

85 and older. Participants had, on average, 6.8 comorbid conditions other than diabetes mellitus (range 2–16). Table 1 categorically summarizes the 20 most-common comorbidities in this sample of individuals with diabetes mellitus. Thirteen of these 20 diagnoses were discordant with diabetic care, and 15 were symptomatic conditions. Furthermore, three of these conditions (renal insufficiency, dementia, depression) were classified as clinically dominant. Forty-seven percent of participants ($n = 43$) had at least one clinically dominant condition, and participants had significantly more diabetes mellitus–discordant than diabetes mellitus–concordant conditions ($P < .001$) and more symptomatic than asymptomatic chronic conditions ($P < .001$).

DISCUSSION

Type 2 diabetes mellitus is common in the very old and is associated with a significant burden of comorbidity. The framework is helpful in demonstrating that the older individuals with diabetes mellitus in this sample experienced predominantly discordant and symptomatic chronic health conditions (Table 1).² A substantial number of participants also experienced at least one clinically dominant condition. In this population, the importance of managing risks and achieving treatment thresholds for blood sugar and pressure control may have less priority in light of high symptom burden and significant illness.

These data suggest that it may be time to reassess the way the healthcare needs of the oldest individuals are met. In elderly adults with diabetes mellitus, comorbidity appears to be the rule rather than the exception. Comorbid conditions have the potential to reduce the effect of diabetes mellitus treatments and increase hospitalization rates in this population.³ In the absence of epidemiological evidence of benefit from targeted diabetic care for individuals aged 85 and older, prioritizing treatment goals according to the individual's functional concerns to help facilitate a patient-centered approach to managing comorbidity has been suggested.² Qualitative data show that these individuals desire this kind of individualized treatment that supports their unique constellation of medical problems.⁴

A clear limitation of this study is that the sample of elderly adults came from a single family practice clinic in an academic health center. The findings may not be generalizable to all persons aged 85 and older. Further qualitative research exploring physician and patient perspectives on treatment preferences and trade-offs between risk management and symptom control would help structure treatment plans in a more patient-centered manner.

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ASSESSING RISK FACTORS FOR UNSAFE DRIVING IN A GROUP OF ELDERLY ADULTS UNDERGOING REHABILITATION

To the Editor: We read with great interest the article recently published by Niewoehner and colleagues¹ on a screening battery to predict road test performance in a population of veterans. We would like to contribute to the topic by reporting data collected on possible risk factors for unsafe driving in a population of elderly adults admitted to a department of rehabilitation and aged care (DRAC).

From January 2012 to June 2012, all individuals aged 65 and older admitted to the DRAC of the Ancelle Hospital (Cremona, Italy) and who were driving a vehicle before hospital admission were screened before discharge using a standardized protocol. This screening is a section of the multidimensional geriatric assessment routinely performed

at the institution and includes physical, cognitive, somatic, and social factors (identified through a caregiver interview) that may be predictors of possible inability to drive a vehicle safely.² Caregivers are interviewed to investigate the driving style of the individuals, their personality type, and any history of citations and accidents. The screening includes the Mini-Mental State Examination as a measure of global cognition;³ the CLOX-1⁴ as a measure of executive function, and the attentive matrices⁵ as a measure of attention, an assessment of alcohol abuse (CAGE questionnaire)⁶ and of sleep disorders (Epworth Sleepiness Scale);⁷

Table 1. Clinical Features and Risk Factors for Car Crashes in a Group of Elderly Adults Undergoing Rehabilitation (N = 34)

Variable	Value
Age, median (interquartile range)	72 (69–78)
Admission diagnosis, n (%)	
Orthopedic	21 (61.7)
Respiratory	7 (20.5)
Cardiology	3 (8.9)
Gait disturbance	3 (8.9)
Caregiver interview, n (%) ^a	
I have concern about the patient's ability to drive safely.	10 (29.4)
Others have concerns about his or her ability to drive safely.	12 (35.3)
The patient has limited the amount of driving that he or she does.	12 (35.3)
The patient will drive faster than the speed limit if the patient thinks he or she will not be caught.	5 (14.6)
The patient will run a red light if the patient thinks that he or she will not be caught.	5 (14.6)
The patient will drive after drinking more alcohol than the patient should.	5 (14.7)
The patient drives at night.	14 (41.1)
The patient drives in the rain.	27 (79.4)
The patient drives in busy traffic.	21 (61.7)
History of citations and driving distance, n (%)	
History of ≥ 2 citations in the last 3 yr	5 (14.7)
Driving <100 km in a week	19 (55.9)
Cognitive evaluation, n (%)	
Deficits in executive functioning (CLOX 1 ≤ 10)	16 (47.1)
Attention deficits (score of attentive matrices ≤ 36)	8 (23.5)
Cognitive impairment (Mini-Mental State Examination score ≤ 24)	7 (20.6)
Somatic evaluation, n (%)	
Alcohol abuse	4 (11.7)
Sleep disorder	4 (11.8)
Polypharmacy (≥ 5 drugs)	26 (76.5)
Visual disturbances	4 (11.8)
Hearing impairment	21 (61.5)
Instrumental activity of daily living dependency (lack of function in >2), n (%)	5 (14.7)
Risk of unsafe driving (number of risk factors), n (%)	
Low (0–3)	22 (64.7)
Medium (4–5)	5 (14.7)
High (>5)	7 (20.5)

^aCaregivers are asked to answer the interview questions using the following scale: 1 = strongly disagree, 2 = disagree, 3 = no opinion, 4 = agree, 5 = strongly agree. Responses with a score of 4 or 5 are reported in the table.

visual and auditory sensory capacities through validated tests, an assessment of instrumental activities of daily living (Lawton Index),⁸ and the presence of polypharmacy. Twelve possible risk factors were determined using this evaluation. A cutoff for unsafe driving defined according to number of risk factors is unavailable,² so for description purposes, participants were categorized according to number of risk factors in three groups (low (0–3), moderate (4–5), and high (>5) risk).

Thirty-four individuals with a median age of 72 were evaluated (Table 1). Approximately 65% were classified as low risk for unsafe driving. Eighty percent did not have cognitive impairment overall, and more specifically, 53% did not have executive dysfunction, and 76.5% did not have attention deficits. Approximately one-third of the caregivers were worried about the ability of the individual to drive a vehicle. Approximately 60% of the individuals had hearing deficits, and there was a high prevalence of polypharmacy.

Individuals aged 65 and older in Italy account for 20% of the population and make up the fastest-growing segment of the population.⁹ In 2008, elderly adults with driving licenses were approximately 13% of the total population, and 10% of these were involved in motor vehicle accidents.⁹ These statistics are interesting if we consider that the prevalence of motor vehicle accidents is similar to those of adults aged 20–50, suggesting that older age itself should not be considered a factor for unsafe driving.⁹ Considering that the studied subjects were inpatients in a rehabilitation setting and thus were frail, the fact that 58% were classified at low risk for unsafe driving indicates that the number of persons aged 65 and older who are unable to drive is low. From this perspective, given the absence of a formal battery to screen for safe driving, we propose that the assessment of risk factors be included in the formal multidimensional geriatric assessment when older adults are referred to a geriatric setting. The relevance of an extended assessment of various risk factors for unsafe driving, including not only cognition performances, but also the visual, psychomotor, and social skills, is outlined in a recent article² and is supported by our preliminary data. This evaluation could allow clinicians to estimate the level of risk of unsafe driving from low to high and possibly refer patients to a road test or to suggest to patients and their relatives that they stop driving. The geriatric team should provide individuals and families with counseling for possible alternatives, because it is likely that cessation of driving will create dependency in the older person and social retirement.¹⁰ Finally, the geriatrics and scientific societies should interact with healthcare policy-makers to create specific transportation programs to meet the increasing need of the older population.

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EARLY HOSPITAL DISCHARGE OF OLDER ADULTS ADMITTED TO THE EMERGENCY DEPARTMENT: EFFECT OF DIFFERENT TYPES OF RECOMMENDATIONS MADE BY A MOBILE GERIATRIC TEAM

To the Editor: The prevalence of older adults admitted to emergency departments (EDs) is growing, reaching 20% of

individuals in the ED in the United States and Europe.^{1,2} Older adults experience a complex interplay between health and social disorders that may lead to mismanagement (misdiagnosis or mistreatment) of acute and chronic diseases. Thus, interdisciplinary management involving a comprehensive geriatric assessment and subsequent specific recommendations from a mobile geriatric team (MGT) is useful to enhance care management of older adults.^{3–5} It was recently reported that an early MGT program combining a brief geriatric assessment (BGA) and subsequent recommendations significantly shortened the length of hospital stay of older adults after hospital admission through the ED.⁵ In that study, the BGA-related recommendations were not standardized. It was hypothesized that standardization of these BGA-related recommendations could further enhance the efficiency of the MGT program and allow early discharge from the ED. Two levels of recommendations were thus distinguished: geriatric recommendations, defined as medical recommendations only (recommendations for the diagnosis and treatment of polymorbid older adults with disabilities), and gerontological recommendations, defined as a combination of medical and social recommendations (the same as above, coupled with the establishment of formal and adapted home-help services). The aim of this study was to determine whether BGA-related geriatric or gerontological recommendations provided by a MGT were associated with early discharge (<24 hours) from an ED.

Between February and June 2011, 168 older adults (mean age 85.0 ± 5.2 ; 64.9% female) who visited the ED at Angers University Hospital, France, were prospectively included in this cohort study. Inclusion criteria were aged 75 older and admitted to the ED at Angers University Hospital. The BGA consisted of the following items: age coded as a binary variable (\geq or <85), sex, polypharmacy (≥ 5 drugs per day), living situation (home vs institution), use of formal or informal home help services (yes or no), history of falls in the previous 6 months (yes or no), temporal disorientation (inability to provide month or year; yes or no), and reason for admission to ED (acute organ failure, mobility and neuropsychiatric disorder, social-related condition, other). Length of hospital stay was calculated using the administrative registry of Angers University Hospital and corresponded to the delay in days between the first day of admission to the ED and the last day of hospitalization in an acute care unit. The Angers ethics committee approved the project. The sample of older adults was categorized into two groups: those with an early hospital discharge (<24 hours) and those who stayed in the hospital for 24 hours or longer. Between-group comparisons were performed using the chi-square test. Multiple logistic regression analyses were used to examine the association between early discharge from the ED (dependent variable) and the two levels of MGT program (geriatric and gerontological recommendations; independent variables) adjusted for participants baseline characteristics. $P < .05$ was considered statistically significant. All statistics were performed using SPSS version 15.0 (SPSS, Inc., Chicago, IL).

Of 168 participants, 28.6% ($n = 48$) received MGT recommendations (16 geriatric recommendations, 32 gerontological recommendations). Thirty-two participants