Medical Advisory Board

Minutes - DRAFT

September 17, 2021 3:00 – 5:00 PM

Meeting conducted via Zoom

1. **Call to Order:** MAB Chair, John Taylor
	1. Zoom Participants: John Taylor, Daniel Pierce, Daniel Potenza, Evan Savage, Frederick Goggans, Jims Jean-Jacques, Linda Schumacher-Feero, Patrick Keaney, Robert Lodato, Thomas Morrione, Cathie Curtis, Larry Boivin, Michelle Cloutier, Thea Fickett, Kenneth Capron (driver)
	2. Absent: Isabella Askari, Dawna Gilbert
2. **Introduction of Deputy Director**  Larry Boivin
3. **Welcome and introductory remarks** Cathie Curtis
4. **Member introductions** All members
	1. New members: Daniel Pierce, Family Medicine; Evan Savage, Physiatry; Jims Jean-Jacques, Cardiology
5. **Approval of Minutes** John Taylor
	1. April 2, 2021 meeting minutes were accepted unanimously by roll call vote
	2. July 22, 2021 meeting minutes were accepted unanimously by roll call vote
6. **Guest Presentation: Kenneth Capron (10 minutes)**
	1. Mr. Capron is a driver with sleep apnea
	2. He reports that he has “emergent sleep apnea” and is not licensed now because of the rules for “severe” sleep apnea.
	3. His concerns include:
		1. The definition of “severe” sleep apnea includes non-adherent but does not consider a driving record without driving incidents.
		2. The current rules use AHI as a measure to determine fitness to drive. He recommends that a measure of daytime sleepiness should be used instead.
		3. The Epworth Sleepiness Scale (ESS) is not included in the definition of “severe” in the rules.
		4. “Treatment emergent sleep apnea” is not mentioned in the rules and all the references are “ancient history, very old”.
		5. Oxygen is important to decrease hypoxic respiratory drive. Comments in the article sent to him by Thea Fickett, indicate oxygen is reserved for patients who do not tolerate PAP therapy. (The article was about treatment emergent sleep apnea.)
		6. He has had 3 sleep studies and none of them included evaluation of oxygen treatment, which is what he was seeking when he went to the doctor in the first place. Now he is scheduled for a sleep study in October which will include evaluation of need for oxygen therapy. He will also have a wakefulness test done.
		7. He is stuck without a driver’s license and he does not have an unsafe driving history. This doesn’t seem right.
		8. The rules for “Active Impairment Profile Level 3c” are very limiting. They are more like punishment than treatment. It is ridiculous for him to go through this when he is not a risk and would not drive if he was a risk.
		9. The rules should be changed, taking into account driving history and daytime sleepiness. AHI as a determinant of driving is not reasonable.
		10. He believes someone told him there was a mistake in the rules. He is not sure what the error was, but the rules should be changed.
	4. The board did not have any questions for Mr. Capron
7. **Old Business**
	1. Functional Ability Profile Revision Updates
		1. Sleep Apnea FAP Patrick Keaney
			1. June 23, 2021 meeting with OSA drivers – Summary of recommendations. Not all recommendations are specific to sleep apnea.
8. Statistics are needed regarding crash risk and medical conditions in Maine, to better inform the MAB in making recommendations for rule changes.
9. Rules need to be the least restrictive and burdensome possible while still taking reasonable steps to promote highway safety. They need to strike a balance between highway safety and a driver’s need to be treated without fear of losing their license.
10. Rules need to include verbiage that will allow a driver with sleep apnea to have time to work with their provider to become compliant and find effective treatment, when appropriate.
11. Oxygen therapy as a treatment should be reviewed to determine if it might be appropriate for some drivers that are not tolerant of PAP therapy.
12. Rules need to allow clinician flexibility in determining when to suspend, how much time is needed to work with a patient seeking appropriate treatment and/or compliance.
13. Operationally, it may be a good idea to consider possibly extending the interval of time between update letters and the due date, as well as between notice of suspension and due date, for all diagnoses.
	* + 1. Dr. Keaney provided some background for the changes.
				1. He explained that the current rules are rigid, they were written between 2014-2016 and became effective in 2016. The references are old and there is newer technology that needs to be included. The changes are being made to decrease the burden on drivers, BMV staff and clinicians. The changes will allow drivers with less risk and drivers who are effectively treated and compliant to be reviewed less frequently; revisions will allow clinicians more flexibility to work with drivers having compliance issues to explore treatment options.
				2. FAP draft revisions are based on review by Dr. Keaney and 3 other sleep medicine physicians.
				3. Determining risk for driving can be difficult. Although there is literature support showing that sleepiness can affect driving, it does not show a clear correlation between ESS, Maintenance of Wakefulness Testing or other measures of sleepiness and crash risk.
				4. FAP changes include less frequent reviews for lower risk profile level 3a drivers and allows higher ESS scores for all profile levels. The changes also allow higher AHI readings for profile level 3b and this should result in fewer people in “profile level 3c – no driving”.
			2. MAB discussion included the following points:
				1. Is there a way to take onto consideration individual driver’s abilities to adapt to their deficits when driving?
				2. The MAB is responsible for recommending rules that affect a broad spectrum of individuals. Rules are created to objectivize standards. If the intent is to look at individual adaptabilities, wouldn’t it mean that each individuals capacity is introducing a degree of subjectivity into the rule?
				3. Some FAP’s are very binary, e.g. seizure disorders. In such cases, either the person had a seizure or they didn’t; either they take their medications or they don’t, and the rules are set up to make sense in that context.
				4. Some conditions exist more on a continuum of behavior or symptoms, or there may be variability day to day or month to month. In these cases, rules are set up allowing some clinician judgment for individual consideration. Then, if there is uncertainty, BMV can bring cases to MAB members for consultation.
				5. Recommendations from the MAB should be made with the goal of seeking a balance between highway safety and the least restrictive requirements for drivers.
				6. Minor changes to order and wording were made to the FAP Table, for the sake of clarity.
				7. FAP format should be consistent between all FAP’s ensure the “and” / ”or” are inserted between criteria/descriptions within each profile level, as appropriate.
				8. The following language should be added to all FAP’s, “Active Impairment”, column 2: “(Profile levels are intended to describe potential for at risk driving; they are NOT consistent with clinical definitions for mild, moderate or severe <diagnosis>.)”
			3. A vote was taken by roll call and approval was unanimous.
		1. Chronic Respiratory Disease FAP Patrick Keaney
			1. The document was simplified, leaving the focus on hypoxia and conditions that cause hypoxia, and diminishing the focus on COPD. No significant changes were made on the Table. Individuals still must be able to maintain O2 saturation of 89% or greater, whether on room air or with oxygen supplementation, except for those who only have exercise or sleep induced hypoxia.
			2. A vote was taken by roll call and approval was unanimous.
		2. Narcolepsy FAP Patrick Keaney
			1. Hypersomnia has been added to the new FAP draft.
			2. The current FAP does not allow nurse practitioners or physician assistants to sign the Driver Medical Evaluation (CR-24) for narcolepsy. The new draft will allow both disciplines to sign if they have had specialized training in narcolepsy.
			3. The current FAP requires narrative documentation regarding narcolepsy and cataplexy. This resulted in an extra form for clinicians and increased review by BMV. Providers will be responsible to assess patients and understand whether narcolepsy and/or cataplexy create risk for driving. The additional form will be discontinued, relieving some burden on BMV staff.
			4. The ESS scores were aligned to be the same for both sleep apnea and narcolepsy, as some patients have a dual diagnosis.
			5. Although it is preferred that neurologists or sleep specialists complete the CR-24 for narcolepsy, this is not a reasonable requirement due to the rural nature of the state and the difficulty with access to specialists in some parts of the state.
			6. Discussion included the need to define the meaning of “recent” crash. In the interest of time, this discussion was deferred for follow-up by e-mail or to the next meeting.
			7. The MAB recommends that BMV and the Secretary of State keep in mind the need for improvements to make crash data available to the MAB and to clinicians. Possibly this could be a topic for future legislation or technology improvements. It would be helpful to have a query or something that would make data accessible to clinicians. Otherwise, clinicians are often not aware of driving concerns regarding their patients and patients are not always forthcoming to disclose this information. This is relevant to other diagnoses as well.
			8. A vote was taken by roll call and approval of the FAP was unanimous, with the understanding that “recent” would be defined before the draft is finalized.
		3. Mental Health FAP Daniel Potenza
			1. This FAP was approved in April but needs further discussion of nomenclature by the MAB.
				1. Over the years, a concern has resurfaced from time to time regarding the “stigmatizing” language of the FAP. In 2016 the FAP language was changed from Psychiatric Disorders to Mental Disorders. Recently, a constituent went to a Representative. The Representative is considering legislation to address the “stigmatizing language” used by BMV unless BMV offers a solution. There have been conversations involving the Secretary of State (SOS), the Deputy Director, Dr. Potenza, Dr. Taylor and Thea Fickett (BMV), regarding the issue.
				2. If there is an acceptable alternative that makes sense within clinical parameters and makes sense from other perspectives, it would be nice to find a compromise to avoid legislation. If this goes to legislation, BMV may be forced to make a change and the outcome unknown.
				3. The proposed solution is to change the name of the FAP from Mental Disorders to Mental Health Conditions. Initial conversations concluded this change could be made without sacrificing the foundation of the DSM as basis for FAP criteria.
				4. Dr. Potenza contacted the Maine Association of Psychiatric Physicians and NAMI about using Mental Health vs Mental Disorders nomenclature. NAMI Maine did not respond.
				5. Dr. Potenza also consulted with the patient advocates at Dorothea Dix Psychiatric Center, and they felt the change from Mental Disorders to Mental Health Conditions would be an improvement and made sense.
			2. The MAB discussion points included:
				1. The opinion that the Diagnostic and Statistical Manual of Mental Disorders is the official manual of the American Psychiatric Association. The term Mental Disorders is the official language of the profession.
				2. The description of “Active Impairment” on the FAP Table states, “On-going symptoms that meet current DSM criteria for a mental disorder”. This language will be unchanged and will be the basis for determining what conditions are reviewed using the FAP.
				3. Psychiatrists treat disorders, not conditions.
				4. This group is a MEDICAL advisory board. Changing the language to make it less stigmatizing will de-medicalize and water it down.
				5. Objective references are needed to define the criteria and define disorders. DSM criteria would continue to be used as the basis for conditions appropriately reviewed under the Mental Health Conditions FAP.
				6. If the document is not a medical document, should the DSM criteria even be included in the FAP?
				7. The FAP is not a “Medical” document, as the audience is greater than the medical profession. If the change makes the document more palatable, the changes should be made.
				8. The reason for consideration of a change in nomenclature is 100% driven by constituent concerns.
			3. A roll call vote was taken to change the FAP name from Mental Disorders to Mental Health Conditions. It passed with one dissenting vote by Dr. Frederick Goggans.
		4. Tourette’s Syndrome Taylor/Potenza
			1. Related to the above discussion of nomenclature and potential legislation, is a question about whether Tourette’s can be evaluated using an FAP other than Mental Disorders.
			2. Tourette’s is treated by both psychiatrists and neurologists. It is a disorder of motor and chronic tics and is often treated by movement disorder specialists.
			3. There are comorbidities associated with the condition that should be reviewed using the Mental Health Conditions FAP when appropriate, e.g. ADHD, OCD and others.
			4. There was consensus to move Tourette’s to the Musculoskeletal and/or Neurological FAP, including input from Dr. Taylor, Neurologist; Dr. Potenza, Psychiatrist; and Dr. Goggans, Psychiatrist.
			5. Thea Fickett will work with Dr. Goggans, Dr. Potenza and Dr. Taylor to determine wording for the Musculoskeletal and/or Neurological FAP.
		5. Other Medical FAP John Taylor
			1. This category will be used for conditions not included in other FAP’s and will help provide a standard for determining risk for driving.
			2. The purpose for creating this new FAP is that in some cases, no single FAP accurately reflects the risk for unsafe driving.
			3. A single condition alone may not cause risk, but the cumulative totality of multiple conditions, the complexity, frailty or fluctuating nature of condition(s), create risk for driving. Examples may include heart failure, renal failure, fluctuating cognition, or others where the clinician believes the person is unsafe to drive, but the condition(s) doesn’t fit the criteria for a specific FAP.
			4. During the April MAB meeting, polypharmacy was referred for inclusion in this FAP. However, when this FAP was drafted, it seemed that polypharmacy would more appropriately be captured using the Prescription Medications and/or Opioid Replacement Therapy FAP. That FAP needs to be reviewed to ensure language is adequate.
			5. The FAP is open ended and leaves a lot up to the clinician to make the best assessment and decision.
			6. This FAP could be open to massive over-use, but it is absolutely needed.
			7. The preamble language stating clinicians “should” include narrative is not meant to be mandatory. Clinicians will need to include the diagnosis and why they are completing the form so BMV can determine appropriate actions.
			8. Initially Medical Other cases should be forwarded to the MAB for review.
			9. These cases will need to be tracked and reported to MAB. Over time, it may become apparent that other FAP’s are needed.
			10. Because it is the totality of the “condition(s)” that determine risk for driving in this FAP, the language will be changed to “No known condition” rather than “No known disorder” for Profile Level 1, “Condition Definition/Example”.
			11. MAB discussion included whether to remove all references to “disorder” in all FAP’s and instead use “condition”. Consensus was to change the language in this FAP, but not necessarily in all FAP’s.
			12. A vote was taken by roll call and approval was unanimous.
		6. Dementia FAP Thea Fickett
			1. For the record, it was noted that the AOTA description of an Occupational Therapy Driving Evaluation will be used in the Appendix, rather than customized language as proposed during the April MAB meeting.
		7. The remaining FAP’s on the agenda were not discussed because there was not enough time.
14. **New Business**
	1. Statistics Thea Fickett
		1. Statistical reports were not discussed due to lack of time
		2. The MAB subcommittee that met with sleep apnea drivers on 6/23/21, recommend that statistics are needed regarding the correlation between crash risk and medical conditions in Maine, to better inform the MAB regarding recommendations for rules.
	2. Resources added to BMV Medical Requirements website:
		1. Clinician’s Guide to Assessing and Counselling Older Driver’s, 4th Edition (2019)
		2. Description of BMV Road Evaluation
15. **Assignments**
	1. FAP’s needing initial review at next meeting
		1. Musculoskeletal & Neurological Thomas Morrione
			1. Add Tourette’s Syndrome language, working with Dr. Potenza, Dr. Taylor, Dr. Savage (Dr. Goggans resigned 9/17/21.)
		2. Unexplained Alteration/Loss of Consciousness John Taylor
		3. FAP page 1– Personnel allowed to complete a CR-24 Thea Fickett
			1. Review all clinicians for all diagnoses
	2. Approved FAP’s which need follow-up
		1. Prescription Medications &/or Opioid Replacement Therapy Frederick Goggans
			1. Is language adequate to cover the polypharmacy concerns?
		2. Substance Use Disorder Frederick Goggans
			1. Review FAP for Seizure and SUD to determine how to handle people with seizures provoked by substance use but not diagnosed with SUD.
		3. Vision Disorders Linda Schumacher-Feero
			1. Do we want to allow people with “progressive” conditions checked on an MVE-103, to be allowed to go into a branch annually as opt out of a new MVE-103 when an update is due? (See FAP page 3, paragraph 3 re: eye exams for persons with progressive)
			2. Can BMV branch vision screening intervals based on age, be eliminated to allow more on-line license renewals?
		4. Sleep Apnea Patrick Keaney
			1. Will FAP allow oxygen as a treatment for sleep apnea? (As requested by driver at 6/23/21 sleep apnea subcommittee meeting)
		5. Narcolepsy Patrick Keaney
			1. Define how “recent” crash will be defined.
		6. Medical Other John Taylor and all members
			1. New cases will need to be reviewed by MAB.
			2. Medical Staff will need training on review process.
			3. All new cases will need to be tracked and reported to MAB
		7. FAP Tables for all FAP’s All members
			1. Add “Risk” to Profile Level descriptors in column 2 – to emphasize that these are not clinical definitions, but rather potential for at risk driving.
			2. Add the following language to all FAP’s, “Active Impairment” row on column 2: “(Profile levels are intended to describe potential for at risk driving; they are NOT consistent with clinical definitions for mild, moderate or severe <diagnosis>.)”
			3. FAP format should be consistent between all FAP’s. Ensure the “and” / ”or” are inserted between criteria/descriptions within each profile level, as appropriate.
		8. Consider whether to extend intervals of time between MD-LT-01 and MD-LT-02 letters and due date, as well as between Notice of Suspension and due date, for all diagnosis
	3. Statistics
		1. BMV to provide update on progress toward analyzing correlation between medical conditions and crash risk.
		2. MAB to identify which conditions will be included in report on road test outcomes by diagnosis?
		3. BMV and the Secretary of State to consider MAB request for improvements to collection of data to help identify correlation between medical conditions and crash risk, as well as possibility for a query of some type that would make crash information available to clinicians. Could this be a topic for future legislation or technology improvements?
16. **Meeting Schedule**
	1. Next Meeting Dates:
		1. Friday, November 5, 2021, 12:00 – 3:00 PM
		2. Friday, April 1, 2022 – 3:00 PM
	2. Location: To be announced whether in person or remote.
17. **Adjournment:** 5:00 PM

**Meeting Handouts:**

1. Agenda

2. Minutes: April 2, 2021 and July 22, 2021

3. FAP Drafts

 Chronic Respiratory

Medical Other

Mental Disorders

Musculoskeletal and/or Neurological Conditions

Narcolepsy

 Prescription Medications and/or Opioid Replacement Therapy

 Sleep Apnea

Substance Use Disorder

Unexplained Alteration/Loss of Consciousness

 Visual Disorders

4. Medical Statistics

5. Vison Statistics