Optimal cuts were determined from a previous study in this sample: MMSE <28 for symptoms of have than the MMSE across base rates.

Methods
- 167 Veterans referred by Neurological services completed an MMSE and MoCA.
- Participants (n=49) had been removed for suboptimal effort, as demonstrated on the Word Memory Test (<22.5), the Test of Memory Malinger (<45), or the California Verbal Learning Test-II Forced Choice (<14).
- Sensitivity (SE), specificity (SP), negative predictive value (NPV), and positive predictive values (PPV) were calculated at each level of screener cut and selected based rates (0.10, 0.30, 0.50, and 0.70).
- Neuropsychological testing, as the “gold standard”, was set to at multiple levels of impairment: ≤-1.5 SD on at least two cognitive domains and ≤-2.5 SD on at least two cognitive domains.
- Optimal cuts were determined from a previous study in this sample: MMSE <28 for -1.5 SD and ≤26 for -2.5 SD; MoCA <22 for -1.5 SD and <21 for -2.5 SD.

Results and Conclusions
- When detecting milder cognitive impairment (<-1.5 SD), the MMSE and MoCA have similar NPV rates across base rates, while the MoCA tends to have greater PPV rates than the MMSE across base rates.
- When detecting severe levels of cognitive impairment (<-2.5 SD), the MoCA tends to have greater NPV, particularly at high base rates, in comparison to the MMSE. PPV rates are similar across base rates among each measure.
- These tables allow clinicians to select the most appropriate measure for their population.