Deb’s review of LSPQ analysis.

1. How is LSPQ score defined? For example, how was A1 of A24 analyzed (continuous or categorical) and how defined?

It can be analyzed two ways:

1. Categorical
   1. Analyze Want/Unsure versus Don’t Want (as done in Angie Fagerlin’s article: Ditto PH. Arch Intern Med. 2001;161:421-430)
2. Continuous (assigning points for each Likert scale response as below and summing across 24 questions)

I suggest we analyze both ways (continuous and categorical).

Andrzej and Rachael – what did we decide about which should be primary?

A1 If you developed a **serious infection**, like **pneumonia**, would **you** want to use **antibiotics** to treat the infection?

I **definitely want** antibiotics. (4 points)

I **probably want** antibiotics. (3 points)

I am unsure. (2 points)

I **probably do not want** antibiotics. (1 point)

I **definitely do not want** antibiotics. (0 points)

1. Consider combining collapsing response categories for Marital status since some are low frequency.

* Combine live-in partner with married
* Combine divorced, widowed, and never married

1. How is depression recoded and new response categories defined (no indication, some indication, depression likely)?
2. How is “DSRS points” defined and calculated?  
   A common approach is to number the response categories for each question with 0 being no impairment. For example, the first question, memory, has points assigned for each response category as below. See attached document DSRS\_Final

**MEMORY**

0 Normal memory.

1 Occasionally forgets things that they were told recently. Does not cause many problems.

2 Mild consistent forgetfulness. Remembers recent events but often forgets parts.

3 Moderate memory loss. Worse for recent events. May not remember something you just told them. Causes problems with everyday activities.

4 Substantial memory loss. Quickly forgets recent or newly-learned things. Can only remember things that they have known for a long time.

5 Does not remember basic facts like the day of the week, when last meal was eaten, or what the next meal will be.

6 Does not remember even the most basic things.

1. We can consider collapsing categories for relationship of care partner to patient for model though they are heterogeneous so I would want to report variable before collapsing in Table 1 of patient/partner characteristics. For model we could include sibling vs not sibling. If variable is not in model, then disregard.
2. Re: Excluded (n=0) <65, no cog test, no English in STROBE diagram

-Agree with Andrzej to removed from its current box. Do any of these apply to “Other” category in Excluded (n=54) box ?

1. How is “refused to participate” under Attrition different from “Refused” in Excluded (n=54) before enrollment?
2. Consider revising STROKE diagram as follows:
3. Total study population (if we have)
   1. Not assessed for eligibility (if we have)
4. Assessed for eligibility
   1. Excluded
      1. Ineligible
         1. Potential dementia
         2. No cognitive test (has unconfirmed current MCI status i.e., could have progressed to dementia or improved back to normal cog)
         3. Deceased
      2. Eligible but not recruited
         1. Refused to participate
         2. Unable to read/write English
         3. Age<65
         4. No study partner
         5. Too ill to complete
         6. Could not locate
5. Recruited
   1. Patient did not complete survey
   2. Care partner did not complete survey
6. Data available for analysis (completed survey)