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Components of the Cognitive Assessment & Care Plan Services

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Hello and welcome. This video will discuss the components of the Cognitive Assessment & Care Plan Services.

All information contained within this video is current as of October 2021.

Begin the Cognitive Assessment & Care Plan Services with a comprehensive history and physical. This is typically completed during a 50-minute face-to-face visit with the patient and an independent historian. This person can be a parent, spouse, guardian, caregiver, or other dependable individual who can assist with supplying your patient's medical history if your patient is unable to provide sufficient or reliable information.

Documentation should include medical decision making of moderate or high complexity as defined by the E/M guidelines. When assessing your patient, pay attention to other factors that may influence your patient's cognitive functioning including chronic medical conditions and health disparities.

There are eight areas of focus during a cognitive assessment:

1. An exam focusing on your patient's cognition function. This may include direct observation as well as interviews with your patient, family, guardian, caregivers, or other reliable individuals. Review pertinent medical records to obtain an accurate history.

2. Complete a functional assessment that includes Basic and Instrumental activities of daily living and decision-making capacity

3. Use standardized instruments for staging dementia such as the Functional Assessment Staging Test (FAST) and Clinical Dementia Rating (CDR)

4. Medication reconciliation and review of high-risk medications, if appropriate

5. Use standardized screening tools to evaluate for neuropsychiatric and behavioral symptoms, including depression and anxiety

6. Conduct a safety evaluation for home and motor vehicle operation

7. Identify social supports to assess caregiver's knowledge and willingness to provide care

8. Create, review, or revise an Advance Care Plan and discuss any palliative needs

Once the Cognitive Assessment is completed, use the information collected during the history and exam to create a written care plan

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The written care plan focuses on the initial plan for addressing neuropsychiatric symptoms, neurocognitive symptoms, functional limitations, and referrals to community resources for the patient and/or caregiver, as needed, including initial education and support.

Remember, detection for cognitive impairment is a required component of your patient's AWV. If you detect a cognitive impairment during an AWV or other routine visit, Medicare covers a separate visit for you to perform a more comprehensive cognitive assessment and develop a care plan for your patient. Performing these services allows you to address potential cognitive impairments in your patients, diagnose dementia or other related conditions, and develop approaches to assist your patients.

Thank you for watching this video on Cognitive Assessment and Care Plan Services.

For further information about the Cognitive Assessment and Care Plan Services, please refer to the Cognitive Assessment & Care Plan Services webpage on the CMS website at www.cms.gov/cognitive.

