



Healthy Aging and ADRD ECHO

Elizabeth Disbrow, Ph.D.

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Guiding an Improved Dementia Experience (GUIDE) Model

Speaker

Elizabeth Disbrow, PhD

Professor of Neurology and

Director of the Center for Brain
Health, LSU Health Shreveport

Elizabeth.Disbrow@lsuhs.edu

(318) 813-3611

Disclosure

In the past 24 months, I have not had any financial relationships with any ineligible companies.

Disclaimer

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Objectives

- 1. Introduce the CMS GUIDE model**
- 2. Discuss eligibility**
- 3. Become familiar with services provided**

What is GUIDE?

The Centers for Medicare & Medicaid Services (CMS) Guiding an Improved Dementia Experience (GUIDE) Model is an 8-year, nationwide, voluntary program launched on July 1, 2024, to improve care for people with dementia and support caregivers.

It provides Medicare payments for comprehensive, team-based care, including care navigation, 24/7 access to support, caregiver training, and respite services.

Objectives are to:

- Improve quality of life for people living with dementia
- Reduce caregiver burnout
- Delay nursing home admissions
- Support aging in place

CARE DELIVERY APPROACH

The model will promote improved dementia care by defining and requiring a comprehensive, standardized care delivery approach that will include the following:



Standardized set of services for beneficiaries and their unpaid caregivers



An interdisciplinary care team to deliver these services



A training requirement for beneficiaries and their unpaid caregivers

The interdisciplinary care team will deliver services by creating and maintaining a **person-centered care plan**, which will include details on the beneficiary's goals, strengths, and needs; comprehensive assessment results; and recommendations for service providers and community-based social services and supports.

CARE COORDINATION

The care plan will identify the beneficiary's primary care provider and specialists and outline the care coordination services needed to help manage the beneficiary's dementia and co-occurring conditions.



CAREGIVER SERVICES

Participants will assess and address caregiver needs and include the caregiver as part of the care team as appropriate. Caregiver services will include ongoing monitoring and support via 24/7 access to a support line.

Beneficiary Eligibility and Alignment

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 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



Not Enrolled in Medicare Hospice

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

- For Advantage Plan members, we are developing a similar program called “Peace of Mind” in collaboration with Allegiance Health which will provide a subset of services.
- This service is specific to our site.

GUIDE Supports 9 Services

1. Comprehensive Assessment

- Once a year
- In person or via telehealth
- Home visit to assess safety and other social factors to be addressed in care plan

Clinical Evaluation

- Cognition-focused evaluation including a pertinent history and examination.
- Functional assessment. (Basic and Instrumental Activities of Daily Living).
- Screening, or referral to screening, for hearing loss
- Use of standardized instruments for staging of dementia.
- Medication reconciliation and review.

Behavioral Health and Psychosocial Needs

- **screening for depression, anxiety, substance use, and suicidal ideation.**
- Evaluation of safety, including, but not limited to, **environmental, driving, wandering, fall risk, and abuse, neglect and exploitation.**

Evaluation

- Functional Assessment Staging Test (FAST) is a reliable measure commonly used to assess functional status in patients with dementia. It can be used to evaluate both basic and instrumental activities of daily living. It helps provide an efficient and comprehensive evaluation of functional ability and the potential for a functional decline over time.
- Patient Health Questionnaire-9 (PHQ-9) is a brief, self-administered questionnaire used to screen for and assess the severity of depression symptoms, incorporating DSM-IV depression criteria and other leading symptoms into a concise tool for clinicians.
- Generalized Anxiety Disorder 7-item scale (GAD-7) is a brief, self-administered questionnaire used to screen for and assess the severity of generalized anxiety disorder (GAD) and other anxiety disorders.
- Epworth Sleepiness Scale is a questionnaire used to measure a person's general level of daytime sleepiness, assessing the likelihood of dozing or falling asleep in various everyday situations.

GUIDE Supports 9 Services

1. Comprehensive Assessment

Health-Related Social Needs (HRSN)

Domains include: **food insecurity, housing instability, transportation needs, social isolation, and safety.**

Advance Care Planning

Development, revision, and/or review of an **Advance Care Plan** and a **Physician Order for Life-Sustaining Treatment** if available and beneficiary wishes to complete.

Coordination

Identification of beneficiary's **primary care provider**, behavioral health provider, and specialty provider(s), if any, and coordination services to manage the beneficiary's dementia and any co-occurring conditions.

Identification of any **community-based services** and supports, and home and community-based services that the beneficiary is receiving.

GUIDE Supports 9 Services

1. Comprehensive Assessment

Caregiver Assessment

Assessment of the caregiver's **knowledge, needs, and social supports, and assess the caregiver's well-being, stress level, and other challenges.**

If the beneficiary does not have a caregiver, the GUIDE Participant shall make a reasonable effort to help identify a caregiver for the beneficiary or make additional efforts and put safeguards into its care delivery to support the beneficiary continuing to reside in the community.

GUIDE Supports 9 Services

2. Personalized Care Plan

- The plan is based on findings from the assessment
- The goals, strengths, preferences and needs of the caregiver and person with dementia
- Coordination with community resources
- Referral to service providers
- Access to caregiver education and support services

3. 24/7 Access to Caregiver Support Line

4. Ongoing Monitoring and Support

- Assignment of Care Navigator – Primary point of contact

GUIDE Supports 9 Services

5. Care Coordination and Transitional Care

- Coordination across doctors
- Assistance with changes in care or living arrangements

6. Referral and Coordination of Services and Supports

- Assistance finding and contacting community based services

7. Medication Management and Reconciliation

- Clinician review and reconciliation of medications

8. Caregiver Education and Support

- Skills training
- Diagnosis information
- Support Group Services
- One-on-one support

GUIDE Supports 9 Services

9. Respite Care

- Provided by GUIDE partner organizations
- In home or long term
- Reimbursement is **capped at \$2,500 per year**

Care navigators can be trained community members or qualified health professionals.

They are trained using the Care Ecosystem Program from UCSF:

<https://memory.ucsf.edu/healthcare-professionals/care-ecosystem>



GUIDE Implementation Plan



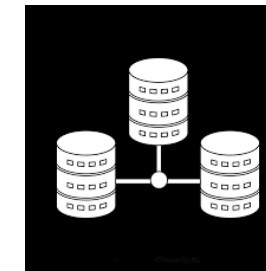
Skilled Home Health

- Comprehensive Assessment
- Medication Management & Reconciliation
- Care Plan



Home Health

- 24/7 Access
- Respite Care



CMS

Data Management (CAMP)

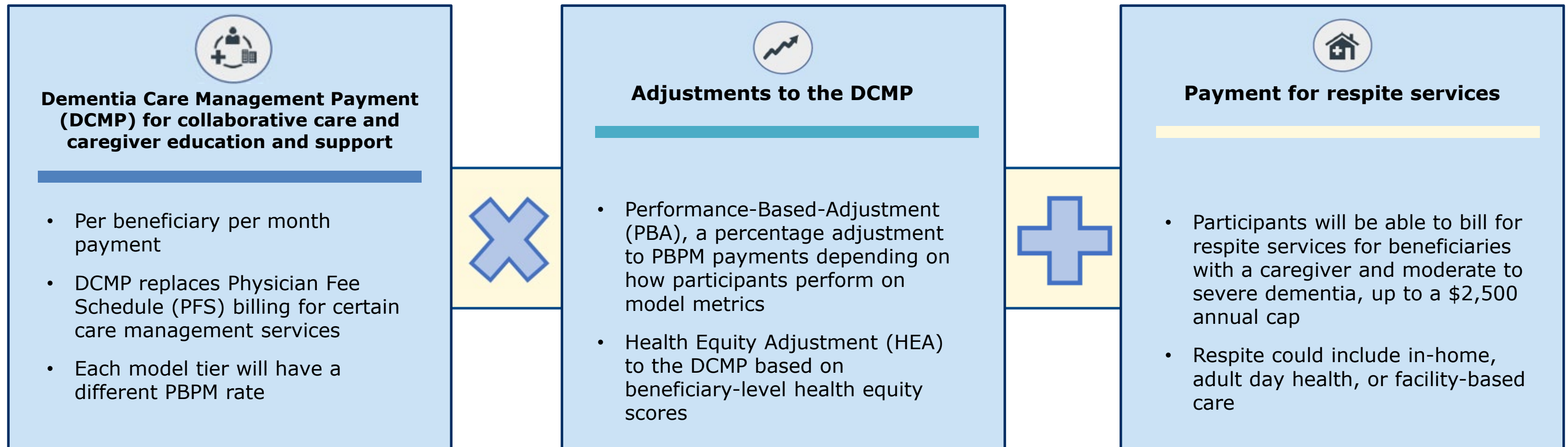


LSU Center for Brain Health
Dr. Kelley Med. Director

- Ongoing Monitoring & Support
- Care Coordination & Transitional Care Management
- Referral & Coordination of Community Services
- Caregiver Education and Support

Payment Methodology

The Model's core payment methodology is a per beneficiary per month care management payment, called the Dementia Care Management Payment (DCMP), that is adjusted for health equity and performance on a set of quality metrics, plus a separate payment for respite services.



Where to sign up or get more information

Website: cms.gov/priorities/innovation/innovation-models/guide

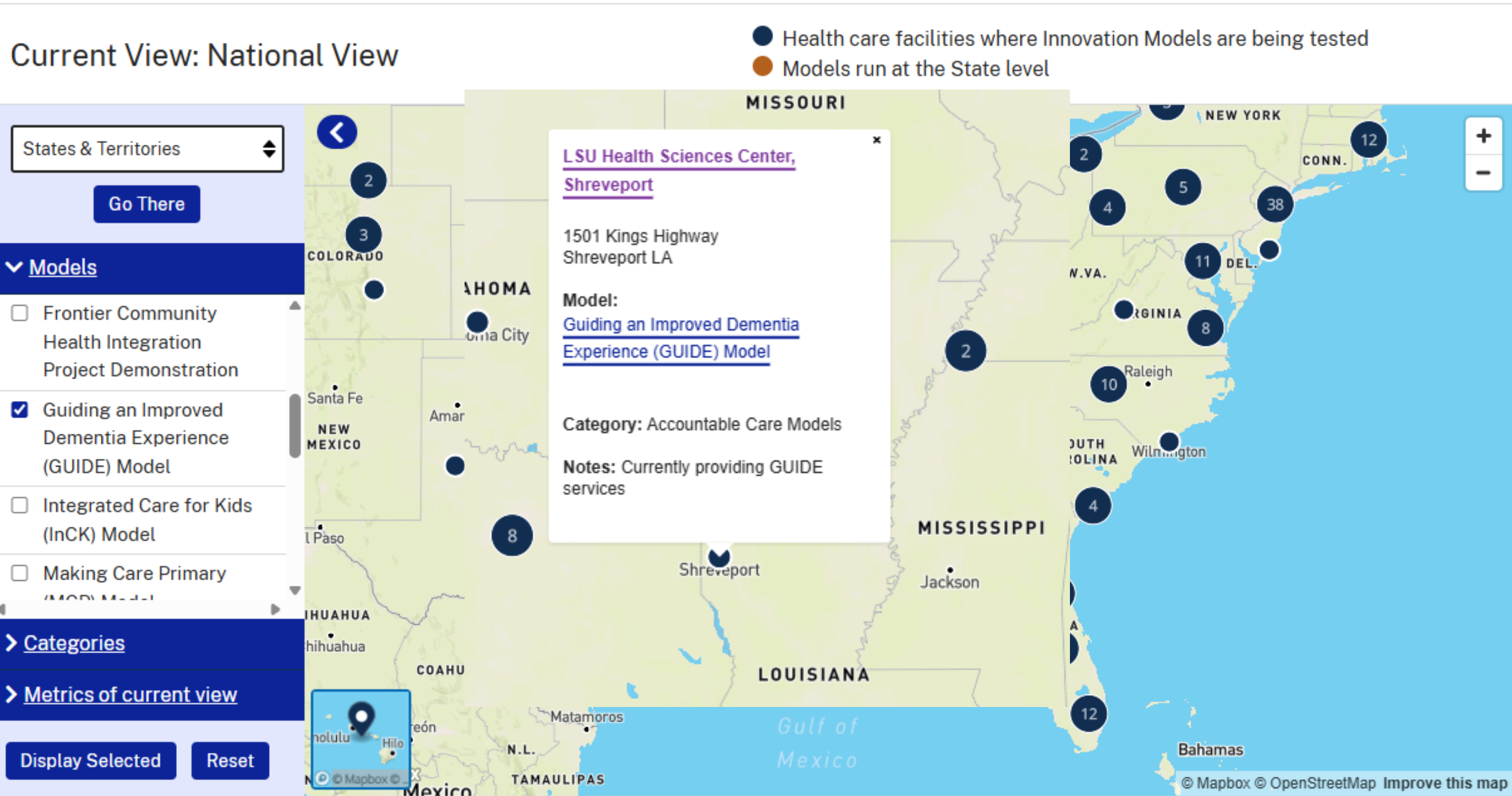
Search: CMS Guide, Guide dementia, Medicare dementia

Participant Information



GUIDE Model participants are Medicare Part enrolled providers and suppliers who establish dementia care programs (DCPs) to provide ongoing longitudinal care and support to people with dementia through interdisciplinary teams.

Participants unable to meet all the GUIDE care delivery requirements independently may contract with Partner Organizations (other Medicare providers and suppliers) to fulfill model requirements.



[View data and create your own visualizations on data.cms.gov](https://data.cms.gov)

Health care facilities where Innovation Models are being tested

Guiding an Improved Dementia Experience (GUIDE) Model

Dementia Care • Medicare Supported • Voluntary Participation • Nationwide

SIGN UP for GUIDE

What is the **GUIDE MODEL?**

The GUIDE Model focuses on comprehensive, coordinated dementia care and aims to improve quality of life for people with dementia, reduce strain on their unpaid caregivers, and enable people with dementia to remain in their homes and communities. It will achieve these goals through Medicare payments for a comprehensive package of care coordination and care management, caregiver education and support, and respite services.



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Guiding an Improved Dementia Experience (GUIDE) Model

Sign Up for GUIDE

Education

More About the GUIDE Model

Support Resources

Resources for Alzheimers & Dementia






CONTACT US

Email GUIDE@lsuhs.edu

Call [318-813-3610](tel:318-813-3610)

Enrollment Contact Information

LSU Health Shreveport GUIDE AAA   

Welcome to the GUIDE Program Referral Form

Thank you for your interest in the GUIDE program.

Completing this form does not enroll the person with dementia in the GUIDE program. We will contact the patient/caregiver shortly with more information.

To sign up or learn more, please select an option and provide requested contact information

Patient/Caregiver

Healthcare Provider Referral

Contact Us

[reset](#)

Requested Information

- Patient Contact Information
- Provider Contact Information
- Clinic Information
- Question portal

Margaret has been diagnosed with dementia. Her daughter, Kathy, is her caregiver. Margaret and Kathy are concerned about Margaret's future and being able to meet her evolving needs at home.

Common Dementia Care Experience

Many people like Margaret and Kathy feel uncertain about how to access the resources and support they need.



Experience Under GUIDE

The Guiding an Improved Dementia Experience (GUIDE) model offers a comprehensive package of services to improve the quality of life for people with dementia as well as reduce the strain on their caregivers.



GUIDE Website

- <https://www.cms.gov/priorities/innovation/innovation-models/guide>

What is the **GUIDE** Model?

The Guiding an Improved Dementia Experience (GUIDE) Model is a new program by Medicare that aims to improve the quality of life for people living with dementia and those who support them.



**Improve
Quality
of Life**



**Reduce
Caregiver
Strain**



**Age
in Place**



**Reduce
Hospital
Encounters**

How does **GUIDE** work?

- Medicare pays for dementia care management services provided by the Center for Brain Health Team.
- They work with your doctors to provide enhanced care.
- There is no co-pay and your insurance benefits and deductibles are not affected.

GUIDE Services

- Dementia Education
- Behavioral Strategies
- Supportive Counseling
- Advanced Directives
- Fall Prevention
- Reduce Hospital Encounters
- Caregiver Support Programs
- Home Assessment & More



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Additional **Information**

LSUHS.edu/GUIDE
1-877-GUIDE LA (484-3352)
GUIDE@lsuhs.edu



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Thank You!

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THANK YOU

Elizabeth Disbrow, Ph.D., Professor
LSU Health Shreveport Center for Brain Health

Elizabeth.Disbrow@lsuhs.edu

(318)813-3611

