NATIONAL HEALTH CARE for the HOMELESS COUNCIL

Dementia Screening in Community Health Centers

Meeting UDS Data Requirements & Ensuring Effective Care

October 8th, 2025

What is the National Health for the Homeless Council?

NATIONAL HEALTH CARE for the HOMELESS COUNCIL

The National Health Care for the Homeless Council is the premier national organization working at the nexus of homelessness and health care.

HRSA Disclaimer

This webinar is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $1,788,315 with 0% percentage financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov.

Learning Objectives

At the end of today's webinar, attendees will be able to:

1. Differentiate between cognitive impairment and dementia
2. Identify screening tool options to screen for dementia within the health center setting
3. Develop a workflow for screening and follow-up assessment for dementia within the health center setting

Agenda for Today's Webinar

- Overview of cognition and dementia
- Review of screening tools for dementia
- Next steps after a positive screen
- Leveraging positive results to support individuals with a wide range of cognitive impairment – from mild cognitive impairment through dementia

Understanding Cognition & Dementia

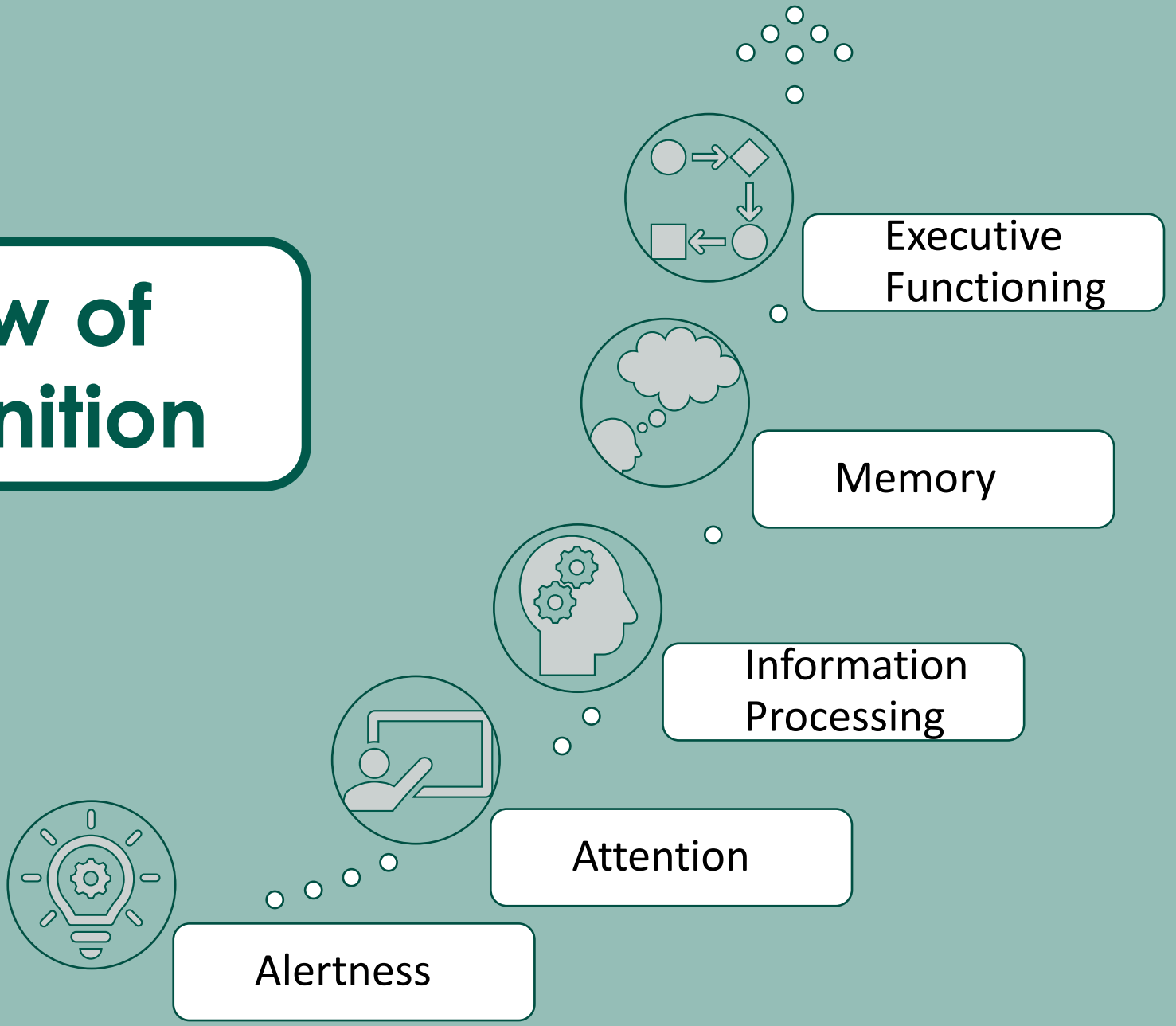
What is Cognition?

Cognition is information-processing functions carried out by the brain that include:

- Attention
- Memory
- Executive functions
- Comprehension and formation of speech
- Calculation ability
- Visual perception
- Praxis skills

(AOTA, 2019; Haskins et al. 2012)

Flow of Cognition



What is Cognitive Impairment?

When cognitive abilities are impaired (often referred to as **cognitive impairment**), a person has trouble with cognitive processes that begin to affect the things they can do in everyday life (CDC, 2013).

Cognitive Dysfunction can be defined as functioning that is below expected normative levels or loss of ability in any area of cognitive functioning (Evans, 2010).

Mild Cognitive Impairment (MCI) is the stage between the expected cognitive decline of normal aging and the more serious decline of dementia. (Mayo Clinic, 2022)

Factors Impacting Cognition

Medical

- Dementia
- Traumatic or Acquired Brain injury
- Developmental Disability
- HIV
- Substance Use
- Mental Health Symptoms
- Medical interventions/ Being in an ICU
- Chronic Conditions

Environmental

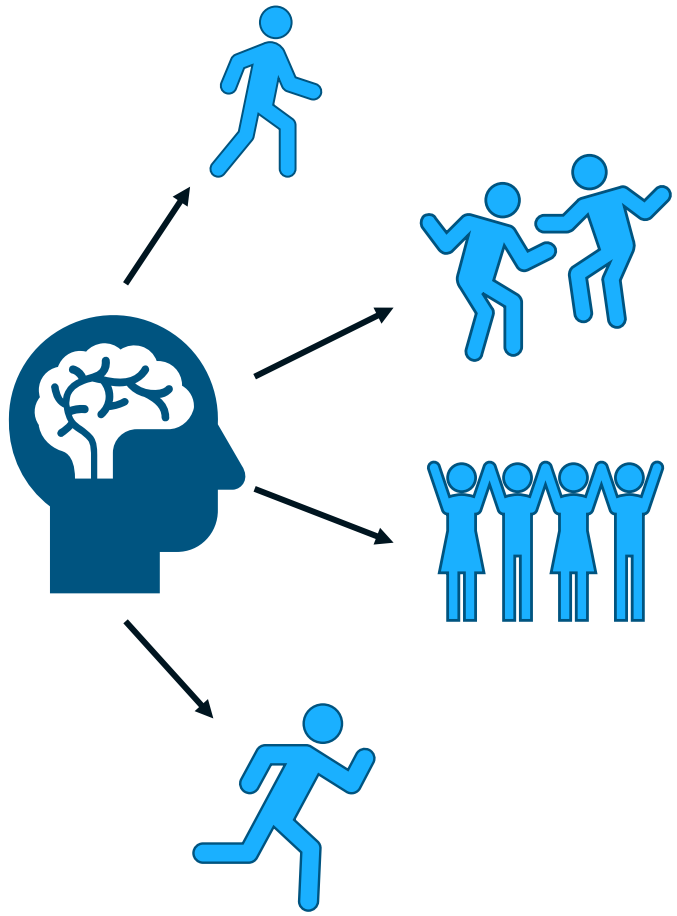
- Unstable, unsafe, or inadequate housing
- Poor nutrition / Lack of access to food
- Sleep Deprivation
- Trauma
- Stress
- Low literacy

Cognition's Impact on Physical Function

The brain directs movement and motor actions

Cognitive skills can affect how a person is able to plan for and follow through on movement

A person may have decreased awareness or problem-solving skills to adjust for physical limitations

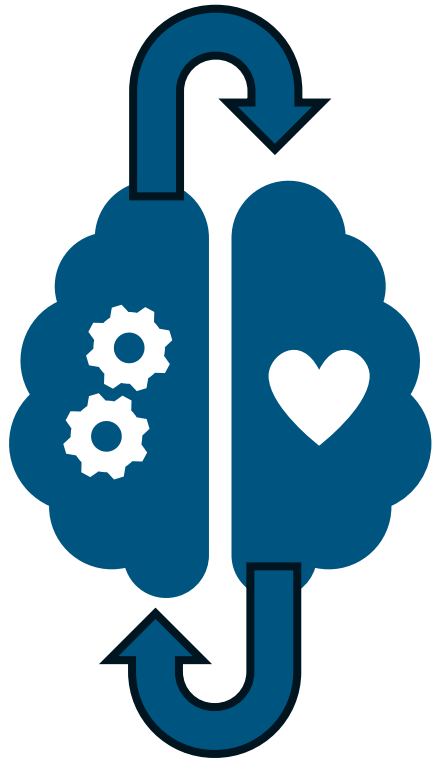


Cognition and Emotional/Behavioral Regulation

Areas of the brain that control cognition can also regulate emotions and behavior

Impacted cognition can cause frustration or anxiety

If emotional regulation is impacted, it can make it harder to use cognitive skills



Activities of Daily Living (ADL)

Activities oriented toward taking care of one's own body and completed on a routine basis.

Bathing/ Showering

Toileting/ Toilet Hygiene

Dressing

Feeding

Eating & Swallowing

Functional Mobility

Personal Hygiene & Grooming

Sexual Activity

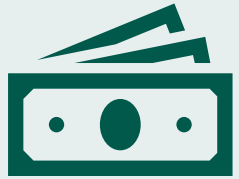
(AOTA, 2020)

Instrumental Activities of Daily Living (IADL)

Activities to support daily life within the home and community (which often require more complex interactions that those used in ADLs).

Home Management

Meal Preparation



Financial Management

Driving & Community Mobility

Shopping

Caregiving

Communication

Safety & Emergency Maintenance

Health Management

(AOTA, 2020)

How Cognition Creates Barriers for People Experiencing Homelessness

Person must follow all organizational rules

Person must participate in large groups or structured activities

Person must follow the organization's schedule

Mistakes and/or relapse result in loss of services

- Difficulty managing time
- Difficulty with memory
- Unable to participate because of difficulty with attention
- Conflicting requirements and restrictions of programs combined with difficulty organizing activities
- Need to prioritize safety
- Unmet health needs, such as pain
- Challenging and stressful experiences
- Lack of sleep

…. And so on

Cognitive Impairment and Health Care

New onset of cognitive impairment

- Due to health condition or event
- Recent diagnosis

Cognitive impairment can get in the way of activities needed for health management

- Attending appointments
- Following medical instructions or learning new strategies
- Taking medications
- Completing paperwork

Health Centers serve populations most affected by cognitive impairment

- Often undetected or under-diagnosed
- Consumers may not have had opportunity for rehabilitation or learning effective strategies
- Access to resources impacts ability to address cognitive needs
- Population faces aging and aging-related health concerns earlier than general population

Identification and Assessment

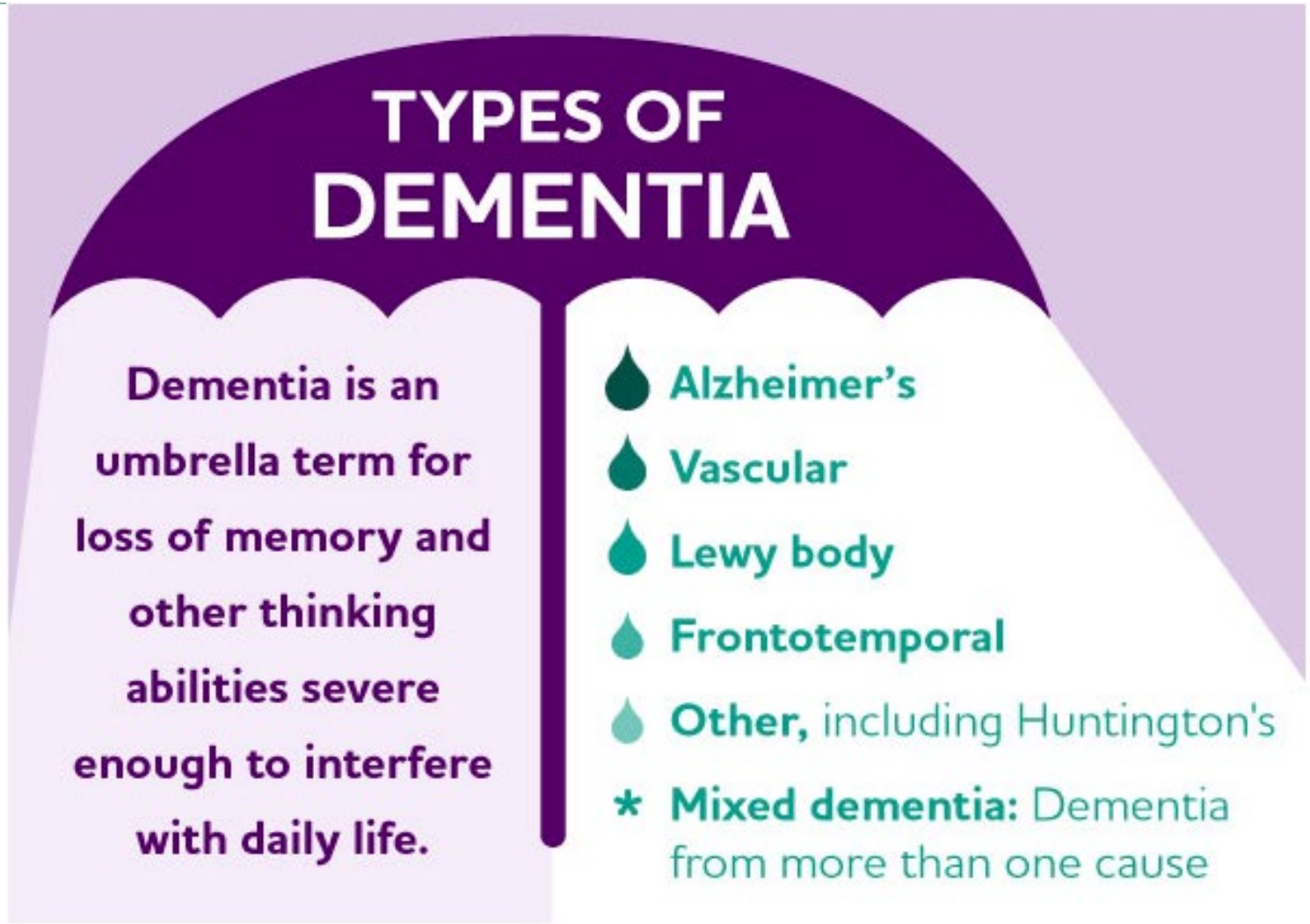
- Understanding **normal cognitive changes** helps differentiate from **dementia-related impairments**.
- **Common Age-Related Cognitive Changes *(Not Dementia)***
  - **Forgetting names or appointments** but recalling them later
  - **Occasionally making errors** in tasks like paying bills
  - **Temporary disinterest in social activities**
  - **Being upset when routines are disrupted**
  - **Occasional word-finding difficulties**
  - **Misplacing items** but being able to retrace steps to find them
  - **Making occasional choices that may not align with safety or realistic needs**

(Mayo Clinic, 2024)

What is Dementia?

- **Definition:** is a general term for loss of memory, language, problem-solving, and other thinking abilities that are severe enough to interfere with daily life.

- Dementia symptoms are **<u>progressive</u>**, which means that the signs of cognitive impairment start out slowly and gradually get worse over time, leading to dementia.



(Alzheimer's Association, n.d.-i)

Mild Cognitive Impairment (MCI)

- A condition involving problems with memory, language, or other cognitive functions that are noticeable but not severe enough to interfere with daily life.
- Clients with MCI do not have significant impairment in their abilities to perform ADLs. They do not meet criteria for dementia.
- Individuals with MCI are at an increased risk of developing Alzheimer's or other dementias.
- **Not** all individuals with MCI progress to dementia; some may improve or remain stable.
- Depression is common in people with MCI, and its presence increases the chances of people with MCI converting to dementia in the next few years.

(Barney & Perkinson, 2016, p. 255)

Alzheimer's Disease

- **Age-related, irreversible dementia** that develops over several years.
- **Most common cause of dementia** in people aged 65+ years.
- Accounts for **60% to 80%** of all dementia cases.
- **Not** a normal part of aging.
- **Gradual onset** with a **slow, relentless cognitive decline** affecting daily activities.
- **No cure** currently available.
- **Definitive diagnosis of AD** is only possible **after death** via **brain autopsy**.

(Alzheimer's Association, n.d.-h; Barney & Perkinson, 2016, p. 248)

Additional Types of Dementia

Frontotemporal Dementia

- **Progressive dementia** typically diagnosed between ages **45–65**.
- Affects the **frontal and temporal lobes** of the brain.
- Leads to **difficulties with**:
  - Communication
  - Goal setting
  - Social behavior
  - Personality changes
- ⚠ **No cure or treatments** available to slow or stop disease progression.

Vascular Dementia

- Vascular dementia is a decline in thinking skills caused by conditions that block or reduce blood flow to various regions of the brain, depriving them of oxygen and nutrients.
- Can occur **suddenly after a major stroke** blocking blood vessels. May develop **gradually** due to **multiple minor strokes** or small vessel disease.
- ⚠ **No FDA-approved drugs** specifically for vascular dementia.

Lewy Body Dementia

- **Abnormal protein deposits (Lewy Bodies)** in the brain disrupt cognitive functioning. Considered to be on the Parkinson's spectrum
- Results in cognitive and motor impairments
- May also cause psychological symptoms and sleep disturbances

(National Institute on Aging, 2021)

Mixed Dementia

- A condition where an individual experiences **two or more types of dementia simultaneously**.
- **Most common combination:** Alzheimer's disease & vascular dementia.
- **Prevalence & Diagnosis**
  - Exact number of cases is **unknown**.
  - **Autopsy studies suggest** it is **more common** than previously believed.
  - Many individuals **diagnosed with a single type** of dementia may actually have **mixed dementia**.

(Alzheimer's Association, n.d.-e; Barney & Perkinson, 2016, p.254)

Impact of Dementia

Emotional

- Affect may not be congruent with actual mood
- Stressors of new environment or unfamiliar people
- Baseline stress from experience of homelessness

Sensory

- Decreased field of visual attention
- Decreased insight into interoception (hunger, thirst, voiding, pain)
- Difficulty filtering sensory input
- Changes to taste receptors

Physical

- Decreased balance
- Increased risk of falls
- Difficulty with swallowing

Cognitive

- Memory
- Attention
- Problem solving
- Sequencing

All of these can then impact a person's function, or ability to do day-to-day activities

Screening for Dementia: Recommended Practices

UDS Requirement

- Alzheimer's Disease and Related Dementias (ADRD) Screening – A new measure is being added to line 26f to capture the **number of visits** where patients received **ADRD screenings** and the number of patients who received the screenings. This measure will encompass assessments representing standardized tools used for the **evaluation of cognition and mental status of older adults.**
- Rationale: The addition of a measure to capture ADRD screenings will be valuable in understanding the level of need and resources required to continue to support the growing aging population served by the Health Center Program. Integrating this measure will enhance the UDS' alignment with other national initiatives, such as the Healthy People 2030 objectives and the National Plan to Address Alzheimer's Disease. Screening for ADRD is increasingly recognized as a critical component of comprehensive primary care, particularly in health centers serving older populations. Adding this measure to the UDS will foster early detection for those at risk for ADRD."

(UDS, 2024)

Utility of Cognitive Screening Tools

- Cognitive Screening tools will give you a **score**, not a diagnosis
- Scores may be stratified into ranges
    - Normal range
    - Mild cognitive impairment
    - Dementia
- **No single test can confirm dementia** (except autopsy). Diagnosis must come from doctor.
- A dementia Diagnosis requires **ruling out other conditions** through:
    - Sensory & cognitive assessments
    - Mental health reviews & physical exams
    - Laboratory/imaging studies
    - Input from care partners
- Identifying and documenting mild cognitive impairment, while not this goal of this UDS metric, is incredibly useful

(Cordell et al., 2012)

Considerations for Screening in Unhoused Populations [1 of 2]

Screening at 55 and older is recommended

- Pre-mature aging experienced by population
- Potential relationship between onset of MCI and first-time homelessness
- UDS requirement suggests older adults “65 and older”

(Brown et al., 2017; Mahmood et al., 2021; Ross et al., 2024; Tuch et al., 2021)

Considerations for Screening in Unhoused Populations [2 of 2]

- Education and literacy levels
- Language and interpretability
  - Several tools are available in multiple languages or can be delivered by interpreters, or can be adapted to those with visual impairment to be delivered via telehealth
- Other impacts on cognition:
  - Co-occurring medical conditions or unidentified conditions
  - External impacts
- Formal neurospych evaluation is a recommended tool for assessing per UDS
  - May have limited access and long wait times (not a feasible “screener”)

(Brown et al., 2017; Mahmood et al., 2021; Ross et al., 2024; Tuch et al., 2021)

Integrating Screening Into Clinic Workflows

Consider how the tool that will fit into your clinic workflow

- Which disciplines are validated to use it
  - C-N-A, nurses, physicians, behavioral health staff, others
- Is the tool appropriate for all of the populations you serve
- How much time does it take to complete
- Cost/training required to use the tool
  - Some tools recommend/require an annual short training
- As part of the intake process or at another time – most tools are facilitated not self-administered screening tools

A trained clinician or provider will need to interpret score.

UDS Listed Screening Tools

- Blessed Orientation-Memory-Concentration Test (BOMC)
- Montreal Cognitive Assessment (MoCA)
- St. Louis University Mental Status Examination (SLUMS)
- Mini-Mental State Examination (MMSE)
- Short Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE)
- Ascertain Dementia 8 (AD8) Questionnaire
- Minimum Data Set (MDS)
- Brief Interview of Mental Status (BIMS)
- Mini-Cog
- Formal neuropsychological evaluation

Screening Tool Considerations

Blessed Orientation-Memory-Concentration Test (BOMC)	Assesses **memory, orientation, and concentration**
	Sensitive to early cognitive changes associated with Alzheimer's disease
	Has not been documented to be used with PEH in formal studies
Montreal Cognitive Assessment (MoCA)	Screens for **mild cognitive impairment (MCI) through multiple cognitive domains**
	Was not validated in PEH but has been used with this population in several studies
	May need to use adjusted cut-off score to avoid false positives among population
	Requires paid training to be able to administer
St. Louis University Mental Status Examination (SLUMS)	**Evaluates cognitive function through multiple domains**
	Not validated in PEH or people under the age of 59
	Has been used in homeless services settings but not evaluated in a formal study
	Assesses similar domains to the MoCA but is free along with free training to use the tool
Mini-Mental State Examination (MMSE)	Assesses **memory, language, spatial skills**
	The MMSE has not been well validated for non-Alzheimer's dementias
	Has been validated worldwide, but not specifically with PEH population

Screening Tool Considerations

Short Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE)	**Informant based questionnaire that compares current performance with performance 10 years ago**
	Can be combined with other cognitive screening tools
	Has been used in the community but not documented for use with PEH, may be a challenge due to reliance of report by a support person or family member that has known the person for 10 years
Ascertain Dementia 8 (AD8) Questionnaire	**Informant based questionnaire that can be administered to the person or a caregiver**, although the caregiver version has been found to be more accurate
	Can be combined with other cognitive screening tools
	Has not been used with PEH, maybe a challenge due to reliance on report of a caregiver
Brief Interview of Mental Status (BIMS)	**Assesses cognitive abilities**
	Validated for use with nursing home patients only
Mini-Cog	**Tests visuo-spatial skills, executive function, and memory**
	Has been utilized in a study with formerly homeless adults

Responding to a Positive Screen

- Positive screen *does not* = dementia
- Positive screen *does not* = NEW impairments if the screen is a first-time screen
- Positive screen *does not* mean someone is unable to live independently

Positive screen is an opportunity to explore further and identify ways to support individuals across a spectrum of cognitive changes and decline.

Recommended Steps After a Positive Screen: Initial Clinical Work-up

Thorough history	TBI history
	Developmental history
	Behavioral Health History
	Attempt to collect collateral information (family, friends, community supports like CM)
Physical Exam	Include and document full neurological examination
	Assess for infection
	Include functional assessments as relevant
Assess for reversible contributors	Prescription and over-the-counter medications review
	Reversible Medical Conditions (Thyroid, Syphillis, B12 deficiency)
	Sleep disturbances including OSA
Neuroimaging c an be considered	Non-contrast head CT
	MRI

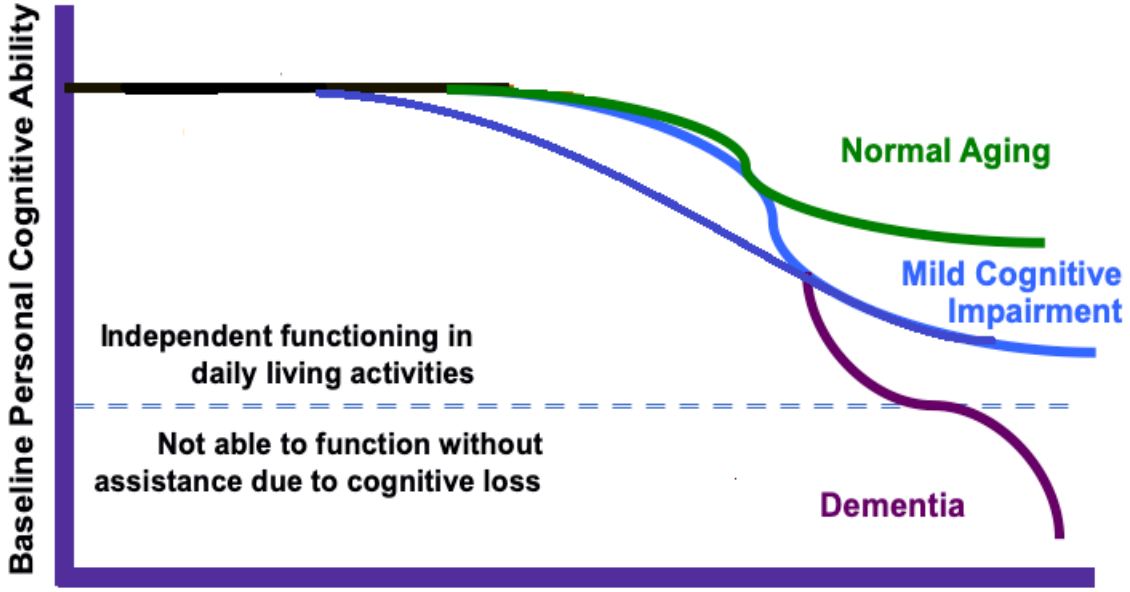
Distinguishing between MCI and Dementia in Practice: Focus on Function Rather than Diagnosis as a First Step

Mild Cognitive Impairment

- Subtle cognitive decline
- **Doesn't significantly interfere with daily activities**
- May or may not progress over time

Dementia

- More prominent cognitive decline
- Progressive
- **Impacts ability to safely function over time**



Graph adapted from : Isitdementiaornormal aging? Mesulam Institute for Cognitive Neurology & Alzheimer's Disease: Feinberg School of Medicine

Recommended Steps After a Positive Screen: Healthcare Considerations

- Encourage regular medication reviews and deprescribing when appropriate
- Explore difficulties in care management and adjust care management plans as needed
- Prioritize non-drug interventions for behavioral and psychological symptoms
- Partner robustly with community supports
- Engage in advanced care planning discussions early, with a focus on surrogate decision makers
- Carefully monitor for progression over time
- If available, refer for neuropsychiatric testing if symptoms are progressive, there are safety concerns, or additional information can help with advocacy

Recommended Steps After a Positive Screen: Housing Considerations

- Individuals with cognitive impairment, MCI, or even mild dementia can live safely in the community, independently and/or with supports in place
- Use screening information to advocate for housing settings and supports that maximize independence
- Pair screening with more robust functional assessment to identify areas of need/support
- Consider community safety planning needs
- Use cognitive screening to identify individuals whose cognitive impairment may put them at risk of losing housing
  - Challenges tracking and paying bills
  - Behavioral and safety challenges
  - Home management/clutter management
- With dementia, create a plan for monitoring changes and safety, and need to transition to higher level of care

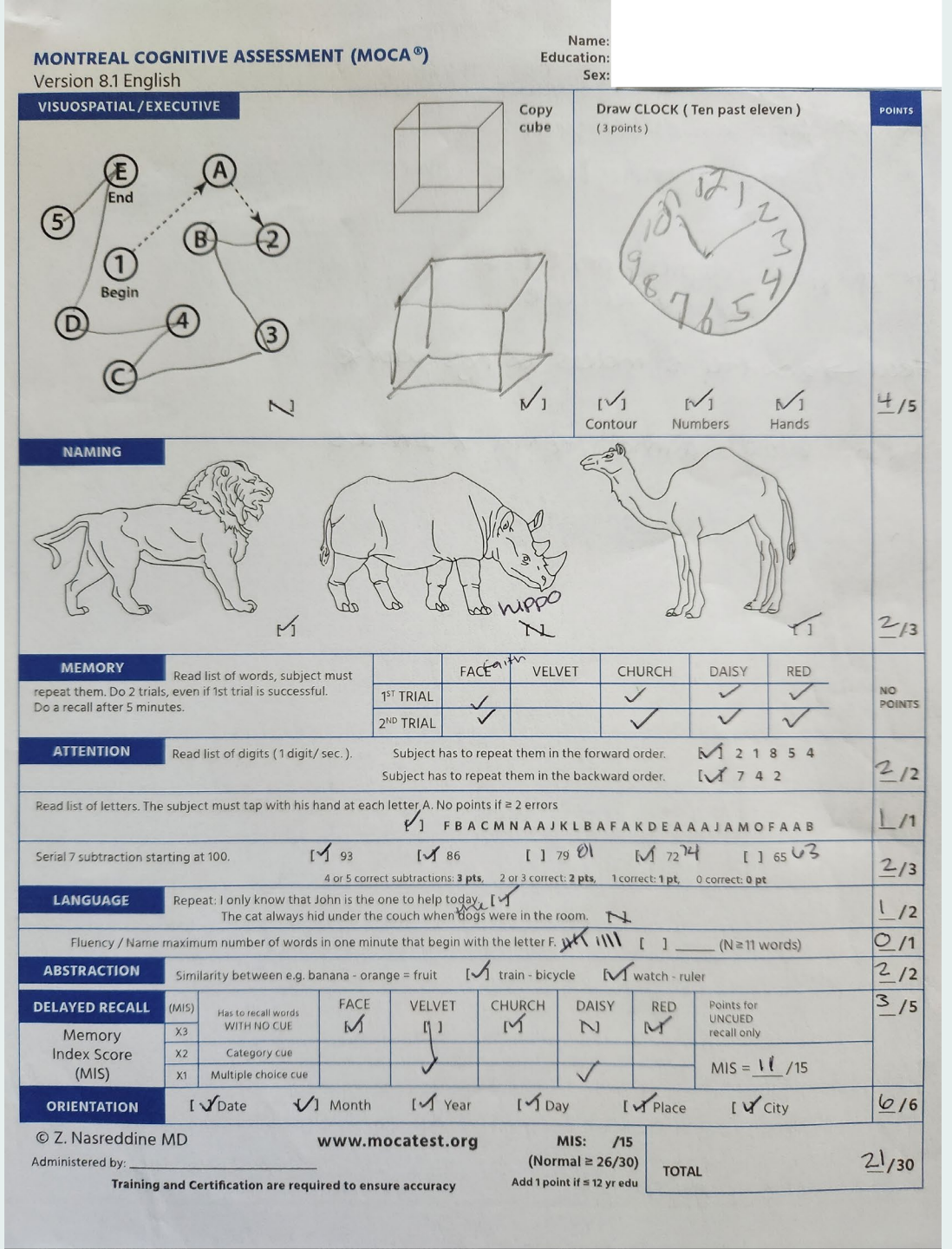
Recommended Steps After a Positive Screen: When to Refer for Specialized Care

- Recognizing when to refer a person with dementia to specialized care is crucial for their well-being and safety. Key triggers for such referrals include:
  - Worsening Behavioral and Psychological Symptoms
  - Increased Fall Risk
  - Significant Cognitive Decline Affecting Safety
  - Uncontrolled Sleep Disturbances
  - Unmanageable Dependency in ADLs
  - Caregiver Burnout
  - Resistance to Care or Support

(Alzheimer's Society, 2021; Cloak et al., 2024)

Case Example

- What are the other factors you would want to consider when interpreting this person's MoCA score?
- What domains of cognition were identified to be currently impacted?
- How might you follow up clinically?
- How might these findings help inform the overall care plan?



MONTREAL COGNITIVE ASSESSMENT (MOCA®)
Version 8.1 English

Name:
Education:
Sex:

VISUOSPATIAL / EXECUTIVE — POINTS

Copy cube

Draw CLOCK (Ten past eleven) (3 points)

[✓] Contour [✓] Numbers [✓] Hands — 4/5

NAMING — 2/3

MEMORY Read list of words, subject must repeat them. Do 2 trials, even if 1st trial is successful. Do a recall after 5 minutes. — NO POINTS

	FACE	VELVET	CHURCH	DAISY	RED
1ST TRIAL	✓		✓	✓	✓
2ND TRIAL	✓		✓	✓	✓

ATTENTION — 2/2

Read list of digits (1 digit/ sec.). Subject has to repeat them in the forward order. [✓] 2 1 8 5 4
Subject has to repeat them in the backward order. [✓] 7 4 2

Read list of letters. The subject must tap with his hand at each letter A. No points if ≥ 2 errors — 1/1
[✓] F B A C M N A A J K L B A F A K D E A A A J A M O F A A B

Serial 7 subtraction starting at 100. [✓] 93 [✓] 86 [ ] 79 81 [✓] 72 74 [ ] 65 63 — 2/3
4 or 5 correct subtractions: **3 pts**, 2 or 3 correct: **2 pts**, 1 correct: **1 pt**, 0 correct: **0 pt**

LANGUAGE Repeat: I only know that John is the one to help today. [✓]
The cat always hid under the couch when dogs were in the room. ✓ — 1/2

Fluency / Name maximum number of words in one minute that begin with the letter F. ||||| [ ] ____ (N ≥ 11 words) — 0/1

ABSTRACTION Similarity between e.g. banana - orange = fruit [✓] train - bicycle [✓] watch - ruler — 2/2

DELAYED RECALL — 3/5

	(MIS)	Has to recall words WITH NO CUE	FACE	VELVET	CHURCH	DAISY	RED	Points for UNCUED recall only
Memory Index Score (MIS)	X3		✓	[ ]	✓	✓	✓	MIS = 11 /15
	X2	Category cue		✓				
	X1	Multiple choice cue				✓		

ORIENTATION [✓] Date [✓] Month [✓] Year [✓] Day [✓] Place [✓] City — 6/6

© Z. Nasreddine MD — www.mocatest.org — MIS: /15 (Normal ≥ 26/30) — TOTAL 21/30

Administered by: _____

Training and Certification are required to ensure accuracy

Add 1 point if ≤ 12 yr edu

Questions & Discussion

References

2021 Alzheimer's disease facts and figures. (2021). *Alzheimer's & dementia : the journal of the Alzheimer's Association*, *17*(3), 327–406. https://doi.org/10.1002/alz.12328

Alzheimer's Association. *About Alzheimer's and Dementia*. https://www.alz.org/

American Occupational Therapy Association. (2020). Occupational therapy practice framework: Domain and process (4th ed.). *American Journal of Occupational Therapy, 74*(Suppl. 2), 7412410010. https://doi.org/10.5014/ajot.2020.74S2001

American Occupational Therapy Association. (2019). Cognition, cognitive rehabilitation, and occupational performance. *American Journal of Occupational Therapy, 73*(Supplement 2), 7312410010. https://doi.org/10.5014/ajot.2019.73S201

Babulal, G. M., Rani, R., Adkins-Jackson, P., Pearson, A. C., & Williams, M. M. (2022). Associations between Homelessness and Alzheimer's Disease and Related Dementia: A Systematic Review. *Journal of applied gerontology : the official journal of the Southern Gerontological Society*, *41*(11), 2404–2413. https://doi.org/10.1177/07334648221109747

Barney, K. F., & Perkinson, M. A. (Eds.). (2016). *Occupational therapy with aging adults : promoting quality of life through collaborative practice*. Elsevier.

Brown, R. T., Hemati, K., Riley, E. D., Lee, C. T., Ponath, C., Tieu, L., Guzman, D., & Kushel, M. B. (2017). Geriatric conditions in a population-based sample of older homeless adults. *The Gerontologist, 57*(4), 757-766. https://www.doi.org/10.1093/geront/gnw011

Cloak N, Schoo C, Al Khalili Y. Behavioral and Psychological Symptoms in Dementia. [Updated 2024 Feb 27]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2025 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK551552/
Cordell, C. B., Borson, S., Boustani, M., Chodosh, J., Reuben, D., Verghese, J., Thies, W., Fried, L. B. (2013). Alzheimer's Association recommendations for operationalizing the detection of cognitive impairment during the Medicare Annual Wellness Visit in the primary care setting. *Alzheimer's & Dementia, 9(2),* 141-150. https://doi.org/10.1016/j.jalz.2012.09.011.

Fage, B. A., Chan, C. C., Gill, S. S., Noel-Storr, A. H., Herrmann, N., Smailagic, N., Nikolaou, V., & Seitz, D. P. (2021). Mini-Cog for the detection of dementia within a community setting. *The Cochrane database of systematic reviews*, *7*(7), CD010860. https://doi.org/10.1002/14651858.CD010860.pub3

Gordon, S.J., Grimmer, K., Bradley, A. *et al.* Health assessments and screening tools for adults experiencing homelessness: a systematic review. *BMC Public Health* **19**, 994 (2019). https://doi.org/10.1186/s12889-019-7234-y

Haskins, E. C., Trexler, L. E., Cicerone, K., Dams-O'Conner, K., Langenbahn, D., & Shapiro-Rosenbaum, A. (2012). *Cognitive Rehabilitation Manual: Translating Evidence-Based Recommendations into Practice*. ACRM Pub.

References

Haskins, E. C., Trexler, L. E., Cicerone, K., Dams-O'Conner, K., Langenbahn, D., & Shapiro-Rosenbaum, A. (2012). *Cognitive Rehabilitation Manual: Translating Evidence-Based Recommendations into Practice*. ACRM Pub.

Mahmood, Z., Vella, L., Maye, J. E., Keller, A. V., Van Patten, R., Clark, J. M. R., & Twamley, E. W. (2021). Rates of Cognitive and Functional Impairments Among Sheltered Adults Experiencing Homelessness. *Psychiatric Services*, *72*(3), 333–337. https://doi.org/10.1176/appi.ps.202000065

Mayo Clinic. (2025). *Dementia*. https://www.mayoclinic.org/diseases-conditions/dementia/symptoms-causes/syc-20352013

Quinn, T. J., Fearon, P., Noel-Storr, A. H., Young, C., McShane, R., & Stott, D. J. (2021). Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE) for the detection of dementia within community dwelling populations. *The Cochrane database of systematic reviews*, *7*(7), CD010079. https://doi.org/10.1002/14651858.CD010079.pub3

Ross, H. M., Dzenga, P., Myers, M., Squires, A., Duncan, S., Caradine, J., Scharf, P., & Bowman, D. M. (2024). Dementia and mild cognitive impairment screening in an emergency homeless shelter. *Alzheimer's & dementia : the journal of the Alzheimer's Association*, *20*(5), 3666–3670. https://doi.org/10.1002/alz.13763

Souza, A. M., Tsai, J. H., Pike, K. C., Martin, F., & McCurry, S. M. (2020). Cognition, Health, and Social Support of Formerly Homeless Older Adults in Permanent Supportive Housing. *Innovation in aging*, *4*(1), igz049. https://doi.org/10.1093/geroni/igz049

St. Louis University Mental Status Exam. https://www.slu.edu/medicine/internal-medicine/geriatric-medicine/aging-successfully/assessment-tools/mental-status-exam.php

Tanwani, R., Danquah, M. O., Butris, N., Saripella, A., Yan, E., Kapoor, P., Englesakis, M., Tang-Wai, D. F., Tartaglia, M. C., He, D., & Chung, F. (2023). Diagnostic accuracy of Ascertain Dementia 8-item Questionnaire by participant and informant-A systematic review and meta-analysis. *PloS one*, *18*(9), e0291291. https://doi.org/10.1371/journal.pone.0291291

Tuch, G., Soo, W. K., Luo, K. Y., Frearson, K., Oh, E. L., Phillips, J. L., Agar, M., & Lane, H. (2021). Cognitive Assessment Tools Recommended in Geriatric Oncology Guidelines: A Rapid Review. *Current oncology (Toronto, Ont.)*, *28*(5), 3987–4003. https://doi.org/10.3390/curroncol28050339

Additional Resources

Resources

- **Resources for Families & Caregivers**
  - **24/7 Helpline: 800-272-3900** – Support for patients and caregivers.
  - **Support Groups:** Local & online groups for advice and community support.
  - **ALZConnected®:** Online forum for dementia-related discussions.
  - **ALZNavigator™:** Interactive tool for personalized dementia care planning.
  - **www.eldercare.acl.gov or call (800) 677-1116**.
  - **Alzheimers.gov:** Provide resources from federal government agencies.
- **Advanced Care Planning:**
  - HHRC Course on Advance Care Planning with People Experiencing Homelessness https://hhrctraining.org/training-courses/training-course/70661/advance-care-planning