Can Your Older Patients Drive Safely?

A review of the functional impairments and situations that put older drivers at risk.

ABSTRACT: In many areas of the world, driving is an essential part of life and for reasons of comfort, convenience, and security remains the primary mode of transportation among older adults. Both normal aging and diseases that are more prevalent in advanced age can substantially reduce older drivers' functional abilities, elevating their risk of involvement in motor vehicle accidents and serious injury or death. Identifying and intervening with older drivers at increased crash risk is an important aspect of preventive medicine. The authors discuss the specific driving risks adults face as they age and how nurses can raise older patients' awareness of these risks. They also discuss the importance of connecting older adults to community resources that may help them continue driving safely for a longer period or find alternative transportation options.

Keywords: age-related functional decline, driver rehabilitation, driving health, driving safety, injury prevention, motor vehicle accidents, older drivers, preventive medicine

Independence and mobility are vital to healthy, successful aging. Until affordable and safe driverless cars are commonplace, people in many areas of the United States, especially those in areas that lack convenient and efficient public transportation systems, will continue to drive well into advanced age, often putting their safety and that of the public at risk.

Several functional abilities required for safe driving decline with normal aging. Age-related diseases, the multiple medications used to treat these diseases, and the effects of normal age-related functional decline can all impair older adults' driving ability, significantly raising their risk of motor vehicle accidents. In addition, because of their fragility, older adults involved in such accidents may be more severely injured than young or middle-aged drivers.

Given that few license renewal policies address medical fitness to drive, the ever-increasing proportion of older adults in the driving population presents a public health challenge. Some see preserving older drivers' mobility through a lack of rigorous license renewal policies as a form of "benign neglect." After all, reports from the Insurance Institute for Highway Safety (IIHS) indicate that older drivers are involved in fewer fatal crashes than they were two decades ago and that they tend to self-restrict their driving as they age.[1] But the IIHS data also show that older drivers are at higher risk for crash involvement per mile driven than any group other than adolescents. Within the framework of preventive medicine, clinicians may justifiably wonder how they can intervene to prevent motor vehicle accidents involving their older driving patients.

This article discusses driving risks associated with advanced age, focusing on the behaviors and situations that put older drivers at greatest risk, as well as the key indicators of an older patient's ability to drive safely. It details the age-related functional changes associated with greater risk of crash involvement, and the need for clinicians to discuss aging, driving safety, and alternative transportation

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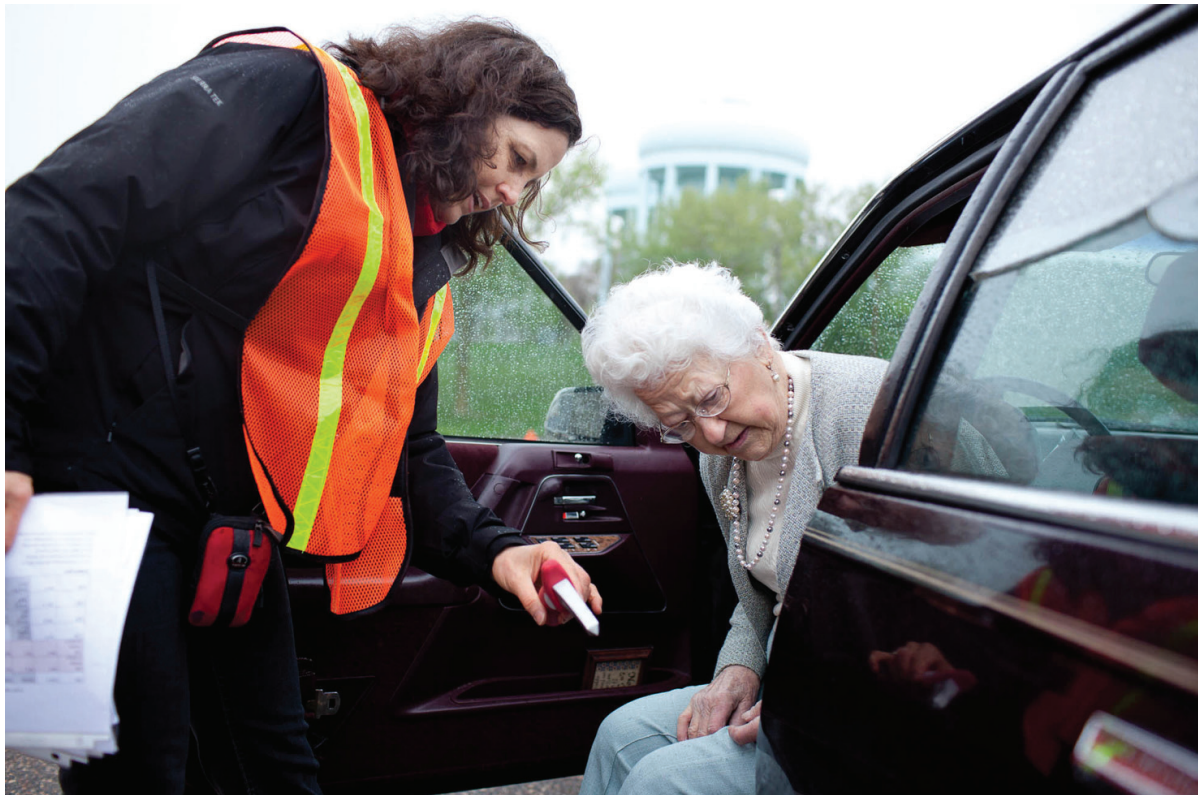


An older driver seeks advice at a local event sponsored by CarFit, a program developed by the American Society on Aging in collaboration with the American Automobile Association, AARP, and the American Occupational Therapy Association to help older adults enhance their driving safety. Photo © Associated Press.

options with their older patients and their patients' families.

AGE DEMOGRAPHICS AND CRASH RISK

In the decade from 2006 through 2015, the most recent period for which data are available from the Federal Highway Administration Highway Statistics Series, the total number of licensed U.S. drivers grew from 202.8 million to 218.1 million, an increase of 7.5% (see Figure 1).[2] By contrast, during this same period, the number of licensed drivers ages 65 to 74 grew from 17 million to 25 million, an increase of 47%, and the number of licensed drivers ages 75 and older grew from 13.1 million to 15.1 million, an increase of 15.3%.[2]

The Fatality Analysis Reporting System (FARS) maintained by the National Highway Traffic Safety Administration (NHTSA) tracks the number of motor vehicle fatalities in which older adults were driving.[3] In the five most recent years for which data are available (2011 to 2015), national counts of fatal crashes involving older drivers (those ages 65 to 74, and 75 and older) rose, though modestly (see Table 1).[3] In fatal crashes involving 65-to-74-year-old drivers, nearly 63% of those killed were drivers and their passengers, while other road users accounted for 37% of related fatalities (see Table 2). For drivers ages 75 and older, however, drivers and their passengers constituted 78% of the fatalities (see Table 3). These data reflect not only the functional decline that occurs in the seventh and eighth decades of life, but also the increasing fragility that occurs with advancing age, as a crash of any level of severity is more likely to result in death for an older adult vehicle occupant than for one that is young or middle aged. The greater risk associated with driving at age 75 and older is also evident in these drivers' greater level of involvement in fatal motor vehicle accidents relative to their representation in the licensed driver population. While drivers ages 65 to 74 consistently represent a lower level of involvement in fatal crashes relative to their representation in the licensed driver population (see Figure 2), drivers ages 75 and older are consistently overrepresented in this regard (see Figure 3).[2,3]

ENVIRONMENTAL RISKS

The most recent FARS data indicate that older driver involvement in fatal crashes varies with the road type and occurs most often on arterials (through traffic), where traffic densities tend to be higher, information processing demands and the potential for distraction because of roadside development are greater, and posted speeds of 45 miles per hour and higher are common. Fatal crashes on such roads are even more prevalent among drivers ages 75 and older than among those ages 65 to 74 (see Tables 4 and 5).[3] Older driver involvement in such crashes is relatively rare on interstate highways or expressways, possibly because of driver self-restriction on these roadways as well as superior design that reduces the potential for conflict.

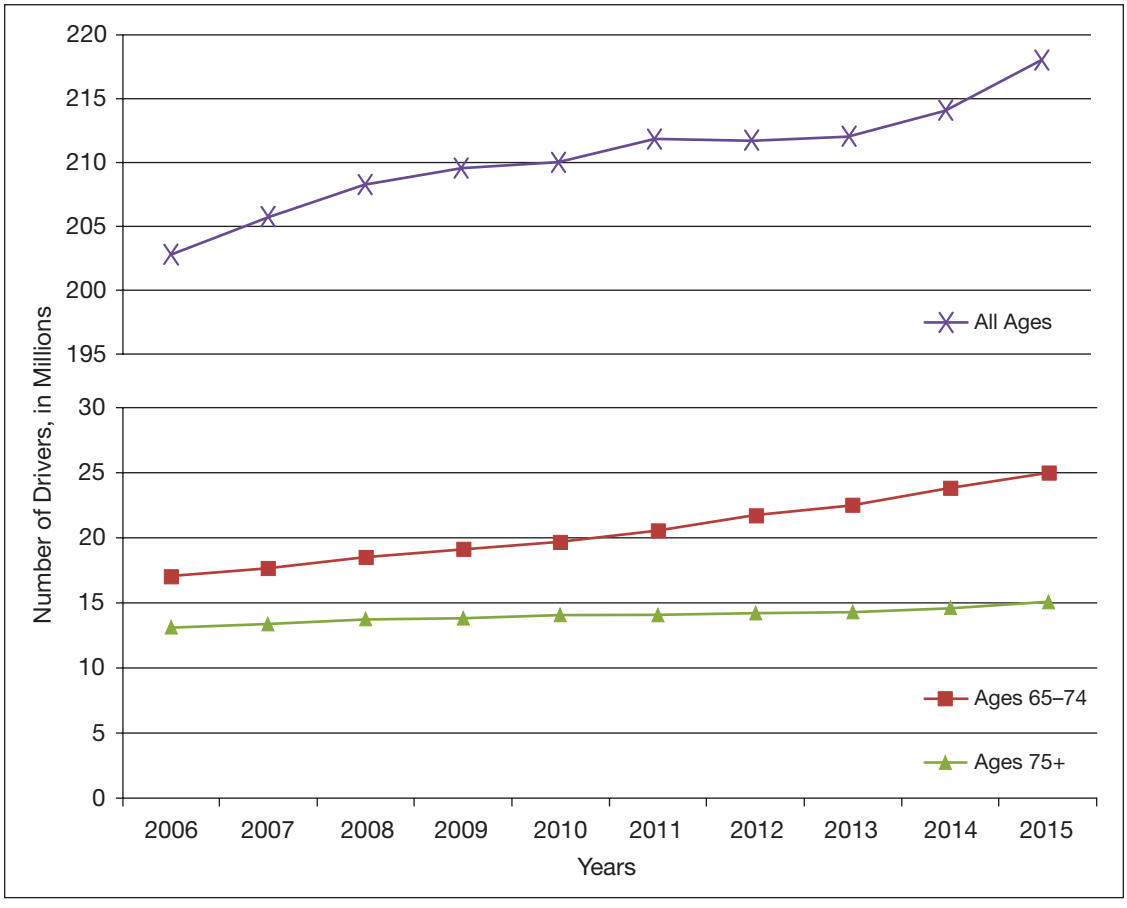
A research study sponsored by the NHTSA sought to determine which age groups, vehicles, roadways, and environmental characteristics were most strongly associated with increased crash involvement for drivers ages 60 to 69, 70 to 79, and 80 or older.[4] Using 2002 through 2006 data from FARS and the National Automotive Sampling System–General Estimates System, this study found that the following activities were most problematic for older drivers:

- making left turns
- negotiating stop sign–controlled intersections
- driving on high-speed, two-lane roadways and multilane roads with speed limits of 40 to 45 miles per hour

Drivers ages 60 to 69 managed most traffic situations nearly as well as their middle-aged counterparts, but both these drivers and older drivers were more prone than drivers under age 60 to err at intersections with flashing signals. Drivers in their 70s demonstrated greater difficulty than those in their 60s in navigating high-speed, multilane roadways, particularly at junctions; in terms of safety, however, their driving was more like that of the 60 to 69 cohort than the 80 or older one. For drivers ages 80 and older, errors negotiating yield sign–controlled intersections were responsible for 26 of 27 fatal crashes.[4]

Certain driving situations, such as navigating intersections that require complex visual searches, rapid

Figure 1. The Number of Licensed Drivers in the United States, 2006–2015



Source: U.S. Department of Transportation, Office of Highway Policy Information, Policy and Governmental Affairs. *Highway statistics series*. https://www.fhwa.dot.gov/policyinformation/statistics.cfm.

Table 1. U.S. Fatal Crashes Involving Older Drivers and the Number of Drivers Killed

Drivers	2011	2012	2013	2014	2015	Total	% Change: 2015 vs. prior 4-year average
Ages 65–74							
Fatal crashes	2,869	3,124	3,210	3,188	3,593	15,984	16
Drivers killed	1,673	1,771	1,844	1,776	2,034	9,098	15.2
Ages 75 and Older							
Fatal crashes	2,457	2,492	2,518	2,581	2,650	12,698	5.5
Drivers killed	2,012	2,003	2,066	2,120	2,171	10,372	5.9

Source: U.S. Department of Transportation, National Highway Traffic Safety Administration. *Fatality analysis reporting system (FARS)*. https://www.nhtsa.gov/research-data/fatality-analysis-reporting-system-fars.

processing of information from multiple sources, and divided attention, create problems for older drivers. Under such conditions, a driver cannot rely exclusively on formal or informal rules, but rather must resort to judgment or executive function.

AGE-RELATED FUNCTIONAL DECLINE

It must be emphasized that the decline in driving abilities is related to functional status, not chronological age. Furthermore, with increasing age, populations become more heterogeneous regarding functional status. Many older adults—including those who are 75 and older—demonstrate no impairments serious enough to compromise driving. Nevertheless, a host of visual, cognitive, and psychomotor functional abilities reliably decline with advancing age.

Vision. Contrast sensitivity, which is the ability to process differences in brightness between an object and its background, has been shown to decrease with age.[5] Reduced contrast sensitivity may impair a driver's ability to detect road hazards, pavement markings, curbs, and road signs, increasing the likelihood of lane boundary crossings and slowing driver reaction times. Likewise, static visual acuity (the ability to distinguish details on a stationary target, such as the letters on an eye chart) and dynamic visual acuity (the ability to distinguish details on a moving target or on a stationary target while in motion—for example, the ability to read road signs while in a moving car) have been shown to decline with age, even in adults with healthy eyes.[6]

In addition to the visual deterioration that occurs with normal aging, several medical conditions associated with advanced age can also diminish vision. For example, it's well established that

- cataracts impair acuity, contrast sensitivity, color discrimination, and depth perception.
- glaucoma constricts the peripheral visual field.
- stroke, trauma, tumors, infections, and surgery can cause hemianopia, a partial loss of the visual field in one or both eyes.
- macular degeneration often causes deficits in both spatial and temporal contrast sensitivity.

Some of these visual deficits can be mitigated by medication or surgery, greatly improving driving performance. For example, a study by Wood and Carberry found that bilateral cataract surgery significantly improved binocular visual acuity and binocular contrast sensitivity, resulting in marked improvement in sign recognition, ability to detect and avoid hazards, and overall driving performance, with improved contrast sensitivity being most predictive of improved driving performance.[7] According to one analysis—which considered the number and cost of motor vehicle accidents, the probability of fatalities, the probability of having cataract surgery, and the age at which cataract surgery occurs and its cost—relaxing the reimbursement standards to allow for early cataract surgery (before significant vision problems develop) would lower the number of motor vehicle accidents and related expenses for 2% to 6% of U.S. drivers ages 60 to 89, resulting in substantial societal cost savings, such as reducing the average number of motor vehicle accidents, fatalities, and per-person crash-related costs by about 21%.[8]

Cognition. Some cognitive disabilities associated with advanced age are predictive of diminished driving performance and risk of crash involvement. Most often cited is a decline in executive function—that is, in the processes that guide behavior incorporating attention, working memory, planning, organization, problem solving, set shifting (moving back and forth between tasks), abstract thinking, judgment, decision making, and the inhibition of inappropriate responses.

Executive function deficits have been identified in adults as young as 45 years of age[9] and have been shown to worsen with age.[10-12] Deficits in the areas of response inhibition (the aspect of executive function that enables a person to suppress behaviors that are inappropriate to the immediate situation, even if they are habitual or were appropriate at another time) and divided attention (the ability to divide attention between

two or more simultaneous tasks) predict diminished driving performance[11, 13] and greater crash risk.[14, 15] Task-switching ability may be determined by performance on the Trail Making Test, Part B, which requires test takers to sequence two sets of stimuli (letters and numbers) in alternating order as quickly as possible.

Working memory deficits are similarly linked to a significant increase in crashes.[16, 17] This ability allows a driver to remember, and apply when needed, navigational directions and rules for traffic operations, while processing and responding to the real-time demands of steering, anticipating and avoiding conflicts, and performing other moment-to-moment vehicle control tasks.

Visual cognitive functions that degrade with age and are known to affect driving performance include visual information processing speed, selective visual attention, and visuospatial ability. The following three tests can significantly predict driving performance and crash risk:

- the Useful Field of View measure for speed of processing and selective (as well as divided) visual attention[18-20]
- the Motor-Free Visual Perception Test, Visual Closure subtest, which measures the ability to visualize spatial relationships among objects[21]
- various maze tests that track the time required to draw a path through a maze either on paper or on a computer screen[22]

Medical conditions that can impair various aspects of cognitive function, with adverse effects on driving performance, include the following:

- stroke[23]
- multiple sclerosis[24, 25]
- type 1 and type 2 diabetes[26, 27]
- hepatic encephalopathy[28]
- obstructive sleep apnea[29]
- Parkinson's disease[30, 31]

Physical function and psychomotor response must be intact for drivers to carry out vehicle maneuvers. Both normal, healthy aging and such conditions as arthritis can reduce flexibility, range of motion, and muscular strength, compromising driving performance.

Increased crash risk has been associated with poor upper-extremity range of motion[32, 33] as well as poor lower-extremity strength and range of motion.[17, 34] Sims and colleagues found that older drivers who had fallen in the previous two years were at elevated crash risk compared with older drivers who had experienced no falls.[33] Any deficiency in head and neck flexibility, which allows a driver to effectively scan the vehicle and surrounding environment, can predict driving impairment and has been found to significantly degrade driving performance, particularly at intersections.[17, 35]

Improving physical function. Physical activities that increase strength, flexibility, and range of motion in older adults may improve driving performance. These include yoga,[36] dance,[37-39] tai chi,[40-42] and various multicomponent exercise programs.[43-45] NHTSA research is currently under way to determine whether there is a direct correlation between better driving performance and greater fitness among older adults.

Table 2. U.S. Fatalities in Crashes Involving Drivers Ages 65–74

Victim	2011	2012	2013	2014	2015	Total No. (%) of Fatalities
Drivers ages 65–74	1,673	1,771	1,844	1,776	2,034	9,098 (51.9)
Passengers of drivers ages 65–74	346	420	355	372	422	1,915 (10.9)
Other road users	1,126	1,251	1,321	1,322	1,501	6,521 (37.2)
Total no. of fatalities	**3,145**	**3,442**	**3,520**	**3,470**	**3,957**	**17,534 (100)**

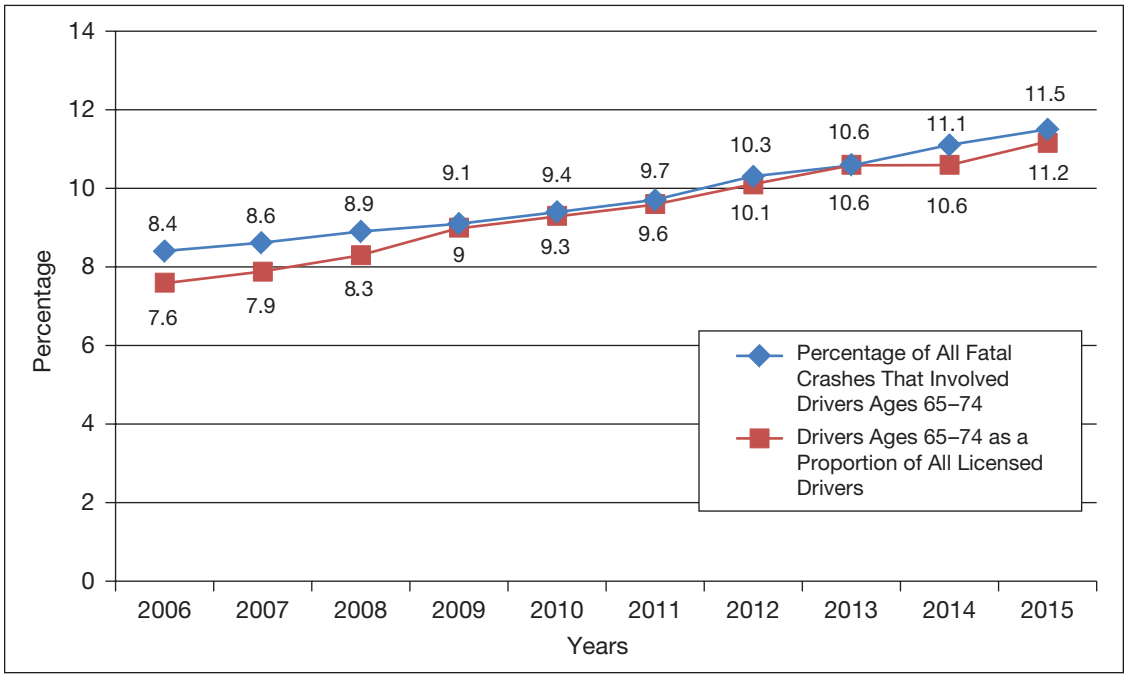
Source: U.S. Department of Transportation, National Highway Traffic Safety Administration. *Fatality analysis reporting system (FARS)*. https://www.nhtsa.gov/research-data/fatality-analysis-reporting-system-fars.

Table 3. U.S. Fatalities in Crashes Involving Drivers Ages 75 and Older

Victim	2011	2012	2013	2014	2015	Total No. (%) of Fatalities
Drivers ages 75+	1,735	1,700	1,757	1,788	1,824	8,804 (63.9)
Passengers of drivers ages 75+	389	391	411	377	406	1,974 (14.3)
Other road users	541	607	561	636	649	2,994 (21.7)
Total no. of fatalities	**2,665**	**2,698**	**2,729**	**2,801**	**2,879**	**13,772 (100)**

Source: U.S. Department of Transportation, National Highway Traffic Safety Administration. *Fatality analysis reporting system (FARS)*. https://www.nhtsa.gov/research-data/fatality-analysis-reporting-system-fars.

Figure 2. Fatal Crash Involvement vs. Proportion of Licensed Driver Population, Drivers Ages 65–74



Sources: U.S. Department of Transportation, National Highway Traffic Safety Administration. *Fatality analysis reporting system (FARS)*. https://www.nhtsa.gov/research-data/fatality-analysis-reporting-system-fars; U.S. Department of Transportation's Federal Highway Administration Office of Highway Policy Information. https://www.fhwa.dot.gov/policyinformation/statistics.cfm.

STARTING A CONVERSATION ABOUT AGING AND SAFE DRIVING

When assessing an older patient, particularly one at high risk for motor vehicle accidents, nurses might introduce the topic of safe driving by simply asking if the patient has experienced any difficulties while driving. An affirmative response opens the door to a discussion of risks associated with the patient's medical or functional status. A negative response presents an opportunity to raise the patient's awareness of "driving health"—that is, to remind the patient that staying safe behind the wheel depends on the ability to see, pay attention, understand, remember, decide, and react quickly and appropriately to ever-changing traffic conditions and that normal aging, as well as disease and medications, can compromise these abilities.

Nurses who work in home health care or in a senior residential setting enjoy the benefit of building long-term relationships with their older patients and can assess subtle and incremental changes over time. They should inquire about any problems the patients experience while performing activities of daily living, such as getting to the grocery store, the pharmacy, or medical appointments. Any concerns should be documented and reported to the primary care provider.

Ideally, nurses should spend a minute or two talking about aging and safe driving during each patient visit; however, such talks are a priority for patients who

- present with signs or symptoms of cognitive impairment.
- have progressive medical conditions.
- will soon be discharged from a hospital following surgery or treatment for traumatic injury.
- have fallen in the past two years.
- have had a recent change in their medication regimen.
- show a marked change from baseline on an annual wellness visit, particularly with respect to functional abilities.

After undergoing knee or hip surgery, particularly of the right leg, some patients may worry that they will be unable to resume driving for an extended period, as these surgeries can slow brake reaction time. Others may underestimate the length of postsurgical recovery and expect to resume driving too soon. Although patients should discuss with their orthopedist the return to driving after knee or hip surgery, two studies have shown that many patients can drive safely after a postoperative period as brief as two to four weeks.[46,47]

Formal driving evaluations. Assessment and clinical data may be used to determine the need for a formal driving evaluation. Several reliable, standardized tools that have been validated as statistically significant predictors of crash risk for older drivers can be used to detect loss of cognitive function, including the following[21,22]:

- the Trail Making Test, Part B
- the Motor-Free Visual Perception Test, Visual Closure subtest
- a maze test
- the Useful Field of View test

All are available in both paper-and-pencil and computer-based form except for the Useful Field of View test, which can be administered by computer only. The paper-and-pencil forms of these tools may not be feasible for in-office screening as they require 10 to 15 minutes with an active test administrator and are more susceptible to measurement error. However, the computer-based screens can be self-administered using, for example, a touchscreen tablet in a waiting room. One such screening tool is currently being pilot tested by the Iowa Department of Transportation under an NHTSA cooperative agreement.

Patients' visual health should be monitored during annual eye examinations. Other important measures of diminished physical capability that significantly increase crash risk may be quickly checked during a patient visit. These include

- being unable to walk from a starting point to a point 10 feet away, turn, and walk back in less than 10 seconds.[48]
- having insufficient head or neck flexibility to look over the shoulder to identify an object (for example, the time on a clockface) 10 feet behind.[17]

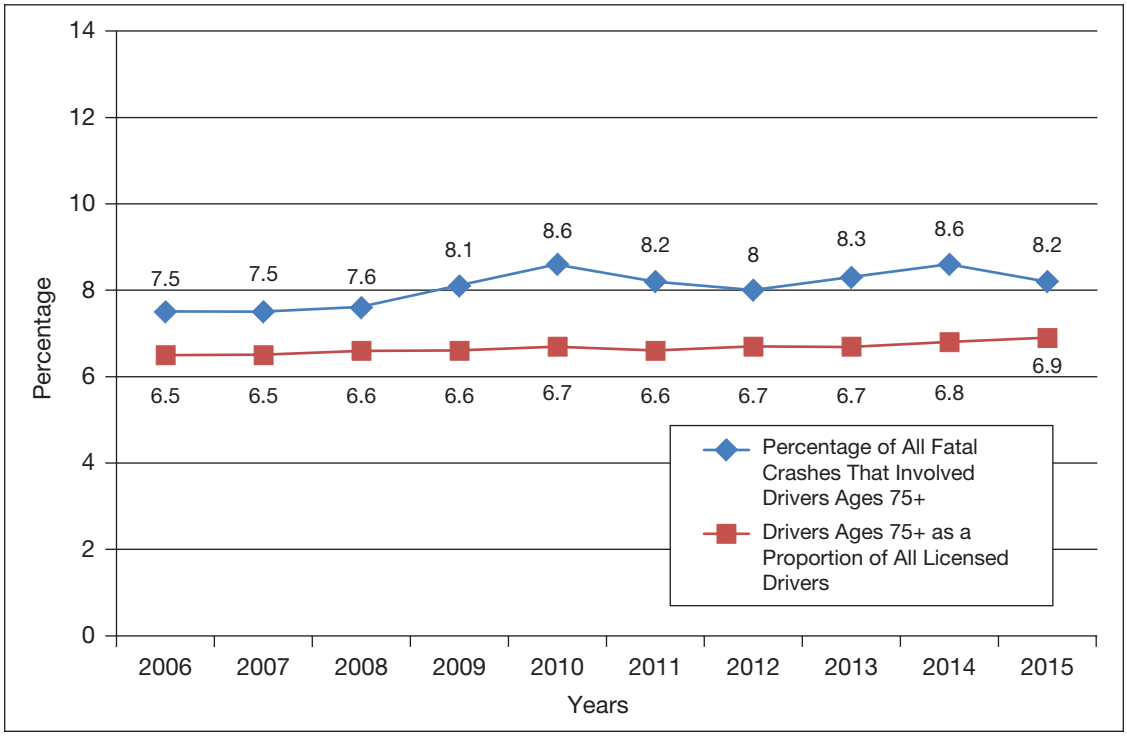
Using validated screening instruments for crash involvement risk is key. For patients with no diagnosis of cognitive impairment, it should be noted that such screens as the Mini-Mental State Exam and the Montreal Cognitive Assessment, which do not focus primarily on the abilities associated with driving, cannot be used in isolation as reliable indicators of crash risk. However, for patients with an established diagnosis of cognitive impairment, a score of 18 or lower on the Montreal Cognitive Assessment should raise concerns about their ability to drive safely.[49]

If additional time and available human resources permit a more in-depth patient interaction, nurses may wish to consult the following publications, which are available online at no cost:

- the American Geriatrics Society's *Clinician's Guide to Assessing and Counseling Older Drivers* (http://geriatricscareonline.org/ProductAbstract/clinician's-guide-to-assessing-and-counseling-older-drivers/B022)
- the *Driving Decisions Workbook* from the University of Michigan Transportation Research Institute (http://hdl.handle.net/2027.42/1321)

For computer-savvy older patients, consider recommending the home educational program, *Roadwise*

Figure 3. Fatal Crash Involvement vs. Proportion of Licensed Driver Population, Drivers Ages 75 and Older



Sources: U.S. Department of Transportation, National Highway Traffic Safety Administration. *Fatality analysis reporting system (FARS)*. https://www.nhtsa.gov/research-data/fatality-analysis-reporting-system-fars; U.S. Department of Transportation's Federal Highway Administration Office of Highway Policy Information. https://www.fhwa.dot.gov/policyinformation/statistics.cfm.

Table 4. U.S. Fatalities in Crashes Involving Drivers Ages 65–74 by Road Type

Road Type	2011	2012	2013	2014	2015	Total No. (%) of Fatalities
Interstate/expressway	490	518	514	517	710	2,749 (15.7)
Arterial	1,661	1,816	1,855	1,892	2,067	9,291 (53)
Collector	556	625	629	578	586	2,974 (17)
Local	417	469	515	464	355	2,220 (12.7)
Unknown	21	14	7	19	239	300 (1.7)
Total no. of fatalities	**3,145**	**3,442**	**3,520**	**3,470**	**3,957**	**17,534 (100)**

Source: U.S. Department of Transportation, National Highway Traffic Safety Administration. *Fatality analysis reporting system (FARS)*. https://www.nhtsa.gov/research-data/fatality-analysis-reporting-system-fars.

Table 5. U.S. Fatalities in Crashes Involving Drivers Ages 75 and Older by Road Type

Road Type	2011	2012	2013	2014	2015	Total No. (%) of Fatalities
Interstate/expressway	292	275	262	276	321	1,426 (10.4)
Arterial	1,418	1,560	1,548	1,599	1,610	7,735 (56.2)
Collector	488	435	461	468	456	2,308 (16.8)
Local	434	404	447	439	285	2,009 (14.6)
Unknown	33	24	11	19	207	294 (2.1)
Total no. of fatalities	**2,665**	**2,698**	**2,729**	**2,801**	**2,879**	**13,772 (100)**

Source: U.S. Department of Transportation, National Highway Traffic Safety Administration. *Fatality analysis reporting system (FARS)*. https://www.nhtsa.gov/research-data/fatality-analysis-reporting-system-fars.

Rx (www.roadwiserx.com), which instructs older adults on the effects of medications on driving and is available online for free.

MAKING REFERRALS

Health care providers may not be comfortable making recommendations about if, when, or how much patients should drive, but referring patients to professionals who can evaluate or rehabilitate their driving can help keep older patients—and others who use the road—safe.

In North America and throughout the world, there is a wide spectrum of driver programs that can determine a person's risk of unsafe driving and, depending on the type and severity of that person's impairment, intervene to help her or him drive safely for longer. For example, patients with little impairment may benefit from an educational driver improvement program or a commercial driving school, which can provide refresher training, help them improve their driving skills, and raise awareness of age-related deficits for which they can compensate through self-regulation (by avoiding driving at night, during rush hour, or on highways). Patients with cognitive, motor, visual, or perceptual deficits following stroke, or those recovering from traumatic brain injury who become easily frustrated, may require referral to a professional who can apply medical knowledge to safe driving ability and assess the effects of cognitive, visual, perceptual, behavioral, and physical limitations on driving performance. Such professionals include

- driver rehabilitation specialists, who can perform in-office clinical evaluations and determine whether an on-road evaluation is needed.
- *certified* driver rehabilitation specialists, who can perform on-road driving performance evaluations (possibly in a vehicle with adaptive equipment).
- occupational therapists certified in driving and community services.

There are three levels of driver rehabilitation programs, all of which provide comprehensive driving evaluation, training, and education, though they differ in the type of services they provide. The NHTSA, in collaboration with the Association for Driver Rehabilitative Specialists and the American Occupational Therapy Association, has described the various services in two very helpful documents[50]:

- "Spectrum of Driver Services: Right Services for the Right People at the Right Time," which describes and differentiates between community-based education; medically based assessment, education, and referral; and specialized evaluation and training services
- "Spectrum of Driver Rehabilitation Program Services," which describes the various levels of driver

rehabilitation programs (basic, low tech, and high tech)

Both documents are available online at www.aota.org/-/media/Corporate/Files/Practice/Aging/Spectrum-of-Driving-Services-2014.pdf. The information contained in these documents can guide nurses in providing advice to patients about the most appropriate level of driver services for their particular needs.

Of course, not all drivers need the services of a driver rehabilitation program. A patient who recovers quickly from a stroke and demonstrates no difficulty with other instrumental activities of daily living may require only a clinical assessment by a physician, an occupational therapist, or a social worker to confirm that any impairments are below the threshold of driving risk and to receive appropriate risk counseling. And a patient recovering from a severe stroke with significant impairments would not benefit from the expensive services provided by a driver rehabilitation program until substantial recovery had occurred. If, however, a patient failed to recognize her or his limitations, a driving performance evaluation might be necessary, if only to convince the patient to stay off the road.

REFERRAL TO THE STATE MOTOR VEHICLE DEPARTMENT

Only six states require health care providers to report patients with impairments that could affect their ability to drive safely: California, Delaware, Nevada, New Jersey, Oregon, and Pennsylvania. The states differ in terms of the conditions each specifies as reportable. Health care providers should familiarize themselves with their state's reporting laws and the procedures to follow when required by law to report a patient to their state's driver licensing agency. Although 44 states do not currently require health care providers to report patients with impairments that could affect their driving, all states accept such reports when provided in good faith to protect the safety of the patient and the public, and some provide health care practitioners with immunity from civil liability.

For some patients, loss of licensure will lead to feelings of depression and isolation. In states with no mandatory reporting law, clinicians will need to weigh these concerns against the risk the patient's driving poses to personal and public safety. Discussing your concern for safety with your patient and recommending driving cessation when you believe she or he is no longer fit to drive (and cannot be helped with medical treatment or other therapies) is an important first step. You may only need to report the patient to the state if the patient is unwilling to comply with your recommendation to stop driving. The American Geriatrics Society's *Clinician's Guide to Assessing and Counseling Older Drivers* includes a chapter on ethical and legal issues surrounding health care practitioner reporting of patients to a state's driver licensing agency and provides case studies illustrating how and when to discuss this topic with patients.

When patients can no longer drive safely, providing information about transportation alternatives and offering emotional support can help them navigate their retirement from driving. This is a time to encourage and applaud the patient's good decision making.

ACCESSING ALTERNATIVE TRANSPORTATION

When a nurse and a patient determine that it is temporarily unsafe for that patient to drive—or in certain cases, that it may be time for the patient to consider permanently retiring from driving—it's essential to discuss alternative transportation options. You could begin this conversation by asking whether the patient has family members or friends close by who are willing or able to assist with transportation. It would also be useful to have a list on hand of community resources that can work with patients to find appropriate local transportation. Occupational therapists in your community may have a transportation resource guide, and the nonprofit Independent Transportation Network of America (ITN*America*) maintains a current, national database of transportation services for aging and visually impaired people called *Rides in Sight* (www.ridesinsight.org). Other helpful links and information may be found on the website of the National Association of Area Agencies on Aging at www.n4a.org.

Be sure to know the most valuable resources in your community for providing mobility counseling and local transportation alternatives. Your referral to this person or group can provide the appropriate pathway for patients to obtain services for community mobility, which is essential for maintaining independence and quality of life. ▼

For 59 additional continuing nursing education activities on topics related to older adults, go to www.nursingcenter.com/ce.

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