Welcome

Coffee Chat: Competency & Decision Making

May 10, 2017

We will begin promptly at 1:00 p.m. EDT.

Event Host
National Health Care for the Homeless Council

NATIONAL HEALTH CARE for the HOMELESS COUNCIL

Coffee Chat: Competency & Decision Making

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Health Care and Housing are Human Rights

Panelists

Laurel Lyckholm, MD

- Clinical Professor of Internal Medicine– Hematology, Oncology, and Blood and Marrow Transplantation, University of Iowa

David Rosenthal, MD

- Medical Director, Homeless PACT, VA Connecticut
- Assistant Professor, General Internal Medicine, Yale University School of Medicine

Annette Mendola, PhD

- Director of Clinical Ethics, University of Tennessee Medical Center

Overview

- Getting to know the audience
- Learning Objectives
- Case Study #1 and discussion
- Case Study #2 and discussion
- Case Study #3 and discussion
- Q&A

Audience Professional Positions

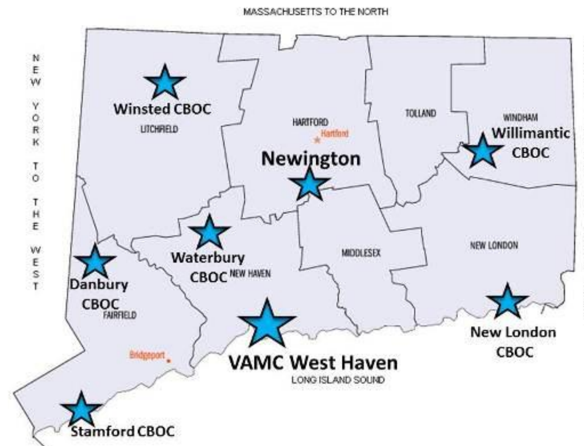
Audience Work Environment

Audience Age

Learning Objectives

- Explore differing approaches and challenges related to competency and decision-making
- Engage in discussion of about relevant case studies
- Highlight strategies and resources for responding to challenging situations

VACT's Errera Community Care Center



Case #1

- Mr. X is 61-year-old M Army veteran.
- He was a healthy furniture repairman until his 50s, avoiding doctors, living with his wife and son with special needs until about 5 years earlier when unfortunately his wife died from liver failure and then subsequently his son died of seizure. He became depressed, increased his drinking, lost his job and his housing. He became connected to VA care through the Homeless primary care and Housing resources at the VA.
- He was fearful and paranoid about all doctors, blaming them for the deaths of his wife and son.

Case #1

- Over the next three years, he slowly engaged with VA care and services, receives a small disability and chooses to live in a long term motel – was diagnosed with depression, alcohol use disorder, b12 deficiency, and progressive loss of function of his arms and legs – was diagnosed with cervical spondylotic myelopathy s/p C3-C6 laminectomies and fusion in 2015 which was unsuccessful in restoring function – now w/significant upper extremity bilateral weakness and spasticity in his lower legs, sustaining countless falls in the community.
- Throughout his illness and multiple hospitalizations related to intoxication and falls/fractures, he maintains a fierce independent streak and regularly refuses care by home agencies (VNAs, home PT/OT, SW, HHA). On multiple occasions, we are informed by VNA or veteran himself that he has fallen, but he refuses to seek medical care. He refuses most medical care and all mental health care and substance use treatment recommendations.

Discussion Questions

- Is he ever incapacitated by his illness?
- Is he competent to make these poor choices in the setting of his untreated mental illness (depression and alcohol use disorder)?
- What is our duty? Medical beneficence vs autonomy

Case #2

- Mr. P is a 61-year-old Navy veteran, no doctors until his 50s, longtime bartender, hypertension, who became connected to VA housing and primary care in 2016 when he was evicted from the small room he was renting for over 20 years after the old owner died and the new owner raised the rent.
- He was diagnosed with very high blood pressure, vit b12 deficiency, and mild cognitive impairment likely in the setting of chronic alcohol use. (MOCA 16/30, repeat with glasses 23/30, SLUMS 25/30), MRI with periventricular white matter loss and volume loss. He was extremely forgetful.
- Because he was difficult to find and often forgetful of appointments, it took over 9 months to help him move from emergency shelter to transitional housing to permanent supportive housing through the HUDVASH program.

Case #2

- After being hospitalized multiple times for Hypertensive urgency related to nonadherence to medications, concerns about his safety at home (keeping food in oven instead of refrigerator; electrical devices on top of the stovetop), he was given a diagnosis of dementia and with the help of his case managers was appointed a conservator of person and estate by the probate courts.
- He continues to live in his own apartment, continues to drink beer, and allows visiting nurses and case managers into the apartment few times a week.

Discussion Questions

- What was different about this case from case #1?
  - Diagnosis differences?
  - Case management differences?
  - Different standards?
- Thoughts/Ideas?

Will defer answers for the discussion at the end.

Case #3

- Pete is a 66 y/o gentleman who sustained multiple injuries following a motorcycle wreck, including multiple rib fx, a crushed pelvis, pulmonary contusion, and pneumothoraxes.
- He is single and a self-described "lone wolf". He is estranged from his family "I don't know where they are or if they're even alive". He has been homeless intermittently for much of his adult life
- With treatment he has good potential to survive his injuries, but this would require a long hospitalization followed by a lengthy rehab stay, and some significant deficits would remain.

- He was oriented to person, but not place or time. He was able to describe his condition fairly accurately. He was not clear on the proposed treatment, but was not receptive to hearing more about it.
- In fact, he was clear that he didn't want any treatment, even with a good chance of survival. He said he does not like doing what he is told to do, especially by doctors and nurses. He does not want to be dependent on anyone for anything.
- He had been in jail, in inpatient mental health, and in a hospital in another state after another wreck, and these experiences contributed to a deep distaste for institutions. He would prefer to die than to live if living meant dependency.

Discussion Questions

- Does Pete have decision making capacity? Why/why not?
  - If not –
    - Is he likely to regain it?
    - Can steps be taken to enhance it?
    - Who should make decisions on his behalf? Should he be treated over his objections?
- If so –
  - Should his treatment refusal be honored?

Medical Treatment: Who Decides?

- The patient, if s/he has decisional capacity

if patient lacks capacity …

- Patient-appointed surrogate
  - Appointment of Health Care Agent or Durable Power of Attorney form
  - Designation on POLST or Advance Directive
  - Other written designation

if there isn't one …

- Physician-appointed surrogate (in TN)

- Medical decision making capacity is defined as an individual's ability to understand the significant benefits, risks and alternatives to proposed health care as these relate to their values, and to make and communicate a health care decision.

- Adults are presumed to have DMC unless lack of capacity can be demonstrated (i.e. assessed and documented)

- Adolescents and children may have capacity for some decisions

Competence

- Can be all or nothing
- Can be discrete levels
- Does not change, unless changed by a Judge
- Decided by a Court

Capacity

- Evaluated in terms of a specific task: decide on surgery, refuse dialysis, etc
- Is determined at a specific time and is re-evaluated if any change
- Can vary from day to day, or within a day
- Decided by the attending physician

- Cognitive impairment is *correlated* with limited DMC, but is not the only criterion
  - Very low cognition usually = lack of capacity
  - Moderately low cognition = not so clear
  - “Orientation” tells us relatively little
  - MMSE lacks specificity/sensitivity for capacity
- Other conditions *may* impair DMC
  - Mental health diagnoses, renal conditions, high blood glucose, etc…
- However, none of these factors *automatically* incapacitates the patient to make medical decisions

- 1. the ability to **C**ommunicate
  - Communication may be written, verbal, or make use of another method, but must be clear
  - May need to be facilitated by translators, paper and pencil, etc.

- 2. the ability to **U**nderstand relevant information
  - Medical condition
  - Proposed treatment
    - Alternatives
    - Possibility of refusing treatment
  - Likely outcomes of accepting or rejecting proposed treatment

4 Abilities for DMC: CU**R**A

- 3. the ability to use **R**eason (i.e. "means-end" reasoning) to process information
  - Does the treatment choice map on to the patient's stated goals?
  - Is it consistent with her or his preferences, given the circumstances?

- 4. the ability to **A**ppreciate the situation
  - Possession of a set of values, goals, preferences
  - Implications of the choice for her/his life in terms of values, goals, preferences

- Patients who have been assessed as lacking capacity may regain capacity
- May have capacity for some decisions and not others
- Caregivers should remain alert for changes in the patient that could affect decision making capacity, and should reassess when additional decisions need to be made

Role of Providers

- You are the advocate for your patients
- Ask yourself:
  - What is the person's current and projected decision-making capacity (DMC)?
  - Is there a legally designated surrogate?
    - If not, who might be an appropriate surrogate?
  - Is there an Advance Directive of any kind available?

Deciding for Others

- Substituted Judgment
  - Use of ACP and previously-stated wishes
  - “What would she say if she could talk to us now?”
- Best Interests
  - consideration of the patient's dignity
  - the possibility and extent of preserving the patient's life
  - the preservation, improvement or restoration of the patient's health or functioning
  - the relief of the patient's suffering
  - any concerns and values the patient would consider

Questions & Answers

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Thank you for your participation.

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