Date: December 9, 2020

PLEASE NOTE that Project ECHO® Care of the Elderly case recommendations do not create or otherwise establish a provider-patient relationship between any ECHO Care of the Elderly Hub team member/presenters and any patient whose case is being presented in a Project ECHO® setting. All resources are posted in the COP website, under Care of the Elderly Resources "Driving and Dementia". You must be logged in to view the resources.

Case Synopsis:

66-year-old male who presented to ED in November for Acute Kidney Injury. His PMHx is significant for CAD with CABG, CVA in 1999, COPD, Type 2 diabetes, and HTN. The patient's wife supports all of the IADL's except he patient continues to drive daily. His wife has expressed some "minor" concern with his driving such as driving too close to the lines or being too close to other vehicles. The patient denies having any concerns with his driving and cognition. He is often found to "laugh off" many questions that seem difficult for him to answer. His wife says he is getting more and more frustrated and agitated when he cannot complete a task on his own. When she encourages him to do it independently, he now gets angry and blames it on his bad joints. This has been happening for a period of one year.

Questions:

1. Other than the mini-mental, what other cognitive testing would you recommend while in hospital?
2. What would be your next steps in determining driving safety?

Summary of Recommendations:

- Additional cognitive testing focusing on visuospatial, attention, and executive function would help support that there are cognitive impairments in domains that may directly affect driving
- Diabetes management optimization given the multiple oral agents and evaluation for possible metabolic complications such as autonomic neuropathy and gastroparesis
- Given his risk factors and hospitalization, it is possible that there may be an element of delirium superimposed on an underlying dementia. This presents some considerations for assessing fitness to drive after the resolution of the underlying acute illness
- Family concerns about driving is an important signal that the person may be an unsafe driver
- Acknowledge that there are a number of consequences of revoking a driver's license including emotional, identity (especially being a Greyhound driver and a possible perception of being a "lifelong driver"), and social issues and provide follow up to monitor for these consequences and refer the patient for additional support as needed
- Could leverage other chronic medical conditions in discussion of driving safety i.e. stroke history, diabetes with low sugars etc.
- Use alternative forms of transportation to address quality of life and support the patient's daily habit of having coffee with friends

- Recruit the help of a third-party person e.g. geriatrician, to act as the “bad guy” regarding the decisions related to driving cessation and reporting to the Ministry of Transportation while the primary care provider can support the individual and family to deal with the subsequent issues, (grief, loss, anger, etc).
- Advising a patient that they are unsafe to drive should include supporting the development of a transportation plan as part of the process by identifying all activities patient used to drive to, arranging a variety of transportation alternatives and making necessary referrals to support the emotion-related aspects of driving cessation
- Incorporate driving as part of a larger goals of care discussion with a safety lens. Another approach may involve reframing driving cessation as another life transition e.g., “retiring from driving”
- Refer to Alzheimer’s Society for guidance and support for the individual and family and for information about any available community volunteer driving services