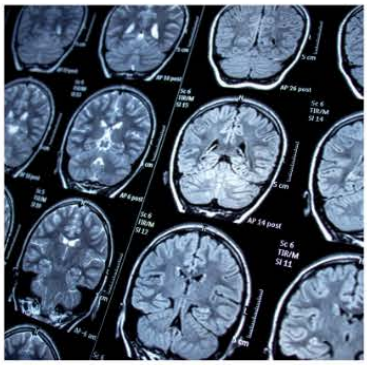
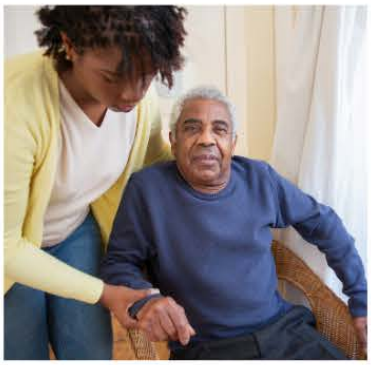
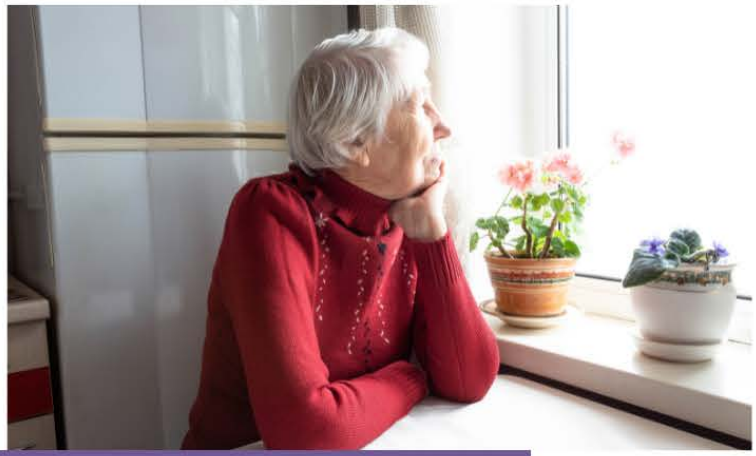
EVALUATION FINAL REPORT

Increasing Access to Quality Dementia Care for California's Aging Population

2026



About this Report

In June 2022, Archstone Foundation awarded a three-year grant to the Alzheimer's Association to support **Increasing Access to Quality Dementia Care for California's Aging Population**, a statewide initiative designed to improve early and accurate dementia diagnosis and enhance the quality of care in primary care settings. The project focused on partnering with primary care providers and their care teams at Federally Qualified Health Centers (FQHCs) and similar community-based health care organizations serving diverse, underserved, and rural populations across California.

The Alzheimer's Association sought to engage 80 primary care practices in this effort. Using a combination of established educational programs, technical assistance, and coaching strategies, the intervention team worked closely with clinic staff to identify barriers to timely diagnosis and high-quality dementia care, and to support the implementation of practical, sustainable solutions for patients and family caregivers.

This evaluation examines whether—and how—the initiative contributed to changes in dementia care delivery in participating primary care practices. It highlights key gaps, challenges, and facilitators in early dementia care and presents evaluation findings, project successes, and considerations to inform future efforts to advance early dementia care in equitable, replicable, and sustainable ways.

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LifeCourse STRATEGIES

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Glossary of Key Report Abbreviations and Terms

Abbreviation	Definition
AFHS	**Age-Friendly Health Systems** is a national initiative led by the Institute for Healthcare Improvement to improve care for older adults by reliably implementing the 4Ms framework: What Matters, Medications, Mentation, and Mobility.
AWV	**Medicare Annual Wellness Visit** is a structured preventive visit for Medicare beneficiaries aged 65 and older that focuses on risk assessment and health maintenance.
DCA	**Dementia Care Aware**–California is a statewide initiative that provides training, tools, and resources to primary care and other health care professionals to improve early identification of dementia and delivery of dementia-capable care.
DCST	**Dementia Capability Scoring Tool** is a 13-item tool measuring dementia capability, developed by the evaluation team. Dementia capability is defined as having the organizational ability to screen, diagnose, treat, and support individuals with dementia and their caregivers with a standardized approach.
EMR	**Electronic Medical Record**
FQHCs	**Federally Qualified Health Centers** are community-based, non-profit, or public health clinics that deliver comprehensive primary care and preventive services to underserved populations.
GUIDE	**Guiding an Improved Dementia Experience** is a CMS-supported care model designed to improve care coordination and support for people living with dementia and their caregivers. It emphasizes comprehensive, person-centered dementia care, including care navigation, caregiver education and support, and integration of clinical and community-based services.
HSD	**Health Systems Director** are Alzheimer's Association staff who provided support and guidance to organizations that participated in the Increasing Access initiative.
Increasing Access	**Increasing Access to Quality Dementia Care for California's Aging** (initiative title).
PACE	**Program of All-Inclusive Care for the Elderly** is a comprehensive care model that integrates medical, behavioral, and social services for frail older adults who are eligible for nursing home–level care but wish to remain in the community.
Participating Systems	**Health systems that meet the inclusion criteria** as FQHCs or community health centers serving rural populations or racial and ethnic minority groups.
Project ECHO	**Project Extension for Community Healthcare Outcomes** is a tele-mentoring model that connects specialty teams with community-based providers through case-based learning and didactic education. In dementia care, ECHO builds provider capacity to deliver evidence-based assessment, management, and support for individuals and their caregivers.
QI	**Quality Improvement**
UCLA ADC	**UCLA Alzheimer's and Dementia Care Program** utilizes a co-management model in which a nurse practitioner with expertise in dementia care collaborates with referring providers and community-based organizations to provide comprehensive, coordinated, patient-centered care for patients with Alzheimer's disease and other dementias.

Executive Summary

The *Increasing Access to Quality Dementia Care for California's Aging Population* project was a three-year initiative (July 2022–June 2025) led by the Alzheimer's Association with funding support from Archstone Foundation. The project sought to improve and strengthen early dementia screening, diagnosis, and care practices in primary care settings, with a focus on low-income, diverse, underserved, and rural communities across California.

To achieve this goal, the Alzheimer's Association deployed four Health Systems Directors (HSDs) to recruit and build longitudinal relationships with primary care practices, exceeding its original target of 80 participating health care systems by engaging 81. These systems were primarily small- to medium-sized Federally Qualified Health Centers (FQHCs) or community clinics, as well as primary care practices serving rural or predominantly minority populations. HSDs recommended processes and resources—framed as "proposals"—aligned with each system's interests and capacity and served as coaches to support implementation.

The Alzheimer's Association partnered with LifeCourse Strategies to evaluate the project. The evaluation drew on quantitative and qualitative data from participating systems, project activity records, and interviews with participants and project staff to assess whether—and how—the intervention contributed to changes in dementia care practices, and to identify key successes and considerations to inform future efforts. This report summarizes the evaluation's findings.

34 systems
participated in Project ECHO, some for multiple years

11 systems
achieved AFHS recognition, including seven at Level 2

5 systems
accepted in the CMS GUIDE model or the UCLA ADC model

10 systems
implemented formal quality improvement projects

15 systems
conducting ongoing monitoring of dementia-related quality indicators

4 systems
implemented durable workflow or policy changes

*Some systems engaged in multiple activities

Key Findings

Many participants demonstrated measurable improvements in dementia care capability. Project and public records indicate that 53% (43/81) of participating systems engaged in robust, durable, or ongoing activities to improve dementia care.

These results aligned with HSD assessments of participant dementia care capability, which indicated that most participating systems improved in at least one dementia care domain. These improvements were observed in systems with varying characteristics, baseline capabilities and readiness levels.

Working with Reality

Participating systems operated under familiar pressures—chronic understaffing, workforce turnover, competing demands, and limited resources. Yet many achieved meaningful and durable improvements in dementia care. Several factors enabled this progress: leadership support that signaled organizational commitment; screening tools aligned with existing workflows; practical, repeatable training; flexible engagement pathways; and an approach that explicitly valued and recognized incremental improvements. Most importantly, trusted relationships between clinic teams and their HSDs created the conditions for change. Persistent, patient coaching helped sustain engagement through inevitable disruptions, fostering environments where improvement could take root over time.

Together, these findings frame the project's core successes and inform future considerations critical to advancing early dementia care in equitable, replicable, and sustainable ways.

Successes

DEMONSTRATED IMPROVEMENTS IN DEMENTIA CARE CAPABILITY

- Among systems with multiple assessments of capability, 90% improved in at least one dementia care domain, and more than one-third showed improvement in six or more domains—indicating meaningful, multidimensional practice change.

TRUSTED RELATIONSHIPS AND SUSTAINED COACHING DRIVE CHANGE

- HSDs' steady outreach, relationship-building, and tailored support were valued highly by participants.
- Persistent, patient coaching and aligning support with readiness and capacity proved essential for sustaining engagement and advancing practice change.

TARGETED TECHNICAL ASSISTANCE PRODUCED MEASURABLE GAINS

- Systems that demonstrated improvement typically had accepted one or more proposals aligned with the domains in which gains occurred, suggesting a link between the targeted support provided by HSDs and measured improvements.

STRONG COMMITMENT TO SUSTAINABILITY AND EXPANSION

- Many participating systems envisioned early dementia care becoming standard practice and had plans to expand efforts across clinical sites.
- Participants identified future priorities, including sustainable financing, telehealth integration, adoption of alternative screening tools, stronger data collection, medical resident engagement, and enhanced behavioral health and case management support.

Future Considerations

Future initiatives aimed at improving early dementia care could combine successful features of Increasing Access with new approaches that might increase efficacy.

TAKE ALL COMERS: LEVERAGE EVERY OPPORTUNITY

- Engage any system interested in improving early dementia care; recognize and celebrate incremental progress.
- Leverage established programs (e.g., Project ECHO, AFHS, GUIDE) and provide modest financial incentives (e.g., small grants) to encourage participation and accountability.

PROMOTE STANDARDIZATION WITH STRUCTURE AND FLEXIBILITY

- Balance structure and adaptability through a hybrid approach that focuses systems on core practice changes while allowing flexible improvement pathways.
- Strengthen ability to monitor and promote progress by introducing standardized baseline and follow-up assessments of capability, clear documentation standards, and scheduled HSD–participant touchpoints.

ESTABLISH SHARED LEARNING

- Build a learning community to foster networking, normalize shared challenges, and disseminate promising practices.
- Use regular communications to highlight participant successes, reinforce collective momentum, and promote adoption of effective strategies.

EXPAND LANGUAGE ACCESS AND AN EQUITY LENS

- Ensure that tools, workflows, and training are culturally and linguistically responsive, adaptable, and grounded in respect for patients' lived experiences.
- Prioritize language access and equity-focused design to support diverse patient populations and reduce disparities in early dementia care.

ENHANCE STRUCTURES AND PROCESSES SUPPORTING EARLY DEMENTIA CARE

- Strengthen partnerships with statewide and regional networks to help FQHCs and similar systems access practical guidance, shared models, and peer learning focused on early dementia care.
- Improve internal workflows for caregiver support and referrals to ensure consistent connection to community-based dementia resources such as Alzheimer's Association chapters and California's Caregiver Resource Centers.

ESTABLISH EARLY DEMENTIA CARE AS A STANDARD OF PRACTICE

- Elevate and standardize dementia care competencies across health care roles through training, education, and certification.
- Promote certification and structured quality improvement efforts to strengthen consistency, confidence, and sustainability in screening and assessment.

PROJECT BACKGROUND

The evaluation examines characteristics of participating systems and sites and assesses practice change across five core areas, including how Health System Directors engaged and supported those systems; changes in organizational structures and care processes; shifts in clinical practice; and the resulting successes and future considerations that emerged over the course of the initiative.

Project Background

The convergence of several demographic, healthcare, and social trends—including increased longevity, the rising prevalence of Alzheimer's disease and related dementias, and the growing burden on family caregivers— is an urgent public health and social service issue. Addressing this crisis requires expanding access to early dementia screening, diagnosis, and care, particularly in communities where such services are limited or unavailable.

In response to these trends and the concurrent emergence of promising dementia interventions, the Alzheimer's Association (the Association) launched a three-year project (July 2022 through June 2025) titled *Increasing Access to Quality Dementia Care for California's Aging Population* (Increasing Access), with support from Archstone Foundation. The initiative was centered on advancing early and accurate dementia diagnosis and enhancing the quality of care for Californians living with dementia.

Project objectives included expanding the use of dementia screening and diagnostic tools; identifying barriers to timely diagnosis and care; and addressing challenges related to screening, diagnosis, referral, and care planning within primary care settings. To support these aims, the Association set a recruitment goal of 80 healthcare provider organizations ("participating systems") across California. Recruitment efforts prioritized small- to medium-sized Federally Qualified Health Centers (FQHCs) and similar primary care practices serving low-income, diverse, underserved, and rural populations.

The Association developed a flexible rollout and implementation process to meet participants' needs. Four Health Systems Directors (HSDs)—Association staff—were each assigned to specific regions of California and tasked with engaging potential participants. For participating systems, HSDs recommended processes and programs, framed as "proposals," that were aligned with each organization's interests, capabilities, and readiness. Proposals were categorized as either Primary or Supportive.

Primary proposals were designed to drive policy and practice changes across the dementia care continuum to improve access and quality of care. **Supportive proposals** centered on implementing specific tools, educational programs, or processes related to screening, diagnosis, or care management**.** In general, Primary proposals addressed multiple facets of dementia care and required substantial, ongoing effort to implement, whereas Supportive proposals typically targeted a single activity or goal and required less effort. HSDs' interactions with a given system could be limited to delivering a single Supportive proposal or could involve a longer-term partnership where multiple Primary proposals were implemented over several years.

Primary Proposals

Primary proposals include structured, comprehensive initiatives that were developed and administered by external organizations, as well as HSD efforts to support system-specific improvement and innovation projects.

External

1. Extension for Community Healthcare Outcomes (Project ECHO) through the University of California, Los Angeles (UCLA) and the University of California, San Francisco (UCSF)
2. Guiding an Improved Dementia Experience (GUIDE) Implementation
3. Institute for Healthcare Improvement Age-Friendly Health Systems
4. UCLA Alzheimer's and Dementia Care (ADC) Model
5. UCSF Care Ecosystem

System-specific

6. Practice Change Implementation support
7. Quality Improvement (QI) Implementation support
8. Systems Change Implementation support
9. Treatment Implementation support

Supportive Proposals

Supportive proposals provide guidance and resources to aid in the implementation of specific tools, educational programs, or care processes related to screening, diagnosis, and care management, as well as activities aimed at raising awareness about dementia care and recruiting systems to participate in the initiative.

Roundtable initiatives

1. Care Management Training
2. Care Planning Toolkit
3. Cognitive Assessment Toolkit
4. Cognitive Impairment Care Planning
5. Care Navigation Training

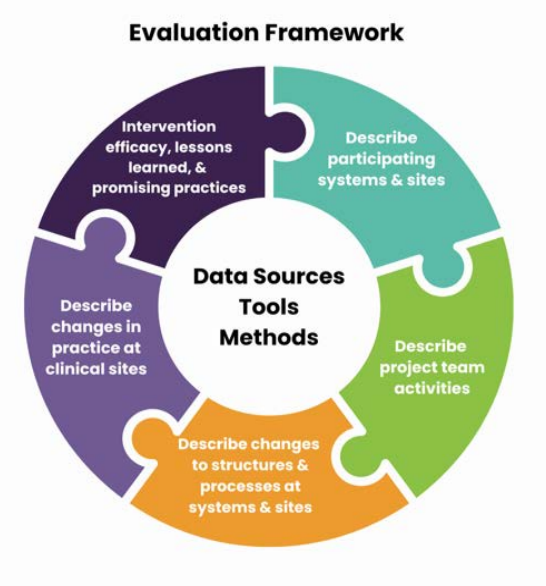
Other tools, resources, and services

6. Annual Wellness Visit Algorithm
7. Coaching and Consultation
8. Community Engagement
9. Conference Partner
10. Dementia Care Aware (DCA) Training
11. Educational Programming (various)
12. essentiALZ Training and Certification
13. Electronic Medical Record (EMR) Enhancements
14. Grant Application Support
15. Health Systems Partner Recruitment
16. Provider-Driven/Auto Referrals

A 27-member Advisory Council, which met quarterly, supported the project by offering guidance, feedback, and referrals to the Association team. Members were selected for their expertise in dementia and primary care, as well as their professional networks. The group included primary care and geriatric physicians, community health network leaders, health plan administrators, academic experts from the University of California, San Francisco, and the University of California, Los Angeles, specializing in geriatrics, neurology, and dementia care, and leadership from both Archstone Foundation and the Association.

Evaluation Framework

LifeCourse Strategies evaluated the Increasing Access project. The evaluation focused on assessing changes in structures, processes, and practices in early dementia care at participating systems and identifying best practices and lessons learned.



To achieve these goals the evaluation developed a theory-of-change-based framework with five focus areas.

1. Describe participating systems and sites
2. Document project team (HSDs and other Alzheimer's Association staff) activities
3. Identify changes in structures and processes within systems and sites
4. Assess changes in practice at clinical sites
5. Summarize intervention efficacy, lessons learned, and promising practices

Methods

The evaluation employed a multi-layered, mixed-methods approach to data collection and analysis. Before finalizing the methodology, the evaluation team clarified the scope of each focus area and identified the information required to address its key evaluation question(s). This process produced an outline for each area, detailing the descriptive elements to be addressed, guiding questions, and the tools and methods selected to answer them. These outlines are provided in Appendix B (Evaluation Focus Areas, Questions, Tools, and Methods). Exhibit 1 below summarizes the evaluation tools and methods employed. Where feasible, existing data sources were used to minimize the data collection burden on HSDs and participants.

Exhibit 1. Tools and Methods for Evaluation Data Collection

Tool/Method	Description
Project Registry	List of participating systems and affiliated clinical sites including organizational characteristics and information on the timing and duration of engagement with the project. Data includes information gathered by HSDs and information available through public records, such as FQHC status.
Dementia Capability Scoring Tool (DCST)	13-item tool measuring dementia capability, completed by HSDs. Dementia capability is defined as having the organizational ability to screen, diagnose, treat, and support individuals with dementia and their caregivers with a standardized approach.
Participant Surveys	Online survey that invited participants to self-assess dementia capability and provide feedback on the project. Questions addressed the dementia capability areas used in the DCST. Survey administered fall 2024 and fall 2025.
Proposal Activity Log	Record of Primary and Supportive proposals shared with participants, extracted from the Association customer relationship management (CRM) database and HSD records.
Proposal Reference Table	List of proposals HSDs shared with participants and the dementia capability aspects they address. Linkages between individual proposals and dementia capability areas were specified by HSDs, in consultation with the evaluation team.
Data Shared by Participants	Data collected by participants to track dementia care performance and improvement, shared with the evaluation team by HSDs or participants.
Participant Interviews	Interviews conducted in spring 2024 with primary contacts at 18 participating systems to explore their motivation and engagement in dementia care, as well as their impressions of the project. Follow-up interviews were completed with individuals representing 9 participating systems in fall 2025.
HSD Exit Interviews	End-of-project interviews with HSDs exploring experiences and lessons learned.
Case Study Interviews	Interviews with project contacts from three participating systems to create detailed case studies.

Integrating Qualitative and Quantitative Data

This report presents a comprehensive assessment of project implementation and changes in dementia care practices at participating systems, drawing on quantitative and qualitative findings. Quantitative findings include participating system and site characteristics; project team activities; participant self-assessments of dementia practices from online survey responses; and Dementia Capability Scoring Tool (DCST) results, including comparisons of initial and follow-up scores across domains of dementia care capability (see the Evaluation Findings section).

Qualitative findings, derived from constant comparative thematic analysis and consensus-based coding of final themes, were used to explain and expand upon the quantitative results by capturing aspects of participant experience and project implementation not reflected in quantitative measures alone. These data included initial and follow-up interviews with a subset of project participants, four HSD exit interviews, and interviews with three participants whose experiences are summarized in case study profiles. All interviews were conducted using a semi-structured approach, and interviewees received an interview guide in advance.

Questions posed to interviewees differed only slightly between the initial and follow-up interviews. This consistency created opportunities to compare and contrast findings over time. HSD exit interview questions focused on their work, including what they were most proud of, their most significant achievements, the most frustrating aspects, considerations related to project sustainability, and advice for future HSDs who may replicate this work and for organizations interested in scaling it. Findings from these interviews, together with those from the initial and follow-up participant interviews, are reported accordingly.

Evaluation Limitations

Several factors may have limited the accuracy or completeness of the evaluation findings. First, the evaluation team was not engaged until October 2023, and a formal evaluation plan was not approved and implemented until April 2024—approximately 18 months after project initiation. This schedule prevented the collection of data describing some participants' dementia care capabilities and activities near the start of their participation.

Second, the project's intentionally flexible design introduced certain methodological constraints. Participating systems addressed different domains of dementia care based on their interests, needs, and readiness. Systems could also join the project at any time, and some participated intermittently. This variability in engagement duration and focus limited the evaluation team's ability to draw conclusions about system characteristics associated with greater or lesser progress, or the relative effectiveness of specific proposals.

Third, one of the core evaluation instruments, the Dementia Capability Scoring Tool (DCST), was used by HSDs and participating systems to assess dementia care capability. Because the tool relied on both HSDs' scoring and systems' self-assessment, the evaluation team could not

fully verify the reliability or objectivity of all ratings. Complementary data—such as participation in Project ECHO, AFHS, other external programs, and proposal focus areas—provided contextual support and helped triangulate observed shifts in practice.

Fourth, time constraints and competing demands on clinic providers and staff limited opportunities for data collection. The evaluation did not include site visits or require routine data submissions, so the evaluation team relied on DCST scores and data shared by a subset of participants to assess practice change outcomes, such as an increase in the percentage of eligible patients screened. Further, connecting with participants was often difficult, particularly after the intervention concluded in July 2025. Response rates for the second participant survey were extremely low, and only 9 of the original 18 interviewees participated in follow-up interviews despite extensive outreach.

Finally, staff turnover at participating systems—anticipated and unanticipated—resulted in some of the follow-up interviews and surveys being completed by individuals less familiar with the project, which may have affected response consistency or depth.

To mitigate these limitations, the evaluation team drew on multiple data sources and employed both quantitative and qualitative methods. Together, these strategies were sufficient to identify instances of practice change among systems with more complete data and to surface broader themes and patterns relevant to overall initiative performance.

Spotlight: Beat the Clock

Time constraints were a major barrier to implementing dementia screening in primary care. In response, many participating systems adopted—or explored—self-administered screening approaches that allow patients or family members to complete assessments in waiting rooms, exam rooms, or at home, reducing provider burden while maintaining attention to early cognitive concerns.

Common tools included the AD8 Dementia Screening Interview and the Mini-Cog. The AD8 is an eight-item, informant-based questionnaire assessing changes in memory, judgment, orientation, and daily function; its brevity, availability in multiple languages, and suitability for diverse populations made it particularly appealing. The Mini-Cog, which combines three-word recall and clock drawing, was also widely used, often administered by medical assistants or nurses, with some systems piloting patient- or family-assisted completion to streamline workflows.

Interest was also growing in the Self-Administered Gerocognitive Exam (SAGE), a 10–15-minute paper-based tool completed at home or in clinic. Although not diagnostic and currently available only in English, SAGE was viewed as a promising option for extending screening beyond the exam room.

Together, these approaches reflect efforts to adapt dementia screening to real-world time constraints by shifting portions of assessment outside the clinician encounter, making early identification more feasible and sustainable in routine primary care.

EVALUATION FINDINGS

Significant structural and operational challenges shaped the delivery of early dementia care across participating systems, even as measurable improvements in dementia care capability emerged. Leadership engagement, data use, and flexible, tailored technical assistance played central roles in enabling focused, incremental practice change—particularly among more deeply engaged participants.

Evaluation Findings

Key quantitative and qualitative evaluation findings addressing the five focus areas are presented in this section.

System and Site Characteristics

Four HSDs were each assigned a geographic region in California and tasked with engaging health systems that met the project's eligibility criteria. The Association provided each HSD with a list of potential participants within their designated area. Additional systems were recommended by the project's Advisory Council and Partner organizations (see the Project Team Activities section for more on Partners). HSDs also identified eligible organizations through their ongoing work in and deep knowledge of their assigned communities.

Systems were considered to be participating if they engaged in a dialogue with an HSD about the importance of early dementia care at their site and the types of support the Association could provide and subsequently received at least one proposal. A total of 81 systems and 28 affiliated clinical sites met this threshold, exceeding the original recruitment goal of 80 systems.

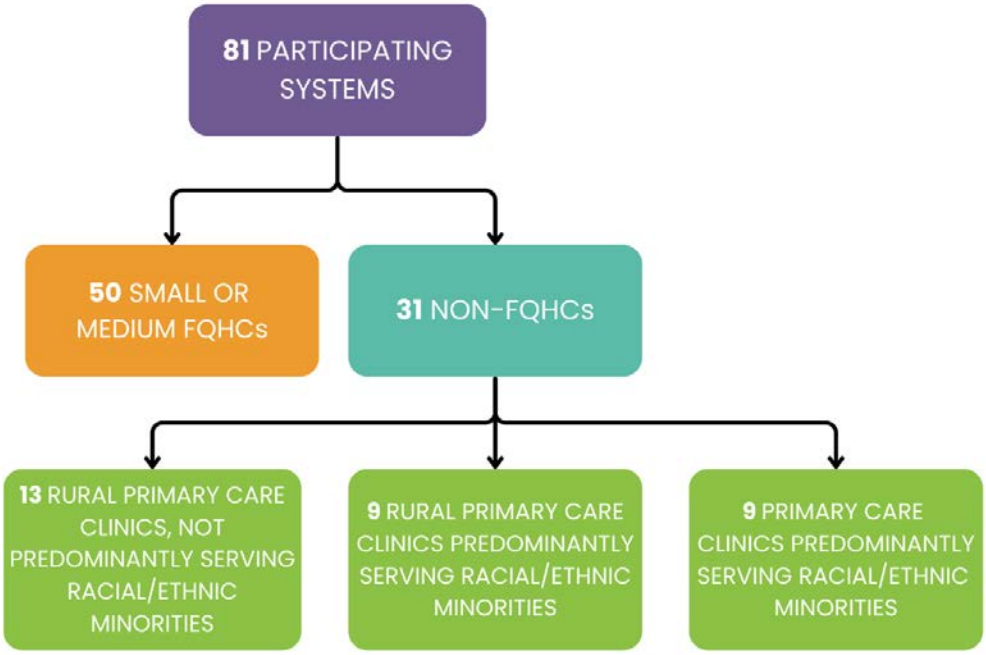
Most participating systems, 50 (61.7%), were small- to medium-sized FQHCs. The remaining 31 systems met initiative inclusion criteria based on their rural designation or because their primary care practices predominantly served racial or ethnic minority populations. Of the non-FQHC systems, 13 operated in rural areas, nine mainly served racial and ethnic minority communities, and nine met both criteria (see Exhibit 2).

Participants represented a wide range of organizational structures and health care models, from standalone clinics to large health systems. Four participating systems were PACE (Program of All-Inclusive Care for the Elderly) programs, six were affiliated with the Indian Health Service or similar tribal health organizations, and fourteen were part of larger health systems such as Adventist or Providence. Some participating systems managed dozens of sites across several regions and served multiple adult populations with differing care needs. With few exceptions, only a subset of clinical sites within a system participated in the project.

The number of patients aged 65 or older cared for by participants varied dramatically, with large public health and health system entities caring for tens of thousands of such individuals, while smaller FQHCs and clinics often served only a few hundred. Patient demographics—including age, ethnicity, and socioeconomic status—also varied widely.

Organizations' previous experience with dementia care, their readiness to adopt new practices, and their capacity to implement quality improvement initiatives and invest in a dementia-informed workforce also varied. While many started the project with strong leadership support and a designated champion, others had minimal or only emerging support at the outset.

Exhibit 2. Participating System Characteristics



Recruitment and enrollment occurred throughout all three project years. Thirty systems joined during project year one, 41 in year two, and 10 in year three. Six systems were actively engaged with HSDs across all three project years, 51 systems participated over two project years, and the remaining 24 systems were engaged for 12 or fewer months.

Participants' Initial Dementia Care Capabilities

An assessment of participating systems' dementia care capabilities at the time of project engagement was conducted using the DCST, developed by the evaluation team and pilot-tested by the project team. The DCST was completed by the HSDs, based on their knowledge of participant policies and practices. Capability was assessed across 13 domains, each scored on a 0 to 3 scale, with higher scores indicating greater capability. The full tool is included in Appendix C. An online self-assessment survey, mirroring the DCST domains, was also administered to participating systems in fall 2024 and fall 2025 to assess alignment between system self-ratings and HSD ratings.

DCST Domain Areas

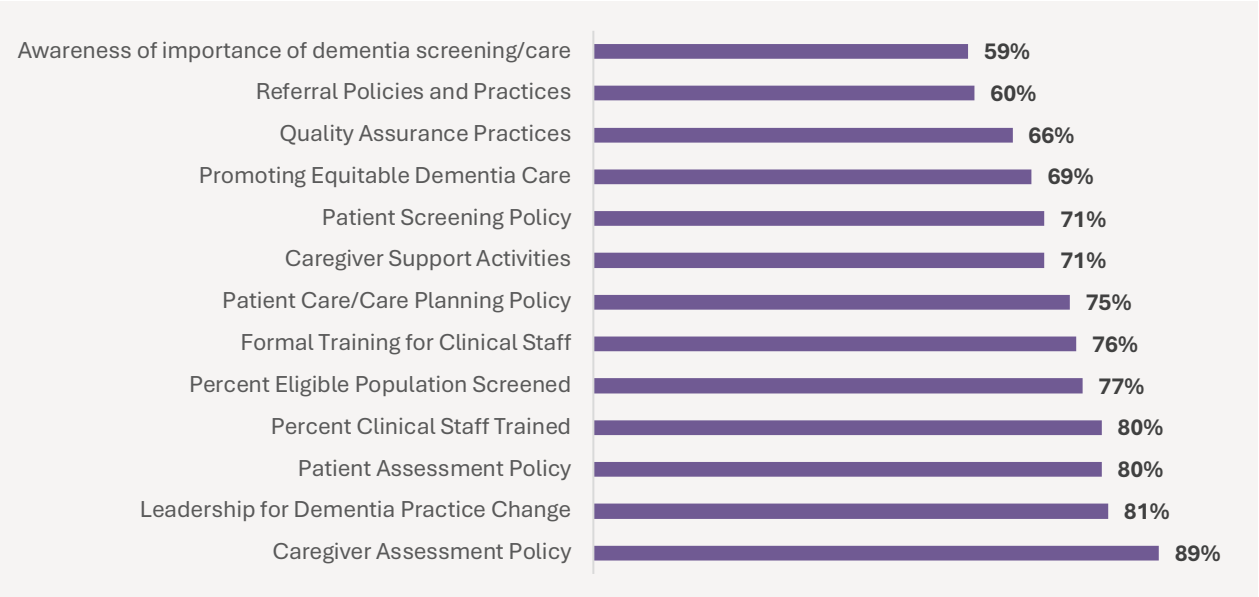
1. Awareness (of the importance of dementia screening/care for the site's population
2. Formal training for Clinical Staff
3. Proportion Clinical Staff Trained
4. Patient Screening Policy
5. Proportion of Eligible Patients Screened
6. Patient Assessment Policy
7. Patient Care/Care Planning Policy
8. Caregiver Assessment Policy
9. Caregiver Support Activities
10. Referrals
11. Quality Assurance
12. Promoting Equitable Dementia Care
13. Leadership for Dementia Practice Change

The DCST was designed to detect incremental improvements in structures and processes that are prerequisites for improved dementia care outcomes. For example, system leaders typically must recognize the importance of conducting dementia screenings before investing resources to track and improve screening rates. A participating system would still be making progress toward that goal if awareness and leadership support improved, even if the proportion of eligible patients screened had not yet increased.

Because the focus of work with HSDs was driven by participant preferences, the DCST included a comprehensive list of possible capability areas. A participating system could elect to address all, a subset, or just one DCST domain in its work with an HSD. There was no expectation that HSDs would be aware of participant capabilities across all DCST domains, and HSDs could elect to skip providing a numerical score and instead mark an area as "Unknown." When analyzing scores, all "Unknown" responses were excluded, and only numerical scores of 0-3 were analyzed.

HSDs provided initial assessments of dementia care capability for 79 participants. As shown in Exhibit 3, HSDs assessed low capability (a score of "0" or "1") for 59-89% of participants across the 13 capability areas. The high proportion of systems with low capability at the time of engagement validated the depth and breadth of the problem the Increasing Access initiative was designed to address.

Exhibit 3. Percentage of Participants with Low Initial Dementia Capability Scores by DCST Domain*



**Among 79 systems for which HSDs generated initial DCST scores, the percentage that had an initial score of "0" or "1" in a specific domain. Number of assessments (denominator) varied by domain, depending on the number of "Unknown" scores. See Appendix F: Supplemental Data, for more details.*

Interviews conducted in 2024 with 18 project participants revealed that more than half of the interviewees had already begun dementia screening or early dementia care activities, or expressed an intention to do so, prior to partnering with the Association. Several systems had engaged with University of California academic health centers (e.g., UCSF, UCLA, UC Davis) to explore dementia care initiatives and partnership opportunities, which in some cases led to participation in training programs such as Project ECHO or Dementia Care Aware. Some participating systems also reported investigating the UCLA ADC model or striving to implement Age-Friendly Health System practices.

While the nature and extent of pre-project dementia care activities varied, most interviewees demonstrated awareness of—and in some cases responsiveness to—the need to strengthen dementia care before joining the project. This context underscores the timeliness and positive reception of the Association's dementia care initiative. Across interviews, participating systems emphasized the value of gaining access to person-centered dementia care tools, resources, and activities through their HSD involvement.

> **"Dr. B, a UC Davis geriatrician, reached out to me about six months before the Alzheimer's project while she was working on a grant to expand geriatric care in rural communities. I shared our interest in dementia screening and assessment, as well as our need for neurology support. She agreed to help, which gave us an early start in addressing dementia care in partnership with UC Davis."**
>
> *- Project Participant*

Challenges in Implementing Early Dementia Care

Participating systems identified multiple challenges to implementing early dementia care and screening. Chief among them was the limited time to conduct screenings and to follow up with patients and families after a positive diagnosis. The time challenge was compounded by other challenges: FQHCs have limited resources and staff; older adults often have many medical needs and comorbidities that take priority over cognitive screenings unless the patient or a family member specifically mentions concerns about memory problems; and adding a cognitive screening to primary care practices is burdensome, as they are already required to conduct multiple health screenings. Because cognitive screening is neither required nor incentivized through reimbursement, many primary care practices find it difficult to implement consistently. Staffing shortages and high turnover across both clinical and non-clinical roles emerged as additional significant challenges.

> **"I don't have time for a MoCA exam [in the primary care appointment], so we have to dedicate another appointment to do that and schedule it. And that's 3, 4, 5 months down the road. By that time, patients have all these other things they want to deal with."**
>
> *- Project Participant*

PROFILES IN PROGRESS

ASIAN HEALTH SERVICES

Developing a Geriatric Specialty to Support Primary Care

Asian Health Services, founded in 1974, provides medical, dental, and behavioral health services to more than 50,000 patients throughout Alameda County. Elder services are integrated across AHS's medical, dental, and behavioral health offerings and serve over 10,000 people. They provide culturally attuned chronic disease management, medication support, and mental health counseling. Their case management services help elders navigate housing, food access, and transportation challenges. AHS is developing a more focused geriatric care service line, including plans to establish a PACE site in 2027.

Collaboration with the Alzheimer's Association. Staff from the Association supported AHS through consultations, promotion of Dementia Care Aware (DCA), exploration of electronic medical record (EMR) enhancements, and connections to dementia experts. This partnership coincided with AHS's system-wide needs assessment of geriatric patients—over 10,000 elders served annually—which highlighted the limitations of dementia screening within the current primary care model.

Challenges in Providing Quality Dementia Care

- Screening Limitations: Standardized cognitive assessment tools are not validated in many languages spoken by AHS patients, leading to inaccurate results and equity concerns.
- Time Constraints: With only three 15-minute visits per year, comprehensive screening is difficult. AHS is exploring take-home and phone-based cognitive assessment tools.

Improvement Activities: Active and Planned

- Geriatric Team Formation: In 2025, AHS hired a geriatrician and formed a mini team (RN + case manager) to support dementia referrals and conduct screenings.
- PACE Program Launch: Scheduled for 2027, with plans to serve 500 elders.
- Risk Stratification: AHS is piloting predictive models to identify patients at high risk for dementia who would benefit from screening and early intervention.
- Medicare Wellness Visit: AHS is considering augmenting this reimbursed visit with more robust cognitive assessments (e.g., MoCA, Rowland Universal Dementia Assessment Scale-RUDAS).

Exploring Solutions. "*Our work with the Alzheimer's Association unfolded at exactly the right time. We were engaged in a system-wide needs assessment of geriatric patients—we take care of over 10,000 elders in our primary care clinics. Our staff are already working at full capacity, and we knew that adding dementia screening to the workload of busy staff was a non-starter. So, we had to find other avenues to explore. We have made some headway, and our journey continues.*" *-Daveena Ma, MD, AHS*

Reflections and Next Steps

AHS found its work with the Association helpful in clarifying barriers to dementia screening in primary care. Engagement with DCA leadership supported exploration of alternative screening approaches for diverse populations facing language and low-education challenges. Concurrent development of an internal geriatric care program, including hiring a geriatrician, further encouraged consideration of more equitable screening options. Based on this experience, AHS recommended that future Association projects adopt more structured interventions grounded in assessments of organizational current capacity and goals.

Interview with Daveena Ma, MD, Associate Chief Medical Officer, AHS

Project Team Activities

Engagement and Long-Term Strategy

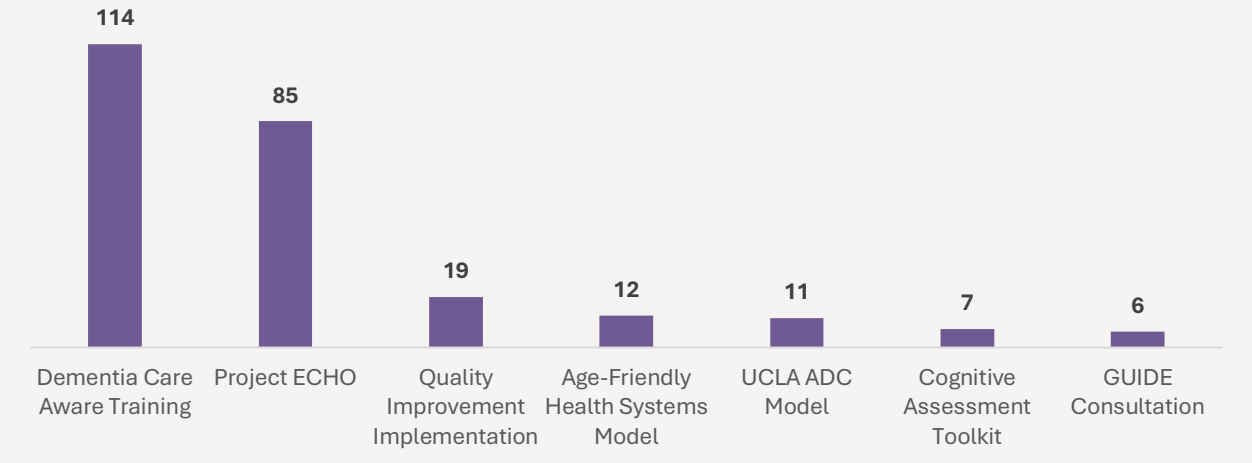
Engagement with participating systems typically began with a "discovery" conversation between the HSD and the site champion—often a Chief Medical Officer or senior administrator. These conversations were used to review the project, explore the system's dementia care needs, and identify how the initiative could provide targeted support. HSDs approached each participating system with respect for existing dementia care practices, intentionally "meeting them where they were," while assessing their interest in and readiness to engage in the project.

A key feature of HSDs' collaborative approach was the emphasis on long-term partnerships over transactional, project-based work. This perspective enabled HSDs to tailor guidance and recommendations to each participant's unique environment and context, leveraging a broad range of external resources and Association-based strategies rather than focusing narrowly on short-term outcomes. Effective engagement also required a nuanced understanding of operational challenges across safety-net and primary care systems, as well as structural factors such as organizational policies, workforce capacity, clinical workflows, and financial constraints.

Proposal Characteristics and Acceptance Rates

Over the three-year project period, HSDs documented providing participating systems with 356 Primary and Supportive proposals[1]. Proposals related to DCA (114) and Project ECHO (85) were the most common, accounting for 56% of all proposal activity (Exhibit 4).

Exhibit 4. Proposals Most Frequently Shared with Participants*



**Focus area of the 356 proposals shared with participants: data extracted from the association CRM or files maintained by individual HSDs.*

[1] An additional 37 proposals focused on sponsorship and revenue-generating activities, including 28 related to the Walk to End Alzheimer's events. While these activities may have contributed to increased awareness of dementia, their primary purpose was not to support practice change; as such, they were not classified as Supportive proposals for the purposes of this analysis.

All HSDs emphasized the importance of DCA in increasing dementia awareness and strengthening other areas of dementia capability. They reported that the program created opportunities to establish connections and build relationships with project participants, particularly through in-person events. HSDs also highlighted the value of DCA conferences, which further supported relationship-building with participants. For one specific population—incarcerated individuals—the program was assessed as less successful, because the curriculum did not adequately align with the unique needs of this population or of the staff who serve them.

> **"DCA was the spirit of this grant, and I really felt that the best use of my time was building relationships through that channel."**
>
> *- HSD*

Participating systems could accept or decline proposals shared by the HSDs. Overall, 89% (193/217) of Supportive proposals were accepted, compared with 45% (63/139) of Primary proposals, resulting in an overall acceptance rate of 72%. The higher acceptance rate for Supportive proposals likely reflects the lower level of effort required to use these resources—an unsurprising finding given the limited resources for practice change at many participating systems.

Most proposals (232; 65%) were associated with externally developed programs, such as DCA, GUIDE, and Project ECHO. Proposals involving customized support from HSDs—such as consultation or assistance with quality improvement efforts—accounted for 30% (107/356) of proposals. Proposals featuring Association-developed resources, such as the Cognitive Assessment Toolkit, accounted for the remaining 5%. Acceptance rates varied by proposal type, ranging from 69% for externally developed programs to 75% for proposals offering customized support and 88% for proposals associated with Association resources.

Number of Proposals Per Participant

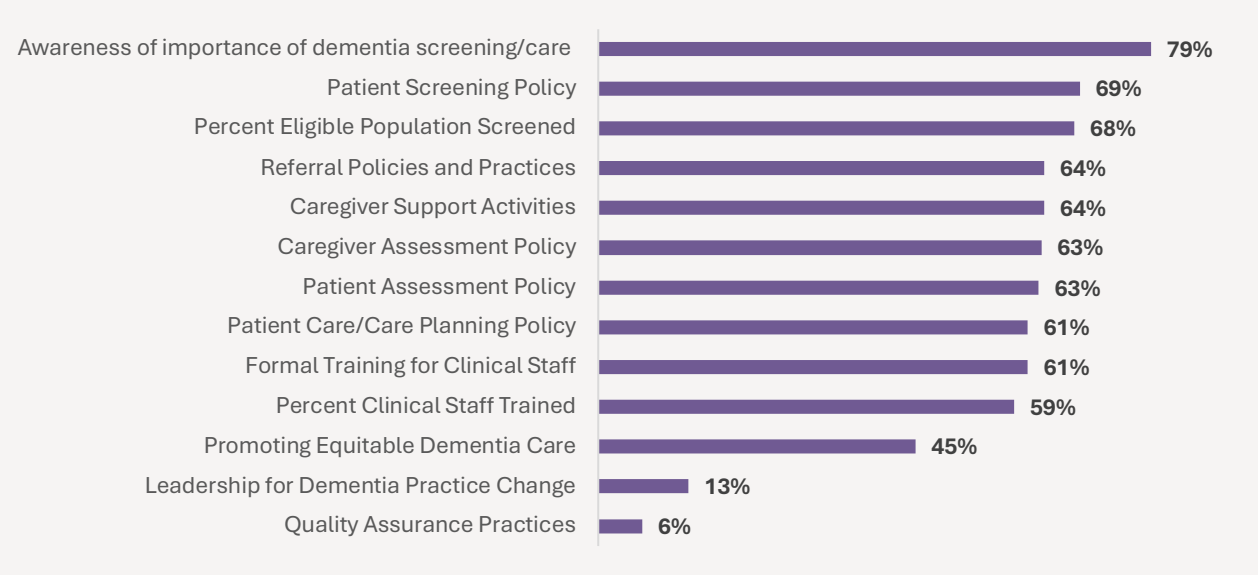
Of the 81 participating systems 78 (96%) accepted at least one proposal. The number of proposals received by individual systems ranged from 1 to 20, while the number accepted ranged from 0 to 15. Most systems (67%) received fewer than five proposals; 25% received between five and ten; and 9% received eleven or more.

Both small rural systems and larger organizations were represented across all proposal volume categories, suggesting that participant interest and availability to pursue dementia care improvements—rather than system size or type—were the primary drivers of engagement. Ten systems elected to "renew" a total of 14 proposals across project years, allowing additional time to pursue more complex initiatives such as quality improvement projects or system-level change implementation.

Proposal Focus Areas

In collaboration with the project team, the evaluation team determined which areas of dementia capability would possibly be impacted by each proposal. Some proposals, like DCA and Project ECHO, could affect nearly all DCST domains; most others had a narrower focus, for example, implementing an electronic medical record (EMR) enhancement to streamline referral processes might only impact a single domain. Amongst accepted proposals, Awareness was the domain that was commonly linked to proposal content (79%), with Patient Screening Policy (69%) and Percent Eligible Population Screened (68%) also emerging as a focus in many proposals (see Exhibit 5). See Appendix F: Supplemental Data for additional detail.

Exhibit 5. Proportion of Accepted Proposals Addressing Each Dementia Care Domain*



**Amongst 256 proposals accepted by participants*

Partners

In addition to supporting the systems that met the project's eligibility criteria, HSDs also engaged organizations, referred to as Partners. These included non-clinical organizations such as advocacy groups, clinical consortia, health plans, community-based organizations, and specialty dementia care providers. Although not assessed for practice change, these organizations played a significant role in the project.

HSDs provided dementia-focused support to several Partners, similar to that offered to eligible systems, helping to expand dementia care awareness and capacity across the broader healthcare ecosystem. In other cases, Partners were instrumental in encouraging eligible clinical entities to participate in the Increasing Access project. Their involvement lent visibility and credibility to the project. For example, one health plan promoted participation among its network providers, and another revised its dementia screening policies in support of the project's early screening practices.

> **"Partner organizations were, and still are, so key to the project work. Some were consortia, like CCALAC (Community Clinic Association of Los Angeles County), which serves the L.A. area. These platforms serve as validators and lend credibility to organizations like ours [Alzheimer's Association]."**
>
> *- HSD*

Spotlight: Leveraging Opportunities

Amid persistent challenges in finding time for cognitive screening in primary care, the Medicare Annual Wellness Visit (AWV) emerged as a timely and strategic opportunity to support early dementia detection. HSDs encouraged participating systems to use the AWV to conduct abbreviated cognitive screenings, and many reported leveraging the visit as a pilot to test screening tools, workflows, and protocols—transforming a routine preventive visit into a viable entry point for early identification of cognitive concerns.

The AWV is a structured preventive visit for Medicare beneficiaries aged 65 and older that focuses on risk assessment and health maintenance. It includes a Health Risk Assessment, screenings for depression, fall risk, and cognitive function, and the development of a personalized prevention plan. While the cognitive component of the AWV is brief—typically five to ten minutes—it provides a valuable window into memory, attention, language, and executive function. Commonly used tools include the Mini-Cog, GPCOG (General Practitioner Assessment of Cognition), Memory Impairment Screen, and informant-based questionnaires such as the AD8 (Eight-item Informant Interview to Differentiate Aging and Dementia.)

Although AWVs are not major revenue drivers compared to complex clinical visits, they offer reliable reimbursement, support quality reporting, and help close preventive care gaps. These features made the AWV an attractive and feasible option for practices seeking to integrate cognitive screening into routine care.

The AWV's strengths include Medicare coverage without cost-sharing, patient engagement in preventive care, and early risk identification. At the same time, its limitations are well recognized: the cognitive screen is brief, not diagnostic, and its sensitivity may vary with patient characteristics. AWV is best understood as an entry point rather than a standalone solution.

By leveraging the AWV, dementia screening can be embedded in routine primary care workflows, making early detection both feasible and more sustainable for populations at highest risk of Alzheimer's disease and related dementias.

PROFILES IN PROGRESS

NORTHERN VALLEY INDIAN HEALTH

A Program Imperative in Dementia Care: Cultural Respect and Trust

Northern Valley Indian Health serves approximately 780 patients over age 55 across its clinic locations in Chico, Willows, Woodland, and tribal offices at the Grindstone and Machupta Indian Reservations. The organization estimates that around 200 patients are living with cognitive decline or dementia, with 31 newly diagnosed in the past year. To strengthen dementia care education and outreach, Northern Valley received a two-year Indian Health Services grant for dementia awareness, which was successfully renewed for an additional three years.

Collaboration with the Alzheimer's Association. The Alzheimer's Association partnered with Northern Valley to identify and address key gaps in dementia care. Support included staff and patient education, training, and assistance in building a Mini Cog screening template within the organization's eClinicalWorks database. Through collaboration with the Association and other community partners—including Passages Caregiver Resource Center, IA² American Indian, and Butte County Public Health—Northern Valley launched a Brain Health Adventures class, organized music therapy groups for patients with cognitive concerns, conducted a three-week caregiver workshop hosted by Passages, and completed training for a virtual dementia tour.

Key Dementia Care Challenges and Program Successes

- Limited staffing, with only one clinician dedicated to the dementia program across multiple locations
- Geographic spread of clinics complicates consistent programming
- Time constraints and scheduling difficulties, compounded by competing priorities
- Provider hesitancy to diagnose dementia, particularly among non-physician providers
- Concerns about program sustainability after grant funding ends

Key Dementia Care Program Successes

- Increased awareness and recognition of dementia among providers and community members
- Successful caregiver support workshops and meaningful one on one patient interactions
- Integration of dementia awareness materials at community health fairs
- Created community partnership with Passages to offer caregiver support groups

Practice Change: Building Trust. "There are several important cultural considerations when working with Native American communities. Building trust is essential, as Native patients often rely on family and friends for health information rather than healthcare providers. For instance, a healthcare staff member who created a beaded necklace alongside a Tribal member helped foster trust, which in turn made the patient feel more comfortable engaging with the care team and services. Developing relationships requires time, cultural sensitivity, and respect for community values."

- Andrea Grove, Dementia Awareness Program Coordinator, Northern Valley Indian Health

Reflections and Next Steps Northern Valley emphasized that a major lesson learned from participation in the Increasing Access project is to "not assume anything." Even medical professionals may have limited knowledge about dementia, underscoring the value of specialized outreach staff. They also learned that community interest in dementia education is often greater than anticipated. Looking ahead, Northern Valley plans to continue its partnership with the Alzheimer's Association, expand caregiver workshops, and develop a sustainability plan before grant funding concludes.

Interview with Andrea Grove, Northern Valley Indian Health

Assessing Changes to Structures and Processes

The evaluation largely focused on structures (i.e., policies and infrastructure that support care delivery) and processes (i.e., how care is provided) that support early dementia care practices.

Structure and Process Evaluation Tools

1. **DCST**: DCST scores generated by HSDs at the time of engagement were used to assess dementia capability across 13 domains and compared to scores collected during follow-up periods.
2. **Participant Self-Assessments**: Online surveys administered in fall 2024 and fall 2025 captured participants' self-assessments of dementia-related capabilities, covering DCST domains and other relevant areas.
3. **Participant Interviews**: Initial and follow-up interviews were conducted with primary contacts; 18 were completed in spring 2024 and 9 in fall 2025.

To assess changes in these areas, the evaluation drew on multiple data sources, including HSD-completed DCST assessments, participants' self-assessments, and interviews. Initial and follow-up HSD-completed DCST scores were compared to identify changes in dementia care capability over time. Participating systems' self-assessments provided an additional quantitative perspective and were used to examine alignment between participants' perceptions and those of the HSDs. Interviews with a subset of participating systems conducted during and after the intervention, along with exit interviews with HSDs, offered further detail and contextual insight. Together, these data suggest that participating systems achieved meaningful improvements in organizational structures and care processes.

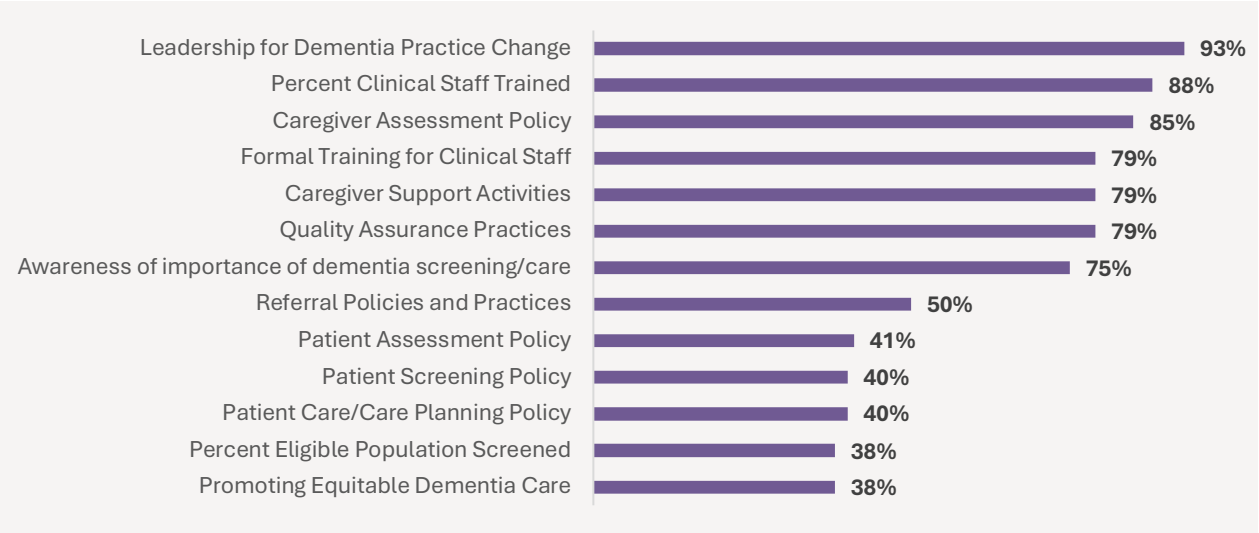
In spring 2024, HSDs used the DCST to generate scores reflecting the current state of dementia capability for their assigned participating systems. For systems that joined the project before the evaluation began, HSDs also provided retrospective scores based on available documentation and their best recollections of each organization's capability at the time of initial engagement. A subsequent round of scoring was completed in spring 2025. In total, 170 HSD-completed DCST assessments were conducted across 79 participating systems, including 40 systems with three assessments, 51 with two assessments, and 28 with one assessment.

Changes in Capability Over Time

Among the 51 systems with at least two HSD-completed DCST assessments, initial scores revealed substantial gaps in capability at the time systems first engaged with the project. Between 8%–76% of systems had an initial score of zero in at least one domain, and many scored zero in multiple domains. The largest gaps were observed in Percent of Clinical Staff Trained (76% with a score of zero), Formal Training for Clinical Staff (75%), Patient Screening Policy (70%), Caregiver Assessment Policy (69%), and Caregiver Support Activities (68%).

As shown in Exhibit 6, follow-up assessments pointed to clear progress, with 38%–93% of systems improving their scores, depending on the domain.

Exhibit 6. Percent of Systems with Improved DCST Scores Initial vs 2nd Assessments*



**Results for 51 participating systems for which HSDs had generated at least two scores. Results shown where a numeric score was available for the domain in both assessments (domains rated "unknown" were excluded). See Appendix F: Supplemental Data, for additional detail.*

Across the 40 systems with three DCST assessments, all domains showed some improvement. Given the very low initial capability, it is not surprising that subsequent assessments reflected marked gains. See Appendix F (Supplemental Data) for additional details.

Comparison to Participant Self-Assessments

To assess alignment between participating systems and HSD perspectives on dementia care capability, an online self-assessment survey was administered in fall 2024. The survey mirrored the DCST domains and used the same 0–3 scoring scale. Thirty-three participants completed at least a portion of the survey. Overall, HSD-generated scores aligned closely with participant self-assessment ratings among this subset of organizations. Additional details are available in Appendix F: Supplemental Data.

Analysis of DCST Assessment Findings

Analysis of DCST assessments indicates positive trends across multiple areas of dementia capability among participating systems with at least two assessments. These improvements are notable given the substantial structural and process gaps in early dementia care described by these systems during both initial and follow-up interviews. Interpreting these findings requires consideration of the difficult operational environment in which most participating systems function (i.e., FQHCs and similar primary care organizations), including competing demands, resource constraints, and staffing challenges. In this context, the positive trends observed among the 51 (63%) systems with multiple DCST assessments may not represent the experience of the remaining 30 participating systems.

Although DCST scores overall indicate substantial improvements in early dementia care capability, important opportunities for improvement remain. Among participating systems with three assessments, several domains—most notably Caregiver Assessment Policy (average score at third assessment 1.75), Patient Assessment Policy (2.10), Percent of Eligible Population Screened (2.13), and Patient Screening Policy (2.13)—continued to have relatively low average DCST scores even after extended engagement with the project. This pattern may reflect the very low baseline capability observed in these areas, suggesting that additional time is required to fully implement and sustain improvements. It may also indicate a mismatch between the level of effort and resources required to advance beyond mid-level performance and available organizational bandwidth and capacity.

Structural and Process Gaps Identified in Interviews

Three significant gaps were identified that affect participating systems' ability to provide early dementia care:

1. **Access to specialists and treatments**, including costs of care, insurance coverage, geographic availability of services, limited number of neurologists, appointment wait times, travel distance and costs, and availability of timely referrals.
2. **Staff knowledge, awareness, and training in dementia care**, including familiarity with community-based dementia care resources such as respite care and caregiver supports.
3. **Dementia care workflows and protocols**, particularly within the context of time-limited primary care visits and existing clinical processes.

Access-related challenges were the most frequently reported and largely outside the control of participating systems, whereas gaps in staff training and clinical workflows were internal challenges.

> **"We do not have any neurologists here in town, so when we refer patients out for dementia management, the next available appointment could be in Fresno, Modesto, or the Bay Area. Some struggle with transportation or family support to take them."**
>
> *- Project Participant*

Participating systems additionally emphasized the need for staff training and workflow adaptations to support dementia screening and care delivery within constrained visit times.

> **"Now that there is headway with dementia treatments, it's become a greater concern for our organization to screen, especially with the aging population growing much more rapidly. But it's still challenging, as training is needed for our care teams to deliver this screening. We only have five minutes to see the patient and do the screening."**
>
> *- Project Participant*

The need to create new or revise existing dementia care workflows and protocols emerged as a significant gap for many participating systems. While several had made progress in addressing this issue, others struggled to find the time and organizational support required to implement these changes amid the constant demands and competing priorities of their clinical settings.

> **"We developed new workflows for medical assistants and added new EMR functions. During a visit, screening questions must be asked, responses documented, and information clearly communicated to the medical provider. We needed to ensure all of this fit smoothly into existing workflows."**
>
> *- Project Participant*

Leadership Buy-In and Role of Data to Drive Quality

Two additional factors emerged that influenced the structures and processes of participating systems: the level and type of leadership buy-in and how systems engaged with data as a measurement of dementia care capability and a quality improvement tool.

Most participating systems interviewed—both initially and at follow-up—reported having leadership support for the dementia care program. Several noted that their CEO or medical director initiated the program and remained actively involved. Others who served as medical directors reported approving the program and overseeing its implementation. Despite leadership buy-in for early dementia care practices, prioritizing the program remained challenging due to competing demands within FQHC environments.

> **"With medical leadership, it is about timing. This is an agenda item that needs to be addressed instead of just a side issue that we'll get to whenever."**
>
> *- Project Participant*

Data also emerged as a compelling driver of quality improvement. Thirteen of the 18 participants interviewed initially reported collecting dementia care–related data, such as the number of screenings, assessments, and referrals. The quality of data collected and participants' ability to use these data to measure progress—particularly in increasing screening rates, referrals, and access to caregiver support—varied across sites.

> **"We determined that we were screening at an extremely low rate, and that was alarming to us because Alzheimer's is a big problem and is just becoming more prevalent as our communities get older. Working with our HSD, we chose a clinic with a screening rate of 2% to pilot use of the Mini-Mental Status Exam (MMSE)."**
>
> *- Project Participant*

> **"We created an analytic dashboard at the suggestion of our HSD to track our screenings and any associated diagnoses."**
>
> *– Project Participant*

PROFILES IN PROGRESS

LOMA LINDA UNIVERSITY HEALTH

Pilot Promotes Changes in Dementia Care Practice

Loma Linda University Health (LLUH), founded in 1905, is a faith-based academic health system that serves a vast region across Southern California, primarily the Inland Empire (San Bernardino & Riverside Counties), with a patient population that is over 50% Hispanic. LLUH includes a medical center, children's hospital, behavioral medicine center, multiple specialty institutes, and a wide range of outpatient and community-based services. These are delivered through primary care clinics, mobile health units, and health education programs.

LLUH's commitment to whole-person care—centered on the needs of individuals, families, and underserved communities—is a foundational principle of its mission. To support older adults, LLUH offers geriatric services, a PACE (Program of All-Inclusive Care for the Elderly) site, and, since July 2024, GUIDE (Guiding an Improved Dementia Experience) Program. In collaboration with the Alzheimer's Association (Association), LLUH has also participated in initiatives such as Dementia Care Aware, Project ECHO, and the Walk to End Alzheimer's.

Collaboration with the Alzheimer's Association. The Association supported LLUH's successful application to the Centers for Medicare & Medicaid Services (CMS) for inclusion in the GUIDE pilot—an eight-year, voluntary Medicare model designed to improve dementia care and reduce caregiver burden. GUIDE has become a cornerstone of LLUH's practice transformation efforts. Developed by CMS to enhance quality of life for people living with dementia, the program emphasizes home- and community-based services and provides comprehensive, coordinated care. Care navigators connect families to clinical and non-clinical resources (respite care, transportation), while integrating with primary care and neurology teams. Supports also include 24/7 helplines and caregiver education to promote accessible, holistic care.

Practice Change Outcomes. "The GUIDE program has transformed dementia care for our patients by providing consistent monthly touchpoints and significantly improving access to healthcare providers. GUIDE's comprehensive approach ensures that individuals with dementia receive timely interventions and ongoing support, ultimately enhancing their quality of life and reducing caregiver burden. We were successful in our application to join Medicare's pilot program due, in part, to the support and resources of the Alzheimer's Association."

- Wessam Labib, MD, MPH, LLUH

Reflections and Next Steps. Since its launch, GUIDE has strengthened dementia care at LLUH through consistent patient engagement, proactive problem-solving, and streamlined access to providers. The program currently serves approximately 125 patients and families, with plans to expand to 200 by the end of 2026. Internal outreach and continued collaboration with the Alzheimer's Association remain central to its growth.

Interview with Wessam Labib, MD, MPH, Division Head & Medical Director, Division of Geriatric Medicine, LLUH

Assessing Practice Changes

The primary evaluation question for this section was whether measurable changes in practice occurred, and if observed changes were associated with support offered by the HSDs. This section also describes factors that facilitated successful engagement, highlights unexpected ways participants leveraged complementary programs and staffing models, and examines the role of HSDs in supporting practice change and sustained engagement.

Evidence of Practice Change

Among the 81 participating systems, 43 (53%) engaged in robust, durable, and/or ongoing activities associated with one or more aspects of improved dementia care. These systems were representative of the full range of clinical settings targeted by the initiative, including 24 small-to-medium FQHCs or community clinics, 11 non-FQHC systems operating in rural areas (four of which primarily served minority populations), and eight non-FQHC systems operating in metropolitan or suburban areas that primarily served minority populations.

Engagement in specific activities was verified through review of public records, participant interviews, and data shared by participating systems. Activities included:

- **34** systems participated in Project ECHO, some for multiple years
- **11** achieved AFHS recognition, including seven at Level 2
- **5** were accepted in the CMS GUIDE model or the UCLA ADC model
- **10** implemented formal quality improvement projects, most focused on improving screening rates
- **15** were conducting ongoing monitoring of dementia-related quality indicators
- **4** implemented other durable changes to processes, such as EMR enhancements to support screenings or referral, or major policy change, such as requiring dementia screenings.

Twenty-two of the 43 (51%) systems were engaged in more than one of these activities, and five of the 43 had multiple clinical sites engaged with the HSDs. Most of the 43 systems accepted proposals related to the specified activities, as shown in Exhibit 7.

Exhibit 7. Linking Dementia Care Improvement Activities and Accepted Proposals*

Activity	# Systems Engaged in Activity	Subset That Accepted Relevant Proposals	% With Accepted Relevant Proposals
ECHO Participation	34	31	91
AFHS Recognition	11	4	36
GUIDE/ADC Model	5	4	80
QI Projects	10	9	90
Quality Monitoring	15	7	47
Other Durable Process Changes**	4	4	100

**Results for the 43 systems engaged in activities associated with one or more aspects of improved dementia care.*
*** Durable process changes include modifications to the EMR to support screening or referrals, or significant policy changes related to screening*

Some systems engaged in these practices without receiving relevant proposals, and not every system that received a relevant proposal implemented practice changes. Even so, the vast majority of systems with verified activity had accepted relevant proposals and were receiving HSD support.

A similar pattern was observed in DCST-reported practice changes. The DCST assesses changes in two key process measures: the percentage of clinical staff who receive dementia-related training and the percentage of eligible patients who are screened. Among the 40 systems with three DCST assessments, all 23 systems with improved scores for Percent Eligible Population Screened and 94% of systems with improved scores for Percent of Clinical Staff Trained had accepted proposals related to these indicators.

Facilitators of Sustainability and Future Success

In both interviews, participating systems were asked to describe what "success" in providing quality dementia care would look like at their site. Nearly all interviewees—most of whom self-identified as highly engaged with the project—were able to articulate a clear vision of success. Commonly reported facilitators included linking project activities to measurable QI initiatives; advocating for organization-wide dementia care policies and standards; formalizing screening and evaluation workflows; improving access to dementia specialists; and aligning dementia care activities with reimbursement mechanisms.

In the initial 18 interviews, approximately one-third of participants expressed strong interest in learning from other systems through a structured learning community, which was not part of this initiative but could be considered in future endeavors. They underscored that participation in an active peer learning model would have benefited them in many ways, including helping sustain their commitment to the project. Interviewees expressed interest in sharing cases, data, best practices, and innovations, and several noted that their own project innovations could

benefit other systems. Examples included developing training videos for medical assistants on administering the Mini-Cog and documenting results in the EMR; delivering early dementia care via telehealth by dementia-trained primary care providers; and using community navigators or quality ambassadors to conduct cognitive screenings prior to clinic visits.

> **"I would like to hear others' clinical and personal experiences [regarding delivering dementia care] and maybe some case scenarios describing what they've encountered while evaluating and managing their patients."**
>
> *- Project Participant*

Unexpected Findings Supporting Early Dementia Care

Two unexpected findings emerged from initial interviews and were confirmed in follow-up discussions. Because both helped to catalyze the work of several participating systems in delivering responsive early dementia care, they merit mentioning.

First, approximately one-third of participants interviewed were working in a PACE program, had a PACE program in their system, or were planning to develop one. Participants described PACE as offering a strong structural foundation for dementia care.

> **"PACE has a team structure and the capability of delivering dementia care in a way that no other program can. In our PACE program, we own the outcomes in a way that gives us all the pieces structurally to provide best-practice dementia care—and we can do it."**
>
> *- Project Participant*

Second, approximately one-quarter of interviewees reported using—or planning to use—medical residents as part of their dementia care programs. Residents were viewed as valuable contributors who could lead quality improvement efforts, support care delivery, and carry newly learned dementia care practices into future clinical roles.

> **"It's helpful that we have one of our residents spearheading this project. She helps provide education and training, responds to other residents' questions about dementia, and offers additional support so they understand what the dementia care workflow looks like in the clinic."**
>
> *- Project Participant*

Role of HSDs in Guiding and Supporting Practice Change

Participants consistently reported positive experiences with HSDs in their roles as coaches, guides, trainers, and educators. Interviewees emphasized HSDs' persistence, flexibility, and collaborative approach as critical factors in helping systems identify feasible next steps and maintain momentum in improving dementia care practices. These perceptions were reinforced in follow-up interviews.

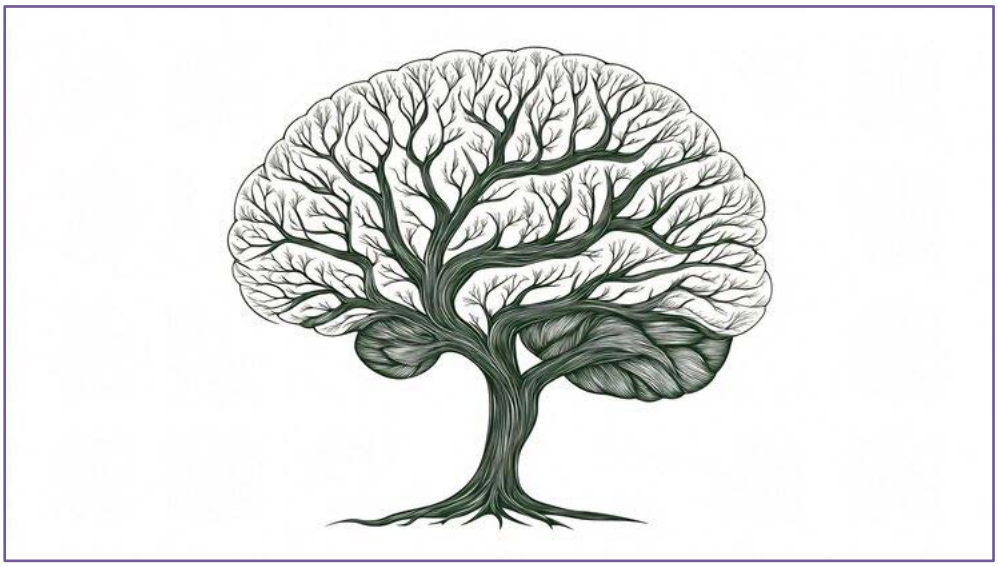
Systems interviewed for the case studies expressed more nuanced relationships to the project and their HSDs. In one case, a participant explicitly identified areas in which the HSD role could be strengthened. This contrast suggests some variability in the depth and visibility of HSD engagement across participating systems.

> **"We really appreciated the outreach from our Association staff contact and access to resources. However, in the context of our clinic and our experience with other QI efforts, the interventions could have been more structured and based on an assessment of our current capacity and organizational goals."**
>
> *- Project Participant*

Practice Change Key Takeaways

The technical assistance and support provided by HSDs were associated with improvements across multiple areas of early dementia care. Improvements in DCST domains related to training and screening are closely aligned with the types of proposals accepted by participating systems targeting those same areas. Offering a range of Primary and Supportive proposals created multiple entry points for engagement, enabling systems to tailor their participation based on readiness, capacity, and interest.

Interviewees who reported deeper engagement with the project were able to articulate clearer improvements in their dementia care practices and identify key facilitators of future success. Finally, systems that leveraged existing resources—such as partnerships with PACE programs and the involvement of medical residents—demonstrated creative and adaptable approaches to improving early dementia care. These strategies reflected more robust project engagement and suggested potentially replicable pathways for similar organizations seeking to sustain and scale early dementia care improvements.



SUCCESSES AND FUTURE CONSIDERATIONS

Project successes underscore the value of sustained coaching, practical support, and relationship-based engagement in advancing early dementia care. These findings inform a set of forward-looking considerations aimed at strengthening future initiatives for FQHCs and similar community-based health care organizations.

Successes and Future Considerations

This concluding section summarizes key project successes and identifies future considerations to advance early dementia care in replicable and sustainable ways. It draws on analysis of project quantitative and qualitative data, as well as the perspectives of participating systems and HSDs.

Successes

Was there an improvement in dementia capability?

Yes. Based on a review of public records, participant interviews, and data collected at project close, 53% of participating systems were engaged in robust, durable and/or on-going activities associated with improvements in dementia care. These findings aligned with DCST results generated by HSDs. Among the 51 participants with multiple DCST assessments, performance across the 13 DCST domains improved for 38%–93% of systems, depending on the domain. Within this cohort, 90% improved in at least one domain, including 19 systems (37%) that demonstrated improvement in six or more domains.

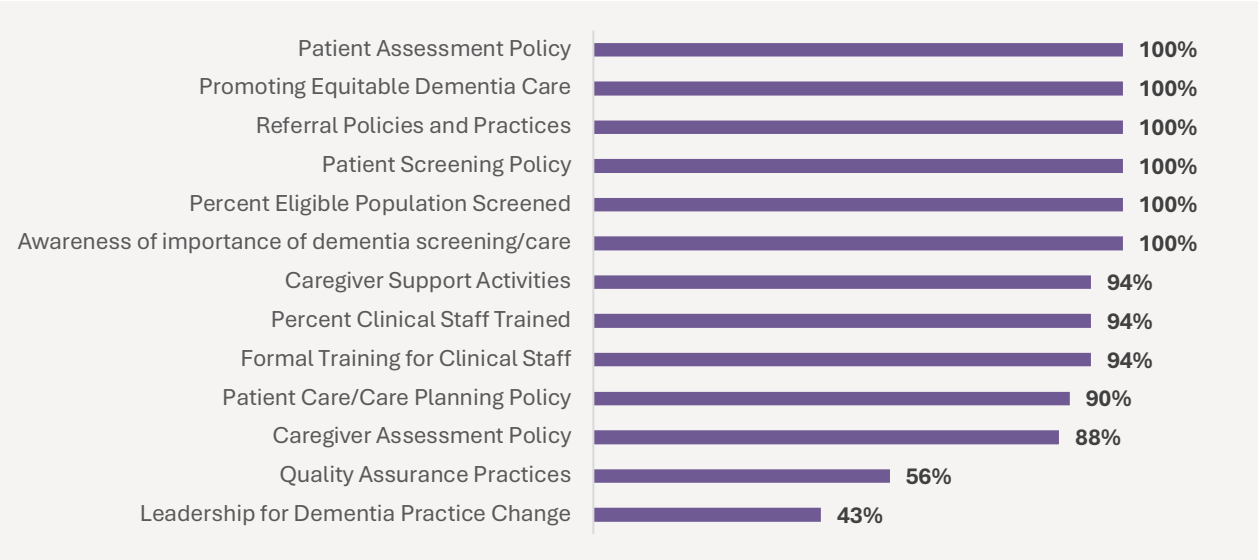
Is there an association between HSD work and improvement in dementia capability?

Yes. In exit interviews, HSDs emphasized that maintaining momentum with clinic partners was often difficult and time intensive. Clinicians were frequently hard to reach or slow to respond, and early enthusiasm for the project sometimes waned as competing clinical demands took precedence. Despite these challenges, HSDs reported that most participating systems valued their steady outreach, regular communication, and ongoing support. They believed these efforts made a meaningful difference in advancing early dementia care—both for systems with limited prior exposure to dementia screening and care resources and for those already engaged in this work but seeking additional tools and guidance to identify next steps.

> **"I am proudest of reaching into hard-to-reach communities, to meet clinics where they were, and help them focus on proposals—for many, it was supportive proposals first, then primary—that aligned with their needs and capacity."**
>
> *- HSD*

Analysis of proposal focus areas and improvements in dementia capability reinforced the connection between HSD efforts and changes in participant practices. Most participating systems that demonstrated improvement had accepted at least one—and often multiple—proposals aligned with the domain(s) in which improvement occurred. Among the 38 systems with three DCST assessments and complete proposal activity records, 43%–100% of participants showing domain-level improvement had accepted at least one relevant proposal (Exhibit 8).

Exhibit 8. Percent of Systems with Improved DCST Scores With Documented Acceptance of a Relevant Proposal*



**Results for the 38 systems with 3 DCST scores and complete proposal activity records.*

Will Changes in Practice Be Sustained?

In follow-up interviews, participating systems were asked to describe the project's future within their organizations. Most envisioned early dementia care becoming standard practice for older adult patients. Several described plans to expand efforts to additional clinical sites. Others emphasized the importance of identifying sustainable payment streams beyond Medi-Cal and fee-for-service reimbursement.

Participants also articulated longer-term goals, including leveraging technology and telehealth, adopting alternative screening tools such as SAGE, collecting more robust screening and referral data, engaging medical residents when available, and strengthening behavioral health and case management support for patients with positive dementia screenings and their families.

> **"As an organization, we've been thinking a lot about the future—especially increasing screening using an alternative test and finding ways to counsel families with our case management teams, even during short encounters."**
>
> *- Project Participant*

Future Considerations

Primary care clinics and organizations working in similar practice environments are acutely aware of demographic, health system, and social trends, including increased longevity, the rising prevalence of Alzheimer's disease and related dementias, and the growing burden on family caregivers. Many also recognize that they are not adequately prepared to meet these challenges, and that ongoing funding constraints and workforce shortages may further impede efforts to achieve meaningful practice change. In this context, advancing early dementia care for underserved and marginalized communities is more urgent than ever.

When combined with the heart of this initiative—the trusted relationships between clinic teams and their HSDs, sustained through persistent, patient coaching that helped create conditions for improvement—the following considerations highlight opportunities to strengthen future efforts to implement early dementia care in equitable, replicable, and sustainable ways, especially for underserved and marginalized communities.

Take All Comers: Leverage Every Opportunity

Continue to engage all health systems willing and able to focus on improving early dementia care and support participants by leveraging available programs and resources.

- Allow for—and explicitly recognize—incremental improvements across any aspect of dementia capability, creating space for organizations with limited capacity.
- Encourage participation in established dementia care initiatives, including Dementia Care Aware, Project ECHO, Age-Friendly Health Systems, and the GUIDE Model.
- Provide modest financial incentives, such as small grants, to support engagement in activities such as data collection, reporting, and workflow development.

Promote Standardization with Structure and Flexibility

Consider refinements to Increasing Access's open-ended design to increase standardization and structure while preserving flexibility:

- Implement a hybrid model in which participating organizations collectively focus on a core set of practice changes while retaining flexibility in implementation strategies.
- Segment participants by baseline dementia care capability, allowing systems to select from a narrower, stage-appropriate set of activities designed to support progression to higher levels of capability.
- Introduce a standardized baseline assessment to strengthen data quality and enable clearer measurement of progress over time.
- Routinely administer the DCST or a comparable tool, jointly completed by participants and HSDs during biannual check-ins.
- Clarify documentation standards for project staff, including expectations for participant interaction notes and consistent use of CRM systems or similar databases, to improve data completeness and evaluability.

- Schedule structured, recurring HSD–participant touchpoints—such as bi-monthly or quarterly check-ins—to sustain momentum, reinforce priorities, and maintain focus on dementia care improvement.

Incorporate Shared Learning

Introduce peer learning through a structured learning community to normalize challenges within a shared priority while fostering innovation, mutual support, and dissemination of promising practices.

- Develop a learning community that includes all participants or targeted subgroups based on shared goals, activities, or organizational characteristics.
- Establish regular communications within the learning community to highlight participant successes, innovative strategies, and practical lessons learned, reinforcing collective progress and motivation.

Expand Language Access and an Equity Lens

Strengthen participating systems' capacity to meet the needs of their diverse communities across cultures, languages, educational levels, and lived experiences.

- Incorporate tools and processes that can be flexibly adapted for diverse patient populations, particularly those requiring additional support or more culturally and linguistically responsive approaches.

Enhance Structures and Processes Supporting Early Dementia Care

Build internal capacity while deepening coordination with external partners.

- Support FQHCs and similar systems in working more closely with statewide organizations and regional networks representing community health centers to access practical guidance, shared models, and peer learning focused on early dementia care.
- Improve internal workflows to more consistently provide caregiver information and resources, and refer to external dementia care partners, such as local Alzheimer's Association chapters and California's Caregiver Resource Centers.

Establish Early Dementia Care as a Standard of Practice

Elevate and standardize core competencies in dementia education and training across health care roles to support consistent, high-quality screening and assessment.

- Explore opportunities to promote dementia care certification as a complement to training, reinforcing quality, consistency, and provider confidence.

> ***"We benefited from the education and resources provided by our HSD. When things became difficult, they took us to where we needed to be. The future involves making early dementia care a standard of care, tailoring it to our patient population with technology, ensuring our workforce is educated, including in the dyadic model [care recipient-caregiver], and bringing everything together with a focus on quality improvement and data tracking."***
>
> *- Project Participant*

Final Thoughts: HSD Advice and Reflections

Advice for future participants:
"Find champions within your system—people you're already working with or trying to work with—who truly care about the project. Learn what they care about and use that to create and launch a QI project. Be patient and build a strong pipeline of other champions and projects in case a particular champion or QI effort does not move forward."

Advice for future HSDs:
"Building trust is essential to keeping the conversation going, and that looks different for everyone. When you offer something, you have to follow up and follow through. The approach is similar to motivational interviewing: to really understand what someone needs, you have to listen—understand their gaps, recognize their successes, and get to know them well enough to personalize the experience and the journey."

"Build your infrastructure and templates—a clear roadmap—before beginning engagement. Having templates to anchor conversations and resources for each phase of the project will be incredibly helpful."

Closing reflections:
"Through this work, I reached across the aisle in ways I hadn't before and was able to bring together people who likely never would have met otherwise. I saw my role as a connector and conduit—a force for positive change within health care. I may never fully know the impact, but the ability to convene and connect people is what the Alzheimer's Association is about."

Spotlight: "Potential Game Changers"

Recent breakthroughs in Alzheimer's diagnosis, treatment, and prevention are reshaping the landscape of dementia care and offering renewed hope to individuals and families confronting early-stage disease.

Diagnosis. A new era of early detection is emerging with the introduction of FDA-cleared blood-based biomarker (BBM) tests that detect amyloid-beta and tau—key pathological features of Alzheimer's disease. In 2025, the Alzheimer's Association issued its first clinical practice guidelines for BBM use, recommending implementation in specialty settings such as neurology, geriatrics, and psychiatry. While BBM tests are not yet stand-alone diagnostic tools, they are more accessible and acceptable to patients than traditional methods and hold promise for expanding diagnostic reach and streamlining pathways to care.

Treatment. Therapeutic innovation has accelerated with FDA approval of monoclonal antibodies such as lecanemab (LEQEMBI®) and donanemab (Kisunla™), which target amyloid-beta plaques and slow cognitive decline in individuals with early Alzheimer's disease. Although not curative and currently limited to specialty care due to infrastructure and monitoring requirements, these therapies represent a significant shift toward disease-modifying treatment.

Prevention. Growing evidence also underscores the role of lifestyle interventions in preserving brain health. Findings from the Alzheimer's Association's U.S. POINTER study demonstrated that structured, multi-domain lifestyle programs—particularly those with coaching support—can improve cognition and resilience in older adults at risk for decline.

Looking Ahead. Together, these advances point toward a more integrated Alzheimer's care model that combines earlier diagnosis, emerging therapies, and prevention strategies. While many innovations remain beyond routine primary care, they offer a hopeful roadmap for the future of dementia care.

Appendix A: Participating Health Systems and Partner Organizations

Participating Systems and Affiliated Sites

Adventist Health Hanford
Adventist Health Community Care/Primary Care
Adventist Health Sonora
Adult Medicine Clinic
Adventist Health Tulare
Adventist Health Ukiah
Family Medicine Residency: AH Ukiah Valley
Alameda Health System
Highland Wellness
Alliance Medical Center
Alta Med
Ampla
Arrowhead County Clinics
Asian Health Services
Chenming + Margaret Hu Medical Center
Bay Area Community Health
Big Trees MD
California Family Medical Group
Camarena Health
Contra Costa County Health Services
Center for Elders' Independence
Center for Elders' Independence PACE - Concord
Center for Elders' Independence PACE - San Leandro
Central Neighborhood Health Foundation
Chaitanya Mahida, MD Inc. & Upinder Basi, MD
Chapa-De Indian Health
Auburn
Clinica Romero
Common Spirit/Dignity Woodland
Yolo Adult Day Health Center
Communicare+OLE
Community Health Partners
Community Primary Care - Herndon
Community Health Systems
University site (Riverside)
Community Memorial Health
Correctional Health Services - LA County DHS
Desert Oasis Healthcare
Bermuda Dunes
Dignity Health Mark Twain
Dignity Health Mercy Redding
Dignity Health Sierra Nevada
DoPH San Bernardino Clinics
Dignity Health Mercy Redding
Dignity Health Sierra Nevada
DoPH San Bernardino Clinics
El Centro Regional Medical Center
Elica Health Centers
Family Health Centers of San Diego
Fresno American Indian Health Project
Fresno Geriatric Medical Group
Golden Valley Health Centers
Hill Country Community Clinic
Innercare (Clinicas de Salud del Pueblo)
Kaiser Permanente Fontana
Kaiser Permanente Riverside
Kaweah Delta Health Care District
La Clinica
LA County DHS
Lifelong Medical
Over 60 Health Center
Livingston Community Health
Loma Linda University Health
Marshall Medical
Morongo Basin Healthcare District
Neighborhood Healthcare
El Cajon site
Temecula site
North East Medical Services
Northern Valley Indian Health
On Lok PACE
On Lok PACE at 30th St.
On Lok PACE at IOA
On Lok PACE Gee Center
On Lok PACE Powell Center
On Lok PACE San Jose Center

Participating Systems and Affiliated Sites

Open Door Community Health Centers
Operation Samahan Health
Mira Mesa site
Peach Tree Health
Marysville Clinic
Redwood Coast PACE
Ridgecrest Regional (Reen Medical Group)
Riverside and San Bernardino Indian Health
Riverside University Health System
Geriatric Clinic
Hospital Primary Care Clinic
Roots Community Health
Round Valley Indian Health Center
SAC Health System
Salinas Valley Health
San Fernando Community Health Centers
San Francisco Health Network
Richard H. Fine People's Clinic
San Ysidro Health
Santa Clara Valley Health
Santa Clara Valley Health - Moorpark
Valley Health Center
Shasta Cascade Health Centers
Shasta Community Health Center
Shingletown Health Center
St. Mary's Medical Center - Providence
St. Paul PACE
Sutter Memorial Hospital Los Banos
Sutter South Valley Region
UCI Health Santa Ana
United Health Centers of San Joaquin
United Indian Health Services
ViaCare
WellSpace Health
Zocalo Health

Partner Organizations

Organization	Type of Organization
California Academy of Family Physicians	Professional society
California Area Indian Health Service	Association
California Primary Care Association	Clinic Consortia
Caregiver Resource Center Orange County	Provides caregiver support services to communities throughout Orange County.
Coalition of Orange County Community Health Centers	Coalition of 27 FQHC/Look-alike clinics
Community Health Center Network (CHCN)	Network of 8 FQHCs
Common Spirit/Dignity North State Quality Care Network	Quality improvement (QI) network that includes physicians and staff at 3 hospitals
Community Health Association Inland Southern Region	Clinic Consortia
County of San Diego HHSA	County/government
Health Alliance of Northern California	Network of Federally Qualified Health Centers
HottoCare	Dementia specialty practice
Inland Empire Health Plan	Medi-Cal managed care plan
L.A. Care Health Plan	Medi-Cal managed care plan
Molina Healthcare	Health Plan with Medi-Cl product
Partners In Care Foundation	Care coordination and community-based health services provider
SCAN Health Plan	HMO + Medi-Cal Plan
Somang Society (CBO)	CBO
The Neuron Clinic	Specialty neurology clinic

Appendix B: Evaluation Focus Areas, Questions, Tools, and Methods

Evaluation Focus	Key evaluation question(s)	Tools and Methods
Describe participating systems and sites	*Were recruitment goals met and how? What were the participant characteristics, including level of initial dementia capability?*	
Organizational characteristics		Project registry
Initial dementia capability		Initial Dementia Capability Scores
Describe project team activities	*How did the HSDs support participants?*	
Efforts to identify and recruit potential participants		HSD Exit Interviews Participant Interviews (first round)
Type and frequency of HSD activities that support participants		Proposal Activity Logs Proposal Reference Table HSD Exit Interviews
Describe changes to structures and processes at systems and sites	*Did dementia capability improve at participating organizations?*	
Creation or enhancement of structures and processes that support optimal dementia care, such as training availability and requirements, or electronic health record enhancements that make it easier to deliver better care.		Dementia Capability Scores (at up to three points in time) Participant Surveys Participant Interviews
Describe changes in practice at clinical sites	*Were there measurable changes in practice?*	
Changes in the proportion of staff trained, older adults screened/assessed, or patients/caregivers referred to services		Dementia Capability Scores Data shared by participants Participant surveys
Intervention efficacy, lessons learned, and promising practices	*Were recruitment goals met? Is there an association between HSD work and improvement in specific aspects of dementia capability? What lessons were learned? Are there promising/best practices that merit dissemination and replication?*	
Did the project design allow the team to meet recruitment and impact goals?		Project Registry
Did HSD work lead to improvement in specific aspects of dementia capability?		Dementia Capability Scores Proposal Reference Table Proposal Activity Log
What are key lessons learned from HSD and participant perspectives?		Participant Interviews Participant Surveys HSD Exit Interviews
What are promising practices for encouraging dementia care practice change among different types of provider organizations?		Participant/HSD Interviews Case Study interviews Analysis of Dementia Capability Scores + Proposal Activity + Registry

Appendix C: Dementia Capability Scoring Tool (DCST)

	Capability Area	0	1	2	3	Unknown
1	Awareness (of importance of dementia screening/care for site's population)	None	Aware but low priority (e.g., it is an issue discussed informally between providers or at clinic provider meetings but no plans to formally address)	Aware, internal priority (planned or active initiatives, e.g., planned educational effort or active QI project)	Active internal efforts and working to raise awareness in the community (e.g., providing ongoing dementia education to patients and caregivers, recruiting patients/caregivers for AA Walk)	Unknown
2	Formal Training for Clinical Staff	None	One-time dementia care training completed (DCA for example)	Ongoing training (e.g., extended educational efforts like ECHO, or dementia care training that is part of onboarding for clinical staff, or refresher training required for existing clinical staff, etc.)	Ongoing internal training **and** training other organizations in dementia care best practices (i.e., coaching or conducting workshops for other sites in the same system)	Unknown
3	Proportion Clinical Staff Trained	None	Some clinical staff trained (estimate <one third)	Many clinical staff trained (estimate between one third and two thirds)	Most clinical staff trained (estimate more than two thirds)	Unknown
4	Patient Screening Policy	None	Policy exists, but clinicians are largely unaware of it, or policy has not been actively supported by site leadership	Policy is in place and operationalized (e.g., the policy is written, communicated to relevant staff, and is supported by site leadership)	Policy is in place and is supported by EMR (e.g., dementia screening is prompted via a **BPA*** or care gap flag)	Unknown
5	Proportion Eligible Patients Screened	None	Some patients are being screened (estimate <one third of those who would benefit from screening)	Many patients are being screened (estimate between one third and two thirds of those who would benefit from screening)	Most patients are being screened (estimate more than two thirds of those who would benefit from screening)	Unknown
6	Patient Assessment Policy	None	Policy exists, but clinicians are largely unaware of it, or policy has not been actively supported by site leadership	Policy is in place and is operationalized (e.g., the policy is written, communicated to relevant staff, and is supported by site/system leadership)	Policy is in place and is supported by EMR (e.g., assessment prompted via BPA or care gap flag; assessment, note template integrated into EMR)	Unknown
7	Patient Care/Care Planning Policy	None	Care plans are developed; however, no formal policy is in place	Policy is in place and is operationalized (e.g., the policy is written, communicated to relevant staff, and supported by site/system leadership)	Policy is in place and is supported by EMR (e.g., care plan template integrated into EMR)	Unknown

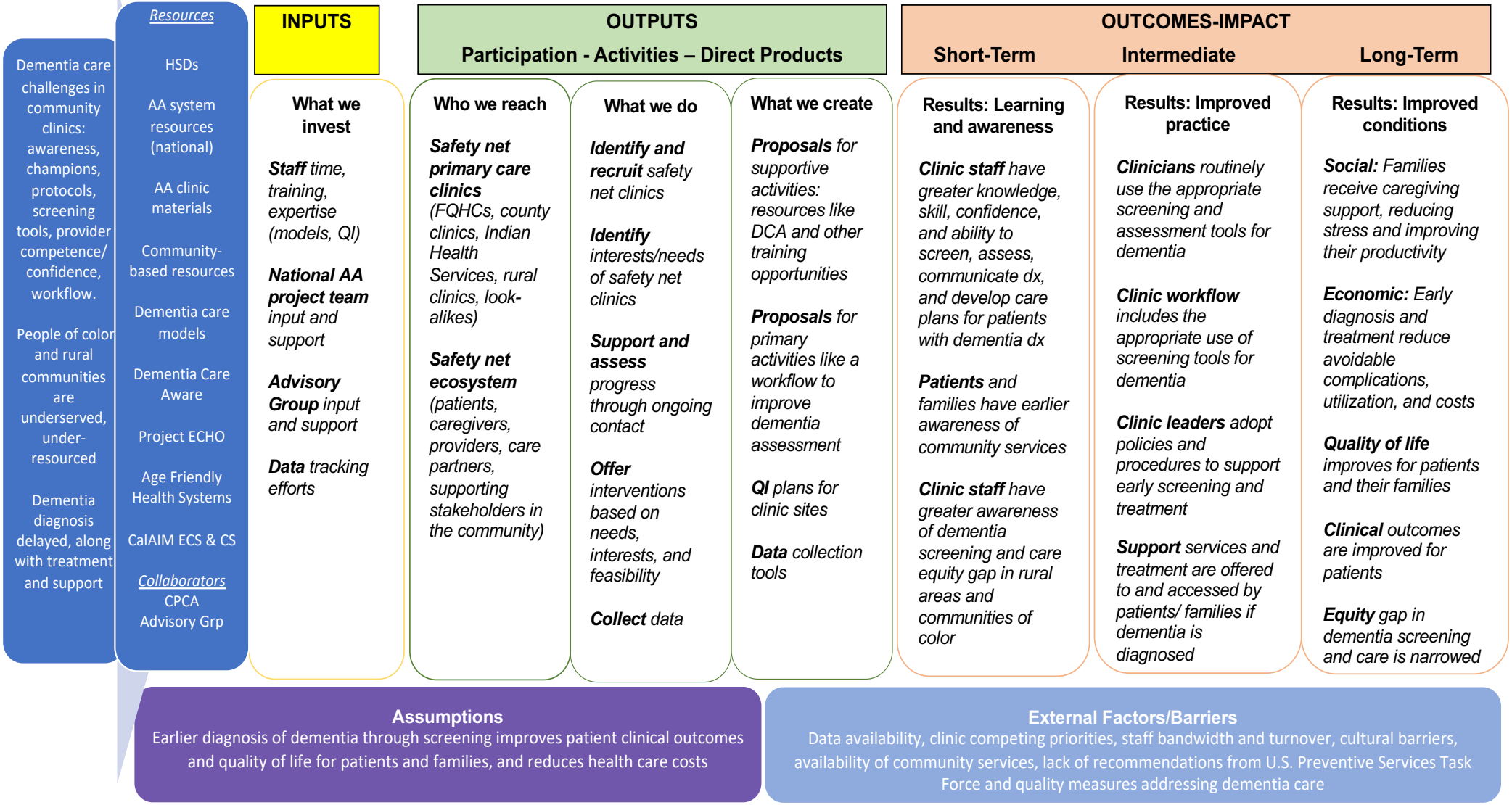
	Capability Area	0	1	2	3	Unknown
8	Caregiver Assessment Policy	None	Caregiver assessments occur, but no formal policy is in place	Policy is in place and is operationalized (e.g., the policy is written, communicated to relevant staff, and supported by site/system leadership)	Policy is in place and is supported by EMR (e.g., assessment template and/or validated tools are integrated into EMR; staff are trained on assessment/tool and routinely use it)	Unknown
9	Caregiver Support Activities	None	Caregivers are supported informally, but there is no policy or standard practice	Structured approach to caregiver support is in place (e.g., policy/standardized approach to referring caregivers to in-person or online resources)	Site follows structured approach to caregiver support, **and** staff use assessment/tool results to make formal caregiver referrals (e.g., behavioral health, In-Home Supportive Services-IHSS)	Unknown
10	Referrals	None	Referrals happen on a case-by-case basis, with no formal policy/standard practice in place	Policy/standard practice is in place and is operationalized (e.g., the policy is written, communicated to relevant staff, and supported by site/system leadership); maintaining an updated list of resources available to patients and families counts as standard practice	Policy/standard practice is in place and is supported by EMR (e.g., process for referring to medical specialists or services for patients and caregivers is integrated in EMR)	Unknown
11	Quality Assurance	None	Ad hoc assessments occur, but nothing is done routinely	Routine assessment of some metrics (tracking use of validated cognitive assessment tools for example)	Routine assessment of metrics and using data/findings to inform Quality Improvement (QI) projects	Unknown
12	Promoting Equitable Dementia Care	None	DEI best practices are reflected in clinic patient-facing materials, for example materials are translated into languages preferred by patient population or materials use inclusive language	DEI practices are reflected in patient facing materials **and** the clinic has DEI policies in place, e.g., creating a safe environment for dementia screening, assessment, and care regardless of patient circumstances and characteristics such as race/ethnicity, gender, gender identity, sexual orientation, age, income, geographic location, disabilities, or housing status	Clinic has equity/DEI key performance indicators such as percent of providers/staff representing diverse patient population, percent of patient records with sexual orientation, gender identity, and disability status data complete; percent of employees and clinicians who have completed cultural competency training	Unknown
13	Leadership for Dementia Practice Change	None	Clinic leaders are aware of practice change opportunities and express interest (e.g., issue discussed informally between providers or at clinic provider meetings but no plans to formally address)	Clinic leaders routinely participate in efforts to improve practice (e.g., via education, implementing new policies, QI projects)	System leaders support clinical leaders in practice change (e.g., allocate time and resources, requires sites to participate education efforts and QI projects, authorize EMR adaptations)	Unknown

Scoring: DCST can have a total score of 0-39, and the tool can also score each capability area; *BPA: Best Practice Advisory

Appendix D: Project Logic Model

Evaluation Logic Model: Increasing Access to Quality Dementia Care for California's Aging Population

Project Goal: To increase access to early and accurate dementia diagnosis and enhance the quality of care for individuals with dementia and their families in California safety net primary care settings.



Legend: Health Services Director (HSD); Dementia Care Aware (DCA); Federally Qualified Health Center (FQHC); Quality Improvement (QI); Project Extension for Community Healthcare Outcomes (ECHO); California Primary Care Association (CPCA); CalAIM Enhanced Care Management (ECM) and Community Supports (CS)

Appendix E: Participant Survey (Fall 2024)

Introduction

This survey gathers information from healthcare organizations participating in the Alzheimer's Association dementia care project. The data collected will help the Association and its funding partner, the Archstone Foundation, understand the project's overall success and challenges and provide helpful insights for others seeking to improve dementia care.

Reminder: You are the only person in your organization to receive this survey. If you are not the right person to complete it, please let your Alzheimer's Association project partner know the name and email address of the person who should, and we will resend the survey to them.

1. Your name
2. Your organization
3. Your email address
4. May we contact you if we need to clarify any of your responses?

Dementia Capability Self-Assessment

These questions are designed to evaluate your organization's readiness to enhance dementia care for the patients you serve.

5. Please select the response that best matches the level of awareness in your organization of the importance of conducting dementia screening and delivering optimal dementia care to your patients.
   - No awareness
   - We are aware but it is a low priority
   - We are aware and it is a priority for us
   - We are working on this internally and we are working to raise awareness in the community
   - Unsure
6. Please select the response that best corresponds to the extent to which formal training in dementia screening/care is available to clinical staff.
   - Formal training is not available to clinical staff
   - One-time dementia care training (like Dementia Care Aware) has been offered to staff
   - Clinical staff have access to ongoing training (for example, through project ECHO, or dementia care training that is part of onboarding)
   - Our staff has access to ongoing training, and we are training other organizations in dementia care best practices (for example, by coaching other sites in your system)
   - Unsure
7. Please select the response that best describes the proportion of clinical staff at your organization that have completed training in dementia screening or care.
   - None
   - Some clinical staff trained (estimate: less than one-third)
   - Many clinical staff trained (estimate: between one-third and two-thirds)
   - Most clinical staff trained (estimate: more than two thirds)
   - Unsure
8. Please select the response that best describes the status of policies that speak to screening patients for dementia.
   - There is no formal policy
   - A policy exists, but clinicians are largely unaware of it, or the policy has not been actively supported by leadership
   - A policy exists, has been communicated to relevant staff, and is supported by leadership
   - A policy has been operationalized and is supported by our EMR (the EMR prompts providers to screen for dementia, for example)
   - Unsure
9. Please select the response that best describes the proportion of appropriate patients currently being screened for dementia.
   - No patients are being screened
   - Some patients are being screened (estimate: less than one-third of those who would benefit from screening)
   - Many patients are being screened (estimate: between one-third and two-thirds of those who would benefit from screening)
   - Most patients are being screened (estimate: more than two-thirds of those who would benefit from screening)
   - Unsure
10. Please select the response that best describes the status of policies related to assessing patients for dementia.
    - There is no formal policy
    - Policy exists, but clinicians are largely unaware of it, or policy has not been actively supported by site leadership
    - Policy is in place and is operationalized and is supported by leadership
    - Policy is in place and is supported by our EMR (assessment note template has been integrated into the EMR, for example)
    - Unsure
11. Please select the response that best describes the status of policies related to providing care and care planning for patients with dementia.
    - There is no formal policy
    - Policy exists, but clinicians are largely unaware of it, or policy has not been actively supported by site leadership
    - Policy exists, has been communicated to relevant staff, and is supported by leadership
    - Policy is in place and is supported by our EMR (a dementia care plan template has been integrated into your EMR, for example)

12. Please select the response that best describes the status of policies related to assessing the needs of caregivers of patients with dementia
    - o There is no formal policy
    - o Policy exists, but clinicians are largely unaware of it, or the policy has not been actively supported by site leadership
    - o Policy is in place, has been communicated to relevant staff, and is supported by leadership)
    - o Policy is in place and is supported by our EMR (for example, validated tools for conducting caregiver assessments are integrated into your EMR)
    - o Unsure

13. Please select the response that best describes the status of caregiver support activities at your organization.
    - o We do not engage in caregiver support activities
    - o Caregivers are supported informally, but there is no policy or standard practice
    - o A structured approach to caregiver support is in place (for example, you use a standardized approach to referring caregivers to in-person or online resources)
    - o We have a structured approach to caregiver support, **and** staff use assessment/tool results to make formal caregiver referrals (for example, to In-Home Supportive Services-IHSS)
    - o Unsure

14. Please select the response that best describes how your organization refers patients with dementia to medical specialists or services.
    - o We do not make referrals
    - o Referrals happen on a case-by-case basis, but no formal policy/standard practice is in place
    - o Policy/standard practice is in place and is operationalized. Note: maintaining an updated list of resources available to patients and families counts as standard practice
    - o Policy/standard practice is in place and is supported by your EMR (for example, a process for referring to medical specialists is integrated in your EMR)
    - o Unsure

15. Please select the response that best describes your organization's approach to assessing and improving the quality of dementia care it provides.
    - o We do not have a QA or QI process for dementia care
    - o Ad hoc quality assessments occur, but nothing is done routinely
    - o We routinely assess some metrics
    - o We routinely assess metrics, and we are using findings in quality improvement projects
    - o Unsure

16. Please select the response that best describes your organization's approach to promoting equitable dementia care
    - o We have not focused on this
    - o DEI best practices are reflected in clinic patient-facing materials; for example, materials are translated into languages preferred by our patient population
    - o DEI best practices are reflected in patient-facing materials, **and** the clinic has DEI policies in place (for example, your organization has a policy regarding expectations for creating a safe environment for dementia screening regardless of patient circumstances and characteristics.)
    - o Clinic has equity/DEI key performance indicators, such as the percent of providers/staff representing diverse patient populations.
    - o Unsure
17. Please select the response that best describes organizational leadership engagement in dementia practice change.
    - o Our leaders are not engaged in dementia practice change
    - o Clinic leaders are aware of practice change opportunities and express interest (for example, issue discussed at clinic provider meetings)
    - o Clinic leaders routinely participate in efforts to improve practice (by implementing new policies, QI projects, etc.)
    - o System leaders support clinical leaders in practice change (for example, allocate time and resources, require sites to participate in education efforts and QI projects, etc.)
    - o Unknown

The remaining questions ask about your experience working with the Alzheimer's Association and the Health System Director, who has been your key contact/partner in improving dementia care at your organization.

18. What have been the most **helpful aspects** of working with the Health System Director from the Alzheimer's Association?

19. Thinking of the activities you have undertaken in partnership with your Health System Director/the Alzheimer's Association, which **activities have been most useful** or **beneficial**?

20. What **changes** would you recommend for how Health System Directors / the Alzheimer's Association supports organizations like yours to improve dementia care?

21. Would you participate in a project like this **again**? Why or why not

Appendix F: Supplemental Data

PERCENTAGE OF PARTICIPANTS WITH LOW INITIAL DEMENTIA CAPABILITY SCORES

HSDs provided initial assessments of dementia care capability for 79 participants. In the table below, the Initial Assessments column details the number of systems for which a domain could be assessed – meaning the HSD did not score the domain as "Unknown." HSDs assessed low capability (score of "0" or "1") in 59-89% of participants across the 13 capability areas.

The high proportion of systems with low capability at the time of engagement validated the depth and breadth of the problem the initiative was designed to address.

Table 1. Percentage of Participants with Low Initial Dementia Capability Scores by DCST Domain*

DCST Domain	# Initial Assessments (n)	% Low Capability (Score = 0 or 1)
Caregiver Assessment Policy	19	89%
Leadership for Dementia Practice Change	70	81%
Patient Assessment Policy	25	80%
Percent Clinical Staff Trained	65	80%
Percent Eligible Population Screened	53	77%
Formal Training for Clinical Staff	76	76%
Patient Care/Care Planning Policy	28	75%
Caregiver Support Activities	35	71%
Patient Screening Policy	42	71%
Promoting Equitable Dementia Care	29	69%
Quality Assurance Practices	29	66%
Referral Policies and Practices	30	60%
Awareness of importance of dementia screening/care	75	59%

**Results for 79 participants with initial DCST assessments.*

NUMBER OF ACCEPTED PROPOSALS POTENTIALLY IMPACTING EACH DCST DOMAIN

In collaboration with the project team, the evaluation team determined which areas of dementia capability would possibly be impacted by each proposal. The table below details the number of accepted proposals associated with each DCST domain.

Some proposals, like DCA and Project ECHO, could affect nearly all DCST domains; many others had a narrower focus, for example, implementing an EMR enhancement to streamline referral processes might only impact one domain.

Table 2: Number of Accepted Proposals Potentially Impacting Each DCST Domain

DCST Domain	Associated Proposals (n)	Accepted (%) (n=256)
Awareness of importance of dementia screening/care	202	79%
Patient Screening Policy	176	69%
Percent Eligible Population Screened	174	68%
Caregiver Support Activities	163	64%
Referral Policies and Practices	163	64%
Caregiver Assessment Policy	162	63%
Patient Assessment Policy	161	63%
Formal Training for Clinical Staff	157	61%
Patient Care/Care Planning Policy	157	61%
Percent Clinical Staff Trained	152	59%
Promoting Equitable Dementia Care	116	45%
Leadership for Dementia Practice Change	33	13%
Quality Assurance Practices	16	6%

CHANGES IN DOMAIN SCORES INITIAL VS. SECOND ASSESSMENT

Among the 51 systems with at least two HSD-completed DCST assessments, initial scores showed substantial gaps in capability at the time systems first engaged with the project, and follow-up scores showed significant improvements. The table below details these findings.

- The "Systems Assessed" column specifies the number of systems where a specific domain could be assessed (i.e., it was not scored "unknown" in either the first or second assessment)
- The "% Systems with Initial Score = 0" column specifies the percentage of assessed systems where the initial DCST score was zero, for each domain
- The "Systems with Improvement at 2nd Assessment" column specifies the number of assessed systems where the second DCST score was better than the initial DCST score
- The "% with Improved Score" indicates the percentage of assessed systems in which the 2nd DCST score was higher than the initial score.

Given that initial capability was so low, with more than half of assessed systems scoring zero on the first assessment in many domains, it is both significant and unsurprising that follow-up assessments showed marked improvement.

Table 3: Changes in Domain Scores Initial vs. Second Assessment*

DCST Domain	Systems Assessed (n)	% Systems with Initial Score = 0	Systems with Improvement at 2nd Assessment (n)	% Systems with Improved Score
Leadership for Dementia Practice Change	43	67%	40	93%
Percent Clinical Staff Trained	42	76%	37	88%
Caregiver Assessment Policy	13	69%	11	85%
Quality Assurance Practices	14	43%	11	79%
Caregiver Support Activities	19	68%	15	79%
Formal Training for Clinical Staff	48	75%	38	79%
Awareness of importance of dementia screening/care	48	29%	36	75%
Referral Policies and Practices	14	36%	7	50%
Patient Assessment Policy	17	65%	7	41%
Patient Care/Care Planning Policy	15	33%	6	40%
Patient Screening Policy	30	70%	12	40%
Promoting Equitable Dementia Care	13	8%	5	38%
Percent Eligible Population Screened	34	44%	13	38%

**Results for 51 participating systems for which HSDs had generated at least two scores. Results shown where a numeric score was available for the domain in both assessments (domains rated "Unknown" excluded)*

CHANGES IN DOMAIN SCORES INITIAL VS. THIRD ASSESSMENT

The trend of dementia capability improving over time was evident when examining scores for the 40 participating systems where HSDs completed three DCST assessments. The table below details the number of systems where the domain could be assessed, the percentage of those systems where the domain was initially scored zero, and the number and percentage of systems where the third DCST score was better than the first DCST score.

Given that 70%-100% of assessed systems showed improvement between the first and third assessments, these findings could indicate that longer engagement with the project (a prerequisite for having three DCST scores) results in more reliable improvement in dementia care capability, even in the setting of very low initial capability.

Table 4: Changes in Domain Scores Initial vs. Third Assessment*

DCST Domain	Systems Assessed (n)	% Systems w/ Initial Score = 0	Systems w/ Improvement (3rd vs. 1st) (n)	% Systems w/ Improved Score
Patient Care/Care Planning Policy	10	30%	10	100%
Caregiver Support Activities	18	67%	18	100%
Leadership for Dementia Practice Change	37	76%	37	100%
Referral Policies and Practices	13	38%	13	100%
Percent Clinical Staff Trained	35	80%	34	97%
Formal Training for Clinical Staff	38	82%	37	97%
Awareness of importance of dementia screening/care	38	32%	36	95%
Caregiver Assessment Policy	8	50%	7	88%
Patient Screening Policy	16	81%	14	88%
Percent Eligible Population Screened	24	38%	20	83%
Promoting Equitable Dementia Care	11	9%	9	82%
Quality Assurance Practices	10	60%	8	80%
Patient Assessment Policy	10	50%	7	70%

**Results for 40 participating systems for whom HSDs had generated at least three scores. Results shown where a numeric score was available for the domain in all three assessments (domains rated "Unknown" excluded)*

COMPARISON OF INITIAL AND FINAL AVERAGE DCST SCORES

Comparisons of average initial and average final domain scores for the 40 systems with three HSD-completed DCST assessments highlight the magnitude of the improvement opportunity and the extent to which improvement was achieved.

The table below details the number of systems where the domain could be assessed (i.e. not scored as "Unknown"), as well as the average initial and final (3rd) score among all assessed systems.

Table 5: Comparison of Initial and Final Average DCST Scores *

DCST Domain	Systems Assessed (n)	Avg. Score (Initial)	Avg. Score (3rd Assessment)
Patient Assessment Policy	10	0.60	2.10
Awareness of importance of dementia screening/care for site's population)	38	0.87	2.50
Patient Care/Care Planning Policy	10	0.80	2.50
Caregiver Assessment Policy	8	0.50	1.75
Caregiver Support Activities	18	0.33	2.61
Promoting Equitable Dementia Care	11	1.00	2.45
Leadership for Dementia Practice Change	37	0.24	2.27
Percent Eligible Population Screened	24	0.71	2.13
Percent Clinical Staff Trained	35	0.26	2.26
Quality Assurance Practices	10	0.60	2.40
Referral Policies and Practices	13	0.62	2.62
Patient Screening Policy	16	0.38	2.13
Formal Training for Clinical Staff	38	0.26	2.34

**Results for 40 participants for whom HSDs had generated three scores. Results shown where a numeric score was available for the domain in all three assessments (domains rated "Unknown" excluded). Note: System Assessed (n) refers to systems where the listed domain could be assessed.*

COMPARISON OF HSD ASSESSMENTS AND PARTICIPANT SELF-ASSESSMENTS

To assess alignment between participating systems and HSD perspectives on dementia care capability, an online self-assessment survey was administered in fall 2024. The survey mirrored the DCST domains and used the same 0–3 scoring scale. Thirty-three participants completed at least a portion of the survey, and for 28 systems, there was a corresponding DCST assessment that was generated by an HSD within 6 months of survey completion.

The table below shows the extent to which participant and HSD perceptions of dementia capability were aligned.

- The "Systems Assessed" column reports the number of systems where both the survey response and the HSD DCST included numeric ratings (i.e., not scored as "Unknown")
- The "Avg Score (HSD Assessment)" and "Avg Score (Participant Survey)" present an average of the scores generated by HSDs and participants, for each domain
- The "Difference (HSD-Participant)" column details the difference between the average scores generated by HSDs and participants

Overall, HSD-generated scores closely aligned with participants' self-assessment ratings in this subset of organizations.

Table 6: Comparison of HSD Assessments and Participant Self-Assessments*

DCST Domain	Systems Assessed (n)	Avg. Score (HSD Assessment)	Avg. Score (Participant Survey)	Difference (HSD – Participant)
Awareness of importance of dementia screening/care	22	1.76	1.39	0.37
Formal Training for Clinical Staff	22	1.35	1.18	0.17
Percent Clinical Staff Trained	21	1.62	1.43	0.19
Patient Screening Policy	9	1.59	1.35	0.24
Percent Eligible Population Screened	14	1.26	1.19	0.07
Patient Assessment Policy	4	1.28	1.23	0.05
Patient Care/Care Planning Policy	6	1.30	1.19	0.11
Caregiver Assessment Policy	6	1.28	1.18	0.10
Caregiver Support Activities	10	1.25	1.15	0.10
Referral Policies and Practices	7	1.30	1.25	0.05
Quality Assurance Practices	6	2.13	1.40	0.73
Promoting Equitable Dementia Care	6	1.31	1.37	-0.06
Leadership for Dementia Practice Change	22	2.14	2.10	0.04

**Results for the 28 systems where there was both a participant survey response and an HSD DCST assessment completed within a 6-month window.*

SYSTEMS WITH IMPROVEMENT IN DCST SCORES THAT ACCEPTED RELEVANT PROPOSALS

The table below details the association between improved DCST scores and accepting at least one proposal that was related (aligned with) the domain where gains occurred. Data is for the 38 systems for which HSDs generated three DCST scores, where there were complete proposal activity records.

- The "Systems Showing Improvement" column presents the number of systems where the third DCST score was better than the first DCST score
- The "% Improved Systems Accepting Related Proposals" column specifies the percentage of systems that showed improvement and accepted at least one proposal related to the specified domain.

Table 7. % Systems with Improvement in DCST Scores that Accepted Relevant Proposals*

DCST Domain	Systems Showing Improvement (n)	% Improved Systems Accepting Related Proposal(s)
Awareness of importance of dementia screening/care	36	100%
Formal Training for Clinical Staff	36	94%
Leadership for Dementia Practice Change	35	43%
Percent Clinical Staff Trained	33	94%
Percent Eligible Population Screened	23	100%
Caregiver Support Activities	18	94%
Patient Screening Policy	14	100%
Referral Policies and Practices	13	100%
Promoting Equitable Dementia Care	11	100%
Patient Care/Care Planning Policy	10	90%
Quality Assurance Practices	9	56%
Caregiver Assessment Policy	8	88%
Patient Assessment Policy	8	100%

**Results 38 systems with three DCST assessments and documented proposal activity.*

About the Authors

Kathleen Kerr, BA, is a health care consultant and partner in the firm Transforming Care Partners. She has more than 25 years of experience in supporting the design, implementation, and evaluation of sustainable, high-quality serious illness programs across settings. Her work is focused on promoting the development of sustainable, quality palliative care programs, with particular emphasis on payer-provider partnerships, and supporting programs that operate in rural areas and those that serve Medicaid beneficiaries. Prior to becoming a consultant, Kathleen worked at the University of California, San Francisco. She regularly develops educational and technical assistance resources for payers and providers and frequently speaks to national and regional groups on scaling sustainable serious Illness programs.

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