DRIVING AND COMMUNITY MOBILITY SECIALTY CERTIFICATION
Occupational Therapy Assistant

Table of Contents: ACTIVITY EVIDENCE FORMS

- Below is one example for each type of form, not for each criterion. The examples are to help you understand how to complete each form, regardless of the criterion.
- The forms that are included are hyperlinked in the table of contents below.
- Please note that these are examples only to help guide you in the type of information to include. For many reflections, your style may be different; for example, more narrative or more bulleted.
- Note that unused forms (pages) are not included in this document. Please do the same with the final set of evidence forms you submit with your application.

**Criterion 1. Knowledge: Diagnostic Considerations**
- **Formal Learning**-- Minimum 10 contact hours needed
- Independent Learning--Minimum 10 contact hours needed
- Publication – Peer-Reviewed

**Criterion 2. Knowledge: Assessment**
- Formal Learning--Minimum 10 contact hours needed
- Independent Learning--Minimum 10 contact hours needed
- Publication – Peer-Reviewed

**Criterion 3. Knowledge: Intervention**
- Formal Learning--Minimum 10 contact hours needed
- **Independent Learning**--Minimum 10 contact hours needed
- Publication – Peer-Reviewed

**Criterion 4. Knowledge: Regulation & Payers**
- Formal Learning--Minimum 3 contact hours needed
- Independent Learning--Minimum 3 contact hours needed
- Publication – Peer-Reviewed

**Criterion 5. Assessment: Performance Skills**
- Client-Based Case Study
- **Mentee** (does not include supervisory relationship)
- Self-Analysis of Video Recording

**Criterion 6. Intervention: Performance Skills**
- Client-Based Case Study
- Mentee (does not include supervisory relationship)
- **Self-Analysis of Video Recording**

**Criterion 7. Intervention: Critical Reasoning**
- Client-Based Case Study
- Formal Specialized Consultation for Intervention
- Mentee (does not include supervisory relationship)
- Program Development
- Research

**Criterion 8. Psychosocial Critical Reasoning**
- **Client-Based Case Study**
- Formal Specialized Consultation for Psychosocial
- Mentee (does not include supervisory relationship)
- Program Development
- Research

**Criterion 9. Ethical Practice** – The 3 ethical practice scenarios are found within the application itself.

**Criterion 10. Establishes Networks**
- Formal Specialized Consultation
- Marketing Activities
- Presentation
- Volunteer Leadership

**Criterion 11. Advocating for Change**
- Advocacy Efforts
- Advocacy Case Study
- Presentation
- **Public Awareness Efforts**
- Volunteer Leadership
Criterion 1 – Knowledge: Diagnostic Considerations

Demonstrates knowledge of primary and secondary conditions that impact occupational engagement related to driving and community mobility.

Guidelines

- **Minimum of 10 contact hours** required.
- Multiple activities may be used to meet the hour requirement for the criterion.
- Learning must have occurred in the past 5 years.

Please identify the type of activity in which you participated:

- [ ] AOTA CE: Participation in Self-Paced Clinical Course or CE Product from the list of AOTA offerings approved for this certification. *Completion of course will be verified by AOTA. Submission of additional documentation beyond this form not required.*
- [x] Non-AOTA CE: Attending workshops, seminars, lectures, or professional conferences with formal established objectives.
- [ ] Participation in post-professional academic coursework. *Attach unofficial transcript.*

1. Activity information.

<table>
<thead>
<tr>
<th>Activity Title</th>
<th>As We Age: Effects on Mobility and Driving</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider/Instructor</td>
<td>Susan Ford and Gloria Chevy</td>
</tr>
<tr>
<td>Activity Date(s)</td>
<td>Sept. 5-7, 20XX</td>
</tr>
<tr>
<td>No. of Contact Hours</td>
<td>16 contact hours</td>
</tr>
</tbody>
</table>


- **A)** This course was a seminar that focused on understanding the various diagnoses affecting the capacities and limitations of older adults and how these changes affect their driving and community mobility
- B)
- C)
- D)
- E)
3. Describe the relevance of the activity to your practice in driving and community mobility. *(average word guideline–200)*

This workshop focused on enhancing health and wellness in older adults in relationship to driving and community mobility. Each day we explored a different system (i.e., motor, sensory, and cognitive) and how that system changes as aging occurs as well as the various associated diagnosis that relate to the system common during the aging process. We participated in group discussions and case studies as part of this learning experience. Common areas of discussion included the following:

a) How an older adult’s occupational performance is affected by driving and community mobility
b) How cognition changes with aging, various diagnoses associated with cognitive decline in older adults, and the impact on driving and community mobility
c) The role of psychological factors and diagnoses in aging and the impact on driving and community mobility
d) The physiological factors and related diseases/illness that impact older adults and the effect on driving and community mobility.
e) Specific motor changes that occur with age and related diagnoses that impact older adults and driving and community mobility.
f) The sensory changes (vision, tactile, olfactory) and various diagnoses that impact older adults and driving and community mobility.

4. Describe how the knowledge acquired from this activity “demonstrates knowledge of primary and secondary conditions that impact occupational engagement related to driving and community mobility.” How did the activity influence the way you practice, or how did it affect your client outcomes? *(average word guideline–200)*

This course had a strong impact on my work with driving and community mobility in older adults. I gained knowledge from evidenced based literature that I did not have – especially in normal changes that can occur has the result of aging as well as the many diseases/illnesses that can affect the various systems in relationship to driving/community mobility. For example, it is common as we age that our peripheral fields can significantly decrease, that some parts of cognition and personality are more stable than others as we age, that cognition has a significant role in reaction time, that exercise and activity can maintaining health, and of course, the importance of continued participation in activities and the community past the time of driving retirement.

The work within the course supported how some of the various changes that can occur with aging and/or disease can not only impact driving safety – but also community mobility. Thus, in my practice, I have become much more aware that once an older adult can no longer drive safely, it is often far from expected that he/she will be able to independently use community resources to remain mobile in the community. I have also began to explore working with social workers and case managers to further explore ways we can provide assistance to older adults and families in these areas (i.e., not only the “typical transportation resources, but unique ways of putting weekly schedules together to include the older adults’ needs and desires).

5. Submit documentation that verifies completion of the activity, such as certificate of completion or unofficial transcript. *Not required for AOTA courses.*

For this example, documentation is not included, but it should accompany this activity if submitted.
INDEPENDENT LEARNING

Back to Criteria

Criterion 3—Knowledge: Intervention

Demonstrates knowledge of relevant evidence specific to intervention in driving and community mobility.

Guidelines

- Minimum of 10 contact hours required.
- Multiple activities may be used to meet the hour requirement for the criterion.
- Learning must have occurred in the past 5 years.

Please identify the type of independent learning activity in which you participated:

☐ Independent reading from AOTA-Approved Independent Learning List in driving and community mobility.
☐ Independent reading of recent peer-reviewed, professional articles, or chapters in textbook not associated with a formal learning course.
☐ Independent review of professional electronic resources (e.g., NIH, CDC, CanChild).
☐ AOTA Journal Club Toolkit (reading & discussion time). Must be AOTA member to access the kit.
☐ AOTA Critically Appraised Paper (CAP, includes submission to the AOTA Evidence Exchange).

1. Why did you choose this activity?
   ☑ Clinical reference for specific population, program, or individual
   ☐ Invited peer review of scholarly work or publication (print or online)
   ☐ Preparation for poster or presentation
   ☐ Preparation for academic lecture
   ☐ Literature review for research project
   ☐ Preparation for serving as a mentor
   ☐ Other, please specify:

2. Bibliography of select item(s) used for independent learning. List in APA format.


3. Date(s) of independent learning

   February 20XX
4. Time spent engaged in independent learning.
   - For reading, estimate 8–12 published pages/hour. Not required for AOTA-identified independent learning list of resources.
   - For journal club, discussion time counts toward 10-hour requirement.

   12 hours including reading, preparation of material for the occupational therapy department journal club, and journal club meeting.

5. Describe the relevance of the independent learning activity to your practice in driving and community mobility. (average word guideline–200)

   All too often in driving rehabilitation practice therapists make recommendations for driving cessation without thought about the clients’ needs as they transition from driving. Practitioners often make assumptions about the ease of transition to transportation alternatives. The studies reviewed for this independent learning specifically examined the difficulties associated with driving cessation and the effectiveness of transit training programs. The researchers’ findings suggest that clients need support as they transition from driving to community mobility options and that support can ease their “loss” of driving and improve both their comfort and use of transit resources.

6. Describe how the knowledge acquired from this activity “demonstrates knowledge of relevant evidence specific to intervention in driving and community mobility.” How did the activity influence the way you practice, or how did it affect your client outcomes? (average word guideline–200)

   As a result of this independent learning, the collaborations with my supervising occupational therapist about discharge planning have changed considerably. I now contribute suggestions to transition toward transportation alternatives and training for that transition when driving cessation is necessary for the client. As a result, therapeutic intervention continues for individuals recommended for cessation with exploration of transportation options in the client’s area; and as necessary, assistance with paratransit applications or paratransit eligibility processes, education about scheduling and the use of transit resources, and in vivo training in the use of transit services with route planning and negotiation of the vehicle, bus stops, and travel to/from bus stops. I feel that my new understanding of the benefits of transit training has enhanced the services provided to clients because I am able to contribute a more comprehensive perspective to the occupational therapy team.
Criterion 4—Knowledge: Regulation & Payers

Demonstrates knowledge of laws and regulations relevant to driving and community mobility, including payer sources.

Guidelines

- Examples of peer-reviewed publication include journals such as AJOT or OTJR.
- May include a chapter in an occupational therapy or related professional textbook, if chapter has gone through peer review (a process in which subject matter experts, using a formal system and defined guidelines, provide content guidance to an author and recommend publication, revision, or rejection of a work).

1. Submit APA reference for the publication. For in-press publication, also include a verification letter or e-mail identifying applicant and anticipated date of publication.


2. If applicant is not identified as first or second author, please describe your contribution/involvement in the development of the publication. (average word guideline—200)

   N/A

3. Provide a reflection indicating why this publication was chosen to represent "knowledge of laws and regulations relevant to driving and community mobility, including payer sources." (average word guideline—200)

   Driver licensing, license renewal, and license restriction laws are particularly relevant to driving rehabilitation practice because licensing agencies are the final decision makers with regard to individual driver licensing. It is the responsibility of state licensing agencies to protect the public’s health, safety, and well-being through license issue, restriction, and revocation. While licensing agencies have the ultimate authority; they often rely on recommendations from occupational therapists that have spent the most concentrated, evaluative time with drivers. Given the importance of licensing, it is important for practitioners to know the impact of their recommendations.

   I wrote this peer-reviewed article as part of an evidence-based literature review on driver licensing policies. Reviewing both the literature and driver licensing policies across the country provided me with valuable knowledge about licensing laws to better understand the range of laws between states. This diversity in knowledge was important for my practice because of my geographic location in South Florida which yields clientele licensed in Florida as well as those licensed in states all across the country. Knowledge of the law is important for my practice with individual clients, but knowing the implications of license renewal laws and restricted licensing on driver performance and safety has been helpful in terms of making recommendations with individual clients as well as with organizations and governmental agencies in a consultative capacity.
MENTORING RELATIONSHIP–MENTEE

Criterion 5—Assessment: Performance Skills
Administers standardized assessments as delegated by the supervising occupational therapist specific to driving and community mobility consistently integrating clinical observations.

Guidelines
- Must represent a minimum of **10 hours** over a minimum of 2 months.
- Does **not** include supervisory relationships.
- Relationship must have occurred in the past 5 years.

1. Dates of mentoring relationship
   
   01/20XX through 05/20XX

2. Approximately how many hours did this represent in total?
   
   10

3. Applicant’s goals for mentoring relationship. **Goals must have been met by time of application. List no more than 3.**
   
   A) Gain a greater understanding of the use of specific tools used to assess visual functioning within the context of driving.
   
   B) Identify at least one new assessment tool to implement in my clinical driving assessment.
   
   C)

4. 

<table>
<thead>
<tr>
<th>Mentor</th>
<th>Jane Doe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Position/Role of Mentor</td>
<td>Clinical Director of Occupational Therapy</td>
</tr>
<tr>
<td>Workplace of Mentor</td>
<td>Anytown Hospital</td>
</tr>
<tr>
<td>Contact Information for Mentor (email or phone number)</td>
<td><a href="mailto:jdoe@email.com">jdoe@email.com</a></td>
</tr>
</tbody>
</table>
5. State why the mentor was selected to help you meet the goals identified above relative to the criterion. *(average word guideline–50)*

I selected this particular mentor because she is knowledgeable about clinical vision assessment tools and is a recognized expert in this field. She has presented both regionally and nationally on the topic of vision assessment and rehabilitation. She works out of a hospital-based OT department in an established and well-known driver rehabilitation program, which is structured similarly to the program in my facility.

6. Briefly describe how the knowledge acquired from this mentoring activity influenced how you “administer standardized assessments as delegated by the supervising occupational therapist specific to driving and community mobility consistently integrating clinical observations throughout the evaluation process.” *(average word guideline–200)*

During our first meeting, I reviewed with Jane the clinical visual tests I use as part of my comprehensive driving evaluation. I recognized the emphasis I placed on assuring my clients meet the state driver’s licensing minimum vision standards, specifically visual acuity and peripheral fields, with less focus on other visual functions. Jane suggested the use of different assessment tools, some of which would provide me with enhanced information about my client’s visual attention and the relationship to their driving performance.

During our next meeting, she demonstrated the computer-based Useful Field of View (UFOV) assessment tool, and the ability to screen client’s visual search skills, divided attention, selective attention and speed of visual processing. In later meetings, Jane allowed me to observe her use the assessment with her clients. After reading and reviewing the manual, I was given the opportunity to practice administering it under her direct supervision. Jane provided me with helpful feedback and critiques in the set up and administration of the tool. For example, beyond the specific instructions that are issued to the examinee, I learned that providing additional feedback is actually counterproductive; however, encouragement can be beneficial.

In my own practice, I was able to add the UFOV assessment to my comprehensive driving evaluation. Since incorporating this tool as part of the clinical assessment, I have observed a correlation between older drivers with poor performance on the UFOV and poor performance and outcomes on their driving evaluation. For example, these clients often missed critical items during the on-road evaluation with delayed decisions and responses while driving, resulting in the need for physical assistance from me to correct their errors. In reviewing the literature, I found that the UFOV is one of the best visual predictors of crash rates for older drivers, surpassing the visual acuity tests used at the licensing agency.

I have also realized how many of my clients with cognitive limitations and a poor UFOV performance have shown greater difficulties in handling complex and demanding driving environments. For example, when given instructions to locate the next gas station on the left side of the multi-lane highway, one client completely missed finding the gas station, and another made a poor executive decision on when to cross the highway, requiring assistance to prevent a collision. I also found additional studies have supported the use of UFOV as part of a clinical driving assessment for persons with cognitive changes after a TBI, or due to MS.

This experience with Jane was valuable, not only in learning new assessment tools, but also observing her experiences and critiques of my administration skills. Although I realize the advantages and disadvantages of using assessments to predict driver performance, I have come to appreciate the benefit of adding this particular tool as part of my comprehensive driving assessment.
SELF-ANALYSIS OF VIDEO RECORDING

**Criterion 6—Intervention: Performance Skills**

In collaboration with the supervising occupational therapist, performs interventions that are unique to driving and community mobility while integrating impact of varying client factors and contexts.

**Guidelines**
- Submission of actual video recording is **not** required for application; however, appropriate permissions should be obtained by applicant whenever engaging a client in a video-taped session.

1. | Age of Client | 23 | 81 |
   | Client Diagnosis(es) | Traumatic Brain Injury | Cerebral Vascular Accident |
   | Setting for Evaluation | Out-patient driving rehabilitation program housed in a rehabilitation hospital | Out-patient driving rehabilitation program housed in a rehabilitation hospital |
   | Date of Video Recording | October 23, 20XX | November 2, 20XX |

2. Provide a brief summary of the video contents and how it demonstrates your ability to "collaborate with the supervising occupational therapist and perform interventions that are unique to driving and community mobility while integrating impact of varying client factors and contexts." (average word guideline – 200)

The video recordings were created for the purpose of gaining more understanding about the use of a piece of equipment recently acquired in the driving rehabilitation program; a driving simulator. Creation of the videos involved two separate video cameras running simultaneously, one aimed at the client’s face and body and one aimed at the video screen of the simulator. After taping, the two videos were combined together in a split screen so practitioners watching the video could make the connection between the client’s action/reaction and what the client was seeing at that time.

The videos were 30 minutes in length and included me providing instructions to the client for about 2 minutes then 28 minutes of the client maneuvering through a series of driving scenarios in increasing complexity. The driving course in the simulator was designed to replicate the assessment road course used with the vehicle which begins in a parking lot, moves on to a residential road, progresses to a busy street with traffic signals and distractions, and culminates on a fast moving highway.

Because the sessions were interventions, I provided ongoing feedback throughout the session as I would normally do in the vehicle on the road in both videos.
After reviewing this video, describe the insights you gained, and reflect on how the analysis experience validated or supported change in your practice related to evaluation. *(average word guideline ~400)*

After my program administrator purchased a driving simulator I was excited about using it with my clients because I felt it would serve as an easier, faster alternative to using the program’s vehicle on the road. However, after watching the videos, I gained a lot of insight into my own practice related to the decision to use a driving simulation, client readiness for a simulator, provision of instructions to different clients, my own feedback style in conjunction with the feedback the simulator feedback, and the complexities of the simulator programming/fit with the driver’s needs.

I assumed the simulator would be an automatic replacement for the vehicle, but the acceptance and transition for the drivers was quite different. The younger driver, aged 23, had a long history with video gaming and he was eager to try out the simulator. However, the 81-year-old driver appeared very apprehensive on the video and I had not taken her lack of experience with technology and fears into consideration.

The vendor who sold us the simulator demonstrated the software and it seemed to operate with ease and was very intuitive. Based on that demonstration and my own comfort with the new equipment, I provided only minimal instruction to the clients. After watching the video, I realized the clients were confused about what to do and how to operate the system. Watching the video made me realize I cannot assume the instructions are clear or the steps are obvious to clients who are inexperienced and have cognitive deficits.

Throughout the duration of the training exercise, I performed in my OTA role in the same way I had in the vehicle. This included providing both positive and constructive feedback about the drivers’ performance. However, after watching the video, I realized that the software also provided visual, auditory, and vibratory feedback when clients hit an object, drove over the curb, drove off the road, or completed a tricky maneuver successfully. Based on the clients’ reactions to the double dose of feedback, it was obvious they were overloaded with stimulation and my provision of feedback was unnecessary, and often poorly timed compared to the feedback from the simulator.

Finally, watching the video made me realize I was poorly prepared to incorporate a simulator into my practice without further training because of the complexities with the software. Similar to an actual road course, one route will not fit all drivers. It quickly became obvious that using the assessment route was not appropriate for a training session. In addition, different drivers have different needs and should be presented with different exercises and challenges which I had not thought through. When I conduct training on the road with a client, I modify the route and challenges based on the plan for that day, and even in real time based on how the client performs to repeat a challenge or grade a challenge to make it easier or harder. I had not been prepared for my transition to this simulator.

Watching the videos, I realized that use of the simulator is not appropriate for all clients and I needed more training to be effective. As a result, I reviewed relevant literature on simulators and participated in an intense training program with the company who developed/programmed the simulator. As a result, I collaborated with my supervising occupational therapist and we changed our approach to simulator use in the following ways:

1) developed a client readiness checklist to determine candidacy for simulator use,
2) wrote an orientation protocol that we use with clients so they understand what is expected of them,
3) require that all clients complete a practice session to become acclimated to the simulator,
4) provide less feedback during training sessions and allow the software feedback to modify the clients’ performance, and
5) created a full range of pre-programmed driving scenarios to satisfy different intervention needs and session objectives.
**CLIENT-BASED CASE STUDY**

**Criterion 8—Psychosocial Critical Reasoning**

In collaboration with the supervising occupational therapist, recognizes immediate and long-term implications of psychosocial issues related to conditions found in clients with driving and community mobility needs and modifies therapeutic approach and occupational therapy service delivery accordingly.

**Guidelines**

- Client-based case study should **not** include any form of standard client documentation (e.g., evaluation summary, discharge plan) or identification of client name(s) or facility information.

1. Date(s) case study represents

   June 20XX

2. Describe the client, client factors, and case contexts for the identified case. The context of the case should be adequately communicated so that relevance and merit of the case to the criterion is easily determined. *(average word guideline – 500)*

   A 35 year old wounded veteran, John Doe, presented to our driving rehab clinic for retraining with a spinner knob to compensate for the loss of his right arm. He had been wounded while in active duty in the Middle East. While serving, his primary job role was a transport driver. During one of his transports, he hit an active unidentified bomb and lose his right arm in the explosion.

   The clinical evaluation completed by my supervising OT reported that John scored incredibly well on task shifting/divided attention, attention, executive function, and visual perceptual skills. In addition, he presented in good physical condition with strong endurance and was actively exploring adaptive prosthetic options for his right arm. His goal was to return to driving in order to fully engage in his roles as carpool provider, father, husband, and worker.

   My supervising occupational therapist administered the behind-the-wheel assessment to John and recommended training in use of a spinner knob.
During his driving training, I introduced John to the spinner knob in a low distraction, low speed environment. After his third session, training was progressing well with John easily mastering smooth control of the vehicle with the spinner knob. As his training progressed to a higher speed and increasing stimuli environment, John began to present with increased difficulties. Specifically, he presented with symptoms of anxiety, over-anticipation of hazards, strain, increased reports of fatigue, and increased perspiration. He was noted to be maneuvering the vehicle in more of a reactive, defensive manner than an assertive, safe manner. Examples included positioning his vehicle to the furthest point in his lane away from traffic rather than centered in the lane, slowing down or speeding up to move away from other vehicles, and increased scanning of his rear and side mirrors in a way that distracted him from his forward scanning. At the presentation of these behaviors, I safely guided John back into a low distraction environment and engaged him in a therapeutic conversation to explore his response. John verbalized that felt he was doing well and was frustrated by his increased anxiety. When I questioned him, he was unable to verbalize any triggers or causes for the increased anxiety. To identify performance patterns, I worked with John to begin to explore his confidence and comfort in various environments and he consistently had difficulties as soon as he approached higher speeds of 45+ mph and increased stimulation.

After exploring the literature, I discovered that individuals trained in combat driving often present with overly sensitive visual perceptual skills as a result of training and work place demands related to active duty. Concerned that John may be presenting with symptoms of residual combat driving, I shared this information with my supervising OT. In addition, this information and John’s performance was then discussed with John and his referring doctor. Together, my supervising OT, John, his doctor and I developed a plan to continue with training, but with the increased recognition and awareness of John’s sensitivity. Furthermore, John’s doctor discussed options with anti-anxiety medications, but John declined and chose to focus on behavioral modification rather than the addition of a medication.

John and I returned to the vehicle for training. I applied the treatment interventions discussed with my supervising OT and worked in a manner to ‘desensitize’ John to various driving situations through slow and controlled introduction of various environments. With guidance from my OT, I identified a list of driving behavior changes and worked with John on each behavior at increasing speeds. We identified a verbal feedback system to help increase awareness to his performance changes in order to allow him the opportunity to correct his own behaviors.

In addition, I provided John with ‘homework.’ John had disclosed that when riding as a passenger in the car, he would disengage himself and try to sleep. We discussed how he has been doing this as a coping strategy. I then instructed John to work as an active passenger in the vehicle by serving as a navigator. By working both as an active passenger and as the driver thru controlled scenario, John established positive coping strategies and skills needed to safely drive in all ranges of driving environments and successfully re-engaged in his life roles as carpooler, father, and husband.

This example demonstrates how I was able to identify psychosocial barriers to performance, work with my supervising OT to identify specific coping strategies and then systematically apply those strategies to promote John’s engagement in driving.
PROGRAM DEVELOPMENT

Criterion 8—Psychosocial Critical Reasoning

In collaboration with the supervising occupational therapist, recognizes immediate and long-term implications of psychosocial issues related to conditions found in clients with driving and community mobility needs and modifies therapeutic approach and occupational therapy service delivery accordingly.

Guidelines

- Program development refers to the creation of a new program or development of an evolving program.

1. Dates of program development

   January 15-March 20, 20XX

2. Briefly describe the program purpose, services offered, and clients served. (average word guideline–250)

   My supervising OT, who is also a driving rehabilitation specialist, and I identified an increasing number of clients – both those in the outpatient rehab clinic and the driving program – in need of support for driving transitions and cessation. In collaboration the OT and I focused our efforts to develop an open support group specifically for clients and their family members facing these issues.

   The purpose of the group is to provide education that empowers the individual facing cessation, provide a supportive environment to allow for identification of associated psychosocial concerns related to driving cessation, and help to facilitate positive coping strategies.

   The program serves and is open to any client or family member from the outpatient clinic and our driving rehabilitation program that is working through or facing driving transitions or cessation.

   This group program has been running for the past 14 months with monthly participants ranging from 4 members to 16 members. The group serves a wide range of clients including individuals with motor impairments, neurological deficits, visual changes, and general declines associated with aging.

3. Describe how this program development activity, including description of resources used, demonstrates your ability to "collaborate with the supervising occupational therapist to recognize immediate and long-term implications of psychosocial issues related to conditions found in clients with driving and community mobility needs and modify therapeutic approach and occupational therapy service delivery accordingly." (average word guideline–500)

   To prepare for this group, I explored a variety of sources, including the research literature regarding implications of driving cessation; as well as community and practitioner resources, including local and regional transportation options, the AARP “We Need To Talk (WNTT) program,” the Hartford Group’s “At the Crossroads,” and the “Drive Well Toolkit” developed by the National Highway Traffic Safety Administration (NHTSA) and the American Society on Aging (ASA). I worked very closely and collaborated with the supervising occupational therapist during this entire process. We reviewed the information together and had lengthy discussions of what seemed to be beneficial to older adults during the driving cessation process.

   We implemented a series of support groups for older adults and their families which were very well received. These groups met on a monthly basis, and through this program, we were able to help clients recognize the various stages of loss associated with driving and helped them explore transportation options that enabled them to continue to participate in their chosen occupations.

   This was a strong example of my ability to modify my therapeutic approach based on psychosocial needs of clients.
**ETHICAL PRACTICE SCENARIO** (Part 2 of 3)—Fiscal & Regulatory

**Criterion 9**—Ethical Practice: Fiscal & Regulatory

Identifies ethical implications associated with the delivery of services in driving and community mobility and articulates a process for navigating through identified issues.

**Guidelines**

- The applicant identifies ethical implications associated with the delivery of services and articulates a process for navigating through the identified issues.
- The applicant shall review the [AOTA Code of Ethics and Ethics Standards](https://www.aota.org/About-Us/AOTA-Code-of-Ethics-and-Ethics-Standards) and align the dilemma with the ethical principle(s) that is/are challenged.

**Ethical Scenarios**

**Scenario #4**

An occupational therapy assistant/DRS is delegated to perform an on-the-road assessment with a client who has dementia and is licensed in a different state. The client splits her time between two states during the year, and is currently driving in both locations. During the assessment, which occurred in the state of non-license, the client performs in a very dangerous manner and there is no question the client needs to be reported to the state licensing agency. The state in which the client is licensed only accepts medical reports from physicians. This is different than the requirements for the state in which the assessment occurred. [For sample purposes only.]

**Scenario #5**

**Scenario #6**

1. To which scenario are you responding?  
   
   #4

2. From the [AOTA Code of Ethics and Ethics Standards](https://www.aota.org/About-Us/AOTA-Code-of-Ethics-and-Ethics-Standards), which ethical principle(s) has/have been challenged in this scenario? Select the top ethical principle(s) that apply, up to a maximum of 3.

   - [x] 1. Beneficence
   - [x] 2. Non-maleficence
   - [ ] 3. Autonomy, Confidentiality
   - [ ] 4. Social Justice
   - [x] 5. Procedural Justice
   - [ ] 6. Veracity
   - [ ] 7. Fidelity
3. Describe how you would apply the ethical principles identified above to guide you toward a resolution for the concern noted. (average word guideline—500)

The fact that this client was not capable of driving in a safe manner suggests she posed a safety risk to herself and other road users. I felt in my role as the occupational therapy assistant, I had a responsibility to uphold Principle 1.D. Beneficence – Recognize the responsibility to promote public health and the safety and well-being of individuals, groups, and/or communities. This posed an ethical dilemma for me since the protection of the public and other road users is in direct conflict to my occupational therapy instincts to promote client independence. However, in the interest of greater safety, my immediate thought was that I needed to discuss my concerns with the supervising occupational therapist and suggest filing a report to the medical advisory board in my state, since that was the typical protocol in my facility. As a result, I discussed the client’s performance with the supervising occupational therapist.

While I recognized the need to protect the client and the public, I also felt conflicted due to Principle 2. D. Non-Maleficence – Exercise professional judgment and critically analyze directive that could result in potential harm before implementation. Suggesting to the occupational therapist that a report be filed to the medical advisory board can have devastating effects on the driver as well as the person’s family and friends. Therefore, I consider the non-maleficence principle very seriously because I don’t want to initiate a process that will be harmful to my client.

The final area of consideration was Principle 5.A. Procedural Justice – Familiarize themselves with and seek to understand and abide by institutional rules; applicable Association policies; and local, state, and federal/national/international laws. In this circumstance, I was very familiar with the medical reporting laws and guidelines in my state, however this client was licensed in another state. My understanding of state-specific driver licensing laws led me to my next area of inquiry because the issue/revocation of a driver’s license is under the authority of the licensing state. Based on this ethical principle, it was my responsibility to understand the licensing in the state of authority for this particular driver so I could be fully informed when conferring with the supervising occupational therapist. When I contacted that state medical advisory board they informed me they would not accept a report from an occupational therapist and informed me they only accept reports from physicians.

The legal implications of this case were very complicated. The state which issued the driver’s license would not accept a report from an occupational therapist. The referring physician was from the state in which the evaluation took place, not the state of licensure, so the occupational therapist was not able to contact the referring physician to file a report with the licensing state. The occupational therapy team was left without a legal course of action even though laws existed in both states. As an alternative, the occupational therapist and I informed the client and the family of our concerns so that I upheld Principle 1.D. to protect the client and the public. In addition, the occupational therapy team contacted the medical advisory board in the state in which the evaluation took place since the client lived in and drove in that state six months per year. That medical advisory board accepted the report since they typically accept reports from occupational therapy and noted she would be barred from licensure in that state.
**Criterion 10—Establishes Networks**

Establishes and collaborates with referral sources and stakeholders to help the client and relevant others achieve outcomes that support health and participation in the area of driving and community mobility.

**Guidelines**

- This should **not** be confused with consultation that is part of the ongoing services provided in your routine job duties but is a request to address a particular issue at a particular site, either external or internal.
- Consultation may include (but is not limited to) developing or evaluating a program or service, developing a strategy for long-term planning, establishing outcomes measures, incorporating national guidelines into internal policies and procedures, assessing and addressing staff educational needs, assessing and addressing resource needs, and validating program/service delivery with current evidence.
- Applicant must have had a **minimum of 10 hours** working with the site.

1. | Entity for Which Consultation Was Completed | Al’s Driving School |
   | Date(s) of Consultation                    | June 20XX-August 20XX |
   | No. of Hours Completed During Consultation | 20 hours over 2 months – Includes initial meeting, preparation for and presentation of informational and educational sessions, research and preparation of written recommendations and follow up meeting. |

2. **Objectives for consultation. Objectives must have been met by time of application. Please list no more than 3.**
   - A) Provide education, educational planning and recommendations for a driving school interested in enhancing their current driving program to include older drivers.
   - B) Appreciate medical issues of older adults and their implications for driving.
   - C) Understand the differences of driving schools and driver rehabilitation programs.

3. **Summarize the consultation results. (average word guideline–200)**

   Over the past 10 years I have co-owned a reputable and financially successful driver rehabilitation program with an occupational therapist. The owner of a driving school in an adjacent county was aware of our practice and asked me to serve as a consultant as they were considering enhancing their current program to include older drivers.

   At our initial meeting, I was informed that they periodically receive requests to “check out” licensed older drivers, often after the driver had experienced a recent illness. Because of their increase in the volume of this type of referral, they were considering developing a specific program to address them.

   The focus of my consultation consisted on providing information about medically at risk drivers and the process for appropriate referral for comprehensive driving evaluations. I provided two educational in-services for the owners and staff to ensure their understanding of the complexity of these types of clients. I also wanted to communicate the importance that person(s) providing this type of service should be appropriately educated and trained. Based on the structure of their driving school and current staff, I stressed the need to hire an occupational therapy driver to...
rehabilitation specialist, who had the appropriate skills to complete these types of evaluations. I shared with the group the education and training occupational therapists undergo to provide driver rehabilitation.

A final report was submitted to the owners of the company which included handouts of all the in-services, educational information about older drivers, current literature, recommended practices, and my final recommendations. I was quite pleased to learn that based on my recommendations, they agreed to hire a driver rehabilitation specialist on a part-time basis who was an occupational therapist.

4. Summarize how this professional development activity influenced your ability to “establish and collaborate with referral sources and stakeholders to help the client and relevant others achieve outcomes that support health and participation in the area of driving and community mobility.”

At the onset of the consultation sessions, I recognized the need to not only provide education to the owners and staff of the driving school, but also the need to establish a trusting relationship with this company so that they would accept my recommendations regarding the medically involved older driver.

As they had already received a handful of requests and completed what they perceived as comprehensive driving tests with older drivers, they felt that they already had a good understanding of this type of clientele. I realized that to lecture them about the differences of their traffic safety tests as compared to my comprehensive driving evaluations may come across as derogatory. To help build our relationship as well as shed some light on the differences, I encouraged them to explain to me what, if anything, they did differently during their sessions with the older driver. I found this to be a good method to help them recognize the unique issues of these clients.

I was given the impression that the business owners preferred to have their current staff to continue to work with these older drivers. Although I expressed some reservations, I wanted to be supportive of the owner’s interest in developing a quality program that would best serve the needs of these clients. I suggested we begin with some in-services to educate the staff about common medical conditions that the older adult might experience and the implications for driving. As suspected, during the in-services I overheard various comments from the staff about their own potential discomfort in working with many of the medical conditions that I was reviewing. Additionally, a few staff members made jokes about how “drivers over the age of 80 should just stop driving”. I attempted to help their staff realize that they needed to support the older driver’s quest for continued independence, to be compassionate about the various medical conditions we were discussing and when they should refer to a driver rehabilitation specialist.

I realized that as a consultant, through the use of clear verbal and written communication, providing succinct relevant information and relating this to what they already knew, we made significant progress in their education and understanding the complexities of working with the medically at risk older driver. As a result the owners realized that although their current staff members were quite skilled as traffic safety educators, they were not adequately prepared to work in this specialized service area.

I was pleased to learn that based on my recommendations, they hired an occupational therapy driver rehabilitation specialist on a part-time basis who would be solely designated to work with their medically-based and/or older driver referrals. Because she is still relatively new to the field, I have since offered her the option to contact our company as a resource or even to refer to us when she is unsure about medically complex cases.

In summary, my work as a consultant for this business was somewhat challenging as their location was close enough to be considered a business competitor. However, I realized that there would not be a significant impact on my business, and there was certainly a need in our area for more driver rehabilitation programs. Another challenge was that I had fairly strong opinions about who should be completing driving evaluations of older adults with medical issues. I felt that my work as a consultant for this business helped me in my professional growth as it allowed me the opportunity to use my skills to influence a business practice and enhance service provision for older drivers.
MARKETING ACTIVITIES

Criterion 10—Establishes Networks
Establishes and collaborates with referral sources and stakeholders to help the client and relevant others achieve outcomes that support health and participation in the area of driving and community mobility.

Type of media used for marketing: (check all that apply)

☐ Presentation to potential referral source audience
☐ Presentation to potential clients
☒ Participation in community event such as health fairs
☐ Speaking to community groups
☐ Development and dissemination of marketing materials (e.g., brochures, Web sites, podcasts)
☐ Participation in media interview (e.g., television news, newspaper)
☐ Other

1. Target Audience of Marketing
   Community and health practitioners, children in the local area, parents

Date(s) of Marketing Efforts
   April - June 20XX, culminating in fair June 20

Approximate Total Hours Engaged in Marketing Activity
   25 hours including planning, collaboration with partner agencies, and a full day community health and safety fair

2. Provide a brief summary of the marketing activity. (average word guideline—50)
   As an occupational therapy practitioner with expertise in community mobility, I was asked to participate in the local community health and safety fair. My efforts focused on bicycle and helmet safety to encourage safe engagement in the healthy occupation of bike riding.

   The event included a table with educational materials about bicycles and cars sharing the road, fitting a bicycle to a rider, and safety information about helmets. With support from a local toy store that donated a variety of helmets, we offered a helmet fitting station to assist families in finding the right helmet for a child and provided instruction on proper donning of the helmet. The toy store also provided coupons so families could purchase a properly sized helmet after completing a fitting.

   Other partnerships with the local police department and the state chapter of Safe Kids USA allowed for the set up and execution of a bicycle rodeo which included the following stations: registration and bike inspection (with a local bike shop), starts and stops, scanning, rock dodge, demon driveway, crazy crossroad, and slalom. The Organizer’s Guide to Bicycle Rodeos (Chaplin, 2005) was used to organize the content and layout of the event.

   The health fair, and specifically the bicycle rodeo were advertised through the public school system, to the occupational therapy and physical therapy practitioners working in the school system, and to local pediatric therapy clinics. “Admission Tickets” to the bicycle rodeo were created and distributed to children who receive therapeutic services via their existing therapist in the schools or community. The “Admission Tickets” served to inform the children and their parents that they were not excluded from participating. The children presenting an “Admission Ticket” were then identified as needing assistance and were supervised through the bicycle rodeo by me or another occupational therapy practitioner. If specific needs related to bicycle riding...
were noted, the children were provided with additional suggestions for therapeutic services to address those needs. Those suggestions could then be brought back to the existing therapist, or parents were welcome to bring the child to my clinic for services.

The networking with community partners (school-based therapists, community-based therapists, local toy store, local bike shop, police department, and Safe Kids USA) allowed for the development and execution of a comprehensive public safety endeavor that met the safety and community mobility needs of children and their families. Through the collaboration with all the partners involved, families of children with special needs and typically developing children became more aware of the community resources (police, local merchants, and health practitioners) they could seek out if a community mobility need arises.

3. Applicant’s objectives for the marketing. *List no more than 3.*

| A) Increase knowledge and resources related to helmet safety for children using any wheeled mobility (bicycle, scooter, skateboards, etc.) |
| B) Enhance performance and knowledge in bicycle safety among children as they navigate obstacles and use roadways |
| C) Increase family awareness of community resources for optimal and safe engagement in community mobility. |

4. Describe how this marketing activity demonstrates how you “*establish and collaborate with referral sources and stakeholders to help the client and relevant others achieve outcomes that support health and participation in the area of driving and community mobility.*” *(average word guideline–200)*

The networking with community partners (school-based therapists, community-based therapists, local toy store, local bike shop, police department, and Safe Kids USA) allowed for the development and execution of a comprehensive public safety endeavor that met the safety and community mobility needs of children and their families. Through the collaboration with all the partners involved, families of children with special needs and typically developing children became more aware of the community resources (police, local merchants, and health practitioners) they could seek out if a community mobility need arises.
**PRESENTATION**

*Back to Criteria*

**Criterion 10—Establishes Networks**

Establishes and collaborates with referral sources and stakeholders to help the client and relevant others achieve outcomes that support health and participation in the area of driving and community mobility.

**Type of presentation:**

- **X** In-service to professionals
- ☐ Academic program lecture
- ☐ Professional level workshop (e.g., state conference)
- ☐ Community

1. Presentation information.

<table>
<thead>
<tr>
<th>Title</th>
<th>Evaluating Driving: How do I know my patient is safe?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target Audience</td>
<td>Rehabilitation staff at area medical facilities</td>
</tr>
<tr>
<td>Date and Time of Presentation</td>
<td>Presentation (45 minutes) within all day conference for geriatrics. March 12, 20XX</td>
</tr>
</tbody>
</table>

2. Brief description of the presentation, including content focus. *(average word guideline–50)*

I planned a presentation that included describing driving as an instrumental activity of daily living and its link to occupational therapy, driving rehabilitation, appropriate screening criteria for referral, and process for ensuring appropriate patients are referred to occupational therapy appropriately and at the right time.

3. Applicant’s objectives for networking. *Objectives must have been met by time of application. Please list no more than 3.*

A) Explain driving, occupational therapy, and driving evaluation and rehabilitation to therapists and physicians in a conference venue.

B) Establish a direct referral link to physicians’ practices through educational presentation.

C) Establish a referral process through other allied health services.

4. Describe how networks were established or strengthened through this presentation and any changes which have occurred as a result of your presentation. *(average word guideline–200)*

The presentation was completed within a specialized geriatric conference in Greenville, North Carolina. Because of the presentation, two geriatric physicians sought me out after the conference to ask about the process of referring their clients to a driving program. In addition, since the presentation, physical and speech therapists have sought me out at work to ask questions about when and if specific clients should be referred for a driving evaluation. The presentation strengthened both my referral stream and improved the process of referring appropriately timed evaluation referrals. This presentation assisted me in forming networks with other health care professionals with whom I continue to collaborate to make sure our clients living in this area are increasing or maintaining their community mobility.
**Advocacy Efforts**

**Criterion 11—Advocating for Change**

Influences services for clients (person, organization, population) in driving and community mobility through independent or collaborative education or advocacy activities.

**Guidelines**
- Active involvement in or facilitation of advocacy activities at the local, regional, state, or national level for the purpose of influencing decision-makers about policy, procedures, services, reimbursement, or occupational justice issues.
- Merely serving as a participant does not constitute advocacy efforts.
- Minimum of 10 hours over at least 2 months.

**Type of advocacy activity:** (check all that apply)
- ☐ Development and dissemination of advocacy materials (e.g., letters, brochures, Web sites, podcasts)
- ☐ Lobbying to/education for policy-makers
- ☐ Organizer of community event (e.g., fundraising, health fair)
- ☑ Subject expert in media interview (e.g., radio, television news, newspaper)
- ☐ Presentation to stakeholder
- ☐ Other

1. **Description of Activity**
   **Target Audience**
   **Date(s)**
   **No. of Hours Involved**

<table>
<thead>
<tr>
<th>Description of Activity</th>
<th>Target Audience</th>
<th>Date(s)</th>
<th>No. of Hours Involved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interviewed on RLTV (Retirement Living TV) on the nationally syndicated show Daily Café about CarFit</td>
<td>Older adult drivers</td>
<td>May 19, 20XX</td>
<td>10 including gathering of background information, pre-interviewing with producers and interviewer, taping, and editing</td>
</tr>
</tbody>
</table>

2. Applicant’s objectives for advocating for change. *List no more than 3.*

   A) Increase awareness about driver-vehicle fit to reduce injuries in the event of a crash
   B) Eliminate the association between driving evaluations/license revocation and injury prevention initiatives
   C)
3. Discuss the results, outcomes, or progress toward change affected by this advocacy effort that demonstrates how you “influence services for clients (person, organization, population) in driving and community mobility through independent or collaborative education or advocacy activities.” (average word guideline – 350)

Careful and extensive work was dedicated prior to taping of the interview specific to preparing the information specifically to address the objectives for change and included several discussions with both on air personalities and producers about the necessary direction of the segment. The show aired at several retirement communities which subscribe to Retirement Living Television. Following the show, the requests for scheduled CarFit events as well as in-person presentations doubled. In addition, offers to present or hold a CarFit event were all accepted whereas previously agencies refused or required extensive education before accepting the offer. The increased acceptance of CarFit and increased number of events resulted in older drivers having increased access to CarFit, learning from the program, and making safety changes in how they use the safety features in their vehicles. The changes I noticed were only local and statewide to my practice at the time, however this advocacy effort aired nationally and was available for viewing online for a least a year after the interview. Therefore the potential reach of this effort was likely much greater than the local/regional change I personally experienced.
**Advocacy Case Study**

**Criterion 11— Advocating for Change**

Influences services for clients (person, organization, population) in driving and community mobility through independent or collaborative education or advocacy activities.

**Guidelines**

- Efforts toward change that influence access to services or promote the health and occupational engagement of clients.
- This should **not** be confused with routine job duties associated with expected occupational therapy service delivery. For example, submitting letters of necessity for equipment would not meet intent.

1. Describe the client (person, organization, population) or program and the context as it applies to an identified need for change. *(average word guideline–100)*

   The population in need of change was older drivers in Anycounty, USA; however since all road users are exposed to older drivers in the county, residents and travelers in the county were the client. Anycounty is elder dense with 368,548 (27.8%) of population over the age of 60 representing 30.9% of all licensed drivers in the county (State Department of Elder Affairs, 20XX). Law enforcement and court agencies in the county expressed concern over management of older drivers with legal infractions and discomfort with placing seniors with traffic violations in jail holding cells with dangerous offenders.

2. Summarize your efforts to influence change. *(average word guideline–200)*

   Efforts to influence change were two pronged and included legal management of offenders as well as crisis management. First, “traffic court” and “elder court” judges and local law enforcement were educated about older driver issues and red flags behaviors. This education led to collaboration with the legal system to find solutions for management of offenders. Next, I brought the issue to the State Aging Driver Council to discuss concerns and request formulation of a solution, particularly when crises arise at the time of the incident when a driver with cognitive impairment is involved. The statewide collaborative partnership which included representatives from several state government agencies, service provision agencies, as well as researchers worked together to develop a system to manage crises when they came up roadside.

3. Describe the change outcomes or progress toward change as a result of your efforts. *(average word guideline–200)*

   There were positive outcomes from both levels of advocacy; at the county level as well as statewide. At the county level, the Elder Court implemented a path for further examination by adding a mandatory driving evaluation by an occupational therapist to the list of potential “sentences” for cases in which performance or medical fitness-to-drive was in question. The courts identified the local driving rehabilitation programs for referral in the “sentence” and my program received about 8 referrals from the court in the following year.

   At the state level, it became obvious that older drivers involved in traffic incidents often cannot be sent driving home, but rather need supportive care with immediate action. The State Aging Driver Council mobilized an effort after requesting funding from the state Department of Transportation, to identify a crisis contact agency in each county in the event that crisis management is needed immediately. In some counties the agency was the Area Agency on Aging and in other counties it was the Department of Children and Families. These agencies were already accustomed to crisis management and understood the need to pick up involved individuals and place them immediately in a supportive or protected housing environment. In addition, some counties identified those protected housing options and included options such as skilled nursing facilities with locked units.
4. Articulate how this case demonstrates your ability to "influence services for clients (person, organization, population) in driving and community mobility through independent or collaborative education or advocacy activities." (average word guideline – 500)

My background and knowledge in occupational therapy and driving and community mobility allowed me to contribute that experience to larger agencies for population-based clients. In the circumstances described, it was too late to address crash or injury prevention. The reality is that traffic incidents occur and the older driver population, particularly those with cognitive impairments, may require services, resources, or infrastructure to manage care following the incident. In the Haddon Matrix (developed by William Haddon, former Director of the U.S. Department of Transportation), there are three phases to injury prevention, with four areas of concern or possible intervention. The advocacy case described specifically addresses the social environment in the post-event of traffic incidents. My influences through advocacy facilitated the development of safety nets to manage older drivers post incident, both acutely after an incident and during the legal follow-up which was often encountered long term after the incident.
PUBLIC AWARENESS EFFORTS

Criterion 11—Advocating for Change

Influences services for clients (person, organization, population) in driving and community mobility through independent or collaborative education or advocacy activities.

Guidelines

- Development of public awareness media for a broad audience to promote topic(s) relevant to the specialty area.

Type of media developed: (check all that apply)

- X Presentation to potential referral source audience
- ☐ Presentation to potential clients
- ☐ Participation in community event, such as health fairs
- ☐ Speaking to community groups
- ☐ Development and dissemination of marketing materials (e.g., brochures, Web sites, podcasts)
- ☐ Participation in media interview (e.g., television news, newspaper)
- ☐ Other

1. Target audience(s) of public awareness.

<table>
<thead>
<tr>
<th>Target Audience of Public Awareness Efforts</th>
<th>Clients, families, caregivers, professionals attending the State Alzheimer’s State Conference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date(s) of Public Awareness Activity</td>
<td>March 15, 20XX</td>
</tr>
<tr>
<td>Approximate Total Hours Engaged in Public Awareness Activity(ies)</td>
<td>1.5 hour presentation plus Q&amp;A, 5 hours to develop</td>
</tr>
</tbody>
</table>

2. Brief Summary of the Public Awareness Message (average word guideline – 50)

To be consistent with the updated message by the Alzheimer’s Association, I wanted to inform audiences that occupational therapy services are not limited to evaluation. Rather, referred early, occupational therapy’s approach considers and integrates evaluation, strategies for continued driving, transition, appropriate alternatives and caregiver strategies.

3. Applicant’s objectives for advocacy/change. List no more than 3.

A) Explain that the occupational therapy evaluation of driving and community mobility provides a person centered plan including driving, transition and cessation when appropriate.

B) Distinguish transition planning from driving cessation

C) Explore strategies, resources and tools available to client and caregivers to establish a contract, explore alternatives, anticipate and implement cessation when the time is right.
The Alzheimer’s Association made a significant move forward when adopting the position “when, not if” meaning once diagnosed with dementia, plans for driving cessation should begin.

I experienced progress toward change immediately following the presentation when responding to consumer and professional’s questions. The emotion behind several comments “I wish I had understood this earlier” became a strong motivator to seek opportunities to preset and accept additional venues to bring this message to more audiences. I believe it is imperative that occupational therapy integrate this message of transition and clarity when driving must cease into specialist and generalist occupational therapy practice. Many resources are available to clinician’s today, but the importance of their use still requires nurturing. Subsequent to this presentation, the state Alzheimer’s Association requested that I offer a Dementia and Driving: The Journey Toward Driving Cessation class using materials that included the “At the Crossroads” toolkit from The Hartford. I deliberately invited an occupational therapist who had contacted me for more information (following my presentation) to co-lead these sessions. She subsequently began offering family education groups guided by the At The Crossroads speaker toolkit for clients and families at her facility.

I continue to talk about these resources as a guest lecturer at the state university and to community groups when invited. The exciting change in practice that I observe is the potential for implementation once educated. Practitioners acknowledge a frustration with not knowing what to say, and this structure not only allows them to hold groups but empowers them with resources and clear messages to integrate into individual client sessions. I believe that occupational therapy needs to address driving and community mobility with a message of transition, education and control for clients and families, and this activity accomplished one step!
**Criterion 11—Advocating for Change**

Influences services for clients (person, organization, population) in driving and community mobility through independent or collaborative education or advocacy activities.

**Guidelines**
- Service with a local, state, national, or international agency or organization that has relevance to the criterion.
- **Minimum of 25 hours** for at least 1 year.

1. **Name of organization**
   - Anytown Public Schools, Anytown, USA

2. **Dates of service**
   - August 20XX-May 20XX

3. **Approximate number of hours of service**
   - 50 hours comprised of assistance in grant writing, meetings to orient stakeholders to the program, and execution of the program during before school and after school travel daily for first two weeks

4. **Identification of the volunteer leadership role served (must be leadership in nature, e.g., officer, chair, committee member, board member)**
   - I volunteered as the “Safe Routes to School” consultant for Anytown Elementary School for the duration of a school year. Safe Routes to School is a national and international movement to create safe, convenient and fun opportunities for children to bicycle and walk to and from schools, and it can also play a critical role in providing more physical activity and enhancing traffic safety. In this role, I assisted the Parent-Teacher Association (PTA) write a Safe Routes to School grant, attended a meeting and oriented stakeholders to the Safe Routes to School Initiative, and provided oversight to the execution of the program for the first two weeks of roll out when the program started.
As an occupational therapy assistant with a child attending Anytown Elementary School, I had safety concerns with the travel to and from school. Based on my experience in traffic safety from my practice in driving rehabilitation, I explored the Safe Routes to School program coordinated and funded by the Federal Highway Administration. I approached the school administration with my concerns and potential solutions and was advised to speak with the PTA. After meeting with the PTA Board, we decided to take action and together we wrote a grant for Safe Routes to School funding to create a coordinated effort at the school to improve safety and engagement of school-aged children as they walked to/from school, were dropped off/picked up at school, and rode the bus to/from school.

Using the resources in the Safe Routes to School toolbox, I provided orientation to stakeholders about the program at a PTA sponsored after school meeting. Separate task groups were established to address one of three areas; pedestrian travel to/from school, the drop-off/pickup area in front of the school, and bus stop safety. I was assigned to the task group for pedestrian travel. My volunteer work included coordinating "walking school buses" by creating walking routes and organizing crossing guards and PTA volunteers to serve as supervisors of the walking school buses. During the same time, the resources I identified from the Safe Routes to School toolbox were used to support the work of the other task groups.

By the end of the school year, the following had been implemented at Anytown Elementary School.

- Walking school buses for walkers at all elementary schools
- Re-routing drop-off/pick-up lanes as necessary at a variety of schools
- Development of policies for school bus riders specific to bus stop behavior, boarding, and exiting the school bus
- Crossing guard training for all elementary school crossing guards
- An expansion of the annual international walk-to-school-day to monthly walk-to-school days
- Pedestrian and bicycle safety assemblies at all middle schools
- Installation of a new bike rack
- PTA sponsored contests for the most days walked to school in a month in three schools
- Partnership with the school system wellness committee and the district Commit 2B Fit program

While I was only involved in the pedestrian travel portion of the initiative, I feel it was my leadership that served as the catalyst for the stakeholders to work together on a single initiative for the safety and wellbeing of the children traveling to school at Anytown Elementary School. While my efforts started as a means to improve community mobility among the children at the school, a positive, unexpected outcome was the overall wellness benefit through the partnership with Commit 2B Fit in the school district.