Decision-Making Capacity Assessment Program

Class 3: May 7, 2025

for Sound Generations Elder Education Institute by

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Morning

- 10 min breaks
- 1 hour lunch

Time	Topic
830a	Agenda, questions/discussion from prior
845a	Polls, your experience with tests/tools
900a	Guest speaker: Kathi Church
920a	Testing as a tool; history; what we're testing Different recommendations
945a	BREAK
955a	MMSE, Clock, Verbal Fluency Brief screens – tests and rating tools
1010a	Cognitive tests
1045a	BREAK
1055a	MOCA role play with Ashica Executive function; Functional
1145a	Questions/discussion
12noon	BREAK FOR LUNCH

Afternoon

- 10 min breaks
- Finish by 410p

Time	Topic
100p	Questions from morning, agenda for afternoon
110p	Informant; Mood/anxiety; Financial
125p	Interview formats, role play with Denise
145p	Questions/discussion
155p	BREAK
205p	Tools for self neglect, undue influence
215p	Case studies in breakout rooms
235p	Groups report back, discussion
250p	Ethical, logistical, and systemic influences
300p	BREAK
310p	Documenting, explaining testing scores
340p	Questions/discussion
400p	Recap, resources, plans for next class/beyond

Heads-up: CEU Questions

These will be multiple-choice and true/false questions.

1. Cognitive testing scores can…
2. The Mini Mental Status Exam is the cognitive test best supported by research.
3. The Cornell and IQCODE are types of …
4. A good cognitive test to use with someone who is a non-native speaker of English is…
5. An important question to ask ahead of doing any assessment is…

Today we're going to

- Review a variety of cognitive testing tools and other assessment instruments.
- Explore in closer detail some selected tools/instruments that are commonly used in assessing decisional capacity.
- Consider ethical, logistical, and systemic influences on the testing process.

Today we're NOT going to…

- **This workshop is <u>not</u> intended to make you suddenly capable of administering these tools!**
- ***<u>Rather</u>***, the aim is that:
  - you understand what the various tests and instruments are and how they differ from one another,
  - you have a starting point at how to pick which tools to use in particular situations, and
  - you know where to go for further resources to build clinical skills.

Guest speaker: Kathi Church, MA, LMHC, NCC

Kathi has been a case manager with the City of Seattle's Aging and Disability Services' (ADS) Case Management Program since January 2003 providing advocacy and social work services to individuals 60 years and older.

Since February 2011 she has worked under the agency's elder abuse program, serving clients county-wide. In this unique role, which combines expertise in the fields of both aging and abuse, she focuses on serving those over 60 who have been struggling with some form of abuse, neglect, or exploitation.

Kathi works closely with colleagues from other agencies including Adult Protective Services, geriatric mental health clinicians, domestic violence advocates, city and county prosecutors, and local law enforcement agencies. She has found that this interdisciplinary and team approach to serving clients has made a tremendous difference in outcomes for them. She works to not only provide advocacy and support but to connect seniors with information and community resources to keep them living as independently as possible.

Kathi also provides consultation services regarding elder abuse cases within ADS, ADS subcontract agencies, and with other community agencies and colleagues across King County.

Prior to working for the City of Seattle, Kathi worked for many years in the field of social work and counseling, providing counseling services in private practice settings as well as case management services for chronically mentally ill individuals in large mental health clinic settings. She received her MA in Clinical Psychology from the University of Colorado at Denver and is a state-licensed and nationally certified mental health counselor.

About the use of testing tools

- Test scores: objective data, complements subjective observations and clinical impressions.
- Numerous cognitive testing tools and other assessment instruments are used in clinical and social services contexts.
- However, training on testing tools is not standardized across medical or graduate education programs, and certification of training or proficiency is not typically required or even available.

Origins of testing tools

- 1880s: Francis Galton's "Anthropometric Laboratory" – physiological tests such as grip strength, height, weight.
- 1890s-1920s: James McKeen Cattell, first US professor of psychology (U.Penn), long-time editor and publisher of scientific journals, developed "mental tests"
- 1905: Binet-Simon intelligence tests – battery approach
- 1911: US military used these tests (and developed more) to screen recruits
- 1916: Stanford-Binet intelligence tests (focus on children)
- 1955: Wechsler Adult Intelligence Scale (focus on adolescents/adults)

Modern cognitive tests have their roots in scientific development in the US and Europe

Applebaum and Grisso's criteria for test/tool

- Created Macarthur Competence Assessment Tool in 1990s.
- Laid out 6 criteria for a capacity assessment tool pertinent to their four legal standards for DMC:

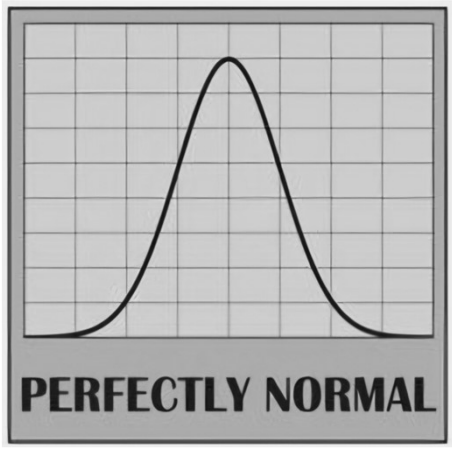
1. Functions assessed relate to legal standards.
2. Content relevant to decision at hand.
3. Content meaningful to the person.
4. Standardized enough for comparisons within and across research groups.
5. Objective, reliable criteria for scoring.
6. Practical for research and clinical use: brief, extensive training not required.

About research – remember statistics class?

- Terms "sensitivity" and "specificity" were introduced by American biostatistician Jacob Yerushalmy in 1947. *(per my class notes and Wikipedia)*
  - Sensitivity (true positive rate) is the probability of a positive test result, when the individual truly is positive.
  - Specificity (true negative rate) is the probability of a negative test result, when the individual truly is negative.
- Norms – score curves for groups by age, education level, gender, language/culture, particular conditions (heart disease, Parkinson's)
- "Clinically researched and validated"

Norms

- Normative data typically gathered on generally healthy individuals – free from significant cognitive impairments, developmental disorders, or neurological conditions.
- Data generally gathered on samples that reflect the broad demographic characteristics of the United States (or other country) including factors such as age, gender, and educational status.



Standardized administration procedures

- Typical standardized administration procedures or expectations include
  (1) a quiet, relatively distraction-free environment;
  (2) precise reading of scripted instructions; and
  (3) provision of necessary tools or stimuli.
- Use of standardized administration procedures enables application of normative data to the individual being evaluated (Lezak et al., 2012).
- Without standardized administration, the individual's performance may not accurately reflect his or her ability.

Problems with tests

- All tests can produce false positives and false negatives.
  - False positives (when a test suggests impairment that isn't actually there)
  - False negatives (when a test doesn't show a problem that is actually present)
- Tests are snapshots in time, and indicators, not diagnostics!
- All test results should be interpreted cautiously.

Limits of testing

- Results can be affected by lack of education, English as a second language, depression, sensory impairment, sleep quality, dysphasia, anxiety, etc.
- Other factors might help elders compensate for decreased cognition (e.g., intellect, education).
- Cognitive tests do not predict functional ability.
- Complication of the "lucid moment" (Shulman).

Score ≠ diagnosis!

Psychometrics

Scientific research

Psychology / Social Work clinical approaches

"Mental Status Exam"

- Theoretical roots in work of philosopher/psychiatrist Karl Jaspers
- To understand a patient's experience through their own description (vs interpretive or psychoanalytic approach)
- Core skill set of qualified mental health personnel

"Mental Status Exam" – not a testing tool

- Key part of the initial psychiatric and/or biopsychosocial assessment.
- Systematic collection of data based on observation and interview regarding symptoms and signs of mental disorders.
- Used to inform decisions about treatment strategy/setting.

- Mnemonic **ASEPTIC**:
  - Appearance/Behavior
  - Speech
  - Emotion (Mood and Affect)
  - Perception
  - Thought Content and Process
  - Insight and Judgement
  - Cognition

Handout: Washington State DOH guidelines for what must be included in a Mental Status Exam (includes memory as well).

But memory isn't really a focus of the MSE

- Memory is most complex cognitive issue – the mechanism that takes information and then encodes, stores, and retrieves it later.
- Because memory is so complex, it is essential to recognize and document what exactly is under evaluation during this part of the assessment.

Complexity = harder to assess

- Memory impairment can be easy to recognize, but can also masquerade as other things, such as having trouble learning new information.
- Normal aging can slightly impair cognition – but typically activities of daily living will remain intact if memory is minimally impacted.

When testing is more/less important

Clients with more mild, subtle, and complex presentation:
Objective tests are more likely to be key part in assessing capacity.

VS

Clients with clear and obvious incapacity, e.g. late-stage Alzheimer's disease:
Unlikely to need (or even to be able to complete) most objective tests.

Testing results become more critical if disputes or legal processes occur: standardized tests results are more defensible as representing objective findings, versus subjective opinion.

What makes a testing tool valid, useful

Guidance from the ABA/APA Handbook for Psychologists:

- Functional tools that have been demonstrated to be psychometrically sound and normed for older adults.
  - Problem: there are not that many available.
- The "best" test battery will depend on the context, the setting, and the particulars of the case.
- Can start with a "brief mental status screening [for] a ballpark estimate of level of functioning" but
- Screening tests lack sensitivity to executive functioning, but can be useful as a starting point and to help in the selection of assessment tools.

Cognitive assessment considerations: NIA/NIH

- It's not typical to do cognitive testing of older adults (especially those who do not express memory concerns).
  - Providers not trained on best way to assess, or use of testing tools
  - Providers unsure what to do with a positive result
  - False positives - unnecessary stress and worry
- Tools not developed, adapted, or researched in relevant populations.
  - For example, adapted tools for assessing cognitive impairment are needed for people with Down syndrome – at increased risk of Alzheimer's.
- Various federally funded studies (were) underway to develop new cognitive testing tools – still 3-5 years out.

So, what are they using?

- Even NIA says "cognitive testing practices and tools are not standardized, and have not been optimized for integration into clinical care, including primary care."
- A systematic review and meta-analysis (Tsoi) showed large variations in the use of mental status tests by physicians:
  - 11 screening tests were identified
  - ranging in administration time from 5 to 20 min, and
  - varying in cognitive domains measured.

Different views

- NIA, Alzheimer's Assn overlap →
- AAFP:
  - Mini-cog, RUDAS, MOCA, AD8, GDS, PHQ9, GAD7, FAQ
- ABA/APA different:
  - Blessed Information Memory Concentration Test (long)
  - Cognistat
  - MacNell Lichtenberg Decision Tree
  - MMSE, MOCA, SLUMS
  - MSQ, 7MS, SPMSQ
  - TICS Telephone Interview for Cognitive Status

	NIA Workgroup	Alzheimer's Association Workgroup
Ascertain dementia (AD8)	X	X
Brief Alzheimer's screen	X	
GPCOG for use with the patient		X
GPCOG for use with an informant		X
Memory impairment screen		X
Mental Status Questionnaire	X	
Mini-Cog	X	X
Short Blessed Test	X	
Short IQCODE for use with an informant		X
Short Portable Mental Status Questionnaire	X	
Short Test of Mental Status	X	
Six-Item Screener	X	

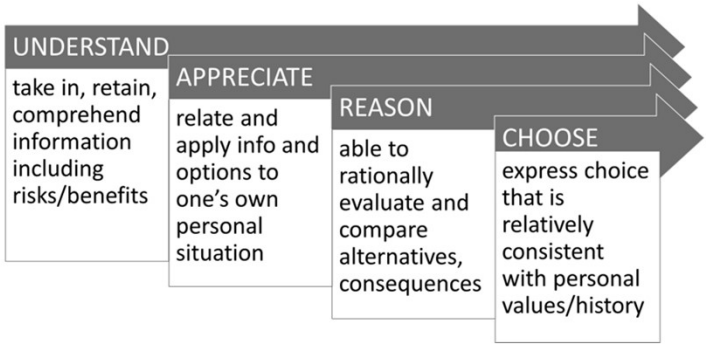
Source: Gerontological Society of America (GSA) Workgroup on Cognitive Impairment Detection and Earlier Diagnosis (Gerontological Society of America, 2015)

Most frequently used by APS

- St Louis University Mental Status Exam (SLUMS)
- Interview for Decisional Abilities (IDA)
- Montreal Cognitive Assessment (MOCA)
- Mini Mental State Exam (MMSE)
- CLOX clock drawing (traditionally given time 1:45)
- Mini-Cog

Specific to the decision making process

- What cognitive tasks are involved at each step? And how can we assess/test for these?



COGNITIVE TASKS LINKED TO DECISION MAKING STEPS

UNDERSTAND	APPRECIATE	REASON	CHOOSE
• Sensation • Perception • Alertness • Orientation • Attention/concentration • Processing speed • Language: read, listen, naming • Working memory, repetition • Recall • Episodic memory • Visual recognition	← *All of those, plus* • Memory: working, episodic, retrieval, long-term memory • Learning • Comprehension/ knowledge • Calculation • Visual-spatial tasks • Creativity, imagination • Self-monitoring	← *All of those, plus* • Executive function • Reasoning: fluid, logical, abstract • Flexible thinking/ adjust to change • Plan, prioritize • Sequencing • Impulse control • Inhibition • Emotional control • Insight	← *All of those, plus* • Expressive language, writing • Task initiation • Organization • Motor control • Social cognition

But first: preview MMSE, clock, verbal fluency

- A lot of tools get compared to the MMSE
- A lot of tools include the clock drawing and verbal fluency tasks

MMSE

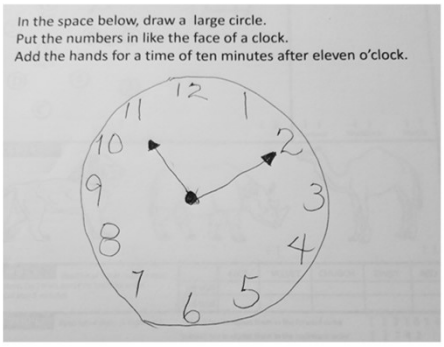
- Mini-Mental State Examination, widely used since 1970s, but…
- Copyright / licensed.
- Low sensitivity (18% for MCI).
- False positives, especially in lower education.
- False negatives in highly educated.

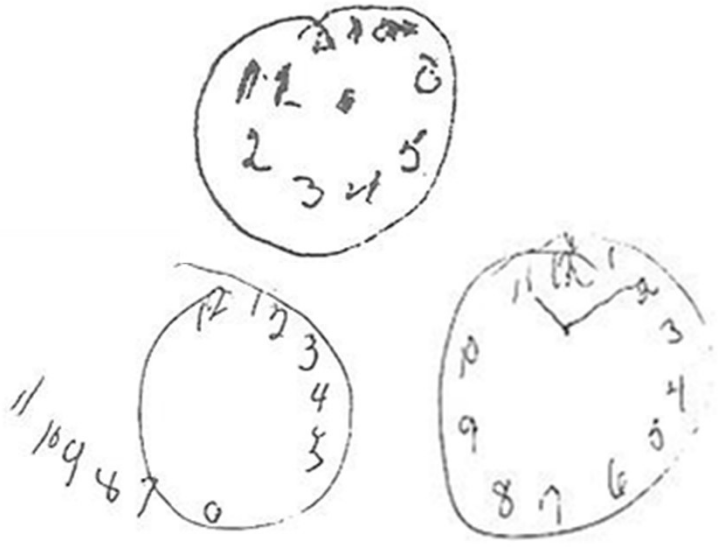
About the clock: shows multiple processes

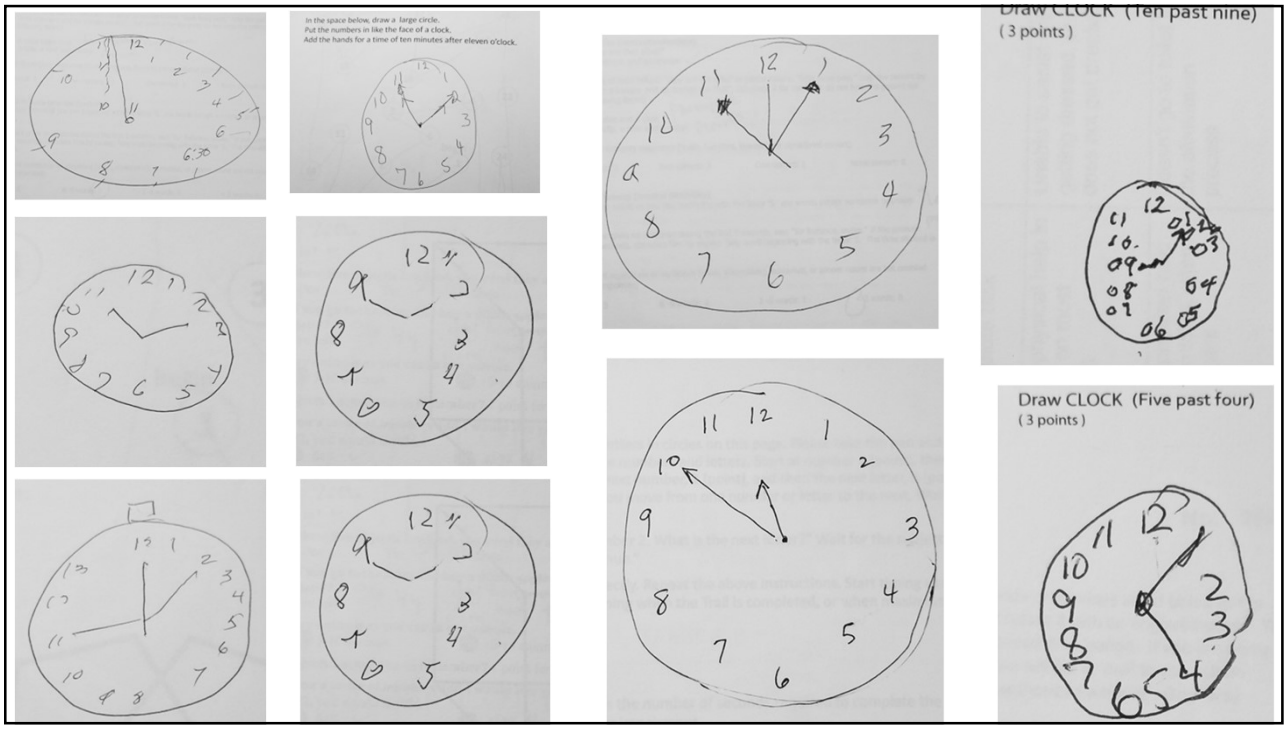
- Executive functioning:
  - Organization: Gathering information and structuring it for evaluation.
  - Regulation: Changing behavior in response to surroundings.
- Global cognitive status:
  - How we learn, remember, problem-solve, and pay attention (not knowledge).
- Visuospatial abilities:
  - To understand visual representations, spatial relationships.
- Attention:
  - Focusing, especially by directing the mind to an object; concentrating.
- Semantic knowledge:
  - General facts, meaning, ideas, concepts – **not** from personal experience.

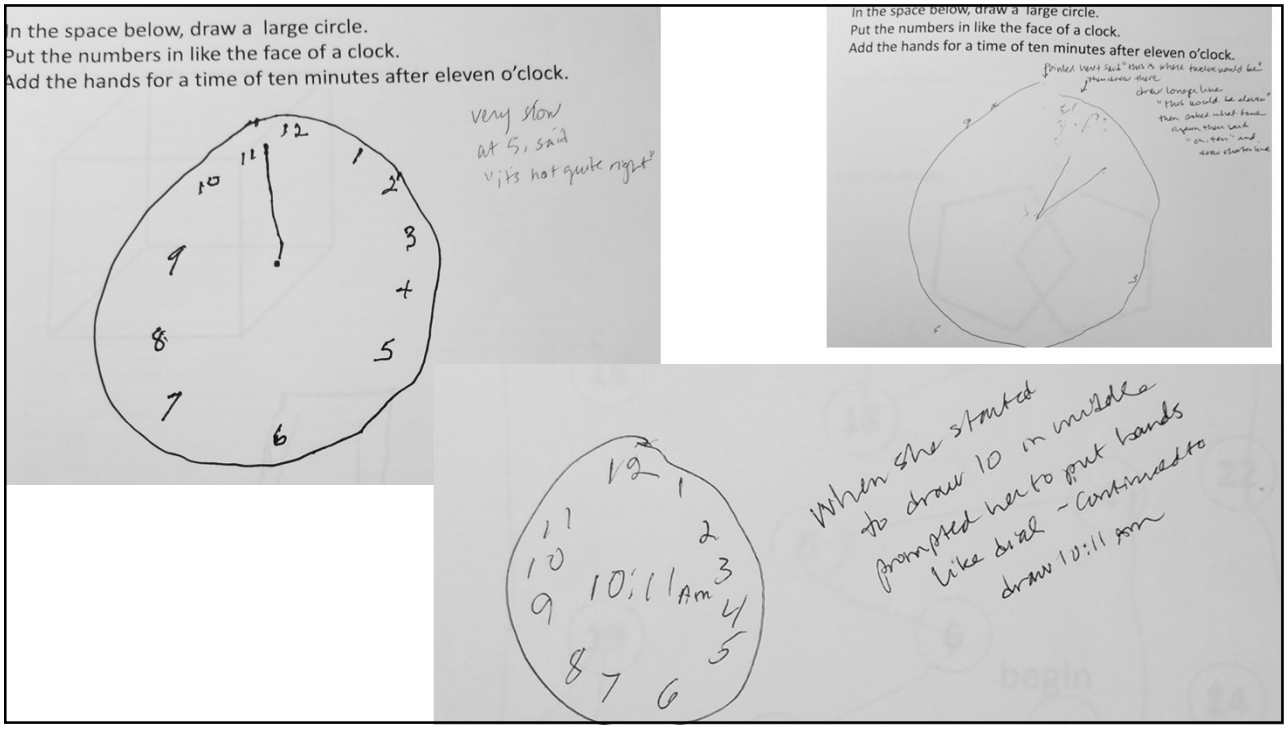
From Dr Carrie Peterson (US/Denmark) – great blog Doctor Dementia
https://doctordementia.com/2015/07/09/the-clock-drawing-test-and-dementia/

Perfect clock… and not so much









Verbal fluency – "animals and F-words"

SEMANTIC FLUENCY	PHONEMIC FLUENCY
Words for things in a category	Words that start with a certain letter
More susceptible to age-related decline, can be earliest sign of dementia.	Relatively stable in aging, likely due to cognitive reserve.

- Both involve energization and self-monitoring, attention, processing speed, language.
- Both can be influenced by education and vocabulary level.
- Different search strategies and memory processes involved.

Cognitive testing and other assessment tools

Brief screens	Blessed, GP-COG, Mini-Cog, SPMSQ / AD8, QDRS
Cognitive tests	MOCA, RUDAS, SLUMS
Executive Function	Frontal, Trails
Functional	ADL, IADL, WHODAS
Informant tools	Cornell, FAQ, IQCODE
Mood/anxiety	GDS, GAI, GAS
Others	Financial, Interviews, Self-Neglect, Undue Influence

Commonly used brief screens

- Designed to detect early cognitive changes.
- Somewhat "quick and dirty" – not as sensitive.
- More heavy on recall.
- May not capture important domains such as attention and executive function.

"Tests"
- Blessed
- GPCOG
- Mini-Cog
- SPMSQ

"Rating Tools"
- Ascertain Dementia (AD8)
- Quick Dementia Rating System (QDRS)

Brief tests: Blessed history

- 1960s: Blessed and colleagues developed the Information Memory Concentration Mental Status Test (26-29 items)
  - First (relatively) brief, standardized cognitive screening test to be developed for people with dementia that is still commonly used in clinical and research practice.
- 1983: Blessed Orientation-Memory-Concentration Test (BOMC) with 6 items
  - Also called the Short Blessed Test (SBT) – more concise, most commonly used
  - AKA: 6-OMC or Six Item Cognitive Impairment Test (6CIT)
- 1995: Blessed Telephone Information-Memory-Concentration Test

Brief tests: Short Blessed Test (SBT)

- Verbal test with 6 items
- 28 points, score 10+ abnormal.
- Easy to administer in about 5 minutes.
- Easy to score – count number of errors
- No training needed.
- Copyright but free to use.

- Orientation to year, month, and time
- Repetition and recall of a short phrase (name and address)
- Counting backward 20 to 1
- Months in reverse order.

Brief Tests: GPCOG

- General Practitioner Assessment Of Cognition
- Developed in Australia in 2002.
- 5 minutes to administer.
- Informant component – compare/ contrast with person's score.
- Web-based GPCOG – same questions, automatically scores.
- Free, available online in many languages.

- Orientation to date
- Repetition and recall of a short phrase (name and address)
- Clock drawing
- Current events

Brief Tests: Mini-Cog

- Created by Dr. Soo Borson and team at UW for use in a primary care visit.
- Three minutes to administer.
- Possible score of 5, score below 3 indicates dementia.
- Free tool, available in many languages, validated across cultural groups.
- Training for use takes about ten minutes.
- Clock drawing may challenge individuals with very low education, literacy or intellectual ability.

- Three-item recall
- Clock drawing

Brief Tests: SPMSQ

- Short Portable Mental Status Questionnaire
- More accurate in identifying moderately or severely impaired dementia, rather than detecting mild impairment.
- Free online, no training needed.

- Orientation
- Personal information
- Presidents
- Count backward from 20 by 3s

Brief tests: task overlap/variety

TASK	Blessed	GP-COG	Mini-Cog	SPMSQ
Orientation	Year, month, time	Date		Date, month, year, day, place
Registration	Name, address	Name, address	3 words	
Attention	Count backwards from 20 to 1, Months in reverse			Count backwards from 20 by 3's
Recall	Name, address	Name, address	3 words	
Clock		Clock	Clock	
Info		Current event		Phone number, age, when born, mother's maiden name President current and former

Brief tools: Ascertain Dementia (AD8)

- Originally informant screening, but then validated as direct questionnaire for the person.
- Can do both person and informant to compare/contrast.
- Takes about three minutes to complete.
- No formal training needed.
- Copyrighted, but use allowed with specific acknowledgment language

- 8 yes/no questions
- Changes from baseline
- Thinking
- Memory
- Behavior

Brief tools: Quick Dementia Rating System

- QDRS rates degree of change vs baseline in cognitive and behavioral areas.
- 10 items, 30 points.
- 5-10 minutes to administer.
- Can do over phone with person and/or informant.
- No training needed.
- Copyright – but use permitted if specific acknowledgment statement is included.

QDRS Scoring:	
0.0-1.5	Normal
2.0-5.5	MCI
6.0-12.5	Mild dementia
13.0-20.5	Moderate dementia
21.0-30.0	Severe dementia

Brief rating tools: variety/overlap

AD8	QDRS
Forgets appointments, thinking/memory	Memory, recall
Month, year	Person, place, time
Judgment, making decisions, finances	Decision making, problem solving, finances
Hobbies, activities	Activities outside home Function at home, hobbies
	Toileting, hygiene
	Behavior, personality
Repeats same things	Language, communication
	Mood
Trouble learning	Attention, concentration

Cognitive tests

- Assess various domains of cognitive functioning
- Different specific items and formats
- Some limitations on usage
- All 30 points – but not exactly the same

- MMSE
- MOCA
- RUDAS
- SLUMS

Montreal Cognitive Assessment (MOCA)

- Created in 1996 as a rapid screen for mild cognitive dysfunction.
- About 10 minutes to administer.
- Paper and app versions (iOs and Android), translated into 35+ languages, and there is a version for blind clients.
- Various editions for re-testing.
- Scoring: total possible 30 points
  - 26 or above is considered normal.
- Training/certification required.

New versions added Memory Index Score

- Memory recall score items = MIS captures recall with cues also.
- Can compare MIS score out of 15 to total score out of 30.
- Provides a more detailed look at memory function within the broader cognitive assessment.

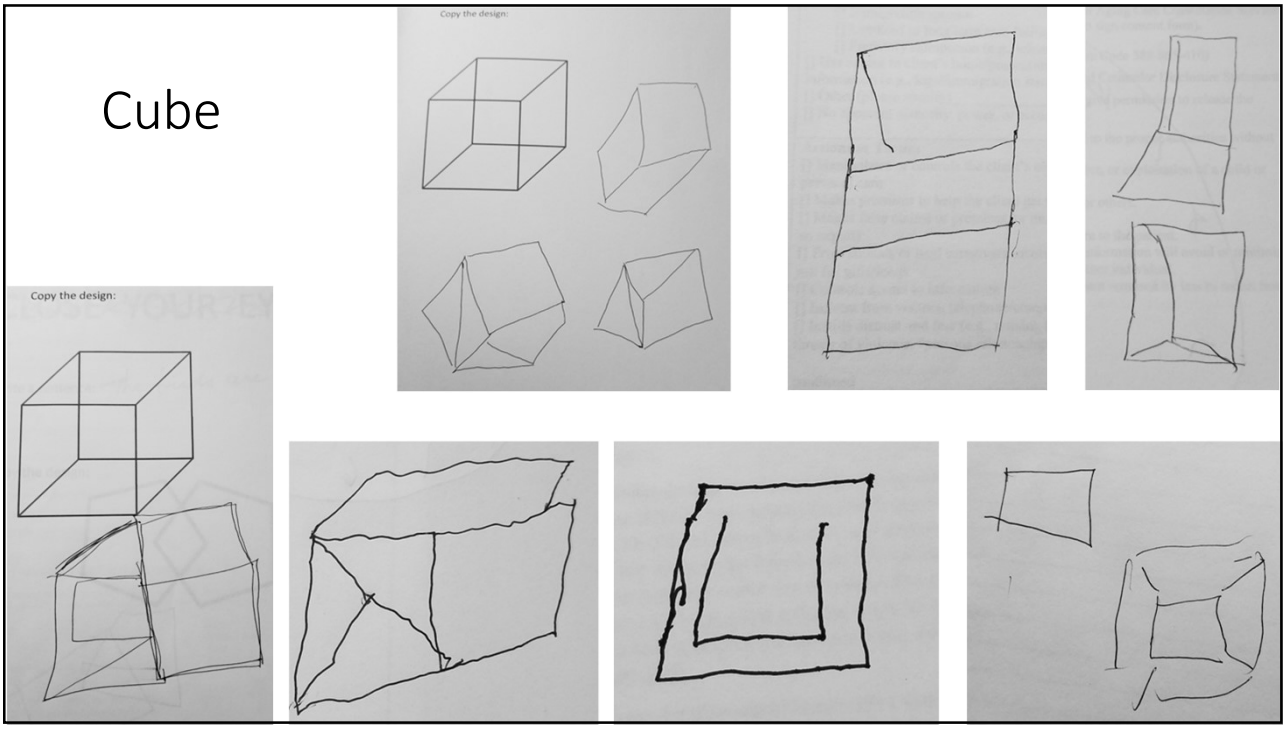
DELAYED RECALL	(MIS)	Has to recall words WITH NO CUE	FACE [ ]	VELVET [ ]	CHURCH [ ]	DAISY [ ]	RED [ ]	Points for UNCUED recall only	__/5
Memory Index Score (MIS)	X3								
	X2	Category cue						MIS =____/15	
	X1	Multiple choice cue							
ORIENTATION	[ ] Date	[ ] Month	[ ] Year	[ ] Day	[ ] Place	[ ] City			__/6

© Z. Nasreddine MD www.mocatest.org MIS: /15 (Normal ≥ 26/30) Add 1 point if ≤ 12 yr edu TOTAL __/30

Administered by: _____

Training and Certification are required to ensure accuracy

Cube



Rowland Universal Dementia Assessment Scale

- RUDAS was created in Australia in 2004 to minimize the effects of cultural learning and language diversity.
  - Use it with non-native speakers of English and low-literacy
- Takes 10 minutes to administer
- Scoring: Lower than 22 indicates cognitive impairment.
  - The lower the score, worse it is.
- Free, available online in 30+ languages/dialects
- Training to administer: 40 minutes

RUDAS – unique aspects

More "real world" focus

- Registration/recall items are shopping list items – making it more tangible than random words
- The judgement question asks how they would cross a busy street with no crossing/lights.

Motor/physical items

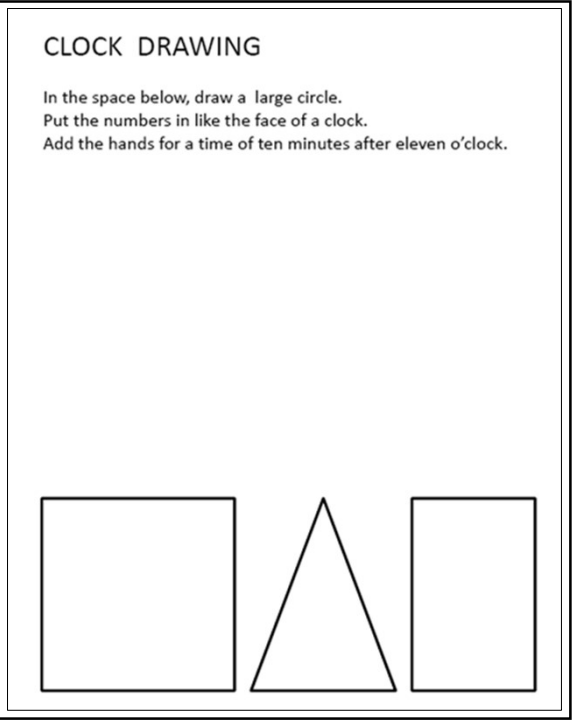
- Praxis exercise is cross-body
- Identifying parts of the body, "your left hand" and "my left eye"
- These might present challenges for people with limited mobility or history of stroke, etc.

St Louis University Mental Status Exam (SLUMS)

- Developed in 2006 by SLU and the VA for use with veterans.
- Good balance between easy and difficult items.
- Version for iPad/iPhone.
- More sensitive for MCI than MMSE.
- Score ranges for MCI and dementia, with differential based on education level.
- Free online for public use.

Shapes

- SLUMS is the only test asking for identification of shapes.
- Because the shapes on the testing page are so small, having a separate page makes it easier to administer these tasks.



TASK / TEST	MMSE	MOCA	RUDAS	SLUMS
Orientation	10 points: year, season, month, date, time; country, town, district, hospital, floor	6 points: date, month, year, day, place, city	(nothing)	3 points: day, year, state
Registration	3 words	5 words	4 word shop list	5 words
Attention	Spell WORLD backwards	Digit span 5 forward, 3 backward List of letters, tap at A		Digit span backward: 2, 3, 4 digits
Calculation	Serial 7's	Serial 7's		Add, subtract
Recall	3 words	5 words, category clue	4 words	5 words Story exercise
Language	Naming, read, write Repeat phrase 3-step command	Name animals (pics) Repeat sentence Name words "F"	Name animals	Name animals Story exercise
Visual	Intersecting pentagons	Clock 3-D cube, tube, or chair	3-D cube Parts of body	Clock Identify shapes
Exec function	3-step command	Mini Trails B		
Praxis	3-step command		Point to parts of body Alternate fist/palm	
Abstraction		Similarities (fruit)		
Judgment			Crossing street	

FACTOR	MMSE	MOCA	RUDAS	SLUMS
Scoring	≤ 23 impaired 18-23 mild 0-17 severe	Add 1 pt to score if ≤ 12y education. 26+ normal	≤ 23 impaired	HS education / < HS educ. 27-30 Normal 20-30 20-27 MCI 14-19 1-19 Dementia 1-13
MCI related	MCI dx scored ≤ 24	MCI dx scored ≤ 18 Most sensitive to MCI	MCI dx scored ≤ 23	MCI dx scored ≤ 26
Ceiling effect (false negative)	71%	18% Slightly higher test-retest reliability		Slightly higher test-retest reliability
Score equivalent to MMSE 25	25	18	22	20

Sources: Buckingham, Delgado-Álvarez, Lee, Ranjit, Trzepacz (separate articles)

Executive function testing in older adults

(Faria)

Domains most frequently assessed:

- mental flexibility,
- verbal fluency,
- planning,
- working memory, and
- inhibitory control.

Tools most frequently used:

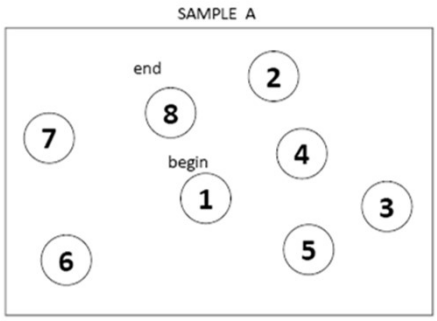
- Trails B
- Verbal Fluency Tests (animals or words)
- Clock Drawing
- Digits Forward and Backward (subtests of WAIS-R or WAIS-III)
- Stroop Test – (color/word task)
- Wisconsin Card Sorting Test (WCST)

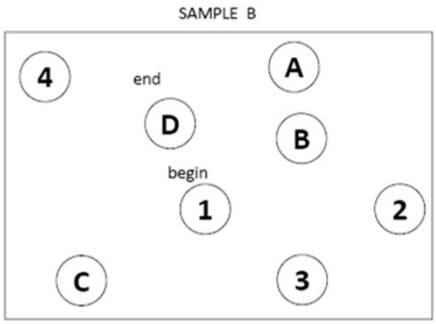
Frontal Assessment Battery (Frontal or FAB)

- Created in 2000 as short executive function assessment
- Distinguishes between frontal-lobe dementia and Alzheimer's type.
- Unique tasks e.g. attention/inhibition, motor exercise, reflex.
- Scoring: maximum of 18, cut-off of 12 for significant dysfunction.
  - Higher scores = better frontal functioning.
  - Lower scores = more impairment.
- Minimal training, but attention required to administer some tasks correctly.
- Free and available online.

Trail Making Test (TMT)

- AKA Trails A & B
- Developed in the 1930s, incorporated into Army tests of intelligence in 1944.
- Now "one of the most frequently used neuropsychological tests in research and clinical practice." (Rabin)
- Dot-to-dot **TIMED** exercise using numbers (1-2-3) and then alternating letters and numbers (1-A-2-B-3-C).
- Motor speed is key – not suitable for all (e.g. movement disorders, bad arthritis).



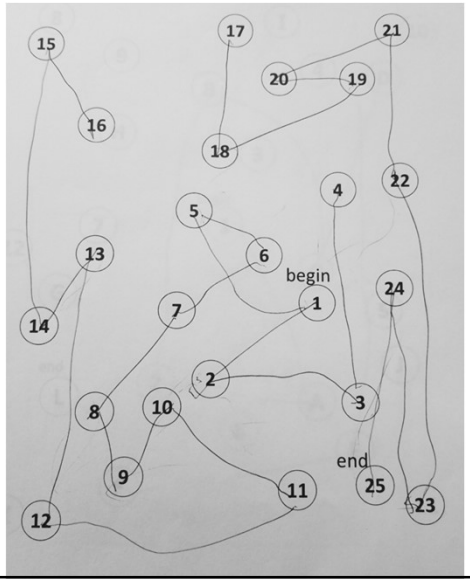


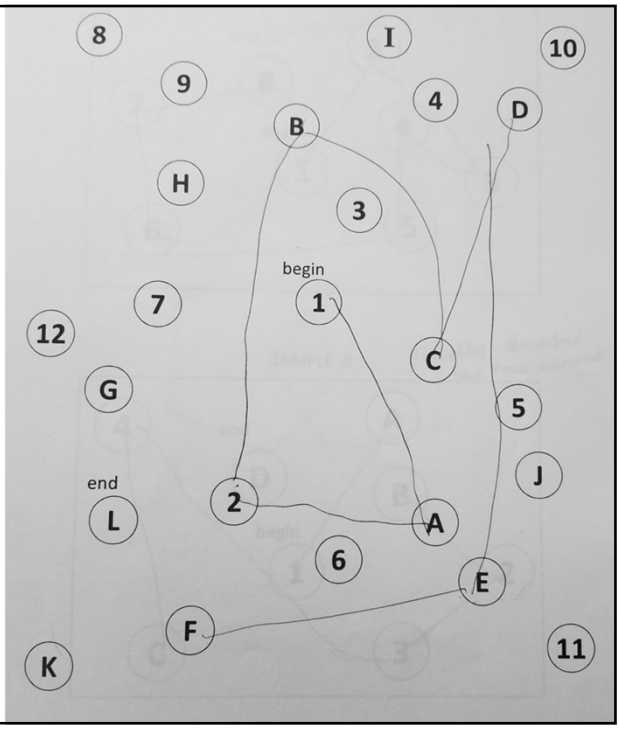
How to administer – timing, scoring

- Instructions to complete samples first.
  - If able to do correctly, do test.
  - If unable to do sample, don't do the test.
- Involves visual search speed, scanning, speed of processing, mental flexibility, and executive functioning.
- Strongly correlates with risk of driving problems.
- Oral TMT (Bastug): verbally count from 1 to 25 for part A, alternate between numbers and letters for part B. Results analogous to traditional test.

SCORING (TIME)		
	Average	Deficient
A	29 sec	> 78 sec
B	75 sec	> 273 sec

Difference A:B





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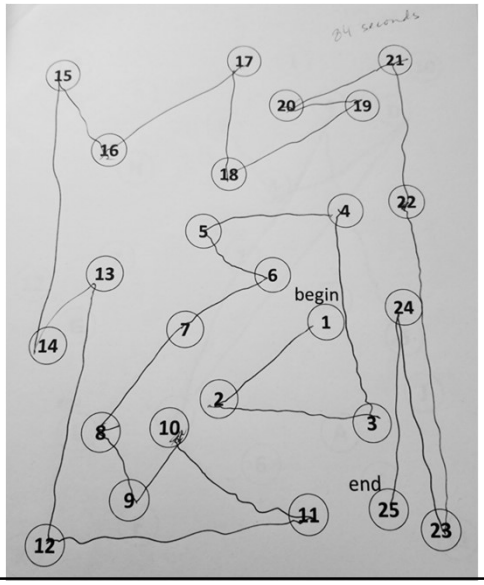
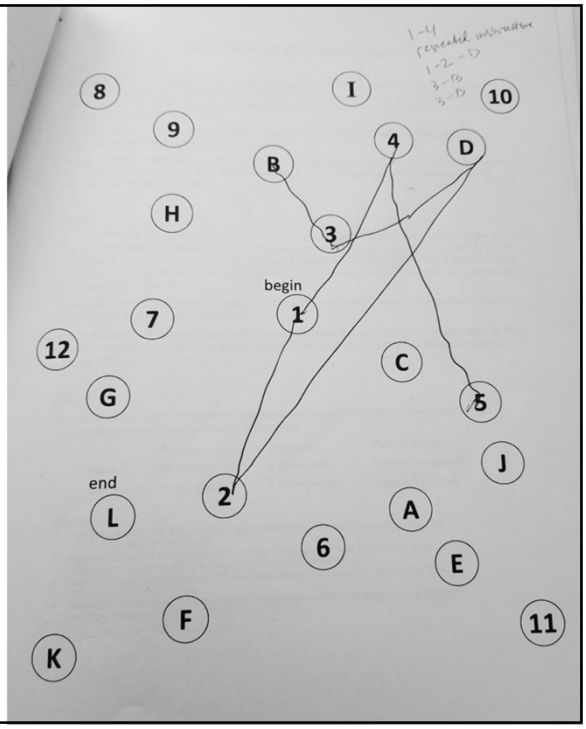
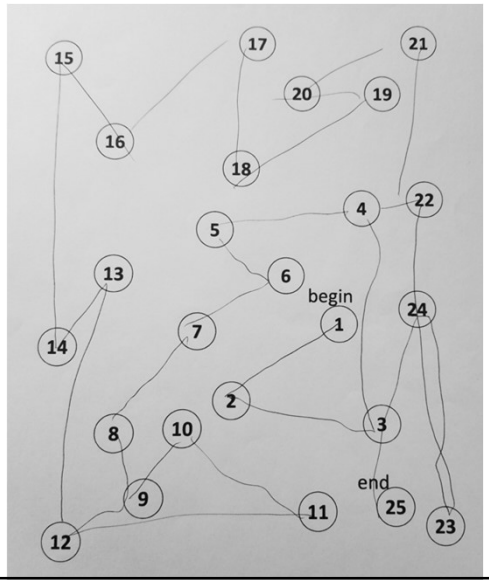
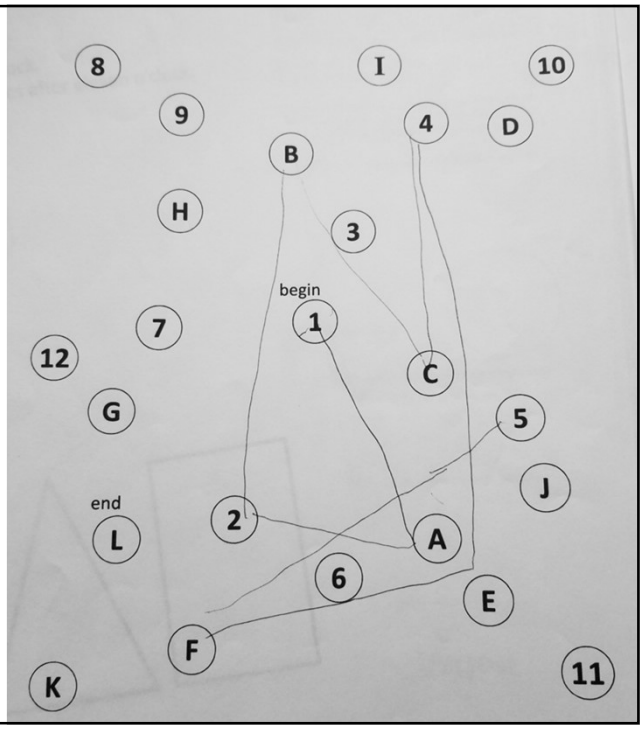




Difference A:B





Functional assessment tools

- Activities of Daily Living – sometimes referred to as Basic ADLs or BADLs
  - bathing, dressing, toileting, transfer/mobility, grooming, feeding
- Instrumental Activities of Daily Living or IADLs
  - shopping, meal prep, phone use, housekeeping, laundry, transportation, medication, finances

- Katz Index ADLs
- Lawton-Brody IADL Scale
- WHODAS

- See also Functional Activities Questionnaire (under Informant tools)

Activities of Daily Living (ADL) – various tools

- Katz Index of Independence in Activities of Daily Living (Katz ADL)
- Since 1970s, useful for common language about function for care planning
  - Score of 6 = full function,
  - 4 = moderate impairment,
  - 2 or less = severe functional impairment.
- Can use with person or informant (or both).
- Sensitive to changes in declining health status, but limited sensitivity to small changes.
- Quick, no training needed.
- A full comprehensive geriatric assessment should follow when appropriate.

Instrumental ADLs (IADL) – also various tools

- Lawton-Brody Instrumental Activities of Daily Living Scale (IADL)
- Created in 1969, measures 8 domains of functioning.
- Score range 0-8 (for women, 0-5 for men).
- Not useful for institutionalized.
- Can use with person or informant (or both).
- Takes 5-10 minutes to administer.
- No training needed.
- A full comprehensive geriatric assessment should follow when appropriate.

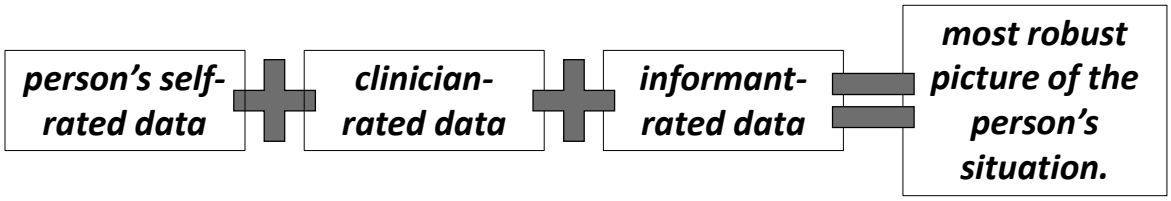
WHODAS 2

- World Health Organization Disability Assessment Schedule 2.0 – created in 2010 to provide a standardized method for measuring health and disability across cultures.
- Referenced in the DSM-V as an "emerging measure"
- 36 questions cover 6 domains →
- Somewhat more complicated scoring/interpretation process,

- **Cognition** – understanding, communicating
- **Mobility** – moving, getting around
- **Self-care** – hygiene, dressing, eating, staying alone
- **Getting along** – interacting with other people
- **Life activities** – domestic responsibilities, leisure, work, school
- **Participation** – joining in community activities

Informant tools

- Collaterals corroborate. Use whenever possible!
- **Not everyone will have an identified informant** (spouse/partner, family, friend, caregiver).
  - Consider neighbors, apartment staff, or anyone that has had more than occasional contact with the person.



Informant tools

Flexibility for informants:

- Can be administered in-person during a visit,
- Can do by phone, or
- Can provide tools for them to complete and return.

- Cornell Scale for Depression in Dementia
- Functional Activities Questionnaire (FAQ)
- Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE)
- See earlier re: AD8, QDRS

Cornell Scale for Depression in Dementia

- For informant to identify signs and behaviors associated with depression in elders with moderate to severe dementia.
- 19 items: score zero, 1 mild, 2 severe
- 10+ probable major depressive episode
- 18+ definite major depressive episode
- Not biased for education or intelligence.
- Free tool, publicly available, translated into 15+ languages.

Functional Activities Questionnaire (FAQ)

- For informant to rate performance on common activities
- Cut off score of 9 indicates impaired function and possible cognitive impairment.

Administration

Ask informant to rate patient's ability using the following scoring system:

- Dependent = 3
- Requires assistance = 2
- Has difficulty but does by self = 1
- Normal = 0
- Never did [the activity] but could do now = 0
- Never did and would have difficulty now = 1

IQCODE

Informant Questionnaire on Cognitive Decline in the Elderly

- For informant (spouse, family, caregiver) to determine whether the person has declined in cognitive functioning in various areas.
- 26 items on everyday situations; short form has 16, score 1-5 each.
- Useful for when person being assessed is unable or unwilling to complete the testing process.
- Not biased for education or intelligence.
- One of the most commonly used informant tools, but limited study of diagnostic accuracy.
- Free tool, publicly available, translated into 15+ languages.
- No real training needed, just follow instructions on scoring.

IQCODE Scoring

- To score the IQCODE, add up the score for each question.
  - For the long IQCODE, divide by 26.
  - For the short IQCODE, divide by 16.
  - The result is a score that ranges from 1 to 5, with 3 indicating no change.
- The higher the number, the worse the decline.
- Cut offs for significant change:
  - Short IQCODE: 3.31 sensitivity / 3.38 specificity.
  - Long IQCODE: 3.27 sensitivity / 3.30 specificity.

Mood/Anxiety, etc.

- Mood and anxiety can significantly impact cognition, so it is important to assess these as well.
- While many mood and anxiety tools exist, few are researched and validated for older adults.

- Geriatric Depression Scale (GDS)
- Geriatric Anxiety Inventory (GAI)
- Geriatric Anxiety Scale (GAS)

Geriatric Depression Scale (GDS)

- Has been tested and used extensively with the older population.

- Long: 30 items, 7-10 minutes
  - 12-15 severe depression
  - 9-11 moderate depression
  - 5-8 points mild depression
- Short: 15 items, 5-7 minutes
  - 10+ almost always indicative of depression
  - 5+ suggestive of depression

Any 5+ score warrants follow-up comprehensive assessment

Geriatric Anxiety Inventory (GAI)

- Fairly sensitive for distinguishing between those older adults who did and did not have Generalized Anxiety Disorder.
- 20 items to assess anxiety severity – also has 6-item short version
- Not designed strictly as a diagnostic tool, but rather to assess anxiety symptoms in general.
- Available in a variety of languages.
- Reliability and validity analyses have focused on predominantly white, ethnically homogenous populations.
- Free but must request license online.

Geriatric Anxiety Scale 2.0 (GAS)

- 25 items – short form 10 items.
- Somewhat more complicated scoring breaks out into sub-scores for cognitive, affective, and somatic domains.
- "GAS demonstrated stronger relationships with measures of self-reported functional impairment than the GAI" (Segal)

Other types of testing/assessment tools

- Financial
- Interview formats
- Self-neglect
- Undue influence

Financial tools

- Longtime leader: Lichtenberg
- Various testing/interview tools
  - Certification required
  - Training provided

Other financial tools

- Financial Capacity Instrument (FCI)
  - 100+ items in various domains, up to an hour to administer.
- FCI-Short Form (FCI-SF)
  - 37 items, about 15 minutes to administer
- Semi-Structured Clinical Interview for Financial Capacity (SCIFC)
  - Another short variant of FCI, 25 minutes to administer.
  - Instead of scores, rates as capable, marginally capable or incapable.
  - Training required, but can be done by non-clinical staff.

All these require training for use and are owned by UAB Research Foundation.

Interview formats

- These are not **tests** with yes/no, multiple choice, or one-word answers.
- These are more like interview formats, used to guide discussion of a person's thoughts around their decision making.

- ACED – Assessment of Capacity for Everyday Decision-Making
- IDA – Interview for Decisional Abilities
- MED-SAIL – Making and Executing Decisions for Safe and Independent Living
- VTPJ – Verbal Test of Practical Judgment

ACED

- Developed by Lai & Karlawish in 2008, used in many APS agencies.
- Analyzes a person's four decision-making abilities: understanding, appreciation, reasoning, and expressing a choice.
- Uses open-ended questions.
- Structured interview guide to capture decision-making process
- Looks at specific information about real situations.
- Gives a framework to support clinical opinion of capacity.

Cornell-Penn Interview for Decisional Abilities

- Standardized framework with semi-structured interview.
- Part of the comprehensive APS assessment for many agencies.
- Has no legal bearing by itself but can be presented as evidence in guardianship hearings.
- Permission needed for use.

For use with:

- Persons 60 years or older
- Not severely cognitively impaired (can have MCI)
- Not acutely psychotic
- Ideal for APS client suffering from elder abuse or neglect but refusing vital services (the "signature" indication)

MED-SAIL

Making and Executing Decisions for Safe and Independent Living.

- Uses scenarios to talk through thinking and decision making.
- Manual has guidance for choosing scenario, framing questions, probing for person to expand on reasoning, etc.
- Similar approach to ACED/IDA.

Verbal Test of Practical Judgment (VTPJ)

- 10 items asking how a person would handle various situations.
- Similar approach to MED-SAIL but not as in-depth.
- "Significantly predicted IADL performance… Valid tool for assessing judgment among older adults with suspected cognitive impairment."
- License required from BCAT.

Self-neglect

Elder Self Neglect Assessment (ESNA)

- 25 items look at physical/psychosocial as well as environmental factors
- Developed with limited testing sample
- Appropriate for use by case managers, APS workers, clinicians, social workers, and researchers

Abrams Geriatric Self-neglect Scale (AGSS)

- Six domains derived from literature on geriatric self-neglect →
- Can be completed by person or informant/observer.
- Can score from perspective of person, observer, or overall.
- Clinician rates answers 0 to 4 in severity.
- Analysis showed acceptable consistency.

1. Prescription medications
2. Personal care
3. Nutrition
4. Environment/housing
5. Financial stewardship
6. Socialization

Undue influence

California Undue Influence Screening Tool (CUIST)

- Developed about 10 years ago for APS (published 2017).
- Checklist for signs, issues, concerns in four categories:
  - Client Vulnerability,
  - Influencer's Authority/Power,
  - Actions/Tactics, and
  - Unfair/Improper Outcomes
- Space to capture examples and details

Validity of mobile tech

- Studies of smartphone or other tech-based testing had found they are comparable to in-person / paper-based testing, BUT
- These studies were predominantly done by developers of such tools, raising questions of bias.
- More recent study found smartphone-based cognitive assessments exhibit concurrent validity with a composite measure of traditional neuropsychological tests. (DeAnda-Duran et al, 2024)

The research and evidence isn't there yet to support broad clinical usage.

Case study discussion

- Each break-out room will have a unique case study to review and discuss for 30 minutes.
- One person volunteer to read the case study out loud for the group.
- One person volunteer to report back on discussion.

- What tools would you consider using and why?
- What steps would you take to support testing environment?
- What questions would you ask to explore capacity?
- What follow up would you recommend?

Testing/assessment as part of the visit

- Other factors to consider: systemic, logistic, social/cultural, ethical
- How is testing perceived
- Introducing testing and supporting engagement
- Closure at the visit
- Documentation considerations

SYSTEMIC	LOGISTICAL	SOCIAL/ CULTURAL	ETHICAL

Awareness of other factors and involved parties in the person's life.

- Systems involvement:
  - Law enforcement
  - APS
  - Courts – guardianship/conservatorship, other issues
- Legal/status issues:
  - Important decisions
  - Documents to complete
- Medical/health issues:
  - Recent or looming healthcare crisis?

SYSTEMIC	**LOGISTICAL**	SOCIAL/ CULTURAL	ETHICAL

Factors to take into consideration before and at the visit

- Visits at person's home:
  - Is it comfortable or distracting?
  - Are there things/people that impact their autonomy and engagement?
  - Are there safety issues for you?
- Visits at hospital, clinic, or elsewhere in community:
  - Do they feel at ease or insecure?
  - Private, calm space?
- Schedule – at a time the person will be at their best.
- Supports – people or things:
  - Family, friends, caregivers can be helpful informants for you also.
  - Multiple copies of tools/tests.
  - Large print or magnifiers for vision impairments.
  - Communication aids like pocket-talkers.

SYSTEMIC	**LOGISTICAL**	SOCIAL/ CULTURAL	ETHICAL

Factors to take into consideration before and at the visit

- Physical impairments:
  - We know that mobility limitations/decline and cognitive decline are significantly correlated.
  - Testing tasks can be impacted by fine motor skills, strength, and flexibility, endurance – accommodate as needed.
- Sensory impairments:
  - Can they see and hear you?
  - Do they have their glasses, hearing aids?

SYSTEMIC	LOGISTICAL	**SOCIAL/ CULTURAL**	ETHICAL

Respect for a person's personal identity, culture, and social role

- Language – for non-native English speakers:
  - Fluency/comfort with English, or
  - Access to qualified interpreters.
- Literacy
  - Education level is indication
  - Reading comprehension
  - Financial literacy
  - Health literacy
- Background and history – how their experience influences their interactions with others.
- Positive supports or negative factors regarding:
  - Family and culture of origin.
  - Current family/cultural context.
  - Community connections – friends, neighbors, senior centers, spiritual orgs, etc.

Loneliness

- For some people experiencing loneliness, having your attention and focus on them can be energizing:
  - They may seem better than usual, or
  - They may want to talk/relate to you rather than engage in assessment process.
- For others, they may be hesitant or even overwhelmed with this unusual interaction.

SYSTEMIC	LOGISTICAL	SOCIAL/ CULTURAL	ETHICAL

Both person centered and clinically/professionally appropriate.

- We're obligated to present the assessment and testing process in an honest way.
- Involve whoever requested the assessment to facilitate/support.
- Be strategic with language and framing, without false reassurance.
- Try for consent, or at least assent.

How is testing perceived?

- People may perceive tests as a threat to dignity and self-respect. (Krohne)
- Older adults have described cognitive tests as stressful, bewildering, and embarrassing. (Martin)
- Resistance to testing may be a function of increasing cognitive impairment, and predictors of distress may be related to perceptions of test difficulty and performance. (Lai)

Are people willing to engage?

- Studies in the past have found that 1/3 refused diagnostic screening. (Fowler)
- And about half who screened positive for dementia refused full diagnostic assessment. (Boustani)
- But a study published in 2019 found most participants (85.5%) were willing to engage in testing – much higher than previous estimates of acceptance. (Wong & Jacova)

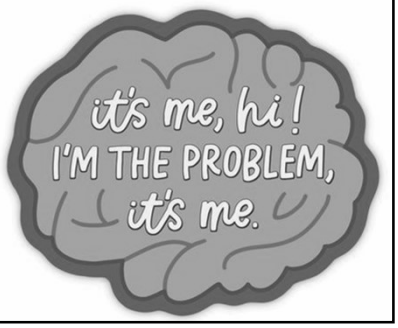
How to we encourage engagement?

"More understanding is needed regarding how older adults can be empowered to engage in their healthcare decisions. In the context of cognitive testing, **one approach to person-centered testing may include inviting older adults to make choices regarding their experience** (e.g., where they take the test, who would be with them during the test, the modality in which the test is taken, how they receive their results). In turn, **such choices may lead to greater acceptance of the cognitive test experience and its results.**"

(Wong & Jacova 2019 – emphasis added)

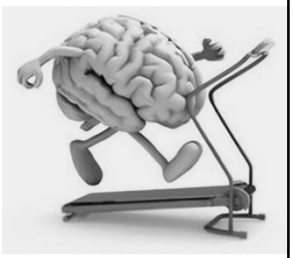
Your approach to testing is important

- Build rapport first – but not so much time that you tire them out.
- Avoid using the word "TEST"
  - or "pass" – "fail" – "quiz" – "easy" – "score"
- Don't give false reassurance.
- Avoid psychobabble.



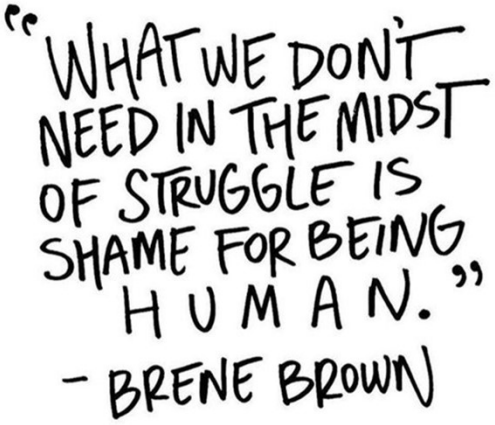
How do you introduce it?

- *I offer everyone I see a "memory check up" to see how your memory and thinking are doing.*
- *We can do memory check-ins later to continue to make sure everything is going okay.*
- *If you're afraid you are struggling with your memory, the good news is that the quicker we find that out, the quicker we are able to be helpful.*
- *May I ask you some questions so we can complete a memory check-up for you?*



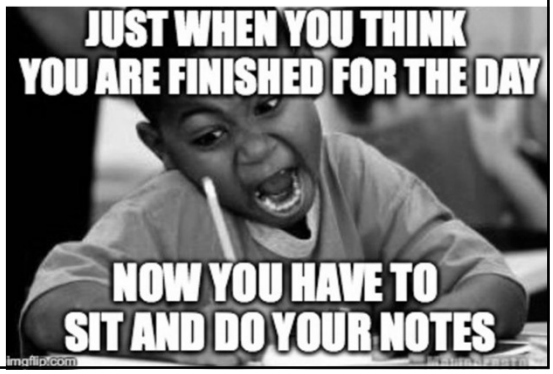
Closure and follow-up plan

- Thank the person for making the time and effort to engage with you.
- Acknowledge that this was not an easy process.
- Discuss results (in a general way if sensitive issues) and what you see as next steps.
- Leave them with a written note summarizing your discussion (and take a photo of it for your records).



After the visit

- Debrief with whoever else was at the visit with you.
- Score testing tools.
- Follow up on any information to get from collaterals (e.g. call clinic for medication list).
- Draft writeup as soon as possible!



Collaterals corroborate

- Especially if someone has **disproportionate executive impairment.**
  - Can give rational reasons, but make irrational decisions – unaware of inconsistency, lack of appreciation of context.
  - This is often a severe problem when insight is lost.
- **Collateral information helps clarify these situations.**
- Families, lawyers, and courts may need introduction to the concept of selective or disproportionate cognitive impairment, and executive dysfunction in particular.

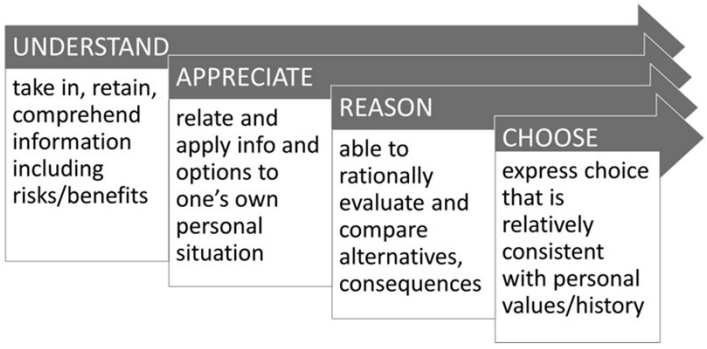
Documenting tests administered

- Your documentation should include a listing of all testing tools used.
- Include any that the person discontinued, was unable to complete, or refused.
- A "Validity Statement" is an essential part of any report – brief statement concerning the validity of any test findings. →
- The validity of test results can be altered by factors such as low effort, frank attempts to exaggerate deficits, or unstable medical status.

"[Person] gave appropriate effort during the testing, and test results are judged to be a reliable and valid indicator of their level of functioning."

Walk through how testing relates to DMC

- Relate data from testing tasks and observations to the areas of cognition and executive functioning involved at each step of DM



Tasks related to understanding

UNDERSTAND

COGNITIVE TASK	ASSESS WITH
Sensation, perception, alertness	Observation, responsiveness to stimuli
Orientation	Questions to person, place, day, date, time, situation Included in various testing tools
Attention/concentration	Observation, STMS, SLUMS, Frontal, KPT
Concentration	Blessed, Frontal, Trails
Processing speed	Naming animals/words, Trails
Language: read/listen, receptive	Observation, interview, read aloud, writing sample, repeat back, naming animals/words
Short-term working memory	Repeat back, recall, included in various tools

Tasks related to appreciating

APPRECIATE

COGNITIVE TASK	ASSESS WITH
Memory: working, episodic	Most tests/tools
Long-term retrieval	Biographical info, historical events
Learning	SLUMS
Comprehension/knowledge	Interview, clock, 3 step command, current events, months backward
Calculation	SLUMS, MOCA, Financial tools
Visual-spatial	Clock, identify shapes, copy figures, Trails
Creativity, imagination	RUDAS, Frontal, MED-SAIL
Self-Monitoring	FAQ, GDS, GAI, GAS, NPIQ, WHODAS

Tasks related to reasoning

REASON

COGNITIVE TASK	ASSESS WITH
Visual-spatial	Clock, copy figures, Trails
Reasoning: fluid, logical, abstract	Frontal, Financial tools, MED-SAIL, JAT, KPT, TOP-J, VTPJ
Problem solving	EFPT, Financial tools, MED-SAIL, JAT, KPT, TOP-J, VTPJ
Flexible thinking / adjust to change	Frontal, Trails, MED-SAIL, JAT, KPT, TOP-J, VTPJ
Plan, prioritize, sequencing	Trails, Financial tools, MED-SAIL, KPT, VTPJ
Impulse control, inhibition	Frontal
Emotional control	GDS, GAI, GAS, NPIQ, WHODAS
Insight	WHODAS, MED-SAIL, JAT, KPT, TOP-J, VTPJ

Tasks related to choosing

CHOOSE

COGNITIVE TASK	ASSESS WITH
Expressive language, writing	Interview, repeat back, writing sample
Task Initiation	EFPT, Financial tools
Organization	EFPT, MED-SAIL
Motor control	Observation, Frontal, RUDAS, TICS, Trails
Social cognition	Observation, JAT, KPT, TOP-J, VTPJ, WHODAS, NPIQ

Explaining testing: examples *(also see handout)*

St Louis University Mental Status (SLUMS) exam: a cognitive screening tool that tests orientation, memory, attention, naming, figure recognition, and calculation. Research has shown it to be more sensitive to cognitive impairment than the historically common Mini-Mental Status Exam (MMSE). A score of 27 or above is normal, and a score 20 or below indicates dementia. **[Person] scored 6 out of 18 for items attempted/administered (33%, dementia indicated for 66% or below). This indicates severe cognitive impairment at the level of dementia.**

Montreal Cognitive Assessment (MoCA): a cognitive screening tool that tests attention and concentration, executive functions, memory, language, conceptual thinking, calculations, and orientation. Research has shown it to be more sensitive to cognitive impairment than the historically common Mini-Mental Status Exam (MMSE). The MOCA-Blind is specifically designed to assess cognition in people with loss of vision. A score of 18 or above out of 22 is normal. **[Person] scored 16 out of 22, indicating significant cognitive impairment most likely at a significant level of dementia.**

Discussion data/DMC: example

- Understanding – [Person] demonstrated cognitive performance deficits in multiple areas essential to being able to understand his situation and relevant information: attention and concentration, short term memory, language fluency, and executive functioning.
- Appreciating – [Person] had limited ability to use information and logic to see consequences of different options or likely outcomes of different actions. His evaluation of factors of his situation were impaired, as was his ability to plan or organize, or carry out tasks, including how to go about gathering information. He seemed unable to fully see the consequences and had limited insight around the situations of both the phone scammers and the construction/contractors.
- Reasoning – Because [Person] had limited abilities to understand relevant information or to appreciate the situation and options, he was not fully able to evaluate options for action to see what might be better or worse options.
- Choosing – While [Person]'s abilities were limited in terms of being able to understand relevant information, appreciate the situation and options, or reason through options for action, he still appeared to be very independent minded and committed to making his own decisions and taking action for himself.

Preparation for next class on June 4

- Case study form to complete – be sure to return it before May 28.
  - This is **strongly encouraged** but not required – we will not be able to cover all case studies in the workshop time.
- Class #4 puts everything we've learned so far into practice:
  - We will review documentation considerations and formats,
  - We'll look at various actual document examples and hear from MDT/APS staff on how capacity reports are used, and
  - We'll discuss YOUR case studies!

For our next class

May 28	Get your case studies to me!
June 4	Case studies and in-depth discussion Next steps for your practice

Coming up – mark your calendars

Capacity Consultation Group	Older Adult Mental Health Consult Group
Hosted by Dr Adria Navarro of USC 12noon to 1pm on zoom on the 4th Thursdays March 27, April 24, May 22, June 26, July 24, Aug 28, Sept 25, and Oct 23 (Nov/Dec TBD) (to sign up, email Adria.Navarro@med.usc.edu)	Sponsored by GRAT/ACCS 12noon to 1:30pm on zoom on selected Tuesdays Feb 18, Apr 15, Jun 17, Aug 19, and Oct 21 Register at https://us02web.zoom.us/meeting/register/tZYuduChrzMtHdwZFNfXLh8vnk_CDPb6Nq6J#/registration

And more!

June 15:	**World Elder Abuse Awareness Day** https://www.napsa-now.org/world-elder-abuse-awareness-day/
Sept 8-10:	**National Adult Protective Services Assn conference (in Bellevue)** https://www.napsa-now.org/annual-conference/
Sept 11:	**NAPSA Financial Exploitation Summit (in Bellevue)** https://www.napsa-now.org/calendar/financial-exploitation-summit-2/