UW Health - Geriatrics

Assessing Capacity in the Memory Care Setting

WAI Core Skills Training

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Learning Objectives

1. Demonstrate understanding of the legal tenants of capacity and how to select formal assessment approaches that best assess these constructs.
2. Differentiate between various forms of capacity assessment (i.e., healthcare, financial, independent living) and the available assessment tools tailored to each area of concern.
3. Describe the strengths and weaknesses across a variety of existing formal capacity instruments.
4. Identify barriers in capacity assessment and how to overcome or account for them in accordance with best clinical practice.
5. Formulate ways to enhance capacity assessment approaches and outcomes based on tools and local resources available.

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The Capacity Evaluation

Introduction and Assessment Framework

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Decision-Making Capacity

- Healthcare decision-making capacity is a patient's ability to:
  - Understand a proposed intervention
  - Weight its benefits, risks, and alternatives, including the option of no treatment
  - Make an autonomous decision regarding care
- Decision-making capacity is a core tenant of informed consent for medical treatment.
  - Requires that consent to treatment be competent, voluntary, and informed
- Capacity evaluations of vulnerable older adults (including those with dementia) reflects an ethical obligation of clinicians to balance promoting the autonomy of an individual against protecting them from harm.
- The demand for capacity assessment among older adults is only increasing as this population is expected to double between 2000 and 2030 (Wan et al., 2005)

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Capacity Evaluations

- The majority of medical health providers judge their training in assessing capacity as "insufficient" (Seyfried et al., 2013)
  - There is low consistency in how professionals evaluate decision-making capacity.
  - Agreement rates of capacity determinations are low (56%) among experienced clinicians assessing patients with mild Alzheimer's disease - compared to 98% for controls (Marson et al., 1997)
- The most useful tools for capacity evaluation are those that are:
  - Reliable and accepted by more than one discipline
  - Adequately balance autonomy with the need for treatment
  - Use objective rather than inferred or subjective means
- In medical settings, the treating physician is often both the clinician questioning a patient's capacity and subsequently evaluating it.
  - Creates a dual-role, may overestimate capacity, and has low inter-rater reliability
  - Neuropsychologists are well suited to assess capacity due to expertise in standardized assessment of fine-grained cognitive and functional abilities and skills in comprehensive report writing.

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Neuropsychologist Role in a Memory Clinic Setting

When there are mild or questionable deficits on standard mental status testing or clinical interview, and neuropsychological testing is needed to establish the **presence of abnormalities or distinguish them from changes that may occur with normal aging**, or the expected progression of other disease processes

When neuropsychological data can be combined with clinical, laboratory, and neuroimaging data to **assist in establishing a clinical diagnosis** in neurological or systemic conditions known to affect CNS functioning

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The Center for Medicare and Medicaid Services (CMS) – Justification for Neuropsychological Assessment

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When there is a need to determine whether a patient can comprehend and participate effectively in complex treatment regimens, and to **determine functional capacity for health care decision-making**, work, independent living, managing financial affairs, etc

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The Center for Medicare and Medicaid Services (CMS) – Justification for Neuropsychological Assessment

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When to Formally Assess Capacity in Dementia?

- Patient refuses treatment in the context of severe medical risk.
- New living and care arrangements are indicated due to safety concerns and the patient refuses.
- Patient exhibits a lack of insight into their medical conditions or health status.
- Discrepant reports of functional status (family vs patient, within family, family/patient vs provider)
- Concern for undue influence/abuse, or anticipated legal involvement (guardianship)
- To determine whether a patient has capacity to write advanced directives.
  - Advanced directives can be challenged in court if a reasonable doubt of incapacity is presumed at the time of completing the document.

The MMSE may help identify patients with dementia at risk for diminished capacity:

- Scores in the moderate to severe range (<16) are highly correlated with diminished capacity.
- Scores between 16 and 24 have variable sensitivity/specificity and may indicate need for formal capacity assessment.

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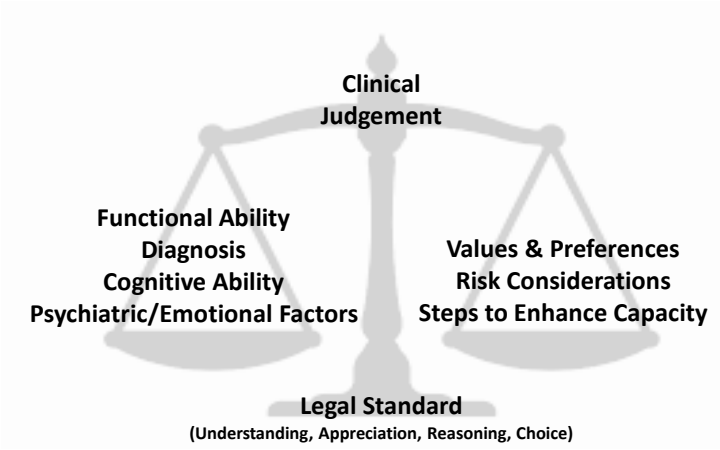
Framework for Capacity Evaluation

- Legal Standard for Capacity
- Functional Elements
- Diagnosis
- Cognitive Underpinnings
- Psychiatric or Emotional Factors
- Values and Preferences
- Risk Considerations
- Steps to Enhance Capacity
- Clinical Judgement of Capacity



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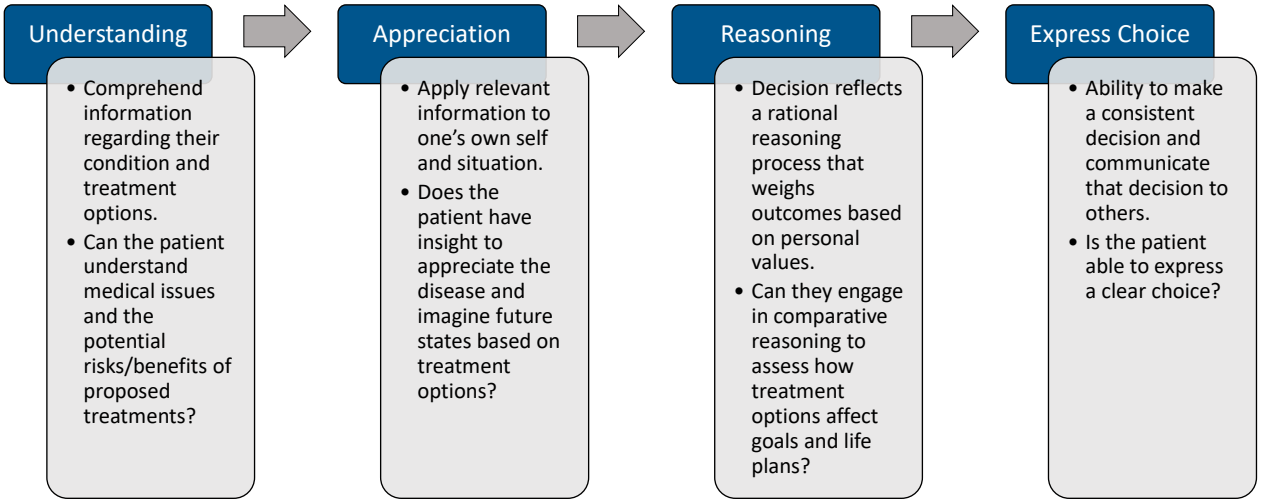
Legal Standard for Decisional Capacity



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Functional Capacity Approach

- There are a range of capacities that can be assessed:
  - Medical Decision-Making
  - Independent Living
  - Driving
  - Financial
  - Testamentary
  - Consent to Research
- Capacity Evaluation Approaches
  - Clinical interview
  - Objective assessment of the capacity in question

- Understanding
  - *Tell me in your own words what your understanding is of the nature of your condition, the recommended treatments, the benefits and risk of those treatments?*
  - *How likely are the benefits and risks to occur?*
- Appreciation
  - *What do you really believe is wrong with your health?*
  - *Do you believe that you need some kind of treatment?*
  - *What is the treatment likely to do for you?*
  - *What do you believe will happen if you are not treated?*
  - *Do you believe the doctor is trying to harm you?*
- Reasoning
  - *What factors were important to you in reaching the decision?*
  - *How did you balance those factors?*
  - *What does Treatment A seem better than Treatment B?*
  - *How will treatment affect the things or people who are important to you?*
- Choice
  - *Have you decided whether to go along with your doctor's suggestion for treatment?*
  - *Can you tell me what your decision is?*

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- Standardized
  - Uses clinical vignettes
  - Normative data available
  - Can poorly relate to contextual and situational nature of decision-making capacity
- Semi-Structured
  - Tailoring of item content to patient
  - Applicable to decision at hand
  - Decreases inter—rater and test-retest reliability
- Performance-Based
  - Completely objective
  - Real world validity

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Healthcare Capacity Instruments

- **MacArthur Competence Assessment Tool – Treatment (MacCat-T)**
  - Semi-structured interview guided by patient's actual condition
  - 15-20 min administration time
  - Proprietary
- **Aid to Capacity Evaluation (ACE)**
  - Semi-structured interview guided by patient's actual condition
  - 10-20 min administration time
  - Open source
- **Capacity to Consent to Treatment Interview (CCTI)**
  - 2 clinical vignettes (neoplasm & cardiac conditions) presented both orally and in writing
  - 20-25 min administration time
  - Standardized with dementia sample
- **Assessment of the Capacity to Consent to Treatment (ACCT)**
  - 3 clinical vignettes of varying complexity presented orally and in writing
  - 15-20 min administration time
  - Developed by a neuropsychologist. Uses structured scoring process to arrive at scores for each capacity component.
  - Formally assesses patient values and preferences.

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Financial Capacity Instruments

- **Independent Living Scales – Money Management**
  - Performance-based and situational questions to assess daily function
  - 15-20 min administration time
  - Extensive normative data
  - Proprietary
- **Financial Capacity Instrument (FCI)**
  - Assesses 6 financial capacity domains (i.e., financial judgement, transactional, financial management, etc)
  - 40-50 min administration time
  - Proprietary
- **Hopemont Capacity Assessment Interview**
  - Semi-structured interview with hypothetical financial scenarios
  - ~30-min administration time
  - Proprietary
- **Older Adult Nest Egg**
  - Patient and family structured interview assessing financial decision making and identifying vulnerabilities
  - 10-25 min administration time (electronic w/ automated scoring and report)
  - Patient: Financial Decision Tracker (specific decision) and Financial Vulnerability Survey (risk for exploitation)
  - Informant: Perceived Financial Exploitation Risk
  - Generates a financial risk rating
  - Open source

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Medical Diagnosis

- Documentation of medical diagnosis is important in capacity evaluation:
  - Causative factor explaining disability
  - Defines prognosis and whether change in status is likely
  - Can identify any treatments that may improve capacity
- Progressive neurodegenerative condition
  - Cognition and decisional ability is likely to worsen over time as disease progresses

Degenerative Brain Disorder:
The loss or dysfunction of an individual's brain cells to the extent that he or she is substantially impaired in his or her ability to provide adequately for his or her own care or custody or to manage adequately his or her property or financial affairs.

6. A. Does the individual have incapacity due to his/her impairments? ☐ Yes ☐ No
   B. Is this incapacity permanent? (Unlikely to resolve with treatment) ☐ Yes ☐ No
   C. Using the definitions on the instruction sheet, specify the condition(s) related to the incapacity.

(Check all that apply)	Is this condition likely to be permanent?
☐ (1) Developmental disability.	☐ Yes ☐ No
☐ (2) Degenerative brain disorder.	☐ Yes ☐ No
☐ (3) Serious and persistent mental illness.	☐ Yes ☐ No
☐ (4) Other like incapacities.	☐ Yes ☐ No

What are the diagnoses for each checkbox above?
Explain: _____

(Excerpt from WI Guardianship Examining Physician's or Psychologist's Report)

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Decisional Capacity: Cognition

Excerpt from WI Guardianship Examining Physician's or Psychologist's Report:

4. Note level of impairment and describe examination findings in the following areas:

Orientation Findings: _____	☐ Intact	☐ Mild Impairment	☐ Moderate	☐ Severe
Attention/Concentration Findings: _____	☐ Intact	☐ Mild Impairment	☐ Moderate	☐ Severe
Sensory/Motor Functioning Findings: _____	☐ Intact	☐ Mild Impairment	☐ Moderate	☐ Severe
Language/Communication Findings: _____	☐ Intact	☐ Mild Impairment	☐ Moderate	☐ Severe
Memory Findings: _____	☐ Intact	☐ Mild Impairment	☐ Moderate	☐ Severe
Reasoning Findings: _____	☐ Intact	☐ Mild Impairment	☐ Moderate	☐ Severe
Other Executive Functioning (Insight, Judgment, Planning, Initiation, etc.) Findings: _____	☐ Intact	☐ Mild Impairment	☐ Moderate	☐ Severe
Emotional/Behavioral Functioning Findings: _____	☐ Intact	☐ Mild Impairment	☐ Moderate	☐ Severe

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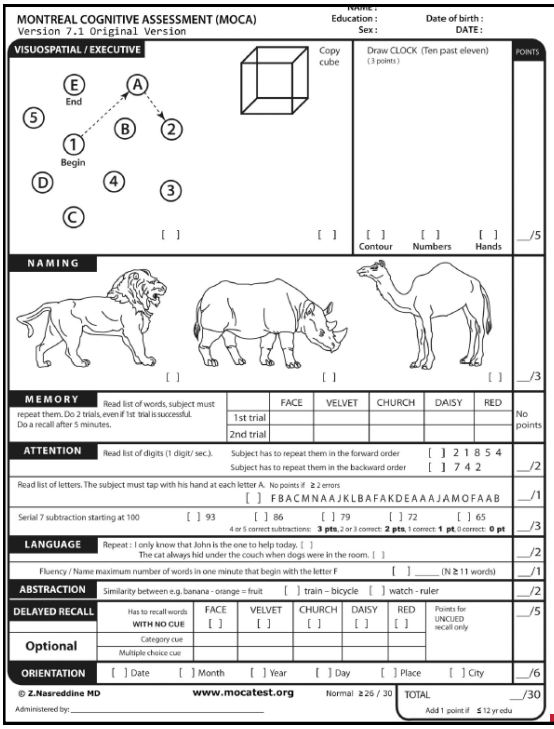

MONTREAL COGNITIVE ASSESSMENT (MOCA)
Version 7.1 Original Version

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

VISUOSPATIAL / EXECUTIVE — Copy cube — Draw CLOCK (Ten past eleven) (3 points) — POINTS — /5

NAMING — /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 — 1st trial, 2nd trial — No points

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 pt — /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 — Has to recall words WITH NO CUE: FACE [ ] VELVET [ ] CHURCH [ ] DAISY [ ] RED [ ]. Points for UNCUED recall only — /5

Optional — Category cue; Multiple choice cue

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

© Z.Nasreddine MD — www.mocatest.org — Normal ≥ 26 / 30 — TOTAL — /30 — Add 1 point if ≤ 12 yr edu

Administered by: _____

Global Cognition

- Administration of a global cognition screening measure (MoCA) can lend support to capacity determination:
  - Estimates disease severity and overall level of cognitive impairment
  - Provides a crude estimate of domain specific cognitive functioning

	Raw Score	Standard	Percentile	Description
GENERAL COGNITION				
Montreal Cognitive Assessment (MoCA)	17/30	-3.16	1	**Impaired**
Memory Index Score	2	-2.40	1	**Impaired**
Executive Index Score	6	-4.98	0	**Impaired**
Visuospatial Index Score	6	-0.31	38	Average
Language Index Score	5	-0.61	27	Average
Attention Index Score	15	-1.44	7	Borderline
Orientation Index Score	4	-7.76	0	**Impaired**

Goldstein FC, Milloy A, Loring DW; for the Alzheimer's Disease Neuroimaging Initiative. Incremental Validity of Montreal Cognitive Assessment Index Scores in Mild Cognitive Impairment and Alzheimer Disease. Dement Geriatr Cogn Disord. 2018;45(1-2):49-55. doi: 10.1159/000487131. Epub 2018 Apr 11. PMID: 29642074; PMCID: PMC5971132.

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Decisional Capacity: Cognition

- Cognitive deficits are the strongest predictor of impaired healthcare decision-making capacity (Palmer & Harmell, 2016)
  - Understanding - *Comprehension and encoding of treatment information*
    - Attention
    - Receptive Language
    - Short-term/Working Memory
  - Appreciation - *Applying information to one's self and one's own situation*
    - Metacognition
    - Insight / Awareness
  - Reasoning - *Information processing and internally arriving at a treatment decision*
    - Executive Functioning (judgement, reasoning, problem solving)
  - Expressing Choice - *Communication of the treatment decision*
    - Expressive language

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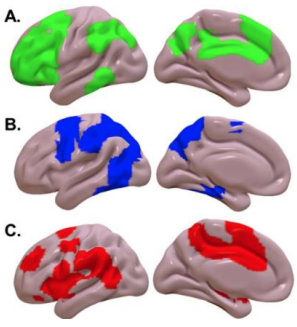
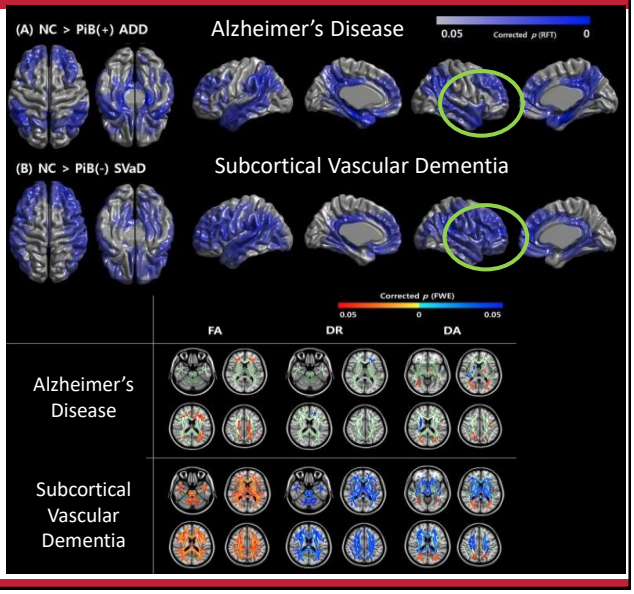
The Neuroscience of Decision-Making

Brain Areas Involved in Decision-Making:

A. Frontoparietal Network: Executive functioning and cognitive control
B. Dorsal Attention Network: Top-down modulation of attention
C. Ventral Attention Network: Reorienting attention and performance monitoring





Jang, H., Kwon, H., Yang, JJ. *et al.* Correlations between Gray Matter and White Matter Degeneration in Pure Alzheimer's Disease, Pure Subcortical Vascular Dementia, and Mixed Dementia. *Sci Rep* **7**, 9541 (2017). https://doi.org/10.1038/s41598-017-10074-x

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Psychotic Symptoms in the Elderly

- Delirium
  - Can occur secondary to prescription medications (anti-cholinergic, sedative-hypnotic) and infection (urinary tract infection, pneumonia)
- Dementia
  - More than 50% of Alzheimer's patients experience psychotic symptoms throughout course of the disease, with 70% developing delusions
    - Delusions often "misidentifications" due to memory loss (simple paranoid beliefs: theft, imposter)
  - Visual hallucinations occur in up to 80% of patients with Lewy Body dementia
    - Not upsetting to the patient, can be pleasant.
- Primary Psychiatric Disorder
  - Remitting/relapsing of chronic psychiatric disorders (schizophrenia, bipolar)
  - Late-onset schizophrenia, or depression with psychotic features

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Psychiatric or Emotional Factors

- Significant psychiatric or emotional disturbance (i.e., severe depression, paranoia or disinhibition) may limit reasoning/judgement
  - However, does not imply impaired capacity
  - Focus on identifying potential influence of psychiatric/emotional symptoms on capacity (cognitive process or behaviors)
- Psychiatric/mood symptoms should always be assessed in capacity workup
  - Thorough review of chart and patient history
  - Interview with patient/family
  - Structured interviews and questionnaires (NPI-Q, GDS, GAS, PHQ-9, HADS)
- Mood or thought disorders can resolve with treatment (reversible factor)
  - Critical to recommend treatment interventions and time frame for re-evaluation of capacity

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Values and Preferences

- A person's values and preferences are the foundation for decisions.
  - Values: underlying set of beliefs, concerns and approaches that guide personal decisions
    - Influenced by family, social network, culture, religion, race, ethnicity, gender, sexual orientation, and life experiences
  - Preferences: preferred option of various choices informed by values
    - Cultural beliefs/practices can inform decisional preferences (role of family/doctor in decisions)
- Values are often maintained despite cognitive dysfunction (Karel et al., 2007)
- Extent to which decisions are consistent with long-standing values
  - Choices based on lifetime values may be rational, even if outside the norm
  - Capacity is not based on mismatch in values between patient and clinician
  - Patients have the right to make "bad decisions"

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Risk Considerations

- Capacity evaluations are intrinsically a risk assessment (Ruchinskas, 2005)
- Involves careful consideration of the patient's social context
  - Strong social and environmental support decreases risk
  - Lack of support and oversight increases risk
- Level of intervention/supervision must match risk of harm to the patient
- Guardianship: Must include a full exploration of least restrictive alternatives
  - Advanced directives
  - Healthcare proxy
  - Durable power of attorney for finances
  - Social Security Representative Payee
  - Supported decision-making agreement (WI)

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Supported Decision-Making Agreement

- Signed into Wisconsin law in 2018 to provide a least restrictive alternative to guardianship.
- Patient retains all decision-making rights and authority.
- Identifies a "supporter" to assist with a variety of elected decisions
  - Medical, psychological, financial, education, treatment, other
- Role of supporter
  - Helps patient access, collect, or obtain information, including records, relevant to a decision.
    - Includes protected health information under HIPPA
  - Helps patient understand options to make an informed decision.
  - Helps patient communicate decision to appropriate persons.

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Steps to Enhance Capacity

- Medical/Mood Factors
  - Identify and treat any reversible causes of impaired cognition
- Sensory Impairment (vision, hearing)
  - Practical accommodates (vision/hearing aides, large print, pocket talker)
- Communication Issues (aphasia, word-finding)
  - Use simple explanations, break information down into basic parts, yes/no format, provide visual aid
- Memory Impairment
  - Not sufficient to determine incapacity - present relevant information for decision (reduce demands on memory)
- Limited Insight (Metacognition)
  - Can use hypothetical situations (vignettes), but often appreciation remains impaired

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(Sullivan, 2004. Neuropsychology Review)

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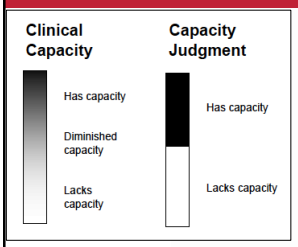
How is Healthcare Decision Making Capacity Assessed?



Clinical Judgement

Functional Ability
Diagnosis
Cognitive Ability
Psychiatric/Emotional Factors

Values & Preferences
Risk Considerations
Steps to Enhance Capacity

Legal Standard
(Understanding, Appreciation, Reasoning, Choice)

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A Model for Capacity Evaluation in the Memory Care Setting

The Geriatrics Cognitive Capacity Clinic

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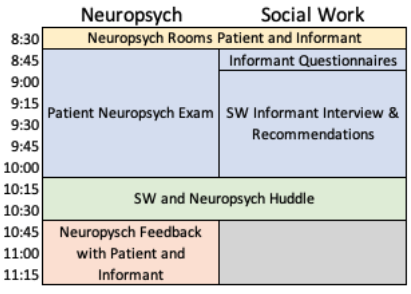
G-CCC Assessment Approach

- <u>Neuropsychologist Role:</u>
  - Neuropsychologists are particularly well equipped to identify relevant areas of impaired cognition or judgement impacting capacity.
  - Assessment includes: patient interview, mood screen, values/preferences, formal capacity instrument, and supplemental neuropsychological testing
- <u>Social Work Role:</u>
  - Independently assess family dynamics and support, longstanding patient preferences/values, safety issues, and functional status
  - Make recommendations to optimize continued independence and to guide planning when incapacity is suspected or indicated



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Capacity Referral Process

Geriatrics Cognitive Capacity Clinic - Referral Request

Does patient have an established diagnosis of dementia: ☐ **NO** ☐ **YES**
(If no, please refer patient to Memory Assessment Clinic first for diagnostic workup)
Date of Diagnosis:
Stage of Dementia:
Suspected Etiology:

Please check areas of capacity that are in question:
(Note: Healthcare Decision-Making Capacity should be primary)
☐ Healthcare Decision Making Capacity
☐ Financial Capacity
☐ Independent Living Capacity
☐ Testamentary Capacity (I.e., writing a will)

Please name person and relation to patient who has historically been most involved in their care:
Name:
Relation to Patient:

Are there concerns for elder abuse or undue influence? ☐ **NO** ☐ **YES**
(If yes, please describe below)

Is there any current litigation or legal involvement? ☐ **NO** ☐ **YES**
(If yes, please describe below)

Are there any known reversible or mitigating factors present (I.e., delirium, medications, vision, hearing, mood) that may be impacting capacity?
☐ **NO** ☐ **YES**
(If yes, please describe below)

REQUIRED: Please describe specific examples or context for what raises concern of diminished capacity or what is prompting the capacity evaluation:

Common Referral Reasons:

- Legal involvement
- Family dispute
- Discrepant reports of abilities (patient vs family, provider vs family, etc)
- Complicated presentation/ comorbidity (psychiatric, intellectual disability)
- Cognitive/sensory issues limiting physician assessment (aphasia, blindness, etc)
- Outdated HC-PoA that does not allow nurse practitioners to make capacity determinations

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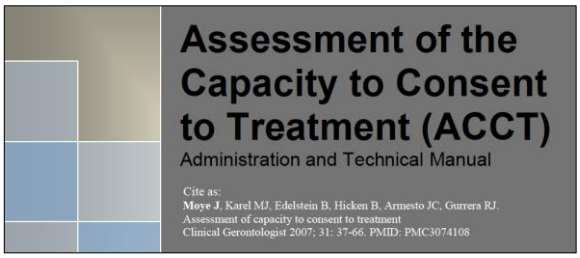
Capacity Clinic Assessment Approach

Clinical Approach

- Consideration of any reversible causes of incapacity (i.e., delirium, UTI, mood) and steps to enhance capacity (sensory/language impairment)
  - Medical record review / referral form
- A formal and direct functional assessment tailored to the capacity issues at hand.
- Objective neuropsychological testing
  - Global cognition (MoCA)
  - Expressive/Receptive Language
  - Executive Functioning
  - Metacognition
- Social Work: Informant interview to administer questionnaires, and assess values/ preferences, family concerns, available support, risks, and barriers.

Capacity Instruments



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Assessment begins by assessing patient's values and preferences:

Please select which three things are most important to your life or make your life worth living:

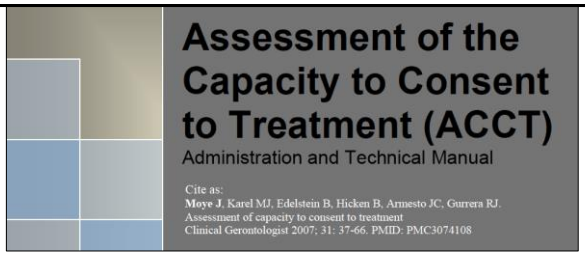
To take care of myself (e.g. bathing, dressing)
To walk or move around by myself
To live at home
To think clearly about things
To make my own life decisions (e.g., about health, finances, housing)
To have relationships with my family and friends
To practice my religion or spiritual life (faith, prayer)
To live without significant pain or discomfort
To do activities or hobbies that I enjoy

When you make an important healthcare decision, how much input do you want from your doctor?

I want to make the decision myself	I want to make the decision mostly by myself	I want to make the decision together with my doctor	I want my doctor to make the decision mostly for me	I want my doctor to make the decision entirely for me

The quality of my life is more important than how long I live.

Very False	Mostly False	Do Not Know	Mostly True	Very True



Followed by presentation of a medical vignette:

The Problem	**Non-healing Toe Ulcer** Infected open sore Does not respond to mediation Lack of blood supply from legs to feet Infection may spread Could lead to death
Choice 1:	Surgery on artery (Incision down leg, insert new artery)
Benefits	Increase blood supply Save toe
Risks	Could die Need help during 6 week recovery
Choice 2:	Surgeon cuts off toe (Quick)
Benefits	Rid of infected tissue Not major surgery
Risks	Use a cane to walk Difficulty with balance

https://heartbrain.hms.harvard.edu/files/heartbrain/files/acct_manual.pdf

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Scoring is standardized based on criteria provided:

R1. REASONING RATIONAL

Rational Reasons

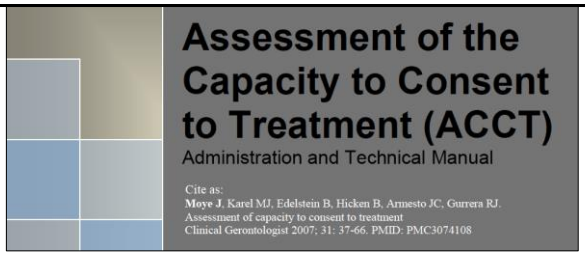
63. Q. **What risks and benefits did you consider when making that decision?**

2	*Answer demonstrates ability to state at least two risks and/or benefits of the treatment as an exact repetition, a correct synonym or definition.* *1 pt for any of the following:* ○ "Surgery." ○ "Increased blood supply." ○ "Saves toe." ○ "Might not work." ○ "Might die." ○ "Amputation gets rid of infected tissue." ○ "You go without major surgery." ○ "Have difficulty with balance afterwards." *Sample 2 pt answers:* ▪ "Getting rid of infected tissue and not having major surgery." ▪ "Chances are I could die and I would have a long recovery."
1	*Answer vague (or only one of exact answer above).* ▪ "The smaller surgery has less risk of dying."
0	*Answer is obviously incorrect or doesn't meet criteria for 1 or 2 pts (or none of exact answers above).* ▪ "It may not work out the way you like it." ▪ "The risks and benefits are about the same for both of them, in my opinion."

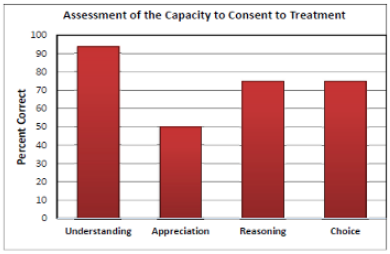
Comparative Reasons

Q. **Tell me why ____ it seems better than ____.**

2	*Offers at least one statement in the form of a comparison of at least two options (stated or clearly implied), with the comparison including a statement of at least one specific difference* ▪ "Amputation is quicker and I'd get back to normal soon." ▪ "With the amputation, there is no guarantee that you have solved the problem of the blood supply." ▪ "Because I will still have an option to do any work, save my toe, and have no need for a cane." ▪ "Moving the artery is a long shot. Since the infection might still be there, it seems best just to get rid of it." ▪ "To me, when replacing the whole artery, the risks in surgery are more than just cutting the toe off. I could live with using a cane."
1	*Makes a comparison statement but does not include a statement of a specific consequence, i.e., says one is better than other without saying why. Offers vague reasons why.* ▪ "That's how you walk – with your toes. I can't lose them." ▪ "Amputation is better than surgery for me."
0	*Makes no comparative statements, is obviously incorrect, OR makes comparison but reason is inconsistent with facts as presented in the vignette.* ▪ "I would just be following doctor's orders."



Results can be graphed for easy interpretation:



ASSESSMENT OF THE CAPACITY TO CONSENT TO TREATMENT (ACCT)				
Understanding - Disorder	3 /8	-2.41	1	Impaired
Understanding - Treatment	10 /16	-1.17	12	Low Average
Appreciation - Distrust	3 /4	-4.13	1	Impaired
Appreciation - Foresight	3 /4	-0.93	18	Low Average
Reasoning - Rational	0 /4	-12.16	1	Impaired
Reasoning - Values	0 /4	-4.02	1	Impaired
Choice - Naming	2 /2	0.22	58	Average
Choice - Communicating	1 /2	-1.00	16	Low Average

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Additional Objective Assessment

COGNITION	
UNDERSTANDING - *Comprehension of treatment information*	
Auditory Attention	*Digit Span (Cognistat)*
Receptive Language	*Token Test, Repetition (Cognistat)*
APPRECIATION - *Applying information to one's self and situation*	
Metacognition/Insight	*IQCODE Subject/Informant Discrepancy*
Awareness	*Orientation (MoCA, Cognistat)*
REASONING - *Information processing and arriving at a decision*	
Judgement	*Test of Practical Judgement*
Abstract Reasoning	*Similarities (Cognistat)*
Executive Functioning	*Clock draw, Trail Making Test*
EXPRESSING CHOICE – *Communicating treatment decision*	
Expressive Language	*Confrontation Naming, Verbal Fluency*

FUNCTION / OTHER ELEMENTS	
PSYCHIATRIC/EMOTIONAL	
Mood	*Hospital and Anxiety Scale (HADS)*
Psychiatric	*Neuropsychiatric Inventory (NPI)*
RISK CONSIDERATIONS	
Independent Living	*Safety Assessment Scale*
Judgement	*Test of Practical Judgement*
ADL/IADLs	*Lawton / SW Interview*
GLOBAL COGNITION	
Disease Severity	*MoCA*

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Routledge Taylor & Francis Group
Check for updates

Re-evaluation of psychometric evidence and update of normative data for the Test of Practical Judgment

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ABSTRACT

Objective: The Test of Practical Judgment (TOP-J) has shown utility in inpatient and outpatient settings in older adults who present with mild cognitive impairment and various dementia subtypes. The TOP-J has two versions (i.e. 9 items and 15 items), and was initially validated within a small rural non-Hispanic White sample. In the current study, we re-evaluated the psychometric evidence and refined scoring criteria and administration guidelines in older adults with more diverse demographic characteristics than the original validation sample. **Method:** Participants ($N = 348$) were recruited from several boroughs of New York City and surrounding areas (mean/median age = 79; mean years education = 15, median = 15.5; 68% female; 30% Black/African-American, 8% Hispanic). **Results:** Reliability and validity were comparable to original findings. Based on confirmatory factor analysis, one item was replaced on the 9-item version, now called TOP-J Form A. Normative data for cognitively intact participants ($n = 261$) were updated and stratified by two education groups. **Conclusions:** The TOP-J is increasingly used in clinical and research settings in the U.S. and abroad, and the current study provides improved normative data and administration and scoring guidelines for use with demographically diverse older individuals.

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KEYWORDS
Judgment; older adults; functional capacity; neuropsychological assessment; Test of Practical Judgment

Test of Practical Judgement (TOP-J) 9-item

- Brief measure that evaluates everyday judgment related to safety, medical, social/ethical and financial issues.
  - *"You are traveling far from home and realize you don't have enough blood pressure pills for the entire trip. What would you do?"*
  - *"You read a report that the government will reduce monthly social security payments from 1,000 dollars to 500 dollars for a certain percentage of recipients. What would you do?"*
- Developed specifically for use in older adults
  - High test-retest (.78) and interrater (.97) reliability
  - 10-minute administration time
  - Scoring rubric with examples
  - Education-adjusted normative data

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Additional Assessments – Financial Capacity

Financial Vulnerability Survey Pro

17 QUESTIONS

For professionals who work with older adults as they make significant financial decisions, including financial planners, attorneys, psychologists, bankers, investment managers, insurance agents, accountants, law enforcement officers, and Adult Protective Services case workers.

INTERVIEW IS ELECTRONICALLY SCORED AND RECORDED. COMPLETION TAKES ABOUT 10 MINUTES

ANSWER 17 QUESTIONS TO DETERMINE THE RISK OF FRAUD, SCAMS AND FINANCIAL EXPLOITATION.

OLDER ADULT NEST EGG FINANCIAL VULNERABILITY SCORE:

Moderate Exploitation Risk

Your responses show mild to moderate stress in key areas that impact financial decision making. They indicate that you have a mildly increased vulnerability to financial exploitation.

Exploitation Risk Rating: 9

Anyone can be vulnerable to financial exploitation, but some older adults are at increased risk. These questions measure the main stressors that can affect financial vulnerability and risk: daily finances, psychological aspects of finances and financial decision-making, and relationship pressures around finances.

RATING REFERENCE

LOW	MODERATE	HIGH
A low score indicates reduced risk of financial exploitation.	An moderate score indicates mildly increased risk of financial exploitation.	A high score indicates a greatly increased risk of financial exploitation.

Financial Vulnerability Survey for Professionals (FVS-Pro)

17 Questions | Approx. time: 15 min. | www.OlderAdultNestEgg.com | ©2022, Peter A. Lichtenberg, PhD

AGE | GENDER: ☐ Male ☐ Female ☐ _____ | RACE/ETHICITY | HIGHEST LEVEL OF EDUCATION

DO YOU LIVE ALONE? ☐ Yes ☐ No

ARE YOU EMPLOYED? ☐ Yes ☐ No

ARE YOU: ☐ Married ☐ Life Partner (unmarried) ☐ Widowed ☐ Single

DATE: / /

SECURE ID CODE: _____

Select one response for each question and describe response when requested

1. How worried are you about having enough money to pay for things?
☐ *Not at all worried (0)* ☐ *Somewhat worried (1)* ☐ *Very worried (2)*

2. Overall, how satisfied are you with your finances?
☐ *Satisfied (0)* ☐ *Neither satisfied nor dissatisfied (1)* ☐ *Dissatisfied (2)*

3. Who manages your money day-to-day?
☐ *I do, without any help (0)* ☐ *I get help from someone (1)* ☐ *Someone else manages all my money (2)*

https://www.olderadultnestegg.com/financial-vulnerability-survey-pro/

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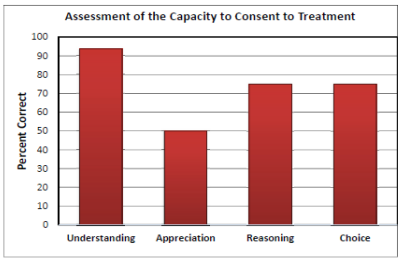
Evaluation Output



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Patient Label Here

Age:	62
Gender:	Female
Race:	Caucasian
Education:	13
Handedness:	RH
DATE OF TESTING	10/3/2022

ACCT SUMMARY SCORE	PERCENT CORRECT
Understanding	94
Appreciation	50
Reasoning	75
Choice	75

	Raw Score	Standard	Percentile	Description
GENERAL COGNITION				
Montreal Cognitive Assessment (MoCA)	26/30	-0.13	45	Average
Memory Index Score	18	2.15	98	Superior
Executive Index Score	10	-1.65	5	Borderline
Visuospatial Index Score	7	0.80	79	High Average
Language Index Score	5	-0.61	27	Average
Attention Index Score	15	-1.44	7	Borderline
ANCILLARY NEUROPSYCH TESTS				
Test of Practical Judgement	25 /27	---	0	Impaired
Clock Drawing Test	10 /10	---	---	Normal
Token Test - Short Form	32 /36	-1	13	Low Average
Semantic Fluency (Animals)	15	-1.50	6	Borderline
Phonemic Fluency (F)	9	-1.26	10	Low Average
Cognistat - Select Subtests				
Orientation	10 /12	---	---	Average
Language, Repetition	6 /12	---	---	Impaired - Moderate
Language, Naming	5 /8	---	---	Impaired - Mild
Attention, Digit Span	1 /8	---	---	Impaired - Severe
Reasoning, Similarities	4 /8	---	---	Impaired - Mild
CERAD				
Trial 1	4 /10	-1.40	8	Borderline
Trial 2	5 /10	-2.14	1	Impaired
Trial 3	9 /10	0.20	57	Average
Delay Recall	2 /10	-3.69	1	Impaired
Savings	22.2 %	-4.37	1	Impaired
Recognition: True Positives	9 /10	-1.60	5	Borderline
Recognition: True Negatives	8 /10	-9.50	1	Impaired
ASSESSMENT OF THE CAPACITY TO CONSENT TO TREATMENT (ACCT)				
Understanding - Disorder	6 /8	-0.09	46	Average
Understanding - Treatment	9 /16	-1.54	6	Borderline
Appreciation - Distrust	3 /4	-4.13	1	Impaired
Appreciation - Foresight	1 /4	-3.87	1	Impaired
Reasoning - Rational	3 /4	-2.78	1	Impaired
Reasoning - Values	3 /4	-0.80	21	Low Average
Choice - Naming	1 /2	-4.13	1	Impaired
Choice - Communicating	2 /2	0.00	50	Average
QUESTIONNAIRES AND CLINICAL SCALES				
IQCODE - Patient	4.12	---	96	---
IQCODE - Informant	4.29	---	---	---
Discrepancy Score	0.08	---	---	---
Safety Assessment Scale (SAS)	25	---	---	---
Values and Preferences - Social	25 /45	---	---	---
Values and Preferences - Autonomy	14/27	---	---	---
MOOD				
HADS - Depression	15 /21	---	---	Abnormal
HADS - Anxiety	7 /21	---	---	Minimal

(Norms based on: RH, 13 years education, Age 62)

NOTES:

- Detailed testing result summary and interpretation
- If patient lacks capacity, neuropsychologist will provide 2nd signature for HC-PoA activation
  - PCP is recommended to serve as 1st signature given their ongoing relationship with patient
- Comprehensive clinical note by Neuropsychologist
  - Incorporates SW report/findings related to risks, barriers, and support
  - Provides clinical judgement of capacity determination based on the 4 tenants of capacity supported by neuropsych findings
  - Recommendations and resources for patient, family, care providers

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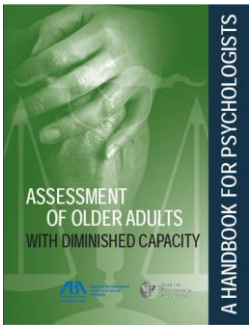
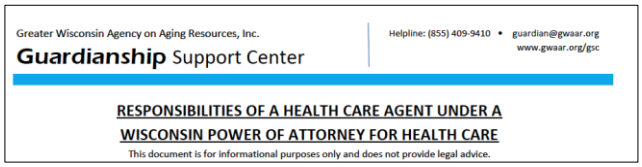
Useful Resources / References



https://www.apa.org/pi/aging/programs/assessment

- Joint effort in 2008 by the American Bar Association and American Psychological Association
- Assessment guide for a variety of capacity evaluations (medical, functional, sexual consent, financial, testamentary, driving, independent living)
- Comprehensive overview of standard capacity instruments
- Appendix with interventions to address diminished capacity
- Appendix of medical conditions affecting capacity
- Compendium of useful websites


Greater Wisconsin Agency on Aging Resources, Inc.
Guardianship Support Center
Helpline: (855) 409-9410 • guardian@gwaar.org
www.gwaar.org/gsc

RESPONSIBILITIES OF A HEALTH CARE AGENT UNDER A WISCONSIN POWER OF ATTORNEY FOR HEALTH CARE

This document is for informational purposes only and does not provide legal advice.

https://gwaar.org/api/cms/viewFile/id/2005212

- Practical guide to families regarding serving as HC-PoA for Healthcare
  - Activation of PoA and definition of healthcare decisions
  - Standards for decisions (good faith)
  - Admitting to residential facilities
  - How to advocate

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Questions / Discussion

- *Any comments or questions?*
- *What barriers have you have faced when assessing capacity in your own clinical setting?*
- *Does your clinic already have an established protocol for assessing capacity? What are the key elements?*
- *Would adopting a formal capacity instrument be advantageous or even feasible in your clinic's approach to capacity evaluations?*
- *What factors make you less confident in your capacity determination?*

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