Capacity is a term used in healthcare to refer to a person's abilities to make a specific decision or perform a specific task. Assessment of clinical capacity refers to a professional judgment made by a clinician about a person's decision-making abilities. This handout presents foundational information relevant for the ***VA EES Assessment of Decision Making Capacity Handout Series.***

Capacity 101

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1 Legal versus Clinical Determinations.

Clinicians may be asked to provide an opinion to another clinician, or for legal procedures such as a guardianship hearing, about a person's abilities to make a specific decision or perform a specific task. Clinical determinations differ from those made in a legal setting in which a judge or other legal professional may determine a person's "legal capacity" which means their legal right to make a decision. Today, the term capacity is used in clinical settings as well as legal settings, but the implications of the determinations differ, in that a clinician's statement about capacity does not alter a person's legal status, while a judicial finding about capacity does. The clinical opinion, while important, does not carry legal weight.

For example, *even if a clinician determines a person does not have the ability to make a financial decision the person still retains the legal right to make that decision until or unless a judge finds the person to lack financial capacity and assigns that legal authority to another person such as a conservator.*

2 Decision-Specific and Task-Specific.

Historically clinicians used the concept of "is this person competent" to describe a general or global quality of an individual, which then was assumed to apply to the person's abilities to make all decisions and do all tasks. Now, clinicians focus their assessments of capacity by asking "capacity for what – where – and when." That is, capacity is situation-specific and task-specific. Evaluations should be focused on the specific task or decision within the context it is made.

For example, *a person may have difficulty making a complex decision with higher risks and consequences such as undergoing surgery yet may be able to make basic decisions such as determining who he or she would like to serve as his or her health care agent through a health care proxy.*

3 Presumption of Capacity and Equal Recognition under the Law.

By law, adults are presumed to have decision-making capacity. Unfortunately, in the past, this presumption was violated when individuals with certain diagnoses or disabilities such as developmental disabilities were presumed to lack capacity. For example, in the past both clinicians and judges may have presumed that just because a person has schizophrenia, cerebral palsy, or a developmental disability, that he or she lacks the capacity in all arenas such as the right to make decisions about marriage, voting, and reproductive health.

For example, *a person should not be presumed or found to lack legal capacity simply on the basis of a diagnosis (e.g., serious mental illness or dementia) or status (e.g., female).*

4

Temporary and Reversible.

While a diagnosis and prognosis do not equate to a level of capacity, they are important to consider because they may affect capacity temporarily. Some diagnoses may result in a reversible loss of capacity, such as delirium.

For example, *a person may have difficulty making a decision after a surgery due to delirium but later be able to make that decision after the delirium is no longer present.*

5

Capacity is different from going Against Medical Advice.

Clinicians may be asked to evaluate capacity when a person "goes against medical advice" or wishes to be "discharged against medical advice." Deciding not to follow medical advice does not necessarily mean a person lacks capacity, but may simply indicate that the person disagrees with the medical advice.

For example, *a person who removes IV lines and walks off a unit to go home may be frustrated, agitated, in pain, or delirious. These actions should not be equated with lacking capacity, which needs to be determined separately.*

6

Capacity is different from Involuntary Commitment.

An individual may be committed to psychiatric treatment because he or she is in imminent danger of hurting himself/herself or others. Legal standards that permit involuntary civil commitment should not be confused with capacity. Commitment laws derive from the state's policy power – to protect society, whereas capacity laws derive from the state's parent obligations – to protect the vulnerable.

For example, *A person who is involuntarily committed due to an intentional overdose and suicide attempt should not be presumed to lack legal capacity.*

7

Support and Enhance Capacity.

It is critical to start and end by asking: "What can be done to enhance this person's abilities?" Support the Veteran's decision-making and functioning by:

- being aware of and adapting to the Veteran's health literacy level,
- considering language and culture,
- adjusting for sensory deficits,
- addressing anxiety or other issues that may make understanding or coping hard, and
- providing access to a wide range of services that may support independent living, driving, financial, and other everyday skills.

For example, *providing medical information in large print, in short, easy to understand bulleted points, providing a picture, involving a loved one, giving a person time to reflect may all enhance understanding of diagnostic and treatment related information.*

8

Focus on Function, not on Outcome.

Sometimes people make decisions that we think are "bad" for them, such as continuing to eat sweets when they have diabetes or continuing to abuse drugs when they have drug addiction. These decisions may lead to bad outcomes for the person from our perspective, but do not mean the person lacks capacity. Instead of thinking about whether the outcome is "good" or "bad" think about if the person has the ability to do the task or decision in question, such as:

- Do they understand and appreciate the information, and
- Can they weigh their decision in light of their own values?

For example, *a person who has many health and personal problems related to drug abuse who chooses to continue drug abuse should not be presumed to lack capacity.*

9

Discuss Values.

Begin your discussions with an exploration of values. Why is the decision or task important to the person? What similar decisions have they made in the past? What makes life meaningful? Who do they want to be involved and not involved in the decision? Also, be aware of your own values. While consistency with values does not equal capacity (e.g., "I want to give this email scammer all my money because he is so nice to me"), it can set the stage for understanding a person's reasoning.

For example, *a person who has exhibited hoarding behavior, and has a very long history of doing so, may value collections and this alone does not mean they lack the capacity to live independently.*

10

Guardianship only as a Last Resort.

Guardianship may be necessary if a person has been abused or exploited and needs protection. However, guardianship should be considered only after other options have been exhausted, including supports and other avenues for decisional support such as advance directives and durable powers of attorney. Also, guardianship, once in place, should be removed if the person regains abilities.

For example, *a person who lacks the ability to manage his or her finances may be able to appoint a durable power of attorney for finances to direct another person to manage his or her finances going forward.*

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Links to free clinical resources may be included in the handout but should not be construed as official endorsement of these tools.

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Additional Resources at: https://www.vapulse.net/groups/assessment-of-decision-making-capacity

References:

1. Ganzini L, Volicer L, Nelson WA, Fox E, Derse AR. Ten myths about decision-making capacity. *J Am Med Dir Assoc.* 2004; 5(4):263-7.

When medical decisions need to be made for a Veteran who lacks capacity to make these decisions, a surrogate must be located. An "unbefriended" Veteran is one who lacks decision-making capacity, lacks advance directives, and has no family or friends available to serve as a surrogate decision maker.[1] With the exception of medical emergencies, legal guardianship for medical decision-making must be sought in these cases.
A related term is "adult orphan" or "elder orphan" which refers to an adult who retains capacity but lacks advance directives and surrogates.[2]

Incapacitated, Socially Isolated Veterans In Need of Surrogates ("Unbefriended")

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Real Life Examples

- *A Veteran has had a stroke which impairs his communication abilities. He has no Next of Kin or emergency contacts listed. He is determined to lack medical decision-making capacity and a surrogate is needed to authorize his admission to a rehabilitation unit.*
- *A homeless Veteran presents with an infection that will require an amputation. He is determined to lack medical decision-making capacity. His friend is unwilling to serve as surrogate and the Veteran is estranged from family.*

What VA Policies may apply?

VA Clinicians must follow VA laws, regulations and policies, in addition to clinical practices, when treating Veterans and sharing Veteran health information. The VA follows a default surrogate consent policy: if a health care agent has not been named, surrogates are sought in the following priority order from the
VHA Handbook 1004.01 on Informed Consent:

a. Health Care Agent.
b. Legal guardian or special guardian.
c. Next-of-kin. The next-of-kin is a relative, 18 years of age or older, in the following order of priority: spouse; child; parent; sibling; grandparent; grandchild.
d. Close friend.

The Handbook further states, "Each facility must have a procedure in place for identifying surrogates, including, if necessary, examining personal effects, health records, and other VA records such as benefits and pension records. If a surrogate is identified, an attempt to contact that person by telephone must be made within 24 hours of the determination that the patient lacks decision-making capacity."

- Check with your local VA for specific policies that may apply.
- Consult with your medical center's ethics committee, colleagues at your institution, or the VA Privacy Officer or District Counsel to ensure any state-specific or local procedures are followed.

How do I understand this person's values and preferences?

This may be especially challenging if the Veteran's ability to communicate is impaired. Ideally, get as much information as you can directly from the Veteran. If the Veteran is unable to communicate, use the following questions and suggestions to guide your search for information about the Veteran[3]

Biography	What is the Veteran's general history of education, occupation, relationships, and interests? What is the Veteran's history of physical and mental health? If unable to interview the Veteran, review the medical record or speak with others who have known the person. Why was this Veteran socially isolated? What led up to the current medical issue?
Social Support	Did the Veteran ever marry, have a romantic partner, or have children? Does the Veteran have siblings or extended family? Was the Veteran in touch with neighbors, a landlord, coworkers, or acquaintances? Did the Veteran attend religious services? Did the Veteran have a "chosen family" or non-traditional family? Any of these people could potentially serve as a surrogate or provide information about the Veteran's wishes.
Past Healthcare Decisions	What medical decisions have previously been made by the Veteran? Has the Veteran refused treatment in the past? Previous notes may indicate preferences for certain treatments or approaches.
Community Connections	Take a team-based, interdisciplinary approach – enlist the support of other professionals whenever possible. Obtain records from other hospitals or medical facilities where the Veteran received treatment.

What can I do to help?

- Enhance capacity and communication
  - Ensure the Veteran is comfortable and address any sensory deficits.
  - Provide information in simple language and in multiple formats.
- Assess relevant capacity domains
  - Guardianship should be limited to only those domains for which the Veteran lacks capacity.
  - See handouts on capacity assessment at **https://www.vapulse.net/groups/capacity-dementia- working-group**
- Respect the Veteran's values and wishes
  - Consider the Veteran's wishes even if they are deemed to lack capacity.
- Take a team-based approach
  - Enlist the assistance of colleagues and relevant groups (such as your medical center's ethics committee) since team consensus is preferred over individual decision-making to provide procedural fairness.[1,5]

What can I do to help?

- Enlist a surrogate
  - Consider non-traditional surrogates who know the Veteran well and will be available over the long term.
  - Refer to your local public guardianship program.
  - When a surrogate has been assigned, communicate your understanding of the Veteran's wishes, values, and history.

How can I prevent these situations?

- Promote advance directive completion among Veterans at risk for becoming unbefriended.
- Identify which Veterans are socially isolated and refer to appropriate VA or community programs to reduce social isolation (e.g. therapy groups, senior centers, volunteer organizations, etc.)
- Discuss healthcare values and wishes with all Veterans.
  Check out The Conversation Project at **http://theconversationproject.org/** for more ideas.

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Additional Resources at: **https://www.vapulse.net/groups/assessment-of-decision-making-capacity**

References:

1. Farrell T, Widera E, Rosenberg L, Rubin CD, Naik AD, Braun U, Torke A, Li I, Vitale C, Shega J. Ethics, Clinical Practice and Models of Care, and Public Policy Committees of the American Geriatrics Society. AGS Position Statement: Making Medical Treatment Decisions for Unbefriended Older Adults. Journal of the Am Geriatr Soc. 2016 Nov 22; doi: 10.1111/jgs.14586. PMID:27874181.
2. Carney MT, Fujiwara J, Emmert Jr. BE, Liberman TA, Paris B. Elder Orphans Hiding in Plain Sight: A Growing Vulnerable Population. Current Gerontology and Geriatrics Research. 2016; 2016: 1-11. Doi:10.1155/2016/4723250
3. Moye J, Catlin C, Kwak J, Wood E, Teaster PB. Ethical Concerns and Procedural Pathways for Patients who are Incapacitated and Alone: Implications from a Qualitative Study for Advancing Ethical Practice. Healthcare Ethics Forum. 2017;29(2): 171–189.
4. Pope TM. Facebook can improve surrogate decision making. The American Journal of Bioethics. 2012;12(10): 43-45.
5. Weiss BD, Berman EA, Howe CL, Fleming RB. Medical decision-making for older adults without family. Journal of the American Geriatrics Society. 2012;60(11): 2144-2150.

Medical consent is required prior to patients undergoing invasive procedures or treatments that carry significant risk of adverse outcomes. Medical consent requires that decisions are informed, voluntary, and made by individuals who have capacity.
Most clinical and legal models of medical consent capacity focus on four abilities.[1]

Capacity to Consent to Medical Treatment

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DEFINITIONS[1]

Ability	The person should be able to:
Understanding	Comprehend information about the disorder and treatment(s).
Appreciation	Determine the significance of the treatment and the option of no treatment, focusing on the nature of the diagnosis and the possibility that treatment would be beneficial or harmful.
Reasoning or Formulating	Compare treatment alternatives in light of consequences, drawing inferences about impact of alternatives on everyday functioning and quality of life.
Communicating a Choice	Communicate a decision, applying to those who are unable to express a reasonably consistent choice.

What VA policies may apply?

VA clinicians must follow VA laws, regulations and policies, in addition to clinical practices, when treating Veterans and sharing Veteran health information. The VA Informed Consent Policy identifies four major components to decision-making capacity: understanding, appreciating, formulating, and communicating.
https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2055

How might dementia affect the capacity to consent to treatment?

Most older adults do not have dementia, and the presence of dementia does not necessarily mean that an older adult lacks capacity for domains such as consent to treatment, choosing a healthcare agent, or other types of decisions. The Dementia Steering Committee recommends that clinicians consider assessing decision-making capacity for adults with dementia during care transitions and/or when obtaining consent for treatment or procedures. Similar to other types of capacity assessments, assessment of capacity to consent to treatment focuses on the individual's abilities and not his or her diagnosis. Broadly speaking, individuals with moderate to severe dementia may have difficulty making complex or high risk decisions with high memory or reasoning demands (e.g., multiple alternatives or outcomes to weigh).

What supports can help?

Considering the Veteran's values and cultural background, ask how much information they wish to know. When disclosing information about the diagnosis, treatments, and option of no treatments, use clear language understandable to the individual. Provide supports as necessary to accommodate for any sensory deficits (e.g., drawings, pocket talkers, magnifying glass). Also consider the Veteran's language, preferred mode of communication (written, verbal, and/or visual), and the individual's health literacy level.

What values might be important to patients who are weighing options for medical treatment?

For patient-centered care it is important to understand the values that influence their reasoning. Potential values domains include[2]:

Value	How evaluated
Self-sufficiency	Having or desiring the capacity to take care of oneself and not depend on others; functioning in one's daily life; "I don't want to be a burden"
Life Enjoyment	Maintaining or desiring a meaningful sense of physical, emotional, and spiritual health; activities associated with enjoyment of one's life
Connectedness and Legacy	Feelings regarding the importance (or lack thereof) of social or spiritual relationships in one's life; conveying how one wants to be understood or remembered by the important people in one's life
Balancing Quality and Length of Life	Weighing one's desire for quality of life with prolonging length of life when evaluating treatment preferences and goals
Engagement in Care	How much the person wishes to engage in care (information wanted, intensity/frequency) and how much the person wants others (clinicians and his/her family and friends) to be involved in care

How do I ask about capacity to consent to medical treatment?[3]

Helpful questions to assess each of the four abilities required for medical consent may include:

Understanding	Tell me in your own words what your understanding is of your condition. What are the risks and benefits of each treatment? How likely are the benefits and risks to occur?
Appreciation	What do you believe is wrong with your health? Do you believe that you need some kind of treatment? What is the treatment likely to do for you? What treatments does your provider recommend? What do you believe will happen if you are not treated?
Reasoning or Formulating	Tell me your thoughts about whether to accept or reject the treatment? Which factors were important to you in weighing different treatment options? Why did some alternatives seem better or worse than others?
Communicating a Choice	Have you decided whether to go along with your provider's recommendation? Can you tell me what your decision is?

Tools and Tips

There have been many tools developed to support the clinician's determination of capacity to consent to medical treatment.
These include:

Aid to Capacity Evaluation	7 item semi-structured interview matching standards in Canada	Download at: **http://jcb.utoronto.ca/tools/documents/ace.pdf**
Assessment of the Capacity to Consent to Treatment	Part 1 assesses values; Part 2 assesses 4 consent standards in light of values	Download at: **https://heartbrain.hms.harvard.edu/acct**

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Additional Resources at: **https://www.vapulse.net/groups/assessment-of-decision-making-capacity**

References:

1. Appelbaum PS, Grisso T. Assessing patients' capacities to consent to treatment. *New England Journal of Medicine*. 1988;319:1635-1638.

2. Naik AD, Martin LA, Moye J, Karel MJ. Health Values and Treatment Goals of Older, Multimorbid Adults Facing Life-Threatening Illness. *J Am Geriatr Soc*. Mar 2016;64(3):625-631.

3. The American Bar Association and the American Psychological Association. Assessment of older adults with diminished capacity: A handbook for psychologists. Washington DC: ABA and APA; 2008.

The capacity to execute a health care proxy (HCP) is a specific type of decision-making capacity. Because decision-making capacity is always task- and decision- specific, the capacity to appoint a healthcare agent is different from the capacity to consent to treatment. A person may retain the ability to execute a HCP even if they do not have the capacity to consent to treatment.

Capacity to Appoint a Health Care Agent

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Real Life Examples

- Can this Veteran with moderate dementia, whose decisional abilities are so impaired he cannot make a medical decision, change his HCP to appoint a different agent?
- Can this Veteran with confusion following a TBI who now needs a medical decision – and has no family or close friends to serve as default surrogate – now execute a HCP to avoid guardianship?

DEFINITIONS

Health Care Proxy (HCP)	A type of advance directive in which an individual (1) appoints another person to make health care decisions on the individual's behalf, and may also (2) instruct that person about preferences for future treatments. A HCP is the same as Durable Power of Attorney for Health Care.
Health Care Agent	The person named in the HCP to make medical decisions on one's behalf if needed. In practice clinicians may call the agent the proxy – although here when we say Health Care Proxy we mean the legal document.
Living Will	The instructional component of the HCP in which the patient says what he or she would want in certain circumstances. In this fact sheet we will address the capacity to appoint a health care agent via a HCP; we will not address the capacity to instruct others in future hypothetical medical decisions which has more in common with the capacity to make a medical decision.

What VA Policies may apply?

VA clinicians must follow VA laws, regulations and policies, in addition to clinical practices, when treating Veterans and sharing Veteran health information.
The following may be relevant.

- VHA Handbook 1004.02: Advance Care Planning and Management of Advance Directives **www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2967**
- VHA Handbook 1003.01: Informed Consent for Clinical Treatments and Procedures **www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2055**
- VA Form 10-0137 is used by patients to document treatment preferences for both medical and mental health care. **https://www.va.gov/vaforms/medical/pdf/vha-10-0137-fill.pdf**

How might dementia affect the capacity to appoint a Health Care Agent?

Most older adults do not have dementia, and the presence of dementia does not necessarily mean that an older adult lacks capacity for domains such as consent to treatment or choosing a health care agent. Similar to other types of capacity assessments, assessment of capacity to appoint a health care agent should focus on the individual's abilities and not his or her diagnosis. Most veterans with mild to moderate dementia can express their preferences for a health care agent. Further, even if an individual lacks capacity, their assent or approval should be sought in an effort to promote their involvement and consideration of their preferences.

What supports can help?

When disclosing the purpose of the HCP, use clear language that the Veteran, family and caregivers can understand easily. Provide supports as necessary to accommodate for any sensory deficits (e.g., drawings, pocket talkers, magnifying glass). Also consider the Veteran's language, preferred mode of communication (written, verbal, and/or visual). Finally, as the HCP can have a good deal of complex language, consider the Veteran's health literacy level, explaining carefully the information written in the document.

What values might be important to patients who are completing a HCP?

An individual's values and cultural background may influence their comfort with completing a HCP. Some individuals may be reluctant to complete a HCP because of previous negative experiences with health care. Some individuals may be isolated and may not have family or friends to appoint. In such situations it is critical to help the person think through whether there might be someone to appoint, and to document their health care values.

How do I ask about capacity to execute a HCP?

Because the HCP is a signed legal document, some courts have focused on the concept of "contractual capacity": e.g., possessing sufficient ability to understand the nature, extent, character, and effect of the particular transaction. In contrast, some statutes use vague standards: e.g., being of sound mind and under no constraint or undue influence. Keeping in mind the concepts of understanding a document and avoiding constraint and undue influence, it may be useful to focus upon the following abilities.

Understanding and Appreciation	**What it means to:** • Give authority to another to make health care decisions, • Through the HCP legal instrument, • In the event of diminished capacity to consent to treatment
Reasoning and Communication	**Ability to communicate and explain:** • A consistent choice of a health care agent, • Who is "appropriate" by virtue of relationship and knowledge

Tools and Tips

As with any decision-making ability, the clinician should start with a presumption of capacity. Furthermore, because HCP are not completed as often as is desired – we wish to encourage completion of HCP, and not create barriers. Therefore, consideration of whether a person has the capacity to execute a Health Care Proxy is likely only to occur when there is evidence of diminished decision-making abilities in other areas. Generally, an evaluation of capacity to execute a HCP can be embedded in the usual clinical conversation, by asking questions as the clinician explains the document. Below is a set of more formal questions that may be useful when needed.

Possible questions to check the Veteran's understanding and preferences:

1. What is a Health Care Proxy / Advance Directive?
2. What is a good thing about having an Advance Directive?
3. What does a Health Care Agent or Proxy do for you?
4. What persons would you consider to be your agent?
5. Who would you choose as your agent?
6. Why would you trust this person?
7. What happens if your illness gets worse and you are unable to speak for yourself?

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References:

1. Moye J, Sabatino CP, Brendel RW. Evaluation of the Capacity to Appoint a Health Care Proxy. *American Journal of Geriatric Psychiatry*. 2013; 21(4): 326-336. PMID: 23498379

Capacity to live independently concerns whether an individual can live at a residence of his or her choosing in the context of relevant environmental, medical, functional, psychiatric, and cognitive factors. Not only does an evaluation of capacity to live independently consider decision-making capacity, but also functional status, as these assessments should include activities of daily living (ADL) and instrumental activities of daily living (IADL). Determining which functional domain is most relevant to the ability to live independently is critical, and may be difficult for the clinician to discern. Often, the issue of capacity arises from safety concerns.

Assessment of the Capacity to Live Independently

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Real Life Examples

- *Prepping for discharge after a stroke, a Veteran wants to return home, where he lives alone and refuses home services. The clinical team questions whether the Veteran can decide to return home alone given his new cognitive deficits.*
- *A Home-Based Primary Care team sees signs of significant personal neglect and the Veteran is not accepting services. The team wonders if a higher level of care is needed and how to approach it if the Veteran refuses.*
- *An outpatient healthcare team worries that a Veteran can no longer live at home and is not sure what supportive services to consider.*

What VA policies may apply?

VA clinicians must follow VA laws, regulations and policies, in addition to clinical practices, when treating Veterans and sharing Veteran health information.

The following polices may be relevant.

- **VHA Handbook 1004.01:** Informed Consent for Clinical Treatments and Procedures
- **VHA Directive 1411**: Home-Based Primary Care Special Population
  Patient Aligned Care Team Program

How might dementia affect Independent Living Capacity?

Most older adults do not have dementia, and the presence of dementia does not necessarily mean that an older adult lacks capacity for domains such as consent to home care services, choosing a healthcare agent, or other types of decisions. Similar to other types of capacity assessments, assessment of capacity to live independently should focus on the individual's abilities and not his or her diagnosis. The capacity to live independently when an individual has dementia depends in large part on the level of caregiver involvement, support services available, the individual's insight into functional status and social situation, and willingness to accept services.

What supports can help?

Approach any evaluation of independent living with a default notion to support the Veteran with resources needed to optimize as much independence as possible. In the majority of situations, when Veterans need more support at home, these can be provided allowing the individual to "age in place." The array of potential supportive services is nearly endless – and varies in availability and whether provided by the VA or a community provider, and may include: home health services, homemaker services, Meals on Wheels, adult day care, technology (e.g., medical alert systems, medication management systems, home telehealth, home-based primary care). Individuals have the right to refuse these services. It is also important to increase these types of supports with changes in illness, functional abilities, and social context. Finally, in some situations the living environment may remain dangerous or unsuitable – in these situations an appropriate intervention may help a person identify a living environment that better meets his or her needs and goals, while respecting his or her values.

How do I assess Independent Living Capacity?

An evaluation of independent living capacity (ILC) can be organized to center on three core aspects:

Understanding *(knowledge of tasks and responsibilities related to living at their desired level)*

Application *(demonstration of ability to perform a task or direct another to perform the task)*

Judgment *(makes adequate and sufficient decisions regarding independent living)*[1]

Functional Element	Sample Questions / Considerations
Understanding	What bills do (would) you have in that setting? What is the usual amount for [service]? How would you pay? What tasks would you need help with at home? What problem may you encounter at home considering [issues that may affect safe independent living]?
Application	Can the Veteran demonstrate relevant ADLs and IADLs as assessed by an occupational therapist or another professional? Can the Veteran problem solve around any limitations to maintain their independence? Are problems with tasks so significant that they are affecting the individual's ability to provide for their essential needs (e.g., food, shelter)?
Judgment	Is there a cognitive or psychiatric condition that significantly interferes with their decision-making ability as it pertains to living at their desired level? Does the Veteran make adequate decisions to ensure immediate safety? Is there insight into significant problems and willingness to accept consequences if help is not accepted?

Additional evaluation considerations: level of risk to the individual (and the community)/ vulnerability, including the seriousness, likelihood, and desirability of the risks involved with the potential living options.

What values are important to consider?

Remaining within the house or apartment that feels like "home" can be extremely important to an individual. In addition, individuals vary a great deal in what they might consider an acceptable living situation. Therefore, it is critical to really try to understand the values that underlie the Veteran's preferences for specific living arrangements.

Some things to consider are:

- What makes a home a home – what is most important about where you live?
- What personal activities are important for you to do at home?
- Do you prefer to live alone or with people? Do you prefer visitors or to be left alone?
- What works well about this house or apartment for you now?
- If you needed help at home, who would you like to have help you? Who do you not want to help you?
- Have you ever thought of moving to senior housing or assisted living? What seems good or bad about that option?

Tools and Tips

- Evaluating independent living capacity may feel overwhelming as it may involve many specific functions – start by identifying the core concern
- As you evaluate independent living capacity, it is natural that other capacities may be questioned – such as medical decision making or financial decision making (handouts for these topics are available at https://www.vapulse.net/groups/assessment-of-decision-making-capacity)
- Like other capacities, an ability to live independently can fluctuate depending on the context and the Veteran's unique issues (environmental, medical, psychiatric, cognitive, and functional abilities)
- Work as part of a team as much as possible
- When evaluating independent living capacity it is critical to focus on function, going beyond cognitive abilities. To do so consider using evaluations by occupational and physical therapies, direct observation in the living setting, and functional assessment tools such as those that assess activities of daily living (ADL) and instrumental activities of daily living (IADL) .
- "Support before you subtract," meaning look for places to add supports and be familiar with resources in your area to promote safe independent community living.
- Be familiar with state statutes on guardianship and conservatorship in your area.

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Additional Resources at: https://www.vapulse.net/groups/assessment-of-decision-making-capacity

References:

1. The American Bar Association and the American Psychological Association. Assessment of older adults with diminished capacity: A handbook for psychologists. Washington DC: ABA and APA; 2008.

*"**Everyday capacity**" refers to decisions about specific daily activities and most often arise in residential treatment settings. Sometimes a residence is considered both a home and a medical treatment setting – such as Community Living Centers or Home-Based Primary Care. In these settings, clinicians are challenged to balance Veteran autonomy and safety. Care providers may need to determine whether a Veteran has the capacity to make what they perceive as a "bad" decision. When our capacity is intact, we all have the right to make decisions – even if they are poor ones. However, there is little guidance for how to make determinations of capacity around these **"everyday"** decisions.*

Everyday Capacity Challenges in Community Living Centers and Home-Based Primary Care

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Real Life Examples

- *Should this Veteran be permitted to go to the store unsupervised/alone?*
- *Can I allow him to skip dinner every night, but have several cookies from the pantry?*
- *Should I let this Veteran stay in bed all day when I think he should be up?*
- *Can this Veteran consent to switching to Tylenol for his pain management?*

What VA Policies may apply?

VA clinicians must follow VA laws, regulations and policies, in addition to clinical practices, when treating Veterans and sharing Veteran health information.

- **VHA Handbook 1004.01**: Informed Consent for Clinical Treatments and Procedures
- **VHA Handbook 1142.01**: Criteria and Standards for VA Community Living Centers
- **VHA Directive 1149**: Criteria for Authorized Absence, Passes, and Campus Privileges for Residents in Community Living Centers
- **VHA Directive 1411**: Home-Based Primary Care Special Population Patient Aligned Care Team Program

How might dementia affect everyday capacity?

Most older adults do not have dementia, and the presence of dementia does not necessarily mean that an older adult lacks capacity for domains such as consent to treatment, choice of daily activities, or other types of decisions. Similar to other types of capacity assessments, assessment of capacity for everyday decisions should focus on the individual's abilities and not his or her diagnosis. In this handout we discuss a range of "everyday" decisions, which, although relatively simple, may have a major impact on an individual's quality of life. Most Veterans with dementia can express preferences for these everyday matters. Further, even if a Veteran lacks capacity, their assent or approval should be sought in an effort to promote their involvement and consideration of their preferences.

What supports can help?

Support in these situations may include assistive support to the Veteran or changes in the environment to improve his/her functioning, as well as support to the staff. For Veterans, provide supports as necessary to accommodate for any sensory deficits (e.g., drawings, Pocket Talkers, magnifying glass). Also consider the Veteran's language and preferred mode of communication (written, verbal, and/or visual), and health literacy. For staff, education and training about autonomy, liability, and "culture change" may help to clarify roles and responsibilities.

What values are important to consider?

Decision-making capacity and cognitive ability are related, but even a diagnosis of dementia or a serious mental illness does not preclude a Veteran from making decisions. Capacity is specific to the decision at hand and can change over time, so a single assessment is not final. For Veterans who are communicative, but lack decision-making capacity, create opportunities for them to express preferences and honor those preferences to the extent possible. The care plan is a road map of the plan to meet the physical, spiritual, and psychosocial needs of the Veteran. Care planning should involve the Veteran to the fullest extent possible or should involve the surrogate decision-maker. If the Veteran has significant impairment, look to their past preferences/values.

How do I assess everyday capacity?

This handout focuses on "everyday" decisions – meaning they are inherently lower risk – and often concern activities not significant medical decisions. If the Veteran is facing higher risk decisions or issues of consent, please refer to other resources found here:

https://www.vapulse.net/groups/assessment-of-decision-making-capacity .

Consider several factors when determining a Veteran's capacity to make everyday decisions. Whether or not a Veteran has decision-making capacity, it may be useful to engage family and surrogates for additional input.

Level of Risk	What is the level of risk involved with the decision at hand? If the Veteran was allowed to do the action, what danger could ensue? Would there be immediate harm? Could others be harmed by the proposed action?
Level of Complexity	How complex is the task (physically, cognitively)? Is the Veteran able to handle parts of the task with assistance?
Cognitive Health	What is the current level of cognitive functioning? Good days versus bad days? What are the Veteran's strengths and weaknesses?
Psychological State	Are there behavioral and/or emotional barriers to safe participation in the desired activity? Concerns about undue influence? Stability?
Enhance Capacity	Are there ways we can modify the environment or the task to allow the Veteran to participate to some extent? Ways to engage surrogates?

Suggestions for Core Questions	Additional Questions
• What good things could come from doing _____? • What bad things could come from doing _____? • Given [bad things], what makes this an important activity for you? • Would you be willing to compromise with me?	• Do you have any concerns about doing _____? • What concerns may your [doctor, family, etc.] have if you did _____? • Do you trust your [doctor, family, etc.] recommendation?

Tools and Tips

- Be sure to document your thought process about specific everyday capacity in the medical record.
- Consult with psychologist, psychiatrist, or other provider as needed to help with determining capacity.
- Consult your ethics committee if there is disagreement in assessments for a complex case.
- If the Veteran is not medically stable, hold off on making a capacity determination if possible.
- In CLCs, talk to frontline staff across shifts about the resident's functioning to obtain a complete picture.
- In HBPC, talk with your team about their observations during visits and encourage active awareness of concerns about everyday decision-making.
- Link: **VA Mental Health in Community Living Centers SharePoint for capacity evaluations**
- Lai JM, Karlawish J. Assessing the capacity to make everyday decisions: A guide for clinicians and an agenda for future research. *American Journal of Geriatric Psychiatry*. 2008;15: 101-111. doi: **10.1097/01.JGP.0000239246.10056.2e**

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Additional Resources at: https://www.vapulse.net/groups/assessment-of-decision-making-capacity

*The terms **financial capacity**, **financial exploitation**, and **undue influence** all relate to financial management. Veterans may be targeted for financial exploitation because of disability payments. At first glance, financial capacity may seem unrelated to healthcare. However, concern regarding a Veteran's finances becomes relevant if funds are being directed away from the Veteran's care without the Veterans' consent, if the Veteran raises a concern to the clinician, or if the clinician observes financial abuse or exploitation which requires reporting under state laws.*

Financial Capacity, Financial Exploitation, and Undue Influence

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DEFINITIONS[1]

Financial Capacity	Broadly refers to the knowledge, skill, and judgment related to managing one's assets.
Financial Exploitation	A type of elder abuse, involving the improper use or theft of another's assets. The individual may or may not have capacity.
Undue Influence	When exploiters – whether family, acquaintances, or strangers – use their power to deceptively gain control over the decision-making of a victim. Often involves financial exploitation. The individual may or may not have capacity.

What VA Policies may apply?

VA clinicians must follow VA laws, regulations and policies, in addition to clinical practices, when treating Veterans and sharing Veteran health information. At the national level, the Veterans Benefits Administration defines a person who lacks financial capacity in the context of need for VA fiduciary as a "person is one who because of injury or disease lacks the mental capacity to contract or to manage his or her own affairs, including disbursement of funds without limitation." (38 CFR 3.353)

How might dementia affect financial capacity and financial exploitation?

Most older adults do not have dementia, and the presence of dementia does not necessarily mean that an older adult lacks capacity for domains such as consent to treatment, choosing a health care agent, or other types of decisions. Similar to other types of capacity assessments, assessment of financial capacity should focus on the individual's abilities and not his or her diagnosis. Very broadly, individuals with mild to moderate dementia likely retain many financial skills, but consideration should be given to the complexity and level of risk involved. Older adults with dementia may be at risk in discerning financial scams when subtle social judgement is necessary in novel situations, particularly if the individual has limited social support.

What supports can help?

Provide supports as necessary to accommodate for any sensory deficits (e.g., drawings, pocket talkers, magnifying glass). Also consider the Veteran's language and preferred mode of communication (written, verbal, and/or visual). Supportive services for finances include: shared bank accounts with a trustworthy person, automatic bill paying and deposits, money management services (e.g., through the Area Agency on Aging), a durable power of attorney for finances, and creation of a trust.

What values are important in considering financial issues with Veterans?

Just as in any capacity assessment, it is important to understand the individual's values that underlie their choices so that the assessment considers consistency with the individual's (and not the clinician's!) values.[1]

General History	What is the Veteran's general history of savings, debt, and investment? Are current patterns consistent with the past? Comparing the current financial picture to the previous can be informative.
Preferences	What is the Veteran's preference for spending versus savings; targets for donations and support (e.g., children, charities); how much risk is comfortable? Financial preferences vary greatly among individuals.
Experiences of Exploitation	Has the Veteran had problems with financial vulnerability in the past? Sometimes a direct question about previous outcomes can be revealing.
Engagement in Management	In the past has the Veteran managed their own finances or has another person assisted ? Does the Veteran wish for support now?

How do I assess financial capacity?

As in any assessment of capacity, the assessment should focus on the specific issue or task at hand. Also consider cognitive and emotional symptoms, complexity of task at hand, risks, values, and supports. It may be useful to organize your consideration of financial abilities in three areas:

Knowledge	Awareness of personal income and assets, as well as general financial principles.
Skills	Ability to perform financial tasks consistent with the Veteran's habits, for example making change, balancing a checkbook, performing online transactions.
Judgment	Ability to make financial decisions, particularly in novel or socially ambiguous situations, consistent with an individual's best interests and values.

Potential questions to consider:[2]

1. Are you concerned about having enough money to pay for your home and food?
2. Who do you turn to if you have questions about your money?
3. Has anyone been frequently asking you for money?
4. Have you received phone calls about lotteries or awards? How have you responded to these?
5. Is any of your money missing? How would you know if it is?
6. Are you concerned about your long term financial security?
7. Do you need to make any big purchases? Are you helping anyone else to make purchases?
8. Has anyone misused your ATM or credit card?
9. Does anyone feel entitled to use your money for themselves?
10. Did anyone put pressure on you to get a reverse mortgage?

Preventing Financial Abuse

- Put financial plans in place.

  See http://www.veteranshealthlibrary.org/LivingWith/AgingVeterans/Dementia/ForCaregivers/142,41452_VA
- Report frauds and scams at www.stopfraud.gov and www.ftc.gov
- Report misuse of veterans benefits at 1-888-407-0144.
- Initiate a request for a VA fiduciary or Guardian for financial purposes.

Tools and Tips

- Publications for professionals and consumers at https://ncea.acl.gov/resources/publications.html and https://www.justice.gov/elderjustice/ eji-brochures

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Additional Resources at: https://www.vapulse.net/groups/assessment-of-decision-making-capacity

References:

1. The American Bar Association and the American Psychological Association. Assessment of older adults with diminished capacity: A handbook for psychologists. Washington DC: ABA and APA; 2008.

2. Conrad KJ, Iris M, Ridings JW, Langley K, Wilber KH. Self-report measure of financial exploitation of older adults. Gerontologist. 2010;50(6):758-773.

The American Geriatrics Society (AGS) differentiates driving capacity from driving fitness. This fact sheet is based on the AGS approach and uses that distinction. The state ultimately decides whether or not an older Veteran has the capacity to drive (e.g., driving test) and retains legal driving privileges (i.e., driver's license). ***It is the clinician's responsibility to fairly and accurately report factors that may contribute to unsafe driving – fitness to drive.***

Capacity and Fitness to Drive a Motor Vehicle

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What VA policies may apply?

VA Clinicians must follow VA laws, regulations and policies, in addition to clinical practices, when treating Veterans and sharing Veteran health information. The following information may assist in identifying relevant polices. Veterans with "neurological and brain disorders," as well as Veterans with "disabilities associated with aging," are among those eligible for the VA Driver Rehabilitation Program (**VHA Handbook 1173.16**). Clinicians should make reports to the Registry of Motor Vehicles in accordance with VA privacy rules, state law and clinical ethics. In general, in order for a VA health care facility, upon its own initiative, to make a report to a State Department of Motor Vehicles (DMV), there must be a standing written request letter on file from the State agency that complies with VHA Directive 1605.01, Privacy and Release of Information.
To view VA DMV privacy rules see also "Reporting to State Department of Motor Vehicles Privacy Fact Sheet" at **https://vaww.vets.vaco.portal.va.gov/sites/privacy/vhapo/Pages/FactSheets.aspx.**
If you have further questions regarding law and policies for reporting within your state, please consult with your facility Privacy Officer or district counsel.

How might dementia affect Fitness to Drive?

Most older adults do not have dementia, and the presence of dementia does not necessarily mean that an older adult lacks capacity for domains such as consent to treatment, choosing a healthcare agent, or other types of decisions. Patients with mild dementia can often drive safely. Opinions on fitness to drive for patients with mild dementia should be based on functional abilities (e.g. ability to pass a road test), and not solely on a diagnosis of dementia per se. As dementia progresses, different abilities and skills may be affected depending on the dementia subtype and individual factors, as well as comorbidities. For example, some individuals with dementia retain the basic ability to operate a motor vehicle, but may become lost when driving or feel challenged when a complex decision is required quickly.

What supports may help?

When assessing an older Veteran's fitness to drive, clinicians should consider whether or not optimizing functional status could allow him or her to continue to drive safely. Identifying and addressing sensory deficits, including visual deficits and hearing loss, is critical. VA prosthetics may be able to assist with adaptive devices, and newer cars may include technologies to assist in safe driving, just as GPS devices may assist in location. Finally, your VA, your state, and/or private organizations and insurance companies may provide education and rehabilitation to improve driver performance.

How do I start?

When the older Veteran driver has significant cognitive impairment and/or lacks insight into their ability to drive (e.g., in certain cases of dementia, stroke, etc.), it is imperative to obtain the help of the caregiver, surrogate decision-maker, or guardian, if available. Caregivers play a crucial role in encouraging the older Veteran to retire from driving and to help the individual find alternative transportation options. Clinicians should inform caregivers that the clinical team will support and assist their efforts in any way possible. In rare instances, it may be necessary to appoint a legal guardian for the older Veteran. In turn, the guardian may forfeit the older Veteran's car and license to ensure the individual's safety. These actions should be taken only as a last resort. From a practical standpoint, hiding, donating, dismantling, or selling the car may also be useful in these difficult situations.

What are the most important areas to consider when assessing fitness to drive?

Three key functional areas are considered as the foundation for fitness to drive: vision, cognition, and motor/somatosensory function. Impairment in one or more of these areas has the potential to increase the older Veteran's risk of being involved in a crash. Once these areas are assessed, the health care provider can determine if referral to a specialist (e.g., ophthalmologist, neuropsychologist, driver rehabilitation specialist) for further evaluation or intervention is needed.

Domain	Potential office-based tests to consider (Select 1 or more from American Geriatrics Society recommendations.)
General	Driving history; Instrumental activities of daily living (IADL); Recent medication changes
Vision	Snellen chart; Visual fields; Contrast sensitivity
Cognition	Montreal Cognitive Assessment (MoCA); Trails B; Clock-drawing test; Maze test
Motor/Sensory	Rapid pace walk; Get up and go; Range of motion

Which states require mandatory reporting from clinicians who become aware of a potential for unsafe driving?

State laws vary as to whether clinicians are mandated to contact the division of motor vehicles. Mandatory reporting states as of 2017 include California, Delaware, New Jersey, Nevada, Oregon, and Pennsylvania.

When should I refer to a Driving Rehabilitation Specialist (DRS)?

DRSs are often occupational therapists who have additional training in driver rehabilitation. DRSs work with older drivers who have dementia and other chronic conditions, especially neurologic and orthopedic problems. Clinicians should consider ordering a DRS evaluation when the Veteran, family, friends, and/or the clinician have concerns about the Veteran's fitness to drive. An evaluation from a DRS is particularly useful when there is disagreement about whether the older Veteran is safe to drive. DRSs evaluate the sensory (vision, proprioception), cognitive, and motor functional abilities which support driving skills, and they may also provide assessment and/or training in the vehicle and on the road. DRSs can recommend either rehabilitation when restoration of abilities is deemed possible, or modifications (e.g., hand controls, left foot accelerator) to compensate for physical impairments. To address issues of normal aging and slowed processing, DRSs can recommend compensatory strategies that may include route modifications (e.g., no left turns, avoid rush hour) or suggest restrictions (e.g. daylight driving only, speed restrictions) to support ongoing driving. DRSs may also recommend to the primary care provider that the older Veteran is unsafe to drive and should retire from driving.

Suggested Online Resources

Driver Rehabilitation for Veterans with Disabilities Program (VHA Handbook 1173.16)	VA handbook of procedures for all matters regarding the Driver Rehabilitation Program for Veterans	**https://www.va.gov/VHAPUBLICAtIONs/ViewPublication.asp?pub_ID=5621**
Driving with Dementia: Hanging Up the Keys	Video from VA partners addresses drivers with cognitive impairment.	**https://www.vapulse.net/videos/7260**

Acknowledgement and Disclaimer

This fact sheet is based on the following reference: Pomidor A, ed. Clinician's Guide to Assessing and Counseling Older Drivers, 3rd Edition. New York: The American Geriatrics Society; 2015.
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Additional Resources at: **https://www.vapulse.net/groups/assessment-of-decision-making-capacity**
References: American Geriatrics Society & A. Pomidor, Ed. (2016, January). Clinician's guide to assessing and counseling older drivers, 3rd edition. (Report No. DOT HS 812 228). Washington, DC: National Highway Traffic Safety Administration.
The American Geriatrics Society retains the copyright. National Ethics Committee of the Veterans Health Administration (2007). Impaired driving in older adult: Ethical challenges for healthcare professionals.