Decision Making Capacity Assessment Professional Training Program

Class 3 – October 29, 2025

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Elder Education Institute

SOUND generations

Agenda

- 15 minute breaks
- 1 hour lunch

- About DMC assessment
  - Cognitive tests
  - Other assessment tools
  - Interviewing for DM

- About doing this work
  - How to approach testing
  - Documenting testing
  - Explaining findings

Time	Topic
830a	Agenda, discussion from Class 2
840a	Polls: your experience with tools
845a	Testing as a tool; history; what we're testing
900a	Guest speaker: Christine Glenn, JD
920a	MMSE, Clock, Verbal Fluency Brief tools – screening and rating tools
940a	BREAK
955a	Cognitive tests "the key players" Executive function; Functional
1050a	BREAK
1105a	Informant; Mood/anxiety; Financial
1145a	Questions/discussion
12noon	BREAK FOR LUNCH
100p	Discussion from morning, afternoon agenda
110p	Interview formats, self neglect, undue influence
200p	BREAK
215p	Case study
245p	Groups report back, discussion
310p	BREAK
325p	Approaches to testing as part of assessment Documenting, explaining testing scores, findings
400p	Questions/discussion, issues from your work
425p	Recap, resources provided, events

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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.

BUT: ***You won't be suddenly capable of administering these tools!***

- We'll look at what they measure/assess, and how they differ from one another.
- You'll have a starting point at how to pick which tools to use in particular situations, and
- You'll know where to go for further resources to build clinical skills in using these tests/tools.

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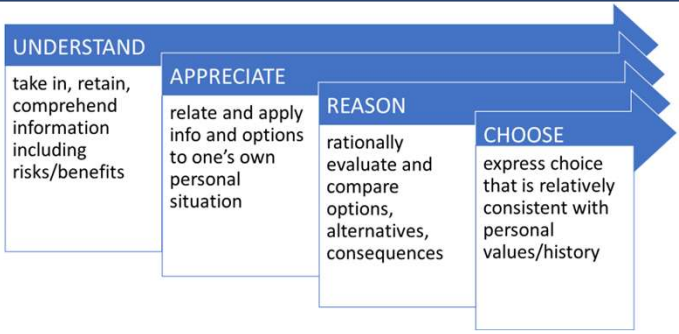
Assessment process: cognition key part

Gather Info	Interview/Assessment Visit(s)	Consult Collaterals	Document Findings
• What's the problem? • What is to be assessed? • What legal standard(s)? • Health status. • Relevant history.	• Probing questions around DM steps of understanding, appreciation, reasoning, and choices. • Cognitive tests, decision aids.	• Get info from family, CG, others. • Review records or other history.	• Clearly record observations. • Discuss analysis of interview and other data. • Clearly state findings and recommendations.

Reminder of what we're assessing

- DM process and cognitive processes involved

DECISION MAKING CAPACITY



FUNCTIONAL ABILITY

Execute the communicated choice – carry out the stated decision.

- Performance of the tasks involved.
- Ability to engage supports if/when needed to do so.
- Ability to adjust to change.

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SPECIFIC COGNITIVE TASKS LINKED TO DECISION MAKING STEPS

UNDERSTAND	APPRECIATE	REASON	CHOOSE
• Sensation • Perception • Alertness • Orientation • 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

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.

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Formal training versus….

Clinical experience:
Making the same mistakes with increasing confidence over an impressive number of years.

Evidence-based medicine:
Perpetuating other people's mistakes instead of your own.

from A Skeptic's Medical Dictionary, by Michael O'Donnell, cited in The Lancet (editorial, Vol 351, January 3, 1998)

EXPERIENCE CAN JUST MEAN MAKING THE SAME MISTAKE WITH INCREASING CONFIDENCE.

Origins of testing tools

- 1880s: Francis Galton's "Anthropometric Laboratory" – physiological tests: grip strength, height, weight.
- 1890s-1920s: James McKeen Cattell's "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

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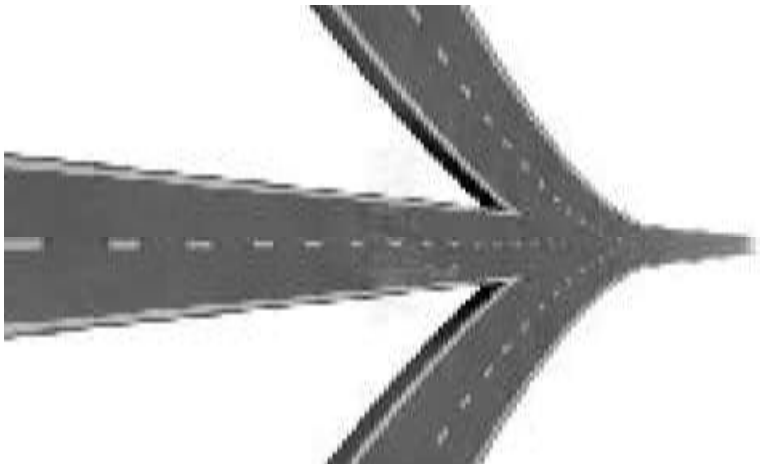
Psychometrics

Scientific research



Psychology / Social Work clinical approaches

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	SPECIFICITY
true positive rate	**true negative rate**
probability of a positive test result, when the individual truly is positive.	probability of a negative test result, when the individual truly is negative.

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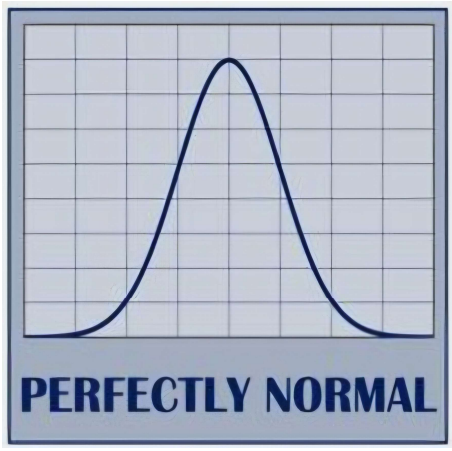
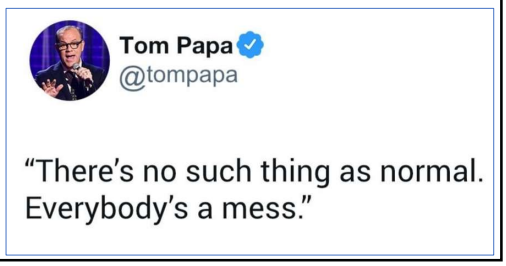
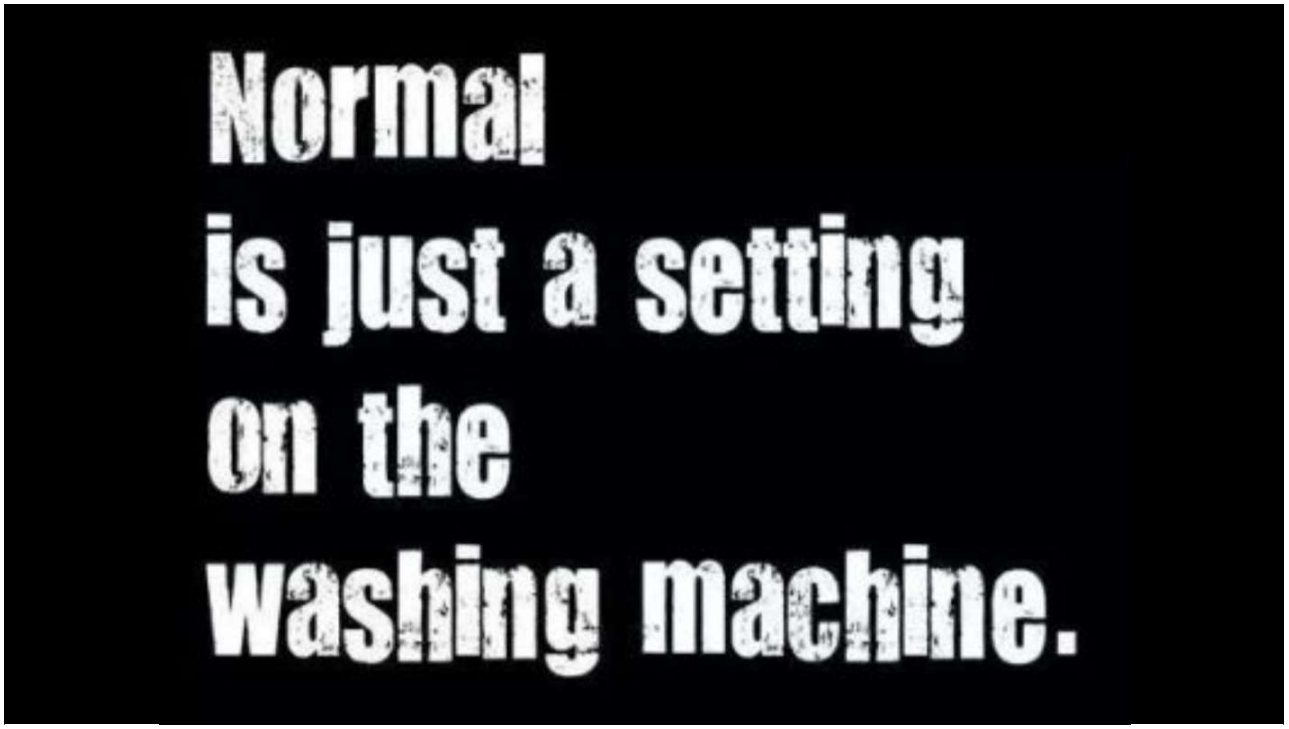
Norms

- Score curves for groups by age, education level, gender, language/culture, particular conditions (heart disease, Parkinson's)
- Normative data typically gathered on generally healthy individuals – without significant cognitive, developmental, 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.







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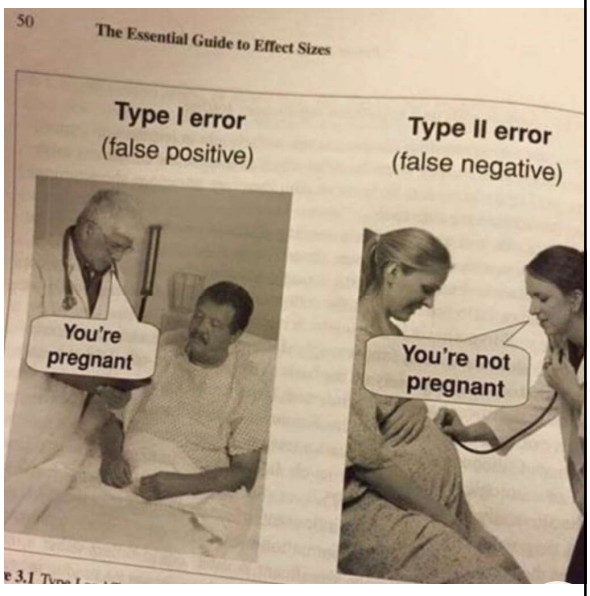
Standardized administration procedures

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



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Limits of testing

- Results can be affected by many things: 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!

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.

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Guest speaker: Christine Glenn, JD

- Christine grew up in Cleveland, Ohio and always had a special place in her heart for the elderly. She found her niche at Washington's Department of Social and Health Services. Christine represents the Department advocating for vulnerable adults in administrative proceedings who have been allegedly abused or neglected, whether it be sexual abuse, financial exploitation, mental abuse, or physical abuse.
- Christine received a BA in communications and BA in psychology from Purdue University, and a JD from Southwestern University School of Law. She was admitted in 1997 to the California State Bar, U.S. Supreme Court, and 9th Circuit Court of Appeals, and in 2003 to Washington State. She is a member of the Washington State Bar Association and the California Bar Association.

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

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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.

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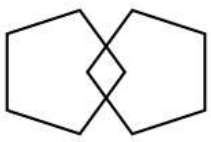
MINI MENTAL STATE EXAMINATION (MMSE)

Name:

DOB:

MRN:

One point for each answer	DATE:		
ORIENTATION Year Season Month Date Time	...../ 5	...../ 5	...../ 5
Country Town District Hospital Ward/Floor	...../ 5	...../ 5	...../ 5
REGISTRATION Examiner names three objects (e.g. apple, table, penny) and asks the patient to repeat (1 point for each correct. THEN the patient learns the 3 names repeating until correct).	...../ 3	...../ 3	...../ 3
ATTENTION AND CALCULATION Subtract 7 from 100, then repeat from result. Continue five times: 100, 93, 86, 79, 65. (Alternative: spell "WORLD" backwards: DLROW).	...../ 5	...../ 5	...../ 5
RECALL Ask for the names of the three objects learned earlier.	...../ 3	...../ 3	...../ 3
LANGUAGE Name two objects (e.g. pen, watch).	...../ 2	...../ 2	...../ 2
Repeat "No ifs, ands, or buts".	...../ 1	...../ 1	...../ 1
Give a three-stage command. Score 1 for each stage. (e.g. "Place index finger of right hand on your nose and then on your left ear").	...../ 3	...../ 3	...../ 3
Ask the patient to read and obey a written command on a piece of paper. The written instruction is: "Close your eyes".	...../ 1	...../ 1	...../ 1
Ask the patient to write a sentence. Score 1 if it is sensible and has a subject and a verb.	...../ 1	...../ 1	...../ 1
COPYING: Ask the patient to copy a pair of intersecting pentagons 	...../ 1	...../ 1	...../ 1
TOTAL:	...../ 30	...../ 30	...../ 30

MMSE scoring
24-30: no cognitive impairment
18-23: mild cognitive impairment
0-17: severe cognitive impairment

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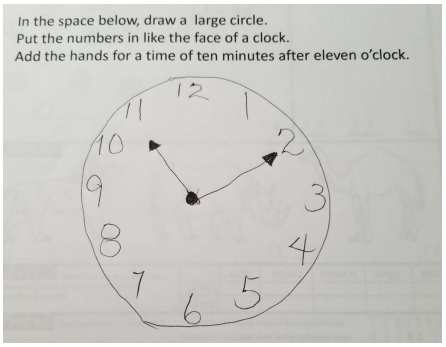
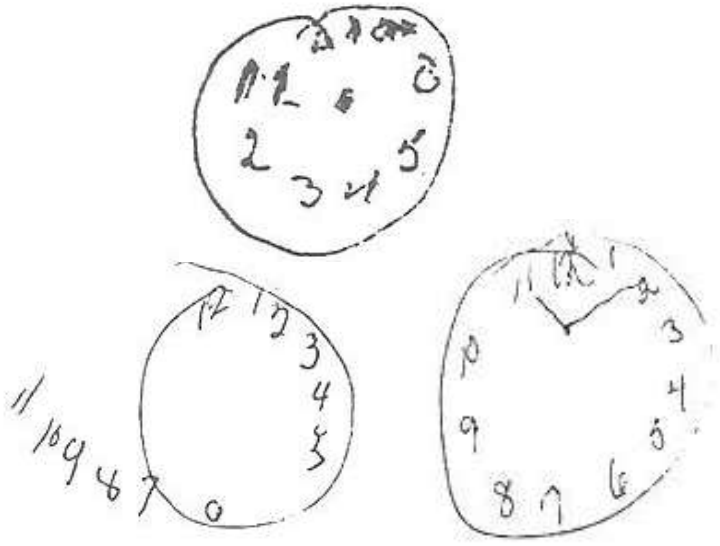
Clock exercise shows multiple processes

Executive functioning	Organization: Gathering information, 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





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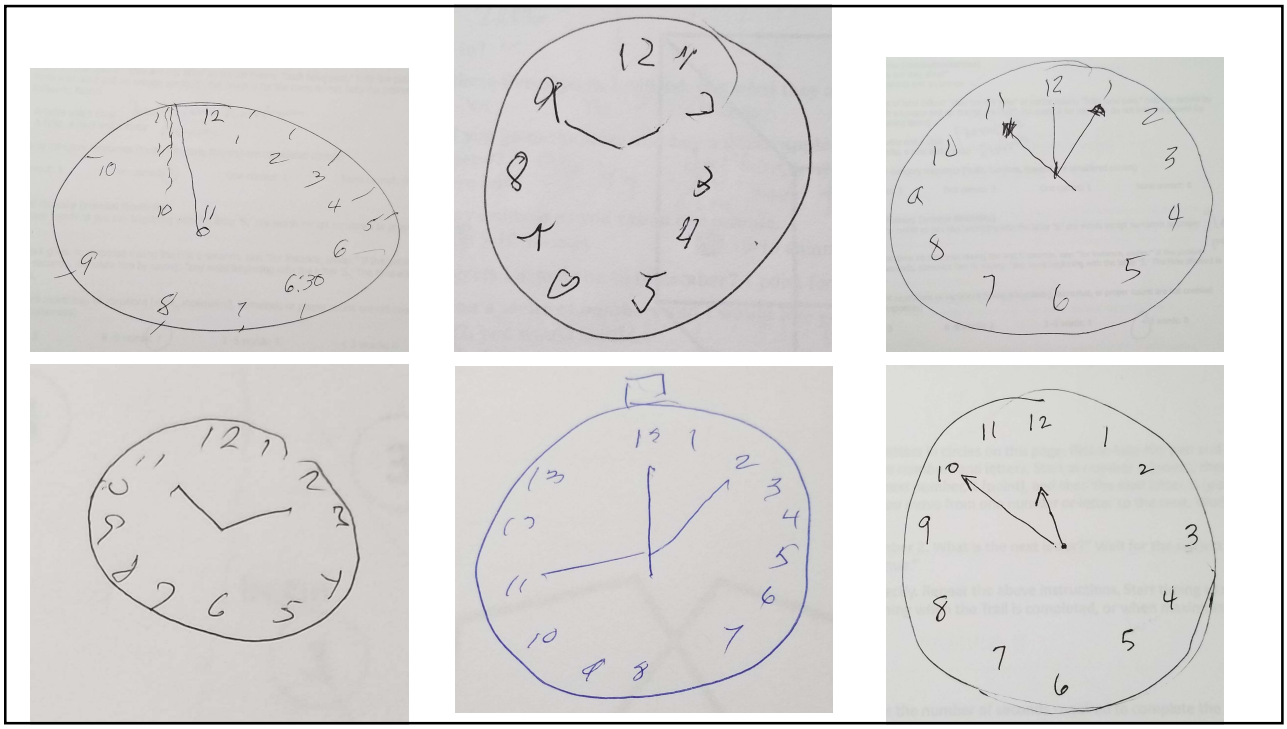

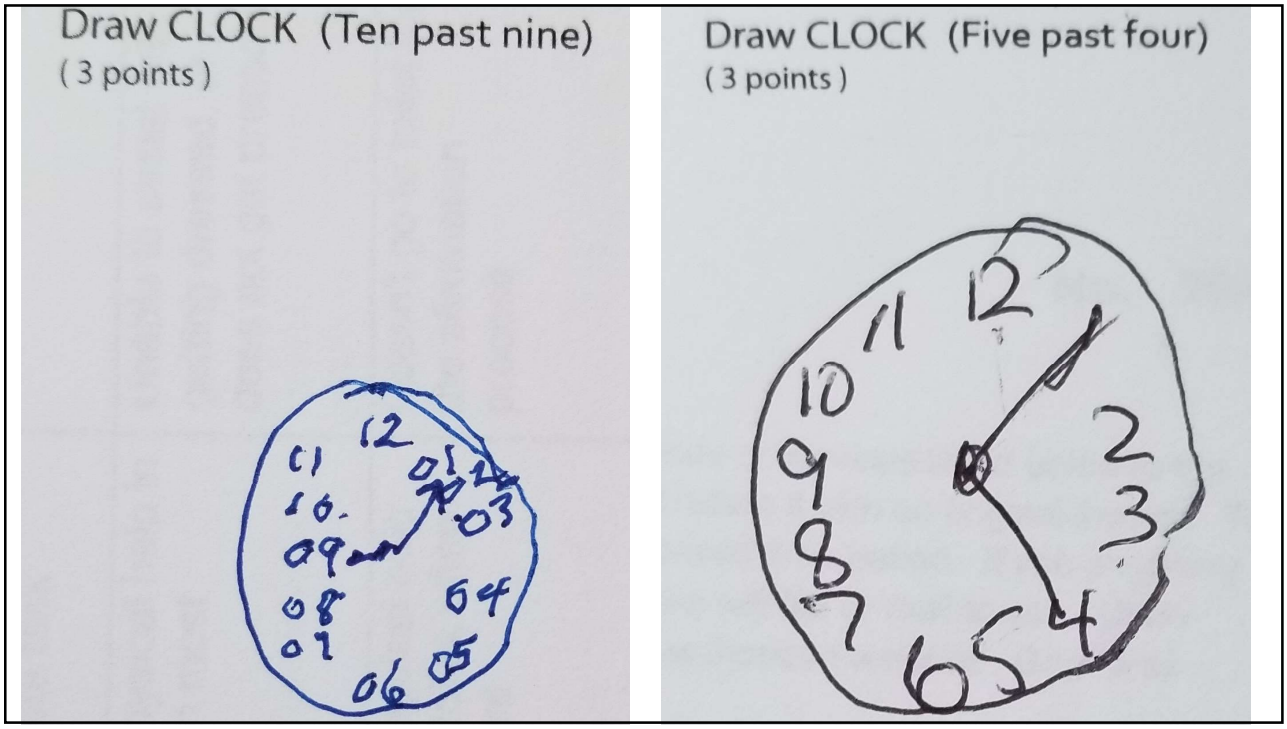

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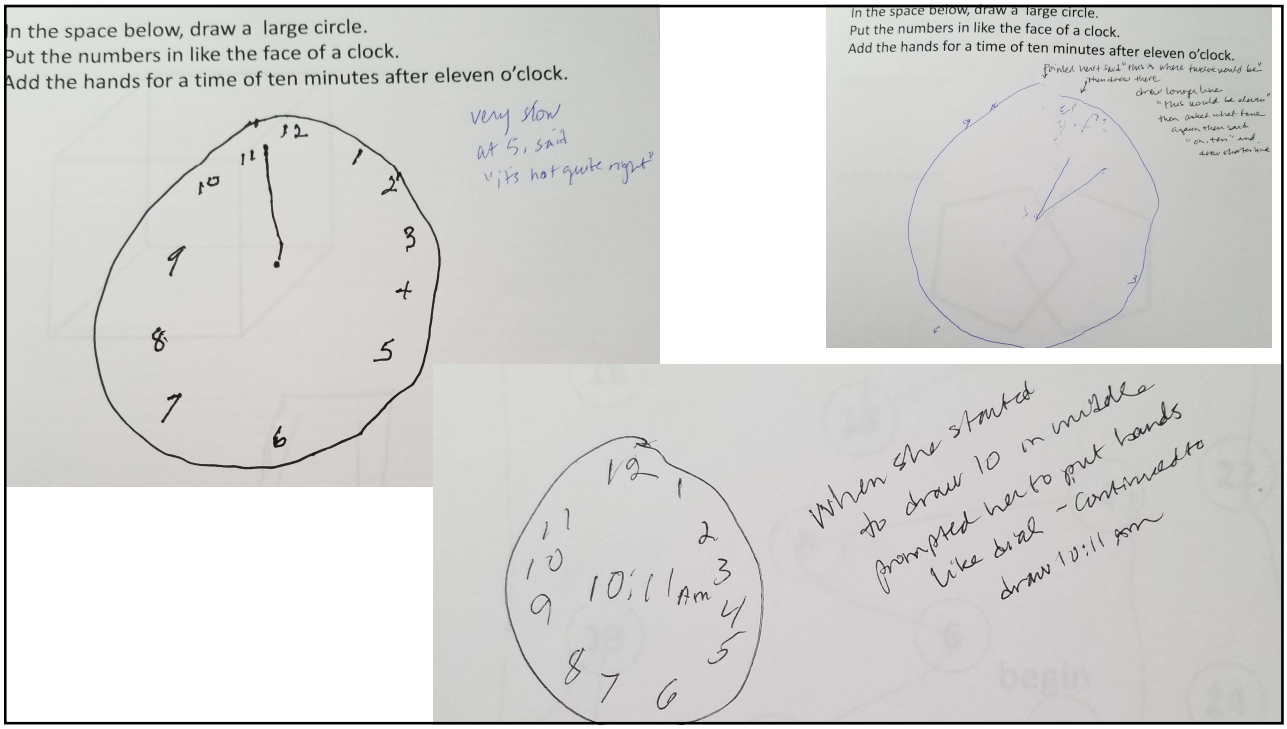

Verbal fluency – "animals and F-words"

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.

**no points for proper nouns/names, repeats, derivatives*

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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

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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.

Short Blessed Test (SBT)

Instructions to the patient: Now I would like to ask you some questions to check your memory and concentration. Some of them may be easy and some of them may be hard.

	Correct	Incorrect
1) What year is it now?	0	1
2) What month is this?	0	1

Please repeat this name and address after me:
John Brown, 42 Market Street, Chicago
John Brown, 42 Market Street, Chicago
John Brown, 42 Market Street, Chicago
(underline words repeated correctly in each trial)
Trials to learn _____ (if unable to do in 3 trials = C)

3) Without looking at your watch or clock, tell me what time it is. (If response is vague, prompt for specific response within 1-hour)

Correct	Incorrect
0	1

4) Count aloud backwards from 20 to 1 (mark correctly sequenced numerals – if subject starts counting forward or forgets the task, repeat instructions and score one error)

0 1 2 Errors

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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

Patient name: _____

Testing date: _____

GPCOG

STEP 1 – PATIENT EXAMINATION

Unless specified, each question should only be asked once.

Name and address for subsequent recall test

I am going to give you a name and address. After I have said it, I want you to repeat it. Remember this name and address because I am going to ask you to tell it to me again in a few minutes: John Brown, 42 West Street, Kensington. (Allow a maximum of 4 attempts.)

		Correct	Incorrect
Time orientation			
1.	*What is the date?* (exact only)	☐	☐
Clock drawing (use blank page)			
2.	*Please mark in all the numbers to indicate the hours of a clock.* (correct spacing required)	☐	☐
3.	*Please mark in hands to show 10 minutes past eleven o'clock.* (11.10)	☐	☐
Information			
4.	*Can you tell me something that happened in the news recently?* (Recently = in the last week. If a general answer is given, e.g. "war", "lot of rain", ask for details. Only specific answer scores.)	☐	☐

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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

Mini-Cog™

Instructions for Administration & Scoring

ID: _____ Date: _____

Step 1: Three Word Registration

Look directly at person and say, "Please listen carefully. I am going to say three words that I want you to repeat back to me now and try to remember. The words are [select a list of words from the versions below]. Please say them for me now." If the person is unable to repeat the words after three attempts, move on to Step 2 (clock drawing).

The following and other word lists have been used in one or more clinical studies.[1-3] For repeated administrations, use of an alternative word list is recommended.

Version 1	Version 2	Version 3	Version 4	Version 5	Version 6
Banana	Leader	Village	River	Captain	Daughter
Sunrise	Season	Kitchen	Nation	Garden	Heaven
Chair	Table	Baby	Finger	Picture	Mountain

Step 2: Clock Drawing

Say: "Next, I want you to draw a clock for me. First, put in all of the numbers where they go." When that is completed, say: "Now, set the hands to 10 past 11."

Use preprinted circle (see next page) for this exercise. Repeat instructions as needed as this is not a memory test. Move to Step 3 if the clock is not complete within three minutes.

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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

THE SHORT PORTABLE MENTAL STATUS QUESTIONNAIRE (SPMSQ)

CLICK TO RESET THE FORM

QUESTION	RESPONSE	INCORRECT RESPONSES
1. What are the date, month, and year?		
2. What is the day of the week?		
3. What is the name of this place?		
4. What is your phone number?		
5. How old are you?		
6. When were you born?		

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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, current president former president

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

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AD8 Dementia Screening Interview

Patient ID#:_____
CS ID#:_____
Date:_____

Remember, "Yes, a change" indicates that there has been a change in the last several years caused by cognitive (thinking and memory) problems.	YES, A change	NO, No change	N/A, Don't know
1. Problems with judgment (e.g., problems making decisions, bad financial decisions, problems with thinking)			
2. Less interest in hobbies/activities			
3. Repeats the same things over and over (questions, stories, or statements)			

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

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The following descriptions characterize changes you may have noticed in your cognitive and functional abilities. The important thing to consider is comparing how your memory and thinking abilities are **now** compared with how they **used** to be – the key feature is ***change***.

Choose the ***one best answer*** for each category that best describes you – Note: not all the descriptions need to be present to choose an answer. Please make only one choice per category.

1. MEMORY AND RECALL	
☐0	**No obvious memory loss** or slight inconsistent forgetfulness that does not interfere with your everyday function
☐0.5	**Consistent mild forgetfulness** or partial recollection of events that may interfere with performing your everyday activities; repeats questions/statements, misplaces items, forgets appointments
☐1	**Mild to moderate memory loss**; more noticeable for recent events; interferes with performing your everyday activities
☐2	**Moderate to severe memory loss**; only highly learned information remembered; new information rapidly forgotten
☐3	**Severe memory loss**, almost impossible to recall new information; long-term memory may be affected

2. ORIENTATION	
☐0	**Fully oriented** to person, place, and time nearly all the time
	Slight difficulty keeping track of time; may forget day or date more frequently than in the past

Brief rating tools: variety/overlap

AD8	QDRS
Forgets appointments, thinking/memory	Memory, recall
Orientation: 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

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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.

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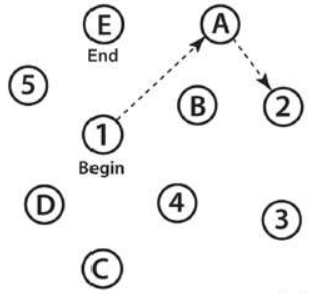
MONTREAL COGNITIVE ASSESSMENT (MOCA®)

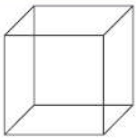
Version 8.1 English

Name: Education: Sex: Date of birth: DATE:

VISUOSPATIAL / EXECUTIVE



Copy cube



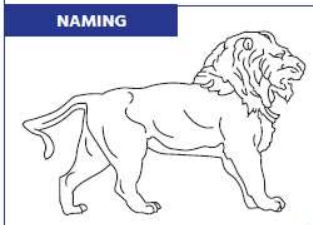
[ ] [ ]

Draw CLOCK (Ten past eleven)
(3 points)

[ ] Contour [ ] Numbers [ ] Hands

POINTS __/5

NAMING



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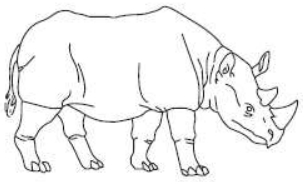

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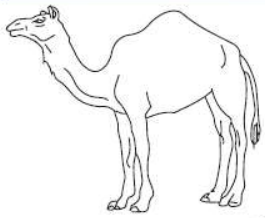

[ ]

__/3

MEMORY Read list of words, subject must repeat them. Do 2 trials, even if 1st trial is successful. Do a recall after 5 minutes.

	FACE	VELVET	CHURCH	DAISY	RED	NO POINTS
1ST TRIAL						
2ND TRIAL						

ATTENTION Read list of digits (1 digit/ sec.).

Subject has to repeat them in the forward order. [ ] 2 1 8 5 4

Subject has to repeat them in the backward order. [ ] 7 4 2 __/2

Read list of letters. The subject must tap with his hand at each letter A. No points if ≥ 2 errors

[ ] F B A C M N A A J K L B A F A K D E A A A J A M O F A A B __/1

Serial 7 subtraction starting at 100. [ ] 93 [ ] 86 [ ] 79 [ ] 72 [ ] 65

4 or 5 correct subtractions: **3 pts**, 2 or 3 correct: **2 pts**, 1 correct: **1 pt**, 0 correct: **0** __/3

LANGUAGE Repeat: I only know that John is the one to help today. [ ]

The cat always hid under the couch when dogs were in the room. [ ] __/2

Fluency: Name maximum number of words in one minute that begin with the letter F. [ ] _____ (N ≥ 11 words) __/1

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

DELAYED RECALL __/5

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

ORIENTATION [ ] Date [ ] Month [ ] Year [ ] Day [ ] Place [ ] City __/6

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Administered by: _____

Training and Certification are required to ensure accuracy

MIS: /15
(Normal ≥ 26/30)
Add 1 point if ≤ 12 yr edu

TOTAL __/30

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Newer 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.

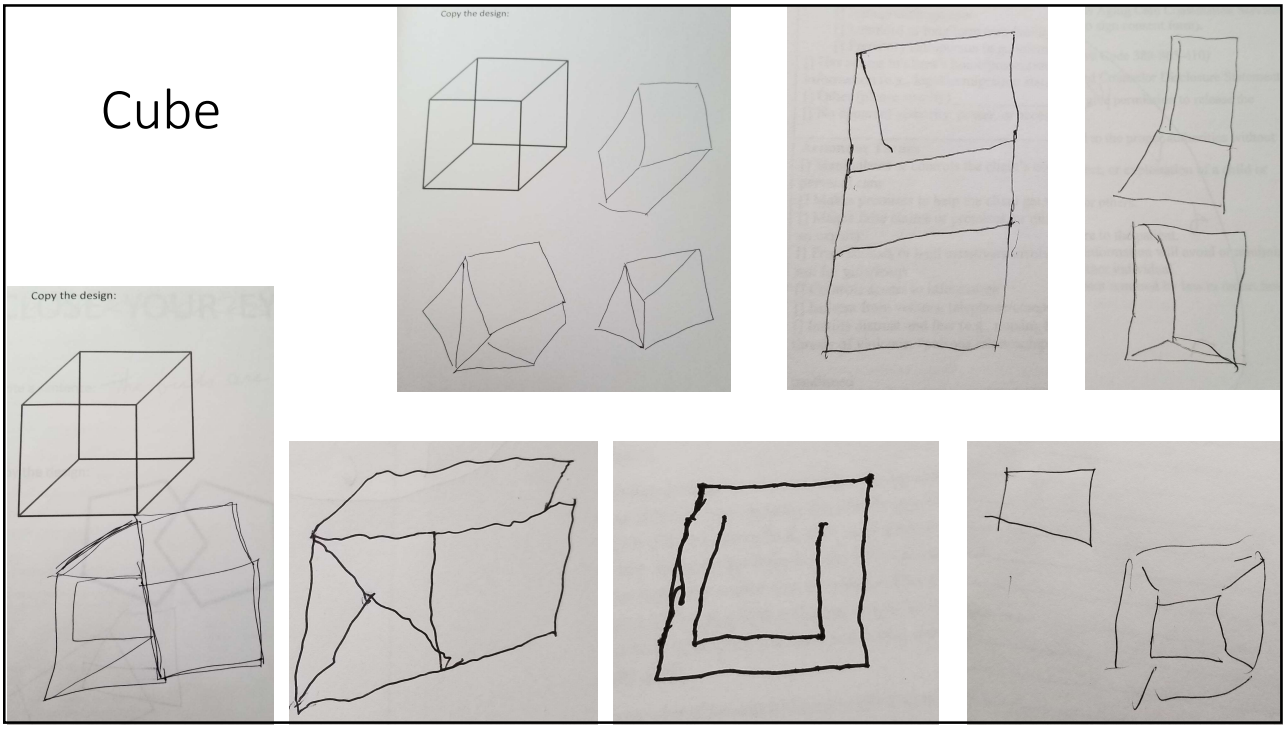
DELAYED RECALL	(MIS)	Has to recall words WITH NO CUE	FACE [ ]	VELVET [ ]	CHURCH [ ]	DAISY [ ]	RED [ ]	Points for UNCUED recall only	__/5
Memory Index Score (MIS)	X3								
	X2	Category cue						MIS =____/15	
	X1	Multiple choice cue							
ORIENTATION	[ ] Date	[ ] Month	[ ] Year	[ ] Day	[ ] Place	[ ]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



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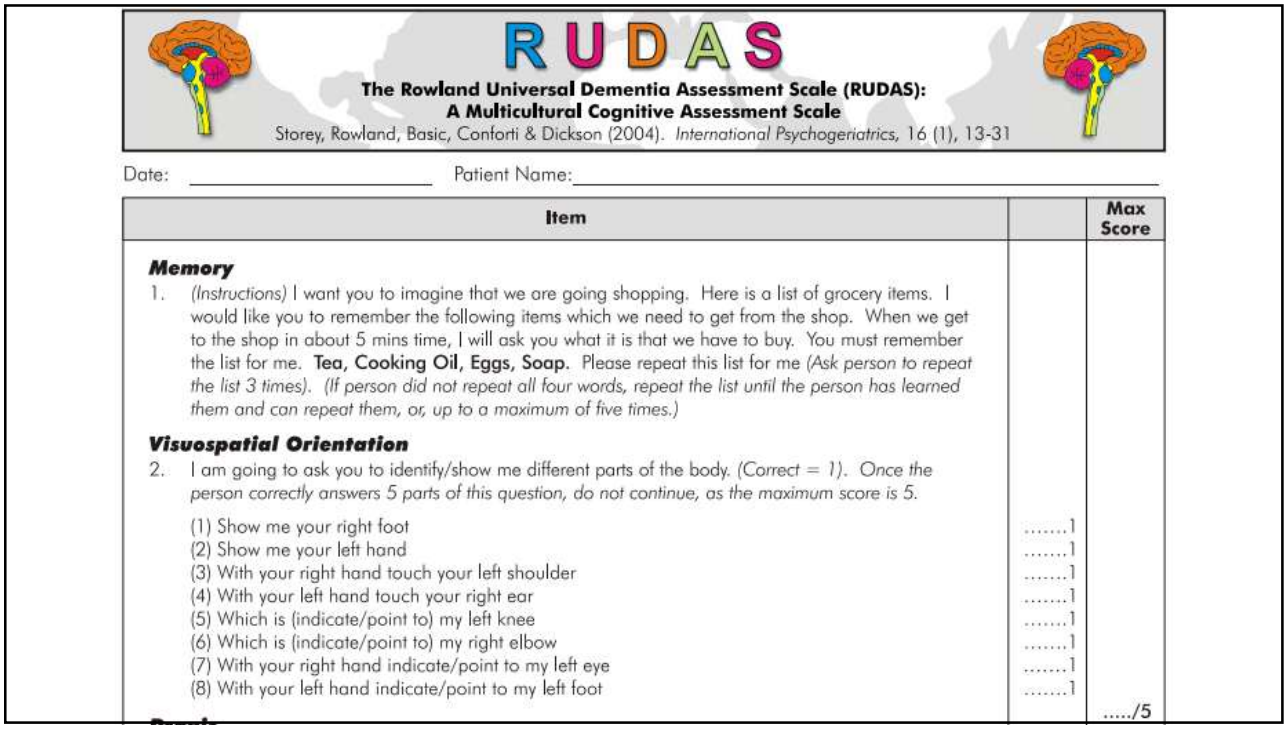
Rowland Universal Dementia Assessment Scale

- 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

The Rowland Universal Dementia Assessment Scale (RUDAS): A Multicultural Cognitive Assessment Scale

Storey, Rowland, Basic, Conforti & Dickson (2004). *International Psychogeriatrics*, 16 (1), 13-31

Date: _____ Patient Name: _____

Item		Max Score
Memory		
1. *(Instructions)* I want you to imagine that we are going shopping. Here is a list of grocery items. I would like you to remember the following items which we need to get from the shop. When we get to the shop in about 5 mins time, I will ask you what it is that we have to buy. You must remember the list for me. **Tea, Cooking Oil, Eggs, Soap.** Please repeat this list for me *(Ask person to repeat the list 3 times). (If person did not repeat all four words, repeat the list until the person has learned them and can repeat them, or, up to a maximum of five times.)*		
Visuospatial Orientation		
2. I am going to ask you to identify/show me different parts of the body. *(Correct = 1). Once the person correctly answers 5 parts of this question, do not continue, as the maximum score is 5.*		
(1) Show me your right foot	1	
(2) Show me your left hand	1	
(3) With your right hand touch your left shoulder	1	
(4) With your left hand touch your right ear	1	
(5) Which is (indicate/point to) my left knee	1	
(6) Which is (indicate/point to) my right elbow	1	
(7) With your right hand indicate/point to my left eye	1	
(8) With your left hand indicate/point to my left foot	1	
		...../5

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Praxis

3. I am going to show you an action/exercise with my hands. I want you to watch me and copy what I do. Copy me when I do this... *(One hand in fist, the other palm down on table - alternate simultaneously.)* Now do it with me: Now I would like you to keep doing this action at this pace until I tell you to stop - approximately 10 seconds. *(Demonstrate at moderate walking pace).*

Score as:

Normal	=	2	(very few if any errors; self-corrected, progressively better; good maintenance; only very slight lack of synchrony between hands)
Partially Adequate	=	1	(noticeable errors with some attempt to self-correct; some attempt at maintenance; poor synchrony)
Failed	=	0	(cannot do the task; no maintenance; no attempt whatsoever)

...../2

Visuoconstructional Drawing

4. Please copy/draw this picture exactly as it looks to you. (Show cube on back page) *(Yes = 1).*

Score as:

(1) Has person drawn a picture based on a square? 1

(2) Do all internal lines appear in person's drawing? 1

(3) Do all external lines appear in person's drawing? 1

...../3

Judgement

5. You are standing on the side of a busy street. There is no pedestrian crossing and no traffic lights. Tell me what you would do to get across to the other side of the road **safely.** *(If person gives incomplete response that does not address both parts of answer, use prompt: "Is there anything else you would do?") Record exactly what patient says and circle all parts of response that were prompted.*

.....

.....

Score as:

Did person indicate that they would look for traffic? (YES = 2;YES PROMPTED = 1; NO = 0) 2

Did person make any additional safety proposals? (YES = 2;YES PROMPTED = 1; NO = 0) 2

...../4

Memory Recall

1. *(Recall)* We have just arrived at the shop. Can you remember the list of groceries we need to buy? *(Prompt: If person cannot recall any of the list, say "The first one was 'tea'." (Score 2 points each for any item recalled which was not prompted use only 'tea' as a prompt.)*

Tea	2
Cooking Oil	2
Eggs	2
Soap	2

...../8

Language

6. I am going to time you for one minute. In that one minute, I would like you to tell me the names of as many different animals as you can. We'll see how many different animals you can name in one minute. *(Repeat instructions if necessary). Maximum score for this item is 8. If person names 8 new animals in less than one minute there is no need to continue.*

1.	5. .....
2.	6. .....
3.	7. .....
4.	8. .....

TOTAL SCORE **/30**

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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.

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Saint Louis University

Mental Status (SLUMS) Examination

Name _____ Age _____

Is patient alert? _____ Level of education _____

(1) 1. What day of the week is it?

(1) 2. What is the year?

(1) 3. What state are we in?

4. Please remember these five objects. I will ask you what they are later.
Apple Pen Tie House Car

5. You have $100 and you go to the store and buy a dozen apples for $3 and a tricycle for $20.
(1) How much did you spend?
(2) How much do you have left?

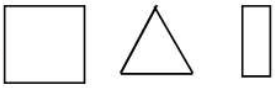
6. Please name as many animals as you can in one minute.
(0) 0-5 animals (1) 5-10 animals (2) 10-15 animals (3) 15+ animals

(5) 7. What were the 5 objects I asked you to remember? 1 point for each one correct.

8. I am going to give you a series of numbers and I would like you to give them to me backwards. For example, if I say 42, you would say 24.
(0) 87 (1) 649 (1) 8537

9. This is a clock face. Please put in the hour markers and the time at ten minutes to eleven o'clock.
(2) Hour markers okay
(2) Time correct

(1) 10. Please place an X in the triangle.



(1) Which of the above figures is largest?

11. I am going to tell you a story. Please listen carefully because afterwards, I'm going to ask you some questions about it.

Jill was a very successful stockbroker. She made a lot of money on the stock market. She then met Jack, a devastatingly handsome man. She married him and had three children. They lived in Chicago. She then stopped work and stayed at home to bring up her children. When they were teenagers, she went back to work. She and Jack lived happily ever after.

(2) What was the female's name?
(2) When did she go back to work?
(2) What work did she do?
(2) What state did she live in?

Scoring

High School Education		Less than High School Education
27-30	Normal	20-30
20-27	MCI	14-19
1-19	Dementia	1-14

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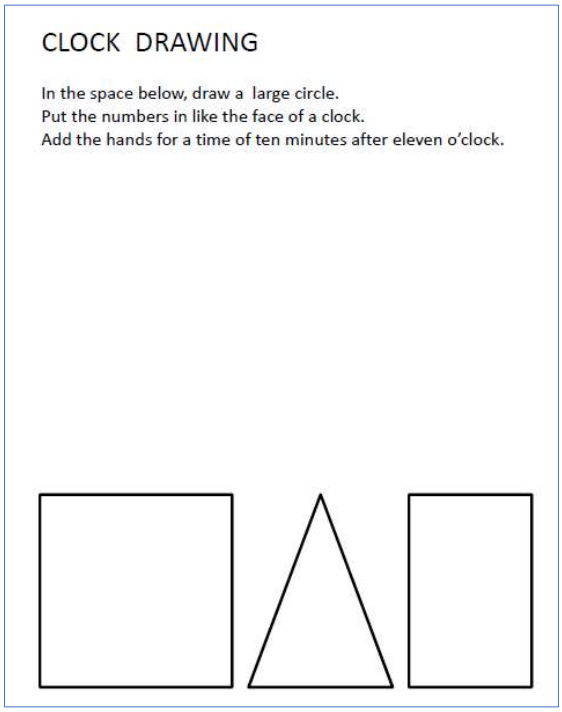
Shapes

- 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	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 shopping list	5 words
Attention	Spell WORLD backwards	Digit span: 5 forward, and 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

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TASK	MMSE	MOCA	RUDAS	SLUMS
Language	Naming, read aloud, write sentence; Repeat phrase 3-step command	Name animals (from pics) Repeat sentence Name "F" words	Name animals	Name animals Story exercise
Visual-spatial	Intersecting pentagons	Clock 3-D cube, tube, or chair	3-D cube Parts of body	Clock Identify shapes
Executive function	3-step command	Mini Trails B		
Praxis/ motor	3-step command		Point to parts of body Alternate fist/ palm exercise	
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 educ. / < 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
Estimated equivalent to MMSE score of 25	25	18	22	20

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

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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:

- Frontal Assessment Battery
- 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.

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Frontal Assessment Battery

Purpose
The FAB is a brief tool that can be used at the bedside or in a clinic setting to assist in discriminating between dementias with a frontal dysexecutive phenotype and Dementia of Alzheimer's Type (DAT). The FAB has validity in distinguishing Fronto-temporal type dementia from DAT in mildly demented patients (MMSE > 24). Total score is from a maximum of 18, higher scores indicating better performance.

1. Similarities (conceptualization)
"In what way are they alike?"

- A banana and an orange

(In the event of total failure: "they are not alike" or partial failure: "both have peel," help the patient by saying: "both a banana and an orange are fruit"; but credit 0 for the item; do not help the patient for the two following items)

- A table and a chair
- A tulip, a rose and a daisy

Score (only category responses [fruits, furniture, flowers] are considered correct)

Three correct: 3 Two correct: 2 One correct: 1 None correct: 0

2. Lexical fluency (mental flexibility)
"Say as many words as you can beginning with the letter 'S,' any words except surnames or proper nouns."

If the patient gives no response during the first 5 seconds, say: "for instance, snake." If the patient pauses 10 seconds, stimulate him by saying: "any word beginning with the letter 'S.' The time allowed is 60 seconds.

Score (word repetitions or variations [shoe, shoemaker], surnames, or proper nouns are not counted as correct responses)

3. Motor series "Luria" test (programming)
"Look carefully at what I'm doing."

The examiner, seated in front of the patient, performs alone three times with his left hand the series of "fist–edge–palm."
"Now, with your right hand do the same series, first with me, then alone."
The examiner performs the series three times with the patient, then says to him/her:
"Now, do it on your own."

Score

Patient performs six correct consecutive series alone: 3
Patient performs at least three correct consecutive series alone: 2
Patient fails alone, but performs three correct consecutive series with the examiner: 1
Patient cannot perform three correct consecutive series even with the examiner: 0

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4. Conflicting instructions (sensitivity to interference)
"Tap twice when I tap once."
To ensure that the patient has understood the instruction, a series of 3 trials is run: 1-1-1.

"Tap once when I tap twice."
To ensure that the patient has understood the instruction, a series of 3 trials is run: 2-2-2.

The examiner then performs the following series: 1-1-2-1-2-2-2-1-1-2.

Score No errors: 3 1 -2 errors: 2 > 2 errors: 1
Patient taps like the examiner at least four consecutive times: 0

5. Go–No Go (inhibitory control)
"Tap once when I tap once."
To ensure that the patient has understood the instruction, a series of 3 trials is run: 1-1-1.

"Do not tap when I tap twice."
To ensure that the patient has understood the instruction, a series of 3 trials is run: 2-2-2.

The examiner then performs the following series: 1-1-2-1-2-2-2-1-1-2.

Score No errors: 3 1 -2 errors: 2 > 2 errors: 1
Patient taps like the examiner at least four consecutive times: 0

6. Prehension behaviour (environmental autonomy)

"Do not take my hands."

The examiner is seated in front of the patient. Place the patient's hands palm up on his knees. Without saying anything or looking at the patient, the examiner brings his own hands close to the patient's hands and touches the palms of both the patient's hands, to see if he will spontaneously take them. If the patient takes the examiner's hands, try again after asking the patient: "Now, do not take my hands."

Score

Patient does not take the examiner's hands: 3
Patient hesitates and asks what he/she has to do: 2
Patient takes the hands without hesitation: 1
Patient takes the examiner's hand even after he/she has been told not to do so: 0

Interpreting results
A cut off score of 12 on the FAB has a sensitivity of 77% and specificity of 87% in differentiating between frontal dysexecutive type dementias and DAT

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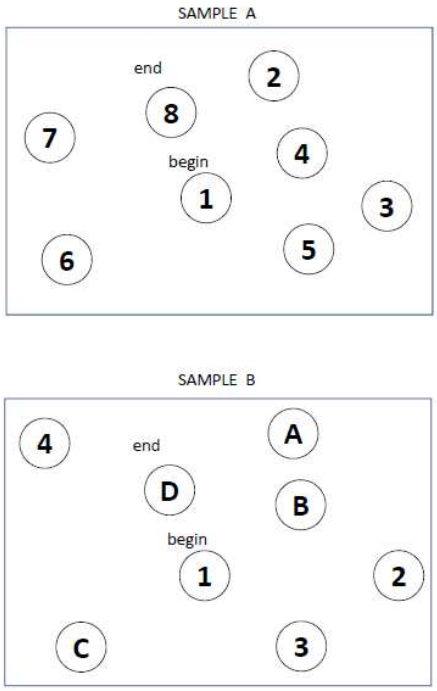
Trail Making Test (TMT)

- 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)



Trails

- Dot-to-dot **TIMED** exercise using numbers (1-2-3) and then alternating letters and numbers (1-A-2-B-3-C).
- Involves visual search speed, scanning, speed of processing, mental flexibility, and executive functioning.
- Motor speed is key – not suitable for all (e.g. movement disorders, bad arthritis).
- Performance strongly correlates with risk of driving problems. *(Papandonatos; Vaucher; various others)*

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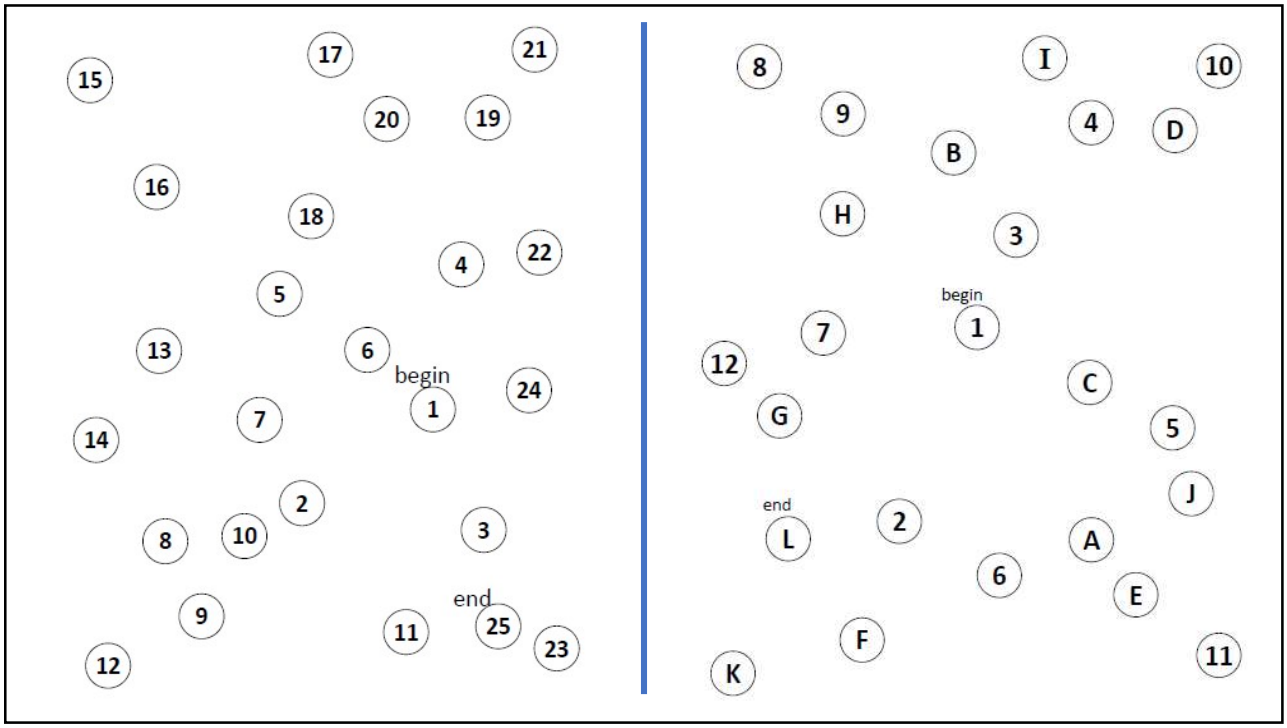
How to administer – timing, scoring

- Explain and have them do samples.
- Have them do Part A (numbers) first:
  - If unable to do sample, don't do the test.
  - If able to do correctly, then do the test.
  - Then repeat process with Part B
- Oral TMT version
  - Helpful with visual/motor impairments.
  - For Part A, verbally count from 1 to 25.
  - For Part B, alternate numbers/letters.
  - Results analogous to traditional test. *(Bastug)*

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



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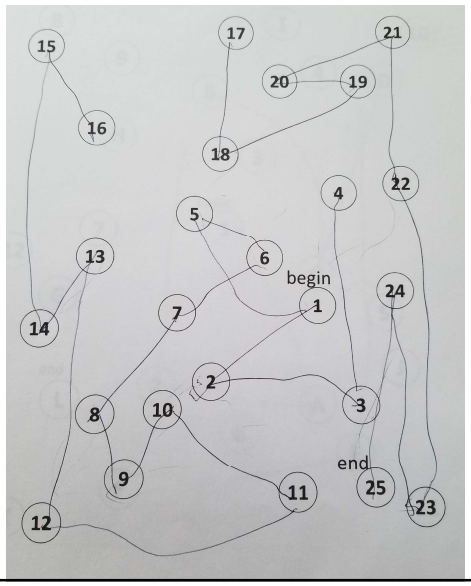
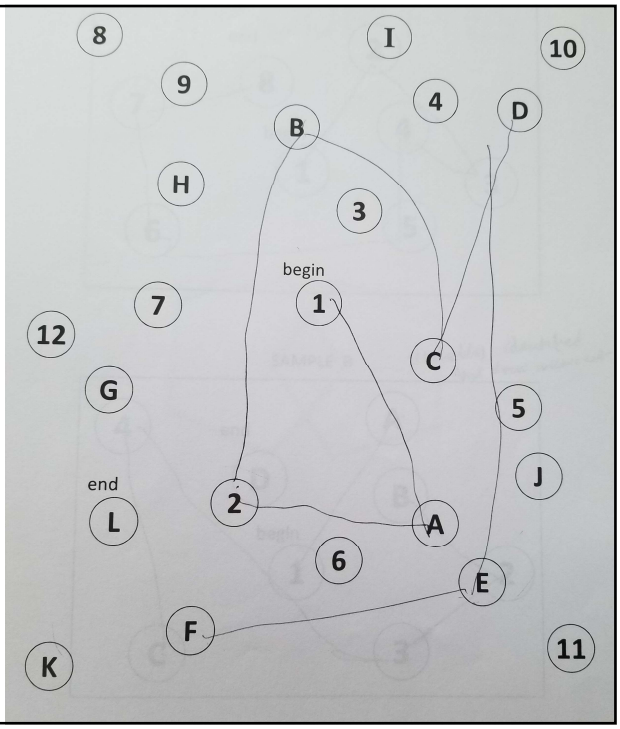
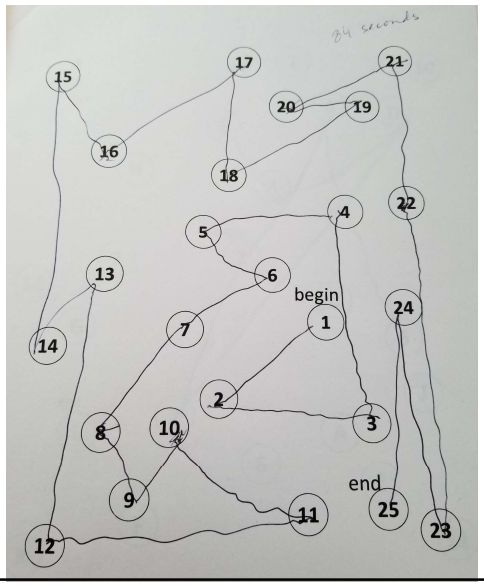
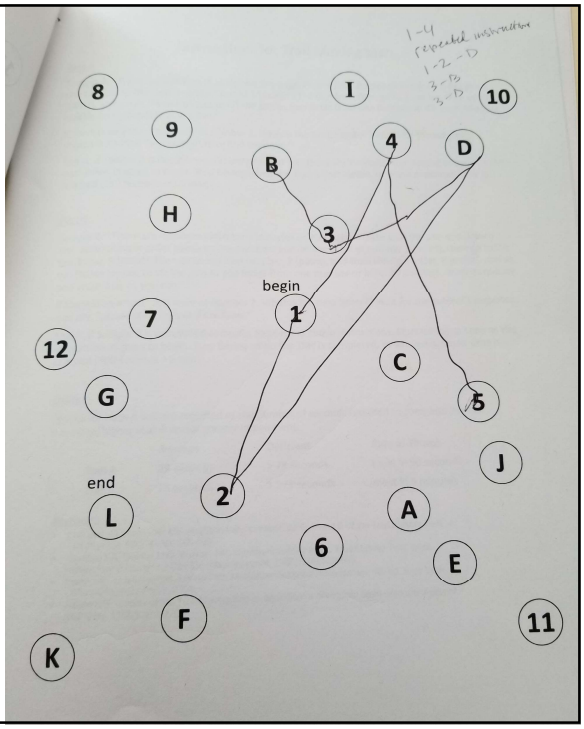
Difference A:B





Difference A:B





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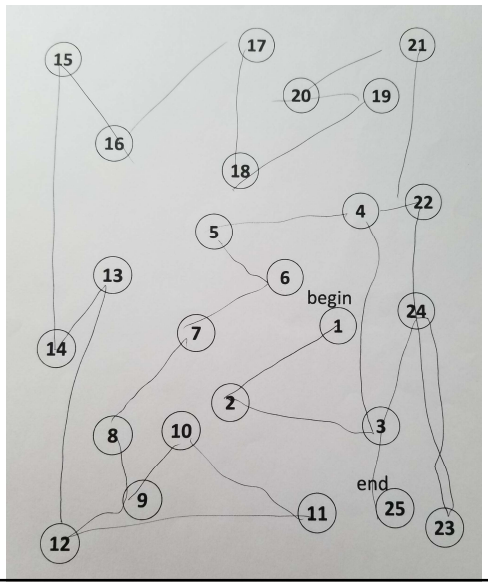
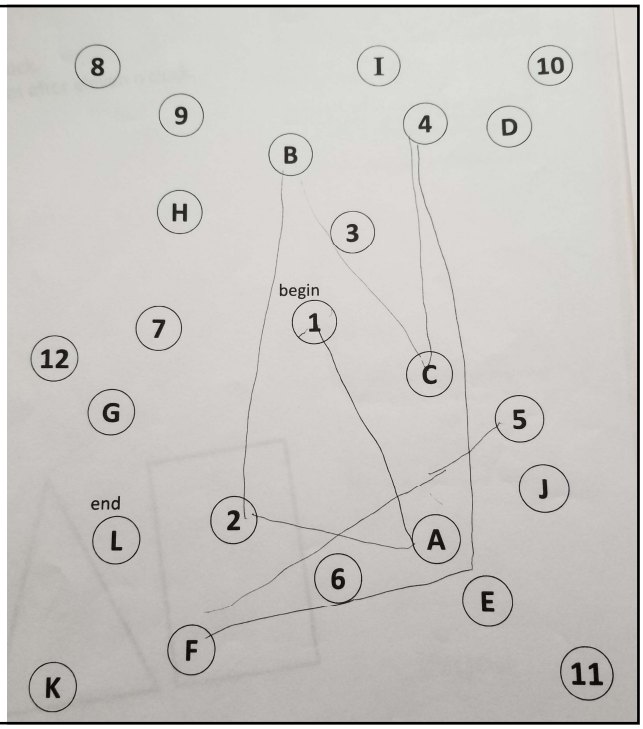
Difference A:B





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)

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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
- 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.

Scoring:
6 = full function,
4 = moderate impairment,
2 or less = severe functional impairment.

Katz Index of Independence in Activities of Daily Living

Activities Points (1 or 0)	Independence (1 Point) NO supervision, direction or personal assistance.	Dependence (0 Points) WITH supervision, direction, personal assistance or total care.
BATHING Points: _____	(1 POINT) Bathes self completely or needs help in bathing only a single part of the body such as the back, genital area or disabled extremity.	(0 POINTS) Need help with bathing more than one part of the body, getting in or out of the tub or shower. Requires total bathing
DRESSING Points: _____	(1 POINT) Get clothes from closets and drawers and puts on clothes and outer garments complete with fasteners. May have help tying shoes.	(0 POINTS) Needs help with dressing self or needs to be completely dressed.
TOILETING Points: _____	(1 POINT) Goes to toilet, gets on and off, arranges clothes, cleans genital area without help.	(0 POINTS) Needs help transferring to the toilet, cleaning self or uses bedpan or commode.

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Instrumental ADLs (IADL) – also various tools

Lawton-Brody Instrumental Activities of Daily Living Scale (LB-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.

LAWTON - BRODY
INSTRUMENTAL ACTIVITIES OF DAILY LIVING SCALE (I.A.D.L.)

Scoring: For each category, circle the item description that most closely resembles the client's highest functional level (either 0 or 1).

A. Ability to Use Telephone		**E. Laundry**	
1. Operates telephone on own initiative-looks up and dials numbers, etc.	1	1. Does personal laundry completely	1
		2. Launders small items-rinses stockings, etc.	1
2. Dials a few well-known numbers	1	3. All laundry must be done by others	0
3. Answers telephone but does not dial	1		
4. Does not use telephone at all	0		
B. Shopping		**F. Mode of Transportation**	
1. Takes care of all shopping needs independently	1	1. Travels independently on public transportation or drives own car	1
2. Shops independently for small purchases	0	2. Arranges own travel via taxi, but does not otherwise use public transportation	1
3. Needs to be accompanied on any shopping trip	0	3. Travels on public transportation when accompanied by another	1
4. Completely unable to shop	0	4. Travel limited to taxi or automobile with assistance of another	0
		5. Does not travel at all	0
C. Food Preparation		**G. Responsibility for Own Medications**	
1. Plans, prepares and serves adequate meals	1	1. Is responsible for taking medication in correct	1

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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.
- Listed as an "emerging measure" in the DSM-V.
- 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

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

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Collaterals corroborate

Common in FTD, LBD, PD, psychosis, delirium, etc.

- 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.

person's test scores and assessment tool results + ***clinician's observations and rating scales/tools*** + ***informant-rated scales and data*** = ***most robust picture of the person's situation.***

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.

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Cornell Scale for Depression in Dementia

Ratings should be based on symptoms and signs occurring *during the week prior* to interview.
Scoring System: A = unable to evaluate, 0 = absent, 1 = mild or intermittent, 2 = severe.
No score should be given if symptoms result from physical disability or illness.

A. Mood-Related Signs				
1. Anxiety – anxious expression, ruminations, worrying	A	0	1	2
2. Sadness – sad expression, sad voice, tearfulness	A	0	1	2
3. Lack of reactivity to pleasant events	A	0	1	2
4. Irritability – easily annoyed, short-tempered	A	0	1	2
B. Behavioral Disturbance				
1. Agitation – restlessness, handwringing, hairpulling	A	0	1	2
2. Retardation – slow movements, slow speech, slow reactions	A	0	1	2
3. Multiple physical complaints (score 0 if GI symptoms only)	A	0	1	2
4. Loss of interest – less involved in usual activities (score only if change occurred acutely, i.e., in less than 1 month)	A	0	1	2
C. Physical Signs				
1. Appetite loss – eating less than usual	A	0	1	2
2. Weight loss – score 2 if greater than 5 lb. in one month	A	0	1	2
3. Lack of energy – fatigues easily, unable to sustain activities (score only if change occurred acutely, i.e., in less than 1 month)	A	0	1	2
D. Cyclic Functions				
1. Diurnal variation of mood – symptoms worse in the morning	A	0	1	2
2. Difficulty falling asleep – later than usual for this individual	A	0	1	2
3. Multiple awakenings during sleep	A	0	1	2
4. Early-morning awakening – earlier than usual for this individual	A	0	1	2
E. Ideational Disturbance				
1. Suicide – feels life is not worth living, has suicidal wishes or makes suicide attempt	A	0	1	2
2. Poor self-esteem – self-blame, self-deprecation, feelings of failure	A	0	1	2
3. Pessimism – anticipation of the worst	A	0	1	2
4. Mood-congruent delusions – delusions of poverty, illness or loss	A	0	1	2

Completed by: _____ Date completed: _____

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Functional Activities Questionnaire (FAQ)

- For informant to rate performance on common activities.
- Cut off score 9: impaired function, 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

Writing checks, paying bills, balancing checkbook	
Assembling tax records, business affairs, or papers	
Shopping alone for clothes, household necessities, or groceries	
Playing a game of skill, working on a hobby	
Heating water, making a cup of coffee, turning off stove after use	
Preparing a balanced meal	
Keeping track of current events	
Paying attention to, understanding, discussing TV, book, magazine	
Remembering appointments, family occasions, holidays, medications	
Traveling out of neighborhood, driving, arranging to take buses	
TOTAL SCORE:	

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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 items.
- Score 1-5 each (much improved to much worse)
- Useful when person is unable/unwilling to do testing.

IQCODE

- 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 training needed, just follow instructions on scoring.

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Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE)

Now we want you to remember what your friend or relative was like 10 years ago and to compare it with what he/she is like now. 10 years ago was in 19__. Below are situations where this person has to use his/her memory or intelligence and we want you to indicate whether this has improved, stayed the same, or got worse in that situation over the past 10 years. Note the importance of comparing his/her present performance *with 10 years ago*. So if 10 years ago this person always forgot where he/she had left things, and he/she still does, then this would be considered 'Hasn't changed much'. Please indicate the changes you have observed by *circling the appropriate answer*.

Compared with 10 years ago how is this person at:

	1	2	3	4	5
1. Recognizing the faces of family and friends	Much improved	A bit improved	Not much change	A bit worse	Much worse
2. Remembering the names of family and friends	Much improved	A bit improved	Not much change	A bit worse	Much worse
3. Remembering things about family and friends e.g.	Much improved	A bit improved	Not much change	A bit worse	Much worse

Mood/Anxiety, etc.

- Mood and anxiety can significantly impact cognition = important to assess for these.
- Many mood/anxiety tools exist, BUT:
- Few are researched and validated for older adults.

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

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Geriatric Depression Scale (GDS)

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

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

Any 5+ score warrants follow-up comprehensive assessment

Geriatric Depression Scale (Short Form)

Patient's Name: _____ Date: _____

Instructions: Choose the best answer for how you felt over the past week. Note: when asking the patient to complete the form, provide the self-rated form (included on the following page).

No.	Question	Answer	Score
1.	Are you basically satisfied with your life?	YES / ***NO***	
2.	Have you dropped many of your activities and interests?	***YES*** / NO	
3.	Do you feel that your life is empty?	***YES*** / NO	
4.	Do you often get bored?	***YES*** / NO	
5.	Are you in good spirits most of the time?	YES / ***NO***	
6.	Are you afraid that something bad is going to happen to you?	***YES*** / NO	
7.	Do you feel happy most of the time?	YES / ***NO***	

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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 Inventory (GAI)

Agree or disagree:

1. I worry a lot of the time.
2. I find it difficult to make a decision.
3. I often feel jumpy.
4. I find it hard to relax.
5. I often cannot enjoy things because of my worries.
6. Little things bother me a lot.
7. I often feel like I have butterflies in my stomach.
8. I think of myself as a worrier.

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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)

Geriatric Anxiety Scale – 10 Item Version (GAS-10)

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Below is a list of common symptoms of anxiety or stress. Please read each item in the list carefully. Indicate how often you have experienced each symptom during the PAST WEEK, INCLUDING TODAY by checking under the corresponding answer.

	Not at all (0)	Sometimes (1)	Most of the time (2)	All of the time (3)
1. I was irritable.				
2. I felt detached or isolated from others.				
3. I felt like I was in a daze.				
4. I had a hard time sitting still.				
5. I could not control my worry.				
6. I felt restless, keyed up, or on edge.				
7. I felt tired.				
8. My muscles were tense.				

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Other types of testing/assessment tools

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

Financial tools

- Longtime leader: Lichtenberg
- Various testing/interview tools
  - Certification required
  - Training provided
- www.olderadultnestegg.com

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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.

Sexual consent: Lictenberg/Strzepek model

- Not a test or specific form, but a framework to look at the issues involved →
- Recommend two-step process of assessment, then team observing residents to determine if their behavior is consistent with their interview responses.

- Awareness of with whom they are having sexual contact and what that person's relationship is to them,
- Ability to say type(s) of intimate sexual activity with which they are comfortable,
- Consistency of behavior with previously expressed beliefs and preferences,
- Ability to decline unwanted sexual activity, and
- Ability to articulate what their reaction will be if the sexual activity ends.

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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

Assessment of Capacity for Everyday Decision-Making

- 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.

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Does the person understand the functional problem?

Describe the functional problem the person is experiencing.
Ask the person to say this back in his/her own words.

Describe the consequences of the functional problem.
Ask the person to say this back in his/her own words.

Does the person appreciate the functional problem?

Does the person believe that he/she has the functional problem you described?
"Do you have any problems with [state the functional problem]?"
If the person does not believe he or she has it, ask why.

Does the person understand the options to manage the functional problem?

Describe the options to manage the functional problem.
Ask the person to say this back in his/her own words.

Does the person understand the advantages of the options?

Describe the advantages to the options.
Ask the person to say this back in his/her own words.

Does the person appreciate the benefits and downsides of the options?

Does the person think that one of the options to manage the functional problem will benefit him/her?
"Please consider this choice [state an option to deal with functional problem]. Do you think [option to deal with functional problem] could benefit you?"
Does the person think that one of the options to manage the functional problem might make things worse for him/her?
"Please consider this choice [state an option to deal with functional problem]. Do you think [option to deal with functional problem] might make things worse for you?"

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Expressing a Choice

Express a choice to manage the functional problem.
"Among the options you have to take care of [functional problem], which one would you pick?"

Comparative Reasoning

How is the person's choice better than another option?
"What makes your choice better than [state another option]?"

Consequential Reasoning

What would happen if the person had to choose another option?
"How would [insert option to deal with functional problem] affect your everyday life?"

Final Choice

Final choice to manage the functional problem.
"Now that we've had a chance to talk about [functional problem] what would you like to do?"

Interview for Decisional Abilities (IDA)

Cornell-Penn Interview for Decisional Abilities

- Standardized framework with semi-structured interview.
- Designed for APS – 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)

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A. Possible Risks: Check all that the client seems to be facing at this time

Abuse

- ☐ Physical Injury
- ☐ Mental Injury
- ☐ Sexual Abuse
- ☐ Unreasonable use of a physical restraint, isolation or medication
- ☐ A threat or menacing conduct

Neglect

- ☐ By caretaker
- ☐ By another person

Self-Neglect

- ☐ Medical (medical care, leaving AMA, not taking medications, etc.)
- ☐ Refusal of community supports
- ☐ Failure to thrive
- ☐ Inadequate food
- ☐ Suicidal
- ☐ Eviction
- ☐ Unsafe housing (filth, vermin, squalid living conditions, inadequate utilities)

Financial Exploitation

- ☐ Misappropriation of property
- ☐ Intentionally taking unfair advantag the known adult lacks capacity to c
- ☐ Person in position of trust takes mo execution of trust or benefit
- ☐ Breach of fiduciary duty, the misuse conservatorship as it relates to pro
- ☐ Use of deception, intimidation, coer person or entity to obtain or use ad funds for profit of such person

B. Identified Risk: Circle the risk above that you believe poses the highest level of endangerment

What wording will you use to describe this risk to the client?

C. Introduction: Consider how you will introduce IDA to the client

For example: *"So let's talk now about some of the decisions that you might be making".*
Or possibly *"Now I'm going to be asking you some important questions having to do with decisions that you might be making. Will th*

D. Interview Instructions: Use the risk identified in the Pre-IDA for IDA Steps 1, 2, & 3

IDA Step 1 - Assessing the Risk in General (Understanding)

A. APS worker asks the client if he/she understands that other people confront the identified risk.
One way to ask: *"I'd like to discuss your thoughts about whether you think that* [insert risk] *can happen to others?"*

B. If the client understands that others can have the risk, APS worker asks the client to explain what could happen if the risk is
One way to ask: *"Suppose someone faces* [insert risk]*, and doesn't do anything about it, what might happen to him/her?"*

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Worker Judgment

Do you think the client understands the risk in general? (check one)

☐ Yes
☐ Maybe
☐ No (If No, stop the interview and speak with your supervisor)

What did the client say that brought you to this judgment? Record the client's own words as closely as possible:

Describe the client's emotions, reactions, non-verbal gestures:

IDA Step 2 - Insight into the Risk on a Personal Level (Appreciation)

A. APS Worker asks the client if he/she is experiencing this risk.

One way to ask: *"I'd like to learn more about **you**. Even though we may have already touched on this in our conversation, do you think **you** are facing [insert risk]?"*

Possible probes: *"Can you tell me why?"* or *"I'd like to know more about your thoughts on this."*

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IDA Step 3 - Ability to Weigh Advantages/Disadvantages of a Plan for Addressing Risk (Reasoning)

A. APS worker asks if the client has a plan to address the risk.

"What are your plans to address the possibility of [insert risk]*?"*

"How would that help address the possibility of [insert risk]*?"*

B. If the client lacks insight (IDA Step 2) or a workable plan (IDA Step 3A), APS worker suggests an alternative plan to address the risk. *"Would you consider* (insert plan) *to address the possibility of* [insert risk]*? Tell me your thoughts."*

C. APS worker asks the client about advantages and disadvantages of a workable plan (from IDA Step 3A or 3B) to address the risk.

*"What would be the **advantages** for you having (insert plan) to address the possibility of* [insert risk]*?"*

*What would be the **disadvantages** for you having* [insert plan] *to the possibility of* [insert risk]*?"*

Post-IDA - Next Steps

Risk used for IDA

Estimated time spent conducting this interview

Summary of Worker Judgments

Step 1 - Assessing the Risk in General (Understanding)
☐ Yes
☐ Maybe
☐ No

Step 2 - Insight into the Risk on a Personal Level (Appreciation)
☐ Yes
☐ Maybe
☐ No

Step 3 - Ability to Weigh Advantages/Disadvantages of a Plan for Addressing Risk (Reasoning)
☐ Yes
☐ Maybe
☐ No

Were there any barriers to completing the IDA (hearing or speech problems, language comprehension, other)?
☐ Yes
☐ Maybe
☐ No

Describe the barriers:

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MED-SAIL

Making and Executing Decisions for Safe and Independent Living.

- Developed by research team headed by Dr Aanand D. Naik MD, at Baylor College of Medicine
- "Not meant to be used in isolation to determine a respondent's status or capacity level."
- 2020 study: "…scores were highly positively correlated with criterion standard capacity determination" *(Mills)*

** standardized physician assessment to make formal determinations of capacity for TX court*

MED-SAIL

- 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.
- Unique component is "probing"
  - Can offer help/clarification to get person to most complete answers.
  - Goal is to understand and record the respondent's thought process.

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MED-SAIL scenarios

1. The door to your home is locked and you do not have a key.....
2. You run out of a medication that you take regularly.....
3. Imagine you are at home and suddenly there is a fire in your kitchen.....
4. You notice that the cut on your foot is not healing and has become infected.....
5. Someone calls you saying you've won $100,000 and all they need from you is your social security number to verify your identity .....
6. You are driving to the grocery store and you get a flat tire.....
7. Your heating/air conditioning system breaks down and it is very cold/hot outside .....

MED-SAIL sample format of questions

1. **Please tell me in your own words what I just said.** *Understanding*
   This question is not included in overall score

   (Yes) Respondent paraphrases statement, repeats statement, or
   (No) cannot do either.

2. **Would this scenario be a problem for you? Why or why not?** *Appreciation*

   (2) Patient answers Yes or No, and explains why or why not
   (1) Patient answers Yes or No, but has no explanation
   (0) No answer; illogical answer

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3. **What would you do in this scenario?** *Expressing a choice*

   (2) Respondent suggests remedy that makes sense and is specific to respondent's life.
   (1) Respondent's response may make sense, but is vague or incomplete
   (0) Respondent avoids answering the question, even after probing; answer makes no sense

4. **What would you do if [respondent's answer to question #3] didn't work?** *Problem Solving/Consequential Reasoning*

   (2) Respondent names at least 1 specific consequence that makes sense.
   (1) Respondent's response may make sense, but is vague or incomplete
   (0) Respondent avoids answering the question, even after probing; answer makes no sense

5. **So you've told me that [respondent's answer to #3] or that [respondent's answer to #4]. Explain what is good and bad about each of these options.** *Comparative Reasoning*

   (2) Respondent names at least 1 disadvantage or advantage to each answer (3 and 4).
   (1) Respondent's response may make sense, but is vague; names 1 disadvantage/advantage.
   (0) Respondent avoids answering the question, even after probing; answer makes no sense

6. **A) What could you do to prevent this scenario from happening? OR B) What could you do to prepare for this scenario in case it really happened?** *Reasoning – Generate Consequences*

   (2) Respondent names at least 1 specific **A)** preventative or **B)** preparatory measure that makes sense.
   (1) Respondent's response may make sense, but is vague or incomplete
   (0) Respondent avoids answering the question, even after probing; answer makes no sense

Use the score boxes below to record scores for each scenario

Scenario 1	Scenario 2	Scenario 3
Total Score: _____ /10	Total Score: _____ /10	Total Score: _____ /10

(total points for all scenarios) / (# of scenarios competed x10)

Overall Score
_____ /_____

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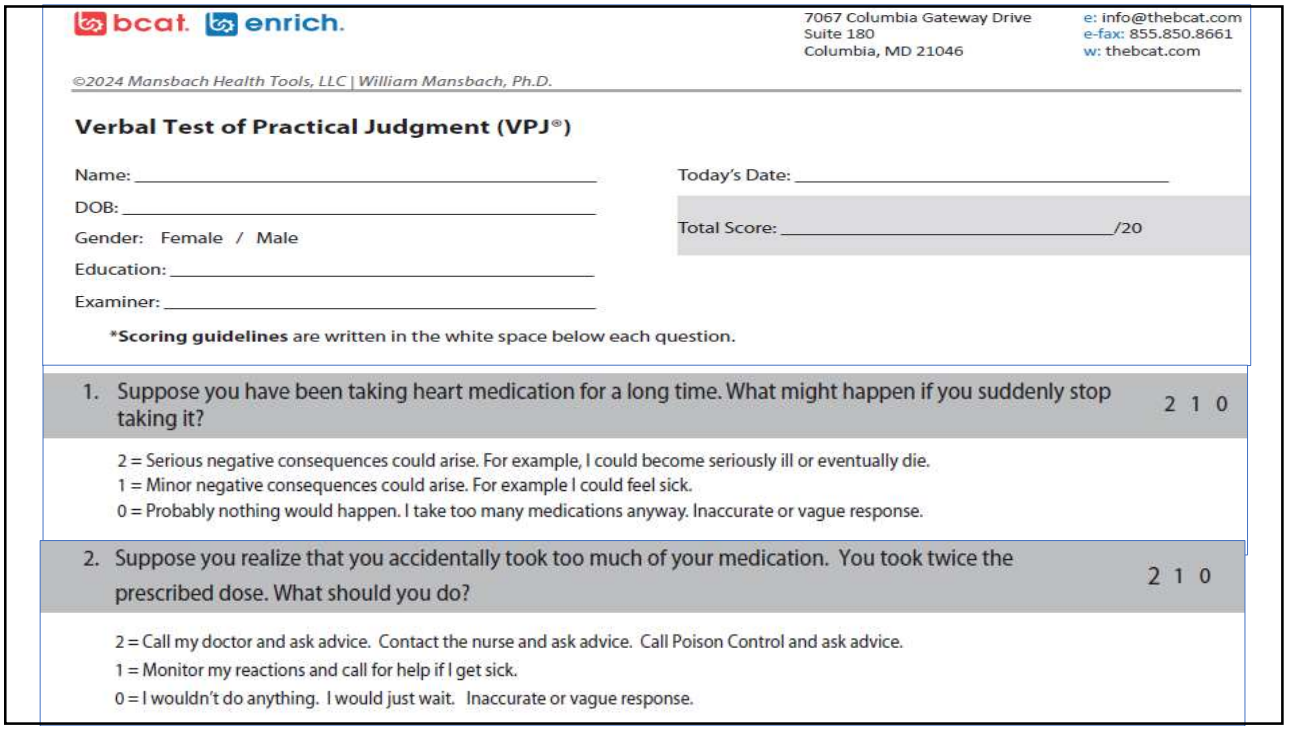
Verbal Test of Practical Judgment (VTPJ)

- 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.



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Verbal Test of Practical Judgment (VPJ®)

Name: _____ Today's Date: _____

DOB: _____

Gender: Female / Male Total Score: _____/20

Education: _____

Examiner: _____

***Scoring guidelines** are written in the white space below each question.

1. Suppose you have been taking heart medication for a long time. What might happen if you suddenly stop taking it? 2 1 0

2 = Serious negative consequences could arise. For example, I could become seriously ill or eventually die.
1 = Minor negative consequences could arise. For example I could feel sick.
0 = Probably nothing would happen. I take too many medications anyway. Inaccurate or vague response.

2. Suppose you realize that you accidentally took too much of your medication. You took twice the prescribed dose. What should you do? 2 1 0

2 = Call my doctor and ask advice. Contact the nurse and ask advice. Call Poison Control and ask advice.
1 = Monitor my reactions and call for help if I get sick.
0 = I wouldn't do anything. I would just wait. Inaccurate or vague response.

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Self-neglect and undue influence

Elder Self Neglect Assessment Abrams Geriatric Self-neglect Assessment Scale	California Undue Influence Screening Tool

Elder Self Neglect Assessment (ESNA)

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

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Elder Self Neglect Assessment (ESNA)

CJE SeniorLife

Instructions: Please answer each question based upon your professional judgment, reports from the older adult directly, or from a 3rd party. Please complete the following sections as best you can, using currently available information. If you have questions about a specific diagnostic description of a mental illness, please refer to the Diagnostic Statistical Manual. There is a comment box at the end of each section. Please write your comments there, and indicate which question they relate to.

Note that items are arranged in order of severity, from low to high. Clustering of items at the low, middle or high end of the assessment should help you determine the overall severity of the self neglect.

ESN Rating Scale
Circle the appropriate number for each question. If completing this electronically, insert an X in front of the correct response.
1 = Yes 2 – No 3 – Suspected Problem (SusP) 4 = Don't know (DK) 5 = Not applicable (N/A)

No.	Elder Self Neglect Indicator	Yes	No	SusP	DK	N/A
1	Does older adult have a lack of follow through with preventive or diagnostic testing related to health conditions?	☐	☐	☐	☐	☐
2	Does the condition of older adult's house, apartment or yard appear unsafe or unsanitary?	☐	☐	☐	☐	☐
3	Does older adult lack sufficient care to meet his/her needs?	☐	☐	☐	☐	☐
4	Does older adult fail to engage in adequate preventive practices (e.g., diet, exercise, smoking cessation)?	☐	☐	☐	☐	☐

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

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CA Undue influence Screening Tool (CUIST)

- Developed about 10 years ago for APS (published 2017).
- Checklist for signs, issues, concerns in four categories →
- Space to capture examples and details

- Client Vulnerability,
- Influencer's Authority/Power,
- Actions/Tactics, and
- Unfair/Improper Outcomes

California Undue Influence Screening Tool (CUIST)

Client's Vulnerability	**Examples/ Comments**
[] Poor or declining health or physical disability [] Depends on others for help or care [] Problems with hearing, vision, or speaking [] Problems with memory [] Problems communicating and understanding [] Does not understand consequences of decisions [] Developmental disability [] Dependent or passive behavior [] Emotional distress (e.g., grief, anxiety, fear, depression) [] Language/literacy barriers [] Isolated from others [] Lives in chaotic or dysfunctional environment [] Influencer knew or should have known of person's vulnerability [] Other (please specify)_____ [] No apparent vulnerability	
Influencer Authority/Position of Power [] Stands in a position of trust, authority, or confidence resulting from: [] Intimate/family relationship [] Caregiver [] Professional standing (e.g., legal professional, spiritual adviser,	**Examples/ Comments**

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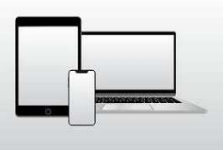
Validity of mobile tech



- 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 quite 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?

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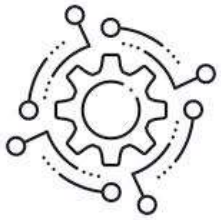
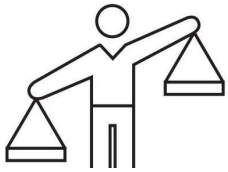
Be mindful of factors at play in testing process

SYSTEMIC	LOGISTICAL	SOCIAL/ CULTURAL	ETHICAL



Aim 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)*

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Are people willing to engage?

We always used to think "NO"

- 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?

"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)

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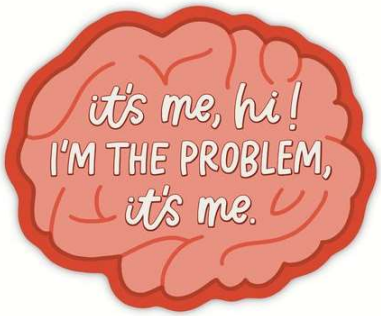
Your approach to testing is important

- 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?*

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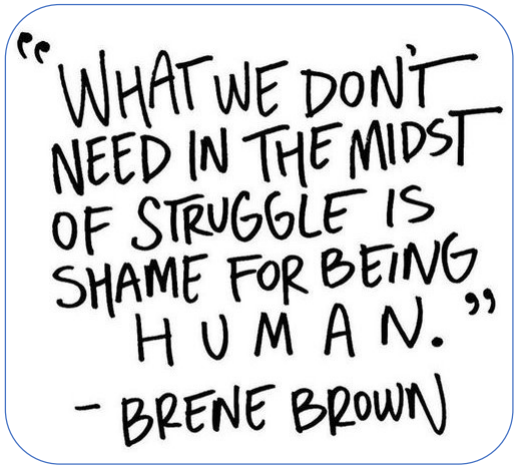
Closure and follow-up plan

- 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!**

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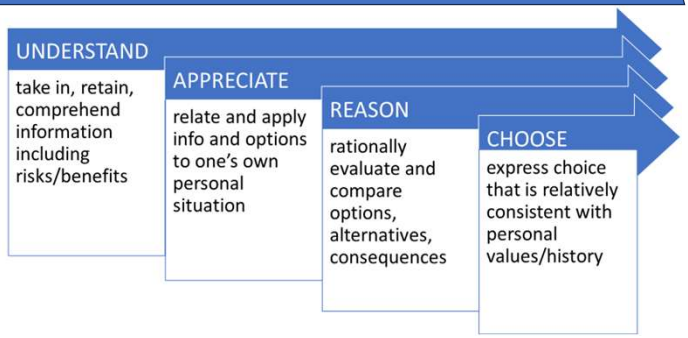
Capture data and relate it to DM steps

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

DECISION MAKING CAPACITY



FUNCTIONAL ABILITY

Execute the communicated choice – carry out the stated decision.

- Performance of the tasks involved.
- Ability to engage supports if/when needed to do so.
- Ability to adjust to change.

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 • Working 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

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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, Trails
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

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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, Financials, 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, Trails
Organization	EFPT, MED-SAIL
Motor control	Observation, Frontal, RUDAS, TICS, Trails
Social cognition	Observation, JAT, KPT, TOP-J, VTPJ, WHODAS, NPIQ

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Documenting tests administered

- List 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 – a 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 – note if these are present.

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

Explain the tests/tools used *(also see handout)*

- Full name of the test/tool
- What it assesses
- Brief explanation of validity, comparability to other tools
- Score range and indications
- **Person's score and what that indicates**

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Explaining testing – example:

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.**

Explaining testing – example:

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.**

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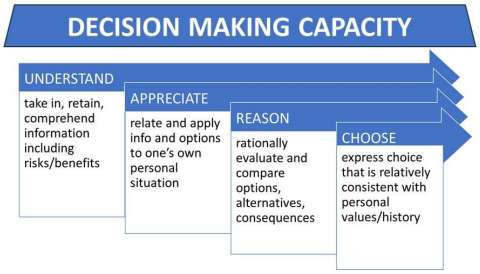
Walk reader through how data relates to DMC

- Explain how data from testing tasks and observations is related to the areas of cognition and executive functioning that are involved at each step of DM:



FUNCTIONAL ABILITY

Execute the communicated choice – carry out the stated decision.

- Performance of the tasks involved.
- Ability to engage supports if/when needed to do so.
- Ability to adjust to change.

Families, lawyers, and courts may need introduction to the concept of executive function and partial or disproportionate cognitive impairment.

(also see handout)

Explaining how data relates to DMC: example *SEE HANDOUT*

- Understanding – [Person] demonstrated cognitive performance deficits in multiple areas essential to her being able to understand her situation and relevant information: [areas/details].
- Appreciating – [Person] had limited ability to use information and logic to see consequences of different options or likely outcomes of different actions. Her reasoning and judgment were moderately impaired. [areas/details].
- Reasoning – Because [Person] has difficulty being able to understand relevant information or to appreciate the situation and options, she therefore is less able to evaluate options for action to see what might be better or worse options. [areas/details]
- Choosing – Because [Person] has difficulties being able to understand relevant information, appreciate the situation and options, or reason through options for action, she is less able to express or communicate a choice and carry out action.

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Also discuss time, complexity, prognosis

- Is current decision making different from history?
- How significant and complex is this decision?
- Is decision making ability likely to improve or not?

Discussing time, complexity, prognosis: example *SEE HANDOUT*

- In examining decision-making capacity, it is also important to consider:
  - Does the person's decision in this situation represent a change from previous decisions? Yes, the mobile home was her biggest financial asset, purchased with her long-time partner; giving it to [F] without any compensation doesn't seem consistent with her prior behavior.
  - Does it affect everyday safety and functioning? Yes, the situation with [F] is affecting her daily life, her mental and emotional well-being, and potentially her safety as well.
  - What is the complexity and substance of the documents, situation, or action? The papers transferring ownership of the mobile home were complex enough that [Person] said she didn't really understand what she was signing. She said [F] was giving her printed eviction notices but she didn't understand whether they were official/legal or not.
- While decisional capacity is time-specific, the fact that these difficulties have been present for at least the past several months if not the past few years indicates that [Person]'s abilities to manage her situation are not likely to improve – in fact, it is highly likely that her cognitive and functional impairments will continue to worsen with age.

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Preparation for next class

- Case study form to complete – be sure to return it before Nov 5th. This is **strongly encouraged** but not required – we will not be able to cover all case studies in the workshop time.

- Our last class puts everything we've learned so far into practice:
  - Documentation considerations and formats,
  - Various actual document examples and how they are used,
  - About hearings and testifying, and
  - YOUR case studies!

Our next classes/events

November 5	***Email your case studies to me!***
November 12	Case studies and discussion, and next steps for your work
November 19	Collaborative Working Group Kick-Off 11am-12pm Pacific time, on zoom

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UW SW Innovations in Aging Series

- Thursdays, 12:30 - 1:30 PM on Zoom
  - Meeting ID: 932 1649 9536 Passcode: 973329
  - Join by phone : 206.337.9723
- November 6th – CHANGES AT THE LAST MINUTE: Family Dynamics at the End of Life. With Wendy Lustbader, MSW.
- November 20th – TRANSGENDER AGING: What Trans Elders Need from Social Workers. With Marsha Botzer, MA.

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