IHS Alzheimer's Program and The National Dementia Care Collaborative

Capacity Building: Exploring Evidence-Based Comprehensive Dementia Care Models

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NDCC National Dementia Care Collaborative

UCLA Health

The John A. Hartford Foundation

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
National Dementia Care Collaborative

Recommendations to Improve Payment Policies for Comprehensive Dementia Care

- One-day convening October 2019 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

Guiding an Improved Dementia Experience (GUIDE) Model

- On July 31, 2023, the Centers for Medicare & Medicaid Services (CMS) announced a new voluntary nationwide model:

Guiding an Improved Dementia Experience (GUIDE) Model

- GUIDE aims to:
  - improve the quality of life for people living with dementia,
  - reduce the burden and strain on unpaid caregivers of people living with dementia
  - prevent or delay long-term nursing home care

GUIDE Required Care Delivery Activities by Domain

Domain	Required Activities
Comprehensive Assessment	Clinical, behavioral and psychosocial, and ACP domains, as well as caregiver needs and capabilities and home visit
Care Plan	Comprehensive person-centered care plan that addresses all assessment domains
24/7 Access	24/7 access to an interdisciplinary care team member or help line
Ongoing Monitoring and Support	Dementia Care Navigator is primary point of contact Minimum contact by model tier
Care Coordination and Transitional Care Management	Coordinate with the beneficiary's primary care provider Support transitions

GUIDE Required Care Delivery Activities by Domain

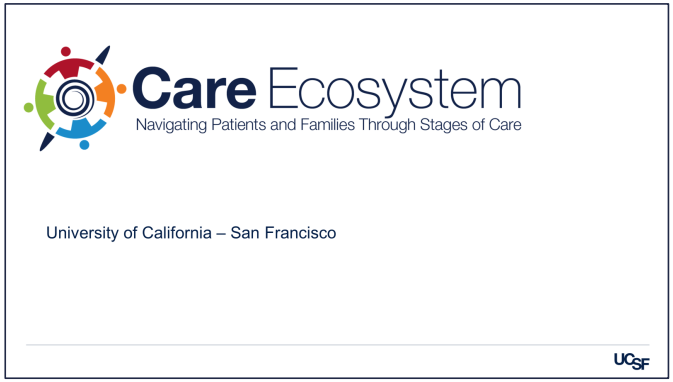
Domain	Required Activities
Referral and Coordination of Services and Supports	Inventory of and referral to local/community services
Medication Management and Reconciliation	Clinician with prescribing authority must review and changes must be shared with PCP
Caregiver education and support	Caregiver skills training, dementia diagnosis information, support group services, ad-hoc 1:1 calls
Respite	In-home respite care, adult day centers, facility-based respite providers

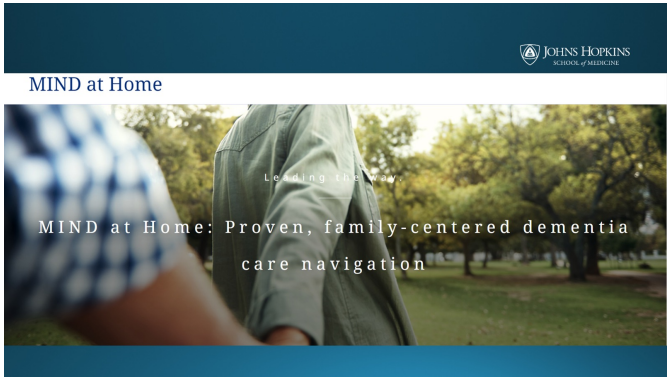
Comprehensive Dementia Care Models

- Aging Brain Care (ABC)
- Alzheimer's and Dementia Care (ADC) Program
- Benjamin Rose Institute Care Consultation (BRI-CC)
- Care Ecosystem
- Integrated Memory Care (IMC)
- MIND at Home

- See links to all programs at:
  - https://www.ndcc.edc.org/six-models-of-ndcc

Comprehensive Dementia Care Models





Alignment of Evidence-Based Models with GUIDE Program Components

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			
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		✓	✓	✓	✓	✓	✓

Thank you!

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