to this as well, where caregivers are actually receiving some services from this. What's the process by which a person is selected and how they select who the caregiver is? And what are the rules around that?

Tonya Saffer, MPH:

Once a beneficiary does get connected with a GUIDE participant, they will be assessed formally using one of two different tools that we require, which is either the FAST assessment tool, that's F-A-S-T, or the CDR assessment tool. Both work to assess functional status and cognition. And once a beneficiary or person living with dementia or possible dementia has been assessed with one of those two tools, they will complete an alignment form with the clinician and the caregiver's information too. And so, the person living with dementia would have to also identify a primary caregiver, if they have one.

If they don't have one, they would still be eligible for the model, and then that information is provided to CMS to double-check eligibility for participation in the GUIDE model. And that would also be used to tier them into level of severity. That level of severity takes into account if there's a caregiver, and if there's a caregiver, it takes into account the caregiver's level of burden using the Zarit Burden Interview. So the caregiver would also be assessed using that Zarit Burden Interview. Both pieces of information, when there is a dyad, would be used to place somebody into a severity tier, and then that tier is then essentially used for payment and that information is communicated back to the participant.

Vince Mor, PhD:

Great. So is there anybody who wants to comment on how different this sort of model is, in terms of providing services to not the patient, the caregiver? Gary?

Gary Epstein-Lubow, MD:

This is landmark, Vince. CMS has historically been, say, challenged for how to get services to support family members of beneficiaries in Medicare. So when this was announced last July that the GUIDE model would provide supports and financial support to the health system that could be passed through directly to caregivers, that's major, tremendous. It's been advocated for for years, and CMS deserves tremendous credit and Tonya's team for getting us to this point.

Vince Mor, PhD:

So that actually brings up another question that I have about the financing of this. Could someone describe how is the per member per month allocation? And does that go on a fee-for-service? Or is it a holistic capitated amount? And who gets the amount?

Tonya Saffer, MPH:

It is per member per month payment, and we call that the Dementia Care Monthly Payment, the DCMP. And it is a comprehensive payment. So as the CMS Innovation Center, one of our priorities is to move away from fee-for-service and more towards value-based care. So that monthly payment, the amount corresponds to the level of severity. So the tier placement that I mentioned previously, for the dyad or for the individual beneficiary. And then, that payment is made. So the participant bills or the clinician under the participant bills for particular G-codes that have been established. So similar to, well, it is, actually, a CPT code that you would see in the physician fee schedule. But that payment then is, the

value part comes into place, because that payment is adjusted by several factors. One is based on quality improvement or performance by the participant and how well they're doing on several domains in caring for beneficiaries. And it also is adjusted by a health equity adjustment that is dependent on the number and proportion of underserved beneficiaries that the participant has in their population.

Vince Mor, PhD:

Great. That's very helpful. Thank you very much. So actually speaking of that, in terms of the health equity payment, some communities or states may have fewer underserved populations, or some areas may have fewer underserved populations, and the underserved populations might feel that they're penalized by not having an indigenous group of health systems that have the capacity to respond to something as innovative and complicated as this. Is there some way in which you're trying to make some provision for supporting groups and areas with less capacity to serve the populations that are in their area?

Tonya Saffer, MPH:

Yes, absolutely. That's a fabulous question. So the health equity adjustment is calculated using a combination of state and national area deprivation index, and a proportion of beneficiaries served who are dually eligible for Medicaid and/or receive the Medicare Part D Low Income Subsidy. These factors are assessed at the beneficiary level, and they're aggregated across all service areas of the participant. It is a budget neutral adjustment, meaning participants are compared against each other and there will be some that receive a positive adjustment and others that receive a negative adjustment to their Dementia Care Monthly Payment. The intent is, as you alluded to in your question, to direct more resources towards participants who have the highest number of underserved beneficiaries, in order to improve health equity. The effectiveness of this approach is also a key component of the evaluation that we have for our models. Health equity adjustments are a new feature of CMS Innovation Center models broadly, and one of the goals is to learn how meaningful they are in improving health equity.

Vince Mor, PhD:

That's really very, very helpful, and this is a new innovative model in so many different ways. It's really very exciting.

Gary Epstein-Lubow, MD:

I have a question. Tonya just mentioned the evaluation. I know you're going to have some questions related to that upcoming, but I wanted to go back to the enrollment, and just to clarify, Tonya, that, after a beneficiary has a confirmed diagnosis of dementia, then they will be enrolled in GUIDE. Will the evaluation take into account any of the beneficiaries who were referred to GUIDE and evaluated but not enrolled?

Tonya Saffer, MPH:

Yes. If they are not enrolled in GUIDE, we would presume that they were not enrolled in GUIDE because they were not eligible. Either they were not enrolled in Medicare Part A and B or they did not show that they had dementia, either mild, moderate, or severe dementia. After that, we would not have data on those individuals. So there would not be an evaluation on those that were not enrolled is my understanding from the evaluation team.

Gary Epstein-Lubow, MD:

Great. So the evaluation will only include beneficiaries who have a confirmed diagnosis of dementia, and I think that's very relevant, Vince, for the evaluation overall. And then, the other question is just, if Tonya could clarify what information will be available for investigators to query that's separate from the information that the evaluating team will be reporting on primary outcomes.

Tonya Saffer, MPH:

There's still a lot that the evaluators are still building their plan, and so, we have a lot of unknowns in exactly what the evaluation will cover. I expect it to be very comprehensive, however, but there will be, so even whether it's included in the evaluation or not, there is an ability for researchers to request data through the CMS ResDAC, R-E-S-D-A-C, to conduct their own independent research utilizing data among model participants. GUIDE data will eventually be part of that ResDAC system for researchers.

Gary Epstein-Lubow, MD:

And will that be matched to claims?

Tonya Saffer, MPH:

Yes, absolutely. So most of that data is claims data. Actually, I think the majority of that data is claims data, if not all of it.

Vince Mor, PhD:

Yeah, all the ResDAC data would be claims data. So Gary, I think this is a being and becoming process. I don't even imagine that the evaluators have yet fully put together their evaluation plan, lots of different data elements. So this will be a complicated process, but it's really great to know that researchers can actually know who the participating providers are and the consortia are. So that it's possible to begin thinking about who's in that population, who's in the denominator from which the numerator of people participating in the plan will be derived. That'll be very interesting to see. But that's the one question I have from a researcher's perspective. Do you anticipate or is there any prohibition against individual consortia providers doing their own internal evaluation on top of, as long as they continue to contribute to be part of the overall evaluation, which might have different components to it, et cetera?

Tonya Saffer, MPH:

Great question, and no, there's no preclusion of GUIDE participants participating in other research initiatives on top of their participation in GUIDE. So if they wanted to conduct their own evaluation of the GUIDE model, we've seen that conducted by other researchers in other CMMI models or CMS Innovation Center models. That's allowed. If they wanted to do a study to test effectiveness of different approaches to something like medication management, as long as they're meeting the GUIDE's care delivery services and requirements of the model, they could test different approaches to see which is more effective in improving outcomes. That's absolutely permitted.

Vince Mor, PhD:

That's terrific to know, because we are hopeful that IPMACT will have a renewal and we may see if we can provide some support for individual consortia that would actually be interested in doing some kind of potential comparative effectiveness study. So this might be something that would be really quite

complimentary in that sense. So I'm going to give you each a last opportunity to comment for just a moment on anything else about GUIDE you think that the listeners might be interested in.

Tonya Saffer, MPH:

Yes, if I could start, there was one point I wanted to emphasize, and Gary did a great job talking about how this is really the first time that CMS has provided support through, particularly CMS Innovation Center, support for caregivers through a model specifically offering respite services for caregivers in the model. One thing we hope to learn from providing respite services is, does it have that impact on reducing burden of caregivers? But one question had been asked to us that I wanted to elaborate further. I didn't answer that question fully, and the question was, why are we collecting Medicare information on the caregiver?

And so, we want to know if the caregiver is enrolled in Medicare. They're still able to receive those respite services, whether or not they are enrolled in Medicare, but if they provide their Medicare ID to us, if they're enrolled in Medicare, it will allow us to also look at the health impacts of the caregiver participating in this model. So how does caregiving and how does respite and reduction in burden also affect their health outcomes as a caregiver? That's something that we hope to include in the evaluation if we get enough information from caregivers on that point.

Vince Mor, PhD:

Great clarification. Thank you very much. Kristin? Gary?

Gary Epstein-Lubow, MD:

Yeah, there was a question that there wasn't enough time for Tonya to answer about non-local or convener GUIDE participants. So if you could explain the opportunity for health systems that may not have been identified as a new program or an established program that will begin this July or next July, what opportunities may there be for health systems to become involved with GUIDE, be a participant through one of these non-local or convener entities?

Tonya Saffer, MPH:

It's a great question, and I think the answer is two part. I'm not sure necessarily that it's an opportunity through conveners, but it's an opportunity broadly across model participants, and that's to, one, serve as a partner organization. So GUIDE participants will be able to partner with different organizations, such as community-based organizations, to deliver GUIDE services. For practitioners, they will also be able to work collaboratively or align to a participant, if they want to provide GUIDE care delivery services as well. And those practitioner and partner, we call them rosters, so the lists of practitioners and partners that participants have collaborated with, or plan to collaborate with or work with in the model, are provided to CMS and updated regularly. So those are really the best opportunities, is looking and seeing who's participated in GUIDE, offering services as a partner or a practitioner. Those are ways, in the established program track or even in the new program track, that others that have maybe not submitted their own application and been accepted for participation, could have a role in the GUIDE model.

Vince Mor, PhD:

Great. Thank you very much. Kristin?

Kristin Lees-Haggerty, PhD:

No new information. I just wanted to reiterate and thank Tonya and CMMI for doing the GUIDE model. It is just such an incredible opportunity and moment to improve dementia care and to learn about it. So I just think it's a really exciting time, and thank you for the opportunity to be part of this.

Vince Mor, PhD:

Great, thank you. Listen, I want to thank Tonya, Gary, Kristin very, very much. This has been very helpful as an adjunct or a supplement to the grand rounds, which was just terrific. I encourage all the listeners to listen to it. I want to thank you very much for the time. And Tonya and everyone else who's involved in this GUIDE initiative, it's going to be a fascinating next five or six years. As this thing gets rolled out and evaluated, we're going to learn an awful lot. I want to thank you, thank CMMI, and I guess Congress and everyone else who's been pushing this particular agenda. It's very, very important to deal with this public health issue. Thank you all very much again for your time.

Tonya Saffer, MPH:

Thank you, Vince. I appreciate the opportunity and CMS Innovation Center appreciates the opportunity for the NIA IMPACT Collaboratory to highlight the work that we're doing in GUIDE. And really appreciate this opportunity, Vince, thank you.

Jill Harrison, PhD:

Thank you for listening to today's IMPACT Collaboratory Grand Rounds Podcast. Please be on the lookout for our next grand rounds and podcast next month.