Medical Advisory Board
Minutes
April 21, 2017

I. Call to Order: MAB Chair, Dan Onion
   A. Present: Jay Taylor, Robert Dreher, Eileen Fingerman, Thomas Morrione, Robert Lodato, Thea Fickett, Larry Boivin, Matt Dunlap
   B. Attended by Phone: Janis Petzel
   C. Absent: Gene Giunti, Paula Kirby-Long, Karen Kurkjian, Linda Grant

II. Introductions Larry Boivin
   A. Secretary of State – Matthew Dunlap
   B. New Chairman – Jay Taylor
   C. New Members – Eileen Fingerman, Robert Lodato, Thomas Morrione
   D. Member background, credentials and seat on Board All Members

III. Welcome and purpose of the Board Matthew Dunlap

IV. Approval of Minutes John Taylor
   A. October 21, 2016 minutes unanimously accepted without revision

V. LD 1426 – An Act To Allow Use of BTL's To Meet Vision Requirements
   A. Secretary of State currently supports bill with some reservations Matthew Dunlap
   B. Overview of legislative process Larry Boivin
   C. Board opposed to LD 1426 for several reasons All Members
      1. Legislation is submitted on behalf of a particular driver wanting to move to Maine
      2. No data to support safety, and subject recently reviewed by Low Vision Working group and MAB
      3. No significant change in bioptic technology that would result in different outcomes for driving
      4. Studies showing bioptic driving is safe were based on telephone surveys to drivers, not objective assessment of crash data
      5. 12/31/2016 FAP written on basis of current, available data and should be followed as written, it is best medical advice of the MAB
      6. American Automobile Association reports different jurisdictions vary in whether or not they allow bioptics for vision testing
      7. FAP currently does not allow clinicians to override FAP rules, whereas proposed statute would allow this
      8. Responsibility to prove safety of bioptic lenses for driving, rests on proponents
      9. A letter of testimony will be submitted to the Legislative Committee, opposing LD 1426. John Taylor will draft letter for Members to review. He will sign and submit it to the Transportation Committee for consideration
      10. If LD 1426 passes, FAP Peripheral Vision rules will need to be rewritten

11. A copy of 2014 Low Vision Working group report will be forwarded to the new Board Members — Thea Fickett
12. Brief history of low vision issues in Maine — Robert Dreher

VI. Review of Complicated Case – Peripheral Vision — Thea Fickett

A. Summary (1):

[redacted]

4. How should Esterman test be used to determine if driver meets peripheral vision standard? Depending on how the test results are interpreted, the outcome will vary.
5. Peripheral vision FAP does not allow a person to miss more than 3 points to pass the Esterman test. Should all missed points within the entire visual field should be counted, or should the test results be based on points missed only within a certain area of visual field? Note that a person blind in one eye may have 2 physiological blind spots simply because they have only one eye.
6. Discussion resulted in consensus that peripheral vision is greater than 40+60=100 and driving privileges should possibly be reinstated.

VII. Old business:

B. Update on implementation of new FAP (rules) — Thea Fickett

1. Approximately 7000 copies distributed to appropriate disciplines
2. Peripheral vision and Esterman test
   a. Changes to peripheral vision standards have resulted in many inquiries from clinicians and drivers. Most questions relate to the following:
      a. How to do the test or don't have equipment to do it
      b. How to score Esterman
      c. The requirement for at least 50 degrees to left and right of fixation
   b. It seems the rule changes may have a disproportional effect on drivers with useful vision in only 1 eye.

c. January to March, 2017 there have been 43 suspensions due to peripheral vision (We are unable to compare 2017 stats with previous year's, as peripheral vision suspensions were not tracked separate from other vision suspensions).
d. 36 drivers were suspended who had been driving prior to rule changes.
e. BMV does not want to take away driving privileges unnecessarily and many of the calls were about drivers that have good driving records but because of rule change, no longer meet vision standard and are being suspended.
f. BMV must function within written rules, but needs clarification regarding interpretation and what constitutes passing score.
g. Evidence supports relationship between peripheral vision and driving safely, but there is no consensus about what constitutes a reasonable cutoff between safe and unsafe driving (Eyesight Working Group 2006).
h. Robert Dreher pointed out that the horizontal peripheral vision of a person with long arms and legs will end approximately at the doorpost (maybe about 30 degrees), while a person who sits up closer to the windshield may be able to see as far as 50 degrees without doorpost creating a blind spot.
i. In order to resolve immediate concerns, Robert Dreher and Thea Fickett will reach out to some other eye care specialists to discuss interpretation of the Esterman result within context of current rules.
j. Future changes to FAP should include re-writing peripheral vision rules to clarify requirements.
k. When drafting new peripheral vision rules, other eye care specialists will be included in the discussion or comments from others will be solicited.
l. If LD 1426 passes as written, the rules will need to be rewritten to reflect new legislation. Otherwise, it will be at least next year, as rule-making is not on this year's legislative calendar.
m. Discussion for future rule changes should include at least the following: deleting "binocular" and "monocular" from FAP language; consider changing left and right peripheral vision minimum from 50 to 45 degrees to allow screening at branches (there is not enough evidence to support taking away driving privileges over failure to meet the 50 versus 45 degrees to left or right horizontally); look more closely at correlation between crash rates of drivers with hemianopsia if available (Netherlands or others); should language regarding drivers with functional vision in only one eye be incorporated since they may have 2 physiologic blind spots and only have the potential for approximately 135 degrees total.

3. Other-Cardiac – transition from old diagnosis list to new list
   a. Those with history of ASHD/CAD/CHF/MI, profile level 3a will no longer be reviewed unless notes on form are contradictory.

b. History of ASHD/CAD/CHF/MI, profile level 3b, end-dated.
c. "Other-cardiac" diagnosis not specified on form, profile level 3b, reviewed again in 2 years.

4. Diabetes
   a. Persons with history of Diabetes profile level 3a or new reviews that come in will no longer be reviewed unless notes indicate Hypoglycemia, and then entered as Hypoglycemia 3a.
   b. History of diabetes profile level 3b will be entered as hypoglycemia 3b.i and reviewed again in 1 year unless notes indicate hypoglycemic unawareness, then they will reviewed case by case.
   c. BMV has received several calls from clinicians with questions and concerns about this FAP. See letter from Dr. Brodsky as an example. There is a gap in the FAP. Profile levels 1 and 2 are clear, but 3a does not define hypoglycemia. And, profile levels 3b and 3c define hypoglycemia as episodes requiring 3rd party intervention. What profile should be used for persons with recent hypoglycemia that is likely to recur but has not required 3rd party intervention? Currently, BMV advising clinician to select the profile level 3a or 3b based on their level of concern in terms of follow-up.
   d. Is concern only for altered level of consciousness or with hypoglycemia itself?
   e. The confusion does not seem to result in unnecessary suspensions.
5. Chronic Pulmonary
   a. Calls have come in from clinicians and drivers with questions about restricting drivers to operating with oxygen. An O2 sat of 89% or greater on room air does not require restriction per current rules. However, if O2 sat on oxygen is the only reading given, driver will automatically be restricted to driving only with oxygen. Some clinicians are not checking/documenting the O2 sat on room air, when in reality the patient is able to maintain O2 sat 89% or above on room air.
   b. There is active dis-incentive for testing on room air as patients might be disqualified for oxygen by insurance if there levels happen to be high.

C. Follow-up 10/21/16 case study - Clinician unwilling to complete mve-103 or CR-24
   1. Dan Onion checked with licensing board and MD's are responsible for making available to their patients their findings and recommendations related to driving safety and responsibilities. A request to complete a BMV form would be a reasonable request from a patient and the physician should provide this information for their patients
   2. Linda Grant spoke with BMV legal counsel, Robert O'Connell and BMV does not have authority to report clinicians to Board of Licensure. It would be acceptable to take information from the clinician over the phone.
   3. The website wording was modified to clarify physician responsibility.

4. Drivers can report their physician to Board of Licensure or find another doctor when this comes up.

D. DHHS Epidemiologist — Thea Fickett

1. Invite Siirri Bennett to meet with MAB once we know what data is available
2. Find out if she is biostatistician or only an epidemiologist
3. Determine if she can provide guidance on how to correlate vision and crash statistics
4. Define what MAB might want to accomplish (E.g. can data be used to correlate visual acuity or peripheral vision and crash statistics?)
5. Data is observational and retrospective at this time

VIII. New business:

D. Medical Review Statistics — Thea Fickett

1. Reviewed 2016 initial and periodic reviews, by diagnosis.

E. Vision Reports — Thea Fickett

1. Reviewed components of Draft Vision Detail Report – January 1 – March 31, 2017.
2. Report is limited to drivers being reviewed (initial or periodic) during time frame queried.
3. Query does not include ALL Maine drivers at for the specified time, due to program limitations.
4. Information received by BMV has limitations, as not all clinicians complete forms correctly or the same (E.g. – If clinician doesn't check yes to driver using bioptic lenses, it simply means we don't know.).
5. Crash information will only include crashes reported in Maine.
6. Crash history may indicate driver is unsafe, but lack of crash history does not necessarily mean they are safe.

F. Drug and alcohol specialty representation on Board — Thea Fickett

1. Discussed whether or not Members support adding this specialty to the membership
2. Issues related to this field are increasing for BMV, and it affects more than just the medical section, such as:
   a. Medication assisted therapy
   b. Pain management
   c. Medical marijuana
   d. Substance abuse
3. Members agreed that an Addiction Specialist with credentials as an MD/DO/PA/NP would be beneficial but not a social work or licensed counselor.
4. Both Janis Petzel and Eileen Fingerman have experience in the area of substance use disorders and Opiate Replacement medications.

VI. Open discussion:

A. LD 1426 - "An Act To Allow Use Of Bioptic Telescopic Lenses to Meet Vision Requirements"

5. Secretary of State, Matt Dunlap, is supportive of this legislation with some revisions.
6. His support does not preclude any Member from giving testimony as individuals.
7. Discussed history of proposed BTL/low vision legislation and 2013 Low Vision Working Group.
8. Responsibility for proving safety of driving with BTL's is on the proponent for the legislation, not BMV.
9. Clinicians should not have the ability per legislation, to override the FAP requirements.
10. Robert Dreher reports the Ophthalmologic Association meeting in Freeport last year also reviewed the issue
11. There are 2 studies that show driving with BTL's is safe, but both of these studies were based on subjective driver interviews.
12. Even articles sent by Chuck Huss do not establish that BTL's are safe**.**
13. Members agreed that legislation as written is not clear, rules in other states vary state by state, data showing safety of driving with BTL's is unclear and the best medical advice of MAB at this time is to follow current FAP.
14. This topic has already been extensively and recently reviewed by MAB.
15. John Taylor agreed to draft a letter for review by Members and submit to SOS or Legislative Committee.
16. Larry Boivin summarized the legislative process.

B. Future meeting agenda

1. FAP revisions
2. On-going case reviews
3. Educating clinicians about how to use FAP
    - Screening for dementia
4. BMV staff training
5. Statistical review
6. Invitation of Siirri Bennett, state epidemiologist, to MAB

C. New Meeting Calendar

1. The standing meeting date of 3rd Friday in April is problematic for some members due to school vacations
2. Thea Fickett will research options for changing dates (E.g. March/April and September/October) for discussion at the October meeting
3. Meeting frequency will be decreased to twice per year unless larger issues arise, then ad hoc meetings will be called if necessary

VII. Meeting Schedule:

A. Next Meeting Date: Friday, October 20, 2017

B. From: 12:00 – 3:00 PM
C. Location: Executive Conference Room
D. 2018 meeting dates: April 20 and October 19, 2018
E. Video conference option is available in local branches with enough advance notice to Thea Fickett

VIII. Assignments:

A. Jay Taylor will draft letter regarding LD 1426 to be submitted as testimony of MAB. It will be e-mailed to Members for approval prior to submission.
B. Members agreed to submit names of eye care specialists to Thea Fickett, to be surveyed for comment on peripheral vision questions and potential rule changes.
C. Thea Fickett will request driver information and of those suspended for peripheral vision in 2017, to date. Review will specifically look at the following questions:
    1. How many suspensions were due to rule changes?
    2. What are other reasons for suspension?
    3. How many of the suspended drivers had only one functional eye?
D. Next meeting, focus on reasons for suspensions and look what may need to be changed.
E. Thea Fickett, allow driver in the case discussed (Dr. Walters patient) today to be reviewed again by eye doctor and give the driver the benefit of the doubt to see if he can be allowed to drive if he has at least 110˚.
F. Thea Fickett, look at calendar for options to re-schedule meeting dates, possibly March/September or change April dates to avoid school vacation and look at April/October
G. Decrease frequency of meetings to 2 per year at this time and increase later if needed
H. Forward copy of old BTL legislation to new members for review

Adjournment: 3:15 PM

<u>Handouts included:</u>

1. Agenda
2. Minutes: October 21, 2016
3. Case example (1)
4. Visual Disorders FAP
5. Medical Review Statistics
6. Draft Vision Detail Report
7. Mileage reimbursement forms