NCCDP
National Council of Certified Dementia Practitioners

2025 ANNUAL REPORT

Memory Care Excellence Network

Introduction

The Memory Care Excellence Network (MCEN) is **NCCDP's** recognition-and-improvement program for long-term care organizations that are committed to best-in-class memory care standards. MCEN is built to help participating communities strengthen resident outcomes and staff competence, and to make that commitment visible through the Memory Care Seal of Excellence, a clear signal to families, referral partners, and surveyors that a community meets rigorous training and practice expectations.

At its core, **MCEN** is an organization-wide framework that raises the bar across people, process, and outcomes. It weaves together **NCCDP's** training pathways and nationally recognized credentials (such as Certified Dementia Practitioner (CDP) and Certified Montessori Dementia Care Professional (CMDCP), operational standards, and ongoing support. so dementia-capable care is delivered consistently across shifts and roles, not dependent on individual champions.

MCEN is also designed to advance the field together by aggregating learning from high-performing programs. Member communities contribute randomized, aggregated data that inform **MCEN** reporting and help identify what distinguishes best-in-class memory care, using tools such as a detailed community survey and SCIDS (Staff Competence in Dementia Care) surveys completed by caregiving staff.

> **In short:** MCEN exists to recognize excellence, standardize and strengthen dementia care practices, and build an evidence-informed picture of what works, so the industry can replicate results that improve quality, safety, engagement, and outcomes for people living with dementia.

Executive Summary

This annual snapshot summarizes bench marking data contributed by 11 communities (10 residential and 1 homecare) in the dataset and 404 Staff Confidence in Dementia Care Surveys (SCIDS). The results reinforce a clear story: *credentialed dementia-care staff demonstrate higher measured competence and markedly better retention,* while facility-level indicators show meaningful variation, creating strong opportunities for peer-learning and standardization.

Workforce Competence (SCIDS)

Workforce capability & consistency (n=404)

The SCIDS scale (2012) by Schepers et al. has been used in healthcare research to evaluate the impact of training programs and identify areas where staff may need additional support. Research indicates that higher SCIDS scores are positively correlated with increased work experience, higher job satisfaction, and more person-centered approaches to care.

To measure staff confidence, we collected SCIDS assessments from 404 respondents and measured the composite SCIDS scores between CDP and non-CDP cohorts

- Median CDP score was 64 and non-CDP was 61
- Standard deviation for CDP was 6.7 vs non-CDP 8.3
- CDP cohort also had a higher minimum (39 vs 34)

4.9%
CDPs have higher confidence

19%
Less variability in CDP scores vs. non-CDP scores (SD 6.8 vs. 8.4).

Staff Retention

Overall vs. CDP Turnover:

- Communities provided annual turnover data for both CDP and non-CDP cohorts
- Overall, direct turnover was 42% at the median, while CDP turnover was 4% at the median, a gap of 38 percentage points.
- Communities provided annual turnover for both CDP and non-CDP cohorts.
- While the sample size is small, we are encouraged by these early results and excited to gather larger datasets in the coming years.

42%
Non-CDP Direct Care Turnover

vs

4%
CDP Direct Care Turnover

Memory Care Engagement and Quality

- High prevalence of Alzheimer's Disease and Related Dementias across the board (66.6%) despite a wide range of community sizes and standalone memory care vs. full spectrum communities.
- Quality indicators were positive, with low elopements (0.5/yr) and low overall medication use despite a high variability in use on the extremes, indicating opportunity for best practice sharing.
- Family and resident satisfaction were good, 87.2 and 88.8, respectively, indicating positive engagement with the community at large.

0.5
Elopment per year

87.2%
Family satisfaction

88.8%
Resident satisfaction

What this Means for MCEN

- The combined competence and retention signals suggest MCEN's training/credential pathways are associated with stronger staff capability and materially better workforce stability—two of the most critical drivers of consistent dementia care.
- Facility-level variation (medication use, deficiencies, engagement intensity) supports MCEN's role as a benchmarking and improvement network, not just a recognition program.
- The inaugural year of the MCEN was a success in terms of data collection and participation. NCCDP had hoped for greater participation of organizations but we learned that manual SCIDS collection was arduous for administration.

2025 Memory Care Excellence Network Members

The inaugural class of the Memory Care Excellence Network launched with 11 founding members, marking an important first step in building a community of organizations committed to advancing dementia care through shared learning, leadership, and operational excellence. While modest in size, an inaugural cohort of 11 is meaningful because it creates a strong foundation for collaboration, enables deeper engagement among members, and signals real demand for a network focused on improving memory care practices. These early adopters are not just participants; they are helping shape the standards, conversations, and momentum that can influence the future of person-centered memory care across the field.

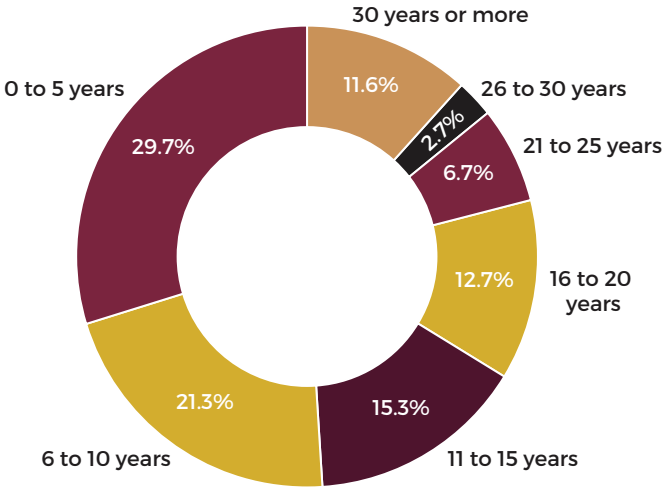
Key Outcomes

- Workforce competence: Overall staff competence showed a median SCIDS score of 63, with scores generally falling in the high-confidence range (IQR 55–68, range 34–78). (SCIDS v3, n=404)
- CDP advantage on competence: CDPs outperformed non-CDPs, with stronger floor performance, while CDPs were 33% more likely to score at or above the overall median of 63.
    a. Median SCIDS: 64 (CDP) vs 61 (non-CDP) → +3 points.
    b. Stronger "floor" performance: Low scores (<50) were about 3× less common among CDPs (5.1%) than non-CDPs (15.4%).
    c. More CDPs in the upper half: 58.8% of CDPs vs 44.1% of non-CDPs scored at or above the overall median of 63 (+14.6 percentage points; ~33% more likely).
    d. (n=216 CDP / 188 non-CDP)
- Retention and stability signal (residential survey): CDPs experienced substantially lower turnover than overall direct-care staff in reporting communities, reinforcing a strong retention signal.
    a. Overall direct-care turnover (residential, n=10): median 21.0% (range 1.3%–59.0%).
    b. CDP caregiver turnover (n=7 reporting): median 4.0% (range 1.0%–28.0%).
    c. Apples-to-apples (facilities reporting both, n=7): overall turnover 34.9% vs CDP turnover 10.0% → –24.9 percentage points (about 71% lower); CDP turnover was lower in 7 of 7 organizations.
- Resident mix and memory-care footprint (residential reporting): Survey data reflected a wide range of community sizes, from standalone memory care neighborhoods to large campuses with AL/IL and memory care. Even with that variation, the data showed a consistently high prevalence of ADRD diagnosis.
    a. Community size: Total beds median 129 (range 24–400).
    b. Memory care capacity: Memory care beds median 29 (range 11–47); memory-care share median ~21.9% (range 3.5%–100%).
    c. Dementia prevalence: Residents with ADRD diagnosis median 68% (range 33%–100%).
- Medication stewardship variation (residential, n=10): Medication-use patterns varied substantially across communities, suggesting meaningful differences in practice and a strong opportunity for peer benchmarking and best-practice sharing.
    a. Antipsychotic use: median 13.5% (range 3.6%–39.0%).
    b. Other dementia-related medications: median 17.4% (range 7.1%–46.0%).
- Engagement and quality indicators (residential reporting): Elopements were low overall, with more than half of communities reporting zero. At the same time, meaningful activities and deficiencies varied widely, suggesting real opportunities for learning and benchmarking across sites.
    a. Meaningful activities: median 18.0 hours/week per resident (range 2.5–48.0), indicating substantial variation in engagement intensity.
    b. Elopements: median 0.5 per year (range 0–3); 5 of 10 communities reported zero.
    c. Deficiencies: median 3.5 (range 0–18), again highlighting wide variability and opportunity for cross-site learning.

- Resident & Family Satisfaction measures: Resident and family satisfaction was strong overall. In general, resident satisfaction from 80–100 is considered good, with scores above 90 considered excellent. Family satisfaction above 85 is also considered strong.
    a. Resident satisfaction: Average 88.8% (n=7; range 80%–98%).
    b. Family satisfaction: Average 87.2% (n=6; range 77.9%–94%).

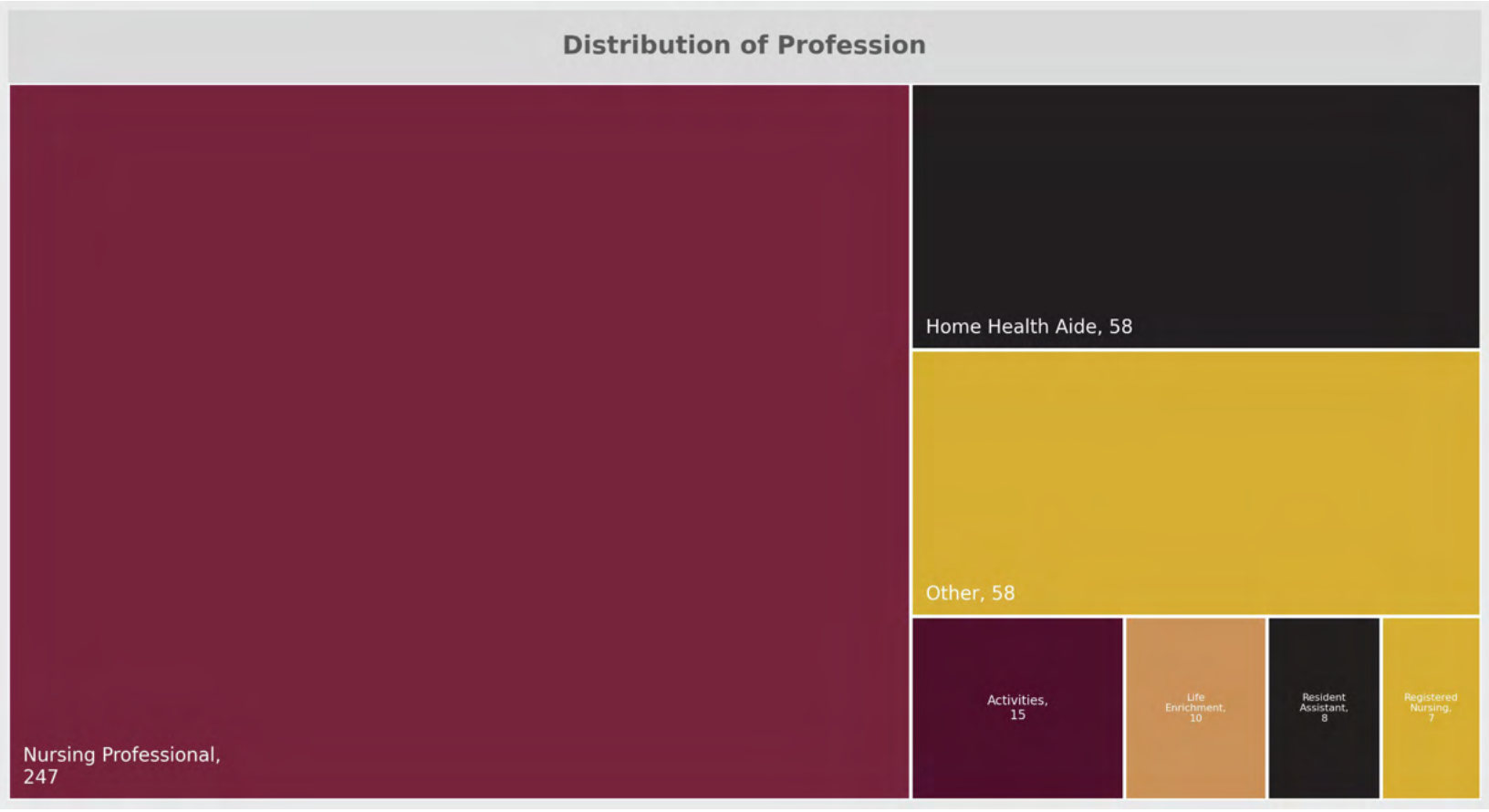
Distribution of Tenure

Across the 404 SCIDS respondents, tenure is weighted toward early-to-mid career staff while still reflecting a meaningful bench of highly experienced team members. The largest cohort has 0–5 years of tenure (120; 29.7%), followed by 6–10 years (86; 21.3%), meaning about half of respondents (206; 51.0%) have 10 years or less in the field. Another 62 respondents (15.3%) report 11–15 years, bringing the total to 66.3% with 15 years or less. On the experienced end, 51 (12.6%) report 16–20 years, 27 (6.7%) report 21–25 years, 11 (2.7%) report 26–30 years, and 47 (11.6%) report 30+ years—so roughly one-third (136; 33.7%) bring 16+ years of experience to the dataset.



Professionals (Staff Mix)

Across the 404 SCIDS staff responses, the profession mix is highly concentrated in direct-care and clinical roles. Nursing Professionals are the largest group (139; 34.4%), followed closely by Certified Nursing Assistants (129; 31.9%) and Home Health Aides (59; 14.6%). Together, these three roles account for 80.9% of all responses, indicating the dataset strongly reflects frontline caregiving and nursing perspectives. The next largest categories are Activities (17; 4.2%), Life Enrichment (11; 2.7%), Administrators (9; 2.2%), and Resident Assistants (8; 2.0%), bringing the top seven professions to 92.1% of the sample. The remainder is a “long tail” of smaller roles spread across 25 total profession categories, with 17 categories represented by fewer than five respondents each (including 12 single-respondent categories), reflecting broad interdisciplinary participation but at lower volumes outside the core



Community Benchmarking

(Residential Communities, n=10)

- Facility mix & scale varies a lot: total beds 24–400 (median 129, avg 155.8).
- Memory care beds avg 28.7; memory-care share ranges 3.5%–100% (median ~22%).
- Dementia prevalence is high: ADRD diagnosis share median 68% (range 33%–100%).
- Medication variation is wide:
    a. Antipsychotic use: median 17% (range 6%–39%, n=9 reporting)
    b. Other dementia meds: median 21% (range 10%–46%, n=9)
- Readmissions are extremely skewed (watch the outliers): among reporters (n=6), median 0.5%, but a max of 30.5%—suggesting either true outliers or definition/reporting differences worth validating.
- Regulatory quality spread: deficiencies median 3.5 (range 0–18). That range is a strong "variation/opportunity" storyline.
- Safety (elopements): average 0.7/year, median 0.5, range 0–3; 5 of 10 report zero.

2026 Goals

For 2026, NCCDP will online data collection with QR-code access for staff, that will overcome the initial administrative obstacles for SCIDS data. Customer education and data collection will be self-administrated. We will expand survey data to compare CMS/HCBS quality measures for assisted living to see how MCEN communities align or exceed peer data. Sharing of peer data will help to create a benchmarking and improvement network among MCEN organizations, creating best practices and setting new industry standards for excellence.

Ohio Department of Aging

The Memory Care Excellence Network has been recognized as a Nursing Home quality improvement project by the Ohio Department of Aging.

Learn more at:

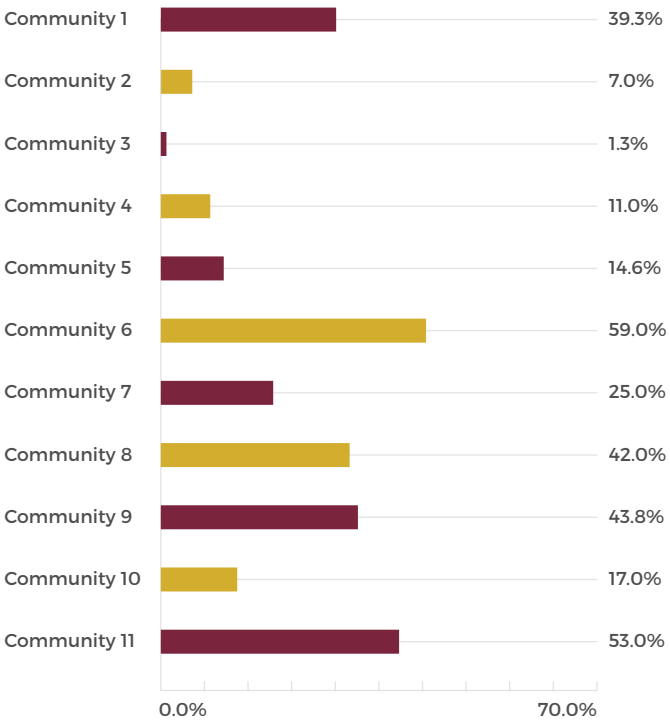
https://aging.ohio.gov/agencies-and-service-providers/nursing-home-quality-improvement/nursing+home+quality+improvement+current+projects/nccdp-mcen

Defining Best-in-Class

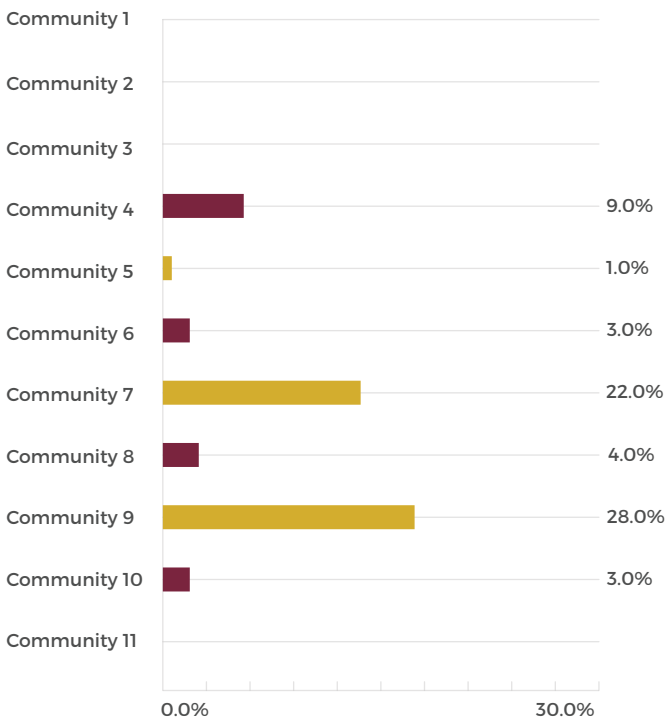
MCEN helps define “best-in-class” memory care by combining a rigorous recognition standard with network-wide benchmarking that turns individual community practices into shared, evidence-informed expectations. Member organizations complete a structured evaluation of staff training, operational practices, and ongoing competency, and those that meet (and exceed) expectations are recognized with the Memory Care Seal of Excellence—a visible marker that a community is operating at a higher standard of dementia care. At the same time, MCEN aggregates data across participating communities to power NCCDP’s Memory Care Industry Report, which highlights trends, best practices, and opportunities for improvement—spotlighting what leading programs are doing to advance quality, safety, engagement, and outcomes, and helping translate those insights into clearer industry standards over time.

Outcomes

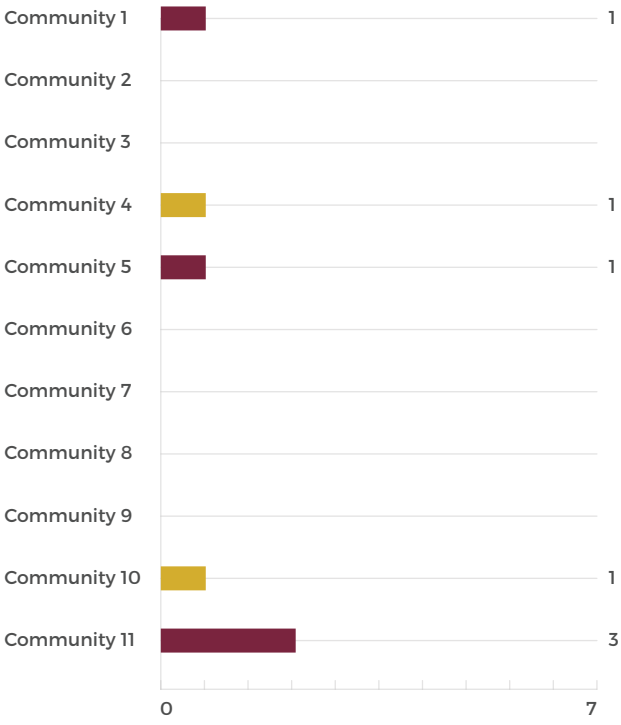
Overall Staff Turnover



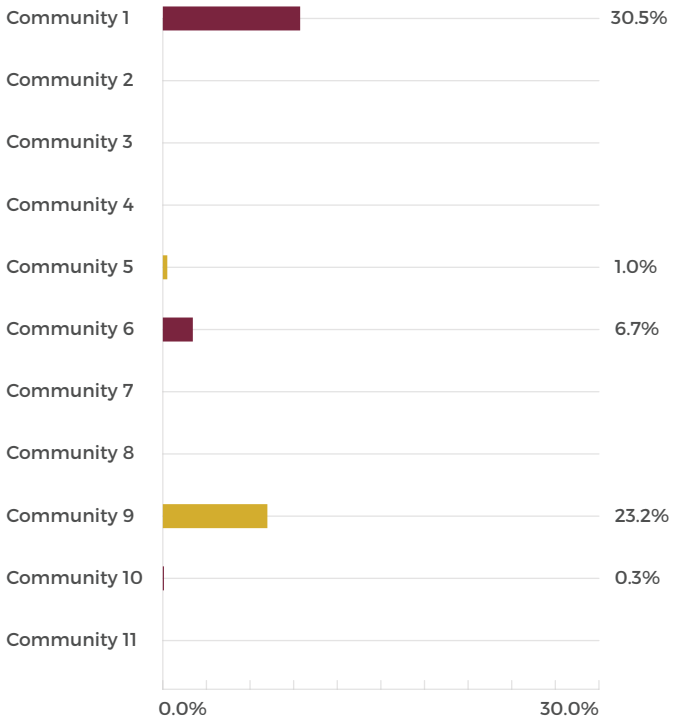
CDP Staff Turnover



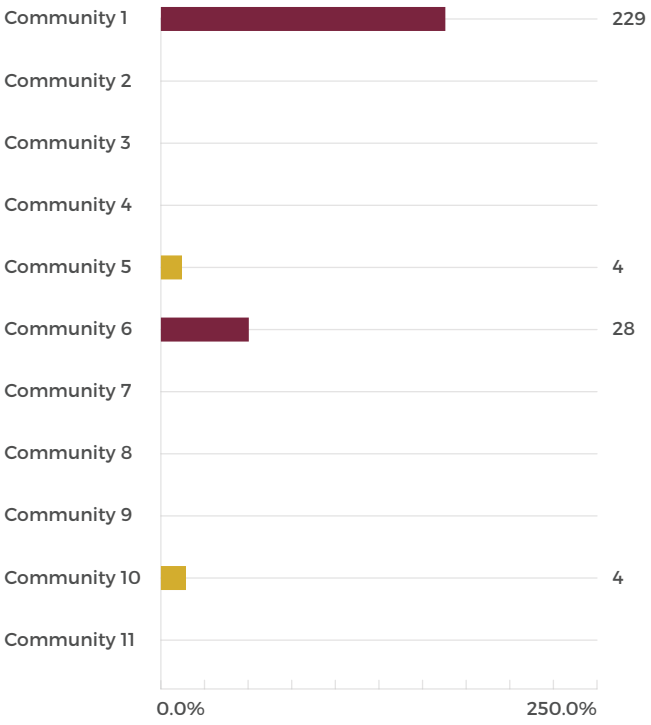
Elopements



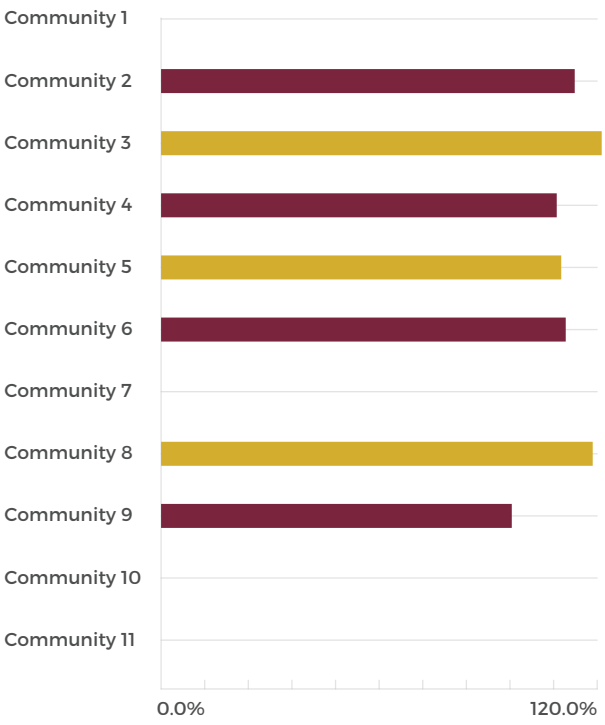
Hospital Readmissions



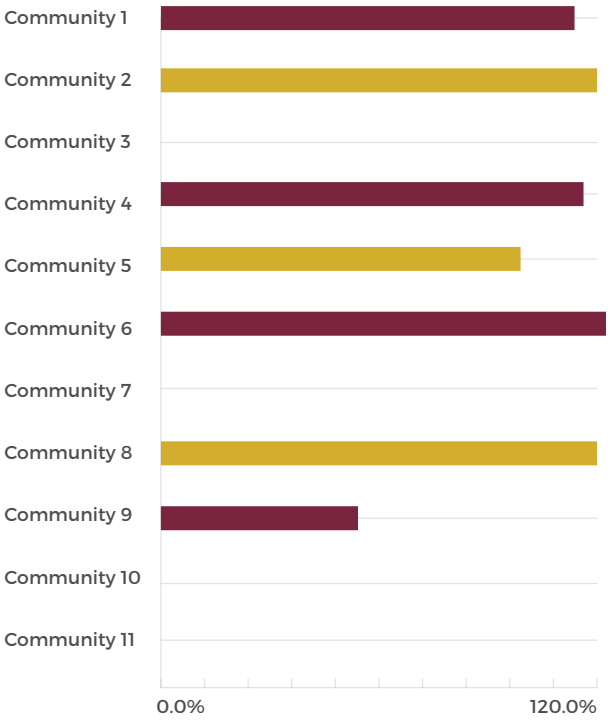
Hospital Admission Rate



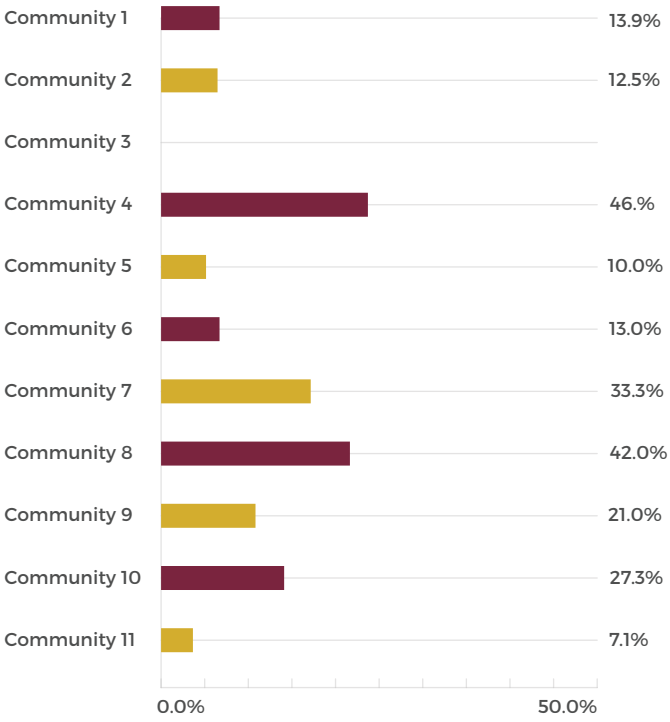
Family Satisfaction Rating



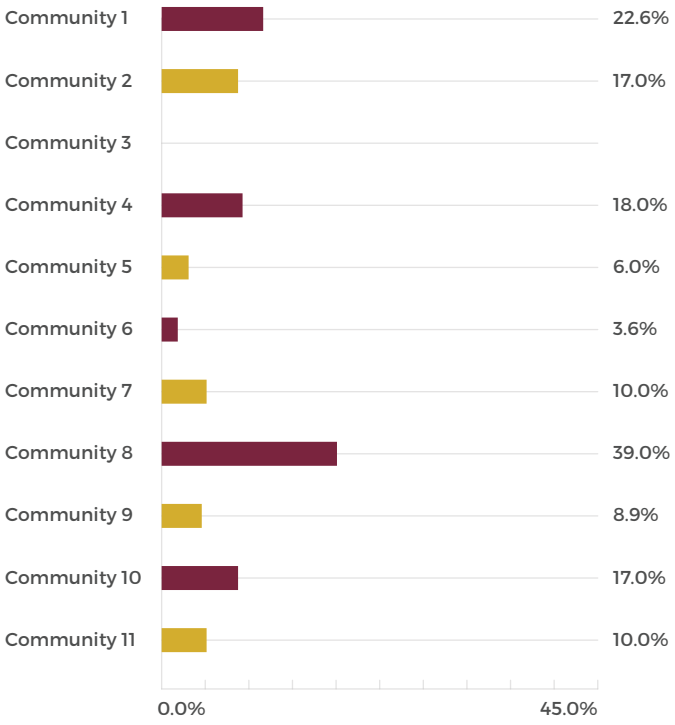
Resident Satisfaction Rating



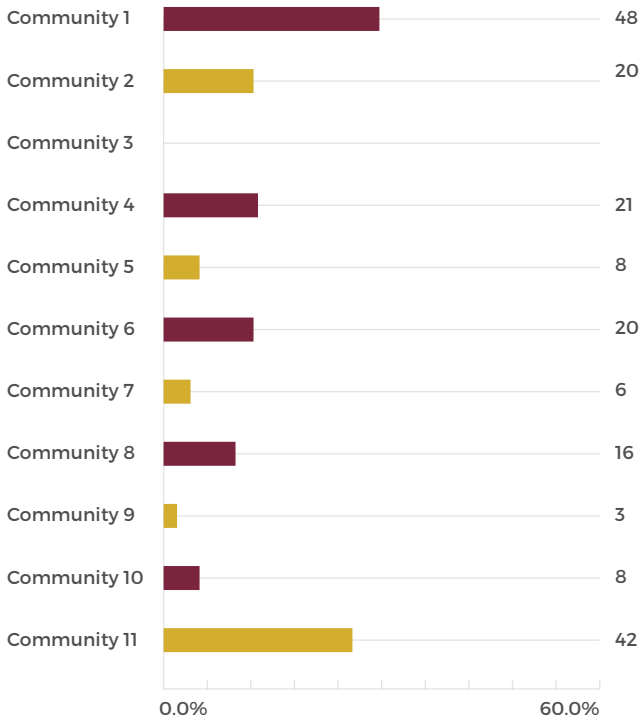
Dementia Medication Use



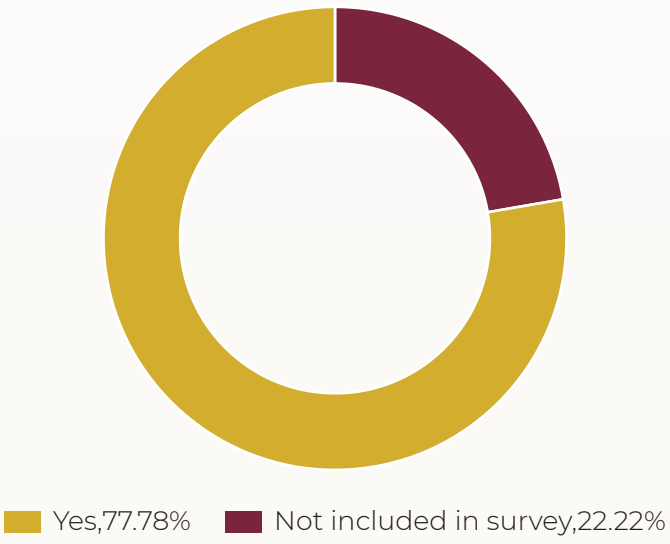
Antipsychotic Use



Resident Activity Planning



Do you have a volunteer program?



Volunteer Program

Our Mission & Values

Our mission is to provide world-class training and education on Alzheimer's disease and related dementias so that every individual living with cognitive change benefits from compassionate, expert care.

NCCDP's vision is to lead a global transformation in care for individuals living with Alzheimer's disease and related dementias, cultivating a future where all caregivers are equipped with the knowledge, skills, and empathy to treat individuals living with cognitive change.

Join the MCEN

Joining the Memory Care Excellence Network (MCEN) starts with an eligibility confirmation and an application process designed to verify that dementia care excellence is happening organization-wide, not just in pockets. Organizations can pursue MCEN recognition for an entire community or a dedicated memory care neighborhood (standalone or within a larger campus). A core eligibility requirement is that at least 50% of full-time caregivers in the certifying community/neighborhood hold NCCDP certifications; applicants also identify their NCCDP corporate group administrator and trainer leadership (CADDCT and/or CMDCPT) and designate a data/compliance contact. Once an organization proceeds, NCCDP conducts the required assessments and collects randomized, aggregated benchmarking data for the annual MCEN report—typically including an administrative community survey, SCIDS (Staff Competence in Dementia Care) surveys for all caregiving staff, and a data collection agreement (with measures that may include areas like pharmacology, falls, and hospitalizations), and may include an in-person or virtual site visit/tour. Organizations that meet the standards are accepted into the network and awarded the Memory Care Seal of Excellence, with ongoing annual eligibility reviews; there is currently no cost to apply, and NCCDP will help communities that don't yet meet staffing/training requirements build a tailored training plan.

NCCDP
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Seal of Excellence 2025

Feel free to reach out to us at
nccdpoffice@nccdp.org.