

and cognitively healthy participants (N=229), as well as “collateral sources” who answered the CARS items about the respondents’ driving. Vision problems and cognitive impairment, both known predictors for driving problems, were correlated with CARS scores. Results indicate that worse eyesight in the right eye is correlated with higher CARS scores (Spearman rho = $-.17$, $p < .01$), but not the left eye. Poor eyesight (i.e., less than 20/40 vision) was correlated with higher CARS scores (Spearman rho = $.12$, $p < .05$). However, cognitive impairment (very mild/mild dementia vs. healthy cognitive functioning) was not statistically significant. Total CARS scores were moderately correlated for respondents and their collateral sources, $r = .32$, $p < .01$. Results indicate that this instrument may be more useful as a tool for initiating difficult conversations about driving safety than for identifying older adults who are at higher risk for negative driving outcomes. Future research is needed to identify additional/alternative items with greater psychometric support.

VISUAL PROCESSING SPEEDS DIFFERENTIATE OUTCOMES OF DRIVING EVALUATIONS OF CONTROLS AND MEDICALLY AT RISK DRIVERS

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Visual processing speed is considered a critical factor for determining driving capacity in older adults. The specific research questions were: 1) is there a statistically significant difference in performance time between the medically at-risk ($n=35$) and controls ($N=242$), 2) does the type of medical condition (e.g., neurological, cognition, complex medical conditions) differentiate performance, and 3) can visual processing speed differentiate between fit and unfit drivers. A cross sectional quasi-experimental design was used to compare the visual processing reaction times between at-risk adult drivers and healthy controls. Participants were medically-at-risk drivers referred for a comprehensive driving evaluation to determine their fitness to drive. The Vision Coach™ “Full-Field-60” task was used to collect reaction times which required participants to tap 60 randomly illuminated red dots. One practice trial was followed by three testing trials that were averaged together. At-risk participants were divided into three diagnostic categories. Fitness-to-drive outcomes were pass, fail, or restrictions. A propensity score method based on age and gender was used to account for the difference in sample sizes by weighting the participants from the two studies for a fair comparison between the two groups. Independent t-tests found a significant difference $t(275) = -6.42$, $p < 0.001$ in trial times between healthy controls ($M = 53 + 10.82$) and medically-at-risk adults ($M = 72 + 17.04$). No significant difference was found between the diagnostic groups ($p = 0.141$), but the Vision Coach™ differentiated between those who “passed” and those who “failed” a driving evaluation ($F(2,32) = 8.28$, $p = 0.001$).

ACHES AND PAINS: HOW DO THEY AFFECT TRANSITIONS FROM DRIVING?

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Chronic pain, which affects more than 1 in 4 middle-aged and older adults, can have profound implications for everyday activities, like driving. Although research has revealed pain’s effect on driving performance, less is known

about driving-related behaviors and self-assessments that are part of the process of transitioning from driving. We address this issue using data from an online survey of 3,441 Floridians aged 50 and older that was conducted between December 2020 and March 2021 and funded by the Florida Department of Transportation. We examine the association between pain and four driving-related outcomes: self-rated driving ability, self-regulated driving, perceived nearness of driving retirement, and planning for driving retirement. Results of multivariate regression analyses indicate that experiencing greater pain is associated with worse self-rated driving ability, more frequent self-regulated driving, and greater perceived nearness of driving retirement. Pain is not, however, associated with greater planning for driving retirement. These findings indicate that although greater pain may hasten the transition from driving, it may not lead to more planning for it. Both patterns suggest that pain may increase people’s risk of experiencing the social isolation that can follow driving retirement. By focusing on transitioning from driving, our study reveals a largely overlooked benefit of reducing pain – It could extend people’s years behind the wheel.

COGNITIVE AND PSYCHOSOCIAL OUTCOMES OF DRIVING DIFFICULTIES IN OLDER ADULTS: A 5-YEAR STUDY

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Many older adults find it difficult to drive a car as they age. However, there are lack of studies on the outcomes of driving difficulties among older adults. The aim of this study was to examine the cognitive and psychosocial outcomes of driving difficulties in older adults. This study was a secondary data analysis using National Social Life, Health, and Aging Project Wave 2 (2010-2011) and 3 (2015-2016). This study followed 1,638 older adults that were of the age 65 and older, who had no difficulties driving a car at Wave 2. Montreal Cognitive Assessment Scale, Center for Epidemiological Studies Depression Scale, Hospital Anxiety and Depression Scale, and Perceived Social Isolation Scale were used. For data analysis, chi square tests, t-tests, and regression analysis were used. After 5 years, 11.1% of people began to have difficulties in driving a car ($n=180$), and 88.9% of people maintained to have no difficulties driving a car ($n=1,441$). Compared to people who maintained no difficulties of driving a car over time, people who began to have difficulties had more severe cognitive decline ($t=4.59$, $p < 0.001$) and more depressive symptoms over time ($t=3.253$, $p=0.001$). Univariate regression analysis also indicated that having difficulties of driving resulted in more severe cognitive decline over time ($b=0.137$, $p < 0.001$) and more depressive symptoms over time ($b=0.097$, $p < 0.001$). Driving difficulties were not related to anxiety or social isolation. As difficulties in driving are related to poor cognitive and psychological outcomes, healthcare professionals should pay more attention to people who experience driving difficulties.

“IS IT TIME TO STOP DRIVING?”: A RANDOMIZED TRIAL OF AN ONLINE DECISION AID FOR OLDER DRIVERS

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The decision to stop or continue driving can be challenging for older adults. In a prospective two-arm randomized trial, we sought to test whether an online driving decision aid (DDA) would improve decision quality. We recruited 301 English-speaking licensed drivers, age ≥ 70 years, without significant cognitive impairment but with ≥ 1 diagnosis associated with increased likelihood of driving cessation, from clinics associated with study sites in three states. They were randomized to view 1) the online Healthwise® DDA for older adults addressing “Is it time to stop driving?”; or 2) a control condition of web-based information. Our primary outcome was decision conflict as estimated by the Decisional Conflict Scale (DCS; lower scores indicate higher quality). Secondary outcomes were knowledge and decision self-efficacy about driving decisions. We examined differences in post-randomization outcomes by study arm using generalized linear mixed-effects models with adjustment for site and pre-randomization scores. Intervention participants had a lower mean DCS score (12.3 DDA vs 15.2 control; $p=0.017$) and a higher mean knowledge score (88.9 DDA vs 79.9 control; $p=0.038$); we found no difference between groups in self-efficacy scores. The DDA had high acceptability; 86.9% of those who viewed it said they would recommend it to others in similar situations. The online Healthwise® DDA decreased decision conflict and increased knowledge in this sample of English-speaking, older adults without significant cognitive impairment. Use of such resources in clinical or community settings may support older adults as they transition from driving to other forms of mobility.

PREVALENCE AND USE OF ADVANCED DRIVER ASSISTANCE SYSTEMS IN THE OLDER DRIVER POPULATION

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Research on advanced driver assistance systems (ADAS) in the older driver population has suggested the potential for ADAS to improve safety and driving comfort by helping aging drivers overcome functional declines commonly experienced in later-life. However, attaining anticipated ADAS benefits is dependent upon drivers' awareness, understanding, and use of ADAS in their own vehicles. Questionnaire data from 2,374 older drivers enrolled in the AAA LongROAD study were analyzed to investigate changes in the prevalence and use of 15 ADAS and how participants learned to use these technologies. From baseline to Year 3, the prevalence of each ADAS significantly increased, with the greatest percentage point increase being for backup/parking assist technology (from 41.5% to 58.8%). The prevalence of one or more ADAS in participants' vehicles increased from 59.0% to

72.0%, and the average number of ADAS per vehicle increased from 2.0 to 3.3. At both baseline and Year 3, approximately one-third of participants reported always using the ADAS available in their vehicle, but nearly one-quarter reported never using their ADAS. The largest proportion of participants at both baseline and Year 3 reported learning to use ADAS by figuring it out by themselves (45.5% and 50.8%, respectively), yet approximately 12.0% of participants at both time points reported never learning to use ADAS. To achieve the expected benefits of ADAS for older drivers, research is needed to better understand why ADAS are not being used more frequently when available, and to develop acceptable and accessible programs for training older adults to use ADAS.

SESSION 6480 (POSTER)

ELDER ABUSE: DETERMINANTS, DISRUPTORS, AND CONSEQUENCES

INVESTIGATING THE CONNECTION BETWEEN AGEISM AND ELDER ABUSE

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Elder abuse is recognized as a pervasive public health problem with detrimental consequences for older adults and society. Although considerable research has examined elder abuse risk factors at the individual level, there is a growing call for the field to move beyond proximal causes and consider broader socio-cultural and structural factors that influence elder abuse. Illustrating this shift, organizations, advocacy groups and researchers have proposed a connection between ageism and elder abuse. However, despite the assertion that ageism is a causal factor for elder abuse, there is a scarcity of research to demonstrate this relationship, and a coherent theoretical framework linking ageism to elder abuse remains to be articulated. The purpose of the current study was to examine the conceptual pathways and limited empirical research connecting ageism and elder abuse, and to develop a conceptual model that links ageism and elder abuse. We conducted a comprehensive review and synthesis of the ageism/elder abuse literature, as well as research from other domains of interpersonal/family violence. Based on this synthesis, the proposed model includes plausible mediators (social isolation, devaluation, depersonalization, infantilization, powerlessness, blame) and moderators (intersection with socio-cultural identities, internalized ageism, policy/social norms) that could be targeted as mechanisms of change in interventions designed to address the issue. As such, it provides a framework for hypothesis-testing and future research on the topic. This study informs a research agenda to bring conceptual clarity and empirical evidence to the study of the connection between ageism and elder abuse.

THE ASSOCIATION BETWEEN FINANCIAL RESOURCES AND STRESSORS AND FINANCIAL EXPLOITATION

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