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Independent Living Capacity Evaluation in Home-Based Primary Care: Considerations and Outcomes of a Quality Improvement Project

Michelle C. Feng, PhD^a, Margaret R. Murphy, PsyD, ABPP^b, and Michelle Mlinac, PsyD, ABPP^b

^aExecutive Mental Health, Los Angeles, California, USA

^bVA Boston Healthcare System, Harvard Medical School, Boston, Massachusetts, USA

Abstract

Objectives—This article describes results of a quality improvement project review of 5 years of capacity evaluations for independent living conducted in one Home-Based Primary Care (HBPC) Program.

Methods—A retrospective chart review was conducted for all patients evaluated for independent living capacity through the Boston VA HBPC Program (N = 25) to identify differences in outcomes for those with and without capacity. Descriptive information included referral sources, capacity decisions, time remaining in the home, and trajectory of patients following evaluation.

Results—All patients evaluated had been diagnosed with a cognitive disorder, and on average, a relatively lower prevalence of mental illness compared with the national HBPC population. Referrals were made primarily by the HBPC team. Patients with capacity were found to have remained in their home longer than those who lacked capacity.

Conclusions—Referral for a higher level of care was typically only recommended when no further intervention could be implemented and active risk in the home could not be managed.

Clinical Implications—In home capacity evaluations are complex and challenging, yet results help family and HBPC team support patients' preferences for staying in their own home as long as possible.

Keywords

Decision-making capacity; home-based primary care; home-based services; independent living capacity; interdisciplinary

Introduction

Home-Based Primary Care (HBPC) is a comprehensive interdisciplinary care model for complex, chronically ill patients within both the US Department of Veterans Affairs (VA)

CONTACT Michelle C. Feng, mfeng@emhla.com, 10801 National Blvd., Suite 601, Los Angeles, CA 90025.

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(Edes et al., 2014) as well as in non-VA healthcare systems (Leff, Weston, Garrigues, Patel, & Ritchie, 2015; Reckrey et al., 2015; Rosenberg, 2012; Stall, Nowaczynski, & Sinha, 2014). VA HBPC teams are typically comprised of nurse case managers, social workers, primary care providers, dietitians, pharmacists, physical and occupational therapists, and providers. All disciplines work together to provide patient-centered care for veterans enrolled in the program (Edes et al., 2014; Karlin & Karel, 2014; Zeiss & Karlin, 2008). VA HBPC mental health providers collaborate with the rest of the HBPC team to determine which patients would benefit from specialized mental health services including psychological assessment and capacity evaluation (Gordon & Karel, 2014).

When a patient's ability to function safely at home becomes a concern, mental health providers in this setting are often asked by the HBPC team to evaluate independent living capacity. The American Bar Association and American Psychological Association define independently living capacity as requiring the 'integration of understanding what is required to live independently, the functional ability to apply one's knowledge ("application"), and the ability to problem solve and appreciate consequences of potential choices ("judgment")' (ABA-APA, 2008). This type of capacity evaluation can help the VA HBPC team identify strengths that can improve or preserve capacity while allowing individuals to age in place. However, these evaluations can encompass unique assessment challenges, especially for mental health providers and trainees new to this setting. In a 2010 VA survey, HBPC mental health providers estimated that they spend about 5% of their time each month performing capacity evaluations and functional assessments, and indicated that further training on capacity assessments would be useful for their work (Karlin & Karel, 2014).

There is little research on the process, considerations, or outcomes of independent living capacity evaluations conducted within the home. Naik, Kunik, Cassidy, Nair, and Coverdale (2010) derived four themes that could predispose vulnerability for adults in the community, from the perspective of social service and healthcare workers who participated in focus groups about the topic. These included: (1) social and demographic factors that could leave the person at risk of manipulation by others, (2) impairment in activities of daily living (including personal care, mobility, ability to manage finances, and self-management of medical conditions), (3) inadequate support system, and (4) a neuropsychiatric condition such as a mood or cognitive disorder. Skelton, Kunik, Regev, and Naik (2010) described the outcome of an interdisciplinary model for home-based independent living capacity assessments with older adults. This model includes an in-home geriatrics assessment followed by an interdisciplinary team meeting to develop a plan of care to support the individual in their homes whenever possible. Specific recommendations are given a chance to be trialed in the home before need for guardianship is considered. The authors reported that just 12 out of 30 individuals evaluated with this model ultimately required placement outside the home.

The goal of this article is to educate readers about the advantages and challenges of conducting independent living capacity assessments within the home. We present findings from a quality improvement project conducted within the VA Boston HBPC program. We also discuss the trajectories of patients following capacity assessments and describe differences in outcomes for patients with and without capacity. While this article focuses on

the VA HBPC program, we believe that the information provided can be useful for all clinicians conducting independent living capacity assessments.

Conducting Capacity Assessments in the Home

Understanding Referral Requests and Reasons for Assessment—The Assessment of Older Adults with Diminished Capacity, a Handbook for Psychologists proposes that evaluations for independent living capacity need to “determine if an individual is a significant danger to her or himself due to limited functional abilities, or due to cognitive or psychiatric disturbances, and also cannot accept or appropriately use assistance that would allow him or her to live independently” (ABA-APA, 2008). The clinician must weigh risks of staying in the home with the person’s ability to make their own decisions about where and how they live. Several articles have emphasized that both decisional capacity (whether they can make sound choices about their living situation) and executive capacity (the ability to act on those choices, direct others to do so, participate in a shared treatment plan, and accept needed help) are important factors to evaluate (Applebaum 2009; Cooney, Kennedy, Hawkins, & Hurme, 2004; Naik, Dyer, Kunik, & McCullough, 2009).

In a similar vein, we have found that the independent living capacity referral question in HBPC is twofold. First, does the patient have capacity to remain in the home? Second, are any additional services or interventions available to enhance the patient’s capacity to remain in the home that the person is willing to accept? If so, the HBPC team attempts to put those measures in place. If not, in collaboration with the rest of the HBPC team, the psychologist will recommend a transition to a higher level of care. Consistent with the framework in the ABA-APA Handbook for Psychologists, our typical independent living capacity evaluation includes an assessment of the individual’s cognition (or they are referred for neuropsychological testing), an assessment of psychiatric symptoms that could be impacting on capacity, a functional measure such as the Independent Living Scales, observations of functioning in the home, and a clinical interview with the patient that includes an assessment of their values and preferences for where and how they live.

Independent living capacity evaluations in HBPC are commonly requested following an incident occurring in the home that is worrisome to the HBPC team and the family (although often not to the patient), such as a fall where the patient was unable to call for help, a small kitchen fire, or signs of self-neglect. Other times, the referral comes as a result of the team feeling stymied by their ability to provide effective care for the patient at home. By the time a capacity evaluation is requested, the team may have reached a plateau in treatment, uncertain what, if any, further interventions will be tolerated by the patient. Clarifying the capacity question may require collaborating with other providers, family, and with competing interests. For example, a family member may be adamant that the patient should remain in the present living situation because they cannot afford a higher level of care, but the patient’s apartment manager is concerned about a recent stove fire and is threatening to evict the patient. The patient’s cardiologist may be concerned about a high risk of stroke due to poor medication adherence, but in-home oversight may not be available or insufficient to address this need.

In states where self-neglect falls under its purview, Adult Protective Services (APS) may be involved (following a report by the HBPC team or another concerned party) and can be key partners in care coordination and planning. In Massachusetts where we practice, competent older adults can refuse involvement from APS, so findings of incapacity may allow for APS to be involved when they formerly had not been. APS may also be able to access and leverage additional resources to enhance the person's capacity to remain in the home. For example, APS was able to facilitate a Lifeline service for one patient who could not otherwise have afforded it. This service allowed for an automated medication dispenser to be put in the home, enhancing his independence. As APS worked with the HBPC team over time, they became familiar with what HBPC could provide and would refer patients they were working with to the program.

Guardianship may be necessary to secure appropriate services or transition the person to a more supportive setting. States vary in requirements for evaluation of incapacity, which may include medical, psychological, and social work assessments (Moye & Naik, 2011). Findings from in home capacity evaluations for guardianship hearings can provide detailed, realistic summaries of patient's strengths, values, and needs. Moye and colleagues (2007) developed a conceptual model and assessment template for evaluating independent living capacity for older adults specifically within guardianship proceedings. The guardianship evaluation template focuses on the assessment of physical and mental conditions, cognitive and emotional functioning, everyday functioning, values and preferences, risk of harm and level of supervision needed, and services that the patient would benefit from. Mental health providers are encouraged to find ways to enhance patient's capacity to minimize or eliminate the need for guardianship (Moye et al., 2007).

Benefits of Assessing Independent Living Capacity in the Home—Assessing the patient in their own home offers a vantage point for the clinician to directly assess the functional elements of independent living capacity, rather than relying solely on a report from the patient or other reporters (Gordon & Karel, 2014). The risks and benefits of the home situation to the patient are often evident by being in the patient's own space with them. For example, during the capacity evaluation, the clinician can observe whether the patient can hear the doorbell ring, use the phone, or locate an emergency call button. Sometimes risks are clearly obvious to providers, such as exposed wires or blocked exits. Failures in self-care are also frequently evident, such as a freezer full of months of home-delivered meals that have gone untouched, piles of soiled laundry, or evidence of hoarding. The clinician may have the opportunity to observe the interaction between formal and informal caregivers and the patient (e.g., does the patient seem receptive, guarded, or dismissive of the overtures of caregivers).

Assessing the patient at home also supports patient-centered care. Seeing the environment firsthand can help the clinician understand what the patient may not be able to put into words. For example, veterans often share their service medals, family photos, devoted pets, and prized possessions. The capacity assessment takes into account the patient's cultural background, preferences, and values. Our clinical interview often includes asking, "What makes your home a home?" Responses to this question can help the clinician make recommendations consistent with the patient's wishes.

Challenges and Ethical Concerns—Clinicians conducting independent living capacity evaluations in the home setting can come across several challenges and ethical issues. For example, a patient’s family members may be present in the home during assessment and may feel the need to assist the patient in answering questions or clarifying for the patient. Willingness of the patient or family members to implement recommendations can also be a challenge. For example, if a recommendation for placement is made, family members may refuse because the patient does not want to leave the home or give up financial resources to pay for long term care. Another recommendation might be for the patient to receive increased services to improve safety in the home, but the patient’s partner refuses to allow more help, insisting that he or she can provide what is necessary. Table 1 provides a list of these common ethical concerns and challenges, as well as suggested approaches toward resolution as it relates to the home setting. We also refer readers to Hicken and Plowhead (2010) for a detailed discussion of the advantages and challenges of home-based mental health service delivery.

Risk Assessment and Intervention in HBPC—Figure 1 describes a conceptualization of the dynamic risk assessment and intervention cycle in HBPC. In addition to routine primary care, for these vulnerable patients, the HBPC team makes an ongoing interdisciplinary assessment of their ability to remain safely in place at home. This assessment is informally conducted at each home visit, and formally reviewed during quarterly treatment planning meetings. The team modifies the treatment plan based on the level of risk, the patient’s personal goals and changing needs over time. To do so, the team recalibrates interventions, enlisting additional disciplines or other services and providers as needed, and evaluates the outcomes of those interventions. This process is co-occurring and often in collaboration with patients’ own periodic reassessment of how their home environment fits their needs (Kaplan, Andersen, Lehning, & Perry, 2015). Patients’ preferences are often to remain in the home as long as possible, and this model works to balance these preferences and values with their basic safety in the home.

While HBPC services have grown significantly in the past decade, there is very little data describing the processes and outcomes in evaluating decision-making capacity in this setting. To our knowledge, we could not identify studies or reports describing outcomes of “real world” independent living capacity assessments. We were interested in understanding the types of patients who undergo capacity evaluations in our HBPC setting and the trajectories our patients follow over time in relation to how long they remained at home, and in many cases, their transition to long-term care. We conducted a quality improvement project to explore these factors. While not a research study, we believe that a consideration of clinical outcomes following these assessments may assist clinicians in further considering the impact of these assessments and how they fit into the overall understanding of whether and for how long patients remain in the home.

Methods

We performed a chart review of all independent living capacity evaluations performed by HBPC mental health providers (psychologists and psychology trainees) at VA Boston from 2008 (when the program began including a mental health provider) to 2014 (when the QI

project began). Patients' capacity evaluation reports and relevant chart notes were reviewed. Patient demographics, time enrolled in HBPC, reason for referral, and capacity evaluation results were obtained. Patients' diagnoses were retrieved from their problem list in their electronic health record. In total, 25 evaluations were reviewed and the main findings of this review are presented below.

Results

Patient Characteristics

Patients included in our study ranged in age from 61 to 98 years old at the time the capacity evaluation was conducted, with an average age of 82.4 years ($SD = 9.6$). All patients in our review had been diagnosed with a form of cognitive impairment prior to the evaluation. Not surprisingly, rates of dementia in this population were found to be higher than the general HBPC population, which has been reported to be 33% (Edes & Burris, 2014). Out of 25 patients, 21 had been diagnosed with dementia, three with a cognitive disorder not otherwise specified, and one with mild cognitive impairment. Chart review also revealed that out of the 25 patients evaluated, four were diagnosed with depression, two with post-traumatic stress disorder (PTSD) and two with an anxiety disorder per their medical record. The mental health diagnoses in this very small subgroup of vulnerable HBPC patients were present at a much lower rate than the general HBPC population, which have been reported to be as high as 44% with depression, 24% with an anxiety or personality disorder, 21% with PTSD (Edes & Burris, 2014). See Table 2 for further demographic information.

Referral Requests

In our review, the majority of requests (13 out of 25) for capacity evaluations were made by other HBPC team members. Patients referred for evaluation by the team had been enrolled in HBPC for an average of 16.1 months ($SD = 14.0$). In comparison, those referred for evaluation by APS (9 out of 25) had been enrolled in HBPC for an average of 5.5 months ($SD = 6.7$). Referrals requested directly from the patient's family (3 out of 25) were for patients who had been enrolled in HBPC for an average of .9 months ($SD = .5$).

We found that the capacity evaluations conducted within HBPC were rarely performed in isolation. For example, 16 of 25 patients had completed a full cognitive and/or capacity evaluation with a psychologist prior to the HBPC evaluation. If not done within HBPC, these were typically performed by outpatient neuropsychologists. In addition, chart review indicated that after the HBPC capacity evaluation, 17 out of 25 patients underwent additional or repeat testing, which was typically conducted during an inpatient hospitalization (medical or psychiatric) en route to long term care, or repeat testing with the HBPC psychologist (often in cases where medical certificates were needed by an attorney in pursuit of guardianship). In 15 of the 25 cases reviewed, APS was also involved at some point throughout the process, collaborating with the HBPC team around care planning.

Capacity Assessment Findings

Capacity evaluation findings were categorized by two decisions made by the evaluator, specifically whether or not the patient had capacity to live independently and whether or not

a more structured level of placement was recommended. Out of the 25 individuals evaluated over this period, five were determined to have capacity to live independently and therefore more structured placement was not recommended. We will refer to this group as Group 1. Out of the 20 patients determined not to have capacity, 9 were recommended placement to a more structured living environment than where they currently lived, such as an assisted living facility or long-term care facility (Group 2) and 11 were not recommended placement (Group 3). See Figure 2 for graphical representation of decision points.

Reasons for Recommending or Not Recommending Placement—Review of patients' capacity reports revealed one of the primary reasons listed for recommending placement to a higher level of care was the determination that capacity was unlikely to be enhanced given the resources available. For example, placement was recommended when the patient was unwilling to use additional supports or resources, when additional supports were not available, and/or when their own behaviors or the home environment posed an active risk to their safety. Reports cited patients' significant medical issues, poor adherence to the treatment plan, and blatant self-neglect.

Reasons why patients without capacity were not recommended placement were also reviewed. Those in this category (Group 3) were believed to be in a situation where there was realistic room for improvement, as in patients were willing to accept increased services and those services were available to the patient. Some of the patients had just been enrolled in HBPC, and it was viewed that being in the program would improve patients' situations to the extent of optimizing safety and taking into account the preference to remain in the home. In other cases a family member who had not been involved was willing to provide more oversight and assistance to the patient. In one instance, the patient's building manager assumed the role of informal caregiver, which allowed the patient to remain at home for over two years following the capacity evaluation.

Time Spent at Home following Evaluation—In our chart review, we also collected information on how long patients remained in their current living situation after the evaluation was completed. See Table 3 for specific results. For patients who remained in the home at the time of the chart review, this value was determined by calculating time between the date of their capacity evaluation and the time of the chart review. In general, patients found to have capacity (Group 1) remained in their home the longest, with an average of 23.2 months after evaluation. In comparison, those without capacity and for whom placement was recommended (Group 2) remained in their home, on average, 15.1 months, and those without capacity and from whom placement was not recommended (Group 3) remained in their home 13.8 months on average.

Group 2 and 3 averaged similar lengths of time in the home post-evaluation, indicating that regardless of recommendation, patients without capacity remained in their home for a shorter amount of time than those with capacity. To gain a clearer understanding of change over time, we calculated the percentage of patients within each group who remained in the home 6 and 12 months after the capacity evaluation (see Figure 3). Findings indicate that the majority of individuals in Group 3 left the home between 6 and 12 months, while a larger percentage of those in Group 2 left the home within 6 months of their evaluation.

Trajectories of HBPC Patients Following Capacity Assessment

At the time the review of chart records was conducted, 17 out of the 25 patients evaluated were known to have transitioned to a more structured level of care at some point (16 in long term care, 1 in assisted living). Four patients continued to remain at home, one was lost to follow-up, two remained in the hospital (one awaiting placement for long-term care and one being treated for an acute condition), and one was in home hospice care. Out of the five patients with capacity, two remained at home, two were hospitalized, and one transitioned to long-term care. We reviewed reasons for ultimately leaving the home according to the chart notes. They included one or more of the following: decisions made by the family /guardian placement, social admissions by HBPC providers, and medical reasons leading to placement from the hospital. Guardianship was ultimately obtained for four of the 20 patients deemed to lack capacity, and one who did have capacity at the time of our evaluation but whose worsening health 9 months later resulted in the need for guardianship. Guardians were enlisted to oversee the care of these five patients. Three of these guardians were unaffiliated attorneys or other agencies, one was a family member, and one was a friend of the patient. Four of the five patients with guardianship were eventually placed into long-term care.

Discussion

Results of this project provide insight into patterns and outcomes regarding independent living capacity assessment in one HBPC program. We found that all of the patients evaluated had been diagnosed with a cognitive disorder, and on average, a relatively lower prevalence of mental illness compared with the national HBPC population. Patients referred for independent living capacity evaluations by family members had been enrolled in HBPC for less than two months prior to evaluation. We believe this may potentially be related to the level of burnout from these caregivers before HBPC has had time to make substantial interventions, or their willingness to finally accept help. An earlier referral to HBPC may help to avoid requests for independent living capacity in a crisis situation. One local effort to have these patients referred to HBPC earlier in their care has been through a Geriatrics in Primary Care demonstration project at VA Boston, in which a geriatrician and geriatric nurse were embedded within primary care. They supported the clinic primary care team in managing complex, high-risk patients, evaluated patients at home when needed, and forged a partnership with our HBPC team to identify appropriate candidates for home-based care (Engel, Spencer, Paul, & Boardman, 2016).

We believe, for this small sample, the results of the capacity evaluations did differentiate between those patients who could remain in the home longer compared with those in more immediate need of placement. We found that patients determined to retain capacity to live independently remained in their home longer than those deemed to lack capacity. Furthermore, a greater percentage of those for whom a higher level of care was recommended (Group 2) left the home within the first six months, compared with those without capacity but for whom placement was not recommended (Group 3). We believe this pattern may be indicative of the HBPC team's level of effectiveness in extending out the time in which those without capacity, but amenable to increased resources (Group 3) can remain at home.

A Model of Trajectories Following Capacity Evaluation

Information gained from the quality improvement project highlighted many of the social, contextual, and patient-related factors that influence whether and for how long patients remain in the home. Given this information, we developed a model to graphically represent the influence of these factors on the trajectories that patients follow after a capacity evaluation (see Figure 4). The paths patients track between the home and more structured living situations are illustrated here, beginning in the home. Patients at times transition directly from the home to more structured settings, represented by the arrow from the “home” to “long-term care” box. This occurs, for example, when guardianship is sought and the patient is transferred to a long-term care setting. The smaller arrows represent the common cycle of patients’ admissions to the hospital due to an emergency medical situation, possibly transitioning to a rehab setting and returning home. At times, admission to the hospital results in transition to a long-term care setting. This can occur when the patient’s medical condition has declined to the point where they can no longer return home safely. This general pattern from the home to the hospital (and at times, long-term care) occurs in parallel and alongside HBPC services and capacity assessment. These patterns of hospitalizations have been described in other areas of research, most notably in care transitions related to geriatric care. For example, Coleman and colleagues (2004) describe the nature of posthospital care transitions and patterns of placement. They highlight the complicated nature of these trajectories and the variability in patterns of care transitions with an older population. Implementation of home-based primary care has been associated with a reduction in hospital readmission rates and shortened lengths of hospital stays, decreasing the frequency of hospitalizations in these patients (see Beales & Edes, 2009; Kinoshian, Tompkin, & Edes, 2008). HBPC services have been shown to add significant value to the care of patients also enrolled in primary care (Engel et al., 2016). For more information on improving care transitions for individual with complex needs, see Coleman, 2003 and Coleman, Parry, Chalmers, & Min, 2006.

The figure demonstrates that completing a capacity evaluation is one step in the process of addressing risk for continued independent living in patients in HBPC. Unlike hospital settings, where patients are restricted from returning home if found to lack capacity, patients already in the home do not necessarily leave the home because they are found to lack capacity. Independent capacity evaluations in the home are shown to be both informed by factors listed and can also influence these factors via the capacity results and recommendations (indicated by the dotted arrows). The role of the VA HBPC mental health provider may range from making recommendations to the referral source to assisting in implementing those recommendations. This might include making referrals to agencies, including Elder Protective Services, and providing education and support to the patient and caregivers during transitions to different levels of care. Involvement of protective services, informal caregivers, severity of acute medical conditions, and willingness of patients to accept services all influence whether or not the patient is able to remain at home.

Implications for Geropsychology Training

In addition to learning the basic skills and knowledge base for conducting these assessments, training and supervision in this context can also be used as an opportunity to have frequent,

open, process conversations. Trainees are taught to be aware of the personal biases they bring to capacity evaluations, particularly in balancing risk and autonomy. Part of the experience is learning to balance how much information is needed with the length of visit (and respect for the patient's ability to tolerate testing), honing behavioral observations skills both of the patient and of the state of their home, and learning to respond effectively to unexpected situations (e.g. what to do when a caregiver is answering questions for the patient in the other room).

Conducting independent living capacity evaluations can feel like a daunting task for trainees, because the outcome may go against the patient's values of remaining in their home. Many individuals we assessed had lived in their homes for the majority of their adult lives, but also had clear safety risks in remaining there. For trainees, making a clear delineated statement of capacity can feel uncomfortable. A common fear they have is that recommending a higher level of care will immediately lead to the patient's removal from their home, which in reality in our setting, is rarely the case. As we found in our review, patients deemed to lack capacity, on average, remained in the home for a similar amount of time regardless of whether placement was recommended or not. Some points of discussion in supervision include: the risks of the patient remaining in the home versus moving residences, the inevitable moral and ethical issues raised when evaluating capacity, the unique values of the supervisor, supervisee, the team, patient, and the patient's family, and how these relationships are respectfully managed when values differ.

Limitations and Future Directions

All evaluations reviewed in our QI project were conducted or supervised by two of the authors within the same HBPC team. Patients reviewed were typically urban/suburban dwelling patients, and therefore some of the processes and resources available will likely differ for teams working in rural settings or areas with less access to services. Our findings therefore, should be interpreted with these considerations in mind. While our sample size is relatively small, the QI project results presented are the first to our knowledge to describe outcomes of "real world" independent living capacity assessments conducted in the home. We believe the information gained from this project provides a glimpse into the types of patients that undergo independent living capacity assessments in HBPC as well as the differences in outcomes for those with and without capacity. We hope our preliminary model will evolve over time as more research is conducted and that future studies will focus on continuing to understand this highly complex and often unpredictable population so as to provide optimal care while residing in the home.

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Clinical Implications

- The advantages of evaluating patients within an ongoing assessment and intervention program run by an interdisciplinary team allows the capacity evaluation findings and recommendations to be patient-centered, supporting patients' preferences for staying in their own home whenever possible.
- HBPC independent living capacity evaluations focus strongly on the practical interventions that can be implemented by the care team itself, coordinated with involved care providers and community agencies.
- Recommendations for placement are typically only made when all viable interventions have been attempted and the active risk of remaining in the home can no longer be adequately managed by the person's support system (which includes HBPC services).
- The clinician should be aware of ethical pitfalls inherent to performing these types of evaluations with vulnerable individuals in an interdisciplinary context. The clinician has to balance the patient's right to self-determination against possible risks of remaining in an environment that may be unsafe. Reports from other HBPC team members and from caregivers can be very valuable to the overall assessment, but can also pose complicating and conflictual information that must be carefully evaluated before being incorporating into the decision making process.
- HBPC provides a rich opportunity for clinical trainees to develop competence in interprofessional teamwork, risk assessment, and clinical ethics.

Figure 1.

Dynamic risk assessment and intervention cycle in home-based primary care.

Figure 2.
Graphical representation of decision-making process involved in recommendation of placement.

Figure 3.
Percentage of veterans by evaluation outcomes remaining at home 6 and 12 months post-evaluation.

Figure 4.

Illustration of social/contextual and patient factors that influence where patients reside. Independent living capacity assessments are shown being both informed by these factors as well as influencing these factors through results and recommendations (dotted arrow).

Table 1

Challenges and ethical concerns in conducting capacity evaluations in the home setting.

Ethical Issue	Approach toward Resolution
Privacy	Schedule when likely to have fewest interruptions. Make other people in home aware of need for privacy and to let patient answer in his/her own words.
Informed Consent *	Explain purpose of evaluation, risks & benefits, limits of confidentiality. If unable to give informed consent may assent May refuse, can still give opinion based on information available
Multiple Roles of the Psychologist:	Refer to other provider for evaluation if seeing patient or caregiver for therapy; if there is no other provider available, seek consultation.
Multiple Stakeholders	Recommend strategies to enhance capacity to be completed within specific timeframe, if no improvement then complete evaluation
Individual's biases	Self-awareness of personal biases about autonomy and risk Assess collateral information based on that individual's biases Seek consultation or supervision, consult to ethics committee
Risk Tolerance	Self/team awareness of risk tolerance Gain knowledge of available resources to promote safety, possible outcomes for recommendation Report to Adult Protective Services if indicated Seek consultation or supervision, consult to Ethics Committee
Willingness to use supports	Help patient and family implement recommendations to enhance the patient's capacity Provide education and support to unwilling parties Problem-solve different behavioral strategies that may increase likelihood of use
Flexibility vs. Precision in assessment	Continual assessment of patient's frustration tolerance Administer most relevant and practical measures first

* There is an exception for informed consent for assessments when "one purpose of the testing is to evaluate decisional capacity." Ethical Principles of Psychologists and Code of Conduct (American Psychological Association [APA], 2010)

Table 2

Demographics of veterans within quality improvement study.

Variable	N (%)
Gender	
Male	21 (84)
Ethnicity	
Caucasian	21 (84)
African-American	2 (8)
Asian	2 (8)
Education	
<12 years	8 (32)
12 years	9 (36)
>12 years	8 (32)
Marital Status	
Never Married	13 (52)
Widowed	7 (28)
Divorced/Separated	4 (16)
Current partner	1 (4)
Living Situation	
Alone in home	21 (84)
ALF	3 (12)
Home with partner	1 (4)

Table 3

Capacity assessment outcomes regarding placement.

		Has Capacity Placement Not Recommended Group 1	Lacks Capacity Placement Recommended Group 2	Lacks Capacity Placement Not Recommended Group 3	All evaluated
N		5	9	11	25
Age	M (SD)	80.80 (9.58)	80.56 (10.99)	84.64 (8.70)	82.40 (9.55)
Months in HBPC		18.35 (17.85)	13.58 (14.10)	5.32 (4.79)	10.90 (12.55)
Months at home after evaluation		23.20 (29.79)	15.08 (22.93)	13.77 (17.08)	16.13 (21.40)
Home 6 mon	N (%)	4 (80)	4 (44)	9 (82)	17 (68)
Home 1 year		3 (60)	3 (33)	3 (27)	9 (36)

Note: Months in HBPC = amount of time enrolled in HBPC prior to the evaluation. Months at home after evaluation = number of months the patient remained at home following capacity evaluation. Home = the number of patients in that group who were still living in their homes at 6 months and 1 year.