INDIAN HEALTH SERVICE COMMUNITY HEALTH REPRESENTATIVE

Project Evaluation Report: Implementation of a Cognitive Screening Tool in a Community Health Setting

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A. EXECUTIVE SUMMARY

The Indian Health Service (IHS), through its Community Health Representative (CHR) Program and Alzheimer's Program, implemented a six-month pilot (January–July 2025) to assess the feasibility of integrating the Mini-Cog© cognitive screening tool into community-based settings. Twenty CHR programs across tribal, federal, and urban sites participated in this second pilot cohort.

Across participating sites, CHRs screened 957 individuals, of whom 16% screened positive for possible cognitive impairment. These findings demonstrate that CHRs can successfully administer cognitive screening in community settings and identify individuals who may benefit from further clinical evaluation. Screening activities also contributed to increased awareness of Alzheimer's disease and related dementias (ADRD) and supported more open conversations about cognitive health within communities.

Of those who screened positive, 22% were referred for further evaluation, and CHRs documented completed follow-up for 42% of referred individuals. Although a small number of confirmed diagnoses were documented within the pilot timeframe, each represents an individual who may not have otherwise been identified without CHR-led screening. Early identification, even at a small scale, is clinically meaningful given the importance of timely diagnosis for care planning, treatment, and patient and family support.

This second cohort builds on an earlier pilot conducted in 2024, further strengthening evidence that CHRs can implement cognitive screening and effectively engage community members in community settings. The extent to which screening translates into diagnosis and care, however, depends on the strength of referral systems and clinical integration. This pilot demonstrates that CHR-led screening is both feasible and valuable as a standalone community-based intervention, while also underscoring the importance of strengthening connections between CHR programs and clinical care systems to maximize impact.

B. BACKGROUND

The IHS has long recognized the critical role of CHRs as trusted, community-based health workers who bridge cultural and geographic gaps in care. In 2024, IHS and partners began piloting the Mini-Cog, a brief cognitive screening tool, in CHR programs. The first pilot cohort launched earlier in 2024, and the second pilot concluded recently.

The first pilot cohort provided initial insights into the feasibility of CHR-led cognitive screening, including training needs, workflow considerations, and early barriers to referral and follow-up. Lessons learned from the first cohort informed refinements to training, technical assistance, and overall program implementation in the second cohort, strengthening the approach and supporting continued evaluation of CHR-led screening in community settings.

These pilots are designed to assess feasibility and inform best practices for how CHRs can support early identification of individuals with possible cognitive impairment and raise awareness of dementia.

By engaging CHRs in this work, IHS is leveraging a trusted workforce with strong community ties to address barriers to care, such as stigma, limited provider availability, and geographic isolation. This initiative builds on decades of CHR contributions to public health in tribal communities, underscoring the importance of partnerships that combine culturally grounded outreach with evidence-based tools. The CHR Mini-Cog pilots represent an important step toward improving ADRD detection and ensuring that American Indian and Alaska Native people receive timely, accurate diagnoses and support.

What is the Mini-Cog?

The Mini-Cog is an evidence-based, quick screening tool for early signs of dementia. Designed to be completed in just a few minutes, the test helps identify individuals who may need a more detailed cognitive evaluation and is intended for use by trained professionals. The tool combines two simple tasks: a three-item recall test for memory and a scored clock-drawing exercise. While the Mini-Cog is a valuable screening measure, it is not a diagnostic tool. Providers, including CHRs, who administer the Mini-Cog must be prepared to make appropriate referrals for patients based on the results. More information about the standardized Mini-Cog instrument is available at www.mini-cog.com.

Who are CHRs?

CHRs are frontline public health workers who serve American Indian and Alaska Native (AI/AN) communities by improving access to health care, addressing social drivers of health, and building community capacity (National Indian Health Board, 2021). They are trusted members of the communities they serve, often sharing lived experiences and cultural knowledge with the people they support. This trust enables them to provide holistic, person-centered care and to act as a bridge between community members and the health care system (Viswanathan et al., 2010).

The CHR Program, established more than 50 years ago, is the only federally funded community health worker program in the United States (Indian Health Service, 2022). CHRs are highly trained and nationally recognized leaders in the community health workforce. They deliver health education, support disease prevention, connect families to clinical and social services, play vital roles in emergency response, and meet urgent community health needs (Johnson et al., 2022; Indian Health Service, 2022). As one IHS leader noted, *"CHRs bring healthcare to the remote areas, addressing the provider shortages. They serve as a link between providers and the communities, and they provide education to the patients"* (Hardin, 2021).

Purpose/Objectives

This pilot project placed CHRs working across tribal, federal, and urban health systems at the center of a new effort to bring cognitive screening into tribal communities. CHRs piloted the Mini-Cog, a brief, evidence-based tool, to identify community members who may need further clinical evaluation. Beyond screening, CHRs played a key role in raising awareness of ADRD among I/T/U staff and tribal members, building peer-to-peer learning networks, testing practical approaches to data collection, and initiating the integration of the referral workflow process.

The IHS Division of Clinical and Community Services (DCCS) served as the formal organizational structure through which the initiative was carried out, implemented through the IHS Alzheimer's Program and CHR Program. Twenty CHR programs were recruited to participate in the six-month demonstration, which took place from January to July 2025. Throughout the project, CHRs worked directly with providers to address barriers to screening adoption, strengthen communication channels, and identify and develop referral processes. This report summarizes activities from the second pilot cohort and shares formative evaluation findings to inform and improve the initiative in future years.

This pilot was designed as a formative implementation initiative to assess feasibility, workflow integration, and early system development rather than clinical outcomes. Findings should be interpreted in the context of a six-month pilot and early-stage implementation, during which referral pathways and closed-loop communication systems were still under development.

C. PROJECT COLLABORATORS

- Michelle Archuleta, MS, MA, IHS National CHR Consultant
- Jolie Crowder, PhD, MSN, RN, CCM, IHS Elder Health Consultant
- Jamie Olsen, IHS Alzheimer's Program Management Analyst
- Emily Tahy-Ceballos, EdD, MPH, IHS Headquarters Public Health Advisor
- Megan Russell, BS, IHS Headquarters Public Health Advisor
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- Kerstin Reinschmidt, PhD, Oklahoma University (OU) Dementia Care Network
- Zahra Alhay, MPH, OU Health Promotion Sciences
- Michael Nugent, MPH, Northern Arizona University Community Health and Engaged Research, Evaluation Support

D. PILOT PARTICIPANTS

Participating programs:

- Blackfeet CHR Program
- Community Home Health Services
- Gerald L. Ignace Health Center
- Gila River Health Care CHR Program
- Grand Ronde Community Health
- Hualapai Tribe CHR
- Indian Health Board of Minneapolis, Inc. Dementia Program
- Kiowa Tribe CHR/SDPI Program
- Nottawaseppi Huron Band of the Potawatomi
- Port Gamble S'Kllalam Tribe Community Health Program
- Pueblo of Isleta Health Center
- Pueblo of Santa Ana CHR Program
- Red Cliff Community Health
- Saint Regis Mohawk Health Services

- MATHC-Mid Atlantic Service Unit
- Monacan Health Center
- Native Healthcare Center
- San Felipe Health and Wellness CHR Program
- Spirit Lake Dementia Program
- Winnebago Comprehensive System Public Health CHR Program

E. ADDITIONAL RESOURCES

- Each of the twenty pilot sites received $10,000, for total direct expenditures of $200,000.
- The pilot project team included SMEs in the CHR program and dementia, and three additional staff provided project support.
- The CHR program lead served as the peer learning webinar facilitator.
- The OU Dementia Care Network (a Health Resources and Services Administration (HRSA) Geriatric Workforce Enhancement Program (GWEP) grantee) provided dementia training at an in-person session, all at no cost to IHS.

F. OVERALL PROJECT EVALUATION QUESTIONS

1. Can CHRs implement cognitive screening using the Mini-Cog?
2. What barriers and facilitators exist to screening at the local level?
3. How can we improve the IHS process for a rapid implementation multi-site pilot to best meet local needs?
4. What national training, educational, or other resources could IHS provide to support local screening pilot efforts?
5. Should the pilot continue beyond year two?

G. EVALUATION METHODS

The project consisted of a mixed-methods evaluation reflecting the following assessments:

- Monthly reports – screening data collection and lessons learned
- Project assessment July 2025 – 14-question survey
- Final participant debrief – qualitative assessment for CHR integration
- Project core team debrief – post evaluation

H. COMPONENTS/TIMELINE - PRE-PILOT

Ahead of the launch, participants completed two training sessions: a December 2024 orientation webinar and a January 2025 in-person session in Phoenix, which covered dementia, CHR roles, Mini-Cog use, and pilot logistics. The kickoff introduced the IHS National CHR Strategic Plan and the pilot's purpose. From February 2025, monthly Zoom meetings with CHR staff and subject matter experts provided ongoing guidance and support.

1. **Meeting 1 - February 20, 2025**
2. **Meeting 2 - March 20, 2025**
3. **Meeting 3 - April 17, 2025**
4. **Meeting 4 - May 22, 2025**
5. **Meeting 5 - June 19, 2025**
6. **Meeting 6 - July 17, 2025**

I. FINDINGS

Key Insights from Monthly Reports

Overall, screening volume and positive screening rates were consistent with expectations for community-based cognitive screening initiatives. The number of individuals screened and the proportion identified as potentially at risk demonstrate that CHRs can successfully administer cognitive screening in community settings and identify individuals who may otherwise go unrecognized.

Screening Volume – the number of individuals screened

- Total number screened: 957
- Highest number of screenings: April (223), followed by March (181)
- Lowest number of screenings: January (122)

Positive Screenings - the number and percentage of individuals who received a positive result during screening

- Total positive screenings: 150 (16%)

Declined Screenings – the number and percentage of individuals who declined to participate in the screening process

- Total declined: 235 (24.5%)

Referrals, Follow-Up, & Final Diagnosis – the number and percentage of individuals with positive screenings were referred for further evaluation, and whether they completed those referrals

- Total referrals: 33 (22%)
- CHR documented completed physician follow-up after referral: 14 (42%)
- Total confirmed diagnoses by project end: 2 (1.3%)

While a portion of individuals who screened positive were referred and completed follow-up, confirmed diagnoses remained limited during the pilot period. This reflects known delays in dementia diagnostic pathways and challenges with closed-loop referral systems. At the same time, each confirmed diagnosis represents an individual who may not have otherwise been identified without CHR-led screening. Early identification, even at a small scale, is clinically meaningful and highlights the value of screening as an entry point into the continuum of care.

Project Assessment July 2025, 14 Question Results

Eighteen of 20 sites (90%) completed the final pilot evaluation assessment.

1. **Program site**

2. **Who was responsible for conducting the screenings?**

The majority of sites (91%) had CHRs and Community Health Workers (CHWs) responsible for conducting Mini-Cog screenings, with only a few sites (9%) having health educators and/or nurses conduct screenings.

3. **The following assisted in the success of your work as part of the Mini-Cog screening pilot:**
    - Dementia training and CHW competency roles by OU
    - Training on using the Mini-Cog assessment tool
    - Project kick-off meeting (program logistics, workplan, and reporting)
    - Monthly collaborative calls and discussions
    - Subject matter expertise and clinical guidance from staff
    - Mini-Cog listserv
    - Program monitoring and follow-up

One hundred percent (100%) of respondents agreed or strongly agreed that all training and support activities listed above assisted in the success of the Mini-Cog project. This was scored on a 5-point scale from strongly agree to strongly disagree.

4. **What activities from the 3-day training and monthly calls were most useful to you?**

Participants identified the most valuable activities as skills and practice training, learning from other organizations' workflow, networking with peers, and small-group discussions. One respondent highlighted that the Mini-Cog training and the opportunity to learn from other CHR programs were especially helpful for developing and sharing implementation strategies.

> *"The mini-cog training…provided was very helpful. Also, learning from the other CHR programs on how they plan to implement and share ideas to engage community members."*

5. **How could the Mini-Cog Listserv be more useful to you?**

Respondents suggested enhancing the listserv by improving cohort communication, offering additional training opportunities, increasing cultural relevance, encouraging sustained participation in the program, and troubleshooting technical issues. However, many sites also expressed high satisfaction, noting the listserv was already a useful resource with no improvements needed.

6. **What could we have done to make the pilot more effective for you and your program?**

Participants viewed the pilot as well-supported and effective, with many commending the program staff's responsiveness and helpfulness. Respondents highlighted the initiative's value in promoting cognitive screening in community health settings, but suggested improvements, including

- more accessible, culturally relevant dementia training,
- better-organized meetings,
- earlier funding distribution, and
- the addition of informational materials such as handouts and flyers.

A few participants also recommended increased awareness of the Mini-Cog program within IHS and potential funding for incentives to boost participation.

Overall, this feedback reflects strong satisfaction with the program's delivery and support, along with constructive suggestions to enhance training, communication, and logistical coordination in future implementations.

7. **Describe the top 3 barriers or challenges you experienced and how you overcame them while participating in the pilot.**

The top barriers reported were client misunderstanding of the screening purpose, limited provider awareness and buy-in, and staff shortages that left CHRs and CHWs overextended. Additional challenges included

- delays in results,
- transportation difficulties,
- limited patient pools,
- inadequate screening settings, and
- weak communication with providers.

One respondent also emphasized the need for ongoing encouragement, as staff were balancing the pilot alongside already demanding workloads.

8. **Describe the two best practices or benefits that came from participating in the pilot.**

The most significant benefits reported were increasing education and awareness of dementia across communities and the workforce, and building trust within communities. Respondents also noted improved CHR skills, enhanced cognitive care for elders, and stronger workflows and screening resources. Additional benefits include developing workforce leadership, improving provider relationships, and making dementia screening routine. Training CHRs and CHWs to deliver screenings helped bridge the gap between clinical settings and community care, strengthening trust and participation.

> *"…we established the Mini-Cog as a culturally sensitive and time-efficient tool to screen for early signs of cognitive impairment…This integration has helped normalize cognitive health conversations, reduce stigma, and support early identification of dementia-related concerns in Native and Indigenous populations."*

9. **Comments about the pilot overall:**

Participants viewed the pilot as a positive and meaningful experience, describing it as well-organized, informative, and valuable for raising awareness of dementia in their communities. Many appreciated the opportunity to gain new knowledge, strengthen their skills, and engage elders in conversations about cognitive health. The project was seen as a privilege that enhanced CHR education, fostered collaboration, and helped normalize discussions about dementia care in community settings.

> *"This was a great opportunity to gain insight about dementia and being able to offer education and information about the different areas of cognitive decline."*

10. **Comments on pilot duration:**

Participants were highly satisfied with the project's six-month duration, describing it as appropriate, well-timed, and sufficient for achieving program goals. Most respondents agreed that the timeframe allowed effective implementation of cognitive screenings and training, while a few suggested extending the pilot to a full year to reach more participants and build on the program's early success.

11. **How important was the financial incentive ($10,000) to your participation in the pilot?**

Participants considered the $10,000 financial incentive an important factor in their ability to participate successfully. Respondents noted that the funding helped cover training, travel, materials, and community outreach costs, while also promoting clinic and staff engagement. Although several participants stated they

would have participated regardless of the incentive because of the program's value to their communities, many emphasized that the funding helped fill critical resource gaps and supported broader program sustainability.

12. **How did you or will you use the money?**
Participants primarily used the $10,000 funding to support training, outreach, and community engagement activities. Most reported allocating funds for travel to training sessions, educational materials, and health events to promote dementia awareness. Several teams used the money to create culturally relevant resources, such as pamphlets and posters, to provide incentives for screening participation and to enhance their CHR programs through equipment and storage improvements. Overall, the funding was viewed as instrumental in expanding program capacity and fostering broader community participation in cognitive health initiatives.

13. **Do you believe that it is appropriate for CHRs to do Mini-Cog screenings?**
All the respondents (100%) agreed that it is appropriate for CHRs to conduct the Mini-Cog screenings. Participants overwhelmingly support CHRs conducting Mini-Cog screenings. Nearly all respondents agreed that CHRs are well-positioned to perform these assessments due to their strong relationships with community members, cultural understanding, and role as trusted frontline health workers. Participants emphasized that, with proper training, CHRs can effectively bridge the gap between clinical care and community engagement, helping to identify early signs of cognitive decline while fostering trust and education around dementia-related issues.

14. **Do you plan to continue implementing Mini-Cog screenings in your CHR program?**
All participants (100%) indicated that they plan to continue implementing Mini-Cog screenings within their programs. This unanimous response reflects strong confidence in the tool's effectiveness and sustainability, as well as a shared commitment among CHRs to maintain cognitive health screening as an integral part of community-based elder care.

Final Participant Debrief Results

The closing monthly meeting was structured as a focus group-style discussion, giving participants the opportunity to reflect on their experiences with the pilot and to provide recommendations for future efforts. Eighteen pilot site participants out of 20 (90% site participation) provided reflections on four topic areas and six questions. Below is a summary of the debrief findings.

Topic Area 1: Setting a Vision for CHR Integration with Dementia Screening

1. **How can we improve dementia screening, prevention, care, and treatment in our communities, and why are CHRs important partners in that effort?**
The majority of sites emphasized that CHRs are trusted community members and should serve as the first point of contact for dementia screenings. Their ability to connect with and communicate effectively in culturally relevant ways makes them key to engaging community members in health care. Participant reflections included:

- *"CHRs are important as they are trusted by the community and are able to speak to them at their level on a more sensitive topic."*
- *"CHRs build the needed relationship to get the individual interested in care/screening."*

Sites also highlighted the importance of community outreach and education to normalize conversations about dementia and encourage proactive care.

- *"…it is essential that we foster an environment in our communities where dementia can be openly discussed without the burden of shame or fear."*

- *"CHRs play a crucial role--as they can assist in educating and reassuring the community that proactive measures are the most effective way to identify early signs of dementia."*

Topic Area 2: The Role of CHRs

2. **How did CHRs contribute to the Mini-Cog screening project?**

The overwhelming majority of sites reported that CHRs conducted Mini-Cog screenings and provided education to patients about their results, reinforcing their central role in both screening and community education.

- *"The CHRs were the 'boots on the ground' and drove the work..."*
- "*CHRs contributed by explaining the screening and making patients comfortable, during dementia education."*
- *"They facilitated the conversation for the Mini-Cog screening and provided education in the form of handouts about cognitive awareness and dementia."*

CHRs also contributed by collaborating with other departments/providers to improve care and raise awareness in communities.

- *"Collaborating with other departments to bring awareness to the community."*
- *"...collaborating with the providers to seek out patients needing the screening, also resources after the screening."*

3. **What barriers did CHRs face in contributing to the screening project?**

Sites reported a range of challenges encountered during the screening project. The most common barriers included limited community awareness and education about dementia, time constraints due to competing responsibilities, staff shortages, and scheduling difficulties.

- *"Being short-staffed while maintaining daily duties and responsibilities led to not being able to conduct as many screenings as we could have."*
- *"The biggest barrier that we faced was the delay in--appointments being scheduled out."*
- *"One significant barrier our CHRs/CHWs faced was limited capacity due to time constraints and limited staffing."*

Some lesser-reported barriers important to note are stigma, adding additional tasks for CHRs, and lack of trust from the patients.

- *"Barriers were trying to inform and educate elders not to be scared to take a Mini-Cog screening."*
- *"Barriers included community members refusing to get screened due to stigma--in regard to dementia."*
- *"Elders not trusting the test, questioning why we are doing the testing and not a physician…"*

Topic Area 3: CHR Integration

4. **How can we change our systems or structures to better leverage the unique strengths of CHRs with Mini-Cog screenings in our communities?**

Many sites proposed incorporating greater communication and awareness to better leverage CHRs' strengths within this Mini-Cog project and communities. A common theme identified was to inform other departments, so they have a better understanding of how to utilize CHRs.

- *"Increasing communications to providers on CHR roles and services. Providers are aware of CHRs but may not know the specific services they can provide, like Mini-Cogs."*
- *"…having CHRs present at health staff meetings so--the department understands their role/services."*

Improving collaboration with other departments was another common response among the sites.

- *"Collaborate with different departments within the clinic and have an additional perspective on the dementia awareness…"*
- *"This collaboration will enable them to partner more effectively with the health facility and potentially engage a greater number of community members."*

5. **What is an actionable step we could take to remove any barriers?**

Some actionable steps the sites provided were proper funding and care teams. Allowing these two to operate at full capacity enables sites to conduct screening and provide relevant services to their communities.

- *"When you think about a care team, we have built ours with the patient at the center, their CHR surrounding the patient, then the patients' providers and all those on the external circle."*
- *"…funding for more CHRs- we have a big patient load and not enough CHRs to provide the best care we can."*

Sites reported include CHRs in meetings, so departments and staff are aware of procedures so they can carry out care more quickly and efficiently.

- *"We have an upcoming meeting--to discuss the recent work of CHRs and how to implement a consistent screening workflow in the clinic."*

Topic Area 4: CHR Program Opportunity and Experience

6. **What was the value of this opportunity for you and your program to be a part of the Mini-Cog pilot?**

There were a few common themes in the sites' responses regarding the value of this opportunity. Connection with community members and providers, dementia awareness, expanded skills/services, educated community, and advocacy/support were among the themes.

- *"This opportunity gave us a different type of connectivity and approach with dementia education with community members."*
- *"This allowed my CHRs to provide another screening tool in the community, further bringing awareness to the need for early detection…"*
- *"Our value was to educate elders--filling the gap between provider and patients."*
- *"…we were able to provide advocacy and support and identify barriers that were specific to those elders and then relay those to the health care team."*

Additionally, the sites reported that this opportunity empowered CHRs, helped remove stigma surrounding dementia screening, and satisfied patients.

- *"It has brought increased knowledge to our CHRs about dementia and opened discussion on the need to offer this type of screening."*
- *"…and an additional awareness of our health and wellness facility on the stigma associated with diagnosing dementia/Alzheimer's."*
- *"They [patients] were so happy and relieved that at least something was being provided regarding assessments for dementia."*

Summary of Final Participant Debrief Results

The most significant takeaway was the consensus on the importance of additional dementia training. Participants emphasized the value of incorporating active teach-back strategies during Mini-Cog training to build confidence in administering the tool. Many also expressed a strong preference for the in-person training formats, which allowed for real-time interaction, questions, and peer learning – components they felt are less effective in a virtual environment.

A second major theme was the resounding support for CHRs conducting dementia screenings. Participants agreed that CHRs are uniquely positioned to carry out this work, given their trusted role in the community, cultural alignment, and ability to engage patients in sensitive conversations about cognitive health.

Finally, participants highlighted the need for earlier and stronger engagement with clinical providers and settings. They recommended establishing clear referral pathways and structured warm handoffs at the outset of future pilots to ensure continuity of care for patients who screen positive. This, they suggested, would both increase provider buy-in and strengthen integration between community-based and clinical care.

Overall, the debrief provided valuable insights that underscore the importance of training, CHR leadership, and clinical collaboration in scaling and sustaining dementia screening initiatives.

Lessons Learned from Core Project Team Debrief

The project team met to conduct a post-project debrief. This process yielded many reflections and lessons. Team debriefs highlighted strengths in preparation, collaboration, and clear kickoff logistics, which improved from the first cohort. Outreach successfully expanded participation to 20 sites, supported by central application processing and active engagement from some area offices. Local successes included leadership and provider support, in-person planning, stronger community engagement, and recognition of CHRs' expanded role.

Key challenges included slow travel and payment processes, confusing communication channels, declining participation over time, uneven engagement across area offices, and inconsistent early data quality. At the site level, stigma, lack of culturally tailored materials, limited time and space, and workflow gaps hindered implementation.

Recommendations included simplifying reporting, consistently engaging area coordinators, using digital tools, reframing screenings as wellness checks, and mentoring newer sites with experienced teams.

J. DISCUSSION

Over the six-month Mini-Cog pilot, 20 programs collectively screened 957 patients, with 16% screening positive. Of the 150 patients who screened positively, 33 were referred. Most screenings (91%) were conducted by CHRs/CHWs, confirming their central role as trusted frontline staff.

Findings across sites consistently indicate that CHRs demonstrated the ability to conduct cognitive screening, engage community members in culturally appropriate ways, and identify individuals at potential risk for cognitive impairment. Importantly, this demonstrates that CHR-led screening is feasible and meaningful in practice even in the absence of fully developed clinical integration. These findings indicate that screening can function effectively as an initial point of engagement in the care continuum, even when downstream systems are still developing.

Findings from the second cohort were consistent with those observed in the initial pilot, further reinforcing that CHRs can effectively conduct cognitive screening in community settings. Replicating these findings across cohorts strengthens confidence in the feasibility and acceptability of CHR-led screening.

At the same time, the pilot highlights that the primary limitation to impact lies in the connection between community-based screening and clinical care systems. Gaps in referral pathways, provider engagement, and feedback mechanisms limited some individuals who screened positive from completing the diagnostic process. These findings suggest that strengthening CHR–clinic integration is essential to expanding the impact of screening efforts.

Implementation Drivers. Sites that integrated screenings into existing workflows (e.g., home health visits, community events) or incentivized staff achieved higher and more consistent screening volumes. Training activities, especially hands-on practice, peer learning, and small-group discussions, were cited as the most useful supports.

Barriers. The most significant challenges included limited client awareness and stigma, provider buy-in and referral gaps, and CHR/CHW staffing constraints. These barriers contributed to modest referral conversion rates and highlighted the need for stronger community education, provider engagement, and workforce support.

***Cultural Relevance*.** Sites emphasized that culturally tailored materials and in-person dementia training with teach-back strategies would improve implementation. CHRs' trusted role in their communities helped reduce stigma and encouraged participation, underscoring the importance of CHR-led models in Native and Indigenous communities.

Operational Lessons. Reporting quality and participation in required meetings varied across sites, often due to competing responsibilities or start-up challenges. While the $10,000 incentive was broadly useful, clearer communication around funding distribution is needed. Simplified reporting and earlier release of funds could improve site performance in future pilots.

Limitations. The absence of provider feedback on diagnoses following referrals limited the ability to assess downstream clinical outcomes and fully understand the impact of screening beyond initial identification. Varying levels of CHR resources and support also affected data quality and comparability across sites.

This pilot contributes to a growing evidence base demonstrating that CHRs can play a meaningful role in dementia care. While prior efforts have emphasized education, outreach, and care coordination, this pilot provides real-world evidence that CHRs can feasibly and appropriately administer standardized cognitive screening tools in community settings.

K. CONCLUSION

This pilot demonstrates that CHR-led screening is both feasible and meaningful as a community-based approach to identifying individuals at potential risk for cognitive impairment. CHRs successfully administered the Mini-Cog, engaged community members, and supported early identification of cognitive concerns, while also increasing awareness of Alzheimer's disease and related dementias and fostering more open conversations about cognitive health.

Training, technical assistance, and peer collaboration were highly valued and supported successful implementation across sites. At the same time, participation varied across programs, referral pathways were limited, and no programs received follow-up confirmation from clinical providers. These findings highlight ongoing challenges in care coordination and data feedback that affects the ability to track outcomes beyond initial screening.

Importantly, even within these constraints, CHR-led screening identified individuals who might not have been recognized otherwise, reinforcing the value of screening as an entry point into the continuum of care.

Overall, the pilot demonstrated successful early implementation of a second cohort conducting dementia community-based screenings and contributes to a growing evidence base supporting the feasibility of CHR-led cognitive screening. Findings also indicate that the full impact of screening is dependent on stronger integration with clinical care systems. Strengthening referral pathways, provider engagement, and feedback mechanisms will be critical to ensuring that individuals who screen positive receive timely evaluation and support. These findings point to several key opportunities to strengthen implementation and expand the impact of CHR-led cognitive screening moving forward.

L. RECOMMENDATIONS

Building on these findings, the following recommendations are proposed to strengthen implementation, enhance coordination with clinical care, and expand the impact of CHR-led dementia screening, which has been demonstrated as an effective entry point for early identification.

Recommendations are organized across key domains identified through the pilot, including workforce capacity, clinical integration, community engagement, and program operations.

Training & Workforce Capacity

- Provide in-person dementia training with active teach-back methods.
- Develop microlearning tools (videos, reference cards, FAQs) for CHRs.
- Address CHR workload by setting caseload targets, scheduling protected time, and offering incentives for quality improvement.

Clinical Integration & Referrals

- Establish standard referral pathways and warm handoff protocols with local providers.
- Implement closed-loop feedback so providers return diagnostic outcomes to CHRs.
- Engage providers early through CME webinars and orientation materials.

Community Engagement

- Expand culturally tailored outreach materials and messaging to address stigma.
- Embed screenings into existing events (senior centers, health fairs) and routine workflows such as home visits.

Program Operations & Funding

- Simplify reporting to a one-page monthly template.
- Release incentive funding earlier and provide clear guidance on allowable uses.
- Strengthen site participation by pairing newer programs with experienced mentor sites.

Measurement & Targets

- Track a core set of metrics:
    - Patients screened per month/site
    - % positive screens
    - % referred among positives (target: ≥60%)
    - % completing referrals (target: ≥70%)
    - % with documented provider follow-up (target: ≥80%)
- Use rapid-cycle testing (PDSA) to refine workflows and scale effective practices.

Governance & Sustainability

- Form a CHR–Clinic Steering Group to oversee performance, troubleshoot barriers, and support provider engagement.
- Develop a Mini-Cog implementation resource guide for CHR orientation and training.
- Explore braided funding sources (public health, aging, behavioral health) to sustain and expand dementia screening.

M. REFERENCES

- Hardin, C. L. (2021). [Director, Division of Diabetes Treatment and Prevention, Indian Health Service]. Quoted in Indian Health Service CHR Program materials.
- Indian Health Service. (2022). *Community Health Representative (CHR) Program*. https://www.ihs.gov/chr/
- Johnson, K., Conroy, N., & Vigil, M. (2022). *Community Health Representatives in the COVID-19 response: Lessons from AI/AN communities*. Journal of Public Health Management and Practice, 28(Suppl 1), S50–S57.
- National Indian Health Board. (2021). *Community Health Representatives: The trusted workforce in Indian Country*. https://www.nihb.org/
- Viswanathan, M., Kraschnewski, J. L., Nishikawa, B., Morgan, L. C., Thieda, P., Lohr, K. N., & Whitener, L. (2010). *Outcomes and costs of community health worker interventions: A systematic review.* Medical Care, 48(9), 792–808. https://doi.org/10.1097/MLR.0b013e3181e35b51

N. APPENDIX A – Mini-Cog Tool

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.

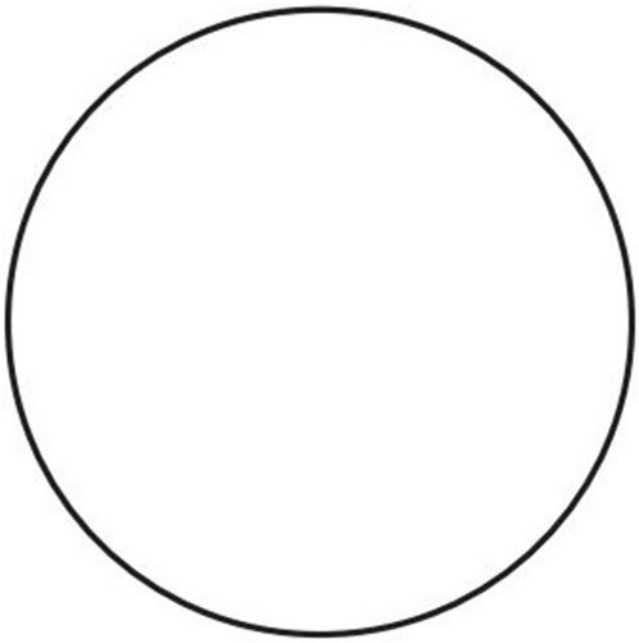
Word List Version: ____ Person's Answers: _____ _____ _____

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.