NDCC
National Dementia Care Collaborative

NDCC INSIGHTS

Annual Assessment and Reassessment for GUIDE Beneficiaries and Caregivers

Practical approaches for GUIDE and comprehensive dementia care providers

April 8, 2026

EDC.ORG

The John A. Hartford Foundation

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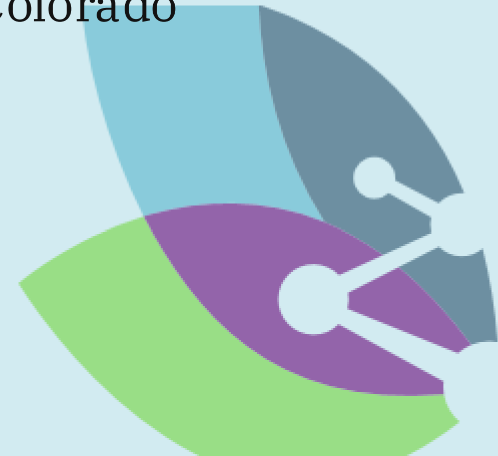

Annual Assessment and Reassessment for GUIDE Beneficiaries and Caregivers

April 8th, 2026

CMS
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Agenda

This webinar addresses the GUIDE Model Annual Assessments and optional Reassessments. The GUIDE Model team will present on the technical requirements for GUIDE Participants. Dr. Hillary Lum will present on the University of Colorado's experience in the GUIDE Model.

1 | Welcome and Introductions

2 | GUIDE Assessments

3 | University of Colorado

4 | Closing and Resources

GUIDE Assessments

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 have 24/7 access to a member of their care team or help line (may be a 3rd party vendor during off-duty hours).

ONGOING MONITORING & SUPPORT
Care navigators provide long-term help to beneficiaries and caregivers so they can revisit their goals and needs at any time.

REFERRAL & SUPPORT COORDINATION
Beneficiaries' care navigator connects them and their caregivers to community-based services and supports.

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

RESPITE SERVICES
Eligible beneficiaries with caregivers may receive GUIDE respite services.

MEDICATION MANAGEMENT
Clinician reviews and reconciles medication as needed.

CAREGIVER EDUCATION & SUPPORT
Caregivers are given education and support via ad hoc calls and caregiver training.

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Why Assessments Matter in GUIDE

- GUIDE is built on the premise that dementia care must be **person-centered, longitudinal, and responsive to change.**
- Assessments serve three core functions:
  - **Determine eligibility and model tier** – ensuring patients receive the right level of support and participants receive the right level of payment
  - **Drive care planning** – informing individualized, person-centered care plans for patients and caregivers
  - ***Track change over time* –** capturing disease progression, caregiver burden, and quality of life to document GUIDE's impact
- Assessment data is submitted to CMS via the Patient Assessment and Alignment Form (PAAF) and used for administrative, evaluation, and quality purposes.

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Overview of GUIDE Assessment Types

Assessment Type	When	Purpose
Initial Comprehensive Assessment	At alignment	Establish baseline; determine eligibility and tier; create care plan
Annual Comprehensive Assessment	Every 12 months (allowable in a 306–425-day window)	Reassess patient and caregiver needs; determine eligibility and tier; update care plan
Reassessment	Optional (as needed between Annual Assessments)	Capture significant changes in dementia severity, caregiver status, and/or residence type

All assessments require patient consent before submitting to CMS.

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GUIDE Assessment Requirements

Initial Comprehensive Assessment includes:

- Patient & caregiver information
- Clinician information
- Dementia attestation
- Dementia staging
- ZBI-22 *(if primary caregiver identified)*
- PROMIS-10
- Home visit assessment *(should occur within two months after the initial comprehensive assessment)*

Annual Assessment includes:

- Patient & caregiver information
- Clinician information
- Dementia attestation
- Dementia staging
- ZBI-22 *(if primary caregiver identified)*
- PROMIS-10

Reassessment includes:

- Patient & caregiver information
- Dementia staging *(if changed)*
- Caregiver information/ZBI-22 *(if changed)*
- Residence type *(if changed)*

Note: ZBI-22 = Zarit Burden Interview; PROMIS 10 = Patient-Reported Outcomes Measurement Information System (PROMIS) Scale v1.2–Global Health

Initial Comprehensive Assessment

Initial Comprehensive Assessment

- **Purpose:**
  - Establishes the **baseline** for each patient and caregiver.
  - Serves as the foundation for the individualized care plan.

Initial Comprehensive Assessment includes:

- Patient & caregiver information
- Clinician information
- Dementia attestation
- Dementia staging
- ZBI-22 *(if primary caregiver identified)*
- PROMIS-10
- Home visit assessment *(within two months of the initial comprehensive assessment)*

- **Outcomes:**
  - Model tier assignment
  - Respite eligibility
  - Person-centered care plan development

- Data is submitted the via PAAF to CMS Health Data Reporting (HDR) system.

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Initial Comprehensive Assessment Process

Requirement	Timeframe	Responsible Party
Administer Required Screenings and Assessments	Prior to PAAF submission	Interdisciplinary Care Team (ICT)
Dementia Staging Tools: • Clinical Dementia Rating (CDR) (0–3 scale) • Functional Assessment Staging Tool (FAST) (1-7 scale) Caregiver Burden (if primary caregiver identified): • Zarit Burden Interview-22 (ZBI-22) (0-88 scale)		
Attest to Dementia Diagnosis	Prior to PAAF submission	GUIDE Practitioner on the Roster
Fill Out and Submit the PAAF	Within two months after the date the dementia staging tool was administered	Clinicians and care navigators gather the required information Data custodians submit via the HDR application
Conduct the Home Visit Assessment	Within two months	Interdisciplinary Care Team (ICT)

Alignment under the GUIDE Model is voluntary.
Participants must obtain patient consent before submitting data.

Note: HDR = Health Data Reporting; PAAF = Patient Assessment and Alignment Form

Annual Comprehensive Assessment

Annual Comprehensive Assessment

- **Purpose:**
  - Updates information that may impact patient tier.
  - Used to evaluate the performance of GUIDE Participants and the model.
  - Informs updates to the patient-centered care plan to reflect the patient's changing circumstances, goals, preferences, and needs.
  - Aligns with other care management payment models to inform annual updates.

Annual Assessment includes:
- Patient & caregiver information
- Clinician information
- Dementia attestation
- Dementia staging
- ZBI-22 *(if primary caregiver identified)*
- PROMIS-10

- **Outcomes:**
  - Model tier assignment
  - Respite eligibility
  - Person-centered care plan development
- Data is submitted via the PAAF to CMS Health Data Reporting (HDR) system.

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Participants must obtain patient consent before submitting data.

Note: HDR = Health Data Reporting; PAAF = Patient Assessment and Alignment Form
Source: GUIDE Participation Agreement

Annual Assessment Fields in PAAF

- The fields shown below of the PAA sheet are required for annual assessments.
- The assessment date must fall within the 306–425-day window from the last Comprehensive Assessment.

PAA-Descriptions | **PAA** | ZBI-22 Descriptions | ZBI-22 | PROMIS-10 Descriptions | PROMIS-10

model_id	entity_id	assessment_date	assessment_type	first_name	last_name	address_line	address_city	address_state	address_postalCode
GUIDE	GUIDE-XXXX	2025-05-22	Annual assessment	John	Doe	123 Elmwood Dr	Springfield	TX	75001

phone	phone_type	residence_type	not_nursing_home	date_of_birth	mbi	staging_tool	staging_score
555-123-8742	Mobile	Private residence	Confirmed - Not nursing home resident	1944-06-06	3FP0TE5NU80	FAST	5

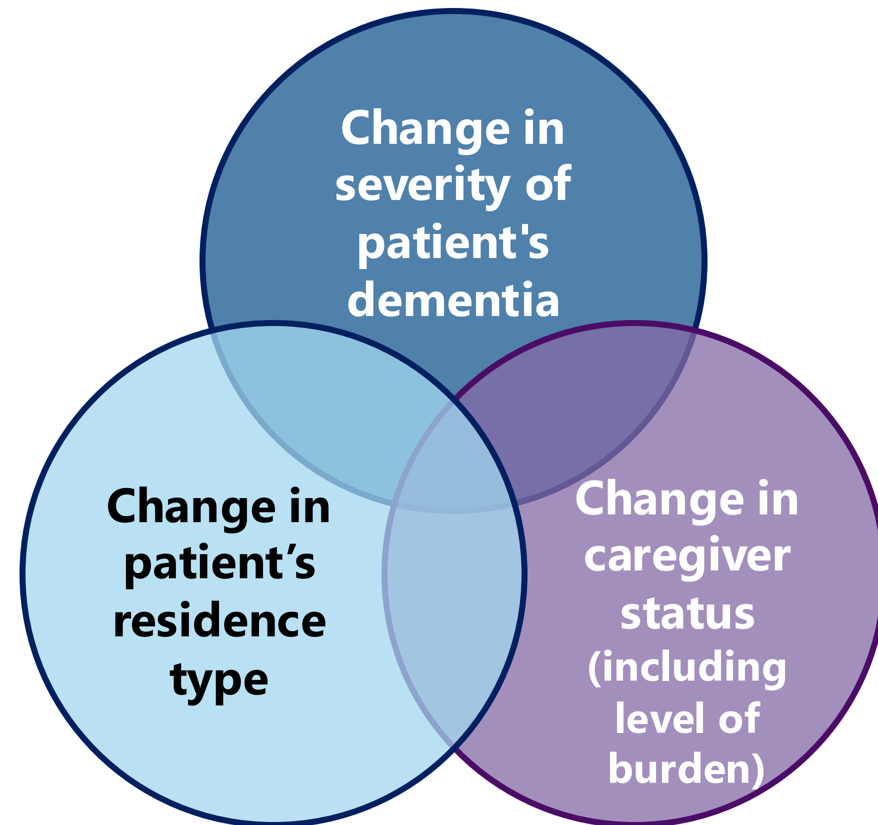
PROMIS_10_score	patient_pcp	has_pcg	clinician_attestation	clinician_first_name	clinician_last_name	npi	tin
Yes	Yes	Yes (one)	Yes, the patient meets the	Jane	Doe	1234567890	123456789

Individual responses to the PROMIS-10 survey are required and must be entered in the PROMIS-10 sheet.

If the patient has a primary caregiver (has_pcg = Yes), you must complete the PCG_ fields, ZBI score, and the ZBI-22 sheet.

Reassessments

Reassessment Reasons



Reassessment includes:

- Patient & caregiver information
- Dementia staging *(if changed)*
- Caregiver information/ZBI-22 *(if changed)*
- Residence type *(if changed)*

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Reassessments Fields in PAAF

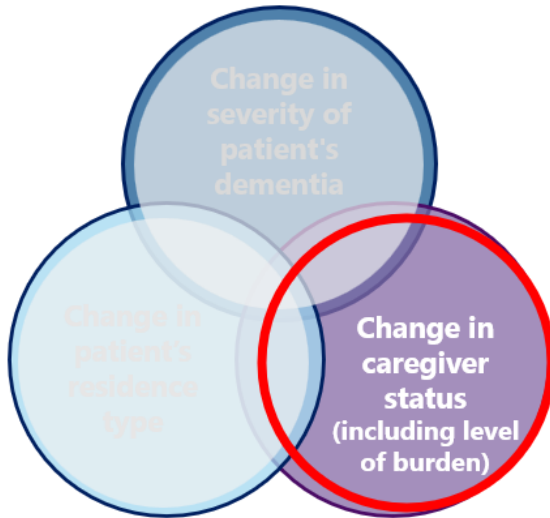
- The fields shown below are required for all reassessments, regardless of the reason.
- Tier changes from reassessments are enacted at most every 180 days.

model_id	entity_id	assessment_date	assessment_type	reassessment_reason
GUIDE	GUIDE-XXXX	2025-05-22	Re-assessment	Re-assessment due to change in severity of patient's dementia
GUIDE	GUIDE-XXXX	2025-05-22	Re-assessment	Re-assessment due to change in caregiver status
GUIDE	GUIDE-XXXX	2025-05-22	Re-assessment	Re-assessment due to change in both severity of patient's dementia and change in caregiver status

first_name	last_name	date_of_birth	mbi	clinician_attestation	clinician_first_name	clinician_last_name	npi	tin
John	Doe	1944-06-06	3FP0TE5NU80	Yes, the patient meets the National Instit	Jane	Doe	1234567890	123456789
John	Doe	1944-06-06	3FP0TE5NU80	Yes, the patient meets the National Instit	Jane	Doe	1234567890	123456789
John	Doe	1944-06-06	3FP0TE5NU80	Yes, the patient meets the National Instit	Jane	Doe	1234567890	123456789

Please review the PAA-Descriptions sheet of the latest PAAF Template for required, optional, and blank fields

Reassessment Reason: Change in Caregiver



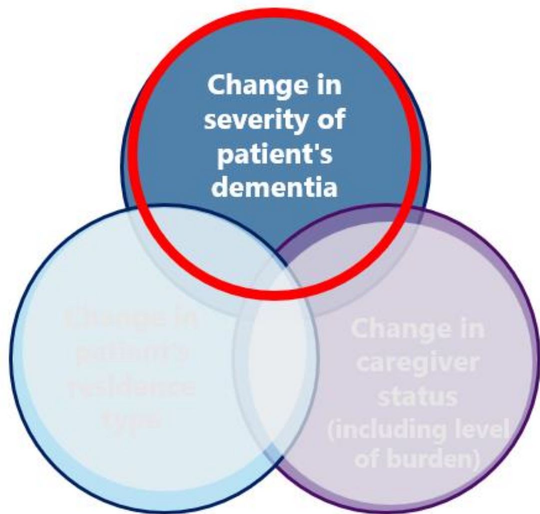
- If a patient acknowledges that their caregiver has changed, due to a change in role, or other reasons, participants are able to submit a reassessment to update the information or retier patients.
  - CMS uses this data to reevaluate the model tier, for evaluation results, for performance measure data and model outcomes overall.

Specific data collected via the PAAF is displayed below:

PAA-Descriptions | **PAA** | ZBI-22 Descriptions | ZBI-22 | PROMIS-10 Descriptions | PROMIS-10

reassessment_reason	caregiver_status	caregiver_status_os	has_pcg	zbi_score
Re-assessment due to change in caregiver status	New primary caregiver		Yes (one)	48
Re-assessment due to change in caregiver status	Same caregiver but change in ZBI score		Yes (one)	72
Re-assessment due to change in caregiver status	Loss of caregiver so patient is without a caregiver		No	
Re-assessment due to change in caregiver status	Other (please specify)			

Reassessment Reason: Change in Dementia Severity



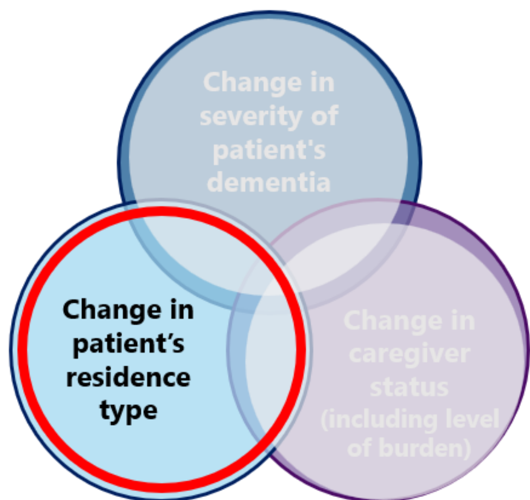
- If a dementia-proficient clinician acknowledges that a patient's cognitive status has changed, participants are able to submit a reassessment.
  - Participants are responsible for reconducting one of the dementia staging tools: CDR or FAST.
  - CMS uses this data to reevaluate the model tier, for evaluation results, and model outcomes overall.

Specific data collected via the PAAF is displayed below:

PAA-Descriptions | **PAA** | ZBI-22 Descriptions | ZBI-22 | PROMIS-10 Descriptions | PROMIS-10

reassessment_reason	staging_tool	staging_score
Re-assessment due to change in severity of patient's dementia	FAST	5
Re-assessment due to change in severity of patient's dementia	CDR	2

Reassessment Reason: Change in Residence Type



- If a patient and/or caregiver acknowledges that a patient's residence type has changed, participants are able to submit a reassessment.
  - Specifically, CMS is interested in understanding more about patients residing in residential care communities and private residences.
    - As part of the 2025 Participation Agreement Amendment, all patients residing in an RCC were moved to a dyad tier to account for assistance provided by RCCs.
  - CMS uses this data to reevaluate the model tier, for evaluation results and model outcomes overall.

Specific data collected via the PAAF is displayed below:

PAA-Descriptions | **PAA** | ZBI-22 Descriptions | ZBI-22 | PROMIS-10 Descriptions | PROMIS-10

reassessment_reason	address_line	address_city	address_state	address_postalCode	residence_type	not_nursing_home
Re-assessment due to change in patient's residence type	1427 Oak Ln	Austin	TX	76013	RCC - Assisted living facility	Confirmed - Not nursing home resident
Re-assessment due to change in patient's residence type	418 Pecan St	Waco	TX	76708	Private residence	Confirmed - Not nursing home resident

Summary

Annual Assessments are a required component of GUIDE because the data helps CMS to better understand the status of patients and caregivers along the 8-year model test.

Reassessments are optional to allow GUIDE Participants to effectively tailor their services to the population they are serving and receive adequate payment.

Annual Assessment and Reassessment for GUIDE Beneficiaries and Caregivers

Perspectives from an Established Program

Hillary Lum, MD, PhD
CU Medicine / University Physicians Inc.
Aurora, Colorado

Our Why

The GUIDE Model is our **opportunity** to:

- Provide comprehensive dementia care
- Support family care partners
- Enhance dementia care across the health system
- Strengthen clinical-community partnerships for dementia

Dementia Care Navigation at UCHealth

Care Ecosystem study

- Started in 2018, funded through Comprehensive Primary Care First:

  175 geriatrics clinic dyads

- Expanded in 2023 through NIA R01 Care Ecosystem study (Dr. Possin)

  153 enrolled dyads from 9 primary care clinics and Neurology

CMS GUIDE Model at CU Medicine

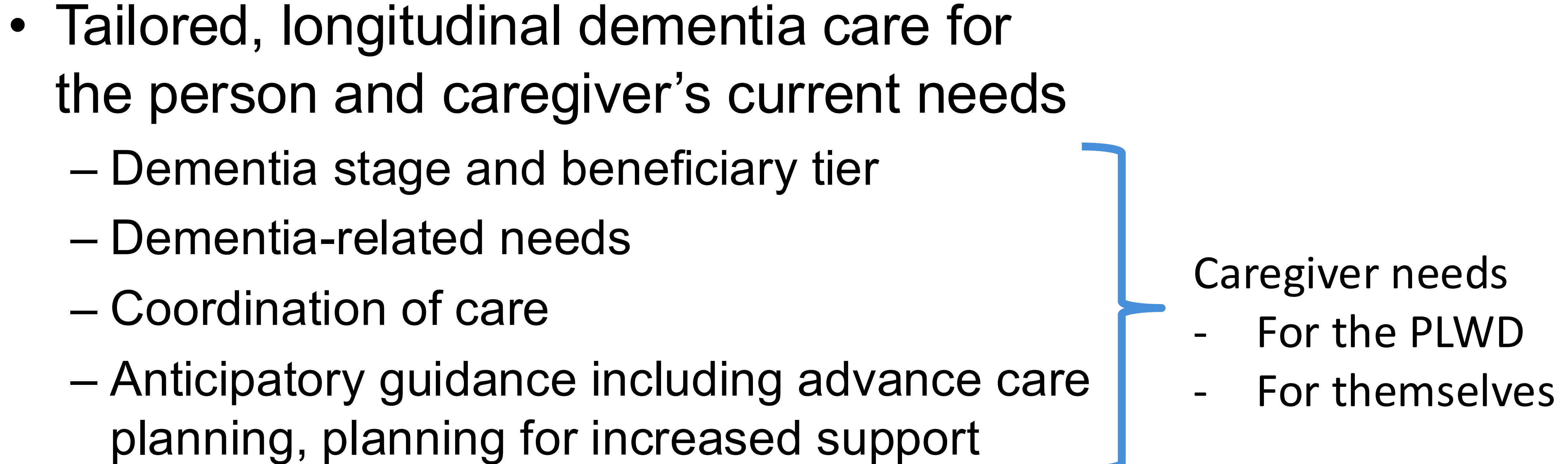
1.8FTE of Care Navigators (3 navigators)

First enrollment Aug 2024

- **168 enrolled as of March 2025**
- Current census of 127

Medicine

Goal of the Annual and Re-Assessment Visits



Scheduling and Coordination for Annuals

Patient/Family Considerations

- Outreach approx. 3 months ahead to schedule 60 min. telehealth visit with GUIDE practitioner, targeting the 4-month period (306-425 days after most recent annual assessment)
- Try to match to GUIDE practitioner who did Alignment visit
- Send portal-based questionnaires
  - Functional assessment
  - Caregiver Rating of Dementia Care Quality
  - Caregiver Satisfaction with Dementia Care
  - PROMIS (via REDCap or by phone)
  - Zarit scale (via REDCap or by phone)

Scheduling and Coordination for Annuals

GUIDE Interdisciplinary Team Considerations

- Within 1 month, team discusses relevant changes from Care Navigator perspective, such as:
  - Advance care planning or prognosis related questions
  - New symptoms
  - Medication questions
  - Care coordination questions
  - Safety needs, such as driving, need for more support

Comprehensive Dementia Assessment & Care Plan

- Start with current GUIDE Care Plan
- Review healthcare utilization (hospitalizations, etc)
- Review dementia-related providers (i.e., primary care, neurology, palliative care, psychiatry)
- Review recent Care Navigator documentation

<u>During the visit:</u>

- “Can you give me an update on how things are going currently? What has changed in the past few months?”
  - Identify any change from mild to moderate to advanced stage
  - Assessment with FAST Scale (or approved dementia severity scale)
  - Review other questionnaires (i.e., functional status)

<u>Document Stage and Tier, including caregiver Zarit score as needed</u>

Comprehensive Dementia Assessment & Care Plan

Goal is to provide dementia-specific input as a dementia specialist

- Dementia-related needs
  - Communication, non-pharmacologic approaches, dementia-related medications, safety, functional status, geriatric review of symptoms, unmet palliative care needs
- Medication Management & Reconciliation
  - Medications aligning with What Matters, prognosis, time to benefit
  - Any additional supplements
  - Deprescribing considerations
- Coordination of care
  - Communication with multiple clinical teams
- Anticipatory guidance
  - Advance care planning (including POLST, do not hospitalize), planning for increased support including home care, palliative care, hospice, etc.

Comprehensive Dementia Assessment & Care Plan

Emphasize and ask for input on GUIDE program

- 24/7 Access
- Ongoing Monitoring & Support - Calls or portal messages
- Referral & Coordination of Services and Supports
- Caregiver Education & Support
- Respite Services

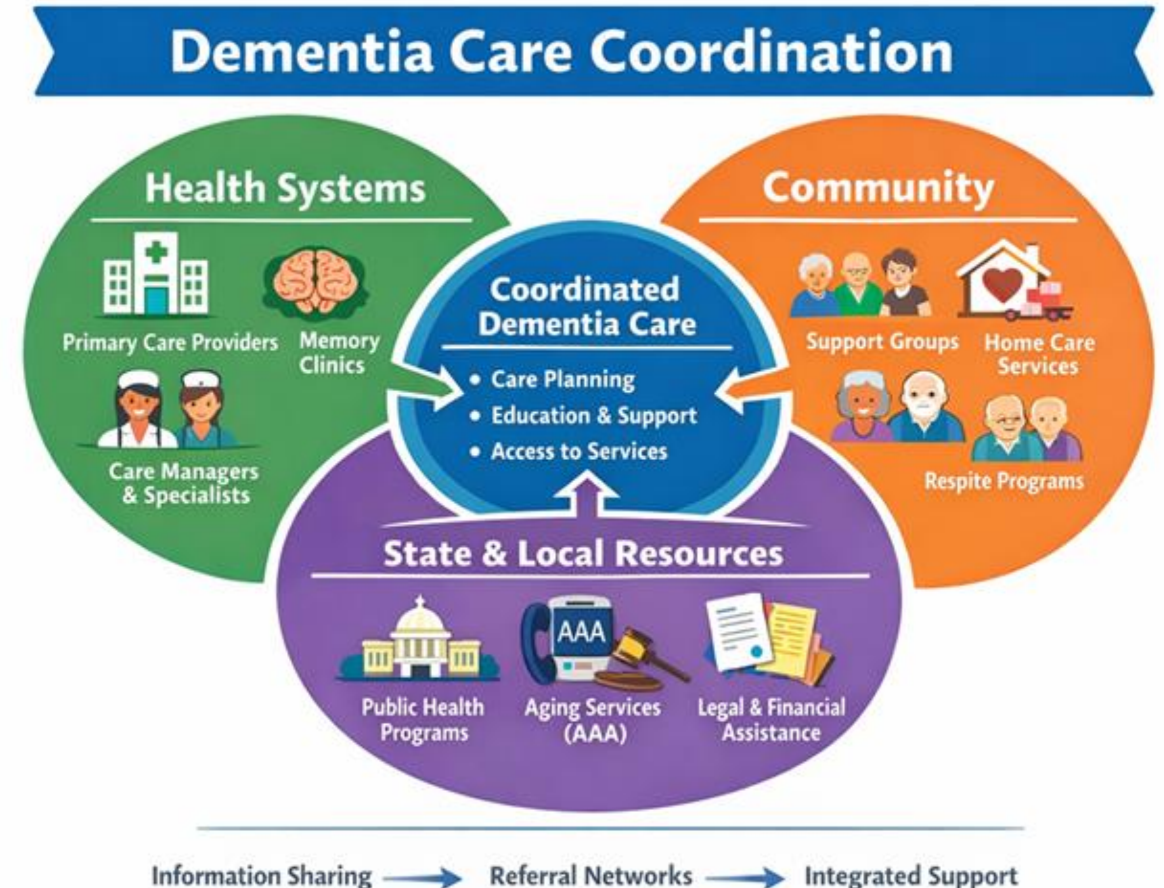


Figure from Section 5. 2026 Dementia Care and Caregiving Research Summit

Follow-up after Assessment

- GUIDE practitioner documentation with specification of Dementia Stage and Tier
- Route to care navigator and relevant clinicians (i.e., neurology, primary care clinicians, others)
- Submit to CMS (we collect/store information using REDCap)
  - PROMIS
  - Zarit scale
- Update Care Plan and share with patient/caregiver, including highlighting follow-up needs

Contacts

- Contact the CU GUIDE Team at 303-724-3141
  - Adreanne Tatro: CU Medicine GUIDE Program Manager
    - Adreanne.tatro@cuanschutz.edu
  - Dr. Hillary Lum: CU Medicine GUIDE Medical Director
    - Hillary.lum@cuanschutz.edu

Save The Date

GUIDE Affinity Group: Wednesday, April 25th

Topic: Strategies for Completing Annual Assessments

NDCC Insights Webinar: Wednesday, May 13th

Topic: Special Populations and Dementia Care Navigation

Please complete the webinar evaluation

Thank you for attending!