The Cognitive Health Assessment for Team Members

Introduction

Primary care team members are uniquely positioned to detect and address patients' cognitive symptoms and functional needs because they:

- Provide "first contact" for new health needs.
- Provide continuity of care via longitudinal relationships.
- Coordinate care referrals to resources and services.
- Provide comprehensive care.

However, a Cognitive Health Assessment (CHA) does not have to be performed by a primary care provider.

The Cognitive Health Assessment Adapted for Team Members

Different people may do different parts of the CHA in whatever way works best for a particular site. Below are the parts of the CHA, adapted for team members:

1. **CHA Part 1**: Take a brief patient history and document it in the patient chart.
2. **CHA Part 2**: Conduct the Mini-Cog or GP-COG and score the results. Ask about Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL). Add the assessment tool(s) used and scored results to the patient chart.
3. **CHA Part 3**: Document a care partner, healthcare agent, or lack of one in the patient chart.

The primary care provider then:

4. Confirms the patient history and scoring, interprets the results, and discusses the results with the patient.
5. Confirms the care partner and/or healthcare agent is documented.
6. Determines the appropriate next steps if the CHA suggests cognitive decline.

Part 1: Take a Brief Patient History (Adapted for Team Members)

An example of a source of information for documenting the history is a response to an annual screening question, such as:

- Do you or others think that you are having trouble remembering things?
- During the past few years, have you or others noticed changes in your thinking abilities?

Part 2: Use Screening Tools (Adapted for Team Members)

In this part of the CHA, you complete the screen, document the patient responses, and score each tool (if needed). You will not interpret the results. If patients ask about how they did, let them know the results will be discussed with them when they see their primary providers, not unlike other test results.

The table below shows some validated tools you can use for Part 2 of the CHA.

	Cognitive Screen Tools	Functional Screen Tools
For Patients	GP-COG Part 1 (General Practitioner assessment of Cognition) **OR** Mini-Cog (This is a short cognitive assessment; Mini-Cog is not a shortened name)	ADL (Activities of Daily Living) / IADL (Instrumental Activities of Daily Living)
For Care Partners	AD-8 (Eight-item Informant Interview to Differentiate Aging and Dementia) **OR** Short IQ-CODE (Short Informant Questionnaire on Cognitive Decline in the Elderly)	GP-COG Part 2 **OR** FAQ (Functional Activities Questionnaire)

A Note on Care Partner Assessments:

- If the patient screens positive (suggests cognitive or functional impairment), obtaining additional information from a care partner or healthcare agent may be helpful at this point but not necessary to move on to the next steps of the evaluation.
- If the patient screens negative (no evidence of cognitive or functional impairment), then it is recommended to obtain additional information from a care partner or healthcare agent utilizing cognitive and functional screening tools such as those listed below. These tools are questionnaires that can sometimes be done over the phone or while waiting in the waiting area.
- If a care partner assessment is needed, each site can determine whether it should be done by a team member or by the primary care provider.

Part 3: Document Care Partner Information (Adapted for Team Members)

Knowing if there is a support system for a patient is crucial for the care team to provide high-quality care in keeping with the patient's wishes. The last part of the CHA is to document the patient's care partners, healthcare agent, or both in the chart. If the patient can't identify either a care partner or a healthcare agent, that should be documented as well.

Care partners may be friends, family members, neighbors, paid caregivers—anyone who knows the patient well enough to identify a change in the patient's cognitive or functional abilities. These partners usually support the patient by providing transportation to appointments, checking in on the patient frequently, or helping with grocery shopping.

A healthcare agent is a legally designated person named in an advance directive. This person has been selected by the patient to make health care decisions on the patient's behalf if the patient cannot speak for him or herself.

Note: These roles may or may not be the same person.

How to Speak with the Patient About Their Care Partner

Start by asking whether the person has a healthcare agent.

If the patient responds yes: Document the name and contact information of their healthcare agent(s).

If the patient responds no: Ask if they want to appoint a healthcare agent to make decisions if they are ever in a position in which they can't make decisions and that their primary provider can help set this up.

Next, ask if they have someone who helps with tasks at home or to coordinate their medical care.

If the patient responds yes: Document the name and contact information of the patient's care partner(s).

If the patient responds no: Ask if there is someone they want you to contact and involve in their care.

If the patient responds no again: Document that the patient could not identify a care partner.

What Happens Next?

After conducting the CHA, you will add the tools you used and the score results into the patient's chart and hand it off to the provider.

When the provider receives the patient's chart, the provider will confirm the history, discuss the results with the patient, and determine the next steps as necessary.

Resources

[Dementia Care Aware website]