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# Validation of an Automatic Video Monitoring System for the Detection of Instrumental Activities of Daily Living in Dementia Patients

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**Abstract.** Over the last few years, the use of new technologies for the support of elderly people and in particular dementia patients received increasing interest. We investigated the use of a video monitoring system for automatic event recognition for the assessment of instrumental activities of daily living (IADL) in dementia patients. Participants (19 healthy subjects (HC) and 19 mild cognitive impairment (MCI) patients) had to carry out a standardized scenario consisting of several IADLs such as making a phone call while they were recorded by 2D video cameras. After the recording session, data was processed by a platform of video signal analysis in order to extract kinematic parameters detecting activities undertaken by the participant. We compared our automated activity quality prediction as well as cognitive health prediction with direct observation annotation and neuropsychological assessment scores. With a sensitivity of 85.31% and a precision of 75.90%, the overall activities were correctly automatically detected. Activity frequency differed significantly between MCI and HC participants ( $p < 0.05$ ). In all activities, differences in the execution time could be identified in the manually and automatically extracted data. We obtained statistically significant correlations between manually as automatically extracted parameters and neuropsychological test scores ( $p < 0.05$ ). However, no significant differences were found between the groups according to the IADL scale. The results suggest that it is possible to assess IADL functioning with the help of an automatic video monitoring system and that even based on the extracted data, significant group differences can be obtained.

**Keywords:** Alzheimer's disease, assessment, autonomy, dementia, mild cognitive impairment, information and communication technologies, instrumental activities of daily living, video analyses

## INTRODUCTION

The increase of persons with dementia is accompanied by the need to identify methods that allow for an easy and affordable detection of decline in functionality in the disorder's early stages. Consequently, the development of computerized assessment systems for

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the elderly is of high interest, and represents a promising new research domain that aims to provide clinicians with assessment results of higher ecological validity.

Dementia is one of the major challenges affecting the quality of life of the elderly and their caregivers. Progressive decline in cognitive function represents a key symptom and results often in the inability to perform activities of daily living (ADL) and instrumental activities of daily living (IADL) [1] such as managing finances or cooking.

Many efforts are currently being undertaken to investigate dementia pathology and develop efficient treatment strategies considering its rapidly increasing prevalence. Mild cognitive impairment (MCI) [2–4] is considered as a pre-dementia stage for Alzheimer’s disease (AD), as many MCI patients convert to AD over time [5]. Studies show that impairment in complex functional tasks, notably due to slower speed of execution [6], may already be detectable in the early stages of cognitive decline and therefore gradually becomes an important target in clinical assessments [7, 8]. Rating scales and questionnaires constitute the essential tools for the assessment and monitoring of symptoms, treatment effects, as well as (I)ADL functioning.

Nevertheless, changes in (I)ADL functioning observed in MCI may be too subtle to be detected by traditional measures assessing global ADLs [9, 10]. Thus, standard tools are limited to some extent in ecological validity, reproducibility, and objectivity [11]. They do not fully capture the complexity of a patient’s cognitive, behavioral, and functional statuses, which do not always evolve in parallel but rather idiosyncratically.

To overcome these problems, Schmitter-Edgecombe et al. developed a naturalistic task in a real world setting to examine everyday functioning in individuals with MCI using direct observation methods [12]. However, this method can also suffer from possible observation biases and difficulties in reproducibility.

For this reason, information and communication technology (ICT) involving imaging and video processing could be of interest by adding more objectively measured data to the diagnostic procedure. Functionality in (I)ADL, which is very closely linked to executive functions [13, 14], may be reflected in activity patterns measurable through computerized systems such as automatic video detection of activities.

Dawadi et al. showed that it is possible to automatically quantify the task quality of daily activities and to perform limited assessment of the cognitive functioning of individuals in a ‘smart’ home environment (equipped with various sensors) as long as the activ-

ities are properly chosen and the learning algorithms are appropriately trained [15]. Sablier and colleagues developed a technological solution designed for people with difficulties managing ADL, providing a schedule manager as well as the possibility to report occurrences of experiences of symptoms such as depression and agitation [16]. However, indicators of cognitive functioning and autonomy were measured using a test battery and scales [16]. Okahashi et al. created a Virtual Shopping Test—using virtual reality technology to assess cognitive functions in brain-injured patients—correlating variables on the virtual test with scores of conventional assessments of attention and memory [17]. Similar work has been done by Werner et al. using a virtual action planning Supermarket game for the diagnosis of MCI patients [18].

Along this line, a project was launched under the name Sweet-HOME (2012), defining a standardized scenario where patients are asked to carry out a list of autonomy relevant (I)ADLs, such as preparing tea, making a phone call, or writing a check, in an experimental room equipped with video sensors. Within this project, Sacco et al. performed a functional assessment with the help of visual analyses by computing a DAS (Daily Activity Scenario) score able to differentiate MCI from healthy control (HC) subjects [19]. However, analysis was based purely on annotations made by a direct observer, and therefore still risked lack of objectivity and reliability. Automatic, computer-based video analysis, which allows for the recognition of certain events and patients’ behavioral patterns, may offer a new solution to the aforementioned assessment problems.

To date, automatic video event recognition has been employed in clinical practice simply for feasibility studies with small samples [20–22]. Banerjee et al. presented video-monitoring for fall detection in hospital rooms by extracting features from depth information provided by a camera [23]. Wang et al. used automatic vision analyses for gait assessment using two cameras to differentiate between the gait patterns of residents participating in realistic scenarios [22].

In order to further evaluate the potential contribution of such technologies for clinical practice, this study aims to validate the use of automatic video analyses for the detection of IADL performance within a larger group of MCI patients and HC subjects carrying out a predefined set of activities. More specifically, the objectives of the study are (1) to compare IADL performances of elderly HC subjects and patients with MCI in a predefined scenario; (2) to compare automatically extracted video data with so-called ‘ground-truth’

(GT) annotations made manually by a human observer; and (3) to assess the importance of automatic video analyses data for the differentiation between the two populations. As a secondary objective, we investigate the relationship between the participants' performance in the scenario and the results of classical neuropsychological testing, in order to verify whether or not the performance in the created scenario is associated with the status of cognitive functioning.

We expect automatically extracted video detection to achieve results as GT annotations when differentiating between the MCI group and the HC group. We also hypothesize that individuals with MCI will perform poorer in the predefined IADL scenario than HC subjects and that difficulties in executive functioning will be related to the amount of completed activities. Further, we expect a significant relationship between the video captured performance in the scenario and the classical neuropsychological test results such as the Frontal Assessment Battery (FAB) [24] or the Mini-Mental State Examination (MMSE) [25] and IADL scales [26].

## METHODS

### Participants

The study was approved by the local Nice ethics committee and only participants with the capacity to consent to the study were included. Each participant gave informed consent before the first assessment. Participants aged 65 or older were recruited at the memory center in Nice located at the Geriatric Department of the University Hospital. For the MCI group, patients with a MMSE score higher than 24 were included using the Petersen clinical criteria [4]. Participants were excluded if they had any history of head trauma, loss of consciousness, psychotic aberrant motor behavior, or a score higher than 0 on the Unified Parkinson's Disease Rating scale (UPDRS) [27] in order to control for any possible motor disorders influencing the ability to carry out IADLs.

### Assessments

Participants were administered a cognitive and behavioral examination prior to completing the video monitoring session. General cognitive status was assessed using neuropsychological tests including: MMSE [25], Frontal Assessment Battery (FAB) [24], Instrumental Activities of Daily Living scale (IADL-E) [28], Montgomery-Asberg Depression Rating Scale

(MADRS) [29], and Geriatric Depression Scale (GDS) to assess depression levels [30]. Additionally, neuropsychiatric symptoms were assessed using the Neuropsychiatric Inventory Scale (NPI) [31].

### Clinical scenario: The ecological assessment

The ecological assessment of IADLs was conducted in an observation room located in the Nice Research Memory Center. This room was equipped with everyday objects for use in ADLs and IADLs, e.g., an armchair, a table, a tea corner, a television, a personal computer, and a library. Two fixed monocular video cameras (eight frames per second) were installed to capture the activity of the participants during the experiment. Using an instruction sheet, participants had to carry out 10 daily-living-like activities, such as making a phone call or preparing a pillbox, in a particular order within a timeframe of 15 min (Table 1). The aim of this ecological assessment of autonomy was to determine to which extent the participant could undertake a list of daily activities with respect of some constraints after being given a set of instructions. After each participant carried out the scenario, a clinician verified the amount of activities initiated and carried out completely and correctly, as well as repetitions and omissions. The information was manually annotated and entered into the database via a tablet. The scenario was recorded using a 2D-RGB video camera (AXIS, Model P1346, 8 frames per second) and a RGB-D camera (Kinect, Microsoft).

Table 1  
List of the activities proposed to the patient during the ecological assessment

Daily Living scenario associated with the protocol	
Activities	« Your task is to perform this list of 10 activities in a logical manner within 15 minutes. These 15 minutes represent a typical morning period of everyday life. »
	– Read the newspaper
	– Water the plant
	– Answer the phone
	– Call the taxi
	– Prepare today's medication
	– Make the check for the Electricity Company
	– Leave the room when you have finished all activities
	– Watch TV
Constraints	– Prepare a hot tea
	– Write a shopping list for lunch
	1. Watch TV before the phone call
	2. Water the plant just before leaving the room
	3. Call the taxi which will take 10 min to arrive and ask the driver to bring you to the market

215 For a more detailed analysis, the main focus was  
 216 placed particularly on three IADLs, namely prepar-  
 217 ing a pillbox, making a phone call, and preparing  
 218 tea, because they fall within the commonly used  
 219 IADL-Lawton scale, and are the most challenging  
 220 activities for appropriately representing a patient's gen-  
 221 eral autonomy level. However, all other activities were  
 222 included in the overall IADL assessment procedure and  
 223 analyses.

#### 224 *Automatic video monitoring system and event* 225 *recognition*

226 In the first step, after each assessment, a clinician  
 227 manually gathered data of the amount of activities car-  
 228 ried out by the participants. This included parameters  
 229 such as activity occurrence, activity initiation, and the  
 230 number of activities carried out completely and cor-  
 231 rectly. In the next step, a computer vision algorithm was  
 232 used to automatically extract different parameters rep-  
 233 resenting movement patterns of the participants during  
 234 the ecological assessment period.

235 The Automatic Video Monitoring System (AVMS)  
 236 herein used has been fully described [32]. It is com-  
 237 posed of two main modules: the vision and the event  
 238 recognition. The vision module is responsible for  
 239 detecting and tracking people on the scene. The event  
 240 recognition module uses the generic constraint-based  
 241 ontology language proposed by Zouba et al. [33] for  
 242 event modeling and the reasoning algorithm proposed  
 243 by Vu and colleagues [34] to describe and detect the  
 244 activities of daily living of interest in this study.

245 The vision module detects people in the scene using  
 246 an extension of the Gaussian Mixture Model algo-  
 247 rithm for background subtraction proposed by Nghiem  
 248 et al. [35]. People tracking over time is performed by a  
 249 multi-feature algorithm proposed by Chau et al. using  
 250 features such as 2D size, 3D displacement, color his-  
 251 togram, and dominant color. The detected people and  
 252 their tracking information (their current and previous  
 253 positions in the scene) are then passed to the event  
 254 recognition module [36].

255 The event recognition module is composed of a  
 256 framework for event modeling and a temporal scenario  
 257 recognition algorithm which assess whether the con-  
 258 straints defined in the event models are satisfied [34].  
 259 Event models are built taking into account *a priori*  
 260 knowledge of the experimental scene and attributes  
 261 dynamically obtained by the vision module. Event  
 262 modeling follows a declarative and intuitive ontology-  
 263 based language that uses natural terminology to allow  
 264 end users (e.g., medical experts) to easily add and

265 modify the models. The *a priori* knowledge consists  
 266 of a decomposition of a 3D projection of the room's  
 267 floor plan into a set of spatial zones that have seman-  
 268 tic information regarding the events of interest (e.g.,  
 269 TV position, armchair position, desk position, tea  
 270 preparation). The ontology employed by the system  
 271 hierarchically categorizes event models according to  
 272 their complexity, described here in ascending order:

- **Primitive State** models an instantaneous value of  
 273 a property of a person (posture or position inside  
 274 a certain zone. 275
- **Composite State** refers to a composition of two  
 276 or more primitive states. 277
- **Primitive Event** models a change in a value of  
 278 person's property (e.g., change in posture to model  
 279 whether or not a person changes from a Sitting to  
 280 a Standing state). 281
- **Composite Event** refers to the composition of  
 282 two of the previous event model types in terms  
 283 of a temporal relationship (e.g., Person changes  
 284 from Sitting to Standing posture before Person in  
 285 Corridor). 286

#### 287 *IADL modeling*

288 The semantic information of the observation room  
 289 where patients conducted the activities of daily living  
 290 was defined. Contextual or Semantic Elements were  
 291 defined at the locations where the activities of daily  
 292 living would be carried out (e.g., telephone zone at  
 293 top-left corner, tea and plant zones at top-right corner,  
 294 and pharmacy zone at bottom-left corner). 295

296 The activity modeling was performed with the sup-  
 297 port of domain experts. The models were mostly made  
 298 taking into account one or more of the following con-  
 299 straints: the presence of the person in a specific zone,  
 300 their posture, and their proximity to the object of daily  
 301 living (when static, e.g., the telephone). These con-  
 302 straints were defined as primitive state models. The  
 303 combination of these models, along with their tempo-  
 304 ral order, was defined as a composite event. Duration  
 305 constraints were also used to establish a minimum time  
 306 of execution for the whole or sub-components of the  
 composite event.

#### 307 *Statistical analysis*

308 Spearman's correlations were performed to deter-  
 309 mine the association between the extracted video  
 310 parameters and the established assessment tools in  
 311 particular for executive functioning, e.g., the FAB.

Comparison between the two groups (i.e., MCI patients and HC subjects) was performed with a Mann-Whitney test for each outcome variable of the automatic video analyses. Differences were reported as significant if  $p < 0.05$ .

#### Automatic activity recognition evaluation

The evaluation compared the performance of the AVMS at automatically detecting IADL with respect to the annotations manually made by human experts. The AVMS performance was measured based on the indices of recall and precision, described in Equations 1 and 2, respectively. Recall index measures the percentage of how many of the targeted activities have been detected compared to how many existed. Precision index evaluates the performance of the system at discriminating a targeted activity type from others.

1. Recall =  $TP/(TP+FN)$  2. Precision =  $TP/(TP+FP)$

TP: True Positive rate, FP: False Positive rate, FN: False Negative rate.

## RESULTS

### Population

19 MCI patients (age =  $75.2 \pm 4.25$ ) and 19 HC (age =  $71.7 \pm 5.4$ ) were included. Table 2 shows the clinical and demographic data of the participants. Significant intergroup differences in demographic factors (gender and age) were not seen. However, significant differences were found between for the MMSE score,

with a mean of  $25.8 (\pm 2.2)$  for the MCI group and  $28.8 (\pm 1.0)$  for the HC group ( $p, 0.001$ ), as well as for the FAB score with a mean of  $14.16 (\pm 1.92)$  for the MCI group and  $16.2 (\pm 1.44)$  for the HC group. The mean IADL-E scores did not differ between groups, with a mean IADL-E score of  $9.9 (\pm 1.7)$  for the MCI group and  $9.6 (\pm 1.1)$  for the HC group.

### Automatic video monitoring results versus ground-truth annotation

The participants performed differently on the IADL scenario according to their diagnostic group; in all three activities (preparing the pillbox, preparing tea, and making/receiving a phone call), the obtained parameters (manually as automatic) showed variations. All results are presented in detail in Table 3. The total frequency of activities as well as the number of correctly completed activities according to manual annotations differed significantly between MCI and HC groups ( $p < 0.05$ ). Two activities, namely preparing the pillbox and making/receiving the phone call, generally took the MCI participants a longer time to carry out. In turn, for the activity of preparing tea, HC participants took a longer time. The same trends, even if not significant, were detected as well by the automatic video analyses; a significant difference was found between MCI and HC groups ( $p < 0.05$ ) in the phone call time. Furthermore, MCI and HC participants differed in the total amount of detected activities carried out; the same activities, preparing the pillbox and making/receiving a phone call took longer for MCI

Table 2  
Characteristics of the participants

Characteristics	HC group $n = 19$	MCI group $n = 19$	$p$
Female, $n$ (%)	15 (78.9%)	9 (47.4%)	0.091
Age, years mean ST	$71.7 \pm 5.37$	$75.2 \pm 4.25$	0.07
Level of Education, $n$ (%)			
Unknown	2 (10.5%)	2 (10.5%)	1
No formal education	0 (0%)	0 (0%)	–
Elementary school	1 (5.3%)	5 (26.3%)	0.405
Middle school	4 (21.0%)	7 (36.8%)	0.269
High school	4 (21.0%)	3 (15.8%)	1
Post-secondary education	8 (42.1%)	2 (10.5%)	0.062
MMSE, mean $\pm$ SD	$28.8 \pm 1.03$	$25.8 \pm 2.22$	<b>0.001**</b>
FAB, mean $\pm$ SD	$16.2 \pm 1.44$	$14.16 \pm 1.92$	<b>0.002*</b>
IADL-E, mean $\pm$ SD	$9.6 \pm 1.12$	$9.9 \pm 1.73$	0.488
NPI total, mean $\pm$ SD	$0.42 \pm 1.43$	$6.16 \pm 6.73$	<b>0.00*</b>

Data shown as mean  $\pm$  SD. Bold characters represent significant  $p$ -values  $< 0.05$ . Scores on the Mini Mental State Examination (MMSE) range from 0 to 30, with higher scores indicating better cognitive function; Scores on the Instrumental Activities of Daily Living for Elderly (IADL-E) range from 0 to 36, with lower score indicating a better functional independency; Scores on the Montgomery Asberg Depression Rating Scale (MADRS) range from 0 to 60 (10 items range from 0 to 6), with higher scores indicating depressive state; Scores on the Geriatric Depression Scale (GDS) range from 0 to 30, with higher scores indicating depressive state. HC, healthy control; MCI, mild cognitive impairment.

Table 3  
Comparison of parameters from video analyses between groups

Video analyses data	HC n = 19	MCI n = 19	p
<i>Manually annotated:</i>			
Activities carried out completely and correctly <sup>†</sup>	9.68 ± 0.48	8.21 ± 1.48	<b>0.00*</b>
Activity frequency total <sup>‡</sup> (activities initiated) <sup>‡</sup>	11.74 ± 2.62	9.58 ± 1.89	<b>0.007*</b>
Preparing Pillbox (f)	1.05 ± 0.23	0.89 ± 0.32	0.086
Preparing Pillbox time	41.17 ± 17.04	46.17 ± 31.18	0.609
Making tea (f)	2.68 ± 0.82	2 ± 1	0.068
Making tea time	41.21 ± 30.60	32.16 ± 35.3	0.175
Phone call (f)	2 ± 0.47	2.21 ± 0.53	0.198
Phone call time	66.61 ± 21.75	83.30 ± 30.96	0.118
<i>Automatically extracted: Activity frequency total</i>			
Preparing Pillbox (f)	1.05 ± 0.23	1.17 ± 0.38	0.271
Preparing Pillbox time	47.64 ± 22.28	70.26 ± 38.01	0.204
Making tea (f)	2.74 ± 1.33	2.12 ± 1.22	0.136
Making tea time	102.3 ± 77.3	79.57 ± 40.92	0.531
Phone call (f)	1.95 ± 0.52	2.17 ± 0.79	0.38
Phone call time	60.32 ± 21.52	112.61 ± 46.31	<b>0.000*</b>

Mann-Whitney test: \*p < 0.05, \*\*p < 0.01 HC, healthy control; MCI, mild cognitive impairment; (f), mean frequency of detected event; <sup>†</sup>Represents the total amount of completely carried out activities without a mistake, <sup>‡</sup>Represents the total of simply initiated activities which are not always necessarily accomplished completely and without mistakes.

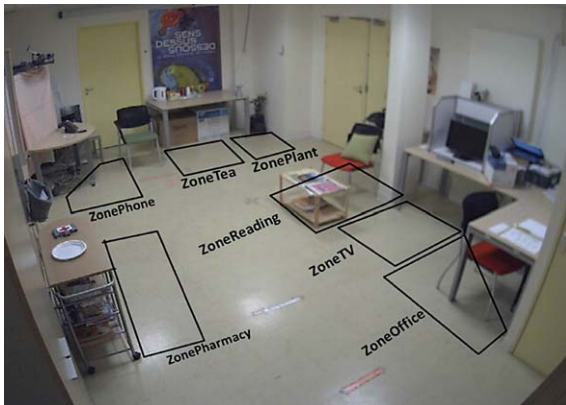


Fig. 1. The experimental room for the IADL assessment. For the automatic activity detection, the room was divided in different zones according to the designated IADL.

participants whereas making tea took longer for the HC group.

According to the amount of carried out activities and rapidity, the best and worst performers were determined in each group. Next, we investigated if participants that performed well showed a difference in the parameters extracted from the automated video analyses compared to participants that did not perform as well on the assessment. This, in turn, could help establish diagnostic-specific profiles of IADL functioning. The results are presented in Fig. 2.

Moreover, the manually and automatically extracted video data parameter 'activity frequency' correlated significantly with neuropsychological test results namely the MMSE ( $p < 0.01$ ) and FAB score ( $p < 0.05$ ).

The obtained correlation analyses results are presented in Table 4. Particularly, from the manually annotated parameters, the time spent to prepare the pillbox correlated significantly negatively with the MMSE scores ( $p < 0.01$ ), whereas the time spent to make a phone call correlated significantly negatively with the FAB scores ( $p < 0.05$ ). The mean frequency of the activity 'making tea' correlated significantly positively with the FAB scores ( $p < 0.05$ ). From the automatically extracted parameters, the detected time spent to prepare the pillbox ( $p < 0.01$ ) and to make the phone call ( $p < 0.05$ ) correlated significantly negatively with the MMSE scores. None of the extracted parameters correlated with the IADL-E scores.

#### Automatic video monitoring results: Experimental results

Table 5 presents the results of the evaluation of the AVMS with respect to its accuracy at detecting the number of activities of daily living annotated by domain experts while watching the experiment video.

From all 10 proposed activities, 'Reading' was detected automatically with the highest precision of 91.30%, followed by 'Preparing pillbox' with 90.24%, and 'Making phone call' with 89.47%.

## DISCUSSION

The presented study demonstrates the additional value of employing new technologies such as automatic video monitoring system in clinical practice for

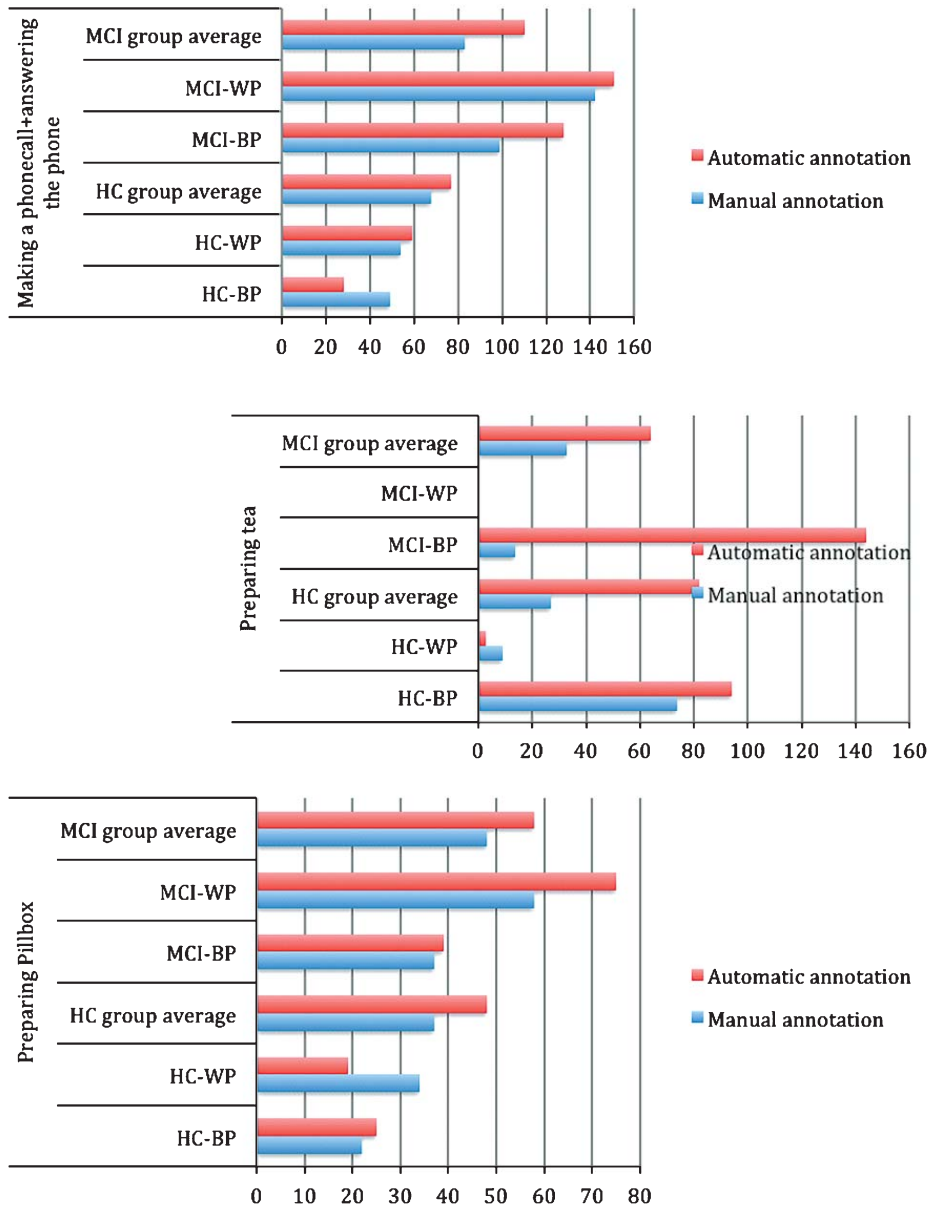


Fig. 2. The average execution times for each activity in blue annotated manually and in red detected automatically. MCI, mild cognitive impairment; WP, worst performer; BP, best performer; HC, healthy control.

412 the assessment of (I)ADL in dementia patients. The  
 413 two main goals of the study were (1) to investigate  
 414 if differences in IADL functioning can be detected  
 415 between MCI and HC and (2) to compare between  
 416 manual and automated assessments of IADL perfor-  
 417 mances in contrast to standard paper scales.

418 The obtained results demonstrate that significant  
 419 group differences between MCI and HC participants  
 420 (even with just a small sample size) can be detected

when using such techniques, and this when regular  
 assessment tools such as the IADL-E questionnaire  
 lack sensitivity to detect these group differences. A  
 detection accuracy of up to 90% for the ‘Preparing pill-  
 box’ activity has been achieved validating clearly the  
 use of AVMS for evaluation and monitoring purposes.  
 Furthermore, the correlation analyses demonstrated  
 that extracted parameters, particularly execution times  
 of activities, correlated significantly with neuropsy-

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Table 4  
Correlation between automatic video parameters, manually annotated parameters  
and conventional cognitive assessments (Spearman's correlation coefficient)

Video analyses data	MMSE	FAB	IADL-E
Spearman correlation coefficient ( <i>r</i> ) / <i>p</i> -values			
<i>Manually annotated</i>	( <i>r</i> )	( <i>r</i> )	( <i>r</i> )
Activities frequency	0.491** <i>p</i> = 0.002	0.394* <i>p</i> = 0.014	-0.035 <i>p</i> = 0.834
Activities completed correctly	0.819** <i>p</i> = 0.000	0.660** <i>p</i> = 0.000	-0.107 <i>p</i> = 0.522
<i>Automatically extracted</i>			
Activity frequency	0.415** <i>p</i> = 0.005	0.273* <i>p</i> = 0.048	-0.071 <i>p</i> = 0.337
<i>Manually annotated</i>			
Preparing Pillbox ( <i>f</i> )	0.055 <i>p</i> = 0.239	0.299 <i>p</i> = 0.063	-0.149 <i>p</i> = 0.127
Preparing Pillbox time	-0.468** <i>p</i> = 0.001	-0.114 <i>p</i> = 0.409	-0.179 <i>p</i> = 0.211
Making tea ( <i>f</i> )	0.27 <i>p</i> = 0.083	0.363* <i>p</i> = 0.042	-0.5 <i>p</i> = 0.391
Making tea time	-0.143 <i>p</i> = 0.222	0.053 <i>p</i> = 0.343	-0.002 <i>p</i> = 0.396
Phone call ( <i>f</i> )	-0.123 <i>p</i> = 0.128	-0.235 <i>p</i> = 0.084	0.002 <i>p</i> = 0.465
Phone call time	-0.280* <i>p</i> = 0.044	-0.332* <i>p</i> = 0.041	-0.145 <i>p</i> = 0.291
<i>Automatically extracted</i>			
Preparing Pillbox ( <i>f</i> )	-0.287* <i>p</i> = 0.043	-0.073 <i>p</i> = 0.295	0.125 <i>p</i> = 0.222
Preparing Pillbox time	-0.618** <i>p</i> = 0.001	-0.241 <i>p</i> = 0.340	-0.05 <i>p</i> = 0.128
Making tea ( <i>f</i> )	0.223 <i>p</i> = 0.60	0.221 <i>p</i> = 0.083	-0.264 <i>p</i> = 0.051
Making tea time	0.016 <i>p</i> = 0.392	-0.101 <i>p</i> = 0.261	-0.114 <i>p</i> = 0.197
Phone call ( <i>f</i> )	-0.248 <i>p</i> = 0.095	0.077 <i>p</i> = 0.330	0.158 <i>p</i> = 0.223
Phone call time	-0.373* <i>P</i> = 0.002	-0.277* <i>p</i> = 0.049	-0.054 <i>p</i> = 0.451

\**p* < 0.05, \*\**p* < 0.01.

Table 5  
Activity/Event detection performance

Activity	Recall	Precision
Phone call	85	89.47
Watching TV	83.33	73.77
Making tea	80.9	80
Preparing Pillbox	100	90.24
Watering Plant	75	61.22
Reading	75	91.3
Average Recognition	85.31	75.9

*n*: 38, MCI: 19 / HC: 19.

chological tests results, namely the MMSE and FAB scores.

The study's results were consistent with those previously presented in [32], where a recall of 88.30 and a precision of 71.23 were demonstrated. Although our evaluation results were obtained from different patients and from a larger cohort, small differences

were observed in precision index which is higher by ~5%, and in the recall index which is lower by 3%. These differences are a result of a trade-off between AVMS precision and recall performance due to a refinement of the event-modeling step. By opting for more strict constraints in such models, we make the system less prone to errors such as misleading evidence. For instance, instead of patients walking toward the plant to water it, they just stretch from the tea table to do so, as this table is just beside the plant.

Activities where the AVMS presented lower precision refer to at least one of two factors: participants performing the activity far from the camera and/or noise from low-level vision components of the AVMS. For example, a few patients stopped close by or inside the activity zones for long periods to read the instructions sheet, which caused false-positive detections of the zone-related activities. In addition, noisy data from

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low-level vision components sometimes shifted the estimation of the position of participants from their actual location to an activity zone close by, mostly when the participants were far from the camera. For the described problems, possible solutions include the adoption of a probabilistic framework to handle noise and event modeling uncertainty, and a multi-sensor approach for cases where the activities are mis-detected by a lack of view of the participants.

If we try to interpret the results, it is not surprising that MCI participants carried out fewer activities in general and took more time, especially for preparing the pillbox and the phone call, which was detected by the observer as well as by the automatic video analysis. Recent studies demonstrated that even in MCI patients, difficulties in the execution of complex IADL tasks, could be observed and linked to possible early impairment of executive function [8]. This is further in line with our finding of significant group differences in the studied population (see Table 2) on the FAB, a test that specifically measures levels of executive functioning.

Interestingly, the preparing tea activity took longer for HC participants and can be explained by the fact that, for the most part, they correctly completed this activity (which takes at least a minimum of 60 s), whereas MCI patients initiated this activity but did not always finish it completely. Therefore, their execution time was shorter but may serve as an indicator of poor task performance.

One major drawback of this study was that healthy control subjects were recruited through the Memory Clinic and therefore suffered in most cases from subjective memory complaints. However, according to classical assessment tools and diagnostic manual they were cognitively healthy. Thus it is debatable whether or not to classify them as healthy controls, as the MMSE and FAB mean scores for that group were relatively low. Furthermore, the study was only based on a small population size. This does not mean that the chosen parameters were not helpful indicators, and they should be validated with a larger population in the future, potentially combined with other ICT data such as actigraphy [37] or automatic speech analyses [38], given the fact that certain significant group differences could be observed.

It can be further argued that the experiment was conducted in an artificial laboratory environment and not in a complete natural setting such as a patient's home. This could have had increased the stress level of the participants and consequently an impact on their IADL performance. It is therefore desirable in the future to conduct this type of assessment in more naturalistic set-

tings, but that may also represent a less controlled environment and therefore a bigger challenge from a technical point of view. Finally, the current study placed less emphasis on multi-tasking in IADL performances, but rather focused more on the simple execution of tasks sequentially. However, in real life, multi-tasking is of great importance and represents complex cognitive processing required for functional ability.

It is important to mention that in the field of automatic video analysis, it is almost impossible to achieve 100% accuracy in the activity recognition, often caused as well by inaccurate manual annotations. The challenge is to define, for example, the beginning and the end of an activity, which represents a common problem in video analyses. Nevertheless, the activity detection by video analyses might be actually a much closer representation of the reality and the real events happening than annotations of a human observer because the latest can be influenced by various confounding factors such as fatigue, distraction, lack of concentration, etc.

The advantages of using such techniques are that the application in daily practice is easy and reproducible, and add an objective measure to the assessment of autonomy. Furthermore, this evaluation provides quicker results than manual annotations and could be even used as an outcome measure in clinical trials in order to evaluate the effect of certain treatments (pharmacological and non-pharmacological) on the functioning of IADLs of patients.

Overall, the study showed in particular that manually annotated data gives a more accurate picture of a patient's status to date, and is better validated by traditional diagnostic and neuropsychological assessment tools. This means that qualitative assessments still seem to better correlate with conventional scoring than quantitative video extracted parameters. Until now, the obtained data still needs interpretation of an experienced clinician regarding the quality of the carried out activities. It should be emphasized that this cannot be replaced by technology and is not the objective of this research.

However, in future studies, we aim for improvement in the activity detection with a larger group sample, in particular to improve the detection of the quality of activity execution, i.e., if an activity was carried out successfully and completely.

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