Clinical Safety & Effectiveness
Cohort # 18

Development of a Standardized Protocol to Assess Capacity for Medical Decision-Making at University Hospital

CENTER FOR PATIENT SAFETY & HEALTH POLICY
UT Health Science Center
SAN ANTONIO
The Team

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AIM Statement

To develop a practical, evidence-supported protocol for the evaluation of patient capacity for medical decision-making to be used by UH psychiatry consultation/liaison service with the goal of training at least 50% of psychiatry residents in the protocol and subsequent implementation within at least 50% of current consults volume by June 1st, 2016.
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<tr>
<th>Project Milestones</th>
<th>Date/Time</th>
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<tr>
<td>Team Created</td>
<td>Dec 2015</td>
</tr>
<tr>
<td>AIM statement created</td>
<td>Jan 2016</td>
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<tr>
<td>Weekly Team Meetings</td>
<td>Jan - present</td>
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<tr>
<td>Background Data, Brainstorm Sessions, Workflow and Fishbone Analyses</td>
<td>Feb - present</td>
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<td>Interventions Implemented</td>
<td>April 26, 2016</td>
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<td>Data Analysis</td>
<td><em>Ongoing</em></td>
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<td>CS&amp;E Presentation</td>
<td>June 3, 2016</td>
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Capacity Evaluations

- “Ability to understand relevant information and to appreciate the reasonable foreseeable consequences of a decision”
- If lacks capacity, patient needs a proxy decision-maker
- Capacity is not all-or-none
- To date, no consistent criteria for evaluation of MDM capacity or standardized protocol/procedure exists to guide this process
- Many providers feel uncomfortable with the resulting events of the patient having or lacking capacity for medical decision making

Flowcharts
Flowchart-1

1. Patient admission → Physician assessment
2. Physician decides treatment

- Patient capacity
  - Capacity assessment not being done correctly
  - Capacity assessment occurs after patient refuses treatment

3. Patient consent
- No → Page C/L service resident
  - Paging wrong #
  - Info provided changes
  - Wrong info provided
  - Request patient information MRN, history, treatment recs

4. Yes → TREAT
   - Patient says gap, but they lack capacity

2
Flowchart-2

1. Does pt. really need consult?
   - Yes
     - Get to the floor
       - Can't find room, or it changed
       - Patient not in room
     - Talk to RN
       - Wrong RN, Can't find RN
       - No standard questions for RN
     - Talk to the patient
       - Cannot find patient
     - Assess understanding, reasoning, current template
       - Not clear which questions are deal breakers
       - MD/Resident insufficient training
       - Cannot find correct form
     - Run cognitive screen (MMSE, CLOX, EXIT25 etc)

2. 3
Flowchart-3

1. **Does patient have capacity?**
   - **Yes** → **Follow up**
   - **No** → **Decide alternative treatment**
     - **Yes** → **Measures to restore capacity**
       - **SW consult PRN** → **Ethics and Legal consult PRN**
   - **No**
Summary Flowchart

1. Patient admission
2. MD assess patient and decides treatment
3. Patient capacity?
4. Patient consent for treatment? NO
5. Page consult service resident
6. Consult service resident
7. Request patient information MRN, Room no. Hx
8. Cognitive screening
9. Talk to patient, assess understanding, run current template
10. Talk to RN
11. Get to the floor
12. Patient really needs consult?
13. Request patient information MRN, Room no. Hx
14. Does patient have capacity??
15. No
16. Decide alternative treatment
17. Measures to restore capacity
18. SW consult
19. Ethics and Legal consult
Process Analysis Tools

**Measurement**
- Capacity Score
  - Premature request before submitting CL
  - Doctor has not seen patient
  - Patient has not refused yet
  - Insufficient medical student resident training

**Environment**
- Cant find room
  - Cant find doctor or nurse
  - Wrong patient information
  - Doc calls for second opinion!!

**Methods**
- MD makes subjective decision to assess cognition
  - No existing protocol or assessment method
  - Pre-assessment information
  - Nurses contact not standardized, delay in CL
  - Capacity at discharge
  - Family opinion

**People**
- Doctor has not seen patient
- Patient has not refused yet

**Management**
- Who makes final decision?
  - No assessment in medical record
  - Wrong number

**Machines**
- Problem Statement
  - Medical decision making protocol is needed
Decision Making Tools: Pareto Chart

Resident Preference for Capacity Assessment Training

Rotation

Resident Preference

CL
INTERN
CL/DID
IP
CL/geri, triage
CL/GERI/IFOR
CL/IP/GERI
CL/outpmed
CL/tirage
Other

26
3
2
2
1
1
1
1
7

57.8%
64.4%
68.9%
73.3%
75.6%
77.8%
80.0%
82.2%
84.4%
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
Data

- **Measures:**
  - Psychiatry Residents (self-report):
    - Perceived self-competence
    - Knowledge assessment, case vignettes
  - Consults Volume/Time:
    - Patient tracking log
Perceived Self-Competence

• E.g., “I feel capable of assessing patient capacity for medical decision-making now”

• Rate: 1 = strongly disagree, 7 = strongly agree
E.g., A 59-year-old woman has a history of schizophrenia and takes Risperdal Consta 50 mg IM every 2 weeks. She is refusing to undergo a recommended screening colonoscopy. She explains that she does not wish to go through the emotional stress of another colonoscopy, even though she realizes that the screening is recommended for prevention and early detection of colon cancer, so refusing the test would increase her risk of having undetected colon cancer. Does she have the capacity to refuse?

a. Yes, because she is on consistent medication for schizophrenia
b. Yes, because she can understand the risks and benefits and convey a choice
c. No, because she has serious, chronic mental illness
d. No, because her mental illness impairs her insight and cognition
Resident Perceived Self-Competence
Total Score (PRE-Intervention) by PGY
Case Scenario Capacity Knowledge Assessment
Total Score (PRE-Intervention) by PGY

TOTAL SCORE (PRE-IV) vs PGY LEVEL

UCL
7.6
9.5
7.8

CL
4.9
5.5
3.2

LCL
2.2
2.3
0.1

Case Scenario Capacity Knowledge Assessment
1) **Training in use of the ACE**
   - **Inform faculty of change in protocol:**
     - 3/29 faculty meeting, 3/30 email
   - **Teach residents about Capacity and ACE:**
     - 4/26 didactic
   - **Train current C/L residents on ACE:**
     - Drs. Lozano and Kilpela
   - **Implement on C/L:**
     - Drs. Lozano and Kilpela
Concerns regarding patient capacity for MDM

Administer ACE

Definitive Conclusion (Y/N)

Proceed Accordingly (Re-evaluate prn)

"Probable" or Inconclusive

Administer MOCA

Definitive Conclusion (Y/N)

Still Inconclusive

Administer further evaluation (e.g., EXIT-25), collateral, etc., until conclude with Y/N
2) Obstacles/lessons learned

- About 50% resident attendance to didactic training
- Implementation of new process difficult
- Concern from residents that evaluation was too narrow
- At times, not fully following new protocol
Resident Perceived Self-Competence Total Pre and Post by PGY

PGY level

4 Qtr Total Score Pre and Post

UCL 32.9
CL 18.3
LCL 3.6
34.8
31.5
22.1
18.9
Results: Resident Perceived Self-Competence

** = p < .01
Results: Resident Knowledge

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<thead>
<tr>
<th>Pre-Intervention</th>
<th>Post-Intervention</th>
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The chart shows a comparison between pre-intervention and post-intervention resident knowledge levels, with both levels being the same at 5.
Results: Consults Volume & Time

- Consults tracking:
  - Pre-Intervention Volume:
    - Feb 01, 2016 – April 26, 2016
    - 27 capacity evaluations
    - Time: Min: 45 minutes
      Max: 26 hours
  - Post-Intervention Volume:
    - Data collection ongoing
    - 9 capacity evaluations thus far
ACT: Sustaining the Results

- Continue to utilize the standardized protocol to assess capacity on the Psychiatry Consult Service
- Provide training on the use of the capacity protocol to all rising PGY 2 Psychiatry residents (“boot camp”)
- Provide annual “refresher” training to all Psychiatry residents
- Provide training to all Psychiatry clinical faculty
- Expand the Psychiatry template for capacity for use by all specialties using the Sunrise EMR at UH
Return on Investment

- Consider downstream impact from delay of treatment
- Bed assignment, housekeeping, transport, nursing time, physician cost
- Patient satisfaction
- PRICELESS!
Conclusions

- With a lot of education, it is possible to implement a standardized protocol to assess MDM capacity
- Residents can gain confidence and knowledge about using a standardized method to assess MDM capacity
- Changing physician behavior is difficult, even when there is a solid evidence base
- Getting buy-in from physicians in other specialties will be even more challenging
Next Steps

- Ramp up training for Psychiatry residents
- Expand training to Psychiatry faculty
- Expand training to physicians in other specialties at UH
- Work with UH leadership to develop a multi-disciplinary approach to deal with patients’ ability to care for themselves after discharge
Our Team!
Thank you!
Questions?