Medical Advisory Board
April 4th, 2025 12:00 Noon
Meeting Minutes
Meeting conducted in person with Zoom attendees

I. Welcome, introductions and housekeeping — Dir. Ireland / Rebecca McCabe

A. Present in person:
   i. Dr Dan Pierce, Lori Towne, Dr Isabella Askari, Dr Dan Potenza, Dr Jay Taylor, Dr Tom Meuser, Kate McBrien, Chris Ireland, Cindy Lincoln, Denise Boutin, Sarah Erving, Lori Merrill, Rebecca McCabe

B. Attendance via Zoom:
   i. Sec. Bellows, Dr Linda Schumacher-Feero, Dr Pat Keaney, Dr Evan Savage, Dr. Bob Lodato, Dr. Jims D. Jean-Jacques

C. Absent: Dr. Kristen Silvia, Dr. Tom Morrione

II. Adoption of November 1st, 2024 MAB meeting minutes — MAB Chair, Dr. Taylor

A. No changes suggested
   i. All in favor to adopt

III. BMV Updates:

A. Sleep Apnea CR24 volume — Rebecca McCabe
   i. Review of Sleep Apnea CR24 driver medical reports processed by the BMV Medical Review unit in terms of impact since last FAP revision in 5/2023.
      - Sleep Apnea comparison

FAP Effective	Profile level 3A definition	Interval for review
12/2016	"…not on treatment"	3 years
5/2023	"…treatments such as upper airway stimulation therapy, surgery, positional therapy, or oral appliance"	3 years

   ii. The data beginning in 2022 showed a low volume likely due to impact from the pandemic and reduced availability of CPAP equipment resulting in patients requesting extensions. There was an increase in the number of 3a "mild risk" reports in 2023, which aligned with the most recent FAP revision in May 2023, and a slight decrease in 2024. This is similar to what Dr Keaney predicted. Upcoming 3-year review for Sleep Apnea is expected to increase the volume of reports in 2026. There was discussion of potential challenges of managing the influx of patients and the need for better communication with the patients to give them ample time such as 6 months' notice to schedule appointments as there have been several sleep clinic closures. Overall patients are pleased with the FAP update for the 3a interval of review of 3 years (to include treatment compliance) and the BMV Medical unit is receiving a lot of positive feedback

from the customers and clinicians. The 3-year timeline has also been beneficial from a clinical and BMV perspective.

B. MAB seat schedule

	MAB seat	Term expiration
Dr Askari	Emergency Medicine	7/2025
Dr Pierce	Family Medicine	7/2025
Dr Savage	Physical Medicine & Rehabilitation	7/2025
Dr Jean-Jacques	Cardiology	8/2025
Dr Keaney	Pulmonary & Sleep Medicine	11/2025

i. Becca to reach out to each member and facilitate re-appointments as needed.

C. Outreach training — Rebecca McCabe

i. Chateau Cushnoc Senior Housing – Augusta 12/5/2024

Driving Fitness, Health, & Aging: Considerations for Safe Mobility (Tom Meuser)

ii. Association for Driver Rehabilitation Specialists (ADED)

- Northeast Chapter Meeting – Virtual 5/21/2025 (Becca M., Sarah E.)

iii. Dementia Care Conference – UMaine, Orono 6/13/2025

- Presented by Maine Rural Dementia Care Training program (Project Director, Dr Cliff Singer), funded by Health Resources and Services Administration (HRSA), and administered by Northern Light Mood & Memory at Acadia Hospital (Primary Care faculty and liaison, Lori Town). Working on education opportunities targeting primary care providers including free CME monthly case conferences. Conference training is not limited to Northern Light.
- *The Clinica Pathway for Dementia in Primary Care* (Lori Towne, FNP)
- *Driving and FAP* (Tom Meuser and Chris Ireland)

IV. New Business

A. Research Update — Dr. Tom Meuser

i. Maine Mature Drivers Project

- The new Maine Mature Drivers Project, led by Dr Tom Meuser and funded by the Maine Bureau of Highway Safety, aims to offer education workshops statewide. There are 20 in person training workshops scheduled statewide (April through September). These outreach events will be an opportunity to share the statewide clinician survey. Potential to focus on specific condition cases like substance use disorder and mental health that could guide the next FAP revision.

ii. FAP Analysis

- Results suggest FAP system is working. Fewer drivers remain licensed as FAP levels increase.

- Most drivers pass road test after one or more attempts. Some fail to show up. High pass rate suggests that standard road test may not evaluate skills relevant to specific health conditions.
- Active licensure is the norm following medical review.
- Overall, drivers who remain behind the wheel following medical review evidence stability or improvement in safety.
- Drivers aged 80 and older were more likely to be de-licensed than younger drivers.
- De-licensing also occurred through death, with mortality highest in conditions associated with advanced age.

iii. Clinical staging and FAP rating table (clinical vs driving severity)

iv. Dementia test scores

- 490 samples of patients with Dementia (3a – 3c)
    a. BMV Medical team documented CR24 clinician notes
    b. 385 CR24 forms (excluding 2024 half year)
        i. 76% of forms included clinician notes
    c. Physicians were most common to complete CR24s, also primary care and family practice
- 132 mental status test were captured on form (34% of CR24s).

NOTE – CR24 form doesn't prompt including mental score however FAP suggests it. Should form require MoCA score?

    a. All on 30-point scale with higher scores associated with better cognitive function
        i. 106 MoCA results (Montreal Cognitive Assessment)
        ii. 21 MMSE (Mini Mental State Exam)
        iii. 2 SLUMS (Saint Louis Mental Status)
    b. Recent literature suggest MoCA probably best tool for driving.
- MoCA score ranges to FAP levels (overlapping)
    a. Overlapping as clinicians must translate clinical severity to requirements of driving.
        i. FAP 1-2, 24+
        ii. FAP 3a, 18-26
        iii. FAP 3b, 12-20
        iv. FAP 3c, >16
    b. Some patients with cognitive impairment retain functions that could be driving ability.
    c. Clinicians might benefit from guidance on MoCA scores and assignment of FAP profile level.
- Specialist clinicians more likely to provide a mental status score
- MMSE correlates more strongly than MoCA

- 24% shared variance for MoCA and FAP rating
- Mental status scores predict clinician FAP ratings. They do not predict passing of road test.
- Consider if patient might be nervous which could impact mental score
- Discussion
    a. Do we want to have system instruction support pop ups for staff when we get mental status scores? Depends on who's administering exam and their training
    b. How many times do you let someone take the road test? 3 times typically for medical or non-medical road tests. In some cases, if the driver is dangerous, the examiner may make decision that they are done driving.
    c. Were there crash or adverse events correlating to MoCA scores and FAP levels? We can look at this.

B. Comprehensive Safety Analysis

Driver cases 2 years before and after medical review (1/1/14 – 12/31/23)

i. Crash and moving violations not explicitly related to medical conditions.

ii. Vision (acuity and peripheral) and other condition combinations showed increase in pre to post crash and moving violations.

- Discussion
    a. Should BMV staff flag these cases for review?
    b. How many of these drivers are actually wearing their correction at the time of the incident? We have no insight into this.
    c. Peripheral vision exceptional case review includes looking at other medical conditions the subject may have to ensure they're in compliance with the other FAP condition (so far none have been delicensed due to another condition). Currently have 17 participants and so far no crashes during the two year program timeline. Most obtain licensure.
    d. Do we have access to crash records? Yes, law enforcement enters incidents in Maine crash system and may submit medical adverse driving reports to BMV.

iii. Patterns

- Drivers with dementia have low crash and moving violations, yet are rated highest for FAP 3b-c.
- Mental health – only 5% are rated 3b-c, yet many are involved in crashes and moving violations.
- Drivers with SUD are most at risk followed by mental health
- Multiple sclerosis rarely is 3b-c and have low crash and moving violation rates. Should this condition be reviewed?

- Discussion
    a. The data is presented as 3a versus 3b-c. Is there value in having 3b-c ratings or should this really be one rating? Perhaps just A and B? This could simplify and reduce burden to provider.
    b. Consider an algorithm based on a series of responses such as awareness of deficits and treatment compliance. Tom used this method in his work with Missouri. Showed predictors of roadway safety. This could be used to assign a FAP rating.
    c. Consider current legislature on cannabis and marijuana
        i. What volume of CR24s are for marijuana use?
        ii. Clinicians sometimes document type of substance use on CR24. Typically, they document for EtOH use. Low volume of records for marijuana.
    d. Prescription meds/opioid use category shows only 1% of crash and moving violations. Should this be an indicator that perhaps this category should go away?
        i. There's a lot of confusion on this FAP category with drivers and clinicians. BMV staff observing clinicians sending in forms for substance use when it should be for opioid replacement, or vice versa.
        ii. Tom M. knows a pharmacist that is interested in serving on MAB and could perhaps help with these conversations
    e. Opioid replacement therapy is a term no longer being used which could be part of the confusion.
        i. Why are we calling that particular medication out as opposed to other treatments? This is stigmatizing. There are other substances being used that are more concerning to driver safety than opioid replacement therapy.
        ii. Consider a high risk category for polypharmacy.

iv. Moving violations
- Substance Use - Drivers with substance use disorder have 2.5 X higher moving violations than control sample. Not much of a control difference though for mental health or seizure.
- Hypoglycemia – Drivers with hypoglycemia show half annual rate in comparison to controls. Same pattern for vision, musculoskeletal / neuro, OSA.
- Discussion – consider type of event
    a. Paroxysmal - Seizure, or episode of hypoglycemia, or stroke
        i. Is there less variance from controls for these?

ii. Are we putting too much effort into paroxysmal conditions?
iii. Hypoglycemia – could it be that drivers are only being reviewed when they have an episode while driving?

b. Non- paroxysmal – Substance use disorder, vision
i. Is there more variance from controls for these?

C. Clinician survey

i. Questions we aim to learn from survey results

- What do clinicians know about the evaluation of medical fitness to drive and do in their practices today?
- How familiar are clinicians with the Maine BMV FAP rating system?
- How knowledgeable and confident do clinicians feel concerning application of the FAP system?
- How do clinicians understand and apply FAP levels in two case vignettes: mental health, dementia?

ii. Discussion

- Survey is for research and includes quality control. Designed as educational tool in addition to data collection tool. It's not for publication and does not have IRB implications, and it's anonymous.
- MAB and BMV staff completed test survey
- Comments
  a. Could you add a blank line to write in a condition category that's not in the list? - sleep apnea, visual acuity, prescription meds, cardiac (arrhythmia), and dummy entry
  b. Do providers need to already be familiar with FAP/CR24 to take survey? We're targeting anybody who potentially could fill out the FAP, even if they've never done it.
- Case vignettes
  a. Case A – schizophrenia (11 respondents)
  i. Intended to be 3a
  ii. Results FAP 2 (1), 3a (3), 3b (5), 3c (2)

  Discussion
  iii. Variability shows opportunity for education on FAP. Translation of clinical severity to driving is part matter of opinion.
  iv. It's helpful to discuss how one chooses the FAP profile rating.
  v. Inter-rater reliability looks poor. This is not a paroxysmal event and requires more of a judgement call beyond FAP guidance. Consider those not treating substance use and

how they may rate. Similar to how we discussed most rate a 3b instead of 3c. Consider adding in another case for seizure condition that's more obvious.

b. Case B – dementia, co-morbidities

Discussion

i. Hard to focus on what's going on except MoCA score.

ii. Planning to poll participants at Dementia conference. Would be helpful to find out what made them make their decision.

iii. It would be better to include the actual FAP in the survey case vignettes for reference. This would help guide them.

iv. Consider presenting case as gestalt approach and then share the FAP to see if they change their view.

v. She's had an occipital lobe stroke. But you didn't tell us anything about her vision and what her visual field looks like after an occipital lobe stroke. Her hitting the mailbox could be because she couldn't see it because of a visual field defect. It doesn't explain why she doesn't remember doing it. So, it's complicated.

1. We could add a text box to include visual field status, with MAB guidance.

vi. Will remove the stroke case and use actual FAP language.

- Provider education
  a. There's a survey question to request FAP training which aligns with Tom's project with Bureau of Highway Safety.
- Mandatory reporting
  a. Question included to express interest for conditions
  b. Seems five states have mandatory reporting for Alzheimer's (or Dementia)
     i. States are mandating select conditions. Alzheimer's and seizure conditions mostly.

iii. Outreach

- Will finalize survey and plan to share with public by next week
- Administer survey at provider training events
- Aim to get 500 responses
  a. Run the survey between April and November
- Target Organizations
  a. Maine Medical Association (may include survey in e-newsletter)
  b. Maine Primary Care Association (CCO will forward to CMOs)
  c. Maine Psychological Association (under review)

d. MAB suggestions
    i. Maine Osteopathic Association
    ii. Maine Nurse Practitioner Association
    iii. MaineHealth
    iv. Target residencies and fellowships
    v. Collaborations with other physicians/clinicians
    vi. Medical students – MAB Dan Pierce could distribute (may also incorporate cases into Medical training program)
    vii. Social workers can complete CR24 for Musc./Neuro, but limited on what they could treat. BMV sees low volume.
    viii. Consider licensing board organizations re-occurring meetings, also Professional and Occupational Regulation.
e. We need the MAB to guide BMV on where to target the survey.

D. Looking ahead — Dir. Ireland

i. FAP revision
- We are tracking questions we asked going into the new FAP
- Survey feedback may guide FAP revision approach

ii. Roadway safety
- Focus on most prevalent conditions
- Highest risk conditions
- Add/replace additional conditions

iii. Over capture/reduce burden
- Focus on co-morbidities
- Progressive conditions
- Non-standardized FAP tables/ratings
- Remove conditions
- Other approach

iv. Discussion
- The expertise in rewriting the FAP now exists within the board members. Current BMV staff was not involved in the last revision.
- We have a high volume of medical condition categories. Should there be a category saying this person should not drive?
- Last time, we reviewed each FAP individually.
- We need a standard process to look at each FAP that we're going to do methodically with the data such as:
    a. What do we have for crash data, moving violation data?
    b. What is the background?

c. Do we really need to be doing this? Most preambles are too long, and providers complain that they don't have time to read it. Should we change it to an easier format such as bullet point?
d. Do we only keep a portion of some FAPs, if they're comorbid? Consider primary care specialists who have to deal with everything like mental health, stroke, diabetes including paroxysmal conditions and longer term semi static or non-static conditions which can have minor exacerbations. What is the risk? Do we need to have the process so conformal?
e. What is the sense of urgency? Survey results should help. Is the clinical environment stressed to show what should be prioritized? Do we want to move more quickly in some areas and do policy making to address some concerns faster rather than reviewing everything at once? Are some things so broken that we want to revise it in pieces?
f. Would help to have electronic version of FAP to interface with EMR and then we could use graduating questions to prompt to the next questions to determine the final FAP rating.
g. These are sorts of questions we'll be asking after we learn the survey results and can discuss in November. Could be a 2-year process and 6 month writing timeline.
h. We used to have 4 MAB meetings a year and now we have two. It's hard to get traction with 6 months between meetings. Consider getting everybody together 4 times a year and also subgroups like we did in the past to review specific FAP conditions. There was value in including people who are not experts in the topic and shared their ideas.
i. We could get providers to trial the new FAP version to get feedback before rolling it out to everyone. Is the new version more user friendly?
j. There's nothing in the FAP book that says the CR24 must look like this. We could consider revising applications and/or CR24 without rewriting the FAP.

V. Open Discussion
   A. FAP roundtable – we will explore opportunities in future discussions

VI. MAB Meeting Schedule
   A. Friday, November 7th, 2025
   B. Friday, April 3rd, 2026

VII. Closing Remarks — Secretary Bellows and MAB Chair, Dr. Taylor

A. Appreciate seeing the sleep apnea data and thinking ahead of how we meet the demand in 2026. Tom's data presentation was remarkable and glad there's funding for the position from Bureau of Highway Safety including public outreach events. Lori Towne is a valuable addition to the MAB and the dementia conference sounds phenomenal. The survey sounds exciting and if the survey tells us the profession wants mandatory reporting, that's a data point. It's helpful to ground this work in data and feedback. It's important to look at the balance of roadway safety and over-capture and review our goals and impacts. Rule making will require planning and keeping current with practice. None of this can be done without all the MAB providers sitting in this room. A huge thank you, this was a great meeting with really robust content and discussions, and I have the best staff. We've come a long way, and we have a roadmap for where we're going to continue to improve. I want to express my deep appreciation for this collaboration and level of work.
B. We've been asking the same questions for over a decade, and I think we're getting closer to answers and rationale for things that we do. There's a triangle of who needs to complete the form, process it and who it impacts. We need to strike a balance and keep making sane iterations.

VIII. Adjournment

IX. Handouts
   A. Agenda
   B. Meeting minutes Nov. 1st, 2024
   C. Presentation: MAB data research
      i. Comprehensive Safety Analysis reports
      ii. Clinician survey