Comprehensive Geriatric Assessment and Goal Setting & Fitness to Drive in the Elderly

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Disclosures

• None to declare
Objectives

• Understand what a comprehensive geriatric assessment is; who it is appropriate for; and how we go about it.

• Highlight CWC PCN Geriatric Assessment and Support Clinic, a Primary Care Model.

• Discuss challenges of Fitness to Drive in the Elderly; and identify local resources to assist in assessment.
Comprehensive Geriatric Assessments

Resources: Ontario Geriatrics Learning Centre; http://geriatrics.otn.ca/
**What is a Comprehensive Geriatric Assessment**

- A holistic, interdisciplinary, diagnostic and treatment process focusing on the medical, psychosocial, and functional capabilities of frail older adults
- Emphasis on ‘interdisciplinary’ approach to manage complex and inter-related issues
- Best done by a team but can be done on your own
- Core team – Physician (NP)/RN/SW/Pharmacist, + OT, PT, Dietician, etc.
Benefits of Comprehensive Geriatric Assessment Services

• Reduces access barriers: patient avoids multiple appointments with excessive transportation requirements
• Comprehensive, coordinated care planning: interdisciplinary diagnostic support focuses on the whole person
• Increases compliance through patient, family & caregiver education
• Reduces caregiver stress and burnout
• Improves quality of life: stabilizes functional decline, avoids or delays transfer to continuing care facilities
• System navigation: reduces fragmented medical specialty and health system care
• Physician support: provides diagnostic and decision-making support for family physician
• Reduces need for admission to more costly acute care services
Who Benefits from Comprehensive Geriatric Assessment

**Too Well to Benefit**
- One or a few medical conditions
- Needing prevention measures only

**Appropriate and Will Benefit**
- Multiple interacting bio-psychological problems that are amenable to treatment
- Disorders that require rehabilitation therapy

**Too Sick to Benefit**
- Critically ill or medically unstable
- Terminally ill
- Disorders with no effective treatment

* e.g. Fernandez, Helen (2007)
Typical Attributes of Medically Complex, Frail Seniors

- Multiple health conditions
- Dependency on others for activities of daily living
- Death of spouses and friends
- Physical weakness and chronic pain
- Depression
- Social isolation
- Transportation problems

- More unpredictable reactions to medications (higher variability of kidney and liver function)
- Relative scarcity of good empirical data (i.e. these seniors are rarely good candidates for clinical trials)
- Atypical presentations of illness
- They are nearing the end of their lives
CGA

- **Pre-assessment** – identifies issues in advance, allows pre-assessment interventions
  - Lab tests
  - Self assessment questionnaire
  - Information letter sent to patients – what to wear, what to expect, ‘please bring medication’, etc

- **Assessment - Patient/Family/Caregiver Goals:** Establish at the outset what the patient and family/care partners want to get out of the assessment
CGA

- Patient Goals – individualized and patient centric; also include family and care partners; often social or functional goals chosen over health related goals

- Patient Goals may include:
  - wish to regain ability to walk independently without walking aids (post op total hip arthroplasty)
  - wish to remain in their home as long as possible
  - wish to manage their bADLs independently

- After developing and implementing recommendations, revisit goals of care regularly
CGA

- Social history – education; occupation; where is home; who lives at home; informal/formal caregivers; finances; EPOA
- Functional history – bADLs (eating, bathing, dressing, grooming, toileting, transfers); iADLs (telephone, shopping, cooking/food prep, cleaning, laundry, driving, finances, medication)
  Super iADLs = finances, medication, driving
- Vision
- Hearing
CGA

• Best Possible Medication History
  – prescription and non-prescription meds
  – medication reconciliation
  – match medication to diagnosis

• History of Presenting ‘Concerns’
  – What are the concerns and how is it affecting the patient, family and care partners?
  – What matters most to them regarding management of these issues?

• Obtain Collateral history – particularly useful with cognitive impairment or psychiatric issues
• Geriatric Review of Systems
  – Habits – smoking/ETOH/exercise
  – Vision & Hearing
  – Cognition – memory concerns; collateral info
  – Mood - PHQ2 (anhedonia; feeling depressed or hopeless)
    PHQ9; GDS; Anxiety – GAD 7
  – Sleep – sleep aids
  – Teeth/Nutrition/Weight change
  – GI & GU – incontinence/constipation
  – Pain
  – Falls in the past 6 months
CGA – Physical Exam

• Standard exam with neurological assessment
• Let history guide your physical exam
• Orthostatic VS useful in ‘fallers’ and patients on antihypertensive medication
• Mobility – TUG, Sit to Stand, GAIT assessment
• Mental Status Exam – Mini cog (3 items/clock)
  – MOCA differentiate MCI vs. Dementia;
  – MOCA – B illiterate/low education; not standardized
  – RUDAS – cross cultural

• (MMSE – copyright issues)
CGA – Physical Exam

• Lab – cbc, lytes, creat, b12, TSH, calcium, albumin
• Additional investigations as appropriate

IMPRESSION/CARE PLAN

• Give plan; Elicit patient preferences; Arrange follow up with appropriate clinicians; Maximize community and socio-economic support; Discuss Wellness and Preventative strategies including vaccinations, smoking cessation, remaining physically and socially active; Discuss Advance Care Planning (GCD); Provide education and support to care givers
• Write note for patient – identify issues and treatment plan; include new medication list if appropriate; arrange follow up appointments
GAS Clinic Model

- MOA/LPN/SW 1.0 FTE; GNC 0.8 FTE; Pharm 0.6 FTE
  - 5 x Family Physicians 0.1 FTE
  - Psychiatrists x 3 – total 0.1 FTE
  - Geriatrician q 6 weeks; a consult & 1 hour case review rounds
  - Neurologists q 6 weeks; a consult & 1 hour case review rounds
  - + 5 GNCs embedded in community clinics
  - Community Resources: Dementia Connect, Calgary Alzheimer Society; Just Like Home – Nurse Next Door, Home Instead

#Referrals to GAS clinic 2014 = 684
# Referrals to GAS clinic 2015 = 753
GAS Clinic Model

• Poster!
Summary CGA

• To learn everything you can about a patient, their supports and environment to find out what factors can be changed
• Best done by a team to facilitate interdisciplinary collaboration
• Emphasis on improving functional abilities and quality of life in line with patient goals
• Monitor outcome of care plan
• Revisit patient goals regularly
Fitness to Drive
Fitness to Drive

• Revised Driver’s Medical form – April 1 rollout on hold! ... Stay tuned...

• Concerns include:
  – More complex/time consuming to complete
  – Increased emphasis on functional assessment – transfers responsibility to physicians to arrange
  – No easy check box to refer for a road test
  – Questions lack clarity
“Fitness”

• Refers to medical fitness – physical, mental, emotional abilities
• Effects of a single major impairment v. layered morbidities impairing function
• Core principle – it is the Functional Impact of the medical condition not the medical diagnosis itself which determines ability to drive safely in most cases
• Physician office assessment – Generally easy to identify individuals that are definitely “Fit” or definitely “Unfit” to drive; Grey area – refer for functional assessment/on road evaluation

Resource: CMA Driver’s Guide
Driver Fitness & Monitoring

- Decision making authority for driver licensing
- Revoke/suspend driving privileges
- For medically at-risk and medically impaired drivers, DF&M relies on information from medical community
- Physicians should advise patients that they are sending a report to DF&M and that the motor vehicle licensing authority has processes for appeal and reinstatement. Patients should be advised not to drive.
- Driver Medicals in Alberta required at age 75, 80, & every 2 years thereafter
Duty to Report

- Discretionary reporting in Alberta, Quebec and Nova Scotia
- Mandatory reporting in other provinces/territories
- Legislation protects physicians/health care providers from any legal actions brought against them for making the report
- Duty to report supersedes the primary caregiver’s private duty of confidentiality
Patient’s Legal Obligation

• Under the Traffic Safety Act:

“a person who holds or applies for a driver’s license must immediately disclose to Alberta Transportation any disease or disability that may be expected to interfere with safe operation of a motor vehicle.”

Insight often lacking with cognitive impairment
Aging

- Increased prevalence of health related conditions that may affect driving
- Age related visual changes – visual acuity; contrast sensitivity (age, cataracts, refractive sx; Dark adaptation/glare recovery (limit driving to day time)
- Hidden Disease - CAN DRIVE pneumonic*
- Multiple Morbidities* – acute/intermittent (episodic) v. chronic persistent disorders

Can Drive*

- Cognition – DDD, psychomotor speed, rx time
- Acute of Fluctuating Illness – seizures, syncope
- Neuromusc/neurological effects – stroke, etc
- Drugs – BDZPs, opioids, anticholinergics
- Record – patient or family report
- In Car Experiences
- Vision
- Ethanol Use

MCI/Dementia and Driving

• Moderate to severe dementia is a contraindication to drive – CMA guideline

• Moderate dementia is defined as the loss of independence in 1 or more bADLs (eating, bathing, dressing, grooming, toileting, transfers), or loss of 2 or more iADLs (telephone use, shopping, cooking/food preparation, cleaning, laundry, driving, finances, and medication due to cognition)

• Mild dementia – may be safe to drive...
MCI/Dementia and Driving

• Driving Record
• Family Concerns
• Cognitive testing
• Trails A&B – visuospatial/executive function
• Clock Drawing – visuospatial/executive function
• Intersecting Pentagons – visuospatial
• No single test has sufficient sensitivity/specificity to determine driving ability
MCI/Dementia and Driving

• Mild dementia – any physician who suspects cognitive problems may affect safe driving should refer patient for a functional driving assessment.

• Mild dementia – if deemed fit to drive, re-evaluate every 6 to 12 months.

• Driving Retirement – initiate discussions early!
Local Resources

• AMA Senior Driver In-Vehicle Driving Evaluation (Senior Driver Refresher Course; CAA’s Senior Driver’s Website, Seniors’ Transportation Info guide, etc.)
• Drive Able – MCI/Dementia; Computer based assessment of cognitive domain, +/- Standardized Road Test
• Safety in Motion (Cochrane) – On Road Assessment
• Standard Road Test at Local Registry
Summary

• Emphasis on the Functional Impact of the Medical Condition on ability to drive not the medical diagnosis itself
• Discretionary reporting in Alberta – moral/ethical obligation
• Patients with cognitive impairment lack insight and are more likely to require intervention
• Gestalt – ‘Fit’ or ‘Unfit’ to drive; grey area – refer for functional assessment