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Care Aware

Early detection. Better care.

The Cognitive Health Assessment

www.dementiacareaware.org

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

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Conducting the Cognitive Health Assessment: The Basics

The Three Parts of the Cognitive Health Assessment

The Cognitive Health Assessment (CHA) has three parts. It was designed for patients ages 65 and older who have not already been diagnosed with mild cognitive impairment or dementia. However, it can be used with any patient showing signs and symptoms of cognitive decline regardless of age.

Part 1

Take a Brief Patient History

Take a very brief cognitive health history of the patient. This history can be:

- The response to an annual screening question (e.g., Have you or friends/family noted changes in your mental abilities?) OR
- The observation of a sign of cognitive decline by someone (e.g., a care partner reports that the patient has difficulty remembering medication changes)

Part 2

Use Screening Tools

Assess the patient directly for both cognitive and functional decline using screening tools. If the patient screens negative, use cognitive and functional screening tools with the patient's care partner, if available. Refer to the next table for a list of recommended tools.

Part 3

Document Care Partner Information

Identify a care partner and document the partner's contact information in the patient's record. Ideally, this is a health care agent who has legal authority to make decisions on behalf of the patient. Even if a patient's cognitive and functional screenings are negative, ask about the patient's support system. If the patient can't identify someone, then document this instead.

Cognitive Health Assessment Screening Tools

For the CHA you need to screen for both cognitive and functional impairment. There are multiple screening tools you can use to check for cognitive and functional decline, and they can be administered to the patient or the care partner. The table below lists several recommended, validated tools.

	Administered to the patient:	Administered to the care partner:
Cognitive Screening Tools	GP-COG: Part 1: General Practitioner assessment of Cognition (for the patient) Mini-Cog	Short IQ-CODE: Short Informant Questionnaire on Cognitive Decline in the Elderly AD-8: Eight-Item Informant Interview to Differentiate Aging and Dementia
Functional Screening Tools	ADLs/IADLs: Activities of Daily Living and Instrumental Activities of Daily Living	GP-COG Part 2: General Practitioner Assessment of Cognition (for the informant) FAQ: Functional Activities Questionnaire

Links to Resources

Dementia Care Aware website
General Practitioner Assessment of Cognition (GP-COG)
Mini-Cog
Short Informant Questionnaire on Cognitive Decline in the Elderly (Short IQ-CODE)
Eight-Item Informant Interview to Differentiate Aging and Dementia (AD-8)
Functional Activities Questionnaire (FAQ)

Patient name: _____

Testing date: _____

GPCOG

STEP 1 – PATIENT EXAMINATION

Unless specified, each question should only be asked once.

Name and address for subsequent recall test

I am going to give you a name and address. After I have said it, I want you to repeat it. Remember this name and address because I am going to ask you to tell it to me again in a few minutes: John Brown, 42 West Street, Kensington. (Allow a maximum of 4 attempts.)

		Correct	Incorrect
Time orientation			
1.	*What is the date?* (exact only)	☐	☐
Clock drawing (use blank page)			
2.	*Please mark in all the numbers to indicate the hours of a clock.* (correct spacing required)	☐	☐
3.	*Please mark in hands to show 10 minutes past eleven o'clock.* (11.10)	☐	☐
Information			
4.	*Can you tell me something that happened in the news recently?* (Recently = in the last week. If a general answer is given, e.g. "war", "lot of rain", ask for details. Only specific answer scores.)	☐	☐
Recall			
5.	*What was the name and address I asked you to remember?*		
	John	☐	☐
	Brown	☐	☐
	42	☐	☐
	West (St)	☐	☐
	Kensington	☐	☐

Add the number of items answered correctly: **Total score:** ☐ **out of 9**

9	**No significant cognitive impairment** Further testing is not necessary
5 – 8	**More information required** Proceed with informant interview in step 2 on next page
0 – 4	**Cognitive impairment is indicated** Conduct standard investigations

Patient name: _____

Testing date: _____

GPCOG

STEP 2: INFORMANT INTERVIEW

Informant name: _____

Relationship to patient, i.e. informant is the patient's: _____

Ask the informant:

Compared to 5–10 years ago,	YES	NO	Don't know	N/A
1. *Does the patient have more trouble remembering things that have happened recently than s/he used to?*	☐	☐	☐	
2. *Does s/he have more trouble recalling conversations a few days later?*	☐	☐	☐	
3. *When speaking, does s/he have more difficulty in finding the right word or tend to use the wrong words more often?*	☐	☐	☐	
4. *Is s/he less able to manage money and financial affairs (e.g. paying bills and budgeting)?*	☐	☐	☐	☐
5. *Is s/he less able to manage his or her medication independently?*	☐	☐	☐	☐
6. *Does s/he need more assistance with transport (either private or public)?* (If the patient has difficulties only due to physical problems, e.g. bad leg, tick 'no'.)	☐	☐	☐	☐

Add the number of items answered with 'NO', 'Don't know' or 'N/A':

Total score: ☐ **out of 6**

4 – 6	**No significant cognitive impairment** Further testing is not necessary
0 – 3	**Cognitive impairment is indicated** Conduct standard investigations

When referring to a specialist, mention the individual scores for the two GPCOG test steps:

STEP 1 **Patient examination:** __ **/ 9**

STEP 2 **Informant interview:** __ **/ 6** or **N/A**

Brodaty et al, *JAGS* 2002; 50:530-534

Mini-Cog©

Instructions for Administration & Scoring

ID: _____ Date: _____

Step 1: Three Word Registration

Look directly at person and say, "Please listen carefully. I am going to say three words that I want you to repeat back to me now and try to remember. The words are [select a list of words from the versions below]. Please say them for me now." If the person is unable to repeat the words after three attempts, move on to Step 2 (clock drawing).

The following and other word lists have been used in one or more clinical studies.[1-3] For repeated administrations, use of an alternative word list is recommended.

Version 1	Version 2	Version 3	Version 4	Version 5	Version 6
Banana	Leader	Village	River	Captain	Daughter
Sunrise	Season	Kitchen	Nation	Garden	Heaven
Chair	Table	Baby	Finger	Picture	Mountain

Step 2: Clock Drawing

Say: "Next, I want you to draw a clock for me. First, put in all of the numbers where they go." When that is completed, say: "Now, set the hands to 10 past 11."

Use preprinted circle (see next page) for this exercise. Repeat instructions as needed as this is not a memory test. Move to Step 3 if the clock is not complete within three minutes.

Step 3: Three Word Recall

Ask the person to recall the three words you stated in Step 1. Say: "What were the three words I asked you to remember?" Record the word list version number and the person's answers below.

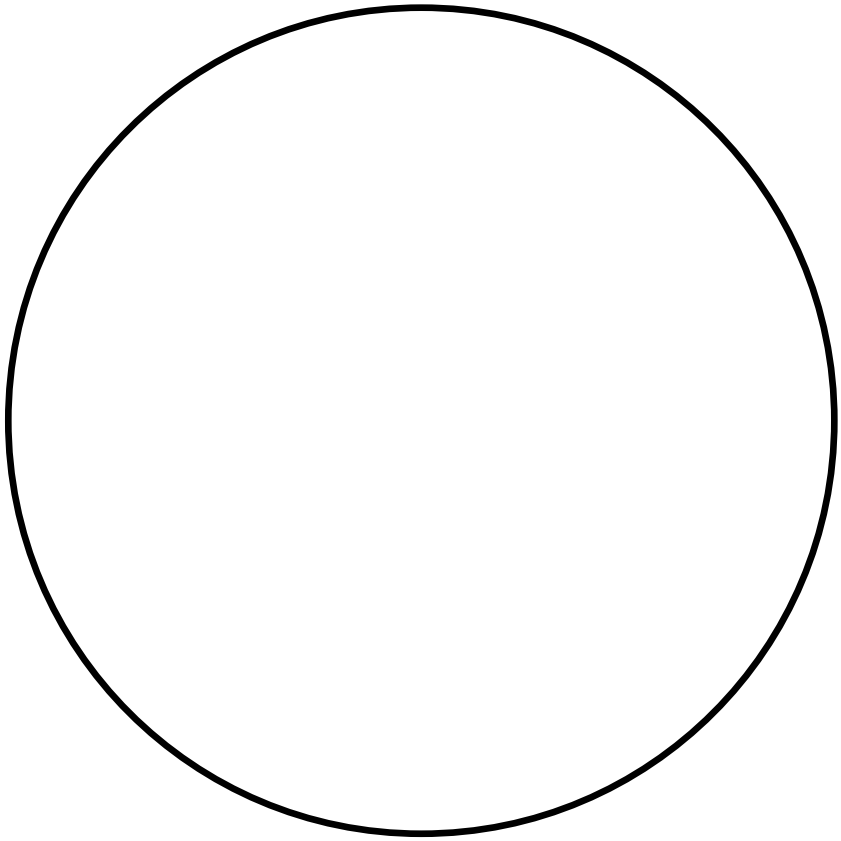
Word List Version: _____ Person's Answers: _____ _____ _____

Scoring

Word Recall: _____ (0-3 points)	1 point for each word spontaneously recalled without cueing.
Clock Draw: _____ (0 or 2 points)	Normal clock = 2 points. A normal clock has all numbers placed in the correct sequence and approximately correct position (e.g., 12, 3, 6 and 9 are in anchor positions) with no missing or duplicate numbers. Hands are pointing to the 11 and 2 (11:10). Hand length is not scored. Inability or refusal to draw a clock (abnormal) = 0 points.
Total Score: _____ (0-5 points)	Total score = Word Recall score + Clock Draw score. A cut point of <3 on the Mini-Cog™ has been validated for dementia screening, but many individuals with clinically meaningful cognitive impairment will score higher. When greater sensitivity is desired, a cut point of <4 is recommended as it may indicate a need for further evaluation of cognitive status.

Clock Drawing

ID:_____ Date:_____



References

1. Borson S, Scanlan JM, Chen PJ et al. The Mini-Cog as a screen for dementia: Validation in a population based sample. J Am Geriatr Soc 2003;51:1451–1454.

2. Borson S, Scanlan JM, Watanabe J et al. Improving identification of cognitive impairment in primary care. Int J Geriatr Psychiatry 2006;21: 349–355.

3. Lessig M, Scanlan J et al. Time that tells: Critical clock-drawing errors for dementia screening. Int Psychogeriatr. 2008 June; 20(3): 459–470.

4. Tsoi K, Chan J et al. Cognitive tests to detect dementia: A systematic review and meta-analysis. JAMA Intern Med. 2015; E1-E9.

5. McCarten J, Anderson P et al. Screening for cognitive impairment in an elderly veteran population: Acceptability and results using different versions of the Mini-Cog. J Am Geriatr Soc 2011; 59: 309-213.

6. McCarten J, Anderson P et al. Finding dementia in primary care: The results of a clinical demonstration project. J Am Geriatr Soc 2012; 60: 210-217.

7. Scanlan J & Borson S. The Mini-Cog: Receiver operating characteristics with the expert and naive raters. Int J Geriatr Psychiatry 2001; 16: 216-222.

AD8 Dementia Screening Interview

Patient ID#:_____
CS ID#:_____
Date:_____

Remember, "Yes, a change" indicates that there has been a change in the last several years caused by cognitive (thinking and memory) problems.	**YES, A change**	**NO, No change**	**N/A, Don't know**
1. Problems with judgment (e.g., problems making decisions, bad financial decisions, problems with thinking)			
2. Less interest in hobbies/activities			
3. Repeats the same things over and over (questions, stories, or statements)			
4. Trouble learning how to use a tool, appliance, or gadget (e.g., VCR, computer, microwave, remote control)			
5. Forgets correct month or year			
6. Trouble handling complicated financial affairs (e.g., balancing checkbook, income taxes, paying bills)			
7. Trouble remembering appointments			
8. **Daily** problems with thinking and/or memory			
TOTAL AD8 SCORE			

Adapted from Galvin JE et al, The AD8, a brief informant interview to detect dementia, Neurology 2005:65:559-564

The AD8 Administration and Scoring Guidelines

A spontaneous self-correction is allowed for all responses without counting as an error.

The questions are given to the respondent on a clipboard for self–administration or can be read aloud to the respondent either in person or over the phone. It is preferable to administer the AD8 to an informant, if available. If an informant is not available, the AD8 may be administered to the patient.

When administered to an informant, specifically ask the respondent to rate change in the patient.

When administered to the patient, specifically ask the patient to rate changes in his/her ability for each of the items, ***without*** attributing causality.

If read aloud to the respondent, it is important for the clinician to carefully read the phrase as worded and give emphasis to note changes due to cognitive problems (not physical problems). There should be a one second delay between individual items.

No timeframe for change is required.

The final score is a sum of the number items marked "Yes, A change".

Interpretation of the AD8 (Adapted from Galvin JE et al, The AD8, a brief informant interview to detect dementia, Neurology 2005:65:559-564)

A screening test in itself is insufficient to diagnose a dementing disorder. The AD8 is, however, quite sensitive to detecting early cognitive changes associated many common dementing illness including Alzheimer disease, vascular dementia, Lewy body dementia and frontotemporal dementia.

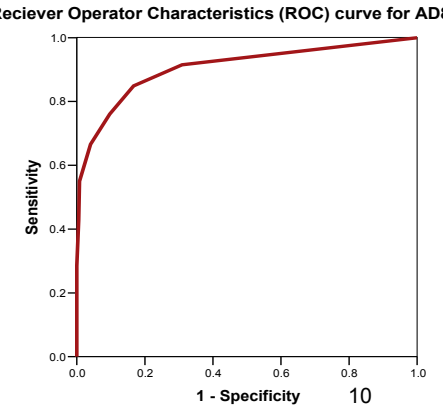
Scores in the impaired range (see below) indicate a need for further assessment. Scores in the "normal" range suggest that a dementing disorder is unlikely, but a very early disease process cannot be ruled out. More advanced assessment may be warranted in cases where other objective evidence of impairment exists.

Based on clinical research findings from 995 individuals included in the development and validation samples, the following cut points are provided:

- 0 – 1: Normal cognition
- 2 or greater: Cognitive impairment is likely to be present

Administered to either the informant (preferable) or the patient, the AD8 has the following properties:

- Sensitivity > 84%
- Specificity > 80%
- Positive Predictive Value > 85%
- Negative Predictive Value > 70%
- Area under the Curve: 0.908; 95%CI: 0.888-0.925



Permission Statement

Short Form of the Informant Questionnaire on Cognitive Decline in the Elderly (Short IQCODE)[1]

by A. F. Jorm

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Note: As used in published studies, the IQCODE was preceded by questions to the informant on the subject's sociodemographic characteristics and physical health.

Now we want you to remember what your friend or relative was like 10 years ago and to compare it with what he/she is like now. 10 years ago was in 20__.* Below are situations where this person has to use his/her memory or intelligence and we want you to indicate whether this has improved, stayed the same or got worse in that situation over the past 10 years. Note the importance of comparing his/her present performance with 10 years ago. So if 10 years ago this person always forgot where he/she had left things, and he/she still does, then this would be considered "Hasn't changed much". Please indicate the changes you have observed by circling the appropriate answer.

Compared with 10 years ago how is this person at:

	1	2	3	4	5
1. Remembering things about family and friends e.g. occupations, birthdays, addresses	Much improved	A bit improved	Not much change	A bit worse	Much worse
2. Remembering things that have happened recently	Much improved	A bit improved	Not much change	A bit worse	Much worse
3. Recalling conversations a few days later	Much improved	A bit improved	Not much change	A bit worse	Much worse
4. Remembering his/her address and telephone number	Much improved	A bit improved	Not much change	A bit worse	Much worse
5. Remembering what day and month it is	Much improved	A bit improved	Not much change	A bit worse	Much worse
6. Remembering where things are usually kept	Much improved	A bit improved	Not much change	A bit worse	Much worse
7. Remembering where to find things which have been put in a different place from usual	Much improved	A bit improved	Not much change	A bit worse	Much worse
8. Knowing how to work familiar machines around the house	Much improved	A bit improved	Not much change	A bit worse	Much worse

9. Learning to use a new gadget or machine around the house	Much improved	A bit improved	Not much change	A bit worse	Much worse
10. Learning new things in general	Much improved	A bit improved	Not much change	A bit worse	Much worse
11. Following a story in a book or on TV	Much improved	A bit improved	Not much change	A bit worse	Much worse
12. Making decisions on everyday matters	Much improved	A bit improved	Not much change	A bit worse	Much worse
13. Handling money for shopping	Much improved	A bit improved	Not much change	A bit worse	Much worse
14. Handling financial matters e.g. the pension, dealing with the bank	Much improved	A bit improved	Not much change	A bit worse	Much worse
15. Handling other everyday arithmetic problems e.g. knowing how much food to buy, knowing how long between visits from family or friends	Much improved	A bit improved	Not much change	A bit worse	Much worse
16. Using his/her intelligence to understand what's going on and to reason things through	Much improved	A bit improved	Not much change	A bit worse	Much worse

*The original tool was published in 1994.

The Alzheimer's Association updated the year 19__ as published in the original tool to 20__ .

Tool Reference: Jorm AF. A short form of the Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE): development and cross-validation. Psychol Med 1994; 24: 145–153.

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alzheimer's association
From The Hartford Institute for Geriatric Nursing, New York University, College of Nursing, and the Alzheimer's Association

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Editor-in-Chief: Sherry A. Greenberg, PhD, RN, GNP-BC
New York University Rory Meyers College of Nursing

Use of the Functional Activities Questionnaire in Older Adults with Dementia

By: Ann M. Mayo, DNSc, RN, FAAN
Hahn School of Nursing & Health Science, University of San Diego

WHY: Dementia is a neurodegenerative disease where functional ability in individuals with dementia (IWD) declines over time. The majority of care costs in IWD are directly attributed to functional disability (Hurd, 2013). Compromised functional ability is unsafe for IWD, anxiety provoking for families and costly to health care organizations. Valid and reliable clinical information about functional ability can be used to individualize care and design safe and supportive environments thereby promoting the highest level of independence for individuals with dementia. Therefore, an effective and efficient method for measuring functional ability is important.

BEST TOOL: The Functional Activities Questionnaire (FAQ) measures instrumental activities of daily living (IADLs), such as preparing balanced meals and managing personal finances. Since functional changes are noted earlier in the dementia process with IADLs that require a higher cognitive ability compared to basic activities of daily living (ADLs) (Hall, 2011; Peres et al., 2008), this tool is useful to monitor these functional changes over time. The FAQ may be used to differentiate those with mild cognitive impairment and mild Alzheimer's disease. To further exemplify the importance and utilization of the FAQ, thousands of research participants across the United States are administered the FAQ annually as part of the National Alzheimer's Coordinating Center (NACC) longitudinal research study taking place in 29 National Institute on Aging-funded Alzheimer's Disease Centers (Weintraub et al., 2009).

TARGET POPULATION: Older adults with normal cognition, mild cognitive impairment, as well as mild, moderate, and advanced dementia (Weintraub et al., 2009). The FAQ is appropriate for clinical settings, such as acute and primary care, rehabilitation, assisted living, and home settings, as well as for research.

VALIDITY AND RELIABILITY: In IWD the FAQ is a consistently accurate instrument with good sensitivity (85%) to identify an individual's functional impairment. The FAQ demonstrates high reliability (exceeding 0.90). Tests of validity have been performed on the FAQ establishing it as an instrument for the bedside and research because it can discriminate among different functional levels of individuals, predict neurological exam ratings and mental status scores such as the Folstein Mini-Mental Status Examination (MMSE) and demonstrate sensitivity to change (Assis, 2014; Malek-Ahmadi, 2015; Pfeffer, 1982).

STRENGTHS AND LIMITATIONS: The FAQ is efficient to administer to older adults giving consistent results across different professionals and settings including primary care settings, as well as with different forms of dementia (Mayo, 2013; Tabert et al., 2002). As with other instruments that measure functional activities using indirect approaches, there may be over or under estimation of abilities because of the lack of direct observations.

FOLLOW-UP: Continued monitoring of IADLs in IWD is important to ensure environmental adaptations keeping these individuals safe. The measurement of IADLs is also important for advancing science. Therefore, the FAQ is an important measure for clinicians and researchers.

MORE ON THE TOPIC:
Best practice information on care of older adults: http://consultgeri.org/.
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Functional Activities Questionnaire

Administration

Ask informant to rate patient's ability using the following scoring system:

- Dependent = 3
- Requires assistance = 2
- Has difficulty but does by self = 1
- Normal = 0
- Never did [the activity] but could do now = 0
- Never did and would have difficulty now = 1

1.	Writing checks, paying bills, balancing checkbook	
2.	Assembling tax records, business affairs, or papers	
3.	Shopping alone for clothes, household necessities, or groceries	
4.	Playing a game of skill, working on a hobby	
5.	Heating water, making a cup of coffee, turning off stove after use	
6.	Preparing a balanced meal	
7.	Keeping track of current events	
8.	Paying attention to, understanding, discussing TV, book, magazine	
9.	Remembering appointments, family occasions, holidays, medications	
10.	Traveling out of neighborhood, driving, arranging to take buses	
	TOTAL SCORE:	

Evaluation

Sum scores (range 0-30). Cut-point of 9 (dependent in 3 or more activities) is recommended to indicate impaired function and possible cognitive impairment.

Pfeffer, R.I., Kurosaki, T.T., Harrah, C.H. Jr., Chance, J.M., & Filos, S. (1982). Measurement of functional activities in older adults in the community. *Journal of Gerontology, 37*(3), 323-329. Reprinted with permission of Oxford University Press.

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DEMENTIA Care Aware

ADL / IADL Checklist

You can assess a patient's functional abilities by asking about their Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). ADLs are activities in which people engage on a day-to-day basis. IADLs are activities related to independent living. ADLs are basic personal care activities related to maintaining hygiene and health. IADLs are higher-level activities that enable a person to live independently in the community.

Use the following checklists to check the level of function relating to each activity.

ADL Checklist

ADL Function	Independent	Needs Help
Bathing		
Dressing		
Transferring, e.g., from bed to chair		
Toileting		
Grooming		
Feeding oneself		

IADL Checklist

ADL Function	Independent	Needs Help
Using the telephone		
Preparing meals		
Managing household finances		
Taking medications		
Doing laundry		
Doing housework		
Shopping		
Managing transportation		

COGNITIVE HEALTH ASSESSMENT SCREEN

Patient sticker/medical record barcode

Patient Name: _____ Date: _____ Translator Present? ___ Y ___N

1. DOCUMENT CARE PARTNER: Is there someone that helps you make decisions about your health and medical care?

FULL NAME: _____PHONE:_____

2. TAKE A BRIEF HISTORY

Do you or others think that you are having trouble remembering things? Check all that apply. ___ Y ___N ___Not Sure

3A. ADMINISTER MINI-COG **Total: _____/5 points**

COGNITIVE SCREEN ABNORMAL (<3/5)? ___Yes ___No

THREE-WORD RECALL (STEP 1):

Look directly at person and say, "Please listen carefully. I am going to say three words that I want you to repeat back to me now and try to remember. The words are [select a list of words from the versions below]. Please say them for me now." If the person is unable to repeat the words after three attempts, move on to step 2 (clock drawing).

___*List 1*: Banana, Sunrise, Chair ___*List 2*: Leader, Season, Table ___*List 3*: Village, Kitchen, Baby

CLOCK DRAW (STEP 2): **Score: _____/ 2 points (0 or 2)**

Say: "Next, I want you to draw a clock for me. First, put in all of the numbers where they go." When that is completed, say: "Now, set the hands to 10 past 11." Use preprinted circle (see next page) for this exercise. Repeat instructions as needed as this is not a memory test. Move to step 3 if the clock is not complete within three minutes.

Clock Draw Scoring:
*2 points for a normal clock or 0 (zero) points for an abnormal clock drawing.
*A normal clock must include all numbers (1-12), each only once, in the correct order and direction (clockwise).
*There must also be two hands present, one pointing to the 11 and one pointing to 2.

If the patient states that they are not able to draw the clock, say "I am going to time you for one minute. In that one minute, I would like you to tell me the names of as many different animals as you can. We'll see how many different animals you can name in one minute." (Repeat instructions if necessary). Maximum score for this item is 14. If person names 14 unique animals in less than one minute there is no need to continue.

(≥ 14 unique animals, score 2 points. Fewer than 14 unique animals, score 0 points.)

THREE-WORD RECALL (STEP 3): **Score: _____/3 points**

Ask the person to recall the three words you stated in Step 1. Say: "What were the three words I asked you to remember?" Record the person's answers below.

Person's Answers: _____ _____ _____

3B. ADMINISTER FUNCTIONAL SCREEN

ACTIVITIES OF DAILY LIVING *if not completed on Senior Health Screen **Score:_____/6 points**

Must be independent. No supervision, direction, or personal assistance (1 point each)

____ Bathing ____ Dressing ____ Toileting ____ Transferring ____ Continence ____ Feeding

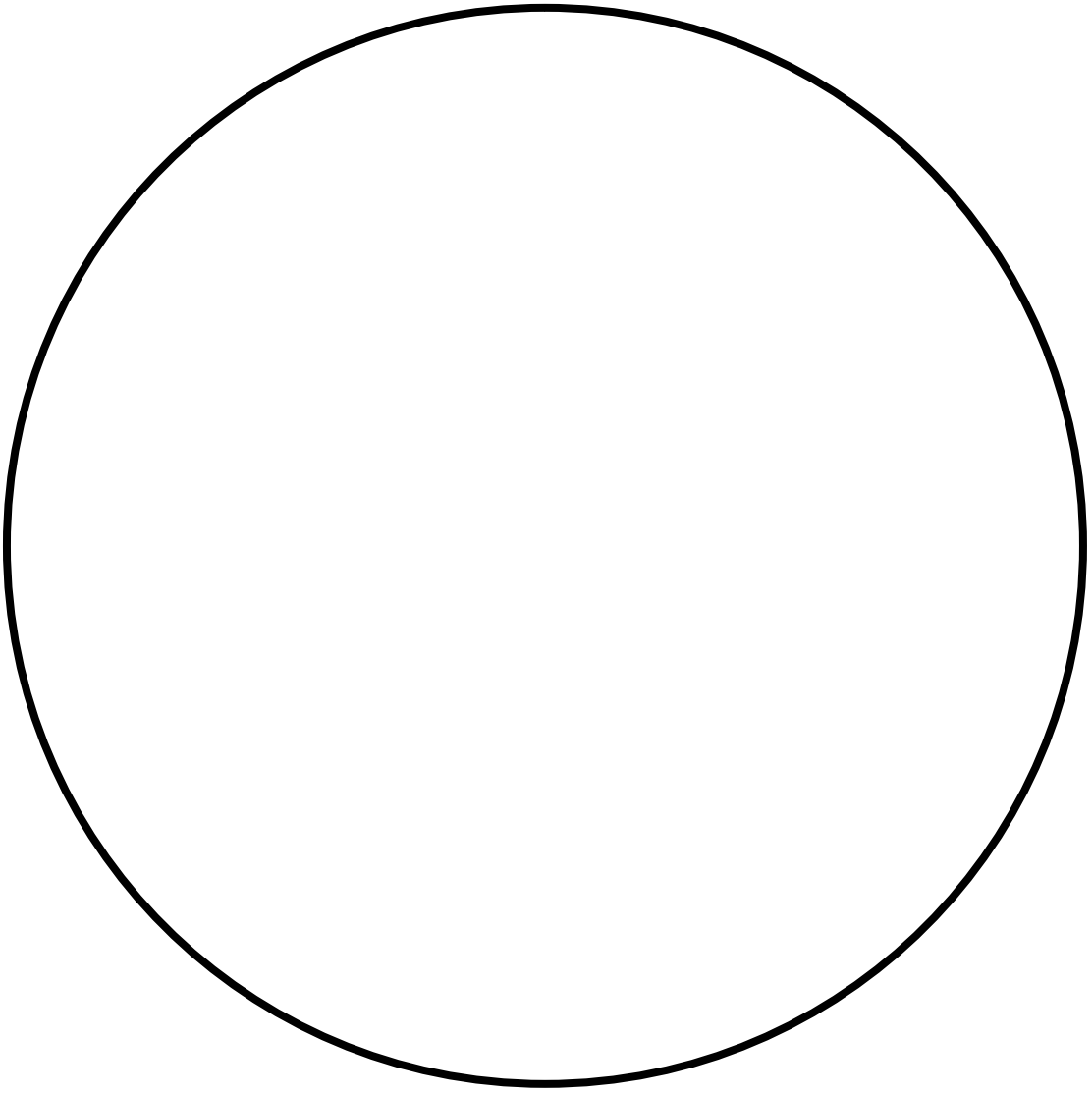
INSTRUMENTAL ACTIVITIES OF DAILY LIVING *if not completed on Senior Health Screen **Score: _____/8 points**

Must be independent. No supervision, direction, or personal assistance (1 point each)

____ Answers Phone ____ Shopping ____ Food prep/cook ____ Housekeeping (participates)

____ Transportation ____ Medication management ____ Finances (includes day-to-day purchases) ____ Laundry

Patient sticker/medical record barcode



Patient sticker/medical record barcode

3C.ADMINISTER INFORMANT SCREEN

AD8 DEMENTIA SCREENING INTERVIEW **Score: _____/8 points**

Give to a family member or care partner to fill out if available.

Remember, "Yes, a change" indicates that there has been a change in the last several years caused by cognitive (thinking and memory) problems.	YES, a change	NO, no change	NA don't know
1. Problems with judgment (e.g., problems making decisions, bad financial decisions, problems with thinking)			
2. Less interest in hobbies/activities			
3. Repeats the same things over and over (questions, stories, or statements)			
4.Trouble learning how to use a tool, appliance, or gadget (e.g., VCR, computer, microwave, remote control)			
5. Forgets correct month or year			
6. Trouble handling complicated financial affairs (e.g., balancing checkbook, income taxes, paying bills)			
7. Trouble remembering appointments			
8. Daily problems with thinking and/or memory			
TOTAL AD8 SCORE			

What to Do After a Positive Screen

The CHA is an initial screening process to detect signs of cognitive decline. The CHA is not a diagnostic tool. If the CHA is positive, next steps involve additional assessments to determine if the decline is due to mild cognitive impairment or dementia. Here is a recommended framework for next steps:

Cognition

If the CHA comes back positive:

- Screen for depression and substance use
- Evaluate for other diseases with cognitive symptoms (e.g., HIV, syphilis, thyroid disorders, obstructive sleep apnea, vitamin B12 deficiency)
- Order labs and head imaging if less than 12 months of symptoms (CBC, electrolytes, BUN/Cr, fasting glucose)
- A more detailed cognitive symptom history is also recommended to identify whether referral to a specialist is warranted.

Function

Based on the results of the functional assessment, consider connecting patients to services based on their needs, such as:

In-Home Supportive Services to obtain a caregiver

Money management services

Meal delivery services

Legal services for access to benefits through Medi-Cal and other programs

Support System

Document the roles and contact information for the patient's support system:

- The care partner for the CHA screen
- Support persons or additional care partners
- Health care agent(s) or durable power of attorneys

Connect the patient's support system to needed services such as legal services for advance care planning.

Start a Brain Health Plan

You can start a brain health plan to maximize brain function in all older adults, but it will especially benefit those with cognitive or functional decline. You can also start the plan before any diagnosis of mild cognitive impairment or dementia is made. A brain health plan consists of the following:

- Make sure vision and hearing assessments are up to date and, if impairments are present, correct them accordingly.
- Review medications for cognitive side effects and reduce as many of these as you can in dose or frequency, and preferably stop them.
- Encourage social and physical activity.
- Continue to address blood pressure and diabetes management goals.

What to Know About Billing for the CHA

Effective July 1, 2022, an annual CHA for Medi-Cal only beneficiaries who are 65 years of age or older is a covered benefit if the beneficiary is otherwise ineligible for a similar assessment as part of an annual wellness visit under the Medicare program (for more information on billing for Medicare patients, visit our website). A provider also must be registered as having completed the core Cognitive Health Assessment training, available on the Dementia Care Aware website. This assessment should be a component of an Evaluation and Management (E&M) visit. When a CHA is performed, bill an additional claim line using **CPT-4 code 1494F Cognition assessed and reviewed.**

Note: For patients under 65 years of age who are reporting symptoms or showing signs of cognitive decline, the provider should do a CHA and then may bill Medi-Cal using normal Evaluation and Management (E&M) codes.

Providers must complete the course Conducting the CHA: The Basics before they can begin billing for the CHA.

Qualifying CHA screenings are eligible for payment in any clinical setting in which billing occurs through Medi-Cal fee-for-service or to a network provider of a Medi-Cal-managed care plan.

The rate is $29 and is limited to once per year, per same provider.

The reimbursement rate depends upon a provider's contract with the patient's **Medi-Cal managed care** plan.

Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) will be reimbursed for this service as part of the Prospective Payment System (PPS) process.

Required Billing Documentation for Medi-Cal Only Beneficiaries

Required documentation only emphasizes the results of the cognitive screen, though we recommend you complete all portions of the CHA. All documentation must remain in the patient's medical record and be available upon request. Billing can occur for 1494F if the provider documents:

1. The screening tool or tools that were used (at least one cognitive screening tool is required to bill this code)
2. That the completed assessments were reviewed by the provider
3. The results of the assessment(s)
4. The interpretation of the results
5. That the results were discussed with the patient, family, or informant, and any appropriate actions were taken

Example of the required documentation:

I reviewed the patient's cognitive health assessment. She scored 1 point on the Mini-Cog, which is abnormal. I disclosed this result to the patient and plan to send for hearing and vision tests, as well as schedule a follow-up for further assessment and care planning at the next visit.