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Early detection. Better care.

Primary Care's Role in Assessing Decision-Making in Patients with Dementia - *A Medical Legal Perspective*

Caleb Logan, Esq.

Elder Law & Advocacy, San Diego

DHCS

Financial Disclosures

The presenters have no financial disclosures.

Housekeeping

We will leave 10-15 minutes at the end of this session for Q&A. Throughout the webinar, you can put your questions into the Q&A/chat functions, and some may be answered in real time.

We will share instructions for claiming Continuing Education (CE) credit at the end of this webinar and via email within 48 hours.

You will receive the recording of this webinar via email within 48 hours

You can also access the webinar slides and recording from the Dementia Care Aware website and YouTube channel.

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Dementia Care Aware Program Offerings

Warmline:

1-800-933-1789

A provider support and consultation service that connects primary care teams with Dementia Care Aware experts

Trainings:

- Online Trainings e.g., Cognitive Health Assessment training
- Monthly Webinars
- Podcasts

Interactive Case Conferences:

- UCLA and UCI ECHO (Extension for Community Healthcare Outcome) conferences

Practice change support:

- UCLA Alzheimer's and Dementia Care Program
- Alzheimer's Association Health Systems

Our Training

Welcome!

Welcome to the Dementia Care Aware (DCA) learning management system. This site provides access to the training modules for the DCA program. When you registered, you were automatically enrolled in the "*The Cognitive Health Assessment: The Basics*" course. Select Start in the "The Cognitive Health Assessment: The Basics" block below to begin.

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Screening for Dementia: The Cognitive Health Assessment (CHA)

Goal: Screen patients older than age 65 annually (who don't have a pre-existing diagnosis of dementia)

Part 1

Take a Brief Patient History

Part 2

Use Screening Tools

Part 3

Document Care Partner Information

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Sign Up for Upcoming Live CHA Trainings

- Dementia Care Aware offers the CHA training as **a free 1-hour live session** multiple times each month.
- Led by Dementia Care Aware partners at the Alzheimer's Association and UC, Irvine.
- Open for anyone who is interested.
- Eligible participants can claim **1 free CE/CME/MOC credit**.

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Learning Objectives

1. Describe the components of capacity from a legal perspective.
2. List 1-2 roles a primary care clinician can have in assessing legal capacity.
3. Identify 2 factors that can affect an assessment of capacity in an older person with dementia.
4. Understand the importance of comprehensive advance planning for all patients.

Introduction

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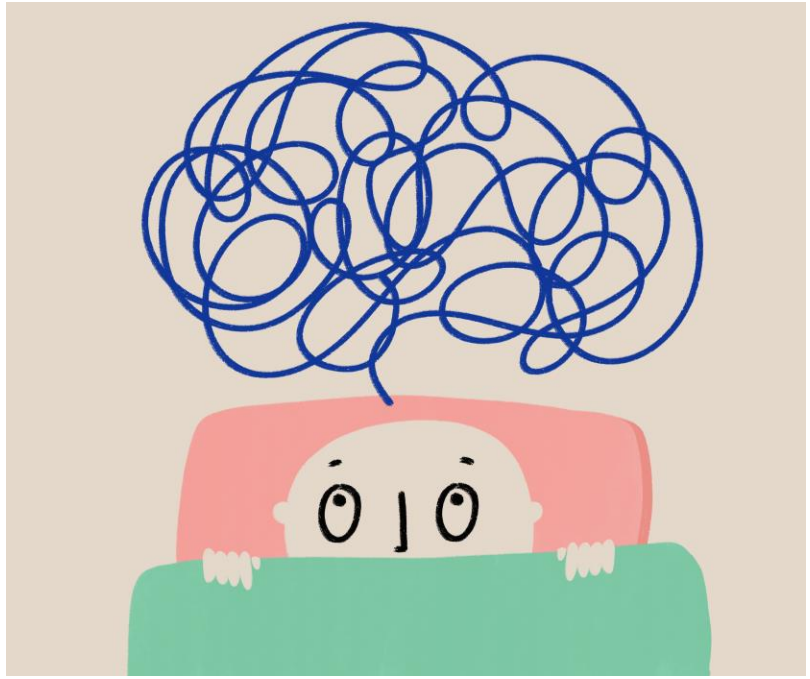
Food for thought



How often is capacity impaired in people living with dementia?

Presentation developed with the input and support of the
DCA Statewide Medical-Legal Partnership Network

Elder Law & Advocacy, est. 1978

- Nonprofit that provides free civil legal services and Medicare counseling to older adults in San Diego and Imperial Counties.
- Mission: To protect seniors by providing legal advice and advocacy, helping them defend their legal rights, and preserve their respected place in the community.
- Primarily pre-litigation intervention.
- Programs:
    - Senior Legal Services
    - Caregiver Legal Services
    - Nursing Home Rights Enforcement Project
    - Financial Abuse Relief Project
    - Elder Abuse Representation Project
    - Elder Tenant Assistance Project (Homelessness Prevention)
    - Health Insurance Counseling & Advocacy Program (HICAP)
    - Medical-Legal Partnership

Agenda

- Introduce principles of legal capacity
- Review an attorney/client case example to identify capacity issue
- Review a doctor/patient case example
- Apply capacity principles to situations involving medical providers

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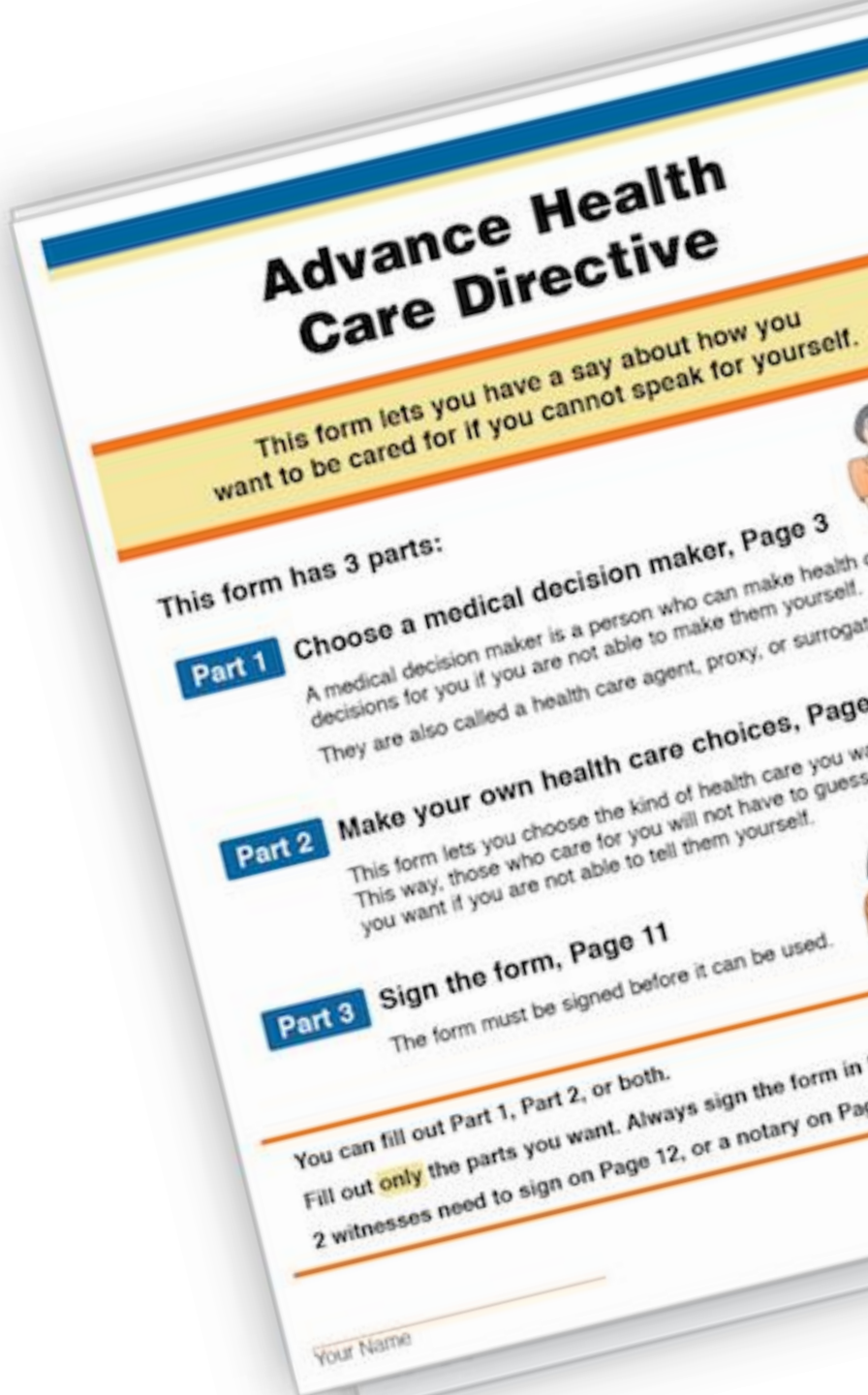
(End of) Life Planning

- Wills
- Trusts (revocable, irrevocable, special needs, inter vivos, testamentary)
- Advance health care directives (health care powers of attorney)
- Financial powers of attorney (durable, springing)
- Payable on death (POD) accounts
- Beneficiary specifications

What do you need for all of these? **Capacity!**



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Capacity principles: the LEGAL framework

- Ability to make a legally-binding decision
- Capacity vs. Competency
- Capacity to do what?
    - Standard is situation-dependent and issue specific.
    - Does the patient have capacity to … **DO WHAT**?
- The law defines capacity for different situations
    - E.g., making a will, making a contract, etc.
    - Capacity is **presumed**

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Capacity – The Medical framework

Medical-Decision Making Capacity:

1. Does the patient **understand** their medical condition?
2. Is the patient able to **communicate** their choice?
3. Can the patient describe the **implications** (i.e. risks and benefits) of their decision?
4. Can the patient explain their decision **rationally**?

Caution: this is a framework for specific medical decisions and isn't appropriate for understanding someone's capacity for non-medical decisions, such as financial matters, or the ability to live safely at home. **The assessment should fit the type of capacity we are assessing.**

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Case Example: Maribel

Maribel is an 80-year-old woman meeting an attorney to discuss advance planning documents. She is widowed with three adult children and lives with her daughter Maria, who is her primary caregiver. Maribel uses a walker and has a diagnosis of dementia. Maria made the appointment and provided most of the answers to the intake questions. Maria brought Maribel to the appointment.

The attorney asked Maria to step out and met with Maribel alone. The attorney explained the advance planning documents to Maribel, who listened and nodded "yes." At times she seemed distant and may have even nodded off. When the attorney asked Maribel if she had any questions, Maribel said "no."

Capacity revisited as applied to Maribel

- Ability to make a decision
- Standard is situation-dependent/issue-specific
- Presumption of capacity

- Capacity is a spectrum/continuum
- Capacity is fluid
- Not dependent on diagnosis

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Legal structure

California organizes laws passed by the legislature into “codes”:

Probate Code	Civil Code
Family Code	Penal Code
Health & Safety Code	Welfare & Institutions Code, etc.

Key player: The Probate Code’s Due Process in Competence Determinations Act

- Rebuttable presumption of capacity
- Diagnosis of mental or physical disorder does **not** equal incapacity
- There must be evidence of deficit(s)
- Deficit(s) must “significantly impair” understanding of specific action or decision in question

❖ The law defines capacity on a continuum. A patient’s presentation and medical history gives evidence of whether capacity exists.

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Maribel, part 2

The attorney met with Maribel a second time. This time, they met in the morning rather than in the afternoon. Maribel spoke clearly about her family and described that Maria was a huge help to her.

The attorney explained the AHCD to her. Maribel said she wanted to name her daughter as agent since she's "my right-hand." Maribel stated that Maria would know her health care preferences but also stated that organ donation would be ok. Maribel said, "I don't need those body parts anymore after I die, so if they can do some good, I would like that." The attorney also asked about life support treatments. Maribel indicated she wanted no such treatments stating simply, "When it's your time, it's your time."

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How do we decide?

Typical legal appointment:

- Meet with client alone
- Presumption of capacity
- Determine what level of capacity the law requires:
    - Decision making capacity (Prob. Code §§ 810–812)
    - Contractual Capacity (Civ. Code § 38; Prob. Code §§ 810–812)
        - Powers of Attorney (Prob. Code § 4120)
    - Testamentary Capacity (Prob. Code § 6100.5)
    - Advance Health Care Directive (Prob. Code § 4609)
    - Informed Consent (Prob. Code § 813)
- Identify mental function deficits, determine whether there is a correlation with the act or decision, and if the deficit "significantly impairs" the ability to understand/appreciate the decision.

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Capacity to make an Advance Healthcare Directive (AHCD)

Prob. Code § 4609.

"Capacity" means a person's ability to understand the nature and consequences of a decision and to make and communicate a decision, and includes in the case of proposed health care, the ability to understand its significant benefits, risks, and alternatives.

See also Prob. Code §§ 4670, 4671(a).

Prob. Code § 4657.

A patient is presumed to have the capacity to make a health care decision, to give or revoke an advance health care directive, and to designate or disqualify a surrogate. This presumption is a presumption affecting the burden of proof.

Capacity to contract

Prob. Code § 812.

Except where otherwise provided by law, including, but not limited to, Section 813 and the statutory and decisional law of testamentary capacity, a person lacks the capacity to make a decision unless the person has the ability to **communicate verbally**, or by any other means, the decision, and to **understand and appreciate**, to the extent relevant, all of the following:

(a) The rights, duties, and responsibilities created by, or affected by the decision.

(b) The probable consequences for the decision maker and, where appropriate, the persons affected by the decision.

(c) The significant risks, benefits, and reasonable alternatives involved in the decision.

- Applies to financial powers of attorney, Prob. Code § 4120
- *See also* Civ. Code §§ 38–41

Capacity to make a Will

Prob. Code § 6100.5.

(a) An individual is **not** mentally competent to make a will if at the time of making the will **either** of the following is true:

(1) The individual does not have sufficient mental capacity to be able to

(A) understand the nature of the testamentary act,

(B) understand and recollect the nature and situation of the individual's property, or

(C) remember and understand the individual's relations to living descendants, spouse, and parents, and those whose interests are affected by the will. **- OR -**

(2) The individual suffers from a mental disorder with symptoms including delusions or hallucinations, which delusions or hallucinations result in the individual's devising property in a way which, except for the existence of the delusions or hallucinations, the individual would not have done.

Supported decision-making agreements

- Agreement between an adult with a disability and a “supporter”
- Supporter helps adult to understand information and communicate decisions
    - E.g., participation in care planning meetings, discharge planning meetings, etc.
    - E.g., communications with financial institutions and planners
- **Does not** stop the adult from acting independently
- **Does not** qualify as evidence of incapacity
- **Does** boost an adult’s ability to manage their own affairs and make decisions

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Additional considerations

- Is there undue influence?
- Are there signs of fraud?

- Next steps:
    - Meet again at a different time?
    - Get a medical expert's opinion?
    - Prepare the documents

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What is “undue influence”?

Welf. & Inst. Code § 15610.70.

(a) “Undue influence” means **excessive persuasion** that causes another person to act or refrain from acting by **overcoming that person’s free will** and results in inequity. Finding undue influence requires considering:

(1) The victim’s vulnerability;

(2) The influencer’s apparent authority;

(3) The influencer’s actions/tactics; and

(4) The equity of the result (inequity alone is **not** enough!).

See also Prob. Code § 86 (adopting the Welfare & Institution Code’s definition of undue influence); Civ. Code § 1575 (defining undue influence as a defense to contract formation).

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Takeaways from Maribel

- Capacity is fluid
- Capacity does not depend on a diagnosis
- Capacity is defined by the law
- Judgment call based on evidence

How can a medical provider help?

Prob. Code § 810(c).

"A judicial determination that a person is totally without understanding, . . . or suffers from one or more mental deficits so substantial that . . . the person should be deemed to lack the legal capacity to perform a specific act, **should be based on evidence of a deficit** in one or more of the person's mental functions rather than on a diagnosis of a person's mental or physical disorder."

Prob. Code § 811(a).

The evidence must show "a deficit in at least one of the following mental functions": (1) Alertness and attention; (2) information processing; (3) thought processes; and (4) ability to modulate mood and affect; **and** "a correlation between the deficit or deficits and the decision or acts in question."

DOCUMENT!!!

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How can a medical provider help?

- Document capacity over time.
- Assess capacity at multiple visits.
- Use the cognitive health assessment (CHA) t
  and assessments.

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Case example: Theo

Theo is 76-years-old and is at his doctor's appointment. He appears to not remember what you spoke about at a previous appointment and is not taking his medications. Theo just had a cognitive health assessment and is showing significant cognitive impairment, specifically with his memory.

Looking at his record you notice that he doesn't have a power of attorney.

Is it too late for Theo to do advance planning?

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Applying Probate Code section 811

(a) A determination that a person is of unsound mind or lacks the capacity to make a decision or do a certain act . . . shall be supported by **evidence of a deficit** in at least one of the following mental functions . . . and **evidence of a correlation** between the deficit or deficits and the decision or acts in question:

(1) **Alertness and attention**, including, but not limited to:

(A) Level of arousal or consciousness.

(B) Orientation to time, place, person, and situation.

(C) Ability to attend and concentrate.

(2) **Information processing**, including, but not limited to:

(A) Short- and long-term memory, including immediate recall.

(B) Ability to understand or communicate with others, either verbally or otherwise.

(C) Recognition of familiar objects and familiar persons.

(D) Ability to understand and appreciate quantities.

(E) Ability to reason using abstract concepts.

(F) Ability to plan, organize, and carry out actions in one's own rational self-interest.

(G) Ability to reason logically.

(3) **Thought processes**. Deficits in these functions may be demonstrated by the presence of the following:

(A) Severely disorganized thinking.

(B) Hallucinations.

(C) Delusions.

(D) Uncontrollable, repetitive, or intrusive thoughts.

(4) **Ability to modulate mood and affect**. Deficits in this ability may be demonstrated by the presence of a pervasive and persistent or recurrent state of euphoria, anger, anxiety, fear, panic, depression, hopelessness or despair, helplessness, apathy or indifference, that is inappropriate in degree to the individual's circumstances.

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Law review

- Presumption of capacity
- Capacity is fluid
- Capacity does not depend on a diagnosis
- Legal standards give guidance
- Ultimate decision is a judgment call based on evidence

Decision making capacity, Prob. Code § 810

- Presumption that everyone can make decisions

Healthcare decision making capacity, Prob. Code § 4609

- Ability to understand the nature and consequences of a decision
- Ability to make and communicate a decision
- Ability to understand a decision's significant benefits, risks, and alternatives
- Note: Applies to all medical decisions, not just AHCDs

Contractual capacity, Prob. Code § 812

- Highest standard
- Ability to understand and appreciate, to the extent relevant, **all** the following:
  - The rights, duties, and responsibilities created by, or affected by, the decision
  - The probable consequences for the decision maker and, where appropriate, the persons affected by the decision
  - The significant risks, benefits, and reasonable alternatives involved in the decision
- Applies also to financial powers of attorney and complicated trusts

Testamentary capacity, Prob. Code § 6100.5

- Ability to understand the nature of the testamentary act
- Ability to understand and recollect the nature and situation of the property
- Ability to remember and understand relations to living relatives and others
- Applies to wills and simple trust matters

Probate conservatorship, Prob. Code § 1801

- Unable to provide properly for the person's personal needs for physical health, food, clothing, or shelter; and/or
- Substantially unable to manage the person's own financial resources or resist fraud or undue influence; and
- A conservatorship is the **least** restrictive alternative to protect the person

Revisiting life planning

"How can I get power of attorney over my parent/spouse/sibling who has dementia and can no longer make their own decisions?"

1. A diagnosis does not determine capacity.
2. You can't!

Probate conservatorships

Request a training for more information!

Conservatorship of the Person

- Medical decisions, like:
  - Residential decisions (placement)
  - Hiring/firing of caregivers and medical service providers
- But NOT:
  - Controlling who can call/visit the conservatee (social contacts)
  - But you can request a restraining order!

Conservatorship of the Estate

- Financial decisions, like:
  - Handling the conservatee's income and assets to provide for the conservatee
- But NOT:
  - Creating a will or otherwise directing distribution of the conservatee's estate after death

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Addressing capacity's fluidity

- State the date and time of your assessment
- State whether capacity should be reassessed within a specific period of time
- Encourage the patient to participate in a reevaluation

Using standardized tools

- Use the Dementia Care Aware Cognitive Health Assessment (CHA) training on how to conduct screening and follow-on diagnosis, including self-reporting versus caregiver-reporting.
- Keep notes about how you assessed capacity:
    - Have you used a standardized screening tool?
    - Did you conduct additional assessments to reach a diagnosis?
    - Try to note some of the exact responses that the patient is providing
- Neither a positive cognitive screen nor a diagnosis automatically means a patient lacks legal capacity for all decisions

Following institutional policies

- Seek guidance from your institution
- Do **not** rely on this program for legal advice about a specific case
- This material is not a substitute for your independent medical judgment or the advice of your ethics committees and institutional legal counsel
- Consult all applicable local standards and policies to conduct assessments, including policies on scope of practice, privacy, elder abuse reporting, etc.

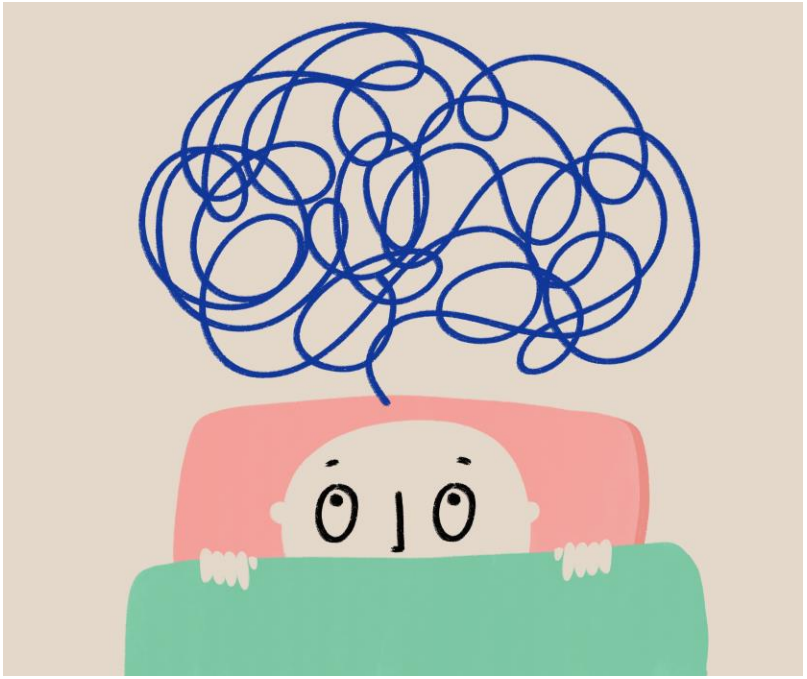
Pitfalls to avoid

- Failing to get patient consent before providing a letter about patient capacity
- Reciting patient history unrelated to capacity for the function in question
- Writing general, sweeping statements rather than specific, function-specific analysis
- Feeling the need to do a legal analysis or make legal conclusions
- Assuming capacity is constant
- Assuming a dementia diagnosis is determinative of legal capacity

- Capacity is issue-specific, not patient-specific
- Capacity is a continuum
- Capacity can come and go
- No medical diagnosis determines capacity

- Document specific deficits of:
  - Alertness and attention;
  - Information processing;
  - Thought processes; and
  - Ability to modulate mood and affect

Have you thought about---



How often is capacity impaired in people living with dementia?

Answer: "Capacity" is more likely to be impaired in someone living with dementia than someone without it.

But every person and every decision needs a specific assessment to answer this question.

THANK YOU | QUESTIONS?

For more information please contact:

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Questions and answers from the webinar

QUESTION: If someone has not designated a DPOA for health care or finances and does not have capacity for a particular decision, what are the options?

Answer: A "next of kin" can be allowed to make decisions on behalf of a patient in a hospital or SNF setting based on California law. And always consult your institution's policy.

In a primary care clinic, this may be trickier and you may not have a relevant policy to consult.

Tips:

- Someone may have capacity to designate a health care decision-maker, but not for more complex decisions. So it is often still appropriate and acceptable to get their verbal or written designation of a DPOA-HC even if you don't feel they have capacity for a specific medical decision that you are about to consult that DPOA for.
- If the patient has capacity at some times but not at others, you can ask them (when they have capacity) to designate an adult as their health care surrogate. This designation **must** be recorded in the patient's health care record and lasts only for the duration of the patient's stay or treatment in the hospital, but in no event can it last longer than 60 days.
- When there is no surrogate, health care agent, or conservator, you can choose a decisionmaker who is the patient's: spouse, adult child, parent, adult sibling, adult grandchild, or adult relative or close personal friend. However, the person chosen must have shown special care and concern for the patient, be familiar with the patient's personal values and beliefs (to the extent known), and be reasonably available and willing to serve.
- Note that is a person has not designated a formal DPOA (e.g. Adv Directive or other legal document) and has not shared that across settings (hospital, SNF, clinic, etc), then often providers in those different places don't know who has been designated. Encourage your patients to make it formal and to share.

For more information:

- See the Medical-Legal Partnership handout on **Advance Care Planning** on the DCA website HERE.
- See the Medical-Legal Partnership handout on **Capacity** on the DCA website HERE.

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Questions and answers from the webinar

QUESTION: If someone has designated a DPOA for health care or finances but now that person is incapacitated or deceased what are the options?

Answer:

Look further to see if the patient designated another person to take the first agent's place. If so, and that second person is willing and able to serve, the second person will be the new decisionmaker. If not, proceed as if the patient had no one designated (see previous slide for the rules in this situation).

Tips:

- Ask them to name a back up person (an alternate health care agent) if they can!

For more information:

- See the Medical-Legal Partnership handout on **Advance Care Planning** on the DCA website HERE.
- See the Medical-Legal Partnership handout on **Capacity** on the DCA website HERE.

Have more questions? Get answers through our Warmline @ **1-800-933-1789** or our support page!

Here are some examples!

What do I prioritize if my patient tests positive for cognitive impairment?

What cognitive assessment should I use for a Spanish speaking patient experiencing homelessness?

What medications should I avoid if my patient has cognitive complaints?

Open your phone camera and scan the QR code to submit questions:

Or visit: www.dementiacareaware.org

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UCSF University of California San Francisco

UCI Division of Geriatric Medicine and Gerontology

UC San Diego School of Medicine

UCLA Health

UCSF-UC Law

DHCS CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

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