

Driving Miss Daisy Should our hospice patients be driving?



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Disclosure

Karen Cross and Shannon Sheek have disclosed no relevant financial relationships.

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6/3/08

Karen Cross, MD
Hospice & Palliative Carecenter
101 Hospice Ln
Winston-Salem, NC 27103

Dear Dr. Cross:

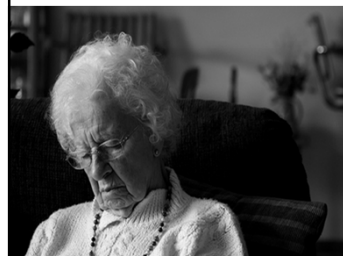
It has come to our attention that one of the residents under your care at Green Gardens Residential Inn is receiving high doses of Methadone and is driving a car. Our pharmacy staff is concerned that his driving ability is impaired by his opioid medications. We wanted to bring this concern to your attention.

Sincerely,

John D. Smith, PharmD, chief pharmacist

Mrs. Stein

79 yr old female with ALS
severely limited neck ROM



CASE OF THE AGING PATIENT
FROM EVIDENCE TO ACTION

CLINICIAN'S CORNER

The Older Adult Driver With Cognitive Impairment "It's a Very Frustrating Life"

David H. Carr, MD
Brian R. Ott, MD

The Patient's Story

Mr W is a 62-year-old retired college professor who lives at home with his wife in an upscale suburban neighborhood that offers both public transportation. Although his wife can operate a motor vehicle, she prefers that Mr W drive. Mr W has obstructive sleep apnea, hypertension treated with lifestyle modifications, treated vitamin B₁₂ deficiency, mild chronic anemia, restless legs syndrome, osteoporosis, edema, and a history of prostate cancer. His only medication is vitamin E.

About 8 years ago, the patient reported mild forgetfulness to his geriatrician. In 2004, Mr W reported that he had lost his way while driving to a familiar museum, had difficulty recalling details of his personal art collection, and had fallen a few times. His score on the Mini-Mental State Examination (MMSE) was 30/30.

In January 2009, he reported that his memory loss troubled him and that driving had become more difficult. He had no driving violations, and neither he nor his wife reported unsafe driving practices. He could independently perform all basic activities of daily living (ADL) and instrumental ADL, and he could walk, swim, and climb stairs.

Although automobiles remain the transportation of choice for many older adults, late-life cognitive impairment and dementia often impair the ability to drive safely. However, there is no commonly used method of assessing dementia severity in relation to driving, no consensus on the assessment of older drivers with cognitive impairment, and no gold standard for determining driving fitness. Yet clinicians are called on by patients, their families, other health professionals, and often their state's Department of Motor Vehicles to assess their patients' fitness to drive and to make recommendations about driving privileges. This article describes the challenges of driving with cognitive impairment for both the patient and caregiver, summarizes the literature on dementia and driving, discusses evidence-based assessment of fitness to drive, and addresses important ethical and legal issues. It also describes the role of physician assessment, referral for neuropsychological testing, screening for functional ability, tools to assess dementia severity, driving evaluation clinics, and Department of Motor Vehicles referrals that may assist with evaluation. Lastly, it discusses mobility counseling (eg, exclusion of hazardous situations) because health care

CLINICAL CROSSROADS
CONFERENCES WITH PATIENTS AND DOCTORS

CLINICIAN'S CORNER

Impaired Driving From Medical Conditions A 70-Year-Old Man Trying to Decide if He Should Continue Driving

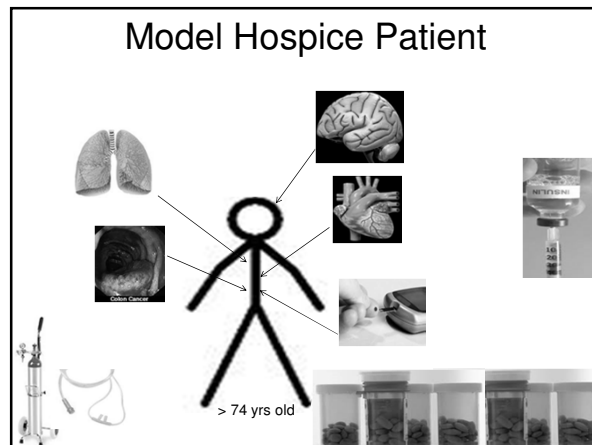
Matthew Hizzo, MD, Discussant

DR. BURNS: Mr P is a 70-year-old right-handed man with a history of idiopathic Parkinson disease, hypertension, and atrial fibrillation. He has Medicare insurance.

Mr P was diagnosed as having idiopathic Parkinson disease 5 years ago. Currently, his main symptom is a right-hand resting tremor. Mr P also has a rapid eye movement sleep disorder with nocturnal movements and daytime sleepiness, as well as occasional double vision.

Mr P is a retired engineer and has enjoyed working on and driving race cars. In 2007, he voluntarily gave up race car driving because he felt that he had lost his "competitive

Some medical disorders can impair performance, increasing the risk of driving safety errors that can lead to vehicle crashes. The causal pathway often involves a concatenation of factors or events, some of which can be prevented or controlled. Effective interventions can operate before, during, or after a crash occurs at the levels of driver capacity, vehicle and road design, and public policy. A variety of systemic, neurological, psychiatric, and developmental disorders put drivers at potential increased risk of a car crash in the short or long term. Medical diagnosis and age alone are usually insufficient criteria for determining fitness to



Medications

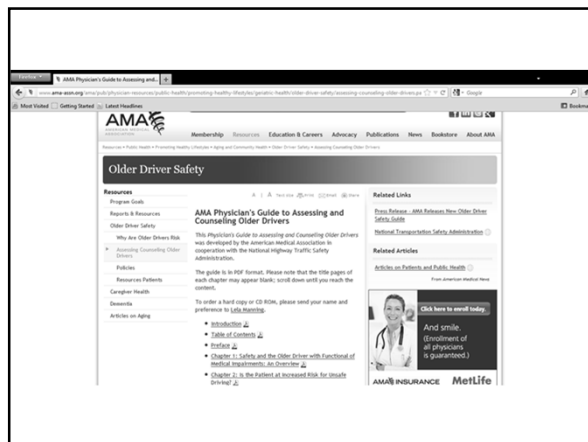
Analgesics	Anxiolytics
Anticholinergics	Antipsychotics
Anticonvulsants	Antihypertensives
Antidepressants	Steroids & NSAIDS
Antiemetics	Alcohol
Stimulants	Diabetic medicines
Muscle relaxants	

Recommendations for opioid therapy

- Refrain from driving for 5-7 days after initiation of opioid therapy or dose increase
- Do not drive if you feel sedated
- Report sedation/unsteadiness/cognitive decline to your physician so the dose can be decreased

Disease specific recommendations

- Ophthalmic
- Neurologic
- Cardiac
- Pulmonary
- Psychiatric
- Musculoskeletal



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If anyone is going to talk to the elderly person about driving, who should it be?



Benefits of rigorous reporting

- Patient safety
- Public safety
- Liability risk



Burdens of rigorous reporting

- Social isolation/withdrawal
- Depression
- Anger at the team/compromised relationships
- ↑ risk of nursing home placement

Quality of Life

- Self-esteem
- Necessary chores
- Maintaining social connectedness
- Our society has not made adequate accommodations for people without transportation

AMA Ethical Opinion

E-2.24 Impaired drivers and their physicians

Physicians should use their best judgment when determining when to report impairments that could limit a patient's ability to drive safely. In situations where clear evidence of substantial driving impairment implies a strong threat to patient and public safety, and where the physician's advice to discontinue driving privileges is ignored, it is desirable and ethical to notify the Department of Motor Vehicles.

State Law Example: North Carolina

Reporting Procedures

Mandatory medical reporting	No
Physician/medical reporting	Physicians are encouraged to report unsafe drivers.
Immunity	Yes, North Carolina statutes protect the physician who reports an unsafe driver.
Legal protection	No
DMV follow-up	Driver is notified in writing of referral.
Other reporting	Will accept information from court, other DMVs, police, family members, and other resources, as long as they are signed.
Anonymity	No, however must request records in writing.

Medical Advisory Board

Role of the MAB	Action is based on majority and/or opinion of specialist. Medical physicians review all medical information that is submitted to the DMV. If more information is necessary, can issue a request. Board decides what action should be taken. This action can be appealed.
Medical Review contact information	Medical Review Unit 3112 Mail Service Center Raleigh, NC 27697 Fax: 919-733-9569

Winston Pain Institute



Department of Neurology-ALS Center

Date: _____
Name: _____

At your clinic visit on _____ the treatment team discussed concerns about your ability to drive and safely operate a motor vehicle due to your medical condition. At this time, we are instructing you to discontinue all driving immediately for your safety and for the safety of others and you complete and pass a formal driving evaluation, which includes an Occupational Therapy clinical assessment and a behind the wheel test done by a licensed drive instructor.

At your clinic visit, a recommendation was made for you to have a driving evaluation to determine your safety in operating a motor vehicle. Ahead of you will find information about scheduling an evaluation through our Occupational Therapy department and a prescription for the evaluation. Please contact that department at 336-716-5004 to schedule an appointment for this important evaluation. If you decide not to pursue the formal driving evaluation, you should discontinue all driving permanently.

If you have questions or need further information, please contact our clinic at 336-716-2395.

Sincerely,

MD _____ Occupational Therapist _____



Suggested 6 step protocol

- Step 1 Identify at risk patient
- Step 2 Is the patient driving?
- Step 3 Assess for impairments in traffic skills

What is needed to drive?

- Vision
- Physical ability
- Reaction Time
- Memory & Concentration
- Divided Attention

Why Occupational Therapy?

- Occupational therapists are experts in addressing the essential and everyday activities of daily life.
- Specialty trained/certified OT's provide driver evaluations, training, educational resources, and guidance to people who want to drive again after a significant health changing event.

Am I a Safe Driver?

Check the box if the statement applies to you.

- I get lost while driving.
- My friends or family members say they are worried about my driving.
- Other cars seem to appear from nowhere.
- I have trouble finding and reading signs on time to respond to them.
- Other drivers drive too fast.
- Other drivers often back at me.
- Driving stresses me out.
- After driving, I feel tired.
- I feel sleepy when I drive.
- I have had more "near-miss" incidents.
- Other structures bother me.
- Left-hand turns make me nervous.
- The glare from oncoming headlights bothers me.
- My medication makes me dizzy or drowsy.
- I have trouble turning the steering wheel.
- I have trouble pushing down the foot pedal.
- I have been stopped by the police for my driving.
- People no longer will accept rides from me.
- I have difficulty backing up.
- I have had accidents that were my fault in the past year.
- I am too cautious when driving.
- I sometimes forget to use my mirrors or signals.
- I sometimes forget to check for oncoming traffic.
- I have more trouble parking lately.

If you have checked any of the boxes, your safety may be at risk when you drive.

Talk to your doctor about ways to improve your safety when you drive.

Appendix 90 - Patient and Caregiver Educational Material

Clinical Assessment

- Driving History
- Instrumental ADLs
- Physical Evaluation – How to Assess
 - Strength, ROM, reaction time, flexibility
- Vision – How to Assess
 - Acuity, visual fields, contrast sensitivity
- Cognition – How to Assess
 - Memory, attention, judgment, problem solving

Short Blessed Test (SBT)¹

¹Have I could like to ask you some questions to check your memory and concentration. Some of them may be easy and some of them may be hard.

1. What year is it now? _____ Correct (0) Incorrect (1)
2. What month is it now? _____ Correct (0) Incorrect (1)

Please repeat this name and address after me:

John Brown, 42 Market Street, Chicago

John Brown, 42 Market Street, Chicago

John Brown, 42 Market Street, Chicago

(Under the words repeated correctly in each trial.)

Trials to learning: _____ (Don't do in 2 trials or 2.)

Good, now remember that name and address for a few minutes.

3. Without looking at your watch or clock, tell me about what time it is. (If response is vague, prompt for specific response) Correct (0) Incorrect (1)
(within 1 hour) _____

Actual time: _____

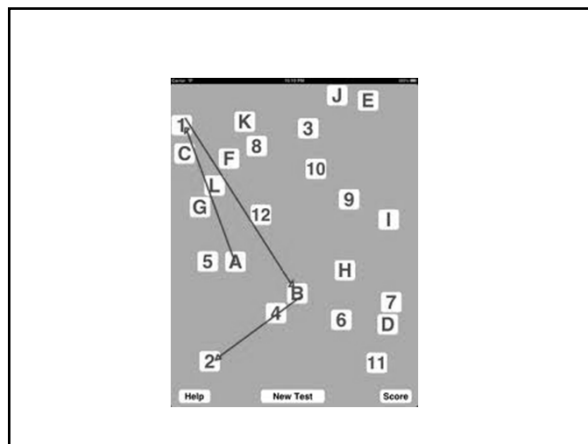
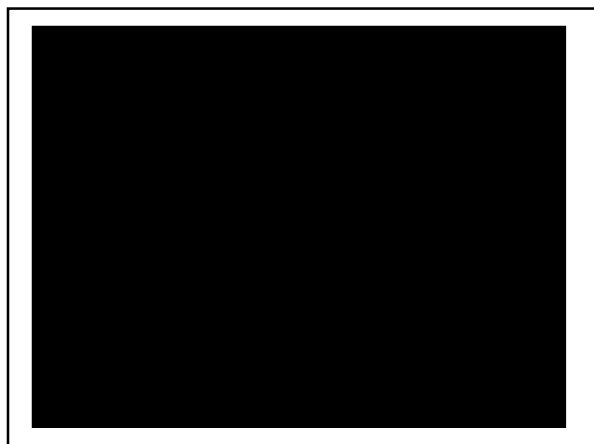
4. Count aloud backwards from 20 to 1. (Mark correctly repeated numbers) 0 1 2 Errors
If subject starts counting forward or forgets the task, repeat instructions and score one error

20 19 18 17 16 15 14 13 12 11

10 9 8 7 6 5 4 3 2 1

Check correct items USE ATTACHED SCORING GRID & NORMS

¹Katzman R, Brown T, Ford P, Ford A, Schreiber R, Robinson M. Validation of a short orientation-memory-concentration test of cognitive impairment. *Am J Psychiatry*. 1981;138:108-109.



Behind-the-Wheel Assessment

- Overall functional mobility
- Pre-driving checklist
- In-traffic assessment
- Varying traffic situations
- Light, moderate, heavy or high-speed
- Parking maneuvers
- Following directions

Recommendations

GOAL: To keep people on the road as long and as safely as possible.

- Treatment goals and plan
- Need for equipment and training
- Need for further rehab services
- Restrictions on driver's license
- Cessation of driving
- Re-evaluation (progressive conditions)

Common driver license restrictions

- Daylight driving only
- No interstate driving
- 45 mph only
- 5 or 10 mile radius of home
- Supervised driving
- Off-peak hour driving only

- Step 1 Identify at risk patient
- Step 2 Is the patient driving?
- Step 3 Assess for impairments in traffic skills

- Step 4 Make team recommendations/referral
- Step 5 Counsel about transportation alternatives
- Step 6 (Worst case) Report to DMV

