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

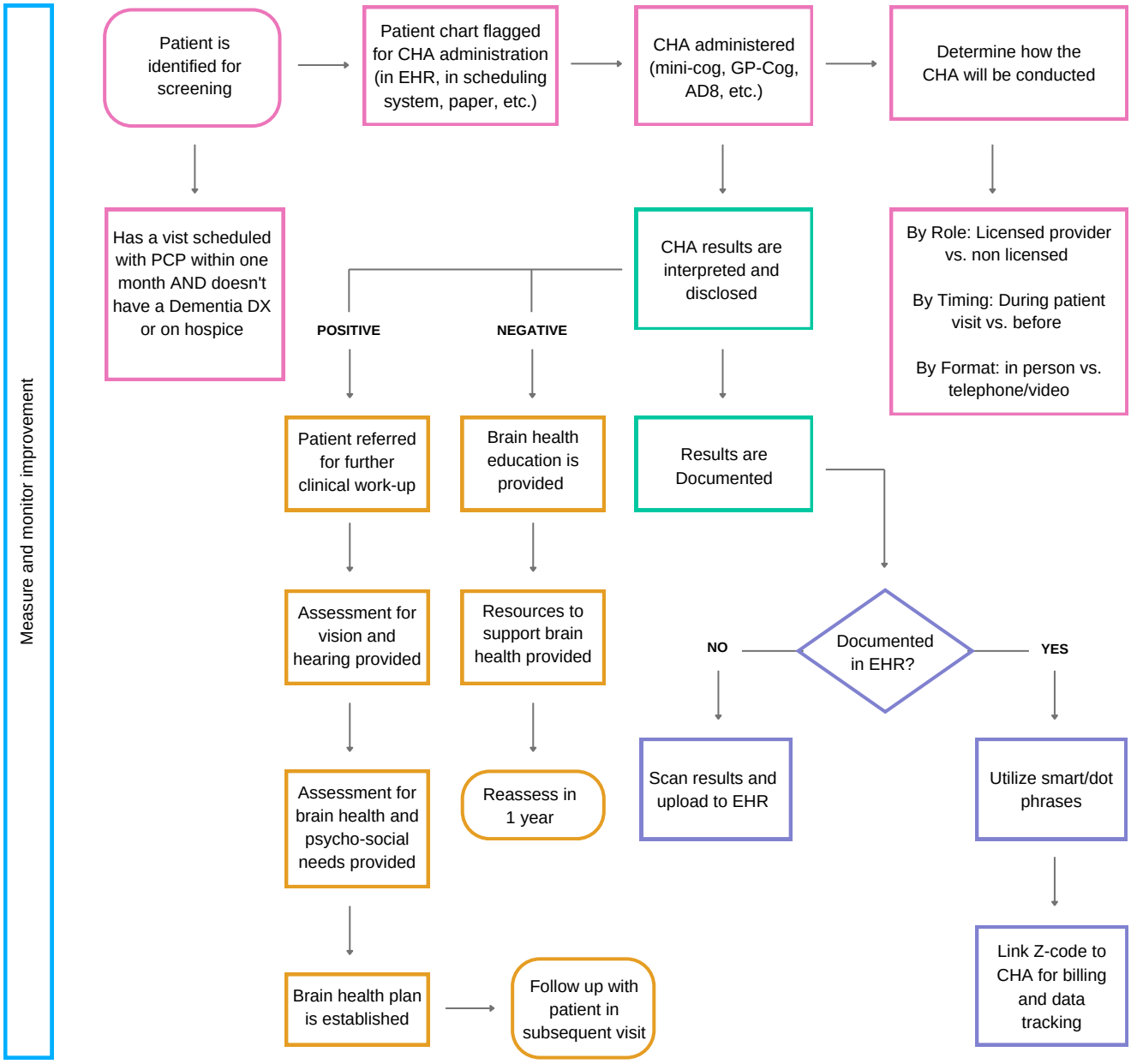
The following page is an example workflow for cognitive screening from identification of patients eligible for a screen through establishment of a brain health plan.

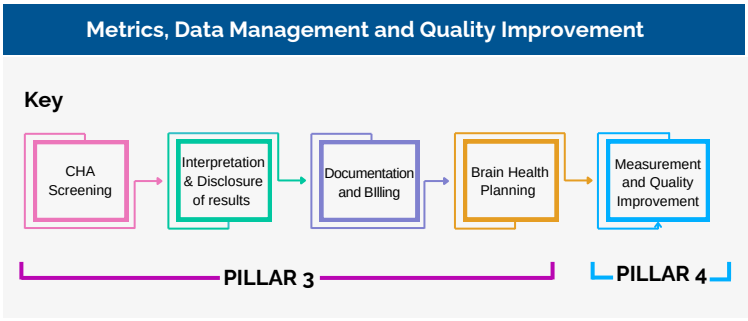
The subsequent actions steps break the process steps down and provide detailed information on how you can create a workflow that fits the needs of your organization and patient population.

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.

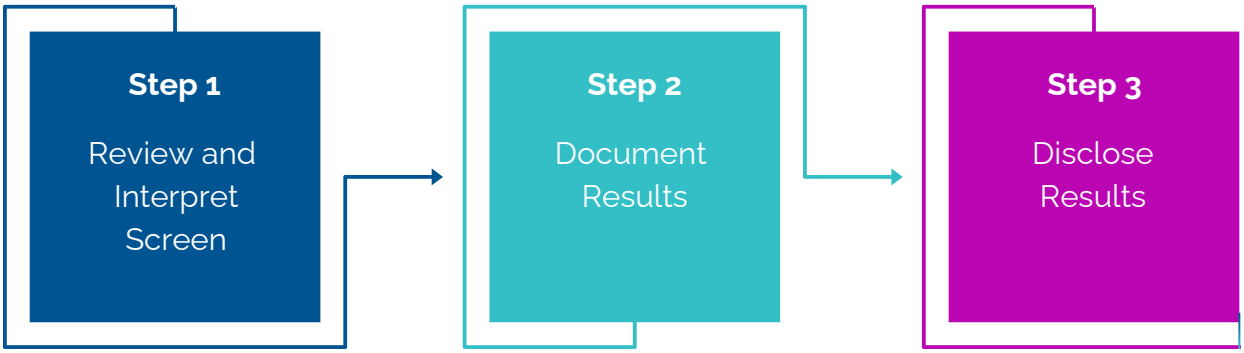
Use this checklist to establish the patient identification and CHA process then add any action items to your project plan:

- ☐ 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.

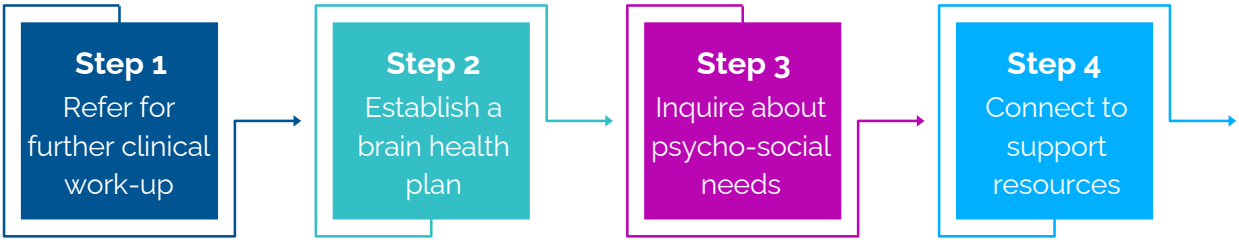
Use this checklist to establish the documentation and billing process then add action items to your project plan:

- ☐ 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?