Care Ecosystem
Navigating Patients and Families Through Stages of Care

UCSF Weill Institute for Neurosciences
Fein Memory and Aging Center

CARE ECOSYSTEM IMPLEMENTATION TOOLKIT 2026

CONTENTS

WELCOME

This toolkit is designed to help organizations plan, implement, improve, and sustain a dementia care navigation program using the Care Ecosystem model. The Care Ecosystem is an evidence-based dementia care navigation model that supports people living with dementia and their care partners throughout the disease.

Who this Toolkit is For

Health care
Health systems
Academic medical centers
Primary care
Neurology
Geriatrics
Telehealth organizations
Home health & hospice
PACE

Community
Community-based organizations
Area Agencies on Aging
Home care agencies
Residential communities
Day programs
Meal delivery service providers
Case management services
Caregiver support programs

The guidance within this toolkit draws on over a decade of research and implementation experience. Links to open-source tools are provided throughout the toolkit and are available on the Care Ecosystem website.

Scan QR code to go to memory.ucsf.edu/care-ecosystem

Included with the Care Ecosystem Implementation Package

- Online navigator training
- Care protocols
- Education materials
- Implementation Toolkit with templates and resources
- Monthly implementation meetings and continuing education sessions

Attribution Policy

CARE ECOSYSTEM IN BRIEF

Purpose

The purpose of the Care Ecosystem is to support people living with dementia and their care partners through continuous, person-centered dementia care navigation. Activities include identifying goals, screening for unmet needs, escalating concerns, planning, connecting to resources, helping with care coordination and providing ongoing monitoring and support.

Core Components

1. Training in dementia
2. Evidence-based Care Protocols
3. Comprehensive care planning
4. Interdisciplinary clinical supervision
5. Longitudinal monthly follow-up

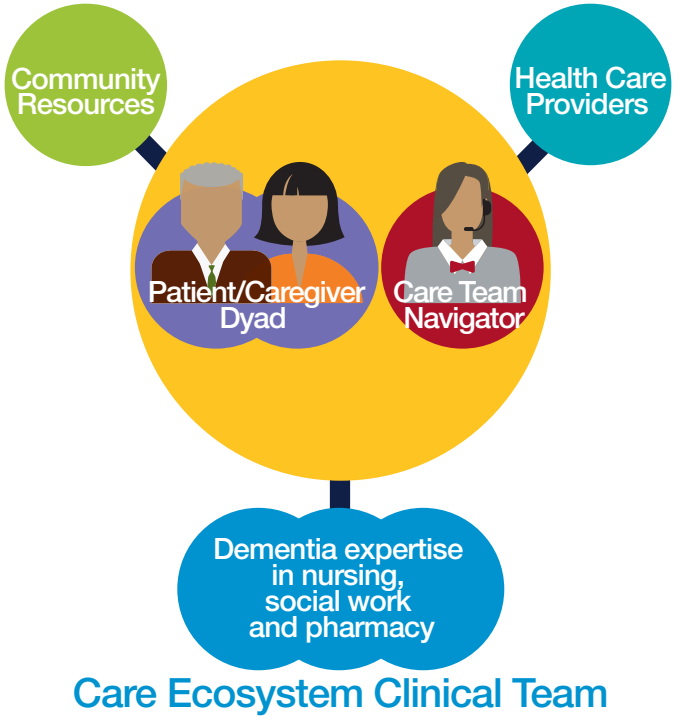

Figure 1. The Care Ecosystem model

Care Ecosystem Team

Care Ecosystem teams vary by organization, but most include the following roles.

Care Navigators may be community health workers, recent college graduates, or medical assistants who are trained to act as the primary point of contact for patient and caregiver dyads.

Clinical Team members have dementia expertise in nursing, social work, and pharmacy and provide help with training, weekly supervision, and as needed triage and consultations.

Referring Health Care Providers are typically primary care, neurology, and geriatrics providers.

Community Resources that navigators refer dyads to include respite agencies, support services (meals, home safety, transportation, caregiver training, support groups), recreation programs, public benefits, and legal services.

The Care Ecosystem Complements Usual Care

The Care Ecosystem was developed to complement existing medical care and bridge community-based services that are essential for people with dementia and their caregivers.

Traditional Healthcare	Care Ecosystem
Episodic visits	Continuous relationship-centered care
Reactive	Proactive planning
Limited time for caregiver support	Emphasis on caregiver support
Medical focus	Medical and community coordination
Limited access	Accessible remote care navigation
Lack of dementia expertise	Training + evidence-based protocols

Implementation Stages

Every organization will have a different starting point and move through the implementation stages on its own timeline. Some will already have dementia care infrastructure in place, while others will be building a program from the ground up. Use these implementation stages as a flexible roadmap and revisit earlier stages as needs, resources, and priorities evolve.

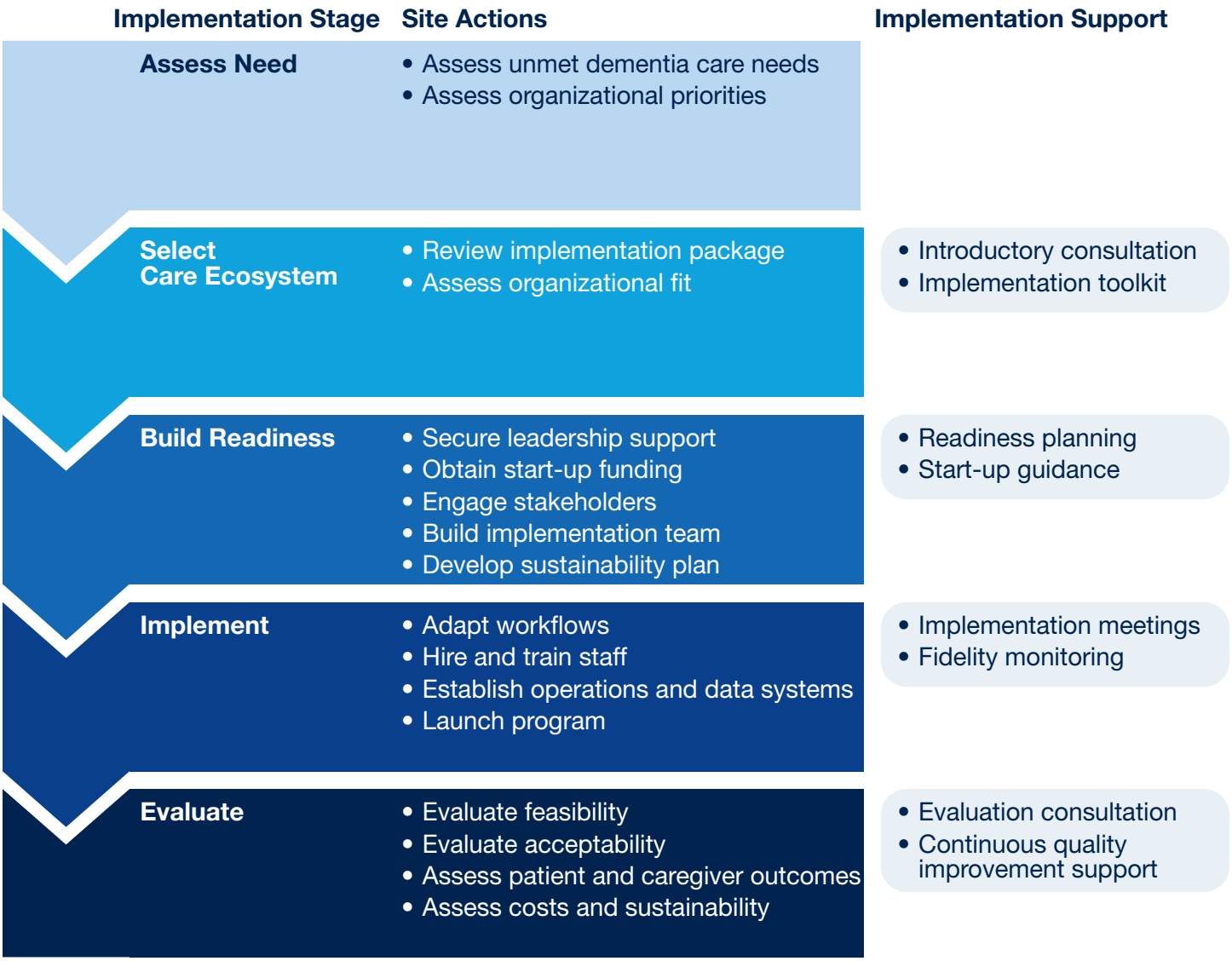

Figure 2. Care Ecosystem Implementation Stages

Lessons Learned from Care Ecosystem Implementers

In 2018, we released the first version of this toolkit and launched monthly implementation meetings with early adopters of the Care Ecosystem model to share experiences, challenges, and effective strategies. Participation grew as additional health systems and community-based organizations adopted the model, with a notable increase following the announcement of Medicare's Guiding an Improved Dementia Experience (GUIDE) Model.

To better understand implementation barriers and facilitators, we surveyed 41 sites that attended at least one meeting; 36 sites responded, including 28 health systems and 8 community-based organizations. Of these, 22 were participating in the GUIDE Model. Findings from this work have been published[1], and key facilitators and barriers are summarized below.

Facilitators

- Identifying a program champion
- Securing buy-in from health system leadership
- Embedding the Care Ecosystem within a supportive clinical or community infrastructure
- Hiring team members who are empathetic and relationship-oriented
- Using the Care Ecosystem's open-source training, care protocols, and implementation guidance, with flexibility for local adaptation
- Establishing strong communication with referring providers or partner programs

Barriers

- Adapting a model designed for clinical settings to community-based environments
- Recruiting appropriate and diverse referrals during early implementation
- Managing staff turnover
- Addressing start-up costs and achieving financial sustainability

1 Sideman AB, Dulaney S, Merrilees J, et al. *J Am Geriatr Soc.* 2025;73(7):2220–2228. doi:10.1111/jgs.19363

OVERVIEW OF THE CARE ECOSYSTEM

Why Dementia Care Navigation?

More than 7 million people in the United States are living with dementia, and that number is expected to nearly double by 2050. At the same time, health systems and communities face workforce shortages, fragmented care, and increasing demand for services that support people living with dementia and their care partners. New disease-modifying therapies for Alzheimer's disease have further increased the need for specialized diagnosis, access to treatment, and ongoing coordinated care.

For many families, navigating dementia care is overwhelming. Care is often delivered across multiple settings, including primary care, specialty clinics, hospitals, home health agencies, and community organizations. Family caregivers frequently coordinate appointments, manage medications and finances, respond to behavioral changes, monitor safety, and locate community resources with limited guidance or support. Family caregivers experience increased stress[2], depression[3,4], physical illness[5,6], and out-of-pocket financial costs[7,8]. Caregiver mental health has been associated with adverse outcomes for the person with dementia including accelerated cognitive decline[9], earlier long-term care placement[10], increased emergency department use[11], elder abuse[12], and mortality risk[13].

Although traditional medical visits are essential, they are not designed to provide the continuous education, coordination, and support that many families need through the course of dementia.

What Is the Care Ecosystem?

The Care Ecosystem is an evidence-based dementia care navigation model that complements medical care provided by primary care clinicians and specialists.

Each participant and their care partner are paired with a trained care navigator who provides ongoing support throughout the program and serves as the primary point of contact. Care navigators work under the supervision of an interdisciplinary clinical team with expertise in dementia care and collaborate closely with medical providers and community organizations.

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2 Vitaliano PP, Zhang J, Scanlan JM. *Psychol Bull.* 2003;129(6):946–972. doi:10.1037/0033-2909.129.6.946

3 Merrilees, J. *Curr Neurol Neurosci Rep* 16, 88 (2016). doi.org/10.1007/s11910-016-0692-z

4 Covinsky KE, Newcomer R, Fox P, et al. *J Gen Intern Med.* 2003;18(12):1006-1014. doi:10.1111/j.1525-1497.2003.30103.x

5 Schulz R, Beach SR. *JAMA.* 1999;282(23):2215–2219. doi:10.1001/jama.282.23.2215

6 Pinquart M, Sörensen S. *Psychol Aging.* 2003;18(2):250–267. doi:10.1037/0882–7974.18.2.250

7 Delavande A, Hurd MD, Martorell P, Langa KM. *Alzheimers Dement.* 2013;9(1):19–29. doi:10.1016/j.jalz.2011.11.003

8 Kelley AS, McGarry K, Gorges R, Skinner JS. *Ann Intern Med.* 2015;163(10):729–736. doi:10.7326/M15-0381

9 Norton MC, Clark C, Fauth EB, et al. *Int Psychogeriatr.* 2013;25(10):1629–1637. doi:10.1017/S1041610213001105

10 Yaffe K, Fox P, Newcomer R, et al. *JAMA*. 2002;287(16):2090–2097. doi:10.1001/jama.287.16.2090

11 Guterman EL, Allen IE, Josephson SA, et al. *JAMA Neurol.* 2019;76(10):1166–1173. doi:10.1001/jamaneurol.2019.1820

12 Browning WR, Yildiz M, Hernandez Chilatra JA, et al. *Res Gerontol Nurs.* 2024;17(5):227–236. doi:10.3928/19404921-20240808-01

13 Lwi SJ, Ford BQ, Casey JJ, Miller BL, Levenson RW. *Proc Natl Acad Sci U S A.* 2017;114(28):7319–7324. doi:10.1073/pnas.1701597114

Care navigation is guided by evidence-based Care Protocols that promote comprehensive, person-centered care while allowing flexibility to address each participant's goals, preferences, and changing needs.

The Care Ecosystem is built around five core components:

1. Training in dementia
2. Evidence-based Care Protocols
3. Comprehensive care planning
4. Interdisciplinary clinical supervision
5. Longitudinal monthly follow-up

The Care Ecosystem centers on an ongoing relationship between the care navigator, the person living with dementia, and the care partner. Care navigators provide proactive support while collaborating with the clinical team, medical providers, and community organizations to address changing needs over time.

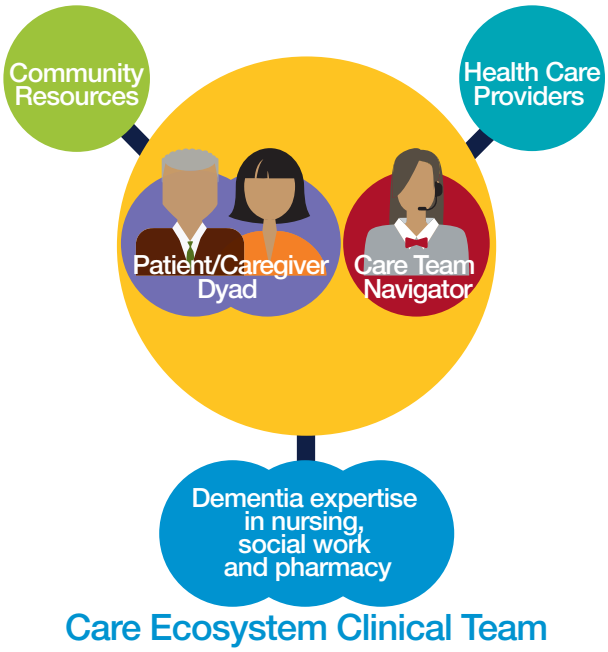

Figure 3. The Care Ecosystem model

How Does the Care Ecosystem Work?

While every organization adapts the Care Ecosystem to fit their setting, care delivery generally follows the same process. After enrollment, participants receive a comprehensive assessment and care plan, followed by ongoing care navigation that adapts as needs change through the course of dementia.

Referral and enrollment

People living with dementia and their care partners are self-referred or referred by a trusted health care provider or community partner. After eligibility is confirmed, participants complete the enrollment process and are assigned a care navigator.

Assessment and care planning

The initial assessment identifies the participant's cognitive, medical, functional, behavioral, safety, advance planning, and psychosocial needs, as well as the care partner's needs. Together, the participant, care partner, and care team develop a person-centered care plan that guides ongoing care navigation.

Monthly care navigation

Regular follow-up is a core feature of the Care Ecosystem. Programs strive to maintain *at least monthly* contact with participant-care partner dyads.

Care navigation contacts are guided by evidence-based Care Protocols and focus on:

- Monitoring changes in health, function, behavior, safety, medications, and caregiver well-being
- Providing education, coaching, and emotional support

- Helping families anticipate and plan for future needs
- Connecting participants with community resources
- Coordinating care with health care providers and community services

Additional contacts may occur during periods of increased need, such as after hospitalization, during care transitions, or when new behavioral or safety concerns arise.

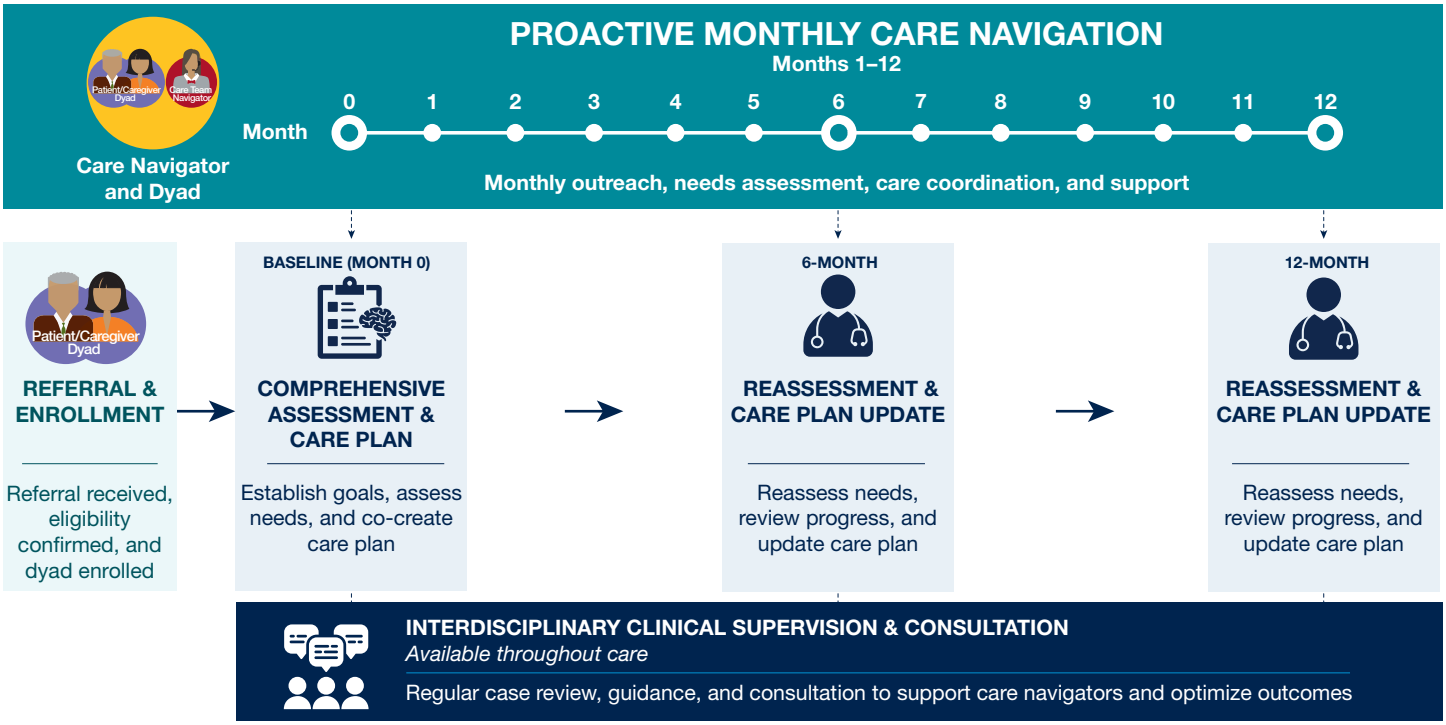

Figure 4. Care Delivery Pathway

Clinical supervision and consultation

Care navigators receive ongoing supervision from clinicians with expertise in dementia care. The clinical team helps navigators manage complex medical, behavioral, psychosocial, medication, and safety concerns that fall outside their scope of practice. New concerns are discussed during regular case review meetings or through consultation as needed. This team-based approach helps ensure that care remains safe, comprehensive, evidence-based, and responsive to changing needs.

Semi-annual reassessment and care plan updates

Needs change over time. Semi-annual reassessment, care plan review, and updates keep the care team aligned as dementia progresses, goals evolve, or major life events occur. Monthly follow-up provides opportunities to reassess priorities, reinforce care plans, and address concerns before they become crises.

GUIDE Consideration In the Care Ecosystem, enrollment usually occurs before the comprehensive assessment. Medicare GUIDE programs follow a different sequence. The initial comprehensive assessment is completed as part of determining eligibility for enrollment and initiating GUIDE services. GUIDE programs will need to adapt their workflows to meet CMS requirements.

Evidence Supporting the Care Ecosystem

The Care Ecosystem was tested in a randomized clinical trial with 780 persons with dementia-caregiver dyads that was conducted from 2015 to 2018 with funding from a CMMI Healthcare Innovations Award. The participants lived in California, Nebraska, and Iowa, and care was delivered from two hubs: one at the University of California, San Francisco, and the other at the University of Nebraska Medical Center. The Care Ecosystem was delivered for 12 months and compared with usual care. Compared with usual care, participants experienced improvements in outcomes for the people living with dementia and their care partners, along with reductions in health care utilization and Medicare costs[14,15,16,17].

Reported outcomes

People living with dementia	Care partners	Health systems
Improved quality of life	Reduced caregiver burden	Lower Medicare costs ($500pmpm)
Reduced emergency department use	Reduced depression	Reduced emergency department use
Reduced potentially inappropriate medication use	Improved self-efficacy	

The treatment effects on total cost of care appeared to be greatest for people with moderate to advanced dementia, who had high healthcare utilization at baseline, and caregivers who were depressed. In a separate study, the cost savings of approximately $500pmpm (per member per month) were replicated by a team at Ochsner Health in Louisiana[18].

In an extension trial, we found that the benefits on wellbeing for the person with dementia and the caregiver were sustained for 5 years or until death, and the most robust treatment effects were in the first 2 years[19].

Pragmatic multi-site research evaluating implementation across diverse health systems and community-based organizations continues to expand the evidence base and identify strategies for successful implementation.

Core Components

The Care Ecosystem was designed to be adaptable. Organizations have successfully implemented the model in health systems, community-based organizations, telehealth programs, and residential and home health settings.

Although workflows and staffing models may differ, five core components should be maintained whenever possible because they form the foundation of the evidence supporting the model.

14 Possin KL, Merrilees JJ, Dulaney S, et al. *JAMA Intern Med.* 2019;179(12):1658–1667. doi:10.1001/jamainternmed.2019.4101

15 Liu AK, Possin KL, Cook KM, et al. *Alzheimers Dement.* 2023;19(5):1865–1875. doi:10.1002/alz.12808

16 Guterman EL, Kiekhofer RE, Wood AJ, et al. *JAMA Intern Med.* 2023;183(11):1222–1228. doi:10.1001/jamainternmed.2023.4764

17 Rosa TD, et al. *JAGS*. 2019;67(12): 2628–2633. doi.org/10.1111/jgs.16076

18 Sawyer RJ 2nd, Pereira Osorio C, Sharma S, Brickell E. *Am J Manag Care.* 2024;30(8):353–358. doi:10.37765/ajmc.2024.89559

19 Possin KL, Dulaney S, Sideman AB, et al. *Alzheimers Dement.* 2025;21(1):e14370. doi:10.1002/alz.14370

Core component	Purpose
Training in dementia	Prepare care navigators through dementia training and experiential learning.
Evidence-based Care Protocols	Guide comprehensive, person-centered care.
Comprehensive care planning	Address cognitive, functional, behavioral, safety, pain, medication, caregiver, resource, crisis and advance care planning needs.
Interdisciplinary clinical supervision	Support care navigators through training, supervision, regular case review and as needed consultation.
Regular longitudinal follow-up	Provide proactive, monthly support that evolves as needs change.

Adapting the Model with Fidelity to the Core Components

One of the strengths of the Care Ecosystem is its flexibility. Organizations are encouraged to adapt workflows, staffing models, technology platforms, and community partnerships to meet local needs. However, maintaining fidelity to the model's core components is important because the published evidence supporting the Care Ecosystem is based on these features.

Maintain
Navigator training
Evidence-based Care Protocols
Comprehensive care planning
Clinical supervision
At least monthly follow-up

Adapt
Experiential training methods
Local resources and workflows
Assessments, workflows, note templates
Staffing model
Method and duration of contact

Adapting the Model within an Existing Care Management Program

The Care Ecosystem can potentially be integrated into an existing care management program, and emerging evidence suggests that dementia-specific training can improve the dementia care provided by existing care managers[20]. However, training alone should not be assumed to reproduce the Care Ecosystem or its outcomes[21].

Dementia care requires specialized competencies that develop through training, clinical experience, and ongoing access to interdisciplinary dementia expertise[22]. When integrating the Care Ecosystem into a broader care management program, consider whether staff will have sufficient exposure to people living with dementia and their care partners to develop and maintain these competencies. Preserve the model's core components — including dementia-specific training and experiential learning, standardized protocols, interdisciplinary clinical supervision, and longitudinal support — and monitor fidelity and outcomes.

20 Mellinger TJ, Forester BP, Vogeli C, et al. Impact of dementia care training on nurse care managers' interactions with family caregivers. *BMC Geriatr.* 2023;23:16. doi:10.1186/s12877-022-03717-w.

21 Forester BP, Vogeli C, Flom M, et al. A pilot trial of CRESCENT in a large academic healthcare system: a CaReEcoSystem Primary Care Embedded DemeNtia Treatment. *Am J Geriatr Psychiatry Open Sci Educ Pract.* 2024;2:19-31. doi:10.1016/j.osep.2024.06.003.

22 Reuben DB, Epstein-Lubow G, Evertson LC, Jennings LA. Chronic disease management: why dementia care is different. *Am J Manag Care.* 2022;28(12). doi:10.37765/ajmc.2022.89258.

BUILD THE PROGRAM

This section provides practical guidance for implementing the Care Ecosystem. The recommendations are based on lessons learned from our own experience and from other organizations that have successfully adapted the model across a variety of health care and community settings.

Build Readiness

Successful implementation begins with understanding your organization's needs, priorities, and available resources.

Identify your population

Estimate the number of people living with dementia who could benefit from care navigation. Potential data sources include:

- Electronic health record data
- Dementia registries
- Medicare population data
- Community needs assessments
- Referrals from community organizations

Consider whether there are populations that may particularly benefit from care navigation, such as people with frequent emergency department visits, individuals living alone, or caregivers experiencing high levels of stress. It may be helpful to review Ochsner's case study on building a value-based business case for a dementia care program in an organization with a large Medicare Advantage population[23] as well as UCLA's paper on reducing the cost of care for subpopulations with chronic conditions like dementia[24].

Align with organizational priorities

Programs are more likely to succeed when they support existing organizational goals. Meet with leaders to understand priorities such as:

- Improving access to care
- Supporting caregivers
- Reducing avoidable emergency department visits or hospitalizations
- Improving patient and caregiver experience
- Advancing value-based care initiatives

Frame the Care Ecosystem as a strategy for helping achieve these goals rather than as a standalone program.

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23 Sawyer RJ 2nd, Pereira Osorio C, Sharma S, Brickell E. *Am J Manag Care.* 2024;30(8):353–358. doi:10.37765/ajmc.2024.89559

24 Gupta R, Roh L, Lee C, et al. *Acad Med.* 2019;94(9):1337–1342. doi:10.1097/ACM.0000000000002778

Engage stakeholders

Early engagement with the people who will use, support, and champion the program promotes successful implementation.

Consider including:

- Executive leadership
- Clinical leaders
- Referring providers
- Nursing
- Social work
- Information technology
- Quality improvement or population health
- Patient and family advisors
- Community partners

Develop Referral Partnerships

Strong referral partnerships are essential to building a sustainable dementia care navigation program. Most Care Ecosystem participants are referred by trusted health care providers or community organizations. Developing these relationships before launch helps establish a reliable referral pipeline and ensures that eligible individuals are identified early.

Potential referral partners include:

- Primary care
- Neurology and memory clinics
- Geriatrics
- Hospital discharge and transitional care programs
- Home health and hospice
- Community-based organizations
- Area Agencies on Aging
- Alzheimer's Association chapters
- Other community organizations serving older adults and caregivers

Meet with referral partners early to understand their goals, referral processes, and preferred methods of communication. Discuss eligibility criteria, referral workflows, anticipated response times, and how the Care Ecosystem will communicate recommendations back to referring clinicians or organizations. Clear expectations established before launch help streamline referrals and strengthen long-term collaboration.

Implementation Lesson Referrals from a trusted health care provider are often the most effective recruitment strategy. Families are more likely to enroll when the program is introduced by a clinician they already know and trust. Many organizations provide referring clinicians with a brief program description or talking points to support conversations about the Care Ecosystem.

Implementation Lesson Several organizations have successfully used electronic health record registries to identify potentially eligible participants from individual providers' patient panels. Rather than relying on providers to remember to place referrals during busy clinic visits, implementation teams review patient lists with clinicians and, in some settings, obtain standing approval to contact eligible patients directly. This approach can reduce the burden on providers while increasing referral volume and ensuring that potentially eligible participants are not overlooked. Organizations should implement this approach in accordance with local institutional policies and privacy requirements.

Create a Business Case

One of the most common concerns when implementing a dementia care navigation program is whether it can be financially sustainable. Although start-up funding is often needed to support implementation, many organizations have found that reimbursement, institutional support, and strategic partnerships can offset a substantial portion of operating costs.

The Care Ecosystem was intentionally designed to deliver high-quality dementia care using trained care navigators supported by an interdisciplinary clinical team. This staffing model enables licensed clinicians to focus on activities that require their expertise while care navigators provide ongoing education, support, care coordination, and monitoring.

Depending on participant volume, staffing, payer mix, and reimbursement strategy, some programs may approach operational break-even through available reimbursement mechanisms. Other organizations combine reimbursement with institutional support, grants, philanthropy, or value-based payment arrangements to create a sustainable business model.

Example Financial Model Assumptions

The example below illustrates one staffing model for an established Care Ecosystem program serving **250 participant-care partner dyads annually**. Actual staffing, participant volume, reimbursement, and workflow will vary by organization.

Component	Planning Assumption
Participant volume	250 participant-care partner dyads per year
Comprehensive assessment and care planning	All participants receive two Cognitive Evaluation and Care Planning visits annually (initial visit in person, follow-up by telehealth). Approximately 580 billable visits are completed each year, assuming about 80 dyads decline PIN services.
Principal Illness Navigation (PIN)	Participants receive up to 10 monthly PIN contacts annually. (The same clinician cannot bill Cognitive Evaluation and Care Planning and PIN during the same month.)
Nurse practitioner	Completes comprehensive assessments, develops and reviews care plans, supervises weekly case conferences, provides ad hoc consultation, reviews documentation, and bills PIN (approximately 16 hours/week).

Component	Planning Assumption
Social worker	Completes initial PIN contact, maintains a caseload of approximately 50 participants, and provides consultation for about 20 participants each month.
Care navigators	Two unlicensed care navigators each manage a caseload of approximately 100 participants, averaging about five PIN contacts per day.
Pharmacist	Provides medication consultation for approximately 20 participants each month.
Clinic coordinator	Schedules Cognitive Evaluation and Care Planning visits.
Program manager	Oversees hiring and onboarding, monitors referrals and PIN enrollment, tracks caseloads through operational dashboards, and supports billing, compliance, and reimbursement reconciliation.

Role	Annual Salary	Effort	+ 40% for Benefits & Overhead
Nurse Practitioner	$175,000	0.5	$122,500
Social Worker	$90,000	0.5	$63,000
Pharmacist	$150,000	0.1	$21,000
Unlicensed Navigator	$70,000	1.0	$98,000
Unlicensed Navigator	$70,000	1.0	$98,000
Program Manager	$150,000	0.2	$42,000
Clinic Coordinator	$70,000	0.2	$14,000
		Total Annual Cost:	**$458,500**

Fee-for-service billing code	Reimbursement Rate	Annual Quantity	Annual Revenue
Cog Eval & Care Planning (99483)	$300	580	$174,000
Principal Illness Navigation (PIN)			
Low needs – 60min PMPM (G0023)	$80	750	$60,000
Moderate needs – 90min PMPM (G0023 + G0024)	$120	1250	$150,000
High needs – 120min PMPM (G0023 + 2xG0024)	$160	500	$80,000
		Projected Annual Revenue:	**$464,000**

Plan Care Navigator Capacity

One of the most common implementation questions is how many participants a care navigator can effectively support. There is no single “ideal” caseload. Appropriate caseload size depends on participant complexity, available interdisciplinary support, operational infrastructure, documentation requirements, and the availability of health care and community resources.

Across Care Ecosystem implementations, full-time care navigators have commonly managed **approximately 60–100 participant-care partner dyads** and completed **approximately 4–8 participant contacts per day**. These contacts often vary in length and complexity. Brief follow-up calls may take only a few minutes, while conversations involving caregiver coaching, behavioral concerns, care coordination, or clinical consultation may require substantially more time. The average duration of care navigation calls is about 30 minutes, with longer calls in the first few months of participation.

During early implementation, organizations often begin with smaller caseloads while care navigators build confidence and workflows mature. Caseload capacity frequently increases over time as documentation systems, operational workflows, interdisciplinary support, and community partnerships become more efficient.

Factors That May Support Larger Caseloads	Factors That May Require Smaller Caseloads
Earlier-stage dementia or lower participant complexity	Advanced dementia or high participant complexity
Integrated health system with a shared electronic health record	Fragmented health care and community systems requiring extensive coordination
Strong network of community resources and support services	Limited availability of dementia-specific community resources
Efficient documentation systems and operational workflows	Manual documentation or extensive administrative burden
Ready access to nursing, pharmacy, social work, and clinical consultation	Limited interdisciplinary support
Experienced care navigators	New care navigators or newly implemented programs
Navigator role focused primarily on care navigation	Additional responsibilities such as recruitment, survey administration, home visits, or extensive travel

Organizations can often increase navigator capacity over time by strengthening operational infrastructure, streamlining documentation, expanding community partnerships, and improving access to interdisciplinary consultation rather than simply increasing individual workload.

Implementation Lesson The financial value of the Care Ecosystem extends beyond direct reimbursement. Many organizations find that reimbursement helps offset operating costs, while additional value comes from improved access to dementia care, enhanced support for care partners, improved quality of care, reduced acute care utilization, and alignment with organizational priorities and value-based care initiatives. Successful programs often combine multiple funding sources — including reimbursement, institutional support, community partnerships, grants, and philanthropy — to build a sustainable business model.

GUIDE Consideration Medicare GUIDE is piloting a new reimbursement model for comprehensive dementia care. Organizations implementing GUIDE should evaluate how GUIDE payments, required services, staffing needs, and operational costs compare with other reimbursement models and funding strategies. Organizations that do not participate in GUIDE may still support dementia care navigation through Cognitive Assessment and Care Planning services, Principal Illness Navigation, value-based payment arrangements, community partnerships, grants, philanthropy, or hybrid funding models.

Appreciate that Building a Sustainable Program Takes Time

Implementing the Care Ecosystem is more than launching a new clinical service. Organizations are simultaneously building a workforce, developing operational infrastructure, establishing referral pathways, refining workflows, implementing documentation and evaluation systems, creating community partnerships, and developing sustainable funding strategies.

Although implementation timelines vary, many organizations find that developing a mature, sustainable program takes **approximately five years**. The pace of implementation depends on factors such as existing dementia care infrastructure, staffing, participant volume, reimbursement strategy, and organizational support.

BUILD YOUR TEAM

Every program requires trained care navigators supported by clinical supervision. The composition of the team varies depending on organizational size, available resources, and reimbursement model. One person may fulfill multiple functions, particularly during early implementation or in smaller organizations.

Role Descriptions

Team Role	Primary Responsibilities	Planning Considerations
Care Navigator	Serves as the primary point of contact for participants and care partners. Provides relationship-based care navigation, education, care coordination, monitoring, and community resource referrals guided by the Care Protocols.	Full-time navigators commonly manage **60–100 participant-care partner dyads** and complete approximately **4–8 participant contacts per day**, depending on complexity, navigator experience, operational infrastructure, and available interdisciplinary support.
Billing Provider	Completes comprehensive assessments, develops and reviews care plans, provides medical management within their scope, and fulfills billing requirements.	May be a physician, nurse practitioner, or physician assistant depending on organizational structure and payer requirements.
Clinical Supervisor (RN or Social Worker)	Provides onboarding, clinical supervision, case review, documentation feedback, and consultation for complex medical, behavioral, safety, and psychosocial concerns.	In one implementation serving approximately 200 participants with two full-time navigators, approximately **4 hours/week** of protected nurse supervision supported onboarding, weekly case review, and consultation.
Social Worker	Provides psychosocial consultation, caregiver support, advance care planning, community resource expertise, and continuity support during staffing transitions.	One implementation protected approximately **6 hours/week** for consultation, mentoring, and coverage. Some organizations also have social workers carry a small participant caseload.
Pharmacist	Reviews medications, identifies medication-related risks, and provides recommendations to the care team and prescribing clinicians.	One implementation protected approximately **4 hours/week** for medication review and consultation. Some organizations provide pharmacist review for all participants, while others triage referrals based on medication complexity or available resources.
Program Manager/ Coordinator	Oversees implementation, recruitment, onboarding, participant tracking, reporting, quality improvement, billing support, and day-to-day operations.	Responsibilities vary considerably across organizations and may be shared among several team members, particularly in smaller programs.
Data & Program Evaluation	Develop and maintain database, dashboards, operational reports, quality reports, and program evaluation. Support recruitment, data management, analysis, and quality improvement.	Often performed by a data analyst, quality improvement specialist, population health analyst, implementation scientist, or program manager. Dedicated support becomes increasingly valuable as programs grow.

Care Navigator Hiring Considerations

Care navigators do not necessarily need prior experience in dementia care. Candidates may be recent graduates, medical assistants, research coordinators, community health workers, direct caregivers, or health

care professionals. No single professional background predicts success. Knowledge about dementia, community resources, and the Care Ecosystem Care Protocols can be developed through structured training and clinical supervision. However, organizations have had varying experiences hiring candidates with different backgrounds. The candidate's interpersonal qualities, previous work experience, goals, and the organizational resources available for onboarding, supervision, and mentoring influence their success in the role.

Regardless of professional background, successful care navigators share a common set of interpersonal qualities that support relationship-based dementia care. During the interview process, we recommend looking for qualities such as:

- Relational warmth and empathy
- Curiosity and active listening
- Reflective thinking
- Organization and problem-solving skills
- Emotional resilience and cultural humility

These qualities are often more difficult to teach than dementia knowledge or familiarity with community resources and are strong foundations for growth through training and clinical supervision.

Consider how a candidate's previous experience aligns with the demands of the role and the level of onboarding and supervision your organization can provide.

Hiring Approach	Potential Advantages	Considerations
Candidates with limited dementia experience	May bring enthusiasm, adaptability, and strong technology or organizational skills	May require more education about dementia, caregiving, and community resources
Candidates with experience working with older adults or caregiver	Familiar with aging, caregiving, and communication with families	Experience may vary in exposure to structured documentation, technology, or caseload management
Candidates with experience in structured health care environments	Often adapt more quickly to electronic systems, documentation, and standardized workflows	May require support developing relationship-based care navigation skills if prior roles were primarily task-oriented
Existing staff transitioning into the Care Ecosystem	Familiar with the organization and patient population	May need additional support adopting Care Protocols, new workflows, and the relationship-based approach to care navigation

Implementation Lesson Hiring strategies may evolve over time.

One organization found that direct caregivers and community health workers required additional support to learn the technology, documentation, and workflow demands of the Care Ecosystem. The organization later adjusted its hiring strategy to prioritize candidates with experience using electronic systems and managing a caseload and observed improved staff retention and job satisfaction.

Another organization initially experienced challenges adapting existing community health workers to the Care Ecosystem without dedicated clinical supervision. After hiring a social worker to provide clinical

supervision and recruiting a highly motivated community health worker for the navigator role, the program was successfully implemented.

Companion Resource:
Care Navigator Hiring Guide

ADAPT CARE PROTOCOLS & PLAN PROGRAM EVALUATION

Before designing workflows, organizations should determine how the Care Ecosystem will be adapted to their local setting. Although the Care Ecosystem's core components should be maintained whenever possible, Care Protocols, educational materials, community resources, documentation templates, and evaluation measures often require adaptation to reflect local practice, reimbursement requirements, and available services.

Adapt the Care Protocols

The Care Ecosystem Care Protocols provide an evidence-based framework for comprehensive dementia care navigation. Organizations are encouraged to review each protocol and adapt local resource information, workflows, educational materials, and organizational contacts while maintaining the underlying clinical recommendations and person-centered approach.

Scan QR code to go to Care Protocols at ucsf.box.com/v/care-protocols

Implementation Lesson Organizations that pilot the Care Protocols with experienced clinicians and care navigators before launch often identify opportunities to improve local workflows, clarify referral pathways, and tailor educational materials before onboarding new staff.

Select Measures for Program Evaluation

Determine eligibility criteria as well as which participant characteristics, operational measures, care quality measures, participant and caregiver outcomes, and experience measures will be collected, who will collect them, and when they will be administered.

Scan QR code to go to Care Evaluation Measures at ucsf.box.com/v/Care-Ecosystem-Evaluation

Operational Measures

Function	Metrics
Program operations	Referral status, enrollment, survey completion
Care delivery	Assessment completion, monthly contacts, navigator caseload size
Program utilization	Contact frequency, duration, participant retention

Participant and Caregiver Outcomes

Outcome	Measure
Dementia severity	QDRS, FAST, CDR
Quality of life	QOL-AD, PROMIS-10 (for GUIDE)
Caregiver well-being	PHQ-9, Zarit, self-efficacy
Caregiver satisfaction	Satisfaction survey
Health care utilization	ED visits, hospitalization
Medication risks	Polypharmacy, potentially inappropriate medications

Care Quality Measures

- Functional status assessment
- Behavior screening and management
- Safety screening and follow-up
- Caregiver assessment
- Pain assessment and follow-up
- Crisis planning
- Medication management
- Education and support
- Advance care planning
- Leisure and recreation preferences

These measures were documented using a checklist of topics discussed for each contact and care plan completion. See care Delivery Measurements and Care Navigation Note in the CE Data Dictionary

Organizations are encouraged to adapt the evaluation plan to meet local needs while maintaining consistency with the original Care Ecosystem evaluation measures when possible.

Whenever possible, select measures that support both care delivery and program evaluation while meeting organizational, payer, grant, or GUIDE reporting requirements.

Baseline and Follow-up Data Collection

Organizations may administer baseline and follow-up surveys by telephone, video, or secure electronic survey platforms. Self-administered electronic surveys can reduce staff time and allow caregivers to complete questionnaires at their convenience. Some organizations send electronic survey links before the comprehensive assessment and encourage caregivers to complete them in advance, while others administer surveys by telephone or incorporate them into the assessment visit. Select the approach that best aligns with your workflow, participant population, and program goals.

Implementation Lesson Some organizations ask caregivers to complete baseline surveys before scheduling or conducting the comprehensive assessment so that results are available during the visit. Others administer surveys after enrollment or incorporate them into the assessment visit to reduce barriers to participation. Consider the tradeoff between maximizing survey completion, minimizing staff effort, and avoiding delays in care.

Organizations using standardized surveys should establish procedures that promote consistent administration across staff and over time.

Whenever possible, follow-up surveys should be administered by someone *other than the person providing care,* such as a program coordinator, recruitment staff member, or another trained team member. Separating care delivery from program evaluation encourages more candid feedback and reduces the potential for social desirability bias.

DESIGN CARE DELIVERY WORKFLOWS

Map how participants will move through the program, how responsibilities will be assigned across the care team, and how information will flow between navigators, clinicians, and community partners. Designing these workflows before staff are trained helps ensure consistent care delivery and provides the foundation for onboarding and operational planning.

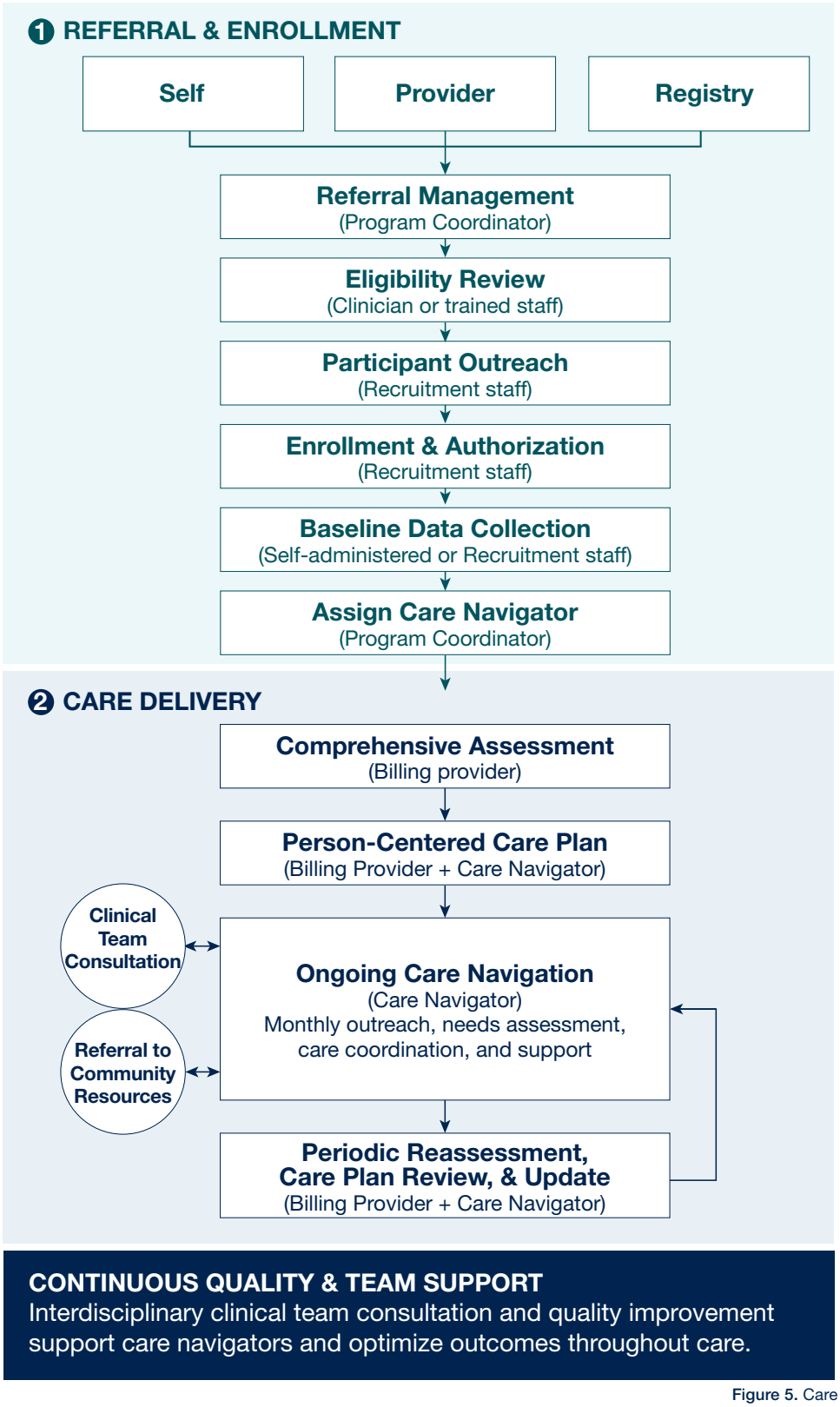

Figure 5. Care Delivery Workflow Planning

CARE DELIVERY WORKFLOW PLANNING WORKSHEET

Use this worksheet during implementation planning meetings to define how participants will move through the Care Ecosystem and how responsibilities will be shared across the care team. The goal is to establish clear, consistent workflows before staff are trained and the program launches.

Planning Question	Decision/Notes
Who can refer participants to the program (e.g., primary care, neurology, self-referral, community organizations, EHR registries)?	
How will referrals be received, reviewed, and tracked?	
Who determines eligibility, and what criteria will be used?	
Who contacts participants and care partners to introduce the program and complete enrollment?	
How and when will baseline surveys or other evaluation measures be collected?	
Who assigns participants to a care navigator, and how will caseloads be managed?	
Who completes the comprehensive assessment and develops the initial care plan?	
How will care navigators, billing providers, supervisors, pharmacists, and social workers communicate and coordinate care?	

Implementation Lesson Some implementation activities require more clinical judgment than initially expected. Several organizations found it helpful to have an experienced nurse or clinician perform eligibility review during early implementation while refining referral criteria and workflows. As decision pathways became more standardized, eligibility review could be delegated to trained non-clinical staff using clear protocols and clinical support as needed.

Implementation Lesson Although recruiting and enrolling participants who are difficult to reach may require additional time and effort, these individuals are often among those who stand to benefit most from the program. Consider flexible approaches that accommodate busy caregiver schedules and lower barriers to communication and enrollment. Providing practical support early in the relationship — such as connecting families with needed resources or helping address an immediate concern — can build trust and encourage ongoing engagement.

GUIDE Consideration Medicare GUIDE programs complete the initial comprehensive assessment before enrollment is finalized. GUIDE organizations should adapt recruitment and enrollment workflows to meet CMS requirements while preserving the core components of the Care Ecosystem.

Operational Tools
Recruitment Script

BUILD OPERATIONAL INFRASTRUCTURE

Reliable operational infrastructure supports consistent care delivery while reducing administrative burden. Establish systems that will support documentation, communication, participant tracking, resource management, and program monitoring.

Whenever possible, build on systems your organization already uses rather than creating parallel workflows.

Documentation

Documentation serves two essential purposes: it creates a clinical record and communicates information across the care team.

Documentation considerations:

- How care navigation contacts will be documented.
- How comprehensive assessments and care plans will be documented and updated.
- How clinical recommendations will be communicated.
- How care plans and updates will be shared with referring providers, when appropriate.
- How documentation will meet organizational and payer requirements.

Care partner documentation considerations

Care partners are important members of the dementia care team and are often the primary contact and informant, as well as recipients of support and respondents to caregiver-reported measures[25,26]. Determine where and how care partner information — including contact information, needs assessments, concerns, and caregiver-reported measures (e.g., depression, burden) — will be documented. Options may include the participant's health record, the care partner's own or linked health record when available and appropriate, or a separate data system such as REDCap. Consider who needs access to this information for clinical care, reassessment, care coordination, quality monitoring, and program evaluation, and establish processes for appropriately linking care partner and participant data.

Documentation Templates

Before implementation, review the documentation required to support care navigation, communication across the care team, billing, and program evaluation.

Organizations may adapt existing documentation or develop templates that fit their local workflows. Ensure that documentation templates meet current reimbursement requirements and program evaluation and reporting needs.

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25 Carbonell E, Mariani D, Golden R. Caring for caregivers within age-friendly health systems: an organizational case study of national scale and spread. *INQUIRY*. 2025;62:1-5. doi:10.1177/00469580251325660.

26 Hollister BA, Yeh J, Ross L, Schlesinger J, Cherry D. Building an advocacy model to improve the dementia-capability of health plans in California. *J Am Geriatr Soc.* 2021;69(12):3641-3649. doi:10.1111/jgs.17429.

Companion Resources
Care Navigation Note Template

Determine Communication Methods

Consider how members of the care team will communicate throughout the program.

Examples include:

- Telephone
- Secure messaging
- Patient portals
- Video visits
- Electronic fax for referrals and document exchange
- Email, when appropriate and consistent with organizational policy

Choose communication methods that support timely coordination while meeting organizational privacy, documentation, and operational requirements. Some methods, like text messaging, may be more accessible for participants while presenting privacy and security risks that limit use.

Develop Tracking and Evaluation Systems

Develop a reliable system for tracking participants throughout the program. For recent projects at UCSF, we have used shared spreadsheets, Epic work queues, patient lists, and workbench reports, as well as REDCap instruments and reports for tracking purposes.

At a minimum, organizations should be able to identify:

- Referral status
- Enrollment status
- Assigned care navigator
- Active participants
- Date of initial comprehensive assessment
- Date of most recent care navigation contact
- Date of next reassessment and care plan review
- Program completion or discharge

Supervisors should also be able to identify participants who require attention, including:

- Participants awaiting enrollment
- Participants awaiting initial comprehensive assessment

- Participants overdue for care navigation contact
- Participants overdue for reassessment and care plan review

Tracking these metrics helps ensure participants receive timely follow-up and reduces the risk that someone is unintentionally overlooked.

Reliable information systems help care teams manage workload, prioritize care, improve efficiency, monitor care quality, and evaluate program outcomes. Different members of the care team require different information based on their roles and responsibilities.

Consider what information each team member needs, how it will be organized, and how frequently it should be reviewed. Information should support the decisions each team member needs to make, from managing day-to-day participant care to evaluating program performance over time.

Team Member	Information Needed
Care Navigator	Assigned participants, participants due or overdue for follow-up, upcoming reassessment and care plan reviews, outstanding clinical recommendations or plans requiring follow-up
Clinical Supervisor	Navigator caseloads, participants awaiting assessment, overdue follow-up, overdue care plan reviews, complex cases requiring discussion
Billing Provider	Participants awaiting comprehensive assessment, care plan review, or documentation completion, recent emergency department visits, hospitalizations, or other significant care transitions requiring clinical follow-up
Pharmacist	Participants awaiting medication review and medication recommendations requiring navigator follow-up
Program Leadership	Referral and enrollment trends, reimbursement revenue, participant and caregiver feedback and outcomes, care quality and utilization impact

Different reports support different decisions and should be reviewed at different intervals.

- **Caseload worklists** help care team members prioritize participant care and coordinate day-to-day activities.
- **Operational reports**, often reviewed weekly or monthly, help supervisors monitor workload, identify participants requiring follow-up, and address workflow challenges.
- **Quality reports**, typically reviewed quarterly, help identify opportunities to improve documentation, training, workflows, and fidelity to the Care Ecosystem model.
- **Program evaluation reports**, often prepared annually or for grant and payer reporting, help organizations evaluate outcomes, demonstrate value, and support funding applications.

Implementation Example Some organizations use electronic health record alerts or automated reports to notify the care team when a participant is seen in the emergency department or admitted to the hospital. These notifications can trigger timely follow-up, medication review, care plan updates, and additional support for the participant and care partner following discharge.

Implementation Lesson The primary purpose of operational and quality reporting is to improve care delivery. Reviewing trends over time can help identify workflow challenges, documentation needs, or training opportunities.

For example, one Care Ecosystem program found that pain assessment and crisis planning were consistently omitted from comprehensive care plans. Reviewing quality reports led to clarifications,

staff training, and clinical supervision that increased completion and documentation of these important care activities.

Resource and Information Sharing

Care navigators routinely connect participants and care partners with community resources and educational materials. As programs grow, maintaining these resources in searchable, regularly updated systems becomes increasingly important.

Consider developing two complementary resources.

Community Resource Database

Maintain a searchable database of local services and referral partners.

Helpful features include:

- Keyword searching
- Filtering by service type, geographic area, language, and insurance
- A standardized data-entry form
- Shared access across the care team
- Links to websites, application forms, and supporting documents
- A system for regularly reviewing and updating content

Implementation Example One organization developed a shared community resource database using Microsoft Lists. Using a standardized data-entry form promotes consistent documentation, while search and filter functions allow navigators to quickly identify appropriate resources based on participants' needs, location, language, and insurance.

Dementia Education Library

Many organizations also maintain a shared library of educational materials that navigators can quickly access and share with participants, care partners, and community providers.

A centralized education library helps ensure that families receive consistent, evidence-based information while reducing the need for navigators to try to recreate educational materials.

Examples include:

- Disease-specific education
- Caregiving guides
- Behavior management strategies
- Safety information
- Advance care planning resources
- Legal and financial planning
- Community resource guides
- Videos, webinars, and printable handouts

Implementation Example The Care Ecosystem Dementia Library is a freely available collection of curated educational materials that organizations can use as a starting point for developing their own education library and adapting it to local needs.

Companion Resources

Community Resource Database Template 

Care Ecosystem Dementia Library 

OPERATIONAL INFRASTRUCTURE PLANNING ACTIVITY

Use this worksheet during implementation planning meetings to identify the operational infrastructure needed to support care delivery.

Planning Question	Decision/Notes
Where will care navigation documentation and outcome measures for the participant and care partner be maintained?	
How will comprehensive care plans be documented, updated, and shared with primary care providers and other treating clinicians?	
How will navigators communicate with participants and care partners (telephone, patient portal, secure messaging, email, text, mail)?	
Will the program use a central phone number, shared inbox, or other centralized communication system?	
How will clinical recommendations be communicated to primary care providers and specialists?	
How will referrals to community organizations be initiated, tracked, and followed up?	
How will participants be tracked throughout the program?	
Which operational, quality, and outcome measures will be reviewed regularly?	
How will community resources and educational materials be maintained and updated?	
How will continuity of care be maintained during staff absences, onboarding, or staff turnover?	

TRAIN YOUR TEAM

Once care delivery workflows and operational systems have been established, prepare the team to deliver consistent, relationship-based dementia care. Effective onboarding extends beyond completing the online training and combines foundational education, experiential learning, structured clinical supervision, and continuing professional development.

Although initial onboarding typically takes **3–4 weeks**, navigator development is an ongoing process. Care navigators continue to build knowledge, confidence, communication skills, and clinical judgment through experience, supervision, and continuing education.

Components of Care Navigator Training

Training Component	Purpose
Organizational orientation	Introduce local workflows, documentation, communication systems, and community resources.
Care Ecosystem training	Build foundational knowledge of dementia care and the Care Protocols.
Experiential learning	Develop communication skills and confidence through observation, role-play, and supported practice.
Clinical supervision	Reinforce learning, apply the Care Protocols, strengthen clinical judgment, and support professional growth.
Continuing education	Maintain competency as dementia care and community resources evolve.

Experiential Learning

Observation, role-play, supported practice, and documentation review help navigators apply the Care Protocols in real-world situations while building confidence and communication skills. Whenever possible, navigators should observe experienced team members conducting assessments, care planning visits, care navigation calls, interdisciplinary consultations, and community resource referrals before managing participants independently.

Clinical Supervision

Clinical supervision is a core component of the Care Ecosystem. Supervision helps navigators apply the Care Protocols, strengthen clinical reasoning, improve documentation, and develop confidence while managing increasingly complex participant needs.

Organizations should gradually increase navigator responsibility as competence develops rather than assigning a full caseload immediately.

Recruitment and Enrollment Training

Recruitment may be performed by care navigators, program coordinators, research staff, medical assistants, or other trained personnel. Regardless of role, staff should receive standardized training in recruitment workflows, eligibility criteria, documentation, participant tracking, and communication with participants and care partners before working independently.

Survey Administration Training

Staff responsible for baseline and follow-up surveys should receive standardized training in survey administration, neutral interviewing techniques, documentation, and participant privacy. Whenever possible, follow-up surveys should be administered by someone other than the participant's care navigator to encourage candid feedback.

Implementation Lesson Successful onboarding is not defined by completing training on a predetermined schedule. Supervisors should gradually increase responsibility while providing ongoing coaching, observation, and clinical consultation as navigators build confidence and clinical judgment.

Companion Resources

folder with
Care Ecosystem Training Curriculum
Care Navigator Training Checklist

DELIVER THE CARE ECOSYSTEM

Following enrollment and baseline data collection, participants transition into ongoing dementia care. Although the timing and sequence of activities may vary across organizations, care delivery generally begins with a comprehensive assessment, followed by the development of a person-centered care plan and ongoing care navigation. Together, these activities establish a shared understanding of the participant's strengths, priorities, and evolving needs while supporting proactive, relationship-based care over time.

Although this section is intended primarily for implementation leaders, many organizations also use it as a practical guide for onboarding care navigators and other members of the interdisciplinary team.

Complete the Comprehensive Assessment

The comprehensive assessment is the foundation of person-centered dementia care. It helps the clinical team understand the person's cognitive, medical, functional, behavioral, safety, psychosocial, resource, planning, and environmental needs while identifying care partner strengths, challenges, and priorities. Information gathered during the assessment guides development of the initial care plan and provides a baseline for future care planning and ongoing care navigation.

Although the billing provider is typically responsible for completing and documenting the comprehensive assessment, care navigators often contribute valuable information gathered during enrollment, baseline surveys, and early interactions with participants and care partners. As the relationship develops, navigators continue to identify changes that inform future reassessments and care plan updates.

Rather than serving as a one-time event, the comprehensive assessment establishes the starting point for a longitudinal, collaborative model of care.

Assessment Domains

The comprehensive assessment should provide a holistic understanding of the person living with dementia and their care partner. Although assessment templates vary across organizations, they should address the major domains below to support person-centered care planning and meet organizational or payer requirements.

Assessment Domain	Examples
Cognitive and Clinical Status	Dementia diagnosis and stage, cognition, decision-making capacity, functional status, medications, pain, sleep, sensory impairment, medical comorbidities
Behavioral and Psychosocial Health	Behavioral symptoms, mood, quality of life, daily routine, living situation, meaningful activities, social history
Safety	Falls, wandering, driving, home safety, weight loss or swallowing concerns, medication safety, financial exploitation, abuse, or neglect
Care Partner Assessment	Care partner relationship, understanding of dementia, willingness and availability to provide care, physical and mental health, stress or burden, support network, respite needs
Resources and Social Needs	Transportation, food, housing, caregiving supplies and equipment, community services, financial and legal resources

Assessment Domain	Examples
Care Team and Care Coordination	Primary care provider, specialists, behavioral health providers, home health or hospice, community service providers, care managers, back-up caregiver, and availability and preferred communication methods
Goals and Advance Care Planning	Personal goals, values, preferences, advance directives, surrogate decision-maker (health care and financial DPOA), and future care planning

These domains provide a framework rather than a checklist. The depth and sequence of the assessment should be individualized based on the participant's needs, available information, and clinical setting. Organizations participating in Medicare GUIDE or using specific billing codes should also ensure that assessment templates meet applicable program and payer requirements.

Implementation Lesson Comprehensive assessments are strengthened when they incorporate information collected throughout the program. Information gathered during enrollment, baseline surveys, ongoing care navigation, and clinical consultations contributes to a more complete understanding of the participant and care partner. Designing workflows that allow this information to inform periodic reassessments and care plan reviews supports continuity.

GUIDE Consideration Medicare GUIDE specifies required assessment domains and standardized instruments for selected measures. Organizations participating in GUIDE should ensure that assessment templates meet current CMS requirements while continuing to support person-centered care planning.

Operational Tools
Comprehensive Assessment Note 
Care Ecosystem Evaluation Measures 

Develop the Person-Centered Care Plan

The comprehensive assessment provides the information needed to develop a care plan that reflects the participant's goals, strengths, preferences, and priorities. Rather than documenting every potential concern, person-centered care planning focuses on the issues that matter most to the participant and care partner while anticipating future needs as dementia progresses. The care plan should be shared with the participant, care partner, primary care provider, and other members of the care team as appropriate.

Although every care plan is unique, most address five broad questions.

Care Planning Question	Examples
Who is this person?	Strengths, interests, routines, meaningful activities, values, and preferences
What are the most important concerns right now?	Medical, behavioral, safety, caregiver, and social priorities
What is our plan?	Education, medication recommendations, community resources, referrals, and follow-up
Who will do what?	Responsibilities of the participant, care partner, care navigator, clinical team, and other providers

Care Planning Question	Examples
What should we prepare for next?	Anticipatory guidance, crisis planning, advance care planning, and future care needs

Although every participant's experience is unique, care planning priorities evolve as dementia progresses. Figure 6 illustrates common priorities that may guide conversations with participants and care partners over time. Care navigators use the Care Protocols to anticipate changing needs while tailoring care to each participant's goals, preferences, and stage of disease.

	MCI	Mild	Moderate	Advanced	End of Life
Common Priorities	Diagnosis & brain health Building a care team Exercise, nutrition, sleep Vision & hearing Legal/financial planning Preventing scams	Managing medications & finances Maintain routines & structure Medical & dental care Driving safety & transportation Home safety & fall prevention Relationship changes	Communication & connection Responding to behaviors & resistance Adapting activities Safety risks (falls, wandering) Increasing help with daily activities Caregiving capacity & limits	Personal care & mobility dependence Skin care & aspiration prevention Caregiver injury prevention Goals of care, treatment decisions Respite & care transitions Grief & loss	Hospice Family presence, holding vigil Cultural traditions, religious rituals Making final arrangements Bereavement Life after caregiving
Navigator Strategies and Resources	Anticipatory guidance Fraud protections Technology adaptations Identify the care team & clarify decision making roles	Information & support programs Medication review & optimization Elder law attorney Proxy access to health record Identify back-up caregiver Coping strategies	Triage acute or distressing changes Caregiver education & skills training Medication review & optimization Respite & long-term care planning Caregiving supplies & mobility aids Coping strategies & support groups	Treatment decision support tools Hospice eligibility & services Personal care training videos Respite & coordinating care transitions Comfort-focused medication review Emotional support	Honoring legacy Grief support groups, bereavement counseling Info & resources for final arrangements Adjusting to life after caregiving Reflecting on and closing relationship as appropriate

Figure 6 Evolving Person-Centered Care Planning Across the Stages of Dementia

Implementation Lesson Comprehensive care plans should evolve over time. Rather than rewriting the entire care plan during each reassessment, many organizations review previous goals, identify meaningful changes, update recommendations, and revise priorities as the participant's needs change.

Implementation Lesson Developing a comprehensive, person-centered care plan often takes more than one conversation. Programs in which the care navigator completes both the assessment and care planning have found that it may take several weeks — or even a few months — to fully understand the participant's needs, establish priorities, and develop a comprehensive care plan. A flexible time frame for completing the initial care plan may be more practical in fully remote, telephone-based programs. Immediate concerns should be addressed as they arise, while the care plan is developed.

Operational Tools

Care Ecosystem Note Templates

Care Protocols

Provide Ongoing Care Navigation

Ongoing care navigation is central to the Care Ecosystem model. Through regular contact, care navigators build trusted relationships with participants and care partners, monitor changes over time, provide education and emotional support, connect families with resources, and help coordinate care across health care and community settings.

Rather than following a scripted sequence of topics, navigators use judgment and the Care Protocols to guide conversations based on each participant's current needs and priorities. It can be helpful to have an experienced nurse or social worker pilot and adapt the Care Protocols for your implementation.

Choosing the Right Care Protocol

The Care Protocols are flexible guides that support navigator training, build confidence during early practice, and can be revisited whenever needed. Most conversations draw on more than one protocol. Start with the participant's and care partner's highest priorities, then use the protocol(s) that best address their current needs. As dementia progresses, different protocols may become more or less relevant, and all may be revisited over time to support comprehensive, person-centered, evidence-based care.

Care Protocol	Use the protocol when…
Prioritizing Immediate Needs	You need to identify urgent concerns or unmet needs. Often used at enrollment or when circumstances change, such as with a new participant, an overwhelmed caregiver, or multiple competing concerns.
Decision Making, Future Planning & Legal Needs	The person or family is getting organized or preparing for future decisions after a new diagnosis or as dementia progresses. Includes multiple steps that are worked on over time and revisited as needed. Starting with building a care team, then communicating preferences, identifying surrogate decision-makers, completing powers of attorney, financial planning, long-term care planning, and goals-of-care discussions.
Brain Healthy Living	Supporting brain health, function, quality of life, and meaningful activities by incorporating movement, good sleep, nutrition, vision and hearing care, health promotion, and social engagement into daily routines.
Safety & Independence	Preventing injuries and promoting independence. Addresses concerns such as falls, wandering, driving, firearms, home safety, weight loss or swallowing concerns, and caregiver safety.
Medication Review & Optimization	Conducting proactive medication reconciliation and reviews to identify potential risks or opportunities for optimization, and new medication-related questions. Helps address polypharmacy, potentially inappropriate medications, adherence problems, side effects, and difficult symptoms or behavior management.
Understanding & Responding to Behaviors	Screening for and helping families understand and respond to behavioral or psychological symptoms that affect quality of life. Includes helping caregiver identify delirium, learn communication and environmental strategies, and adjust expectations and reframe goals. Helps address agitation, aggression, hallucinations, delusions, sleep disruption, anxiety, repetitive questions, depression, apathy, restlessness, and disinhibition.
Caregiver Well-Being	Providing emotional support and promoting respite and self-care to sustain caregiving over time. Includes stress management, coping, grief, navigating family conflict, balancing caregiving with personal needs, and preventing burnout.

Care Protocol	Use the protocol when…
Education, Resources & Care Coordination	Personalizing education and connecting families with resources while coordinating care across health care and community settings. Includes dementia education, long-term care planning, language-appropriate resources, eligibility for services, support groups, home care, financial assistance, transportation, adult day programs, and residential care.
Crises & Care Transitions	Preparing for and responding to acute events and transitions across care settings, including hospitalizations, emergency department visits, rehabilitation stays, home health, behavioral crises, and long-term care placement.
End-of-Life Care	Supporting families during advanced dementia as care shifts toward comfort, quality of life, and hospice. Includes comfort-focused care, preparing for the final arrangements, and bereavement support.

Relationship-Based Care Navigation

Relationship-based care is central to the Care Ecosystem. Through regular contact, care navigators develop trusted relationships with participants and care partners that allow them to recognize changing needs, provide education and emotional support, coordinate care, and anticipate future challenges. These relationships develop over time through consistent follow-up, active listening, and reliable follow-through.

Although the Care Protocols provide guidance for common dementia-related concerns, care navigation conversations should remain flexible and responsive to each participant's priorities rather than following a scripted sequence.

Experienced navigators generally structure conversations around four questions:

Conversation Goal	Examples
Understand what has changed	Changes in health, function, behavior, safety, caregiver well-being, medications, or living situation.
Follow-up on previous goals and action plans	Were materials reviewed, calls made, strategies tried, decisions considered, and what adjustments need to be made?
Identify current priorities	What concerns are most important to the participant or care partner today?
Provide support	Education, coaching, emotional support, care coordination, community resources, or consultation with the interdisciplinary team.
Agree on next steps	Summarize the plan, clarify responsibilities, and determine when follow-up will occur.

Rather than attempting to address every concern during a single conversation, navigators work with participants and care partners to identify priorities and develop achievable next steps. The focus of each contact may change over time as dementia progresses and circumstances evolve.

Implementation Lesson Effective care navigation is guided by relationships rather than scripts. Some conversations focus on solving practical problems, while others provide opportunities to support caregivers through uncertainty, grief, or future planning. Experienced navigators adapt each conversation to the participant's goals, communication style, and changing needs while consistently following through on commitments.

Communicate Clinical Concerns

Care navigators help participants and care partners navigate health care and community systems while working within a defined scope of practice.

Recognizing when to seek additional input, communicating concerns clearly, coordinating recommended actions, and following through are essential components of high-quality care navigation.

Determine When Clinical Consultation Is Needed

Most participant concerns are not urgent and can be addressed through personalized education, support, coaching and community resources guided by Care Protocols. Some situations will require consultation with the interdisciplinary clinical team or communication with the participant's health care providers.

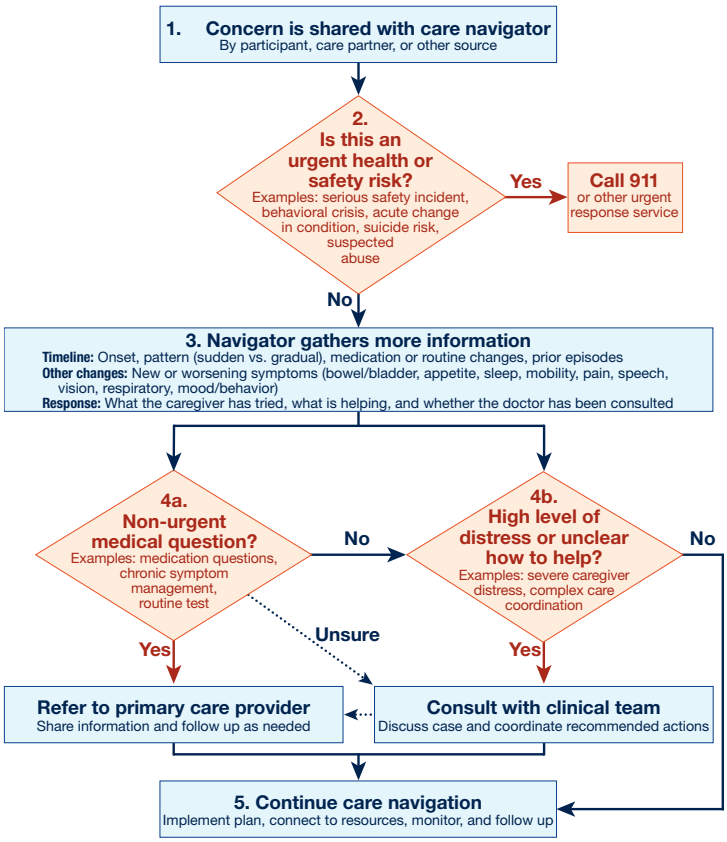

Figure 7. Clinical Consultation Workflow

Consider which concerns require **immediate clinical consultation**, who will be contacted, and how. Organizations may want to establish workflows or guidance for the following kinds of situations:

- Serious safety incidents, behavioral crises, severe caregiver distress, or acute changes in condition
- Concerns for suicide risk
- Suspected elder abuse or neglect
- Complex care coordination around unmet basic needs

Implementation Lesson New care navigators often consult with the interdisciplinary team more frequently than experienced navigators. This is a normal part of developing judgment and confidence. During onboarding and early implementation, organizations should encourage timely consultation and use case review as an opportunity for coaching and mentorship.

Implementation Lesson Some organizations have found that locating care navigators near members of the interdisciplinary clinical team increases opportunities for informal consultation, observation, and mentoring. These brief interactions can strengthen communication and make it easier to address questions that may not require formal case review. When co-location is not possible, organizations should consider alternative strategies to facilitate timely consultation and team communication.

Communicate Concerns Clearly

Structured communication helps the clinical team quickly understand the situation and provide timely recommendations.

Many organizations use the **SBAR (Situation, Background, Assessment, Recommendation)** framework to organize clinical communication.

- **Situation:** What is happening now?
- **Background:** What information provides important context (e.g., timeline, triggers and other changes, condition improving, worsening, or staying the same)?
- **Assessment:** What concerns you most?
- **Recommendation (or Request):** What guidance or assistance is needed?

Using a consistent communication framework helps navigators organize their observations, communicate concisely, and strengthen clinical judgment over time.

Regular interdisciplinary case review meetings provide opportunities to discuss routine questions, review complex situations, and learn from colleagues. These meetings also support navigator development by strengthening communication skills and clinical decision-making.

Implementation Lesson New care navigators often present more information than is needed when seeking clinical consultation. Regularly practicing SBAR (Situation, Background, Assessment, Recommendation) during interdisciplinary case review helps navigators learn to identify the most important clinical information, ask focused questions, and communicate recommendations clearly and concisely. These skills develop with experience and regular feedback.

Coordinate Care and Maintain Continuity

Care coordination extends beyond communicating clinical recommendations. Care navigators help participants and care partners successfully navigate health care and community systems while ensuring that recommended actions are completed, information is shared across settings, and continuity is maintained as needs change over time.

One of the defining features of the Care Ecosystem is the ongoing relationship between the care navigator, the person living with dementia, and the care partner. Maintaining this continuity requires effective communication, reliable documentation, interdisciplinary collaboration, and operational systems that support participants through clinical changes, care transitions, and staffing changes.

Coordinate Care

Many participant concerns can be addressed through education, coaching, and the Care Protocols. Others require coordination with health care providers, community organizations, or members of the interdisciplinary team.

Care coordination activities may include:

- Sharing recommendations with participants and care partners.
- Communicating recommendations to primary care providers, specialists, or other members of the care team.
- Coordinating referrals to community organizations and support services.

- Following up on referrals, appointments, or recommended interventions.
- Updating the care plan as needs evolve.

The goal of care coordination is not for the care navigator to personally solve every problem, but to help participants and care partners successfully access the services and support they need while ensuring important recommendations do not fall through the cracks.

Support Care Transitions

Transitions often represent periods of increased vulnerability for people living with dementia and their care partners. Hospitalizations, emergency department visits, changes in living situation, new caregivers, or transitions to home health, palliative care, or hospice frequently require additional communication, reassessment, and follow-up.

Organizations should establish workflows that describe how significant care transitions are identified, communicated to the care team, incorporated into the care plan, and followed by additional support as needed.

Implementation Lesson Care coordination can be time consuming, particularly when navigating unfamiliar community resources, benefits, or health care systems. When a team member develops an effective process — for example, obtaining a disability parking placard, applying for a public benefit, or accessing a local respite program — consider documenting the steps in a brief local guide and adding it to the program's shared community resource database or knowledge library. Over time, these practical guides become valuable organizational resources that improve consistency, reduce duplication, and help onboard new staff.

Implementation Lesson Communicate clinical recommendations with a respectful and collaborative tone. The interdisciplinary team may have expertise in dementia care, but the participant's treating clinicians bring valuable knowledge of the individual's broader medical history, competing priorities, and treatment history. Recommendations are most effective when they provide concise clinical context, explain the rationale, and acknowledge the treating clinician's role in determining the most appropriate course of care.

Maintain Continuity

Participants and care partners benefit from having a consistent care navigator who understands their history, goals, preferences, and support network. At the same time, organizations should anticipate vacations, illness, onboarding, staff turnover, and other situations in which responsibilities may temporarily shift among team members.

Reliable documentation, participant tracking, communication systems, and care coordination workflows help ensure that important information is shared and recommended actions continue moving forward during staffing transitions.

Before implementation, consider:

- How participants will be reassigned during staff absences.
- How temporary coverage will be documented and communicated.

- How the covering team member will receive important background information, including current priorities, recent recommendations, and pending follow-up tasks.
- How comprehensive care plans and clinically important recommendations will be shared with treating clinicians and other members of the care team.
- How referrals to community organizations and recommended services will be tracked and followed up.
- How participants and care partners will be informed about temporary staffing changes.

Implementation Lesson Organizations have developed different approaches to maintaining continuity during staffing transitions. Some temporarily redistribute participants across the navigator team, while others have a clinical team member, such as a social worker, maintain a small participant caseload to provide coverage during onboarding, extended leave, or staff turnover. This approach can help maintain continuity of care while also providing mentorship and support for new care navigators.

Provide a Standardized Welcome Packet

Every participant and care partner should receive consistent guidance about how to communicate with the Care Ecosystem team and navigate health care and community systems. Providing standardized guidance early helps establish clear expectations, reduces confusion, and ensures participants know how to access the appropriate level of support when questions or concerns arise.

Topics typically include:

- When to contact the care navigator.
- When to contact the primary care provider or another treating clinician.
- When urgent clinical consultation is needed.
- When to call emergency services.
- How after-hours concerns are managed.
- How and when follow-up communication will occur.

Implementation Lesson Review these communication expectations early in the relationship and revisit them periodically, particularly after hospitalizations, changes in living situation, or other major transitions in care.

GUIDE Consideration Medicare GUIDE programs are required to provide access to 24/7 triage for urgent concerns. Organizations participating in GUIDE should establish clear workflows describing how participants and care partners access after-hours support and how information is communicated back to the Care Ecosystem team to support continuity of care.

Operational Tools
Participant Care Team Contact Guide

PLAN PROGRAM LAUNCH

Confirm Readiness

By this point, your organization has assembled a team, trained staff, designed the care delivery process, and established the operational infrastructure needed to support the Care Ecosystem. The final step is to confirm your readiness and determine your approach to launching implementation.

Few organizations launch with every process fully refined. Successful implementation depends less on having a perfect plan and more on creating opportunities to learn, adapt, and improve during the early stages of implementation. Aim to have a minimally viable product ready to launch and plan for frequent check-ins to review and iterate workflows in the first few months.

Determine Launch Strategy

Organizations have successfully implemented the Care Ecosystem using different launch strategies. The best approach depends on your organization's experience, staffing, existing dementia care infrastructure, referral sources, leadership support, and implementation goals.

Phased Launch

Many organizations begin implementation with a limited number of participants, clinics, or referring providers before expanding.

A phased launch allows organizations to:

- Test new workflows.
- Refine documentation and communication.
- Build team confidence.
- Identify operational challenges.
- Adjust processes before expanding.

Organizations adapting the Care Ecosystem within an existing dementia care program may also choose to pilot selected components such as comprehensive care planning and medication reviews before implementing the full model.

Broad Launch

Some organizations begin with a pre-screened registry or waitlist and enroll a larger number of participants over a relatively short period.

This approach may be appropriate when organizations:

- Have an established dementia care program.

- Have experienced clinicians and navigators.
- Have strong operational infrastructure.
- Need to rapidly establish a participant panel.
- Have leadership support for a more intensive implementation effort.

A broad launch requires sufficient staffing, clear operational processes, and frequent communication to manage increased referral and enrollment activity.

Implementation Example Organizations have successfully implemented the Care Ecosystem using both phased and broad launch strategies.

Some organizations began with a small number of participants or a single clinic while refining workflows before expanding.

Others integrated the Care Ecosystem into an established dementia care program and enrolled a large number of participants shortly after implementation.

Successful implementation depended less on the launch strategy itself than on maintaining regular communication, protecting time for clinical supervision, and adapting workflows as the program evolved.

Support Early Implementation

The first several months of implementation are an opportunity to learn how the program functions in your local setting.

Consider scheduling:

- Regular implementation team meetings and review of operational reports.
- Weekly interdisciplinary case review.
- Workflow debriefs with navigators and supervisors.
- Regular communication with referring providers and organizational leadership.

Implementation Lesson Make weekly goals (e.g., number of referrals processed, outreach calls made, participants enrolled), evaluate challenges and successes, and adjust approach in small tests of change. Small adjustments made early and often prevent larger operational challenges as the program grows.

LAUNCH READINESS CHECKLIST

Use this checklist to help your team confirm readiness to implement the Care Ecosystem.

Team

- ☐ Care navigators hired
- ☐ Staff training completed or underway
- ☐ Clinical supervision established

Care Delivery

- ☐ Care delivery and clinical consultation processes designed
- ☐ Adapted Care Protocols available
- ☐ Care partner communication plan established

Operational Infrastructure

- ☐ Documentation and communication systems established
- ☐ Participant tracking system developed
- ☐ Operational reporting plan established
- ☐ Central community resource database and education library available
- ☐ Continuity of care plan established

Launch Planning

- ☐ Launch strategy selected
- ☐ Referral sources engaged
- ☐ Early implementation meetings scheduled
- ☐ Launch timeline communicated

SUSTAIN THE PROGRAM

"I never feel alone because my navigator is always there for me."
— Care partner participating in the Care Ecosystem

The Care Ecosystem is built on relationships. Sustaining the program requires more than securing funding — it depends on demonstrating value, collaboration, and continually adapting to better meet the needs of people living with dementia and their care partners.

As health care, reimbursement models, and community resources continue to evolve, successful organizations maintain fidelity to the Care Ecosystem's core components while adapting their business model and organizational relationships to best serve their communities.

Develop a Sustainable Business Model

Few dementia care navigation programs rely on a single funding source. Successful Care Ecosystem programs often combine reimbursement, organizational investment, grants, philanthropy, and collaborations to create a sustainable business model that reflects their setting, participant population, and strategic priorities.

Potential funding strategies include:

Health Care Reimbursement

Organizations embedded within health systems may support dementia care navigation through available reimbursement opportunities, including:

- Medicare GUIDE payment model
- Cognitive Assessment and Care Planning (CPT 99483)
- Principal Illness Navigation (PIN)
- Other care management reimbursement opportunities

Value-Based Care

Organizations participating in Medicare Advantage, accountable care organizations, or other value-based payment arrangements may find that dementia care navigation supports broader organizational goals by improving quality of care, reducing unnecessary health care utilization, enhancing caregiver support, and improving patient and clinician experience.

Grants and Philanthropy

Many Care Ecosystem programs begin with grants, philanthropic support, or institutional innovation funding. These resources often provide the flexibility needed to launch new programs, pilot innovative approaches, or expand services while reimbursement pathways mature.

BUILD A DEMENTIA CARE NETWORK

No organization or program can meet every need of people living with dementia and their care partners. Consider developing a network of clinical, behavioral health, community, and social service partners that complement the services provided by the Care Ecosystem.

Partner Function	Examples	Potential Contributions
Primary & Specialty Medical Care	Primary care, neurology, geriatrics, memory clinics	Diagnosis, medical management, specialty consultation, referrals, coordinated care
Acute & Transitional Care	Home-based urgent care, hospital-at-home, transitional care, emergency departments	Acute evaluation, hospitalization avoidance, post-discharge follow-up, care transitions
Behavioral Health	Therapists, psychologists, psychiatrists, behavioral health programs	Participant and caregiver depression, anxiety, grief, counseling, behavioral health treatment
Medication Support	Pharmacists	Medication review, medication risk reduction, deprescribing recommendations
Community & Caregiver Support	Alzheimer's Association, Area Agencies on Aging, caregiver resource centers, support groups	Caregiver training, support groups, education
Respite & Daily Living Support	Adult day programs, respite providers, home care agencies	Caregiver relief, supervision, personal care, social engagement
Palliative & Serious Illness Care	Palliative care, hospice	Goals-of-care discussions, symptom management, advance care planning, end-of-life care
Social & Legal Services	Transportation, meals, legal services, benefits counseling, housing resources	Address social determinants of health, legal planning, financial and practical support
Public Health & Community Initiatives	County aging services, public health departments, dementia-friendly communities, faith organizations	Community outreach, education, policy initiatives, regional collaboration

Implementation Lesson Sustaining a dementia care navigation program depends on strong relationships across health care, community, and government organizations. Some relationships are informal collaborations that facilitate referrals, education, and care coordination, while others are formal partnerships that support staffing, reimbursement, contracts, or shared services.

Demonstrate Value

Long-term sustainability depends on demonstrating the value of the Care Ecosystem to the individuals and organizations that support it. Different stakeholders define value differently, so organizations should communicate outcomes that align with the priorities of each audience.

Stakeholder	Examples of Value
Health system leaders	Improved access to dementia care, care quality, operational efficiency, financial sustainability

Stakeholder	Examples of Value
Health care providers	Practicing at the top of license, better care coordination, caregiver support
Community organizations	Expanded access to services, caregiver support, health equity, community impact
Payers	Quality of care, health care utilization, value-based performance
Funders and policymakers	Program reach, participant outcomes, sustainability, community impact

Evaluation data help demonstrate the effectiveness of the program, but numbers alone rarely capture the full impact of relationship-based dementia care.

Tell the Story of Your Program

Stories help explain what program metrics cannot. With appropriate permission and protection of privacy, consider collecting participant, care partner, clinician, and community partner stories that illustrate the program's impact.

Stories might describe:

- A caregiver who felt more confident managing challenging behaviors.
- A crisis that was prevented through timely care navigation.
- A clinician whose workload was reduced through ongoing care coordination.
- A community partnership that improved access to services.
- A family that felt supported through the progression of dementia.

Narratives like these complement evaluation data by helping leadership, funders, policymakers, and community partners understand the human impact of relationship-based dementia care.

Implementation Lesson Different audiences respond to different forms of evidence. Quantitative data demonstrate program performance, while participant and caregiver stories communicate the lived experience of dementia and the value of having a trusted partner throughout the caregiving journey. Together, data and stories create a more compelling case for sustaining and expanding dementia care programs.

CONTINUE LEARNING AND CONNECTING

The landscape of dementia care continues to evolve through new treatments, payment models, technologies, and opportunities for collaboration. The Care Ecosystem was designed to evolve alongside these changes while maintaining a commitment to relationship-based, person-centered dementia care. Successful programs continue to learn from other organizations, share their implementation experiences, and participate in collaborative learning networks that can help programs adapt to changing demands and innovations. A growing number of national organizations now support the implementation of evidence-based dementia care. Implementation teams may benefit from exploring tools and engaging with the following organizations working to advance dementia care access and quality.

Organization/Resource		What You'll Find
Care Ecosystem		Implementation toolkit, Care Protocols, online care navigator training, Dementia Library, monthly implementation meetings, and continuing education.
Alzheimer's Association Health System Initiatives		Regional Health System Directors, dementia care navigation implementation support, health system resources, and strategic guidance.
Alzheimer's Association Professional Education (AlzPro)		Professional education, dementia training, certification, and clinical resources.
National Dementia Care Collaborative (NDCC)		Implementation support for evidence-based dementia care programs with a focus on GUIDE implementation. Affinity groups and webinars across programs including the Care Ecosystem, UCLA ADC, Indiana ABC, Benjamin Rose WeCare, Emory Integrated Memory Care, and Johns Hopkins MIND at Home.
Dementia Care Navigation Roundtable		National collaboration advancing dementia care navigation through guiding principles, implementation resources, policy work, and business case tools, including the Dementia Care Financial Model for value-based care.
Best Programs for Caregiving		A searchable directory of evidence-based dementia caregiving programs. Compare programs to identify models that best fit your organization or community. (Caregiver)
Davos Alzheimer's Collaborative		Resources to support health systems implement early detection and brain health navigation.

THANK YOU FOR WORKING TOWARD BETTER DEMENTIA CARE

The Care Ecosystem was developed to help organizations build sustainable dementia care navigation programs that complement medical care, strengthen community partnerships, and support families throughout the course of dementia. We hope this toolkit, the Care Protocols, navigator training, and implementation resources help you build a program that meets the unique needs of your community.

We look forward to learning from your experiences and continuing to improve the Care Ecosystem together.

Stay Connected

Visit the Care Ecosystem website to access:

- Care Protocols
- Care Navigator Training
- Dementia Library
- Implementation Toolkit and companion resources
- Monthly implementation meetings
- Continuing education opportunities
- Updates and new implementation resources

memory.ucsf.edu/care-ecosystem

Bookmark our site for easy access to the latest resources and events.

UCSF Weill Institute for Neurosciences

Fein Memory and Aging Center