Decision Making Capacity Assessment Professional Training Program

Class 3 – June 3, 2026

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Elder Education Institute
SOUND generations

Agenda

- Have Tools Handout?
- 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, polls
845a	Testing as a tool; history; what we're testing
900a	Guest speaker: Kathi Church, ADS CM
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

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…

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Class	1 (May 6)	2 (May 20)	3 (June 3)	4 (June 17)
Capacity specific topics	• History and background • Legal/clinical views of capacity • Types of decisions and capacities	• Impact on DM of cognition, dementia, and mental health • Other factors impacting DM	• Cognitive tests, other tools for assessment • Interviewing frameworks • Collateral tools	• Case studies from class participants • Review, Q&A, additional resources
Work process topics	• Scholarship, approaches to assessing DMC • Process overview • Referrals and collaboration • Formats/models for assessment	• Consent/assent • Visit supports • Assessment Qs, values, risk • Less restrictive alternatives e.g. Supported DM models	• Approaches to testing • Explaining testing findings • Documentation • Usage/impacts	• Court/testifying • Mentors, shadowing • Collaborating • Marketing your services

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.

Cognition/function/data: key parts of DMCA

Gather Info → **Visit(s) for Interview/ Assessment** → **Consult Collaterals** → **Document Findings**

- Problem?
- What to assess, legal standard(s)?
- What report is needed?
- Health status.
- Limited info/ background.

- Consent/Assent.
- Thorough assessment with probing questions on DM steps, values, historical choices, etc.
- Use appropriate cognitive tests, decision aids, supports, etc.

- Get info from family, care providers, etc.
- Review records or other history.
- Validate what was reported by person/others.

- Clearly record observations.
- Discuss interview
- Explain analysis of various data.
- Clearly state findings and recommendations.

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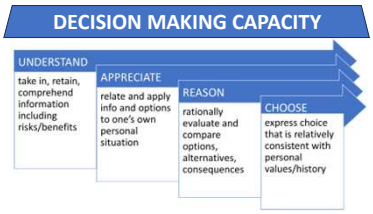
Reminder of what we're assessing

- Decision making process steps and the cognitive/EF tasks involved



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.

SPECIFIC COGNITIVE/EF 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.

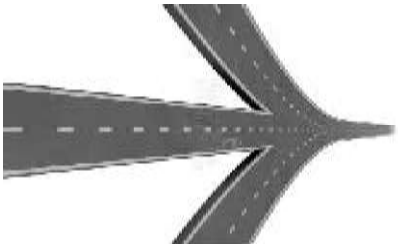
Origins of testing tools

- 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

Psychometrics

Scientific research



Psychology / Social Work clinical approaches

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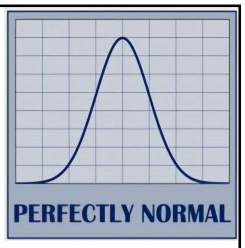
About research – remember statistics class?

- 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.

Norms

- Data generally gathered on samples that reflect broad demographic characteristics (e.g. of country) including factors such as age, gender, and educational status.
- Normative data typically gathered on generally healthy individuals – without significant cognitive, developmental, or neurological conditions.
- Score curves for groups by age, education level, gender, language/culture, particular conditions (heart disease, Parkinson's)



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.

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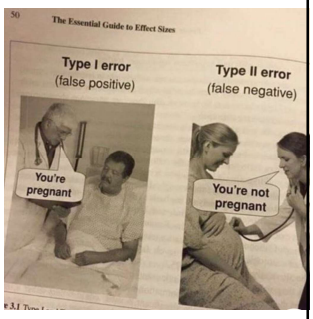
Problems with tests

- 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.



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 (for medical DMC).
- 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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Look to criteria for what tests/tools you use

Applebaum & Grisso criteria:	*Try for:*
Functions assessed relate to legal standards.	Assess cognitive/EF tasks in each DM step
Content **relevant to decision** at hand.	Appropriate content, or tailor when possible
Content **meaningful to the person.**	
Standardized enough for comparisons within and across research groups.	Proven in research Clinically validated Normed for population
Objective, reliable criteria for scoring.	Clearly useful data
Practical for research and clinical use: **brief,** extensive training not required.	Practical for situation, not too burdensome on client

Guest speaker: Kathi Church, MA, LMHC, NCC

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

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

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

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

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

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

Tools Handout: Page 2

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.

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 a specific 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/

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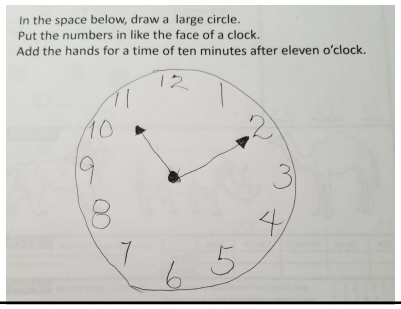
Perfect clock…



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.

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

Verbal fluency – "animals and F-words"

- **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.

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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

Tools Handout: Page 3

Brief tests: Short Blessed Test (SBT/BOMC)

- 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.

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Tools Handout: Pages 4-5

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

Tools Handout: Page 6

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

Tools Handout: Page 7

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

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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

Tools Handout: Page 8

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

Tools Handout: Pages 9-10

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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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

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

Tools Handout: Page 11

Montreal Cognitive Assessment

- MoCA created in 1996 as 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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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

Tools Handout: Pages 12-13

Rowland Universal Dementia Assessment Scale

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

RUDAS – unique aspects

More "real world" focus

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

Motor/physical items

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

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Tools Handout: Page 14

St Louis University Mental Status Exam

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

Shapes

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

(Tip: do this for MoCA also)

CLOCK DRAWING

In the space below, draw a large circle.
Put the numbers in like the face of a clock.
Add the hands for a time of ten minutes after eleven o'clock.

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)

Executive function testing in older adults

(Faria)

Domains most frequently assessed:

- Mental flexibility,
- Verbal fluency,
- Planning,
- Working memory, and
- Inhibitory control.

Janie – input/comments?

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)

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Tools Handout: Pages 15-16

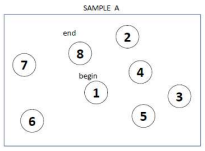
Frontal Assessment Battery (Frontal or FAB)

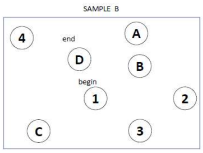
- Created in 2000 as short executive function assessment
- Distinguishes between frontal-lobe dementia and Alzheimer's type.
- Unique tasks, e.g. attention/inhibition, motor exercise, reflex.
- Scoring: maximum of 18, cut-off of 12 for significant dysfunction.
  - Higher scores = better frontal functioning.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

Tools Handout: Page 17

Trail Making Test

- AKA TMT or 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 sample correctly, 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.
  - Scoring analogous to traditional test. *(Bastug)*

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

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)

Tools Handout: Page 18

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.

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Tools Handout: Page 19

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.

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

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 data and reported info*** = ***most robust picture of the person's situation.***

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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

Tools Handout: Pages 20-21

Cornell Scale for Depression in Dementia

- For informant to identify signs and behaviors associated with depression in elders with moderate to severe dementia (who may not say they're feeling depressed).
- 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.

Tools Handout: Page 22

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

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Tools Handout: Pages 23-24

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.
- 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.

Discussion/questions

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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Tools Handout: Page 25

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

Tools Handout: Page 26

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.

Tools Handout: Page 27

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)

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Other types of testing/assessment tools

- Financial
- Sexual consent
- Interview formats
- Elder abuse and exploitation: self-neglect, undue influence

Financial tools

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

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.

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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.

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?"

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?"

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Role play

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)

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?

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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?"*

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] *t 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:

MED-SAIL

Making and Executing Decisions for Safe and Independent Living.

- Uses scenarios to talk through thinking and decision making.
- Manual has guidance for choosing scenario, framing questions, probing for person to expand on reasoning, etc.
- Unique component is "probing" questions around thinking/reasoning.
- 2020 study: "…scores were highly positively correlated with criterion standard capacity determination" *(Mills – referring to standardized physician assessment to make formal determinations of capacity for TX court)*

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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

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

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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.

bcat. enrich.

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Verbal Test of Practical Judgment (VPJ®)

Name: _____ Today's Date: _____

DOB: _____

Gender: Female / Male

Education: _____

Examiner: _____

Total Score: _____/20

***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.

Elder Abuse and Exploitation Issues

- Self neglect
- Undue influence

FYI:

- Native Elder Life Scale
- APS Tools Inventory

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Self neglect

- Actual forms are hard to access!
  - Abrams Geriatric Self-neglect Scale (AGSS)
  - Self-Neglect Severity Scale (SSS)
  - Self Neglect 37 (SN37)
- 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.

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)?	☐	☐	☐	☐	☐

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

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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	**Examples/ Comments**
[] Stands in a position of trust, authority, or confidence resulting from: [] Intimate/family relationship [] Caregiver [] Professional standing (e.g., legal professional, spiritual adviser,	

Other resources

- APS Tools Inventory
  - Information on screening and assessment tools (92 tools currently).
  - Primarily for use by APS caseworkers to support their work with APS clients.
  - https://elderjustice.acl.gov/apsinventorytool#gsc.tab=0
- Native Elder Life Scale
  - Culturally tailored to assess quality of life, social support, and potential mistreatment among Native American elders, incorporating culturally relevant indicators.

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… but it's getting there.

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Additional tests/tools – comments?

- BCAT
- Neuropsych
- OT
- SLP

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?

If you have extra time, discuss any tools you've used and what you've found helpful/challenging, etc.

About doing this work

Approaches to testing
Explaining testing findings
Documentation
Usage/impacts

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Be mindful of factors at play in testing process

SYSTEMIC	LOGISTICAL	SOCIAL/ CULTURAL	ETHICAL

Remember, 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)*

Are people willing to engage?

We always used to think "NO"

- Studies in the past 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)

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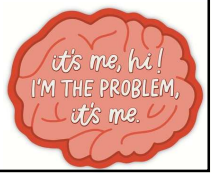
How to we encourage engagement?

"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)

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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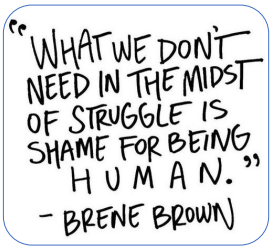
Closure and follow-up plan

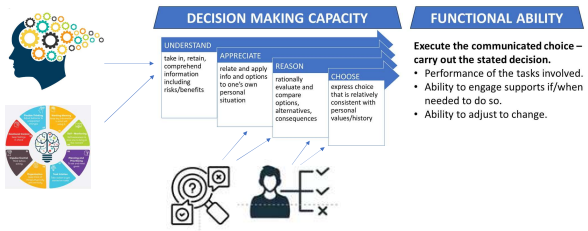
- Thank the person for making the time and effort to engage with you.
- Acknowledge that this was not an easy process.
- Discuss results (in a general way if sensitive issues) and what you see as next steps.
- Leave them with a written note summarizing your discussion (and take a photo of it for your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



After the visit

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

Capture data and relate it to DM steps



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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

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 (in various testing tools)
Attention/concentration	Observation, STMS, SLUMS, Frontal, KPT, Trails
Concentration	Blessed, Frontal, Trails
Processing speed	Observation, 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, JAT, KPT, TOP-J, VTPJ
Motor control	Observation, Frontal, RUDAS, TICS, Trails
Social cognition	Observation, JAT, KPT, TOP-J, VTPJ, WHODAS, NPIQ

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. →
- Validity can be impacted 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."

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

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

Explaining testing – example: RUDAS

Rowlands Universal Dementia Assessment Scale (RUDAS): a cognitive screening tool that measures a variety of mental abilities including language, reasoning, problem solving, attention and working memory. The RUDAS was designed for use with multicultural populations and is validated to be less influenced by language and education level than other tests. A score below 20 indicates likely dementia.

[Person] scored 24 out of 30, indicating mild cognitive impairment.

OR

[Person] scored 19 out of 30, indicating significant cognitive impairment, most likely at a moderate level of dementia.

OR

[Person] scored 12 out of 30, indicating very significant cognitive impairment, most likely at a significant or advanced level of dementia.

Explaining testing – example: SLUMS (partial)

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. **While initially engaged, [Person] said he was too tired to complete all questions. [Person] scored 6 out of 18 points for items attempted/administered (33%, dementia indicated for 66% or below). This indicates severe cognitive impairment at the level of dementia.**

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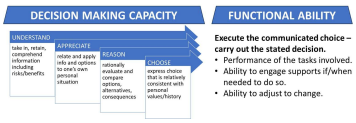
Explaining testing – example: MoCA Blind

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.

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:



(see handout)

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

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.

Usage/impact of a DMCA report/document

- Evidence in law enforcement or APS investigation
- Testimony in court proceedings
  - Guardianship, conservatorship, protective arrangements
  - Criminal trials, sentencing hearings
- Recommendations for care planning or case management services, strategies
- Guidance for family, caregivers, DPOA agents

Helpful to

- ID limitations of your analysis,
- Forecast changes based on your prognosis, and
- Suggest timing or circumstances for re-eval.

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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!

Mark your calendars

June 10	***Email your case studies to me!***
June 17	Case studies and discussion, and next steps for your work

Also coming up

Capacity Consultation Group	Older Adult Mental Health Consult Group
Sponsored by ACCS 12noon to 1:30pm Pacific time on zoom Tuesdays: July 21, Sept 15, and Nov 17. Registration is required: https://tinyurl.com/ysrywebv	Sponsored by GRAT/ACCS 12noon to 1:30pm Pacific time on zoom Tuesdays: June 16, Aug 18, and Oct 20. Register for one or all meetings at https://us02web.zoom.us/meeting/register/MaxDVsm0S7mH66y7zecILQ#/registration

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Treatment Advocacy Center webinars

Focused on real world challenges and solutions for the SMI (severe mental illness) community.

Competency Solutions- June 10, 7 pm ET:
- Judge Cynthia Lu, Kristine Riley, Heather Neil
- Washoe Co, Nevada AOT team

Family Solutions- July 1, 7 pm ET:
- Bob Krulish - mental health educator, advocate, and author
- Shomari Smith - creator of SMI focused app, Kairos

Treatment Solutions- August 3, 6 pm ET
- Dr. Susan Partovi - street medicine doctor and author of "Renegade MD"
- Dr. Sarah Kopelovich - Associate Professor at University of Washington

Register: https://us02web.zoom.us/webinar/register/WN_dvFTtvDYTFCu2WMO1UDIfw#/registration

WORLD ELDER ABUSE AWARENESS DAY

Building Strong Support for Elders

- Every year on **June 15,** World Elder Abuse Awareness Day (WEAAD) provides an opportunity for all of us to promote dialogue and action on the issue of elder abuse, neglect, and exploitation.
- National Weekend of Prayer & Action for Elder Justice: June 12-14
- Resources online at https://ncea.usc.edu/

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