Older Driver Safety Summit Final Report

*Project Title: Foster Occupational Therapy Engagement in Older Drivers addressing gaps through Pathways FINAL REPORT* NHTSA Cooperative Agreement

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Executive Summary

The objective of the Expert Summit was to explore the shared understanding of the array of resources states use or may access to build a comprehensive network of services and resources (public and private) to support senior driver safety and mobility and meet NHTSA’s *Uniform Guidelines for State Highway Safety Programs* - Guideline No. 13 Older Driver Safety. Our intention was to facilitate discussion, encourage experts to share strategies and initiatives they would describe as “working” to improve procedures to address older driver safety.

In order to meet the vision of supporting medically-at-risk aging drivers, an impact statement was developed. The statement - *A safety network supporting the medically-at-risk older driver to remain safely mobile and engaged* succinctly expresses the overall objective of the Gaps and Pathways Project. This summit was designed to specifically focus on exploring the role and potential contribution of occupational therapy services and expertise in order to build pathways of service delivery between occupational therapy generalists and specialists with the major key stakeholders.

Invited key organizations and stakeholders included state licensing agency officers/managers, law enforcement, medical providers, driving instructors, transportation researchers, consumers, and senior advocates from associations (e.g., AARP, AAA, Easter Seal). The medical providers included physicians, occupational therapists, and driver rehabilitation specialists. Representatives were from the AOTA, Centers for Disease Control (CDC), Governor Highway Safety Association (GHSA), American Association of Motor Vehicle Administrators (AAMVA) and the Association for Driver Rehabilitation Specialists (ADED). Representatives from Medscape of WebMD and Syneren Technologies, Inc. were invited as observers although they were also invited to participate and present.

A logic model format was used to structure the meeting. Using the impact statement, outcomes were confirmed; theoretical underpinnings were identified; with the summit discussion used primarily to identify resources/inputs (talent in the silos) and the pathway activities. Two interactive small group activities were used to identify 1) ideal pathways between stakeholders and 2) identify the barriers or gaps and problem solve how to build pathways with a focus on occupational therapy services.

The Summit participant/experts were a diverse group and as such, was a rich source of varied information, ideas, and agendas. With the goal to ensure that all participants interacted, significant time was spent in both the activities and the discussion. Based on summit reflections and discussions and post summit activities, a final logic model identify the needed next steps:

- The term medically-at-risk defining needs to be clearly defined; differentiated from those who are “older adults” and those who may have impairment because of medical conditions.
- There are diverse screening tools and it may be that different entry points for the medically at risk driver to be identified (e.g., EMS, law enforcement, physician). It continues to be important to emphasize that screening should not be used for licensing decisions. A project may be to identify and categorize these tools in terms of 1) roles in primary, secondary, and tertiary levels, 2) administrated and most importantly interpreted by whom, and 3) to whom the results are intended (e.g., physician, aging adult or caregiver).
• Medically advisory boards may be the key or “hub” of meeting the needs for the medically at risk driver. Education to enhance and/or expand the role of the medical review board is clearly needed.

• The quality of content of the resources is most critical, although access is clearly important with linkage to the state licensing agencies.

• There is a need to increase a clear understanding of when and how to refer to driving evaluation and rehabilitation that may be different for each state as well as each community. The focus on expanding the generalist occupational therapist requires further education.

• Websites are a powerful tool for getting information for a large number of people, but can be difficult to negotiate. With many resources and tools available, a clear plan is to ensure that is it organized in a central place so that education can be easy to find and accessible to all. This will also include the ability to give and send hard copies for individuals that do not have internet access or do not want to use the internet. Both the AOTA website and the Clearinghouse need to be aligned with the same messages, so resources are available for the major stakeholder. For the consumer, the list of DRS needs to be aligned with the Spectrum of Driver Services.

• Using a demonstration project to educate both the state licensing agencies and the area occupational therapists needs to be done to achieve the two outcomes of 1) MAB appropriately determine risk for medically-at-risk driver and 2) Medically-at-risk driver offered appropriate services. Although there may be multiple reasons the medically-at-risk driver does not get appropriate services, it is often due to not having access to a DRS, not being able to pay for the service, or the waiting list for a DRS. Specific deliverables that will assist in this process is the Spectrum of Driver Services, the Diagnosis sheets, the Performance Appraisal for Driving tool, the ethical module, and the consensus statements, which all have been developed.

• It is well known that physicians (or primary providers) are seen as the key individual with whom the decision about driving rests. The objective is to improve education with appropriate materials so that improved services of the medically at risk driving and clearer funding for evaluations and support for alternative transportation options is achieved.

• With the education modules produced and available, it may assist in the education to understand how to address the IADL of driving and community mobility, CMS funding, the relationship between occupational therapy generalists and specialists for evaluation/rehabilitation for driving, and alternative transportation.

• With the improved materials (Older Driver Guide) being developed by AGS, the achievement of improved services of the medically at risk driving and clearer funding for evaluations and support for alternative transportation options will be highlighted.

• Law enforcement is a critical stakeholder for older drivers. Models to educate law enforcement needs to be duplicated and occupational therapists, especially those with DRS specialization, could be leaders/advocates in this area.

• The state licensing boards are critical stakeholders for older drivers, as they ultimately make the decisions about driving. Although Iowa DMV has issues with referrals, they are a DMV at the cutting edge and working hard to find the right level of screening and methods of referral. This model needs to be enhanced by education of the DMV and occupational therapists (generalists) in the area so that the model system can be evaluated
and then duplicated in other licensing agencies. A demonstration project in Iowa with referral pathways needs to be developed with pre and post outcomes to see if changes are made for getting medically-at-risk drivers to more appropriate services.

- Working with experts in public health may enable occupational therapists to explore the collaboration with insurance companies to evaluate the use of evaluations and resources. This project would give older drivers and families more ownership and empowerment as well as clearer lines of funding for evaluation, rehabilitation, and support of alternative options.
- The CDC is clearly linking driver safety with falls. Occupational therapists are interested in both areas, but there has not been enough research to link these two areas. Materials, education and research need to be expanded to get a baseline understand of occupational therapists knowledge about the link between falls and driving.
- Florida is a leader in with older drivers and services, having created many resources targeted to providing good information, empowering older adults to use alternative options and demand services. It would be important to evaluate the system in Florida from the occupational therapy perspective and evaluate how we can be leaders and advocates to start some of the same processes in other states.
- Maryland is clearly a leader when considering a well functioning Medical Review Board. A goal would be to evaluate Maryland’s system and educate occupational therapists leaders to assist their state in implementing the generalist/specialist model and advocating for improved MABs.

Through the earlier work of the Gaps and Pathways, many resources have been developed and now available. The key of this summit was to identify the gaps that either need target materials or need pathways using available resources. The general occupational therapist who can provide expertise, information, and support for driving and community mobility. The use of the logic model was a unique perspective that was useful for structuring the meeting. It was an excellent tool in organizing the resources and, most importantly, the activities that should be planned for the next step of the processes. The Pathway Activities of the logic model, based on the resources, these tasks can be examined and used to meet the outcomes and ultimately the vision of the model. Thus, the Expert Summit, couched with its pre-summit information and after summit activities, should be viewed as meeting its objectives.
Chapter 1: Introduction

1.1 Context

As part of the American Occupational Therapy Association (AOTA) and National Highway Transportation Safety Administration (NHTSA) Cooperative Agreement for Project DTNH22-11-H-00340 titled Foster Occupational Therapist Engagement in Older Persons, this report summarizes the planning, implementation, and outcomes of the modification that was proposed and funded to further examine the gaps and pathways between occupational therapy and other key stakeholders.

1.2 Objective

The modification, titled Older Driver: Expert Summit and Develop Guidance for MAB and DRS Pathways was primarily designed to bring together key representatives from critical stakeholder groups involved in the identification, screening and evaluation, reporting, processing, rehabilitating and transitioning the medically-at-risk driver.

During the process of planning the Older Driver Expert Summit, the project staff developed a vision statement. The statement - A safety network supporting the medically-at-risk older driver to remain safely mobile and engaged (further described) succinctly expresses the overall objective of the Gaps and Pathways Project.

The Objective of the Expert Summit was to explore the shared understanding of the array of resources states use / may access to build a comprehensive network of services and resources (public and private) to support senior driver safety and mobility. The Summit was intended to gather expert input describing what is working as well as articulate the “gaps,” barriers or problems that prohibit progress. Our intention was to facilitate discussion, encourage experts to share strategies and initiatives they would describe as “working” to improve their procedures to address older driver safety.

This Older Driver Expert Summit was focused on exploring the role and potential contribution of occupational therapy services and expertise. Occupational therapy practitioners have the skills and knowledge to perform driving screening, evaluation, and rehabilitations and thus has the unique position to be a major contributor to meeting the objective of improved driver safety. NHTSA’s Uniform Guidelines for State Highway Safety Programs - Guideline No. 13 Older Driver Safety encourages the development or expansion of “medical advisory boards” that include the knowledge of specialized services (e.g., physicians, occupational therapy, driver rehabilitation services). Thus, this modification’s objective was to assist in building our understanding of the pathways of service delivery between occupational therapy generalists and specialists with the major key stakeholders in order to meet the vision statement of supporting medically-at-risk aging drivers.

1.3 Background

Dickerson and Schold Davis\(^\text{1}\) have discussed the stakeholders who directly address older drivers, and grouped them into four categories according to their essential function: 1) the older driver

\(^{1}\) Dickerson, A.E. & Schold Davis, E. (2014). Driving experts address expanding access through pathways to older drivers rehabilitation services: Expert meeting results and implications. Occupational Therapy in Health Care, 28, 122-126.
and/or family members are the consumers, 2) the researchers who provide the research evidence needed for making decisions about fitness to drive, especially related to assessment and screening, 3) the state licensing agencies that make decisions about licensing, and 4) the practitioners who provide the professional skilled service at the level of the consumer. In most cases, this is the driver rehabilitation specialist (DRS) /occupational therapist who provides an expert evaluation and recommendations. Although there are other important stakeholders, were proposed as a starting point when planning for and developing the invitee list for the Expert Summit.

The second important perspective identified for the summit was the relationship between occupational therapy generalists and occupational therapy specialists (i.e., occupational therapists specialized in driver rehabilitation services). Over the last ten years, it has become clear that a goal to expand the number of DRS to meet the need of older drivers has not been sufficient, especially when considering the varied and individualized needs of the older driver with medical conditions. Dickerson and Schold Davis² have developed a framework from which to illustrate how the already skilled occupational therapy generalist can assist in differentiating between the driver with medical conditions who would benefit from a specialized evaluation by a DRS from those that 1) do not demonstrate risk and therefore do not demonstrate a need for specialized evaluation or services, 2) those who are so impaired specialized evaluation is inappropriate, and 3) assist in understanding the best timing for a referral to the specialized (See Figure 1. below).

![Figure 1. Conceptualization of how occupational therapy generalists may collaborate with driver rehabilitation specialists.](image)

Chapter 2: Planning the Summit

2.1 Overview

The core project staff (Elin Schold Davis and Anne Dickerson) worked with the NHTSA Contracting Officer’s Representative (COR) to develop a plan to bring together the critical stakeholders for a 1 ½ day meeting in January or February of 2015 with the expectation to gain of comprehensive understanding of what resources are already available, consider what is working, and understand the challenges impeding progress. The plan was to contract with an outside facilitator who would use the problem solving/goal setting paradigm of the Logic Model. The core team did proceed to engage Dr. Thomas Meuser and use the Logic Model as the paradigm, where the Logic Model offered an introductory framework followed by discussion of the resources and pathways identified by the stakeholders.

2.2 Logic Model as Paradigm

The logic model is a paradigm used by organizations to facilitate thinking, planning, and communications about program objectives and actual accomplishments.\(^3\) It is defined as a picture of how an organization does its work, with the theory and assumptions underlying the program and linking both short and long term outcomes with program activities/processes.\(^3\) The W.K. Kellogg Foundation Logic Model Development Guide\(^3\) that was used to support this summit.

The Team created a template during the planning of the summit as shown in Figure 2. As the theoretical underpinnings are key to the logic model, we decided on a few occupational therapy and psychology theoretical approaches for the meeting. The vision statement, as it was originally worded, was placed as the “impact” statement or desired outcome, and the list of anticipated outcomes for the project was started.

The facilitator, Dr. Thomas Meuser, was tasked to become familiar with the Logic Model and build content into the logic model’s categories and interactions as an objective of the Summit Meeting.

2.3 Participants

Critical to the success of the Summit was inviting individuals from key organizations and diverse perspectives. A participant list was generated identifying key organizations and stakeholders. This list included state licensing agency officers/managers, law enforcement, medical providers, driving instructors, transportation researchers, consumers, and senior advocates from associations (e.g., AARP, AAA, Easter Seal). The medical providers included physicians, occupational therapists, and driver rehabilitation specialists. Representatives were actively recruited from the AOTA, Centers for Disease Control (CDC), Governor Highway Safety Association (GHSA), American Association of Motor Vehicle Administrators (AAMVA) and the Association for Driver Rehabilitation Specialists (ADED).

Representatives from Medscape of WebMD and Syneren Technologies, Inc. (both contractors for NHTSA) were invited as “observers” although they were also invited to participate and present. The goal of Medscape’s participation was to consider how this project might interact with the present Medscape/NHTSA project to develop education for primary care practitioners. Staff from Syneren were invited to assure interaction between the Clearinghouse for Older Road User Safety (ChORUS) (NHTSA/Federal Highway Administration (FHWA) Project) to this project since all resources and outcomes from this project will likely be placed on the website.

From the time this modification started, names were added to the potential list with a target goal of about 15 invited experts. Once the date of March 4-5, 2015 was finalized, the names of the participants were also finalized, as some members initially invited were not able to attend on those dates. Appendix A includes the final list of attendees with their contact information, a brief bio, and photograph.
2.4 Preparatory materials

Appendix B is the invitation emailed to all the attendees. All participants were contacted prior to the invitation letter as a courtesy. With the confirmation letter, attendees received: 1) the Spectrum of Driver Services (refer to Appendix C), which they were asked to review, 2) a list of attendees, their organization, and a short bio, 3) trip and meeting reminders, and 4) a alert that they would be receiving an email with a link to an electronic survey to gather data about underlying assumptions and beliefs.

2.5 Preliminary Analysis of Attendees’ Perspective

In an effort to prepare the experts for the meeting, the core team decided to email the participants a list of quests to allow us to “set the stage” with some of their preliminary thoughts and descriptions of resources they typically use. The email began with an introduction, instructions to review the NHTSA’s Uniform Guidelines for State Highway Safety Programs - Guideline No. 13 Older Driver Safety (attached in the invitation letter) and the 11 questions. The email also asked for input on key terms and concepts.

The questions were created and sent to the summit leaders for review on February 20, 2015, reminder February 26, 2015 and March 2, 2015. All 20 attendees responded.

2.5.1 Directions

The email included the following directions:

Introduction At the upcoming Experts Summit meeting, we will strive to understand and integrate the gathered Expert's recommendations and collective knowledge. As experts, we want candid opinions and suggestions to help establish a foundation for the discussion and ongoing work.

As you prepare for answering these questions, consider the following:

Aim of the Project: to explore our shared understanding of the array of resources states can access to build a network of services and resources (public and private) to support senior driver safety and mobility. NHTSA’s Uniform Guidelines for State Highway Safety Programs - Guideline #13 Older Driver Safety encourages the development or expansion of “medical advisory boards” that include the knowledge of specialized services (e.g., physicians, occupational therapy, driver rehabilitation services, etc.).

Expert Summit’s Contribution: will generate a heightened understanding of successful use of tools, resources and the pathways that facilitate access and utilization while identifying barriers and/or needs to providing appropriate services to the medically-at-risk aging driver.

Although it is acknowledged that resources and services related to driving benefit all drivers, this summit will focus specifically on the medically-at-risk aging driver.

2.5.2 Preliminary questions

The eleven questions are in Appendix D.

2.5.3 Data

As indicated, all invited participants answered the questions. The report generated from
the tool used called Qualtrics compiled all responses in an Appendix E. An abbreviated report was generated from the outcomes for presentation to the at the Summit (see Appendix F).

2.6 Consumer Input

In an effort to gather input from consumers (older drivers or caregivers), a strategy was developed to also set up an electronic survey to gather input with open ended questions to gather individualized information.

The project staff contacted Susan Cohen to represent consumers to assist in recruiting and analyzing the data. Ms. Cohen is a consumer who has been actively attending meetings and conferences on older driver safety, agreed to assist.

2.6.1 Consumer Questions Introduction

This inquiry is an exploratory study designed to reveal issues associated with older driver safety. We are asking you to participate if you are an older driver with a medical impairment or a family member of an older driver with a medical condition.

There are only a four questions with space for you to add your thoughts, ideas or perceptions. There are no right or wrong answers. We do not want any personal identifying information, although you are free to share stories or experiences concerning older drivers.

None of the answers will be published or used in traditional research. Instead, any insights will be used as ideas for resources or areas of need for further targeted research.

Thank you very much for your time and thoughtful consideration in answering the questions.

2.6.2 Consumer Questions

1. In your community and/or state, what resources or information have you found to be helpful in either assisting you (or family member) with issues about driving relicensing and interacting with the licensing agencies? Note: Examples of resources might be webpages, brochures, individuals, agencies, reading materials, advice from professionals.

2. In your community and/or state, what resources or information have you found to be helpful in either assisting you (or family member) with issues driver evaluation and/or driver rehabilitation?

3. In your community and/or state, what resources or information have you found to be helpful in either assisting you (or family member) with improving older driver safety?

4. In your community and/or state, what resources or information would you consider important and would like to see developed or implemented to assist in improving driver safety including, but not limited to:
• Driving relicensing and interacting with the licensing agencies
• Driver evaluation and/or Driver rehabilitation
• Improving driver safety

2.6.3 Results
Ms. Cohen viewed the questions at approximately six times. In one of the last discussions, she felt the questions were too open ended and suggested alternative questions that did not meet the intent of the information the project needed. Although Ms. Cohen indicated she was going to contact individuals to complete the study, no one responded to the survey.

2.7 Agenda
The agenda (see Appendix G) was developed to gather input, allow for invited contribution with a priority given to discussion and sharing of resources, ideas and the identification of gaps and needs. Two specific activities were designed to allow for small group interaction and the generation of written ideas the team could analyze post meeting.

2.7.1 Presentations
The core project staff reviewed each confirmed attendee, and selected four participants to inform the group of their programs through a brief presentation. Throughout the meeting, the facilitator made an effort to link presentations and discussions with the appropriate component of the logic model.

2.7.2 Talent in the Silos and Resources
Using the Spectrum of Driver Services as a “model” for understanding the distinctions between driving program services, the project staff sought to generate ideas for how the Spectrum could be expanded or enhanced. The point was not to “break down the silos” but to understand how each stakeholder plays a unique role and it is the pathways or connections between the silos that need to be developed and enriched.

The first small group task was structured to gain the experts ideas to build upon the Spectrum columns. The experts were divided into three groups to do this task, with an assigned facilitator: Medical review board, health care professionals, and licensing. Appendix H is the activity format.

2.7.3 Pathway activity
The concept of the second small group activity was to build upon the previous “talent in the silos.” Participants were broken into pairs and asked to consider how an individual “older driver” might move from an incident through the “system”. We asked the participants to discuss and record (on their worksheet) the “pathways” they consider present and most importantly identify the “gaps” between the silos that present barriers to access for consumers, families, health care providers, and state licensing agencies (to name a few). Appendix I is the worksheet format that was developed to facilitate this activity. Description: a large size (11x17 inches) cardstock printed with a series of boxes to use as a “building block” of stakeholders and pathways. A set of cards with names of
stakeholders (see Appendix I) was also given to prompt their consideration of possible and probable stakeholders.

Chapter 3: Summit Meeting

3.1 Overview

The Expert Meeting was scheduled as a 1 ½ day meeting on March 5-6th in Bethesda Maryland. The core team, including our COR, met with the facilitator at AOTA headquarters and the hotel business office to make final preparations the day prior to the meeting. Most of the attendees were present for the meeting, though a winter storm affected the area and some attendees/observers from the local area were not able to attend.

3.2 Materials for Attendees

Each attendee was provided a folder with copies of: An updated attendee bio with photographs, Spectrum Table of Older Drivers Services, a picture of the partial Logic Model (Figure 2 above), and a copy of Model of Older Driver Screening and Assessment (Appendix J).

A power point presentation was used to structure the meeting and support the presentations and activities. The final presentation is in Appendix K.

3.3 Introductions

Elin Schold Davis welcomed the attendees and observers; Brian Chodrow, NHTSA representative and COR for this project, introduced the Expert Summit; and each attendee was asked to introduce themselves speaking briefly what he or she felt could contribute to the submit. After introductions, Ms. Davis began the summit by introducing the purpose and background of the Summit reinforcing the fact that each attendee was an important member and has a role in the discussions.

The next agenda item was for the staff from the Older Driver Clearinghouse (now known as ChORUS) to describe their purpose and overall plans. Since there was not local staff present, Mr. Chodrow outlined the purpose and mission of the Clearinghouse.

After introductions, the facilitator began the core purpose of the meeting. Dr. Dickerson recorded notes.

3.4 Logic Model Presentations and Activities

As facilitator, Thomas Meuser was tasked to describe the logic model, introduce the Impact Statement, and facilitate the discussion of ideas, resources used and needed, and “pulling the threads” of ideas between the components of the logic model. Dr. Dickerson reported on the outcomes of the pre-questionnaire.

3.4.1 Outcomes

After a short discussion, the Summit Experts present affirmed the Impact Statement. The theoretical underpinnings were identified and contributions for possible inclusions were requested. The outcomes already identified (on the proposed Logic Model) were discussed and participants confirmed the outcomes were appropriate and should remain outcomes.
3.4.2 Resources

With a direct reference to NTHSA’s Uniform Guidelines for State Highway Safety Programs, No. 13, the discussion focused on resources.

3.4.2.1 Elin Schold Davis described resources on Older Driver Safety website and resources developed through the past NHTSA projects.

3.4.2.2 The NHTSA videos were highlighted as useful.

3.4.2.3 Debra Carney described the role of the state licensing agencies. As a rural state, she described several initiatives underway within the state and collaboration with NHTSA. Iowa is tracking a new program designed to identify the medically at risk driving through a cognitive test screening. Building capacity to send the consumers to occupational therapy was identified as a gap.

3.4.2.4 Jenny Nordine described the role of the DRS, ADED, and the strategic plan of ADED to increase the capacity through collaboration with AOTA. The Spectrum Table of Driver Services is considered a seminal document, already incorporated on the ADED website in identifying DRS.

3.4.2.5 Mary Jo Maguire described the role of the generalist. Because driving and community mobility is an IADL, the generalist is doing an occupational therapy evaluation, not a driving evaluation, but can look at all the component skills that underlie driving.

3.4.2.6 Dr. Alice Pomidor describe how American Geriatrics Society (AGS) is updating, expanding the former *AMA Physician’s Guide* to make it multi-disciplinary, with an hourglass idea of the DRS being used when only necessary. It will be totally on line with the core done by the end of the year and pieces rolled out over the next few years.

3.4.2.7 Stephen Murphy, as a representative of WebMD demonstrated Medscape (as the educational component for primary care practitioners), an example of their latest education about older drivers, as a project funded by NHTSA. Incentivizing CME has been an effective method of getting information out to practitioners.

3.4.3 Talent in the Silos

One of the points we wanted to solidify for this part of the summit meeting, was to underscore that our goal was not to “break down any silos,” but to understand each stakeholder, agency, or professional does have a role and all need and should work within their guidelines, roles and ethics. What is needed is to build pathways between the silos and in part, it was important to identify what resources were already developed, established, or “what is working.”

As a method of asking the group to conceptual this idea and using the *Spectrum of Driver Services* as a reference, the members were divided into three groups: Medical review board, health practitioners, and licensing. The team selected three facilitators: Cheryl Irmiter, Vanya Jones, and Gail Holley. The Medical review board included: Carl Soderstrom, Nanette Schieke, Jenny Nordine, Greg Brunette with Cheryl Irmiter as facilitator. The health practitioners were: Wendy Stav, Nancy Lundebjerg, Mary Jo
Maguire, Alice Pomidor with Vanya Jones as facilitator. The licensing group was Ike Iketani, Debra Carney, Kevin Lewis with Gail Holley as facilitator.

As described in 2.7.2 and using Appendix H, the groups were assigned to three rooms and given approximately 45 minutes to complete the task. Appendix L is a copy of the licensing and MAB groups, as the health practitioners did not complete the form.

3.4.3.1 Medical Advisory Board group reported that there ideal program would have a MAB review all complex cases, but needed the link to others to provide education and make the transition. For the typical cases, there should be education and give guidelines to other health care providers (e.g., nurse practitioners) to be able to make decisions.

The group brought up the question “What is the role of the MAB?” Should there be a concern about the psychological or social? The principle job is to make decisions, however, there could be a link between the MAB and the community to assist the older driver with services (transition).

Law enforcement can be linked to the community, but there are some issues, especially as law enforcement is part of the community.

3.4.3.2 The driver licensing group described the many educational resources and service programs available. They identified some collaborative examples of resources tailored for the communities (e.g., Michigan, Florida). What is important is 1) not to reinvent the wheel, 2) have consistent educational resources for each community, 3) tailor for each community, 4) build different resources for the driving and for the caregiver, and 5) share the resources, especially those that work.

3.4.3.3 The health providers group considered the stakeholders who “touched you” (i.e., the drivers). Emergency medical service (EMS) providers were discussed as “new” group of providers that have not been considered before as needing training about driving, as they are first responders for older adults. However, it was acknowledged that scope of practice laws in each state may be barriers. Older adults may not call EMS if they thought it may lead to a nursing home.

The concept of what might be the first question about driving to engage the driver rather than be an antagonist was considered, although no consensus was attained.

It was acknowledge that physicians have a very short time with patients and when to have a discussion. Older adults have so many conditions and often several physicians following their care. The group felt there might be two points of entry that be focus points for the older adult and introduce driving: The “welcome to Medicare” and the yearly annual physical. The primary reporter could start the case.

3.4.4 Presentations Related to Pathways

Prior to starting the planned activity, there were three presentations/discussions
3.4.4.1 Ike Iketani, a retired California highway patrol officer, described his participation in the Training, Research, and Education for Driving Safety (TRENDS) program as well as his experience as law enforcement in California. The law enforcement education module of 2005 was 40 hours, was decreased to 16 hours, decreased to 2 hours and now is about 30 minutes. The work with TRENDS has created the Driver Orientation Screen for Cognitive Impairment (DOSCI) card, used in a validated study to assign law enforcement with questions when encountering a questionable older driver. California and Iowa is currently working collaboratively in a NHTSA project.

There are available resources that demonstrate how to talk with people on the side of the road, but the best strategies are to get involved with Carfit (a community-based educational program for “fitting” seniors in their vehicles) and other activities or summits to interact with seniors. Entry level is not the best; recruits come from basic entry with mind sets that are often difficult to change. Thus, older adult interactions are best with experienced officers.

3.4.4.2 Nanette Schieke described two initiatives that highlight the inter-connectiveness of services. She described the DMV as the “hub of the wheel,” Ms. Schieke described Maryland’s medical review process and the link with the Maryland Research Consortium. With a reevaluation in 2010, the change has moved to professional training and sharing of information. The 2012 symposium was very successful with plans for June 2015 to include workshops to meet educational needs.

Ms. Schieke has collaborated with Gail Holley to build an “Aging Road User Safety: Interstate Collaboration.” Building a contact list of colleagues to share ideas, policies, and justifications, the group has grown to 11 states on the quarterly phone calls with potential to build action plans for the future.

3.4.4.3 Gail Holley followed up with a description of how the state of Florida has embraced interconnectiveness. Florida has an established coalition that is very broad based with 28 organizations with different views, but all with a goal for reducing crashes. The coalition is focused on engaging in place, empowerment of people (e.g., “you hold the keys”), streamline the message, use flyers to get the resource, and push the message of “the joy of not driving” as a positive message for when the person cannot drive.

The Florida Guide for older Drivers was shared. Designed for ages 50-65, it includes what to do, where to go for things, and has website.

3.4.5 Pathway Activity

As outlined in 2.7.5, the primary objective for the planned activity was to have the experts identify the “pathways” between the silos. The directions were to have pairs of individuals consider and identify stakeholders and the linkages between stakeholders. Using the formatted outline (boxes and arrows, Appendix I), the pair of experts discussed
and detailed the silos and strategize to find barriers and as well as methods of building the interconnectiveness between the stakeholders. The “Piggly Wiggly” video of the older driver was used as an example of “what should happen in this case?”

3.4.5.1 Although the planning for this activity seemed well conceived, the implementation did not work as anticipated. It would appear that the activity was not structured adequately, nor was the discussion facilitated to meet the goal of finding possible pathways and barriers between the stakeholders. Appendix M is an exact summary from the ten sheets that were completed.

3.4.5.2 The discussion on this activity began on the second day and the group was reminded that the boxes were the “silos” and programs need to work within their boundaries. The concept was to collect information about how to facilitate the pathways as well as identify the barriers. The main points of the discussion included:

- There is significant lag time between processes (e.g., MAB to physician, DRS referral time, state licensing agencies) resulting in a significant barrier to the process.
- Insurance was discussed as a method of incentive and notification. There was some disagreement about whether or not there was motivation for companies to get involved. However, the Hartford Insurance Company has become part of the solution in agreeing to pay for driving evaluations for their insured clients who have had a crash. Regardless though, insurance is not currently a primary source of referrals and will likely not be one (Kathy Sifrit).
- Physicians cannot take licenses away and most are not educated about fitness to drive; blame needs to be taken from the health care professionals and aligned with the licensing agencies.
- EMS was highlighted as first responders. Education might be directed towards these professionals. The ER was also suggested as a place to educate and use as a referral source.
- DMVs cannot have lists of DRS anymore, becomes an issue for consumers on where to go.
- Communities need champions, but it cannot just be one agency or person, it has to be coalition (like FL).
- Many things happen at the same time, so there often are no clear lines.

3.5 Federal Transit Administration (FTA) Summit

Cheryl Imiter reported on the FTA Summit that was planned for the next week. The goal of the summit was to have the leaders build partnerships to overcome barriers to transportation. Some of the barriers identified include: Barriers between counties, leverage points, limited public transportation, being able to qualify for programs, and transportation deserts.
3.6 Reimbursement

Mary Jo Maguire, as the representative for AOTA on the CMS coding committee, reported on her perspective on reimbursement for driving and community mobility. After a description of how the generalist occupational therapist can perform a comprehensive occupational therapy evaluation, which includes driving, the debate of reimbursement provided the group with an array of differing opinions. While at least one expert claimed that CMS does not cover driving evaluations, others provided the background and evidence that it can be covered. It was highlighted that it depends on the intermediaries interpretation and some agencies do not want to risk audits. It was identified that there are no separate codes for physicians to bill either, however the Center for Disease Control is recommending the annual wellness checkup, which includes ADL and IADL.

3.7 Parking Lot

As the summit was started, the facilitator was to focus the discussion to the logic model and use the “parking lot” as way to divert topics that cannot be addressed in the summit meeting. Appendix N is a typed list of the notes on the parking lot.

3.7.1 Discussions

There were discussions on some of the topics.

3.7.1.1 A point of discussion was how, especially in smaller communities, that banks, grocery stores, pharmacies, etc. could become partners with the goal to embrace communities to assist with older adults. Businesses might have safety tips for parking lots.

3.7.1.2 Pharmacies and the older driver seems natural, but there are often multiple pharmacies. Snowbirds have no regular pharmacies. The sedating medications and hang over effect should be addressed. Also mail order is taking over, but could allow for tracking medications. There needs to be systematic responsibility.

3.7.1.3 Universal design for vehicles, aging drives, automobile manufacturers was discussed briefly.

3.7.1.4 EMS/ER was highlighted as a possible entry point of checking older drivers. Should have a “box” to check about “not to drive” when leaving the ER. CARF will be adding this.

3.7.1.5 Sleepy drivers is a problem as sleep apnea is under recognized and hard to follow. Patients are not compliant, although cure is so easy. Law enforcement is indicated that fatigue is a factor in crashes, those who are sleep deprived and medical issues.

3.7.1.6 The use of silver alert – can the MAB be alerted if there is a silver alert and get social services involved for a referral for evaluation.

3.8 Priority Areas and Final Comments

The final session of the summit was a discussion on the priority areas of older driver safety when we consider the different stakeholders and pathways of service. These topic areas can be considered the
3.8.1 Alternative Transportation

All experts at the summit confirm that alternative transportation is the key issue to older driver safety. If it is not available, older drivers are going to drive.

3.8.1.1 Mobility networks need to be formed and they need to be senior friendly and have an efficiency of service.

3.8.1.2 A cultural shift in how transportation is viewed is needed; a willingness and readiness to access options. How do we move and change the mindset? Use mobility network to build confidence and have good experiences early in a person’s lifetime. We have graduated licenses for young; graduate licenses for older adults?

Start education at an earlier time (e.g., AARP), the younger older adult.

3.8.1.3 There needs to be issues resolved with older pedestrians (e.g., traffic lights and crosswalks).

3.8.2 Public Health Perspective

Can driving be considered a public health risk and pursue this issue at the broader level.

3.8.2.1 There may need to be a consideration of different entry points for accessing services. Of the services currently available, what are the stakeholders aware of the services? And who are all the stakeholders and what are their possible contributions?

3.8.2.2 How do polices/enforcement that is used for collecting information help us to understand the magnitude of the driver violations for medically at-risk drivers/older drivers? If conventional methods are not accurately capturing the scope, this will have important implications such as:

- Resource allocation because of the scope,
- Less media sensationalism of individual acts and development of more accurate information, and
- Accurate measure for trends in older drivers to determine the impact of prevention/intervention efforts.

3.8.2.3 With a larger public health perspective to impact driving, consider:

- Prevention efforts – working with younger populations to prepare for changes in aging.
- Considering tools for identifying changes and linking the outcomes to services.
- Dealing with the transition from current to former driver?

3.8.2.4 How do we consider the life course perspective in addressing the issue of the older or medically at risk driver? If at the age of 40 years old, the average age adults start to have vision issues, are there considerations for programming,
education, or assessment? How can we understand the progression of changes over time that help a person understand changes in their abilities.

3.8.2.5 What motivates behavior change? What needs to be done to get people to change behavior (driving behavior). How can we use these motivators for change in older driving behaviors?

- It is a decisional balance of pros/cons.
- Threat of severity – how real is the problem for me?
- Self-efficacy – what is my confidence to do what you want me to do?
- Intention – is there a behavior that will help and will I do that behavior?

3.8.3 Identifying the Medically at risk

Focusing on the NHTSA handout Model of Older Driver Screening and Assessment, we asked the experts to consider the transitions between the silos and pathways and articulate what are the critical pieces. With that, several final issues were identified:

- Driver Licensing agencies currently focus on vision; could they based it more on cognition; more evidenced based tools needed.
- Extensive testing is not going to be possible at the state level – looking for the easy screening tool.
- There is no “silver bullet.”
- Not everyone can be screened. It is not practical and needs to be done on a risk ratio.
- The Fitness to Drive Tool by Classen with good psychometrics might be used with caregivers.

3.8.4 Final Comments from Participants

Final comments from each expert participant was sought as a debriefing strategy after the meeting.

- Alice Pomidor – The Physician’s Guide to Assessing and Counseling Older Drviers is being revised and will emphasize and validate the use of various stakeholders.
- Nancy Lundebjerg – There needs to be a federal action plan, in order to plan a safe community, so we understand what that community feels like.
- Cheryl Imiter – Feels there are so many opportunities in the community and work to be done; If the medical communities can be connected with ADL and IADL, we will build up the assessment for safety and quality of life.

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4 Psychometrics of the Fitness-to-Drive Screening Measure, S Classen, CA Velozo, SM Winter, M Bédard, Y Wang OTJR: Occupation, Participation and Health 35 (1), 42-52
• Nanette Schieke – There are great ideas, identification of resources, good research, and things are at a practical level. It is important to have a national model of what is the best. Have the government help people what can be done – make it into a “symphony.”

• Mary Jo Maguire – It is a public issue for all: fall prevention and driving is linked, we do not have the safety work with driving and we need to have more prevention for safe driving as falls and driving are high risk activities.

• Elin Schold Davis – Driving is a treatable condition – we cannot use the approach of not doing anything about it (like previously done with Alzheimer’s). “Stop driving” should not be the message – we need messaging around the positive experience and remember what driving is to a person.

• Vanya Jones – Driving is centered on a person’s life, it is quality of life.

• Gail Holley – We are on the same page, the network needs to be a network. In Florida, we have the ideal – but the message is still not clear. Need to vet the driving evaluators in Florida – how can that be done?

• Elin Schold Davis - The aging driver is vulnerable to messages that tell them they can keep driving. There is a rise of programs and we must protect the consumer.

• Sharon Beall – Can we use AARP to educate?

• Kevin Lewis – Driving test for the aging driver, what elements need to be tested (e.g., left turns, roundabouts, parallel park) what do you see? What makes it a standard evaluation?

• Wendy Stav – you match what you see in the clinic to what issue you think you will see on the road and go behind the wheel.

Chapter 4: Post-Summit Activities

4.1 AOTA Conference Presentations

The annual AOTA conference was April 16-19th in Nashville, TN. With over 7,000 occupational therapists, we recognized it as a critical event to further explore the assumptions of the logic model and Expert Summit. Continuing the education of occupational therapists about the Gaps and Pathways Projects was also an essential objective. Although there were a number of driving and community mobility sessions, the two that specifically used deliverables from the Gaps Pathways Project are highlighted here.

4.1.1 Older Driver Update Session

The update session is a summary of the work of AOTA’s Older Driver Initiative, with particular emphasis on the more recent Expert Summit. The session included a summary of the achievements of the Older Driver Initiative over the last ten years emphasizing the Gaps and Pathways Project. This session was well attended with over 100 participants.

The Expert Summit was specifically described (Appendix O is the Powerpoint with notes for the session). Reviews of the session are not yet available, however, the
audience responded well with questions and comments. Several individuals noted to us that there were conflicting sessions that prevented them from attending this session.

4.1.2 Subacute Session addressing driving.

This session (the full title being: Addressing the Instrumental Activities of Daily Living (IADL) of Driving and Community Mobility in Sub-Acute Rehab: A Strategic Role for Generalists and Specialist) at the AOTA conference illustrates the use of several deliverables of the Gaps and Pathways Project (see Appendix P).

4.3.2.1 The Table of Spectrum of Driver Services was presented (and given as a handout) within this session and explaining each section. During the session, the Table was examined and described so that the audience could understand its value and usefulness. Providing this Table with the conceptual slide (Figure 1 above), provided valuable information for the generalist to use the Spectrum to provide driving services to clients.

4.3.2.2 The driving “framework” developed by Dickerson and Bedard, was described and used in a case study to illustrate how the generalist occupational therapist can use evaluation results already gathered and observations from other ADL and IADL to make judgments about the client’s abilities and skills for driving. This framework, just recently named the Performance Appraisal for Driving (PAD), was also a handout for the participants.

4.1.2.3 The Diagnostic Sheets created collaboratively with Genesis Rehab and the Gaps and Pathways Project were shared in both handouts and using them specifically in case studies during the session. Their usage and ability to be modified to fit a therapist’s own setting was emphasized.

4.2 Outreach to Occupational Therapy Practitioners

The AOTA conference also offered an additional opportunity to reach out to occupational therapy practitioners at the Older Driver Booth in the Expo Hall. As a result of the Expert Summit activities, the Team wanted to explore what current older driver resources are being used by practitioners, what is useful and why, and what additional resources are needed. We also wanted to get information from therapists about the different driving program models. This will be critical information for future development of resources and identifying “what is working.” Finally we wanted to continue to educate practitioners who do not understand the importance of addressing driving and community mobility as an IADL.

Due to the nature of an exhibit hall, we knew an interview or lengthy decision was not always feasible. Identifying the three objectives above (1-feedback on resources, 2- program models, 3-education) we developed a general plan for each of these objectives (Appendix Q). Mary Jo Maguire was the primary lead person, engaged to participant at the conference in this role, to speak with therapists and gather the desired information. Other individuals also manned the booth throughout the expo.

4.2.1 Feedback on Resources

The expectation, from previous conferences and phone calls to AOTA, was that some practitioners would wanting assisting in developing a driving program or pathway to use in their setting. For this, we had 100+ copies of the resources from the Gaps and
Pathways project (listed on the plan, Appendix Q). For the larger or print resources purchase (e.g., AOTA Driving and Community Mobility book, OTHC special issue), we had desk copies to review. A postcard was developed and 100 were stamped to give to attendees and asked to offer comments about any of the resources (see Appendix R for a copy of the postcard).

4.2.2 Program Models

It is particularly important to get information on the vast different kinds of program models. However, the Expo was not conducive to collecting the information we needed. However, there were select individuals to which contact information was gained in order to explore program models. Key were two AOTA leaders in the Home Health Special Interest Section. Currently there is discussion how to link home health with the Gaps and Pathways Project resources.

4.2.3 Education

In terms of education of driving, this goal appeared to be the best achieved at the Expo. All handouts were given out within the first two days of the expo.

4.2.4 Outcomes

Ms. Maguire’s summary report of her interactions (as well as others) offers some insight into the numbers of therapists that seek information and are unaware of the available resources (see Appendix A). However, as mentioned, it may reflect those looking for information rather than others who feel they already have the knowledge or resources. Nevertheless, the numbers of handouts was quickly exhausted.

4.2.4.1 Postcards. Although there were over 40 distributed, at this point in time, only one postcard has been returned. Appendix T is the copy of returned postcard.

4.2.4.2 Ms. Maguire did record contact with 63 individuals, recording their names with about 20 email addresses. Using those email addresses may be a start to solicit information about the content that was available at the booth and inquire if and how resources may have been used.

Chapter 5: Analysis

5.1 Analysis of Pre-Summit Evaluation of Attendees’ Perspective

Appendix U summarizes the results of the 11 specific questions used to gauge perspective of the attendees and assist in setting the stage for the summit’s discussions. Each question is listed, all comments included, a collective analysis, and possible outcome strategies based solely on this report.

5.1.1 Potential Strategies

Currently, based on the combined output of the summit and this report, potential strategies should be considered or further explored.

5.1.1.1 The term medically-at-risk defining needs to be clearly defined, especially as development of the Older Driver Clearinghouse. It needs to be differentiated
from those who are “older adults” and those who may have impairment because of medical conditions. The short discussion of the oldest of the old warrants further examination for the characterization of medically at risk because of fragility and frailty.

5.1.1.2 There are diverse screening tools and it may be that different entry points for the medically at risk driver to be identified (e.g., EMS, law enforcement, physician) and it continues to be important to emphasize that screening should not be used for licensing decision making. There are already a variety of methods to screen, including many self-screening tools, that are used by service providers, which is the intent to collect these with the Clearinghouse. How screening tools are used for the three levels (i.e., primary, secondary, tertiary) needs to be explored and clarified. A project may be to identify and categorize these tools in terms of 1) roles in primary, secondary, and tertiary levels, 2) best administrated and most importantly interpreted by whom, and 3) to whom the results are intended (e.g., physician, aging adult or caregiver).

5.1.1.3 Education to enhance and/or expand the role of the medical review board is clearly needed and should continue to be a focus.

5.1.1.4 There is a clear recognition that there are significant resources developed between major agencies, both private and public with it being overwhelming to consumers and professionals. The Clearinghouse was recognized as a potential key in organizing and becoming the public repository and method of organization the information. However, it will be critical to make sure methods of delivery are useful to users, the types of resources are clearly identified, and it provides some level of evidence for some of the materials.

5.1.1.5 The quality of content of the resources is most critical, although access is clearly important. Linkage to the state licensing agencies is very important and it needs to have some method of being updated to correspond to current changes.

5.1.1.6 It was evident from the pre-evaluation and from discussion at the summit, there is a great need to increase the methods of driving evaluation and rehabilitation with a clear understanding of when and how to refer, which may be different for each state as well as each community. The focus on expanding the generalist occupational therapist adding services to this area was supported, but there remains miscommunication. Continual expansion of education is essential and resources such as the Clearinghouse and Medscape are potentially new outlets. The AGS online Driving Guide for health care practitioners will be an important tool to use for expanding this concept.

5.1.1.7 Medically advisory boards may be the key or “hub” of meeting the needs for the medically at risk driver.

5.1.2 Consumer Input

The outreach to consumers prior to the Summit was not successful, although the Summit Experts all frequently reflected on the consumer perspective, especially in terms of access and alternative transportation.
5.2 Summit Analysis

The Experts of the Summit were a diverse group and as such, was a rich source of diverse information, ideas, and agendas. With the goal to ensure that all participants interacted, significant time was spent in both the activities and the discussion. The minutes for the meeting reflect the range of topics that were both extremely pertinent to the topic and also those that were less related to the objectives of the meeting. However, based on post summit reflection and discussions, a final logic model was completed.

5.2.1 Logic Model

This logic model is a summary analysis of the objectives of the meeting and as such, reflects the “objectives, plans, and resources” for future work for expanding the role of the occupational therapist for older driver safety. The Inputs and Resource column reflects resources that are available, but may need to be highlighted, marketed, or enhanced to be more “user friendly.” The column of Pathway Activities was the crux of the Summit and are the activities that require future planning and funding.

Figure 3. Final Logic Model Framework based on Expert Summit Meeting and Post Analysis.

5.2.2 Components

5.2.2.1 The Impact statement was affirmed by the Expert Summit members with only some minor editing (e.g., the word citizen eliminated, net changed to network).
5.2.2.2 The theoretical underpinnings reflect the literature on: 1) cognitive aging, 2) important components of the Model of Human Occupation\(^5\) (an occupational therapy theory)\(^6\), and 3) there are theories and models about making transitions such as from driving to a passenger.

5.2.2.3 The Outcomes were added prior to the Summit, based on the Team’s expertise, discussions in meetings/conferences when discussing planning for the Summit (e.g., TRB January meeting, AAA State Summits, preplanning meetings), and the pre-summit evaluation. These were discussed and affirmed during the summit with editing completed for clarity.

5.2.2.4 Inputs: Resources & Talents in the Silos was a major activity of the first day as well as the pre-summit evaluation. The AOTA website is the main source of the deliverables from other projects. The other resources outlined here represent 1) major sources of model programs (e.g., Maryland Medical Review Board, Florida’s coalition) and 2) potentially new methods of using or gaining resources (e.g., Medscape, Older Drivers Clearinghouse, AGS resource guide). All of these resources need to be highlighted and made accessible and visible to occupational therapists for usage.

5.2.2.5 The Pathway Activities include the ideas specifically gained from the Expert Summit. These are the critical activities gleaned from the activities, discussion and comments from the Experts. These activities need to be framed into new actions and followed as to how each can be measured for achieved the outcomes to measure overall achievement of the impact statement.

5.3 Future Plans – Linked to the Logic Model

Soon after the summit, the core team developed a list of tasks and ideas to use the outcomes from the Summit. Some of these resulted in the activities described in Chapter 4 as Post Summit Activities. Using the logic model structure and activities, each Input will be linked to a Pathway Activity(ies) and linked to an outcome.

5.3.1 Link 1: Analysis and Recommendations

Websites: Clearinghouse /AOTA → Organizing information in one “place” for ease of used for consumers (evaluate utilization) → Education (easy & accessible) for all stakeholders.

Websites are a powerful tool for getting information for a large number of people. However, it can be overwhelming when so many sites pop up and, particularly for the older consumer, it becomes even more difficult to negotiate the websites that are overstimulating and complex. There are many resources and tools available, so a clear plan is to ensure that is it organized in a central place so that education can be easy to find and accessible to all. This will also include the ability to give and send hard copies for individuals that do not have internet access or do not want to use the internet.


\(^6\) It is clearly recognized that there are several other occupational therapy theories that address these same theoretical components; they are not included due to space and MOHO can be recognized as representative if a theoretical model to be included.
Both the AOTA website and the Clearinghouse need to be aligned with the same messages, so there is not confusion, and through each, the resources are available for the major stakeholder. For AOTA, the major stakeholder is the clinician. In addition to the having the resources available, they must be framed so they can be used easily by the generalist when accessing. The plan must be to continually monitor and give feedback to the webmaster to ensure clear organization. For the consumer, the list of DRS needs to be aligned with the *Spectrum of Driver Services*. A system in place so that new DRS are added and ones no longer in place are deleted.

AOTA already working with the Clearinghouse as expert consultants to assist in giving feedback and strategic input as this website is being developed. This needs to continue, considering the major stakeholders of occupational therapists, physicians (and other health care providers), licensing agencies, researchers, and consumers. The accuracy and currency of the driver rehabilitation and occupational therapy services will be essential to the success of this website for these stakeholders.

Evaluation: Information gathered now and after implementation of the steps would measure the success of this activity.

### 5.3.2 Link 2: Analysis and Recommendations

**Deliverables of Gaps & Pathways**  
- Link state licensing agencies with generalist OTs for IADL evaluations (demonstration project).  
- MAB appropriately determine risk for medically-at-risk driver AND Medically-at-risk driver offered appropriate services.

Although there may be multiple reasons the medically-at-risk driver does not get appropriate services, it is often due to not having access to a DRS, not being able to pay for the service, or the waiting list for a DRS. In addition, drivers with medical conditions often do not return to driving because of not getting appropriate evaluation, rehabilitation, or information that would allow for interventions/modifications to return to driving or have assistance in finding alternative transportation. The major objective of Gaps and Pathways is to bridge the gap between occupational therapists generalists and specialists. Specific deliverables that will assist in this process is the *Spectrum of Driver Services*, the Diagnosis sheets, the *Performance Appraisal for Driving* tool, the ethical module, and the consensus statements. All of these have been developed. The pathway activities need to a demonstration project with a state licensing agency (e.g., Iowa) where medically-at-risk drivers can be properly referred to appropriate services.

Evaluation: Use a demonstration project, educating both the state licensing agencies and the area occupational therapists to achieve the two outcomes (*MAB appropriately determine risk for medically-at-risk driver: Medically-at-risk driver offered appropriate services*) prior and post of the demonstration project.

### 5.3.3 Link 3: Analysis and Recommendations

**Physician training Medscape**  
- Clarify CMS funding for evaluation and rehabilitation AND investigate missing links between services  
- Medically-at-
risk driver offered appropriate services AND availability of clear lines of funding of evaluations and support of alternative options.

It is well known that physicians (or primary providers) are seen as the key individual with whom the decision about driving rests. Unfortunately, not all primary care providers know or understand the options and associated implications of costs associated with referrals to either occupational therapy generalists or specialists for evaluation/rehabilitation of the IADL of driving. With improved education with appropriate materials, the achievement of improved services of the medically at risk driving and clearer funding for evaluations and support for alternative transportation options should be achieved.

Evaluation: Use of evaluation means of educational format on Medscape and with specific locations, evaluation of referral systems.

5.3.4 Link 4: Analysis and Recommendations

Education Module for OT — Clarify CMS funding for evaluation and rehabilitation AND investigate missing links between services Medically-at-risk driver offered appropriate services AND availability of clear lines of funding of evaluations and support of alternative options.

It is clear that many occupational therapists do not understand how to address the IADL of driving and community mobility, understand how to address CMS funding, and the relationships that should be developed between occupational therapy generalists and specialists for evaluation/rehabilitation for driving, and that alternative transportation needs to be address with those who cannot drive. With this module produced and available, it may assist in the education of these topics with occupational therapy practitioners.

Evaluation: Evaluate the usage of the module and its implications as it is distributed and used online.

5.3.5 Link 3: Analysis and Recommendations

AGS Guide for Healthcare Professionals — Link OT and DRS with Area Agencies on Aging and/or mobility managers (demonstration project). Drivers and families have ownership and empowerment of the decisions AND availability of clear lines of funding of evaluations and support of alternative options.

Primary care providers and other health care providers often to not know or understand what occupational therapy generalists or specialists can provide in terms of evaluation/rehabilitation of the IADL of driving. With the improved materials from the Guide being developed by AGS, the achievement of improved services of the medically at risk driving and clearer funding for evaluations and support for alternative transportation options should be achieved. Most importantly, if the AGS Guide can provide AAonA access and education with the guide, AAonA, an advocate agency for older adults can assist with the preventative education for drivers and families at the grassroots and therefore facilitating ownership and empowerment of driving decisions.
Evaluation: Using a demonstration project, empowerment, ownership, and education can be evaluated.

5.3.6 Link 6: Analysis and Recommendations
Law Enforcement work (TRENDS as model) Link Law Enforcement with DRS (TRENDS -duplicate) Medically-at-risk driver offered appropriate services.

Law enforcement is a critical stakeholder for older drivers, as they are often the ones on the scene of a crashes or observing at risk behaviors. However, most law enforcement officers do not know about the medically-at-risk driver and how they may be different from the “impaired” driver. TRENDS has developed the DOSCI screen and educated law enforcement officers about options. This model needs to be duplicated and occupational therapists, especially those with DRS specialization could be leaders/advocates in this area. If educate law enforcement (and eventually the judicial system) can be educated about the options and opportunities available, the medically at risk drivers will be more likely to be offered appropriate services. Using opportunities to demonstrate this in other communities with occupational therapists would be one method to achieve this pathway.

Evaluation: Using a TRENDS model in other communities can be measured prior and post by law enforcement officers to see if changes are made for getting medically-at-risk drivers to more appropriate services.

5.3.7 Link 7: Analysis and Recommendations
Iowa DMV as model Investigate the missing links between services Medically-at-risk driver offered appropriate services.

The state licensing boards are critical stakeholders for older drivers, as they ultimately make the decisions about the privldege to driver. Although there may be agencies that have model systems of dealing with medically-at-risk driver, there is no perfect system as the systems have been dealing with budget cuts, low numbers of DRS, and the increasing numbers of older and medically compromised drivers. Although Iowa DMV has issues with referrals, they are a DMV at the cutting edge and working hard to find the right level of screening and methods of referral. This model needs to be enhanced by education of the DMV and occupational therapists (generalists) in the area so that the model system can be evaluated and then duplicated in other licensing agencies. If we can create a system that offers appropriate pathways to both generalists and specialists, the medically at risk drivers will be more likely to be offered appropriate services. Using opportunities to demonstrate this in other communities with occupational therapists would be one method to achieve this pathway.

Evaluation: Institute a demonstration project in Iowa with referral pathways and measure outcomes pre and post to see if changes are made for getting medically-at-risk drivers to more appropriate services.

5.3.8 Link 8: Analysis and Recommendations
Public health focus on prevention. Insurance companies with DRS and OT (evaluate utilization and outcomes). Drivers and families have ownership and
empowerment of the decisions AND availability of clear lines of funding of evaluations and support of alternative options.

Occupational therapists are generally not employed in public health, although their domain of practice does cover prevention. This resource will be a new one in this area it may need to be an area of focused growth. Working with experts in public health may enable occupational therapists to explore the collaboration with insurance companies to evaluate the use of evaluations and resources. If this comes to fruition, it would give older drivers and families more ownership and empowerment as well as clearer lines of funding for evaluation, rehabilitation, and support of alternative options.

Evaluation: Since this would be such a new area of exploration, the evaluation may be on what marketing is created, networking links established, and collaborations with insurance companies.

5.3.9 Link 9: Analysis and Recommendations
CDC Driver safety connection with falls. Investigate missing links between services. Drivers and families have ownership and empowerment of the decisions AND Medically-at-risk driver offered appropriate services.

The CDC is clearly linking driver safety with falls. Occupational therapists are interested in both areas, but there has not been enough research to link these two areas. Working closely with the CDC to explore this linkage would be an important goal. If we can educate occupational therapists about the linkage and about using evaluation results as well as interventions to improve performance skills, we will be able to offer the medically at risk driver more appropriate services and also give more drivers and families more ownership to improve their performances and empowerment for decision making.

Evaluation: This also would be a new area of exploration and education. Materials, education and research need to be expanded before evaluation can be completed. However, it would be useful to get a baseline understand of occupational therapists knowledge about the link between falls and driving.

5.3.10 Link 10: Analysis and Recommendations
Florida system as model. Evaluate system of transportation options in FL for consumers. Drivers and families have ownership and empowerment of the decisions AND Medically-at-risk driver offered appropriate services.

Florida is clearly a leader in “connecting the dots” with older drivers and services, having created many resources targeted to providing good information, empowering older adults to use alternative options and demand services. It would be important to evaluate the system in Florida from the occupational therapy perspective and evaluate how we can be leaders and advocates to start some of the same processes in other states. A worthwhile demonstration project would be to use educate a system with the generalist/ specialist model within a system in Florida instead of using alternative methods or using the specialists. The model system of Florida still can be improved and with the totality of the project, it can become a state-of-the-art model to emulate.
Evaluation: Institute a demonstration project in Florida with referral pathways and measure outcomes pre and post to see if changes are made for getting medically-at-risk drivers to more appropriate services and/or empowering drivers and families.

5.3.11 Link 11: Analysis and Recommendations
Maryland’s Medical Review Board as model. Investigate missing links between services. Medical Advisory Boards (MAB) established and valued.

Maryland is clearly a leader when considering a well functioning Medical Review Board. However, because of the long term functioning of that system and the expertise staff, it may not be possible to implement the same model in other states. This is especially true because Maryland has some unique laws that govern driving evaluation. However, with appropriate education and using the other demonstration projects, working with occupational therapists/DRSs to build similar relationships and systems, other states could begin to build a process that can be successful that will lead to having an established MAB that is valued. Method: Carefully evaluate Maryland’s system and educate occupational therapists leaders to assist their state in implementing the generalist/specialist model and advocating for improved MABs.

Evaluate: Survey pre and post implementation of education on how to advocate at the state level.

5.4 Conclusions
Through the earlier work of the Gaps and Pathways, we have realized that many resources are available, but no necessarily being utilized, including the general occupational therapist who can provide expertise, information, and support for driving and community mobility. The Expert Summit was conceived as a strategy to explore the shared understanding of what resources are currently available for states to use in order to provide services to support senior driver safety and mobility. Our intention was to facilitate discussion, encourage experts to share strategies and initiatives they would describe as “working” to improve their procedures to address older driver safety. The specific objective was to specifically address the “gaps” between physicians, medical advisory boards, state licensing agencies and the driver rehabilitation specialists when addressing the medically at risk older driver. We wanted to identify, explore, and expand the linkages between services in order to develop some turn key programs or ideas for states to incorporate into their older driver safety programs.

Although not all gaps or pathways were identified or explored, the summit should be viewed as a success. There was overwhelming consensual agreement on the impact statement (i.e., vision) and on the outcomes (i.e., long term goals). As the attendees were a diverse group and through lively discussion, there was much exploration about the methods, strategies, and implications of how to achieve the outcomes. The planned activities provided small group discussion that became overly focused in some cases, but actually did add some ideas that may not have potentially been brought to the attention of the larger group.

The use of the logic model was a unique perspective that was useful for structuring the meeting, especially for the planning and the first day of the meeting. Although it was not integrated as meaningfully in the second day of the meeting, it because an excellent tool in organizing the
resources and, most importantly, the activities that should be planned for the next step of the processes. The *Pathway Activities* of the logic model, based on the resources, these tasks can be examined and used to meet the outcomes and ultimately the vision of the model. Thus, the Expert Summit, couched with its pre-summit information and after summit activities, should be viewed as meeting its objectives.
Appendix A. Older Driver Summit 2015 Attendees

**Greg Brunette, CDRS**  
Driver Rehabilitation Program Clinical Manager  
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Greg Brunette is a certified driver rehabilitation specialist (CDRS) who has worked in the Driver Rehabilitation program at Mary Free Bed Rehabilitation Hospital for the past 25 years, 6 years as clinical manager and 19 years as a driving instructor. The Driver Rehabilitation program sees 300 to 350 individuals a year, addressing driving and transportation needs. Greg’s background is in education, a graduate of Aquinas College and a driver education certificate from Michigan State University. He has been a CDRS for the past 18 years.

**Sharon Beall**  
Manager, Strategy & Analytics  
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Sharon Beall has more than 30 years of experience in program and volunteer management, operations, leadership and human resources, with a strong background and expertise in strategic planning, resource management, transportation and safety, and volunteer training and development. Sharon has served the last five years as the Manager, Strategy and Analytics for AARP Driver Safety, the second largest program within AARP, and the largest award winning driver improvement course designed for drivers age 50 and older. In this role, Sharon manages the programs offered under the Driver Safety umbrella, which include AARP Smart Driver, the CarFit program, We Need to Talk and the online Driving Resource Center. Most recent accomplishments include leading the research, development and launch of AARP’s Smart Driver Course curriculum both classroom and online. Additionally, Sharon manages training and development for over 4,400 volunteers who support Driver Safety Initiatives. She manages partnerships and coalitions to advance the issue of driver safety. Sharon is a tenured employee at AARP for over 34 years. Prior to her role with AARP Driver Safety, Sharon served as the Sr. Manager of Programs for AARP Human Resources and Director of Board and Executive Operations for AARP Services, Inc.
Deb Carney
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Deb Carney has worked with the Iowa Department of Transportation since 1977, concentrating on drivers with medical and vision conditions. For the past 24 years, she has worked in older driver safety. Her duties include: Oversight of the medical review team, the medical advisory board, and the driver reexamination process; development and implementation of training programs for all licensing staff; and educational outreach (e.g., CarFit training) and presentations to older driver and advocacy groups. She works closely with the medical community, driver rehabilitation centers, and law enforcement agencies. Deb is the department’s representative and point of contact for older driver safety advocacy groups and organizations including: AARP, the Department of Elder Affairs, Iowa Medical Society, Alzheimer’s Association, Epilepsy Foundation of Iowa, and the Autism Society of Iowa.

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Brian Chodrow is a Program Analyst in the Safety Countermeasures Division of the National Highway Traffic Safety Administration (NHTSA). His primary responsibility is implementing strategies, programs, materials and information for use by national organizations promoting primary highway safety issues of interest to NHTSA. As part of his duties, he is responsible for providing technical and policy guidance in designing specific traffic safety education programs and projects concerning older road users and public transportation. He also has extensive experience in impaired driving issues having previously worked on judicial, prosecutorial, law enforcement and corrections projects. He began his law enforcement career as a police officer and has also worked as a probation and parole officer for the Virginia Department of Corrections. Other work attributes include working for the Attorney General of Virginia in the Corrections-Litigation Section, and the Natural Resources Section. He obtained a Bachelor of Science degree in Law Enforcement and Corrections from the Pennsylvania State University and has completed additional graduate course work in Criminal Justice at the Virginia Commonwealth University. He is a graduate of the Mississippi College School of Law was admitted to the Virginia Bar.
Ann Dellinger, PhD, MPH
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Ann M. Dellinger, Ph.D., M.P.H., serves as chief of the Home, Recreation and Transportation Safety Branch of the Division of Unintentional Injury Prevention, at CDC’s National Center for Injury Prevention and Control. There she oversees the older adult falls, sports and road safety work of the Center. Dr. Dellinger currently conducts several studies in the area of motor vehicle safety focusing on older drivers, child occupant and pedestrian injury, injury risk behavior and international road safety. She consults with domestic and international organizations including the U.S. Transportation Research Board, the World Health Organization (WHO) and the Pan American Health Organization (PAHO). She serves on the editorial boards for Traffic Injury Prevention and Clinical Medicine Insights: Geriatrics. Dr. Dellinger is the recipient of the Department of Health and Human Services Secretary’s Awards for Distinguished Service for assistance during the Oklahoma City bombing (1997) and the World Trade Center/Anthrax Investigation Emergency Response Team (2002).

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Dr. Anne Dickerson has been an occupational therapist for over 30 years primarily teaching in occupational therapy programs. She has been at East Carolina University since 1993 and is the Director of ROADI – Research for the Older Adult Driver Initiative. Anne has an occupational therapy degree from Temple University, a master’s degree in allied health education/health administration from Texas State University, and a PhD in developmental psychology from Florida International University. Her primary area of research is in older adults and she is a leader in the practice area of driving and community mobility. Current research projects include the use of GPS with older adults, standardization of assessment and screening tools, development of a framework for driving referral and “driving” terminology and the exploration of pathways of service between occupational generalists and specialists. She has numerous publications and presented nationally and internationally on the topic of driver evaluation and rehabilitation. Anne is editor of Occupational Therapy in Health Care, was awarded a fellow in both the American Occupational Therapy Association and the Gerontological Society of America, was a delegate to the 2005 White House Conference on Aging, and has been awarded multiple honors from professional organizations and universities.
for service, teaching, and research. Anne was recently named as a member of the Safe Mobility of Older Persons subcommittee of the National Transportation Research Board (TRB).
Dr. Vanya Jones’ research agenda has focused on injury factors and their impact on the health of vulnerable populations to 1) explore psychosocial and environmental factors for injury outcomes of older adults and 2) develop and evaluate theory based interventions that utilize psychosocial and environmental factors to reduce the burden of injury on high risk populations. Dr. Jones is an Assistant Professor at the Johns Hopkins Bloomberg School of Public Health and a core faculty member in the Johns Hopkins Center for Injury Research and Policy. Through her work, she has collaborated with the Maryland Motor Vehicle Association as an evaluator for the Seniors on the M.O.V.E. (Mature Operators Vehicular Education) older driver curriculum. Currently, she serves as the Maryland site principal investigator of the American Automotive Association (AAA) for Traffic Safety’s LongROAD older adult driver longitudinal cohort study. The LongROAD study has several states and universities collaborating to explore the complex issue of driving behavior and cessation of driving among older adults, driving regulations, and motor vehicle crashes. In addition, she is currently a member of the Safe Mobility of Older Persons subcommittee of the National Transportation Research Board (TRB).

For the past ten years, Gail Holley has managed the Florida Department of Transportation’s aging road user program “Safe Mobility for Life.” In this role, she leads a multi-disciplinary statewide Coalition represented by 28 member organizations as they work together to create resources and implement Florida’s Aging Road User Strategic Safety Plan. The broad strategic plan, comprised of ten emphasis areas, is designed to reduce crashes for older adults by improving their safety, access, and mobility. This balanced comprehensive approach was developed to ensure that aging Floridians maintain independence and remain active in the community even after they transition from driving.
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D. R. “Ike” Iketani is a consultant to the University of California San Diego School of Medicine, Training, Research, and Education for Driving Safety (TREDS) group, currently providing training to law enforcement in the identification of cognitively impaired drivers. A retired Assistant Chief and 32-year veteran of the California Highway Patrol, he has been involved in developing and presenting older driver awareness programs for over 12 years. He is a past chair of the Law Enforcement Workgroup for the Governor’s Older Californian Traffic Safety Task Force, and has served as a subject matter expert for the National Highway Traffic Safety Administration in the development of standardized law enforcement training for responses to older drivers. An Academy instructor and Adjunct Faculty for the California Community Colleges, Assistant Chief Iketani’s goal is to ensure law enforcement is properly educated and effectively prepared to identify cognitively impaired drivers.

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Dr. Cheryl Irmiter is an Assistant Vice President at Easter Seals, Inc. At Easter Seals, she supports the national office with practice solutions, including education. As one of the largest home and community based organizations, serving various populations, Dr. Irmiter has the opportunity to bridge the national health care and policy changes within local practice for programs that impact seniors, veterans, children, and their caregivers. In addition, she is an adjunct faculty member of Loyola University Chicago School of Social Work where she teaches Master’s level human behavior across the lifespan and research courses. Other appointments include the University of Chicago Social Service Administration Program and the Northwestern University's Feinberg School of Medicine. Prior to this position; she was a senior scientist at the American Medical Association in the Science, Medicine and Public Health Division. Her work addressed an array of practice and policy issues from older adult driving to chronic disease management. Dr. Irmiter has nearly 15 years of direct clinical care experience working with adults and older adults in community medical and psychiatric health care. She has numerous publications and presentations throughout her career, and has been nominated and received
various awards recognizing her scholarship and ability to bridge clinical practice and research for the underserved.
Kevin R. Lewis
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Kevin R. Lewis has over 40 years of Information Systems, Computer Hardware/Software Integration, and Driver Licensing experience. He served in the United States Navy in the military intelligence arena and graduated from the University of Maryland with a degree in Business Administration. Kevin has worked for a wide variety of employers, including NASA, where he worked on the first 3 Space Shuttle launches and the Defense Advanced Research Projects Agency (DARPA) where he was responsible for managing the Agency’s Data Processing Center as well as providing computer hardware support for over 1,500 workstations. Kevin joined AAMVAnet in August, 1997 as the Driver Systems Implementation Manager and became Manager of the Operations Department in June, 1998. In March of 2000 he assumed the position of CDL Safety Director in AAMVA’s Programs department. He currently serves as Director of Driver Programs in AAMVA’s Member Services and Public Affairs Division and is the staff liaison to the AAMVA Driver Committee.

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Deborah Lieberman is the Director of Evidence-Based Practice in the Professional Affairs Division at the American Occupational Therapy Association (AOTA) in Bethesda, MD, and the Staff Liaison to the AOTA Commission on Practice. She received her occupational therapy degree from Tufts University and her master’s degree in Health Services Administration from George Washington University. Throughout her career, Ms. Lieberman has held a variety of clinical and administrative positions, including establishing and directing the Occupational Therapy Department at the National Rehabilitation Hospital in Washington, DC. In addition, she has been involved in occupational therapy activities on a national and state level, including serving on the Board of Directors for the American Occupational Therapy Political Action Committee and on the editorial board of several journals, including the American Journal of Occupational Therapy. In 1994, she was recognized as a fellow of the AOTA.
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Nancy Lundebjerg is Chief Operating Officer of the American Geriatrics Society (AGS) and incoming Chief Executive Officer, effective April 2015. Ms. Lundebjerg oversees public policy, internal and external communications, professional and public education, membership, governance, and grant-funded projects supporting the work of a society that represents more than 6,000 health professionals specializing in geriatric care. She is the senior staff lead for the Association of Directors of Geriatric Academic Programs, a supporting foundation of the AGS. She is also lead staff member for the Geriatrics-for-Specialists Initiative, a multi-specialty effort funded by the John A. Hartford Foundation and Atlantic Philanthropies designed to increase awareness of and knowledge in the care of older adults among surgical and related medical specialties. She is an ex officio member of the Council of the Section for Enhancing Geriatric Understanding and Expertise among Surgical and Related Medical Specialties, which works to advance integration of geriatrics principles into surgical care. Ms. Lundebjerg represents AGS in a variety of venues, most notably serving as Co-Convener of the Eldercare Workforce Alliance, a coalition focused on the workforce shortage of health professionals, direct-care workers, and supports for family caregivers catering to the needs of older adults. Ms. Lundebjerg holds a BA in English Literature from Connecticut College and a Master of Public Administration degree from the University of Hartford, where she was a Woodruff Scholar.

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Mary Jo McGuire is the owner of Rehab Educators, a private practice in Akron, Ohio, made up of eleven occupational therapists, who provide services in the home and community to people across the lifespan. An important part of their practice is serving the driving and community mobility needs of older adults, and of people of all ages who have survived traumatic brain injury. Mary Jo is also the Vice-President of the Board of Directors of the Northeast Ohio Brain Injury Foundation, a 501c3 organization serving brain injury survivors and their families in the Greater Akron area. She was the co-editor, with Elin Schold Davis of Driving and Community Mobility: Occupational Therapy Strategies Across the Lifespan, published by the American Occupational Therapy Association. Since 2013, Mary Jo has served as the American Occupational Therapy Association's representative to the American Medical
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Tom Meuser, PhD, is a Clinical Psychologist and Applied Gerontologist. He directs the Gerontology Program at the University of Missouri - St. Louis where he enjoys mentoring graduate students and organizing collaborative projects on aging. A primary focus of his research is on mobility transitions in aging, specifically the driving to non-driving transition. He was the founding Co-Chair of the Subcommittee on Elder Mobility & Safety for the Missouri Coalition for Roadway Safety which seeks to promote positive mobility through statewide initiatives. He also served as the lead program evaluator for the Older Drivers Project of the American Medical Association. Known for his applied research, his latest measure - The Assessment of Readiness for Mobility Transition (ARMT) - is designed for professional and lay use to foster dialogue and planning around mobility change.

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Stephen Murphy is WebMD’s liaison to the Federal Government for the provision of education, dissemination and research services. Working with NHTSA, NIH, SAMHSA, CDC, HRSA and other agencies, Steve helps Federal staff implement continuing medical education (CME) activities, survey healthcare providers and consumers on knowledge, attitudes and opinions, and disseminate information to the 64 million unique monthly WebMD consumers and the 2.8 million Medscape healthcare provider members. Steve has worked in health communications in Washington DC for over 20 years and has managed traffic safety, immunization, HIV, health insurance, substance abuse, senior health, women's health and other national campaigns. Steve has a B.A., Business and Communications, American University, Washington, DC.
Jenny Nordine is the current President of the Association of Driver Rehabilitation Specialists (ADED) Board of Directors. Prior to joining the Board of Directors, she served ADED as Education Committee chair beginning 2010 as well as the NMEDA CAMS-HP committee beginning 2011. Additional board experience includes our Arizona Brain Injury Board, and the Arizona State Rehabilitation Committee.

Jenny has been an Occupational Therapist in private practice since 2001 and a certified driver rehabilitation specialist (CDRS) since 2002. Her practice has grown to include the states of Arizona and New Mexico, including 4 full-time CDRS’s and support staff. Their practice focuses on safety for aging drivers through Senior Safety Assessments as well as medically based Adaptive Driving Assessments.

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Alice Pomidor, MD, MPH, AGSF is the Chair of the Public Education Committee of the American Geriatrics Society. She is also chair of the AGS Editorial Board, sponsored by NHTSA, currently revising and expanding the AMA Physician’s Guide to Assessing and Counseling Older Drivers to support the interprofessional clinical team and online resources. Dr. Pomidor is a Professor in the Department of Geriatrics at the Florida State University College of Medicine and their member of Florida’s Safe Mobility for Life Coalition (www.flsams.org) as emphasis area leader for the Prevention and Early Recognition team. She is a geriatrician who has been actively involved for over 25 years in clinical care and teaching of medical students, residents, and geriatric specialists.
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Gabe Rousseau is the Safety Operations Team Leader at the Federal Highway Administration. He and his team work on safety issues related to pedestrians, bicyclists, older road users, motorcyclists, speed management, Intelligent Transportation Systems, local and rural roads, and other issues. Gabe has been with FHWA since 2002 and has a PhD in human factors with a focus on cognitive aging.

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Ms. Schieke has been in government service for over 25 years with most of that time was in the area of governmental affairs, first at the local government, then moving up to state level. For the past 8 years, she has been the chief lobbyist for Maryland Department of Transportation in its interactions with the Maryland General Assembly. Currently, Ms. Schieke serves as the Chief in the Driver Safety Division of Maryland MVA with a main focus on building and sustaining partnerships of local, regional, and national professionals in the driver safety arena. In this position, Nanette manages the State’s older driver safety program and has been successful in spearheading major projects, including: organizing and facilitating regional workshops, statewide older driver educational symposia, developing outreach and public awareness projects, and working on numerous projects within Maryland’s licensing agency.
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Elin Schold Davis has coordinated the American Occupational Therapy Association's (AOTA) Older Driver Initiative since 2003. She is a registered/licensed occupational therapist (OTR/L) and a certified driving rehabilitation specialist (CDRS). Her experience in long term care and adult rehabilitation at The Sister Kenny Rehabilitation Institute Minneapolis, Minnesota, led her to her current position with The American Occupational Therapy Association as the Coordinator of the AOTA Older Driver Initiative. Ms. Schold Davis has authored articles, co-edited the book Driving and Community Mobility: occupational therapy strategies across the lifespan and lectured nationally and internationally on the topics of both cognitive rehabilitation and driving.

In her current position with AOTA, Ms. Schold Davis manages projects funded by the National Highway Traffic Safety Administration developed to build awareness of occupational therapy’s role in senior safe mobility and increase the capacity of occupational therapy programs to address driving as an instrumental activity of daily living. Significant initiatives include collaboration with The MIT Age Lab and The Hartford’s Center for Mature Market Excellence to develop the educational brochure Your Road Ahead: A Guide to Comprehensive Driving Evaluations, and the CarFit collaboration between AAA, AARP and AOTA. Schold Davis is a member of the Transportation Research Board’s Safe Mobility for Older Person’s Committee and member of the National Older Driver Safety Advisory Council.

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Kathy Sifrit has been a research psychologist in the Behavioral Safety Research Office of the National Highway Traffic Safety Administration since 2006. She has a Ph.D. in Human Factors.
Psychology from Wichita State University and has spent more than 15 years doing research in older driver safety and performance.
Dr. Carl Soderstrom earned his M.D. degree from the State University of New York – Downstate Medical School. Over a 25 years period he was a member of the surgery faculty of the University of Maryland and the research faculty at the School’s National Study Center for Trauma and EMS. He has published over 100 peer-review papers, chapters and report with his primary focus has been on injury prevention, particularly related to substance abuse and injury associated vehicular crashes. He has been the principal investigator of numerous injury prevention studies. In 2002 Dr. Soderstrom was appointed as the Associate Chief of the Medical Advisory Board (MAB) of the Maryland Motor Vehicle Administration, becoming the Chief in 2005. He leads the MAB in providing advice regarding medical fitness to drive and policy based on current research. Dr. Soderstrom is a Fellow of the American Association for the Surgery of Trauma and the Association for the Advancement of Automotive Medicine, serving as President for two years. He is a Fellow of the American Association for the Surgery of Trauma and serves on the Geriatric Trauma Committee. He is also a Faculty Associate at the Johns Hopkins University Bloomberg School of Public Health Department of Health Policy & Management. Dr. Soderstrom continues to serve on local, regional, and national committees, societies, and task forces addressing issues related to injury prevention including the National Research Council’s Safe Mobility for Older Persons Committee. Dr. Soderstrom has provided testimony on numerous injury prevention legislative initiatives, particularly those related to impaired driving. In 2003 he testified in the National Transportation Safety Board (NTSB) hearing on Medical Review of the Non-Commercial Driver. In 2010 he testified in the NTSB’s Forum on Safety, Mobility and the Aging Driver.

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Wendy B. Stav received a BS in occupational therapy from Quinnipiac University and a PhD in occupational therapy from Nova Southeastern University, as well as a specialty certification in driving and community mobility. For more than 17 years her work has focused on driving and community mobility related to program development, medical reporting policies, driver licensing guidelines for medically at-risk drivers, assessment predictability, and occupational therapy practice. Dr. Stav’s research and professional involvement includes activities at the state and national levels including AOTA’s Older Driver Initiative, co-authorship of AOTA official documents and Occupational Therapy Practice Guidelines of Driving and Community Mobility for Older Adults, collaboration with the American Medical Association’s Older Driver Project, the American Association of Motor Vehicle Administrator’s Older Driver
Working Group, and contribution to three separate evidence-based literature reviews on older drivers. Dr. Stav was named to the AOTA Roster of Fellows in 2009 for her contributions to the advancement of driving and community mobility practice and received the Maryland Occupational Therapy Association Award of Merit for similar contributions to driving rehabilitation practice. In 2012, she returned to Nova Southeastern University as the chair of the Occupational Therapy Department.
Appendix B. Invitation Letter Sent to Experts for Summit

Good Morning!

First, we want to sincerely thank you for agreeing to join us in Bethesda on March 5-6\textsuperscript{th} to participate in our Expert Summit, a task of the Gaps and Pathways Project funded under the cooperative agreement between the American Occupational Therapy Association (AOTA) and the National Highway Traffic Safety Administration (NHTSA). It is our wish to accomplish great things in 1 ½ days, so we hope you can take a few minutes to review the attached documents and assist us in gathering some baseline data on Summit member’s underlying assumptions and beliefs in the area of older driver safety.

Please be on the lookout for an email from Dr. Anne Dickerson that will provide a link to the system we are using to collect your responses to 11 questions (we estimate 5 to 7 minutes to complete). This data will assist our facilitator in preparation so that we may, as they say, hit the ground running.

As you prepare for the Summit and your responses to the 11 questions, please consider the following:

Review attached documents provided for your reference. (Copies will be included in your meeting packet).

- A list of attendees and organizations (photos and bios compiled to date).
- A paragraph description of the Expert Summit.
- The Spectrum of Older Driver Services, a reference we will use at the summit.
- NHTSA Highway Safety Program Guideline No. 13

Meeting: A Logic Model meeting format will guide our exploration of programs, tools and resources. We will spend some time in the first hour explaining this process, however, the idea is to use the structure of the Logic Model to reveal underlying assumptions, strengths, needs, resources, inputs, and external factors involved in program planning, in this case, a pathway of services to support safe mobility for the medically at risk older driver.

Aim of the Project: to explore our shared understanding of the array of resources states can access to build a network of services and resources (public and private) to support senior driver safety and mobility. NHTSA’s Uniform Guidelines for State Highway Safety Programs - Guideline #13 Older Driver Safety encourages the development or expansion of “medical advisory boards” that include the knowledge of specialized services (e.g., physicians, occupational therapy, driver rehabilitation services, etc.).

Expert Summit’s Contribution: will generate a heightened understanding of successful use of tools, resources and the pathways that facilitate access and utilization while identifying barriers and/or needs to providing appropriate services to the medically at risk aging driver.

Travel reminders:
For those that requested reservations at the **Bethesda Doubletree Hotel** (8120 Wisconsin Ave 20814, 1-301-652-2000), your rooms are reserved under your name on AOTA’s master account. You may be asked to leave your credit card for any incidentals, but the room is paid. Internet is provided in your room free of charge, per AOTA’s contract.

Continental buffet style **breakfast** is provided to meeting guests on the second floor in the EMC Foyer (outside of our Ballroom D Meeting Room). Food is available on both Thursday and Friday from 7:00 to 9:00AM. Catering staff are available to assist you with any special food requests.

Our meeting will begin promptly at **9:00AM in meeting room Ballroom D**.

Thursday dinner: we have a group reservation at 6:30 PM at Guapo’s (Mexican); next store to the hotel. Please remember that alcoholic beverages cannot be included on the group tab.

**Questions?** Contact Zuzana Jurisova (zjurisova@aota.org) 800-729-2682 X2834 or Elin Schold Davis ([escholddavis@aota.org](mailto:escholddavis@aota.org)) cell 612-990-4145

Thank you again for generously agreeing to take time away from your very busy schedules to participate. We are looking forward to working together at the Summit!

Elin
## Appendix C

**Spectrum of Driver Services: Right Services for the Right People at the Right Time**

A description consumers and health care providers can use to distinguish the type of services needed for an older adult.

### Community-Based Education

<table>
<thead>
<tr>
<th>Program Type</th>
<th>Driver Safety Programs</th>
<th>Driving School</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Typical Providers and Credentials</strong></td>
<td>Program specific credentials (e.g., PAADP and AAA Drive Improvement Program).</td>
<td>Licensed Driving Instructor (LDI) certified by state licensing agency or Dept. of Education.</td>
</tr>
<tr>
<td><strong>Required Provider’s Knowledge</strong></td>
<td>Program specific knowledge.</td>
<td>Trained in course content and delivery.</td>
</tr>
<tr>
<td><strong>Typical Services Provided</strong></td>
<td>1) Classroom or computer-based refresher for licensed drivers: review of rules of the road, driving techniques, driving strategies, state laws, etc. 2) Enhanced self-awareness, choice, and capability to self-limit.</td>
<td>1) Enhance driving performance. 2) Acquire driver permit or license. 3) Counsel with certified driving counselor. 4) Recommend continued training and/or underlying mental health evaluation. 5) Remedial Programs (e.g., license reinstatement courses for teens/adults, license point reduction course).</td>
</tr>
<tr>
<td><strong>Outcome</strong></td>
<td>Provides opportunities for education and awareness. Enhances skills for healthy drivers.</td>
<td>Indicates risk or need for followup for medically at-risk drivers. Determines fitness to drive and provides rehabilitative services.</td>
</tr>
</tbody>
</table>

### Medically-Based Assessment, Education and Referral

<table>
<thead>
<tr>
<th>Program Type</th>
<th>Driver Screen</th>
<th>Clinical IADL Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Typical Providers and Credentials</strong></td>
<td>LICENSED INSTRUCTOR (LDI) CERTIFIED BY STATE LICENSING AGENCY OR DEPT. OF EDUCATION.</td>
<td>OCCUPATIONAL THERAPY PRACTITIONER (GENERALIST OR DRIVER REHABILITATION SPECIALIST). OTHER HEALTH PROFESSIONAL DEGREE WITH EXPERTISE IN INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL).</td>
</tr>
<tr>
<td><strong>Required Provider’s Knowledge</strong></td>
<td>Knowledge of relevant medical conditions, assessment, referral, and / or intervention processes. Understand the limits and value of assessment tools, including simulation, as a measurement of fitness to drive.</td>
<td>Knowledge of medical conditions and the implication for community mobility including driving. Assess the cognitive, visual, perceptual, behavioral and physical limitations that may impact driving performance. Knowledge of available services. Understands the limits and value of assessment tools, including simulation, as a measurement of fitness to drive.</td>
</tr>
<tr>
<td><strong>Typical Services Provided</strong></td>
<td>1) Counsel on risk factors associated with specific conditions (e.g., medications, fractures, post-surgery). 2) Investigate driving risk associated with changes in vision, cognition, and sensory-motor function. 3) Determine actions for the at-risk driver: refer to IADL evaluation, driver rehabilitation program, and / or other services. 4) Discuss driving cessation; provide access to counseling and education for alternative transportation options. 5) Follow reporting / referral structure for licensing recommendations.</td>
<td>1) Evaluate and interpret risks associated with changes in vision, cognition, and sensory-motor function due to acute or chronic conditions. 2) Facilitate remediation of deficits to advance client readiness for driver rehabilitation services. 3) Develop an individualized transportation plan considering client diagnosis and needs, family caregivers, environmental and community options and limitations: Discuss resources for vehicle adaptations (e.g., scooter lifts). Facilitate client training on community transportation options (e.g., mobility managers, dementia-friendly transportation). Discuss driving cessation; for clients with poor self-awareness, collaborate with caregivers on cessation strategies. Refer to driver rehabilitation program. Document driver safety risk and recommended intervention plan to guide further action. 5) Follow professional ethics on referrals to the driver licensing authority.</td>
</tr>
<tr>
<td><strong>Outcome</strong></td>
<td>Programs are distinguished by complexity of evaluation, types of equipment, vehicles, and expertise of provider.</td>
<td>Programs are distinguished by complexity of evaluation, types of equipment, vehicles, and expertise of provider.</td>
</tr>
</tbody>
</table>

**ADDS = Health professional with specialty training in driver evaluation and rehabilitation.**

**CDRS = Certified Driver Rehabilitation Specialist Certified by AREMA (Association for Driver Rehabilitation Specialists).**

**SCDM = Specialty Certified in Driving and Community Mobility by ADOTA (American Occupational Therapy Association).**

**Quality Approved Provider by NASDA (National Mobility Equipment Dealers Association).**

**Driver Rehabilitation Programs: Defining Program Models, Services, and Expertise.**

Occupational Therapists In Health Care, 20(2), 173–181, 2014

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Page 52
### Spectrum of Driver Rehabilitation Program Services

A description consumers and health care providers can use to distinguish the services provided by driver rehabilitation programs which best fit a client's need.

<table>
<thead>
<tr>
<th>Program Type</th>
<th>DRIVER REHABILITATION PROGRAMS</th>
<th>LOW TECH</th>
<th>HIGH TECH</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Determine fitness to drive and / or provide rehabilitative services.</td>
<td>Driver Rehabilitation Specialist; Certified Driver Rehabilitation Specialist*, Occupational Therapist with Specialty Certification in Driving and Community Mobility, or in combination with LDI. Certification in Driver Rehabilitation is recommended as the provider for comprehensive driving evaluation and training.</td>
<td>Driver Rehabilitation Specialist; Certified Driver Rehabilitation Specialist*, Occupational Therapist with Specialty Certification in Driving and Community Mobility, or in combination with LDI. Certification in Driver Rehabilitation is recommended as the provider for comprehensive driving evaluation and training.</td>
</tr>
</tbody>
</table>
| Levels of Program and Typical Provider Credentials | **BASIC**  
Provider is a Driver Rehabilitation Specialist (DRS) with professional background in occupational therapy, other allied health field, driver education or a professional team of CDRS or SCDOM with LDI**. | **LOW TECH**  
Driver Rehabilitation Specialist*, Certified Driver Rehabilitation Specialist*, Occupational Therapist with Specialty Certification in Driving and Community Mobility, or in combination with LDI. Certification in Driver Rehabilitation is recommended as the provider for comprehensive driving evaluation and training. | **HIGH TECH**  
Driver Rehabilitation Specialist; Certified Driver Rehabilitation Specialist*, Occupational Therapist with Specialty Certification in Driving and Community Mobility* |
| Program Service | Offers driver evaluation, training and education. May include use of adaptive driving aids that do not affect operation of primary or secondary controls (e.g., seat cushions or additional mirrors). May include transportation planning (transition and options), customization planning, and recommendations for clients as passengers. | Offers comprehensive driving evaluation, training and education, with or without adaptive driving aids that affect the operation of primary or secondary controls, vehicle ingress / egress, and mobility device storage / securement. May include use of adaptive driving aids such as seat cushions or additional mirrors. At the Low Tech level, assistive equipment for primary control is typically mechanical. Secondary controls may include wireless or remote access. May include transportation planning (transition and options), customization planning, and recommendations for clients who plan to ride as passengers only. | Offers a wide variety of adaptive equipment and vehicle options for comprehensive driving evaluation, training and education, including all services available in Low Tech and Basic programs. At this level, providers have the ability to alter positioning of primary and secondary controls based on client's need or ability level. High Tech adaptive equipment for primary and secondary controls includes devices that meet the following conditions: 1) capable of controlling vehicle functions or driving controls, and 2) consists of a programmable computerized system that interfaces / integrates with an electronic system in the vehicle |
| Access to Driver's Position | Requires independent transfer into OEM® driver's seat in vehicle. | Addresses transfers, seating and position into OEM® driver's seat. May make recommendations for assistive devices to access driver's seat, improved positioning, wheelchair securement systems, and / or mechanical wheelchair lifting devices. | Access to the vehicle typically requires ramp or lift and may require adaptation to OEM® driver's seat. Access to driver position may be dependent on use of a transfer seat base, or clients may drive from their wheelchair. Providers evaluates and recommends vehicle structural modifications to accommodate products such as ramps, lifts, wheelchair and scooter bases, transfer seat bases, wheelchairs suitable to utilize as a driver seat, and / or wheelchair securement systems. |
| Typical Vehicle Modification: Primary Controls: Gas, Brake, Steering | Uses OEM® controls. | Primary driving control examples:  
A) mechanical gas / brake hand control;  
B) left foot accelerator pedal;  
C) pedal extensions;  
D) park brake lever or electronic park brake;  
E) steering device (spinner knob, tri-pin, C-cuff); | Primary driving control examples (in addition to Low Tech options):  
A) powered gas / brake systems;  
B) power park brake integrated with a powered gas / brake system;  
C) variable effort steering systems;  
D) reduced diameter steering wheel; horizontal steering, steering wheel extension, joystick controls;  
E) reduced effort brake systems. |
| Typical Vehicle Modification: Secondary Controls | Uses OEM® controls. | Secondary driving control examples:  
A) remote from button;  
B) turn signal modification (remote, crossover lever);  
C) remote wiper controls;  
D) gear selector modification;  
E) key / ignition adaptors. | Electronic systems to access secondary and accessory controls.  
Secondary driving control examples (in addition to Low Tech options):  
A) remote panels, touch pads or switch arrays that interface with OEM® electronics;  
B) wiring extension for OEM® electronics;  
C) powered transmission shifter. |

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**DRS** - Health professional degree with specialty training in driver evaluation and rehabilitation.  
**LDS** - Certified Driver Rehabilitation Specialist - Endorsed by AHEAD (Association for Driver Rehabilitation Specialists)  
**SCDOM** - Specialty Certified in Driving and Community Mobility (by AOTA American Occupational Therapy Association)  
**OEM** - Original Equipment Installed by Manufacturer  
**CDRS** - Certification in Driving and Community Mobility (by AOTA American Occupational Therapy Association)  
**LDI** - Licensed driving instructor.  

*Driver Rehabilitation Programs: Defining Program Models, Services, and Expectations. Occupational Therapy In Health Care, 28(2):177–187, 2014*
Appendix D. Pre-Summit Preparatory Attendees Questions

1. When you consider the older driver with impairments, from your perspective and/or organization, what resources that you currently use that are helpful in your work (or constituents)? This is not meant to be an exhaustive list – but what resources come immediately to mind that are used frequently; bullet points are fine. Indicate not applicable if needed.
   Space was given to list items.

2. Why have these been useful?
   Space was given to list items.

3. Thinking of the resources you find most valuable, rank the factors that contribute to this decision.
   Rank: Cost, Policies, Inadequate resources (knowledge), Inadequate resources (skill levels), Lack of training, Lack of education, Options for Other

4. From our perspective and/or organization (or constituent group), what can you immediately identify as barriers to meeting the needs of the medically-at-risk driver? Again, not meant to be exhaustive; use bullet points.
   Space was given to list items.

5. Considering barriers for meeting the needs of the medically-at-risk driver, how would you rank the barriers?
   Rank: Content, Cost, Accessibility, Required to use, Options for Other

6. Each participant of this summit comes with unique expert perspective from your organization or professional background, address or offer what you want an opportunity to contribute.
   Space was given to list items.

7. What current resources do you find useful for older drivers or their families?
   Space was given to list items.

Please indicate whether you agree with each of the following statements. Any additional comments or qualifiers are welcome

8. We have moved from the “older driver” to the “medically-at-risk driver” when describing the at-risk or unsafe driver (i.e., function, not age).
   Agree, Disagree, Comment/Qualifier with space

9. The medically-at-risk driver requires access to services by an array of providers that are able and qualified to provide such services.
   Agree, Disagree, Comment/Qualifier with space
10. I support the NHTSA Highway Safety Program Guideline#13 to “Establish a Medical Advisory Board (MAB), consisting of a range of medical professionals, to provide policy guidance to the driver licensing agency to implement.”

   Agree, Disagree, Comment/Qualifier with space

11. Do you agree? Pathways between stakeholders facilitate the use of core services and components of a local/regional/national safety to support the medically-at-risk older driver to remain safely mobile and engaged citizens.

   Agree, Disagree, Comment/Qualifier with space

12. What current resources do you find useful for older drivers or their families?

   Space was given to list items.

   Please indicate whether you agree with each of the following statements. Any additional comments or qualifiers are welcome

13. We have moved from the “older driver” to the “medically-at-risk driver” when describing the at-risk or unsafe driver (i.e., function, not age).

   Agree, Disagree, Comment/Qualifier with space

14. The medically-at-risk driver requires access to services by an array of providers that are able and qualified to provide such services.

   Agree, Disagree, Comment/Qualifier with space

15. I support the NHTSA Highway Safety Program Guideline#13 to “Establish a Medical Advisory Board (MAB), consisting of a range of medical professionals, to provide policy guidance to the driver licensing agency to implement.”

   Agree, Disagree, Comment/Qualifier with space

16. Do you agree? Pathways between stakeholders facilitate the use of core services and components of a local/regional/national safety to support the medically-at-risk older driver to remain safely mobile and engaged citizens.

   Agree, Disagree, Comment/Qualifier with space
Appendix E. Survey Output from Qualtrics

Last Modified: 03/04/2015

1. We have moved from the “older driver” to the “medically-at-risk driver” when describing the at-risk or unsafe driver (i.e., function, not age).

<table>
<thead>
<tr>
<th>#</th>
<th>Answer</th>
<th>Response</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Agree</td>
<td></td>
<td>13</td>
</tr>
<tr>
<td>2</td>
<td>Disagree</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>3</td>
<td>Comment/Qualifier</td>
<td></td>
<td>13</td>
</tr>
</tbody>
</table>

Comment/Qualifier

We're moving in this direction, I don't think we're there. This term makes sense, except in cases where there is no diagnosis of health but there is decline in ability. For example, speed of processing can slow down, but there isn't always a diagnosis related to that change in a person.

I work on roadway infrastructure rather than driver focused issues, so I'll leave this to the experts.

At-risk assumes we are only trying to prevent negative outcomes. There is a whole range of performance issues that are not addressed. Also, the use of the term "driver" limits the conversation to the private automobile and leaves out pedestrian, transit, and bicycle travel which is relevant in many cities nationwide.

We also use "aging driver" as opposed to "older driver"

We state both - take our cue from NHTSA Guidelines and SHSP to call it our "older driver safety program" and our focus on many materials is health, functional ability, and "medically-at-risk" drivers.

Medically does not account for psychological and social issues. 'at risk" can embrace the social determinants that contribute to driver safety.

Referring physicians do not use this term.

We agree with this policy which is reflected in the Maryland MVA website which mentions both. While referral concerning older drivers over represent the proportion of "older drivers" it is important for consider all ages with certain medical conditions to be "medically-at-risk drivers."

Our agency has not made this change but we support it.

not sure medically at risk is always interpreted as functionally impaired, but OK to function

All older drivers are at risk for loss of function because of natural changes of aging plus medical comorbidities. It depends how early you want to identify and provide services. Primary prevention would promote early screening/detection of impairment before someone actually became disabled and unsafe. Secondary prevention detects known problems and rehabilitates them. This sounds as if you are addressing only tertiary prevention, which would be how to find persons so disabled by their conditions that they cannot be rehabilitated and must just be forced to stop driving. I disagree with only tertiary prevention. If you are only the place where the public is punished and not helped, they will never report voluntarily.

Keep in mind that older drivers are more frail than younger drivers and do not survive even minor crashes as well as younger drivers. While medically at risk is an acceptable term much work remains to be done on older drivers to keep them safe in normal day to day driving.
2. The medically-at-risk driver requires access to services by an array of providers that are able and qualified to provide such services.

<table>
<thead>
<tr>
<th>#</th>
<th>Answer</th>
<th>Response</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Agree</td>
<td></td>
<td>18</td>
</tr>
<tr>
<td>2</td>
<td>Disagree</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>3</td>
<td>Comment/Qualifier</td>
<td></td>
<td>3</td>
</tr>
</tbody>
</table>

Comment/Qualifier
Do these services focus on health care or social support?
I work on roadway infrastructure rather than driver focused issues, so I'll leave this to the experts.
I checked agree, but a check didn't not appear.


<table>
<thead>
<tr>
<th>#</th>
<th>Answer</th>
<th>Response</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Agree</td>
<td></td>
<td>17</td>
</tr>
<tr>
<td>2</td>
<td>Disagree</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>3</td>
<td>Comment/Qualifier</td>
<td></td>
<td>6</td>
</tr>
</tbody>
</table>
I work on roadway infrastructure rather than driver focused issues, so I'll leave this to the experts.

We have that in MD and have for quite some time.
Prefer the use of health professional, This will ensure that social workers, caregivers, and other para professionals can be included to share the need to address the social determinents. Moreover, it can embrace preventive services and approaches to driving retirement.

Maryland has the oldest highly functioning MAB in the U.S. It was established in 1947. Over the decades the Maryland MVA administration has strongly supported in spirit and financially it MAB. not until shown to benefit

There should be strong consideration given to having professionals with expertise in older adult transportation, rehabilitation and retraining options, and professional counselling on the medical advisory board, not just medical professionals. In addition, there should be education for a broad scope of service professionals who come into contact with older adults on a frequent basis regarding screening, referral and reporting. Older adults see their medical providers on a rare basis compared with the vast array of other older adult service providers (senior centers, social service agencies such as ARDCs, etc) and there would be much improved opportunities for detection and referral for preventive mobility maintenance. Medical providers and DMVs are generally the contacts of last resort, at which point in time it is often too late to preserve the older adult’s independent mobility.

<table>
<thead>
<tr>
<th>Statistic</th>
<th>Value</th>
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</thead>
<tbody>
<tr>
<td>Min Value</td>
<td>1</td>
</tr>
<tr>
<td>Max Value</td>
<td>3</td>
</tr>
<tr>
<td>Total Responses</td>
<td>20</td>
</tr>
</tbody>
</table>

4. Do you agree?: Pathways between stakeholders facilitate the use of core services and components of a local/regional/national safety to support the medically at risk older driver to remain safely mobile and engaged citizens.

<table>
<thead>
<tr>
<th>#</th>
<th>Answer</th>
<th>Response</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Agree</td>
<td>19</td>
<td>90%</td>
</tr>
<tr>
<td>2</td>
<td>Disagree</td>
<td>1</td>
<td>5%</td>
</tr>
<tr>
<td>3</td>
<td>Comment/Qualifier</td>
<td>4</td>
<td>19%</td>
</tr>
</tbody>
</table>

Poorly worded statement. If it is using local/regional/national safety "programs" that works. And the use of the term "citizens" should be changed as it excludes a large portion of the driving public.
I work on roadway infrastructure rather than driver focused issues, so I'll leave this to the experts.
has the potential to facilitate
I think I agree--Safety what? System, net, organization—please clarify?
5. When you consider the older driver with impairments, from your perspective and/or organization, what are resources that you currently use that are helpful in your work (or constituents)? This is not meant to be an exhaustive list – but what resources come immediately to mind that are used frequently; bullet points are fine. Indicate not applicable if needed.

<table>
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</tr>
<tr>
<td>Max Value</td>
<td>3</td>
</tr>
<tr>
<td>Total Responses</td>
<td>21</td>
</tr>
</tbody>
</table>

From the perspective of Law Enforcement: Educational Resources, Direct Training Resources, Evaluation Instruments, Statistical Resources, Subject Matter Expertise, Direct Interaction with the affected demographic groups, Knowledge of available services

NA

Referral to rehab professionals (OT) for evaluation and intervention. Input from specialist physicians and other professionals (eg, neuropsychologists) on tough cases. Use of common screening measures to quantify cognition, executive and other skills related to driving safety. Referral to Area Agency on Aging for mobility and transit-related counseling and planning.

Medical Advisory Board, Car Fit, and the Motor Vehicle Administration

At FHWA, we don't work specifically on addressing driver impairments but we do have a guide that aims to help transportation agencies design roadways (and pedestrian facilities) that address the needs of older road users. The key resource is our Handbook for Designing Roadways for the Aging Population. (see http://safety.fhwa.dot.gov/older_users/handbook/)

- Area agencies on aging and senior centers that provide transportation
- Transit services
- Skilled evaluation of skills by an occupational therapist
- Travel training programs to transition to transit
- Delivery services (food, prescriptions, library resources)

It really depends on the impairment and/or severity of the impairment. With this in mind these are overall helpful resources:

- Certified Driver Rehab Specialists
- Driver Skill Assessments
- Driver safety courses
- CarFit
- Florida's Medical Reporting Form and subsequent Medical Review Process

Is "older driver with impairments" used to mean the same as a medically at-risk driver?

resources specifically used to pull info to help individuals / education materials: NHTSA Video Toolkit on Medical Conditions
NHTSA Driver Well Toolkit
NHTSA Driving Safely While Aging Gracefully
The Hartford publications, including We Need to Talk and Reasons to Consider a Driving Eval
AAA Senior Driving, including Roadwise Review
AARP Smart Driver course booklet
Physician's Guide to Assessing and Counseling Older Drivers
MD's list of Driver Rehab Programs
for building a statewide older driver safety program:
NHTSA Guidelines
AAA older driver recommendations to states
best practices and promising practices from other states (via TRB & LifeSavers info)

relationship with trusted person/organization
assistive devices (mirror, seat)
pharmacist (medication consultation)
items in Assessing, Counseling and Treating Older Drivers -book.

Mobility management (Easter Seals).

Hartford Booklets/Patient Education
ARMT
Driving Health Inventory
Fitness to Drive Screening
Driving Habits Questionnaire
Clinical evaluation
On road evaluation

AOTA Older Driver Resources - print and web-based; content experts
For medical fitness to drive assessments (the work of the Medical Advisory Board) and the MVA's Driver Wellness and Fitness Division the following are key resources:

- Reports from Physicians/Treatment Providers (not all clients have M.D. are care providers. Reports from NPs and PAs and other clinicians are acceptable in many cases.)
- Reports from Driver Rehabilitation Specialist (DRS) are critical to making medical fitness to drive recommendations. DRS reports may be requested by the MVA, or DRS reports are proactively submitted. These reports are considered primary referrals and generate a case and recommendations from the MVA's MAB.
- For over a decade the MAB has hosted quarterly meetings with all of the DRS programs. The meetings include nurse case reviewers from the Driver Wellness and Safety Division and adaptive equipment vendors. Through this dialogue all of the participants are kept aware of developments in the various professions. These dialogues have been of value in changing policy in the MVA relative to medical fitness to drive assessments.
- Health Questionnaire submitted by clients
- Driving Records
- Police referrals (In Maryland Request for Re-examinations submitted by law enforcement are primary sources of referrals. That means they generate a case for review.)
- Fact Sheets for Medical Professionals
- Driver Fitness Medical Guidelines
- Physician's Guide to Assessing and Counseling Older Drivers
- Medical Advisory Board
- Driver Assessments clinical assessment WITH on road assessment engaging physician and family providing mobility resources

AOTA D&CM book
Harford booklets
OTHC journal special issue
n/a as part of my work at CDC
AOTA
AOA
The Hartford
- Driver Fitness Medical Guidelines 2009, NHTSA—provides succinct information along with the evidence
- NHTSA Fact Sheets for medical professionals—sometimes also use as handouts
- Hartford At the Crossroads program for caregivers--comprehensive information written in very good language
- AARP resources—We Need to Talk online video seminars—gives examples of how to have a conversation
- http://www.aarp.org/home-garden/transportation/we_need_to_talk/
- Michigan Driving Decisions workbook—http://www.um-saferdriving.org/My results/counseling page—can save a URL for later discussion
- Fitness-to-Drive Screening Measure Online—http://ftds.phhp.ufl.edu/
- Gives keyform with answers indicating concern and a recommendations page. Cannot save, must print. Gives caregivers/professionals an evidence-based assessment to work with the older adult.
- AAA Roadwise Review—empowers older adults to raise awareness of their own skills, has the Useful Field of View and explains what it is - https://www.aaafoundation.org/roadwise-review-online
- CarFit--helps older adults understand vehicle safety, great outreach program which is viewed as nontreating and provides an opportunity to provide additional information.
- AMA Physician’s Guide to Assessing and Counseling Older Drivers—has multiple pieces of the puzzle in one place for medical professionals, has a recommended screening process which is not too difficult

We are in the midst of developing resources via a cooperative agreement with NHTSA. These will be targeted at health professionals.
<table>
<thead>
<tr>
<th>Statistic</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Responses</td>
<td>21</td>
</tr>
</tbody>
</table>
6. Why have these been useful?

Text Response

Improving communication skills, development of empathy, knowledge of medical issues, awareness of statistical evidence, knowledge of available services, and sharing of personal experiences.

Health professionals need an array of go-to resources that they can trust and access readily for patient support. It is critical that patients feel supported and respected in this process of fitness evaluation and planning that may come after.

Yes, but my reason for using these resources was as a researcher and not a practitioner.

If we design roadways to be safer for older drivers (e.g., increased font size on signs, reducing conflicts at turning movements), we typically see safety benefits for all road users.

They consider the whole person and their need to continue engagement at the community level even if the person is no longer deemed safe to drive.

They allow older adults to stay proactive about their safe driving (driver safety courses, CarFit);

Provide professional assessment of driving ability (CDRS, Driver Skill Assessments); Put the decision on whether someone has the medical criteria or vision standards to drive into the hands of the licensing authority. (medical reporting form and medical review process)

Bases of materials used in building our website several years ago, and have used them since to develop educations materials (tip cards, roll-call video, factsheets, brochure, etc) and incorporate into training workshops. The last item - specific to Maryland -- used to encourage anyone concerned about functional ability to drive safely to seek out an assessment from an OT.

It is not about education or access all the time. Readiness, assistance with alternatives, and process are essential to understand the meaning of the issue and to help individuals address the loss/es.

Useful in helping clients and family members understand the strengths and weaknesses (and attitudes) of the medically at risk driver.

Clinical - identification of abilities prior to on road driving On road - good indicator of performance, strong face value with drive

Developed with a variety of target audiences in mind Breath and scope of resources Variety of formats

See above comments

Fact Sheets provide a quick and useful for reference for physicians, facilitates conversation with their patient, routine use of these sheets enhances front counter staff's familiarity with driver conditions. Driver Fitness Medical Guidelines are used as reference by our examiners and hearing officers, medical advisory board, and have been provided to administrative law judges for consideration during appeals. Both the Medical Guidelines and the Physician's Guide to Assessing and Counseling Older Drivers have been used to develop policy and rule changes for initial approval by the Medical Advisory Board.

determining safety on the road needs to be an assessment On the Road. not a few questions in a doctors office or a generalist making decisions based solely on age engaging others allows the older driver to be supported and able to utilize resources in the community

The resources make sense to therapists.

Assistive Devices and Therapy, Driving Rehabilitation, Eye Impairments Research and publication both physical and mental impairments and how it relates to driving

See above--annotated
7. Thinking of the resources you find most valuable, rank the factors that contribute to this decision. Click and drag into order.

<table>
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<tr>
<th>#</th>
<th>Answer</th>
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Other

Supported by validation

(Note: one of these (for something like 'required use' disappeared and I'm not sure how to get it back

User-friendly lay language handouts

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8. What current resources do you find useful for older drivers or their families? Bullets points are fine.

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<thead>
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<th>Text Response</th>
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<tbody>
<tr>
<td>Educational Resources, Training Courses, Presentations with statistical background, Personal experiences.</td>
</tr>
<tr>
<td>NA</td>
</tr>
<tr>
<td>Area Agencies on Aging are excellent. Alzheimer's Association. My state has a growing group of mobility managers.</td>
</tr>
<tr>
<td>At FHWA we don't really work with older drivers and their families directly.</td>
</tr>
<tr>
<td>- self assessment and family assessment resources so families know when there is a legitimate concern.</td>
</tr>
<tr>
<td>Florida's Guide for Aging Drivers <a href="http://www.FLsams.org">www.FLsams.org</a> (<a href="http://www.SafeandMobileSeniors.org">www.SafeandMobileSeniors.org</a>) see above</td>
</tr>
<tr>
<td>No dealing directly with the end users.</td>
</tr>
<tr>
<td>Hartford Booklets/Patient Education ARMT Driving Health Inventory Fitness to Drive Screening Driving Habits Questionnaire Clinical evaluation On road evaluation</td>
</tr>
<tr>
<td>NA</td>
</tr>
<tr>
<td>A comprehensive website regarding medical fitness to drive provided resources for client, their families and clinicians. For instance the site advises drivers and their families of matters that should be considered relative to fitness to drive. Information about referral of clients is provided, including a physician reporting form. The list of Driver Rehabilitation Specialists is provided. Comprehensive information about the referral and review process is provided to all website users.</td>
</tr>
<tr>
<td>Departmental materials addressing Driver License Renewal, Driving With Diminished Skills, Driving Retirement, Older Drivers and Risk. Request for Reexamination - departmental form. Referral and elinks to support agencies, i.e. Alzheimer's Association, Epilepsy Foundation, etc. Fact Sheets for Medical Professionals - describe driving actions related to health conditions community based mobility education in use of public transportation education with regard to living location</td>
</tr>
<tr>
<td>Hartford booklets Families like face to face discussion with an &quot;expert&quot;</td>
</tr>
<tr>
<td>WNTT AARP Driving Resource Center See above. I use these resources as part and parcel of the work.</td>
</tr>
<tr>
<td>AAMVA's Grand Driver program which contains information on safe driving and information on how families can work with their older drivers to continue making them safe drivers.</td>
</tr>
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<table>
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9. From your perspective and/or organization (or constituent group), what can you immediately identify as barriers to meeting the needs of the medically-at-risk driver? Again, not meant to be exhaustive; use bullet points.

<table>
<thead>
<tr>
<th>Text Response</th>
</tr>
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<tbody>
<tr>
<td>Appropriate emphasis on the problem, impacted time frames for training/education, personnel resources.</td>
</tr>
<tr>
<td>Availability/accessibility.</td>
</tr>
<tr>
<td>Lack of public awareness and individual incentive to address fitness to drive in advancing age.</td>
</tr>
<tr>
<td>Inconsistent service landscape. Not just urban vs. rural. Physicians and other health professionals still not attuned to this issue sufficiently to provide a safety net.</td>
</tr>
<tr>
<td>The change in requirements for transportation, the negotiating new skills for mobility, understanding the progression of need for a medically-at-risk driver, and access to consistent quality non stigmatizing resources.</td>
</tr>
<tr>
<td>The key from an infrastructure standpoint is: - making sure that at risk drivers have alternatives to driving on their own. This could include having pedestrian facilities or transit stops that are safe and easy to get to.</td>
</tr>
<tr>
<td>- insufficient number of driving evaluation programs</td>
</tr>
<tr>
<td>- incomplete transit services which do not cross municipal or county lines</td>
</tr>
<tr>
<td>- very limited reimbursement for driving evaluation or intervention services</td>
</tr>
<tr>
<td>Availability of Certified Driver Rehab Specialists (we need more!); High cost of assessments (non-reimbursable medical expense); Need for more community based mobility options; Perception that driving is the only way to stay mobile and engaged in community; Infrastructure changes to support safe access to other modes of transportation (walking, transit, biking); Access and use of public transportation</td>
</tr>
<tr>
<td>lack of understanding and acceptance of need to plan ahead for transportation -- on an individual level and with professionals not integrating this consideration into everyday practices</td>
</tr>
<tr>
<td>trusted source of easy-to-understand, compressed and precise info - readily available</td>
</tr>
<tr>
<td>availability of alternatives to driving</td>
</tr>
<tr>
<td>lack of coordination and communication among agencies and organizations that touch the lives of seniors</td>
</tr>
<tr>
<td>Education A lack of understanding about the psychological needs of this population. Funding funds are needed to ensure all health professionals can communicate about this population and work together to address the needs.</td>
</tr>
<tr>
<td>Client fear of not being able to demonstrate competence; fear of moving into a stage of life where there is no return to a certain lifestyle that driving provides.</td>
</tr>
<tr>
<td>Cost for medically-at-risk driver</td>
</tr>
<tr>
<td>Cost for medical facility providing on road evaluations</td>
</tr>
<tr>
<td>Reluctance of at-risk-driver to participate</td>
</tr>
<tr>
<td>Reluctance of physician to report</td>
</tr>
<tr>
<td>Occupational Therapy practitioners lack of recognition that driving/community mobility is a basic component of everyday practice</td>
</tr>
<tr>
<td>Occupational Therapy practitioners feeling &quot;at a loss&quot; for resources within their community</td>
</tr>
<tr>
<td>Occupational Therapy practitioners not feeling comfortable with their level of skills and expertise</td>
</tr>
<tr>
<td>While the MVA's Medical Advisory Board has and continues to provide extensive outreach education to clinicians, medical societies, and community groups, there will always be the need to educate clinicians, community services about the the referral and review process.</td>
</tr>
<tr>
<td>This is a problem is all jurisdictions in the United States. The vast majority of physicians and nurses do not know of the existence of the MAB. In addition, they are not aware if they have any obligations about reporting/referring their clients to the MVA. Indeed, they are</td>
</tr>
</tbody>
</table>
not aware if their patients have any obligations.
Availability of driving assessments, directory of services  Cost of driving assessments
Legislation or rules to allow DMV referral to driving assessment  Legislation or rules to allow cognitive screening
cost, lack of medicare support  accessibility of assessment
Professionals not knowing about resources that are available.
identifying functionally impaired (medically at risk)
Insurance doesn't cover costs for services and equipment  Not enough medical practitioners that specialize in Driving
Failure of US society to regard driving as a privilege instead of a right  Design of US housing
which requires use of independent individual transportation for survival, especially in rural areas
No evidence-based simple screening measure (yet) usable by professionals/the public to assess driving disability  Lack of alternative transportation options  Fear of dependency and isolation
Cost of alternative transportation
Accessibility of programs  Lack of viable transportation alternatives
*lack of access to other means of transportation

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10. Considering barriers for meeting the needs of the medically-at-risk driver, how would you rank the barriers? Click and drag to order.

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<th>Answer</th>
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<td>Inadequate resources (skill levels)</td>
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Page 66
Other
my order did not work.
Mandatory reporting
Available staff to provide outreach education
viable transportation alternatives
lack of public transportation alternatives

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I look forward to interacting with all participants, I hope to impart the experiences of our law enforcement training programs and the impact of improved education and the development of better skills through our efforts.

My role is primarily as a listener, and as a secondary role, to speak to NHTSA's history in the area of mobility for older adults and individuals with medical or other limitations.

I know this issue in depth from the perspective of the health professional and referral in the current service landscape. I also bring significant knowledge on state-level policies and programs.

Considering the ecological perspective of the medically-at-risk driver - they are adults with skills, knowledge, attitudes, and emotions that are nested in supports of friends, physicians, families (or lack there of), that are in communities with resources (or lack there of), and in states with policies (or lack there or) - that coordinated effort is required to create a last impact for the medically-at-risk driver.

I guess I'd say that I bring the roadway perspective. Our agency (FHWA) and out stakeholders (State DOTs and local transportation agencies) don't work with road users directly (other than, perhaps, in getting community input on transportation planning for the future), but how the road and communities are designed likely affect the degree of risk that older road users take (if they don't have other convenient and affordable options).

Occupational therapy has a comprehensive skill set to offer both older adults as well as organizations providing services to consider clients with health issues and their community mobility needs. Occupational therapy is uniquely qualified to offer evaluation, intervention, and consultation services across the spectrum of community mobility (community design, community walkability and bikeability, determination of medical fitness to drive, recommendation and training in adaptive equipment, transit design and staff training, travel training in the use of transit, child passenger safety for grandparents transporting grandchildren, etc. Occupational therapy is an untapped resource in this widespread issue.

I am just excited that this is happening and look forward to being able to exchange ideas, learn, and contribute as much as needed to this important issue.

Simply to help in the effort to coordinate and organize the wealth of information available and identify the gaps, with an emphasis on building collaborative relationships amongst the professionals involved.

The person-in-their environment; all health providers interest and opportunity to contribute; how to engage in the educational processes. psychological perspective of the older adult and their caregiver.

I hope that my voice and presence will help others recognize the role of the generalist-Occupational Therapist in providing professional services to medically at risk drivers---not only in increasing the individual's awareness of skills needed for driving, but also in addressing the "aftermath" after retirement from driving.

I want to be part of the discussion of how medically at risk drivers are identified, assessed and assisted with driving. In my area, I do not see services being more affordable, more popular or more valued, even though the population is growing. I routinely hear from families that are desperate for answers to medically at risk driver issues.
Not sure; organizational perspective of AOTA; garnishing resources.
I have been on the medical advisory board for 13 years and served as its chief for the past 11 years. As chief I have had the honor and privilege to participate in expert panels, workshops and hearing both on the local, regional, and national/international levels. As a result I bring to the table a good bird's eye view as well as on-the-ground practical knowledge of the issues that work and don't work, as well as what is needed to advance referral and reviews for medical fitness to drive.

Pilot of cognitive screening tool developed by UCSD TREDs, DOSCI Upcoming pilot of cognitive screening program

Most importantly, I welcome the opportunity to learn from all participants.

Support keeping medically at risk or older drivers mobile as long as possible.

I am a geriatrics physician who is intimately familiar with the medical issues for older adults from clinical practice, the perspectives of older adults themselves, and also their caregivers' concerns. I have trained multiple interprofessional colleagues for the past 30 years in community and academic settings regarding the practice of geriatrics and also participated on the editorial boards of the different editions of the AMA Physician's Guide to Assessing and Counseling Older Drivers. I am strongly concerned with health literacy for older adults as Chair of the Public Education Committee for the American Geriatrics Society and have lived through driving retirement and disability with my own family. I believe I can contribute a valuable perspective on the reality of how the issues for older adults and driving actually play out in the clinical setting, where the gaps are, and how these might affect policy planning.

The AAMVA jurisdictions deal with each and every driver in the US, from teens to seniors and offer many opportunities for training and education of older drivers, health care professionals, law enforcement and family members.

Content expertise in health professional education and strategies for reaching a physician audience (in particular).

<table>
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<th>Value</th>
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Appendix F. Survey Results Summarized for Expert Summit
March 5, 2015

1. We have moved from the “older driver” to the “medically-at-risk driver” when describing the at-risk or unsafe driver.
   a. 62% agree;
   b. 24% disagree;
   c. 13 comments
      • “moving in that direction.”
      • Medically-at-risk – include all drivers with medical conditions
      • Medically-at-risk – does it include normal aging?
      • Depends on services are defined in terms of primary, secondary, tertiary prevention.

2. Almost all agreement on the statement that medically-at-risk driver requires access to services by an array of providers that are able and qualified to provide such services.

3. Supporting the NHTSA guideline to establish a MAB.
   a. 85% agreement
   b. Several commented using health care professional or professionals with expertise in older adult transportation, rehab, counseling, or adult service providers.
   c. The need to show that it benefits.

4. Pathways between stakeholders facilitate the use of core services and components of a local/regional/national safety net to support the medically at risk older driver to remain safely mobile and engaged citizens.
   a. 90% agreement on the premise
   b. Some comments about the wording

5. What resources are useful (everyone offered something):
   a. Knowledge: resources in education, training, services
   b. Physicians Guide & Hartford booklets
   c. NHTSA Toolkits, videos, fact sheets,
   d. AOTA resources (website, printed materials)
   e. Referrals to DRS: BTW evaluations,
   f. Screening tools (e.g., DHI, AAA, AARP)
   g. Medical advisory boards

6. Why useful: professionals need an array of go-to materials, not all about education – need to improve awareness and communication, all are developed with variety of target audiences, important for clients and families.

7. Most valuable resources: factors that contribute to this decision:

<table>
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<th></th>
<th>Rank #1</th>
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<td>2</td>
<td>1</td>
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</table>

8. Resources useful to older drivers and families.
   a. Similar to what has been expressed.

9. What are the barriers to meeting the needs of medically at risk drivers?
   a. Availability and access
b. Emphasis of the problem/ lack of awareness/lack of understanding by public, medical profession, (specifics – MAB, resources, )
c. Changes in transportation/ lack of alternative transportation
d. Client fear, reluctance of physician to report,
e. Availability to driving assessments and/or CDRS, high cost of assessments, limited intervention, lack of reimbursement, lack of OTs understanding their role and contributions,
f. Client fear
g. Lack of a good screening tool

10. Barriers to meeting the needs:

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<tr>
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<th>Rank #1</th>
<th>#2</th>
<th>#3</th>
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<td>3</td>
<td>7</td>
<td>3</td>
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<tr>
<td>Inadequate resources/skill levels</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>6</td>
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</tbody>
</table>

Lack of alternative transportation!!

11. What do I bring – wonderful perspectives – so exciting to see what is going to happen at this meeting.
Appendix G. Agenda for Summit

March 5 Agenda
(Italics means the notes are for only for us.)

9:00 Welcome – Elin Schold Davis, AOTA
Welcome to the American Occupational Therapy Association – Maureen Freda Peterson, Chief Professional Affairs Officer, AOTA
Introduction to the Summit – Brian Chodrow, JD, Program Manager, NHTSA

Ensure agreement from the group on recording.
Introduction of Experts for the Summit
• Name, primary focus for older drivers.

9:30 Elin: Purpose and Background of the Summit: Showing the video of the parking lot crash “Each of you have a role in the impact statement” – based on the crash video

9:50 Syneren Technologies Corporation – Clearinghouse for Older Road User Safety (ChORUS) – Deanna Smith, Hallena Lawson (describing their project, what it involves, and what they want to learn – invite handouts.)

10:05 Break

10:15 Logic Model overview - Tom takes over.
Impact and Core statement [Confirm this with the group – but not necessarily change. Ensure that understanding of terms is shared.]
➢ Show NHTSA video of stroke: Demonstration of medically at risk, also resources.
Theoretical underpinnings - brief

10:45 Break

11:00 Outcomes: What is essential to the safety net and something we can measure. [Review the ones we have, from the survey, and solicit for more]
Anne – Results from on line survey.

11:30 Inputs – Available Resources – [Start with presentations and offer opportunities to list and describe resources (not describe specific screening tools, but groups of tools)]
Presentations about Resources - 5 minutes each
Elin - AOTA Older Driver Initiative -
➢ Deb – role of licensing agency,
➢ Jenny – role of specialist
➢ Mary Jo – role of generalists versus specialist
➢ WebMD – Stephen Murphy
➢ Alice - AGS – AMA Guide and Education
Group lists other resources.

12:30 Lunch

1:30 **Talent In The Silos**
- *Table of Spectrum of Driver Services* used as reference
- Three groups to identify: Who are the players and what do they do, what is realistic for them to do.

Three Groups:
- Medical review board – Carl Soderstrom, Nanette Schieke, Jenny Nordine, Greg Brunette, Ann Dellinger – Cheryl Irmiter (facilitator)
- Health Practitioners – Wendy Stav, Nancy Lundebjerg, Mary Jo Maguire, Alice Pomidor, Deborah Lieberman - Vanya Jones (facilitator)
- Licensing – Ike Iketani, Debra Carney, Kevin Lewis, Gabriel Rousseau - Gail Holley (facilitator)

2:45 Break

3:00 **The Pathway Activities**

*Presentations about Interconnectiveness - 5 minutes each*
- Ike – Project of TRENDS – (Iowa & California)
- Nannette – Interstate connectiveness
- Gail – Florida threads of service – how a state is really embracing the connectiveness.

**Pathway activity** – Revisit why we are having this summit, we reviewed the summit, we looked at the talent in silos, necessity of interconnectiveness, we want you as experts to find how the best connects, how we put some words, what training is needed, what referrals pathways need to be understood, build, established.

Be creative and expansive, not to be worry about service being reasonable or consider cost, what would serve the individual; can it help meet the impact statement.

**Contributions from the Group.**

4:00 **Wrap up for the Day; Instructions for Tomorrow**

Friday, March 6:

7-8:45 Breakfast

9:00 Welcome Back; Review of Activities, Goals for the Day

9:15 Day Activity depending on Thursday events.

10:15 Break

10:30 Activity
11:00  Review of the “Parking Lot”  
12:00  Round – Up  

Appendix H. Spectrum Expansion Activity  

Check group:  MAB _________        Health Professions ______________    Licensing 
________________

<table>
<thead>
<tr>
<th>Name (Service or program)</th>
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<tbody>
<tr>
<td>Program Type</td>
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<tr>
<td>Typical Providers and Credentials</td>
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<tr>
<td>Required Provider’s Knowledge</td>
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<tr>
<td>Typical Services Provided</td>
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Appendix I. Pathways Activity Sheet

**Creating Pathways for the Case About**

**Task**: Considering our Impact Statement and Logic Model elements, consider what "sites" or stakeholders, resources or activities would be needed to create the ideal Pathways to ensure a safe route for an individual to remain safely mobile and engaged in the community. Identify the "sites" or use the cards (associated with individuals) in the boxes. Add more boxes and/or arrows as needed to identify gaps or opportunities.

List of cards given with Pathway Activity:
- State licensing agency
- Insurance
- Occupational Therapist (Generalist, Rehab Service)
- Advanced Practice Nurse/PA
- Driver Rehabilitation Specialist
- Religious Organization
- Physician
- Geriatric Care Manager
- Medical Review Board
- Resource Hotline
- Law enforcement
- Health Professional or program
- Judicial System
- Driving School/Safety Education
- Alternative Transportation Service
- Family/Caregiver
Appendix J. Model of Older Driver Screening and Assessment

Model of Older Driver Screening and Assessment

- Assess for BTW performance, crash risk, IADLs
- Screen for crash risk

- At-risk DMV
- At-risk physician’s office & DMV
- At-risk? Physician’s office
- Not at risk—stop looking for now
- Not at risk—screen all or screen based on presence of risk factors

Older Driver Universe—screen all or screen based on presence of risk factors
Appendix L. Results from Spectrum Expansion Activity; Two groups  
Medical review board: Carl Soderstrom, Nanette Schieke, Jenny Nordine, Greg Brunette, Cheryl Irmiter (facilitator)

<table>
<thead>
<tr>
<th>Service or program</th>
<th>Minimal/What now?</th>
<th>What could do?/Optimal Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>May or may not currently exist</td>
<td></td>
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</table>

| Program Type | | |
| Functions and services | | Complex cases – administration/guidelines for types of cases. |

| Typical Providers and Credentials | | |
| Who are the people? | | |
| Ophthalmologist/Optometrist Neurologist Internist | | Very physician address every case • Cardiologist • DRS • Psychiatrist • Social worker (psychosocial) • Layperson • Epidemiologist (crash cause) |

| Required Provider’s Knowledge | | |
| What training would be required to fulfill their role addressing the safe mobility of seniors? | | Only medically trained to touch cases – especially at entry point. Community based information on needs and integration with transitions. Departments of both planning and Aging: Bio/social/psycho issues, ombudsman to address on holistic level for each case. |
| Distinguish professional training (e.g., MD from “new”) | | |

| Typical Services Provided | | |
| What’s available currently? | | |
| What needs to be developed? | | |
| What education/training is needed? | | |

| Expected Outcome | | |
| How does this person/program support older driver safety? | | Did it actually help the person? |

*The overall impact*
Service or program | Community Safety and mobility coordinator | Statewide Multi-disciplinary safety and mobility coalition
--- | --- | ---
May or may not currently exist

**Program Type**
Functions and services

**Typical Providers and Credentials**

Who are the people?

Health care
Law enforcement
Licensing (very broad)

**Required Provider’s Knowledge**

What training would be required to fulfill their role addressing the safe mobility of seniors?
Distinguish professional training (e.g., MD from “new”)

Bringing own expertise and willingness to share the information.

**Typical Services Provided**

What’s available currently?
What needs to be developed?
What education/training is needed?

Pieces of information are available

**Expected Outcome**

How does this person/program support older driver safety?

*The overall impact statement!*

- Reduces crashes
- Promoting advanced planning
- Empowerment
- Consistent educational tools and resources
- “Don’t reinvent the wheel.”
Appendix M. Data from the “Pathways” Activity Sheet

Boxes are indicated by letter (First box=A, second box = B, etc)
Notes are included.

Sheet 1. Feedback Pair: Wendy Stav and Vanya Jones (Ideal scenario)
A. Law Enforcement: Training law enforcement. Also Insurance contacted.
B. Medical Review Board: Well functioning MAB without a caseload that prevents timely evaluation.
C. Physician: Aware of Driver rehab specialist, has a referral pathway; no long waiting lists
D. Driving Rehab Specialist
E. Referrals: Alternative transportation, Social Service, Religious support, Family/Caregiver
F. Notes: Details
   1. Crash
   2. Law enforcement called: Private property, no ticket but created a report, sent report to MAB.
   3. Medical Review Board-investigation needs report from MD.
   4. Physician evaluates and is concerned “hot mess.” Referred for a driving Evaluation
   5. Driving rehab specialists-evaluates, Mr. Johnson FAILS! Refers for additional services:
      i. Alternate transportation and training
      ii. Social service for meals on wheels etc.
      iii. Family/Caregiver for support
      iv. Religious Institution for support and transportation

Sheet 2. Feedback Pair: Wendy Stav and Vanya Jones (Reality)
A. Mr. Johnson: Safety Education. Completed Roadwise Review. Failed to go see physician.
B. Physician: “Am I a good driver?” but no other information given. OK from physician. Letter from attorney: Being sued.
C. Insurance drops Mr. J (No link between insurance and licensing unless you renew). Calls daughter in another state “I have no insurance. And I’m being sued.”
D. Daughter calls Resource Hotline. Referral to social service.
E. Alternative transportation and resources including Geriatric Care Manager. Medical Review Board.

Sheet 3. Carl Soderstrum and Jenny Nordine
A. Physician: Has to want to address issue to elicit the info Re: crash. Does Trails B and MOCA
B. MVA referral
C. Cognitive Assessment; MVA branches: physician report, health questions, driver record, driver test – Fails.
D. CDRS determines if Mr. Johnson can safely drive
E. Pass. CDRS documents. Board decisions: Follow up annually with restrictions-Case closed

Sheet 4.
A. Law Enforcement: Suspended license immediately, referral to MAB
B. MAB: Cognitive Assessment, Physician report: diabetic, neuropathy
C. CDRS: Evaluation and training. Adaptive equipment or reassessment?
D. MVD: Drive, Test with hand controls, Restrictions

Sheet 5.
A. Law enforcement: Gets a citation
B. Insurance: Defends driver
C. Law suit
D. Judicial System
E. Notes: Opportunities
   1. Judicial System: Can send to Medical Review Board
   2. Insurance: Can refer to Occupational Therapist **Can Auto Insurance Companies require an OT Eval.
   3. When citation is given, referral for PCP

Sheet 6. Mary Jo Maguire and Cheryl Irmiter
A. Law enforcement. No citation, but Insurance is notified.
B. Medical Review Board notified.
C. State driver Licensing Agency
D. OT Eval.
E. Area Agency on Aging: Care manager and waiver
F. Notes:
   1. Issues:
      a. Client continues to drive/problem with timeline.
      b. Can law enforcement report without citation?
   2. Insurance system increases premium but not social responsibility.
      a. Can they have a role to insure follow up care?
   3. To compress timeline: Can Medical Review Board recommend OT involvement?

Sheet 7. Feedback Pair: Nanette and Gail
A. Law Enforcement and EMS, Urgent care, or health professional
B. Judicial system, MAB, Family/Caregiver
C. OT, Physician, Social Service, Geriatric Care Manager
D. Resource Hotline, Vision Specialist, Driver Rehab, Driving School
E. Alternative Transportation Options. Religious/Volunteer Program

Sheet 8.
A. Family/Caregiver; Driving School/Education; Law Enforcement
B. State Driver Licensing Agency
C. Physician; Health Professional; Advanced Practice; Vision Specialist
D. Driver Rehab; OT
E. Medical Review Board: Resources Hotline

Sheet 9. Mary Jo Maguire and Cheryl Irmiter
A. Law Enforcement and Insurance
B. Easter Seals: for wife
C. Family Member and Primary Care Provider.
D. Notes:
   1. Primary care provider knows nothing of OT and No referral to AAonA
   2. Does Easter Seals have the duty to get involved with Mr. Johnson?
   3. How does communication occur among the systems-closing loops
   4. What is needed for something to happen?

Sheet 10. 5 Alternative paths
A. Law Enforcement, State Driver Agency, Health Professional, DRS, Alternative Transportation Service
B. Driver Rehab Spec, Physician, State Driver Licensing Agency, OT, Geriatric
C. Law Enforcement, Family Caregiver, State Driver Licensing Agency, physician/health professional, Social services, resource hotline.
D. Family/caregiver, education, Physician, vision specialist or OT, Alternative transportation service or DRS
E. 52 yr. old/Law Enforcement, DMV, Health professional or Judicial(?) or DMV or testing, Caregiver/Safety Driver Education

Sheet 11. Alice Pomidor, Kevin Lewis, Ike Iketani: Alternative paths
A. Insurance and Law enforcement (citation)
B. Law enforcement to State DLA to MAB to Vision specialist.
C. Law enforcement to judicial system
D. Law enforcement to EMS to ER with physician or Nurse – does not survive (religious institution).
E. Law enforcement to EMS to ER with physician or Nurse to family caregiver to DRS, OT or Driving school to vision specialist (continues to drive).
F. Law enforcement to EMS to ER with physician or Nurse to social service professional: Does not drive: Alternative transportation service, Resource Hotline, Geriatric Care Manager.

Sheet 12. Mary Jo Maguire – possible referral pathways.
A. Medical Review Board refers to Physician, refers to generalist OT: refers to Area Agency on Aging, Para transit, and/or CDRS.
B. Medical Review: refers to Physician AND/OR Refers to generalist OT
   a. OT refers to AAoA who gets a Medicaid Waiver for Transportation Assistance.
   b. OT refers to Para transit.
   c. OT refers to CDRS-If money is available.
   d. OT refers to Drivers Evaluation with OT if money is not available.
C. Medical Review Board: Physicians: Area Agency on Aging: Case Manager: generalist OT to CDRS or Drivers Evaluation.
D. Physician (or nurse practitioner) or Area Agency on Aging care manager or AAoA Aging Hotline refers to CDRS and if recommends cessation of driving refers to generalist OT for a comprehensive OT Evaluation.

Appendix N. “Parking Lot” Comments Typed from Notes

1. Medicare to cover/promote an annual OT evaluation, to include screening.
2. Use safety/mobility network instead of safety net.
3. 69 entities in the US and Canada, all doing the same thing in 69 different ways.
4. Changing attitudes – “when do you plan to stop driving?” – marketing Accreditation – for CMS, for ACGME, for M of Certif.; A question can be placed to ask how the organizations can do this or how they do it.
5. Are “incentives” for younger people to start driving later… similar to “reasons” for older drivers to consider driving “retirement”?
6. For the record: When older adults are “under investigation” many have care benefits to cover OT to facilitate awareness of deficits and transition.
7. Stakeholders – vision
9. Do we capture parking lot crashes in state data? IIHS says 14% of older driver crashes are in parking lots. Seems we need to capture for full picture.
10. Need to support research to test the influence/impact of resources.
11. Stakeholder: Automotive industry and universal design missing.
12. Rural and urban mobility
14. Vehicle manufacturer and designers as stakeholders
15. Technology-based solutions? Versus newer driver expectations
16. Bring the generalist OT driving education to Iowa.
17. Training is essential for all stages of the pathway. We cannot assume the paths we design are executed as intended.
18. DMV as “hub” for a mobility network.
19. Preserving mobility is not just continued driving.
   a. Automatic referral for OT evaluation provides support and baseline
21. Medical Review Board – Need for them to understand the need for comprehensive OT evaluation to give to physician.
22. Does the impact statement need to call out a population? Medically at risk older drivers or state “support the well being of people to….”
23. Caregivers – 40-50 year old healthy person is driving OA. They are at risk for medical/health/psychological issues to get in the way of driving.
24. Older adults are in Piggy Wiggley more than MD offices.
25. Community organization s (e.g., Piggly Wiggly, churches,) can be part of stakeholder group.
26. Ask the PW staff about the number of car accidents or bad drivers. Stakeholders: “Piggly-Wiggly”, churches and synagogues.
27. ENR for hospital/ER discharge instructions
   a. ___ May ___ May not drive until__________
29. CHORUS – Clearing House for Older Road User Safety
Appendix Q. Plan for Distributing and Evaluating the Pathways Materials at AOTA Conference

There are generally three types of therapists who visit the booth. This will be the plan for Mary Jo Maguire to use with those who stop by the booth. It is anticipated we will collect feedback from 100+ visitors to use to determine which materials to improve, print with higher quality/quantity, and what should be redone.

**Group 1. Starting (or want to start) a Driving Pathway or Program**

*Give following Resources:*
1. Spectrum Sheet – for knowledge and share
2. Consensus statements – knowledge and share
3. Fact sheet
4. Decision Tool for Identifying Driving Potential and Risk
5. List of resources to use:
   - Pathway materials – OTHC descriptions
   - AOTA SPCC
   - Driving & Community Mobility Book
   - AOTA Website; Note: *Because you do not need reinvent the wheel – use the information on the Older Driver website.*
   - Practice Guidelines
   - CEs on CDs
   - Hartford Booklets
   - NHTSA – Fact sheets & videos

*Evaluation Plan:*
1. Postcard – Send back to you on what resources were most helpful.
2. Leave email address/business card – to do send a qualtrics survey on 1) if the information given at the booth was helpful, 2) ask about each resource (only answer for those they used), 3) status of development 4) program model.

3.

**Group 2. Working in established driving program: Self-identity as a driving specialist**

*Offer the resources:*
1. Spectrum Sheet – for knowledge and share
2. Consensus statements – knowledge and share
3. Pathway materials – OTHC
4. Driving & Community Mobility Book
5. Decision Tool for Identifying Driving Potential and Risk

*Evaluation Plan:*
1. Ask about their specific program model and credentials; Mary Jo to take some notes
2. Leave email address/business card – to either have you call for a conference call or qualtrics survey about their program model.

3.

**Group 3. Novice**

*Offer the Resources:*
1. Spectrum Sheet
2. Consensus statements
3. Fact sheet
4. List of resources
   - Pathway materials – OTHC descriptions
   - AOTA SPCC
   - Driving & Community Mobility Book
   - AOTA Website
   - Practice Guidelines
   - NHTSA – Fact sheets & videos
   - CEs on CDs

Evaluation Plan: Postcard – Send back to you on what resources were most helpful.
Mary Jo record: Reason for stopping by.
Appendix R.  Post card for AOTA Expo

Thank you for visiting the AOTA Driving Booth in the Transportation Zone at Conference in Nashville!  We hope you learned about resources that may be helpful to you and your clients.  Give us some needed feedback.  Please check off the resources you received or viewed at the booth.  Then circle the resources you found particularly interesting/valuable.  Please add a comment about anything particularly helpful and why.  Thank you!

_________ Spectrum Table       _________ Consensus Statements
_________ Fact sheets                _________ Pathway Materials (OTHC)
_________ Resource Sheet       _________ Web links
_________ AOTA text/SPCC     _________ Driving & CM Practice Guidelines
_________ Hartford booklets  _________ NHTSA Fact sheets & Videos

What did you find particularly helpful?  What additional resources do you need to be able to address driving and community mobility more effectively in your practice?  Or- Comment via email at driverhelp@aota.org  Subject: Driving Booth.  Comments:
Appendix S.  Report from AOTA Booth at Expo  
April 16-18, 2015  
Submitted by Mary Jo McGuire MS, OTR/L, OTPP, FAOTA  
(edited for clarity/brievity by Anne Dickerson)

The 2015 EXPO provided an opportunity for AOTA to network with OT students, practitioners, educators, and the public (other exhibitors) to advance the agenda of safe driving and community mobility, and the role of OT practitioners in supporting this agenda.

“Straw Poll Questions”
An effort was made on Thursday night and Friday 11-4, to collect information from whoever came to the booth, regarding 7 specific questions.

<table>
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<tr>
<th>N = 63</th>
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<tbody>
<tr>
<td>1. Have you ever been on the AOTA Older Driver website? 35% YES</td>
</tr>
<tr>
<td>2. Do you know about the Gaps and Pathways project (and products)? 10% YES</td>
</tr>
<tr>
<td>3. Do you know about the Hartford materials? 32% YES</td>
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<tr>
<td>4. Do you know about AOTA’s book on Driving and Community Mobility? 32% YES</td>
</tr>
<tr>
<td>5. Are you aware that there are Practice Guidelines specifically for Driving and Community Mobility? 35% YES</td>
</tr>
<tr>
<td>6. Do you know that AOTA offers CE on CD? 10% YES</td>
</tr>
</tbody>
</table>
| 7. Do you know what the acronym NHTSA stands for? 9% YES  
(very generous/small errors accepted as YES)  |

32-35%  
- Visited the Older Driver Website  
- Aware of the AOTA Practice Guidelines [AD: Could be in a general sense, about all practice guidelines]  
- Aware of Driving and Community Mobility Book, although did not recognize its use for the generalist.  
- Aware of the Hartford Materials  
10%  
- Aware of the Gaps and Pathways Project  
- Aware of CE on CD  
9%  
- Only two knew what NHTSA is, with other close.  

Therapists were then offered a stamped postcard to take home so that they could further continue to communicate which resources they valued, and/or additional feedback to Elin Schold Davis and Anne Dickerson.

Limitations
In my opinion, the people who would come to the booth are people who want to learn about the subject. People who are familiar with all of the resources, and practicing with high level of awareness of all the resources, would not visit the booth. They have the information they need, and are visiting other booths. Therefore the low numbers regarding awareness of resources is to be expected.
Observations:

- Most of the students and clinicians coming by the booth at the Expo wanted a brief contact, looking for “take-aways” and did not want to engage in much conversation.
- The effort to collect ‘real info’ from them was tolerated when they were offered a token gift. Many left without giving contact info.
- If we want to do a follow-up survey, it may be more beneficial, to be upfront about the desire to collect info, and to offer a “take-away” in exchange for their business card or email address so we can communicate with them after conference.
- Clinicians who use the Hartford materials were very enthusiastic. Many therapists knew about the “At the Crossroads” booklet, and stated they used it in practice. There seemed to be satisfaction with the resource and no comments, concerns or desire for update or changes.
- The Gaps and Pathways Resource Page (2-sided) was very well received; the clinicians appreciated this annotated summary with pictures of the resources.
- Most of the clinicians did not have any name recognition regarding “Gaps and Pathways Project.”
- The Spectrum of Driver Services was well received and ran out.
- Many students stopped by the booth, positive attitude and appreciated the resources.
- Educators were looking for the new CD.
- One educator stated that she is now requiring students to purchase the Driving and Community Mobility text.
- One OTA Educator sought out support for the appropriateness of including Driving and Community Mobility in the curriculum of the OTA student.
- Several doctoral level students stopped by to discuss their intent to investigate and develop better resources regarding alternative modes of transportation. They were encouraged to use the AOTA website, and to reach out to Elin Schold Davis for further support on their work.
- Many students and practitioners stopped by to pick up their Car Fit ribbons. There were others who had no idea what CarFit was. Having the Car Fit ribbons at the booth was a nice touch that provided a reason for folks to reach out for more information.
- Therapists were very interested in hearing about the ARMT, Fitness to Drive, and the Traffic Signs Tests—all available for free online.
- There were a small number of people who asked about how to get AOTA specialty certification; those who asked did not know that it was a competency based process.
- One therapist thought that you HAD to be specialty certified in order to be able to address driving.
- There was no awareness of the one hour CE available on Ethics and Driving, although it was clear the individuals liked the idea and it may be a way to educate and draw therapists into this area.
- Several therapists questioned whether Medicare and the private insurers cover “driving evaluations.” They were very open to the discussion that an OT Evaluation addresses IADLs which include driving and community mobility.

Observations from others at the booth

- A woman from Alaska, where resources are limited, she has to cover a large geography and there is a lack of specialist availability. Her situation presents her with unique
challenges and potentially puts her at risk of doing things that are outside of a generalist’s skill set. I think if we could come up with a way to support people in this scenario, that would be good.

- Another woman from Mississippi who was aware of most of the resources and was doing some partnering with a specialist already. She was discussing that relationship and the relationship with the community. Case studies and/or models of how this could look might be nice.
- Most of the people that I spoke to were new to driving. The majority consisted of students and generalist OT's.
- A woman from Swedish Hospital (Seattle) was interested in a driving simulator for her clinic and another woman who was interested in obtaining resources for her boss who wants to start a driving program in the clinic.
- Most were wanting to learn more about driving and what CarFit is about.
- Two generalist OTs really wanted to learn more about driving and any available tools on the AOTA website. I went into more depth about the "Practitioners Toolkit" and "Gaps and Pathways" topics with them and they were satisfied.
- Another woman was looking specifically for "Community Mobility" resources.
- I was impressed by the OT educators I spoke with and the inroads we have made there.
- There still seems to be a segment that think a simulator is needed for clinical evals, and will help them start a driving program.

Summary from M.J. Maguire

- The currently available resources need to be better advertised and marketed. The stakeholders are not well known; the support of the stakeholders was a very positive issue when discussed with practitioners.
- Many continue to perceive this area as one for the “CDRS” to address, and did not realize that there were resources for the generalist to be able to use. The role of the generalist OT and OTA is not well understood.
- Myths and attitudes regarding reimbursement continue to be an issue. The various “pathways” has created some confusion. Many OT practitioners actively state that “driving evaluations” are not reimbursable, and use this as a reason not to address driving and community mobility. The internal conflicts related to this have a negative impact on the advancement of the role of the generalist in this area.

Recommendations from M.J. Maguire

- The booth needs a literature rack where information/booklets/handouts can be displayed. Could there be one for professionals and one for clients.
- Continued development of resource handouts. Consider one that could provide the generalist with information regarding quick access of some foundational tools for use in practice. Give websites with descriptions.
- Consider a NHTSA booth- The National Highway Traffic Safety Administration is NOT a well known entity to most members of the OT profession.
- Have give aways – could we give flashdrives with resources on them.
- Have Hartford materials handy to give away.
• Clarify Roles and Credentials - Clear handout regarding what various levels of clinicians CAN DO, and what the various credentials enable someone to do (along with basic eligibility criteria).
• Highlight the ethics hour of education.
• Website information needs to be highlighted.
Thank you for visiting the AOTA Driving Booth in the Transportation Zone at Conference in Nashville! We hope you learned about resources that may be helpful to you and your clients. Give us some needed feedback. Please check off the resources you received or viewed at the booth. Then circle the resources you found particularly interesting/valuable. Please add a comment about anything particularly helpful and why. Thank you!

☐ Spectrum Table  ☐ Consensus Statements
☐ Fact sheets ☐ Pathway Materials (OTHC)
☐ Resource Sheet ☐ Web links
☐ AOTA text/SPCC ☐ Driving & CM Practice Guidelines
☐ Hartford booklets ☐ NHTSA Fact sheets & Videos

What did you find particularly helpful? What additional resources do you need to be able to address driving and community mobility more effectively in your practice? Or- Comment via email at driverhelp@aota.org Subject: Driving Booth. Comments:

[Handwritten note: would love more variety of videos]
Appendix U. Survey Results Summarized for Expert Summit
March 5, 2015

1. We have moved from the “older driver” to the “medically-at-risk driver” when describing the at-risk or unsafe driver.
   a. 62% agree;
   b. 24% disagree;
   c. 13 comments
      • “moving in that direction.”
      • Medically-at-risk – include all drivers with medical conditions
      • Medically-at-risk – does it include normal aging?
      • Depends on services are defined in terms of primary, secondary, tertiary prevention.

2. Almost all agreement on the statement that medically-at-risk driver requires access to services by an array of providers that are able and qualified to provide such services.

3. Supporting the NHTSA guideline to establish a MAB.
   a. 85% agreement
   b. Several commented using health care professional or professionals with expertise in older adult transportation, rehab, counseling, or adult service providers.
   c. The need to show that it benefits.

4. Pathways between stakeholders facilitate the use of core services and components of a local/regional/national safety net to support the medically at risk older driver to remain safely mobile and engaged citizens.
   a. 90% agreement on the premise
   b. Some comments about the wording

5. What resources are useful (everyone offered something):
   a. Knowledge: resources in education, training, services
   b. Physicians Guide & Hartford booklets
   c. NHTSA Toolkits, videos, fact sheets,
   d. AOTA resources (website, printed materials)
   e. Referrals to DRS: BTW evaluations,
   f. Screening tools (e.g., DHI, AAA, AARP)
   g. Medical advisory boards

6. Why useful: professionals need an array of go-to materials, not all about education – need to improve awareness and communication, all are developed with variety of target audiences, important for clients and families.

7. Most valuable resources: factors that contribute to this decision:

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8. Resources useful to older drivers and families.
   a. Similar to what has been expressed.
9. What are the barriers to meeting the needs of medically at risk drivers?
   a. Availability and access
   b. Emphasis of the problem/ lack of awareness/lack of understanding by public, medical profession, (specifics – MAB, resources, )
   c. Changes in transportation/ lack of alternative transportation
   d. Client fear, reluctance of physician to report,
   e. Availability to driving assessments and/or CDRS, high cost of assessments, limited intervention, lack of reimbursement, lack of OTs understanding their role and contributions,
   f. Client fear
   g. Lack of a good screening tool

10. Barriers to meeting the needs:

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<td>Inadequate resources/skill levels</td>
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</table>

Lack of alternative transportation!!

11. What do I bring – wonderful perspectives – so exciting to see what is going to happen at this meeting.