

Navigating the New Frontier *of Community-Based Dementia Care*

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Grantees undertaking projects under government sponsorship are encouraged to express freely their findings and conclusions. Points of view or opinions do not, therefore, necessarily represent official Administration for Community Living policy.



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Disclosure of Interest

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Speakers Bureau

NA

Clinical Trials

NA

Advisory Board

Eisai, Leqembi Advisory Board

I own no stocks or equity in any pharmaceutical company

Where we are headed...

1) Describe dementia navigation and goals of the CMS GUIDE model of care

2) Discuss state-wide public health approaches to improve quality of life for people with dementia and caregivers

3) Identify local resources to help families navigate dementia progression at home

IT KILLS MORE THAN
BREAST CANCER AND
PROSTATE CANCER
+
COMBINED

1 IN 3
SENIORS DIES WITH
ALZHEIMER'S OR
ANOTHER DEMENTIA

THE LIFETIME RISK FOR
ALZHEIMER'S AT AGE 45 IS

1 in 5
FOR
WOMEN

1 in 10
FOR MEN

“Following a dementia diagnosis too many individuals and families are left on their own groping in the dark for services that can help them. I don’t want others to go through what I did. I lost two to three years searching for answers. It was time I could have spent differently.”

— Pamela, individual living with early-onset Alzheimer’s disease



OVER **11 MILLION**
AMERICANS PROVIDE
UNPAID CARE
FOR PEOPLE WITH ALZHEIMER'S
OR OTHER DEMENTIAS



THESE CAREGIVERS
PROVIDED MORE THAN
18 BILLION HOURS
VALUED AT NEARLY
\$347 BILLION

IN 2024, ALZHEIMER'S
AND OTHER DEMENTIAS WILL
COST THE NATION
\$360 BILLION

———— \$\$\$\$\$ ————

BY 2050, THESE COSTS
COULD RISE TO NEARLY
\$1 TRILLION



Dementia Care Navigation is “a program that provides tailored, strengths-based support to persons living with dementia and their care partners across the illness continuum and settings to mitigate the impact of dementia through collaborative problem solving and coaching.”

Caregiver
Experience
Stephani A.



Stephani Atkinson

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.

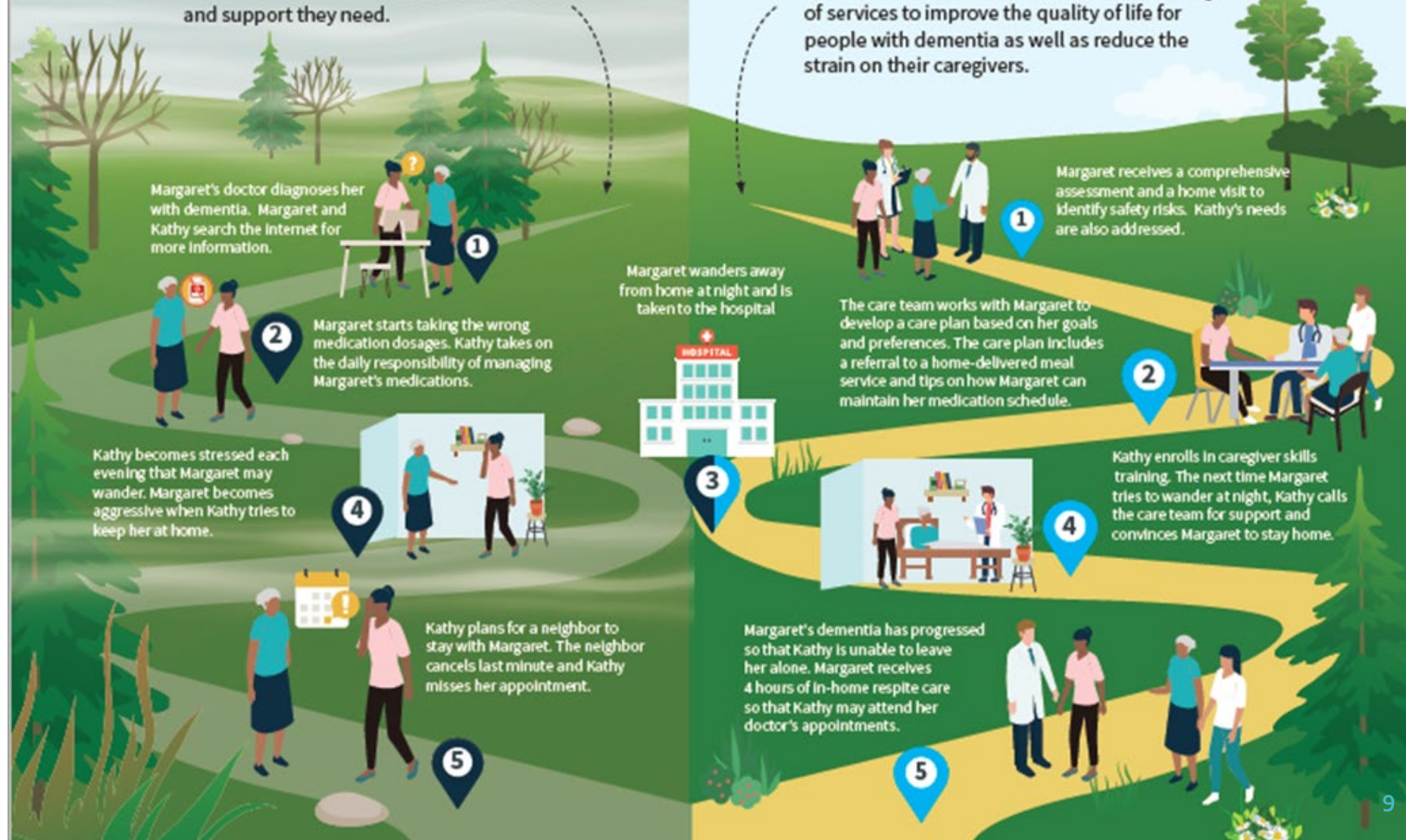
Common Dementia Care Experience

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.

Navigating New Frontiers



Guiding an Improved Dementia Experience (GUIDE) Model Overview Factsheet



MODEL PURPOSE

Dementia takes a toll on not just the people living with the disease but also on their loved ones and caregivers in a way that almost no other illness does. About 6.7 million Americans currently live with Alzheimer's disease or another form of dementia, a number that is projected to grow by nearly 14 million by 2060. To help address the unique needs of this population, the GUIDE Model aims to:



Improve quality of life for people living with dementia by addressing their behavioral health and functional needs, coordinating their care for dementia and co-occurring conditions, and improving transitions between community, hospital, and post-acute settings.



Reduce burden and strain on unpaid caregivers of people living with dementia by providing caregiver skills training, referrals to community-based social services and supports, 24/7 access to a support line, and respite services.



Prevent or delay long-term nursing home care for as long as appropriate by

Who can participate in GUIDE?

*People with Medicare Advantage plans and other commercial insurance plans are not eligible for GUIDE.



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 Parts 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

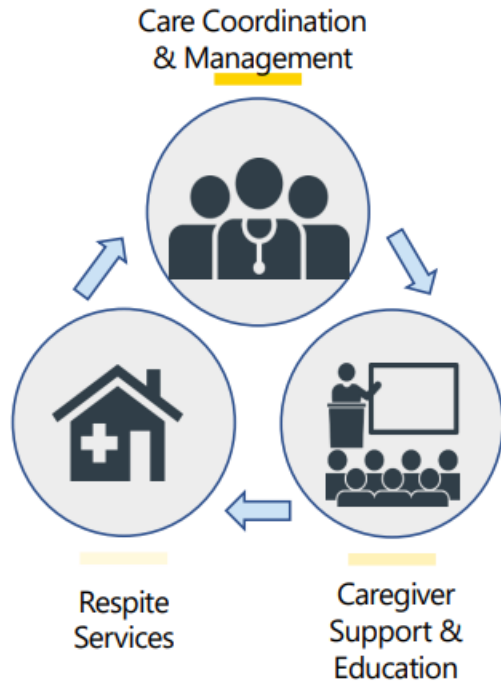


Not Enrolled in PACE

Services overlap significantly with the services that will be provided under the GUIDE model

Model Purpose and Overview

The GUIDE Model will test whether a comprehensive package of care coordination and management, caregiver support and education, and respite services can **improve quality of life for people with dementia and their caregivers** while **delaying avoidable long-term nursing home care** and **enabling more people to remain at home** through end of life.



Care Coordination & Management

Beneficiaries will receive care from an **interdisciplinary team** that will develop and implement a comprehensive, person-centered care plan for **managing the beneficiary's dementia and co-occurring conditions** and provide **ongoing monitoring and support**.

Caregiver Support & Education

GUIDE participants will provide a **caregiver support program**, which must include caregiver skills training, dementia diagnosis education, support groups, and access to a personal care navigator who can help problem solve and connect the caregiver to services and supports.

Respite Services

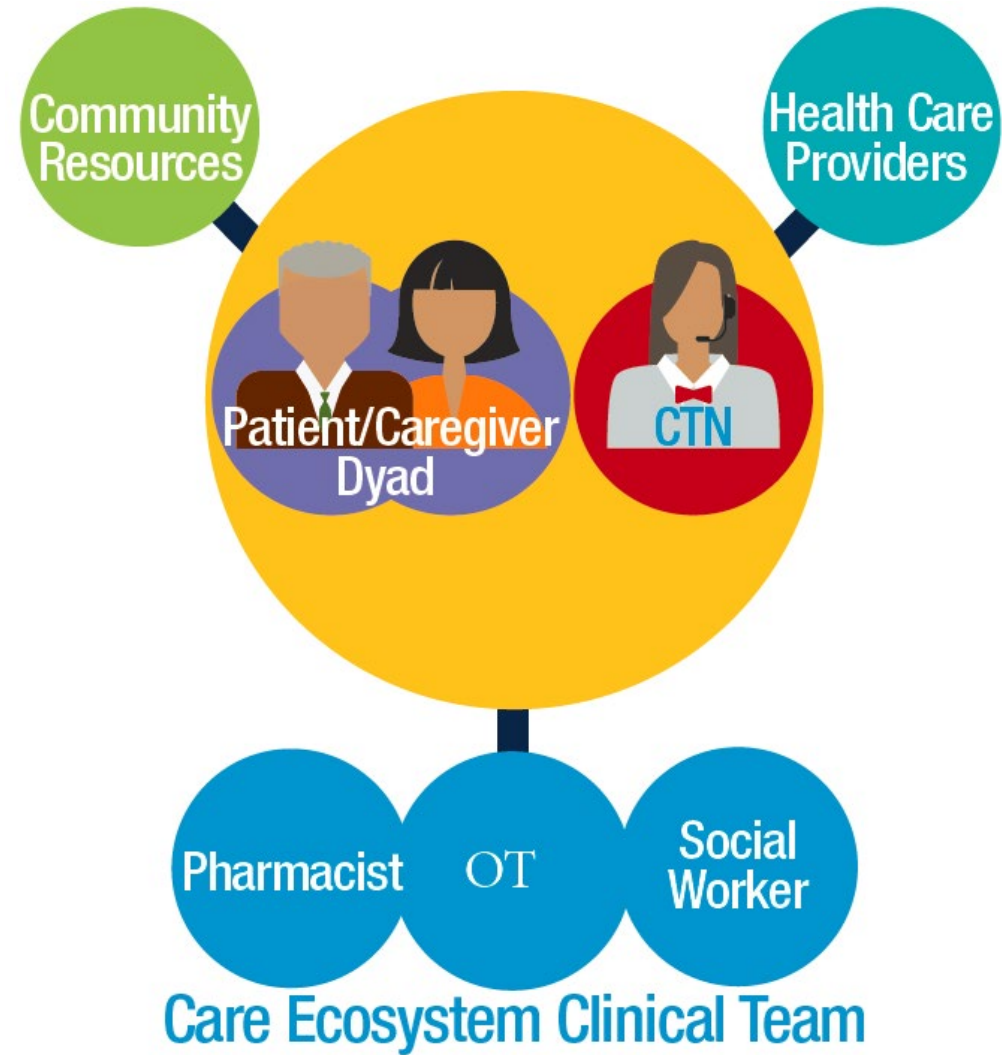
A subset of beneficiaries in the model will be eligible to receive payment for respite services with no cost sharing, up to a cap of **\$2,500 per year**. These services may be provided to beneficiaries in a variety of settings, including **their personal home, an adult day center, and facilities that can provide 24-hour care** to give the caregiver a break from caring for the beneficiary.

Caregiver
Experience
Stephani
Atkinson



Stephani Atkinson

Interdisciplinary Team Support



Care Delivery Requirements

Participants must provide specified services across the domains outlined below. Participants will tailor the exact mix of services based on each beneficiary's individual care plan.

COMPREHENSIVE ASSESSMENT

Beneficiaries and caregivers receive separate assessments to identify their needs and a home visit to assess the beneficiary's safety.

CARE PLAN

Beneficiaries receive care plans that address their goals, preferences, and needs, which helps them feel certain about next steps.

24/7 ACCESS

Beneficiaries and caregivers can call a member of their care team or a third-party representative using a 24/7 helpline.

ONGOING MONITORING & SUPPORT

Care navigators provide long-term help to beneficiaries and caregivers so they can revisit their goals and needs at any time and are not left alone in the process.



REFERRAL & SUPPORT COORDINATION

Beneficiaries' care navigator connects them and their caregivers to community-based services and supports, such as home-delivered meals and transportation.

CAREGIVER SUPPORT

Caregivers take educational classes and beneficiaries receive respite services, which helps relieve the burden of caregiving duties.

MEDICATION MANAGEMENT

Clinician reviews and reconciles medication as needed; care navigators provide tips for beneficiaries to maintain the correct medication schedule.

CARE COORDINATION & TRANSITION

Beneficiaries receive timely referrals to specialists to address other health issues, such as diabetes, and the care navigators coordinate care with the specialist.

Intake & Immediate Needs

Possin, K., et. Al. (2018). *Care Ecosystem Toolkit*.

Medication Reconciliation and Review

Possin, K., et. Al. (2018). *Care Ecosystem Toolkit.*; Holden, T. (2021) *Behavioral and Psychological Symptoms of Dementia: A Practical Guide.*

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Behavior Management

Possin, K., et. Al. (2018). *Care Ecosystem Toolkit*.
Gitlin, L (2012)

Safety Screen and Recommendations

Possin, K., et. Al. (2018). *Care Ecosystem Toolkit*.

Referrals and Education



Possin, K., et. Al. (2018). *Care Ecosystem Toolkit*.



Decision Making (Advance Care Planning)

Possin, K., et. Al. (2018). *Care Ecosystem Toolkit*.

Caregiver Well-being

Possin, K., et. Al. (2018). *Care Ecosystem Toolkit*.

Missouri Alzheimer's & Dementia Program



***Alzheimer's and
Dementia
SHOW ME ECHO***



***Beth Richards, TRS,
Program Director***

***Missouri Alzheimer's
and Dementia Program***

***University of Missouri-
Columbia***

***School of Medicine,
Center for Health Ethics***

***Alzheimer's Disease |
Health & Senior Services
(mo.gov)***

State-wide
Resources to
improve
dementia care
in the
community

MO Telehealth Network Dementia ECHO

<https://showmeecho.org/>

Missouri Caregiver Support Program

<https://cabllc.com/caregiver-training-and-relief-program/>

Family Caregiver Support Program through AAAs

<https://eldercare.acl.gov/>

Alzheimer's Association – Greater Missouri Chapter

<https://www.alz.org/greatermissouri>

Memory Care Home Solutions

<https://memorycarehs.org/>

Memory Care Home Solutions



Delivering Evidence-Based Dementia Services for 20 years

1. **Dementia Navigation Program** (interdisciplinary team of OT, SW, and dementia navigators)
2. **Occupational Therapy**
3. **Individual Caregiver Counseling**
4. **Community and Professional Education**

Services are grant-funded and/or covered by health insurance

- Reduce caregiver stress
- Keep families together!
Reduce/delay nursing home placement and hospital time



ONLINE
Resources to
improve
dementia care
in the
community

Family Caregiver Alliance

<https://www.caregiver.org/>

Best Practice Caregiving

<https://bpc.caregiver.org/#home>

Teepa Snow: Positive Approach to Care

<https://teepasnow.com/>

Alzheimer's Association

<https://www.alz.org/>

BOLD Public Health Center of Excellence on Dementia Caregiving

<https://bolddementiacaregiving.org/>

Questions?

Thank you!





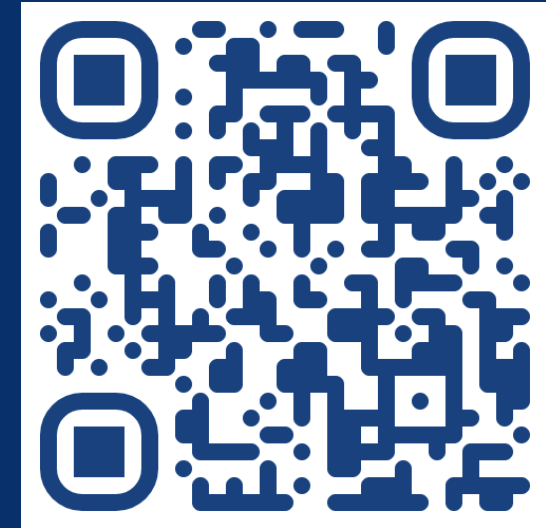
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HOME SOLUTIONS®

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Empowering Families. Transforming Dementia Care.

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