

Finances in the Older Patient With Cognitive Impairment

"He Didn't Want Me to Take Over"

Eric Widera, MD

Veronika Steenpass, MD

Daniel Marson, JD, PhD

Rebecca Sudore, MD

THE PATIENT'S STORY

Mr L is a 76-year-old retired salesman. He is of Japanese descent and has a history of Alzheimer dementia, transient ischemic attacks, carotid stenosis, type 2 diabetes, hypertension, dyslipidemia, presbycusis, and radiation treatment for parotid carcinoma (4 years ago). He presented as a new patient to a geriatrics primary care clinic accompanied by his daughter. He had been diagnosed with Alzheimer dementia 2 years earlier at a memory disorders clinic and had been taking donepezil, 10 mg and memantine, 10 mg twice a day since that time. His other medications included metoprolol, 25 mg; simvastatin, 20 mg; clopidogrel, 75 mg; and loratadine, 10 mg.

Mr L had been widowed for 16 years. He lived by himself in a modest apartment, had a paid caregiver during the day, and was able to safely stay alone at night. He was independent in his activities of daily living (ADLs) except that he needed assistance with bathing. He was dependent for most instrumental activities of daily living (IADLs), such as medication management, but was reportedly still signing checks. Records from the memory clinic revealed a Mini-Mental State Examination (MMSE) score of 24 out of 30, assessed 2 years ago, and 16 out of 30, assessed 1 year ago. At the time of the dementia diagnosis, Mr L completed a durable power of attorney for health care, but never completed a durable power of attorney for financial matters. All bank accounts remained solely in his name.

During a follow-up clinic visit 3 months later, Mr L's daughter reported to the geriatrician that he was becoming

Financial capacity can be defined as the ability to independently manage one's financial affairs in a manner consistent with personal self-interest. Financial capacity is essential for an individual to function independently in society; however, Alzheimer disease and other progressive dementias eventually lead to a complete loss of financial capacity. Many patients with cognitive impairment and their families seek guidance from their primary care clinician for help with financial impairment, yet most clinicians do not understand their role or know how to help. We review the prevalence and impact of diminished financial capacity in older adults with cognitive impairment. We also articulate the role of the primary care clinician, which includes (1) educating older adult patients and their families about the need for advance financial planning; (2) recognizing signs of possible impaired financial capacity; (3) assessing financial impairments in cognitively impaired adults; (4) recommending interventions to help patients maintain financial independence; and (5) knowing when and to whom to make medical and legal referrals. Clearly delineating the clinician's role regarding identification of financial impairment could establish for patients and families effective financial protections and limit the economic, psychological, and legal hardships of financial incapacity on patients with dementia and their families.

JAMA. 2011;305(7):698-706

www.jama.com

Author Affiliations: Geriatrics and Extended Care, Department of Veterans Affairs Medical Center, San Francisco, California, (Drs Widera and Sudore); Division of Geriatrics, University of California at San Francisco, San Francisco (Drs Widera, Steenpass, and Sudore); Department of Neurology and Alzheimer's Disease Research Center, University of Alabama at Birmingham (Dr Marson).

Corresponding Author: Eric Widera, MD, VA Medical Center 181G, 4150 Clement St, San Francisco, CA 94121 (eric.widera@ucsf.edu).

Care of the Aging Patient: From Evidence to Action is produced and edited at the University of California, San Francisco, by Seth Landefeld, MD, Louise Walter, MD, C. Bree Johnston, MD, and Anna Chang, MD; Amy J. Markowitz, JD, is managing editor. **Care of the Aging Patient Section Editor:** Margaret A. Winker, MD, Deputy Editor.

See also p 707.



CME available online at www.jamaarchivescme.com and questions on p 723.

increasingly irritable, angry, and “stingy” with respect to money. For example, he refused to sign a check to purchase hearing aids, stating that they were “too expensive,” and refused to hire a substitute caregiver while his main caregiver was on vacation. His daughter also stated that the bank had phoned on a number of occasions over the past year to make her aware of questionable transactions. For example, since Mr L liked an air humidifier he had ordered, he purchased 3 more, resulting in costs of approximately \$1000. Mr L’s daughter asked the geriatrician to write a letter to the bank stating that her father lacked financial capacity. The daughter remarked, “I could get him to sign papers in order to sign over his assets to me, but if he really knew what it was about, he would never sign. He would be furious.”

Mr L’s daughter, Ms L, and Dr Y were interviewed by a Care of the Aging Patient editor in April 2010.

PERSPECTIVES

Ms L: *My father . . . always . . . knew exactly when bills were coming and when he had to pay. At this point, he would say that he didn’t order whatever the bill was for and he would refuse to pay it. . . . He just kept saying that his memory wasn’t very good, but he was fine. He was okay with me checking his mail, but not with me paying his bills. He didn’t want me to take over.*

Dr Y: *The daughter . . . wanted a letter to the bank saying that her father lacked capacity to make decisions about his own finances. He still had access to his money and there was a lot of stress between them.*

Overview

Financial capacity can be defined as “the ability to independently manage one’s financial affairs in a manner consistent with personal self-interest.”¹ Financial capacity comprises a range of conceptual, pragmatic/procedural, and judgmental skills acquired over a lifetime² and is highly vulnerable to the cognitive changes accompanying conditions such as mild cognitive impairment (MCI) and Alzheimer disease.³⁻⁶ Impairment of financial capacity usually occurs very early in the course of cognitive impairment,⁷ at a time when both patients and family members may be largely unaware of encroaching deficits in financial skill.⁸⁻¹¹

Financial capacity can be distinguished from medical decision-making capacity by its multidimensionality¹² and scope of activity.² Although medical decision making is primarily a verbally mediated activity occurring at discrete points in time, financial capacity involves a range of knowledge, performance, and judgment skills that are exercised on an ongoing basis.

The core financial skills that all adults must retain to live independently include basic monetary skills such as identifying and counting money, understanding debt and loans, conducting cash transactions, paying bills, and

maintaining judgment to conduct financial activities prudently and avoid financial abuse. When these core skills become impaired, families and caregivers often turn to physicians to make determinations about financial capacity,¹³ as did Mr L’s daughter. We review diminished financial capacity in older adults with cognitive impairments and the physician’s role, which includes knowing when and to whom to refer patients with suspected financial impairment for further medical or legal aid.

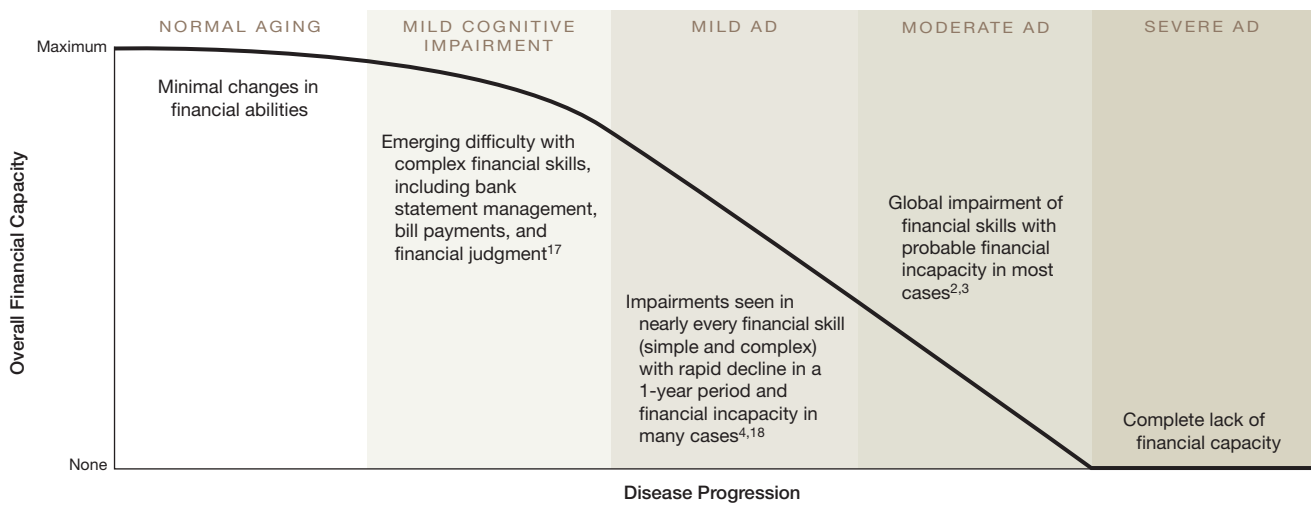
Methods

We searched MEDLINE, PsycINFO, CINAHL, and the Cochrane database for peer-reviewed English-language articles from 1966 through June 2010 on the following topics: (1) financial abilities of older adults with dementia or MCI; (2) outcomes of financial impairment including that of elder abuse; and (3) structured instruments to assess financial capacity. We included the search terms *activities of daily living; finances; delirium, dementia, amnesic cognitive disorders; financial capacity; financial management; and mild cognitive impairment*. We specifically selected articles that pertained to financial skills, financial capacity assessment, and elder abuse in addition to dementia or MCI. We excluded studies that pertained to financial impairment from nondementia causes such as psychiatric disorders. When searching articles on financial capacity instruments, we excluded studies that did not present primary research data. Our data synthesis was based on Alzheimer disease as a paradigm for dementia-related disorders, and our recommendations were informed by our clinical experience caring for patients with MCI and Alzheimer disease.

Epidemiology

More than 5.3 million individuals in the United States currently have Alzheimer disease, a number that is expected to reach between 11 million and 16 million by 2050.¹⁴ Functional disability is a core feature of dementia, initially manifesting in impairments in IADLs, such as managing medications, using the telephone, shopping, and handling finances,¹⁵ followed eventually by impairments in basic ADLs, such as bathing and dressing.¹⁶

The ability to manage finances is one of the first IADLs to decline in MCI and Alzheimer disease, and becomes progressively impaired (FIGURE 1).^{2-4,6,17-19} Patients with amnesic MCI are at high risk of progressing to Alzheimer disease.^{21,22} These patients have memory impairment alone or in combination with other cognitive impairments such as verbal or executive functioning. However, these impairments are not as severe as those seen in dementia.²⁰ MMSE scores generally are greater than 24 out of 30 points depending on age and education.²³ IADL impairments may emerge in amnesic MCI, particularly impairments in complex financial tasks such as financial conceptual knowledge, bank statement management, and bill

Figure 1. Conceptual Schematic of Progressive Decline in Financial Capacity in a Person With Alzheimer Disease (AD)

payment skills.^{17,18} Even at this early stage in cognitive decline, older adults are vulnerable to financial mismanagement and abuse. Moreover, patients with amnesic MCI who progress to Alzheimer disease over a 1-year period demonstrate overt declines in checkbook management and overall financial capacity.⁶

Patients with mild Alzheimer disease demonstrate emerging global impairments of both simple (eg, counting currency) and complex financial skills (eg, paying bills, balancing a checkbook).² Over a 1-year period, these financial deficits often worsen rapidly.⁴ Patients with moderate and advanced Alzheimer disease show a global loss of financial skill and usually lack capacity to manage their finances independently.^{2,3} It is important to note that a few patients may retain varying financial skills and judgment even through the moderate dementia stage, and an evaluation beyond MMSE is needed before financial incapacity is determined.²

The Importance of Financial Capacity to Patients and Families

Dr Y: *He lacks the capacity . . . to know what . . . he's paying for. He's at risk for being taken advantage of by telemarketers. If he has access to his credit cards, then he could lose a lot of money.*

Ms L: *He was just writing checks for small things like books and vitamins, but it could turn into him writing checks for larger amounts.*

For patients with Alzheimer disease and their families, financial capacity is a crucial IADL impairment that has clinical, psychological, economic, and legal implications. Financial impairment is often one of the earliest clinical signs of an emerging dementia and, like loss of other capacities such as driving, can be psychologically distressing.²⁴ Financial impairment can also lead to important economic and safety

consequences for patients and significant stress and burden for caregivers.²⁵ Caring for patients with Alzheimer disease and helping them to maintain independence requires significant out-of-pocket costs,²⁶ and financial mismanagement or abuse may significantly compromise patients' and their families' quality of life. Furthermore, the inability of cognitively impaired patients to manage their finances has been identified as one of the strongest predictors of perceived caregiver burden.²⁷

Financial abuse and loss of financial skill may also necessitate interaction with the legal system. Elder financial abuse is common and accounted for an estimated 30% of all substantiated elder abuse reports to adult protective services in 1996, the most recent year for which national data are available.²⁸ Concerns about elder financial abuse were noted by both Mr L's physician and his daughter. Individuals with cognitive impairment often have significant deficits in financial judgment, making some vulnerable to scams and other financial exploitation.^{29,30} Vulnerability to abuse can occur even early in the course of MCI and may increase as individuals continue to decline cognitively.^{17,18} However, this does not occur in all cases. Once patients lose financial capacity, courts may need to appoint a conservator to manage finances or resolve family disputes over assets.

The Physician's Role

Ms L: *I think that the doctor should, immediately after assessing a patient, tell the parent and the child that the child should be a signer on their bank account. They should do it before they get sick. [S]ometimes it happens so fast . . . you don't have time to take care of it.*

Busy clinicians do not have the time, training, or expertise to be financial capacity or estate planning experts. However, finances are central to an elderly person's independence and well-being, regardless of their socioeconomic

status. As a result, patients and families increasingly seek and expect help from their clinicians, as did Mr L's daughter.³¹ An interprofessional team that includes social work services and case managers can provide invaluable help with these requests. However, many primary care physicians lack access to such support³² and need a clear guide on how to effectively help patients and their families. We believe that the physician's role in monitoring financial capacity of patients includes (1) educating older adult patients and families about the need for advance financial planning; (2) recognizing signs of possible impaired financial capacity; (3) assessing financial impairments in cognitively impaired adults; (4) recommending interventions to help patients maintain financial independence; and (5) knowing when and to whom to make medical and legal referrals (FIGURE 2).

1. Educating Patients and Families About the Need for Advance Financial Planning.

Ms L: *The doctor really needs to talk to them [patients and families] about what would happen "if" . . . and to make sure that they have some sort of contingency plan in the event that something happens. I just felt that I needed to have the ability to get onto his accounts so I could take care of his finances or at least pay his bills so they wouldn't shut off the electricity.*

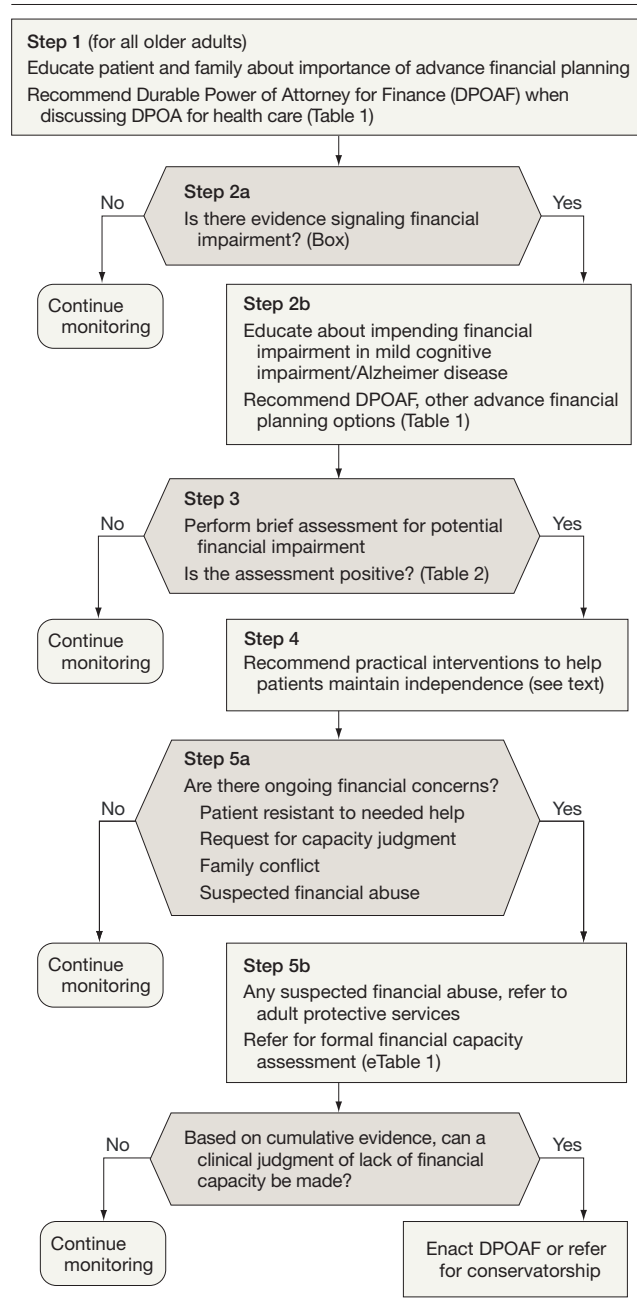
A loss of ability to manage finances due to acute or chronic illness can be highly stressful for patients and families. In such circumstances, having a trusted designee to act in one's stead is essential to avoid devastating financial consequences. Therefore, we recommend that clinicians educate all patients about the need for advance financial planning and recommend that patients complete a durable power of attorney for finance matters (DPOAF).

The Durable Power of Attorney. Executing a DPOAF is an important initial step in advance financial planning (Figure 2, step 1). When a patient signs a DPOAF, the patient authorizes another individual or entity, such as a family member, to make designated financial decisions on the patient's behalf. The DPOAF can take effect immediately or only after the patient has been deemed to lack capacity, and can grant global financial authority or restrict authority to certain transactions.³³ Most states provide statutory DPOAF forms that can be acquired free of charge—often on state bar association Web sites (Resources, available at <http://www.jama.com>). However, it is advisable that a lawyer draft a DPOAF so that it can be tailored to patients' individual needs.³⁴ For further financial planning, clinicians can encourage patients and their families with means to seek out qualified legal or financial advisors. Legal aid and subsidized legal services can be found through local and national Alzheimer Associations around the world and, in the United States, through area agencies on aging and state bar associations (Resources).

Other Advance Financial Planning Options. Online banking is one means by which a family member can assist and oversee the finances of a cognitively impaired older per-

son. Another option is the joint bank account, which allows dual access to and oversight over funds, as well as automatic ownership of the funds by the surviving account holder upon the patient's death.³⁵ The risk associated with this type of account is that the joint account holder is under no legal obligation to act in the patient's best interest. For patients with financial means, a living trust, which should be prepared by a lawyer, provides instructions for how the trust assets are to be managed during the patient's lifetime

Figure 2. Approach to Financial Issues in Elderly Patients



Box. Evidence That Signals Possible Financial Impairment**Evidence From Preexisting Diagnoses or Clinicians' Assessments**

A diagnosis of a medical condition that may affect cognition or functional ability (ie, mild cognitive impairment, Alzheimer disease, stroke)

Impairments in basic cognitive tests (abnormal Mini-Cog, Mini-Mental State Examination <24 depending on age and education norms,³⁶ Montréal Cognitive Assessment <26, or problems with reciting serial 7s or 3s)

Noticeable change in appearance or poor hygiene

A history of recent loss of a partner who may have been managing finances

New family members or caregivers accompanying patient to clinic visits

Evidence From Direct Reports of Patients, Family Members, or Caregivers

New difficulty with common financial skills (calculating change, writing a check, organizing financial documents, managing assets)

Forgetting to pay utility bills or rent; eviction or service disconnection

Concern or confusion about "missing funds" in bank accounts

Reports of erratic, unusual, or uncharacteristic purchases, withdrawals, or gifts

Accusations that people are stealing or mismanaging the patient's money

and distributed after death. Unlike joint accounts, trustees can be held legally liable for breach of fiduciary duties. Finally, wills give individuals control over the disposition of their property after they die. Assistance of a lawyer is strongly recommended in preparing a will, although some statutory forms can be obtained online.

2. Recognizing Signs of Possible Impaired Financial Capacity.

Clinicians need to be aware of evidence that a patient has, or is at risk for financial impairment (Figure 2, step 2a). This evidence may derive from preexisting medical diagnoses that predispose patients to financial incapacity, the physician's assessment of cognition, or direct reports from patients, family members, or caregivers that the patient is having financial difficulty or cognitive impairment. The BOX lists specific examples that signal potential financial impairment based on our clinical experience and our review of the literature.²

Preexisting medical diagnoses that can affect cognition or functional ability, such as MCI, Alzheimer disease, or stroke, should alert the clinician to potential current or future impairment of financial capacity. In this regard, Mr L's

clinicians should have recommended completion of a DPOAF either at the initial diagnosis of Alzheimer disease or when he presented to his outpatient physician with a preexisting diagnosis of Alzheimer disease. However, the diagnosis of dementia can often occur well after the onset of cognitive impairment. Brief and effective screening tools are available that can aid in identifying dementia, including the MMSE and the Mini-Cog,^{37,38} although these lack sensitivity to detect early stages of cognitive impairment. The Montréal Cognitive Assessment (MoCA) is a free, brief, and validated screening tool with high sensitivity and specificity for detecting MCI and dementia (<http://www.mocatest.org>).^{39,40} Impairments in these commonly used cognitive assessments may indicate possible financial impairment. For instance, a patient may not be able to recite serial 7s or 3s on the MMSE.⁴¹ However, these tests were not designed to measure financial capacity,⁴² and, as noted previously, no studies have determined the exact cutoff scores for cognitive screening tests to determine which patients become financially impaired. Thus, deficits in any of these tests may best serve as a prompt for the clinician to probe further about financial capacity.

Direct reports from patients or their family members may come before a formal diagnosis of MCI or Alzheimer disease.⁴³ These reports may be the first signal to the clinician of the need to pursue further cognitive testing or of the potential for impairment in financial capacity. Examples of direct reports include patients mentioning they have forgotten to pay bills or family members acknowledging that their loved one has fallen for a marketing scam.

Once evidence of financial impairment is suspected, clinicians should educate patients, families, and caregivers about the progressive course of Alzheimer disease, the inevitable loss of financial capacity and financial judgment, and the risks of financial mismanagement and exploitation (Figure 2, step 2b; TABLE 1). Clinicians should also provide education about patients' common lack of awareness of their own financial difficulty and the "warning signs" of financial impairment, such as missing, late, or repeated payment of bills.⁹⁻¹¹ Family members of patients with cognitive impairment are receptive to such education. For instance, a Finnish study of 1943 spouses of individuals with Alzheimer disease found that only 10% had discussed legal preparations with the patients' physician,³¹ but 48% expressed a need for financial discussions. Families also prefer that these discussions occur at or soon after the time of the diagnosis of Alzheimer disease, as opposed to waiting until problems arise. In one study of 100 dementia caregivers in Great Britain, 94 wanted to know about financial issues related to Alzheimer disease, with most wanting to have the discussion at the time of diagnosis.⁴⁴

3. Clinician Assessment of Financial Impairment, Financial Abuse, or Both.

Ms L: *It had gotten to the point where it took him a half hour to write a check. First he couldn't find his checkbook,*

Table 1. Initiating Advance Financial Planning and Referral Discussions^a

Intervention for Patients and Their Families/Caregivers	What Clinicians Can Say
Recommend a durable power of attorney for finances	Before diagnosis of cognitive impairment
	<p>"Because of serious illness, memory problems, or being in the hospital, everyone, at least for a short while, may need help with their money and paying bills."</p> <p>"Have you thought about who you would entrust to help with your money and property in case you could not manage on your own?"</p> <p>"A special form called a durable power of attorney for financial matters allows you (your loved one) to name someone to help you (him/her) with your (his/her) money now or when you are (he/she is) unable to manage on your (his/her) own."</p>
Educate about future financial impairments	After diagnosis of cognitive impairment
	<p>"It is common for patients with memory problems and dementia to have problems managing money. Many times, patients do not realize they have a problem. But, it is important to think about what you (he/she) can do now to protect your (his/her) money and property. Have you thought about this?"</p> <p>"Signs that you (your loved one) may need help with your (his/her) money or property include having difficulty balancing your (his/her) checkbook, paying bills, or making correct change."</p>
Recommend practical interventions to support patients with financial impairment	"There are some things you can put in place now to help manage your (your loved one's) money. These include automatic bill pay and direct deposits through your (his/her) bank. There are also services that help manage your (his/her) money. You can call the Alzheimer's Association ([800] 272-3900) for referrals or suggestions. It may also be a good idea to talk with a social worker or someone at your (his/her) bank."
Refer for formal financial capacity assessment	"I am worried that your (your loved one's) memory loss is causing you (him/her) to have problems managing your (his/her) money. I would like to order some special tests. If you do (he/she does) have problems managing your (his/her) money, the tests will tell us what kinds of things you and your family can do to keep your (his/her) money safe."

^aExamples of statements and questions that clinicians can use to meet the individual needs of the clinician, patients, and surrogates. Statements and questions should be modified as needed (eg, when clinician is speaking with a family member or caregiver vs the patient).

then he would find it and it would . . . take so long. He'd forgotten how to spell, so he would ask me: "How do you spell hundred?" The doctor . . . spent time talking to us so she could learn more about my dad's mental and physical state. . . . One of the things that she asked me about was how I was dealing with his finances.

Brief Questions to Probe for Possible Financial Impairment. Clinicians may need to ask patients and caregivers a few targeted questions to further assess for financial impairment. A brief assessment may be necessary because patients with Alzheimer disease, such as Mr L, are often unaware of or in denial about the nature and extent of their decline in financial function. In addition, family and caregivers often give inaccurate or fluctuating estimates of patients' financial abilities.⁴⁵

Brief questions should begin with an assessment of the general environmental demands placed on patients in managing their finances, as well as changes from the patients' premorbid level of financial functioning (Figure 2, step 3). TABLE 2 offers screening questions that are based on previously defined key financial domains² and our clinical experience. If needed, clinicians may then ask more specific questions such as whether the patient has recently written checks that were not paid by the bank due to insufficient funds in the account or had money stolen. Patients' responses should be compared with collateral reports from family or caregivers with significant knowledge of the patient's financial affairs. Answers to these brief questions are often sufficient to alert the clinician to the presence of financial impairment and to recommend interventions to help patients maintain financial independence, and in some cases, make medical and legal referrals (Figure 2).

©2011 American Medical Association. All rights reserved.

Table 2. Informal Assessment: Brief Questions to Probe for Potential Financial Impairment or Vulnerability^a

	Clinician's Questions for Patients and Family
General questions	<p>"Who manages your money, property (and/or investments)?"</p> <p>"Do you have anyone besides yourself on your checking and savings accounts?"</p> <p>"How long has it been like this?"</p> <p>"Are you having any problems?"</p>
Specific questions	<p>"Are you having any new problems making change (and/or calculating tips)?"</p> <p>"When was the last time you were late paying a bill?"</p> <p>"When was the last time you bounced a check?"</p> <p>"Have you received any letters or phone calls from your bank with concerns about your account?"</p> <p>"Has anyone stolen or cheated you out of money?"</p>

^aQuestions are based on our clinical experience and from an understanding of the key financial domains described in the literature.² Statements and questions should be modified as needed (eg, when clinician is speaking with a family member or caregiver vs the patient). These questions have not yet been validated.

Addressing Suspected Financial Abuse. Physicians have an ethical and professional obligation to assess for and address elder financial abuse.⁴⁶ Although a number of elder abuse screening instruments are available, not all screen for financial abuse.⁴⁷ Physicians should be alerted to potential financial abuse by patients' reports of not being able to afford food or medications they could once afford, reports of new acquaintances who take up residence or come to appointments with a cognitively impaired person, and reports of others taking or mismanaging the patient's assets. Interviewing the caregiver and the patient separately is recommended.⁴⁸ In a vast majority of US states, clinicians are mandated to report suspected elder abuse.⁴⁹⁻⁵¹ The jurisdiction and the older individual's living

(Reprinted) JAMA, February 16, 2011—Vol 305, No. 7 703

situation will dictate whether to report suspected abuse to adult protective services and/or other public agencies. Reporting numbers, government agencies, and state-specific laws can be found at the National Center on Elder Abuse Web site (Resources).

4. Practical Interventions to Help Patients Maintain Financial Independence.

In addition to recommending a DPOAF, physicians or other health professionals, such as social workers, can recommend practical financial interventions to help patients maintain independence (Figure 2, step 4). For example, financial institutions can help by automatically depositing checks into an individual's account, paying bills, setting up overdraft protections, and notifying a third party if bills are not paid on time. In addition, benefit providers including the US Social Security Administration, US Department of Veterans Affairs, civil service and railroad pension programs, and some state programs can appoint a representative payee to receive and manage benefits.⁵² The rules for eligibility, implementation, and monitoring will vary among programs, although most require some type of regular accounting of how the benefits are used. Daily money management programs can also assist with tasks such as bill paying, checkbook management, insurance claims, and tax preparation.⁵³ These programs are offered by a variety of public non-profit agencies and private for-profit organizations (Resources).

5. When to Make Medical and Legal Referrals.

Dr Y: *There are tests that you can do that help determine someone's capacity to make financial decisions. Mr L has significant dementia. This man had been followed up for a couple of years with a known diagnosis of dementia, so I saw no problem with writing the letter that he lacked capacity.*

Although clinical judgments are not legal adjudications, a clinician's opinion about a patient's financial capacity carries a great deal of weight with families, financial institutions, and legal professionals.¹³ A clinical judgment of incapacity may ultimately work to protect patients from financial harm, but may also unfairly result in a loss of autonomy and financial independence. Thus, clinicians should have a high level of confidence before making a written attestation concerning a patient's financial capacity, and therefore may wish first to refer to experts in financial capacity assessment.

Referral for Formal Financial Capacity Assessment. There may be ongoing concerns even after a clinician recommends practical planning and financial interventions. In these situations, clinicians may need to consider a formal referral for financial capacity assessment (Figure 2, step 5a). Referrals may be necessary in cases in which (1) the patient is impaired but lacks insight and is resistant to needed help; (2) there is family conflict and an independent opinion is needed; (3) financial abuse is suspected; (4) a relationship with the patient or family is not established and the clinician

is being asked to make a financial capacity determination; or (5) the clinician needs guidance in making a sound decision in the patient's best interest. In Mr L's case, given his lack of insight and cooperation, as well as the concern for financial mismanagement and risk for abuse, outside referral for formal assessment of financial capacity appeared warranted.

If available, physicians need to know where they can refer patients for financial capacity assessments and the strengths of different professional disciplines in making these determinations.¹³ For example, neuropsychologists, geropsychologists, and forensic psychologists use standardized psychometric testing to assess a patient's cognitive, emotional, and everyday functioning in order to make clinical judgments of financial and other capacities. In addition, forensic psychiatrists can also advise on financial and legal issues within the context of a comprehensive understanding of a patient's cognitive and medical circumstances. Also, occupational therapists are experts in qualitatively assessing a wide range of functional skills, formulating impressions of capacity for independent living, and making recommendations for possible supportive interventions.

In addition to knowing where to refer patients, it is helpful for clinicians to know what tests to request from these consultants.⁵⁴ This study provides a Web-only table (eTable, available at <http://www.jama.com>), which describes existing performance-based tests (ie, the patient performs specific tasks) that assess financial abilities in older adults with cognitive impairment. For each test, the eTable presents financial domains measured, as well as reliability and validity data. Global functional measures that have the most robust validity and reliability data and the most direct application to clinical assessment of financial capacity include the Direct Assessment of Functional Status (21 financial items)⁵⁵ and the Independent Living Scales (17 financial items),⁵⁶ which assess basic financial skills as part of a broad-based IADL evaluation. Tests specific to financial capacity that have been most well studied include the Financial Capacity Instrument (112 financial items within 20 tasks and 9 domains)^{2,6,17,57} (eTable). Neuropsychological and neuropsychiatric evaluations can be used to supplement the objective financial capacity findings. As a qualification, to date, none of the identified global or specific tests of financial impairment have been associated with hard financial outcomes such as legal incapacity or elder financial abuse.

Objective information from performance-based financial tests can assist both clinicians and family members in arriving at more sound judgments regarding a patient's financial capacity and can support negotiations with patients who are reluctant to acknowledge impairment or seek help. Such information can also guide clinicians in advising whether, when, and in which financial areas families or caregivers need to assume proxy financial responsibility.

Court-Appointed Conservatorship

Dr Y: *Sometimes there has to be a catastrophe before you can intervene or you have to go for conservatorship.*

A clinical judgment of financial incapacity is generally made when there is substantial incongruence between an individual's current financial abilities and supports, and the financial needs and demands the patient experiences in everyday life. An existing DPOAF can often be implemented following a clinical determination of financial incapacity.⁵⁸ If a DPOAF has not already been executed and the patient lacks decision-making capacity to sign a DPOAF, pursuing a court-appointed conservator (or guardian in some states) may be the only option for securing oversight of financial activities. Court proceedings for conservatorship can take months and involve substantial legal expenses.⁴² In addition, the probate court judge will decide if a conservator is needed and who the best choice of conservator will be. In many situations, courts will give preference to involved family members. This may be problematic if the patient has a domestic partner who is not recognized by the state to act on the patient's behalf, or the patient has a contentious relationship with family members. Conservatorship is generally an option of last resort and underscores the importance of advance financial planning. At the same time, seeking conservatorship and the protection of the court can be an effective strategy in cases of significant family conflict, where there is concern for abuse, or where there is misuse of an existing DPOAF.

CONCLUSIONS

Financial capacity is essential for an individual to function independently in society. Alzheimer disease is a relentlessly progressive disease that inevitably leads to a complete loss of financial capacity. Physicians need to take active roles in assisting patients with MCI and Alzheimer disease and their families with financial concerns. Diagnosis of cognitive impairment generally, and MCI and Alzheimer disease specifically, should signal possible diminished financial capacity and prompt the physician to encourage patients and families to proactively engage in financial and legal advance planning. Timely identification and informal assessment of financial impairment can often lead to the establishment of effective financial protections and can limit the economic, psychological, and legal hardships of financial incapacity in dementia.

Conflict of Interest Disclosures: All authors have completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest. Drs Widera and Steenpass report no disclosures. Dr Marson reports serving as a consultant to the American Bar Association and the American Psychological Association; previous service as a consultant to Medivation Inc and Rush University; receipt of research support from the National Institutes of Health and serving as the primary investigator (HD053074, MH55247, AG021927, AG16582, AG24904 [site primary investigator], and AG10483); receipt of royalty payments as the coinventor of the Capacity to Consent to Treatment Instrument, and anticipates receiving royalty payments in the future as the inventor of the Financial Capacity Instrument (both instruments are owned by the University of Alabama at

Birmingham Research Foundation); and provision of expert consultation and testimony in multiple legal cases during the past 5 years. Dr Sudore reports funding in part by a Pfizer Fellowship in Clear Health Communication.

Funding/Support: Dr Widera reports support by a Geriatrics Academic Career Award from the Health Resources and Services Administration and by the Hartford Foundation as a Center of Excellence Faculty Scholar. Dr Marson reports having served as the primary investigator and was supported in part by grants from the National Institute on Aging (2R01 AG021927 and 1P50 AG16582), and from the National Institute of Child Health and Human Development (1R01 HD053074). Dr Sudore reports having received support from the US Department of Veterans Affairs, Veterans Health Administration, Office of Research and Development, Health Services Research and Development, the San Francisco Research Enhancement Award Program, and a Pfizer Fellowship in Clear Health Communication. The Care of the Aging Patient series is made possible by funding from The SCAN Foundation.

Role of the Sponsor: The funders had no role in the collection, management, analysis, and interpretation of the data; and preparation, review, or approval of the manuscript. The contents herein do not represent the views of the US Department of Veterans Affairs or the US Government.

Disclaimer: This manuscript was written in the course of employment by the US Government and it is not subject to copyright in the United States.

Online-Only Material: A list of relevant Web sites and the eTable are available at <http://www.jama.com>.

Call for Patient Stories: The Care of the Aging Patient editorial team invites physicians to contribute a patient story to inspire a future article. Information and submission instructions are available at <http://geriatrics.medicine.ucsf.edu/agingpatient/>.

Additional Contributions: We acknowledge Wendy M. Greenberg, JD, Morrison & Foerster, LLP, for her legal advice during the drafting of this article (no compensation was received).

REFERENCES

- Marson DC, Hebert T. Financial Capacity. In: Cutler BL, ed. *Encyclopedia of Psychology and the Law*. Thousand Oaks, CA: Sage; 2008;1:313-316.
- Marson DC, Sawrie SM, Snyder S, et al. Assessing financial capacity in patients with Alzheimer disease: a conceptual model and prototype instrument. *Arch Neurol*. 2000;57(6):877-884.
- Marson DC, Martin RC, Wadley V, et al. Clinical interview assessment of financial capacity in older adults with mild cognitive impairment and Alzheimer's disease. *J Am Geriatr Soc*. 2009;57(5):806-814.
- Martin R, Griffith HR, Belue K, et al. Declining financial capacity in patients with mild Alzheimer disease: a one-year longitudinal study. *Am J Geriatr Psychiatry*. 2008;16(3):209-219.
- Sherod MG, Griffith HR, Copeland J, et al. Neurocognitive predictors of financial capacity across the dementia spectrum: normal aging, mild cognitive impairment, and Alzheimer's disease. *J Int Neuropsychol Soc*. 2009;15(2):258-267.
- Triebel KL, Martin R, Griffith HR, et al. Declining financial capacity in mild cognitive impairment: a 1-year longitudinal study. *Neurology*. 2009;73(12):928-934.
- Pèrès K, Helmer C, Amieva H, et al. Natural history of decline in instrumental activities of daily living performance over the 10 years preceding the clinical diagnosis of dementia: a prospective population-based study. *J Am Geriatr Soc*. 2008;56(1):37-44.
- Loewenstein DA, Arguelles S, Bravo M, et al. Caregivers' judgments of the functional abilities of the Alzheimer's disease patient: a comparison of proxy reports and objective measures. *J Gerontol B Psychol Sci Soc*. 2001;56(2):78-84.
- Okonkwo OC, Griffith HR, Vance DE, Marson DC, Ball KK, Wadley VG. Awareness of functional difficulties in mild cognitive impairment: a multidomain assessment approach. *J Am Geriatr Soc*. 2009;57(6):978-984.
- Okonkwo OC, Wadley VG, Griffith HR, et al. Awareness of deficits in financial abilities in patients with mild cognitive impairment: going beyond self-informant discrepancy. *Am J Geriatr Psychiatry*. 2008;16(8):650-659.
- Van Wieringen LE, Tuokko HA, Cramer K, Mateer CA, Hultsch DF. Awareness of financial skills in dementia. *Aging Ment Health*. 2004;8(4):374-380.
- Kershaw MM, Webber LS. Dimensions of financial competence. *Psychiatry Psychol Law*. 2004;11(2):338-349. doi: 10.1375/1321871042707241.
- American Bar Association Commission on Law and Aging; American Psychological Association. Assessment of older adults with diminished capacity: a handbook for psychologists, 2008. <http://www.apa.org/pi/aging/programs/assessment/index.aspx>. Accessed June 1, 2010.
- Alzheimer's Association. 2010 Alzheimer's disease facts and figures. *Alzheimer's Dement*. 2010;6(2):158-194.
- Lawton MP, Brody EM. Assessment of older people: self-maintaining and instrumental activities of daily living. *Gerontologist*. 1969;9(3):179-186.
- Katz S, Ford AB, Moskowitz RW, Jackson BA, Jaffe MW. Studies of illness in the aged: the index of ADL: a standardized measure of biological and psychosocial function. *JAMA*. 1963;185:914-919.

17. Griffith HR, Belue K, Sicola A, et al. Impaired financial abilities in mild cognitive impairment: a direct assessment approach. *Neurology*. 2003;60(3):449-457.
18. Okonkwo OC, Wadley VG, Griffith HR, Ball K, Marson DC. Cognitive correlates of financial abilities in mild cognitive impairment. *J Am Geriatr Soc*. 2006;54(11):1745-1750.
19. Baird A. Fine tuning recommendations for older adults with memory complaints: using the Independent Living Scales with the Dementia Rating Scale. *Clin Neuropsychol*. 2006;20(4):649-661.
20. Petersen RC, Roberts RO, Knopman DS, et al. Mild cognitive impairment: ten years later. *Arch Neurol*. 2009;66(12):1447-1455.
21. Sabbagh MN, Shah F, Reid RT, et al. Pathologic and nicotinic receptor binding differences between mild cognitive impairment, Alzheimer disease, and normal aging. *Arch Neurol*. 2006;63(12):1771-1776.
22. Winblad B, Palmer K, Kivipelto M, et al. Mild cognitive impairment—beyond controversies, towards a consensus: report of the International Working Group on Mild Cognitive Impairment. *J Intern Med*. 2004;256(3):240-246.
23. Petersen RC, Aisen PS, Beckett LA, et al. Alzheimer's Disease Neuroimaging Initiative (ADNI): clinical characterization. *Neurology*. 2010;74(3):201-209.
24. Moye J. Theoretical frameworks for competency in cognitively impaired elderly adults. *J Aging Stud*. 1996;10(1):27-42. doi:10.1016/S0890-4065(96)90015-8.
25. Moberg PJ, Rick JH. Decision-making capacity and competency in the elderly: a clinical and neuropsychological perspective. *NeuroRehabilitation*. 2008;23(5):403-413.
26. MetLife Mature Market Institute. Market survey of long-term care costs: the 2009 MetLife market survey of nursing home, assisted living, adult day services and home care costs, October 2009. <http://www.metlife.com/assets/cao/mmi/publications/studies/mmi-market-survey-nursing-home-assisted-living.pdf>. Accessed June 1, 2010.
27. Razani J, Kakos B, Orieta-Barbalace C, et al. Predicting caregiver burden from daily functional abilities of patients with mild dementia. *J Am Geriatr Soc*. 2007;55(9):1415-1420.
28. National Center on Elder Abuse; American Public Human Services Association. The national elder abuse incidence study: final report, September 1998, Washington, DC. http://aoa.gov/AoA_Programs/Elder_Rights/Elder_Abuse/docs/ABuseReport_Full.pdf. Accessed January 26, 2011.
29. Lachs MS, Williams C, O'Brien S, Hurst L, Horwitz R. Risk factors for reported elder abuse and neglect: a nine-year observational cohort study. *Gerontologist*. 1997;37(4):469-474.
30. Garre-Olmo J, Planas-Pujol X, López-Pousa S, Juvinya D, Vilà A, Vilalta-Franch J; Frailty and Dependence in Girona Study Group. Prevalence and risk factors of suspected elder abuse subtypes in people aged 75 and older. *J Am Geriatr Soc*. 2009;57(5):815-822.
31. Raivio MM, Mäki-Petäjä-Leinonen AP, Laakkonen ML, Tilvis RS, Pitkälä KH. The use of legal guardians and financial powers of attorney among home-dwellers with Alzheimer's disease living with their spousal caregivers. *J Med Ethics*. 2008;34(12):882-886.
32. Hinton L, Franz CE, Reddy G, Flores Y, Kravitz RL, Barker JC. Practice constraints, behavioral problems, and dementia care: primary care physicians' perspectives. *J Gen Intern Med*. 2007;22(11):1487-1492.
33. Uniform Power of Attorney Act, National Conference of Commissioners on Uniform State Laws, §5109 (a) (2006).
34. Stiegel LA, Klem EV. Power of attorney abuse: what states can do about it: AARP Public Policy Institute, 2008. http://assets.aarp.org/rgcenter/consume/2008_17_poa.pdf. Accessed July 10, 2010.
35. Overman W Jr, Stoudemire A. Guidelines for legal and financial counseling of Alzheimer's disease patients and their families. *Am J Psychiatry*. 1988;145(12):1495-1500.
36. Mungas D, Marshall SC, Weldon M, Haan M, Reed BR. Age and education correction of Mini-Mental State Examination for English and Spanish-speaking elderly. *Neurology*. 1996;46(3):700-706.
37. Borson S, Scanlan J, Brush M, Vitaliano P, Dokmak A. The mini-cog: a cognitive 'vital signs' measure for dementia screening in multi-lingual elderly. *Int J Geriatr Psychiatry*. 2000;15(11):1021-1027.
38. Borson S, Scanlan JM, Watanabe J, Tu SP, Lessig M. Simplifying detection of cognitive impairment: comparison of the Mini-Cog and Mini-Mental State Examination in a multiethnic sample. *J Am Geriatr Soc*. 2005;53(5):871-874.
39. Nasreddine ZS, Phillips NA, Bédirian V, et al. The Montreal Cognitive Assessment, MoCA: a brief screening tool for mild cognitive impairment. *J Am Geriatr Soc*. 2005;53(4):695-699.
40. Smith T, Gildeh N, Holmes C. The Montreal Cognitive Assessment: validity and utility in a memory clinic setting. *Can J Psychiatry*. 2007;52(5):329-332.
41. Folstein MF, Folstein SE, McHugh PR. "Mini-mental state": a practical method for grading the cognitive state of patients for the clinician. *J Psychiatr Res*. 1975;12(3):189-198.
42. Gutheil TG, Appelbaum PS. *Clinical Handbook of Psychiatry and the Law*. 3rd ed. Philadelphia, PA: Lippincott Williams & Wilkins; 2000.
43. Nichols LO, Martindale-Adams J. The decisive moment: caregivers' recognition of dementia. *Clin Gerontologist: J Aging Ment Health*. 2006;30(1):39-52. doi: 10.1300/J018v30n01_04.
44. Wald C, Fahy M, Walker Z, Livingston G. What to tell dementia caregivers—the rule of threes. *Int J Geriatr Psychiatry*. 2003;18(4):313-317.
45. Wadley VG, Harrell LE, Marson DC. Self- and informant report of financial abilities in patients with Alzheimer's disease: reliable and valid? *J Am Geriatr Soc*. 2003;51(11):1621-1626.
46. Aravanis SC, Adelman RD, Breckman R, et al. Diagnostic and treatment guidelines on elder abuse and neglect. *Arch Fam Med*. 1993;2(4):371-388.
47. Fulmer T, Guadagno L, Bitondo Dyer C, Connolly MT. Progress in elder abuse screening and assessment instruments. *J Am Geriatr Soc*. 2004;52(2):297-304.
48. Lachs MS, Pillemer K. Abuse and neglect of elderly persons. *N Engl J Med*. 1995;332(7):437-443.
49. Jogerst GJ, Daly JM, Brinig MF, Dawson JD, Schmuck GA, Ingram JG. Domestic elder abuse and the law. *Am J Public Health*. 2003;93(12):2131-2136.
50. Tueth MJ. Exposing financial exploitation of impaired elderly persons. *Am J Geriatr Psychiatry*. 2000;8(2):104-111.
51. Reed K. When elders lose their cents: financial abuse of the elderly. *Clin Geriatr Med*. 2005;21(2):365-382.
52. Social Security Administration. A guide for representative payees, SSA publication No. 05-10076, January 2009. <http://www.ssa.gov/pubs/10076.html>. Accessed June 15, 2010.
53. Wilber KH. The search for effective alternatives to conservatorship: lessons from a daily money management diversion study. *J Aging Soc Policy*. 1995;7(1):39-56.
54. Moore DJ, Palmer BW, Patterson TL, Jeste DV. A review of performance-based measures of functional living skills. *J Psychiatr Res*. 2007;41(1-2):97-118.
55. Loewenstein DA, Amigo E, Duara R, et al. A new scale for the assessment of functional status in Alzheimer's disease and related disorders. *J Gerontol*. 1989;44(4):114-121.
56. Loeb P. *The Independent Living Scales*. San Antonio, TX: The Psychological Corp; 1996.
57. Earnst KS, Wadley VG, Aldridge TM, et al. Loss of financial capacity in Alzheimer's disease: the role of working memory. *Aging Neuropsychol Cogn*. 2001;8(2):109-119. doi:10.1076/anec.8.2.109.839.
58. Moye J, Armesto JC, Karel MJ. Evaluating capacity of older adults in rehabilitation settings: conceptual models and clinical challenges. *Rehabil Psychol*. 2005;50(3):207-214. doi:10.1037/0090-5550.50.3.207.

WEB RESOURCES

GENERAL RESOURCES

Alzheimer's Association

<http://www.alz.org>
or (800) 272-3900

This Web site offers resources for patients and their families living with Alzheimer disease including information on legal and financial planning. The Alzheimer's Association also offers a 24-hour helpline, open daily, which provides information and support for patients, caregivers, and health care professionals.

For a listing of Alzheimer's Associations in countries other than the United States, visit <http://www.alz.co.uk/>

Eldercare Locator

<http://www.eldercare.gov>
or (800) 677-1116

Eldercare Locator, a public service of the Administration on Aging, connects older US residents and their caregivers with state and local agencies on aging and community-based organizations that serve older adults and their caregivers. Eldercare Locator also provides state reporting numbers for suspected elder abuse.

LEGAL ASSISTANCE

American Bar Association

Commission on Law and Aging

<http://www.abanet.org/aging>
or (312) 988-5000

This American Bar Association Web site includes a comprehensive listing of

the statewide resources available to help older individuals with law-related issues. The American Bar Association also maintains a database of all national, state, and local bar associations at <http://www.abanet.org/barserv/stlobar.html>.

Legal Services Corporation

<http://www.lsc.gov>
or (202) 295-1500

The Web site of the Legal Services Corporation, a nonprofit corporation established by the United States Congress, offers a directory of high-quality civil legal assistance to low-income US residents.

National Academy of Elder Law Attorneys

<http://www.naela.org>
or (703) 942-5711

This Web site includes a searchable directory of elder law attorneys with expertise in durable powers of attorney, estate planning and probate, conservatorship, and elder abuse.

FINANCIAL ASSISTANCE

AARP (American Association of Retired Persons) Money Management Program

<http://www.aarpmp.org>
or (888) 687-2277 for English and (877) 627-3350 for Spanish

The AARP Web site provides one of the largest networks of money

management programs available to help seniors manage their financial affairs.

Benefits Check Up

<http://www.benefitscheckup.org/>

Developed and maintained by The National Council on Aging (202) 479-1200, Benefits Check Up is a comprehensive Web-based service to screen for benefits programs for seniors with limited income and resources.

ELDER ABUSE RESOURCES

National Committee for the Prevention of Elder Abuse

<http://www.preventelderabuse.org>
or (202) 682-4140

This Web site provides information related to elder abuse, including what to do if you feel someone you know is being abused, provides services available to stop abuse, and offers resources in the community.

The National Center on Elder Abuse

<http://www.ncea.aoa.gov/>
or (302) 831-3525

The National Center on Elder Abuse Web site contains information on elder abuse, including financial exploitation. It provides contact information for reporting elder abuse for each state and other resources on a state-by-state basis.