

1 **Applications of the R.A.I.S.E. Assessment Framework to Support the Process**
2 **of Assessment in Primary Progressive Aphasia**

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17 **Keywords:** primary progressive aphasia; therapeutic assessment; person-centered care

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24 **Abstract**

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26 **Purpose:** To establish the extent to which person-centered processes are integrated in assessment
27 procedures, the R.A.I.S.E. Assessment framework was used to evaluate measures that are
28 typically used when assessing people living with PPA.

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30 **Method:** Forty-five assessment tools were evaluated through the lens of the five R.A.I.S.E.
31 principles: building the client-clinician **R**elationship, **A**ssessment choices, **I**ncluding the client
32 and care partners, providing **S**upport, and **E**volving procedures to match client capability and
33 progression. The principles were operationalized as questions for raters to evaluate whether a
34 measure met this aspect of the R.A.I.S.E. Assessment framework.

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36 **Results:** Ten measures commonly used in the assessment of people living with PPA met all
37 R.A.I.S.E. principles. These measures centered upon the elicitation of naturalistic discourse,
38 conversation, client self-report, and clinician ratings. Thirteen measures did not meet any of the
39 criterion and represented standardized evaluation procedures do not provide the opportunity to
40 connect to the client, elicit or provide feedback or support, nor to adapt in response to need or
41 performance.

42

43 **Conclusions:** Whether using standardized or informal assessment tools, a relational and
44 qualitative approach to providing assessment is paramount to promote client success and
45 therapeutic engagement. We provide guidance through the R.A.I.S.E. framework on practices to
46 cultivate person-centered processes of assessment in the care of people living with PPA.

47 **Introduction**

48 The recently introduced R.A.I.S.E. Assessment framework (Gallée et al., 2023) provides a
49 multidimensional person-centered approach to comprehensive assessment of people living with
50 primary progressive aphasia (PPA). Moreover, this framework highlights the necessity for the
51 clinician to consider the following features when conducting assessments: (1) build the
52 Relationship with the client, (2) make conscious choices about the formality and standardization
53 of Assessment approaches and types, (3) Include and incorporate the client and care partner's
54 feedback, (4) provide Support to the client and actively advocate to enhance their agency, and (5)
55 ensure that the provided assessment appropriately *Evolves* over time as the condition progresses
56 and the needs of the client change (Gallée et al., 2023). In this paper, we apply the R.A.I.S.E.
57 assessment framework to provide in-depth analysis of assessment tools routinely used in the
58 evaluation of speech, language, and communication symptoms for PPA. Through this analysis,
59 we aim to establish the extent to which the principles of R.A.I.S.E. are addressed by each tool
60 and establish the relative overlap of the framework's principles and the assessments as they exist
61 independently (e.g., based on the instructions provided/original formatting). This discussion will
62 help inform clinical decision-making by providing guidance to clinicians as to which adaptations
63 can be made to enhance a better fit against the R.A.I.S.E. Assessment framework and to inform
64 the future development of new assessment tools.

65 The R.A.I.S.E. Assessment framework was developed to provide clinical guidance for the
66 assessment process when working with people living with PPA. Speech-language assessment for
67 PPA is an indispensable feature of establishing a diagnosis, monitoring change in symptoms, and
68 informing treatment targets (Gallée & Volkmer, 2023). For the latter function, progress or
69 decline following intervention is evaluated by comparing pre- and post-therapy assessment

70 outcomes. In a review by Volkmer et al. (2020), measures typically used to examine the effects
71 of functional interventions for PPA broadly fell into the following categories: interviews and
72 questionnaires, formal tests of language, conversation analysis, and rating scales largely based on
73 clinician judgement. For a progressive condition with both variability and uncertainty, the need
74 to select efficacious and person-centered assessment tools consistent with the principles of the
75 R.A.I.S.E. Assessment framework is essential to ensure assessment itself is supportive and of
76 therapeutic value (Hersh et al., 2013). There is therefore a direct need to evaluate the extent to
77 which assessment tools commonly used in PPA, and components of the assessment process (e.g.,
78 case history), align with the framework’s principles. In addition to *what* is evaluated in
79 assessment, we set forth to evaluate the *process* of assessment and *how* we assess, including how
80 these elements are considered in commonly used tools. When we read an assessment manual, we
81 need to go beyond the standardized protocol - we need to think about the 'tool' and the 'process'
82 from a relational and supportive perspective. This study further aimed to examine how
83 assessment protocols explicitly involve the person and their caregivers in discussion around the
84 “process” of assessment and whether this process is delivered in a supportive manner. As the
85 R.A.I.S.E. Assessment framework centers on providing person-centered evaluation, we
86 hypothesize that a predictor of alignment with its principles is the extent to which the assessment
87 measures a client’s participation rather than impairment.

88 **Methods**

89 The assessments analyzed in this paper were drawn from those provided in Henry and
90 Grasso (2018), Gallée et al. (2023), and Volkmer et al. (in preparation), as exemplars of tools
91 that are commonly used to diagnose, evaluate, and monitor speech, language, and
92 communication outcomes in PPA. The assessments were organized by the domains of speech,

93 language, and communication that are typically of interest when it comes to providing a
94 diagnosis of PPA as well as identifying one of the established three subtypes (e.g., semantic,
95 nonfluent, or logopenic). Of note, certain assessments are subtests drawn from comprehensive
96 assessments of aphasia, such as the “*Picnic Scene*” task from the *Western Aphasia Battery-*
97 *Revised* (WAB-R; Kertesz, 2020) and the Aphasia Impact Questionnaire-21 (AIQ-21; Swinburn
98 et al., 2019). All assessments were evaluated upon the parameters outlined in Table 1. Responses
99 to each of these prompts were scored on a two-point scale: yes (1) and no (0). For all
100 components, responses were coded as yes = 1 or no = 0 for each criterion, resulting in a
101 maximum possible score of 2 for each principle. A total score was calculated as the sum of all
102 principle scores, where the possible range of scores was 0-10. Consensus was first established
103 through discussion for 15% of the assessment protocols in a discussion by two authors (J.G. and
104 J.C.). Once joint reliability on these 15% tools was established, one author (J.G.) coded the
105 remaining assessments with 85% integrated reliability. Codes were then reviewed by the other
106 author (J.C.) where no corrections were made.

107 <insert Table 1>

108 **Results**

109 A total of 45 assessment tools were evaluated in the context of the R.A.I.S.E. Assessment
110 framework using the criteria described above. Of the 45 assessments, 13 did not meet the criteria
111 of any of the five components. Of the remaining 32 tools, 15 met the principles of *Relationship*,
112 17 met the criteria of enabling instructions to be tailored or adapted to the person during
113 Assessment (14 involved formal, standardized assessment which precluded this), 15 met all
114 criteria of *Inclusion*, 16 met the criteria of *Support*, and 13 met the criteria of *Evolve* (see Table
115 2).

116 <insert Table 2>

117 <Figure 1>

118 More than half of assessments partially met the criterion of the specific R.A.I.S.E.
119 components, i.e., scored 1 of the 2 possible points for a given principle. For example, CLQT+
120 “Personal Facts” partially met criterion for Assessment as the clinician has some flexibility to
121 probe when a client’s response is incomplete or delayed while sticking to scripted prompts; this
122 same assessment also met criterion E1 but not E2 for *Evolve* as only the verbal modality is
123 scored as accurate), resulting in a total of 27 assessments meeting partial criterion for certain
124 principles. A total of 10 assessments met all evaluated aspects of R.A.I.S.E. These consisted of
125 assessment tools and components that elicited naturalistic language samples (e.g., conducting a
126 targeted case history and eliciting self-reports about communicative abilities), clinician rating
127 scales (e.g., the PASS; Sapolsky et al., 2014), and self-rating scales, (e.g., the CAT-2 “*Aphasia*
128 *Impact Questionnaire 21*”; Swinburn et al, 2019). More broadly, thirteen assessment tools were
129 in strong alignment with the R.A.I.S.E. Assessment framework. An assessment was determined
130 to be in strong alignment with R.A.I.S.E. when the tool met at least one of the criteria for each of
131 the five principles (Figure 1).

132 <insert Table 3>

133 ***Relationship***

134 Of all 45 assessments, two met partial criteria and 15 met both R1 and R2. Both the
135 CUDP (Whitworth et al., 2015) and CLQT+ “Personal Facts” (Helm-Estabrooks, 2017) met R1,
136 where clients were asked questions that would allow their clinician to understand them in the
137 absence of the clinician being able to respond meaningfully to this information (see Table 2).
138 Notably, assessment tools that met full criterion for *Relationship* predominantly consisted of

139 observational scales for clinicians to fill out based on a variety of conversation-based activities
140 (e.g., the ASA [Simmons-Mackie et al., 2004] or PASS [Sapolsky et al., 2014]). Outliers to this
141 trend were the AIQ-21 (Swinburn et al., 2019) and the “Conversational Questions” subtest of the
142 WAB-R (Kertesz, 2020). The principle of *Relationship* did not correlate significantly with any of
143 the other principles.

144 ***Assessment***

145 Three met partial criteria met both criteria for Assessment. Partial credit was assigned to
146 the CUDP (Whitworth et al., 2015), the WAB-R “Picnic Scene”, and CLQT+ “Personal Facts”
147 as these measures allowed clinicians to provide cues or prompts to identify clients’ strengths and
148 support needs (A2). With exception for the Aphasia Needs Assessment (ANA; Garrett &
149 Beukelman, 2006), the same measures that met criterion for *Relationship* met criterion for
150 *Assessment* by additionally tailoring scripts to the client’s unique needs (A1). The principle of
151 *Assessment* did not correlate significantly with any of the other principles.

152 ***Inclusion***

153 While no tools met partial criteria, a total of 15 met both criteria for *Inclusion*. Consistent
154 with the outcomes for *Relationship* and *Inclusion*, the majority of these measures consisted of
155 observational rating scales and one self-report scale (AIQ-21; Swinburn et al., 2019). The
156 principle of *Inclusion* did not correlate significantly with any of the other principles.

157 ***Support***

158 Nine met partial criteria by meeting the criteria of promoting advocacy for the client by
159 identifying individual strengths, challenges, and needs (S1). Sixteen additional measures met full
160 criterion for *Support*, largely overlapping with the assessment tools that met all components for

161 *Relationship, Assessment, and Inclusion*. The principle of Support strongly correlated
162 significantly with *Evolve* at $r(43) = .64$ ($p < .05$).

163 *Evolve*

164 Twenty-three assessment tools met partial criteria for *Evolve* and an additional twelve
165 met all criteria.

166 *Co-Occurrence of R.A.I.S.E. Principles*

167 Beyond the 11 assessments that met all criterion, there were nine assessment tools that
168 met at least one criterion for two or more principles without meeting full criteria. Seven of these
169 assessment tools met criteria for both *Relationship* and *Support*. Of these, only the “Spontaneous
170 Speech” subtest of the Progressive Aphasia Language Scale (PALS; Leyton et al., 2011) and the
171 Communication Confidence Rating Scale for Aphasia (CCRSA; Cherney et al., 2011; Babbitt et
172 al., 2011) met all five principles of R.A.I.S.E. Notably, for the remaining seven assessments, the
173 respective of combinations of the R.A.I.S.E. principles for whom criteria was met only occurred
174 once (see Table 2).

175 **Discussion**

176 The purpose of this study was to evaluate how commonly used assessment tools, and
177 components of the assessment process, are in line with the principles of the R.A.I.S.E.
178 Assessment framework. Our results demonstrated that many standardized assessments, when
179 used on their own, do not fulfill the principles of R.A.I.S.E. and are at risk of undermining the
180 therapeutic relationship. Conversely, approximately a quarter of assessment tasks showed strong
181 alignment with the R.A.I.S.E. framework (e.g., where at least partial criterion was met for each
182 of the five principles) and were more inherently equipped to enable therapeutic assessment, that
183 is “assessment of support, with support, and as support” (Hersh et al., 2013, p. 162).

184 Differentiating assessment tools and components in this way provides valuable insights into
185 assessment practices. Importantly, the evaluation process stepped beyond consideration of the
186 psychometric properties of assessment tools, to consider the more relational, supportive, and
187 therapeutic aspects of assessment. We will discuss key findings and how they can be used to
188 guide assessment practice, propose modifications to existing assessment processes and position
189 the development of new assessment tools as a priority for action in the PPA field.

190 *Using R.A.I.S.E. to Guide Assessment Practice*

191 The assessment tools and components evaluated fell along a continuum of low to high
192 alignment with the R.A.I.S.E. Assessment framework, providing an objective framework to
193 guide assessment practice and judicious selection of assessment tools in practice. The assessment
194 tools at the lower end of the continuum tended to be standardized in nature and designed for
195 diagnostic and classification purposes, while those at the higher end were frequently informal
196 and highly oriented towards client participation in more naturalistic paradigms. Knowing where
197 different assessment tools fall along the continuum and how they align with R.A.I.S.E. principles
198 allow a more considered approach to planning and facilitating assessment sessions and
199 interactions. For example, a small number of assessments were identified that intrinsically
200 promote *Relationship*, such as a case history and personal narratives. As such, these assessments
201 have value in the early stages of the assessment process to build rapport and relationships, before
202 administering more standardized assessments, like the WAB-R (Kertesz, 2020) and CAT
203 (Swinburn et al., 2022). The importance of establishing rapport prior to administration is
204 recommended in the CAT manual (Swinburn et al., 2022), affirming that what comes *before* and
205 *after* standardized assessment is essential!

206 Inclusion of client and clinician feedback in the assessment process was also evaluated. As
207 anticipated, many formal assessments constrained provision of feedback during the assessment
208 process to comply with standardization of administration. This is important for allowing
209 comparison to a norm but restricts opportunities within the assessment for support and mutual
210 benefit. This is especially true of assessments that do not allow for the clinician to provide
211 tailored cueing when the client is challenged, produces errors, or does not provide a response.
212 For example, in the Cognitive-Linguistic Quick Test PLUS (CLQT+; Helm-Estabrooks, 2017)
213 “*Generative Naming*” task, for a client who has expressed concern over their performance, only
214 the following direction is deemed acceptable: “I’m not allowed to help you. Just do the best you
215 can.” While many clinicians will naturally provide additional support through personalized
216 commentary (e.g. “After we have finished, we can talk this through”), this guidance is rarely
217 presented or discussed in test manuals. The CAT (Swinburn et al., 2022) is one exception, where
218 the need for care when administering standardized assessments is explicitly acknowledged,
219 encouraging responsiveness to a person’s needs while adhering to the task instructions. Swinburn
220 et al. acknowledge giving feedback or a summary of performance at the end of the assessment,
221 highlighting the need to emphasize the positives and to acknowledge any negative emotions that
222 were expressed during the assessment, for example, acknowledging that those feelings are
223 commonly experienced by people with aphasia (or PPA). Examples of phrases are provided,
224 drawing on the work of Cheng and colleagues (2020), for example, “I know it’s tough now.
225 We’re here to support you. We’ll do everything we can to help.” (p.46). If the person
226 demonstrates engagement with the results, providing a summary is recommended, however, a
227 template for this is not provided. Such forms of feedback acknowledge, include, and support the
228 client, setting the foundation for a long-term relationship between client and clinician.

229 Explicit opportunities to Support, such as those described above, and advocate for the client
230 were rarely considered in assessment protocols, as this was dependent on the clinician’s ability to
231 determine a client’s unique strengths, challenges, needs, and goals, based on assessment
232 prompts. This principle is fundamental in clinicians supporting clients and their networks to
233 "use" the assessment information gathered (assessment as support; Hersh et al., 2013). Social
234 network analysis is an example of an assessment tool that allows clients and clinicians to work
235 collaboratively (promoting *Relationship*) to create an accessible output and resource through the
236 assessment process (aligning with *Support and Advocacy*; Vickers et al., 2010; Hillary &
237 Northcott, 2017). The relative size and quality of a person’s social network is visualized,
238 supporting functional and person-centered goal setting and outcome measurement, while helping
239 the person with PPA and their family advocate for the services and supports they need to “grow”
240 their social network and strengthen connectedness.

241 Finally, the extent to which an assessment *Evolves* over time was analyzed. Certain
242 standardized assessments of select modalities, such as in confrontation naming, help the clinician
243 track more nuanced change over time. A positive example of a standardized assessment that is
244 amenable to changes in naming ability is the CLQT+ “*Confrontation Naming*” subtest (Helm-
245 Estabrooks, 2017), in which the clinician has the opportunity to provide credit for partially
246 correct responses. Such a scoring modification can easily be, and anecdotally often is,
247 implemented by clinicians in practice.

248 An exemplar of an assessment with strong R.A.I.S.E. alignment is the AIQ-21 (Swinburn
249 et al., 2019), which provides clear direction to the clinician, noting explicitly how the “manner”
250 of AIQ administration should feel “qualitatively different” in mood and tone to the standardized
251 components of the assessment. Importantly, the authors highlight that “...as much support,

252 encouragement, and feedback as possible” should be provided during administration (p.41).
253 Examples of supportive features are provided, including rewording and repeating questions,
254 using gesture, and smiling during administration (aligning with *Relationship and Support*). As
255 demonstrated in Table 1, informal assessments of naturalistic language can also meet all
256 components of the R.A.I.S.E. Assessment framework. Finally, both client and clinician-based
257 rating scales, such as the PASS (Sapolsky et al., 2014) are amenable to the principles of the
258 framework in that they comprehensively capture a client’s unique strengths, challenges, wants,
259 and needs in a manner that establishes a relationship, is inclusive of client and care partner
260 feedback, supports the client, and is adaptable to the client and over time. Examining the
261 assessments with strong alignment with R.A.I.S.E. lens highlights attention to the relational and
262 supportive aspects of assessment and provides useful directions for enhancing assessment
263 practices and developing new assessment tools in the future.

264 *Using R.A.I.S.E. to Enhance Assessment Practices*

265 The evaluation process allowed examination of every aspect of the R.A.I.S.E. framework
266 and revealed a paucity of existing assessments that align with all elements. As such, we see
267 significant potential for using the R.A.I.S.E. evaluation framework in principle-based way to
268 enhance assessment practices. Knowing how well an assessment aligns with R.A.I.S.E. can
269 inform *how* an assessment might be best administered and the supports or scaffolds that may
270 need to surround the assessment process. For example, when using assessments that score at the
271 lower end of the R.A.I.S.E. continuum, and for when meeting people with PPA for the first time,
272 the clinician must go beyond standardized assessment protocols to determine (and reveal) a
273 person’s strengths, rather than focusing on impairments, to create a comprehensive and mutually
274 beneficial assessment process. As a further example, when administering assessments that do not

275 allow feedback or provision of tailored cues or instructions during administration, clear
276 expectations can be provided for the client and their family. Using the R.A.I.S.E. framework to
277 drive assessment practice, promotes reflection on why standardized tasks are required and why
278 they need to be delivered in constrained ways (e.g. to ensure a reliable picture of performance to
279 support diagnosis and/or to allow sensitive tracking of maintenance or decline over time) and
280 ensures we provide this context to the person and their family. Further, constrained assessment
281 tasks can be carefully balanced with more flexible, responsive, and supportive tasks that allow a
282 person’s strengths and effective strategies to be identified and revealed – promoting a sense of
283 competence, as well as an understanding of support needs. As such, using the R.A.I.S.E. ratings
284 in this way allows us to plan the aims, structure, flow, and “feel” of our assessment sessions in a
285 more considered and sensitive way – ensuring we never assess to “destruction” (Gallée et al.,
286 2023).

287 Alternatively, rather than abandon the instructions of standardized assessments, the relative
288 rigidity of these assessment tools can frequently be softened by adding strengths-based
289 modifications. For example, this could include offering an alternative response modality and
290 providing cues, or opportunities to complete items outside of the official protocol or formal
291 administration, particularly if a person has been anxious about one aspect of their performance.
292 Where formal outcomes of a psychometrically established test are required and the assessment
293 cannot be modified mid-procedure, care can be taken to set clear expectations and prepare the
294 client for the assessment process. Further, appropriate debriefing and opportunities to repeat
295 items can be created afterwards. For example, after providing the test instructions, allowing the
296 client to ask questions and adapting prompts to elicit the targeted response, permits the clinician
297 to not only follow test protocols and to conduct standardized assessment, but further enables

298 collection of a separate, and arguably richer, set of data related to the modifications and scaffolds
299 that allow a client to flourish in communication. This combined manner of data collection can
300 result in a dynamic and person-centered process of assessment while using readily available,
301 commonly used standardized assessment materials.

302 Other ideas for using R.A.I.S.E. to enhance assessment practices, include identifying ways
303 to transform assessment outcomes into accessible and useable formats to advocate for funding or
304 extended hospital stays, or to promote how well family and friends understand PPA. Such
305 additional layers of support ensure assessments are empowering and useful for all stakeholders.
306 As advocated for by Hersh and Boud (2024), it would be promising to see these supportive and
307 R.A.I.S.E. aligned elements more formally embedded within assessment protocols in the future.
308 Further, the *Evolve* principle, ensures we select assessment tools in the early stages of the
309 continuum of care that can be used over time to track maintenance and evolution. Conversely,
310 having to continuously change the assessment tool restricts interpretation of the rate and nature
311 of decline. Discourse assessments are a good example of a tool that offers longevity and
312 sensitivity over time. Clinician ratings, such as those collected by the PASS, provide similar
313 flexibility in that the suite of measures or tools may change in response to progression and
314 capability, but the interpretation and ‘classification’ of performance is documented in a
315 standardized and trackable manner. Consistency in tool use allows the clinician to document
316 performance in a more coherent and meaningful way over time, serving to help maintain the
317 **R**elationship while also **E**volving as necessary.

318 *Development of New Assessment Tools and Approaches*

319 The outcomes of this work provide direction for the development of new assessment tools
320 in the PPA field that align with R.A.I.S.E. and support more person-centered and therapeutic

321 assessment practices (Hersh et al., 2013; Hersh & Boud, 2024). The need to develop assessment
322 approaches that prioritize the relational, supportive, and therapeutic aspects of assessment, while
323 also maintaining attention to robust psychometric properties, particularly when individualized
324 person-centered practices are emphasized, is critical. Given the progressive nature of PPA, we
325 need to explicitly consider and integrate the principles of *Relationship* and *Evolve* into
326 assessment tools and the assessment process. Based on the results of this evaluation, the
327 development of tools that draw on naturalistic language elicitation, clinician or self-report scales,
328 and that result in accessible language that is easily transferable between clinicians, evaluation
329 timepoints, clients, and care partners should be prioritized.

330 To reliably share information and allow for this relationship to flourish, there is a strong
331 need for the clinician to use common terminology across the disease trajectory that is accessible
332 yet flexible to changing symptoms. While measures, such as the PASS, closely address the need
333 for flexibility and use of common or consistent terminology/scoring (e.g., scores of 0-3), there
334 remains room for measurement tools with a strengths-based, rather than impairment-based, scale
335 with built-in supports to create objective ratings that boost inter-rater and intra-rater reliability.
336 The development of a scale, for example, that asks objective questions that can be reliably
337 tracked over time would be a positive step forward in meeting this need. Finally, our findings
338 motivate the need for tools that facilitate immediate feedback and accessible language for the
339 clinician to share with the client and care partners to contextualize the outcomes of the
340 assessment.

341 **Conclusion**

342 Evaluation tools are core features of assessment. Broadly, there are two forms of measures
343 readily available to us: standardized measures with the option of comparing client performance

344 to normative scores, and personalized tasks to evaluate functional performance. Through this
345 analysis using the R.A.I.S.E. Assessment Framework, we have aimed to draw clinicians'
346 attention to these relational and qualitative aspects of assessment that are essential for a client's
347 wellbeing and therapeutic engagement. The clinician's role is then to create and incorporate the
348 context of the clinician-client relationship, be purposeful in choice of tools while maintaining the
349 implications of their use, and consider how these are introduced, explained, and used to prompt
350 further intervention.

351 *Limitations*

352 This study did not include all assessment tools that are used in the evaluation of people
353 living with PPA, such as the American Speech-Language-Hearing Association Functional
354 Assessment of Communication Skills for Adults (ASHA FACS), Cookie Theft, Apraxia Battery
355 for Adults, nor were all subtests of comprehensive evaluations analyzed. Despite this, we believe
356 to have presented analysis outcomes on a representative array of assessment tools that illustrate
357 the range of approaches clinicians can take in evaluation. Furthermore, in our analysis,
358 psychometric properties were not evaluated. Inclusion of a review of the psychometric properties
359 of assessment tools used in working with this population could contribute to a more
360 comprehensive audit of assessments.

361 **Acknowledgements**

362 This research was supported by the National Institute on Aging (U24AG074855 to J.G.,
363 Role: Postdoctoral Fellow).

364 **Data Availability**

365 The datasets generated during and/or analyzed during the current study are available from
366 the corresponding author on reasonable request.

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488 **Figure Captions**

489 **Figure 1: Examples of assessments along the spectrum of alignment with the R.A.I.S.E.**

490 **principles.** Strong alignment is indicated by a score of 9 or above (represented by green
491 to aqua), whereas the absence of alignment is equivalent to a score of 0 (represented by
492 red).