Medical Advisory Board

Minutes - DRAFT

November 5, 2021 12:00 – 3:00 PM

Meeting conducted via Zoom

1. **Call to Order:** MAB Chair, John Taylor
	1. Zoom Participants: John Taylor, Daniel Potenza, Evan Savage, Isabella Askari, Linda Schumacher-Feero, Patrick Keaney, Robert Lodato, Thomas Morrione, Shenna Bellows, Cathie Curtis, Chris Ireland, Dawna Gilbert, Larry Boivin, Michelle Cloutier, Thea Fickett,
	2. Absent: Daniel Pierce, Jims Jean-Jacques
2. **Membership Changes** Larry Boivin
	1. New Director of License Services – Chris Ireland
	2. Retirement of previous Director of License Services – Linda Grant
	3. Resignation of Dr. Frederick Goggans
		1. The Secretary of State is currently seeking a replacement
3. **Appreciation for Services of MAB Members** Shenna Bellows
	1. The work of the MAB is important, it matters and is appreciated
	2. Remarks of appreciation were also made by Cathie Curtis and Larry Boivin
4. **Introductions**
	1. Personal introductions and description of affiliation made by each member
5. **Approval of Minutes** John Taylor
	1. September 17, 2021 meeting minutes accepted as written unanimously by roll call vote
6. **Old Business**
	1. Functional Ability Profile Revision Updates
		1. Sleep Apnea FAP Patrick Keaney
			1. This FAP was already approved but brought before board following further discussion by the Sleep Apnea subcommittee regarding:
				1. 2021 AAMVA survey of other jurisdictions showing Maine’s current rules to be somewhat restrictive, thus supporting proposed rule changes to decrease frequency of monitoring for drivers who are effectively treated and adhere to their treatment; adding verbiage to allow clinician’s some flexibility to work with driver’s in seeking effective treatment
				2. Oxygen therapy as an alternative treatment, as requested earlier this year during a subcommittee meeting with certain drivers. Sleep provider discussion included the following points:

 Oxygen therapy is not a classic approved treatment, but is used in some cases for people who are intolerant of CPAP

There are ongoing studies with oxygen treatment and rules need to allow for flexibility to include newer treatments

Verbiage added to allow other or new treatments to be considered on an individual basis when effective in treating AHI and excessive somnolence, when recommended by the clinician and upon review of the Medical Advisory Board.  Assessment by a sleep specialist may be required

Verbiage added to address drivers who have not been compliant with PAP therapy if there are no specific concerns for unsafe driving, the driver is willing to seek effective treatment, and if the clinician submits a letter to request that driving be allowed while patient is in the process of pursuing treatment. This verbiage will also be helpful for drivers affected by the Phillips CPAP recall.

* + - 1. Changes were made in an effort to maintain highway safety while providing increased flexibility.
			2. Changes were approved unanimously
		1. Narcolepsy FAP Patrick Keaney
			1. This FAP was already approved contingent on a definition of “recent crash”
			2. The neurologist and sleep providers on this subcommittee did not think it was appropriate to clarify any further, as there are too many possible scenarios and a clinician should be allowed to use their judgment in determining if a crash is relevant
			3. Clinicians need better access to crash data, as they are often unaware of crash history
			4. Better crash data and correlation to medical conditions is needed to help address safety concerns, as stated at the last meeting
			5. Unanimous vote approved leaving “recent crash” as previously written
		2. Musculoskeletal and Neurological Conditions FAP Evan Savage
			1. FAP revisions reviewed and discussed
			2. Language changes will allow the clinician greater flexibility to use their own judgment in some situations
			3. “Mild”, “Moderate”, and “Severe” on the FAP Table have been changed to clarify that these are not clinical definitions but rather a classification of risk for driving. (Note: This change has been incorporated into all FAP’s.)
			4. Language regarding personal assistive medical devices added for clarification of when a road test will be required. This change allows a clinician to determine if a road test is needed when a person uses a cane. A walker or other types of assistive devices will still require that a road test be administered
			5. Musculoskeletal and neurological conditions are included in the same FAP category because neurological conditions often lead to muscular problems
			6. There is significant overlap between some FAP’s and certain conditions. This may require more than one FAP to be completed
			7. Tourette’s movement disorder is now included in the Miscellaneous Musculoskeletal and Neurological Conditions FAP although it may at times also warrant a separate FAP for Mental Health
			8. For those with Multiple Sclerosis, a clinician may recommend a longer interval for review for profile level 3a when a patient’s whose condition is quiescent
			9. This FAP was approved unanimously
		3. Unexplained Alteration/Loss of Consciousness John Taylor
			1. FAP revisions reviewed and discussed
			2. This remains a general and vague FAP, intended for use when no other FAP is appropriate and when seizures and cardiac conditions have been ruled out
			3. The language for vasovagal is consistent with the Cardiovascular Conditions FAP.
			4. This FAP was approved unanimously
		4. Medical Other John Taylor
			1. This FAP was discussed at the last meeting but not finalized.
			2. This FAP is not well defined purposefully, to provide FAP guidance when there are multiple conditions or fluctuating conditions that cause concern for unsafe driving. Some examples are listed in the FAP, if others are identified please forward to John Taylor or Thea Fickett for inclusion in the FAP
			3. This FAP should only be used when there is no other appropriate FAP and when the condition(s) create concern for unsafe driving. Many of the cases where this FAP is used originate from a police report of crash or erratic driving
			4. Concerns for driving caused by polypharmacy should be reviewed using the Prescription Medications and Opioid Replacement Therapy FAP
			5. Submission of Adverse Reports of Driving are exclusively at the discretion of the police officer. Police are not mandated to report medical conditions or to submit reports to BMV for erratic driving
			6. Statistics are needed to indicate correlation between certain medical conditions, restrictions and crash rates, in order to determine if there is a correlation between medical evaluations (CR-24’s) and keeping the road safe
			7. This FAP was approved unanimously
		5. Mental Health FAP Daniel Potenza
			1. This FAP was approved previously but presented again for further discussion
			2. The key to understanding Mental Health is looking at the functional ability of the person, not just their diagnosis
			3. Symptoms of these diagnoses do seem to recur over time
			4. The FAP title was changed from Mental Disorders to Mental Health to decrease the “stigmatizing” nature of the language, as perceived by some constituents
			5. Tourette’s Movement Disorder was moved to the Musculoskeletal and Neurological FAP following the last meeting.
			6. Tourette’s is often treated by neurology or psychiatry. It is not often associated with driving impairment but it could be
			7. After reviewing the language changes and table, the group voted unanimously to approve the FAP
		6. Prescription Medications and Opioid Replacement Therapy FAP
			1. This FAP was approved previously but is brought back for further discussion
			2. Is language adequate to address cases where there is concern for driving due to polypharmacy
			3. The authors of this FAP have both resigned from the board, so this question is brought to all members present today
			4. Unanimous vote confirmed language is adequate to address polypharmacy concerns
		7. Substance Use Disorder FAP
			1. This FAP was already approved but returned for additional discussion
			2. Following case consultations with Dr. Taylor and Dr. Goggans, this was added to the agenda. There were cases where drivers were suspended following receipt of a Driver Medical Evaluation, profile level 3c for substance use disorder (SUD). Both cases were suspended following seizures related to substance use or withdrawal, however neither individual had been officially diagnosed with a substance use disorder. Should the FAP language related to seizures provoked by substance use or withdrawal be changed?
			3. Should the SUD FAP criteria be used even if the person has not been assessed for a SUD?
			4. At times these reports come from the ER because of the seizure and may or may not be related to a driving incident; it may or may not be a first-time occurrence
			5. Often there is more than one provider involved in these cases. In both of these cases, the neurologists advocated that the suspension should not apply because the person was not diagnosed with a substance use disorder, even though substance use or withdrawal was the cause of the seizure
			6. SUD profile level 3c suspensions following a seizure currently require at least 6 months of sobriety
		8. The vote was unanimous to approve keeping language as written for both the Seizures and the Substance Use Disorder FAP’s
		9. Visual Disorders FAP Linda Schumacher-Feero
			1. This FAP was already approved, but BMV is requesting MAB input on a couple of vision related issues. The FAP is presented here for reference purposes
			2. Can a person with a progressive condition go to a branch for vision screening instead of going to their eye doctor for an updated eye examination? Current practice does not allow this
				1. Some individuals don’t have insurance to cover eye exams, some insurance does not pay for an eye exam on an annual basis, for some it is a matter of convenience
				2. The current eye examination is very basic for visual acuity and allows confrontation testing of visual field
				3. The FAP was written with the intent of keeping similarity between the eye doctor examination and BMV screening
				4. The BMV vision screening is reliable and accurate, but it only tests very specific, set points
				5. If a person fails vision screening at the branch, they are referred for an eye examination per the current practice
				6. Screening at the BMV branch office would pick up the majority of defects that would create a hazard for driving. Some might be missed such as defects due to glaucoma
				7. Eye doctors can do more detailed testing of visual field.
				8. Only an eye doctor can assess if a person has a progressive condition
				9. Once a person has been determined to have a progressive condition, they need to continue to be reviewed unless an eye doctor says they no longer have a progressive condition
				10. The branch screening should not allow a person to go from a Profile Level 3 to a Profile Level 1 or 2.
				11. BMV needs to develop a system for monitoring and tracking people who go to the branch for their “update” to ensure that they continue to be reviewed
				12. Allowing this “opt out” for drivers seems consistent with a philosophy of not dictating medical care
				13. The vote to approve the following was unanimous

BMV may allow persons with progressive conditions to go to the branch for screening as an opt out for submitting an Eye Examination form from their doctor, as long as those with progressive conditions continue to be reviewed until an eye doctor says they no longer have a progressive condition

* + - 1. Currently, BMV requires vision screening at initial licensure and then at certain intervals based on age. Does the MAB think these are necessary or could they be changed to allow more online license renewals?
				1. See statutory requirement, Title 29-a §1303. “Vision Test requirements”:

Test Requirement. A person must pass the vision portion of a license examination:

At the time of the first license renewal after attaining 40 years of age;

At every 2nd license renewal after the renewal listed above until attaining 62 years of age; and

At every license renewal after attaining 62 years of age.

* + - * 1. Discussion included the following points:

Why were the age ranges chosen?

No one knows as they were determined by the MAB and BMV many years ago

What are other states doing?

BMV will look at what other states are doing and may do an AAMVA survey

Dr. Schumacher-Feero states the data shows vision decline becomes an issue around age 70, so possibly we are over testing

How many people have an issue and what are the age groups where vision referrals occur?

We don’t currently have a report to show this, we may be able to get the number of vision referrals, not sure

Would it be wise to change from current practice to no vision screening between age 16 – 70?

BMV will try to get information about other jurisdictions

Dr. Schumacher-Feero will do more research on the data to see if there is a medical basis for age-based screening

In the meantime, her recommendation would be to keep a vision screening between 40-45 years, again around 60 and then at every screening starting at age 70

* + - * 1. No vote is needed, as this issue does not affect the FAP and BMV is simply looking for feedback from the MAB
		1. FAP Pages 1-3 Revisions
			1. Reviewed updates and revisions to these pages
			2. Discussed personnel that may complete CR-24’s
				1. In addition to current disciplines listed in the narrative, MAB discussion included the following:

This is a Medical Advisory Board; therefore, it would make sense that people who are allowed to sign the CR-24 should have some medical training.

Speech and Language Pathologists (SLT) will be added to narrative and allowed to sign CR-24. Normally, they would treat people with cognitive issues, aphasia, stroke and brain injury. They will be added to the list of

Certified Drug and Alcohol Counselors (CADC) are sometimes the only provider able or willing to complete a form for substance use disorders (SUD). They will be allowed to complete CR-24, but only for SUD. There was reluctance to approve this group, but since they are used by the Driver Education and Evaluation Program for drivers who have been convicted of OUI, and because at times they are the only health care provider the driver may have, it was decided to allow. They will not be able to diagnose but they should be able to apply the FAP criteria for substance use disorder. They will not be added to the list of qualified personnel in the narrative. The wording on pages 1-2 allows for use of personnel that are not specifically listed

Naturopaths will not be allowed to complete CR-24’s as they are not medical personnel

The paragraph on pages 1-2, titled “Nature of Medical Report” was modified based on discussion during the meeting.

Medical professionals should not be certifying or evaluating outside their area of expertise or knowledge

* + - 1. BMV will consider creating a table or something equivalent so staff know which personnel are qualified to treat specific conditions
			2. Changes were approved unanimously, including the following: (Note: Dr. Keaney and Dr. Potenza were absent for this vote)
				1. Naturopathic Doctor’s will not be allowed to sign CR-24
				2. Speech and Language Pathologists approved as qualified personnel and will be allowed to sign
				3. Certified Drug and Alcohol Counselors approved for use, but this discipline will not be added to the list of approved professionals in the narrative on page 1. They will only be allowed to complete forms for SUD.
1. **New Business**
	1. Statistics: Overview Jan-Jul 2021 for vision and medical
		1. Discussion points:
			1. What are the real world ramifications of FAP statistical reports
			2. Current detailed reports provide the number of crashes per person, and can be sorted to obtain number of crashes by diagnosis, but we don’t know if the driver was at fault
			3. Currently, one staff person is analyzing crash reports for 2020 to try and determine is crashes were at fault or not
			4. Crash reports do not provide enough detail to know whether a specific medical condition caused a crash in many instances
			5. There are limitations because of information documented by police and because of how the Bureau of Highway Safety and BMV systems communicate
			6. Crash rates for those with medical conditions need to be compared with those of the general driving population
			7. Bureau of Highway Safety can provide crash information for general population upon request
			8. Statistics needed by MAB need to be identified clearly to focus analysis of data most purposefully
			9. What data is already available and what ability does BMV have to analyze now
			10. BMV has started to drill down on crash information for vision reviews, but not for medical
			11. Explore possibility of engaging outside resources such as a statistician or epidemiologist to review data currently available and assist the MAB in identifying what data and reports would be most useful
			12. Can BMV engage outside resources such as UNE, MaineGeneral, or DHHS epidemiologist to assist in making decisions about how to use data or assist in processing data
			13. Is there an option for a portal where clinicians can directly enter Driver Medical Evaluation and Eye Examination forms? This would make the lives of many providers easier, eliminate the current challenges with unreliable faxing, and potentially allow direct capture of data from the clinicians
			14. Would it be possible for BMV to directly interface with the electronic medical record health information network resources? Maybe the rules and the forms could be available for clinicians to access directly from the electronic record
			15. Technology modernization is a high priority for BMV
2. **Follow-up Needed**
	1. Seek replacement for the Addiction Medicine seat
	2. Seek better crash data to correlate crash data with medical conditions
	3. Look into options that might allow clinicians to access crash data for their patients
	4. Create procedures for drivers with progressive conditions to choose to have an “update” at a branch office rather than going to eye doctor
	5. Conduct an AAMVA survey regarding practices for vision screening in other jurisdictions. What age intervals do they use
	6. Discuss further whether to change age requirements for vision screening to renew driver’s license (currently in statute)
	7. Create a table or some equivalent summary to identify what personnel are qualified to complete Driver Medical Evaluation forms for specific diagnoses categories
3. **Meeting Schedule**
	1. Next Meeting Dates:
		1. Friday, April 1, 2022, 12:00–3:00 PM
		2. Friday, November 3, 2022, 12:00–3:00 PM
	2. Location: To be announced whether in person or remote.
4. **Adjourn:** 3:00 PM

**Note: All votes were taken by roll call.**

**Handouts:**

Agenda

Minutes 9/17/2021

FAP Revisions

* Sleep Apnea
* Narcolepsy
* Musculoskeletal and/or Neurological Conditions
* Unexplained Alteration/Loss of Consciousness
* Medical Other
* Mental Health
* Prescription Medications and/or Opioid Replacement Therapy
* Substance Use Disorder
* Vision Disorders