Title

Implementing the Guiding an Improved Dementia Experience (GUIDE) Model within UCSF Care at Home

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Implementing the Guiding an Improved Dementia Experience (GUIDE) Model within UCSF Care at Home

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Background

- About 6.7 million Americans currently live with Alzheimer's disease or another form a dementia.
- People with dementia often experience fragmented care, poor health outcomes and high cost of care
- In July 2024, the Centers for Medicare & Medicaid Services (CMS) launched the Guiding an Improved Dementia Experience (GUIDE) Model for Medicare patients. GUIDE is a voluntary model testing the impact of providing comprehensive services and supports for people with dementia and their caregivers.
- Care at Home, UCSF's home-based primary care Geriatrics practice, began participating in GUIDE in October 2024.

Project Goals

Current State: 0 patients at UCSF participated in the GUIDE program.

Target state:

1. Enroll eligible patient-caregiver dyads within Care at Home into GUIDE.
2. Embed GUIDE care navigation into Care at Home standard work.
3. Create a sustainable GUIDE program within UCSF Care at Home without addition of FTE.
4. Demonstrate the feasibility of implementing GUIDE within a UCSF longitudinal primary care practice.

PROBLEM STATEMENT: Baseline enrollment in the Medicare GUIDE program was below target, with 0 patients enrolled at baseline since Care at Home did not meet all GUIDE requirements, including the ability to offer paid respite for caregivers and structured education for caregivers managing dementia-related behaviors at home. Care at Home already had experience delivering other components of the GUIDE Model, such as comprehensive home-based assessment, 24/7 on-call services, medication reconciliation, and medical management for persons living with dementia.

WE INCREASED ENROLLMENT IN THE MEDICARE GUIDE PROGRAM FROM 0 TO 104 PATIENTS WITH DEMENTIA BY INTEGRATING GUIDE REQUIREMENTS INTO CARE AT HOME'S STANDARD WORK.

Project Plan and Intervention(s)

Implementing the GUIDE model contributed to Patient Experience, Quality & Safety, and Financial Strength pillars of UCSF's True North Pillars. Care at Home implemented standardized workflows to support GUIDE program implementation.

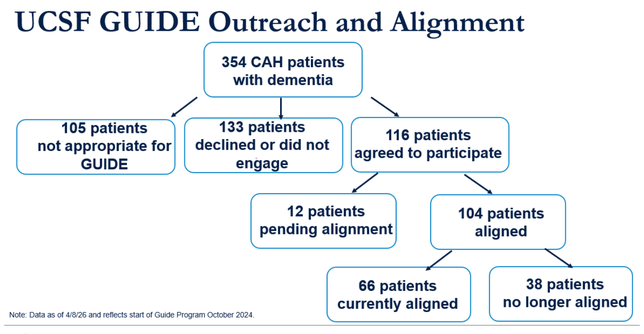
Planned Steps / Interventions:

1. Create a standardized home-based comprehensive assessment template that conformed with GUIDE requirements
2. Adapt regular Interdisciplinary Team Meetings to discuss GUIDE care plans
3. Develop dementia care manager outreach templates focused on supporting caregivers
4. Partner with two local agencies to offer home respite services to caregivers of patients in GUIDE
5. Build program outcome tracking into Care at Home's monthly scorecard
6. Work with UCSF's Revenue Cycle team to bill Medicare for capitated monthly care management payments and respite care

Project Outcomes, Results & Impact

Enrollment in GUIDE increased from 0 to 104 patients, with GUIDE integrated into standard work for Care at Home. 76% of our patients are moderately or highly complex.

UCSF reports patient quality of life, caregiver burden, and high-risk medication use for GUIDE patients to CMS. CMS also measures total per capita cost of care and rate of nursing home entry. In our first year, these metrics were pay for reporting.



Note: Patients are unaligned if they are deceased, enter hospice, or become a long-term nursing home resident.

Tier	Required Contacts	Number	%
Low Complexity Dyad	Quarterly	14	21.2%
Low Complexity Individual	Once/month	2	3.0%
Moderate Complexity Dyad	Once/Month	41	62.1%
Moderate/High Complexity Individual	Twice/month	2	3.0%
High Complexity Dyad	Once/month	7	10.6%
		66	100.0%

Source: CMS alignment report as of 4/8/26

Conclusions, Next Steps, & Lessons Learned

Conclusions: Implementing GUIDE within a Geriatrics primary care practice is feasible and has been integrated into standard work.

Next Steps: After initial enrollment of ~30% of eligible Care at Home patients with dementia into the GUIDE model, we are currently trialing strategies to increase enrollment of eligible but not currently enrolled patient-caregiver dyads into GUIDE, including clinician-led discussions about the benefits of GUIDE. With increased enrollment and integrating GUIDE enrollment into Care at Home practice enrollment, we hope to demonstrate financial viability. This may support further dissemination of primary care-based dementia navigation across UCSF Health. We will monitor GUIDE quality performance in future years.

Lessons Learned: GUIDE is a feasible model to implement in UCSF longitudinal primary care. Patients and their caregivers are benefiting from GUIDE respite services in addition to routine, dementia-focused care navigation.

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