CASE STUDY

Implementing the CHA for Los Angeles Department of Health Services

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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). The pilot sites include Harbor-UCLA, Lomita Family Health Center, Martin Luther King Jr., and Rancho Los Amigos.

Site Demographics

Number of sites	28 health centers & 4 hospitals across LADHS *4 pilot sites chosen from within the system*
Number of patients seen annually	800,000 unique patients across LADHS
Location type (rural, urban, etc.)	Primarily Urban across LADHS
Staff model (provider heavy, social work on staff, etc.)	Provider heavy within the pilot clinics - providers are performing the majority of the screens
Percent enrolled in Medi-Cal	22% across LADHS
Percent over 65	7% across LADHS

Background

Before the Dementia Care Aware pilot program, the Los Angeles County Department of Health Services (LA DHS) lacked a consistent approach to cognitive screening for older adults. One method included a question in the annual *Staying Healthy Assessment* questionnaire, asking patients if they or others noticed any memory difficulties. This straightforward yes/no/skip question helped identify those needing further cognitive evaluation. However, this method was discontinued in 2023, creating a gap in the basic screening process that had previously assisted practitioners in detecting cognitive decline.

To address this gap and enhance cognitive screening rates for patients aged 65 and older, particularly those with Medi-Cal only coverage, LA DHS implemented the cognitive health assessment (CHA) at four pilot sites. It was hypothesized that lower screening and diagnosis rates within the DHS system were due to competing priorities and factors that diverted providers' attention from cognitive assessments.

By standardizing and streamlining the cognitive screening process, DHS aimed to facilitate early detection of cognitive impairment. The pilot included integrating a digital CHA tool within the Cerner EHR system to prompt annual screenings and establishing a regular CHA training curriculum for physician residents providing care at these sites.

Establishing a Foundation

Our DHS clinics historically used the Mini-Cog, MOCA or RUDAS screen when a cognitive assessment was indicated. However these tools, can be lengthy and/or did not include a functional assessment in addition to the cognitive component. Therefore, they did not meet the standard protocol of the CHA. Implementing the CHA allowed us to use a quick and comprehensive tool that can be used by all members of the primary care team.

Though DHS leadership was supportive of the Dementia Care Aware project and efforts, our leadership team was not able to formally implement the CHA screening tool system wide. Therefore, it was decided that **CHA implementation would be piloted at 4 sites** more closely associated with a physician that was a member of the Dementia Care Aware team, which helped to drive buy-in.

Quick Tips!

Engaging leadership and champions early is an important indicator for success. Learn more about the different types of champions here!

Building Capacity

We started by training all relevant staff in small group and team meetings with our Dementia Care Aware team leaders at each pilot site . We focused on making a leadership connection to initiate a training opportunity. Hosting virtual meetings within standing meetings was successful and typically yielded between 10 and 40 participants.

Each team was given a 10-15-minute introduction during an initial virtual meeting. We would then follow up with the formal cognitive health assessment training. Groups determined if they preferred to meet virtually or in-person. Overall, about half of the trainings were hosted virtually and the other half were provided as Lunch & Learn training sessions.

Implementing with a Team

To implement the Cognitive Health Assessment (CHA) effectively, our team designed a workflow to identify eligible patients, flag them for screening, facilitate provider-administered screenings, and collect results data. Data analysts run a report in Cerner to find patients with upcoming appointments who have neither a dementia diagnosis nor another condition or medication that would exclude them from being screened. The admin team reviews these lists and flags eligible patients using a sticky note on their chart, which provides a visual cue for clinical providers to perform the CHA during the visit.

To streamline the screening process, we created a user-friendly CHA version that integrates seamlessly into existing workflows. While tools like the MoCA and RUDAS were considered, the Mini-Cog was chosen for its straightforward scoring and efficiency in primary care settings. Initially, we opted for a paper version of the CHA, featuring clear instructions, a single-page format, and availability in English and Spanish to accommodate the diverse DHS patient population. An alternative test, the Animal Naming Tool, was also included for patients unable to complete the clock test due to physical limitations, education level, remote visits, or unfamiliarity with analog clocks.

During the CHA rollout, DHS leadership worked to incorporate the CHA tool into the Cerner system as an electronic version, aiming to expand screenings efficiently and systematically. The electronic version is generated at patient intake points and reappears annually. After about a year of development, we are in the draft phase of the CHA tool, moving toward system-wide approval.

Increasing the number of CHA screenings is an ongoing initiative requiring constant support and monitoring. Leadership strategies include integrating cognitive health assessment support into regular meetings, dedicating time to CHA practice, resolving workflow issues, and acknowledging top performers.

Physician champions from each pilot site meet bi-monthly to share updates, analyze trends, adjust workflows, and address challenges, incorporating feedback from nurse practitioners and physicians for collective decision-making and knowledge sharing across sites.

Measuring and Monitoring Improvement

Between May 2023 and March 2024, DHS completed over 800 CHA screens. **DHS pilot clinics screened on average, 16% of all eligible patients.** We also noted considerable spike in the percent of eligible patients screened following trainings and refreshers. Since implementing the CHA screening, two of the pilot sites have conducted a follow-up review of patients that screened positive. It was noted that over a six-month period following a positive screen there were **beneficial downstream effects for many of the patients, including additional workups, timely diagnoses, and advanced care planning.**

Prior to this pilot, our system did not have a process to collect dementia screening data. The ability to generate previously unavailable patient population data has helped guide the DHS system to provide higher-quality patient care and capture screening reimbursement, which can have tremendous implications on funding for a large system like DHS.

Quick Tips!

Integrate SMART goals whenever possible to measure the impact of an implementation project.

Future Considerations and Next Steps

Our future goals include improving tool integration and screening rates at existing sites, understanding patient outcomes over time, and expanding the screening to more DHS sites using first-year results to maintain momentum.

The CHA pilot leadership team is currently collaborating with DHS leadership to create a system-wide CHA tool that triggers eligible patients for screening automatically. The automation will also save time by eliminating the need for manual uploading of paper forms, which will allow clinic staff more time to focus on patient care.

We are also investigating the outcomes of patients who screen positive on the CHA by using chart reviews to assess follow-up procedures, the timing of interventions, and the proportion of positive screens resulting in a dementia diagnosis.

Key Takeaways

1. **Leveraging champions is crucial:** These individuals are early adopters or leaders and recognize the added value to their patients' lives through early detection.

2. **Health plans can be your ally in systems change:** Health plans wield significant influence in driving change within large medical systems. If a health plan covers the cost of screening and mandates it, the system will prioritize it.

3. **Know your patient population:** Patient population considerations are paramount in implementation planning. Factors such as language and education level significantly impact the challenges encountered during CHA implementation.

4. **Explore what exists in your EHR:** Utilizing the existing EHR system (such as Cerner, in the case of DHS) and exploring integrated CHA options is essential. We encountered a cumbersome and inaccurate Mini-Cog tool within the Cerner system, necessitating redesign and collaboration with the leadership team for correction. It's crucial to explore existing tools within the EHR and focus efforts on transitioning away from paper-based systems.

5. **Be creative and flexible:** Creativity is key, both in training and in coaching practitioners to use available tools. There is a robust cache of resources and information provided by Dementia Care Aware. Getting the providers to complete the training was the largest hurdle. We would encourage scheduling time in standing meetings and creating captive audiences to ensure providers know and understand the benefits of screening and how to support their patients.

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.