EVALUATION SUMMARY

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

September 2, 2026

Initiative led by the Alzheimer's Association • Funded by Archstone Foundation

Evaluation conducted by LifeCourse Strategies

TODAY'S TOPICS

Agenda

1. Project Background
2. Approach
3. Evaluation Methods
4. Key Findings
5. Challenges
6. Successes
7. Future Considerations
8. Next Steps and New Initiatives

SECTION 1

Project Background

A statewide, three-year initiative to strengthen early dementia screening, diagnosis, and care in primary care practices serving diverse, underserved, and rural Californians.

Too many Californians face dementia without a timely, accurate diagnosis

Timely detection and accurate diagnosis change outcomes — but too often, that's not what people living with dementia experience.

Underdiagnosed & under-disclosed

Alzheimer's and other dementias are severely underdiagnosed and under-disclosed — the gap is widest in communities of color.

A shrinking care workforce

The U.S. would need to triple the number of geriatricians practicing in 2019 to meet 2050 demand for Alzheimer's care.

Better outcomes, lower costs

Timely detection, accurate diagnosis, and proper management of dementia improve health outcomes and reduce the cost of care.

Source: Alzheimer's Association, 2020 Facts and Figures

PROJECT BACKGROUND

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

A three-year initiative, completed June 2025, that helped FQHCs and community-based primary care providers across California strengthen how they support people living with dementia.

Who it served

FQHCs and community-based primary care practices (Systems) — California's safety-net health care system.

The team behind it

Four Health Systems Directors (HSDs) — two in Northern California, two in Southern California — recruited and supported participants.

Advisors

A 27-member Advisory Council — including geriatric and primary care physicians, academic experts, health plan leaders, and community network leaders — supported recruitment and met quarterly to guide the project.

SECTION 2

Approach

HSDs recommended processes and resources — framed as “proposals” — aligned with each system's interests and capacity, then coached teams through implementation.

APPROACH

How Support Was Delivered

APPROACH

Types of Proposals

Variation in focus and scope

PRIMARY

Comprehensive initiatives requiring substantial, ongoing effort

- Project ECHO (UCLA / UCSF)
- GUIDE Model implementation
- Age-Friendly Health Systems (AFHS)
- UCLA ADC Model
- UCSF Care Ecosystem
- System-specific QI & practice change support

SUPPORTIVE

Targeted tools, training, and processes — lower effort, higher acceptance

- Dementia Care Aware (DCA) training
- Cognitive Assessment Toolkit
- Care Planning & Care Navigation tools
- EMR enhancements
- essentiALZ training & certification
- Coaching, consultation & community engagement

SECTION 3

Evaluation Methods

LifeCourse Strategies applied a mixed-methods, theory-of-change-based framework, combining quantitative and qualitative data to assess whether — and how — the initiative changed dementia care delivery.

EVALUATION METHODS

Evaluation Framework

A theory-of-change-based framework organized the evaluation around five focus areas:

1. Describe participating systems and sites
2. Document project team (HSD) activities
3. Identify changes in structures & processes
4. Assess changes in practice at clinical sites
5. Summarize efficacy, lessons learned & promising practices

EVALUATION METHODS

Key Data Sources & Methods

1	**Dementia Capability Scoring Tool (DCST)**	13-domain tool (0–3 scale) completed by HSDs; 170 assessments across 79 systems
2	**Participant Surveys**	Online self-assessment mirroring DCST domains, fielded fall 2024 and fall 2025
3	**Proposal Activity Log**	356 Primary/Supportive proposals tracked via the Association's CRM and HSD records
4	**Participant Interviews**	18 initial interviews (spring 2024); 9 follow-up interviews (fall 2025)
5	**HSD Exit Interviews & Case Studies**	End-of-project interviews with all 4 HSDs, plus 3 detailed case studies

EVALUATION METHODS

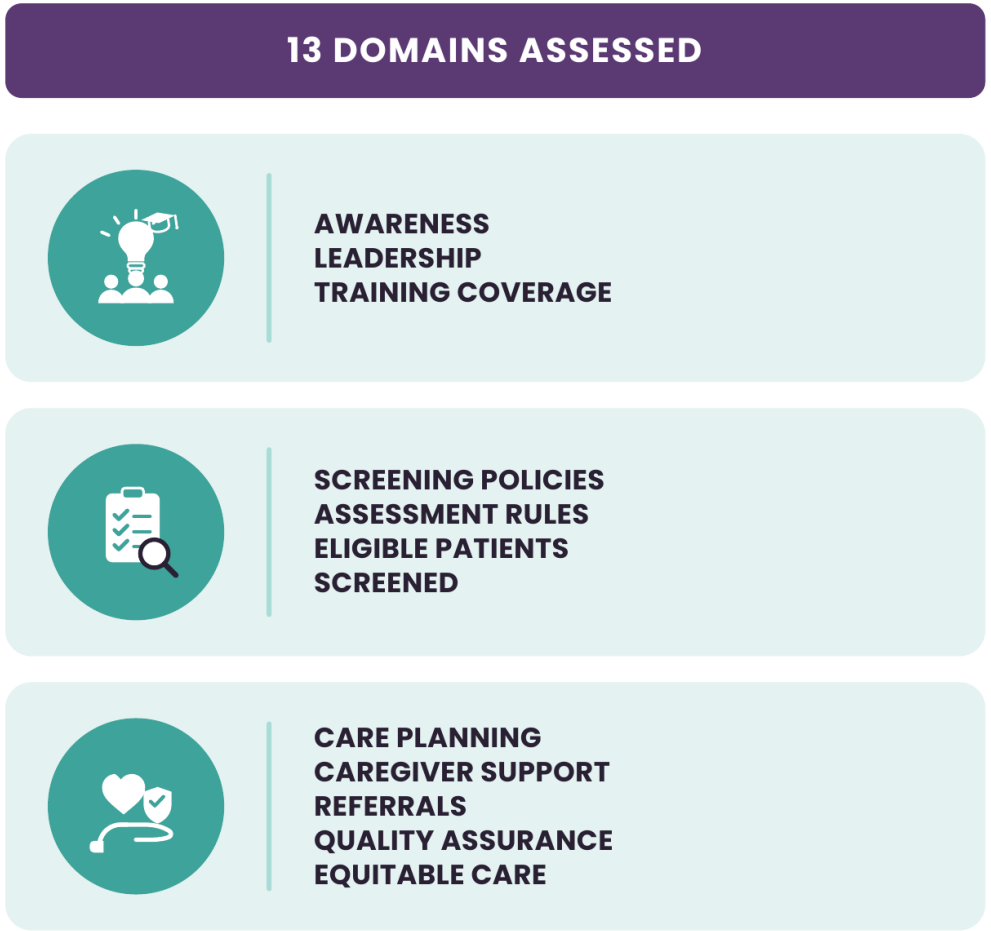
Defining and Measuring Capability

How capability was defined

- Standardized ability to screen, diagnose, treat, and support.
- The DCST tracked organizational readiness and workflows.

13 DCST domains

- Awareness, leadership, and staff training (policy and % trained) for dementia-related care.
- Screening and assessment policies, plus the share of eligible patients screened.
- Care planning, caregiver assessment and support, referrals, equitable care, and quality assurance.



EVALUATION METHODS

DCST Scoring Example

Formal Training for Clinical Staff

0 **Score 0**: None

1 **Score 1**: One-time dementia care training completed (DCA for example)

2 **Score 2**: 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.)

3 **Score 3**: 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)

“We determined that we were screening at an extremely low rate, and that was alarming 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.”

- Project Participant

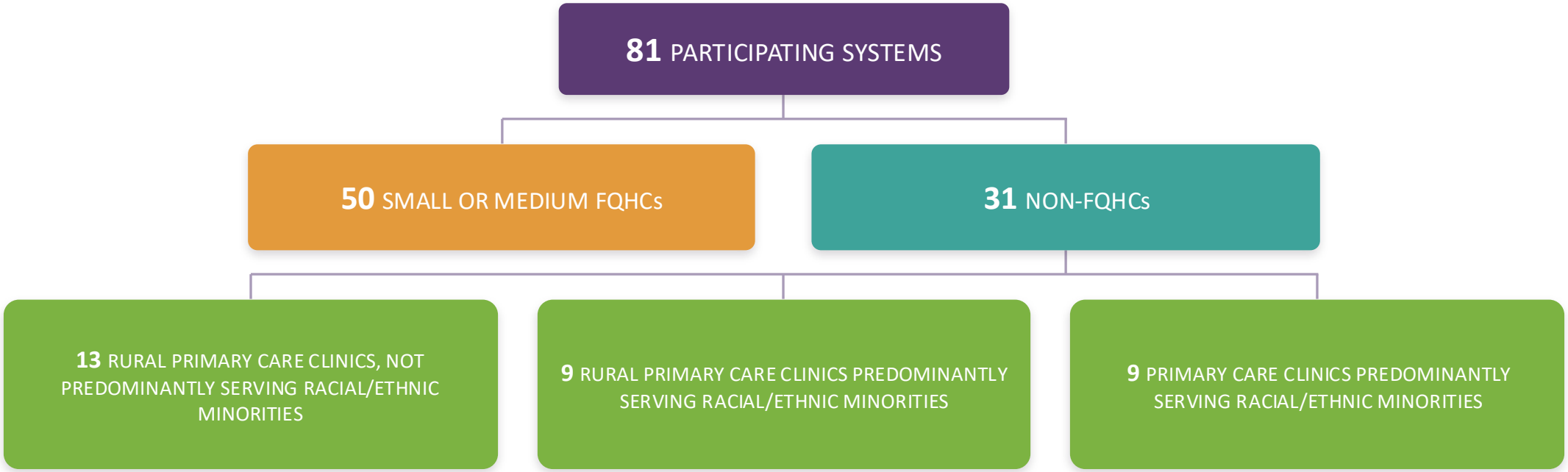
SECTION 4

Key Findings

Despite very low baseline capability, most participating systems demonstrated measurable, and often durable, improvements in dementia care — closely linked to the technical assistance HSDs provided.

KEY FINDINGS

Participating Systems Snapshot

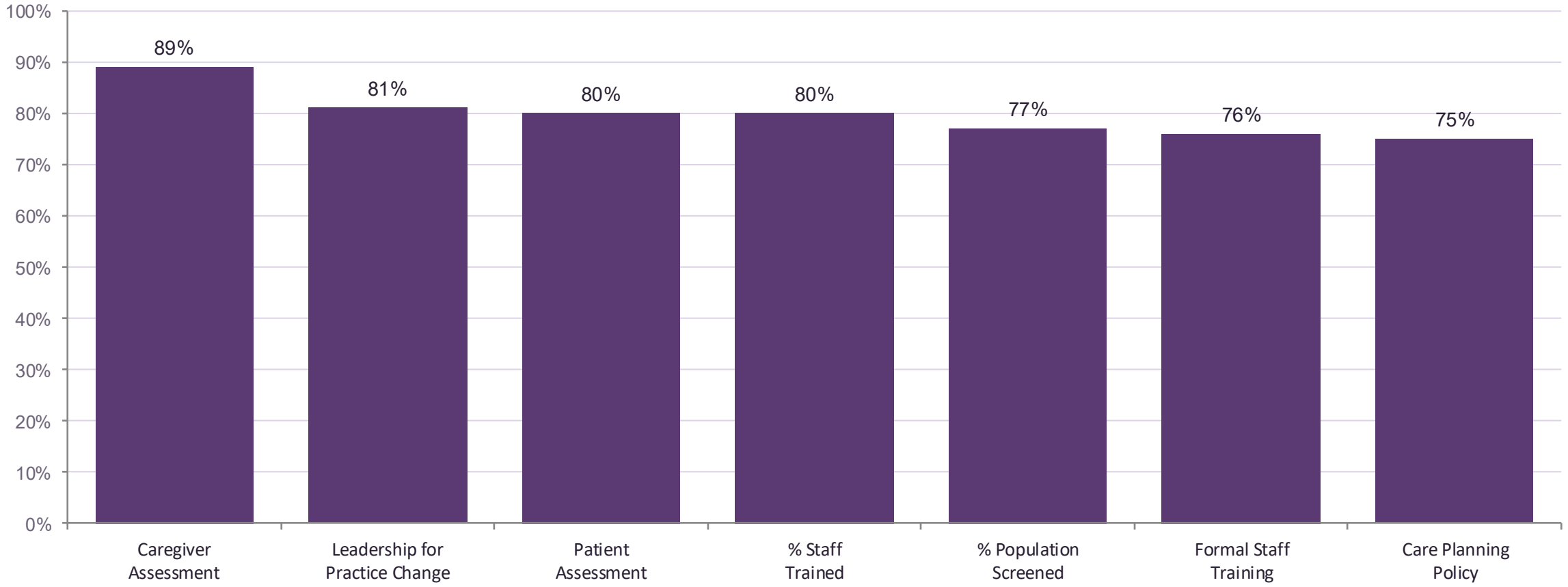


Also represented: PACE programs (4), Indian Health Service / tribal health organizations (6), and systems affiliated with larger health networks such as Adventist and Providence (14).

KEY FINDINGS

Wide Capability Gaps at Baseline

% of participating systems with "low" initial capability (score of 0 or 1) by DCST domain — among 79 systems initially assessed



KEY FINDINGS

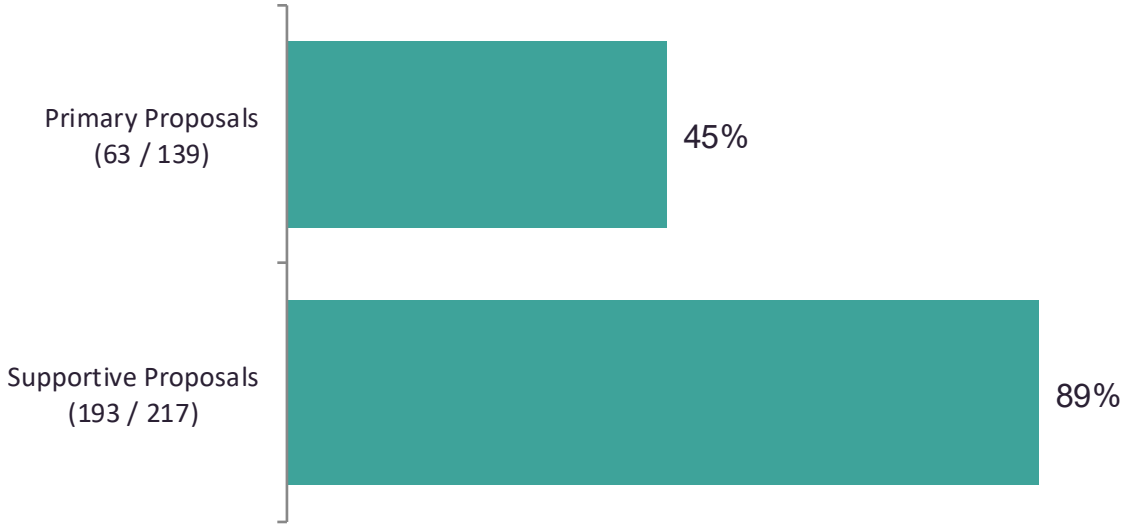
Proposals Shared & Accepted

356
Primary & Supportive proposals shared with participants

78 / 81
Systems accepted at least one proposal (96%)

72%
Overall proposal acceptance rate

Acceptance Rate by Proposal Type



- Dementia Care Aware Training (114) and Project ECHO (85) were the two most-shared proposals — 56% of all proposal activity.
- Proposals tied to external programs (DCA, GUIDE, ECHO) made up 65% of all proposals shared.
- Higher acceptance of Supportive proposals reflects their lower implementation burden for resource-constrained clinics.

KEY FINDINGS

Measurable Improvement in Dementia Care Capability

53%

43 of 81 participating systems

engaged in robust, durable, or ongoing dementia care improvement activities

- Among the 51 systems with multiple DCST assessments, **90% improved** in at least one dementia capability domain.
- More **than one-third improved in six or more** of the 13 DCST **domains** — indicating meaningful, multidimensional practice change.
- Improvements were observed across systems with varying characteristics, baseline capabilities, and readiness levels

KEY FINDINGS

Practice Change Activities

Among the 43 systems with verified robust or durable dementia care improvement activity:

34

systems participated in Project ECHO, some for multiple years

11

achieved AFHS recognition, including 7 at Level 2

5

were accepted into the CMS GUIDE model or UCLA ADC model

10

implemented formal quality improvement projects

15

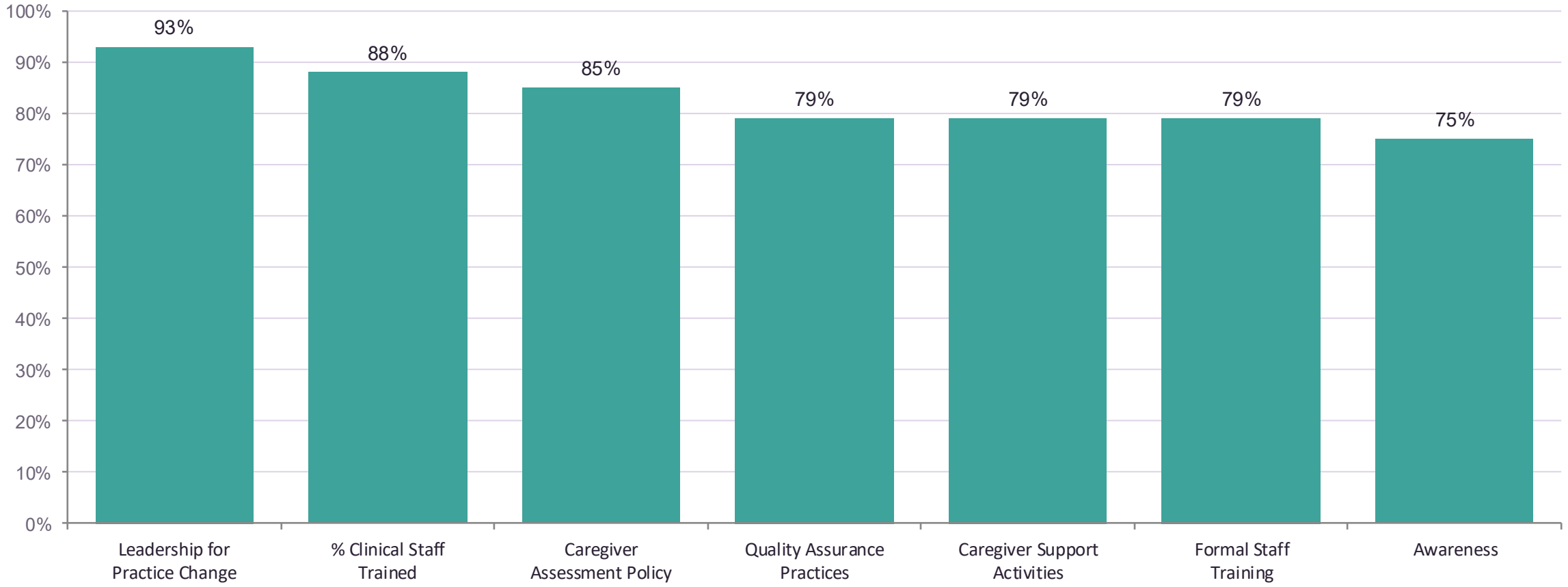
are conducting ongoing monitoring of dementia quality indicators

4

implemented durable workflow or policy changes

Capability Improved Over Time

% of systems (of 51 with two+ DCST assessments) whose score improved between initial and follow-up assessment



KEY FINDINGS

HSD Support Linked to Improvement

Proposal alignment mattered

- Most systems that improved had accepted relevant proposals.
- Pattern held across ECHO, QI, and other durable changes.

Training and screening moved together

- When screening and training scores improved, related supports were typically in place.
- Suggests targeted offers helped translate intent into workflow change.

HSD coaching as the connector

- HSDs matched proposals to readiness, then stayed engaged through follow-up.
- Relationship-based support strengthened adoption despite staffing and time pressure.

Selected Domains: % of Improved Systems with an Accepted, Related Proposal

Patient Screening Policy	100%
Referral Policies & Practices	100%
Percent Eligible Population Screened	100%
Percent Clinical Staff Trained	94%
Caregiver Assessment Policy	88%
Patient Care / Care Planning Policy	90%

“It’s become a greater concern for our organization to screen, especially with the aging population growing 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

SECTION 5

Challenges

Chronic understaffing, workforce turnover, competing clinical demands, and limited reimbursement shaped early dementia care delivery at nearly every participating system.

CHALLENGES

Barriers to Early Dementia Care

1

Time Constraints

Limited appointment time for screening and follow-up; cognitive screening competes with other required health screenings.

2

Resource & Staffing Limits

FQHCs face chronic understaffing and high turnover across clinical and non-clinical roles.

3

Reimbursement Gaps

Cognitive screening is neither required nor incentivized through reimbursement, making consistent implementation difficult.

"I don't have time for a MoCA exam [in the primary care appointment]... 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

CHALLENGES

Structural & Access Gaps

1

Access to Specialists & Treatment

Limited number of neurologists, long appointment wait times, travel distance, and insurance coverage barriers — largely outside participating systems' control.

2

Staff Knowledge & Training

Gaps in staff familiarity with dementia care and with community-based resources such as respite care and caregiver support.

3

Workflows & Protocols

Difficulty embedding screening within time-limited primary care visits and existing clinical workflows.

“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.”

- Project Participant

SECTION 6

Successes

Trusted, patient coaching relationships between clinic teams and HSDs — combined with flexible entry points and recognition of incremental progress — created the conditions for durable practice change.

SUCCESSES

Trusted Relationships Drove Change

- **Demonstrated improvements in dementia care capability**: 90% of systems with multiple assessments improved in at least one domain; over one-third improved in six or more.
- **Sustained coaching**: HSDs' steady outreach, relationship-building, and tailored support were highly valued by participants.
- **Targeted technical assistance**: systems that improved typically had accepted proposals aligned with the specific domains where gains occurred.

> *"We benefited from the education and resources provided by our HSD. When things became difficult, they took us to where we needed to be."*
>
> — Project Participant

SUCCESSES

Sustainability & Unexpected Findings

Strong Commitment to Expansion

- Many systems envisioned early dementia care becoming standard practice and plan to expand across additional clinical sites.
- Priorities for the future include sustainable financing, telehealth integration, alternative screening tools, and stronger data collection.

Two Unexpected Catalysts

- ~1/3 of interviewees had, or were building, a PACE program — offering a strong structural foundation for dementia care.
- ~1/4 were using or planning to use medical residents to help lead dementia QI and care delivery.

"PACE has a team structure and the capability of delivering dementia care in a way that no other program can. 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."

"It's helpful that we have one of our residents spearheading this project. She helps provide education and training, and offers additional support so others understand what the dementia care workflow looks like in the clinic."

“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

SECTION 7

Future Considerations

There are opportunities to build on what worked.

FUTURE CONSIDERATIONS

Strengthening Future Initiatives

1 Take All Comers

Engage any interested system; recognize incremental progress and provide modest financial incentives.

2 Structure with Flexibility

Focus systems on core practice changes while allowing flexible improvement pathways.
Use standardized baseline and follow-up assessments of capability, clear documentation standards, and scheduled HSD–participant touchpoints.

3 Establish Shared Learning

Build a peer learning community to normalize challenges and disseminate promising practices.

4 Expand Language Access & Equity

Ensure tools, workflows, and training are culturally and linguistically responsive.

5 Enhance Structures & Processes

Strengthen regional partnerships and internal referral workflows to community-based dementia resources.

6 Standardize Practice

Elevate dementia competencies through training and certification across health care roles.

EVALUATION LIMITATIONS

Limitations & Closing Thoughts

- Evaluation team was not engaged until 18 months after project start — limiting early baseline data collection.
- The project's intentionally flexible design meant systems joined at different times and addressed different domains, limiting comparisons across systems.
- DCST relied on both HSD scoring and system self-assessment; reliability could not be fully independently verified.
- Post-intervention response rates were low — only 9 of 18 original interviewees completed follow-up interviews, and staff turnover affected response consistency.

Bottom Line

Working with reality — not around it — produced real gains.

Despite chronic understaffing, turnover, and competing demands, trusted HSD relationships and flexible, incremental support helped many California primary care systems make lasting progress in early dementia care.

SECTION 8

Next Steps and New Resources

Introducing

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Launched April 2026

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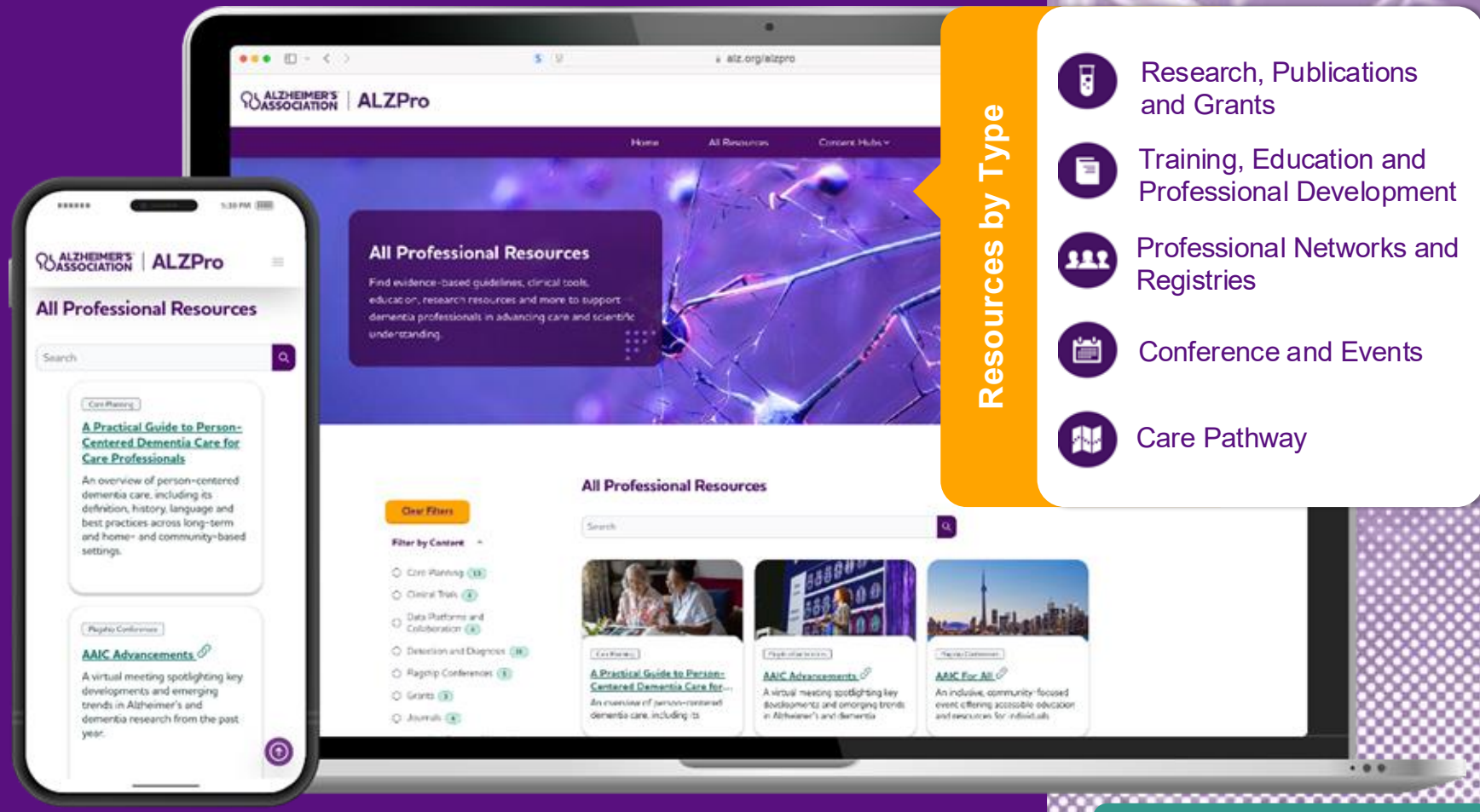

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