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MORE OPTIONS FOR DEALERS AND DRIVERS
“T
his was the
best ADED
conference overall that
I have attended! Many
thanks to the conference
team and presenters!!!”

Erratum notice
On page 23 in the summer 2016 News Brake an article ran recognizing Professor Sherrilene Classen as a driving force for safety. However, when this news release was included, we failed to site the original sources. Please refer to the below websites for the original sources of the information contained within the News Brake.
http://news.westernu.ca/2016/06/professor-driving-force-safety/

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The articles published in News Brake reflect the opinions of their authors, not the editor, the ADED organization at large, or its Board of Directors. As such, ADED neither takes a position on, nor assumes responsibility for, the accuracy of the information or statements contained in any articles published in News Brake.

Additional issues are available by contacting the ADED office. News Brake is published quarterly. Articles by members and nonmembers of the ADED association are accepted at the discretion of the editor and as space permits.
For advertising rates, please contact Staci Frazier, OTR/L, CDI, CDRS at 603-793-9335 or email to snpfraz@comcast.net.

NewsBrake Fall 2016
President’s Address

DID YOU FEEL THE BUZZ IN COLUMBUS? I am writing this installment for the NewsBrake in mid-September and can still feel the energy that was palpable at our annual conference in August! At first, I thought it was simply my own excitement because I had never experienced conference as ADED’s “President” before, but I quickly realized that others were feeling the wonderfully positive vibe as well.

After considerable reflection, I attribute this aura of positive energy to the alignment of three stars.

Every single ADED conference I have attended has truly been a fantastic experience. This does not just “happen”. Our conference team (spearheaded by Katy Greene & Stacey Stevens and the working crew of Clinton Matney, Laura & Brian Iadarola and Tommy Crumpton) works countless volunteer hours each year to put together just the right cocktail of education, hands-on learning and social opportunities to have our members counting down the months until they return to the next year’s conference. Phil Lauerman, a CDRS from West Virginia, posted in ADED's Topic of the Month forum (July) that his top attractions at our annual conference are 1) networking, 2) knowledge and 3) motivation / friendship. Go check out Phil’s post, as he further explains (more eloquently than I ever could) how each of these elements have helped him in his clinical practice through the years. Our conference team succeeded again this year in putting together a great program with relevant and diverse seminar topics, knowledgeable and engaging speakers as well as an outstanding exhibit hall. This provided the foundation toward creating the aura of positive energy in Columbus.

Is it possible for a Strategic Plan to be pivotal in creating a “buzz of energy”? I was skeptical too, when this thought first came to me, but I honestly feel it is the case. The ADED Board worked hard to develop and finalize a three-year strategic plan in this year’s 1st quarter. We shared it with the membership in the spring NewsBrake, and at the Annual Membership Meeting at conference. We also introduced the Ad-Hoc Committees that have been pulled together to work on the specific goals of our Strategic Plan. The Champion of each of these Ad-Hoc committees summarized to the membership what their committee has done thus far and where the committee is going in the near future. It was quite clear at our membership meeting that ADED has an Action Plan and that the Action Plan is moving forward! This set the tone for the launch of our VOLUNTEER HUB in the Exhibit Hall. With Gina Lewis leading the charge, her creative juices flowing and her magnetic personality shining, we had micro-volunteers lining-up at the Volunteer Hub to offer whatever time they can afford in the coming months to help us move our projects forward! We had well over 30 micro-volunteers who signed on to either join a committee or to be called upon as needed in the future. We were amazed by the response and are eager to put these micro-volunteers onto our moving ADED train! For any members who could not attend conference but who may be willing to offer up a few hours here and there for ADED, please reach out to Gina Lewis (ginalewis@adapt-solutions.ca) and c’mon aboard! We are so excited by the engagement of our members, and I really feel that this added to the aura of positive energy in Columbus… BTW…we achieved Goal 5.1 of our Strategic Plan to “develop a productive body of engaged volunteers from the membership to build the organization”!

Of course, none of the above could have been achieved without the dedication and engagement of the ADED leadership and volunteer core. The train does not drive itself, folks! The direction provided by our Executive Director, Liz Green, the new ideas generated by our Education Services Manager, Lynn Mortilla-Rocap, the experience and commitment to ADED provided by our current Board of Directors, the involvement of the Chairs and members of our standing committees (Certification, Publications, Professional Development, Education, Board Development and Scholarship committees) and the leadership of our chapter officers are all crucial to ensuring that our association moves forward and continues to evolve. I have come to realize that working together with others who share a common passion cannot help but create a buzz and a positive energy! And so aligns the third star.

I hope you were able to attend conference and to feel the aura of positive energy first hand. It was a great experience; from Dr. Carr’s incredible Keynote Address to Bill Butt’s (dSi) incredible moves on the dance floor at the banquet, the buzz was palpable. A huge thank you to all who made the stars align in Columbus, and if you could not make it this year, you KNOW the stars will be shining even brighter in Albuquerque, New Mexico 2017!

Dana

Dana Benoit, MSc, OT, CDRS

ADED’s Leadership Core

Conference Committee

Strategic Plan’s Volunteer Hub
Notification of proposed ADED Bylaw changes

In accordance with the 2016-2018 Strategic Plan, a special Ad Hoc Committee was convened by Dana Benoit, ADED President, to review and update the bylaws. The committee incorporated suggestions and feedback from a consultant specializing in nonprofit governance as well as from members of the current board of directors. Special recognition and gratitude go to the Bylaw Review Committee for their time and dedication to this project: Mary Beth Meyer (chair), Lori Benner, James Kennedy, Michele Luther Krug, and Amy Lane.

The updated bylaws have been presented to membership in two forms:
• CLEAN VERSION: This version is the easiest to read with all changes incorporated.
• TRACK CHANGES: This version displays all changes and edits to the document and is more challenging to read.

Notable changes to ADED Bylaws:
1. Article II: Members, Section 4
   a. Revocation of membership was clarified and defined.
2. Article III, Board of Directors, Section 6
   a. Role and functions of the board were further defined and identified.
3. Article III: Board of Directors, Section 8
   a. Chapter liaison responsibility was moved from President Elect to a Board Member at Large. This change is in alignment with the role of the Board Member at Large as liaison between membership and the board.
4. Article V: Committees, Section 2
   a. The “Board Development” Committee’s name is changed to “Leadership Development” Committee to reflect a broader scope and role.
5. Article IX: Noninurment:
   a. Noninurement statement was moved, intact, to the end of the document.
6. (deleted) Article VI: Executive Director
   a. The Executive Director section was removed and is addressed in the job description.
7. Article III: Board of Directors and Article V: Committees
   a. Term limits for the board, committees and chairs were redefined.

Notable dates for bylaw adoption:
• Final bylaws vote for adoption period: November 1-15, 2016
• Updated bylaws effective date: January 1, 2017

Help for CDRS Renewal Using Non-Direct Driving Course Credits

The current Contact Hour Activities Policy 403 asks CDRS applicants to write a “statement of relevance” when submitting a CE course that is not directly related to driving. In an effort to clarify what is expected of applicants in the statement, the certification committee has broken down the statement into three questions as follows:
1. How do objectives/goals/abstract of the course apply to the topic of driving?
2. How does the information learned at this course change your understanding and decision making regarding your driving rehabilitation practice?
3. How will you apply the knowledge gained at this course to your rehabilitation driving practice?

A statement of relevance is written to help stimulate the clinical reasoning process of learning and is especially important when non-direct driving courses are attended. Remember that only 6 non-direct driving course contact hours will be accepted per renewal cycle. Those hours must be from a course that you have attended in person and not online. The questions will be added to the CDRS renewal application to help facilitate the process.

Membership Benefits

It is ADED’s mission to provide a professional network promoting excellence in the field of driver rehabilitation, thought leadership and advocacy in support of safe, independent community mobility. We are proud to have you along for the ride.

ADED is always striving to add new and useful items for members. This past year we have added a tool kit for starting or expanding your driving program: http://www.aded.net/?toolkit.

ADED has put together information for those of you struggling with Medicare. The information can help you successfully pursue funding through Medicare: http://www.aded.net/page/450.

Are you taking advantage of everything ADED has to offer? A full list of ADED benefits can be found here: http://www.aded.net/?page=110.

Rest assured, you will be receiving information on your upcoming membership renewal. Your ADED profile can be accessed with your username and your established password. If you are having problems logging in to the ADED website, you can reset your password here: https://aded.site-ym.com/general/email_pass.asp.

If you ever need any help related to ADED about your account, please let us know via email at info@aded.net or by picking up the phone (866) 672-9466.

CHAPTEr NEWS

The Ontario Chapter held their semi-annual chapter meeting and education day on October 15, 2016 during which we were delighted to hear presentations from Lloyd Updike and Brian Harper of Braun Mobility, Isabelle Gelinas from McGill University, NMEDA Canada president and Sure Grip representative Russ Newton and David Parton from Mobility in Motion. Thank you to all who participated!

As well, we are excited to announce that ADED and CAOT are joining forces to bring the Canadian National Driver Rehab Conference to Ottawa Canada on October 12 & 13, 2017.

“Q”uality of the seminars was outstanding this year!”
This edition of the NewsBrake follows another amazing ADED conference. As always the educational and mentoring opportunities were phenomenal. Each year the range of lectures, including those for experienced and new driver rehabilitation specialists, grows. The exhibit hall continues to expand and offers such a wealth of information to us working in this field.

The volume of new professionals entering the field who attended this conference was an exciting prediction of things to come. Their fresh insight and desire for knowledge was exhilarating. As always, I saw first time attendees welcomed into the ADED fold. I heard many people talk about the warmth, openness and inclusion felt by coming to the conference, an experience that most had not experienced at other professional conferences. I have no doubt that each new attendee left with a new list of professional contacts and friends.

In Columbus, I had the pleasure of meeting my entire committee in person. We are striving to continue to bring new information and ideas to the ADED membership via the NewsBrake. We are looking at new options for organizing the educational material featured. The winter 2016 edition of the NewsBrake will feature older driver educational topics. If anyone has an idea for an article or has a topic related to older drivers that they would like to see featured, please contact me.

I want to extend a special thank you to the board, volunteers and ADED staff who make the annual conference a possibility. The amount of juggling that goes on behind the scenes to make an event like this successful is overwhelming, and they do it with what seems like ease. Thank you also to all the members who expressed an interest in starting to volunteer for the organization. The future is very bright for ADED.

Surrounding this note are some pictures taken a new way, with a selfie stick. They highlight some of the fun that happens after the work is done at an ADED conference. The people you meet in this organization will be your peers, mentors and professional colleagues. However, they will also become your friends and family. I am truly blessed to get to know you all.

Love,
Staci

Staci Frazier, OTR/L, CDI, CDRS
snfraz@comcast.net
603-793-9335
A record number of driver rehabilitation specialists, mobility equipment dealers and manufacturers gathered in Columbus, OH to celebrate 40 Years of Independence Through Mobility. A total of 312 attendees came together excited to see old friends, make new connections and learn about the changes, opportunities and growth of our industry. Columbus was a repeat location for the ADED conference, and we were excited to re-visit the city. A huge “thank you” goes out to the Conference Team: Katy Greene and Stacey Stevens. They volunteered their time and talent year-round, and it is safe to say that with this publication, next year’s show is already being planned under the direction of ADED’s newest staff member, Lynn Mortilla-Rocap, Education Services Manager. It is always an adventure to put on a conference of this size, and we wouldn’t be successful without our army of volunteers. Brian and Laura Iadarola coordinated the silent auction which benefits the Memorial Fund. Dan Allison and his crew of champions brought in nearly $1,000 in donations during the 50/50 raffle ticket sale. Clinton Matney’s logistics skills were instrumental in orchestrating the exhibit hall move in. Tommy Crumpton and Dr. Paul Ross, I Am Ministries, provided the Sunday morning worship service. Our new attendee orientation was conducted by Leah Belle and Mary Beth Meyer. I encourage you to take a moment to personally thank all these volunteers who put in time, energy and care towards a very successful conference.

The Mentor Program continues to be a popular program with both mentors and mentees. VIP’s and mentors were invited to a meet & greet Friday evening and had a chance to meet the ADED board. This special networking opportunity was made possible by generous sponsorship from Mobility Works. Through the mentor program, new conference attendees were paired with returning attendees and introduced to our exhibit hall vendors and other professionals in the field. The goal is for mentor teams to continue their contact throughout the year. These partnerships will be an instrumental part of the program’s development and growth. Special thanks go to Leah Belle and Mary Beth Meyer for coordinating this program.

The exhibit hall was a bustle of activity throughout the conference. To kick off conference and the exhibit hall, product demonstrations were offered Saturday evening. Attendance at Saturday Night Product Demos was well attended, and participating exhibitors were pleased with the turnout and ability to have additional time to demonstrate their products. During the unopposed exhibit hall hours, attendees enjoyed opportunities to visit with our 49 exhibitors. The Soap Box Sessions were offered in the exhibit hall which pairs driver rehabilitation specialists and exhibit hall vendors for short presentations, giving attendees the opportunity to hear real life examples and case studies. The poster presentations were well attended and demonstrate a growing interest in research in the realm of driver rehabilitation.

Class of 2016. I am thrilled to welcome 22 new Certified Driver Rehabilitation Specialists to the ranks! A total of 32 candidates sat for the CDRS examination in August. The exam was offered both at conference and testing centers throughout the US and Canada. We are proud of those who sat for the exam and understand that this is an important step in your career.

A highlight of conference is our annual awards banquet, where special leaders in our industry are recognized. We are grateful to our banquet sponsor, BraunAbility, for making this evening possible. Dr. David Carr, conference keynote speaker, was honored to receive the Distinguished Service Award. The Achievement Award went to Rudy Schinz, best known for his work with Driving Systems, Incorporated. The Commercial Award was presented to Faye Shanor of Ford Mobility. For his service to ADED and the industry, Roger Kelsch was inducted as a Lifetime Honorary Membership.

There are benefits to early renewal! Renew or join between October 1 and December 1 and you will be automatically entered for a chance to win a 50% discount conference registration! This valuable prize will be awarded to 20 winners.

CDRS renewals. By now, those with CDRS expiring in 2016 should have received their renewal notices. On-line renewal applications are available at www.aded.net. In order to avoid late penalty or suspension of CDRS status, all renewal applications are due on or before November 1st. As a reminder, 15% of applications are randomly selected for audit; be sure to have your supporting documents handy! Those selected for audit will be contacted in writing requesting further documentation. It is the responsibility of each CDRS holder to retain records of attendance and approval for non-ADED approved contact hours.

ADED Board of Directors Elections. Elections for the 2017 ADED Board of Directors closed on October 20th. Members will get to ‘meet’ their new board in the Winter issue.

It is my great pleasure and honor to be of service to ADED. The staff is here to assist you. Please feel free to contact me, Robert Dant or Lynn Mortilla-Rocap if you have suggestions or comments. We are here for you! 866-672-9466. info@aded.net

Elizabeth Green, OTR/L, CDRS, CAE
ADED Executive Director
Great opportunity for learning & networking—wonderful experience!
Thanks to our Conference Sponsors

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silver Q’Straint/Sure-Lok

silver Stereo Optical

silver Veigel/dbaMPD

bronze DriveMaster

bronze Mobility Works

bronze NMEDA

“T was great. Lots of information that I needed.”
"The most valuable part of the conference was the opportunity to gather new information and education; loved receiving the “best practices” too; also the positive vibe of the leadership with regards to our future as an organization!"
“T
his was one of the
best conferences I
have been to with course
offerings, the number
and type of vendors, and
the conference team’s
enthusiasm.”

“E
evryone was very
friendly and it was
a great way to meet new
people from different areas
and different experience
types.”
Applications of Adaptive Vehicle Modifications
Dean Robertson, CDRS and Chad Strowmatt, LOT, CDRS

Introduction to Driver Rehabilitation
Natalie Drouin, OTR/L, CDI, CDRS and
Kimberly White, M.S., OTR/L, CDRS

Accelerating Your Private Practice into the Fast Lane
Jenny Nordine, OTR/L, CDRS

Exploring Potentials: Above and Beyond, New Strategies for Rehabilitative Driver Training
Ronn Langford, Founder/President
Master Drive
ADED 2016 Presenters

Pre-Conference Workshops 8/13/2016

Joysteer Certification Workshop
Robert de Vos Burchart, Michael Schmid, James Kennedy, Chad Strowmatt, Tim Brant

Key Note 8/14/2016

Beyond DuctTape: What Every Evaluator Needs to Know
Ann Hegberg, MS, OTR/L, CDI, CDRS and
Eva Richardville, OTR, ATP, CDRS, CAPS

Exploding the Myths and Meeting the Challenges of (50,000,000 Licensed) Older Drivers
Dr. David B. Carr, MD
ADED 2016 Presenters

**Seminars 8/14/2016**

Dementia and Driving: Current Evidence and Clinical Relevance
Peggy P. Barco, OTD, OTR/L, SCDCM, CDRS,
Carol Wheatley, OTR/L, CDRS
and Dr. David Carr, MD

**Seminars 8/15/2016**

Behind the Wheel with ADHD
Ann Shanahan and Gayle Sweeney,
Shanahan Sweeney Coaching

Medical Advisory Boards, Licensing Agencies and Driver Rehabilitation: Developing Competencies
Anne E. Dickerson, PhD, OTR/L, SCDCM,
FAOTA, Elin Schold Davis, OTR/L, CDRS

Digital Resources for the Driver Rehabilitation Specialist
Gayle J. San Marco, OTR/L, CDRS
Navigating the Legal Landscape
Diana Robertson, MCoT, CDRS

Distraction, Drowsiness, and Neurological Impairment: An Evidenced-based Approach to Driving Assessment and Intervention
Sherrilene Classen, PhD, MPH, OT REG. (ONT.), FAOTA, Liliana Alvarez J., PhD, MSc, O.T., Sarah Krasniuk, R.Kin, MSc, HBK, PhD Student, Melissa Knott, MSc(OT), OT. Reg. (Ont.), CWCE, CCLCP, PhD Student

Technologies to Assist Learner Drivers on the Autism Spectrum
Johnell Brooks, PhD, Miriam Watson, OTR, CDRS, CDI

Driving Cessation: Let’s Talk About It!
Amy Brzuz, OTD, OTR/L, CDRS

A New Tool for Assessing Driving Behaviors at Intersections
Pierro Hirsch, PhD
ADED Annual Awards
Presented August, 2015 | Columbus, Ohio

Presidential Citations
presented by ADED President, Dana Benoit

Alyssa Merilees  Mary Beth Myers

Exiting Committee Chairpeople

Scholarship Committee Chair: Jill Sclease  Publications Committee Chair: Staci Frazier
This competitive award is given to individuals or groups outside the scope of ADED who have demonstrated distinguished service and/or support to the overall area of mobility for persons with disabilities. This individual or group, while not members of ADED, will be selected for their discernible and unique contributions to this field. (Examples of such candidates could be representatives in the political/governmental arena; prominent medical or educational people; television, motion picture or other media personalities; etc.)

Note: The Distinguished Service Award (DSA) is considered the most prestigious award presented by this Association, to a non-member.

David B. Carr, MD

This award exemplifies an individual who has demonstrated distinguished service, support, and research contributions in the area of mobility and disabilities. David B. Carr has demonstrated leadership, has national and international exposure, extensive research and involvement in medical fitness to drive, and has dedicated his career to assisting individuals and communities in addressing the needs of older drivers.

LEADERSHIP

Dr. Carr’s leadership skills are evident in his many roles as a geriatrician. He is currently recognized as a leader at Washington University School of Medicine in St. Louis as well as other health care center facilities throughout St. Louis. At Washington University, he is the Clinical Director of the Division of Geriatrics and Nutritional Science, Clinical Director of Neurorehabilitation, and the Professor of Internal Medicine and Neurology. Additionally, he is the Medical Director of The Rehabilitation Institute of St. Louis and the Medical Director of Parc Provence in St. Louis. Throughout all of his many leadership roles – a continuous thread has been his focus on fitness to drive and is recognized as a clinical and research leader in how we currently approach older drivers with medical impairments.

In addition to all of the above, Dr. Carr serves as an outstanding and resourceful mentor to a variety of clinicians and students. He has mentored medical students, pharmacy students, psychology students, and occupational therapy students. Much of his mentoring revolves around fitness to drive. Dr. Carr is always collaborative with peers, both within and outside the university setting. His leadership provides students with a wealth of opportunities and experiences in driving research. His mentorship and research experiences commonly culminate in peer reviewed publications that have been internationally recognized.

NATIONAL AND INTERNATIONAL EXPOSURE

Dr. Carr is clearly nationally and internationally recognized in driving research. He has been active both nationally and internationally in educating physicians and clinicians in how to address driving in older adults with medical impairments. He has worked closely with occupational therapists and driving rehabilitation specialists throughout his career. He serves as a national consultant and on boards related to his expertise in the older driver. These include, but are not limited to, AAAM/NIHTSA Medical Fitness to Drive Consensus Committee, AMA Older Drivers Project, Physician Guide to Assessing and Counseling Older Drivers, American Association on Aging/Drive-Well Speakers Bureau, Board Member of ITN American, Consultant for Traffic Injury Research Foundation, Medscape Educational Consultant on Alzheimer’s Disease and Older Drivers, and the AAA Foundation for Traffic Safety Consultant – Occupational Therapy/ADED Enhancement Initiative. Additionally, Dr. Carr has given over 200 lectures/presentations across the United States, Canada, and Ireland related to research findings and current evidence related to the older driver.

RESEARCH AND CLINICAL INVOLVEMENT IN MEDICAL IMPAIRMENT AND FITNESS TO DRIVE

Dr. Carr has been active in investigating older drivers with medical impairments and publishing findings for the last 25 years. He has been on numerous driving-related grants as either a PI or co-investigator. He has provided leading research in helping clinicians understand how to identify and assess the older adult who may be having difficulty with driving due to medical impairment (i.e., dementia). He also has been instrumental in studies/publications investigating the role of medication use and driving in older adults, the effect of the voluntary reporting laws related to driving safety, and in understanding the effects of driving cessation and alternative transportation options for older adults. Additionally, he assisted in developing one of the first standardized “road tests” (Washington University Road Test – WURT) which has been replicated in many national/international driving studies. As a geriatrician, Dr. Carr exemplifies his knowledge in addressing driving concerns with his patients. He shows compassion, caring, and expert management when working with his patients and their families related to driving issues.

PERSONAL DEVOTION

It goes without saying that David Carr, MD, has devoted his career to improving our understanding of driving in older adults with medical impairment. His extensive research, publications, national and international presentations and consulting relationships related to driving demonstrate his personal devotion and passion towards supporting best practice related to driving. His past and continued work will help us, as driving rehabilitation specialists better assess and make recommendations related to various medical impairments and driving. We are very fortunate to have such an outstanding physician to help provide the evidence related to addressing the various medical issues that can impact driving performance.

In summary, Dr. Carr is a superb physician, generous colleague, and has shown a personal devotion throughout his career to driving and mobility. Congratulations to a very deserving recipient of this award!
AED Annual Awards

Achievement Award

A competitive award presented to an individual member of ADED who demonstrates outstanding contributions in the field of Driver Evaluation and/or Education. Material is not limited to the current year, but may be cumulative. This is presumed to be the most important award received by a member of this organization and the second most prestigious award presented by the Association.

NOTE: The Achievement Award is considered the most prestigious award presented to an ADED member, and the second most important award presented by the Association.

Rudy Schinz

Rudy started in this industry with Charlie Scott over 40 years ago. He is still going strong as he travels a number of days during the week to make sure that all clients and evaluators have what they need and is able to consistently provide quality evaluations on a regular basis. He has assisted many folks in the goal to return to independent driving status after injury or illness. Many of these individuals are still on the road today and some even have the original vehicles, which validates that DSI/Scott System equipment does at times last the mechanical life of the vehicle and then some. In past experience working with DSI and Rudy, it has always been a learning experience for all involved! Rudy always goes the extra mile (no pun intended) to make sure that both the evaluation process and the final fit and training in a client’s own vehicle is thorough and complete. He often will come to the facility for the initial stages of the equipment and vehicle evaluation spending many extra hours setting the vehicle up, modifying the current set-up or at times, making minor to major adjustments to an evaluator vehicle (and often times charging little if any for said adjustments). Rudy is a person who is always seeing the glass half full, working to make it completely full by the end of the evaluation and, with delivery of the client’s own vehicle. Often that delivery involves driving the van half way across the country when a client or evaluator needs assistance, Rudy is ready to fly out and assist in any way possible. Rudy is one of those individuals who always thinks of ways to make an evaluation custom for the client from “Duct taping” a rock on the steering servo under the vehicle to modifying a lever arm to fit the specific needs of a client.

Prior to Rudy’s work with Charlie in the 70’s to make an electrical secondary control system, most systems were very inconsistent and not replicated. Today, there are a number of manufacturers in the industry making secondary control options; however, without many of Rudy’s groundbreaking designs, we would possibly not be as advanced as we are today.

Rudy is very deserving of this award because without his knowledge, expertise and engineering mind, many people would not be returned to the independence that they have grown to know and cherish post injury. Congratulations, Rudy, on the ADED Achievement Award!

Lifetime Membership Award

A non-competitive award presented to a member(s) of the Association who has met the following eligibility requirements:

Eligibility
a. ADED member for 15 or more years.
b. Served a total of 10 or more years as an ADED officer, ADED national board member, conference team member, ADED standing or ad hoc committee member (positions can be combined to total 10 or more years).
c. Age 55 and/or within 5 years of retirement.

Roger Kelsch, RKT, CDRS

Roger has been an active member of ADED for over 25 years. He started working at Edward Hines JR VA Medical Center in 1984. He completed the Driver Rehabilitation Instructors training course through the Veterans Administration in 1985. He has been involved in teaching the 2-week course in Long Beach at the VA training facility for numerous years. Roger has been an advocate for ADED with the VA, serving as a liaison between the two organizations for many years. Roger served on the editorial review board for the ADED Newsbrake in the late 1990s.

Roger took the first ADED certification test in 1995. Being a glutton for punishment, Roger served two terms on the ADED certification committee, first in 1997 and again in 2011. Not only did he serve on the committee, he also chaired the committee in 1999 and was co-chair in 2011. He has been active in the Midwest ADED chapter, also serving as the chapter president in 1996. Roger was on the conference planning committee for several years when the conferences were held in Chicago.

Roger has done much to promote driver rehabilitation and ADED over the years, both nationally and locally. He is a very deserving candidate for this award. Congratulations to Roger as the recipient of the Lifetime Honorary Membership Award.
A competitive award presented to a Vendor or Corporate member or Organization who has demonstrated outstanding contributions in the field of driver rehabilitation /vehicle modifications.

Faye Shanor, Ford Mobility Motoring Program

The Ford Mobility Company has led the way towards making automobiles accessible for the consumer with physical and visual disabilities, beginning shortly after the passage and signing into law of the ADA, the Americans with Disabilities Act. Ford Motor Company began offering rebates for installment of aftermarket vehicle modification to driver primary controls, passenger ingress, egress and to assist with stowing assistive technology through its Mobility Motoring Program. They also recognized the benefit of the popular Ford Econoline full-size van for the mobility audience.

In the community, Ford has had a significant program through the Ford Mobility Motoring effort to educate consumers and advocate for inclusion of all persons with disabilities. The DaVinci Awards are an example of this effort as well as attendance at NMEDA, ABILITY Expos, ADED and many other organizations who support this mission. They are consistent participants in these events and support these organizations and their members to advocate for persons with disabilities across the ages.

Ford engineers have led the way in establishing collaborative and supportive relationships with aftermarket modifiers and manufacturers who share the same common goal of accessibility for those with disabilities. The QVM program was developed to assure the end user a safe and reliable vehicle purchasing option.

Faye Shanor has been the project manager of the Ford Mobility Motoring Program for almost 20 years. She has been an advocate, educator and liaison with Ford Corporate and Design Engineering, embracing the needs of the disabled driver or passenger along the way. Congratulations to Ford and Faye as recipients of this year’s commercial award.
A Case History and Lessons of an Academic Research Team Using Driving Simulators

Johnell Brooks, PhD
Clemson University

After attending ADED in Columbus and talking to numerous attendees about research, I decided it was time to share my research experiences with ADED members to encourage others that research is a fun, rewarding process that develops over time and with experience. I hope that my personal case history will benefit your future research pursuits and that you will enjoy your experiences as much as I have enjoyed mine!

As an eager graduate student in a psychology department, my first driving simulator study examined the effects of severe visual challenges on steering performance of healthy young drivers (Brooks, Tyrrell & Frank, 2005). It was exciting to build the driving environments using DriveSafety’s drag and drop tile system to create my own custom-designed roadway environments, continuously curvy roads. Our study dramatically manipulated blur, luminance levels and field of view to extremes well beyond what a driver would ever reasonably experience. After weeks of data collection, it was time to analyze the data and write a manuscript. Because I am not a programmer, I spent months (literally months) using Excel to analyze the numerous variables that were collected multiple times per second. It was an important life lesson to realize that one needs to have a concrete data analysis plan prior to starting data collection. Exploring every possible variable was not realistic, even in an academic environment. On the positive side, it was immensely valuable to understand the more than 60 possible variables that can be and were collected, as well as the frequency of those recordings, which in our case was 60 times per second. These simulator data variables (e.g., Accel, CollisionVelocity, HeadwayDistance, HeadwayTime, LaneHeading, LaneIndex, LanePos, etc.) were originally created and named by engineers and programmers who likely never interacted with occupational therapists, driving instructors or psychology graduate students. For me, it was equivalent to learning a new language, the language of engineers and traffic safety experts.

Going through the labor-intensive exercise of analyzing the data “by hand” made me appreciate the importance of needing an interdisciplinary team, starting with a programmer! It was incredibly helpful to understand what data the simulator collects, how the raw data need to be manipulated to become “useful” and the actual frequency of the data I realistically need in comparison to every imaginable data point that I collected.

Once the data were analyzed, the next valuable lesson was watching my family and friends’ reactions to our team’s very exciting findings; their eyes literally glazed over instantaneously as I passionately told them about the drivers’ deviation from the lane’s center position for each condition. Ironically, at the same time, I was taking Human Factors courses, which have the overarching goal of studying the capabilities and limitations of human operators so that systems/products can be designed to be safe, productive and satisfying (Chapanis, Gardner & Morgan, 1985). As I was conveying the simulator study results to my friends and family members, I was being neither productive nor satisfying to the individuals with whom I was communicating! Jacob Nielsen’s book, *Usability Engineering* (1993), discusses what can be classified as the 10 “golden rules” to ensure that usability principles are followed. When applying his rules to reporting data, there are three that are key: 1) use simple and natural dialogue instead of technical jargon, 2) speak the end users’ language and 3) be consistent. Abelson’s book, *Statistics as a Principled Argument* (1995), is another excellent read that takes one through the process of how to present quantitative data in a coherent story. These meaningful experiences with regard to effective communication taught me to change technical statements such as, “When using X diopters of blur, the participant’s collision velocity was X, with an average lane position of –X.X meters from the center of the lane on lanes with curves with an average radius of X degrees, while traveling a velocity of X, while the accelerator fluctuated between X & X” to more practical statements such as, “When the driver was wearing special glasses that made the scene so blurry that he could not even read the largest E on an eye chart while standing 3 feet from the eye chart, the driver was able to stay in his lane, an astonishing XX% of the drive which used continuously curvy roads; on the other hand, he missed seeing X of the 10 pedestrians standing within a few feet of the edge of the lane.” We must all remind ourselves that the technical language we use every day with our co-workers most likely does not make any sense to individuals outside of our field. We must put the burden on ourselves to determine the words and process needed to convey our results in a clear, concise and meaningful manner.

Jumping ahead a few years… As an eager, young faculty member in a psychology department, our team used an adapted version of a DriveSafety RS-600 driving simulator, consisting of a full vehicle surrounded by multiple screens (See Figure 1A). As a result of interdisciplinary collaboration with bioengineers, civil engineers and mechanical engineers, our studies focused on the impact of cell phones and texting on lane keeping (Crisler, Brooks, Ogle, Guirf, Alluri, & Dixon, 2008); examining drivers’ head and neck movements (Roach, McKee, Goodenough, Brooks & DesJardins, 2010); speed choice and driving performance in simulated foggy conditions (Brooks, et al., 2011); and the impact of A pillars (the pillar between the windshield and the front doors) on what the driver sees and misses (Goodenough, Brooks, Crisler, & Rosopa, 2012). While we felt we were addressing real-world, clinically relevant issues, we unfortunately did not include anyone with a purely medical background on our team. This problem was compounded by the fact that at that point in time, clinicians rarely, if ever, attended our academic conferences. Largely as a result of developing a partnership with a geriatrician, we started to appreciate the potential clinical applications of many of our efforts. While the RS-600 simulator served our purposes in a purely academic setting quite well, it was very large and filled much of a spacious classroom. Due to the space constraints in the hospital where we hoped to locate a simulator, we were able to obtain a grant for two smaller DriveSafety RS-600 partial, full-width vehicle

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A) RS-600 Full Car

B) RS-600 Half Car
Adapting to the Clinical Environment

One requirement of working with the hospital was shadowing a variety of physicians and other clinicians in a broad range of clinics for an academic year. During these in-clinic observations, it became increasingly apparent to me how many patients had absolutely no clue what their doctors and medical professionals were telling them about their health. During this timeframe, the local CDRS from the same hospital system sent the physician that I worked with a carefully constructed letter asking why she was not invited to be part of the driving simulator program we were establishing in his practice. Wow! What a wake up call for our team. I am still embarrassed to say that this was entirely justifiable. Thanks to her letter, we met with her and her administrator to see how this physician group regularly referred patients to the CDRS, her frustration with us was entirely justifiable. Thanks to her letter, we met with her and her administrator to see how we could start collaborating, and we eventually moved the driving simulator and research program from the geriatrics department to the rehab department. We learned several valuable lessons during our time in the geriatrics department, starting with the fact that what is ideal for an academic research lab is not necessarily what is ideal for a clinical setting. Since the obstacles we encountered from having a large footprint driving simulator led to the reports we use today, a high level overview of the challenges included:

- Space – The simulator was too large for a clinical environment. It completely filled an x-ray room. A smaller simulator was needed.
- Complexity – The system was too complex for a clinician to quickly use the simulator, due to the fact that eight computers plus other components needed to be started. A turnkey system with one power switch and a simple interface was needed.
- Cost – While the price of simulators has dropped dramatically in recent decades, the larger simulator was simply too expensive for broad-scale clinical use. A less expensive system was needed.
- Visual immersion – Our simulator had large, wrap-around display screens that provided a full 180-degree field of view for the driver. While this was very realistic, the large field of view caused those who were sensitive to simulator sickness to be overwhelmed by the strong illusion of motion from the displays. Though our simulation and traffic engineers insisted the wide field of view was important, having a significant percentage of patients become uncomfortable or even sick was unacceptable for clinical practice.
- Adaptation protocol needed – We did not have a systematic simulator adaptation protocol. The vice president of a university visited the program, and he decided he should start with an urban driving environment with lots of curves, stops and traffic. He immediately experienced simulator sickness. A systematic adaptation protocol was needed for everyone who uses the simulator, regardless if they were a guest or a client.
- Driving scenarios – We did not have enough driving scenarios to meet the diverse needs of the patients. A library of clinically-useful driving scenarios was needed.
- Team members – While we had a growing interdisciplinary team, we did not originally have an OT on our team. We started attending the AOTA and ADED conferences.
- Billing – We could not bill in the geriatrics department. We moved to the OT department.
- Reports – Clinicians and patients wanted immediate feedback. All of our previous studies used the academic process of collecting all data, then analyzing all of the data afterwards. This simply does not work in a clinic. Immediate, objective data with printable reports were needed.

These lessons-learned paved the path for our next steps. Our team worked diligently to develop a small-footprint driving simulator (Figure 1C and Figure 1D) that would meet the needs of a diverse range of patients, while being designed for use in clinical settings. This was accomplished by getting continuous feedback from OTs, engineers, physicians and, most importantly, seniors who were our initial target patient population.

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A Case History and Lessons of an Academic Research Team (Continued)

Conducting Usability Studies

An iterative design process was used along with usability studies for each iteration of the simulator that was developed. For example, one series of studies determined the ideal display configuration (Goodenough, Brooks, Pagano & Evans, 2012). At the same time, we also conducted a series of studies to understand the needs of our end users – both the clinicians and patients. This process started with a study examining physician interactions with aging patients concerning driving fitness as well as physicians’ understanding of their reporting obligations and requirements (Witte, Brooks, Logan & Beeco, 2009).

Our next step was to interview physicians and senior citizens to understand their attitudes about using driving simulators in clinical settings (Crisler et al., 2012). One of the most significant lessons learned from that study was realizing that it is our responsibility as clinicians and researchers to educate physicians about the capabilities and limitations of using driving simulators in clinical settings. While it was encouraging that all of the physicians we interviewed were willing to refer their patients to a driving simulator program for therapeutic purposes, it was shocking to learn that 97% of the physicians were willing to refer their patients to a driving simulator program to have their driving assessed.

The one physician who was not willing to refer his patients was a palliative care doctor whose patients never return to driving: therefore, he would not have them spend their money to have their driving assessed. The reason it was so shocking for us that all of the remaining physicians were willing to refer their patients to a driving simulator program to have their driving assessed was because not a single doctor asked if there is evidence to demonstrate that a driving simulator is appropriate for such an assessment. It is critical for the therapists who use driving simulators, or any tool for that matter, to make sure the physicians, the patients and their families, as well as other consumers understand the capabilities and limitations of using driving simulators in clinical settings.

The usability studies on the development of the reports were equally as important as the usability studies on the physical driving simulator. Our team invested a lot of time and energy to ensure the development of user-centered reports for patients and medical professionals who will use the reports (Beeco et al., 2010). It is critical the reports are easy to understand, use images over text when possible (to serve as a reminder of the task when the patient takes the report home), are on a middle school reading level, are available immediately after the driving simulator task ends, and are in black and white to keep costs of ink as low as possible. Since simulators are used to address a broad range of community mobility and pre-driving skills, it was also important for our team to ensure the reports make sense to young adults with intellectual disabilities or who are on the Autism Spectrum Disorder (Brooks, Mossey, Tyler, & Collins, 2013; Brooks et al., 2016).

In addition to conducting usability studies on the physical simulator and the reports, our team also conducted usability studies on the instructions the simulator operator reads to the client and the interface the simulator operator uses to control the simulator. Sometimes the solution to one problem caused another obstacle. For example, when we first had the idea for a small-footprint simulator, we thought it would be important to position the simulator operator next to the driver, as if the simulator operator was in the passenger seat. It quickly became obvious this was a very bad idea because “polite” drivers would want to make eye contact when the simulator operator was speaking. This put the driver in the horrible position to transfer his or her visual attention from the simulated world to the real world and back, which contributes to simulator sickness. As a result, a “home” position was assigned for the simulator operator to stand directly behind the driver. While this solved the simulator sickness issue, it made it impossible for the simulator operator to see the driver’s feet. The solution was to use the simulator operator’s interface to show the degree to which the gas and/or brake pedal is depressed.

Our team even conducted usability tests on our simulator sickness questions and procedures, which revealed the need to make changes to the original 1-9 scale used to access motion sickness; many of our participants felt the scale should be changed to 0 – 10 because it felt wrong to them to report a “1” when they felt no symptoms (Brooks et al., 2010).

Over the years we have developed interactive exercises, adaptation drives, naturalistic drives and corresponding reports to use with a broad range of patients. The development of these tools has been in close collaboration with OTs who graciously offered their feedback and advice. The research efforts over the past decade have taught me that “it takes a village” to develop tools and services to improve the quality of patients’ lives and that together we can make a difference. It is so rewarding and motivating to attend ADED and meet with clinicians who are using the tools that we have developed. The translation from research to relevant applications for practice in a clinical setting must rely on both establishing a multidisciplinary team that includes health care practitioners and collaborating to develop and implement an umbrella of shared knowledge.

Disclaimer: This “case history” uses DriveSafety simulators for examples due to the author’s familiarity with DriveSafety. The topics discussed also apply to other driving simulator manufacturers. Special thanks to Leah Belle, Nathalie Drouin, Casey Jenkins, Roger Kelsch, Ken Mehrick, Joe Neczek, Susan Pierce, Susie Touchinsky, Connie Truesdail, and countless others who helped make the documentation of this case history a reality.

References

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A Case History and Lessons of an Academic Research Team (Continued)


“T
his was my first year to attend the ADED conference. I attended the two day course on introduction to driver rehabilitation. I thought the course was very well put together. Having two experienced presenters allowed for different views on varying topics. They both did an incredible job at relating their personal experience to their teaching points. I came away from this feeling much better about starting out in driver rehabilitation.”
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Benefits to Volunteering/Mentoring as a CDRS

One of the biggest reasons that I was hired 27 years ago by the Driver Rehabilitation Department at Mary Free Bed Rehabilitation Hospital was quite literally “ADED”. The 1989 ADED conference in my home town of Grand Rapids, Michigan was the reason that I was hired. In 1989, host facilities were responsible for the conference in its entirety. Many hands were needed to get the job done. So, what can I do to help the organization that has helped me for so many years? I can be a mentor.

The mentoring program is a fantastic opportunity to meet a new member and discuss current issues within the industry. It gave me the opportunity to pay forward some of the time that other ADED members have given to me so freely. Walking through the exhibit area and introducing a new member to current ADED members allowed me to witness again what ADED does best: welcoming, educating, valuing new ideas and making new connections. It gives me hope and encouragement. Although my career has changed in so many ways, the core of ADED remains the same, and I would not want it any other way.

Greg Brunette, CDRS

Leah Belle and Mary Beth Myers, Board Members at Large

Congratulations to the “Class of 2016”! ADED is pleased to announce 22 new CDRS who successfully passed the August 2016 CDRS exam. We are proud of your accomplishment and welcome you to the “CDRS Family”.

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The time had come and we knew we had to make a change. At 70 pounds and over 4 feet tall, it was becoming increasingly difficult to safely transfer our 9 year old daughter in and out of our unmodified van. Between school and therapies, we were averaging at least 6 transfers a day. It was hard not only for us physically but also for Kinsley, as we struggled to transfer her from wheelchair to car seat. We had been looking at vans with a ramp conversion but were unsure how we would afford the options we needed. The Ralph Braun Foundation and the grant we received were an answer to prayer! The van we were able to purchase is perfect for Kinsley and our family. She loves being able to stay in her wheelchair, going up and down the ramp and helping buckle her seatbelt. From the very first day we drove the van, we experienced a new freedom! We had stopped going places because we were worn out physically, and it was too difficult to get Kinsley in and out. Kinsley is a social butterfly and loves to be out and about. It is now possible, thanks to your foundation that helps people achieve that freedom of mobility. We are forever grateful that you saw our situation and decided to help change our lives! Many thanks. – Rebecca, Bradley and Kinsley

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CEDER: A Novel On-Road Approach for Retraining the Cognitive-Perceptual Skills Required for Driving

Truong, M-T, OT MSc1, Gélinas, I., OT PhD2, Fillion, G., OT3, Aucoin, L.1, Morin, R.3, Turbide, J.1, Côté-Leblanc, G1.

INTRODUCTION: CEDER, a novel intervention program, is a structured and progressive approach stimulating cognitive-perceptual skills of the client with the use of pictures and videos of driving scenarios, adapted commentary driving while sitting in the passenger seat and behind the wheel training. Objectives: 1) provide information on its clinical applicability and 2) present preliminary results of its impact on driving performance.

METHOD: A quasi-experimental pilot study is conducted to evaluate the impact of the approach.

Preliminary data with a limited sample did not reveal an increase in the number of pass on an on-road evaluation for the participants who underwent the CEDER approach compared to matched controls trained under standard practices. Trends are however observed for improvements in the performance on cognitive and perceptual tests after CEDER training. The majority of participants found the approach very helpful for improving their driving awareness and ability.

Adult drivers (n=9) with cognitive-perceptual impairments who had failed a comprehensive driving evaluation were recommended CEDER retraining. Participants were compared to a matched control group (age, sex, severity of impairments) (n=9) trained on the road using standard practices.

DISCUSSION: Preliminary data with a limited sample did not reveal an increase in the number of pass on an on-road evaluation for the participants who underwent the CEDER approach compared to matched controls trained under standard practices. Trends are however observed for improvements in the performance on cognitive and perceptual tests after CEDER training. The majority of participants found the approach very helpful for improving their driving awareness and ability.

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Driving and Community Mobility Skills Building Bootcamp

Jennifer C. Radloff, OTD, OTR/L, CDRS and Anne Dickerson, PhD, OTR/L, SCDCM, FAOTA

Our pilot program was designed to evaluate and improve the IADL of driving and community mobility skills of teens and young adults with High-Functioning Autism Spectrum Disorder (HF ASD). The camp was held over seven weeks; the first week was five consecutive 6 hour days, followed by six weeks at an average of two 90 minute sessions per week. Assessment measures included visual screening (Optec), road sign knowledge, Useful Field of View, Assessment of Motor and Process Skills, Test of Everyday Attention, Behavioural Assessment of the Dreyfus Syndrome. Outcome measures included P-Drive on driving simulator, Interactive Metronome (IM), and Vision Coach (VC). Interventions included 30 minutes each session on each of the following: driving simulator, IM or VC, and a skill-building activity. Activities included traffic sign knowledge, hazard detection, CarFit, mapping and navigation skills, trip planning, use of public transportation, and What Do You Do If... scenarios.

We had 7 out of 8 participants complete the entire program. All participants were males between the ages of 15 – 19 years old. Three participants had permits and five had taken formal driver’s education courses without achieving their licenses. Five out of seven participants made significant improvements on the P-drive pre and post-test (p=.008).

Preliminary analysis shows improvements on the IM in both task averages and SRO% for those receiving IM (n=4) when comparing pre and post-scores. Outcome scores on the VC showed greater improvements in the group receiving VC (n=3) compared to the group receiving IM. However, we did note that overall all participants made some level of improvement in comparing pre- and post-scores of the IM and the VC. This is likely due to all participants receiving one or the other interventions and both of these interventions address visual-attention skills. Participant and parent perceptions of the camp were positive for improving skills along with self-confidence.

Normative Data on the Grommet Maze Task Used in Pre-Driver In-Clinic Screening

Matt Abisamra, OTR/L, CDRS & Mary P. Shotwell, PhD, OT/L, FAOTA

In-clinic, pre-driving evaluation consist of a variety of tools. The Grommet Maze is one tool used to measure upper extremity range-of-motion, coordination as well as visual motor performance. Despite this tool being used as part of clinical evaluations, there does not appear to be normative data in the literature about this “assessment” tool.

The purpose of this study was to:
Explore age-related means for this assessment in non-disabled and disabled participants
Explore the predictive nature of the assessment in terms of passing or failing:
The in-clinic pre-driving evaluation
The behind-the-wheel driving evaluation

Results indicate that there are differences in age groups, particularly older adults. The mean score of 11.7 seconds was found for both disabled and non-disabled groups. In a group of 30 people with disability, the Grommet Maze was predictive of passing/failing the in-clinic and the BTW evaluations. Though results appear promising, the numbers of participants with disability was small, and thus, further study is indicated.
 PTSD is considered a disorder of physical and emotional dysregulation rather than as an anxiety disorder, although many veterans also suffer from co-morbid anxiety and depressive disorders. The parts of the brain impacted by PTSD include the amygdala (fight or flight alarm system) and the hippocampus (information-processing for memories of life and experiences), with communication between the two structures and the rest of the brain, including the ventromedial prefrontal cortex (emotional processing and decision-making, disrupted as a result of PTSD. Changes in brain activity, particularly increased activity in the amygdala and decreased activity in the prefrontal lobe, along with the inability of the hippocampus to store the over-production of the amygdala as long-term memory, results in the feeling of constant danger.

The Department of Veterans Affairs utilizes evidence-based psychotherapy and/or psychopharmacology as the first line of defense in treating PTSD. Research has shown the most effective medications for treating PTSD include Zoloft, Paxil, Effexor, and Prozac. VA/DoD practice guidelines also include proven effective traditional therapeutic approaches, including exposure-based therapies, cognitive-based therapies, stress inoculation training, and eye movement desensitization and reprocessing. Increased use of Complementary and Alternative Therapies (CAM) in the VA system has been documented, with only acupuncture and meditation accepted as evidence-based treatment at this time. Complimentary refers to the use of these techniques in combination with conventional approaches, and Alternative refers to their use in lieu of conventional practices.

The types of treatments used most often in specialized PTSD programs are mindfulness, stress management/relaxation, progressive muscle relaxation, biofeedback, and guided imagery. Alternative approaches for the treatment of PTSD continue to grow faster than science can catch up, including the use of therapy dogs, yoga, outdoor retreats, and art and music programs.

The effectiveness of exposure therapy to treat driving phobia along with PTSD has led to an increased use of virtual-reality exposure therapy due to its advantages, including a controlled environment for the delivery of sensory stimulation with increased efficiency and greater willingness of patients to participate in VRET over in vivo exposure. Virtual-reality can be a bridge to the natural driving environment. Inadequate training was cited as the most common reason for not using exposure, followed by concerns with patients decompensating.

This case study involved therapeutic treatment including a combination of cognitive-based therapy, utilizing parts of the VA Deployment-Related Driving Stress Management Course, and DriveSafety driving simulator for desensitization to driving; and mindfulness-based cognitive therapy in the use of therapeutic activities on the driving simulator and in the natural driving environment. Mindfulness-based cognitive therapy (MBCT) is defined as paying attention in a particular way, on purpose, in the present moment, and non-judgmentally. MBCT is utilized traditionally as a form of relaxation through focused meditation. The aim of MBCT is to shift the individual’s perspective in a way that counteracts psychopathological processes, with the goal of changing the brain to access the present moment pathway-the right insula of the brain, which has connections to the amygdala and other structures of the brain involved in the modulation of interoceptive processing. Interception is the sense of the physiological condition of the entire body, and can be disturbed with error-signaling as a result of learning and prediction. MBCT focuses on adopting a new way of being and relating to thoughts and feelings. While concentration is the focus on something, mindfulness is the awareness of the presence of mind. MBCT helps change the process of thinking, not just the content of our thoughts.

I had the pleasure of working with my veteran, GT, starting in June 2014. GT was a 50-year-old convoy escort in Iraq in 2004-2005, and reported very limited driving since 2009, due to driver anxiety, which he described as “phobia” and “paranoia.” GT reported a motor vehicle accident in 2010, in which he lost control of his vehicle while driving under an overpass, and struck an abutment. GT’s goal was to drive with less anxiety and more confidence, and enjoy driving again. The pre-driving assessment revealed adequate test scores for brake reaction time, vision skills, visual perception, and cognitive-perceptual skills. The driving simulator test was the only test that showed some difficulty for maintaining centered lane position while identifying target letters on three monitor screens and responding to brake lights ahead, essentially performing three tasks at the same time on the driving simulator. The behind-the-wheel assessment was scheduled for a later date, per GT’s request, due to increased low-back and LE pain, no doubt exacerbated by the 5 ½ hour drive from Selma, Alabama to the VA in Augusta, Georgia.

Two months later, the on-road assessment was discontinued after 2 miles on the VA campus, during which GT displayed maladaptive driving behaviors, including unnecessary speed reductions and steering away from oncoming vehicles, with excessive off-road scanning. Gradual return to driving was recommended, and the Driving Performance (video) Test was completed, with scores ranging from Average-to-Excellent on 5 skill areas: “Search,” “Identify,” and “Predict” received Average scores, “Decide” scored Above Average, and “Execute” scored in the Excellent range. My treatment plan needed to include strategies for reducing driver anxiety for a veteran who demonstrated essentially good pre-driving skills, but was hindered from returning to driving due to PTSD related to combat-related driving experiences.

My initial approach incorporated portions of the VA Deployment-Related Driving Stress Management Course, which was designed for group settings, and which I adapted for individual use. Topics covered included identifying and ranking driving-related triggers, why driving stress lingers after return from deployment, and warning signs in bodily reactions, emotions, and thoughts. GT rated extreme driver anxiety with debris and objects on the side of the road and driving under overpasses. Visual (photo of granddaughter), mental (“this is NOT Iraq”), and verbal (“at ease”) safety cues were developed for reducing driver anxiety. GT persisted in thinking that his driver anxiety should be resolved after so much time had elapsed since his return from Iraq, and to test his theory, he “drove” on a realistic driving scene on the driving simulator for a few minutes, during which time he displayed bodily reactions including perspiration, muscle tension, and tight grip on the steering wheel; and emotional responses including fear and increased anxiety. Once GT realized even a driving simulator could create driving stress, he appreciated the depth of his driver anxiety and understood that it couldn’t be controlled by telling himself otherwise. As much as he told himself he shouldn’t feel his fear, the feelings didn’t go away.

For similar reasons, I am not a big fan of cognitive behavior therapy, nor was I confident in an approach that strictly focused on confronting the source of driver anxiety, either in the actual driving environment or on a simulator. One drawback to using exposure therapy for GT was geographical distance, which prevented regular, frequent sessions. My inclination was to find a way to bring back the joy of driving for GT, rather than focus on the fear of driving. Capitalizing on GT’s strengths gave me more treatment options for challenging his skills. As an occupational therapist for many (Continued)
years, it made sense to provide purposeful activities that steered (pun intended) GT closer to the driver seat without actually focusing on the ultimate task, i.e. driving. Since driving triggered maladaptive driving behaviors that worked during deployment, GT needed a new way to look at driving without triggering inappropriate driver behavior and negative thoughts.

The first goal was to get GT comfortable in the driving simulator seat. This was achieved using the “Interactive” DriveSafety driving simulator programs, non-threatening, task-oriented driving-related exercises to facilitate a different way of relating to operating the primary driving controls by creating a fun, game-like approach with the result of decreasing anxiety while focusing on the tasks, reinforcing mastery and proficiency in pre-driving skills, and eliciting a sense of enjoyment and accomplishment. The interactive simulator games included Steering Static, Pedals Static, Steering Chase, Pedal Chase, Copy Cat, and Slider. After succeeding with interactive simulator programs, “Instructional” simulator programs were utilized, focusing on lane position and speed control. GT performed well on all the instructional programs, which further reinforced his skill level without increasing driver anxiety.

In conjunction with simulator programs, vehicle-passenger activities were introduced, and involved visual search and scanning for specific targets, including stationary objects such as moving houses and For Sale signs, as well as moving objects, such as pedestrians and oncoming vehicles. The number of different objects and complexity of visual scanning skills increased as training progressed. The final activity completed as a vehicle-passenger, Scavenger Hunt, involved locating 21 different commercial businesses on a busy, four-lane road, facilitating visual search and scanning, and divided attention skills, which allowed GT absolutely no time to look for driving-stress triggers.

At session 6, GT’s goal was to drive around the VA campus one time (~1 mile), during which he was assigned two tasks while driving: counting the number of right and left turns executed, and monitoring vehicle speed to within 2 miles of the posted limit. Focusing attention on driving-related tasks inhibited maladaptive driving behaviors and facilitated mindfulness by being in the present moment, without making judgments—mindful seeing, mindful attention, and mindful engagement. Jazz music was also played on the radio for its calming effect. When GT returned home, he began driving in his neighborhood for very short distances consisting of a 2-block radius. He reported one set back when encountering aggressive teenagers playing basketball in the road.

Driving simulator programs progressed to Naturalistic driving scenes, with the goal of desensitization to the driving environment without the use of distractors. Driving scenes without traffic were utilized initially and, progressed from rural to urban, freeway, suburban and residential roads, with and without traffic. 10 minutes driving tolerance was demonstrated until symptoms of simulator sickness were elicited. 30 minutes of simulator driving was completed at lower vehicle speeds after the break, during which time simulator sickness symptoms subsided. 3 miles behind-the-wheel on the VA campus were completed during the AM session, with 7 miles of VA campus and residential roads in the PM session. Mild driver anxiety was elicited by a truck following close behind.

Independent driving increased to a 4-block radius in the neighborhood without incident. At session 8, GT completed a 22-mile driving route, displaying mild driver anxiety, with cues needed for increasing and monitoring vehicle speed. Local landmarks were used to redirect visual attention from potential maladaptive driving behaviors. At the last treatment session, GT reported driving 15 minutes when alone and for up to 60 minutes at a time while accompanied. He has completed individual and group PTSD therapy programs, and was still attending weekly group sessions. The driver evaluation route was successfully completed on 22 miles of residential, downtown, city, and interstate roads, with no driver anxiety observed or reported.

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How Can the Gap & Pathways, as Well as Other Current Projects, Help Me?

by Susan Touchinsky, OTR/L, SCDCM, CDRS

In the NewsBrake Volume 40, Number 1, Winter 2016 Edition, we brought you your first update on the American Occupational Therapy Association (AOTA) and National Highway Traffic Safety Administration (NHTSA) Gaps & Pathways Project. This article will continue to share resources resulting from the Gaps & Pathways Project as well as additional resources that have resulted from collaborations with NHTSA, the American Geriatrics Society (AGS), and the Transportation Review Board (TRB). We will explore contributions to the driving rehab industry and highlight the value of these resources for the ADED member.

**UPDATES & CONTRIBUTIONS FROM THE GAPS & PATHWAYS PROJECT: AOTA & NHTSA Gaps & Pathways Project**

Survey of Licensing Requirements for Driver Rehabilitation Programs: This resource was developed through surveying driver rehab specialists (DRS) to determine current state requirements for practicing as a DRS with experienced and/or novice drivers, requirements for becoming a driving instructor and/or driving school, and communication standards with the state’s medical advisory board. Use this resource to review current state standards as a starting point when developing a driving program. In addition, work from this project points to the continued opportunities for ADED to advocate and establish standards for the DRS with individual state DMVs. To view the report: https://www.aota.org/~/media/Corporate/Files/Practice/Aging/Driving/survey-licensing-requirements-driver-rehabilitation-programs.pdf

To view a summary of the state licensing requirements: https://www.aota.org/~/media/Corporate/Files/Practice/Aging/Driving/program-licensing.pdf

Diagnosis Driving Pathway Sheets: These resources were developed for the OT practitioner to use when developing client-specific interventions for driving and community mobility. The resources are based on common medical diagnosis groups. They may be used by the OT generalist and OT Driving Champion to help guide clinical reasoning and intervention approaches related to Driving and Community Mobility. The Driving Pathways by Diagnosis Sheets may be used to help develop and facilitate a plan of care. The Pathway sheets include recommendations for treatment interventions, assessment tools, recommendations, considerations, and guidance on when to refer to an OT DRS. Diagnoses covered include amputation, arthritis, cardiovascular, cerebral vascular accident, mild cognitive impairment and dementia, neuro muscular disease, orthopedic, and Parkinson’s disease. Receive your free copy of this resource by emailing susan.touchinsky@genesishcc.com.

The Ethical & Professional Obligation to Address Driving when Delivering Occupational Therapy Services: Occupational therapy (OT) practitioners interface with a large number of drivers recovering from injury or illness on a daily basis, yet many practitioners remain hesitant and unsure of their role when it comes to driving and community mobility. While the in-vehicle evaluation and training is a specialized skill for the DRS, the OT can support assessment of performance skills, provide interventions to strengthen pre-driving activities, and help to facilitate appropriate referrals to the DRS. Share and reference this free, 1 hour continuing education video with OT practitioners to help increase an understanding of the OT role with driving & community mobility. By taking time to discuss the OT versus DRS roles, we can help to build the confidence of the OT practitioner, facilitate positive mentorship, and increase appropriate referral flow. The free Ethical & Professional Obligation to Address Driving when Delivering Occupational Therapy Services is available through https://www.aota.org/Practice/Producive-Aging/Driving/Ethics.aspx.

**ADDITIONAL UPDATES & CONTRIBUTIONS FROM THE FIELD**

Clinician’s Guide to Assessing & Addressing Older Drivers: This is the updated revision to the AMA’s Physician’s Guide to Assessing & Addressing Older Driver. American Geriatrics Society (AGS) has revised this project to include additional resources to the clinician, including the Maze Test and a 10 foot Snellen Chart. The guide continues to include a range of resources for addressing concerns for the adult driver, common medical conditions and potential impact, and highlights individual state resources for medical review units. https://geriatriccareonline.org/

ChORUS: The Clearinghouse for Older Road User Safety, better known as ChoRUS, is a FREE website managed by the Roadway Safety Foundation (RSF), Federal Highway Administration (FHWA), National Highway Traffic Safety Administration (NHTSA), Syneren Technologies, and Bonzzu. This incredible resource is a great, one stop shop for information on adult drivers and safety. ChoRUS covers topics including safer roads, being a safe road user, safer vehicles, family and caregiver resources and alternative transportation, research, and policy, enforcement, and medical fitness. One unique feature of the site is the ability to view older road user research by state. Visit the site at https://www.roadsafeseniors.org/ to learn more.

Taxonomy and Terms for Stakeholders in Senior Mobility: In its July 2016 issue of Transportation Research Circular, the Transportation Research Board shares Taxonomy and Terms for Stakeholders in Senior Mobility. This resource is especially valuable for researchers, DRSs, and other transportation professionals as we work to standardize the communication about senior mobility. In addition, the document focuses on “communicating potential solutions to preserve and extend safe, independent transportation options for older persons” (from http://www.trb.org/Main/Blurbs/174681.aspx). Content includes taxonomy and definition of terms for driving evaluation and rehabilitation, alternative transportation options, and assistive technologies in driving and community mobility. A free copy of this circular is available for download at: http://onlinepubs.trb.org/Online-pubs/circulars/ec211.pdf.

Congratulations to several of our own ADED peers who contributed directly to the Gap & Pathway Project!

Susan Touchinsky, OTR/L, SCDCM, CDRS

Director of Driving Rehabilitation by Genesis Rehab Services

Susan.touchinsky@genesishcc.com

“Each year I feel more comfortable networking and meeting others in the field.”
Camera Use for Behind the Wheel Driving Assessments

by Stephanie Scharf, OTR/L, CDRS, CDI, C/NDT

I was asked to write about my use of cameras in the rehab vehicle during road assessments. I have chosen to use the camera system for clients who are one-time evaluation and not clients who are seen for training. (This is the therapist’s choice.) The question of confidentiality has come up. Our legal department at the hospital approved the wording on the consent form each patient has to sign. On the consent form, it is explained that the camera only records the drive; it does not photograph or “see” the client at all, but their voice will be recorded. This is also explained verbally to each patient prior to the signature of the consent.

I initially used a GoPro Hero mounted on the outside hood of the car, but the outside noise made it very difficult. Mounting the same camera on the inside dash has worked better. Just be sure to adjust the placement and mounting so it will not occlude the patient’s or the therapist’s view.

I recently received a new vehicle for the program, and the camera was updated to the GoPro Hero4 as well. The problem was the dash in the new car would not allow the adhesive to stay on to attach the camera or the suction cup attachment. (I tried all types of mounting devices.) I bought a pad used to place a GPS on a dash and then suction-cupped the camera to the pad and this worked well.

One of the physicians in our practice wanted the new vehicle to be up-fitted with a system called RaceKeeper. This system is used in race cars and is a multi-camera dual system with Trivinci, LLC. The system installed uses a bullet style camera mounted on the windshield behind the rear view mirror and on the back window where the brake light is located so there is no occlusion of vision. The system has a GPS and everything is synchronized with the dual cameras. Of course, this system was not intended for what I use it for, but it works nicely. RaceKeeper has many options. I did not have the accelerometer or brake attachments put on the system, which would have been nice, but there was some question how the system would work if I had to use my instructor brake.

The videos are downloaded into the patient’s medical records, and I use the videos to show patients and caregivers where errors occurred during the drive if there is a question regarding any of my recommendations. It’s a nice tool to back up any of the recommendations or use for teaching points.

With each camera system, the video is downloaded to the patient’s medical record; this takes a lot of time! The GoPro Hero would break a one hour drive into 2 files, which was easy to download and in the order of the drive. The GoPro Hero4 broke the drive into 4 files, and while downloading them into the patient’s file they were not in order; therefore, I would have to go back and renumber them in the patient’s file. Since there were 4 files, it took longer to download than the original GoPro; however, this could be a compatibility problem with my hospital system’s computers. I don’t know because I am not very tech savvy! The RaceKeeper clarity of video is excellent, and this video is also downloaded from a sim card to the hospital computer to be placed in the medical record.

There are draw backs to the RaceKeeper, given that it takes several hours to download the one hour drive route into the patient’s medical record, but it is only one file. There were compatibility issues again with the IT Department at the hospital getting this system installed for the downloads into patients’ files, but we did get it approved—finally! The system is expensive, costing $3800.00. With this said, the clarity is excellent, and you can use the GPS to pinpoint your location when showing clients if there were any errors in their drive, plus many other features that I have not used yet because I haven’t had the need.

I like using a camera system in the car for my one-time evaluations, and I liked the GoPro Hero and the Race Keeper System. This is my personal preference, and I am not trying to promote any type of camera system over another one.

Stephanie Scharf, OTR/L, CDRS, CDI, C/NDT
Palmetto Health, Columbia, SC
Empowering Aging Baby Boomers Behind the Wheel
Older Driver Safety Awareness Week is Dec. 5-9, 2016

BETHESDA, MD — As baby boomers enter the over 65 age bracket at an alarming rate (10,000 each day), the concern for older drivers’ safety and independence is greater now than at any time in our history. Adults 65 and older make up more than 16% of all licensed drivers, nationwide. And the numbers are growing as baby-boomers age. By 2040, it is estimated that 1 in 5 Americans will be 70 or older.

The American Occupational Therapy Association (AOTA) along with AAA, AARP Driver Safety, The Hartford Financial Services Group, Inc., the National Highway Traffic Safety Administration (NHTSA), the National Center for Senior Transportation (NCST), and other organizations are raising awareness of ways to keep older drivers safe on the road through AOTA’s Older Driver Safety Awareness Week (Dec. 5-9, 2016).

Held annually on the first week of December, the campaign raises awareness of the growing population of older adults and their transportation needs. Each day covers a theme critical to empowering older drivers and their families:

Monday, Dec. 5: Anticipating Changes That Can Affect Driving. As part of the natural aging process, most people experience physical, cognitive, and sensory changes that can affect driving. Being in tune with these changes is the first step to remaining safe.

Tuesday, Dec. 6: Family Conversations. The holidays are a great time to bring up a loved one’s driving safety. Waiting until an accident happens can leave the driver feeling as if he or she needs to defend themselves. Planning ahead is the most successful way to safely maintain older driver’s independence.

Wednesday, Dec. 7: Screening and Evaluations With an Occupational Therapist. Driving fitness evaluations range from self-assessments, which can be useful educational tools to help identify potential challenges, to a comprehensive driving evaluation from an occupational therapy driving rehabilitation specialist.

Thursday, Dec. 8: Interventions That Can Empower Drivers. Often times, suggestions made during a driver evaluation go beyond minor mirror or seat adjustments and may involve the use of adaptive equipment or vehicle modification.

Friday, Dec. 9: Staying Engaged in the Community. If a driver feels that they need to limit or stop driving, they may fear a loss of independence or life of isolation. There are many resources available to help older drivers maintain their quality of life.

“Just as we plan for our financial futures, we need to plan for our transportation futures as we age,” says Elin Schold Davis, OTR/L, CDRS, project coordinator of AOTA’s Older Driver Safety Initiative. “Respecting the physical, cognitive, and sensory changes that come with age may require adjustments in driving patterns, vehicle equipment, or a skills refresher, but do not have to mean giving up the keys and living in isolation without access to transportation. Older Driver Safety Awareness Week is dedicated to building awareness of the growing array of options available to seniors to support their goal of driving safety and maintaining an active lifestyle. Occupational therapists certified in driver rehabilitation offer drivers an individualized evaluation to explore the range of solutions to stay on the road safely and confidently.”

Founded in 1917, the American Occupational Therapy Association (AOTA) represents the professional interests and concerns of more than 193,000 occupational therapists, assistants, and students nationwide. The Association educates the public and advances the profession of occupational therapy by providing resources, setting professional and educational standards, and serving as an advocate to improve health care. Based in Bethesda, Md., AOTA’s major programs and activities are directed toward promoting the professional development of its members and assuring consumer access to quality services so patients can maximize their individual potential. For more information, go to www.aota.org.
2016 ADED ONLINE AUCTION

Online Auction. Raising money for a good cause: The Memorial Scholarship Fund

The Annual ADED Auction raises money for the Memorial Scholarship Fund. This fund supports students attending any one of ADED’s 2-day courses. These students are typically new to the field or are seeking to expand their program services. The fund helps ADED’s efforts to bring new practitioners to the field and with assisting current programs to advance their services. Our 2015 inaugural online auction was a great success, bringing in over $15,000 to support the Memorial Scholarship Fund. 2016 fundraising goal: $30,000

Funds raised through 2016 online auction: $28,860
The on-line auction is essential to our ability to support the fund.
We appreciate all our auction donors!

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ADA Scholarship Recipients
(In no particular order):
Mariann Bevenour, Hoang Le, Susan Le, Susan Wolf, Kelly Wood

Spirit of Crescent Scholarship Recipients
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Bobby Breeding, Clayton Jewell, David Sternberg, Angela Brown, Karen Craven, Sandra Wataoka, Gregory Rinehardt, Ginger Hoang Le, Sue Toale Knapp, Kelly Wood

Thank you to the donors:
Superior Vans, MC Mobility, United Access, Crescent Industries, VMI, Ability Center, NMEDA, MPS, Performance Mobility
BraunAbility MXV Mythbusters – What You Need To Know

by Haley Checkley

The BraunAbility MXV has been on the market for just a few months, but it’s dominated mobility news. Why? Wheelchair users who never aspired to own a minivan now have an option that may fit their personality and lifestyle a bit better. So what’s holding you back? We’re out to bust a few myths surrounding the MXV:

MYTH #1 – My power wheelchair is too big for an MXV.

It’s a fact that an SUV is going to have less cabin space than a minivan, and when BraunAbility engineered the MXV, we maximized interior space wherever we could. The widened doorway, infloor ramp, angled seat bases and sliding shifter combine to give this accessible SUV interior maneuverability that’s comparable to a minivan. Power and manual wheelchair users alike are finding it easy to enter, exit and navigate into the front driver or passenger seat.

MYTH #2 – I can’t transfer from my wheelchair in an MXV.

The BraunAbility MXV is especially exciting for wheelchair users who are currently transferring into a mainstream vehicle because they don’t want to drive an accessible minivan. A B&D 6-way transfer seat base can be installed, allowing a wheelchair user to secure his/her wheelchair, extend the transfer seat back and rotate toward the wheelchair, and then transfer safely into the seat to move into the driver position. And, of course, the front seats are removable, so you could drive or ride from your wheelchair as well.

MYTH #3 – The MXV is more expensive than any wheelchair van.

If your heart is set on a BraunAbility MXV, but you assume this innovation comes at a price tag that’s out of your range, think twice. The MXV starts at $60,000, which is equivalent to similar upscale minivans. In fact, the 2015 MXV Model Year Closeout Event gives you another $7500 off the price of the vehicle. If you’re a veteran, you’ll also qualify for a $1000 Freedom Rebate on a 2015 or 2016 BraunAbility MXV. The style, the space, the swag – go “explore” for yourself. Bottom line, if you are interested in the MXV but haven’t seen it in person, it’s time to visit your local BraunAbility dealer. Seeing is believing.

NEW FROM B&D INDEPENDENCE!

The improved design allows the Transfer Seat Base to be driven in any up/down position and up to 4” back from the full forward position. This new feature allows each user to select the unique and personalized driving position that is right for them. This addition to the B&D family of products is made for comfort and designed for you!
AMF-Bruns Offers Protection in Rear-End Collisions

Wheelchair restraints combined with head & backrest system help stabilize passengers.

Cleveland, OH • July 26, 2016: The National Highway Traffic Safety Administration (NHTSA) says that the head, neck, chest, pelvis, abdomen, legs and feet are the most common body parts to be injured in a motor vehicle crash. The best protection is a shoulder & lap belt system combined with a 4-point wheelchair restraint system.

AMF-Bruns of America – a global leader in the vehicle modification industry – offers this protection through its wheelchair securement and occupant restraint systems. In the 1970’s they developed the first wheelchair safety system and invented the world’s first 4-point retractor wheelchair anchoring system. Founded in Germany in 1958, the U.S. distribution facility opened in 2013.

AMF-Bruns of America offers a one-stop solution:

PROTEKToR®-System Wheelchair and Occupant Restraints: A wide variety of wheelchair and occupant restraints that meet the latest international and national standards, including RESNA WC18 for wheelchairs with an integrated lap belt.

FutureSafe® Head and Backrest: An adjustable head and backrest system with an upper anchor point for the shoulder belt that helps ensure passenger security in a collision. This system meets RESNA WC18 and ISO 10542 standards.

“The combination of these two products stabilizes the passenger in the event of a rear-end collision, reducing the chance for injury and trauma,” says Peter Haarhuis, CEO of AMF-Bruns of America. “Our mission is to offer safe, flexible and innovative passenger transport solutions for the paratransit industry, which ultimately improves the quality of life for the physically challenged.”

For more information call 877-506-3770 or go to www.amfbrunsamerica.com.

ABOUT AMF-Bruns of America:
AMF-Bruns of America is a global market leader in the field of vehicle technology for the physically-challenged. Our company expertly combines state-of-the-art technology with skills accumulated from over 50 years’ experience in the mobility industry. We manufacture wheelchair securement products, occupied restraint systems and associated equipment for the safe transportation of people with limited mobility. Our product leadership and focus in providing safe, flexible and leading edge solutions for wheelchair passenger travel speak for itself, as we have been credited for several industry “firsts”. We ensure the highest degree of quality in accordance with ISO 9001. Today we service customers in more than 50 countries throughout North and South America, Europe, Australia and Asia. Our state-of-the-art testing and research facility in Germany employs some of the industry’s brightest minds who are committed to taking the technology to the next level. For more information visit www.amfbrunsamerica.com.
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ADAPT SOLUTIONS Product Update: Chrysler Pacifica

We are happy to inform you on our developments with the Chrysler Pacifica. As of October 1st, the LINK is available in all 4 positions in the new minivan: Driver, front passenger, and both mid-row positions. As of the first of October, the SPEEDY-LIFT is available for both the Driver and Passenger, mid-row positions. The XL-SEAT is not currently available for the Pacifica. The space required to fit the product is simply not available. Alternative solutions are being investigated. Keep an eye out for updates on the progress of the XL-SEAT early in 2017.
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We have scheduled the 3 hour live webinar (approved for 3 hours of continuing education by ADED) once per month thru December, all beginning at 10am Central Time on:

Tuesday, December 13th, January 10th, February 14th

To register:
http://behindthewheelwithadhd.com/driver-rehabilitation-specialists-webinar/

Also, wanted to make you aware that Top Driver, one of our certified schools, has taken what they learned from the training and developed a level of drivers education for the teen who struggles with Executive Function.

Ann Shanahan, ADHD/Executive Functioning Coach, 312-428-1133
Co-Author of “Behind the Wheel with ADHD”

“It was a great experience networking and learning everything I did.”

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APPLICATION DEADLINE: 12/15/16

**Introduction to Driver Rehab.**
April 28-29, 2017. Denver, CO at the DSAA Conference
APPLICATION DEADLINE 2/28/17

Albuquerque, NM ADED Annual Conference
APPLICATION DEADLINE: 4/28/17

Albuquerque, NM ADED Annual Conference
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Hanover, MD Ann Arundel Community College
APPLICATION DEADLINE 8/20/17
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<td></td>
<td></td>
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<tr>
<td>Alyssa Merilees</td>
<td></td>
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<tr>
<td><a href="mailto:alyssa.merilees.clethb@ssss.gouv.qc.ca">alyssa.merilees.clethb@ssss.gouv.qc.ca</a></td>
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<tr>
<td>Amy Lane</td>
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<tr>
<td><a href="mailto:laneak@upmc.edu">laneak@upmc.edu</a></td>
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<tr>
<td>Board Development</td>
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<td>CHAIR:</td>
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<tr>
<td>Amy Lane</td>
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<td><a href="mailto:laneak@upmc.edu">laneak@upmc.edu</a></td>
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<tr>
<td>1st Term: 2016-2017</td>
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<td>MEMBERS:</td>
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<tr>
<td>Lori Benner</td>
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<td>Maryfrances Gross</td>
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<td>Chad Strowmatt</td>
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<td>Professional Development</td>
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<td>CHAIR:</td>
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<tr>
<td>Alyssa Merilees</td>
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<td><a href="mailto:alyssa.merilees.clethb@ssss.gouv.qc.ca">alyssa.merilees.clethb@ssss.gouv.qc.ca</a></td>
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<td>1st Term: 2016-2017</td>
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<td>MEMBERS:</td>
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<tr>
<td>Jennifer Biro</td>
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<td>Jesse Hunter</td>
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<td>Marc Samuels</td>
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<tr>
<td>Carrie Monagle</td>
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<tr>
<td>Nathalie Drouin (liaison)</td>
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<tr>
<td>Finance Committee</td>
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<tr>
<td>CHAIR: Peggy Gannon</td>
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<tr>
<td><a href="mailto:peggy.gannon@brookshealth.org">peggy.gannon@brookshealth.org</a></td>
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<tr>
<td>2nd term 2016-2017</td>
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<td>MEMBERS:</td>
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<tr>
<td>Liz Green</td>
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<td>Jerry August</td>
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<td>Eva Richardville</td>
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<tr>
<td>Scholarship</td>
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<tr>
<td>CHAIR: Jill Scleease</td>
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<tr>
<td><a href="mailto:jill@drivingtoindependence.com">jill@drivingtoindependence.com</a></td>
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<tr>
<td>1st term: 2015-2016</td>
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<td>MEMBERS:</td>
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<tr>
<td>Nathalie Drouin</td>
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<tr>
<td>Cassandra Johnson</td>
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<td>Brian Martin</td>
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<td>Dana Moore-Wills</td>
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<td>AD-HOC Committees</td>
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<td>Research-Reports to Prof. Development</td>
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<td>CHAIR: Beth Rolland</td>
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<tr>
<td>TEAM: Anne Dickerson, Johnell Brooks</td>
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<td>Grants-Reports to Finance</td>
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<tr>
<td>CHAIR: Beth Rolland</td>
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<tr>
<td>Code of Ethics Review</td>
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<tr>
<td>CHAIR: Gina Lewis</td>
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<tr>
<td>TEAM: Ann St. John, Dianna Robertson, Amy Lane</td>
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<td>Government Relations</td>
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<tr>
<td>CHAIRS: Dan Allison, Cassy Churchill</td>
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<tr>
<td>TEAM: Anne Dickerson, Carol Wheatley</td>
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<td>CDRS Branding</td>
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<tr>
<td>CHAIR: Leah Belle</td>
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<tr>
<td>TEAM: Nathalie Drouin, Beth Gibson, Cassy Churchill, Lynn Mortilla-Rocap</td>
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<td>Certification Pathway</td>
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<tr>
<td>CHAIR: Jenny Nordine</td>
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<tr>
<td>TEAM: Dana Benoit, Roger Kelsch, Kathy Woods, Chad Strowmatt</td>
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<td>Volunteer Development</td>
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<td>CHAIR: Gina Lewis</td>
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<tr>
<td>TEAM: Board Dev. Committee, Peggy Gannon</td>
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<td>Program Development</td>
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<tr>
<td>CHAIRS: Mary Beth Meyer, Peggy Gannon</td>
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<tr>
<td>TEAM: Heather Shields, Eva Rodriguez, Ginger Le</td>
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</table>
### 2017 ADED MEMBERSHIP APPLICATION

**Membership period runs January 1 – December 31, 2017**

Please provide contact information as you want it to appear on the website directory:

<table>
<thead>
<tr>
<th>Name:</th>
<th>Credentials:</th>
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<tbody>
<tr>
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<table>
<thead>
<tr>
<th>Company:</th>
<th>Telephone Number:</th>
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<table>
<thead>
<tr>
<th>Mailing Address:</th>
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<table>
<thead>
<tr>
<th>Fax Number</th>
<th>E-Mail Address:</th>
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<table>
<thead>
<tr>
<th>Website Address:</th>
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- **Directory Opt out:** please DO NOT post my information on the [www.ADED.net](http://www.ADED.net) membership directory
- **Mailing Address change:** I would like my ADED mail to go to this address:

Please indicate your membership level below:

<table>
<thead>
<tr>
<th>Membership Level</th>
<th>Membership Dues</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individual</strong></td>
<td></td>
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<tr>
<td>Member</td>
<td></td>
</tr>
<tr>
<td>Individual members shall include all persons involved in provision, implementation, or administration directly related to the provision of driver rehabilitation.</td>
<td></td>
</tr>
<tr>
<td>Individual RENEWING Member: Rate=$145</td>
<td>Individual NEW Member: Rate=$155</td>
</tr>
<tr>
<td><strong>Facility</strong></td>
<td></td>
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<tr>
<td>Member</td>
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<tr>
<td>A facility member shall be an individual member employed by a business or agency involved in provision, implementation, or administration directly related to the provision of driver rehabilitation.</td>
<td></td>
</tr>
<tr>
<td>New membership</td>
<td>Renewing membership</td>
</tr>
<tr>
<td>Facility Member-LEVEL 1* (1-3 Individuals): Rate=$290</td>
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</tr>
<tr>
<td>Facility Member-LEVEL 2* (4-6 Individuals): Rate=$580</td>
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</tr>
<tr>
<td>Facility Member-LEVEL 3* (7-10 Individuals): Rate=$1015</td>
<td></td>
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<tr>
<td><strong>Please provide list of facility members including contact info</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Mobility Equipment Dealer</strong></td>
<td><strong>Corporate</strong></td>
</tr>
<tr>
<td>Member</td>
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</tr>
<tr>
<td>Mobility equipment dealer members shall include businesses involved in providing installation, services, and/or retail sale of equipment, vehicles, or rental vehicles for individuals with disabilities.</td>
<td></td>
</tr>
<tr>
<td>New membership</td>
<td>Renewing membership</td>
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<tr>
<td>Rate=$200</td>
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<tr>
<td><strong>Associate</strong></td>
<td></td>
</tr>
<tr>
<td>Member</td>
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<tr>
<td>Associate members include students, educators, researchers or other stakeholders with an interest in the mission of the Association who are interested in gaining more knowledge about the field but do not provide driver rehabilitation services. Associate members shall not have voting rights, nor are they eligible to serve as an officer.</td>
<td></td>
</tr>
<tr>
<td>New membership</td>
<td>Renewing membership</td>
</tr>
<tr>
<td>Rate=$125</td>
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</tbody>
</table>

**PLEASE RETURN THIS APPLICATION WITH PAYMENT IN US CURRENCY FOR PROPER PROCESSING.**

REMIT TO: 200 First Ave NW Suite 505 Hickory N.C. 28601

For credit card payments: complete the following information and fax to 828-855-1672 or mail to address above.

- **VISA** Account #: 
- **AMERICAN EXPRESS** Expiration Date: month: / year: 
- **MASTERCARD** 
- **DISCOVER** Card Holder’s Name: 

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*Associate* $125

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**ee NSBREAK** Fall 2016

NewsBreak Fall 2016 45
**2016 ADED BOARD OF DIRECTORS**

**Dana Benoit**  
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PAST PRESIDENT  
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jenny@drivingtoindependence.com

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lbelle@ghs.org

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PRESIDENT ELECT  
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Dan_Allison@Shepherd.org

**Cassy Churchill**  
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MOBILITY EQUIPMENT DEALER  
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**Peggy Gannon**  
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TREASURER  
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**Gina Lewis**  
Adapt-Solutions  
CORPORATE  
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ginalewis@adaptsolutions.ca

**Beth Gibson**  
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SECRETARY  
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bgibson@freedomandmobility.com

**Elizabeth Green**  
OTR/L, CDRS, CAE  
EXECUTIVE DIRECTOR  
Toll free: 866-672-9466  
direct line: 828-855-1623  
cell phone: 828-302-2119  
Elizabeth.green@driver-ed.org
Carospeed Menox Hand Controls
www.autoadapt.com
Distributed in the USA and Canada by Driving Systems Inc.

Scott System Driving Controls

The CP05 Palm Control steering knob is equipped with 3 rocker switches to provide six switches in total. Each switch is designed and programmed to operate specific secondary controls. The switches provide primary and residual operations. The primary operation is achieved by a smooth touch of the button. The residual operation is achieved by holding the button ON for about one second.

dSi provides the technology necessary for disabled drivers to experience independence.

The Scott Driving System has been developed over the last 40 years and is a complete system which permits the physically challenged to safely perform all driving tasks without assistance, including entering and leaving the vehicle. The system provides for safe extended mobility for the driver who must remain in his or her wheelchair while driving. The system has been successful in a variety of disabilities. Patients with post polio, multiple sclerosis, muscular dystrophy, spinal muscular atrophy, and spinal cord injury up to C4/C5 are successfully driving on a daily basis.

- Reliability
- Low Maintenance
- Long Service Life
- OEM Steering Option

dSi provides the technology necessary for disabled drivers to experience independence.
Introducing the 2016 BraunAbility® MXV® built on the Ford Explorer.

Get Out There.

Introducing the 2016 BraunAbility® MXV® built on the Ford Explorer.

The world leader in mobility for over 40 years, BraunAbility® is pushing the boundaries of mobility. No matter what the vehicle, BraunAbility® is committed to making your life a moving experience.

• Innovative door operation design
• Removable driver/passenger seats
• Tow package available
• Sliding shifter for increased space
• Infloor, lighted ramp
• Ramp on/off switch
• Nerf bar comes standard

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www.braunability.com/aded