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Assessment Case

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Contextual Statement:

I am presenting the case of an 86-year-old Caucasian divorced WWII veteran who was referred for evaluation of his medical decision-making and independent living capacities. He was referred to our Home-Based Primary Care team by his VA PCP to provide services as he had difficulty attending clinic appointments. He had a medical history that included stage III kidney disease, cerebrovascular disease, dementia NOS, hypertension, and B12 deficiency. This veteran had been screened for admission to the HBPC program about six months earlier, and the nurse who saw him at home at that time had been concerned for his well-being in that environment. She felt that the home was in deplorabl e conditions and after speaking with the veteran's daughter, she arranged to have him undergo a social admission to the hospital for further evaluation. He had been evaluated by the consultation psychiatry service who felt that he had diminished capacity to care for himself and recommended he return home with services.

At the initial screening, his daughter reported her ongoing concerns to the nurse, saying she felt the veteran should be placed in long-term care, and that she felt he was failing in the home despite the additional assistance he was getting. She would bring photos of his home to the physicians evaluating him in the hospital. Since returning home, elder protective services had put some services into place (daily meals on wheels, and a home health aide twice a week). They had also had heavy chore services remove much of the clutter in the home. His daughter was driving from out of state every day to check on him, and to oversee his medications. Among the many red flags of self-neglect was his frequently calling emergency services with reports of intruders in his home. According to his daughter, he continued to wear a gas mask at night and would tell her that he was seeing some substance dripping from the ceiling. Though she did not believe he was wandering, the neighbors found him outside at odd hours, in various stages of dress. She seemed to be doing her best to keep him at home but had reached the limit of what she was able to provide.

Despite the services in the home, he continued to demonstrate self-neglect. His medication adherence remained poor in that he would forget to take the medications his daughter had put in his medication planner. While he was receiving the meals on wheels, it was unclear how many he was eating. His daughter would find some in the trash when she visited but there were many in the refrigerator and freezer that were left untouched and expired. The lifeline was providing some triaging of his calling the authorities but according to his protective services worker he was putting a strain on the local emergency services. He was vulnerable to undue influence as evidenced by his history of financial exploitation; his daughter continued to manage his finances at his request.

My approach to capacity assessment is based on the framework in the ABA-APA Capacity Handbook for Psychologists (2008). I typically have a lengthy electronic medical record to review. I examine contextual and cultural factors that could be contributing to the presentation. In this particular instance, he had been engaged with the VA for many years. According to his daughter, his pattern of self-neglect had occurred in the past several years, and was not reflective of a life-long pattern per se. His functional decline was somewhat evident in the record, particularly as his behaviors became more erratic in the two years prior to my evaluation. My goal is to look for less restrictive solutions to resolve the problem without need of a capacity evaluation. I select tests that range from structured to unstructured measures of functioning. The battery I used in this assessment is typical of what I use: a clinical interview including assessment of values (I use many questions from the Handbook), semi-structured interview (Hopemont Capacity Assessment Inventory), a functional measure (Independent Living Scales), evaluation of cognitive functioning (RBANS) and mood screener (Geriatric Depression Scale). Both the demands of my setting (in primary care) and the needs of the veteran necessitate me to have a battery that is comprehensive but also brief enough for the veteran to tolerate. The topics that are addressed in a capacity evaluation can be distressing for some veterans so I am flexible in my approach as needed, and emphasize that this is their opportunity for their perspective to be heard. I also have the ecological validity of seeing the environment the person is actually living in. In my conclusions I recommend ways to enhance capacity if possible, such as increasing the level of care in the home.

This evaluation was completed in his home, which required some modifications to what would be done in the clinic setting. He had just one chair suitable for testing, but did offer me his lawn chair to sit on. The surface of his table was small, as he had medication planners, paperwork, and other items covering much of it. A benefit of testing in his home environment was that it allowed for directly observing his environment and how he interacted with it. If I had seen him in a clinic or hospital setting, I would not have been able to appreciate the richness of this data. It took some time to build rapport with him but he seemed to appreciate my role and the purpose of testing. He had recalled that others had previously evaluated his ability to make his own decisions. His daughter arrived after we had finished the capacity questions and waited in the other room while he completed the cognitive testing.

This veteran had not previously had cognitive testing. The goal was not to clarify his diagnosis but rather to better understand how his cognitive functioning would bear on his capacity. On this administration his domain scores were higher than his functional status would suggest. According to his daughter I had been seeing him at his best (late morning). At the subtest level his performance was impaired on several tasks including visual attention and delayed recall of unstructured verbal information. Having a cue or greater structure did help his performance but there was some decay in his retention over time even with this assistance. On immediate memory, language, verbal attention, and delayed visual memory tasks his performance was preserved. He seemed to rise to the occasion of the structured test but left to his own devices he would fall apart. If we had more time together I would have included more tests of executive functioning such as Trails and a clock-drawing task to better assess his planning and organization. If we had further diagnostic questions I may have referred him for full neuropsychological testing, but this was not a clinical priority given that he was not showing for any clinic appointments.

To evaluate his decision-making capacity, I focused on four functional elements: his understanding, appreciation, reasoning, and ability to express a choice. In this situation, his understanding of his current medical needs was limited. He understood that he had medications to take but was unable to correctly do so independently even with the medication planner. His appreciation of his current circumstances was poor as he did not seem aware of his own self-neglect or the hazards that had been in his home. He generally understood that others had been worried about his living status but could not appreciate why they might be concerned. His judgment and reasoning were poor as he was not able to weigh risks and benefits of the situation he was presently in (though basic reasoning of a past personal situation was intact). During the interview he was able to express the choice to remain in his home, however he had been packing up personal items over the past week. He was not sure why he had been doing this.

While it appeared most likely that the impairments were due to his dementia, I also recommended that updated labs (B12, RPR, TSH) be done to rule out reversible causes of dementia. Routine blood panels and a urinalysis had been negative. I recommended that he be seen by our outpatient geriatric psychiatrist to evaluate for a medication that could address the sundowning. While occasionally irritable, he did not appear depressed. While he had been rated for 'neurosis' following his military service, he had not history of mental health treatment. Further clarification was limited by his being a poor historian. He could not recall particular difficulty readjusting after the service. The veteran did not meet criteria for a full diagnosis of PTSD. However, his misperceptions and false beliefs may have been related to his wartime experiences. It could have been that intrusive images, thoughts and feelings that he could keep at bay while he was healthy could no longer be adequately coped with under stresses of late life.

The ethical issues in this situation are those I address frequently in my setting. Self-neglect does not automatically mean a lack of capacity. In cases of self-neglect, I have to balance the individual's autonomy with protecting them from harm (non-malfeasance). In this case, there was often a disconnect between his stated decisions and what he was able to carry out. For example he wanted to be adherent to his medications but was unable to organize and follow through on this effort. He could not provide a reasoned rationale for his self-neglecting behavior, nor could he appreciate the risks of such behavior. He could communicate that he wanted to remain at home and had some external supports to carry out this plan. If at all possible I wanted to balance his preference for remaining at home while reducing the risks in that environment. Thus my recommendations were geared towards enhancing his ability to remain in his home as long as possible.

In terms of enhancing his capacity in his current environment, I recommended that he consider adult day health which would provide more structure and a social outlet for him. It would also afford the daughter some respite. He and his daughter were agreeable. I referred to our occupational therapist to complete a home safety evaluation. I recommended an automated medication dispenser that was available from the lifeline company. Because the caregiver was a critical part of his remaining in the home, I provided her with education around dementia. We spent 30 minutes that day discussing her concerns, and reviewing ways that she could enhance the safety of the home environment. I provided her with a resource on caring for someone with dementia from the US Department of Health and Human Services. I find this resource to be a good first step for families because it is comprehensive

(100+ pages) but very clear and easy to read. If I had more time with her we would have focused on further education about dementia, validating the care she had been providing, establishing respite opportunities, and encouraging her own self-care.

Elder Protective Services was already involved in this case, but had they not been I would have made a report to them. In this case they were not requesting the evaluation so did not ask for a copy of the report. Our social worker and I spoke with them after my evaluations to review our recommendations. When I file a report I inform the veteran that I am doing so. Our VA has a standing letter of disclosure to EPS so no formal written release of records are necessary.

In the week after my evaluation, he was seen by the primary care provider, who activated the daughter as his health care agent. Within another week his behaviors escalated such that he was calling emergency services or pressing his lifeline twice daily. The emergency services would come and he would send them away. The social worker completed her evaluation which included a Zarit caregiver burden screen for the daughter which was significant for caregiver strain. A social admission was again arranged for the veteran to be admitted for placement. Given the quick escalation of his symptoms, delirium could not be ruled out. Following this admission he was placed in a long-term care setting. The situation that the veteran was in may have been able to be sustained for longer if I had a chance to begin regular caregiver support and if more of my recommendations had been able to be completed. However, I believe the emotional and travel demands on the caregiver as well as the demands on the local community resources made the less restrictive plan only a temporary one.

More recently I have begun including the wording of the state laws and VA policies explicitly within the report. For example, in Massachusetts, the legal standard for medical decision-making capacity is: "The ability to understand and appreciate the nature and consequences of health care decisions, including the benefits and risks of and alternatives to any proposed health care, and to reach an informed decision." I write my summary explicitly around these guidelines.

Informed Consent: My setting does not utilize specific written consent for psychological services. I obtain informed consent verbally, and if the person cannot provide consent, I seek their assent to participate. In this instance, the veteran did appear to have the ability to provide informed consent and did so. I reviewed the nature of the assessment and the possible outcomes including that his daughter as HCP would be asked by the medical team to make decisions on his behalf.

References:

American Bar Association Commission on Law and Aging, & American Psychological Association. (2008). Assessment of older adults with diminished capacity: A handbook for psychologists. Washington, DC.

Evaluation (including History and Psychological Test Data):

CAPACITY EVALUATION

Mr. O.T. is an 89-year-old veteran who was seen at home face-to-face for 120 minutes for capacity evaluation. He is service-connected for 'neurosis'. Met with his daughter for an additional 30 minutes after the evaluation to obtain collateral information, caregiver support and treatment planning.

PRESENTING PROBLEM: Veteran referred for evaluation for capacity to determine placement and to make medical decisions. His daughter is requesting the evaluation. Mr. T was admitted to HBPC 8/19/13. Veteran presently resides in his own home. His daughter (primary caregiver), R.T., visits him nearly every day, commuting from her home out of state. She has reportedly been increasingly concerned about his living alone, and his safety there. Elder Protective Services has been involved, and are providing services to improve his safety at home. He presently receives meals on wheels, and a home health aide several times a week as part of their plan of care for him.

He was initially screened for HBPC services approximately one year ago, on 10/26/12. The nurse who screened him was concerned about the state of veteran's home and his well-being there. At that time, he was often sleeping with a respirator mask on, and was reportedly worried about "stuff" raining in from the ceiling or coming up from the floor at night. He also reported to her that he was barricading the doors at night. It was unclear whether his utilities were working in the home. Due to these concerns, the HBPC team coordinated a social admission to the VA hospital.

During that admission, a capacity assessment was completed by C/L psychiatry team on 10/29/12. The attending psychiatrist noted:

> "Pt expresses a clear preference about going home and is very resistant to going to a NH. he minimizes his inabilities and limitations and has limited insight into his need for care. He does express (reluctantly) a willingness to have some help in his house. He shows an elemental understanding of his needs, expresses an understanding of what he needs to do to care for himself (cook, clean, take meds), and with added support at home he might be able to do this.
>
> Would recommend SW involvement to maximize home services to maintain pt's independence. His ability to understand his needs is limited and should work with pt and family to arrange safest and most reasonable d/c plan. he shows elemental capacity to understand his needs but a more in depth understanding is lacking."

He was also seen by Geriatrics service during that admission, who made a diagnosis of dementia, and felt it was a likely of vascular etiology. He was discharged to home with VNA on 11/2/12. Later that month, VNA were again concerned about him - he was admitted to a non-VA inpatient geriatric psychiatry unit, started namenda (shortly d/c) and aricept, with question of Lewy Body Dementia. Was reportedly placed at a SNF near his daughter for rehab. Per notes, the reported d/c plan was for him to return to live with daughter, but he ultimately ended up at home. Daughter reports he did show some improvement on aricept initially, but as medication adherence has declined in recent weeks, she feels he has also declined. She has been filling his medication planner daily. Today his planner is empty, he has no awareness that this could be a problem. He is unsure when he last took medication but does not think he has taken any today.

His daughter reports that she feels he is unsafe in the home and has been advocating for LTC placement for some time. He frequently calls emergency services in his town. Last weekend he complained to her of hip pain. She brought him to the VA, where he then denied problems. He was evaluated and d/c home. The following night he called 911 to take him to local ED, then once there denied any problems.

With regard to his finances, she has been serving as his power of attorney, and managing his day-to-day financial needs. She reports that she purchased the home from him several years ago for a dollar. Subsequently she found out he had been financially exploited by his friend, and she then began managing his finances. States that she would later find credit cards and other items in his name, which she has been able to sort out. During the visit today, a vice-president from his

bank called her to inform her that his house was about to be foreclosed on. Unbeknownst to her, there had been a $70,000 mortgage placed on the home a few years ago. She closed out checking accounts about three months ago, unaware that they were being drawn on to pay off the mortgage. The mortgage is now three months past due and the house is close to foreclosure. She states she has no idea where that money went. Veteran also states he was not aware of the mortgage. She will be following up with the bank manager later today to discuss this further. Mr. T affirms that R should continue to manage his financial affairs.

Psychosocial History: Mr. T lived in his current town for most of his life. He completed high school. He served as a medic in WWII in Europe. States he was at several major battles. Worked as a presser for one company for 40 years, and retired in 1997. Veteran was divorced in 1998, and did not remarry. He had only one child. His brother and sister reportedly had Alzheimer's disease. Daughter notes that his sister was in a LTC facility near his home, and that he has that experience in mind when stating he does not want to be in a nursing home.

Prior to receiving psychiatry consult during his inpatient medical stays during the past year, veteran has no past mental health treatment. Prior PCP notes refer to 'shell shock'. Veteran denies nightmares or flashbacks. He denies depressive symptoms or thoughts of harm to self/others. Non-smoker, no significant substance use history per chart notes, though did often spend time at his VFW post. Daughter does not believe he is drinking alcohol.

MEDICAL INFORMATION:

a) Active Problem List

Code	Description
294.8	Dementia NOS (ICD-9-CM 294.8)
585.3	Chronic Kidney Disease, Stage III (Moderate) (ICD-9-CM 585.3)
173.9	Squamous Cell Carcinoma of Skin (ICD-9-CM 173.9)
433.10	Occlusion and Stenosis of Carotid Artery, without Cerebral Infarction
435.9	TIA
401.9	Hypertension (ICD-9-CM 401.9)
266.2	Vitamin B 12 Deficiency (ICD-9-CM 266.2)

b) Active Outpatient Medications (including Supplies):

Medication	Status
AMLODIPINE BESYLATE 2.5MG TAB TAKE ONE TABLET BY MOUTH EVERY DAY FOR HEART	ACTIVE
DONEPEZIL HCL 10MG TAB TAKE ONE TABLET BY MOUTH EVERY DAY	ACTIVE
METOPROLOL TARTRATE 25MG TAB TAKE ONE TABLET BY MOUTH TWICE A DAY FOR BLOOD PRESSURE/HEART	ACTIVE
SIMVASTATIN 40MG TAB TAKE ONE-HALF TABLET BY MOUTH AT BEDTIME FOR REDUCING CHOLESTEROL	ACTIVE
Non-VA ASPIRIN 81MG EC TAB 81MG BY MOUTH EVERY DAY	ACTIVE

c) Imaging: Most recent MRI brain on file from 2007:

MRI EXAMINATION OF THE HEAD: 06/06/07

Only diffusion weighted and FLAIR axial images were obtained. The patient complained of pain in the shrapnel in his shoulder and the study was discontinued.

There is no acute diffusion abnormality. FLAIR axial images show white matter changes from small vessel disease. There is no mass-effect or midline shift. Eyes and orbits appear normal and symmetrical.

CONCLUSION: Incomplete study. No acute ischemic process. Non specific white matter changes due to small vessel disease.

Primary Diagnostic Code: NO SIGNIFICANT OR MINOR ABNORMALITY

BEHAVIORAL OBSERVATIONS:

Mr. T took some time to answer the door. States he had difficulty getting up from his easy chair. He was unshaven, dressed but somewhat disheveled. He wore glasses for the examination. He indicated he could hear me adequately. In pleasant spirits, though irritable when speaking about his wish to stay at home. He states that his home health aide had been there that morning to give him a shower, because she comes on Thursdays. When I told him it was Friday, he then told me she

comes on Thursdays and Fridays. Veteran spoke in full sentences. Some poverty of content noted. He is a limited historian, particularly for recent events. He does not recall having had the recent hurricane. He is aware the Red Sox lost a playoff game yesterday, but cannot recall who they played or who was pitching. False beliefs are noted. He is suspicious of certain individuals in the neighborhood. No overt hallucinations noted, and he denied these during the examination. He denied any thoughts of harm to himself or others.

INFORMED CONSENT: Reviewed purpose of testing and possible outcomes, including that his HCP may be invoked if he was felt to lack capacity for decisions about placement. I also discussed that if I felt veteran were at risk of neglect or abuse I would report to Elder Protective Services. Veteran agreed to participate, and told me clearly and firmly that he felt he could manage in his own home. He could not recall the name of his case manager at EPS but agreed that I could share information with them if necessary.

ENVIRONMENTAL OBSERVATIONS:

Mr. T states he has lived in his current home since 1960. The home exterior has not been well-maintained. Caregiver states that a neighbor boy had been willing to regularly mow the yard, but veteran asked him to leave. The interior of the home is aging, not well-maintained either. His bed is in the middle of the living room. He tells me he has trouble getting out of his recliner this morning, but eventually 'pushed myself to get out.' He shows me his walker, but does not use it to ambulate around the house. Did agree to keep it next to his recliner to aid in his getting up. Encouraged him to use it, though paths around the home are not as open as they could be.

There are boxes in the kitchen with his pots and pans. He has also packed up his favorite trains. Daughter notices today that he has taken down family photos from the refrigerator. Veteran is unsure why he is packing, but thinks he may be leaving soon. However, does repeat his wish to stay in the home - he cannot seem to resolve this discrepancy. Later states he thinks he will unpack again.

Furniture in home is in some disrepair. Has only one sturdy chair (I sat in the only other chair, which was a lawn chair in his kitchen). Kitchen table was mildly disorganized. He was unable to find his daughter's phone number - she states she repeatedly leaves it for him but he loses it. Daughter found milk left out on counter, though it was still cold. Unclear if he is eating any of his meals on wheels, he has many saved in the refrigerator. Daughter also brings him meals which he reheats.

TESTS ADMINISTERED:

Clinical Interview with veteran and caregiver, Repeatable Battery for the Assessment of Neuropsychological Status (RBANS) Form A, portions of Hopemont Capacity Assessment Inventory and Independent Living Scales (ILS), Geriatric Depression Scale (15-item), PTSD for primary care screen (PTSD-PC)

TEST RESULTS

COGNITION:
Across indices, Mr. T' Total Scale Index Score on the RBANS was 78 (7th %ile), which falls in the borderline range. On the RBANS, Mr. T's performance varied across domains, and across different tasks within particular domains, summarized as follows:

ATTENTION: On the Digit Span subtest of the RBANS, Mr. T was able to accurately repeat a string of 5 digits. This performance falls within the average range (z=-0.55) and suggests intact basic attention. On the Coding subtest, however, the veteran performed within the impaired range (z=-0.17). There is a discrepancy between intact performance on an auditory attention task and impaired performance on a visual attention task.

VISUOSPATIAL/CONSTRUCTIONAL: On the Figure Copy subtest of the RBANS, Mr. T performed within the average range (z=-0.15). On this task he drew most details accurately, though displayed some carelessness in execution. On the Line Orientation subtest, the veteran also performed within the average range (z= -0.65). Overall, these subtests suggest generally intact visuospatial functioning and constructional abilities.

LANGUAGE: On the Picture Naming subset of the RBANS, which is a test of

confrontational naming, the veteran was able to accurately name 10/10 items, a performance in the average range (z=-0.10). On the Semantic Fluency subtest, the veteran produced 11 fruits and vegetables in 60". This performance falls within the borderline range (z=0.16).

IMMEDIATE MEMORY: On the List Learning subtest of the RBANS, the veteran was provided with a list of 10 items across four trials. He demonstrated a relatively flat learning curve (4, 5, 5, 5) across the trials and his overall performance on this task fell within the low average range (z=-0.93). He was provided with a short story across two learning trials, he performed in the average range (z=-0.59). On the first trial, he was able to encode 6 of the 12 components of the story, and this improved to 7/12 components on the second trial.

DELAYED MEMORY: After a short delay, the veteran was unable to spontaneously recall any of the items from the word list, a performance falling within the impaired range (z=-1.70). When provided with target and foil words in a yes-no format, the veteran accurately identified 8 of the 10 words with no false positives, yielding low average list recognition (z=-1.70). On the Story Recall subtest of the RBANS, Mr. T was able to spontaneously provide just 2 of the 12 components of the story after a delay. This performance falls within the borderline range (z=-1.93), slightly worse than previous testing. Finally, on the Figure Recall subtest, the veteran performed within the low average range (z=-0.10). He was able to recall some of the details of the figure after a delay, though added extraneous details that were not in the original design.

MOOD: On the Geriatric Depression Scale, the veteran scored 0/15. He reported feeling generally optimistic about the future, able to fend for himself as needed, and denied subjective distress. He reported no thoughts of harm to himself or to others. He denied any history of harm to himself or others. The PTSD-PC screen was also negative. His daughter indicated she did not think her father was depressed but does find him irritable in the evenings.

CLINICAL INTERVIEW: Mr. T stated "my daughter wants to put me away in the nursing home." He feels he is coping well in the home. He describes having spent time in the SNF, and that he wanted to return home. "I want my house." He is not sure how frequently his daughter comes to check on him, thinks once a week. Says he is grateful for her assistance. He states he spends his time watching TV and sitting in his chair, otherwise cannot identify any other activities. Used to go to the Post to socialize with friends, but no longer does so. He is not driving, and has no vehicle. States 'they took my license away' after a past accident. Daughter reports case manager at Elder Services pursued this. R and her husband disabled the car, and he no longer has it.

Mr. T reports that he receives help from his next-door neighbor and can turn to him in an emergency. However, he also feels that this neighbor's wife watches him with a spyglass. He is also anxious about 'Cambodians' he believes live down the street. Says they bang on his windows and door, then run away. He states he has to 'holler at them' to stop. He denied feeling his phones or tv were tapped or that he was hearing voices.

He states that he does not go out into the yard, and that he feeds the bird from his back door. Daughter reports the back porch is in disrepair and not safe for him to stand on - veteran states he is aware of this. She has gotten reports from the neighbor that he is often out in the yard at odd times.

Veteran reports he has a .22 in the home, though daughter reports that they have removed all the firearms from the home. She notes that there are many padlocked safes and chests in the home, and she is not sure if he still has the keys. She is not sure what items he is keeping secure.

ILS: On the Health and Safety subscale of the ILS, Mr. T fell into the dependent range of functioning. For most questions dealing with immediate safety issues (ie. needing medical help quickly, seeing black smoke in his kitchen), he stated he would push his lifeline button. He had some difficulty discriminating when to use it in more complex scenarios. He stated he would push his button if he couldn't read the small print on his medication bottles. He was unaware of the importance of knowing medication side-effects. He could identify just one of his medications by what it does (dulcolax). Had empty bottles in a small shoebox on his table. Daughter keeps his medication bottles with her. He was unable to problem-solve some hypothetical home situations because he was adamant that such

a thing would never happen to him.

He recognized that if there were a problem with the home, he would let his daughter know about it. She reports past incident when he could not smell the gas leak in his home. He states he now checks the stove before he goes to bed. He does not answer the phone, even when daughter calls.

HOPEMONT:
On this semistructured interview, Mr. T was able to identify and define 'risk', 'benefit', and 'making a choice'. He described making the choice to save two men during the war, and identified the risks and benefits of that situation. When presented with hypothetical medical decision-making scenarios (eye infection, CPR), he was able to identify the risks and benefits of each with some assistance, and make a decision for each scenario. Of note, he indicated that if he were faced with the decision to have CPR, he would want to have it. Daughter present for this portion and states she understands her father's wishes. She is unsure if he had been made DNR during any prior hospitalizations.

With regard to his own situation, Mr. T is unable to identify the risks and benefits of his living independently. He vacillates about whether he needs the in-home services he already receives. He does not appear to appreciate safety issues in the home and in managing his health and medications.

SUMMARY:

Mr. O T was referred to this provider for evaluation of his capacity to make decisions about his ability to live independently and to make medical decisions. He has a history of mixed dementia, anxiety disorder, and chronic medical issues including hypertension. Cognitive testing today suggestive of borderline to mild impairment on tasks of visual attention, delayed memory, and executive functioning. His performance on tasks of immediate memory, visuospatial functioning, and naming were intact on this administration.

It is my impression that veteran lacks the capacity to make decisions about his living situation. The veteran's cognitive and functional impairment, and reduced ability to compensate for such impairment, may leave him unsafe in novel situations. He demonstrated a lack of understanding surrounding important safety measures, such as how to contact his daughter. Of note, veteran is functioning below what cognitive testing would suggest. He demonstrates little insight into his own care needs, and his poor understanding of his ability to keep himself safe in the home.

When at his best, he appears to have adequate capacity to make other types of simple medical decisions, particularly if they are framed in a straightforward manner, and the risks, benefits, and choices are clearly stated. He appears willing to follow through on medical recommendations that are unrelated to placement. He knows he should take his medication, and wants to do so, but cannot recognize that he is taking them incorrectly. Even with daily visits from his daughter, he appears to be failing to take his medications as prescribed.

Mr. T's misperceptions and false beliefs further compromise his safety in the home. Daughter reports he was at his best during the interview today, during which he exhibited baseline persecutory delusions. Per reports, he becomes more confused and suspicious as the day progresses, likely sundowning. His poor judgment leads him to frequently contact authorities based on his false beliefs. He is also at risk of undue influence from others.

Situation is tenuous, but no immediate risks today and is already being followed by protective services who have indicated their support in keeping him in the home as long as is feasible. With veteran and daughter’s consent, I spoke with his protective services case manager. They feel with regular visits from his daughter, the situation is tenable for the time being. At this point, will recommend maximizing services in the home (detailed below) as much as he will tolerate, with close monitoring from team. As rapport grows with team, he may be more tolerant of interventions to support him at home. Should these interventions fail, would recommend daughter consider placement at that time.

DSM-IV DIAGNOSIS:

Axis I: Vascular Dementia with Delusions
        R/O PTSD

Axis II: None
Axis III: See Active Problem List above
Axis IV: Self-Neglect, Housing problems, Financial problems, Functional declines secondary to health problems
Axis V: GAF = 25

RECOMMENDATIONS:

- Consider updated labs to r/o any reversible causes of cognitive impairment that could be contributing to current presentation.

- Discussed with daughter implementing additional safety measures to support veteran in the home. Specifically discussed contacting Lifeline to obtain automated medication dispenser. Also recommended she enroll veteran in SafeReturn program.

- Veteran does agree today to consider adult day health. This type of structured program and supervision could be very instrumental in keeping him home for the near future. We discussed VA-run day program at Soldiers Home which may be a good fit socially, but he indicated he would prefer a contract day program instead, which would be closer to his home.

- HBPC SW evaluation is pending and Zarit caregiver burden screen will be administered at that time. Daughter requesting support around managing financial issue that emerged today.

- Will continue caregiver support and work with team around treatment planning. Reviewed my contact information and contact information for Alzheimer's Association. Provided her with US Dept Health and Human Services book on caregiving for a loved one with dementia. Encouraged her own coping strategies, including delegating to her husband if possible, seeking opportunities for self-care.

- Referral placed to Geriatric Psychiatry. Will coordinate care with this provider.

- Recommend home safety evaluation by HBPC rehab team.

- Daughter would appreciate receiving HBPC PCP services in the home. HBPC medical director is scheduled to evaluate the veteran tomorrow for assignment to her panel.

- Veteran and his daughter gave permission to team to review this information with his case manager at protective services. Recommend team continue to coordinate care with EPS.

RBANS RESULTS

Domain	Index Score	Confidence Interval	Percentile
Immediate Memory	87	78-96	19%
Visuospatial/Const	89	75-103	23%
Language	89	77-101	23%
Attention	72	61-83	3%
Delayed Memory	75	62-88	5%
Total Scale	78	71-85	7%

Subtest	Raw Score	Z Score	Percentile	Descriptor
List Learning	19	-0.93	18	Low Average
Story Memory	13	-0.59	27	Average
Figure Copy	17	-0.15	42	Average
Line Orientation	14	-0.65	25	Average
Picture Naming	10	0.90	82	High Average
Semantic Fluency	11	-1.73	4	Borderline
Digit Span	8	-0.55	30	Average
Coding	14	-2.94	0.17	Impaired
List Recall	0	-1.70	0.01	Impaired
List Recognition	18	-1.29	10	Low Average
Story Recall	2	-1.93	3	Borderline
Figure Recall	7	-1.07	14	Low Average

(Manual norms used)