CHAPTER 5  THE DRIVER REHABILITATION SPECIALIST

Key Points

- A driver rehabilitation specialist (DRS) is a health care professional who is best qualified to make a fitness-to-drive decision when the at-risk older adult has functional impairments in physical, visual, or cognitive abilities.
- A comprehensive driving evaluation is completed by a DRS and includes clinical assessment of underlying component abilities, a medical and driving history, an on-road evaluation, and an alternative transportation plan if needed.
- Older adult driving programs vary in terms of typical providers, costs, availability, required knowledge, services provided, and according to the level of complexity of adaptive vehicles (i.e., basic, low tech, high tech), types of programs, and outcomes.
- Not all older adults require the specialized services of a driving rehabilitation specialist. Screening and assessment by appropriate clinical team members can collect necessary information for evidenced-based decisions.
- Before referring to a DRS, advise the older adult about the reason for the referral, the goals of the assessment and rehabilitation, the evaluation and tests that will be done, and the expected out-of-pocket cost for these services.

After scoring Mr. Phillips’ (introduced in previous chapters) performance on the CADReS toolbox assessments, you discuss the results with him. You assure him that he scored well on the cognitive tests, but that his performance on the visual and motor tasks indicates a need for further evaluation and treatment. You recommend that Mr. Phillips make an appointment with his ophthalmologist, whom he has not seen for over a year. You also recommend that he begin exercising regularly by walking for 10-minute intervals, three times a day, and stretching gently afterward. His son, who is present at the clinic visit, offers to exercise with him several times a week.

When Mr. Phillips arrives for his follow-up appointment, he is wearing new glasses. His vision with the new glasses is 20/40 in both eyes. You retest his motor skills, and he is now able to complete the Rapid Pace Walk in 8.0 seconds. His range of motion on finger curl and neck rotation, however, remains restricted and his Trails B test has not improved. With Mr. Phillips’ agreement, you refer him to a driver rehabilitation specialist (DRS) for an evaluation and adaptive equipment, if necessary.

Although there may be improvement in visual, cognitive, or physical abilities, older adults may still demonstrate functional impairments that affect their driving performance. In these cases, a driver rehabilitation specialist (DRS) is an excellent resource to explore solutions supporting continued driving. A DRS can perform a comprehensive driving evaluation that includes in-depth clinical assessment of functional abilities plus an on-road driving assessment.
the older adult’s performance, a DRS develops a summary of the evaluation results and an individualized plan for safe mobility. This plan may include any of the following:

- A recommendation for continued driving with or without restrictions (e.g., no night driving, no highways)
- An “interval recommendation” for reevaluation because of progressive conditions (e.g., early dementia, Parkinson disease). This may include a driving cessation plan (see Appendix C).
- Intervention to restore abilities (e.g., improve range of motion, strength, or flexibility)
- Adaptive techniques or the use of devices to compensate for functional deficits (e.g., hand controls, left foot accelerator)
- A recommendation for the older adult driver to cease driving

This last, difficult recommendation typically is followed by a plan to explore resources, alternative forms of transportation, and the supports the older adult requires (e.g., escort, curb-to-curb, or door-to-door). An example may be found in Appendix C. For those unwilling or unable to understand the cessation recommendation, caregivers should be provided with strategies to prevent access to the car and to manage ongoing resistance and arguments demanding access to the car. Other clinical team members may also be helpful when supporting older adults and caregivers who lack insight.

This chapter provides information about driver rehabilitation, the clinical specialty that offers comprehensive driving evaluation and planning, and what data is required to respond to the question, “Can_____drive?” For the clinical team, this question may follow an interaction with the older adult driver or a request from his or her caregiver. Physicians and nurse practitioners in particular may be asked to respond if the older driver receives a letter from a Medical Review Board, vehicle licensing agency, or law enforcement. An example may be found in Appendix C. Health care providers may be asked to complete a State medical reporting form such as the example found at http://dor.mo.gov/forms/1528.pdf.

The Driver Rehabilitation Specialist Defined

DRSs “provide clinical driving evaluations and driving mobility equipment evaluations and intervention to develop or restore driving skills and abilities.”1

DRSs are often occupational therapists who have additional training in driver rehabilitation. In addition, DRSs with underlying degrees in medical fields may come from backgrounds such as physical therapy, kinesiotherapy, or psychology. Those with nonmedical backgrounds tend to come from transportation and community mobility backgrounds, such as driving school instructors.

Two national associations offer certification in driver rehabilitation. The Association for Driver Rehabilitation Specialists (formerly Association of Driver Educators for the Disabled, still known as ADED) requires education and experience qualifications and passing a certification examination (www.aded.net/?page=215). Persons of varied backgrounds may apply for
certification through ADED. ADED also requires that the certified driver rehabilitation specialists (CDRSs) renew their certification every 3 years by fulfilling a minimum amount of contact hours. The American Occupational Therapy Association (AOTA) offers Specialty Certification in Driving and Community Mobility (SCDCM) (www.aota.org/Education-Careers/Advance-Career/Board-Specialty-Certifications/Driving-Community-Mobility.aspx). This portfolio-based professional certification is awarded on approved application by a credentialing body at AOTA. The SCDCM includes a development plan and must be renewed, via application, every 5 years. Only occupational therapists may apply through AOTA for certification for this advanced level of achievement. Although many DRSs either hold certification or are in the process of obtaining the necessary education and experience to sit for the examination, in most States certification is not required to practice driver rehabilitation.

**Functions of Driver Rehabilitation Specialists**

DRSs evaluate the sensory (vision, proprioception), cognitive, and motor functional abilities which support driving skills, and may also provide assessment and/or training in the vehicle and on the road. DRSs can recommend either rehabilitation when restoration of abilities is deemed possible, or modifications (e.g., hand controls, left foot accelerator) to compensate for physical impairment. To address issues of normal aging and slowed processing, DRSs can recommend compensatory strategies that may include route modifications (e.g., no left turns, avoid rush hour) or suggest restrictions to support ongoing driving. Although driver rehabilitation programs vary, most typically consist of a comprehensive driving evaluation that includes the following elements:

**Clinical Driving Evaluation**

- Clinical assessment, including review of driving history, driving needs, and license status; review of medical history and medications; functional assessments of vision/perception; physical abilities (may include range of motion, motor strength, coordination, sensation, and/or reaction time); and cognition.
- On-road evaluation to determine degree of safety risk for driving, including assessment of vehicle ingress/egress, mobility aid management (e.g., ability to transport a wheelchair or scooter), vehicle preparation, vehicle control, adherence to traffic rules and regulations, environmental awareness and interpretation, and consistent use of compensatory strategies for visual, cognitive, physical, and behavioral impairments.
- Communication of assessment results and recommendations to the older adult, the caregivers, and/or referring health care provider/agency. Although this is the most frequent model, the process for communication of results may vary by program model and local referral agreement. Variations include sending driving evaluation results to the clinical team to relay to the older adult driver and caregivers:
- Return to driving with adaptive driving equipment and instruction after installation and/or driver retraining using a vehicle equipped to match the older adult’s individual needs.

- Recommendations consistent with State laws for continued driving with restrictions. Some States do not offer restrictions, whereas others may limit geographic areas (e.g., 5-mile radius from residence or local routes) or conditions (e.g., no night or highway driving) in which the older adult drives. *(Note: Recommendations are informal, but “Restrictions” describe a licensing action associated with the license similarly to how listing a required vision correction is part of licensure.)*

- Return to driving after education or refresher, including self-study, classroom, or on-road. It is important to specify if the intention of seeking on-road driving lessons is to establish/maintain defensive driving skills.

- Interval” reevaluation is indicated when an older adult demonstrates adequate skills to drive at present but has a progressive disorder that may cause future decline (e.g., dementia, Parkinson disease).

- Temporary driving cessation, noting potential for improvement and driving in future. Recommend intervention to improve deficits in vision, perception, motor and/or cognition. This is advised when the older adult has medical condition(s) that can improve over time (e.g., stroke, heart attack, traumatic brain injury) and can return for reevaluation.

- Permanent driving cessation. This is advised when an older adult does not demonstrate the necessary skills to compensate for visual, perceptual, or cognitive deficits to safely resume driving, and the potential for improvement, even with intervention, is poor. In these cases, the message is that all options were explored and considered. Alternative transportation options and a support network should be addressed with the older adult.

**Passenger Vehicle Evaluation**

- Assessment of vehicle, vehicle modifications, and equipment needed for the older adult’s safe transport as a passenger or driver.

- Needs of caregivers as drivers or passengers should also be considered (e.g., inability to assist with transfer due to arthritis, limitations in stowing mobility devices, transporting scooter). In these cases, certain lifts or tie-down systems may be recommended because of a caregiver’s physical limitations.

**Treatment and Intervention**

- Adaptive driving instruction or driver retraining, with or without vehicle modifications.

- Coordination of vehicle modifications:
Vehicle consultation: The DRS serves as a consultant to older adults who are purchasing a new vehicle to ensure that the vehicle will accommodate the necessary mobility limitations (door opening or seat height to optimize ease in transfer, ease in applying adaptive equipment now or in the future).

Vehicle modification recommendations: The DRS provides written recommendations for all vehicle/equipment needs to the older adult driver, third-party payer, and vehicle/equipment dealer.

Adaptive Equipment/Vehicle modification inspection: The DRS is involved with the older adult and adaptive equipment dealer in a final fitting to ensure optimal functioning of the recommended vehicle/equipment.

A comprehensive driving evaluation can last 1–4 hours, depending on the older adult’s disabilities and driving needs. After the clinical driving evaluation, the on-road evaluation is performed if the older adult driver meets the minimum State standards for health and vision and holds a valid driver’s license or permit. The on-road evaluation is performed in the DRS’s vehicle equipped with dual brakes, a rear-view mirror and eye-check mirror for the DRS, and any necessary adaptive equipment. (Note: Some programs divide the evaluation into 2 days in consideration of fatigue or require on-road driving on two separate occasions to evaluate for consistency).

Older adults who perform poorly on the clinical driving evaluation may or may not be offered the on-road portion of the evaluation. If the older adult driver is deemed too impaired, the risk to the driver and evaluator may preclude an on-the-road evaluation for safety reasons. However, even after poor performance on the clinical driving evaluation, the DRS may still conduct an on-road evaluation in some cases:

- Older adults who perform poorly on some individual components of the clinical driving evaluation may still demonstrate safe driving because there is no assessment tool that accurately predicts on-road performance as clearly as the on-road assessment and driving is an overlearned skill.²,³,⁴
- Older adults and their family and caregivers may need concrete evidence of unsafe driving. However, in the case of the older adult with cognitive impairment that lacks insight, the on-road evaluation may in fact not change their perception.
Older Adult Drivers Who Can Benefit from Driver Rehabilitation Specialists

Driver evaluation and rehabilitation are appropriate for older adult drivers with a broad spectrum of visual, physical, and/or cognitive disabilities. DRSs work with older adult drivers who have dementia, stroke, arthritis, low vision, learning disabilities, limb amputations, neuromuscular disorders, spinal cord injuries, mental health problems, cardiovascular diseases, and other causes of functional deficits.

Vehicle modification can be as straightforward as providing extended gear shift levers, padded steering wheels, or extra/larger mirrors to patients with arthritis, and training the older adult driver in their use.

Rehabilitation can also be as complex as working with an older adult with dementia and his or her caregivers to determine the individual’s driving needs, plan appropriate driving routes (e.g., avoiding left hand turns or busy intersections), supervise practice drives, and provide close and extended follow-up.

Services of Driver Rehabilitation Specialists

Because driver rehabilitation is a multidisciplinary profession, programs are diverse and provide services at different levels; clinical team members should recognize which level is needed when referring an older adult driver to a DRS.

The three main levels of DRS programs can be defined as basic, low tech, and high tech (Table 1, Appendix C). The basic program is appropriate for older adult drivers with limited physical impairments who require only very basic adaptive equipment in the vehicle. The low-tech program can address the needs of older adult drivers who may need mechanical or low-tech vehicle modifications or equipment (e.g., hand controls, left foot accelerator, spinning knob for one-handed steering), including training in safe use on the road. The high-tech program is necessary for older adults who need to drive from a wheelchair or need high-tech equipment, such as low-effort steering.\(^1\) Upper level programs also provide basic program services.

Other services can also provide support for some older adults without specific medical conditions who may need help with driving. For example, if an older adult has a stroke and can no longer drive, and the spouse has a license, but has not driven in 10 years, referring the spouse to a driving school for a driver refresher course may improve confidence and safety.

Ideal programs will offer road time with a driving instructor. Conversely, if an older adult demonstrates clear impairments in other instrumental activities of daily living (IADLs) but is focused on the IADL of driving, the clinical team could consider referral to a general practice occupational therapist who can offer a traditional professional evaluation of IADLs, including high level/complex IADLs. The question of driving competence may be the first clue the clinical team has that may lead to a general review of IADL status and intervention goals to improve quality of life. Through this pathway, the clinical team and/or the occupational therapist can determine when or if the older adult may be prepared to benefit from comprehensive driving evaluation.
Performing a driving evaluation too early in an older driver’s recovery may result in failure that could be misunderstood as permanent, such as in patients with stroke who have not fully recovered. If the older adult agrees to not drive until evaluated, delaying until after a recovery period of 6 to 12 months, the outcome may be more favorable, preventing premature driving cessation.

It is important to note that the services of an occupational therapist are covered by third-party payers, Medicare, and Medicaid.

**Cost of Driver Assessment and Rehabilitation**

The cost of driver assessment and rehabilitation varies between programs and according to the extent of services provided. As a general figure, the range of the private-pay model is currently about $300 to $600 for a full assessment and $125 an hour for rehabilitation. If adaptive equipment is required, sample costs might be approximately $70 to $100 for a spinner knob, $400 to $500 for a left foot accelerator, and $700 to $900 for hand controls. Costs for reduced-effort steering systems, wheelchair lifts, raised roofs, and dropped floors on vans run in the thousands of dollars.

Two programs that have funding to cover expenses associated with comprehensive driving evaluations, driver rehabilitation, and vehicle modifications are States workers’ compensation and vocational rehabilitation programs. These programs focus on the disability population and return-to-work, so many older adult drivers will not qualify for either program. Coverage from Medicare, Medicaid, and private insurance companies is variable and depends on local interpretation of policies (e.g., government fiscal intermediaries). The Veterans Administration programs may also cover DRS evaluations and training for spinal cord and mobility-related injuries, although not all States have a VA driver rehabilitation program. Many driver rehabilitation programs choose to offer private pay only, because current reimbursement models are inadequate to cover the expenses of this individualized and highly trained service. Because rates and extent of insurance reimbursement vary, older adult drivers should be encouraged to inquire about program rates, insurance coverage, and payment procedures when they are required to pay up-front and receive reimbursement at a later time.

Of interest, a recent source of funding for DRS services has been for one automobile insurance company to add reimbursement for a comprehensive driving evaluation to its auto insurance plan in some regions, if performed by a DRS who is also an occupational therapist, for up to 3 years after an accident and up to $500. When balanced against the personal and global costs to the older adult driver and the community of a crash, or services needed to support an older adult lacking independent mobility, this may prove to be a cost-savings strategy.

**Finding a Driver Rehabilitation Specialist**

Driver rehabilitation programs and DRSs are located across the country, although availability is typically in urban areas or large medical centers. DRSs can be in private practice or affiliated...
with hospitals, rehabilitation centers, driving schools, and State departments of motor vehicles. DRS services may also be accessed through area agencies on aging, universities, and area departments of education. Before referring older adults to driving rehabilitation services, it is important to ensure the appropriate level of service needed is available. The credentials and knowledge level of the provider, typical services provided, and expected outcome should match the needs of the older adult driver and caregivers. A background in driver education alone is likely insufficient for appropriate assessment of medically impaired drivers and correct interpretation of the assessment.

To find a DRS in the local area, calling the occupational therapy departments in local hospitals or rehabilitation centers is a good place to start. The local chapters of subspecialty organizations such as the Alzheimer Association may keep up to date driving evaluation program information on their websites. The ADED’s online directory is a good source of information (http://aded.site-ym.com/search/custom.asp?id=1984) and lists DRS services by State and type of program. The AOTA website is another source to locate a DRS by State (http://myaota.aota.org/driver_search/index.aspx). Many local chapters of the Alzheimer’s Association (www.alz.org/care/alzheimers-dementia-and-driving.asp) also provide lists of area driving evaluation programs.

When selecting a DRS or driver rehabilitation program, the older adult driver and/or caregivers may wish to inquire:

- How many years of experience does the DRS (or program) and what types of clients do they serve? In many cases, experience may be a more important indicator of quality than certification alone. There are many well-qualified DRSs who are not certified.
- Does the DRS provide a comprehensive driving evaluation that includes both clinical and on-road assessments? A DRS who provides both components of the evaluation (or a program whose team of specialists perform both components) is ideal. Referral to two separate specialists or centers is inconvenient for the older adult and the clinical team member and often presents a greater insurance reimbursement challenge. In addition, some programs use a driving simulator program, which should not be used to replace the on-road component. Simulators have the advantages of reliability and safety, but they are not standardized and have limited validity when compared to the performance based road test. In addition, in older adults they may induce motion sickness, which can limit the findings.
- Does the DRS provide rehabilitation and training? A comprehensive DRS provider and/or program should ideally be experienced in both evaluation and rehabilitation. If the older adult driver will likely need any adaptive devices or vehicle modifications, he or she and their caregivers should go to a “low tech” or “high tech” program (see Appendix C) that has the appropriate equipment to evaluate and train the driver in their use.
- How much can the older adult driver expect to pay out-of-pocket for assessment, rehabilitation, and adaptive equipment?
- Who will receive a report of the assessment outcome? Most of the time, reports are
sent to the older adult driver and to the referring clinical team member and/or referring agency (e.g., workers’ compensation or office of retirement services). Some DRSs also send reports to caregivers, at the request of the caregiver and with the older adult’s consent. Whether or not the DRS reports to the State licensing agency is variable and should be clearly stated before the evaluation is initiated. In States with mandatory reporting laws, the DRS and/or physician may send a report to the State licensing agency; even if reporting is not legally required, some DRSs will still send a report in the interest of public safety and ethical responsibility.

- If the older adult receives recommendations to cease driving, does the DRS provide any counseling or aid in identifying alternative forms of transportation? Note that DRS counseling does not preclude the need for follow-up by the clinical team. Many times, the older adult and caregivers may be too distressed at the time of DRS counseling to deal with additional information. Mobility counseling is crucial for reinforcing this information and providing continued mobility in the community, as well as demonstrating the health care provider’s involvement and support.

Making the Referral

Before making the referral, advise the older adult about the reason for the referral, the goals of the assessment and rehabilitation, the evaluation and tests that will be done, and the expected out-of-pocket cost for these services.
“Mr. Phillips, I’m pleased that you can see better with your new glasses and that your physical fitness has improved with your walking. I’d like you to keep up the good work. However, I’m still concerned about slowed processing and ability to move your neck. I’m worried that you can’t see around you well enough to drive safely. I’d like to send you to someone who can assist us with your driving abilities. Consider this a kind of “driving check-up” to be sure you are fit to drive.

“A person called a driver rehabilitation specialist will ask you some questions about your medical history and test your vision, strength, range of motion, and thinking skills—similar to what we did the last time you were here. He or she will also take you out on the road and watch your driving. He or she might recommend some accessories or modifications for your car, such as extra mirrors, and show you how to use them.

“The cost of these assessments ranges anywhere from $300 to $400, and there may be additional costs for accessories or rehabilitation training. However, it is possible that insurance may pay for part of the assessment and training. I know this sounds like a lot of money, but I think this is important for your safety. If you were in a serious car crash, your medical bills or the costs for someone you injured could end up costing you more money. We should try to prevent that from happening.”

Some programs require a written physician prescription, others may not. Understanding your local requirements or clinic policies are important to appropriately and efficiently referring the older adult. A driving evaluation prescription should list specific reasons and needs that justify the evaluation and/or rehabilitation. For example, “OT driver evaluation for hand weakness such as poor finger flexion or for limited neck rotation secondary to arthritis,” “DRS evaluation for hemianopsia secondary to stroke,” or “DRS evaluation for cognitive impairments secondary to Alzheimer disease” provide guidance for the DRS and are more likely to be reimbursed by insurance. (Most DRS programs will also send the physician a referral form that includes space for a list of current diagnoses and medications.) In contrast, vague orders for “an older adult,” “debilitated,” or “frail” older adult do not provide adequate guidance to the DRS and can complicate insurance reimbursement.

If appropriate and feasible in the clinical team setting, a follow-up appointment should be scheduled for after the driving evaluation. If the older adult is safe to drive (with or without restrictions, adaptive devices, and/or rehabilitation), recommendations made by the DRS should be reinforced. When applicable, caregivers should be informed of these recommendations. Also remember that older adult drivers should be counseled on health maintenance and safe driving behaviors, and encouraged to start planning alternative forms of transportation in case they ever become necessary. If the older adult is not considered fit to drive, then mobility access should be ensured and followed up with services that support driving cessation (see Chapter 6).
Special mention is made of other rehabilitation specialists who may help address impairments that are not uncommon in older adults. For instance, physical therapists may be able to improve muscle weakness, range of motion, or physical fraility. Visual rehabilitation may be available in some specialized centers. Neurophthalmologists or optometrists may provide vision training, especially for older adults with neurologic insults that affect convergence, alignment, nystagmus, eye apraxia, and/or visual neglect from stroke, head injury, brain tumors, and trauma.

**When Driver Assessment Is Not Option**

Unfortunately, driver evaluation and rehabilitation services may not always be readily available in the local area. Even if a DRS is available, the older adult may refuse further assessment or be unable to afford it. However, some patients and caregivers in DRS shortage areas may be willing to travel to have this type of evaluation, particularly if the chances are good that the evaluation may result in prolonging driving life expectancy and safety.

It is important to distinguish whether this is an elective recommendation or essential to ongoing driving. If the latter, steps for stopping driving until assessment is done must be clearly communicated to the older adult driver and caregivers and, if necessary, also to the State licensing authority. Older adults who refuse on the basis of cost should be reminded that operating a motor vehicle is expensive and that this type of assessment is critical for safety and important when considered against the cost of a motor vehicle crash. It is the clinician’s ethical duty to report to the licensing authorities, if there are clear indications that the older adult is demonstrating unsafe driving practices with resulting risk to themselves and the public.

If comprehensive driving evaluation through a DRS is not available, there are several options:

- **Advocacy efforts** can be undertaken to inform local rehabilitation providers that the clinical team is seeking local driving rehabilitation services for older adults. Rehabilitation providers must know of local interest to recognize the need for program growth.

- **Most occupational therapists** are “generalists” who can provide an occupational therapy evaluation of IADLs. (These are typically provided services reimbursed by Medicare and Medicaid as occupational therapy services). Because driving is an IADL, these assessments can be used to determine driving risk and potential for risk. Occupational therapists in general practice may also be able to perform specific assessments that provide results correlated to driving risk as well as mobility counseling. Referral to these types of health professionals may actually be a more widely available option in many communities.

- **Driving education specialists** are often based at high schools or affiliated with programs for novice drivers. Some of these specialists have developed experience in assessing and counseling older adult drivers. Certain instructors may also be affiliated with a medical facility and provide the on-road component of the comprehensive driving evaluation.
• Private driving schools and driving education programs may be available in the local area. However, they may not have expertise in evaluating older adults with medical impairments.

• Further evaluation by another health professional such as a geriatrician, neurologist, psychiatrist, or neuropsychologist can be considered for an older adult who has a chronic condition such as Alzheimer disease or an episodic acute illness (e.g. seizure disorder).

• If changes in driving behavior are likely to improve the older adult’s driving safety (e.g., avoiding driving at night, rush hour, adverse weather conditions, etc.), the clinical team member can make recommendations. However, officially, State policies vary in the area of restrictions. Strict adherence to these policies can be made a condition for licensing through the State licensing agency or Medical Review Board. State policies should be checked before making these recommendations. It also has to be acknowledged that the research literature on the benefits of license restriction is not clear. In general, when possible, it is generally better to lean towards driving autonomy with license restriction, but if there are concerns that the older adult would not honor the restrictions then driving cessation may be the best option.

• If the older adult’s driving safety is an urgent concern, the clinician may wish to report to the State licensing agency, which will have steps to follow that may include a State driving assessment. Depending on the particular State’s reporting laws, physicians may be legally responsible for reporting “unsafe” drivers to the State licensing agency. (For a discussion of the legal and ethical issues, see Chapter 7; for a list of State licensing agencies and other resources on State laws, see Chapter 8.) The older adult should be made aware of the referral/report to the State licensing agency, which should be documented and also offered to the older adult in writing. This may place the clinical team member in a difficult position. Many States require physicians to fill out forms that require medical information and vision testing results and to provide an opinion on whether the driver should undergo visual and/or on-road testing.

• If the older adult has no medical contraindications to continued driving, he or she should be offered education and handouts such as the Ten Tips for Aging Well and Safe Driving Tips (available in this guide). All older adults should be encouraged to develop a driving plan, and to become familiar with and able to successfully access alternative forms of transportation. Planning ahead is invaluable to support aging in place while bridging short- or long-term disruptions in the most common and familiar form of transportation—the personal vehicle.
References


