

GUIDE

NATIONAL
HEALTH CARE
for the
HOMELESS
COUNCIL

Dementia Screening in Community Health Centers

2026



Introduction

Dementia is the seventh leading cause of death among all diseases and one of the major causes of disability and dependency among older people globally.¹ Alzheimer's is the most common form of dementia, representing 60-70% of all diagnoses. About 1 in every 9 people age 65 and older has Alzheimer's dementia, and it's estimated about 200,000 Americans under the age of 65 develop a form of dementia per year (which is considered early-onset dementia). Experiencing homelessness appears to be both a risk factor for, as well as a possible consequence of, Alzheimer's Disease and related dementias (ADRD), however, this relationship is complex and connected to other co-morbidities and non-medical drivers of health.² Initial studies focused on cognitive impairment or dementia in homeless older adults identified that a significant proportion of this population screened positively for dementia and/or cognitive impairment.^{3,4} Studies have found a high rate of cognitive impairment (25%) among all homeless adults but note that the current evidence likely is under-representative and rates may be even higher.^{5,6}

In 2025, the Health Center Program Uniform Data System (UDS) released guidance that health center programs would need to integrate screening for dementia within clinic workflows and practices, this guidance can be found in the [2025 UDS Manual](#) (introduced in the manual on page 76). Health centers, including Homeless Health Care programs (or those who receive 330h funding), will now be required to report on dementia screenings minimally for adults 65 and older. Prior to this guidance, dementia and cognitive screening were not always a standard practice of health center care. However, this recommendation for screening aligns with health center patient population shifts, as programs are seeing an increase in the number of older adults seeking and receiving care. The UDS requirements present health centers with an opportunity to identify and address unmet health care needs related to cognition and dementia, as the presence of cognitive impairment or dementia can impact a person's physical function, behavioral health, and overall ability to manage their health. Identification of dementia and cognitive impairment can result in improved care planning and health outcomes. These conditions can also impact an individual's ability to obtain and maintain accessible, safe, and stable housing, with cognitive impairment linked to first time homelessness in an older adult population⁷, making this new UDS metric even more important and potentially impactful for Homeless Healthcare Programs.

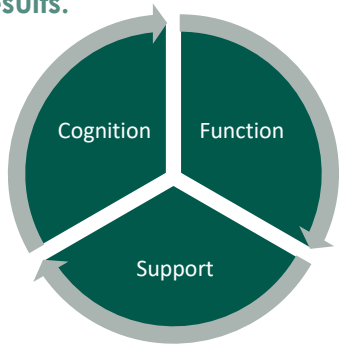
UDS Guidance

*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."

This guide is intended to build an understanding of cognition and dementia within the health center population, offer recommendations for integrating screening into the health center setting, and outline an approach for care planning based on screening results.

A comprehensive approach to evaluating, diagnosing, and creating care plans for individuals with cognitive impairment and dementia includes a focus on cognition, function, and the supports that are available to the person or might be needed to support health, safety, and independence. While the UDS requirement to screen for dementia focuses only on the first step – evaluating cognition, this guide will use the more comprehensive “cognition, function, and support” framework to structure each section.



Framework for Dementia in Health Centers

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Understanding Cognition and Dementia

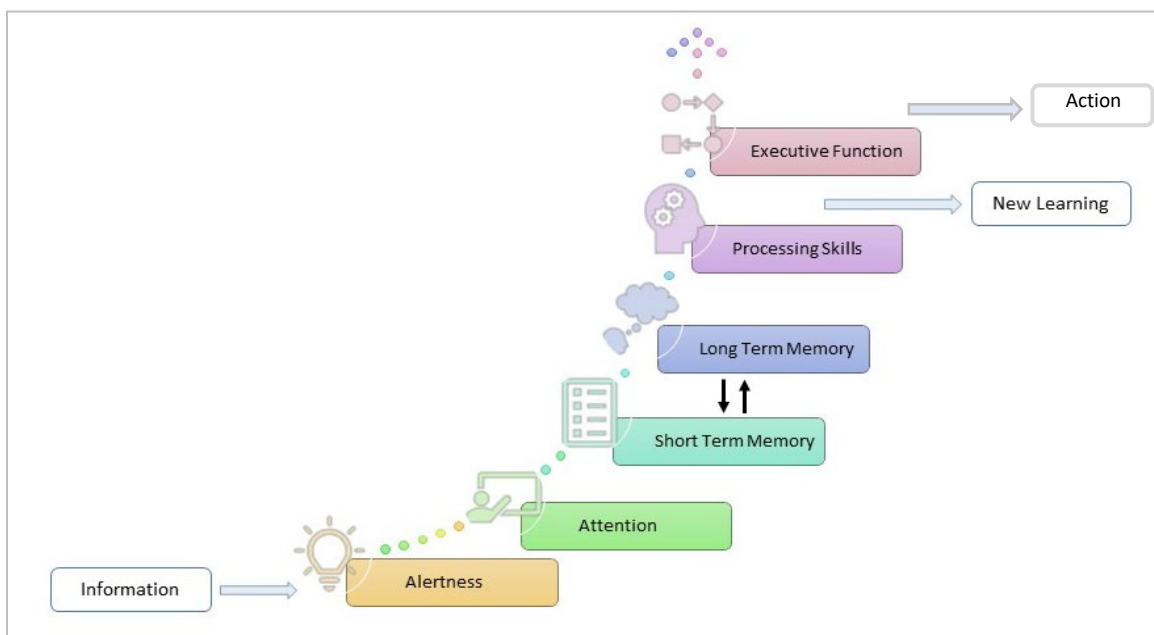
It is helpful to have a general understanding of cognition in order to both understand dementia and to be able to effectively implement and respond to dementia and cognitive screenings.

Cognition	
Cognition is generally defined as “information-processing functions carried out by the brain.” The Diagnostic and Statistical Manual of Mental Disorders (DSM) defines six key domains of cognitive function: complex attention, executive function, learning and memory, language, perceptual motor-control, and social cognition.⁸ Cognition is an underlying skill that contributes to a person's ability to do everyday activities.	Cognitive Impairment is when cognitive abilities are impaired, and a person has trouble with cognitive processing which may begin to affect the things they can do in everyday life. Cognitive impairment is a description of a symptom that manifests as a result of a variety of conditions or circumstances. Cognitive impairment can be a result of cognitive decline or can be a static symptom of a person's condition.
Cognitive Dysfunction is when cognition is functioning below expected normative levels, or loss of ability in any area of cognitive functioning.	Mild Cognitive Impairment (MCI) is the stage between the expected decline in memory and thinking that happens with age, and the more serious decline of dementia. MCI may include problems with memory, language, or judgment. MCI can affect any cognitive domain and it means that the person has appreciable cognitive decline in the abnormal range, but they have not yet experienced functional changes.
Cognitive Changes related to aging are typically more subtle or are experienced occasionally, and do not impact a person's overall ability to function within their day-to-day lives. These are often a result of changes in the brain that happen as a person ages but can be accelerated when a person has multiple health co-morbidities.	Cognitive Decline is the reduction in one or more cognitive abilities, such as memory, awareness, etc. Some cognitive decline is part of typical aging, but more severe or rapid decline could indicate the presence of an underlying neurodegenerative condition and occur alongside changes in functioning.

As described in the definition above, cognition is made up of multiple processes and functions of the brain. When we consider how cognition impacts a person's ability to do everyday activities and learn information, it is helpful to understand how different components of cognitive skills build on each other to allow an individual to engage in and respond to everyday life activities. The visual below illustrates this concept, and although is not comprehensive of all cognitive functions (such as speech). The components within the illustration are those most frequently assessed by cognitive screening tools, including those that

screen for dementia, and are typically most observable and noticeable by the individuals themselves. The cognitive components listed (alertness, attention, memory, information processing, and executive functioning – defined in [Appendix A](#)) are listed in order of complexity – thus, in order to use the more complex skills (e.g. executive functioning), the preceding skills must also be in place.

Flow of Cognition



Many factors can impact a person's cognitive functioning. These impacts may be temporary or long-standing depending on the cause. [Medical conditions that can impact cognition](#) but do not typically result in a progressive downward trajectory like a neurodegenerative disease, include:

- Traumatic brain injury
- Acquired brain injury
- Syphilis
- Other neurological conditions
- Metabolic conditions
- Chronic conditions
- Acute and chronic pain
- Developmental delays
- Mental health symptoms
- Active and/or a history of substance use
- Medical interventions
- Being treated in an intensive care unit
- Hearing and/or vision loss
- Sleep apnea

Although there are a multitude of medical causes for cognitive impairment, a person's cognition is also significantly impacted or worsened by their environment. Many environmental and circumstantial factors affect cognition, and the following are more likely to be encountered by people who don't have stable or safe housing. These factors should be taken into consideration when interpreting cognitive screening tests and making a diagnosis of MCI or Dementia.

Environmental factors for consideration include:

- Unstable, unsafe, or inadequate housing
- Poor nutrition/lack of access to food
- Sleep deprivation
- Recent stressful or traumatic events
- Chronic stress
- Low literacy

Cognitive impairment is an outcome of a range of medical and environmental conditions. Neurodegenerative diseases, including the dementia syndromes listed below, are one of many possible medical conditions that can cause or contribute to cognitive impairment. Differentiating these terms is important, as cognitive impairment (which is a symptom) is not equivalent to dementia or Mild Cognitive Impairment, which are diagnosable syndromes. Screening tools often identify the areas of cognition that have been affected or contribute to impairment, which can be a helpful tool when exploring potential causes or diagnoses following screening.

The next table introduces the types of neurodegenerative diseases that cause dementia. Each type of dementia will initially present differently with a specific range of symptoms and functional impacts. Over time, all of these conditions cause impairment in all cognitive domains. Familiarity with the types of dementia is important for the diagnostic process and the person's potential trajectory.

Neurodegenerative Diseases

Neurodegenerative diseases are conditions that gradually damage and destroy parts of your nervous system, especially areas of your brain. These conditions usually develop slowly, and the effects and symptoms tend to appear later in life.

Dementia

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

Some of the diseases that cause dementia syndromes are called "dementia" as well.

Alzheimer's Disease is the most common form of neurodegenerative disease that leads to dementia. Early on, it most prominently causes short term memory loss, and over time affects all areas of cognition including executive function and behavior. This is a gradually progressive condition.

Frontotemporal Dementia is a type of neurodegenerative disease that is caused by a group of disorders that gradually damage the brain's frontal and temporal lobes. These damages first cause changes in thinking and behaviors. Early symptoms can include unusual behaviors, emotional problems, trouble communicating, challenges with work, and difficulty with walking.

Lewy Body Dementia is also known as dementia with Lewy bodies, is the second most common type of progressive neurodegenerative disease after Alzheimer's disease. Protein deposits, called Lewy bodies, develop in nerve cells in the brain regions involved in thinking, memory and movement (motor control). Lewy body dementia causes a progressive decline in mental abilities. People with Lewy body dementia might have visual hallucinations and changes in alertness and attention. Other effects include Parkinson's disease signs and symptoms, such as rigid muscles, slow movement, walking difficulty and tremors.

Vascular Dementia is a general term describing problems with reasoning, planning, judgment, memory and other thought processes at the level of dementia impairment caused by brain damage from impaired blood flow to the brain, most commonly, but not always, caused by a stroke.

Mixed Dementia is a dementia condition characterized by symptoms and abnormalities of more than one type of dementia at once. Usually, mixed dementia entails a combination of Alzheimer's disease and vascular dementia.

Reversible dementia is the type of dementia that can be partially or completely cured through treatment and proper management by targeting the underlying cause. This is very rare.

A person's cognition has an influence both on their physical function as well as their overall behavioral health. Movement, or motor actions, are directed by the brain and areas of the brain that also control cognition. An injury to one area of the brain (such as a brain injury) may impact both someone's physical function and aspects of their cognition. Cognitive skills also affect how a person is able to plan for and follow through on movement, and the ability to recognize the need for and implement strategies for safety or to compensate for physical limitations. Like physical function, the areas of the brain that regulate emotions and behavior also overlay with areas that control cognition. Impacted or decreased cognitive skills are symptoms of many behavioral health conditions, and a change in brain health can simultaneously result in changes to emotional/behavioral regulation and cognitive skills. Additionally, many people's behavioral health symptoms will be exacerbated by changes in cognition; for example, anxiety can increase when someone is aware they are experiencing challenges or changes in their memory.

Practically, what is seen by health center providers and by the individuals themselves will be changes or impacts to the person's "functioning," or, their ability to participate in day-to-day activities. Functional activities that are often most observable by clinicians and are a top priority to health center clients include activities or daily living (ADLs) or instrumental activities of daily living (IADLs), which are defined in the next two figures:

Activities of Daily Living (ADLs)

Activities oriented toward taking care of one's own body and completed on a routine basis.¹⁰
ADLs include:



Bathing/
Showering



Toileting/Toilet
Hygiene



Dressing



Feeding



Eating &
Swallowing



Functional
Mobility



Personal Hygiene
& Grooming



Sexual Activity

Instrumental Activities of Daily Living (IADLs)

Activities to support daily life within the home and community (which often require more complex interactions than those used in ADLs).¹⁰

IADLs include:



Home Management



Meal Preparation



Financial Management



Driving & Community Mobility



Shopping



Caregiving



Communication



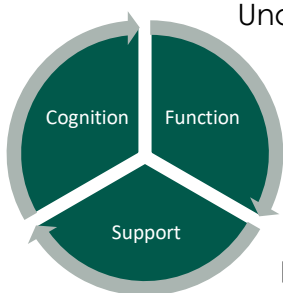
Safety & Emergency Maintenance



Health Management

Changes in ADL or IADL can be key indicators that someone may be experiencing changes in their cognition and can be a helpful way to conceptualize a person's changes in "function".

Understanding how cognition impacts ADL and IADLs is also helpful in identifying support strategies that can be implemented to help the person engage in their health care and follow through on their health care plan, as well as strategies to support transitions into housing and other community living environments. Although cognitive screening tools, such as those used for dementia, do not assess functional skills such as ADL or IADL, a person's results on the cognitive screening can help guide providers in identifying next steps and explore where the potential cognitive impairments may be creating barriers in the person's life, as manifestations of cognition's impact on function will be individual to each client. For example, if cognition is impacting IADLs, a person may need more support to be able to manage these tasks in the community, such as paying bills or cleaning their home, which are essential skills for housing stability.

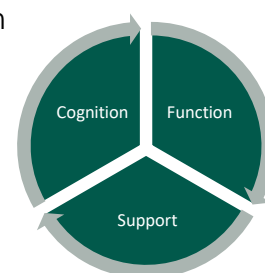


Integrating Dementia Screening into Health Center Settings

Who Should be Screened and When

As shared in the introduction, dementia is a leading cause of morbidity and disability in older adults in general, with homeless older adult populations having higher rates of both cognitive impairment and dementia compared to the general population. Like other clinical screening tools, the goal of the UDS Alzheimer's Disease and Related Dementias (ADRD) Screening metric, is to identify symptoms of cognitive impairment early or when individuals do not recognize or self-report evolving cognitive symptoms. Integrating dementia screening into the health center setting will allow clinicians to engage in early interventions: evaluating the cause of cognitive decline, treating reversible or contributing causes of dementia, assessing impact on functioning, developing individualized tailored treatment plans, and proactively engaging in advanced care and community safety planning, and support enhancements. From a Homeless Health Care clinical care perspective, the new dementia screening metric provides an opportunity to identify homeless individuals with mild cognitive impairment, in addition to those with dementia, who can benefit from additional support and tailored medical care plans, as an important strategy to support health, safety, and community independence. The UDS metric focuses on screening adults 65 and older. Given the prevalence of premature geriatric conditions in homeless individuals age 50 and older⁹, clinics can opt to adopt a younger age cutoff for routine cognitive screening to better meet the needs of their community. Finally, at the health center level, population level information from universal screening can help justify the resources needed to support the growing aging population.

While the new UDS metric focuses solely on the cognitive screening step, the diagnostic and care planning approach outlined below will incorporate cognition, functioning, and support needs considerations.



Screening Tools

A number of cognitive and dementia screening tools are used in clinical practice. Each tool assesses slightly different cognitive domains. Most tools provide a score that is stratified into ranges – normal range, mild cognitive impairment range, or dementia range. UDS lists 10 dementia screening tools that can be used by health centers to meet the Alzheimer's Disease and Related Dementias (ADRD) Screening metric. The next chart summarizes 7 of the recommended tools that are most applicable to health centers. The information in this chart can help clinicians and health centers choose the screening tool that is most useful for their specific population, interdisciplinary team structure, and care settings.

When selecting the right tool for your health center, it is important to consider which team members will be responsible for administering the screening tool and how screening will fit into overall clinical workflows. Helpful considerations include reviewing your team-based care structure and capacities, current workflow for screening tools, ability to train staff from a variety of disciplines to use and administer a new tool, and anticipated workflow for responding to positive screening results. There may also be institutional preferences for a specific tool. Consistency, and the ability to track changes in screening tool performance overtime, can be very helpful. Finally, it is important to consider how test results will be uploaded to your electronic health record (EHR) in a way that allows information to be visible and tracked over time.

Name of tool	What it assesses:	Who can administer:	Length of Test:	Notes & Homeless Population Specific Considerations
Mini-Cog	Uses a 2 question test to assess • Visuo-spatial skills • Executive function • Memory	Any member of the team	3 minutes to complete	• Has been utilized in a study with formerly homeless adults
	Where to find it: Mini-cog PDF			
	Borson, S., Scanlan, J. M., Chen, P., & Ganguli, M. (2003). The Mini-Cog as a screen for dementia: validation in a population-based sample. <i>Journal of the American Geriatrics Society</i> , 51(10), 1451–1454. https://doi.org/10.1046/j.1532-5415.2003.51465.x			
Montreal Cognitive Assessment (MoCA)	Screens for mild cognitive impairment (MCI) by assessing multiple domains: • Visual-spatial/Executive functioning • Naming • Memory • Attention • Language • Abstraction • Orientation	Staff who have completed the training	10-15 minutes to complete	• May need to use adjusted cut-off score to avoid false positives among homeless population • Requires paid training to be able to administer and score • Not validated but has been used with homeless population in studies • Adapted versions are available for individuals who are blind or have limited educational background.
	Where to find it: MOCA			
	Nasreddine, Z. S., Phillips, N. A., Bédirian, V., Charbonneau, S., Whitehead, V., Collin, I., Cummings, J. L., & Chertkow, H. (2005). The Montreal Cognitive Assessment, MoCA: a brief screening tool for mild cognitive impairment. <i>Journal of the American Geriatrics Society</i> , 53(4), 695–699. https://doi.org/10.1111/j.1532-5415.2005.53221.x			

Name of tool	What it assesses:	Who can administer:	Length of Test:	Notes & Homeless Population Specific Considerations
St. Louis University Mental Status Examination (SLUMS)	Evaluates cognitive function through multiple domains: • Visuospatial/Executive functioning • Short term memory • Working Memory • Delayed recall • Calculation • Language/verbal fluency • Orientation	Staff who have completed the annual training	7-10 minutes to complete	• Free annual training available at https://www.youtube.com/watch?v=z4ctoWU-qzw&feature=youtu.be • Assesses similar domains to the MoCA but is free along with free training to use the tool • Not validated for homeless-population or people under the age of 59 • Has been used in homeless services settings but not evaluated in a formal study
	Where to find it: SLUMS			
	Tariq, S. H., Tumosa, N., Chibnall, J. T., Perry, M. H., 3rd, & Morley, J. E. (2006). Comparison of the Saint Louis University mental status examination and the mini-mental state examination for detecting dementia and mild neurocognitive disorder--a pilot study. <i>The American Journal of Geriatric Psychiatry</i> , 14(11), 900–910. https://doi.org/10.1097/01.JGP.0000221510.33817.86			
Mini-Mental State Examination (MMSE)	Evaluates cognitive function through multiple domains: • Orientation • Registration • Attention & Calculation • Recall • Language • Visual-spatial	Trained clinicians	5-10 minutes to complete	• Has not been well validated for non-Alzheimer's dementias • Has been validated worldwide, but not specifically with the homeless population
	Where to find it: MMSE			
	Folstein, M. F., Folstein, S. E., & McHugh, P. R. (1975). "Mini-mental state". A practical method for grading the cognitive state of patients for the clinician. <i>Journal of Psychiatric Research</i> , 12(3), 189–198. https://doi.org/10.1016/0022-3956(75)90026-6			

Name of tool	What it assesses:	Who can administer:	Length of Test:	Notes & Homeless Population Specific Considerations
Blessed Orientation-Memory-Concentration Test (BOMC)	6 item test that assesses • Memory • Orientation • Concentration	Clinical and non-clinical staff	5 minutes to complete	• Adapted from the longer (29-item) Blessed Information-Memory-Concentration (BIMC) test • Sensitive to early cognitive changes associated with Alzheimer's disease • Tool has not been used with homeless-population in formal studies
	Where to find it: BOMC Test			
	Katzman, R., Brown, T., Fuld, P., Peck, A., Schechter, R., & Schimmel, H. (1983). Validation of a short Orientation-Memory-Concentration Test of cognitive impairment. <i>The American Journal of Psychiatry</i> , 140(6), 734–739. https://doi.org/10.1176/ajp.140.6.734			
Short Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE)	Informant-based questionnaire comparing current performance with performance 10 years ago that assesses the following domains • Memory • Language • Executive Function • Visuospatial Skills • Calculation	Completed by a relative or friend who has known the elderly person for at least 10 years	10-15 minutes for informants to complete	• Can be combined with other cognitive screening tools to enhance diagnostic accuracy • Has been used in community but not documented for use with homeless-populations • May be a challenge in health centers due to reliance of report by a support person or family member that has known the person for 10 years
	Where to find it: Short IQCODE			
	Jorm A. F. (1994). A short form of the Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE): development and cross-validation. <i>Psychological Medicine</i> , 24(1), 145–153. https://doi.org/10.1017/s003329170002691x			

Name of tool	What it assesses:	Who can administer:	Length of Test:	Notes & Homeless Population Specific Considerations
Ascertain Dementia 8 (AD8) Questionnaire	8-item yes/no questionnaire that can be administered to the person or a caregiver that assesses the following domains: • Judgment & Problem Solving • Interest/Motivation • Repetition • Learning/Adaptation • Orientation • Memory • Daily Functioning	Any team member	3 minutes to complete	• Caregiver version has been found to be more accurate • Can be combined with other cognitive screening tools • Has not been used with homeless-populations • May present a challenge in health centers due to its reliance on caregiver reports
	Where to find it: AD8			
	Citation: Galvin, J. E., Roe, C. M., Powlishta, K. K., Coats, M. A., Muich, S. J., Grant, E., Miller, J. P., Storandt, M., & Morris, J. C. (2005). The AD8. <i>Neurology</i> , 65(4), 559-564.			

Clinical Follow-up to a Positive Screening

A clinician should review and evaluate all dementia screening results that suggest any degree of cognitive impairment. A 'positive' result on a screening tool is not sufficient to identify a neurodegenerative disease or make a dementia diagnosis. A dementia diagnosis requires a comprehensive clinical evaluation, which includes a thorough history, in-depth cognitive evaluation, laboratory studies, neuro-imaging, functional assessment, and a review of community support needs. A positive result also does not necessarily indicate **new** symptoms or a **new** diagnosis of cognitive impairment. A positive screen also does not indicate that someone is unable to live independently in the community. For example, an individual may have been navigating safely in the community with mild cognitive impairment for an extended period of time prior to being screened. Rather, screening provides an opportunity to document cognitive status at a specific moment in time. Evaluating functioning and community safety with existing supports are essential parts of this assessment.

Follow-up care should focus on a person's overall brain health and balance the resources and care that are available to the person and make the most sense in the health center environment alongside the most prevalent medical, functional, and support needs identified by both the individual and the clinician working with them. The follow-up clinical assessment helps flush out the larger context and trajectory of symptoms. The assessment processes outlined below do not and realistically cannot happen all at one time and can take several months to over a year to complete. Many of the positive screens in the health center setting will identify individuals with mild cognitive impairment or early dementia. **It is important to consider two key questions after a positive screen to help with the triage process – 1) has there been concerning progression over time and 2) has the level of cognitive impairment impacted your patient's ability to safely and independently function in the community.** These questions can help providers determine which level of support individuals need more urgently and how to triage additional diagnostic resources and community supports.

The following chart outlines the elements of the clinical evaluation that should follow a positive screening test. The [Alzheimer's Association](https://www.alz.org/) offers practice guidelines for following up on positive screening. This chart offers considerations focused specifically on an approach for the homeless populations. Since a comprehensive evaluation takes time, in many instances up to a year, clinicians should prioritize items that evaluate for 'red flags' or can quickly guide a 'brain health' treatment plan.

Clinical Evaluation following positive screen in health center (recommendations):

History: collected via interview or chart review

- ☐ Physical health
- ☐ Mental health history
- ☐ Traumatic brain injury (history or recent)
- ☐ Timeline for and progression of cognitive symptoms
- ☐ Prescription and over-the-counter medication review
- ☐ Sleep history
- ☐ Substance use history
- ☐ Developmental history

Physical Exam

- ☐ Full neurological exam
- ☐ Evaluate for infection
- ☐ Functional assessments as relevant*
- ☐ Vision screening[†]
- ☐ Hearing screening[†]
- ☐ Depression screening[†]
- ☐ Brain injury screening to identify possible history of head injury
- ☐ Repeat cognitive screening if there is concern that sleep deprivation, physical illness, behavioral health (BH) conditions impacted initial screening results

Laboratory Studies: to identify possible reversible causes of dementia

- ☐ TSH (Thyroid Stimulating Hormone)
- ☐ B12 (vitamin deficiency)
- ☐ RPR (syphilis screen)
- ☐ HIV
- ☐ CBC (complete blood count)
- ☐ Comprehensive metabolic panel
- ☐ ESR (test for general inflammation)

Imaging/Studies: Review imaging with EHR. Can consider:

- ☐ Non-contrast head CT
- ☐ Brain MRI
- ☐ Formal neuro-psychiatric testing
- ☐ Audiology referral

Collateral Information: Attempt to collect collateral information on noticeable change in mood, cognition, safety, and self-care from:

- ☐ Family
- ☐ Friends
- ☐ Case managers or care coordinators
- ☐ Care partners
- ☐ Shelter or permanent supportive housing staff

* See [Appendix B](#) for suggested functional assessments.

† Routine primary care screening such as the Snellen Test

The goal of the comprehensive clinical evaluation is to determine if the cognitive screening results reflect mild changes in cognition that can be part of the regular aging process, mild cognitive impairment, environmental factors, other conditions (such as brain injury), or progressive dementia that is impacting social activities, occupational functioning, and daily activities. The evaluation helps to identify mitigatable factors contributing to cognitive decline such as metabolic conditions, nutritional deficits, infection, medication side effects, and sleep disorders. The evaluation can help identify the specific cognitive domains that are impacted, information that can help guide personalized clinical care and community safety planning. Finally, the evaluation helps identify the functional impacts of these cognitive changes and which community supports would be most helpful in maintaining safety and independence.

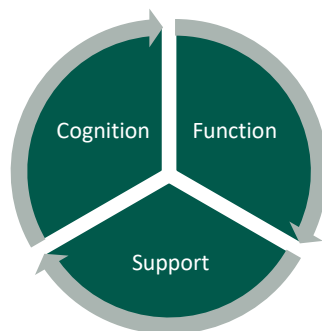
Developing an Effective Workflow

Health centers will need to identify an effective workflow to systematically identify and screen clients. Once a screening tool has been selected for the health center, programs need to determine who will be administering the screening and what indicators will prompt providers to complete the screening, and what type of visits the screening will occur during. Following that, workflows should include how and where providers document findings, identify and complete action items, and integrate findings into the client's care plan.

For example, a health center may opt to automatically screen all individuals age 60 and over, with the screening completed by the nurse during a standard medical visit with a provider. The provider will then review, interpret, and make a follow-up care plan and referrals based on the screening results. This health center may also encourage providers to additionally screen those younger than 60 who present with symptoms or indicators of cognitive impairment or dementia.

The health center and its providers will also need to develop a workflow to respond to the results of the screening. As with any screening tool, it is best practice to ensure providers are equipped with resources and processes to respond to screening results, and not just to screen for the sake of screening or to simply meet UDS requirements. In addition to the Clinical Follow-up described in the previous section, providers will also want to consider which resources the person may need to connect to and/or referrals to make. Connection to resources will be individual to each health center's community and what is available to older adults and/or people with cognitive impairment or dementia.

Depending on the health center structures and what is available in the community, internal and external referrals can address cognition, function, and community supports.



Cognition:

- Neuroimaging and lab work not able to be completed within health center setting (as applicable)
- Neuropsychiatric assessment

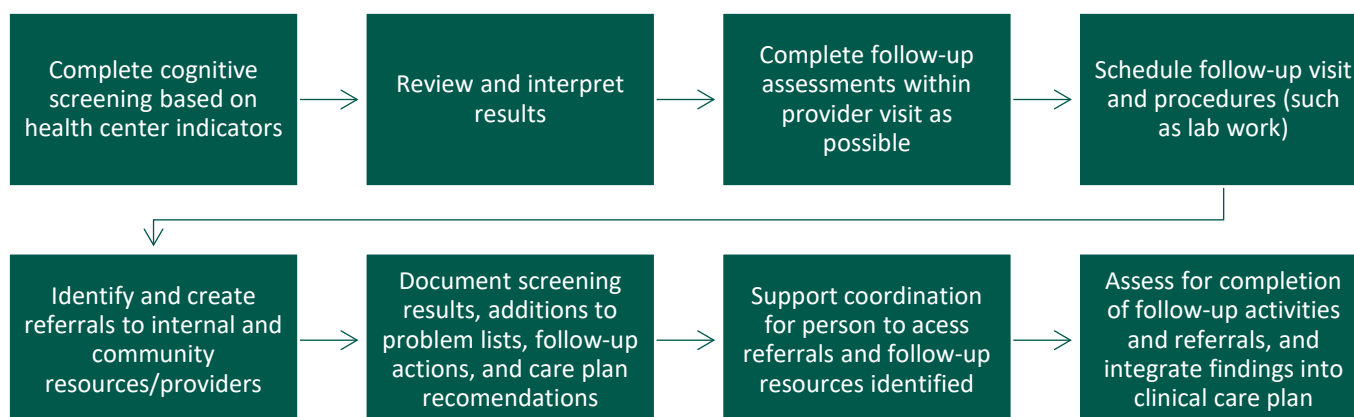
Function:

- Occupational therapy for assessment of function and recommendations for accommodations and housing supports
- Speech language pathologist to assess and address impacts on communication, language, and other cognitive skills
- Resources to support vision and hearing aid assessments and related Durable Medical Equipment (DME)

Supports:

- Case management for additional support to navigate systems and follow through on external referrals
- Community Health Workers to address challenges in the community, such as providing support for transportation, accompanying the person to medical appointments and helping record information
- Geriatric or specialty teams focused on older adults, dementia, and brain wellness
- In home support and/or caregiver services
- Financial management supports

Some of these resources, such as access to formal neuropsychiatric testing, may be limited within your community. Other recommendations, such as referrals to specialty testing or imaging, may be hard to coordinate. Since evaluation can occur overtime and in phases in some cases, connection to case management or community health workers will be a necessary first step to support follow-up with additional referrals and recommendations. This is especially important when the individual's cognitive impairment may affect their ability to initiate and follow through on these referrals and activities.

Overview of screening process for providers within health center setting

Documentation and Meeting UDS Requirements

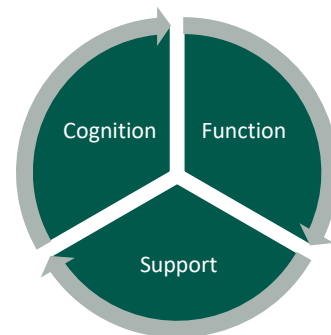
Documentation of screening results are important both for health centers to meet UDS requirements and to provide appropriate medical/clinical care. As discussed previously, providers should not add a dementia diagnosis to a person's problem list based on the cognitive screening alone. However, based on the tool used and information gained, providers may add other diagnostic codes such as G31.84 (mild cognitive impairment, unspecified) if providers have enough information to diagnose, or add to the problem list based on specific areas identified on the screening (e.g. R41.840 attention and concentration deficit). Needed referrals and resources should also be documented and flagged for care team members to see, identify, and respond to as needed.

Providers may also want to include recommendations based on information gained from the screening to support the person's engagement in care and care plan. Health centers can work with dementia specialists or rehabilitation providers (such as occupational therapy practitioners) to create a drop-down menu with basic recommendations and accommodations that can be communicated across the care team. For example, if a client scores low in the memory portion of the assessment, recommendations for care planning might include "The person may need appointment reminders" or "The person may need information repeated multiple times." These additions will help health center providers go beyond meeting basic requirements for screening to improving care for older adults, people with cognitive impairment, and dementia by 'brain health' related strategies directly into workflows.

Finally, health centers will want to use existing processes to extract data from their EHR to report to UDS, aligning with the requirements described previously.

Using Information Gained from Screening

As identified in previous sections, the goal and role of a cognitive screening tool is not to provide a firm and final diagnosis, but rather to identify individuals who need further assessment. However, there is a wealth of information that can be gained and explored once the screening is completed and while further diagnostic activities are underway. In addition, if follow-up evaluations do not identify the person has dementia, the results from the cognitive screening can still be used to facilitate improved health and housing outcomes for clients. In some cases, areas of cognitive impairment may be hindering a person's ability to effectively engage in health care services; in other cases, the person may have developed compensatory strategies independent of clinical interventions and be functioning and managing daily demands. This section will explore ways that health centers can support all clients across areas of cognitive impairment, regardless of diagnostic cause.



Strategies for Supporting Clients

When a screening indicates the presence of cognitive impairment, providers can take a “universal precautions” approach to accommodate for impacted cognition (supporting function), while continuing with medical care to identify the cause of the impairment and related diagnoses. Taking a universal precautions approach also aligns with [health literacy best practices](#) and helps providers and organizations accommodate a range of cognitive needs. These basic accommodations are compensatory strategies, or strategies that provide a mechanism to enable a person to complete a functional activity more independently. Within the context of the health center, the strategies suggested in this document will focus on assisting the person to engage with health care providers and complete health management tasks^{‡, 10}

It's important to remember that people may not know what strategies would be helpful or may be uncomfortable asking for help. Providers can approach this by integrating the recommended strategies within all encounters (universal precautions) and presenting additional strategies routinely during their visits. For example, a provider might say “A lot of people find it helpful to take notes during their doctor's appointments. Would you like a notebook to write down information from today? I'm also happy to write the information in the notebook if that's helpful.” In this example, the strategy is being presented as something commonly used, with different options the person can select, which can minimize internal stigma or discomfort, and may also be helpful for those that have decreased awareness about their skills. Basic strategies to support people with cognitive impairment are listed in the next table.

[‡] Health management is defined as “activities related to developing, managing, and maintaining health and wellness routines, including self-management, with the goal of improving or maintaining health to support participation in other occupations (daily life activities).” This includes activities such as medication management, symptom management, attending appointments, etc.

Strategies for Supporting People with Cognitive Impairment

Strategy	How to do it	Examples
Checking for comprehension	Instead of asking the person yes/no questions or “if they understand,” ask them to: - Summarize the instructions or information using their own words - Show you how to do what you instructed	“I want to be sure I was clear. Can you tell me what you understood?” “Can you summarize what we did or talked about today?” “We’ve talked about a lot of things today...what do you think was most important?”
Simplify instructions	When doing a complicated or new task: - Provide the instructions only 2-3 steps at a time - Allow the person the opportunity to follow the steps before continuing - Fix mistakes as they happen to ensure the person learns the steps correctly	“First, you take the cap off the inhaler and the spacer. Then, you shake the inhaler about 10 times. Now, you show me those steps.” (Additional steps can be presented once the person is able to follow the first two steps).
Repeat information	Review and repeat important information during and across visits: - Ask the person to demonstrate and repeat back information - Use verbal and visual instructions, or narrate while demonstrating to reinforce information - Check information at multiple points during the interaction	“I’m going to change the dose, so now you’ll take the medication in the morning when you wake up and then when you go to sleep at night. When will you take the medication?” At the end of the visit “Tell me again when you’ll be taking the medicine?”
Provide Handouts	Provide written instructions that are: - Written at a 6-8th grade reading level, using plain language and avoiding medical jargon when possible - Offered in large print (at least 16-point font) - Include only the most relevant information	A 1-page hand-out that simplifies colonoscopy preparation instructions. A medication list with pictures of the medication and exact times to take the medication. Example resource on diabetes risk.

Strategy	How to do it	Examples
	• Use easily identifiable visuals or pictures • Link videos or demonstrations that a person can reference later	(For more guidance on creating accessible resources, please see the Creating Accessible Printed Resources guide)
Provide tools to organize health information	Support the client in organizing information to help them remember and reference it. Health centers can increase access to these tools by providing and support clients to use: • Labeled or color-coded folders • Notebooks to record information, take notes, and write questions ahead of time • Appointment cards or pocket notebooks	Create health management booklets for the organization that all providers can use and contribute to. Use simplified medication trackers to organize medication information and dosing. Provide appointment reminders for upcoming appointments.
Increase capacity of providers to provide support	Consider how staff can be a support: • Increase the availability of staff and providers to spend more time with patients to allow for teaching and use of strategies • Develop provider roles that can assist with health management activities • Allow more frequent visits to help with repetition and practice of skills	Community Health Workers who can accompany patients to outside appointments and referrals. Registered Nurses (RNs) who can provide medication education and pillbox support. Use pharmacies that can provide medications in blister packs or weekly medication refills.

This is a small sampling of different strategies that can be used to accommodate cognitive impairment within the health center setting. For people with dementia specifically, compensatory strategies can be helpful for a duration of time before the disease progresses. With dementia, patients will be less likely to learn new skills but will be responsive to more direct instructions and support, or with strategies that are familiar and have been used before. With other types of cognitive impairment, using strategies over time can result in improved skills and in some cases improved cognition.

(For more recommendations on addressing health management skills and using adaptive or compensatory strategies, please see the [NHCHC Health Management Toolkit](#)).

Although these strategies can support individuals in engaging in health care services, when possible, clients should be referred for specialty services that can do more comprehensive assessment of the impact of the cognitive impairment on all or other areas of function (such as ADL or other IADL) and provide opportunities for skill building and to develop more personalized strategies. Often occupational therapy practitioners or speech language pathologists are skilled in assessing and addressing various areas of cognitive impairment and functional skills. This will be additionally helpful to address skills outside of the health care/clinical context, and to support clients as they transition into or maintain housing.

Adapting Medical Care Plans to Support Individuals with Cognitive Impairment

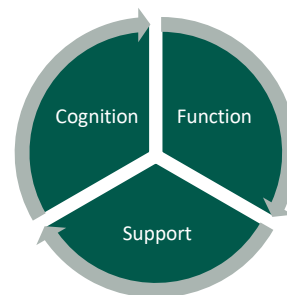
Clinicians and care teams can take a similar “universal precautions” approach to adapting the approach to clinical care for individuals with cognitive impairment. Recommendations that can apply to all clients, but especially benefit those with cognitive impairment or dementia include:

Prioritize Medication Safety	Partner Robustly with Community Supports
- Engage in regular medication reviews with a focus on medications that can impact cognition or are riskier for older adults. The ABC Calculator support medication reviews and offers a list of high-risk medications - Simplify dosing schedules - Deprescribe when appropriate, especially if there are medications that are known to cause confusion or are flagged to be less safe for older adults - Prioritize non-pharmacologic interventions for behavioral and psychological symptoms	- Adapt care plans to meet the level of community support available - Consider referrals for additional support via case management, health aid, financial support, etc. - With permission, establish bi-directional communication to request feedback on community navigation, safety considerations, and additional community support needs
Engage in Advance Care Planning Early	Regularly Evaluate the Success of the Care Plan & Simplify Care Plans for All Comorbidities
- Identify surrogate decision makers - Explore core values - Initiate the Advance Care Planning process even before there are signs or symptoms of dementia, cognitive impairment, or other conditions that would lead to palliative or end-of-life care needs - Know the local laws and processes for determining and formalizing medical powers of attorney	- Explore difficulties with case management - Carefully monitor for further cognitive decline over time - Monitor for changes in ADL/IADL capacity over time - Pursue additional cognitive testing, such as neuropsychiatric testing if not initially available, when symptoms are progressive, there are evolving safety concerns, or this additional information can assist with appropriate placement

Longitudinal Care Planning

Considerations for Shelter and Housing Support

The impact of cognition on function will be individual for each person, based on the cause and duration of the cognitive impairment, and the life experiences the person has had.⁷ It should not automatically be assumed that lower scores on cognitive screening tools mean that the person is unable to care for themselves or participate in community living. Often individuals with cognitive impairment (not related to dementia) have the capacity to learn new skills, use compensatory strategies, and engage in familiar and routine activities. Longitudinal care planning also integrates the model of cognition, function, and supports.



Existing environmental factors can significantly exacerbate cognitive difficulties that might be caused by a medical condition. Some cognitive issues may also be resolved once the person is within a safe environment and able to get adequate sleep and meals, or with the treatment and resolution of a medical condition. Thus, the transition into supportive and stable housing may result in an improvement in cognition for individuals who have been homeless. Further, individuals who have been living with cognitive impairment for some time may have already adopted strategies or know what supports would be helpful and may currently be limited in using them due to being homeless. While homeless, people often have minimal control over their environment and limited opportunity to use strategies that could be helpful. Housing allows the opportunity to use and implement strategies and increases opportunity and access to additional supports such as caregivers that are not available in the shelter or unsheltered setting.

Ideally, following a cognitive assessment, individuals will have an opportunity to participate in additional assessments and conversations regarding their functional skills to determine the impact of cognition on their function, along with identifying supports and strategies that can allow them to better participate in health and shelter services or transition into housing. The person may initially benefit from a higher intensity of compensatory supports combined with skill building, with the intensity of support decreasing over time as the person becomes more independent in their skills. These supports can be in the form of environmental strategies, or by integrating different services or staff that can provide a variety of support types. In some cases, this can also include education for family or other social supports the person has available. There are some cases in which the person would likely benefit from ongoing support (e.g. rep payee services) for specific activities but will be able to self-manage others (e.g. home cleaning). Ideally, the person's housing services will be able to identify and implement an individualized support plan based on the person's experience and needs.

Dementia Specific Considerations

Different than other types of cognitive impairment, dementia is a progressive condition, that, at this time, has no cure. Individuals with dementia will experience a progression of symptoms that often coincide with a decline in skills and that will impact all domains for cognition over time. It is helpful for teams to know indications for further workup and specialty referrals. It is also important to have realistic expectations for what people with dementia will be able to learn and do, including their ability to engage with behavioral agreements and expectations, especially in new environments. Progressing cognitive symptoms should impact the course of

care planning, including identifying housing supports that are the safest and most realistic for clients.

Indications to Refer Individuals to Specialized Care

Care teams should consider referring individuals for specialized care and consider more supportive placement options (such as long-term care or assisted living) for any of the following:

- **Worsening Behavioral and Psychological Symptoms:** Individuals with dementia may exhibit neuropsychiatric symptoms such as delusions, hallucinations, apathy, anxiety, depression, or disinhibition. These behaviors can significantly impact their quality of life and may require specialized interventions. Given the underlying drivers of these symptoms, non-pharmacological approaches to addressing behavioral concerns should be implemented before the use of any pharmacological agents, which may be more challenging in non-skilled settings.
- **Increased Fall Risk:** Dementia can heighten the risk of falls due to factors like impaired judgment, balance issues, and medication side effects. Falls can lead to serious injuries, making it essential to address this risk promptly.
- **Significant Cognitive Decline Affecting Safety:**
 - Unable to adhere to behavioral agreements, program requirements, or care plans that address safety or behaviors.
 - Wandering and Getting Lost: Individuals may leave home and become disoriented, increasing the risk of harm.
 - Forgetting to Turn Off Appliances: This can lead to household hazards, such as fires.
- **Uncontrolled Sleep Disturbances:**
 - Increased nighttime confusion or restlessness (sundowning).
 - Insomnia or excessive daytime sleepiness leading to disorientation
- **Unmanageable Dependency in Activities of Daily Living (ADLs):** As dementia progresses, individuals may struggle with basic self-care tasks such as bathing, dressing, toileting (including worsening incontinence), and eating. When caregivers find these dependencies overwhelming, seeking additional support becomes necessary.
- **Caregiver Burnout:** Caregivers experiencing extreme stress, anxiety, or physical exhaustion may struggle to provide adequate care.
- **Resistance to Care.**
- **Declining Assistance with ADLs or Medical Treatment.**
- **Increased Agitation or Aggression toward Caregivers.**

Shelter and Housing Considerations for Dementia

Long-term care and support planning for people with dementia will look different than someone living with other forms of cognitive impairment. It is important to keep in mind that once a person has been diagnosed with a form of dementia, there will be a point at a minimum they will require at least intermittent daily supervision; the need for supervision will increase as their disease progresses. Considerations for long-term planning for dementia include:

- Identifying a support network to ensure they will go to all medical appointments and follow-up care.
- Monitoring and determining when they no longer have decision making capacity and may need guardianship or conservatorship.
 - Ideally this would be determined with the person early in their diagnosis and disease progression, but providers should be familiar with this process in the case the person is likely unable to proactively engage in this process.
- Transitioning to a living environment with increased supports in place to safely engage in daily activities.
- Connecting the person to intensive ongoing community supports, such as intensive case management, Adult Protective Services, or local Home and Community Based Services.
- When and where to transition the person to a higher level of care when it is determined to be needed.
 - This may require navigating benefits that would make them eligible to access these services, such as income or health insurance.
- While the person is awaiting long-term care, and if living in shelter or other homeless services environments, staff should be provided with training for dementia-responsive de-escalation strategies, as behavioral management strategies differ than those used with individuals other behavioral health conditions.

Conclusion

The new UDS Alzheimer's Disease and Related Dementias (ADRD) Screening metric gives health centers the opportunity to better understand and serve individuals with cognitive impairment and dementia. Universal screening will proactively allow health centers to address reversible causes of cognitive impairment, identify individuals with mild cognitive impairment who can benefit from additional support to maintain health and independence, and to proactively create safe, dignified, and supportive plans for individuals with dementia. Clinic wide screening will also provide important information about the scope of need for the growing older adult populations, essential information that can be used to support additional services.

Recommended Resources

- Additional training and resources on dementia care, as well as a 24-hour helpline, is available through the Alzheimer's Association at [Alz.org](https://www.alz.org)
- Resources to assist with placing individuals with dementia in senior housing can be found at the Department on Aging website: areaagencyonaging.org
- Access training on [de-escalation and crisis prevention](#) for people with dementia.
- Understand barriers to higher [levels of care](#) and support needed to increase access for homeless individuals
- For more information on determining need for guardianship:
 - [Healing Hands: Strategies for Conservatorship](#)
 - [Legal Documents | Alzheimer's Association](#)
 - [Adult GuardianshipFactsheet.pdf \(alz.org\)](#)
- Advance Care Planning Resources
 - [Advance Care Planning with People Experiencing Homelessness | HHRC](#)
 - [Prepare For Your Care](#)
 - [The 5 Wishes](#)
 - [What Matters to Me](#)

Appendix A: Cognition Terms

The following terms exemplify the various components of cognition, though it is not a comprehensive list. These components are typically most observable and noticeable by the individuals themselves, especially those who are more cognitively intact. They are listed in order of complexity – thus, in order to use the more complex skills (e.g. executive functioning), the preceding skills must also be in place.

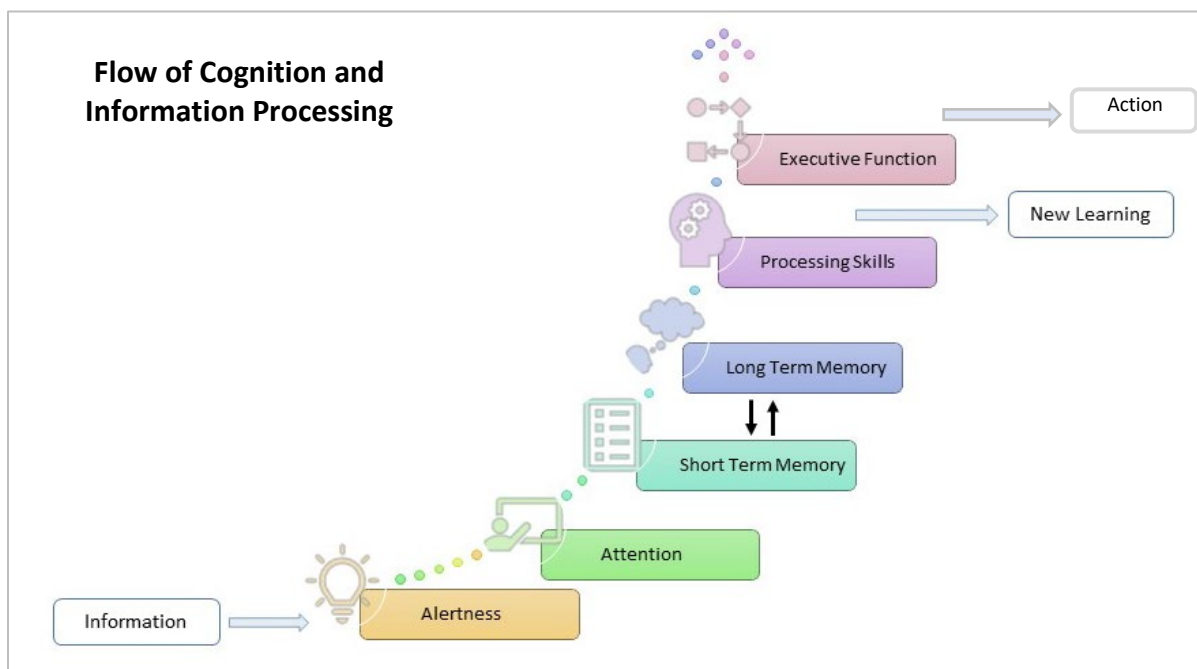
Alertness (also known as arousal) is the state of being awake, aware, attentive, and prepared to act or react.

Attention is the ability to control focus (to engage and disengage) despite a presence of internal and environmental stimuli.² Attention is broken down into several sub-types, and is necessary for other cognitive skills.

Memory is the ability to recall information. Memory requires the person to be able to attend to, encode, store, and then retrieve information. Like attention, memory is also broken down into several sub-types.²

Processing Skills (also known as cognitive processing) is a sequence of ordered stages where sensory input or information is transformed, reduced, stored, recovered, and utilized. Processing skills are how a person uses new and stored information to operate effectively within their environment.

Executive Functioning refers to the integrative cognitive processes that determine goal-directed and purposeful behavior; executive function allows for the orderly execution of daily life functions. Executive functions include skills such as creating goals, problem solving, planning, initiating, and organizing actions, and adapting actions based on outcomes or changes in the activity.²



Appendix B: Assessing Function

Within the context of health care and dementia, the term function can be broadly applied and may mean different things by different disciplines. In the context of this resource, “function” is defined as a person’s ability to participate in day-to-day activities. Functional activities that are often most observable by clinicians and are a top priority to health center clients include activities of daily living (ADLs) or instrumental activities of daily living (IADLs), including and particularly health management.

Assessing function or full functional capabilities can be challenging within the health center setting unless the health center has an occupational therapy practitioner on site. However, a range of assessments and screens can provide an initial look at different components of function.

When a screening or in-clinic assessment indicates decreased functioning, or the provider has concerns in changes related to ADLs or IADLs (due to dementia or otherwise) they may also refer out to rehabilitation providers (such as occupational or physical therapy) for a more in-depth assessment.

Functional assessments that can be administered in the health center environment include:

- [Asking the client about their ADLs and IADLs](#). This includes any concerns or barriers they encounter. Providers can note if the person’s report is inconsistent with their observed appearance or skills.
- [Timed Up and Go Test](#): assesses geriatric mobility and risk of falls.
- [Walking While Talking Test](#): is a dual-task measure of divided attention to examine cognitive-motor interactions, especially for identifying fallers. This may be especially useful when the person scores below cut-off ranges on cognitive screening tools.
- [STEADI Fall Risk tools](#): Comprehensive set of clinical tools to assess for and respond to fall risk.
- [WHODAS 2.0](#): The World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0) is a 36-item, generic assessment tool used to measure health and disability across six functional domains: cognition, mobility, self-care, getting along, life activities, and participation.

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¹ [Dementia \(who.int\)](https://www.who.int/)

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