CHANGING THINKING!

ADVISORY 24-5 (draft v.1)

BENEFICIARIES

WHAT ARE BENEFICIARIES?

"Beneficiary" is an individual who is enrolled in Medicare.[1] A "GUIDE Beneficiary" is an Eligible Beneficiary who is voluntarily aligned to the Participant for the purposes of computing GUIDE Payments and evaluating quality performance. To aid Participants with locating potential eligible Beneficiaries, on a monthly basis, CMS provides to the Participants a list of the GUIDE Beneficiaries that are aligned to the Participant, each GUIDE Beneficiary's model tier assignment, the length of the GUIDE Beneficiary's alignment to the Participant, and other beneficiary-level data, such as GUIDE Beneficiary's Medicare Beneficiary Identifier, first name, last name, date of birth, and gender via an Beneficiary Alignment file.

POTENTIAL BENEFICIARIES WITH INTELLECTUAL DISABILITY

Adults with intellectual disability who are Medicare eligibles or beneficiaries are clientele for GUIDE Participant services is the also have dementia and reside at home with caregiver, or in another non-institutional setting (such as an apartment or group home).

ESTABLISHING ELIGIBILITY (ALIGNMENT) FOR GUIDE

At the beginning of the first model performance year, GUIDE Participants are required to offer their eligible patients, who reside in the GUIDE Participant's zip code–based service area, the opportunity to voluntarily align to the GUIDE Participant and join the model. GUIDE Participants must complete an initial comprehensive assessment visit for beneficiaries that may be eligible for the GUIDE model. For those beneficiaries who consent, GUIDE Participants will submit a Patient Assessment and Alignment Form to CMS via the CMS.gov ePortal. GUIDE Participants are encouraged to meet a minimum threshold of 200 aligned beneficiaries by the end of their second performance year and maintain this alignment level throughout the rest of the Model Performance Period. Beneficiaries will remain aligned to the GUIDE Participant until they become ineligible. For example, an aligned beneficiary would be deemed ineligible if they no longer meet one of the beneficiary eligibility requirements or stop receiving model services

[1] Guiding an Improved Dementia Experience (GUIDE) Model Participation Agreement

from the GUIDE Participant (e.g., they move out of the program service area, they no longer wish to be aligned to the GUIDE Participant, they cannot be contacted.

Once a potential eligible beneficiary is identified, the next step is for the GUIDE Participant to schedule the person with dementia, or suspected dementia, for an initial comprehensive assessment. The GUIDE Participant may choose to do an initial prescreening call to rule out beneficiaries who are ineligible for the GUIDE Model, but this is not required. During the initial comprehensive assessment, the GUIDE Participant's interdisciplinary care team will assess the beneficiary and their caregiver (if applicable) across required domains, including cognitive function, functional status, clinical needs, behavioral and psychosocial needs, and caregiver burden, with the goal of confirming a dementia diagnosis and creating a comprehensive care plan. If the interdisciplinary care team assesses a beneficiary or refers a beneficiary for additional diagnostic testing and determines that the beneficiary does not have dementia or otherwise qualify for the GUIDE Model, the GUIDE Participant can bill for an appropriate Medicare covered professional service that corresponds to the services rendered (such as Current Procedural Terminology code 99483).

Beneficiaries must have dementia to be eligible for alignment to a GUIDE Participant but may be at any stage of dementia—mild, moderate, or severe (note that mild cognitive impairment is not a dementia diagnosis and is not sufficient to meet this eligibility criterion). To confirm that beneficiaries have dementia that makes them eligible for the GUIDE Model, CMS will rely on clinician attestation rather than prior claims based ICD10 dementia diagnosis.

A practitioner on the GUIDE Participant's GUIDE Practitioner Roster must attest that, based on their comprehensive assessment, beneficiaries meet the National Institute on Aging Alzheimer's Association diagnostic guidelines for dementia5 and/or the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM5) diagnostic guidelines for major neurocognitive disorder.6 Alternatively, they may attest that they have received a written report of a documented dementia diagnosis from another Medicare enrolled practitioner. This attestation occurs at the time the Patient Assessment and Alignment Form is submitted to the CMS.gov Enterprise Portal (ePortal).

During the initial comprehensive assessment, if the interdisciplinary care team determines that the beneficiary may be eligible to be aligned and wishes to be aligned to the GUIDE Participant, then the care team obtains the beneficiary's consent to voluntarily align to the GUIDE Participant.

This somewhat technical explanation is what CMS has shared with the approved GUIDE Participants and governs the sequencing of how they locate and ascertain eligibility for Beneficiaries to align with the GUIDE program. As we review this more in depth, we'll be

offering more information on how we, the NTG, might interface with this process with respect to our training offerings.

TIERS AND CRITERIA, SCORING, AND CARE FACTORS

This Table is provided as background for the other information that follows – particularly related to the information in the Appendix C matter.

Model Tiers – Table 1

Beneficiary Type	Tier	Criteria	Corresponding Assessment Tool Scores
Beneficiaries with a caregiver	Low complexity dyad tier	Mild dementia	CDR= 1, FAST= 4
	Moderate complexity dyad tier	Moderate or severe dementia *AND* Low to moderate caregiver strain	CDR= 2-3, FAST= 5-7 *AND* ZBI= 0-60
	High complexity dyad tier	Moderate or severe dementia *AND* High caregiver strain	CDR= 2-3, FAST= 5-7 *AND* ZBI= 61-88
Beneficiaries without a caregiver	Low complexity individual tier	Mild dementia	CDR= 1, FAST= 4
	Moderate to high complexity individual tier	Moderate or severe dementia	CDR= 2-3, FAST= 5-7

Source: Guiding an Improved Dementia Experience (GUIDE) Model Participation Agreement

BENEFICIARIES' CARE AND SUPPORTS

Environmental modifications

"Environmental Modification Beneficiary Engagement Incentive" refers to the environmental modifications that the Participant may choose to make available to GUIDE Beneficiaries in accordance with Appendix A of the Model Participant Agreement. GUIDE Participants may provide in-kind environmental modifications to GUIDE Beneficiaries if all the following requirements satisfied: (1) The Participant reasonably determines that the environmental modification advances one or more of the following goals of the Model: (a) improves quality of life for the GUIDE Beneficiary, (b) reduces burden and strain on the Caregiver, and (c) delays the GUIDE Beneficiary's move to a nursing home. In addition, the environmental modification shall have a reasonable connection to the GUIDE Beneficiary's health care and the environmental modification shall be furnished by the Participant (or by an agent of the Participant acting under the Participant's direction and control). Participants shall arrange and pay a handy worker or home improvement contractor to install any physical modifications.

The total retail value of payments for environmental modifications made by the Participant on behalf of a GUIDE Beneficiary is limited to up to $1,000 per year. Further, any work performed must involve a pre-contract review of the workers, showing that (1) they are at least 18 years old (2) they have passed a

background check; (3) They have and maintain Commercial General Liability Insurance; (4) are licensed or certified in the state that the GUIDE Beneficiary is residing; and (5) are bonded as may be legally required in the state that the GUIDE Beneficiary is residing. Environmental modifications may include, but are not limited to, grab bars, flexible shower heads, safer flooring, signs, improved lighting, railing installation or other home modifications to prevent injury.

Respite Services

"GUIDE Respite Services" means temporary services provided to a GUIDE Beneficiary in their home, at an adult day center, or at a facility that can provide 24-hour care, for the purpose of giving the Caregiver a break from caring for the GUIDE Beneficiary. "GUIDE Respite Payment" is the payment for furnishing GUIDE Respite Services to Eligible Respite GUIDE Beneficiaries. CMS will pay the Participant for GUIDE Respite Services furnished to Eligible Respite GUIDE Beneficiaries up to an annual cap of $2,500 per Eligible Respite GUIDE Beneficiary.

With respect to respite services, to be eligible to receive GUIDE Respite Services ("Eligible Respite GUIDE Beneficiary"), the GUIDE Beneficiary must have a Caregiver and be assigned to either the moderate complexity dyad tier or the high complexity dyad tier as noted above in outlined in Table 1. Entities (whether the Participant or the contracted entity) that is furnishing GUIDE Respite Services must be one of the following at all times while providing GUIDE Respite Services during the Agreement Performance Period: (1) A Medicare-certified facility that can provide 24-hour care; (2) A Medicare-certified provider that provides in-home respite services; (3) A Medicaid-certified adult day center; (4) A Medicaid-certified facility that can provide 24-hour care; (5) A Medicaid-certified provider that provides in-home respite services; or (6) A company or organization licensed or certified in the state in which the company or organization is providing services, to provide one of the following services: (a) respite care, (b) home care, (c) residential services, (d) adult day services, or (e) residential facility or group home (not a private residence).

All direct care workers that provide in-home GUIDE Respite Services need to meet the following requirements prior to providing in-home GUIDE Respite Services: (1) Be at least 18-years-old; (2) Pass either a criminal history background check completed by a private agency or a background check of the type that may be required by the state in which the direct care worker is providing services to be licensed or certified as a direct care worker; (3) Be licensed or certified as a direct care worker in the state in which they are providing services if such licensure or certification is a requirement to work as a direct care worker in said state; and (4) Meet the training requirements to be a direct care worker, if any, of the state in which they are providing services.

The above standards would apply to providers of intellectual disability services and to all direct support professionals in their employ. Potentially, when state licensure is absent, providers and DSPs could take a 'certificate' course from the NTG to qualify, or potentially quality by gaining an E-badge in dementia care from the NADSP/NTG. This would enable such providers to enter into Partner contracts with GUIDE Participants.

Care Delivery Services

The following was extracted from Appendix C: GUIDE Care Delivery Services (Source: Guiding an Improved Dementia Experience (GUIDE) Model Participation Agreement) and provided to give a background on what are the basic requirements for Participants and Navigators when undertaking assessment and provision of services to Beneficiaries.

APPENDICES

Appendix C: GUIDE Care Delivery Services
Care Delivery Services

1.0 Comprehensive Assessment

1.1 Comprehensive Assessment:

1.1.1 Participant shall deliver a Comprehensive Assessment of, and care planning for, the GUIDE Beneficiary in accordance with the requirements below.

1.1.2 Frequency:

1.1.2.1 Participant shall perform a Comprehensive Assessment of the GUIDE Beneficiary. The Comprehensive Assessment will initiate the model intervention and serve as the initial model visit.

1.1.2.2 Participant shall complete a new Comprehensive Assessment under the terms of this Section 1.1 for any GUIDE Beneficiaries that the Participant may have previously assessed as a patient prior to the GUIDE Beneficiary voluntarily aligning with the Participant for purposes of this Model.

1.1.2.3 After the initial Comprehensive Assessment, Participant shall perform a Comprehensive Assessment of the GUIDE Beneficiary at least once every twelve months.

1.1.2.4 The Participant has the discretion to re-assess the GUIDE Beneficiary more frequently; however, CMS will only accept data from reassessments once every one-hundred-and-eighty (180) days.

1.1.3 Modality:

1.1.3.1 An assessment may be performed via telehealth or in-person in the Care Team's office or other outpatient home or domiciliary based on the preference of the GUIDE Beneficiary and/or Caregiver.

1.1.3.2 The assessment shall be administered by appropriate members of the interdisciplinary Care Team according to their license and scope of practice.

1.1.4 Required Domains:

1.1.4.1 Clinical:

1.1.4.1.1 Cognition-focused evaluation including a pertinent history and examination.

1.1.4.1.2 Evaluation of medical decision-making of moderate or high complexity.

1.1.4.1.3 Functional assessment (e.g., Basic and Instrumental Activities of Daily Living).

1.1.4.1.4 Screening, or referral to screening, for hearing loss.
1.1.4.1.5 Use of standardized instruments for staging of dementia.
1.1.4.1.6 Medication reconciliation and review.

1.1.4.2 Behavioral Health and Psychosocial Needs:

1.1.4.2.1 Evaluation of GUIDE Beneficiary for behavioral health needs, including screening for depression, anxiety, substance use, and suicidal ideation.
1.1.4.2.2 Evaluation of safety, including, but not limited to, environmental, driving, wandering, fall risk, and abuse, neglect and exploitation.

1.1.4.3 Health-Related Social Needs:

1.1.4.3.1 Screening of GUIDE Beneficiary's health-related social needs (HRSN) in accordance with the requirements detailed in Section 12.01(E) of this Agreement.

1.1.4.4 Advance Care Planning:

1.1.4.4.1 Development, revision, and/or review of an Advance Care Plan and a Physician Order for Life-Sustaining Treatment (POLST) if available and GUIDE Beneficiary wishes to complete.

1.1.4.5 Coordination:

1.1.4.5.1 Identification of GUIDE Beneficiary's primary care provider, behavioral health provider, and specialty provider(s), if any, and coordination services to manage the GUIDE Beneficiary's dementia and any co-occurring conditions.
1.1.4.5.2 Identification of any community-based services and supports, and home and community-based services that the GUIDE Beneficiary is receiving.

1.2 Caregiver Assessment:

Participant shall deliver an assessment of the Caregiver in accordance with the requirements below.

1.2.1 Participant shall identify the Caregiver(s) and their ability and willingness to assume, or to continue to furnish, assistance.

1.2.2 Participant shall assess the Caregiver's knowledge, needs, and social supports, and assess the Caregiver's well-being, stress level, and other challenges.

1.2.3 If the GUIDE Beneficiary does not have a Caregiver, the Participant shall make a reasonable effort to help identify a Caregiver for the GUIDE Beneficiary.

1.2.3.1 If the Participant and the GUIDE Beneficiary are not able to locate a Caregiver for the GUIDE Beneficiary, then Section 1.2: Caregiver Assessment and Section 8: Caregiver Education and Support do not apply to that GUIDE Beneficiary, and instead the Participant shall make additional efforts and put safeguards into its care delivery to support the GUIDE Beneficiary continuing to reside in the community.

1.3 Home Visit Assessment

1.3.1a For GUIDE Beneficiaries in the low complexity dyad tier or low complexity individual tier: Participant may, but is not required to, visit the GUIDE Beneficiary and, if applicable, his or her Caregiver in person at the current residence of the GUIDE Beneficiary. If the Participant does not visit the GUIDE Beneficiary in person, the visit may be performed remotely through electronic means.

1.3.1b For GUIDE Beneficiaries in moderate or high complexity dyad tiers, or moderate to high complexity individual tier: Participant shall visit the GUIDE Beneficiary and, if available, his or her Caregiver at the current residence of the GUIDE Beneficiary. If the Caregiver or other members of the Care Team are not present, the Participant may facilitate participation of the Caregiver and other

members of the Care Team by enabling such individuals to participate in the visit remotely through electronic means.

1.3.2 The home visit with the GUIDE Beneficiary should occur within two months after the initial Comprehensive Assessment and can be performed by any member of the interdisciplinary Care Team.

1.3.3 During the home visit, the Participant shall assess the following: i) safety of the home environment and the GUIDE Beneficiary's ability to navigate and manage the home environment, ii) GUIDE Beneficiary's function in activities of daily living, and iii) other environmental, social, and behavioral factors that might impact the function and needs of the GUIDE Beneficiary and their Caregiver.

2.0 Care Plan

2.1 Based on findings from the initial Comprehensive Assessment, including the HRSN screening, home visit, and guidance from the GUIDE Beneficiary and the Caregiver, the Participant shall develop elements of the person-centered care plan with recommendations for i) addressing the GUIDE Beneficiary's goals, strengths, preferences and needs, ii) the required domains of the Comprehensive Assessment, iii) the coordination of community-based services
and supports, including respite services if applicable, and a listing of recommended service providers and which individual or program is responsible for payment of each service provider, and iv) the Caregiver's education and support services.

2.2 The initial care plan and future revisions shall be led by the GUIDE Beneficiary. At the discretion of the GUIDE Beneficiary and as appropriate to the individual, the Participant may also incorporate input from the Caregiver. The Participant shall share the initial care plan and future revisions with the GUIDE Beneficiary and their Caregiver along with any relevant education, supports, and other resources, to carry out the goals of the plan.

2.3 The Participant shall modify the written care plan as needed, or requested, to reflect the GUIDE Beneficiary's changing circumstances, goals, preferences, and needs.

2.4 The person-centered care plan shall be incorporated into the GUIDE Beneficiary's electronic health record and shared with the GUIDE Beneficiary's primary care provider (if the GUIDE Beneficiary's primary care provider is not a member of the Participant's Care Team) and any specialist or other provider in accordance with *Section 5: Care Coordination and Transitional Care Management.*

3.0 24/7 Access

3.1 Participant shall provide either (i) 24/7 access to an interdisciplinary Care Team member or (ii) maintain a 24/7 helpline that the GUIDE Beneficiary and/or their Caregiver may call to speak with either a member of the Care Team or a third party engaged by the Participant to provide communication with human support (e.g., not artificial intelligence) during off-duty hours. A third party engaged by the Participant to provide communication during off-duty hours shall share with the interdisciplinary Care Team information of any communication with a GUIDE Beneficiary and/or their Caregiver.

3.2 If the Participant uses a 24/7 helpline, the 24/7 helpline shall be available to receive ad hoc one-on-one support calls from the Caregiver (see Section 8.2.4).

4.0 Ongoing Monitoring and Support

4.1 The Care Navigator shall be the primary point of contact for the GUIDE Beneficiary and their Caregiver.

4.2 The Care Navigator shall provide ongoing contact with the GUIDE Beneficiary and/or Caregiver to revise and maintain the person-centered care plan as needed (see Section 2), identify unmet needs and coordinate clinical and community-based services and supports (see Section 6), monitor medication management and adherence (see Section 7), and provide caregiver education and support (see Section 8) as may be needed to support the GUIDE
Beneficiary and their Caregiver.

4.2.1 If the Care Navigator is a non-clinical professional, the Care Navigator should consult with the Care Team's clinical team members for any medical or other issues that present complexity.

4.3 Frequency: Participant shall maintain a minimum contact frequency with the GUIDE Beneficiary and/or their Caregiver. Minimum contact requirements vary by model tier, as follows:

4.3.1 GUIDE Beneficiaries <u>with a Caregiver</u>

- o Low complexity dyad tier: at least quarterly
- o Moderate complexity dyad tier: at least once a month
- o High complexity dyad tier: at least once a month

4.3.2 GUIDE Beneficiaries <u>without a Caregiver</u>

- o Low complexity individual tier: at least once a month
- o Moderate to high complexity individual tier: at least twice a month

4.4 Modality: Participant may provide ongoing contact in-person (in-clinic or in-home), by phone, and/or by audio-visual modalities in accordance with the GUIDE Beneficiary's and/or Caregiver's preferences, as applicable. Short Messaging Service (SMS) <u>may not</u> be used to contact the GUIDE Beneficiary or Caregiver to meet the minimum contact frequency, but can be used, with the GUIDE Beneficiary's and Caregiver's consent, in other communications.

5.0 Care Coordination and Transitional Care Management

5.1 If the GUIDE Beneficiary's primary care provider is not a member of the Participant's Care Team, Participant shall coordinate with the GUIDE Beneficiary's primary care provider and notify the GUIDE Beneficiary's primary care provider that the GUIDE Beneficiary is participating in a dementia care management program and ensure that the primary care provider has access to the GUIDE Beneficiary's care plan and any updated/revised care plans.

5.2 Participant may refer the GUIDE Beneficiary to a specialist or other provider to address any physical or behavioral health (such as, mental health or substance use) co-occurring conditions of the GUIDE Beneficiary. Participant may notify the specialist or other provider that the GUIDE Beneficiary is participating in a dementia care management program and send the specialist or other provider the GUIDE Beneficiary's person-centered care plan, and any updated/revised care plans, by electronic health record, fax, or mail. The Participant shall also notify the GUIDE Beneficiary's primary care provider of the referral to a specialist and/or other provider. If the primary care provider is actively comanaging the GUIDE Beneficiary, the Participant should make this referral in consultation with the primary care provider. The Care Team must close the referral loop with the specialist by ensuring the Care Team receives documentation from the GUIDE Beneficiary's visit and any changes to his or her care plan.

5.3 If the Participant refers the GUIDE Beneficiary to a specialist or other provider, a member of the Care Team shall introduce the GUIDE Beneficiary to the new provider if requested by the GUIDE Beneficiary and/or their Caregiver so that the new provider is aware of the patient history and can share recommendations with the Care Team for incorporation into the care plan.

5.4 Participant shall provide care coordination services, medication management/reconciliation, and support to the GUIDE Beneficiary in transitions between their personal residence and care settings, such as a hospital, emergency department, nursing facility, and/or hospice.

5.5 Participant shall provide additional care coordination services needed to help manage the GUIDE Beneficiary's dementia and co-occurring conditions, if any, across the care-continuum.

6.0 Referral and Coordination of Services and Supports

6.1 Participant shall i) refer and connect GUIDE Beneficiaries and their Caregivers to community-based services and supports that address the common needs of persons with dementia and their caregivers (e.g., home-delivered meals, adult day centers, personal care, environmental modifications, contractors, food banks), and/or ii) enter into a written agreement with a local Area Agency on Aging or a Tribal Aging Program (funded through Title VI of the Older Americans Act) requiring that the local Area Agency on Aging or Tribal Aging Program assists GUIDE Beneficiaries and their Caregivers with coordinating community-based services and supports.

6.2 If the GUIDE Beneficiary is eligible for and receiving home- and community-based services (HCBS) through a state Medicaid program, the Participant shall contact and attempt to coordinate the delivery of community-based services and supports and HCBS with the GUIDE Beneficiary's waiver/HCBS program case manager. Coordination between the Participant and the GUIDE Beneficiary's waiver/HCBS program case manager shall include sharing information about the GUIDE Model and reviewing the services that the GUIDE Beneficiary receives through both the GUIDE Model and Medicaid for the purpose of understanding gaps or duplication in the GUIDE Beneficiary's care.

6.3 Participant shall join or maintain a community referral inventory system that includes resources for the health-related social needs screened as part of the Comprehensive Assessment (see Section 1.1.4.3), and the Care Navigator shall refer and connect the GUIDE Beneficiary and their Caregiver to resources relevant to their needs.

6.4 Participant shall maintain, or have access to, an inventory of community-based resources for services and supports that address the common needs of persons with dementia and their Caregivers (e.g., home-delivered meals, adult day centers, personal care, environmental modification, contractors, food banks) and as appropriate, share these resources with the GUIDE Beneficiary and their Caregiver.

7.0 Medication Management and Reconciliation

7.1 A clinician with prescribing authority shall review and reconcile the medications that GUIDE Beneficiary is taking at the time of the initial Comprehensive Assessment, at any additional future assessments, and then periodically as requested by other members of the Care Team, the GUIDE Beneficiary or the Caregiver, as appropriate. Medication review would customarily include, as part of

this element, a review of prescription drugs, over-the-counter medications, supplements, natural treatments, and/or any other substances the GUIDE Beneficiary might be using for any purpose.

7.2 If clinically advisable for the GUIDE Beneficiary, Participant's advanced practice nurse, physician assistant, or physician shall consider prescribing medications that are beneficial for the GUIDE Beneficiary.

7.3 If clinically advisable for the GUIDE Beneficiary, Participant's advanced practice nurse, physician assistant, or physician shall de-prescribe any medications that are inappropriate for the GUIDE Beneficiary to continue taking.

7.4 Participant shall share recommended changes to the GUIDE Beneficiary's medications with the GUIDE Beneficiary's primary care provider and other medical specialists, as applicable, and confirm that the relevant medical provider, either the primary care provider or the medical specialist, agrees to the proposed change to the GUIDE Beneficiary's medications prior to the GUIDE Beneficiary changing their medications.

7.5 Participant's Care Navigator shall provide information on supports to help the GUIDE Beneficiary maintain the correct medication schedule, such as pill reminders, pill boxes, and/or software applications.

8.0 Caregiver Education and Support

8.1 In order to provide education and support to the Caregiver of a GUIDE Beneficiary, Participant shall administer a caregiver support program, which is based on the caregiver assessment referred to in Section 1.2 and is responsive to ongoing Caregiver needs.

8.2 The caregiver support program shall offer the following services:

8.2.1 Caregiver skills training: Participant shall provide the Caregiver with the option to receive training to help the GUIDE Beneficiary continue to live as safely and comfortably as possible in the community. The training shall include the following topics: emergency services, safety in the home, assistance with activities of daily living (ADL) and instrumental ADLs, responding to and managing the GUIDE Beneficiary's behavioral and psychosocial symptoms, identifying and obtaining help across the care continuum, working with health care and other community-based providers, recreation, social and leisure activities, making plans for the future, and caregiver self-care and stress management.

8.2.2 Dementia diagnosis information: If GUIDE Beneficiary and/or Caregiver wish to receive further information regarding the GUIDE Beneficiary's dementia diagnosis, Participant shall speak with and provide written educational materials to the Caregiver regarding the GUIDE Beneficiary's dementia diagnosis. These materials may include, but are not limited to, information on dementia, common behavioral changes, functional status, and resources available publicly and through the Participant. These materials should be comprehensible to a lay person and in the primary language spoken by the GUIDE Beneficiary and the Caregiver.

8.2.3 Support group services: Participant shall provide the Caregiver with the option to participate in a group setting where a facilitator trained in dementia and caregiving shall work with caregivers on self-care, home safety, caregiver skills, personal care, and managing challenging behaviors.

8.2.4 Ad hoc one-on-one support calls: Participant shall be available for one-on-one support calls with the Caregiver to address issues in furnishing care and support to the GUIDE Beneficiary as the issues arise. For example, these calls may focus on the Caregiver's needs and goals by coaching

caregivers on stress management, self-care and well-being behaviors, and how to identify and address behavioral challenges and functional status of the GUIDE Beneficiary, and support safety of the Caregiver, and the GUIDE Beneficiary. The calls may be initiated by the GUIDE Beneficiary, the Caregiver, or the Participant. The Participant's requirement to maintain minimum contact with the GUIDE Beneficiary in accordance with Section 4.3 may be used to satisfy this requirement for one-on-one support calls.

8.3 Modality: All services may be provided virtually or in-person. In addition, Participant shall deliver the services listed under Section 8.2 as follows:

8.3.1 Caregiver skills training: Must be provided by either a member of the Care Team or through a contracted vendor or community organization that is reimbursed by the Participant; may be provided in a one-on-one setting or group format.

8.3.2 Dementia diagnosis information at program entry: Must be provided directly by a member of the Care Team in a one-on-one setting.

8.3.3 Support group services: May be provided directly by a member of the Care Team, through a contracted vendor or community organization that is reimbursed by the Participant, or through referral to a community organization that offers support group services to the community free of charge. GUIDE Beneficiaries and Caregivers may decline to participate in support groups or change their mind about participation at any time.

8.3.4 Ad hoc one-on-one support calls: Must be provided directly by a member of the Care Team.

8.4 In addition to the required services listed above, the Participant should consider whether to provide the following optional services:

8.4.1 Peer-to-peer support: Experienced caregivers, whose caregiving experience has come to an end, would provide practical information, and support and mentoring to the Caregiver.

8.4.2 Resources or referrals for self-care and well-being instruction (e.g., group walks, meditation classes): Specialized services centered around caregiver stress and health management. Services could include, but are not limited to, mindfulness and relaxation techniques, cognitive behavioral therapy, musical and arts classes, and exercise classes.

8.4.3 Assist with education on the role of the caregiver: Information on the traditional responsibilities of a caregiver for a person living with dementia and the resources available to them through the Participant.

8.4.4 Accessing community-based resources: Coaching the Caregiver on how to access community-based resources relevant to their caregiving role, such as transportation, nutrition support, homemaker/yard services. This service is in addition to the referral support provided under Section 6 Referral and Coordination of Services and Supports.

8.4.5 Psychological counseling referral: The Caregiver may work with a specialist on developing new behaviors or strategies to help address caregiving demands, identifying areas for improvement for the beneficiary-caregiver dyad, or assistance in addressing depression, anxiety, and suicidal ideation in the Caregiver and/or the GUIDE Beneficiary.

9.0 Respite

9.1 Participant shall provide GUIDE Respite Services to Eligible Respite GUIDE Beneficiaries who choose to receive GUIDE Respite Services. GUIDE Respite Services are furnished based on the Eligible Respite GUIDE Beneficiary's qualifying status. Participants and Eligible Respite GUIDE Beneficiaries shall decide how much GUIDE Respite Services the Eligible Respite GUIDE Beneficiary will receive taking into

consideration the Eligible Respite GUIDE Beneficiary's need for GUIDE Respite Services and the Respite Cap.

9.2 Participant shall provide in-home GUIDE Respite Services directly or contract with at least one provider of in-home respite services. The contract must specify how the Participant will reimburse the respite provider for Respite Services rendered to Eligible Respite GUIDE Beneficiaries.

9.3 Participant may also contract with adult day centers or facilities that can provide 24-hour care to deliver GUIDE Respite Services in these settings to Eligible Respite GUIDE Beneficiaries.

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V. 8/20/2024

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