Cognitive Health Assessment

Implementation Guide

A Practical Step-by-Step Guide to Cognitive Health Assessment (CHA) Implementation

DEMENTIA Care Aware

UCSF

Contents

Introduction

More than half of people living with dementia die without ever being diagnosed even though it affects over 10% of adults 65 and older. Those who are diagnosed are often told in the moderate or later stages of the condition.

Yet, evidence suggests that the earlier we detect dementia, the more we can do. We can slow it down by intervening with brain health strategies, help people plan for the future, and mitigate unwanted health and quality of life outcomes, such as caregiver stress and a person's vulnerability for adverse events including driving accidents. Medications that may alter the course of certain diseases leading to dementia, like Alzheimer's disease, are rapidly coming into medical practice. And, most importantly, again and again people living with dementia and their care partners say that they wish they knew earlier so they could have control over their life when living with this condition.

One clear way to improve our care for people living with dementia is to screen and detect it earlier. However, screening for dementia in patients aged 65 and above is infrequent in primary care. Fewer than half of all primary care providers in California incorporate screening for dementia as a standard practice. Incorporating the cognitive health assessment (CHA), developed by Dementia Care Aware, as an annual screen for patients 65 and older is a way to start to address this gap.

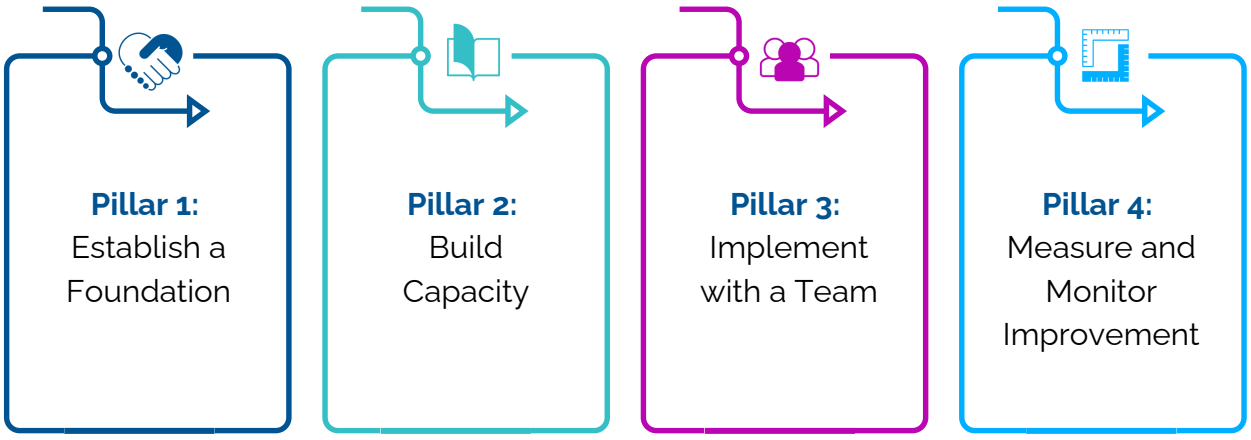
This guide is designed to walk quality improvement and change management leaders through the process of making cognitive screening routine practice in primary care settings for adults over 65 years of age.

This guide is an implementation tool created to help your health system build the necessary infrastructure to support clinical best practices for cognitive screening and care for dementia. It has been developed for primary care professionals by dementia experts across California that have been implementing Dementia Care Aware's cognitive health assessment in their clinics over the past year.

The guide contains detailed examples for primary care teams that illustrate how to make practice improvements. Through stakeholder engagement, education and training, and sustainable process and infrastructure development, you will create a plan that fits the needs of your clinic.

Dementia Care Aware understands the uniqueness of your clinic or health system. Each system has structures and patient populations that call for a tailored approach to implementation. That is why our guide is organized into 4 pillars that allow you to select a starting point that works for you.

Although you can start anywhere along the process, we recommend starting with pillar one to confirm all the foundational components are in place before you move forward.



Each pillar contains a useful questions or checklist section developed to help you think through your needs and gather information for each area of improvement. Answers to your questions can be added to this **project planning document** so you can build and document your plan as you move through the pillars.

Support documents for each pillar can be downloaded individually by clicking on the links in the guide, or as a **comprehensive appendix**.

Also included in each section are process steps within the overall workflow that starts with identifying patients that need to be screened and terminates with the establishment of a brain health plan post screen.

The process steps are organized based on best practices for cognitive screening and care for dementia and recommendations made by Dementia Care Aware partner sites. Workflows may be modified to meet the needs of your organization; however, all major steps should be included to meet standards for best practice.

See the **full workflow here.**

Case Study

Health Services
LOS ANGELES COUNTY

Finding a Way to Better Dementia Care

This case study describes the implementation of the Cognitive Health Assessment (CHA) as an annual cognitive screening tool at pilot sites within the Los Angeles County Department of Health Services (LA DHS).

Please note:

Although the Cognitive Health Assessment Implementation Guide is intended to be self-directed, the materials and resources in the guide can be used in parallel with hands-on support from our Dementia Care Aware **practice support partners**.

Visit them at the **UCLA Health Alzheimer's and Dementia Care (ADC) Program**, the **National Dementia Care Collaborative (NDCC)** and the **Alzheimer's Association Health Systems Directors** for more information.

Key

Words in **magenta** indicate a hyperlink.

Pillar 1

Establish a Foundation

Pillar 1: Establish a Foundation

> The first pillar of this guide focuses on the critical process of engaging local champions and decision makers to demonstrate the value and relevance of integrating cognitive screening for dementia into practice. This section includes tips on how to engage stakeholders, identify areas of need, establish initial metrics and goals, and organize next steps into an action plan to align a proposal with organizational priorities (i.e., mission, vision, strategic goals).

Action Steps

1. Understand your Purpose, Priorities, and Environment
2. Identify and Engage Decision Makers and Champions
3. Scope an Initial Proposal
4. Determine Next Steps

Documents you'll need to complete pillar 1	Supplementary resources
• The Importance of Cognitive Screening and Early Dementia Detection • Project Plan Workbook for Cognitive Health Screening • Making a Case for Cognitive Screening SBAR Template	• Identifying Champions • Suggested Cognitive Screening Metrics and Measures • Dementia Care Aware Program Offerings

Below you will find four action steps to guide you in securing organizational support for implementing cognitive screening in your primary care practice. A to-do list is provided to help you complete each step.

ACTION STEP 1:

Understand your Purpose, Priorities, and Environment

To-do List:

- [ ] Learn about the purpose and benefits of early detection
- [ ] Discuss organization priorities with leadership
- [ ] Discuss the current state of processes and protocols with frontline staff

To ensure the success of any change, it is important that the proposed change meets a need, fulfils a requirement, demonstrates an added benefit for the organization, or ideally all three!

Learn about the purpose and benefits of early detection.

Visit the **Dementia Care Aware website** to learn about the importance of detecting dementia early, the benefits of cognitive screening and brain health planning, and what is required to provide this service for patients experiencing cognitive impairment.

Discuss organization priorities with leadership.

Engage your leadership to gain insights into the organization's priorities and needs. Discuss their perceptions of needs and the policies guiding decision-making. Conversations may revolve around (1) how implementing dementia screening aligns with the needs of the patients that the organization serves (e.g. How many are older adults?), (2) initiatives the clinic or health system is currently pursuing, and (3) the mission, vision, and goals of the organization. Think about if and how your organization is currently meeting the needs of your patients, and challenge what you think you know about the current state of dementia care in your organization to avoid making assumptions about whether your patients' needs are currently being met or not.

Some questions to ask leadership:

1. What are the top three priorities right now for this organization, and how do you see them evolving in the coming year?
2. What are the biggest influences that shape how the organization sets priorities or goals?
3. What are some key metrics that the organization is monitoring?
4. In your view, how could a new program for screening older patients for dementia fit into our organizations current priorities?

Learn from frontline staff

Another next step, or to pursue at the same time, is to engage frontline staff in understanding their perspective on including a new screenings process for dementia into clinical care.

Some questions to ask frontline staff:

1. What dementia care needs have you noticed for patients and their care partners?
2. How equipped do you feel to provide screening and care planning for patients?
3. What are the barriers to screening for dementia?

ACTION STEP 2:

Identify and Engage Decision Makers and Champions

To-do List:

- [ ] Identify decision makers and dementia care champions
- [ ] Establish a workgroup of all relevant project participants and stakeholders

Use what you learned from Action Step 1 to identify your organizations decision makers and dementia care champions. Conversations with your organization's leadership will help you identify the people who have decision making power and influence over access to resources and can help get things done.

Develop a plan to sustain engagement with those individuals. In an environment with constantly changing priorities, you will need to insure dementia care stays on the organization's priority list.

How to Spot a Champion

There are many ways to define a champion, but simply put, a champion is an advocate of a program or a cause who provides momentum and connections to ensure success. They are vital for ensuring practice change. Champions are generally passionate, motivated, positive thinkers, problem solvers. well connected, and action oriented. Particularly around the change management issue that you are trying to address. Clinician engagement in the change process has been identified as a critical factor for establishing and sustaining change.[10]

Learn more about the **different types of champions here.**

Some questions to ask yourself and others in this process:

1. Who is dependent on whom and for what resources?
2. What layers of approval or dependencies exist?
3. How do frontline and leadership interact and influence one another?
4. Who makes financial decisions?
5. Who are the key people to influence? What different approaches are needed for these audiences?
6. What time and resources are available?
7. Who in the organization will be most affected by this initiative?

ACTION STEP 3:

Scope an Initial Proposal

To-do List:

- [ ] Match your needs with Dementia Care Aware program offerings
- [ ] Draft a high-level proposal to leadership
- [ ] Draft communications (SBAR, Memo, Emails, Flyers) to disseminate information to staff on the project's overall intent and goals.

Now that you understand your organizational priorities and who you need to engage, you're ready to match those needs with Dementia Care Aware program offerings and draft a high-level proposal to leadership. Be mindful of the scope and propose by starting small using a pilot approach.

You can find a document outlining the benefits of and incentives for annual screenings and early detection here.

Studies show that "those directly and indirectly affected by change are more likely to commit to and embrace change when they contribute to the decision-making about the change and understand why and how the change is going to improve patient and/or staff experiences or the healthcare environment (Harrison et al., 2021). Keep this in mind when developing your plan so you have a higher change of success.

When drafting your proposal, provide data and clear connection to strategies, whenever possible. Understand that decision-makers who control vital resources are constantly approached by others to support projects, and address issues throughout the organization so it may take time and multiple conversations to arrive at an agreed upon solution.

Your organization might have a template or protocol for such proposals, but utilizing a Situation, Background, Assessment and Recommendation or Request (SBAR) format is something to consider. Reference our **Making a Case to Leadership SBAR here.**

ACTION STEP4:

Determine Next Steps

To-do List:

- [ ] Craft a more detailed plan
- [ ] Figure out concrete next steps and how to monitor progress
- [ ] Set up a communication plan to keep stakeholders and leadership in the loop on implementation progress.

You may be given a greenlight to move forward after engaging with leadership, however discussions may bring concerns, hesitancies, and barriers to the surface. If your initial proposal was not approved as is, take a step back and address any questions or concerns from leadership and work together with champions to come up with creative solutions. It could be that the pilot might need to wait until there is capacity in the organization, or that the proposal needs to be scaled down to a simpler approach to determine feasibility.

If you do have the go-ahead, it may be worth crafting a more detailed plan to think through how to approach implementing the CHA practically. Work with a few champions to figure out some concrete next steps and how you will monitor the work over time. Your organization might have a template or protocol for such project plans, but we have drafted an example project plan template and workbook for reference.

Access the Project Planning document here.

Here are some questions you might want to ask:

1. What is the timeline for this pilot? At what points will you check in on the process?
2. Who needs to be involved?
3. In what forums will people discuss the work?
4. How do you determine the impact and/or success of the pilot?
5. What ways are you going to engage the members of the clinic in the process?

Pillar 2

Build Capacity

Pillar 2: Build Capacity

> This pillar reviews education and training plans to help ensure that all staff have the knowledge and tools to successfully provide quality dementia care.

Action Steps

1. Create your Education and Training Plan

Documents you'll need to complete pillar 2	Supplementary resources
• Cognitive Health Assessment: The Basic Training • The Cognitive Health Assessment • Project Plan Workbook for Cognitive Health Screening	• Dementia Care Aware eLearning Course Catalog • Tips to Adjust the Cognitive Health Assessment for Diverse Populations • The Cognitive Health Assessment for Team Members • Next Steps After a Positive Screen • Telehealth and the Cognitive Health Assessment (CHA) • Advanced Care Planning [video] • Assessing and Connecting with the Care Partner [video] • Dementia Mini-Course Flyer • The Alzheimer's and Dementia Care ECHO® Program for Health Systems and Medical Professionals • Adapting "CHA: The Basics" Training to Reach Learners Across California - Led by University of California, Irvine

PART 1:

Education and Training

Cognitive screening is not a new concept, and many primary care settings have protocols and processes in place to address cognitive concerns. However, training and education are key tools for introducing new findings, reinforcing previous learning, and bringing all staff into alignment with the purpose and goals of cognitive health. Dementia Care Aware offers training on an approach called the Cognitive Health Assessment (CHA) as well as supplemental courses, webinars, and podcasts for those wanting to go deeper into specific topics.

The **Cognitive Health Assessment Training** course teaches a standardized protocol for cognitive screening that can be adjusted to meet the specific needs of each patient. It can be used as an annual approach to cognitive screening, including within the Medicare annual wellness visit or at any time as the start of a comprehensive evaluation for someone with signs or symptoms of dementia.

The assessment is free and includes instruments validated in primary care that are easy to score and available in multiple languages. The course is offered as an online self-paced course or live virtual training.

Learners that complete the training will:

1. Learn about dementia and screening tools for dementia.
2. Gain confidence in screening for dementia in older adult patients in a primary care setting through examples of real-world implementation of the cognitive health assessment.
3. Know how to start a brain health plan in collaboration with their patient.
4. Qualify and learn how to bill for the assessment for patients with Medi-Cal only coverage using CPT code 1494F and other payers.

Click here to sign up for the Cognitive Health Assessment training.

Click here for additional courses, webinars, and podcasts to learn more about dementia care.

Case Study

UCI Division of Geriatric Medicine and Gerontology

Meeting the Needs of Busy Clinicians

This case study describes the development and dissemination of in-person and virtual training led by University of California Irvine, to expand the reach and number of medical professionals trained in the Cognitive Health Assessment (CHA).

Additional Dementia Care Training

The following resources are recommended for continuing education beyond the initial CHA the basics course. Click on the resources below to learn more.

Tips for Adapting the Cognitive Health Assessment for Diverse Populations – Recommended for clinics with diverse patient populations (i.e., language discordance, physical disabilities, substance use, unstable living situation, or learning challenges).

The Cognitive Health Assessment for Team Members – Recommended for clinics that want to learn how to include team members (i.e., nurses, medical assistants) in the cognitive assessment process.

Next Steps After a Positive Screen – Recommended to understand best practices for getting from a positive screen to a diagnosis and ongoing care planning.

Telehealth and the Cognitive Health Assessment (CHA) – Recommended for clinics that serve patients who may have difficulty getting to your clinic.

Advance Care Planning – Recommended for all clinics serving older adults to learn about the purpose of advance care planning and common kinds of legal decision support.

Assessing and Connecting with the Care Partner – Recommended for learning basic strategies to support care partners.

Dementia Mini-Course – Recommended for clinics wanting a comprehensive dementia course. Topics include the spectrum of cognitive dysfunction, behavioral treatment of complications, managing common co-morbidities, effective caregiver support programs, and more.

The Alzheimer's and Dementia Care ECHO® Program for Health Systems and Medical Professionals - webpage that provides information about how the Alzheimer's and Dementia Care ECHO® Program works and how to participate.

Use this checklist to create your education and training plan, then add identified action items to your project plan:

- [ ] Identify who in your organization will schedule and manage the training.
- [ ] Establish when/where will the training take place (e.g., in zoom at a Monday staff meeting, ad hoc lunch and learn etc.).
- [ ] Determine who will conduct the training.
- [ ] Identify special circumstances related to the population your organization serves or other organization specific concerns that need to be addressed in the training (i.e., language discordance, cultural appropriateness, etc.).
- [ ] Determine how the organization will keep track of who has completed training including ensuring all new staff complete a training upon onboarding.
- [ ] Develop a plan for continuing education beyond the initial CHA the basics course.

Pillar 3

Implement with a Team

Pillar 3: Implement with a Team

> This pillar provides practical and tactical guidance for implementing cognitive assessment screening processes and creating your workflow. It includes workflow examples, and tips for supporting interpretation and disclosure of screening results, documentation and billing best practices, and brain health planning strategies.

Action Steps

1. Establish CHA Screening Protocol
2. Determine Process for Interpreting and Disclosing Results
3. Finalize Documentation and Billing Guidelines
4. Document Clinical Work-up, Brain Health Planning and Connection to Resources Protocols

Documents you'll need to complete pillar 3	Supplementary resources
• Workflow Example • Cognitive Health Assessment: The Basics Training • Tips for Utilizing the Electronic Health Record • Project Plan Workbook for Cognitive Health Screening • Suggested Cognitive Screening Metrics and Measures	• Adapting the Cognitive Health Assessment for Diverse Populations • Electronic Health Record SBAR Example • Guide to Cognitive Impairment Screening and Billing in California • Dementia Care Aware Billing FAQ • Next Steps and Management After a Positive Screen • Implementing a Brain Health Plan • The Bold Public Health Center of Excellence Early Detection of Dementia Toolkit

Documents you'll need to complete pillar 3	Supplementary resources
	• Implementing the Cognitive Health Assessment with a Care Team in the San Francisco Health Network • Building Cognitive Health Assessment Workflows in EPIC at University of California, Irvine • Leveraging Multidisciplinary Teams to Conduct Cognitive Screens Prior to Office Visits at the University of California, San Diego

Creating Workflows

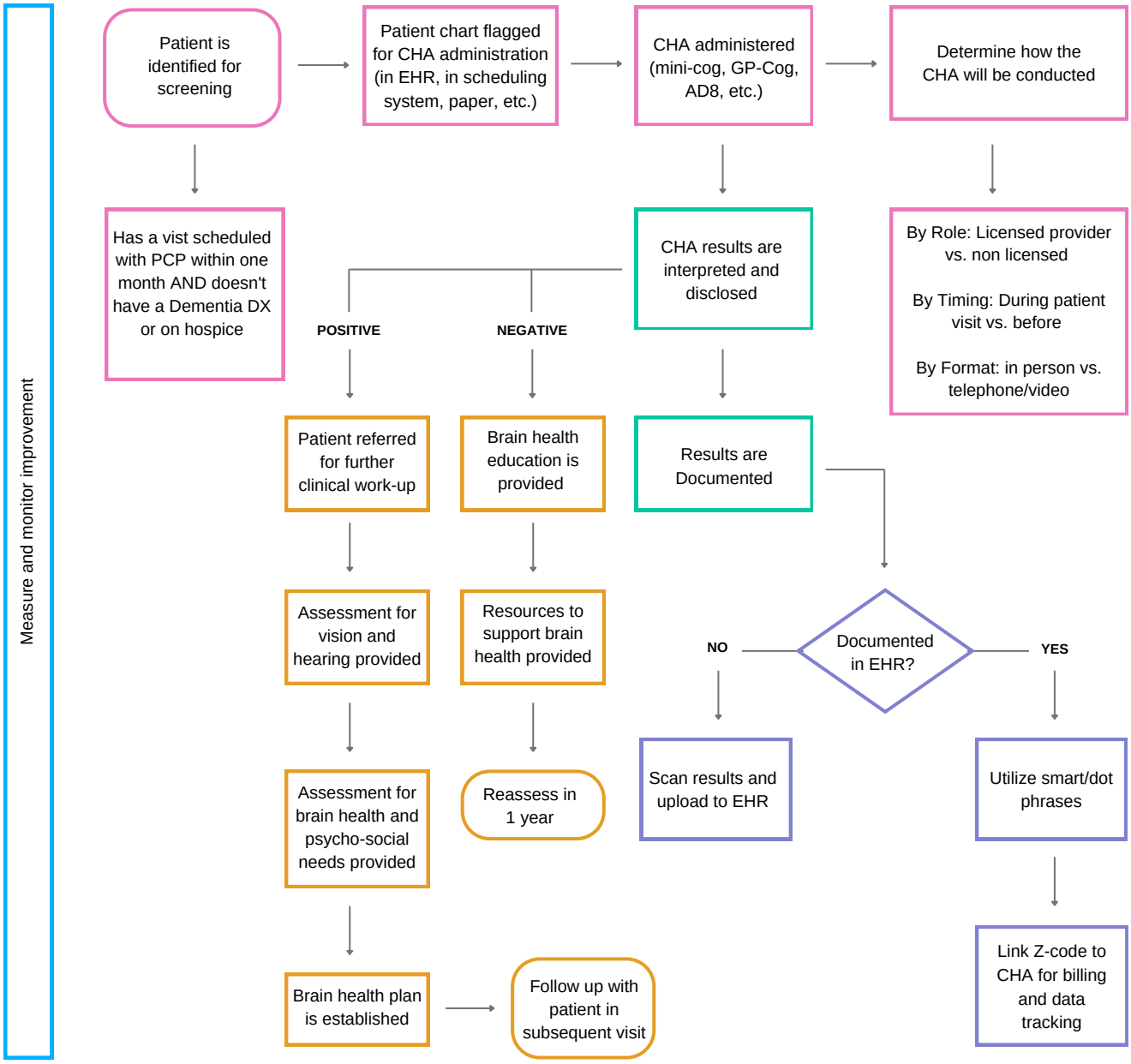
The following page is an example workflow for cognitive screening from identification of patients eligible for a screen through establishment of a brain health plan.

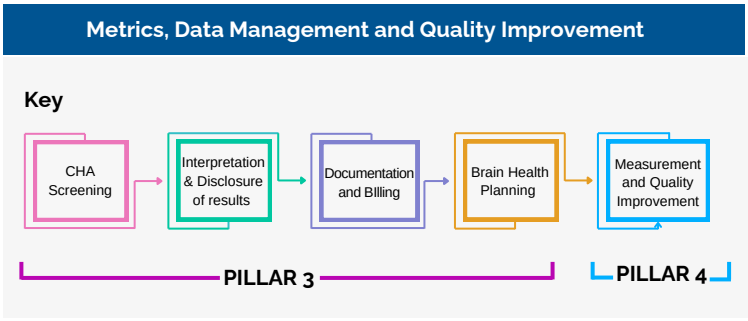
The subsequent actions steps break the process steps down and provide detailed information on how you can create a workflow that fits the needs of your organization and patient population.

Be sure to review your **metrics plan** as you develop the workflow. Modifications can be made regarding who does what and when, however all steps should be included to ensure best practices and standards of care are provided.

Please see the example workflow on the next page.

Cognitive Health Assessment Workflow





ACTION STEP 1:

Establish the CHA Screening Protocol

Process Steps:

A Cognitive Health Assessment (CHA) should be completed annually for patients over 65 that have not previously been diagnosed with dementia. It is crucial to the CHA process to identify eligible patients and establish a system to track and measure progress toward providing routine cognitive screening.

Therefore, it is recommended that the electronic health record be used to identify eligible patients whenever possible, whether via automatic reports, schedule lists, or chart reviews. The CHA is comprised of a formal, standardized cognitive assessment, a functional assessment, and documentation of a care partner.

The specific assessments used are up to the discretion of the provider or clinic, however, the key components are briefly assessing cognition, function, and if the patient has a support partner. **The full cognitive health assessment as recommended by Dementia Care Aware can be found here.**

To support these recommendations, primary care sites need to have the tools and resources on hand so clinicians can easily access the assessment/s and document outcomes.

Modifications can and should be considered to accommodate specific population needs including but not limited to assessments for people with limited literacy, motor or sensory limitations, or languages other than English. See **Tips to Adjust the Cognitive Health Assessment** for helpful strategies and other assessments options to meet your patient's needs.

Quick Tips!

1. Conduct the CHA with patients over 65 without a previous dementia diagnosis.

2. Patients should be identified with in 1 month of a scheduled appointment.

3. Utilize your EHR whenever possible to identify eligible patients.

4. Use Dementia Care Aware recommended CHA and make modifications based on the patients' needs.

Case Study

Multidisciplinary Teamwork Increases Patient Access to Screening and Care

UC San Diego

This case study details the implementation of an interdisciplinary screening program using the Montreal Cognitive Assessment (MoCA) at the University of California San Diego.

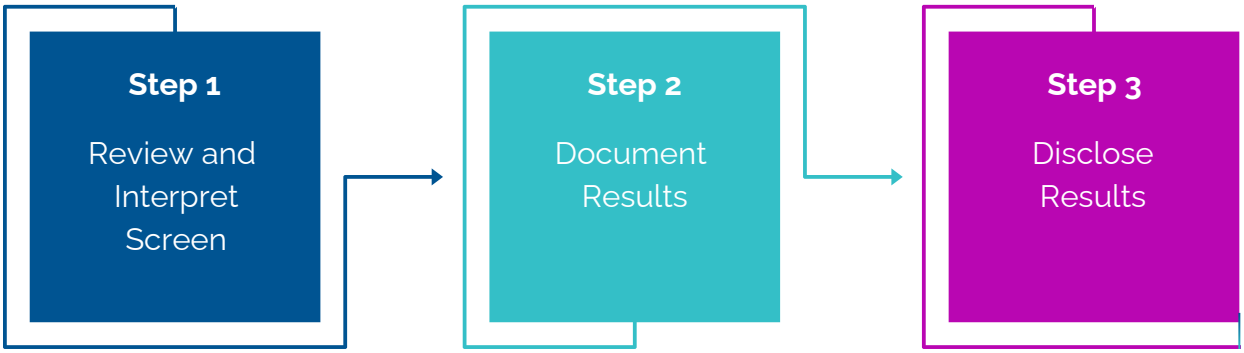
Use this checklist to establish the patient identification and CHA process then add any action items to your project plan:

- ☐ Determine what role **(who) is responsible** and/or what system (EHR) will be used to identify patients for screening.
- ☐ Identify **what triggers or alerts** are in place or need to be developed to notify staff that a CHA is recommended for their patient.
- ☐ Determine **when the CHA will be administered** (e.g., prior to or during PCP appointment).
- ☐ Establish **where the CHA will be administered** and by whom (e.g., in patient room by a physician, over the phone by nurse practitioner).
- ☐ Identify **what screening tools will be used**. (We recommend choosing assessments that best fit your patient population and workflow, e.g.: Mini-Cog and ADL/IADL, or GP-Cog pages 1 &2.).
- ☐ Determine if modifications or supplemental screens are required to meet the **needs of special patient populations.**

ACTION STEP 2:

Determine the Process for Interpreting and Disclosing Results

Process Steps:



Positive Cognitive Health Assessment (CHA)

- **Symptom:** The patient or caregiver has a cognitive or memory concern (source: history, observation, AND/OR
- **Patient has a new functional impairment** (source: ADLs/IADLs checklist, or other validated tools) AND/OR
- **Positive cognitive** screen with a validated tool (source: Mini Cog, GP-COG, other validated tools)

Interpretation and disclosure of cognitive screening results is a pivotal step in the CHA process. It lays the path for all following cognitive health conversations and care planning.

Therefore, when building your process, you and your team should consider the timing of each step (i.e., workflow) and the roles (e.g., MA, NP, MD) that will be conducting each aspect of the CHA relative to interpretation and disclosure. If you wish to ensure the service meets eligibility requirements for reimbursement, a billing clinician must complete the screening, interpretation, and disclosure of the results.

See **Billing and Payment information here.**

When disclosing and counseling patients and their care partners on screening results, extra time and resources should be considered in process and workflow development to provide the recommended intentionally hopeful, holistic, and strengths-based approach as summarized below.

Make Time
Schedule a longer appointment to explain results, answer questions

Set the Foundation
Assess the patient and family's understanding of what a positive screen means, discuss goals, and expectations

Provide Hope
Assure patient and care partner that there are many things that can done to support brain health

Establish a Partnership
Use empathic communication, develop, and maintain connection.

Address Unique Needs
Tailor communication to the unique needs of the patient,, explain how the results were reached, and what happens next

Provide Resources
Provide written and/or visual information, referrals, and follow-up sessions as needed

For more information see on best practices for interpretation and disclosure see **The Bold Public Health Center of Excellence Early Detection of Dementia Toolkit**.

Use this checklist to establish the interpretation, disclosure, and documentation process then add identified action items to your project plan:

- ☐ Determine **when, where, and by whom the CHA will be interpreted** (prior to, during, or after the MD/patient conversation, in the presence of the patient, etc.).
- ☐ Determine **who will disclose the CHA results** to the patient and/or their support person, and what approach will be used during disclosure.
- ☐ Determine **how and where CHA results and disclosure will be documented** in the patient record (narrative summary note, assessment comments, checkbox on a flowsheet, etc.).

ACTION STEP 3:

Finalize Documentation and Billing Guidelines

Process Steps:

See the **Dementia Care Aware Billing FAQ** for details.

Electronic Health Records (EHR) systems are used for much more than tracking patient health. They can be designed to assist with adherence to clinical standards of care, best practices, organization protocols, mandatory reporting requirements, appropriate use of billing codes, and to capture data needed to improve patient care.

Quick Tips!

Use tools like smart phrases, Z-codes, templates, plug ins, and flowsheets to document the CHA.

The EHR serves as the existing central database and documentation source for healthcare professionals and serves to streamline data for quality care and improvement efforts. Therefore, it is recommended that the EHR be used for documenting the cognitive screening process. Dementia Care Aware recognizes that EHR system use varies in type and capacity of use across health care organizations, and that EHR changes and updates are complex and often require support from a variety of stakeholders.

To assist with these challenges, Dementia Care Aware has developed resources for integrating the cognitive health assessment into an EHR including a **tipsheet** and **how-to guide for making a case for EHR integration**. Tools outlined in these documents can be used to standardize documentation across users and offer recommended fields for reporting.

Quick Tips!

Whenever possible, work directly with your EHR champion and/or developer to discuss what needs to be built out. Make sure clinicians and other relevant healthcare professionals are present when you meet with the developer so they can provide examples of solutions that will work for them as the primary documenters.

Case Study

UCI Division of Geriatric Medicine and Gerontology

Collaborating to Integrate the CHA in EPIC

This case study details the integration of the Dementia Care Aware Cognitive Health Assessment (CHA) into Epic Systems' Electronic Health Record (EHR) for the University of California, Irvine through interprofessional collaboration.

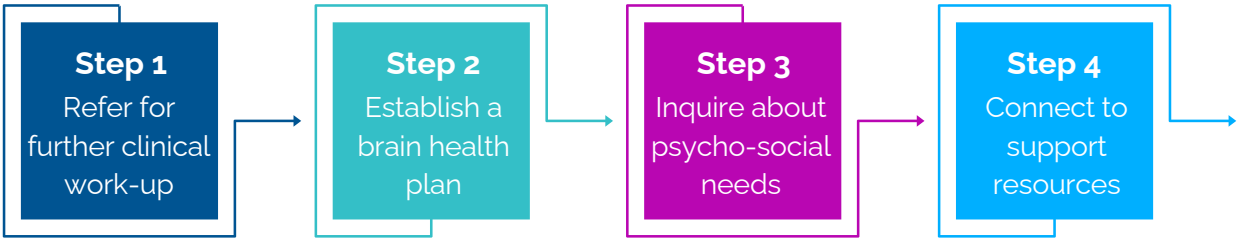
Use this checklist to establish the documentation and billing process then add action items to your project plan:

- ☐ Identify **EHR modifications** that will be required to implement documentation of cognitive health assessments (e.g., smart/dot phrases, etc.).
- ☐ Identify the **tech savvy EHR champion** that will advocate for implementation support..
- ☐ Determine **what approvals are necessary** for finalizing proposed EHR changes.
- ☐ Identify **who will be involved in creating EHR changes** and how needs will be communicated to them for builds.
- ☐ Determine the **expected timeframe** for implementing EHR changes.
- ☐ Determine **what level of EHR access** is needed for the roles involved in patient identification, screening, and documentation.
- ☐ Determine **how appropriate billing codes will be linked** to CHA screens to track screenings and/or reimbursement.
- ☐ Determine **what needs to be done to prepare and align the EHR for reporting** based on your metrics.

ACTION STEP 4:

Document Clinical Work-up, Brain Health Planning and Connection to Resources Protocols

Process Steps:



Planning should include further clinical work-up to understand why the screen was positive and determine if a patient has dementia. A clinical work-up can be tailored to a specific patient's clinical scenario, completed over several visits, and may include assessments for hearing, sleep, vision, depression, alcohol use, as well as labs, imaging and review of medications.

Click here to learn more about Next Steps and Management After a Positive Screen.

Brain health planning refers to key aspects of care planning that have been shown to improve cognition in older adults, prevent dementia in unaffected adults, or slow the rate of decline if someone does have dementia. After a positive screen, this is a key part of the clinical plan. A first step is to inquire about any psychosocial needs which includes access to or opportunities for social engagement, nutritious food, and physical activity. Patients should then be connected to support resources as indicated most importantly for care support and advance care planning.

Processes to support further clinical work-up, brain health planning, and connection to resources should be included in the development of your implementation plan.

Processes should include steps for making referrals to specialists or other providers, documenting and tracking referrals, connecting patients and care partners to community resources, and other related tasks that need to be completed at your clinic.

Click here for details and to learn more about Implementing a Brain Health Plan.

Case Study

San Francisco Health Network

The Value of Teamwork in CHA Implementation

This case study describes embedding Dementia Care Aware (DCA) teams into pilot dementia screening programs in primary care. The teams use cognitive health assessments (CHA) and support patients, caregivers, and healthcare teams with brain health planning and community resources.

Please Note:

This guide provides information from identifying patients for screening through the immediate post-CHA process only and does not include steps through a confirmed diagnosis.

Use this checklist to establish the brain health planning, further clinical work-up and connection to resources process then add identified action items to your project plan:

- ☐ Identify the point in the care process **where brain health planning will occur** (e.g., during the initial visit when assessment was conducted, after visit, etc.).
- ☐ Determine **who will assess for resource needs** and who will provide these resources (e.g., MD, MA, Nurse, SW).
- ☐ Establish what elements and recommendations will be included in **the initial brain health care plan** (i.e. brain health handout, advance care planning, basic dementia education).
- ☐ Establish what **elements and recommendations will be included in subsequent visits** for follow-up (connection to community organizations, home health referral, etc.).
- ☐ Determine how **information will be presented/provided to patients and care partners** (e.g., in person education, physical tip sheets, referral to social work).
- ☐ Determine where in the patient record will **brain health planning be documented** and by whom?

Pillar 4

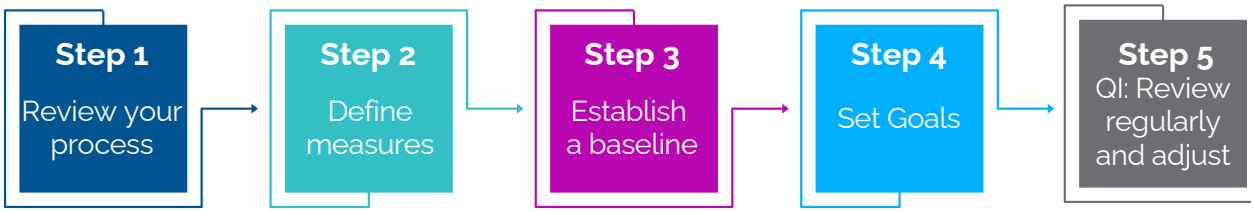
Measure and Monitor Improvement

Pillar 4: Measure and Monitor Improvement

> This pillar outlines ways to measure and maintain your efforts to have a lasting impression on patient care for years to come.

Documents you'll need to complete pillar 4	Supplementary resources
• Suggested Cognitive Screening Metrics and Measures • Project Plan Workbook for Cognitive Health Screening	• CMS defined measure types

Process Steps:



Though this pillar is listed last, it underlies the entire process and helps align process tasks with the purpose or intention of the service.

Whether you are starting from the ground up and adding the cognitive health assessment as a new clinical protocol or updating processes to be more comprehensive it is important to set goals, measure progress and adjust milestones to understand if and how you were successful.

ACTION STEP 1:

Review your Process.

You can't improve your process if you don't understand it. Before diving into quality improvement, it is important to have a good understanding of the process and what parts of the process you need to measure and ultimately improve.

Prior to establishing measures:

- identify who will be performing the process of interest,
- understand how data is currently collected,
- know where those data are stored and retrieved,
- and define how data will be analyzed.

> "Without data, you don't know if you have a problem, you don't know if you're making any headway in solving that problem, and you don't know whether the interventions that you're trying to test or implement are holding...
>
> For all of those reasons, measurement is at the crux of all quality improvement efforts."
>
> *-Michael Posencheg, MD*

ACTION STEP 2:

Define your Measures.

Now that you know what you can measure, it's time to narrow things down to what you should measure. **CMS has defined a handful of measure types,** but for the purpose of this toolkit we are going to focus on two primary types of measures:

- **Process:** measures the activity performed. An example might be % of eligible patients that received a screening or % of clinical staff completed the CHA training.

- **Outcome:** measures the final product or results. An example of this could be CHA positivity rates, rates of diagnosis for dementia related diagnosis (dementia, MCI, Alzheimer's) or provider confidence and compliance to protocols following training and support.

ACTION STEP 3:

Establish a Baseline

Once you establish your measures it is important to determine the baseline upon which you will measure change.

For example, if you were interested in measuring screening rates, or the number of screens per month, it would be important to know how many screens were conducted before the start of the project. If the number of screens is not well understood or able to be easily measured before the start of the project, the baseline can be defined after the first few months of the project.

ACTION STEP 4:

Set Goals

After establishing and defining the baseline, set goals using the SMART goal framework:

Specific	Goals should be straightforward and state what you want to happen. Be specific and define what you are going to do. **Ask:** Who needs to be involved? Where is the project going to occur? What actions will you take?
Measurable	If you can't measure it, you can't manage it. Choose goals with measurable progress and establish concrete criteria for measuring the success of your goal. **Ask:** What metrics will determine if you meet your goal?
Achievable	Goals must be within your capacity to reach. If goals are set too far out of your reach, you will not be successful. Accomplishing goals keeps you motivated. **Ask:** Is the goal realistic? Do you have the necessary skills and resources?
Relevant	Goals should be relevant. Make sure your goal is consistent with your other goals and aligned with the goals, purpose, and intentions of your company, manager, or department. **Ask:** Why is the project important? Does the project align with other efforts?
Time-bound	Set a time frame for the goal. Putting an end point on your goal gives you a clear target to work toward. Without a time limit, there's no urgency to start taking action now. **Ask:** What is the start date? What is the end date? When will the metrics be measured?

Examples of a potential SMART goals:

- **All clinic staff will be trained on the CHA by June 30, 2024**

1. Specific = all clinic staff gives a denominator
2. Measurable = Will be trained provides a tangible intervention or training and/or communications
3. Achievable = broad enough with a doable time frame
4. Relevant = educated and trained staff facilitates confidence and competence
5. Time Bound = clear end date of June 30, 2024

- **Increase current CHA screening rates by 15% by March 2025.**

1. Specific = Current CHA screening rates gives a denominator
2. Measurable = 15% provides a tangible measure
3. Achievable = broad enough with a doable time frame
4. Relevant = increasing screening rates represents action toward timely identification of cognitive concerns and potential dementia
5. Time Bound = clear end date of March 2025

ACTION STEP 5:

Review and Revise

Regularly review data, progress towards goals and make necessary adjustments. With data defined and goals in mind, work with appropriate staff such as your IT champion to build reports to allow for regular data review. Determine how often you want to review data; it will likely be monthly or quarterly for these processes.

Using the reports, visualize data whenever possible using tools like run charts or pie charts so that it is easy to understand and communicate the progress to team members. Use the visuals and reports to discuss the progress regularly in both staff huddles and relevant meetings with key executive stakeholders.

> During discussions with frontline staff, elicit ideas and feedback on how the process is working or not working for them, and request ideas for improvements, modifications, or updates. Transform these ideas into Plan, Do, Study, Act strategies (PDSAs) to test ideas and interventions (See this **Plan-Do-Study-Act (PDSA) Worksheet** for more information).
>
> During discussions with executive stakeholders, demonstrate progress towards goals, contextualize the benefit of the project relative to larger organizational goals and purpose, and update them on any improvements or course corrections in progress. Elicit their thoughts on how to better align the process with overarching organizational and care delivery goals.

Reports and visualizations should be used to monitor the impact of suggested improvements, interventions, and changes. Adopt changes that work, adapt those that need some additional work, and abandon those that had no impact on the goals and outcomes.

Use this checklist to establish measures and reports then add action items to your project plan:

- [ ] Define measure, metrics, milestones, and goals.
- [ ] Establish ways to regularly review data to track progress towards goals.
- [ ] Identify ways to actively engage staff in improvement efforts.

Resources and References

RESOURCES

The Dementia Care Aware Warmline

The Dementia Care Aware Warmline is designed to provide decision-making consultation for clinicians and primary care teams in California around dementia screening, assessment, diagnosis, management, and care planning. Consultation also includes assistance with implementation challenges and practical support for embedding cognitive screening and care into routine clinical practice.

Learn more about the Warmline or call 1-800-933-1789 Monday – Friday from 9am – 5pm PST.

Resource	Format
Adapting "CHA: The Basics" Training to Reach Learners Across California - case study describing the development and dissemination of live in-person and virtual CHA training led by UC Irvine.	PDF
Advanced Care Planning – video that explains advance care planning, common legal decision supports, and available resources to complete advance care planning.	Webinar Recording
Assessing and Connecting with the Care Partner – video that describes how to connect with and assess care partners to support their well-being.	Webinar Recording
Billing and Payment – website that provides answers to frequently asked questions about billing and payment for cognitive screening	Webpage
Building Cognitive Health Assessment Workflows in EPIC - case study describing the integration of the Dementia Care Aware Cognitive Health Assessment (CHA) into Epic Systems' Electronic Health Record (EHR) at the UC Irivine.	PDF
CMS Defined Measure Types – website that provides information about quality measure types and definitions per the Centers for Medicare and Medicaid Services	Webpage
Cognitive Health Assessment Training – webpage that describes the Cognitive Health Assessment Training and how to access the course	e-Course Webpage
Cognitive Health Assessment: The Basics Training – informational document that contains step-by-step guidance and instructions for conducting the Dementia Care Aware cognitive health assessment.	PDF
Dementia Care Aware Billing FAQ – informational document that provides answers to frequently asked questions about billing and payment for cognitive screening	PDF

Dementia Care Aware eLearning Course Catalog – webpage that contains information about 8 courses available through Dementia Care Aware	e-Course Webpage
Dementia Care Aware YouTube Channel – numerous educational videos on dementia screening, care, and brain health planning.	Video Webpage
Dementia Mini-Course – informational document that describes a comprehensive dementia course with multiple modules from UCLA Health.	PDF Course Description
Electronic Health Record SBAR example – worksheet that helps you work through how to make a case for EHR investment to support cognitive screening.	PDF
Guide to Cognitive Impairment Screening and Billing in California – This resource provides Medicare and Medi-Cal billing information for cognitive impairment care pathways and services but is not exhaustive.	PDF
Identifying Champions – informational document that describes champion types and characteristics.	PDF
Implementing a Brain Health Plan – webinar recording that walks the viewer through brain health planning after a cognitive screen.	Webinar Recording
Implementing the CHA for Los Angeles Department of Health Services - case study describing the implementation of the Cognitive Health Assessment (CHA) at pilot sites within Los Angeles DHS.	PDF
Implementing the Cognitive Health Assessment with a Care Team in the San Francisco Health Network - case study describing the process of embedding an interdisciplinary team into pilot dementia screening program sites (two community-based and two hospital-based clinics).	PDF
Leveraging Multidisciplinary Teams to Conduct Cognitive Screens Prior to Office Visits at the University of California, San Diego - case study describing the implementation of an interdisciplinary screening program using the Montreal Cognitive Assessment (MoCA)	PDF
Making a Case for Cognitive Screening SBAR Template – worksheet that helps you work through how to make a case to leadership for implementing cognitive screening.	PDF
Next Steps After a Positive Screen – informational document that describes the important next steps after a patient screens positive for cognitive impairment.	PDF
Next Steps and Management After a Positive Screen – webinar recording that describes the important next steps after a patient screens positive for cognitive impairment.	Webinar Recording

Plan-Do-Study-Act (PDSA) Worksheet – a worksheet to help you apply the PDSA framework	Webpage
Project Plan Workbook for Cognitive Health Screening – Worksheet for creating a comprehensive cognitive screening implementation plan .	PDF
Suggested Cognitive Screening Metrics and Measures – informational document that contains recommended metrics for measuring progress and outcomes.	PDF
Telehealth and the Cognitive Health Assessment (CHA) – informational document that describes how the cognitive health assessment can be completed via telehealth	PDF
The Alzheimer's and Dementia Care ECHO® Program for Health Systems and Medical Professionals – webpage that provides information about how the Alzheimer's and Dementia Care ECHO® Program works and how to participate.	Webpage
The Bold Public Health Center of Excellence Early Detection of Dementia Toolkit – designed by the Bold Public Health Center to assist in thinking about the value of early detection of dementia and how to develop an initial plan.	PDF
The Cognitive Health Assessment for Team Members – informational document that describes how the cognitive health assessment can be completed using a team approach	PDF
The Importance of Cognitive Screening and Early Dementia Detection – informational document that can be used to make a case for cognitive screening implementation	PDF
Tips for Adapting the Cognitive Health Assessment for Diverse Populations – informational document that describes strategies and tips to adapt the CHA for diverse patient populations.	PDF
Tips for Utilizing the Electronic Health Record – informational document for creating a cognitive screening EHR implementation plan.	Webpage

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