Guiding an Improved Dementia Experience (GUIDE) Model Strength in Partnerships Factsheet

MODEL BACKGROUND

The GUIDE Model is a voluntary national Model offered in all states, U.S. territories, and the District of Columbia. The GUIDE Model will have two Participant tracks, one for established dementia care programs and one for new dementia care programs.

DURATION
The GUIDE model will run for 8 years with a one year pre-implementation period to support new program development.

BENEFITS
The GUIDE Model provides an alternative payment methodology for Participants to deliver comprehensive dementia care with the aim of improving quality of life for people with dementia and their caregivers.

BENEFICIARIES
Model beneficiaries are community-dwelling Medicare FFS beneficiaries, including beneficiaries dually eligible for Medicare and Medicaid, who have dementia.

A GUIDE Participant has the option to contract with other organizations to meet the care delivery requirements of the model. This document provides general suggestions for partner identification and outreach; it is not intended to endorse certain organizations/organization types.

PARTNERSHIP OVERVIEW

PARTNER ORGANIZATIONS

If a GUIDE Participant contracts with other Medicare providers/ suppliers or non-Medicare enrolled organizations to meet the GUIDE care delivery requirements, these contracted partners will be known as "Partner Organizations."

PARTNER ORGANIZATION ROSTER

The GUIDE Participant will be expected to maintain a list of Partner Organizations ("Partner Organization Roster"). GUIDE Participants may change partnerships or form new ones at any point during the model.

PARTNER ORGANIZATION OVERLAP

Both Medicare-enrolled and non-Medicare enrolled entities may contract with and be a Partner Organization to more than one GUIDE Participant.

PARTNER ORGANIZATION TYPES

GUIDE Participants may contract with different types of Partner Organizations to meet Model requirements. The following are a few examples:

- **Community Based Organizations***
- **Home Health Agency**
- **Hospice Agency**
- **Physical / Occupational Therapy Practice**
- **PACE Programs**

*Home and community-based/long-term services and support providers including organizations which provide respite services, caregiver education and training, support groups, adult day health, and personal care services.

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IDENTIFYING POTENTIAL PARTNERS

Model applicants can use a combination of strategies and resources, provided below, to identify and engage potential Partner Organizations.

Classify potential partners by services provided and geographic location.

Prioritize potential partner organizations by presence in a community and experience with population both in terms of cultural competency and dementia capability.

Evaluate potential partner organizations with supplemental information, such as the following resources:

CMS STAR RATINGS ***ACL Resources*** ***NIH ADRC Directory***

Consider identifying and engaging partners who serve underserved populations with higher incidence of dementia.

ENGAGING PARTNERS

The following suggested tactics and messaging can help facilitate partner engagement.

ENGAGEMENT TACTICS

Use existing partner networks. Contact current partners in your network and share GUIDE materials and messaging. Outreach messaging may include an ask for current partners to share with their networks.

Identify and contact new partners. Use publicly available Medicare provider lists and other resources to identify providers in your area for initial outreach through email, calls, or meetings.

Engage CBOs, associations, and other professional organizations. Contact connector organizations such as CBOs or national, state, local professional or trade associations to identify partner organizations and initiate outreach.

Share Model communications materials, including available factsheets and Model website links to ensure clarity and consistency of Model messaging.

PARTNER MESSAGING

The GUIDE Model provides an opportunity for partners to enhance care coordination and care delivery within a geographic area, improving outcomes for people with dementia and their caregivers.

The GUIDE Model's learning and network systems will enable partners to advance their existing capabilities and expand their network.

Funding Incentives*: Partner Organizations should expect to be compensated through their contracts with GUIDE Participants for the services that they are providing as part of the GUIDE Model.

Note: GUIDE Participants will receive a monthly Dementia Care Management Payment (DCMP) for providing the GUIDE care delivery services to each beneficiary. The DCMP may be shared with Partner Organizations as the GUIDE Participant and Partner Organizations may agree in a contract to provide services.

*For more information on the DCMP and other funding incentives, please visit the GUIDE Model Incentives to Participate Factsheet.

Model Contact Information and Resources

RFA: https://www.cms.gov/files/document/guide-rfa.pdf

Email: GUIDEModelTeam@cms.hhs.gov

Webpage: https://innovation.cms.gov/innovation-models/guide

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PARTNERING CAN HELP BUILD STRONGER DEMENTIA CARE PROGRAMS

To meet GUIDE Model eligibility, applicants may engage partners prior to and after applying to the Model. Model participation requirements and partnering requirements vary by applicant track, provided below.

ESTABLISHED PROGRAM PARTICIPANT

Prior to Applying:

- Have a currently practicing interdisciplinary team that has provided at least 6 of the 9 care delivery domains described in the Care Delivery Section for at least the past 12 months, to people living with dementia.
- Be a Medicare Part B enrolled provider or supplier that is eligible to bill under the Medicare Physician Fee Schedule.
- Meet the Model's care delivery and care team requirements and compile a Proposed GUIDE Practitioner Roster and Proposed Partner Organization Roster, if applicable.

NEW PROGRAM PARTICIPANT

Prior to Applying:

- Develop roadmap to implement a dementia care program that integrates strategies for staffing and staff training, development of program protocols and workflows, and establishing a referral network, among others.

Upon Signing Participation Agreement:

- Attest to having established a single, Part B enrolled TIN that is eligible to bill under the Medicare Physician Fee schedule.

During Pre-Implementation Period:

- Meet the Model's care delivery and care team requirements and compile a Proposed GUIDE Practitioner Roster and Proposed Partner Organization Roster, if applicable. two months before first performance year.

For more information about Established Program Track and New Program Track Participant eligibility and Care Delivery Requirements under the GUIDE Model, please refer to the GUIDE Model Overview Factsheet on the GUIDE Model Webpage.

CARE DELIVERY REQUIREMENTS

If they would like, the GUIDE Participant may contract with one or more other providers, suppliers, or organizations, including both Medicare-enrolled and non-Medicare enrolled entities, to meet the following care delivery requirements:

24/7 Access	Beneficiaries and caregivers have 24/7 access to a member of their care team or help line (may be a 3rd party vendor during off-duty hours).
Referral and Support Coordination	Beneficiaries' care navigators connect them and their caregivers to community-based services and supports.
Respite Services	Respite Services are temporary services provided to a beneficiary in their home, at an adult day center, or at a facility, for the purpose of giving the caregiver a break from caring for the beneficiary.
Caregiver Education and Support	Caregivers are given education and support via ad hoc calls and caregiver training.

MODEL TIMELINE