



# Reporting to SGI by Occupational Therapists

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# WHY ?

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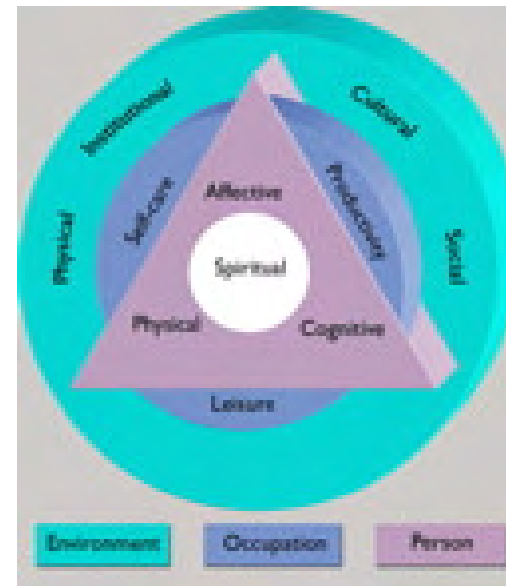


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# Driving is . . . . .

- An instrumental activity of daily living
- An important component in community mobility
- A valuable occupation



# Our 'Mobility' Lifespan



*Walking*



*Get your license!*



*Road Trips...*



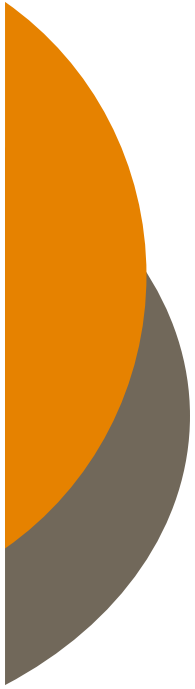
*Driving Cessation*

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# What is your own view of the task of driving?





## So who are the medially at risk drivers?

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# Medical Standards address 3 different types of conditions

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- **Functional limitations**
  - certain medical conditions or combinations of conditions lead to limitations in functional capabilities.
- **Associated Risk**
  - where the risk of a catastrophic event due to a medical condition may be judged to be unacceptable.
- **Use of substances judged incompatible with driving**
  - illicit drugs, alcohol and medications may interfere with fitness to drive.

## Conditions

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### ➤ Age-related Changes

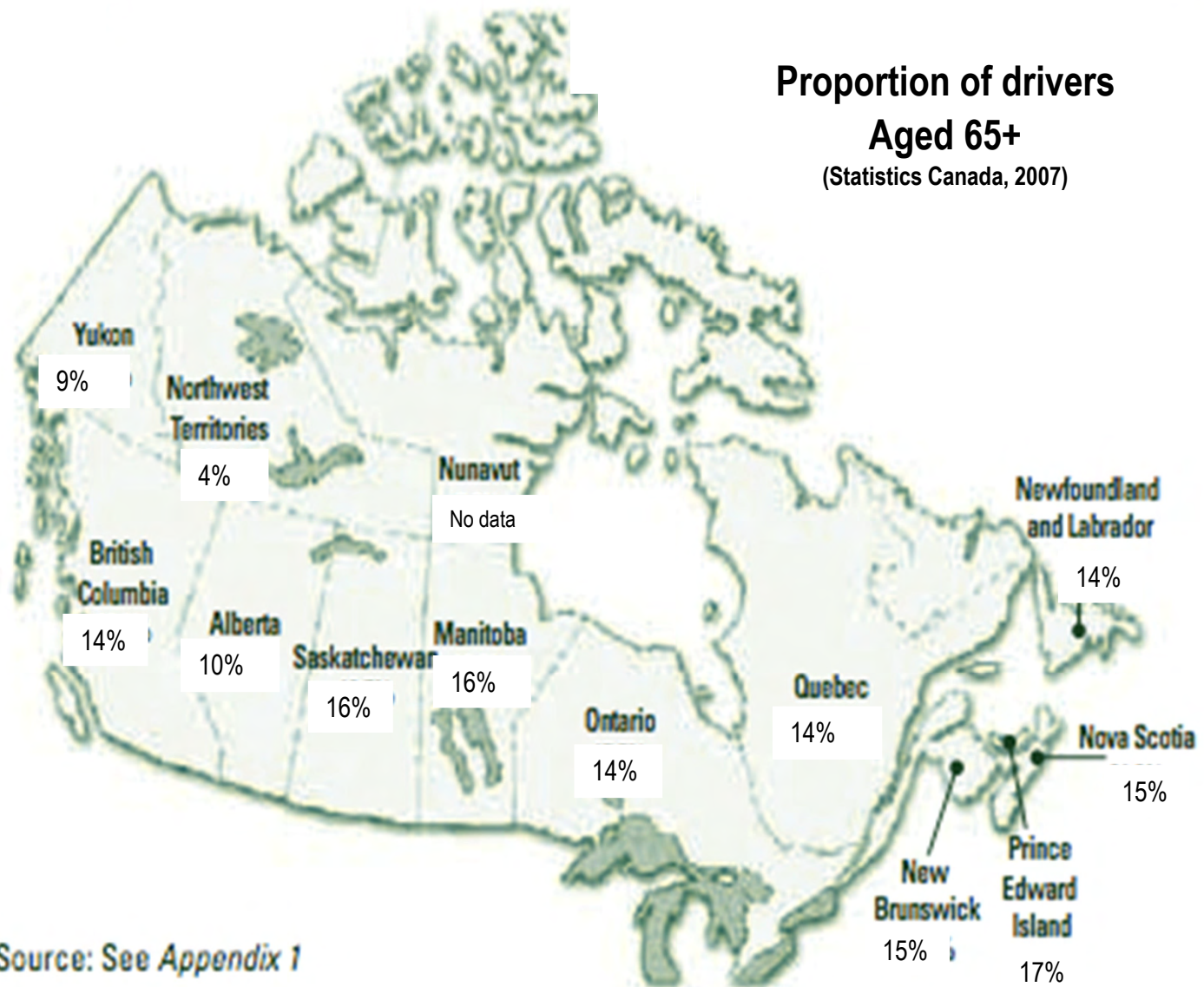






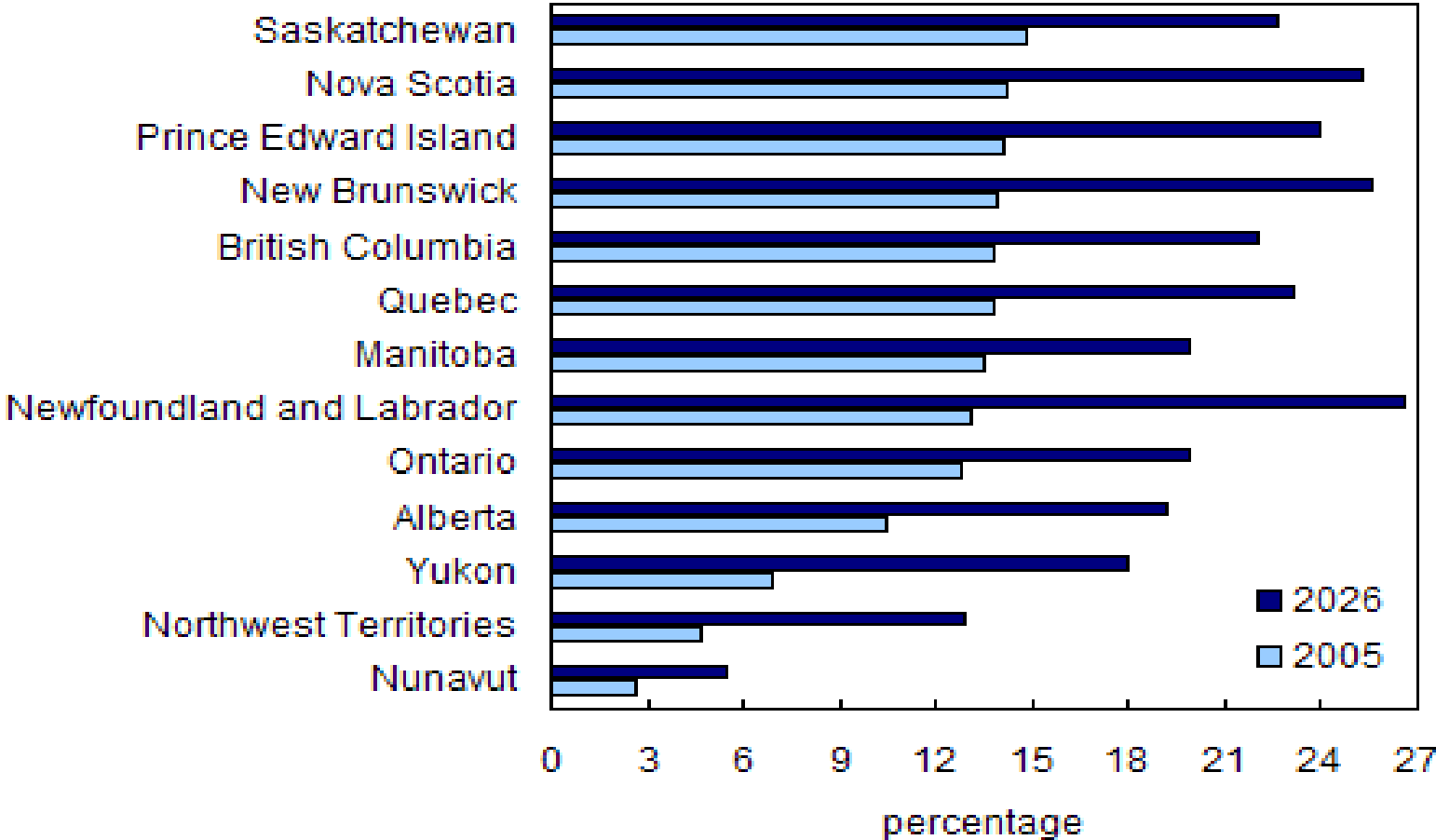
## Proportion of drivers Aged 65+

(Statistics Canada, 2007)



Source: See Appendix 1

# Percentage of population aged 65 or older comprised of seniors, by province, 2005 and projection for 2026



Sources: Statistics Canada, Censuses of Canada; Population Estimates, Population Projections for Canada, Provinces and Territories, 2005.



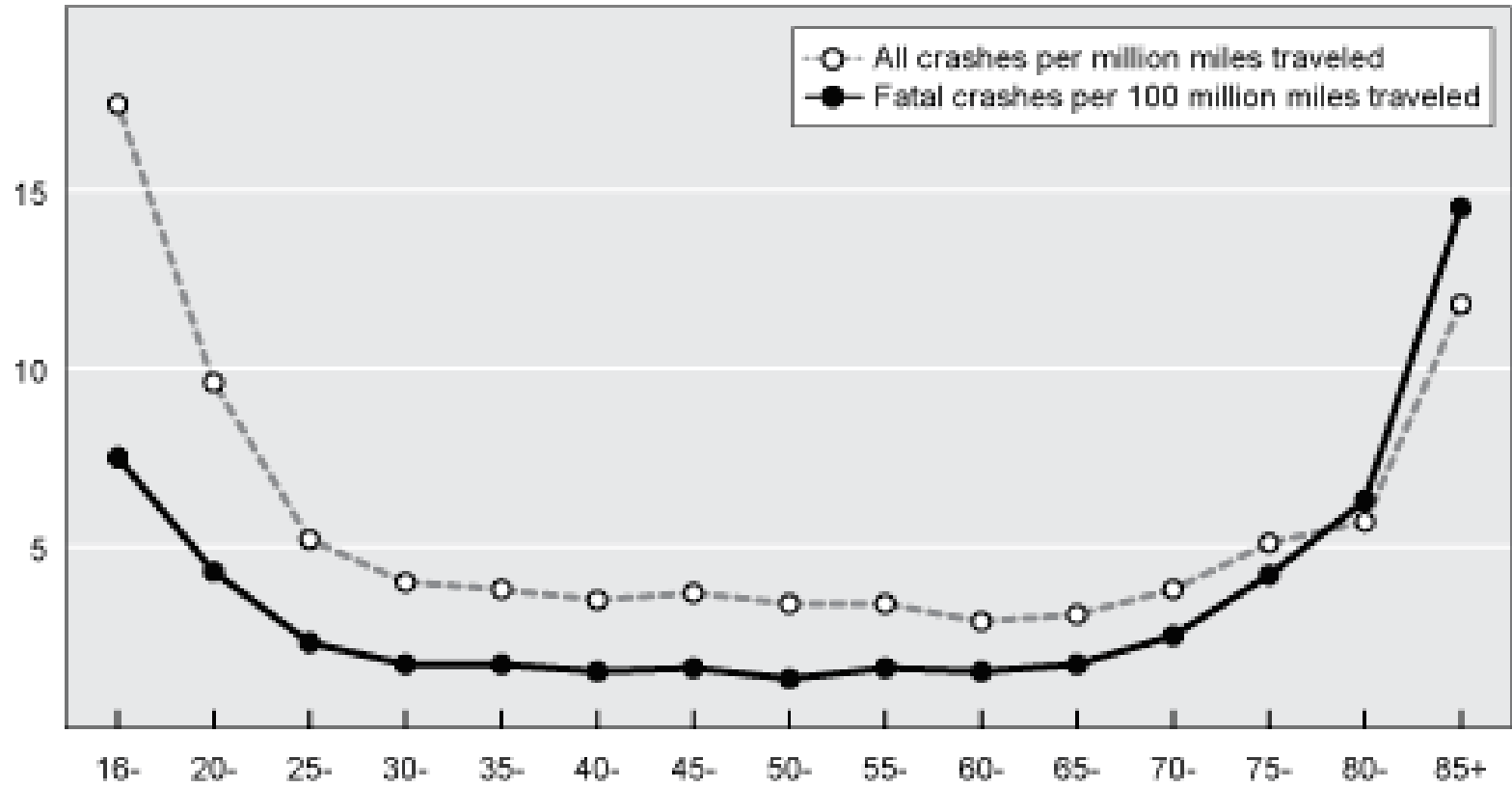
# An aging Canadian population means increased incidences of:

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- Dementia
- Stroke
- Diabetes
- Arthritis
- Visual disorders
- Etc...

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## Conditions

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- Early Alzheimer's or Dementia
- Acquired Brain Injury
  - Includes traumatic and pathological (including CVA)
- Musculoskeletal injury
  - Amputations, multi-trauma, arthritis, etc.
- Spinal cord injury
- Neurological conditions
  - Parkinson's, Multiple Sclerosis, Neuropathy , Muscular dystrophy, etc.

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## Conditions

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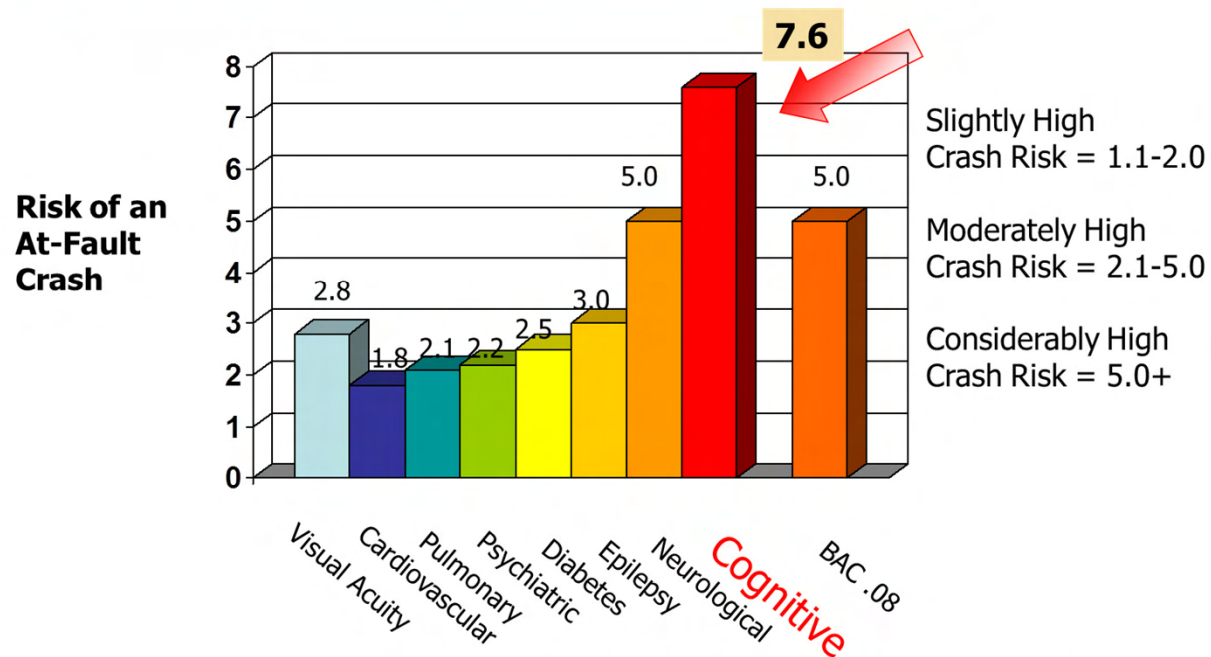
- Congenital disorders
  - Spina Bifida, Cerebral Palsy, etc.
  
- Visual Health Conditions
  - Retinitis Pigmentosa, Macular Degeneration, Visual Field Deficit, etc.
  
- Psychiatric
  - Anxiety, Schizophrenia etc.
  
- Other
  - Although not usually the primary reason for referral, many clients have diabetes with vision changes that are a concern for driving.
  - FASD, Asperger's, HFA, ADHD, LD, Low IQ
  - Bariatric
  - Conditions associated with short stature

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# Health Conditions & Crash Risk

## Health Conditions & Crash Risk



(See Vernon, 2002; Vaa 2003; Sagberg, 2003; Charlton 2004; Dobbs, 2002 [Red Flags])

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# Medical Conditions that are not compatible with driving



- Unstable/untreated seizure disorder
- Unexplained/Recurrent Syncope
- Unstable cardiac
- Unstable or unpredictable hypoglycemic episodes
- Non-integrated startle reflex (CP) or uncontrollable/unpredictable spasms
- Active psychosis
- Untreated cerebral aneurysm
- Severe dementia
- Certain vision deficits



What role is there for OT in determining the capacity for safe driving?



OCCUPATIONAL THERAPY  
DRIVING ASSESSMENTS

# What role is there for OT in determining the capacity for safe driving?

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- As OTs, we are asked to identify drivers who may be at risk from a medical perspective.
- OT's in general are NOT being asked to determine driving competence, unless this is the mandate of their program e.g. DEP or DAP
- SGI will make final determination based on all information that they have available e.g. medial reports, police reports, road tests, etc.

# What role is there for OT in determining the capacity for safe driving?

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- Generalist
  - Ask each client about community mobility in the context of assessment.
  - May perform basic screening
  - May provide general education on community mobility, driving alternatives, warning signs.
  - May gather information from functional observation that suggests driving concerns exist

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# What role is there for OT in determining the capacity for safe driving?

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## Advanced training

- Screening, education and functional observation
- Assessments specifically to determine driving readiness or readiness to proceed with the next level of evaluation.
- Vehicle and equipment recommendations
- Ingress/egress (transfer) training
- Mobility device and seating prescription
- Remediation or retraining of pre-requisite skills

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# What role is there for OT in determining the capacity for safe driving?

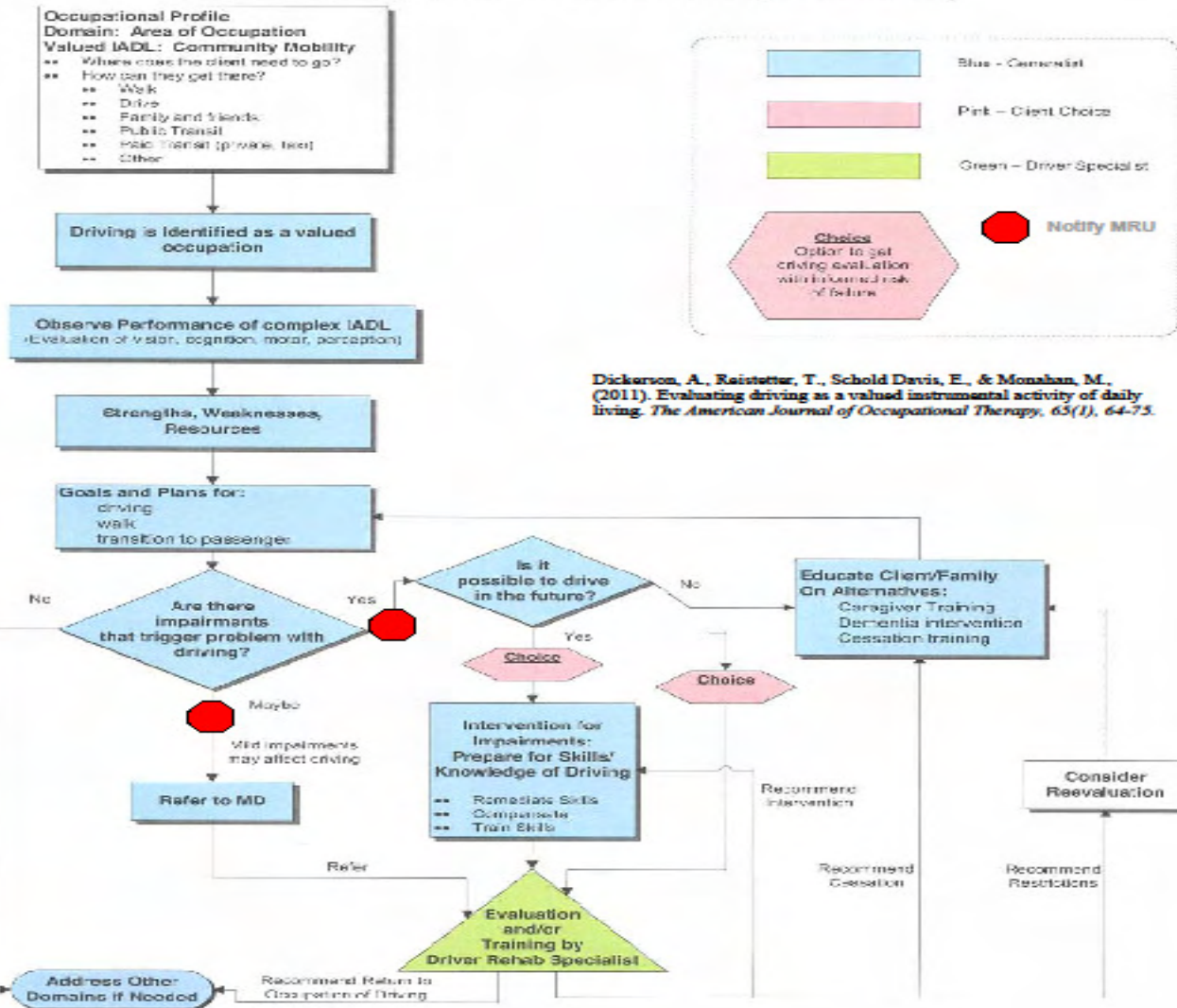
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## Driver Rehabilitation Specialist

- Performs a comprehensive, function based driving assessment usually including an on-road evaluation
- Gives an opinion on medical fitness to drive
- Basic or advanced vehicle modifications/equipment recommendations
- Provide consultation
- Education of peers, professionals, public

# Occupational Therapy Process for Driving and Community Mobility



Dickerson, A., Reistetter, T., Schold Davis, E., & Monahan, M., (2011). Evaluating driving as a valued instrumental activity of daily living. *The American Journal of Occupational Therapy*, 65(1), 64-75.

Dickerson, A., Reistetter, T., Schold Davis, E., & Monahan, M., (2011). Evaluating driving as a valued instrumental activity of daily living. *The American Journal of Occupational Therapy*, 65(1), 64-75.





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## Resources/References

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### Reference Materials:

- American Medical Association (AMA) - Physician's Guide to Assessing and Counseling Older Drivers
- AOTA – OT Practice Guidelines for Driving and Community Mobility for Older Adults
- Canadian Medical Association (AMA) – Determining Medical Fitness to Operate Motor Vehicles – 7th edition – available for free as a PDF, or \$35 for a hard copy
- Canadian Council of Motor Transport Authorities (CCMTA) - Medical Standards for Drivers – free download  
[http://www.ccmta.ca/english/pdf/medical\\_standards\\_march\\_2009.pdf](http://www.ccmta.ca/english/pdf/medical_standards_march_2009.pdf)
- Driver Rehabilitation Across Age and Disability: An Occupational Therapy Guide (w/CD-ROM) by Sue Redepenning

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## Resources/References

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Special Journal issues regarding driving:

- AJOT - (March/April 2010), Vol 64, No 2, Special Issue on Older Driver Safety and Community Mobility
- Australian OT Journal (2012) Vol 59
- CJOT – (2011 April), Vol 78, No 2
- OT Now – (2010 September/October), Vol 12, “Community Mobility, Driving and OT”

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## Resources/References

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### Journal articles:

- Dickerson, A., Reistetter, T., Schold Davis, E., & Monahan, M., (2011). Evaluating driving as a valued instrumental activity of daily living. *The American Journal of Occupational Therapy*, 65(1), 64-75.
- Korner-Bitensky, N., Toal-Sullivan, D., & von Zweck, C., (2007). Driving and older adults: a focus on assessment by occupational therapists. *Occupational Therapy Now*, 9(4), 3-5.
- Marshall, S., Molnar, F., Man-Son-Hing, M., Blair, R., Brosseau, L., Finestone, H., Lamothe, C., Korner-Bitensky, N., & Wilson, K. (2007). Predictors of driving ability following stroke: A systematic review. *Topics in Stroke Rehabilitation*, 14(1), 98-114.
- Menard, I., et al, (November 2006). Canadian Psychiatrists' Current Attitudes, Practices, and Knowledge Regarding Fitness to Drive in Individuals with Mental Illness: A Cross-Canada Survey. *Canadian Journal of Psychiatry*, 51(13).
- Vrkljan, B., McGrath, C., & Letts, L., (2011). Assessment tools for evaluating fitness to drive: A critical appraisal of evidence. *Canadian Journal of Occupational Therapy*, 78(2), 80-96.

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So..... What do you do when you are asked.....

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Should this person drive?

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## What is your approach?

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- I need to have a relationship with my client; bringing up the subject of driving will destroy my relationship
- I don't have adequate knowledge regarding driving or the situation to address it.
- I don't have the time or resources to adequately determine whether or not this person is safe to drive anymore
- My job is to treat people with medical problems, not how to deal with patient's loss of freedom to operate a vehicle.
- I feel forced to have to address this (e.g. due to mandatory reporting guidelines); this is not client centered to me

### VERSUS

- I care about my client; driving is an important life role to them
- It is uncomfortable.. But talking about driving is no different than having to deal with sexuality issues.... It is just a part of their life that needs to be addressed
- I have empathy and compassion; if there is anger and fear, that is normal and I can facilitate and support my client.
- I have to address the needs of the individual, the family, as well as the community.
- I wouldn't want him/her to get hurt or hurt someone.
- If I bring up driving and the situation becomes too difficult, I can still inform the physician, SGI, DEP and others confidentially.

# Do I assess or not....and what does assessment mean?



The focus of "assessment" for most OTs is

- To complete in office pre-driving/off road standardized and non standardized tests
- To take the information you have from these tests as well as observations to make the determination of whether you have concern about driving and whether there needs to be follow up about it with SGI, to the client, families, other involved parties.

"If I do some paper pencil tests and am not sure, why don't I just take him for a drive?"

- We already reviewed the CAOT framework for general, advanced and specialized and it is in the scope of Occupational therapy and it is your decision if you feel that your skills and knowledge give you the confidence and comfort to proceed.
- Do you feel competent to do an off-road or on-road assessment?
- Are you confident in defending your decision in court or for appeals.
- Recommendations from a comprehensive driving assessment has to reflect all aspects for driving (e.g. seating, optimal conditions versus bad weather conditions, driving at night, type of driving environments, restrictions, equipment type, winter/summer, with the kids in the back seat, to address driving for a job etc.)

There is a big difference between taking someone for a drive and actually assessing driving.



What are the key performance components to evaluate?

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# Performance Components

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- Physical Ability - *Motor Function*
  - Coordination
    - The ability to execute smooth, accurate, controlled movements
  - Gross motor abilities
    - Includes gross range of motion and strength of the upper and lower extremities, grip strength, proprioception, kinesthetic sense and fine and gross motor coordination.
  - Range of motion, strength and flexibility of the extremities
    - (e.g., ankle extension and flexion are needed to reach the gas pedal and brake) and upper body range of motion (e.g., shoulder and elbow flexion are necessary for turning the steering wheel; range of motion of the head and neck are necessary for looking at the side and rear for vehicles and for identifying obstacles at the side of the road or cars approaching from a side street).
  - Reaction time
    - The time taken to respond to a stimulus; depressing the brake pedal in response to a child running out on the roadway, swerving to avoid an animal on the road, etc.
- Physical Ability - *Sensorimotor Function*
  - The combination of sensory and motor functioning for accomplishing a task which are usually reflexive or automatic e.g., ability to sit upright, etc. (vestibular disorders, PVD, SI).

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# Performance Components

- **Cognition and Visual Perception**
  - **Divided attention**
    - - The ability to attend to two or more stimuli at the same time.
  - **Selective attention**
    - - The ability to selectively attend to one or more important stimuli while ignoring competing distractions
  - **Sustained attention**
    - The ability to maintain an attentional activity over a period of time
  - **Short term memory**
    - Retention of information that is currently being processed in a person's mind
  - **Working memory**
    - Ability to temporarily store for a short period of time and manipulation of the information/ use the information with time constraints/taking in and updating information necessary for completion of the task at hand. (Hear on radio detour at 25<sup>th</sup>; remember and retain this in order to make a change in route)
  - **Complex reaction time**
    - Response time taken to respond and the appropriateness of the response to 2 or more stimuli
  - **Visuospatial abilities**
    - Recognition of objects, figure ground, closure, form constancy.
  - **Executive functioning**
    - Planning and organization, reasoning and problem solving, conceptual thought, decision making and judgment.
  - **Visual information processing**
    - The processing of visual information beyond the perceptual level (e.g., recognizing and identifying objects and decision making related to those objects) which involves higher order cognitive processing.



# Performance Components



## Visual function:

- Acuity
  - Clarity of visual information
- Visual field
  - Area of vision when fixation is stable
- Scanning and Tracking
  - The ability to visually follow a moving stimulus or sequentially appearing in different locations
  - Problems commonly seen in the persons with congenital neurological disorders
- Contrast Sensitivity
  - The amount of contrast an individual needs to identify or detect an object or pattern. Almost 50% of persons age 65+ have some degree of cataracts.
- Depth Perception
  - The eye's ability to perceive the world in three dimensions and to judge distance; to determine distances between objects and to tell if something is near to us or far away. People who lose the sight of one eye often have difficulties with depth perception.
- Glare Resistance and Recovery
  - The degradation of visual performance caused by a reduction of contrast. It can occur directly, by reducing the contrast between an object and its background, i.e. directly affecting the visual task, or indirectly by affecting the eye. By age 60 it is 50% slower to recover from change in light intensity.
- Perception
  - The process of interpreting, selecting, and organizing sensory information.

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# Testing

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There are some standard tests that will indicate a “predictor” for driving or not driving but the fact is that research has shown that many older adults that do not score well on “tests” are able to function quite well during the actual activity.

- There is no specific screening test that can 100% predict MVC risk.
  - When physicians/health professionals use cognitive tests such as the MMSE, clock-drawing test, Trails, Cube draw, Pentagon, Clock draw, Ruler drop etc., they should keep in mind that none of these tests have well-validated cut-off scores for persons with dementia or specific diagnosis (and when validated, such cut-off scores will likely be averages and may vary by individual).
- When completing tests there are other factors to consider
  - e.g. the qualitative dynamic information regarding how the test was performed such as observations such as slowness, hesitation, multiple corrections, anxiety, impulsive or perseverative behaviour, lack of focus, forgetting instructions, inability to understand, etc.

The activity of driving is multi-faceted and humans are multi-faceted so having the expectation of a simple standardized test to determine true capacity for driving is not realistic.

Using both standardized and non- standardized assessment tools are appropriate.

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## What tests you use depends on:

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### Time

- How much time and resources do you have?  
5 min screen or time to do a detailed assessment over 2 weeks?

- Resources available
  - Multi- domain tests versus single domain are most beneficial for limited time resources and screening
  - Standardized tests versus non- standardized tests
- What performance components are impacted by the illness or injury

# Methods of screening and assessment



Research has identified many tools that can be utilized in the screening and assessment of the domains related to driving.

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Motor sequence screen  
MMT  
Berg balance test  
Right heel pivot test  
MMSE  
letter cancellation test  
MVPT  
Trails A/B  
Clock drawing  
The Short blessed test  
Drivable, UFOV, Dynavision  
CBDI  
Money road map test  
Behavioral inattention test  
Rey complex  
EXIT- 25  
Beery VMI  
Ravens  
Cognistat  
ADL Profile  
FIM  
Allen Cognitive scale

ROM testing  
Test of lower extremity proprioception  
The motricity Index  
Pegboard test  
Bells test, Star cancellation test  
Porteous Mazes  
Visual confrontation  
CLOX  
MOCA  
CDT, Simard  
Mini-cog  
Symbol digit modalities test  
Sign identification test  
AMT  
WAIS Picture completion,  
ACE- R  
RUDAS  
Confrontation, OPTIC, Pelli-Robson, Snellen  
CCT, MIS, GPCOG  
Adaptive Behavior Assessment Systems  
Behavioral rating inventory of executive function  
Informal assessment of executive function

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## Other factors to consider

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- Medication issues
  - Taking 20 medications, poly-pharmacy
- Number of co-morbidities
  - Progressive neurological diagnosis and chronic conditions combined.
- Age
  - There are significant sensory, physical, and cognitive changes that happen as we age.
    - All domains slow down and become impaired.
      - Vision –Colors appear fades and washed out, especially the color red (brake lights of cars ahead), Decreased endurance for night driving due to eye strain, Decreased depth perception causing more difficulty to judge speed and distance of vehicles movement during left turns, passing, crossing highways etc and changes in Acuity
      - Physical – reduced ROM, proprioception, coordination and response speed
      - Cognitive – selective attention, processing speed, new learning, decreased readiness to respond to stimuli
    - Multiple co morbid conditions with a cumulative effect.
    - Multiple medications that can result in significant side effects.
    - More experience on the road but can not process the information fast enough.
    - Do not recover fully (i.e.: often left with long term disability)
    - Life roles change as we age due to retirement, illness such as relocation (e.g. different location that is not as familiar etc), have to drive their spouse to appointments, live in an area without any other transportation options



## Other factors to consider:

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- Behavioral issues - Anger management, aggressive attitude, impulsive behavior, child like behavior, perseverative, chronic addictions
- Self awareness and perception
- Higher survival rate post injuries with more functional limitations living in the community
- Inclusion programs in the schools
  - Kids with disorders or disabilities are in the same classes as their peers; there is an expectation that everyone has the right to driver education program.
- Societal expectations
  - Inconvenient to not drive, they have the right to maintain independence etc.
  - Minimal discussion in the community that driving cessation in your lifetime
  - There is more self assertive communication styles and more educated older adults with more demands and pressure regarding the rights, regulations and responsibilities.
- Changes in the communities we live in. Decisions have to made faster in a more congested traffic environment.

# Questions to consider when assessing/screening the client



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- Is the person oriented?
  - Does the person have receptive difficulties?
  - Can the person follow a 3 step instruction?
  - Does the person appreciate or understand consequence?
  - Can they learn new information?
  - Can they generalize from one task to another?
  - Can the person deal with change?
  - Have some flexibility in their thinking?
  - Does the person get lost? Do they have problems navigating?
  - Is there any collateral information from the family regarding driving?
  - Can the person do their ADLs, IADLS without assistance?
  - What kind of problem does the person have? Is it stable /unstable, temporary, permanent, progressive in nature, congenital or variable from day to day?
  - Is the person driving? Is driving important to them.
  - Do they have a driver's license?
  - Do they drive for work?
  - Do they drive with people in the vehicle?
  - Does the person have some self awareness? Do they have insight?

Remember: The goal is to determine whether you have any concern for driving safety and whether SGI should be notified. You do not have to have the answer of Yes or No.

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# The Process:



- Identify medical conditions that may pose threats to safe driving.
  - Follow Physician's guidelines for driving (e.g. CMA guidelines) (e.g. no driving one month minimum post CVA)
  - Provide rehabilitative services to enable the resumption of safe driving after illness and/or injury.
  - Address driving with clients with a progressive diagnosis. E.g. you must ask the person if they are driving and document driving safety concerns and follow provincial reporting guidelines.





## The Process:

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- Complete screens or assessment tools to gather information.
- Consider additional factors such as observations of emotional control, frustration, cognitive or physical fatigue, activity tolerance, general distractibility, ability to understand and respond to social cues etc. Do not underestimate the importance of social cues with respect to safe driving.
- Use your judgment when reviewing test scores and take other factors into account, what is your gut feeling? Ask yourself "Would I get into or allow a loved one in a car that the patient is driving?"
- From this information, categorize the client as:

"clearly safe," , clearly unsafe" or "unclear/not sure"

When the answer is unclear , needs further testing or investigation, it is appropriate to make a referral to the Driver Evaluation Program or other service (e.g. Medication review, GEM, psychiatry etc).

Please note that anyone can make a referral to DEP or DAP. The person is not required to have a class 7 or a class 5 license to be assessed and they do not have to have a valid license at time of the assessment.

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# The Process:



- **“Clearly unsafe,”**
  - Talk to your client (and support people) about concerns & driving in general
  - Have discussions about driver cessation:
    - Explanation why the person is at risk
    - Raise public safety issues..... How would you feel if...?
    - Involvement the family and/or support system in the discussion
    - Reinforcement of recommendations by giving a prescription “ do not drive” can be helpful
    - Referrals for resources to assist with caregiver burden, community management etc.
    - Discuss driving alternatives
- **“Unclear – needs more testing,”**
  - SGI will make the decision of how to proceed, but the more specific information you can provide the better. You see a client in person and for a longer time than in a doctor office etc.

On Road Testing options: Road test versus DAA versus DEP

Questions to ask yourself: Rule of road, point system, method of pass-fail dual control versus personal vehicle, cost, type of limitations and factors – physical versus cognitive, slowing down versus executive function, time on road, high speed low speed, evaluator background, guided not guided , interaction, reporting to SGI , physicians, referral source, allowance for clinical opinion, consideration of medical problem, collateral information etc. restrictions being requested and whether they will follow it, can they deal with distractions within the vehicle, distractions from the external environment.

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## The Process:

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- Advise and facilitate the client submitting change of medical status form to SGI and/or fill out medical reporting form. Even if you fill out the medical reporting form, this promotes responsibility taking.
- Report and communicate any concerns to the primary physician and other health professionals involved with regular client contact/care. Make appropriate referrals as needed.
- Document concerns, rationale and actions taken.
  - This could include phone and written contact with the physician
  - Verbal communication with the client or family regarding issues.
  - What referrals have been made to a specific resource (e.g. SW, DEP, Rehab, Cognitive clinic, community therapies, optometry/ophthalmology etc.)
  - Written contact with SGI - Medical Reporting Form
  - Any other pertinent information

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It is acknowledged that driving is a part of life that everyone wants to have and expects to have. When a person can no longer drive their life roles change significantly and no matter where a person lives, being able to drive has a huge impact on their level of independence.

As Occupational Therapists, we care about our clients well being, independence and quality of life. We also care about our community and the safety within it.

It would be devastating to find out that you could have prevented a death or severe injury if you would have responded when a person was known to be at risk.

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- After these educational sessions SSOT will be compiling commonly asked questions and an FAQ sheet will be available on the SSOT website.
  - If you have specific questions that you would like posted, send your email to SSOT.

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# Contact Information

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## **SGI Medical Unit**

Phone: (306) 775-6176

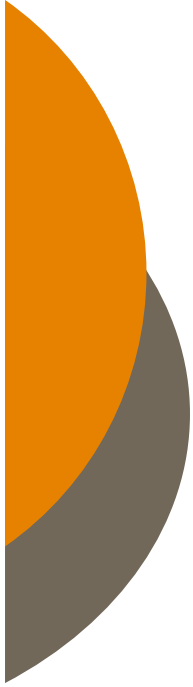
1-800-6678015 ext. 6176

E-mail: [mruinquiries@sgi.sk.ca](mailto:mruinquiries@sgi.sk.ca)

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## **SSOT Website**

<http://ssot.sk.ca/mandatory-reporting-to-SGI>



## Contact Information

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### **SSOT Working Committee for SGI Mandatory Reporting Co-Chairs:**

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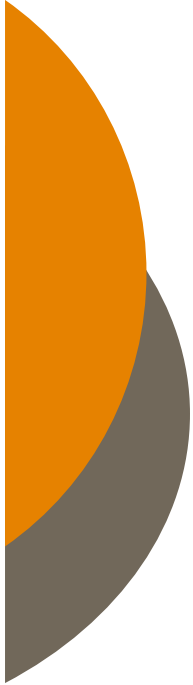
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# SSOT Working on SGI Mandatory Reporting

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