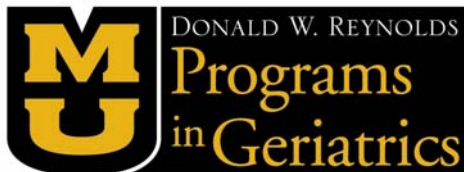


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EVALUATION of the ELDERLY DRIVER

♦Kevin Craig, MD, Academic Fellow
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Driving is a part of every-day life for most Americans, including many elderly. Often physicians are asked (or should ask themselves) whether a patient is safe behind the wheel. Driving in our society is necessary to acquire goods and services for independent living -- including food, clothing and medications -- for going to work, medical appointments, obtaining banking services, and countless other activities. Driving affords access to activities that give life meaning, value, significance and purpose, including socialization, volunteering, recreational and religious activities. The loss of this activity can be devastating to an individual, leading to the inability to live independently, decreased activity levels, and often to low self esteem, feelings of helplessness, loneliness, isolation, anxiety and depression. The loss may cause anxiety and guilt for family and friends as well. In fact, according to Mike Taylor, driver evaluation therapist at Rusk Rehabilitation Center in Columbia, the loss of the driving privilege may be a forerunner of nursing home admission.

The difficulty of driving is often underestimated. Driving is the most complex activity of daily living that the average person performs on a day-to-day basis, and

it is the most dangerous activity of an elderly person with significant age-related decline. Driving requires integration of numerous skills in a multi-stimuli, ever-changing environment, involving searching, identifying, predicting, deciding, and executing. Elderly drivers often have difficulty with each of these steps. Driving errors committed by older drivers include inadequate search and scanning, difficulties in lane keeping, incorrect vehicle positioning for turns, inappropriate or delayed stopping, unsignaled lane changes, failing to understand or respond appropriately to road signs or signals, failure to yield right-of-way, inaccurate judgments of speed or gaps in traffic, and more difficulty performing left turns than right turns.

Elderly patients often have physical reasons for such errors. Functional changes include visual, cognitive and motor components.

Visual: reduced visual acuity, visual contrast sensitivity, sensitivity to changes in angular size and motion, and color vision, increased susceptibility to glare and slower glare recovery.

Cognitive: poor pattern recognition and visualization of missing information, less efficient

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Kevin Craig, MD

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visual search, reduced area of visual attention, impaired selective attention ability, less efficient divided attention, slower attention switching and less efficient working memory.

Physical: Loss of limb strength, flexibility, sensitivity or range of motion, reduced ability to rotate head and neck.

These changes often lead to accommodations by elderly drivers such as performing less night driving, avoiding dense traffic or high speed roads, reducing overall mileage, avoiding driving in bad weather, driving shorter distances, waiting for larger gaps in traffic, allowing longer headway in traffic, and choosing slower speeds.

But often, these adaptations are not enough. Elderly driver accidents account for 13% of all deaths of both passengers and drivers. Motor vehicle crashes are the leading cause of injury-related fatalities for ages 65-74, and the second leading cause for those older than 75.

Sixteen million of the 175 million U.S. drivers are over 70. Still, recommendations are not common for medical evaluation of driving fitness of all patients with acute or chronic medical conditions.

So when should we perform an evaluation? Red flags for unsafe drivers include acute events such as myocardial infarction, stroke, hypoglycemic episode, syncope, vertigo, seizure, surgery, dementia and delirium. Others

include patient or family concern and chronic problems such as visual, cardiac, neurological, psychiatric, metabolic, renal, musculoskeletal, and respiratory disease. Medications such as anticholinergics, anticonvulsants, antidepressants, antiemetics, antihistamines, antihypertensives, antiparkinsonians, antipsychotics, benzodiazepenes, anxiolytics, muscle relaxants, narcotics and stimulants may also cause driving problems.

When you see a red flag, how do you evaluate? Start with a driving history: ask about near misses, traffic citations, and changes in driving patterns. Is the patient driving fewer miles per month, avoiding busy or unfamiliar roadways, or limiting driving to good weather or daylight hours? Look for physical or mental concerns.

When any of these changes are noted, screening for driving impairment is appropriate. Screening instruments include GRIMPS and ADRes. See the tables on the following pages for specifics about these tests.

If the trial or clock tests are abnormal, evaluate for dementia with:

- ♦ Mini mental status exam
- ♦ Labs for CBC, CMP, pulse ox, TSH, B12, CT or MRI
- ♦ Geriatric Depression Scale

Then treat or refer for treatment, recommend driving cessation, and/or refer to a driver rehabilitation specialist for evaluation. Recommended driving cessation may involve giving a "Do Not

Drive” prescription, reminding the patient that it is for his/her own and others’ safety, and asking the patient how they would feel if they were in a crash and injured or killed someone. We can also use economic arguments, involve family and friends for support, and report the patient to the state driver’s license bureau. See insert: “How to Report An Unsafe Driver in Missouri.”

For referral to a driver rehab specialist, the patient should meet evaluation criteria – have optimal functional status, be seizure-free for six months, have a valid driver’s license, a physician’s prescription for evaluation, an activity tolerance of two hours, and must meet minimum standards for visual acuity and peripheral vision.

Evaluation by the specialist includes a client interview, pre-driving skills, physical, visual, perceptual and cognitive assessments, and if the patient is able to pass these, a behind-the-wheel assessment. Recommendations from a driver’s evaluation may include what type vehicle may be driven, adaptive equipment, and activity recommendations. These may encompass resumption of driving with no restrictions, or cessation of driving with recommendations for alternative transportation options, no driving over 45 mph, no highway driving, no driving during peak times or rush hour, daylight driving only, no interstate driving, no driving during inclement weather, driving only within a certain radius of the home address, and driving only

GRIMPS (Gross Impairments Screening Battery of General and Mental Abilities)

Available at www.drivinghealth.com

Test	To evaluate:
Rapid pace walk.	Lower limb mobility
Alternate foot tap.	Lower limb mobility Reaction time
Cued and delayed recall.	Memory
Arm reach	Upper limb mobility Head-neck rotation
MVPT. (Motor Free Visual Perceptual Test)	Recognition of objects from partial information
Scan test.	Visual fields and attention
Trailmaking A&B.	Cognitive flexibility Divided attention Processing speed Scanning Sequencing Visuospatial skills Visual acuity Contrast sensitivity

between the home and given locations.

What can, or should, you do if your patient refuses driver evaluation or cessation? Laws vary between states, but in Missouri, reporting is not required. If a report is made in good faith, an individual is immune from civil liability when making a report, reports may be made anonymously, and there is no violation of the physician-patient relationship in making a report. Reporting may be done by physicians, courts, DMV clerks, peace officers, social workers and family members. For more information about reporting in

Missouri, contact the Missouri Department of Revenue, Division of Motor Vehicle and Driver Licensing at www.dor.state.mo.us or (573) 751-4600. The following is a link to the physician’s report form: <http://www.dor.mo.gov/mvdl/drivers/forms/1528.pdf>. This form may also be found as an insert in this issue of *Long Term Links*.

Driving, while not included in most lists of activities of daily living, is a part of everyday life for many elderly Americans, and these people are the patients we see, aware or not, in our offices every day. As their physicians,

we should ask if this patient is safe to be driving. The task is one we should not take lightly, for the difficulty, both practically and emotionally, of being involved in this evaluation is great. The decision of whether to continue driving is one which is truly important in the care of our patients.

Family members who are concerned about the driving ability of a patient should be encouraged to explore this concern with their loved one. First, they should talk to the loved one to determine his or her feelings about driving. Do not have this talk in the car, and be sure you have the loved one's full attention. Explain why you are concerned, and realize that the loved one may become upset. Consider presenting an agreement not to drive. (Samples can be found in the free guide *At the Crossroads: A Guide to Alzheimer's Disease, Dementia and Driving* available from The Hartford, 200 Executive Bldg., Southington CT 06489.)

Suggest alternatives to driving, such as friends or relatives willing to drive the patient, taxi or shuttle company phone numbers, bus or train schedules, volunteer driver information from churches, or community centers, and information from the local agency on aging.

Encourage an evaluation by a physician or driver education specialist.

Social activities should be encouraged so the patient does not feel isolated by the loss of the driving privilege,

and family members should "be there" to support the patient through this loss.

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take lightly, for the difficulty, both practically and emotionally, of being involved in this evaluation is great. The decision of whether to continue driving is one which is truly important in the care of our patients.

Contact Dr. Craig at craigk@health.missouri.edu.

Driving evaluations are performed in Missouri at:

Rusk Rehabilitation Center

315 Business Loop 70
Columbia MO 65203
(573) 817-4684

St. Joseph's Health Center
300 First Capitol Drive
St. Charles MO 63301
(314) 768-5232

Boone Hospital Center
1601 E. Broadway
Columbia MO 65201
(573) 815-3868

Rehab Institute
3011 Baltimore
Kansas City MO 64108
(816) 751-7700

Helpful Resources:

American Automobile Association Foundation for Traffic Safety:
www.aaafoundation.org.

American Association of Retired Persons 55 ALIVE Driver Safety Program: www.aarp.org/drive or (888) 227-7669.

Physician Guide to Assessing and Counseling Older Drivers: <http://www.ama-assn.org/ama/pub/category/10791.html>

Model Driver Screening and Evaluation Program: <http://www.nhtsa.dot.gov/people/injury/olddrive/index.html>

Locations for driver evaluation in the St. Louis area: [http://www.alzstl.org/Resources/Drive%20Assess %20MO.pdf](http://www.alzstl.org/Resources/Drive%20Assess%20MO.pdf)

Association for Driver Rehabilitation Specialists: www.aded.net

Promoting Safety and Independence Through Older Driver Wellness Free Online Course: www.asaging.org/webseminars

National Association of Private Geriatric Care Managers:
www.caremanager.org

ADRes (Assessment of Driving Related Skills)

<u>Test</u>	<u>To evaluate:</u>	<u>Minimum requirement:</u>
Vision.	Visual fields. Visual acuity	.55° in each eye 20/40
Rapid pace walk.	Lower limb mobility20 feet <9 seconds (10 feet each way)
Range of motion.	Upper/lower limb mobility. Motor strength.	“within normal limits” 4/5 (movement vs. gravity/ some resistance)
Trailmaking B.	Cognitive flexibility. Divided attention Processing speed Scanning Sequencing Visual-spatial skills	<180 seconds
Clock-drawing test.	Long and short term memory. Visual perception Visual-spatial skills Selective attention Executive functions	All 8 correct elements

Julie Eckstein to Lead Department of Health and Senior Services

Governor Matt Blunt has nominated Julie Eckstein of St. Peters as director of the Missouri Department of Health and Senior Services.

Eckstein, 41, is president and owner of Community Calendars.net, LLC, which provides online information about various community events in the St. Louis region and beyond. She opened the business in February 2000 and has managed all elements of its planning and

growth. Eckstein is also executive director of Healthy Communities St. Charles, having been involved since 1994, working on committees dealing with issues of alcohol and tobacco use, communicable diseases, head injury prevention, heart health and fitness, immunization, and senior services. The program won the Governor’s Award for Community Health in 1995, 1996, 1997 and 1998. Eckstein has also worked in St. Charles County economic development

and as director of corporate wellness programs at SSM Healthcare.

“Julie Eckstein understands the importance of good community health planning and brings an impressive management background to a state department charged with helping improve the quality of life for all Missourians,” Blunt said. “I am pleased that she has accepted this challenge and I know she will be an effective advocate for good health initiatives in our state.”



New Data Suggest Quality of Care Improving in Missouri Nursing Homes

New data released from the Centers for Medicare and Medicaid Services (CMS) suggest that health care quality is improving in Missouri nursing homes, and that progress occurs much faster when facilities work with an external coach. The data are based on a group of four clinical care topics.

Primaris is a non-profit healthcare consulting firm that serves as Missouri's federally-designated Medicare Quality Improvement Organization (QIO). Under contract with CMS, an agency of the U.S. Department of Health and Human Services, the group provides quality improvement assistance to nursing homes, home health agencies, hospitals and physicians.

The numbers indicate that improvement was profound in a group of 81 nursing homes that agreed to work intensively with Primaris. Intensive work includes hands-on training with quality experts, instruction in best practices and sharing in-depth resources. These services were provided under the firm's contract with CMS and were offered at no cost to nursing homes.

The study compared data from June 2002 to June 2004. In particular, it concluded that among these homes:

- ♦ Number of long-term residents experiencing pain: 15.9% in 2002, 6.5%

in 2004 -- 59% relative improvement (RI)

- ♦ Number of newly-admitted residents experiencing pain: 33.6% to 20.9% -- 38% RI.
- ♦ Number of residents developing a pressure sore: 9.7% to 7.3% -- 25% RI.
- ♦ Number of residents needing extra assistance with daily activities: 17.3% to 14.3% -- 17% RI.

"Those rates are better than national averages," said Richard Royer, Primaris CEO. "Although there is more work to be done, these data are encouraging. They suggest that our assistance helps improve healthcare quality."

Nurses from the Quality Improvement Program for Missouri (QIPMO) collaborate with Primaris staff to provide technical assistance to Missouri facilities. Each nurse works with a group of "select families" who agree to participate in the CMS sponsored initiative. With onsite technical assistance, facility staffs develop quality improvement projects and make changes in the care they deliver so that resident outcomes improve (as demonstrated in the outcomes mentioned by Primaris). The QIPMO program evolved from research conducted at the University of Missouri that demonstrated that quality of nursing home care can improve with onsite assistance from expert nurses and data-driven feedback reports of how well each facility does with their residents' outcomes.

Since QIPMO began as an official state program in 1999, expert nurses have conducted more than 1400 site visits to more than 400 different long-term care facilities in the state. Missouri is in the lead in developing ways to help improve care to seniors needing long-term care in this country.

To schedule a confidential facility visit, call Jane Williams at (573) 882-0206, or email williamsja@health.missouri.edu.

From Missouri Association of Homes for the Aging Hotline newsletter, 12/31/04; additional information on QIPMO by Marilyn Rantz, RN, PhD.

♦♦News & Notes♦♦

Cruise Ships Could be Next "Assisted Living Option"

Northwestern University researchers, comparing costs of cruise ship living to those of traditional assisted living, found cruising to be only about \$2000 higher over a 20-year period, while offering a superior quality of care.

Cruise ships could be ideal living options for older people since they already offer many amenities common to assisted living facilities, including meals, onsite physicians, and housekeeping and laundry service.

- ♦ From Missouri Association of Homes for the Aging *Hotline* newsletter, 12/31/04

◆◆News & Notes◆◆

CMS Website Offers Medicare Provider Education, Lists Preventive Services

Check out a new addition to the Medicare Learning Network -- the Preventive Services Educational Resource Web Guide, available at http://www.cms.hhs.gov/medlearn/preventive_services.asp. It has links to information about preventive services benefits offered under Medicare.

Among them are: the initial preventive physical examination and cardiovascular disease and diabetes screening tests. Information on colorectal and breast cancer screening also may be accessed at the site. Materials on bone mass measurement, pelvic exams, Pap tests and glaucoma screens are expected soon.

Also offered are downloadable educational publications -- some tailored for providers and some for patients -- about various aspects of the Medicare program, as well as links to Web-based training modules.

- ◆ From *AAFP Direct*, newsletter of the American Academy of Family Physicians, 1/21/05

CMS Selects 10 Practices for Pay-for-Performance Demonstration Project

Ten large medical groups across the country -- including five that provide family medicine residency training -- will participate in a

pilot program testing the efficacy of pay-for-performance reimbursement. Participants were named by CMS Administrator Mark McClellan, MD, PhD, in a Jan. 31 announcement that, observers say, marked the beginning of federal efforts to shift Medicare to a pay-for-performance system.

In making the announcement, McClellan hinted that President Bush would likely recommend a pay-for-performance system similar to that proposed on Jan. 12 by the Medicare Payment Advisory Commission. (See <http://www.aafp.org/x31675.xml> for more.) MedPAC indicated the program should be a budget-neutral system in which a percentage of current Medicare monies would be set aside in a fund from which pay-for-performance incentives would be paid.

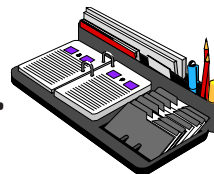
- ◆ From *AAFP Direct* 2/4/05

AMDA's Clinical Corners

AMDA has developed a new portion of its website (<http://www.amda.com>) creating links to clinical topics. This section was developed to provide a source of information on topics relevant to long-term care practitioners. Articles, tools and resources, education and CME programs, lists of products and publications (including clinical practice guidelines [CPGs] and tool kits for implementation of the CPGs), and web resources/links related to various topics are all available at the click of a mouse to help meet the challenges of providing quality healthcare to our long-term care population.

- ◆ From <http://www.amda.com>

For your Calendar



American Medical Directors Association 28th Annual Symposium: *Quality Leadership in Long-Term Care: Affirming the Physician Role*. March 17-20, 2005 in New Orleans. Information available at <http://www.amda.com>.

19th Annual Geriatric Symposium April 28- 29, 2005. University Plaza Hotel, Springfield MO, sponsored by CoxHealth of Springfield. For information contact Jill Johnson at (417) 269-5062 or e-mail jill.johnson@coxhealth.com.

Core Curriculum on Medical Direction in Long-Term Care June 12-18, 2005. Summer conference will be held June 12-18

in Keystone CO. Online registration is now open at <http://www.amda.com>.

Missouri Association of Homes for the Aging Annual Conference and Exposition. September 7-9, 2005 at Lodge of the Four Seasons Resort, Lake Ozark MO.

Midwest Regional Conference on End-of-Life Care, November 14-15, 2005. Hyatt Regency Crown Center, Kansas City MO. For more information call (816) 350-7702 or e-mail cindy@mohospice.org.

Minutes: Best Practices Symposium February 4, 2005

Present: Debra Cheshier, Michael Roth, Dr. Jeffrey Kerr, Mary Alice Futrell, Dr. David Brunworth, Carolyn Spradlin (Primaris), Dr. Charles Crecelius, Dr. David Cravens, Dr. Michael Dykstra, Dr. William Rosen, Betty Markway, Carol Scott (Ombudsman), Dr. Leonard Hock, Jr., Wendy Bruemmer, Sue Heisler, Elizabeth Wilson, Don Reynolds (Center for Practical Bioethics), Patricia Wyatt

DHSS: The Governor has called for a possible 20% reduction in budgets. Discussions are in progress on where cuts will be made.

Director Dick Dunn has left. Ron Cates is serving as interim director as he has done several times before. (*See story on Page 7 on appointment of Julie Eckstein as director of DHHS – Editor.*)

Debra Cheshier explained the Senior Count publication currently in progress by DHSS along with Primaris, AARP and others. It will address consumer patterns, housing issues, and educational needs of the elderly. The first publication should be available next year.

At the CMS meeting, Debra learned that other states (Iowa and Kansas for example) are doing much of their paperwork electronically, including license renewals and other routine forms and documents. She is very interested in pursuing this issue for DHHS.

FENCE (Furthering Education for Nurses who

Care for the Elderly) is attempting to teach administrative skills, including how to manage CNA's. The group is discussing certificate of completion versus testing and board certification. Dr. Crecelius reaffirmed that they hope to have a pilot program ready to review this summer.

Intimacy in Long-Term Care: Donald Reynolds of the Center for Practical Bioethics is providing leadership to develop a policy for intimacy in long term care residents. Issues involve residents' rights, questions of competency, survey evaluations, and sexually aggressive residents. The policy is expected to be out sometime this year.

When to Initiate CPR: Dr. Crecelius revisited issues including the role of the LPN, the low success rate of CPR, and the need for formal policies on initiating CPR and declaring death. This subject will be discussed again at the next meeting.

Protime Protocols and Standing Orders: Dr. Crecelius recommends the use of coumadin flow sheets to reflect the history of dosage and impact. Dr. Kerr stated he already has a protocol. Problems occur when Medicaid substitutes generic warfarin, causing variance in the protime readings. Protime should be done at least monthly. Dr. Crecelius asked Betty Markway if it would be possible for the department to implement a

protocol. Standing orders do not allow for the non-prescriber to make choices. Betty stated the protocol must be specific.

Dr. Crecelius brought up the discussion of medications that require the consumer be informed of side effects. Betty said our regulations do not prohibit the prescriber from ordering specific medications. She said even the medications on the Beer's list can be used but the physician must document in the medical record the reason for the medication and the facility should have a system for monitoring the resident for adverse effects.

Culture Centered Pilot Project with CMS: Carolyn Spradlin discussed this project identifying ways to make long term care facilities more home-like. The pilot will end in July; in August they plan to start the statewide program MC5 (Missouri Coalition Celebrating Care Continuum Change). Julie Wilson with the Ombudsman's office is the contact for information on MC5.

Office for Community Independence: Sue Heisler talked about this newly formed unit, designed to help Missourians live in the least restrictive environment. She gave a quick overview of the services offered by their section. The phone is (573) 526-0714 or (800) 235-5503.

The next meeting is scheduled for May 6, 2005.

♦ submitted by Jeff Kerr DO
President, Missouri Association of
Long-Term Care Physicians