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FINANCIAL CAPACITY OF OLDER AFRICAN AMERICANS WITH AMNESTIC MILD COGNITIVE IMPAIRMENT

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Abstract

This study investigated financial abilities of 154 patients with mild cognitive impairment (MCI) (116 Caucasian, 38 African American) using the Financial Capacity Instrument (FCI). In a series of linear regression models, we examined the effect of race on FCI performance and identified preliminary predictor variables that mediated observed racial differences on the FCI. Prior/premorbidity abilities were identified. Predictor variables examined in the models included race and other demographic factors (age, education, gender), performance on global cognitive measures (MMSE, DRS-2 Total Score), history of cardiovascular disease (hypertension, diabetes, hypercholesterolemia), and a measure of educational achievement (WRAT-3 Arithmetic). African American patients with MCI performed below Caucasian patients with MCI on six of the seven FCI domains examined and on the FCI total score. WRAT-3 Arithmetic emerged as a partial mediator of group differences on the FCI, accounting for 54% of variance. In contrast, performance on global cognitive measures and history of cardiovascular disease only accounted for 14% and 2%, respectively, of the variance. Racial disparities in financial capacity appear to exist among patients with amnesic MCI. Basic academic math skills related to educational opportunity and quality of education account for a substantial proportion of the group difference in financial performance.

Keywords

Mild Cognitive Impairment; financial capacity; IADL; disability; ethnicity; African American

INTRODUCTION

Functional impairment occurs in many cases of amnesic mild cognitive impairment (hereafter referred to as MCI), especially among individuals who are progressing to dementia¹. Relative to cognitively intact older adults, individuals with MCI may have

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difficulty performing certain complex instrumental activities of daily living (IADLs) such as managing finances^{2, 3}, handling medications⁴, grocery shopping^{4, 5}, and making medical decisions⁶. In addition, individuals with MCI may be slower to complete certain IADL tasks⁵. Individuals with MCI who demonstrate such functional deficits at baseline are more likely to develop dementia at a follow-up visit^{7, 8}. Therefore, detection of new functional impairment in patients with MCI is important for identifying individuals at greater risk for further decline⁹.

While progress has occurred in understanding functional impairment and change in MCI^{1, 10}, current knowledge of this subject is based almost exclusively on studies of individuals of European/North American ancestry. It is presently unknown whether findings from these studies generalize to minority populations. The lack of minority studies of functional abilities in MCI represents an important current health disparity and research gap. Very little is known about functional impairment, and its relationship to diagnostic status and progression to dementia, in African Americans with MCI and how that might differ from Caucasians. If differences in functional abilities exist across racial groups, factors explaining these differences need to be identified. Potentially important factors include demographic variables (age, education, gender), quality of education, history of cardiovascular disease¹¹⁻¹³, and level of cognitive impairment.

Financial capacity is an important instrumental activity of daily living (IADL) for understanding functional impairment in patients with amnesic mild cognitive impairment (MCI) and dementia^{7, 9, 14-17}. Financial capacity comprises a broad range of conceptual, pragmatic, and judgment abilities, ranging from basic skills, such as counting coins, to more complex skills, such as managing a checkbook and paying bills¹⁴. The capacity to manage one's own finances is a core aspect of individual autonomy^{15, 18, 19} and is a critical skill for independent living^{14, 20}. Using a direct performance measure, our group has demonstrated that patients with MCI have impairments in financial capacity relative to healthy adults^{2, 6} and that patients with MCI converting to dementia also show significant decline in financial capacity over one year¹⁰.

An unanswered research question concerns racial disparities in financial capacity among patients with MCI. To date, there have been no studies examining racial disparities in financial capacity among patients with MCI. The present study seeks to address this critical research gap by investigating financial capacity in African American and Caucasian patients with well characterized MCI. Using the Financial Capacity Instrument (FCI)¹⁴, we investigated how these groups performed on the eight FCI domains and total score. We also sought to identify variables that might account for possible racial disparities in financial capacity.

METHOD

Participants

Participants were 154 patients with amnesic MCI (116 Caucasians, 38 African Americans) who were recruited from the community into an ongoing longitudinal study of functional change in MCI (1R01 AG021927) between June 2004 and August 2008. Although racial differences in functional abilities was not a primary aim of the ongoing R01 project, the data set contains valuable functional assessment data on both African American and Caucasian patients with MCI.

Participants with MCI either presented for clinical evaluation at the University of Alabama at Birmingham (UAB) Memory Disorders outpatient clinic or were recruited as volunteers from the community to be in the study. Participants were diagnostically characterized

through the UAB Alzheimer's Disease Research Center (ADRC). The ADRC diagnostic consensus conference team consisted of neurologists, neuropsychologists, a geriatric psychiatrist, and nursing staff. Participants underwent neurologic and neuropsychological evaluations and were determined to be free from any severe medical illness (e.g., major strokes or brain cancer) or psychiatric disorders (e.g., severe depression or schizophrenia) that could compromise cognition. However, participants with mild depressive symptoms were not excluded. The ADRC diagnostic consensus team was blinded to the results of the financial capacity measure.

All MCI participants met the original Petersen/Mayo criteria for MCI^{21, 22}: (1) subjective memory complaint by the patient and/or a knowledgeable informant (e.g., family member), as reported in interview with a neurologist; (2) objective impairment on memory tests (in this study, one or more memory test scores falling approximately 1.5 SD or more below age and education appropriate norms); (3) overall preserved general cognitive functioning (using clinical judgment and neuropsychological test results); (4) largely intact functional abilities (based on historical information obtained in the patient and informant interviews, and ratings by an informant on a functional capacity rating form [Forsyth Functional Capacity Form⁶]), and (5) absence of dementia at baseline evaluation²³. The Clinical Dementia Rating scale (CDR)²⁴ was used in the diagnostic work-up but was not by itself determinative of MCI diagnosis.

Written informed consent was obtained from each study participant. The UAB institutional review board approved the use of human subjects for this study.

Measures

Financial Capacity Measure—All participants completed the FCI, a standardized psychometric measure that directly assesses financial abilities¹⁴. The FCI is based on a conceptual model which views financial capacity at three levels: specific financial abilities (tasks), broader financial activities (domains) important to independent functioning, and overall financial capacity (global scores).² The FCI has demonstrated high levels of reliability, and content and construct validity, in previous studies of persons with AD and MCI^{2, 3, 10, 14, 25}. The current version of the FCI directly assesses financial abilities across 20 tasks, 9 domains, and 2 overall or global scores (Domains 1-7 Total Score; Domains 1-7 and 9 Total Score). In the present study, the primary FCI variables of interest were the first seven domain scores (Basic Monetary Skills, Financial Conceptual Knowledge, Cash Transactions, Checkbook Management, Bank Statement Management, Financial Judgment, and Bill Payment) and the global score for Domains 1-7. The FCI domains measure simple financial skills such as counting coins/currency and making 1-item grocery purchases, as well as more complex skills such as using a checkbook register, using a bank statement, and preparing bills for mailing. Domains 8 (Knowledge of Personal Assets/Estate Arrangements) and 9 (Investment Decision Making) were not analyzed because they are not core financial capacity domains and assess higher order financial knowledge and skills that may not be acquired by many previously independent functioning older adults. Trained technicians administer and score the FCI using well-operationalized criteria described elsewhere¹⁴.

Prior/Premorbid Financial Capacity Form—Because current financial capacity varies across individuals as a function of prior financial experience, we controlled for lack of prior financial experience. The Prior/Premorbid Financial Capacity Form (PFCF) is a patient and informant completed instrument that rates a person's level of experience across all FCI variables²⁶. The PFCF was administered to each study participant and also to a knowledgeable collateral source (e.g., family member). Ratings on the PFCF reflect

participants' "ability when he/she was best able to handle money" and were classified into one of four mutually exclusive categories: 1) could do task without help; 2) could do task but needed help; 3) could not do task even with help; or 4) no prior experience performing the task. Participants were excluded from the analyses (for particular domains and for the total score) if they and their family member reported that they never performed a specific financial task (e.g., balancing a checkbook/register).

Global Cognition—The Mini Mental Status Examination (MMSE)²⁷ and the Dementia Rating Scale, 2nd edition (DRS-2) ²⁸ were given as measures of global cognitive status.

Academic Math Skills—Basic academic math achievement skills were measured with the Wide Range Achievement Test-Third Edition (WRAT-3) Arithmetic subtest²⁹. The WRAT-3 Arithmetic subtest is a 55-item timed test of oral (15 items) and written (40 items) arithmetic problems.

History of Cardiovascular Disease—History of hypertension, hypercholesterolemia, and diabetes mellitus were established on the basis of participant report or findings from the medical/neurological examination.

Data Analyses

Demographic and clinical variables were compared between the African American and the Caucasian MCI groups using independent sample *t* tests (age, education, MMSE score, DRS-2 Total Score, WRAT-3 Arithmetic subtest (as a measure of math achievement and quality of math education), CDR Sum of Boxes, and Geriatric Depression Scale [GDS] score³⁰) and χ^2 test or Fisher's exact tests for categorical variables (gender, history of diabetes, hypertension, or hypercholesterolemia, and CDR global score). Independent *t* tests were also used to compare group differences on the FCI variables.

Because we were interested in determining the possible relationship between race and financial performance, we modeled this relationship explicitly using a series of linear regression models. The base model (model 1) included FCI total score as the dependent variable and race as the predictor variable. Next, we tested five additional models to examine how conceptually-selected covariate groups mediated the relationship between race and financial capacity. Each of the five covariate-adjusted models included model 1 plus the specific covariate(s) of interest: model 2 was model 1 plus the term for WRAT-3 Arithmetic subtest score; model 3 was model 1 plus terms for global cognitive variables (DRS-2 Total Score and MMSE score); model 4 was model 1 plus terms for demographic variables (age, years of education, and gender); and model 5 was model 1 plus terms for cardiovascular disease (history of hypertension, diabetes, and hypercholesterolemia). Finally, in model 6 we tested a 2-block model in which block 1 (forced entry) included the term for race, and block 2 (forward entry) included all variables from models 2 through 5 above that were significant at the .05 alpha level. Covariates were retained in block 2 of model 6 if the change in R^2 achieved by their entry was significant at the .05 significance level.

All statistical analyses were performed using SPSS 13.031. Findings with a two-tailed *p* value .01 were considered significant.

RESULTS

Table 1 presents the results of the group comparisons on demographic and clinical variables. African American MCI patients had significantly fewer years of education, proportionately more women, more persons with diabetes, and lower WRAT-3 Arithmetic scores, than Caucasian MCI participants. There were no group differences for age, DRS-2 Total Score,

MMSE score, CDR Sum of Boxes score, or GDS score. Groups were also similar in the proportion of persons with a history of hypertension or hypercholesterolemia, and in CDR global scores.

Four Caucasian MCI patients (3.4%) and two African American MCI patients (5.3%) reported having no prior experience with the skills tested on one or more of the seven FCI domains, and thus were excluded from further analyses. Groups did not differ in the proportion of participants excluded in each group ($\chi^2 = 0.25$, $p = .46$).

Results from the group comparisons on the FCI domains and total score are presented in Table 2. African American MCI patients had significantly lower scores compared to the Caucasian MCI patients on domains of Basic Monetary Skills, Financial Conceptual Knowledge, Cash Transactions, Checkbook Management, Bank Statement Management, and Bill Payment. African American MCI patients also had lower FCI Total Scores. The groups performed equivalently on the domain of Financial Judgment.

Table 3 presents the results from the linear regression mediator models of racial differences in overall financial capacity. The base model including a variable for race was significant. None of the adjusted models (models 2 through 6) fully accounted for the racial group effect but several of the models substantially reduced it. The most robust model was model 2, which adjusted for WRAT-3 Arithmetic subtest score and accounted for 54% of the racial group effect on FCI performance. Model 3, which adjusted for DRS-2 Total Score and MMSE, accounted for 14% of the racial group effect. Age, education, and gender together (model 4) accounted for only 10% of the racial group effect. History of cardiovascular disease (model 5) accounted for only 2% of the racial group effect. In the final regression model, we entered the term for race in the first block, and then forward-entered all variables that were significant in models 2 through 5 (age, education, WRAT-3 Arithmetic subtest score, DRS-2 Total Score, and MMSE). Only WRAT-3 Arithmetic subtest score and DRS-2 Total Score were selected into the second block of this model. Together, these variables accounted for 54% of the racial group effect in FCI total score performance among patients with MCI.

DISCUSSION

The aim of the current study was to investigate financial capacity in African American and Caucasian patients with amnesic MCI using the FCI, a direct performance measure of financial capacity. We found that African American and Caucasian MCI groups performed differently across a range of financial skills. Specifically, African American MCI patients performed below Caucasian MCI patients on FCI total score, and on domains measuring basic monetary skills, financial conceptual knowledge, cash transactions, checkbook management skills, bank statement management skills, and bill payment skills. Interestingly, we also found that WRAT-3 Arithmetic substantially mediated group differences on the FCI total score. Global cognitive status also partially mediated group differences, but to a much smaller extent.

As described above, the MCI groups differed on a variety of financial skills. The largest domain discrepancy between groups was observed on bank statement management (Domain 5), with group mean raw scores differing by nearly 7 points. Domain 5 is a complex financial domain that requires participants to identify and explain parts of a bank statement and identify specific transactions on a bank statement. Even though we attempted to control for group differences in terms of level of prior experience, there still may have been differences in terms of task familiarity and practice on this domain. A second significant discrepancy was demonstrated on financial conceptual knowledge (Domain 2), with a group

difference of 5.5 raw score points. Domain 2 is also comprised of complex financial tasks, such as defining various financial concepts and applying financial conceptual knowledge in everyday practical situations. We were surprised to find a difference between groups on basic monetary skills (Domain 1) because this domain generally measures simple financial skills, including naming and counting coins and currency and indicating the relative monetary values of different coins and currency. However, the group difference on Domain 1 was small and was likely not clinically meaningful.

The present study is one of the first to empirically investigate and compare financial capacity among African American and Caucasian elders with MCI. However, race/ethnic group differences in financial abilities have been investigated in other patient populations, and our findings are in line with these prior studies. A comparative study of Spanish and English speaking older adults reported greater impairment among Spanish-speaking dementia patients on a check writing task³². In contrast, there was no difference between the Spanish and English speaking controls, suggesting a possible interaction between dementia diagnosis and functional capacity performance. A recent study reported finding differences in the money management skills of African American and Caucasian elders, but these differences were no longer significant after adjusting for group differences in reading ability³³. However, that study did not comprehensively examine financial abilities as done in this study. Other studies have reported race/ethnic group differences in other functional abilities. Moody-Ayers and colleagues examined differences between white and black elders in a variety of ADLs and reported that black elders had a higher frequency of ADL disability compared to white elders, and that cognitive impairment was an important mediator of ADL disability³⁴. The present study extends these prior studies by focusing on patients with MCI and using a psychometrically-based performance measure that decomposes financial capacity into component abilities.

In the second part of our study, we sought to identify variables potentially underlying the identified racial disparities in financial capacity performance. Although none of the covariates that we examined fully accounted for group differences on the FCI, basic academic math ability, as measured by the WRAT-3 Arithmetic subtest, accounted for a substantial proportion of variance (54%). Our finding that academic math skills was a strong mediator of the racial group effect on FCI is similar to other studies demonstrating that academic reading skills account for much of the disparity in cognitive test performance seen in African American and Caucasian elders³⁵. Similar to the WRAT-3 Reading subtest, the WRAT-3 Arithmetic subtest may be measuring important differences in early academic experiences such as quality of education. Although we did not have a measure of reading ability available for this study, the WRAT-3 Arithmetic subtest is a relevant measure of academic ability in relation to math and by extension financial abilities, and has been shown in a prior study to have a very strong correlation with financial capacity across the dementia spectrum of older controls, patients with MCI, and patients with mild AD³⁶. In this regard, the WRAT-3's predictive power far exceeds that of global mental status variables such as DRS total score and the MMSE. However, it is likely that the WRAT-3 Reading subtest may capture additional variance in the models that the WRAT-3 Arithmetic subtest does not capture. Studies are needed to compare the WRAT-3 Arithmetic and Reading subtests in individuals with varying levels of cognitive impairment to better understand how these measures of achievement together mediate performance in different race/ethnic groups. It would also be important to determine whether education-related variables affect WRAT-3 Arithmetic performance.

This study also identified other mediator variables of racial disparities in financial capacity in MCI. Specifically, we discovered a significant but weaker relationship between global cognitive functioning and race differences on the FCI, with performance on the DRS-2 and

MMSE together accounting for 14% of the racial group effect in FCI performance. This finding suggests that the differences in financial abilities demonstrated by our groups were not due to varying levels of global cognitive impairment. Rather, it appears that the WRAT-3 Arithmetic subtest may be also capturing an additional aspect of cognition associated with financial knowledge, skills, and experience acquired during the developmental period.

We also investigated the contributions of age, years of education, and gender and found a weak relationship between these variables and racial differences in financial capacity performance. Together, these variables only accounted for 10% of the racial group effect. Our finding that years of education does not adequately adjust for racial disparities in health outcomes is in line with findings from neuropsychological studies that show that years of education by itself does not account for differences in cognitive outcomes³⁵.

Finally, we examined whether history of cardiovascular disease and risk factors (hypertension, diabetes, and hypercholesterolemia) explained group differences in financial abilities. Financial capacity is a highly cognitively demanding IADL, and cardiovascular disease could indirectly affect financial abilities through cumulative insults to the brain that could result in arithmetic difficulties and other cognitive changes related to financial capacity. Given the higher rates of cardiovascular disease and associated risk factors present among African Americans¹², we were surprised to find that history of hypertension, diabetes, hypercholesterolemia only accounted for 2% of the racial group effect. Although it is possible that we would have obtained different results if different measurements of vascular disease (e.g., white matter hyperintensities on MRI) were used or if more finely grained quantitative assessments were used (e.g., blood pressure levels versus categorical variables assessing history of cardiovascular disease), our findings suggest that these health variables may not be primary factors in explaining differences in the financial abilities of African American and Caucasian patients with MCI.

Finally, we examined a forward-entry regression model that tested the contributions of age, years of education, WRAT-3 Arithmetic subtest score, DRS-2 Total Score, and MMSE score to the race differential in financial capacity. Interestingly, only WRAT-3 Arithmetic and DRS-2 Total Score were selected in this model, together, accounting for 54% of the racial group variance in FCI performance among patients with MCI. This model also performs equivalently with the model that only included WRAT-3 Arithmetic.

Other variables contributing to racial disparities in financial capacity performance need to be identified. One possibility is that groups differed in terms of task familiarity. Although we attempted to include only those patients who had prior experience performing the financial tasks examined, it is still possible that unmeasured group differences in financial task familiarity existed. Many of the older African American patients in this study came from economically disadvantaged backgrounds during the 1920's – 1940's, due to socio-political inequalities previously in place in the South, and therefore may have had fewer opportunities to acquire and practice certain financial skills than their Caucasian peers.

Race or education may not be variables that explain the differences found in the study. Variables that need to be examined in future studies are urban/rural distinctions and income. Income may determine the older person's experience with money. Level of income impacts familiarity with finances. In terms of urban/rural considerations, Caucasian and African American rural elders may look very similar given that their financial circumstances and access to educational resources may be similar.

It is also possible that the African American MCI group had greater difficulty performing financial tasks because they had more severe disease compared to the Caucasian MCI group.

The demarcation between MCI and dementia is sometimes unclear and diagnoses are ultimately determined by clinical judgment. However, we do not think that our results occurred due to there being a greater proportion of actual mild dementia cases in the African American MCI group. The groups did not differ in terms of CDR rating scores, a clinical staging instrument, and as previously noted, adjustment for DRS-2 Total Score and MMSE performance only reduced the racial group effect by 14%.

Some limitations of the present study should be mentioned. First, the relatively small sample of African American MCI patients raises potential concerns about the stability of the study findings. Future studies including a larger sample of African Americans with MCI will further enhance our understanding of racial disparities in functional abilities in MCI. Second, we only included amnesic MCI patients in our study, so it is not clear whether the findings generalize to non-amnesic MCI, cognitively healthy, or dementia populations. Third, although the financial capacity instrument used in this study assesses real-world financial tasks¹⁴, the assessments took place in a clinical laboratory setting which does not always completely reflect actual performance in the home or community setting, where there is less structure, more extended time periods, and where additional environmental distractions may be present. Fourth, our groups were not matched for several demographic and clinical factors (e.g., years of education and gender); we chose not to match our groups on these variables because we were interested in examining the relationships between demographic and clinical variables to group differences in financial capacity performance. As previously noted, none of these covariates completely explained the group differences.

Finally, a potential limitation is that no study to date has specifically examined construct validity of the FCI separately for African Americans and Caucasians. However, we believe that the FCI possesses acceptable levels of construct validity in our MCI groups for several reasons. First, African Americans were included in the original sample used to validate the FCI instrument for patients with MCI². Second, in preparing the present paper, we examined construct validity using a key neuropsychological predictor as an index measure. For each of the MCI groups, we investigated the within group correlation of WRAT-3 arithmetic score to FCI total score (sum Domains 1-7). We found that the correlations were very similar for both groups: .63 ($p < .001$) for Caucasian MCI participants and .71 ($p < .001$) for African American MCI participants. WRAT-3 Arithmetic was the strongest correlate of FCI total score in both MCI groups, as it has been in another study³⁶. Finally, we compared the correlations of FCI domains (1-7) to FCI total score across the two MCI groups. Despite the sample size differences, we found a similar pattern and magnitude of domain correlations across the two groups, suggesting that the FCI domains are operating in a similar way across the two racial groups. Accordingly, we believe that there is initial evidence suggesting that the FCI has construct validity in both MCI groups. It will be important in future studies to investigate more formally the construct validity of the FCI (and other financial and IADL instruments) in different racial/cultural groups.

In summary, we found differences between our two racial groups on many of the financial variables examined. Adjustment for group differences on the WRAT-3 Arithmetic subtest substantially reduced the racial group effect, but none of the mediator variables examined completely eliminated the racial group effect. Therefore, other variables not examined in the current study remain to be identified in order to explain racial differences in financial abilities of patients with MCI. WRAT-3 Reading subtest is a good candidate measure to examine; it may account for additional variance in the racial group effect in financial abilities by tapping quality of education or verbal knowledge. The authors hope that the study findings will stimulate interest in future studies of functional capacity in ethnic minorities and other economically disadvantaged groups. This research may lead to new

insights and may help identify educational and other interventions for reducing disparities in this critical IADL.

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Table 1
Demographic and Clinical Characteristics of Study Participants

Variable	Caucasians with MCI n = 116	African Americans with MCI n = 38	p
Age	71.1 (7.3)	68.4 (8.2)	.054
Gender, n (%)			
Male	60 (51.7)	8 (21.1)	.001
Female	56 (48.3)	30 (78.9)	
Education (Years)	15.2 (2.8)	13.5 (3.1)	.002
Hypertension, n (%)	63 (54.3)	27 (71.1)	.069
Diabetes mellitus, n (%)	13 (11.2)	14 (36.8)	<.001
Hypercholesterolemia, n (%)	55 (47.4)	19 (50.0)	.782
MMSE	28.2 (2.0)	27.5 (1.8)	.058
DRS-2 Total Score	132.2 (6.5)	129.6 (7.4)	.037
CDR Sum of Boxes ^a	1.5 (0.08)	1.3 (0.12)	.302
CDR global rating, n (%) ^a			
0	5 (4.4)	0 (0)	.215
0.5	108 (95.6)	38 (100.0)	
WRAT-3 Arithmetic	39.2 (4.7)	34.1 (4.9)	<.001
GDS score (max = 30)	6.7 (5.0)	7.8 (5.0)	.350

Note. Values are means and standard deviations unless otherwise noted. MCI = amnesic mild cognitive impairment; GDS = Geriatric Depression Scale; DRS-2 = Dementia Rating Scale, 2nd edition; MMSE = Mini Mental Status Exam Score; WRAT-3 Arithmetic = Arithmetic subtest of the Wide Range Achievement Test, 3rd edition; CDR = Clinical Dementia Rating Scale.

^aCDR values were not available for 3 Caucasian MCI participants.

Table 2
Comparisons of Group Performance on the Financial Capacity Instrument (FCI) in
Patients with Amnesic MCI

FCI Domains and Tasks	Range	Caucasians with MCI n = 116	African Americans with MCI n = 38	p
		Mean (SD)	Mean (SD)	
D1. Basic monetary skills	0-34	31.1 (3.5)	27.2 (4.7)	<.001
D2. Financial concepts	0-32	28.2 (3.2)	22.7 (5.9)	<.001
D3. Cash transactions	0-24	20.7 (3.1)	17.5 (3.6)	<.001
D4. Checkbook management	0-50	46.8 (4.1)	43.6 (6.1)	.005
D5. Bank statement management	0-39	32.5 (4.8)	25.8 (6.8)	<.001
D6. Financial judgment	0-16	13.4 (3.2)	12.5 (3.7)	.159
D7. Bill payment	0-46	40.7 (6.3)	35.8 (8.2)	.001
FCI Total Score – Domains 1-7	0-241	214.0 (18.1)	186.2 (27.1)	<.001

Caucasian MCI sample size was 116 except on Domain 2 (n = 114), Domain 4 (n = 114), Domain 5 (n = 114), Domain 7 (n = 114), and Total Score (Domains 1-7) (n = 112).

African American MCI sample size was 38 except on Domain 2 (n = 37), Domain 3 (n = 36), Domain 4 (n = 37). Domain 7 (n = 36) and Total Score (Domains 1-7) (n = 36).

Table 3
Summary of Separate Regression Models Examining the Effect of Race on FCI Total Score (Domains 1–7) in MCI Patients (N = 148)^a

Model [†]	Estimate [‡]	SE [‡]	B [‡]	p [‡]	% change in β for race
1. Race	–27.76	3.95	–50	<.001	---
2. Race, WRAT-3 Arithmetic	–12.39	3.37	–23	<.001	54.0%
3. Race, DRS-2 and MMSE	–23.64	3.5	–43	<.001	14.0%
4. Race, Demographic Variables	–24.58	3.73	–45	<.001	10.0%
5. Race, Cardiovascular Disease	–26.78	4.17	–49	<.001	2.0%
6. Race, WRAT-3 Arithmetic & DRS-2 Total Score	–12.57	3.21	–23	<.001	54.0%

Caucasian MCI sample size was 112.
African American sample size was 36.
Model 2 is model 1 plus the term for WRAT-3 Arithmetic subtest score
Model 3 is model 1 plus the terms for Dementia Rating Scale, 2nd Edition Total Score (DRS-2) and Mini Mental Status Exam (MMSE) score
Model 4 is model 1 plus the terms for age, years of education, and gender
Model 5 is model 1 plus the terms for history of hypertension, diabetes, and hypercholesterolemia
Model 6 is model 1 plus terms for WRAT-3 Arithmetic subtest and DRS-2 Total Score

^a Only participants with prior experience performing financial tasks were included in the analyses.
[†] Model 1 includes the term for race only
[‡] These values refer to the effect of race on FCI total score across the 6 models.