



CHANGING THINKING!

Advisory 24-3 (v2)

Education/Training

GUIDE EDUCATION AND TRAINING REQUIREMENTS

As of July 1, 2024, the 96 participating organizations in the Established Program Track began their participation in the GUIDE Model. These participants are required to develop and implement a Health Equity Plan, which must identify disparities in outcomes in their patient populations and implement initiatives to measure and reduce these disparities over the course of the GUIDE Model. Among the patient populations are adults with intellectual and developmental disabilities (I&DD), as well as a range of 'related' neuroatypical conditions.

The process of 'alignment' for beneficiaries with the GUIDE Model involves undertaking a home visit to assess the potential beneficiaries and their home situation, including the impact of dementia caregiving upon the immediate caregivers. These initial home visits are undertaken by Care Navigators.

CMS provides a financial incentive [a 'Health Equity Adjustment to the DCMP'] for Participants that maintain a Health Equity Plan that includes recognition and focus via a plan that speaks to developing and implementing strategies for outreach and engagement of Eligible Beneficiaries from historically underserved communities to the Model. The Plan needs to (a) identify and address health disparities observed in its GUIDE Beneficiaries; (b) implement initiatives to measure and reduce these health disparities over the course of the Model; (c) identify and select evidence-based interventions for addressing health disparities and achieving equitable outcomes; and (d) describe how the Participant is setting goals and monitoring progress of goals and recruitment over time. It is by including I&DD beneficiaries and caregivers in the HEP that can aid Participants with receiving a HEA to their DCMP.

WHAT ARE CARE NAVIGATORS?

Care Navigators can come from a variety of professionals, including but not limited to community health workers, social workers, and registered nurses, as well as person specially hired and trained to fill these positions. While care Navigators are not required to have specific credentials or professional accreditation, preliminary investigations with Track 1 Participants are finding Participants are staffing Navigator roles with seasoned professional personnel (such as OTs, nurses, and social workers) in the first instance, as they are more able to handle the initiation of a new program, managed an extended caseload, make quicker determinations of beneficiary needs, and make more efficiently mandated monthly contact time. On-boarding new hires necessitates more training demand and broader information content. For professionals, often caseloads of 100 or so are the norm for this group, while lesser caseloads (e.g., 50+) are more ideal for new hires and those with paraprofessional status. Participants also are noting that seasoned employees are retained for longer terms as Navigators. Information such as this leads to possible development of training content at two different levels, one for staff lacking experience in human services, and one for those with extensive experience.

Individuals who work as Care Navigators must receive training on a variety of specific topics related to dementia (these are listed in Table A, further down in this advisory). Some topics that the Care Navigator training must include are conducting person-centered care planning, providing culturally competent care, and managing behavioral and psychosocial symptoms of dementia.

GUIDE Participants are responsible for ensuring that their Care Navigators receive training that meets the model requirements. Our focus within the CT! Project is not on providing the full package of training for caregivers, but to provide required ancillary training and education specifically on content related to I&DD.

WHAT ARE THE SPECIFICS FOR TRAINING CARE NAVIGATORS?

This section provides a thumbnail sketch of what CMS requires that each Participant do with respect to developing and administering an initial and annual training for Care Navigators. For Established Track Participants such training needs to be in place as of the beginning of Performance Year 2024. For the rest in the New Program Track, the training must be developed and administered by the beginning of Performance Year 2025. CMS permits the Participants to use training programs that are available to the public or develop their own training of the required topics listed in Table A.

CMS requires that Participant must ensure that its initial Care Navigator Training is a minimum of 20 hours and includes the following: (a) a *minimum of 10 hours of didactic instruction*, which may be a live (either virtual or in person) or a pre-recorded web-based training; and (b) a *minimum of 10 hours of experiential training*, which must be live (either virtual or in person). The Participants are required to “assess its Care Navigators following the initial Care Navigator Training to ensure comprehension.” Table A covers the specific topics that need to be covered in the training.

Table A	Mandated Training Topics for Care Navigators
Topic	Further Detail of Topic
<i>Background on Dementia</i>	Overview of dementia as a medical condition; Progression of disease and balancing dementia with other co-morbidities
<i>Overview of Assessments</i>	Assessments available related to dementia; Recommendations for a successful assessment
<i>Care Plan</i>	What is a care plan; Including beneficiary in the development of plan
<i>Person-Centered Planning</i>	What person-centered planning means; How to incorporate into planning
<i>Challenging Behaviors</i>	Behavioral symptom management; Common behavioral changes due to dementia and how to address
<i>Functional Needs</i>	What are activities of daily living (ADLs) and instrumental activities of daily living (IADLs); Evaluation of ADLs and IADLs; Common changes in ADLs and IADLs due to dementia and how to address; Medication monitoring and maintaining a medication schedule
<i>Advanced Care Planning</i>	What is an advance medical directive and POLST form; How to assist beneficiary in advance care planning
<i>Decision-Making Capacity</i>	What is capacity for medical decision-making; What it means when a beneficiary does not have capacity for medical decision-making; supported decision-making
<i>Safety</i>	Considerations for safety at home, in public, and driving; elder abuse, neglect, and financial exploitation; access to weapons and dangerous substances
<i>Communication</i>	Communication strategies for persons with dementia and their caregivers

<i>Coordination of medical care and community services</i>	Communication with clinical providers; Supporting beneficiary in transitions between settings; Accessing community-based services and supports, including respite services; Working with case managers and other coordinators to address gaps and duplication in a beneficiary's community-based services and supports
<i>Supporting a Caregiver</i>	Caregiver strain and support (e.g.: peer-to-peer support, support group, 1:1 support); In-home caregiver training and importance of caregiver education
<i>Diversity in Dementia</i>	Treating dementia and communicating with diverse populations in a culturally competent way

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

The caregiver education under the model is not standardized by the GUIDE Model. Participants have the option to establish their own programs and provide caregiver training themselves internally, or the participant can contract with a third-party vendor to provide these services.¹

ANCILLARY TRAINING REQUIREMENTS

After the initial training, Care Navigators *must take an additional two (2) hours* of training each Performance Year in accordance with the following: (1) the annual training may be developed and offered by the Participant or be a continuing education training offered by a third party; (2) the annual training may be on a topic chosen by the Participant or the Care Navigator; and (3) the Participant shall retain confirmation, in a form or manner that the Participant chooses, that its Care Navigator completed the annual training.

Behavioral and Psychological Symptoms of Dementia. The GUIDE Model addresses Behavioral and Psychological Symptoms of Dementia (BPSD) through its care delivery requirements and required training for Care Navigators. The GUIDE Model requires Care Navigators to be trained to work with caregivers in identifying and managing common behavioral changes due to dementia. GUIDE Participants will also assess the beneficiary's behavioral health as part of the comprehensive assessment. It would be useful for the Care Navigators to have information on hand as to how to factor in the presences of I&DD when addressing BPSDs. One of our educational topics would be factoring in I&DD when addressing BPSDs.

Comprehensive Assessments. GUIDE Participants are required to complete new comprehensive assessments for purposes of the GUIDE Model before a beneficiary can voluntarily align to the GUIDE Participant for purposes of the GUIDE Model. It would be useful to the Care Navigators to have information on hand as to how to factor in the presences of I&DD when undertaking a comprehensive assessment. One of our educational topics would be factoring in I&DD when undertaking a comprehensive assessment.

Care Support. GUIDE Participants are required to administer a caregiver support program. Required services of the caregiver support program include caregiver skills training, dementia diagnosis information, support group services, and ad hoc one-on-one support calls. It would be useful for Care Navigators to have information on hand as to how to factor in the presences of I&DD when designing general caregiver support (within the context of long-term caregiving by families of adults with I&DD). One of our educational topics would be understanding long-term I&DD within the context of recommending and providing care supports.

¹ Guiding an Improved Dementia Experience (GUIDE) Overview Webinar

I&DD Community Support Resources. 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 is intended to achieve these goals through Medicare payments for a comprehensive package of care coordination and care management, caregiver education and support, and respite services. GUIDE includes a focus on people with dementia who are dually eligible for Medicare and Medicaid and, as with other people supported by the model, help them to remain safely in their homes for longer. The Care Navigator would provide long-term help to beneficiaries and their caregivers to reevaluate and revise their goals and needs at any time during the provision of supports. One important facet is that Care Navigators would connect beneficiaries and their caregivers to community-based services and supports, such as respite, and other services that aid the beneficiary and his or her caregiver. It would be useful for Care Navigators to have information on hand regarding how to factor in the opportunities existing within the local I&DD systems and advising caregivers and designing caregiver support. One of our educational topics would be connecting with and leveraging local supports from the I&DD providers (either as Partners or unique community resources for supports for adults with I&DD).

MODALITIES FOR PROVIDING I&DD SPECIALIZED TOPICS

The topics noted above could be developed into a two-hour training/education package for Care Navigators to take as part of their Ancillary Training requirements options. The design would include content delivered via a digital learning platform that could be taken at will and with a completion exam, offered for a certification of completion. This would align with our stated goal to: *“Create self-directed digital training pack series specifically developed to cover three critical areas of caregiving & ID/dementia knowledge, screening and diagnosing, and connections to services/supports.”*

We could also offer an equivalent mini-training/education package for Care Navigators that would mirror the requirement training topics in Table A from an I&DD perspective. That would entail offering information when there is divergence to the main topic materials when a Care Navigator is assessing or working with a caregiver/family of a beneficiary with I&DD.

Content modules would likely be in 30 minutes completions, within a two-hour package to comply with the CMS requirement for annual continuing education.

EDUCATIONAL OPPORTUNITIES FOR PARTICIPANTS

CMS requires that each Participant participate in “CMS-sponsored learning activities designed to drive improvement and foster innovations in care delivery through sharing best practices or new knowledge that emerges from participation in the Model.” They also require the Participant to “actively engage in a variety of learning events, learning communities, and sharing promising tools and ideas, as well as its lessons learned.” Currently, it is unclear whether our CT! Project activities might fall under this requirement, but we can certainly work with CMS to have content on I&DD included in any ‘learning activities’ that CMS sets up or sanctions.

EDUCATIONAL OPPORTUNITIES FOR PRACTITIONERS

CMS defines the “GUIDE Practitioner” an individual that (a) is a Medicare-enrolled physician or other nonphysician practitioner identified by an individual National Provider Identifier (NPI); (b) bills under the TIN of the Participant; (c) is not precluded by CMS from participation in the Model; and (d) is identified by the Participant on the GUIDE Practitioner Roster. The “GUIDE Practitioner Roster” is a list that

identifies each GUIDE Practitioner that is approved by CMS for participation in the Model. Participants need to identify all of their GUIDE Practitioners on a GUIDE Practitioner Roster, and these are limited to only those GUIDE Practitioners who received prior written approval by CMS. These GUIDE Practitioners are the ones that provide Medicare billable services that align with the Participant.

With respect to clinical services, GUIDE Practitioners can provide various clinical supports, including undertaking the determination of the presence of dementia and potentially identifying staging and prognosis for clinical progression.

The NTG could offer via webinar or other media informational sessions for practitioners on (1) clinical aspects of I&DD coincident health conditions, (2) assessing and diagnosing adults with I&DD for dementia and stage determinations (with I&DD adaptations for the CDR and FAST), and (3) prescribing post-diagnostic supports as part of the overall Dementia Care Management Plan (DCMP).

As CMS has noted that 68% of the selected applicants identify their organization as a physician group practice or clinic, with the balance, community-based organizations, health systems, hospice agencies, and other providers, this gives us an opportunity to market to a relatively naïve group with respect to understanding and considering I&DD. Many Practitioners on the GUIDE Roster will be unfamiliar with the differences posed by adults with I&DD with respect to their assessments. A targeted orientation, and an introduction to the KAER ID Companion, would be a potential product within a welcoming market.

This would align with our stated goal to *“Offer and deliver at least two webinars for GUIDE Model Participants/Practitioners/ Navigators focusing on key factors related to adults with ID.”*

EDUCATIONAL OPPORTUNITIES FOR PARTNERS

Given that Partners may comprise many of the outside providers enabling the GUIDE Participants to meet their obligations for providing GUIDE Model services, we could also target a webinar or information ZOOM sessions for various I&DD providers within the ANCOR, ACCSES, The Arc, and other networks. This would serve to increase uptake on Partners contracts for the provision of respite, caregiver support, and other services needed to be provided as part of the DCMP. *See our Advisory 24-1 on ‘Targeting Partners’.*

PRODUCING OTHER MEDIA THAT WOULD HELP PARTICIPANTS, PRACTITIONERS, AND CARE NAVIGATORS

We have in stock several technical materials that should be updated and could then bear the logo of the CT! Project and made available as aids in enabling the alignment of a greater number of adults with I&DD living with dementia with the GUIDE Model. These could include our Q&A, advisories, etc. We would need to vet them and work to update them with specific application to the GUIDE market. We need also to make all Participants aware of the ID companion to the KAER tool as a foundation for many of their activities in the I&DD realm.

DEVELOPMENT PRIORITIES

First, investigate options for an on-line efficient and affordable digital platform lease that would be used for our on-line training activities. Information about the structure of the platform would serve as the basis for context design and presentation manner.

Second, undertake a series of focus group meetings or interviews with personnel working as Navigators (or who have been in such roles prior to the GUIDE program) to determine what they perceive as needed information and training related to intellectual disabilities and related conditions.

Third, create a survey, various ZOOM or Survey Monkey, to target various components of GUIDE (i.e., Navigators, Practitioners) to determine training and technical assistance needs related to intellectual disabilities\.

Fourth, begin preliminaries in planning for one or two webinars, to be offered by subscription and directed toward the Participant network on our impression of aligning I&DD issues with their Health Equity Plan and Care Navigator training and operations.

Fifth, work toward alignment of I&DD content within the main education program being developed by the Alzheimer's Association, so that I&DD content is acknowledged and the NTG noted as a source for third party training opportunities.

Sixth, undertake a market assessment to determine the market value of our training/education offering so that we can set a 'working price' for our products.

-30-

v. 9/20/24

This product was supported in part by the Special Olympics Systems Change for Inclusive Health Subgrant, funded by the Centers for Disease Control and Prevention. The contents of this project are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention or the US Department of Health and Human Services.