NATIONAL TRANSPORTATION SAFETY BOARD

PUBLIC HEARING ON THE MEDICAL OVERSIGHT OF NONCOMMERCIAL DRIVERS

L'Enfant Plaza
Washington, D.C. 20594

Wednesday, March 19, 2003
8:00 a.m.

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P R O C E E D I N G S

8:11 a.m.

CHAIRMAN GOGLIA: Good morning, everybody.

We are reconvening the hearing this morning, and Mr. Marshall, Dr. Marshall, would you call the first panel?

DR. MARSHALL: The first session of the morning is entitled Awareness and Training, and Mr. Suydam will give you an introduction for the Technical Panel and also for the witnesses.

Awareness and Training

MR. SUYDAM: Thank you. Thank you, Dr. Marshall.

My name's Ken Suydam. I'm an investigator with the Office of Highway Safety.

With me today on the Technical Panel are Dr. Mitch Garber, the Safety Board's Medical Officer, and Mr. Marc Ducote, an investigator with the Office of Highway Safety.

The purpose of this panel is to discuss the existing and proposed needed programs that aid doctors, law enforcement, licensing authorities, and others who report, manage or counsel medically high-risk drivers.

Awareness and effectiveness of such programs will also be specifically addressed during this panel.

The witnesses for this panel will include Dr. Claire Wang, the Medical Advisor to the American Medical Association's

Older Driver Project, Sgt. Robert Ticer, a 12-year veteran of the Arizona Department of Public Safety, currently assigned to NHTSA reviewing law enforcement older driver programs, and Ms. Jill Reeve, the Program Supervisor for the Medical Review Unit, Bureau of Driver Services, Motor Vehicles, Wisconsin Department of Transportation.

Thank you all for joining us this morning, and I'd like to begin the questions with Sgt. Ticer.

Sgt. Ticer, with your temporary assignment to NHTSA from the Arizona Highway Patrol, could you give us a brief description of what your job position is and your job responsibilities are at NHTSA?

SGT. TICER: Yes. My position's a one-year assignment on a cooperative agreement from Arizona with the Department of Transportation at NHTSA. I'm working on a program, titled "Data Collection in Older Driver Programs and Law Enforcement", and what my duties are are to locate law enforcement agencies across this country and document their programs that deal with older drivers, just about any program in the realm of older driving, putting -- after I find those programs, my job is to put them in a resource guide with the programs to make it available to law enforcement executives and other people.

MR. SUYDAM: Could you describe the programs and initiatives that you're currently involved in or that are being tested or implemented nationally by the law enforcement community

to help educate, identify or manage medically at-risk or older drivers? Would you tell us about those programs?

SGT. TICER: The programs I've found by talking with many agencies across the country deal with training as one of the issues out there as well as the referral process that I talked about yesterday. Every law enforcement agency that I've talked to in this country has a type of referral system to refer drivers who have medical conditions or the officer feels conditions that are unsafe to drive to the -- they have the opportunity to send in referrals to the Motor Vehicle Department for re-examinations and/or medical reviews. So, every agency I've found, as I've talked to them, have that type of program. So, those programs are documented.

Some of the training programs that I've noted during my discussions with these agencies are training programs specifically designed for drivers. We've heard about the AARP Driver Safety Program as well as the AAA Traffic Foundation Program. Some of the programs out there such as those have trained police officers to be instructors in those programs, and agencies are now taking on the approach of having law enforcement officers teach those programs at their agency, helping the older drivers or drivers that may have medical conditions understand the need to self-assess their skills and their needs to ensure that they're driving safely.

Also, officers are involved in training of older

drivers on certain things to keep them driving safer, such as how their vehicles are, ensuring that they're set up properly and safely, and also talking about current safety considerations in their communities specific for those locations.

I found that community service officers in some of these agencies are involved in programs at the senior citizen centers where they're providing literature through pamphlets, information on safety tips, and also teaching older drivers specifics concerning occupant protection, ensuring that they're using their seatbelts or safety belts while driving their cars and talking to them about the hazards of not wearing their restraints.

Also, I've been finding some of the law enforcement agencies out there that have the programs are writing articles in some of the senior citizen newsletters on safety tips, again talking about the occupant protection and the needs of older drivers as they age, some of the considerations out there, putting it out there so that it's available in the community for them to read.

Senior citizens academies are something that's starting to pop up in police agencies and law enforcement agencies where senior citizens are involved in an academy-type situation, such as 16 hours or 24 hours, at the police department to teach them the operational procedures of the law enforcement agencies. A portion of that academy training is traffic safety, and the older folks who are in the senior citizen academies receive safety

information on safe driving.

One program I found in Ross County, Ohio, with the Sheriff's Department, they have trained a couple of the police officers as instructors in the AARP Driver Safety Program. They've implemented a couple other things to tack on to it. One of them is quite neat, if you can find the newspaper out there. There's a picture of a sheriff deputy with his hat on in a golf cart and he's got this lady who looks just like anybody's grandmother. She's driving next to him with the impairment goggles on, driving through the parking lot, and they put that into their training curriculum to let these folks know how it feels to drive a vehicle when they're impaired and they also touch on impairment by prescription drugs, specifically with that crowd. So, bringing that to their attention to let them know a little bit, hey, this is a topic that we need to be aware of, not just impaired driving by alcohol but also by prescriptive drugs and other medications out there. So, I've seen the spin-offs in some of the driver safety programs that agencies put a little bit more emphasis in.

There's another agency I noted that is teaching reaction times and checking for night vision. They've set up some of the training curriculum in their course to let the older drivers check their reaction times and their vision as a way of self-assessing, bringing it to their attention.

In the realm of training, I've also noted some of

these agencies are progressing towards training the police officers in how to better interact with drivers out there. I touched yesterday on the Drug Recognition Expert Program. That's being implemented across the country as well as training on Alzheimer's identification, letting the officers know what this disease is, what dementia is, and how to interact with people and how to identify it and what the hazards are when it relates to driving.

Some agencies I've found are doing video productions on public television, getting the message out there towards the community, not just older drivers but the community in general, on driving safely and what are some of the risks out there as the body ages and some things to be aware of with your vision and your motor skills.

I touched yesterday about the emergency medical technician training and paramedic training that's being implemented in some agencies across the country to better ensure how to identify medically-impaired people, and on a bigger scale, I've noted, with the California Highway Patrol, they've started or actually have been invited in by the University of San Diego on the Traffic Safety Initiative there. They've taken the lead in that state on checking into ensuring that -- let me look at the note on that so I get it right here.

What they've done is they've been involved in the San Diego State University and recommended that the Highway Patrol as

a state agency fosters the development and implementation of a comprehensive statewide strategic initiative on traffic safety among older adults. So, they're involved in programs there on a statewide basis.

Going to the other side of the country, in New York, the Governor of New York State has directed the New York State Police on Project 2015 to look into older driving as the baby-boomers age.

So, we're looking at it on a small scale from the little law enforcement agencies to the big agencies, putting that information out there, putting it into a resource guide and making it available for law enforcement to look at the overall picture of traffic safety.

MR. SUYDAM: You're looking at programs and trying to implement -- looking at the programs that are being implemented nationally from New York to California, and they're all different types of programs.

What obstacles have you encountered or seen these programs encounter in the implementation of these actual programs?

SGT. TICER: The obstacles that police and law enforcement are encountering are, Number 1, that education part. This has been something that hasn't really been thought of. Law enforcement has in the past concerned themselves with fighting crime. You go to the traffic part of it, looking into DUI enforcement, specific training programs out there. That, I would

say, is the biggest obstacle, is letting law enforcement know that this is something we need to look at. The medically-impaired driver, the older driver who may be having problems with driving safely. That's the Number 1 obstacle.

The second obstacle is the allocation of resources in the law enforcement agency. Again, their resources are going into the crime-fighting aspect as well as DUI. It's trying to find the manpower to implement these programs. Those are the two obstacles that I've noted out there in my conversations.

MR. SUYDAM: Let me turn the question around then a little bit. What would be the -- what do you think the acceptance level or the acceptance response would be from the law enforcement community, since it is something not relatively new but just different, and how about the folks that you're dealing with that these programs actually affect?

SGT. TICER: From the over 50 agencies that I've talked with that have relevant programs, those agencies are -- the people in their community, their law enforcement community are very accepting of these programs.

Law enforcement has a concept called Community Policing, and this is brought right into the realm of community policing because it's getting the senior citizens and the rest of the community and the law enforcement to work together to ensure that the highways are safe. So, it's very accepted.

Going to the other part of this, when I talk to law

enforcement agencies and I bring this up and say what are you doing in the realm of older driving, and they say, well, we really haven't thought about that or nothing, and then, as I explain some of the programs, I've had nothing but acceptance come back from those conversations. So, I think it's very accepting out there, and I think the agencies that will bring this in will welcome it.

MR. SUYDAM: Thank you very much.

That's all I have for Sgt. Ticer.

Dr. Garber or Mr. Ducote, do you have anything else?

DR. GARBER: I do.

Sgt. Ticer, we've heard a couple of times now that a good predictor of medically-related crash involvement for people with potentially impairing conditions is previous medically-related crash involvement, and it sort of makes sense on the face of it.

What do you think is the best way -- we've also heard that it's difficult for law enforcement to often recognize when that's the case, that, you know,

-- and even to be looking for that since they're looking for very often prosecutable offense rather than something that may not have any legal issues attached to it.

What's the best way that you have seen out there of educating law enforcement personnel on recognizing and reporting these types of incidents? What's the thing that you've seen that impressed you the most as being effective in taking an officer who

otherwise wouldn't be looking for it or wouldn't know what to look for and getting them to the point where they would look for it and would know what to look for?

SGT. TICER: The Drug Recognition Expert Program which I've talked about has trained over 5,000 law enforcement officers in this country. When you look at the size of the country and how many law enforcement officers there are in this country, 5,000 isn't very many.

I think the continuing training of officers in drug recognition, which has a large emphasis on prescription drugs, over-the-counter drugs needs to be continued, and I know it's reality that not all law enforcement officers will be able to receive this training, but I think as a part of receiving that training, those law enforcement officers need to take that back to their communities and to their departments and educate the other police officers on the effects of driving while impaired and bring it to their attention and show them some of the signs and symptoms that they can notice out there on the routine traffic stops and then call in the expert, the DRE, to conduct evaluations to see if people are or are not under the influence of drugs.

DR. GARBER: Well, let me -- if you don't mind, I think I'm going to stick on that issue, on that topic a little bit, because the DRE Program, as I understand it, is primarily focused and was primarily put together because law enforcement folks who were good at recognizing alcohol impairment and who had

curbside tests to do that did not have anything for illicit drugs. It was primarily designed and has been maintained primarily for illicit drugs, though there is a component, as you say, of certain prescription drugs in there.

Do I have that wrong? Is that about right?

SGT. TICER: No, sir. I don't think that is right. It's not primarily for illicit drugs. There's seven different type of drug categories that the Drug Recognition expert looks for out there. Illicit drugs is just one portion of those seven categories.

DR. GARBER: Has it in fact been validated for any specific prescription drugs?

SGT. TICER: Validated? Yes, it's been -- if you look at the categories, there's the central nervous system depressant category, central nervous system stimulant, narcotic/analgesic.

As a DRE makes their determinations out there and notices what they see and puts it on paper and looks at it and then puts it toward the symptomatology chart, they don't look at the exact specific drug, as I indicated yesterday, just if it's in that category, but it has met the validation.

DR. GARBER: But again, I guess my question is, has anybody actually said okay, let's take Tramadol, which is a very frequently-prescribed narcotic or near narcotic analgesic, has anybody looked to see if DREs can routinely detect impairment to Tramadol?

In many cases, the impairment is quite subtle. It's cognitive impairment and not psychomotor impairment. We're looking at people who have problems with executive functioning, with higher-level judgment types of things and things that may not necessarily appear obvious on certain of the tests that are done.

While I understand that the DRE folks are in fact trained to recognize categories, broad categories of different types of impairment, my question still is, to what extent has this been validated for the 6,000 or 10,000 prescription drugs and over-the-counter medications that are out there?

Over-the-counter -- impairment due to over-the-counter antihistamines, which has been discussed previously by the Board, as I understand, there is no DRE component for antihistamines for that sort of evaluation. It would probably come under the idea of depressant drugs, but again, as far as I'm aware, there's been no validation of that.

Are you aware of any validation that's been accomplished so that we know that DREs are in fact specifically capable of detecting impairment from these specific types of drugs?

SGT. TICER: I can't give you the validations. What I look at is individual cases as they go into courts to see if the judge will recognize the DRE as an expert witness. If they're recognized in that court as an expert witness in drug recognition, then they're able to testify as to their observations, and then

they'll bring in expert witnesses, such as physicians or other doctors, who have more experience in that.

DR. GARBER: Well, then let me ask one follow-on question to that. To what extent -- what is the extent of specific training of DREs in medical conditions; that is to say, to what extent would they be able to recognize an individual who was just coming out of a seizure or an individual who was suffering from a cardiac abnormal rhythm of the heart, somebody who was having some mild dementia? To what extent are these people specifically trained to recognize those issues?

SGT. TICER: The DRE looks at -- going back to what I said yesterday, they look at --

DR. MARSHALL: Sgt. Ticer, could you talk a little bit closer to your microphone, please?

SGT. TICER: I'm sorry.

They look at the person and see if that person's impairment is consistent with their blood alcohol level. If it's not, they conduct a standardized systematic evaluation which is standardized field sobriety testing. They check blood pressures, pulse rates, temperatures. They check pupil sizes. They check reaction to lights. They check the body for muscle rigidity, see if they're flaccid, rigid. They conduct horizontal gaze nystagmus.

Once they make those observations, they write them down and they look at the symptomatology chart and see if it

matches with any of the impairing factors on some of the seven different drug categories. If they don't find what they're noting as something that's impairing or what they believe to be impairing by drugs and they still note impairment, the step that a DRE uses at that point is they contact or get that person to the hospital, so that a physician can check them out and ensure that they're not a medical condition or, if there is, they can get the treatment.

There's been examples across this country where DREs have went through that procedure and told he arresting officer, this person's not impaired by drugs but there is some other medical condition going on, and they've directed them to the appropriate physicians and have found that in some cases, there's been some brain tumors and other type of incidents that have impaired the person medically and they were able to get them on the right course of being treated.

DR. GARBER: Let me shift just a little bit then and ask you, what training have you seen that is most effective in getting police and other law enforcement to report situations that they see? In other words, a routine traffic stop, the little old lady in the -- who looks like my grandmother in the car.

What educational efforts have you seen that have been effective in increasing reporting rates among law enforcement folks out in the community to the DMV or the MVA or whoever it is that may be able to use that information?

SGT. TICER: I would say a combination of the training

on general traffic enforcement, taking it to the standardized field sobriety testing which includes the horizontal gaze nystagmus, and then the DRE. Those are the type of training programs that will allow an officer to gain that experience on how to recognize impairment and those are the ones --

DR. GARBER: I'm sorry. Rather than recognition, I'm saying what about reporting? How do we -- okay. Let's say we have an officer that recognizes the impairment. What process can we use to educate them to -- where they report it to, when they report it?

As I think you had mentioned, it's very difficult to get people to report when they believe that the person is, you know, not doing something intentional.

SGT. TICER: Are you asking me about how to report? If they stop somebody and that person's a medically-impaired driver, how to report that?

DR. GARBER: How do we educate them that they should be reporting? How do we educate them how to report it?

SGT. TICER: Well, I think law enforcement officers need to have a little bit more training in their initial academy training on how to recognize people who are medically impaired and the hazards that can happen or hazards that occur with people driving medically impaired and again give them a little bit of training on how to properly fill out the forms and get it to the Motor Vehicle Department for the re-examination and the referrals.

So, I think it just takes a little bit more training in the academy as well as some of the first responder training in the academy to teach these officers how to recognize some medical impairment out there.

DR. GARBER: Thank you.

MR. SUYDAM: Thank you.

Mr. Ducote, do you have anything for Sgt. Ticer?

MR. DUCOTE: No, I don't.

MR. SUYDAM: Thank you.

That concludes my portion of the -- thank you, Sgt. Ticer.

We'll go to Dr. Garber.

DR. GARBER: Yes. I've got questions directed at Dr. Wang. Thank you for being here.

Dr. Wang, can you tell us how many physicians there are currently in clinical practice, give us a round number, how many physicians there are in clinical practice in the United States today?

DR. WANG: In the U.S., there are approximately 670,000 physicians involved in patient care.

DR. GARBER: And would you say that most of these physicians know and understand their state laws or responsibilities regarding reporting or evaluating conditions that might impair driving?

DR. WANG: I would say that many physicians don't know

their state reporting policies and procedures, but I also think that this really depends on the state in which they practice, and also --

DR. MARSHALL: Dr. Wang?

DR. WANG: Yes?

DR. MARSHALL: We're going to have to get the mike a whole lot closer. Thanks.

DR. WANG: In terms of the state in which they practice, whether or not that state has well-defined reporting laws and policies, and extent to which they publicize this is really going to have an effect on physician awareness.

In terms of the medical specialties, I think that physicians who are involved in primary care practice or those specialists, such as ophthalmologists or neurologists, who treat conditions that can impair driving performance are probably more likely to know about their state reporting laws and procedures.

I don't have a percentage of physicians who do know reporting laws, but I do know that in an informal survey of my friends and colleagues who are in the medical field, not a single one of them knew their state's reporting laws, and I can also quote you some data from a study that was done by Cable, et al. They surveyed geriatricians across the nation and asked them if they knew how to report a patient with dementia who's a potentially dangerous driver. What they discovered was that --

DR. GARBER: And I'm sorry. These are -- when you say

geriatricians, you're talking about people that primarily treat older individuals?

DR. WANG: Exactly. And what they found was that about 30 percent of respondents had absolutely no idea how to report. When they looked specifically at the State of California, which does have a standardized reporting policy and has a law that states that physicians must report patients with dementia, what they discovered was that in the State of California, fewer than 10 percent of physicians didn't know how to report, and so this is an example of variation between states here.

DR. GARBER: In general, how would most physicians know how to report? I mean, does California, for instance, have a training program for the physicians? Is it just because a couple of people got sued in high-profile lawsuits? I mean, what is -- how do physicians know and how can they find out what their reporting laws, if they have an interest or need to know that information?

DR. WANG: I think that in many cases, physicians find out through word of mouth from their colleagues or maybe they pursue this information out of necessity, like if they have a patient that they believe is an unsafe driver and they will take the initiative of calling the driver licensing agency and finding out their reporting policies.

Also, as Dr. Broadhurst mentioned yesterday, some states will set up physician guidelines and actively distribute

these and so there is this reference material in case physicians want to look it up.

Also, in some cases, when states develop new reporting laws, they may take the lead in publicizing this. An example is the State of Oregon, which has a new physician reporting law which goes into -- which becomes active very shortly, and what they've done to publicize this is they've set up an initiative in which they have a training curriculum for physicians. This is going to be a 10-20 minute curriculum presented at grand rounds during which they tell physicians what the reporting law is, what types of patients need to be reported, and how to report them. At the same time, they're also going to be training social workers, since, after all, these are the professionals who will be helping counsel patients on retirement from driving and help hook them up with alternative transportation resources.

They also have a public awareness campaign, since they want the general public to know what this law is and how it's going to affect them, and so this is an example of the State Department of Transportation really taking the lead in getting the message out there.

DR. GARBER: Now, one of the things we heard from Dr. Broadhurst, though, yesterday was that in a very busy practice, when somebody's basically, you know, trying to see enough patients to survive on, what -- how are these folks getting this type of education?

I mean, I understand, sure, if you're at Johns Hopkins and you're attending grand rounds where you have speakers coming in, but if I'm in rural North Carolina, if I'm in Asheville, North Carolina, how do I find out that there's been a change to the North Carolina reporting requirements? How is that information going to get to me? What are the ways that I can find that out?

Then, secondarily, if I'm a physician who's never had any contact with this issue whatsoever and nobody's ever told me anything about it, I suddenly have a patient who scares the hoo-hoo out of me, and I want to say this guy shouldn't be on the road anymore, what can I do? What's the actual logistics of it? Where do I find this information?

DR. WANG: That's a very good question, and the fact of the matter is that there really isn't any standardized training out there.

In medical school, you don't really learn about the medical or the legal aspects of patient driving safety, the legal aspects being awareness that many states have reporting laws and procedures that you can use and the medical aspect being just the awareness that certain medical conditions and medications can impair driving safety, knowing how to counsel patients in those situations, and just even knowing how to counsel patients on how to stop driving, and so that really isn't formally taught in medical schools.

In terms of other ways that you could access this

information, some states will have physician guidelines, but it's whether or not you pick up the book and actually read it. I know that some state medical associations have been looking into this. The State of Nebraska, for example, recently adopted physician guidelines for assessing impaired drivers, and while I don't know the specifics about this, I do believe that they are going to have some training for that. Some specialty societies, like the American Academy of Geriatric Psychiatry, they have had some training at their annual conferences, but I think in general, it's really hit or miss.

DR. GARBER: So, it sounds like right now, the physician who has an interest in this is not only going to have to seek it out but they're going to have to work a little bit to find out how they do this. It's not the sort of thing where there's a textbook on everybody's desk that says here's how you do this. They're actually going to have to -- somebody who's seeing 40 patients a day is going to have to take an hour out of their time to try and figure out how the system works, if they even have that opportunity.

DR. WANG: Hm-hmm. Absolutely. It is a complicated topic and that's probably the reason we don't have a standardized curriculum that's been accepted by the medical community as a whole.

I mean, when you think about it, a lot of physicians don't feel comfortable talking to their patients about driving

because they're concerned that they might be breaking bad news, they are concerned that their patient might not listen to them, and they don't want them to feel that they're taking away their patient's sole or primary form of transportation, and then you also get into issues of how exactly do you diagnose, assess or treat unsafe driving. It's not a disease where there's a simple diagnostic test and you send off a blood test and you get a result.

Then there's also the issue of whether or not you do have enough time in your busy practice to adequately counsel a patient on driving safety and then, if you do tell the patient not to drive, how do you make sure they still have a way of getting around, and so I think that these are all issues that need to be resolved before we can really adequately train physicians on this.

DR. GARBER: Well, in your opinion and perhaps you can mention if the AMA has a position on this issue as well, what should the role of the physician be in reporting these medical conditions? We've heard from some other folks that there should not be mandatory reporting, for instance. What do you believe the role of the physician should be in reporting these conditions and, for that matter, in evaluating them? Should they be primarily responsible for that?

DR. WANG: I think in terms of evaluating and reporting, again I divide this up into two roles. There’s the legal role, which is the awareness that there are reporting laws

and they should abide by them. What really helps with that is knowing that on the other end, on the state licensing agency end, there is a medical advisory board or there is some kind of process which will also take into account the patient's medical condition. So, it's not just a question of reporting the patient, shipping them on and not knowing what happens.

In terms of evaluating the patient or the medical role, I think that physicians should be aware of what kinds of medical conditions, medications or functional deficits can impair driving performance, and they should counsel their patients accordingly. I think that they should also know about assessment and rehabilitation options, and they should refer their patients to these whenever they are available in the community, if they feel the patient would benefit from this.

I think that if they feel that the patient is not capable of driving safely, despite any medical interventions or rehabilitation, then at that point, they should recommend that the patient stop driving. I really think that driving cessation should be considered the last resort. I think really the primary goal of the physician should be to keep the patient on the road safely as long as possible, using whatever kind of medical interventions or medical treatments are possible or referring the patient for driver rehabilitation, and at this point, if these options have been exhausted and the patient still isn't capable of driving safely, then at that point, I think the patient should

retire from driving.

DR. GARBER: Thank you.

Obviously you personally and the AMA have given this issue a great deal of thought. What are you, meaning the AMA, what is the AMA doing to try and address this issue? What specific actions has the AMA taken to try and get doctors even more educated or more aware of this type of issue?

DR. WANG: The AMA has actually dealt with the issue of driver safety for a very long time, since the 1930s in fact, and we've recognized that while most physicians believe it is their responsibility to counsel patients on driving safety, they might lack the tools needed to put this into their clinical practice, and to address this need, in January 2002, the AMA created the Older Drivers Project with support from the National Highway Traffic Safety Administration.

We chose to focus on older drivers in particular since they are the population that's greatest at risk for medically-impaired driving, but really the tools and recommendations that we've come up with can be applied to any age group.

Under this project, we've come up with a number of recommendations and tools. We have come up with a reference list of medical conditions and medications that can impair driving and then driving safety recommendations for each one of these. These recommendations are based on scientific evidence and clinical consensus.

We also have a state-by-state reference list of licensing requirements and reporting laws, so that physicians can refer to this list and know what's available in their state. We have recommendations on how to assess those functions that are important for driving, namely vision, cognition and motor impairments, and how to do it simply and inexpensively in the office setting. We have recommendations for how to counsel the patient on driving retirement. We discuss driver rehabilitation as a resource.

We also have patient handouts because many physicians don't have the time to sit down and counsel their patients for 15 minutes on how to find alternative transportation options. So, we've put together a number of patient and family handouts in very simple easy-to-read language that the physician can hand out, and then, last but not least, we've tied this all together into a step-by-step management plan or algorithm that we call the Physician's Plan for Older Driver Safety.

DR. GARBER: And all of this information, again as a physician in rural wherever, how do I know that it exists? How do I get a copy of it? Where does that come from, and who can get it? Does it cost anything? What format is it in? Can you give us some information? If I'm a physician that wants to know about this, how do I find out about it?

DR. WANG: Sure. All of these tools are going to be published in a book called the Physician's Guide to Assessing and

Counseling Older Drivers, and this is going to be available for download on our website later this Spring, and it will be available in hard copy this Summer. This is going to be available free of charge and so anybody can go on our website and order a copy, and it's also available for CME credits. So, physicians who read this guide can fill out the questionnaire and be eligible for CME credits.

We are also in the process of planning a training of trainers program for more active dissemination of these tools in the community through hospital grand rounds, meetings of state medical societies or medical specialty societies, and this program is going to be launched in the Fall of this year. So, we're hoping that as we train additional trainers, they'll take these materials and really spread the awareness in their own communities.

DR. GARBER: And finally, do you expect this information to be updated as additional information comes along, as additional tools are developed?

We've heard here about some screening tools or programs that may be in the works. Are those going to be added to this information as that comes along or is this a static document?

DR. WANG: Absolutely. We really do plan to update this as we can. What we'd like to do is we'd like to get a lot more physician feedback on this and see if they really find that these are effective tools or if they have any feedback on how it

can be more useable.

In developing these, we had about 80 individuals involved in the project as advisors or reviewers, and these individuals are experts in the field of older driver safety. They're researchers. They're representatives from state medical societies, medical specialty societies, government offices and patient advocacy groups, and so we feel that we have a pretty good product because we did get a lot of feedback from all these different people, but at the same time, we would like to have a feedback evaluation phase for these tools that we've created, and if possible, we'd even like to do clinical testing to see if these are effective at reducing crash risk in the population.

DR. GARBER: And you said Spring of this year. I know the meteorologists tell me that it's Spring, although this morning, it was a little difficult to tell.

Do you have a better, more specific time frame as to when that may be?

DR. WANG: Fingers crossed, we're hoping it'll be on our website in May of this year, and we're also hoping for hard copies no later than July.

DR. GARBER: Thank you.

That's all I've got. Are there any questions for Dr. Wang?

MR. SUYDAM: I don't have any questions. Thank you.

MR. DUCOTE: No questions.

DR. GARBER: Then I'd like to pass it over to Mr. Ducote for questions of Ms. Reeve.

MR. DUCOTE: Good morning, Ms. Reeve. Thank you for coming.

The Safety Board understands the Wisconsin Department of Motor Vehicles provides training to its officers to help them identify conditions which may impair a person's driving ability.

Could you describe this training program and its implementation?

MS. REEVE: Wisconsin's Department of Transportation rules were devised using functional ability levels necessary to exercise reasonable control over a motor vehicle versus age or specific disease and because our laws on medical conditions are basically pre-defined for us in our statute, our work is done specifically by four different groups of people.

We have field office staff who are responsible for on-site issuance of driver's license products. We don't do central office issuance. So, if you go in to apply for a driver's license, you get it right away, as long as you meet all of the standards. Then we have our central office staff who set up follow-up standards for people with medical conditions. They make licensing decisions based on medical reports and take medically-related questions from the public at a rate of about 35,000 per year, and then the Medical Review Board which is compromised of doctors who volunteer their services to the Department of

Transportation for reviewing and making recommendations to the department on cases of patients who are appealing their cancellations that the department has made.

If their license is still denied after that review by the board of physicians, there is a judicial review process within the court system that they can make sure that we've followed all the set guidelines in the statute.

We have a 104 field offices throughout our state with approximately 400 staff. So, those staff are initially trained as overhires. So, they're extra people that aren't needed to do the work on a daily basis. They're usually hired in groups of eight to 25 and they start with three continuous offsite weeks of training at a different location on all the different things of driver's licensing, not just medical issues but everything it takes, vision minimums, how the field staff can determine if a person needs a medical report issued before they can determine if a person can be licensed that day. You know, there's a number of ways that that can happen, and then after they learn the basics, the staff return to their station for 12 weeks of practice with an assigned mentor, and then they return to offsite training again for an additional three weeks of advanced driver's license training, which includes how to conduct re-examinations of people with medical conditions, reading the medical reports, the confidentiality laws, and all of the more advanced things.

The Central Office Medical Review Unit attend that

training and present, including we have one nurse consultant who gives extensive information to the staff on common conditions, such as diabetes, seizure disorders and cardiac issues. The staff is tested for knowledge of the various areas and must achieve a certain percentile to complete their initial training or they have to stay.

The field and central office staff are progressive positions. So, they start at a lower level, do the basics of the job, and as they gain knowledge and test and meet quantity and quality standards, they can move up to the next level.

The Central Office Medical Review staff are considered higher-level customer representatives who it takes a total of two years to actually train them on all processes. We separate all of the issues into a variety of categories, some being much easier because the guidelines are very set. You know, we have set vision guidelines, things that just cannot be overturned, and they can learn them quickly, and the rules apply pretty much straight across the board. So, they can learn things in levels, and as they learn more, they can progress to more difficult in the office.

We teach them the basic medical cases first and then they increase as they meet the quality and quantity areas in each area.

The review board volunteers. There's about a 189 doctors in Wisconsin that volunteer. They're supplied with copies of the laws and transportation rules, and we aren't really

concerned so much with them knowing the rules and the laws of the state but with just telling us pointblank do they meet the functional abilities to drive.

They give us a medical opinion at these review boards, but the Wisconsin Department of Transportation makes the final decision. There's no mandatory reporting law in Wisconsin, and the doctors have no civil liability with the drivers because the department ultimately makes that decision. They are also -- the Medical Review Board doctors who participate and their hospitals who let them go are given yearly reports by condition as to how many were approved, how many were disapproved, and conditions, how many by condition were given to them.

Then the judicial review process is handled by the department's attorneys and the Wisconsin Department of Justice attorneys. A judicial review is filed by the driver against the department and the courts determine if we've followed proper statutory requirements in the cancellation of that person's driver's licenses. The attorneys interpret the statutes and the laws for us and we have never lost a judicial review.

So, with the public, we have a Bureau of Transportation Safety, a bureau within DOT that offers information on reporting medically-impaired drivers. We have over 20 brochures that are given to the public and all of the field stations and sent to all doctors on reporting medical conditions to the department.

So, that pretty much covers it. We have a 600-page driver licensing manual that separates everything into sections, so it's easy for the people to find.

MR. DUCOTE: Okay. While implementing these programs, have you all encountered any type of obstacles in the program?

MS. REEVE: Yeah. The biggest obstacle is that there's so many people being trained and everybody has their own way of doing things. So, you're talking about 400 people in a very diverse state, some metro, some very small towns, and so if the people know, especially in the smaller towns, if they're familiar with these people that they're retesting, it complicates things in the fact that they put a personal spin on it versus being able to stay objective.

But we have gone into a system where we're doing limited area testing, so that people can keep their driver's licenses for just the areas, the things that they need to do, and that's one of the first things that we ask people when they're ordered in for re-examination, is, you know, what do you really need your driver's license for? You know, do you just go to church? Do you just go to the shopping center? How many miles do you really need to drive? We do the best that we can to make sure that they're medically safe but that if we can accommodate them that way, we've done a lot of that.

The other thing is when people are -- the Department of Transportation employees who are what we call examiners and

those are the people who do the driving examinations, we have just started a program where we do directed versus non-directed tests for people of cognitive functions that might be impaired where, instead of giving them orders, take a left here, take a right here, go here, we're basically saying this is the way we're going to go, and we direct them in that direction and then we'll say now take us back the way that we came, and it's actually been very successful in determining if someone is able to not get lost.

Some of the other issues with the obstacles are, of course, the length of time it takes somebody to train someone in full and then how many things change during that time frame because, of course, you know, medical conditions change, medications change. We need to get that information out to all the people who are dealing with this and that can be quite challenging when you're talking about a pretty widespread state with rural areas of getting that staff back up to date on those things.

Of course, budget is -- our state is in one of the budget crises that many states are experiencing. Wisconsin has an extreme lack of technology. The medical staff in the central office has to use five to six different programs to process one case, which, of course, can be pretty tedious and also in training, it's very difficult.

Wisconsin is also doing -- has a 33-percent increase in workload with about five less staff in the central office, and

then we had two years ago, and then the legislative mandates that don't really take into consideration the fact that we have a lack of technology and inability to implement it as quickly as we need to.

MR. DUCOTE: Well, considering the lack of technology and what you mentioned, is there anything else that you would need to overcome these type of obstacles?

MS. REEVE: Well, one of the other problems that we have in Wisconsin is -- and you guys were referring to it before, we have what's called a Driver Condition and Behavior Report and it can be reported to the Medical Review Unit by a number of different entities. Regular lay people, neighbors, family members, whatever can fill one of these out on someone that they feel has a driving condition that should be checked out. These are available at our website. They can call us. They can even just write letters with -- we require two signatures, one writing the statement and someone else that can verify the statement. Those can also be filled out by the medical professionals. They can also be filled out by law enforcement.

More than 60 percent of them we receive from law enforcement. However, in more than 40 percent of those cases, there are situations where people have done things that they should have probably received citations for, but I think the grandmother/mother kind of atmosphere hits it and then they're not given tickets, and the first thing that comes into our office is,

you know, why are you doing this to us because we have a clean driving record. An example of that is we had a lady hit the back end of a school bus with flashing red lights, just had no idea she was supposed to stop, thank gosh, nobody was hurt. However, the person was not ticketed, but a Driver Condition and Behavior Report was sent in to our office to try to investigate it, and so it's situations like that that it puts us in a spot where the Department of Transportation is definitely the bad guys in those situations and we don't mind that because that's what our role is in the government, but it would be really helpful to, I think, have mandatory reporting and then also have some kind of system for reporting these Driver Condition and Behavior Reports.

MR. OSTERMAN: Excuse me. Do you see that a lot? The anecdotal comment you just made about drivers who are confused about why they were referred?

MS. REEVE: Often. Very often.

MR. DUCOTE: Earlier, you told us that you've never been overturned on a denial. Can you tell us about what kind of percentage of denials you have going right now?

MS. REEVE: Sure. In 2002, we actually had 6,384 or something to that actual people whose licenses were canceled and sometimes I think we run into a terminology problem because I think every state calls it something different. Well, we call them cancellations.

In these cancellations are included people who have a

three-month mandatory loss of their license, a cancellation or a personal surrender of their license based on having a seizure disorder or having a loss of consciousness, and so some of them in those numbers include those people. Of those 6,000, 1,400 were rescinded which a big part of that is the people who are seizure-free and are getting their licenses back. So, of that 4,600+ or whatever, only 350 of those applied to appeal their decision on medical review, to the Medical Review Board, and all but 100 of those were not -- were overturned. So, only a hundred were overturned, and about 64 of those were commercial driver's licenses which we aren't talking about here, but the Wisconsin statutes do have a clause where, because it involves someone able to support their family or bring an income, doctors on the review board can grant exceptions to some of the different laws and so set forth in our statutes.

One of them is the two-year seizure-free period for CDL licenses and insulin-dependent diabetics.

MR. DUCOTE: Okay. Mr. Suydam or Dr. Garber, do you have any questions for Ms. Reeve?

MR. SUYDAM: Mr. Reeve, how many reviews are done each year by the review board?

MS. REEVE: By the actual medical doctors?

MR. SUYDAM: Yes.

MS. REEVE: We had 340 last year. In 1992, we had 85. So, you can see that it's increasing.

MR. SUYDAM: You had 340. That's the total number of reviews that were done in the State of Wisconsin?

MS. REEVE: Yeah. Reviews, and this again is Wisconsin holds things a little bit differently, where the medical staff in the central office actually reviews the normal medical cases, where we reviewed 35,000. So, we reviewed 35,000 medical reports. They're all on basic different follow-ups or canceled or whatever the different process is, but of those 35,000, 6,000 of those people were canceled and 300 of those cancellations were -- wanted to appeal their decision.

MR. SUYDAM: So, you actually reviewed 35,000?

MS. REEVE: Yeah. About 35,000 medically-impaired drivers. We don't do anything by age.

MR. SUYDAM: Okay. And 60 percent, I think you said, came from law enforcement referrals?

MS. REEVE: Yes.

MR. SUYDAM: How about the other 40 percent? How many -- well, let me ask you this. How many were -- do you estimate were reported by physicians?

MS. REEVE: By physicians? It's a very small percentage. Normally, physicians that are on our review board, of the 189 or whatever, they're very, very good about -- because they know what we do at review boards and the importance of having good medical information from the doctors in order to support our decisions, they're really excellent about sending them in, but I

would say that probably maybe 10 percent are from doctors and the rest are from the general public.

MR. SUYDAM: The physicians that review the medical review, would they be reviewing the case or the --

MS. REEVE: Yeah.

MR. SUYDAM: -- referral?

MS. REEVE: They were kind of reviewing our decision, based on the medical -- the decision we made to cancel, the department made to cancel them. They're reviewing the person's medical information to see if we were valid to cancel those people.

MR. SUYDAM: Do they have the opportunity to review the person's driving record at the same time?

MS. REEVE: We do tell them if they've had accidents or non-accidents, and one of the biggest questions they usually will ask is, well, why do they have a clean record, and a lot of times, it is because we have found that there's about 65 percent of the drivers in Wisconsin right now are between the ages of 60 and 69, and a lot of the people, I think, especially with elderly drivers, they put themselves in a position where they start to limit themselves where they're going, and there's a very small percentage of people who actually venture beyond, you know, doing more than what they really should, and it seems that those are the people who end up in our review board area. They just don't understand that they're a danger. It's a highway safety issue.

MR. SUYDAM: You mentioned the three-month period for a person with seizures where they had to be seizure-free, is that --

MS. REEVE: Yeah. Any loss of consciousness.

MR. SUYDAM: Okay. Now, I don't know if you recall testimony yesterday from the Maryland representatives where they said that the license had to be returned under their current statutes after the three-month period.

MS. REEVE: It doesn't necessarily have to be returned. They have to -- at three months, after the three-month period, that's a mandatory, there's no exceptions to that for anyone, for CDL drivers or anything.

At that three-month period, they have to submit a medical report to us from their primary physician basically stating, you know, what their current health situation is, when their last episode was to confirm that there hasn't been any more, if they're following their medical treatment, what kind of medicines they're on, and then there's a decision made at that time. It isn't -- I would say the majority of the people do get their licenses back, but there are a certain percentage that don't at that time, based on their medical history for non-compliance or --

MR. SUYDAM: My last question is, out of -- you were talking about automation and funding and problems. These 35,000 people that you review their files, how are they actually tracked?

Are they computerized? How do you pull them up?

MS. REEVE: Yeah. What we have is in our multitude of systems in Wisconsin, we have a very, very old DOS, if anybody remembers that, database, and it takes care of some of them, especially the neurological conditions and stuff, and basically we have a number of -- a variety of different medical forms from the Department of Transportation. One is kind of for all the different conditions, one is for school bus follow-up. There's many different forms, but it's set up with logic so that someone can enter this form, they enter the different drugs the person is on, when their last episode was, and it does a consultation for them and basically tells the person where the follow-up should be, if it should be a six-month follow-up or whatever. Most epilepsy cases or loss of consciousness cases can go for a two-year to a five-year follow-up without restrictions on their license in any way, but they would just have to file medical reports that often.

So, we keep track of some of the medical reports through that system. We also have a follow-up system and another computer program which each week runs off a list of people who need to have new medical reports filed and that list is usually about, I would say, a 140 to 200 people long that's for all various conditions, from diabetes to whatever it may be.

You can be followed up in periods of three months, six months, yearly. Diseases that are less progressive, like some of the first diagnosed Parkinson's and multiple sclerosis, can be as

far as 24 months, based on their medical reports, but we have set guidelines for all of those.

MR. SUYDAM: My last question will be what type of -- what different types of licenses are issued by the State of Wisconsin?

MS. REEVE: We don't have anything. Like if somebody was stopped by a police officer, you would have a regular Class D license which is to drive any kind of basic car or truck. If somebody had a restriction based on the fact that they had a loss of consciousness six months ago or something, the only way the person stopping that person would know that is if they reviewed their driving record and knew all of the little abbreviations for the different medical conditions and stuff.

Because, since medical information is considered confidential, we're in the process of changing anything that said DMED, which is the name of our central office group, to like LPI, which is license prohibits issuance. There's still a way you can tell, you know, like if somebody failed to file an examination that was required, they will get canceled immediately and they're asked to return their license until they file that report and it's acceptable.

You know, we have CDL licenses, but basically a Class D license. It can be restricted, if they take a limited area test that might say you can only drive a 25-mile radius from your home or you can only drive a car if you have continuous oxygen use or,

you know, there's restrictions like that that are put on the actual license that can be read, but as far as knowing if someone's had a seizure or if they're diabetic or what their actual condition is, it is not on their license.

MR. SUYDAM: But you do have -- there are separate classes of licenses, such as you just said, like 25 miles and five miles?

MS. REEVE: They're also considered Class D licenses, but they just have special restrictions based on examiner testing or doctor recommendations.

MR. SUYDAM: That's all I have. Thank you.

DR. GARBER: Just a couple of questions.

Dr. Soderstrom yesterday mentioned what he called counter referrals. These were people who -- a 94-year old man walks into the DMV and starts having a discussion with somebody who's not there.

Does the -- do you get any significant percentage of these referrals in that way through the clerks at the Department of Motor Vehicles?

MS. REEVE: Yeah. We count those kind of separately. They're not like normal Driver Condition and Behavior Reports. The staff in the different field offices, they can -- if they feel -- if it's somebody that's like having a conversation with themselves, of course, you know, there's an issue there. So, what they would do is before they would issue their driver's license,

they would issue a medical report to the person and tell them that they have to have that filled out and returned to the Medical Review Unit in the central office and approved before it can be -- before they can have their driver's license issued.

DR. GARBER: Do you have a feeling for how frequently that occurs?

MS. REEVE: Oh, all the time.

DR. GARBER: Do you have any numbers? Do you have any percentages?

MS. REEVE: I don't have any specific numbers, but I would say, you know, we -- and it probably doesn't seem like much to some of the larger states, but I would say we get about 50 a week from the hundred field offices. Most of them honestly are more for physical impairments which then what the field offices do is before they license them, they take them out on a road test to make sure that their physical impairment doesn't hamper their driving skills at all. Like people with walkers, people with canes, people that seem to have a real hard time getting around.

It might not necessarily be a medical condition, it might just be something physical. So, they'll take them out, make sure that everything's okay, see if they need to have any extra restrictions put on their license, like automatic transmissions, things like that, and then they do that almost immediately. Usually if they can, they do it the same day, and then their license is still issued.

DR. GARBER: Does the license renewal always involve an on-road test?

MS. REEVE: No, never.

DR. GARBER: Okay. So, this would be a special situation where --

MS. REEVE: It would be special.

DR. GARBER: -- they would look at that person and say we need to put you into a driving test scenario?

MS. REEVE: Right.

DR. GARBER: What's the interval between driver's license renewals in Wisconsin?

MS. REEVE: It just -- I want to say four years ago, it went to eight years, and before that, it was four years.

DR. GARBER: Okay. So, if I'm 94 years old, I don't get looked at again till I'm 102?

MS. REEVE: Right. Unless something happens in between.

DR. GARBER: Okay. And the training that you described for the counter clerks, it sounds like they've got a pretty good idea of what the big picture is as far as how these people get evaluated and referred and -- but do they have any specific training in how to recognize impairment in an individual that walks up to the counter?

MS. REEVE: Yeah. They do, and we basically really focus on, like I said before, functional ability, and the nurse

consultant attends their training and she's actually an RN. She attends and she's taken our statutes which basically outline what conditions we have authority to check in on or, you know, to follow up on, and she explains what -- with each one, like with diabetic conditions or with seizure disorders, those kind of things, what kind of functional impairment things they need to look for and then we also have the self-reporting mechanism on any driver's license application. So, if somebody's applying for a duplicate or renewal, anything like that, they have self-reporting where one of the questions is, have you had any loss of consciousness due to any of these eight things, and it can be, you know, heart, head, you know. There's like six or eight of them, and if they check that box, they automatically get issued a medical report and their license won't be renewed until we get that medical report back from them.

DR. GARBER: Now, the only way that the duration of the license can be limited, though, is if it goes through that medical review process, right? That can't be done at the counter?

MS. REEVE: Correct.

DR. GARBER: Okay.

MS. REEVE: Correct.

DR. GARBER: And one last question. You had mentioned the fact that you send brochures to all doctors in the State of Wisconsin?

MS. REEVE: Anybody in the review board, and then

anybody who's done reviews and their hospitals, and then what we do is every year, we have to recruit because basically, I'm almost embarrassed to say this, but we pay our volunteering, and so when they come to these review boards, they get paid a $25 per diem. So, it isn't -- it's a pretty big challenge to get people to volunteer and that's by statute that we pay mileage and $25, and so a lot of our doctors are retired, and so -- but they still keep their medical license intact, and so we do a lot of outreach with -- there's a group in Wisconsin of retired doctors, and the nurse -- an RN actually meets with them, goes over any new medications, those kind of things.

We're very lucky because we feel because people volunteer and they do get paid such a small stipend, that, Number 1, they're not biased in any kind of way, Number 2, they really are just looking at the person's physical health and what their medical reports say, and they just tell us how they think it should be.

DR. GARBER: These are the people that are reviewing those 340 cases a year, right?

MS. REEVE: Right.

DR. GARBER: Now, I guess I'm talking about, what about the 29-year old doctor a few years out of medical school trying to build up a private practice in Wisconsin? How does that person get touched by the DMV? How do they know how to report somebody to you?

MS. REEVE: Every year, we -- which we do it in the month of January, we send out a list to all -- our database of doctors is actually more in the 500s and only a 189 of them participate. We have outreach with each of the major hospitals. For instance, we have what's called the Marshall Clinic and it's a small town that we actually do in-person review boards, but their clinic supports the DOT and basically tells their doctors that they will give them time off paid to attend these review boards, and the nurse consultant will go to the main hospital. They have all these little outreach -- you know, it's called the Marshfield Clinic, but it might be in a different city. I don't know if people in other states do that, but they have all these outlying clinics and those people will all come in to the main clinic and we go over the review board process. We have some example cases for them.

Right now, we're working with the University of Wisconsin Hospital, with their Department of Neurology, with their third-year interns, who are kind of looking at it as not just a learning experience but a really good way to see the diverse group of -- you know, we go from 16-year olds to, you know, 90-year olds.

DR. GARBER: I'm sorry. I'm sorry to interrupt you, but again, it sounds like you're talking about the major centers.

MS. REEVE: Hm-hmm.

DR. GARBER: Those folks are getting that and again,

what we've heard in the past, particularly from Dr. Broadhurst, is that that may not be getting out into the rural areas.

So, again, I guess, is there a way that you could in fact send these brochures to every physician in Wisconsin? Could you do that? Could you get together with the state medical licensing folks and say who is everybody and let's just send them a brochure?

MS. REEVE: This year, what we did is we went to the American Medical website, basically punched in the different zip codes or the Wisconsin areas and we sent letters to everyone who we didn't have on our list.

DR. GARBER: Okay.

MS. REEVE: Explaining the process and --

DR. GARBER: So, what I'm hearing is generally, you'd have to be avoiding the issue in Wisconsin to not know at least that it existed?

MS. REEVE: Yes.

DR. GARBER: Okay. Thank you.

MS. REEVE: In fact, they are probably sick of getting letters from me.

MR. SUYDAM: I have another question. If I'm a resident of Wisconsin and I move to Michigan, I go to Michigan and I turn in my driver's license and under the reciprocity agreements, they'll check to see if I have a valid license because of violations, etc., they won't want to issue me a license, etc.

Is any of my medical activity suspensions, etc., that are on my Wisconsin DMV file dealing with being seizure-free, having my license removed for a period of time, is any of this information exchanged with the other state?

MS. REEVE: If the person is on follow-up with us. So, in the seizure disorder situation, they're almost 99 percent on follow-up. So, yes, that information would be exchanged. They would have to provide that information. We would provide that information to them. What they do with it is their choice, but we do provide any information on anyone who is still on a follow-up in Wisconsin.

MR. SUYDAM: Will you issue me a driver's license in Wisconsin if I have a post office box?

MS. REEVE: Absolutely not. You have to prove residency.

MR. SUYDAM: Thank you.

Mr. Ducote, do you have anything else?

MR. DUCOTE: No, I have no more questions for her.

MR. SUYDAM: Anything else, Dr. Garber?

DR. GARBER: No.

MR. SUYDAM: Dr. Marshall?

DR. MARSHALL: No.

CHAIRMAN GOGLIA: Okay. We'll go to the parities and we'll start with the Federal Group today. Surprise, surprise.

(No response.)

CHAIRMAN GOGLIA: No questions.

Advocacy Group II? Advocacy Group I? Oh, wait a minute. Recall.

DR. DONALDSON: Hello. I'm Gerry Donaldson from the Advocates.

I just wanted to ask Ms. Reeve. Is the eight-year interval for the license renewal in Wisconsin based upon some empirical indicators about the driver's competence or is it basically an administrative burden reduction?

MS. REEVE: Originally, it's kind of a little bit of both. They did a study when they were doing it, and one of the things they found, that if someone is going to be impaired, it doesn't matter if it's a four-year license or it's an eight-year license, it's going to happen in less time than four or eight years, and so they took that and weighed it upon the eight-year license.

We've had a lot of interest in decreasing the amount, based on age, which we refuse to do at this point because we don't base any of our licensing decisions soley on age. We do have an Older Driver, you know, Safety Committee which we do reporting and we're changing our re-examination process based on some of the things we're finding in there, but because we don't base anything on age, we found that because the difference in the progression of diseases, regardless if it's four years or an eight-year license, that it's not going to make that big of a difference.

The thing that is, I guess, remarkable is we do have five people in Wisconsin that are over a hundred years old with licenses, and I happened to call all five of those people because there was this huge issue, like how can a hundred-year old person have a license, and all five of these people lived on their own and it was just one of those things where it was like wow, and they've never -- they have clean bills of health and everything is fine.

We have people who say when they come in that could you just renew this for two years because I don't think I'm going to be alive in -- when I'm 90.

(Laughter.)

MS. REEVE: They don't want to pay the $24.

(Laughter.)

CHAIRMAN GOGLIA: Okay. Is that your only question?

DR. DONALDSON: Yes.

CHAIRMAN GOGLIA: Advocacy Group I?

MS. STRAIGHT: Audrey Straight, AARP.

For the whole panel, one of the things I'm curious about is in the interaction between the various government employees or interactors with the public, in their training, is there any sensitivity training component?

I think what I'm thinking of particularly, I mean, this whole issue about driving as may have been mentioned, the research that we've done and that is, you know, just sort of

obvious in a society that is as auto-dependent as our society is, the first words that come out of anybody's mouth about this is this is about independence.

The kind of research I've done also suggests that it's about self-esteem. So that, in order to get sort of compliance and buy-in to taking care of one's self, the people who are supposedly doing the training or the interacting with, the interfacing with the public really needs to understand how deep the emotional impact of this issue is, and I wondered if, in any of your training programs, there is a component for sensitivity training about who you're dealing with.

DR. WANG: That is actually something that we address in the Physicians Guide to Assessing and Counseling Older Drivers, and in counseling patients on retirement from driving, one of our recommendations is for physicians not to say things like I want you to quit driving or I want you to stop driving, but instead use words like I think that maybe it's time for you to retire from driving because those words normalize the experience and they sound more positive and people can really understand retirement rather than, you know, quitting or stopping sounds very negative.

We also recommend that physicians address alternative transportation options so that the patient is aware that the doctor thinks that it's important for them to get around and for that reason, we've created handouts which list ways that patients can find alternative forms of transportation. So, on one hand,

the doctor can still address that, but they don't have to spend 15 minutes actually going through everything with them, and we also think it's very important, if the doctor tells the patient that it's time for them to retire from driving or reports them to the DMV, that they make it clear why this is being done. The patient should know why exactly their driving safety is at risk. I mean, it could be their vision. It could be their cognition or motor function, but it should be made very clear to them, and they should also continue to follow up at future visits and probably also in writing. The patient should receive some sort of letter stating, well, as we discussed at visit on this day, I recommended that you retire from driving for this reason, and if you have any additional questions, please let me know. I'm happy to help. I'm also enclosing these handouts for you.

SGT. TICER: Interacting with the public is something law enforcement does want to do better and there's a program that comes out of Seminole County, Florida, Deputy Dottie Bergette-Dreggers, where that agency is teaching a class to law enforcement and it's titled "The Graying of America: How It Will Affect The Delivery of Law Enforcement Services to Law Enforcement Agencies Across the United States".

What that program is, I sat through it, it's about an hour-long program that she teaches to law enforcement officers on how to interact better with older individuals and how to recognize sensitivity issues, such as how to interact better with them and

what happens as a person ages, some of their situations that occur with their vision, their hearing, their coordination, and brings it to the attention of law enforcement officers so they can understand that a little bit better.

She's been teaching that across the country now, and I see that programs like that, I'm hoping, will continue and give officers some better sensitivity training.

MS. STRAIGHT: I just want to -- I've been restraining myself on this for the last two days, and there's a certain amount going back and forth here between are we talking about medical conditions or are we talking about older drivers.

I hope, AARP hopes that there is a growing awareness and a refocusing, as is suggested by having this hearing, on the impact of medical conditions on driving capabilities as opposed to the impact of age, which I think has for many years just been really a surrogate for medical conditions because there is a higher incidence of the medical conditions that impact driving capabilities with age, but it would be preferable if the growing way we talk about it is about medical condition and about functional limitation because that's something often the people can do something about whereas you really can't do a lot about age. I mean, the alternative is not preferable.

Ms. Reeve?

MS. REEVE: We don't -- again, we've focused nothing -- I mean, we do have some handouts. We have the Driving Safely

While Aging Gracefully, which I think was -- AARP was actually involved in compiling that handout. We do have those, but we don't deal with age in any -- with any aspect as a reason for denying or canceling a driver's license. It's totally functional ability.

We have everything separated out from cognitive skills to diabetes to the heart situations, as what impairs -- what is considered impairing functional ability for our staff, and so they don't look at it on an age thing. It's all functional ability.

MS. STRAIGHT: And getting back to the original question, do you do any sensitivity training for the personnel that have direct contact with the public about these issues?

MS. REEVE: We do, and in the training agenda, there is actually -- it's almost a two-full-day session on basically counseling drivers on the need for re-exams or problems in the office with their vision or they have to issue additional medical reports and how that should be handled and the confidentiality nature of the situation and how important it is not to embarrass people because if you've ever been in any normal DMV office, there's a thousand people in there at the same time, and it would be very easy to really embarrass someone, based on the fact that they might have marked a box yes or the examiner might have seen something that just doesn't seem quite right, and so yes, they're taught almost exactly how to handle things.

MS. STRAIGHT: And do you feel like -- you may have

said something about this, but do you do anything with the people whose licenses are canceled about transportation options?

MS. REEVE: We have a handout of all the Area Commission on Aging, if it is an aging issue. In Dame County in Wisconsin, there's what's called -- they can dial 2-1-1 and it's basically a line to the Department of Health and Social Services. It offers them a wide variety of options for not only transportation but for Meals on Wheels to having someone to pick them up to go to church. It's really a nice option. A lot of people look at it as being some kind of welfare and we try to encourage them through the brochures that it's -- they're there to help you. That's what it's for, and we've used that for people from being 28 years old to people that are 90. It just has been a huge help.

Our rural communities aren't as lucky because, of course, their public transportation isn't as accessible, and so Wisconsin has a challenge that way, but we are working on it.

MS. STRAIGHT: Thank you.

MR. COHEN: This is Perry Cohen with the Parkinson's Disease Foundation.

I wanted to ask Ms. Reeve. You mentioned some data on neurological conditions, and do you do special studies or do you have reports that you publish on those?

MS. REEVE: We do for the board doctors, the doctors who have reviewed them. It's a little bit hard in the DOS program

to maintain specific things, like how many people are on follow-up at a time, but I do have, for 2002, how many people per week we were following up on which is kind of an interesting thing. It's not really an exact science just because of that. For that year, we followed up on this many people. That's not necessarily a good indicator, but if I can find the report here, I'll be in good shape.

MR. COHEN: Do you break that out by condition?

MS. REEVE: Yes, we do. Well, neuro is broken out by condition. Neurological reviews in 2002 were 2,610. So, 2,610 people were reviewed for neurological conditions.

MR. COHEN: Out of 35,000?

MS. REEVE: Right. Those are the people that are on constant -- on follow-up of different variations.

MR. COHEN: We talked about data yesterday, but since you weren't here yesterday, I wanted to raise that, but I wanted to raise a general issue with respect to Parkinson's Disease.

I'd like to find out from anybody, from any in the audience or -- to what extent is there a problem with Parkinson's Disease and driving?

MS. REEVE: Well, in Wisconsin, we have -- I would say we don't keep specifics on -- like we call things neurological conditions. We don't separate them into epilepsy, Parkinson's, those kind of things, but in my experience with the department, I have probably seen maybe five Parkinson's cases where the doctors

have said we would like this person to be followed up every two years for limb and, you know, basic mobility, but we have very few people with Parkinson's on follow-up.

MR. COHEN: And so, can I ask a general question to everybody?

MR. OSTERMAN: No, not particularly. To the panel, you mean, or to the audience?

MR. COHEN: Yeah. To the audience. Well, I could do that later.

MR. OSTERMAN: Well, let's do the panel only.

MR. COHEN: All right.

MR. OSTERMAN: Okay.

MR. COHEN: And what kind of resources do you have specifically available for training and follow-up for particular patient groups? For example, with Parkinson's Disease, the issue might be very different than with epilepsy because there's very rare instances of seizures or black-outs.

MS. REEVE: For Parkinson's, like in Wisconsin anyway, it would be again totally based on their functional ability from the standpoint of limb movement, hand movement, any impairment in their physical.

MR. COHEN: And I wanted to ask Mr. Ticer, on your Drug Recognition Program, how do you distinguish between drug-induced problems or -- well, the medications help the functionality of the patient as well as maybe have some side

effects, and how would you distinguish between those?

SGT. TICER: We just look at the impairment of the driver. If the driver's impaired by alcohol or drugs, then we would look into an impairment charge, but if they're using medication and it's doing what it's supposed to do, keep them functioning properly, they would not be arrested or charged in that manner.

We look at that, if somebody ended up in that situation, we'd conduct an evaluation on them, like I said earlier, to see how well they could do on some standardized field sobriety test and also check their eyes and their blood pressure, temperature and pulse rates, if they ended up getting into that point, to see if they were okay, and if they were, then we'd be fine with that, even if they were taking a drug, as long as it was prescribed to them and it was doing what it's supposed to do.

MR. COHEN: Yeah. I guess I would be surprised if you -- and the numbers that she indicated, I would be surprised if you detected anybody, even if they were in an accident, whether they would be -- have a problem from their medication or from their impairment.

SGT. TICER: Well, we have people that we deal with in collisions that abuse prescription drugs. Those are the ones we're really looking at, people who are getting a prescription for Valium or Xanax or Soma, some of the type of drugs like that out there where you see some very obvious impairment, but I can tell

you from being involved in the DRE Program in over 10 years of that program, I have not dealt with anybody having an issue with medications as it relates to Parkinson's Disease. I haven't seen that and I haven't heard that. So, I believe you're right on that. We're not seeing that. If it's there, we don't notice it. We're seeing the obvious.

MR. COHEN: And I would expect that most people self-regulate and that's probably the appropriate strategy to provide education to help people self-regulate, and things like the doctor's guide would be a very valuable resource.

DR. WANG: In terms of the Physicians Guide, I just want to read to you the recommendations we have for Parkinson's Disease and anti-Parkinsonian medications.

For Parkinson's Disease, we have, “patients with advanced Parkinson's Disease may be at increased risk for motor vehicle crashes due to both motor and cognitive dysfunction,” and we go on to say that, ”physicians should base their driving recommendations on the level of motor and cognitive symptom involvement, the patient's response to treatment, and the presence and extent of any medication side effects.”

We also recommend that if the physician is concerned about any of these symptoms, then a driver evaluation, including on-road assessment, performed by a driver rehabilitation specialist can be useful.

For anti-Parkinsonian medications, we list some of the

common side effects that can include excessive daytime sleepiness, lightheadedness, dizziness and blurred vision and confusion that can all impair driving performance, and we recommend that physicians counsel patients about these side effects so they can self-regulate if they experience them.

MR. COHEN: There's one other issue with respect to Parkinson's, especially in advanced patients. There's a fluctuation on and off during the day, so that sometimes during the day, you're fine, other times you're not, and you have to be able to self-regulate, so you could pass the driving test when you're on, but when you're off, you can't do nothing.

MS. REEVE: We have what we think is an estimated 10,000 cases of Parkinson's in Wisconsin. So, the percentage that we follow up are on very slight at the time, and they're usually not sent in by a doctor. It's usually designated through being followed up on a different disease or a different accident and becomes apparent later in the reports that are filed that the Parkinson's is an additional situation with them, and so then it just becomes part of their normal follow-up, where they might be diabetic and have Parkinson's or whatever, the combination of both of the diseases are followed up on equally.

MR. COHEN: Okay. Thank you very much.

MR. FLAHERTY: Gerald Flaherty from the Alzheimer's Association.

For Dr. Wang. Physicians need CMEs on risk issues,

risk assessment. What -- would it be possible for the AMA or would the AMA encourage CMEs specifically to address driving issues related to medical conditions, such as Alzheimer's Disease, and other medical conditions?

DR. WANG: In general, the American Medical Association, through its Older Drivers Project and the guide that we're creating, this is going to be an activity and it does address some driving issues related to medical conditions, such as Alzheimer's.

We actually have a statement in this guide addressing dementia specifically, and we encourage physicians to diagnose dementia as early as possible, if they suspect it. In chronic progressive disorders, like Alzheimer's dementia, this is a particular concern. It's very complex because at some point, the patient is usually too cognitively impaired to drive and also at that point, they may be too cognitively impaired to be aware of that, and so for that reason, it's really important to get the patient involved early, if they want to have some kind of say in their future management and to get the family involved, so they can start to plan for other resources.

We also have recommendations for dementia, how physicians can help patients with dementia, and those are based on the Alzheimer's Association's Policy Statement.

MR. FLAHERTY: Thank you.

A follow-up question. Since we've had -- and the

guide, I'm sure, will be helpful in this regard, but we've had a terrific lot of difficulty across the country in getting primary care doctors to refer to our agency and I'm sure others have had the similar problems.

How can the AMA help us to get primary care docs to refer patients and families to agencies like ours for counseling and other services that these folks usually need in order to cope with the diseases, like Alzheimer's or Parkinson's or epilepsy or others?

DR. WANG: One of the ways that we can do that is by including resources on the handouts that physicians will be handing out to patients, and I believe that we actually do list Alzheimer's Association on one of these. If we have omitted that on the handouts or on our website, that's something that we would look into in the future.

MR. FLAHERTY: Okay. Thank you.

For Sgt. Ticer and this follows on a question that we discussed briefly yesterday. Given the many other training requirements for police, would it be useful in your opinion to create a training tool that folds as many of these driving issues that are related to medical conditions into one training tool or curriculum for police nationwide, and this would be a tool that might be potentially endorsed by groups, like the National Chiefs of Police or the National Sheriffs Association? Is that even a remote likelihood?

SGT. TICER: I think it's more than a remote likelihood. From the last two days, everything I've heard here and you've heard from me on law enforcement is training issues for police officers, if you could put all that together, and I don't think it would take more than a few hours of training.

Putting Parkinson's Disease, Alzheimer's, all these different issues, and the growing concern of medically-impaired drivers, putting it all into the curriculum, making it available across the nation, I think it would be not only acceptable, but I think it would be a great thing, and I think it would meet the role of traffic safety in reducing deaths and injuries on the highways.

So, speaking for law enforcement, I would tell you that I think it's a great idea.

MR. FLAHERTY: Thank you.

And just a quick follow-up to that. At what point would the training be most effective with new recruits or with veteran officers as an in-service training?

SGT. TICER: I think it would be both. I think it should be in academy, but going back to my academy days, it's just like being in boot camp. You're going to get all this information at once and then you're going to go out and you're going to forget a lot of what you learned.

So, I would think that the initial training in the academy would be good and then some time throughout a career, some

roll call trainings, during some annual trainings for law enforcement, either mid-year or an eight-hour block or a four-hour block, somewhere in there, but I think both would be beneficial.

MR. FLAHERTY: Thank you.

And one quick question for Ms. Reeve, and you may have answered this. Do you refer your clients for any further help to agencies, like the Association for Counseling, around the no-drive issue?

MS. REEVE: We unfortunately are not an advocacy group. We do refer them to the Department of Vocational Rehabilitation because they are a state agency and then also to the Department of Health and Human Services in Wisconsin because they're also --

MR. FLAHERTY: But you wouldn't give out particular pamphlets from organizations, like the Alzheimer's Association or Parkinson's Foundation and so on?

MS. REEVE: I'm not sure. They would have to be approved before we could them out, of course, but I know that we did do the Older Driver brochure in association with AARP, and so I'm sure, you know, it's definitely a possibility.

MR. FLAHERTY: Okay. Thank you.

DR. STROHL: Kingman Strohl, American Sleep Apnea Association.

This is for Ms. Reeve and Sgt. Ticer. Problem sleepiness is not just for untreated sleep apnea but for other

disorders. Is this being recognized or at least strategized as an issue at the medical board level?

MS. REEVE: Yes, it is.

DR. STROHL: And in terms of being able to in those conditions that can be treated, are there plans for rehabilitation or for retesting of people in terms of this particular issue in which people don't have a blood test and there's not an event like a seizure and things of that sort?

MS. REEVE: Well, with noncommercial drivers, it's very different than with commercial drivers because of the restrictions with the federal medical card, but with a normal driver in Wisconsin with sleep apnea, if they're not following some kind of treatment program based on the medical report we receive from their doctor, whether it be CPAP or, you know, the different medications or whatever that shows that it's, you know, basically under control, those cases usually are sent to the review board. The review board will offer suggestions to people with those situations to what could help their situation which really is basically the same with almost any disease that we have.

If there's something that that person could provide us from a medical professional or a test that could be taken, we will always encourage that, if it will mean that the licensing decision could be changed, and so, you know, we do recommend different things that way. We cannot tell them what to do, and we don't like to encourage any extra costs on their part. However, if it's

detrimental to them to keep their driver's license, we like to give them some ideas as to what they may do, especially in situations like sleep apnea, that could improve their chances of getting their license back.

DR. STROHL: I'm concerned that in some ways, if there was a mandatory reporting, as there are, say, in California, that people with well-treated sleep apnea, without sleepiness, are still being reported because they have a categorical illness rather than a functional impairment.

MS. REEVE: No. We might -- if it causes an accident, okay, that's a different story. Like if their sleep apnea caused the driver condition and behavior report of an accident, they're going to be on our follow-up for, you know, a lot longer extended period of time. However, if it's just -- they're just diagnosed with sleep apnea and it's controlled and the doctor states that, they could be taken off follow-up after the first six-month review that's sent in, based on the information that we receive.

DR. STROHL: And then, Sgt. Ticer, are there any recognition strategies for detecting a drowsy driver?

SGT. TICER: Right now, the National Highway Traffic Safety Administration, with Lesboa Research Group, is bringing out this issue of drowsy driving into the law enforcement community. Right now, it's in a focus group stage, and it's getting ready to go out to different regions of the United States, to selected police departments and sheriffs departments and highway patrol

departments, to start looking into how serious of a problem is drowsy driving out there. They're strategizing that right now, and they're also looking into, in this strategy, looking into a public awareness campaign to bring it out to the public, the public drivers, such as they would in the past on DUI campaigns, a drowsy driving campaign to bring it out and raise some issues there. So, I think that's on the forefront and it's coming.

DR. STROHL: Thank you.

One more question for Dr. Wang. I'm looking forward to this project because I think, as you said, general medical impairment, not just the older driver project, maybe it should be changed so that the ageism is not emphasized, but the -- and I'm sure it has both functional as well as diagnostic-based assessments.

I'm concerned, though, also, with recommendations that might come from the Department of Motor Vehicles to get your license back and the variations that there might be in practice of physicians assessing patients and the cost for those assessments.

So, in particular, are there reimbursement codes or generalized acceptance of those codes by medical providers and Medicare in particular, if a patient is asked to be reassessed for the purposes of having their license looked at or returned or restored or denied, and are those generally accepted, and can physicians actually be expected to be reimbursed for this important activity?

DR. WANG: In terms of office-based functional assessment, there are current procedural terminology codes or CPT codes that physicians use to bill. We've actually included these in an appendix of our guide so that physicians can just find them and put the codes. They will get reimbursed for them--because we checked on that.

When we're talking about things like driver rehabilitation assessment or referral to those programs, those are excellent resources in which the patient can undergo in-office evaluation and an on-road assessment. Unfortunately, availability and affordability are two major obstacles to those at present. There are, I think, between 400-600 driver rehabilitation specialists in the United States which clearly isn't enough to handle the potential patient load, and in terms of affordability, Medicare and other insurance companies won't always reimburse for that.

I know that the American Occupational Therapy Association is looking at initiatives to increase the number of occupational therapists who are trained in driver rehabilitation, and at the same time, they're actively lobbying for Medicare reimbursement for OT-performed driver assessment under the assertion that this is an instrumental activity of daily living.

Also, I just wanted to address your age remark. We do make it very clear in our guide that even though this is for older drivers, it's not really a question of age but really a question

of function.

DR. STROHL: Thank you.

And you mentioned, also, in terms of this, is that there was going to be clinical testing of this document or plans for that, and in general, can you just briefly outline any plans for assessment of this important project?

DR. WANG: There are really two things that we hope to do. We hope for a feedback evaluation phase. That may be six months to a year after this guide gets out. We'd like to do interviews with clinicians to see how they're using these tools, if they find that they're helpful, and what recommendations they would have for making them usable and practical.

The other project that we're thinking of, which is infinitely more complicated, would be actual clinical testing of these tools to see if they can reduce crash rates. That would involve actually finding primary care practices, geriatric practices, and asking the physicians to use these tools and comparing them to control groups and then following up over a period of years to see what the crash rates of age and medical history controlled patients are like, and that is going to be much more complicated. We are hoping that we can get funding for this and hoping that we can find clinics to participate, but that will be in the future.

DR. STROHL: Thank you.

MS. WARD: I'm Julie Ward with the Epilepsy

Foundation.

Dr. Wang, just a quick follow-up. It does sound very much like this guide would be incredibly valuable. It addresses such a critical need of getting the information out to the doctors. I, too, am somewhat concerned that with a title like Older Drivers, it may not occur to doctors and stuff that it would have a wider use for people with medical conditions that are not necessarily linked with age, like seizures or diabetes or whatever.

DR. WANG: We purposely designed one of our chapters-Physicians the reference to medical conditions and medications that can impair driving performance--We purposely designed that so that it can be a stand-alone. The rest of the guide mainly deals with the issue of older drivers, but that one really deals with all sorts of medical conditions, not ones that are just limited to older drivers.

The recommendations that we have for seizure are based on the consensus statement of the American Academy of Neurology, the Epilepsy Foundation of America, and the American Epilepsy Society. So, we do conform with those.

MS. WARD: Thank you.

In terms of -- I just have a couple follow-up questions regarding Wisconsin, and you may have just answered this, in terms of how long the follow-up once you're in the system with the medical condition, and the other clarification question,

you had mentioned that you thought there should be mandatory reporting. Did you mean by law enforcement or by physicians?

MS. REEVE: By physicians. Basically, if something doesn't happen as far as a traffic accident or a Driver Behavior Report being filed on the person, someone can be suffering from a seizure disorder that's more than just one seizure every, you know, year or something, and we would know nothing about it, unless it was reported by the person individually.

What happens now is if a seizure is reported, either through a doctor or from a Driver Behavior Report, a lot of people seem to tell the police that when they're pulled over, they had some kind of a black-out, and so it's not just epilepsy, it's any loss of consciousness. That just seems like a very -- it's something that happens quite frequently.

Their driver's license is basically taken away for three months, and if they get a clean bill of health after that or basically they're on a seizure medication, it was diagnosed as being a seizure and not something separately, like a syncope or something related to a heart condition, they basically -- and they will all be on follow-up, also, but for different reasons.

All seizure disorders are followed up for a minimum of two years. At the two-year point and that's usually in six-month intervals, at the two-year point, they're given -- the doctor's also sent a sheet that says do you feel that this person should continue to be followed upon past this two-year period, yes or no,

and based on that report and then the subsequent medical reports and they're following their treatment programs, at two years, they would be taken off of the follow-up until or if they had another seizure or loss of consciousness. So, we do it at two years. That's the minimum for an actual diagnosis or disorder. But the physicians do have the option of not going the five years because we do have the five-year follow-up period, also.

MS. WARD: What about your experience in Wisconsin that led you to believe that mandatory reporting by physicians, which I think much of the discussion yesterday pointed out a lot of the problems that that raises in terms of patients wanting to be honest with their doctors about the number of seizures and treatment -- it was my understanding that the Wisconsin law worked, you know, works fairly well for people as far as for safety and for people with epilepsy. You know, why do you think there's a need?

MS. REEVE: Well, I think we're missing a big portion of -- and this isn't just definitely not seizure disorders, but I think that we're missing a big portion of drivers. We find a lot of the medical reports are very contrary to things found in the Driver Condition and Behavior Report, such as the one that I explained with the lady running into the back of the school bus with the flashing red lights. She had a serious -- that ended up being a pretty serious cognitive disorder, and her doctor said she was perfectly fine, you know, there's absolutely nothing wrong

with her.

Well, at that time, maybe that was the case, but then what we do is we will send the Driver Condition and Behavior Report and say could you explain why you think that that situation might have happened, and when he read that, he ended up doing other tests and he found out that the lady had a very specific problem that she had not been clear with him on, and I guess if -- and I think there's some cases where doctors are afraid to lose their patients or to be the person to say you really are at the point where you need to retire from driving because I think that in some situations, that is a very offensive and degrading thing to be told, and it's an independence issue, and I think everybody in this situation understands how important driving is for people, but it just seems that we don't always get what we would consider, based on the previous facts we get, truthful or complete medical reports, based on the situations that caused them to come about.

MS. WARD: Just a follow-up in terms of the transportation alternatives and the counseling. I mean, I commend, I think each of the panelists has mentioned that that's an important aspect of what's provided to people, and for people with epilepsy, it is independence, it is self-esteem, but it's also economic self-sufficiency, if you can't get to your job, you know, that's really what drives folks because we can't say that there's public transportation available and so many of the transportation alternatives are -- may be categorically denied to

people with epilepsy.

I mean, you may not be able to maintain a driver's license because you're not seizure-free, but that doesn't necessarily mean you're disabled enough to qualify for paratransit services or that there's public transportation available or that, you know, some of the programs are age-dependent for eligibility. You may not meet the age requirements. So, there's really -- you know, while I commend each of you for trying to address that issue, there really may not be alternatives for people. It's a huge crack in the service delivery system that people with epilepsy can face and other conditions as well.

MS. REEVE: Hm-hmm. It is.

MS. WARD: Particularly rural areas are particularly challenging.

MS. REEVE: Hm-hmm.

MS. WARD: Okay. Yes. Thank you very much.

MR. FLAHERTY: Gerald Flaherty, Alzheimer's Association.

I just have a very quick follow-up question for Ms. Reeve. Is it the diagnosis that you want the physician to be mandated to report or is it the functional ability at some point in the course of the disease, of a disease, for example, such as Alzheimer's?

MS. REEVE: We're looking -- it's always very helpful, we find that doctors on the review board want to have someone have

a diagnosis. It seems a lot of times, medications are left out which, as Mr. Ticer has, you know, alluded to, you know, if we don't know what kind of medications there are, there isn't really a way that the Medical Review Department can look at a medical report and say, hey, this person's perfectly fine to drive because we don't have any idea what kind of medications or how many they're on.

So, there is a big lack in people reporting medications, even though it's asked for, but we basically look as a medical review department on judgment and cognitive skills. There's, I think, six questions on the report regarding that, and basically we have a situation where, if there's a certain number of those marked, it is a flag for an automatic retest of their driving skills, both knowledge and driving.

MR. FLAHERTY: Here's my point -- my question more specifically. The Alzheimer's Association, of course, is encouraging early diagnosis, where we've identified other conditions that can lead to Alzheimer's disease, mild cognitive impairment, that don't necessarily entail impairment of driving skills.

Now, do you want physicians who diagnose someone quite early in the disease process to be mandated to report that?

MS. REEVE: No. I mean, I think, you know, what we want is just, you know, the truth, you know. If the person has mild cognitive impairment and the doctor seriously feels at that

point that it's mild and that really right now, it's only affecting one of six of these judgment insight things, you know, that is something that we're going to watch for how often we follow up on the person, not -- it's not going to be a basic -- that person's got a cognitive problem, we're canceling them. We would rather know earlier than later because it gives us the opportunity to set that person up to be more successful and probably have their driver's license a lot longer.

MR. FLAHERTY: Thank you.

CHAIRMAN GOGLIA: Okay. State Group?

MS. COHEN: Lori Cohen, American Association of Motor Vehicle Administrators.

My question is for Dr. Wang. We had the opportunity to review the Physicians Guide for Counseling and Assessing Older Drivers.

MR. OSTERMAN: Lori, hold on a second. You can't hear her at all?

MS. COHEN: Is this on? Okay.

We've had the opportunity to --

MR. OSTERMAN: Still? Hold on. In the booth.

MS. COHEN: Is it on?

MR. OSTERMAN: No. We have a connection issue. Yes, please.

MS. COHEN: Working? Yes? Okay.

AAMVA has had opportunity to review the AMA Physicians

Guide for Counseling and Assessing Older Drivers, and in particular, the stand-alone chapter that you mentioned gives medical conditions and then how to assess individuals as individuals which is great.

Do you feel that this has applications for medical advisory boards, and how overall should the DMVs take advantage of this document?

DR. WANG: I think this could also have some advantages for medical advisory boards, depending on how each medical advisory board operates. My understanding is that there are two different structures for medical advisory boards. Some medical advisory boards meet mainly to set policies and regulations for the driver licensing agencies, and other medical advisory boards, as we've heard about, will actually review individual cases.

I think that the materials that we have could probably have applications for both. I think that with some of the recommendations we've laid out, it could help some medical advisory boards actually lay out policies for how to regulate some drivers with certain medical impairments, and then in terms of the other case, I think that those medical advisory boards reviewing individual cases might find some of these guidelines useful in determining how they assess and evaluate certain patients.

MS. COHEN: Thank you.

CHAIRMAN GOGLIA: Okay. Medical?

MR. ARCHER: I have a two-part question for Dr. Wang.

My feeling about this area is it cries out for some kind of uniformity, you know, and I was struck when you mentioned the fact that even doctors will vary dramatically as to their knowledge of the process from jurisdiction to jurisdiction, based on whether or not they're legally required to report or not, and so I was wondering, first of all, do you think it would be desirable to find a mechanism that's used uniformly throughout the country? So, if you're a doctor in New York or in North Carolina or wherever, you're treated exactly the same, your obligations and requirements are the same, and that would be true of all the patients as well, and a little advocacy, I suppose, but if you had uniform requirements and training requirements that we've been talking about all along could actually be geared to the country and not to individual states, I'd be interested in your thoughts on that.

DR. WANG: In terms of uniform reporting requirements, I think from the medical standpoint, that would be useful. We haven't really pushed for this because we know that in the face of budget cuts especially, it's whether or not each state has the ability to actually set out something like this and handle the caseload that would come in if all physicians were required to report.

In terms of uniformity in training, it is possible to set up some sort of uniform and consistent guidelines for

physicians, but again this would vary specialty by specialty. For example, if you're looking at radiologists and pathologists, they don't really treat patients or at least live patients, and so you probably wouldn't have them conform to the same things or have them trained in the same way, whereas other specialists, like urologists or OB/GYNs, they might perform some procedures or prescribe certain medications that could impair driving but certainly not to the same extent as the primary care doctor.

MR. ARCHER: Thank you.

Then one other question. It seems to me as an attorney, I happen to be an attorney, that it would be helpful to any doctor in this situation to have a statute in his or her jurisdiction explicitly authorizing their right to notify the proper authorities. That's not necessarily a reporting requirement, just an authorization, so it would do two things. One, it would insulate the doctor from reliability, and the second thing, it would give the doctor a hook to say to the patient that he wanted to report why he or she was reporting, namely, well, it's authorized in statute.

I'm wondering if that's your view, too, or not.

DR. WANG: I agree with that. Some states that don't require reporting will still have a statute saying that they encourage physicians to report or physicians are allowed to report. Other states also have legislation specifically protecting physicians against liability for breach of

confidentiality, and then, also, what other states also have is legislation protecting the physician against injuries if they have previously reported that patient, in the event that patient is involved in a crash.

I would add that in terms of reporting patients, case law has found that physicians who report in good faith generally are not liable.

MR. ARCHER: Thank you.

CHAIRMAN GOGLIA: You need to pass the mike to the Medical Group.

MS. STRESSEL: Donna Stressel from the Association of Driver Rehabilitation Specialists.

My question is for Ms. Reeve. Earlier, you mentioned that when you have a person come in to renew their license and they have a physical disability, maybe coming in on a walker or having ambulation problems, that they may be flagged for an on-road assessment.

Are your examiners trained or knowledgeable of vehicle modifications or adaptive equipment that could be available to them to help them to maintain safe driving, and if so, are they referred to the appropriate agency facility that would either provide them with the training in how to use that and the knowledge on how to get that equipment into their vehicle?

MS. REEVE: Yes, they are, and they also have a list of the area people, depending on the position in the state that

they're in. We actually in Wisconsin don't have a lot of people who do do that, but they do have a list of people who can accommodate that. But they do determine through their physical function if they're -- if that's what's needed, if modifications to the vehicle are needed. We don't automatically assume that just based on the first observation because of the cost entailed, but they are trained on that, also.

MS. STRESSEL: Thank you.

DR. BREWER: Phil Brewer, American College of Emergency Physicians.

For Ms. Reeve. I think we're picking on you quite a bit, so I'll get to Sgt. Ticer in a second. What impact, if any, is the current budget crisis that's affecting virtually all state governments right now having on your office?

In Connecticut, for example, the Governor has already laid off at this point about 2,800 state workers, including at least one person in the DMV Medical Qualifications Unit, and as a corollary to that, how would your office manage a doubling or tripling or more of reports if everybody reads the AMA's material and begins reporting people, and as the number of drivers over 65 triples in the next 10 years, along with the accompanying medical conditions that that's going to result in?

MS. REEVE: Because we're already doing a 35-percent increase without any changes, it's definitely a concern for us. We have been eliminated from the cuts at this time, which, you

know, is probably going to be a temporary thing.

One of the things in the State of Wisconsin is that as people retire, they're not going to be replaced, and so that is the biggest concern of the Medical Review Department, is that there happens to be some very well-trained long-term employees who could retire at any time, and if those people wouldn't be replaced, we would definitely have a backlog of medical reports. So, you know, that's the biggest concern right now.

Currently, we process reports within four days of receiving them which is a pretty good turnaround with eight to 10 staff, but it will make a huge difference.

DR. BREWER: So, that's what I thought I was going to hear, which I don't think any of us wants to hear.

MS. REEVE: You know, honestly, I don't think that there's many states that are in real good shape that way right now. So, it's not just Wisconsin that will experience that.

DR. BREWER: So, unfortunately, in spite of these new materials that are going to be coming out, it's not clear that the states are going to be able to handle the increased volume, if people -- if the materials work as intended which will be increased volume of reporting.

For Sgt. Ticer. Again, quoting Dr. Soderstrom, the 800-pound gorilla in this whole arena is the chronic alcohol abuse problem that far and away more than all of these other medical conditions causes daily, daily injuries and death. I can say as a

practicing emergency physician for the last 16 years, I haven't had a single shift that I've ever worked that I didn't have at least one patient injured in an alcohol-related crash, no exceptions, and so given that and given the fact that multiple studies have shown that drunk drivers who are injured in crashes and admitted to hospitals actually have a very low risk of being charged for DWI, even though the police are aware of where that person is and very often they're aware of the fact that they were drunk, what things can law enforcement do to increase even just that one category of incident?

In other words, an injured drunk driver who is admitted to the hospital. There's a number of studies that have been done on this, and the range is anywhere from a low of seven percent of admitted drunk drivers, admitted for trauma, to a high of only just over 50 percent. What can be done just for that one thing because this is where the big bang for the buck is?

SGT. TICER: Two things. Number 1. Going back again to training, when you do a DUI investigation or DWI, as it's called in some places, when a person's already at the hospital and the officer has to complete their scene investigation and get to the hospital, it goes a little bit differently than a regular car stop where they go through the field sobriety test and go through it that way. So, I think the training has to be put out there or at least reiterated that the procedure, how to go about securing the blood evidence at the hospital and completing an investigation

at that time because it's really -- it's actually a lot easier to do than a regular traffic stop for DUI because it's simply obtaining that evidence at the hospital and interviewing the driver, if that's possible, if they're conscious, and then submitting the evidence and submitting the report to the district attorney or the county attorney for prosecution, and if the person's admitted in the hospital, the officer doesn't have to spend an evening booking that person in the jail or handling it that way. So, it's really quite a simple process. So, I think that would, Number 1, be the training issue.

Number 2 would be the supervision in law enforcement and the management. I'm a big believer in that, as long as the supervision and the management says this is what needs to be done, we're going to do it this way and then hold the line officers responsible for that, I think that could address that topic.

DR. BREWER: One of the studies on this issue looked at what were the various specific factors that made it more or less likely that an officer would come to the hospital as part of the investigation and interview the driver and perhaps charge them, and one of the big factors was how far it was from the officer's jurisdiction and this crash site to the hospital.

There is a concept that I like to call do ask/do tell, and Indiana is one state that has passed a law within the last couple of years, and it allows investigating officers to call the hospital and speak with the doctor or nurse and the law

specifically allows the doctor or nurse to tell that officer whether the person appears to them to be under the influence of drugs or alcohol, in which case, the officer can make that 40- or 50-mile trip to the hospital, knowing that there's already probable cause.

Do you think most officers, if there were laws like that in all the states, do you think that that would have a significant impact on how often these cases get investigated in person on site at the hospital?

SGT. TICER: I think that would be a real easy way of doing it. If the doctor or nurse could tell them this person's intoxicated or impaired, then I feel that that officer would feel compelled at that point to get in there and do their job.

In my experience, I wish that was the case. Where I work at, we -- the law I've done it is I've worked on the community policing aspect of becoming friends with the people in the emergency room, knowing who my friends are, the nurses and doctors, so that, when I make that call, they're going to give me that information. I don't know if they have a law that requires them to do that or not, but until a law occurs, it's a matter of establishing a relationship there.

So, I think one way to look at the follow-up is ensuring that law enforcement does the actual physical follow-up at the hospital on every collision where somebody goes to the hospital. There's cases where the officer can get in there and do

it his or herself, or if they're tied up 40 or 50 miles away, they can call the local jurisdiction or if they're a state agency, someone from the agency in that area, to do the follow-up.

I think by the face-to-face contact, then that officer's going to develop their probable cause through the smells, the observations and then again feel compelled to do their job.

DR. BREWER: Thank you.

DR. JOLLY: Til Jolly from the Association for the Advancement of Alternative Medicine.

Just a quick question for Ms. Reeve. I think I heard you say that you got a medical advisory group of a 190 some odd physicians?

MS. REEVE: We don't use them all at the same time.

DR. JOLLY: Right. No. A little unwieldy.

MS. REEVE: We'd need a room like this.

DR. JOLLY: Just have a question about that. That's a little different from the models I heard yesterday.

MS. REEVE: Hm-hmm.

DR. JOLLY: It's all volunteers.

MS. REEVE: Hm-hmm.

DR. JOLLY: Do you have some way of monitoring or do you have a mechanism by which you monitor the quality and consistency of the work they do, since they only probably do one or two or three cases a year?

MS. REEVE: Well, what we have are -- it's very different. We have in-person and by mail. So, a person can choose to appear in person or they can choose to have their case sent to one of these -- three -- actually three of these doctors in the exact -- in the same field. The in-person boards are made up of a neurologist, internal medicine person and a psychiatrist, and so, if you appear in person, of course, some of the things seem a lot more apparent than what you read on a file. However, the denial rate is basically the same.

We have more people request by mail boards than in-person boards, but we do hold one in-person board each month in a different area of the state, so that the consumers don't have to travel right to the center of the state all the time.

We do find that there are doctors who don't respond quickly enough to by mail boards and they're taken off the list immediately because we try to give people a 10-day turnaround and decision, and we're very conscious -- well, we try very much to be very conscientious of that.

There are some people who make the same decision all the time, and you know that it's kind of like a check-off sheet, so we take those people off of the board and we do evaluate it really on a case-by-case basis.

DR. JOLLY: Thank you.

CHAIRMAN GOGLIA: Did I get everybody? I did.

Back to the Technical Panel. Do you guys have any

additional questions?

MR. SUYDAM: No, we don't. Thank you.

CHAIRMAN GOGLIA: Okay. Up here to the front. Elaine?

MS. WEINSTEIN: I just have one question for Ms. Reeve. Do you have a sense of what percent of the reviews you do are related to alcohol versus the other medical issues we've been talking about?

MS. REEVE: Actually a very small percent of ours are actually alcohol- and drug-related. In 2002, of the 300, only 17 were alcohol- and drug-related. We do have an alcohol and drug department which actually, unless their alcohol and drug is considered to be a medical problem, those people are dealt with through the other agency. So, that's a very small percentage of our work.

CHAIRMAN GOGLIA: Mr. Osterman?

MR. OSTERMAN: No.

CHAIRMAN GOGLIA: You don't have any? I skipped you because I thought you had too many.

DR. ELLINGSTAD: No. Our Technical Panel did a thorough job.

CHAIRMAN GOGLIA: Okay. Raphael?

DR. MARSHALL: Before I ask my question, I'd like to again remind the witnesses and the parties here that we do have a docket which is open to the public, and so if there's any

documents that you feel would help with our investigation or would help the general public, I'd urge you to include that in our docket by bringing the documents to me either today or later on or maybe even talking to your Technical Panel members about it.

My question is to Ms. Reeve. You had mentioned that you have about 50 counter referrals a week, and there seems to be a trend for a lot of other states to actually have license renewals done through the web, and I was wondering if you do that in Wisconsin, and what your opinions are about that.

MS. REEVE: No, we don't do it in Wisconsin. Part of that is because of our eight-year renewal process. When we switched to eight years, we realized the importance of seeing every single person at eight years because it's such an extended period of time, and at that time, we require a vision screening and to actually see the person, to see the person they are. So, I don't see web renewals as being anything for Wisconsin's future at this time.

I do see duplicates as a possibility, like when someone loses their license or changes their name, which would be one less chance for us to see the person, but not regularly, no. I think the law is it's to be done in house.

CHAIRMAN GOGLIA: A very informative panel. Thank you very much for your time and the information that you've given us.

It's time for a break. 15 minutes. 10:45 return.

Will the next panel just go directly to the table so that we can start?

(Whereupon, a recess was taken.)

CHAIRMAN GOGLIA: Okay. We're back on the record.

Raphael, please.

DR. MARSHALL: The next session is entitled Non-Regulatory Efforts, and Dr. Jana Price will now introduce the Technical Panel and the witnesses.

Non-Regulatory Efforts

DR. PRICE: Good morning, and thanks for coming.

I'll be joined today by Mr. Marc Ducote with the Office of Highway Safety and Ms. Danielle Roeber, who is with the Office of Safety Recommendations.

The purpose of this session is to learn about and discuss the current programs available to help reduce the incidence of medically-related accidents through education, outreach and other types of proactive measures.

We've heard about some programs already today, especially those targeted towards physicians and law enforcement, but we're hoping to learn more about the types of programs that are available, both for people with medical conditions, their physicians and others.

The witnesses for this session will be Ms. Mary Jane O'Gara, who is a member of the AARP Board of Directors, Ms. Alexandra Finucane, who is Vice President of Legal and Government

Affairs for the Epilepsy Foundation, Mr. Rex Knowlton, who is immediate past president of the Board of the Community Transportation Association of America, and Executive Director of Wheels for Wellness, and Mr. Timothy Hoyt, who is Vice President of Safety for Nationwide Insurance.

We'll begin with Mr. Ducote asking questions to Ms. O'Gara.

MR. DUCOTE: Thank you, Dr. Price.

Good morning, Ms. O'Gara. We've heard much about disqualifying certain people from driving for their medical conditions. What programs does the AARP support or endorse to help people who may have been medically disqualified from driving?

MS. O'GARA: Okay. Thank you.

I'd like to approach this two ways. First of all, AARP fully supports people staying independent and able to drive safely for as long as they can because driving and transportation is part of an improved quality of life.

Saying that, I will say that when it becomes necessary for someone to be counseled to quit driving or someone has their own reservations about driving, we would suggest that there are paratransit programs and transit programs available in communities around the country which will support this type of assistance, door-to-door for people who are disabled, and more varied in what is available to people who might not fit in the qualification of being truly disabled but have some type of handicap that makes it

impossible for them to continue driving.

As you know, it's been mentioned already this morning, the fact that states are being hard hit on their budgets, and this is not something which could, you know, provoke a lot of dollars to bring in to improve the transit system which really needs to happen. But we have to be aware that when someone needs to know, this person should receive information directly from the sources that are available, and I would say through the doctors' offices is the first, very first contact. The doctor-patient contact is so very, very critical, and usually, as we saw yesterday when Dr. Broadhurst spoke, that the fact that there is a strong relationship between doctor and patient, the doctor can counsel the patient about how to get some type of assistance when they cannot drive on their own, and also, there are AARP offices now in every single state, and one of the things that can happen is that the doctor can get information and the state office of AARP can provide information to each doctor office to help people find the assistance they would need.

The other thing I'd like to say right up front is the AMA program is absolutely terrific, and we are so pleased to see that this kind of process has been developed to help people better understand driving capabilities and to help those who serve older people to better recognize the kinds of things that might be creating a problem for the elderly. The signage, the medication, the lighting on highways and all those are part of that factor.

AARP has a program that has been going on for 29 years called its Driver Safety Program, the 55 Alive Driver Safety Program. It's a driver instruction classroom program which has been highly successful, millions of people have gone through this program, and I guess it just is not as well known as it needs to be, but it is a volunteer-taught classroom instruction program for people over the age of 55. Anyone who wishes can ask to receive the instruction when classes are formed. The AARP in various states works with other entities, such as hospitals, schools, the Red Cross, to conduct classes at their sites, and this teaches people an awareness of the medical impact as they grow older of prescriptions they are taking. It makes them aware of aging deficits which occur, the perception, the ability to maneuver as easily, maybe an arthritic condition impacts on physical being, and this kind of program just opens doors for change and helps a person learn how to make the kind of adjustments that are needed to be able to continue driving for as long as they safely can continue to drive.

I've heard so many tell me about the terrible impact that occurs when one can no longer continue to drive and maybe lives in the suburbs or in a rural part of the state, and there is no transportation available. So, this kind of program will help and we're going to make this copy available for the record, so that we would strongly encourage relationships be developed between the communities in each state to help provide this kind of

instruction.

MR. DUCOTE: Okay. Do you see any -- are there any obstacles to implementing these programs that provide transportation to the people who can no longer drive, and what would they be?

MS. O'GARA: Well, the kind of obstacles you see are things like printing that is not recognizable for older people. I know that you can't go around and change signage all over in a city or community, but as billboards are remodeled, as there are new signs built, they should be larger and very readable. Any information that you have to give to people relative to driving should be in readable language.

The access roads need to be well lighted because people, when they make adjustments to driving, can make it by perhaps not driving at night or taking different roads which are not as busy as an interstate. They can take measures which enable them to drive safely without, you know, stopping completely.

I think one of the things, too, when you talk about transit support for the handicapped or for an older person, the sensitivity of the people who are assisting. Many retirement homes have their own kinds of vans and things, but the driver is such a critical element to it, and the manner in which people are approached, whether it's from the driver licensing bureau to the institution which is going to provide some kind of assistance to a person to get a ride, their sensitivity to how to deal with people

is really a critical element because people are -- they don't like to ask for help as they grow older. They have to call upon often a family member or somebody who is going to assist them to get transportation, so they will limit their kinds of access. They'll go out to a doctor's office and they'll go get groceries, but they might not be as likely to say they'd like to go to the opera or to go to a movie or to go to the barber as much as they would to take something that's absolutely essential. But the way that a person is greeted, the manner in which they are politely assisted, makes them still feel like an individual rather than a child, and I think that's very important in the way we work with older people.

MR. DUCOTE: What programs does the AARP have to help individuals assess their ability to drive?

MS. O'GARA: The Driver's -- 55 Alive Driver Instruction Program is a very good program. It not only deals with the impact of certain prescriptions, there's a whole listing on prescriptions and how one might be impacted by a blood pressure pill, by a pill which is a pain killer. There is also a listing in here of the different places in the community where one would receive help if they need it. Meals on Wheels is another agency, the Offices on Aging are another group that are very, very helpful to people, and one should keep these kinds of lists available whenever you're dealing with a person that's going to need assistance.

I think, also, we have to be reminded that the family

is, with the physician, probably the tightest connection that an older person will have as they get older, as they become widows or widowers, and the family should be brought into the counseling early, if there is a health problem, because these are the folks who will be helping to make the decision with their parent, and I think that we often forget that they don't know where to get the information either.

So, making the information available is very critical, and AARP provides through its state office an avenue for anybody to contact relative to getting the kind of resources available in a community.

MR. DUCOTE: Okay. This hearing was prompted by the Safety Board's investigation of a vehicle crash involving an epileptic driver.

Does the AARP have any additional suggestions that could help us avoid this type of accident in the future?

MS. O'GARA: Well, the AARP believes mobility for non-drivers can be improved by assuring that there are transportation alternatives available. As I said, the transit/paratransit and volunteer driver programs all play a role in making sure that those who can no longer drive remain connected to their daily activities in their communities because they not only contribute to the quality of life but they let the older person continue to be part of the action in the community, and although current public transportation by older persons is limited, the older

segment of the 65+ age group, specifically drivers 75 and older, tend to use public transportation to a greater extent than those who are 65 to 75.

Eleven percent of all persons age 65 and older reported using public transportation the previous month. However, 20 percent of non-drivers 75 years or older used public transportation on a monthly basis. Transportation programs that best meet the needs of older persons, particularly those with medical conditions and functional limitations, are those in which the vehicle driver and service options are customer friendly. For vehicles, this includes low floor and kneeling buses to help those with hip and joint problems, and buses with lifts for wheelchairs. For drivers, courtesy and assistance in boarding as needed are highly valued. Service options that better serve older persons are those that provide it during evenings and weekends and that offer door-to-door service. That provides service to those not eligible for paratransit under the Americans With Disabilities Act and provide a wide range of destinations.

Use of public transportation also is enhanced by well-maintained sidewalks that allow easy access to bus stops and by the sheltered benches at bus stops and at resting points.

We talk about what kind of options are available. Well, the fact that the issue of medical disqualification from driving does bring up a question. Because of the strong role of driving in allowing older Americans to live independently, public

policy should enable individuals to drive for as long as they can safely do so. We believe that a review of the impact of the medical condition on the driver performance must recognize that impaired functioning rather than the medical condition alone is the key.

As you said, epilepsy can result in seizures and it did cause the crash that prompted this hearing. If properly monitored and medicated, seizures are very rare. As we try to improve safety, we must be careful not to assume that because a condition exists, it will result in impaired driving function. In many cases, conditions can be mitigated as when eyeglass prescriptions are updated or cataract surgery is performed.

Further, regulation of individuals with medical conditions should be a last resort and should be carefully tailored to allow for treatment and control of medical conditions. Prohibition of driving based on medical condition should only occur upon a clear showing that a given condition is a strong predictor of crash risk, as is the case with the Alzheimer's Disease. For example, medical advisory boards could take the lead in assessing drivers who are identified as at risk because of a medical condition and not regular Department of Motor Vehicle staff. The State of Maryland is a good example of a medical advisory board.

Does that answer it?

MR. DUCOTE: Thank you, Ms. O'Gara.

MS. O'GARA: Yes.

MR. DUCOTE: Dr. Price, do you have anything for her?

DR. PRICE: I just have one question.

You mentioned early on that AARP sees the link between the physician and the individual as a very important one, and I just wanted to follow up and ask in terms of your outreach, do you direct any of your information about, say, Alive 55 to physicians so that they can share that information with their patients, and if so, how do you interface with physicians?

MS. O'GARA: Yes, Dr. Price. It's a very important element of our communication program. I worked as a state president in Nebraska prior to coming to the Board of Directors of AARP, and we had a -- we worked closely with both the Metropolitan Omaha Medical Association and the Nebraska Medical Association, and this is the kind of partnership which can help both of our associations, for us to help individuals and for doctors to be able to work with their clients. We feel we have similar goals, and we can work very well together.

We provide information wherever available, and it has occurred to me, you know, since coming here, that it would be very good for us to provide the kind of information we have relative to the drivers training course to all doctors' offices through the AMA because it is just a natural kind of connection.

DR. PRICE: Thank you.

MR. DUCOTE: That will conclude my questioning of Ms.

O'Gara.

MS. O'GARA: Thank you.

DR. PRICE: The next questioning will take place by Ms. Danielle Roeber of Mr. Timothy Hoyt.

MS. ROEBER: Sorry.

DR. PRICE: Forgive me. The next witness will be Alexandra Finucane from Epilepsy Foundation.

MS. ROEBER: Ms. Finucane, good morning. Thank you for coming.

MS. FINUCANE: Good morning.

MS. ROEBER: I heard in the last session, Ms. Ward was commenting on the fact that individuals with epilepsy may not be able to partake in some of these transportation alternatives.

Could you talk a little bit about what alternatives are available for those who have been deemed medically disqualified? Are there programs you support, endorse?

MS. FINUCANE: To go specifically to the types of alternatives for the people with epilepsy who cannot drive because of their seizures are not controlled, there are really a variety of programs, but I would not say that they are formal in the sense that they vary from affiliate to affiliate.

We have 60 affiliates with the Epilepsy Foundation. They are not present in every state. They're present in about half of the states, and each affiliate maintains sources of where people can get alternative transportation, if it's through

paratransit, if it's through rides, if it's through a personal program that they have, for instance, you know, bringing people to and from support groups, but those are really very -- they vary a lot from affiliate to affiliate.

DR. MARSHALL: Ms. Finucane, would you please hold the mike a little bit closer?

MS. FINUCANE: Sure.

DR. MARSHALL: Thank you.

MS. FINUCANE: We do encourage people to use public transportation and paratransit. As Julie Ward pointed out, we do have an issue with paratransit in that sometimes people with epilepsy are not considered disabled enough to qualify for those services, and so we work with our affiliates in educating local paratransits as to why the person with epilepsy would need to be on that service.

We also have an issue, I think, with public transportation in that sometimes people with epilepsy will have seizures on public transportation and bus drivers may not want them on the bus. People are afraid when they see those actions, the activities that they engage in, and so we find that often there's -- we have to do work with the local transportation officials to understand what epilepsy is, how it can manifest itself, and how a person can safely ride on public transportation.

MS. ROEBER: Thank you.

On the issue of how epilepsy might affect an

individual who has that illness, does the Epilepsy Foundation and/or its affiliates provide information to the individuals with epilepsy about how it can affect, and do you provide information to parents or family members, I guess I'm thinking along the Al-Anon, if your family members as a group know how to deal with this and help them confront their issues?

MS. FINUCANE: Yes. As you can imagine, and in fact, Dr. Krumholz mentioned the focus group information that we developed recently, that we received recently, it kind of surprised us that transportation was the Number 1 issue that people with epilepsy and their families reported as the problem, the biggest problem they had to face. Number 2 was employment and that's obviously they're related. It's hard to keep a job and get to a job if you have a hard time getting to the job. But that really identified that this is -- continues to be a critical issue for people with epilepsy despite new treatments and better care.

We do and we have always done education in the form of having pamphlets and information on driving and epilepsy and/or you and your driving. Some of that information is in your hearing book. There is an example of what we currently have on our website. It's rather similar to what's in our pamphlets which predate the existence of the web.

We are exploring giving out this information in a more and more simple manner for those people who aren't on the web or making sure that we're really -- making sure the information is

understood by people at all levels of functioning, and just so you have an idea of the numbers of people that we reach, we get a 150,000 hits to our website every month and those are hits -- I don't just mean people who come, I mean people who have stayed for eight minutes or longer is how we're defining it. So, people are actually using the site. The majority of those people are either people with epilepsy or family members. So, a significant proportion of people are getting their information about driving and epilepsy from the web.

There's another group obviously, the people who don't use the web. It's still 40 percent of our population, and for those people, we have pamphlets called Driving and You in both low literacy levels and other higher -- more detailed information.

We have driving charts. People commonly come to us and want to know what are the driving laws in my state, I'm thinking of moving to another state, what are the driving laws in that state. So, people are very interested in knowing the alternatives. You can get every driving law provisions as they relate to epilepsy on our website by plugging in the name of the state and it will print it out for you.

We do have -- we also do make that chart available in physicians' offices in a big full color glossy thing. A lot of our neurologists ask for that because it is an issue that they hear about from their patients.

Pamphlets. I think that's it for written information.

MS. ROEBER: Do you have any longstanding partnerships with other organizations, be it Alzheimer's or be it AARP, people that you can pull together your resources for providing transportation alternatives and confronting these issues with the policymakers?

MS. FINUCANE: I would say that that is very locally driven. Our local affiliates will get together with other groups to try and make sure that they have some resources for the people who cannot drive. It's particularly important in terms of getting to doctors' appointments and getting to jobs. So, it's very much locally driven by what's available in the community.

Our partnerships are more -- at the national level are more in line with the medical groups that are really addressing the issues of epilepsy and driving where we try and work with them to make sure that we have common understandings and up-to-date information.

MS. ROEBER: My last question. As you can imagine from the presentation about the fact that one of the crashes we're investigating involved an epileptic driver, do you have any suggestions or ways of preventing that crash from occurring, that type of crash from occurring again?

MS. FINUCANE: Well, you know, there's really multiple prongs. I don't know all the details of what your investigation is showing. I have to say I've been involved in this area for a long time. I was completely horrified by -- that this person

managed to be driving from all signs that I could see, but how that -- so, you know, our local affiliate has been working with the medical -- with Maryland to figure out what was going wrong there with that system.

I do think a couple of things are apparent and one of them is public education and physician education is still not adequate. I don't know whether the individual involved was involved with -- knew our affiliate. I don't know whether they -- he had ever come to the national office for information. We may not have been as clear as we could be that the three-month seizure-free period that's commonly referred to in many of these laws is a reference to a signal that risk of having a future -- of risk of having a future seizure. It's not an automatic three-month seizure-free, you can drive and have a seizure every three months.

What it relates to is that, according to the statistical data that the doctors tell us, if you've been seizure free for three months, the chance of having a seizure again goes way down by the three-month period. By six months, it goes down a little bit more. By the time you get out to a year, it goes down incrementally more, but the big significant jump is in that three months. So, therefore, the three-month seizure-free is a predictor of likelihood of being seizure free for the continuing period, but if you're having a seizure every three months, I mean, you know, that to me is recurrent seizures, and I think all

medical professionals would have said those are recurrent seizures and the person should not be driving. That message, you know, is -- I mean, it just points out an obvious example that that needs to be clear and made more clear if it was not.

I think, you know, we do do training with and work with neurologists and I would say neurologists are pretty good because this is a source of concern. It's a potential liability for them. They do have patients who they're worried are going to get out on the road and might have an accident, how to talk to them. So, most physicians -- most neurologists do always talk with their patients, at least this is what I understand, talk with their patients about epilepsy.

At professional meetings every couple of years, there will be a session that involves medical/legal aspects of epilepsy. Driving is a critical one in one of their sessions. Periodically, there are articles published in medical journals for neurologists about the issues that surround driving and employment and epilepsy.

So, it's clearly a continuing interest there, and I think neurologists are relatively well informed about that. I think, you know, the issue now as medical care and delivery of medical care may change is to what extent do primary care physicians and other delivery people recognize these same issues, and I don't think the mechanisms to train people who are not specialists is anywhere near as good as it is for specialists in

those areas.

MS. ROEBER: Thank you.

Any questions, Mr. Ducote?

MR. DUCOTE: No.

MS. ROEBER: Dr. Price?

In that case, I will go ahead and move on to Mr. Hoyt from Nationwide.

What information do you gather about the medical conditions of the drivers you insure, and how do you use that information or how do you acquire that information?

MR. HOYT: I'm going to give you a protracted answer to that question because I think it will set us up for some other things we want to discuss.

Private auto insurance -- first of all, I'm with Nationwide Insurance and it's a writer of private auto insurance and so if the issues are on health insurance, I'm probably not going to be real helpful here today, but private auto insurance basically is to provide a financial protection product to individuals who are licensed to drive, and we're regulated by the states that license those drivers to drive. there are variations from state to state on insurance regulations and the way that we might underwrite or determine the risk associated with a certain individual.

I can tell you Nationwide does not and what I know of other private auto insurers, we do not gather information about

medical conditions of drivers we insure. We do not use medical conditions to underwrite auto insurance.

In general, what we use is information that is available, based on previous loss experience of those drivers and information that's available through the state motor vehicle records to underwrite insurance, to assess the risks of those individuals we insure.

It's been noted here several times in presentations to this panel that increased risks may be associated with medical conditions that might impair an individual’s ability to drive and that those who are impaired are at significant risk of increased crash involvement. However, if the individual's prior experience or prior loss experience shows or the motor vehicle records indicate that they've been involved in crashes, that is to us a way of recognizing they're at increased risk for future crash involvement.

In general, if they're licensed to drive in a state, then there are financial protection products available to them, so that they can continue to drive. Those products, however, depending on how much of a risk they are, may very quickly become unaffordable. If they are licensed to drive, there are financial protection products available to them.

So, in short answer, we don't gather information on medical conditions.

MS. ROEBER: I would also ask, do you gather

information, since you are an actual company, on people who drive your vehicles, and how do you acquire that? What do you do with that information?

MR. HOYT: We do. Because they're our employees, we have obviously more information about them than we would of individuals that we insure.

Let me just -- because a number of our employees drive motor vehicles and we have a fairly significant size fleet, there are some conditions or -- let me just read to you a part of the policy for withdrawal of company car driving privileges.

It says, "Privilege of driving a company car may be withdrawn for any of the following but not limited" -- these are legal terms, "... not necessarily limited to the following limitations". Number 7 on the list is a medical condition that affects the employee's ability to drive a company vehicle as determined by the Nationwide Medical Director or the Employee Health Services.

So, we do that. There are evidences of one particular medical condition, I guess, that we do look at fairly aggressively with regard to our employee drivers, and that is with regard to operating a motor vehicle under the influence of alcohol.

Based on information that is available and research, when we have an employee driver involved in an incident where they were either involved in a crash or cited for driving under the influence of alcohol, we have some fairly aggressive procedures

that we follow. We do that for a number of reasons. First of all, based on what I know from research information, interactions with the National Highway Traffic Safety Administration and law enforcement agencies across the country, it's very difficult to get arrested for drunk driving. At one point in time, I think it was estimated that I could drive drunk every Friday and Saturday night for the next 10 years and statistically I'd run the risk of being arrested once. If we have an employee driver who is arrested for drunk driving, we begin with an assumption that we need to look at an assessment and go through an assessment of is there an alcohol or drug dependency. There conditions and procedures that must be followed. Employee drivers immediately removed from driving a vehicle for the company, until we complete those procedures.

In furtherance to that, there was some statements made here the other day with regard to, I think it was, bread and butter issues of individuals getting back their license because they must have their license to drive in order to work. I can tell you from a liability perspective, for our own employee drivers, it is very specifically stated in our policies that they cannot use employment for Nationwide as a way to get their driver's license back. It's specifically excluded. That is done so we will be assured they will go back through the process necessary to assure that if there is a dependency, it will be addressed, and we can move forward from that perspective. So, we

do work hard on the DUI side of it.

MS. ROEBER: One final question. Should you become aware of a medical condition, whether it be someone you insure or an employee, can you provide that information to the licensing agency? Would you? What might you do with that?

MR. HOYT: In consultation with my counsel, I think the suggestion was that even if we were aware of that information, we would probably not be able to share that information with others.

MS. ROEBER: Thank you.

Mr. Ducote?

MR. DUCOTE: No questions.

MS. ROEBER: Dr. Price?

DR. PRICE: I have a couple.

First, I just wanted to ask. You said that Nationwide doesn't gather any information about medical information, and I was just wondering, to your knowledge, is that a consistent policy across many insurers?

MR. HOYT: I asked our Underwriting Department, who has recently been doing some benchmarking against other insurers across the country, if that was the case. I was told that as far as we knew, there were no insurers who were using medical conditions as a condition for underwriting their insurance.

In fact, I was told that Nationwide probably hasn't asked a question about medical conditions for the last 20 years.

DR. PRICE: Okay. Just a follow-up to that. You stated that you primarily use loss information or information that you get about person's licensing. We learned earlier that occasionally, a person may have their license suspended because of a report from a family member or self-report and that that might go through a process of appeals and may -- someone may have their license suspended and then brought back through an appeals process.

Are you privy to some of that license revocation information, and would that influence insurability?

MR. HOYT: I'm going to give you a rather long answer again to that question. I'm sorry. It's not simple and straightforward.

Clearly there are costs associated with re-underwriting an individual or a group of individuals for insurability, and for the most part, unless we are seeing a significant crash loss experience, the probability that we’re an going to go back and look at the motor vehicle record of that individual is fairly low, and therefore the actions of the licensing agency in the intervening period probably won't be looked at again.

If we had an agent or individual who was writing a large book of business that had adverse loss experience, his or her whole book of business might be re-underwritten, in other words, look again at the motor vehicle records of all of those

that they have in their portfolio of insureds. That might happen, but in general, we don't do periodic motor vehicle record searches.

I can tell you on our employee drivers, I run motor vehicle records searches on our employee drivers every quarter, and that we do look at those records as indicative of whether an individual ought to be continuing to drive on company business, but I can tell you that with all the millions of people we insure, even at a few dollars apiece, we do not go back and look at the motor vehicle records of all those we insure, unless we're seeing loss experience that says you need to go back and look at it again.

DR. PRICE: Thank you.

MS. ROEBER: Is that it for Mr. Hoyt? Thank you very much.

Jana?

DR. PRICE: I'll be taking the next questions with Mr. Rex Knowlton.

I want to start by citing some recent survey findings that were produced by the Bureau of Transportation Statistics. In their large-scale National Household Travel Survey, they found that about nine percent of all people surveyed and about 24 percent of people aged 65 and older report having a medical condition that makes it difficult for them to travel outside of the home, and I just want to start by asking you, Mr. Knowlton,

about the programs that you work with to help people whose travel is hindered due to medical conditions.

MR. KNOWLTON: I'd like to answer that from two perspectives, if I might. I am the Executive Director of a non-profit company called Wheels of Wellness that operates in the City of Philadelphia and has been providing non-emergency transportation service since 1959.

I am also on the Board of Community Transportation Association of America representing the Mid-Atlantic Region on that Board. Community Transportation Association is an association of community transit providers, numbering just under 4,000 nationwide, and along with the American Public Transportation Association represents public transit, if you will.

From the position as the -- my paid position, if you will, as Executive Director of Wheels, Wheels has programs that serve the community in and around Philadelphia that primarily fall into three categories. We have our volunteer program which is a program that provides what has been called paratransit service here to folks that are unable to qualify for any other program, primarily for medical purposes, using a combination of paid and volunteer drivers.

We have a program that provides transportation to folks in the HIV community that is funded through Ryan White Title I funding, that provides transportation to Philadelphia and the four surrounding counties for services that are about 60- percent

medical for meeting those transportation needs, and the lowest cost available which is the federal mandate. So, that includes if folks are able to access fixed route transportation, includes provision of fixed route transportation as well as paratransit.

We also have our largest program, the Medicaid Program, and we provide transportation to folks on medical assistance for medical purposes that reside in the City of Philadelphia, and this program is funded through Title 19 funding and again requires us to provide the least cost transportation. So, if folks are able to access fixed route systems, bus, subways, rail, that kind of option, that's the mode that is utilized. If folks are not, then paratransit is provided.

So, those are programs that are administered in Philadelphia and there are similar programs administered around other urban areas and certain rural areas. As has been suggested by a previous member of the panel, there is more or less a splintering of transit service that is provided. There's not one type of transportation service. It's very specific to the location at the community level and also the state as well.

For example, in Pennsylvania, there is a program that is funded by the lottery that provides significant funding, 85 percent of the cost of transportation, if you're over 65. So, folks that are over 65 in Pennsylvania have affordable options for transportation, whether they be fixed route transportation or paratransit. There are many of the hours, 22 out of the 24 hours,

throughout the day on fixed route programs, folks are able to ride free if they're over 65. That's in Pennsylvania. New Jersey has a similar program with casino revenues but all states don't have that option or opportunity.

At the national level, there are major programs that help people that we're talking about. It has -- the Americans With Disabilities Act or the ADA service has been referenced on the panel as well, and ADA service is available to individuals that essentially live within a radius of three-quarter mile either way of a fixed route system. So, if folks live within a fixed route system and they are not able to access the fixed route system, there's a paratransit option that is provided. Of course, there are many communities across the country that don't have a fixed route system and thus that option is not provided and that is not an option for the rural areas of the country.

Finally, in terms of Medicaid, the Medicaid Program recognizes the need for non-emergency transportation and is available in all of the 50 states. It's a state-run program. It's matched roughly 50/50 federal/state. There's some variation there, but approximately 50/50 federal/state. But each state has a major say in how that program is run. So, you will see variations on the program as you go from one state to the next.

DR. PRICE: Thank you.

And following up on that, it sounds like there are a lot of programs both in Philadelphia and across the country that

are targeted to groups. It sounds like occasionally, you'll see that ones are targeted to specific groups, based on the region in which they live, the particular medical condition they're facing, or some times age.

I know it was brought up earlier in an earlier session about these issues of people who are falling in between gaps or have to coordinate with multiple services, and I was just wondering if you could address that from both hats you wear and how you see that? Is there any programs that are dealing with that currently, the coordination?

MR. KNOWLTON: Does everyone have three days?

(Laughter.)

MR. KNOWLTON: The two major challenges for us in transportation are funding and coordination and they're kind of linked. I'd like to just back pedal just for a quick moment and talk about funding because it kind of leads into coordination.

There's two major pockets of money that's available for funding of transportation. One comes from through the Department of Transportation and one comes through the Department of Health and Human Services. The Department of Transportation money is generally, the vast majority of that money, not all but the vast majority of it, goes to transit authorities across the country and is available for all modes of transportation that are provided by transit authorities.

The Transportation Efficiency Act is the founder of

that. That Act is currently up for reauthorization. The current program expires at about a $7 billion level and probably one of the most conservative estimates for funding of that is that's needed is about twice that amount, about $14 billion and that begins to shed some of the concern on the funding issue from the DOT side.

On the HHS side, the HHS programs are very splintered. There are many programs. Medicaid is a major program that provides transportation. Medicare is another major program that does not have any vehicle for non-emergency transportation. Medicare has a vehicle for emergency transportation, and as a result, there's about $2.5 billion a year that is being spent in Medicare transportation, but they go for emergency purposes or they're supposed to go for emergency purposes.

The Government Accounting Office put out a study in July of 2000 called "Rural Ambulances: Medicare Fee Schedule Payments Could Be Better Targeted", and basically what that study says, among other things, is about 50 percent of the ambulance transports are actually non-emergency, non-emergency utilization, and another group has followed up on that, the Westat Group, and they basically said that 14 percent of the Medicare patients who arrive in ambulances do not require emergency medical treatment. In many areas, particularly rural areas, of the country, that's the way folks have to get where they need to go. So, the trade-off is about a per trip cost, and as I refer to trip, I'm

referring to a one-way cost, so if one goes into the doctor's office, that's one trip, and you come out of the doctor's office, that's a second trip, per trip cost on the emergency goes about -- a little over $500 a trip because of all the different things that are needed in an emergency transport, and non-emergency goes at about, depending on what numbers you're looking at, $25 to $30 a trip. So, there's a major cost differential there and a major problem in terms of an inability to fund a growing Medicare population and meet their non-emergency needs.

Other areas of HHS funding include the Older Americans Act, and in many parts of the country, transportation is funded through the Older Americans Act as well as TANF which is the Temporary Assistance to Needy Families. There is transportation money in TANF. There's transportation money in Head Start. There's transportation money in a lot of these pockets, and the reason I elaborate on them is because each pocket has their rules and that's where we get to coordination.

It's very difficult to coordinate programs that have different criteria, some of which are mutually exclusive. Some programs, you can group people in, some programs, you can't group people in. Some programs want door-to-door service, which is, in our business, there's three levels of service, curb-to-curb, which is like a taxicab, door-to-door, which is one goes from the vehicle to the door to get the individual, and then there's door-through-door, which one goes through the door. Each level of

service has different cost factors. Each level of service has different insurance implications, and all these things come to the table when one tries to coordinate. It's extremely complex. Rules are made in a vacuum within one funding stream.

The most recent example that we're wrestling with as an industry is HIPAA, the Health Insurance Portability and Accountability Act, which is well intentioned, but from a transportation perspective, we find ourselves debating whether we're business associates or not, and if we are, what are our responsibilities, and for many of the systems that are coordinated, maybe they do medical at five percent of their business. So, you know, you have a business decision to make. Do you want to get into that level of paperwork and whatnot for a certain percentage of your business?

So, I'm sorry. It's an extremely long answer. It's an extremely difficult problem, and it is trying to be confronted. The good news is that FTA, the Federal Transit Administration, and HHS, specifically the Aging as well as the old HCFA group, CMS, are talking now at the federal level. Dick Doyle, the regional administrator of FTA in Region III, is heading this effort, and there's some hope that we can get some of these areas coordinated between these funding streams, and what that would do, that would allow us to provide more service and less duplication.

DR. PRICE: Thanks.

I just have one more question before I pass it along.

It's a little more in the local level, directed towards your work with Wheels.

For the clients that you serve, what do you see are some of the kind of daily obstacles that they're facing with trying to get in touch with these kinds of services and the kinds of areas where you'd like to see more work done?

MR. KNOWLTON: Well, it has been mentioned, the whole topic of outreach and education, and that's on-going, no matter what level. We have advisory groups as a transportation provider that include the medical community. Our primary contact in the medical community for probably the first 40 years of our existence was the social worker. We have managed care in place now. It came in in '96 in Philadelphia. Wit that, pretty much the social workers have gone away, and the outreach from a transportation perspective is extremely difficult under that scenario because there's a number of people in the hospital setting that handle transportation. It's not centralized, if you will.

So, we're more successful with certain institutions than other institutions. Trying to get the word out to the community is done through public service announcements and different outreach not only through the Internet but also, you know, through pamphlets and brochures and those kinds of things.

What's most difficult for the individual is navigating the maze, and by that, I mean, there's many folks that fall with one foot in one camp and one foot in another or maybe no foot in

any camp. In my operation, if you're over 65, again I'm in Pennsylvania, you should be in pretty good shape if you're over 65 because you can get -- if you require paratransit service -- you're in excellent shape if you just need fixed route service because outside of two peak hours, one in the morning and one in the afternoon, you can hop on any bus and go anywhere for no charge.

If you're requiring paratransit service, it's a nominal cost. It's 15 percent of the cost. So, it's probably $3-4, something like that, for a ride. So, it can be affordable. However, if you're under 65 and you're on Medicaid, you're in good shape because we can transport you under our Medicaid agreement. If you're not on Medicaid, however, and eligibility fluctuates sometimes on a month-to-month basis, then all of a sudden, you're not able to access that. You fall into what we call our volunteer program, and as a non-profit, we take as many people as we can. The problem is you can't take everybody.

There are -- in our Medicaid operation, we serve 5,000 trips a day on paratransit service. On our Title I service, we serve about 350 trips a day on our Title I service. Those folks will go because it's an entitlement and we will get reimbursed for that. If you fall outside of that, on our volunteer service, we service about a 120 trips a day, and I'm pleased to be able to do it using a combination of volunteer and paid drivers, but we turn back an average of 20 trips a day.

So, what that means is people have waited a month and a half or whatever to get their medical appointment and then, all of a sudden, we can't take you. We can't take you not because you've waited a month and a half or anything, it's pretty much geographic and time constraints. I mean, it's planning for transportation is a big puzzle and you try to get the most amount of trips on a vehicle at any one time, but you can only ride people for a certain amount of time. So, you can't ride somebody around all day while you're picking up other people and whatnot.

So, geographic limitations dictate availability many times, and there are always, always people that can't be served, and our operation is no different than any other operation across the country.

DR. PRICE: Thank you.

I'm going to ask if Mr. Ducote or Ms. Roeber have any questions. Mr. Ducote, do you have any?

MR. DUCOTE: No, no questions.

DR. PRICE: Then Ms. Roeber?

MS. ROEBER: Something I read in the past 24 hours or so gave me an idea, and I want to bounce it off of you since you are a very knowledgeable expert on transit programs.

What about the possibility of providing a voucher program, something where you could just use the average taxicab and have vouchers that will help to cover the cost?

MR. KNOWLTON: Voucher programs work and they're used

in some areas. Obviously they don't work in rural areas because there's not taxicabs hanging out there. But in some small urban and urban areas, they work. L.A. has had a pretty fair amount of success with a program such as that.

It is certainly plausible and it's a way in which we can as transit providers, we can at least begin to meet some of our peak demand. We use taxis as part of our operation, and we try to use taxis to cut down the peaks, if you will.

The difficulty -- there are difficulties. Our drivers are put through 32 hours of training, eight hours of which are sensitivity training. Taxicab drivers are not, and the biggest challenge in reliability with taxis is that given a paying fare or a voucher, that cabbie is likely to take the paying fare. But it is a topic that's alive and well.

I have the opportunity actually next month to address the Taxicab Association, and it's an area where we are trying to work and we are trying to make some improvements.

MS. ROEBER: Thank you.

No more questions.

DR. PRICE: With that, then I'll pass it to Dr. Marshall.

DR. MARSHALL: Okay. We'll go to the tables and Advocacy I.

MS. STRAIGHT: The first question I want to address actually to Ms. Finucane and to Rex Knowlton.

I'm very interested in this issue of ADA and the non-eligibility of people who may not be able to use fixed route but who, for the same reasons, shouldn't be driving or can't drive.

I wonder if you could both talk about whether you have experience with that, and what in fact -- I was thinking about this a lot last night, trying to think of examples because I intuit that there are all sorts of people out there who can't drive but aren't eligible for ADA paratransit, but I -- when I try to think of examples, given that ADA eligibility is supposed to be based on functional ability to use or functional inability to use fixed route, I was trying to think of situations in which people who -- just, you know, for instance, -- well, I was trying to think of examples of where that would take place.

So, I wonder if you two could address that issue.

MS. FINUCANE: I can give you some examples and actually the issue of eligibility for services for people with epilepsy is a chronic one. It's not just paratransit, it happens with VR services. It's even happened for coverage under the ADA for discrimination cases as well, and it's primarily because epilepsy is an episodic disorder, and when you look at the functional limitations, somebody says, well, you don't have mobility problems, I don't notice anything about you and maybe you might have a seizure in a month, why on earth do you need this service? So, it's really to document for paratransit that in fact this is a continuing condition, you don't know when you will have

the seizure, it'll manifest itself in this way, you know, if it happens, and that for safety reasons, you need to use paratransit.

I think we're generally successful in the cases where it's come up, but it has to be argued and we do periodically get, our affiliates in particular, periodically get the call from somebody who needs paratransit and has been told, well, you don't meet the eligibility requirements, prove it to us.

MS. STRAIGHT: So, the focus there really is -- it's -- for people with seizure conditions, it's really the issue of safety in using the fixed route, not having the curb-to-curb --

MS. FINUCANE: It's partly the safety. It's also when you don't have the fixed route obviously alternatives.

MS. STRAIGHT: Right. And let me couch this in I'm really talking, you know, in this very limited urban world in which there is --

MS. FINUCANE: Right. But we do have the issue as well with public transportation. There are people who feel like it is threatening and it is burdensome for them to go through the Metro system. I mean, those of us who are from the Washington area, we may remember the case where a man was arrested when he had a seizure while getting onto a Metro train. So, there are reasons why people say I would feel better if I had a car coming to my or a bus coming to my house that could take me so that I don't have to have the risk of having a seizure at the side of the station, at a platform, on the street somewhere, and have to deal

with people's inability to handle those circumstances.

MS. STRAIGHT: Thank you.

MR. KNOWLTON: In the urban environment, there is variation from community to community in terms of interpretation of the ADA and the hoops that one might argue folks get put through.

In Philadelphia, there's a 12-page form that one needs to complete to begin to consider qualification and then you have the Functional Assessment Test and whatnot.

There are folks that do not qualify for paratransit and it's become increasingly prevalent as the fixed route systems across the country have now, since 1990, been buying buses that are accessible for at least the physically-challenged and thus the harder look from the transit authorities' perspective, I sense. Some of those folks can fall out into community transportation options which are essentially as good as the community support system is that is present.

The Commonwealth of Pennsylvania has Philadelphia and Pittsburgh on either end, but we have 67 counties and the majority of the counties are rural communities that don't have any ADA service at all. There's a pilot that has just been completed that's run over the last two years targeting eight of those counties and specifically this issue, providing paratransit services where they're needed but they're not in place, if you will, and the demand has been essentially overwhelming in these

communities.

So, it's kind of, I think, a microscopic type of reaction, that the President is trying to address -- that we're seeing in Pennsylvania in the President's New Freedom Initiative, which is part of the T-21 reauthorization, that would fund transit, such as this, at the rate of a $145 million, and it would begin to -- not totally but begin to provide options for people that require transportation that are outside of that fixed route that currently don't have those options.

MS. STRAIGHT: Now, do you know, would the New Freedom money be available -- I know a number of the government programs are limited to capital expenditures on the DOT side, at least for the elderly and the persons with disabilities side. Will the New Freedom -- is it proposed that the New Freedom money be available for operations as well?

MR. KNOWLTON: Absolutely. Jena Dorne, the FTA Administrator, visualizes New Freedom as a partial answer to this need and recognizes the importance of operating the funds, yes.

MS. STRAIGHT: Thank you.

MR. COHEN: My name is Perry Cohen. I'm with the Parkinson's Disease Foundation.

I wanted to ask Ms. O'Gara. Your 55 Alive Program. Does that have information on specific medical conditions in it?

MS. O'GARA: It's just a listing of, as an example, high blood pressure, a medication which is taken for it, and what

the reaction might be. It isn't an attempt to diagnose. It's just to --

MR. COHEN: No, no. Information on driving risk or driving advice for people with different medical conditions?

MS. O'GARA: Yes. Yes, it does. There's an area on safe medication use and safe driving. The whole emphasis is on how to be a better safe driver, and so a lot of the book is devoted to providing you the tools to be able to do that.

MR. COHEN: Okay.

MS. O'GARA: I'll be glad to share it with you.

MR. COHEN: Yeah. I'd like to see it.

I wanted to ask Sandy. Your information on driving laws by state. Is that -- could you describe that a little more?

MS. FINUCANE: We have surveyed through multiple means, survey and actually researching it ourselves with law clerks, all the information on driving and epilepsy, and it addresses all the issues that we care about, mandatory reporting laws or the state reporting laws, immunity laws, what is the seizure-free requirement, what's the appeal mechanism, is there a medical advisory board in place. So, all those details are answered for each state, any state that you plug into the system.

MR. COHEN: So, do you find some states to be more consumer-friendly than others?

MS. FINUCANE: Sure.

MR. COHEN: Okay.

MS. FINUCANE: Yeah. And I mean, this is a very -- I mean, this is -- the reason why we do this is it's a very complicated area for people to navigate. You know, what is the system in my state? What do I have to do? What's the form look like? Obviously we have actually promoted Wisconsin's model as the -- as one that seems to be working, as simple, and that our model laws are based upon that type of system, but it's nevertheless cumbersome for the person with epilepsy and that's how they view it.

You know, whether we like it or not, they have a lot of forms that they have to fill out. You know, they have to go make extra doctors' visits that they have to pay for in order to be legitimately licensed.

MR. COHEN: Also, do you have the issue that we had with Parkinson's Disease? We did some research and we found, based on a national probability sample of longitudinal -- from a longitudinal aging survey, that 52 percent of the patients saw a neurologist over a five-year -- during a five-year period.

Do you have that issue that many of the patients don't actually see the specialist and therefore don't get the kinds of counseling that would be the most appropriate?

MS. FINUCANE: Well, we haven't done a recent study on that. Every person with epilepsy sees an EEG specialist and most of them see a neurologist once. That's the old data. We haven't done it recently. The question is, is how often do they see that

neurologist after that time period? We know neurologists give them -- ask for information about driving and may mention it because of the people who come to us and say I need driving information for my patients.

MR. COHEN: Okay. Thank you.

MR. FLAHERTY: Gerald Flaherty, Alzheimer's Association.

For Mr. Knowlton. I want to commend you, first, for your work with the taxi drivers. We're doing -- especially the sensitivity piece. We're doing something similar to that in Boston with the Boston Elder Affairs Commission, the Police Department's Hackney Division, the Alzheimer's Association.

But here's my question with a bit of a short preamble. Given that wandering and getting lost is a particular and serious issue in Alzheimer's Disease, and then given, also, that about 75 percent of people with Alzheimer's are living in the community, they're not in institutions, and further that at some point, the vast majority of these folks will not be driving and will, many of them, need some sort of alternative transportation, you've said -- mentioned the door-to-door and door-through-door model of transport in talking about some of the difficulties of funding. That kind of transport would be especially important to folks with Alzheimer's Disease.

What in particular are you and your agency and anyone else you know of doing to get this issue front burner at the

federal funding level?

MR. KNOWLTON: The importance of door-to-door is being -- that message is being sent as part of the coordination discussions that are occurring at the federal level.

One of the distinct barriers that separates the -- and I don't like to categorize too broadly, but primarily the transit authorities from the community transit providers is this issue because transit authorities will pretty much provide a curb-to-curb service and that's in line with their charge, if you can visualize, you know, the history behind picking up a bus. I mean, you know, you pretty much go out to the bus stop and you get on to the bus, and ADA requires similar service to be provided. So, many of the transit authorities provide the curb-to-curb service and there are elements of the community, not only the Alzheimer's but there's also some children's issues.

We transport 29 percent of our paratransit operation are under the age of 19. So, there's some children issues, too, on the health and human service side, particularly with the growth of out-patient treatments on the medical side and whatnot. So, door-to-door is important. It's an important element, and it is being handled at that level. Additionally, it is being understood by the insurance industry which has been another challenge in terms of coverage because there are differences in exposure when one provides a curb-to-curb service versus a door-to-door versus a door-through-door and to try to get some realistic costing of the

door-through-door or the door-to-door is meeting with some level of success over the last few years.

MR. FLAHERTY: Thank you.

And a short question for Ms. O'Gara. In the course of your education and outreach with folks who provide alternative transportation, do you discuss the issues that I just mentioned around the risk of wandering and getting lost among people with Alzheimer's Disease?

MS. O'GARA: Well, that's a scenario that we really feel needs to be discussed, particularly with the doctor and the patient and the family, because this is not widely known, and the sensitivity is a critical issue.

There's a whole area out there of need to develop structures to be able to instruct people for how they can more safely transport people. There's a driver assessment infrastructure we discussed that needs to be developed with trainer and certification for rehabilitation specialists. There's an increasing interest in expertise among occupational therapists about driver rehabilitation, and typically in the case of the stroke victim, there needs to -- it needs to have a health model, so that people will understand what they are dealing with. You know, there's a lot of forgetfulness involved in the whole thing, and certainly the patient would not be aware of how to help themselves, and also just getting information that it's available and that there is a need for this kind of infrastructure to be

developed is a critical thing.

I do think that -- I don't know, you know, at what level you are discussing this, but AARP at the state level works with a lot of Alzheimer's volunteers and we have a very close association with the various chapters in each state because, you know, realistically, the aging people are the ones that have Alzheimer's. So, we kind of work together to try to determine how we can meet a community need that way.

MR. FLAHERTY: Okay. Thank you.

And we do work with AARP in Massachusetts. So, thank you.

DR. STROHL: Kingman Strohl, American Sleep Apnea Association.

Ms. Finucane and Ms. O'Gara, I think throughout the last day and a half, I've been struck by the complexity of the issue we're addressing, and the National Transportation Safety Board should be commended for taking on sort of medical problems in general and noncommercial drivers, also, because you start looking at all the stakeholders that, besides the Department of Transportation, which the state medical boards, might include places where I'm more comfortable, that is the National Institutes of Health, including National Institute of Aging, National Institute of Neurologic Disease and Stroke, Child Health, and these are issues that we address with multidisciplinary sleep issues, not just sleep apnea.

AMA is involved. We've heard needs of assessment, education, multidisciplinary approaches. No one particular disease can run with this, even though there are common themes, and the different audiences that you have include not only the public but doctors, law enforcement, EMT.

Are there any models out there that can start to create assessment tools, products, that would be looked at in both research, education, and service that you've seen from your fields that are out there, perhaps at university-based settings or things of that sort?

MS. O'GARA: I am not aware of anything at that level, but the assessment problem, we are emphasizing that it needs to include the health model in order to be successful, and certainly it's something that needs to be addressed.

I'm not certain whether there's any other information available, but as I said, I think that the very fact that we are all starting to work together in the community kind of model to bring these similar problems to try to find a solution from them is very critical, and I would encourage you to work with the AARP at the state level to see what kinds of research is happening at the university level because we have two medical schools in Omaha and various kinds of -- they're attempting to develop different kinds of processes, and nothing has been finished, but certainly there's need for it, and I think that we'll have to work together to meet some kind of end that will be helpful to everybody.

DR. STROHL: Because we have an Alzheimer's center at our institution, and to go with them to start to talk about these issues would be the first place, and that there would be the other model at medical centers to include things like comprehensive cancer centers which also look at rehabilitation, behavioral outcomes, assessment outcomes and have certain goals that are multidisciplinary.

MS. O'GARA: The very fact that the population is aging at such a degree. In 2030, one out of five people will be over the age of 85. There were two million people over 85 in 1998. There will be 10 million in 2030. The population is growing so dramatically, that these kinds of things can't be ignored any longer, and I'm just glad we're all starting to try to work together.

MS. FINUCANE: I have two thoughts on that. One is, it's sort of de facto, the model, and that is the epilepsy, the treatment of people with epilepsy and driving over time. I think that, you know, the -- I mean, this is probably more regulated a condition than any other medical condition and it's been happening for years, and we can perhaps learn from the mistakes that were made, you know, in terms of how people were treated and stigmatized by that and how to do this in an effective way. I think all parties are involved in that issue and they have been. I think we're also seeing here some of the limitations of that system obviously.

The other thing is, as somebody mentioned, the public health role here for an idea, and we haven't really talked about that at all, but it's an interesting idea; that is, is safe driving really a public issue that could be addressed by public health systems, particularly dealing with the medical issues. I think nobody's really thought of this at all in terms of, you know, diabetes, cardiovascular disease. All these things do have an impact. The medications that are more and more prevalent for multiple conditions. Should we be treating this as a public health issue and using those models to educate the general public about the impact and the relationship between public health and driving?

DR. STROHL: Thank you.

MS. WARD: Julie Ward with the Epilepsy Foundation.

For Mr. Knowlton. The Epilepsy Foundation has worked very closely over the years with the disability community, the Consortium for Citizens With Disabilities, in support of expanded public transportation options, expanded funding for making systems accessible. You know, we support the New Freedom Initiative and the various funding things.

On the -- I recognize that Medicaid is a pretty significant source of funding, but as I understand it, it's limited only -- limited in terms of doctors' appointments, getting back and forth and that kind of transportation. It's not a reliable alternative for people who need transportation for work

or on a regular basis, is that correct? Are you aware of other programs? I think vocational rehabilitation does provide some transportation funding, but are there other programs in your state for work, assisting people with work?

MR. KNOWLTON: First of all, that is correct. Medicaid is for medical purposes only. It's not beyond that.

CTAA has completed a toolkit on what's called the Job Access Program which essentially provides a mechanism for folks in certain communities to get to and from jobs. A lot of the focus is on reverse commute because a lot of the transportation challenges these days pertain not necessarily to getting into the city, quote unquote, but getting, you know, from suburb to suburb, if you will, and obviously the rural challenges that are confronted.

So, the Job Access Program is relatively new, four or five years old, and continues to be funded and serve as a model for certain communities. There is required a fair amount of local buy-in and fiscal commitment, if you will, in order to draw down some of the federal dollars, but there have been some successful models implemented there.

The toolkit itself, it's kind of -- CTAA has done three toolkits. We're in the process of doing our third. The Job Access Toolkit, which was targeted for people looking for jobs, the Department of Labor was involved in it, and all the interested parties for folks that are on the employment scene, if you will.

We did a medical toolkit which included the Epilepsy Foundation and others in terms of increasing awareness of medical transportation, and now we're in the process in conjunction with AARP and some others in looking at a senior toolkit, and I can make those available. They're available on the CTAA web, I think. I'm not a hundred percent sure, but I can make those available, you know, for the hearing because all of those are good resources, somewhat current, and they basically try to address the mobility needs of the people in the nation which is multifaceted. It's not just medical. There's many mobility needs that we confront.

MS. WARD: Thank you.

CHAIRMAN GOGLIA: Okay. I think we will now take our lunch break.

MR. COHEN: Could I make a little quick comment? Perry Cohen from the Parkinson's Disease Foundation.

Sandy mentioned the public health issue, and I wanted to try to reinforce that and ask the question, whether managed care gets -- or health insurance -- because we don't have any representatives from health insurance, whether health insurance or managed care are interested in this subject, whether it's a big cost item for the health care system, and which would motivate, if it were, would motivate some more education and particularly with respect to the issue of specialists and non-specialists, I frankly don't -- from what we've heard, I haven't been impressed that the doctors that see most of the patients have much time to spend on

educational activities that we have mentioned and that more of a public health or organized approach would be appropriate for getting the information out.

Anybody have any comments on that?

(No response.)

MR. COHEN: Okay. Thanks.

CHAIRMAN GOGLIA: Okay. Thank you.

If we can return at 1:45 and the panel come back and take their seats, and we'll get on with the afternoon, and we'll start with Advocacy Group II.

(Whereupon, at 12:26 p.m., the hearing was recessed for lunch, to reconvene this same day, Wednesday, March 19th, 2003, at 1:45 p.m.)

A F T E R N O O N S E S S I O N

1:48 p.m.

Non-Regulatory Efforts

CHAIRMAN GOGLIA: Back on the record.

Is everybody ready? All right. I believe we were going to start with Advocacy Group II.

Lori, good afternoon.

MS. COHEN: Good afternoon.

Yes, I had a question, please. This is Lori Cohen with the American Association -- what?

CHAIRMAN GOGLIA: I had you so rattled that we weren't starting with the State Group, we were starting with Advocacy Group II. Everybody should know that I have been teasing her since the minute she came into this hall. I've been waiting for the return. Being a parent with three daughters, I understand the return part. So, she just hasn't delivered it yet.

DR. DONALDSON: Are you ready for us, Mr. Goglia?

CHAIRMAN GOGLIA: Yes.

DR. DONALDSON: Advocacy Group II would like to defer to Ms. Cohen over the State Group.

(Laughter.)

CHAIRMAN GOGLIA: Go ahead.

MS. COHEN: Mr. Chairman? Okay. I have a question for Mr. Hoyt.

Departments of Motor Vehicles can place restrictions on licenses as a means to help drivers with certain conditions keep driving, and it seems that there's a role for insurance companies as far as incentives go. I know that a family member of mine in California chose to stop driving at night. He was kind of on the fence about it, but his insurance company offered an incentive, a discount, if he would not drive at night and that's

what he chose to do.

I'm wondering if you feel there's a role for incentives such as that to assist with safer driving, and if so, can it become a more common occurrence than it is now?

MR. HOYT: A simple answer to the question is there are opportunities for discounts where I can substantiate to my actuaries that there's a pay-off, and in these areas of restricted driving and the likes, night-time driving, I think that the companies that are offering these incentives understand that there is a pay-off for them and therefore they can offer a discount.

What a lot of times happens to insurance companies is that they're asked to give a discount because logically or intuitively the thought is it will result in lower expenses or lower losses. What -- for instance, let me just give you an absurd example. If we were to write an insurance policy for tee-totalers and offer a discount to individuals who said they don't drink, we would have a lot of people who would take out the insurance policy simply because of the discount associated with it, and we would not see any significant difference in our loss experience.

So, it's -- whenever I talk about or have opportunity to speak to a discount, you have to understand that actuarially, I have to be able to show my business partners that it actually results in loss savings. But where those loss savings are possible, it's entirely possible to give those kinds of discounts

and obviously in the case of your father, that was an observed occurrence.

MS. COHEN: Is it worth studying or do you see -- foresee it being studied?

MR. HOYT: My guess is that there must have been an actuarial study done by that particular insurance company. It'd be worthwhile to see if we can get that information disseminated to other insurers who are not currently doing it. I'm not aware of the study. So, I'd be interested in it.

MS. COHEN: Okay. Thank you.

CHAIRMAN GOGLIA: Medical Group?

MS. WATSON: I'm Miriam Watson from the Association of Driver Rehabilitation Specialists.

My question is directed to Tim Hoyt. It's sort of a follow-up question, similar to what Lori was stating. Often in driver rehabilitation, we see folks that have had strokes, traumatic brain injury, maybe early Alzheimer's and Parkinson's Disease, and sometimes what's happened is the medical doctor has recommended that the person no longer drive after our recommendation that they no longer continue that privilege, and one of the situations that can occur is that the person just continues to drive and nothing's notified to the insurer, the insurance company in that situation.

My question is, let's say somebody whose physician has recommended that they no longer drive decides to drive, has an

accident, is the insurance company going to cover that person?

MR. HOYT: The answer to that question is yes. If they paid for the insurance coverage, it would be an exercise in bad faith for the insurer not to offer the coverage to that individual. There may be other liabilities associated with it that would exceed the policy limits on the policy simply because of the negligence of the driver who chose to drive. There would probably be some suits that might exceed the policy limits very quickly in that situation, but at least for the immediate insured, they paid for the coverage, they should get the coverage.

MS. WATSON: One more question kind of along that same vein. But if -- let's say we have a responsible driver in that they decide to enroll in a driver rehabilitation program where they're looked at by a specialist who is going to conduct a clinical and then an on-the-road assessment.

My question is, you know, health insurance companies don't universally cover that service, and my question is, would it be -- I think it might be beneficial for the auto insurance company to provide a discount or help provide coverage for that evaluation, and I was wondering if that's anything that's ever been addressed and looked at.

MR. HOYT: I'm not aware that it's ever been exposed or thought about. Good idea.

MS. WATSON: Thank you. Thank you.

No further questions.

DR. WANG: Claire Wang, American Medical Association.

I have a comment and a question for Ms. O'Gara. First, Ms. O'Gara, I'd like to thank you for speaking so kindly of the American Medical Association's Older Drivers Project, and I'd also like to let you know that we do list AARP's 55 Alive Driver Safety Program as a resource on our patient handouts.

My question to you is, I was wondering if the impact of the Driver Safety Program on driver behavior and crash rate had ever been studied, and if not, whether or not this was something that might be looked at in the future.

MS. O'GARA: I don't believe we have done any type of survey like that. I'm sorry. Maybe Audrey Straight can give you an answer on that.

MS. STRAIGHT: We've done, putting a staff hat on here, we've done some research on -- internal to the program on what graduates tell us about changes in behavior. We've also done some research as a result of what they've learned during the Driver Safety Program. We've done some research on -- we've used the 55 Alive database more or less for research on attitudes about driving cessation, but we have not done the kind of evaluation that I think -- of the impact on safety, to the best of my knowledge. There was some research done a number of years ago, but there's a much larger database of graduates at this point.

DR. WANG: Thank you.

My next question is open to all of the panelists. Over the past two days, we've talked repeatedly about the challenge of providing transportation to non-drivers in the rural community. I was wondering if any of you knew of any model programs or could describe elements that would really help assist people living in the rural community in finding transportation.

MR. KNOWLTON: Many of the members of CTAA are rural transit providers, and there are some extremely effective programs that are providing transit service to folks in the community. It's probably best if I make this issue, I guess, of the CT Magazine, which is called Rural America Needs Transit Available for the docket because it goes into about six or eight different model systems.

If I describe one briefly, an entity by the name of Carts that operates in Texas, in an eight-to-10-county area, has had a fair amount of success in terms of coordinating at the community level transportation for both health and human service needs as well as those areas that we were talking about briefly before lunch that are not served, not touched by ADA, thus not served, and there are some of those models that are being looked at for expansion at the national level, but that's just one that comes to mind.

DR. WANG: Thank you.

DR. JOLLY: Til Jolly from -- did you have a comment?

MS. STRAIGHT: If I could amend my answer slightly,

and I'll submit this to the docket, if I can find it. I think there was an alternative or an outside evaluation done by an academic in California some time in the last couple of years of the Driver Safety Program and its impact, and if I can find that, I will submit it to the docket.

CHAIRMAN GOGLIA: Okay. Thank you.

DR. JOLLY: Til Jolly from the Association for the Advancement of Automotive Medicine.

This is primarily for Ms. O'Gara. You mentioned in your remarks the medical model of management of driving issues in the older public, and the medical model for -- I'm not a primary care physician, I'm an emergency physician, but the medical model of disease screening includes things like colon cancer and breast cancer and all these other sorts of things that people get screened for based on age with a proviso that their family history means they may get screened for it earlier, like colon cancer or breast cancer, heart disease, whatever.

If you take that out to its next extension, the primary care physician with an older driver in front of them might want to consider specific screening based on the risk that we know is present that at an older age, one is more likely to have dementia or other illnesses that might make driving more difficult, and most primary care physicians aren't qualified to do a lot of that examination on their own.

Would you endorse some sort of screening based on age

to be defined by some experts, either by a medical specialist or a medical advisory board or the surrogate, the driver licensing people at an increased frequency because of the known increased risk of dementia in the older person?

MS. O'GARA: I think lots of the -- when I referred to the medical model, what I was saying was that I believe that it is the person's functional ability to drive rather than to focus in on the fact that that individual might have Alzheimer's or might have Parkinson's or something of that nature, but I think that the most research that is done relative to the aging is probably done by the AARP.

As far as the functional ability of people to continue to stay active and for their minds and bodies and spirits to be totally involved as they grow older is -- much of the research that we do, I believe, in the 50+ series that we began introducing several years ago focuses on this type of capability. So, certainly our research would be available for the medical community.

DR. JOLLY: But in -- sorry. But in the instance where a clinician stays with the patient with potential illness, which in this case is crash injury which is an illness, just like any other disease, should that person then be screened for risk of that disease more frequently because of the known increased risk of dementia or some other problem at that age? 65, 75, 85, pick a number.

MS. O'GARA: Yeah. I definitely believe that and probably at 65, if you have a background of having had numerous accidents. Certainly for the individual and for the community, we would choose to pick a lower age just to be protective of both entities. So, if that helps you any. I'm not the expert in that area.

DR. JOLLY: Okay. Thank you.

DR. BREWER: Phil Brewer from the American College of Emergency Physicians.

This is for Mr. Hoyt. One of the issues that seems to have come up or been expressed in various ways is the public health model and where does the issue lie, who has -- who owns the issue of reducing impaired driving, who owns it more than other people perhaps, and I just want to say that one thing that everybody needs to be aware of is that primary care physicians, the traditional almost Norman Rockwell model of the primary care physician who follows the same patients for 20-30-40 years, no longer exists in all practical terms.

At Yale New Haven Hospital, there are fewer than five primary care internists who follow their patients when they get admitted to the hospital. The idea of the one physician knows everything about a group of patients, unfortunately because of -- mainly because of reimbursement issues, is a thing of the past or rapidly becoming a thing of the past. So, that unfortunately would have been a great model 20 years ago. It's not going to be

any more.

Now, because it's been said, particularly when we talk about law enforcement, that there are many crashes which do not result in citations and therefore do not result in any notation on the driver's driving record, would you be in favor of, as a matter of routine, automobile insurance companies sharing their claims data with licensing agencies, so that even when there is no citation, at least the driver's license issuing agency, the DMV in my state, is at least aware that an individual has had three claims in the last year or five claims in the last two years or whatever, as a way of trying to pinpoint people who are otherwise slipping through the cracks?

MR. HOYT: Let me try to answer that. I don't know if I can give you a short answer on this one either.

As I indicated in the response to the questions that were asked earlier, a good portion of the information that is used by private auto insurers comes from the motor vehicle records of the state themselves, and in many cases, as a result of significant deductibles, if you will, on insurance policies, private auto policies, a lot of those incidents where there's no traffic record, they occur in parking lots or other locations like that, don't come to the attention of the insurers either, and so identification of whether they were impaired or not impaired is not on those records either.

I mean, in our claims information, there's a couple of

areas where we couldn't fulfill that need in my estimation. One, we might have information about claims being filed. We won't have any information about whether alcohol impairment was an issue or something else was an issue or whether they're just bad drivers. They've got a lot of poor habits.

Having said that, there was one other thing that you mentioned in a question to a previous individual that I think might be helpful here. You indicated that -- and I think Dr. Jolly also indicated that you have seen in practice and in treating individuals a number of individuals who present themselves for emergency care who are not followed up on as being alcohol impaired and the likes, and to some extent, you laid that back on the law enforcement agency for not coming back and following up on those issues.

One bit of research that may be interesting to you, the Insurance Institute for Highway Safety has done a couple of studies on the ability of a police officer to identify an alcohol-impaired driver quickly and readily at roadside sobriety checkpoints, and if I remember the research correctly, the indications are that they have less than a .500 batting average in identifying individuals who are over the legal limit when they drive through a sobriety checkpoint in the short period of interaction they have with an alcohol-impaired driver. I suspect an individual who's being treated on scene and involved in an accident where they're injured, the interactions between the

officer and that individual may be fairly short-lived. Unless there are other things, at the scene, which indicate or suggest the possibility of alcohol impairment the officer is not aware. The doctors and those who are treating them probably are the only individuals who are aware that there was alcohol involved in that crash.

Part of what we have talked about here today is information sharing and providing information and means for identifying those with medical problems. There may be an opportunity at that point because the officer may not even be aware. There may be incidents where they are and distance and other things were spoken to this morning. may come into play. I think very frequently, the doctors who are treating are probably the only ones who know that there was alcohol involvement.

But in response, my sense is that there are lots of opportunities for us to make improvements in the system as it exists now. Whether the availability of information from the insurer on how frequently our insurance customers are involved in a crash. It is helpful for us to know there's a risk of crash and then pricing the product according to the risks that we're going to see. I don't know that there's anything that would tie it back to medical conditions or even that there is a propensity to drink alcohol. In many cases, such as you suggest in the question, there is no traffic citation or police report on the crash, the claim presents itself without any other supporting information and

the individual could have spent three days getting themselves straightened up, shall we say, before we become aware of it. I doubt it's going to be real helpful in identifying medical conditions because we don't collect it.

DR. BREWER: Well, it wouldn't necessarily be a way of identifying a medical condition. It would be, it would seem to me, very helpful to a medical advisory board who receives a report from a physician or a neighbor or however it works in that given state that receives an impaired driver report, if the medical advisory board were aware that that individual had had several claims over a short period of time. That would be corroborative information that would probably nudge them to dig a little deeper and particularly as I think we've also established, the numbers are going to go up and the resources are not. The resources that the states have to investigate these cases are not going to go up. In fact, they're going down, and so there's going to have to be some sort of triage of who do I investigate thoroughly and who do I not, and if I get a single letter that says, you know, John Doe is impaired and I look at John Doe's driving record and there have been no moving violations in the last three years or five years, however long they keep that data, I'm going to move on to John Doe II who's had a couple of moving violations, but if I have insurance claims data that says there have been no moving violations but there have been two insurance claims in the last two years, that may be a way of deciding that.

So, would that be -- how much of an administrative problem would that be for the insurance industry to provide that information as a matter of routine? People have to have proof of insurance. Perhaps that information could be included along with proof of insurance information.

MR. HOYT: There are a huge number of privacy issues that would have to be climbed over in order to do that. I see there's some -- there may be some opportunity for exploration there, but there are as many problems associated with that as there are opportunities, and it certainly warrants some additional looking at, but it has costs associated with it and a lot of legal issues that would have to be clearly resolved before that would be a standard way of looking at it. Some potential.

MS. FINUCANE: I'd like to just respond to a previous question that the gentleman from the AAAM had.

You know, you raised the issue of asking people, I believe, if they're older than a certain age, having something on their intake forms when they go to the doctor about medical conditions.

DR. JOLLY: Not exactly. What I was asking was in maybe not as direct a way as I could have, whether age as a marker of risk of illness, because it's a marker of risk of some illnesses, as a marker of risk of illness would then be legitimate for use as for a motor vehicle administration, say, to retest that person more frequently, do a driving test, as a surrogate for

health evaluation because really that's the -- the motor vehicle administration's probably more qualified to tell whether somebody can drive very well than a physician is and that, I know that some states are stretching out the length of time between license examinations, if there even is an examination, but if we're concerned about an aging population, there may be an opportunity for some states to shorten that based on age which could be called ageism but also could be called preventive medicine.

MS. FINUCANE: And my response to that would be that, well, if preventive medicine would mean we'd want to look at the causes of crash no matter what the age, and there's obviously big differences there. Why not consider the idea that as part of the medical process, you're asked the question, have you had a crash, been in a car accident in the last year, and everybody's asked that question. At least you're beginning to -- and then, if their answer is yes, then it triggers some other things. Maybe not -- maybe it's a referral somewhere else, but it's using the system to actually get at the real problem which is the crashes, no matter what the age.

CHAIRMAN GOGLIA: All set? Federal Group?

(No response.)

CHAIRMAN GOGLIA: Nothing.

Okay. Back to the Technical Panel.

MS. ROEBER: Yes, I have a question for Mr. Hoyt.

Do you think the insurance companies are at a

disadvantage by not collecting the medical information? Would you think it would be helpful for you to collect such information so you can make a fully informed insurance decision?

MR. HOYT: I think the discussions that we have had during the past two days here have indicated the importance of medical review panels and providing that information and that being a cause or opportunity for action for licensure and the likes.

I think there are lots of administrative burdens and other things that would come into play were the insurance industry to even begin to try to collect that information. I'm more inclined to follow the model that we continue to follow, which is to look to the state to make the determinations as to whether the medical status of an individual is beginning to demonstrate impairment that would affect their ability to drive and therefore their licensure and we'd stay in the business of providing financial protection for those individuals who were licensed to drive.

MS. ROEBER: One more. Are there any preventive measures that you can think of outside of collecting medical information that could help you, certainly you financially, from incurring a cost for those people who might pose a danger because of medical problems or that could help ensure that other people aren't injured on the roadways because of those medical conditions?

MR. HOYT: There's a whole litany of things with regard to the alcohol-impaired driver that still need a lot of work. I think we've identified and heard discussions from various people in this panel and elsewhere about the opportunities for improving the systems and the information.

I am deeply concerned that as hard as it is for an individual to get arrested on DUI, that there are so few opportunities or ways to get those drivers who are arrested assessed as to whether there is an alcohol dependency and to provide some motivation at that point for them to deal with it. In fact, one of the -- you heard me express a fact, I hope I made it clear that I was talking about our employee drivers when I made this statement, but you heard me say that we do not allow an individual to use their employment as a reason to get their license back if they are suspended on a DUI, and part of the reasoning behind that is, is we're trying to provide a motivation since they have to -- they want to be employed, is to provide a motivation for them to go through the hoops that they must go through and that they do an assessment. They (those who are arrested on DUI)have to follow certain procedures before they get back in a car. We don't want them out there driving in the meantime. Clearly there are lots of other liability issues associated with them getting their license back to drive for the company.

MS. ROEBER: Thank you.

No more questions.

DR. PRICE: That completes the Technical Panel's questions.

CHAIRMAN GOGLIA: Okay. Thank you.

I'm reminded that it wasn't clear whether the Advocacy Group II had any questions or they were just joining me in piling on Lori.

MR. SNYDER: Thank you, Mr. Chairman.

I do have a couple questions. A follow-up question for Tim Hoyt.

Is it your understanding that under current law, insurance companies could share claims data with a government agency that's identifiable to the individual?

MR. HOYT: No.

MR. SNYDER: So, you'd need to change the privacy laws if you were going to do that?

MR. HOYT: Absolutely.

MR. SNYDER: Secondly, would you want immunity in order to do that from litigation in case you were wrong or there was some element that was contestable in the future?

MR. HOYT: Clearly.

MR. SNYDER: Yeah. And third, do all insurance companies have the same databases or are you really talking about hundreds of databases trying to all funnel down into one state database, and is there experience with that in terms of the proof

of insurance databases around the country and the cost versus the benefit there? Could you comment on that?

DR. MARSHALL: Mr. Hoyt, would you please talk a little closer to the mike?

MR. HOYT: I'm as close to this as I can, sit on the forward edge of my chair.

Clearly, the databases are unique to the companies that are writing the insurance, at least as far as loss cost information goes. There are some general collections of accident data that are useful in some research studies, for instance, that are collected by the Insurance Institute for Highway Safety, which does collate a fairly significant database from all insurance companies, but there are lots of indications that there are huge economic -- would be huge economic costs associated with the development or the ability to transfer information from the data systems that exist within the individual companies in providing information on proof of insurance or other things like that. Those databases don't sync very well with lots of other places where information could be provided or linked together.

So, my experience, getting that data would not be easy, and that it would be done on the individual basis, individual company basis, and would have some huge financial aspects associated with it.

MR. SNYDER: And as you said, is it correct that you'd need to change privacy laws and provide immunity as well?

MR. HOYT: Absolutely.

MR. SNYDER: Okay. Thanks.

CHAIRMAN GOGLIA: Okay. Up here to the Board of Inquiry. Elaine?

MS. WEINSTEIN: I have one question for Mr. Hoyt.

You mentioned that you do quarterly reviews of your fleet drivers. Can you give us the results of those?

MR. HOYT: This is one of the reasons why I think I continue to be amazed. We have in excess of 5,300 fleet drivers and another approximately 2,000 drivers that drive more than 2,000 miles a year and are reimbursed by the company and therefore, since they represent a significant amount of exposure to us, we run motor vehicle records on those individuals.

I never cease to be surprised that every quarter when we run those, we find between four and five individuals who've been arrested on a drunk driving charge. I'm, surprised because we are extremely proactive in providing information and education and all the rest associated with drunk driving. It's pretty indicative that there's a significant number of individuals who are wrestling with problems associated with alcohol, and I'm glad that at least as a company we have set things in place that encourage these drivers to go through an assessment and all of the other things that have to be done to assure that there are not dependencies and that if there are dependencies, that they are being addressed.

With regard to other findings, we have found a significant number of drivers who have other moving violations. We have on average somewhere at about two or three percent of our fleet drivers who we consider at-risk drivers and who we are following varying procedures with attempting to get them to modify driving behaviors.

Clearly, the objective there is that these are individuals who we've hired, who we've put out there to do a job for us. We've trained them. We have a lot invested in them. We value our people. We'd like to see them stay employed. We can get early intervention (by doing reviews of their motor vehicle records and loss experience) get early interactions between that individual's exhibiting poor driving behaviors and their supervisors. This gives us opportunity to avoid not a crash or something worse that would take them out of our employ and we'd lose their services for a long period of time. There are other losses associated with crashes involving at risk drivers that have huge financial risks and the like. So, proactivity in safety issues, we think, has had, we know has had a huge pay-off.

MS. WEINSTEIN: Have you seen a reduction in crashes?

MR. HOYT: Yes, we have. I have to be honest with you. We did not run a baseline study on this. When we got into it, the need was so urgent, that I didn't take the time to do a baseline study. We've simply used the two opening years of our experience as baseline experience. That was 1997 and 1998, as I

recall, they were two biggest loss years. That program continues today. As I say, we run motor vehicle records on our drivers four times a year. The loss reductions: we have reduced our crash frequency by more than half, and (at a three year cost which includes all of the administration costs of the program, motor vehicle record search costs and the costs of our event data recorder research, of somewhere around $800,000).

The pay-off has been that compared to our original years, we have seen over $3.4 million in loss cost savings. So, on a direct cost-benefit ratio, we are seeing a significant savings. If you include soft costs in addition to that, we're probably seeing between $10 and $25 savings for every dollar invested in the program.

MS. WEINSTEIN: Thank you.

I have no more questions.

CHAIRMAN GOGLIA: Dr. Ellingstad?

DR. ELLINGSTAD: I have no questions.

CHAIRMAN GOGLIA: Mr. Osterman? Raphael?

(No response.)

CHAIRMAN GOGLIA: Okay. Thank you very much.

We have a return.

MS. STRAIGHT: I'm sorry. I think it's important, since Ms. O'Gara was asked directly for AARP's policy on the basis for testing on an age basis for testing, that I clarify the record on that.

AARP supports functional assessment to identify those at greatest risk. We believe that there should be evidence of risk to trigger that assessment. We therefore do not oppose a functional assessment based on age where age is a predictor of functional impairment.

CHAIRMAN GOGLIA: Okay. Thank you.

I thank the panelists for their time and it was quite interesting today.

Raphael, will you prepare the next panel? Call the next panel?

DR. MARSHALL: Okay. The next session will be the last session of the hearing. It is entitled Public Policy, and Ms. Roeber is head of the Technical Panel and she will introduce the rest of the Technical Panel and its witnesses.

DR. COMPTON: Just give us a minute to change seats.

DR. MARSHALL: I'd also like to remind the party tables to please state their names and their organizations prior to speaking.

Thanks.

(Pause)

Public Policy

MS. ROEBER: Good afternoon.

We are getting situated. My name is Danielle Roeber, and I am in the Office of Safety Recommendations and Accomplishments, and I will be joined today on this panel with

Kevin Quinlan, who is also in the Office of Safety Recommendations and Accomplishments, and Dr. Jana Price, who is in the Office of Research and Engineering.

We're going to be finishing this up on a public policy discussion, kind of the big picture, how can we incorporate what people have said, what are their concerns and questions that would come up with some of the suggestions and comments that we have heard.

I do want to let everyone know we actually had a third witness, Jim Reed from the National Conference of State Legislatures. He is conveniently located in Denver which had its largest snowstorm in the last five years Monday night and Tuesday morning. So, he's unable to join us.

I have provided and you probably saw first thing this morning, he provided written answers to a draft set of questions that we had given all the witnesses, and to the extent that it comes up or applies, we're going to try to incorporate some of his answers in the questions. Everyone, as far as I know, has been given a copy of these. Keep in mind that the questions may have changed slightly, but it was good that he could give us these answers in any event. Unfortunately, what I can't give you is the opportunity to follow-up question him because he's not here, but this afternoon, we're going to go ahead and start with questions from Dr. Price.

DR. PRICE: Thank you.

I'd like to start by asking a very general question to the entire panel, and I'm going to do my best to briefly summarize the response from Jim Reed from NCSL once I ask the question.

As you know, the public hearing has included discussions of several crashes attributed to medical conditions, and for the first question, I would simply like to ask what are your thoughts, suggestions for reducing these types of crashes, and I'd just like to take a minute and just, very briefly however, give the responses that Jim Reed from the NCSL provided to that. He provided four suggestions which you should have, but I'm going to just read them briefly for the benefit of the audience members who don't have that information.

The first on his list was a set of unified state laws requiring mandatory physician reporting. As a state organization, NCSL believes that individual states have the right and prerogative to legislate according to each state's individual needs but also sees some benefit in uniform standards, and I'll just let you read the rest of that. It's very long.

The second suggestion was to encourage driving assessments for at-risk drivers, to consider the notion of impairment questionnaires where individuals that have to fill out questionnaires that address their potentially-debilitating conditions and those questionnaires could be developed by medical advisory boards.

The third would be subsidized alternative

transportation for drivers determined to have significant medical impairments, and finally, he suggested specialized training for elderly drivers. For example, he suggested the 55 Alive Mature Driving Course.

So, perhaps Mr. Calvin, we could start with your suggestions and responses to that question, also.

MR. CALVIN: Now? Okay. Thank you very much. It's a pleasure to be here today. We have -- actually, I have five areas that I've listed. I'll try to be brief with them.

The first is determining, establishing and maintaining medical standards. Second is advocating remediation. I'll expand on these after I go through the list. Determining best practices and how you use best practices. Continuing data collection and research and (5) being active in conducting training and awareness programs.

The initial one on determining, establishing and really maintaining medical standards, the Department of Motor Vehicles as well as the medical community need to know how medical and cognitive factors affect driving and what to do about it. AAMVA has a long history, and by AAMVA, the acronym is the American Association of Motor Vehicle Administrators. We do have a long history in this regard.

In 1980, we did work along with NHTSA to publish a Functional Aspects of Driver Impairment: A Guide for State Medical Advisory Boards. It was a document that was a part of

basically a series of guideline documents. We have a working agreement, a formal working agreement with NHTSA which we work on mutually agreed-upon programs that benefit both NHTSA and AAMVA and our members. We've published over 30 guideline documents over the years, basically dating back to the late '70s. So, we're very active in it, and I think it is very important when we talk little bit later on establishing best practices documents that would allow us to hopefully act upon establishing some sort of a level playing field from jurisdiction to jurisdiction.

More recently, AAMVA has contributed to the American Medical Association's upcoming publication on Physicians Guide to Assessing and Counseling Older Drivers, which I'm sure has come up during the course of this hearing, which is due to be published in late Spring.

With the help from AAMVA, NHTSA, I think the medical and research communities, the Department of Motor Vehicles throughout this country need to continue to refine the guidelines, so that we can make uniform and informed licensing decisions.

I believe it was mentioned yesterday, and I don't recall the name of the person that said this in one of the panels, but talked about setting a societal threshold for risk, and I thought that was a very interesting comment, a very interesting thought. If you go to the dictionary and look up the definition of the word "safe", it says absence of risk. Really and truly, when we start talking about, you know, in its purest sense, there

is no such thing as a safe driver. There are just different degrees of safe. Some drivers are safer than others.

I think it's important that we come to some sort of agreement on where we draw the line for defining that level of risk, both medically as well as human factors wise, when it comes to decision making and basing the decisions that a driver makes behind the wheel.

Advocating -- the second one. Advocating remediation, I think, is important. There is an option besides just saying yes, you get a license or, no, you can't, and that option is to take care of your condition and then, after you do that, there is a possibility that you can get your license or get your license back and that option is called remediation.

Counseling and interviews, I think, are important. I don't think we do a very good job of that on an individual basis within the states. It is expensive to do and it is very time-consuming to do, but I think that is an area where we can improve upon.

Determining best practices, the third item. Best practices are a tool for promoting uniformity. I've spent my whole life, basically working life at AAMVA, trying to encourage uniformity and thinking of ways that we can get some semblance of uniformity in our programs that we promote to our jurisdictions. We aren't a regulatory body. We can't make any of the jurisdictions do anything, but what we can do is develop model

programs, develop standards, which in turn are used to put together best practice documents.

The best practice documents then lend themselves to the development of model laws and policies which in turn, if promoted and used correctly by our jurisdictions, will help to start creating a level playing field. I like to use the term uniformity with flexibility and that normally gets a laugh, but we try to make it as easy as possible for people to follow, for jurisdictions to follow our model programs, and to do that in absence of a regulation, a federal regulation, you need to build in some flexibility.

Continuing data collection and research, I think, is important. Most of the people, when you think of the Department of Motor Vehicles, think of record keepers. We do do that and we do a pretty good job of that, but it is important that we continue to collect data and conduct research that can help in this area.

The fifth thing is conducting training and awareness and education programs. AAMVA has developed and established a Certified Examiner Training Program. We have over 4,000 examiners right now North American-wide that are certified. It has three components, soon to have a fourth. We deal with -- actually deals with the training of examiners, passenger vehicles, commercial vehicles, and motorcycle applicants, and these programs are part of our International Driver Examiner Certification Program or IDEC Program.

We're working on a fourth piece. It's called Examining Drivers With Disabilities. The program acquaints the examiner with the type of disabilities that may be acquired during an individual's life span. It does a number of things that we're excited about. It works with the examiner that comes in contact with the individuals that come in for testing that might have a disability. It helps make them familiar with and works with them on adaptive equipment. It also deals in helping them talk with, not necessarily interview, but to talk with and to interact with the individual. It's important that our examiners are aware of the various disabilities that they might come in contact with, that people have and might come in contact with, and to work with them.

I think sensitivity training was mentioned in the last panel. We don't call it that, but essentially it is awareness and working with the individual examiner in this regard. This program will become a part of our IDEC Program that will be available to states and state examiners, and you have to keep in mind that our examiners and the people that give our tests, that many of the clerks, many of the people that interact with individuals coming in our doors are some of the lower-rung people on the totem pole at the DMVs and training is very, very important to them and for us to do the job that we need to do, and we've made giant strides in the last 10 years in this area, but we do have a long way to go, and this particular program, I think, will go a long way to

helping in that regard.

So, those are five areas that I think we feel very, very strongly about.

DR. PRICE: Thank you very much.

Dr. Compton, would you like to address the same question?

DR. COMPTON: Yes. Thank you.

I'd like to just start by commending the National Transportation Safety Board for holding these hearings. I think the issue of medical oversight of noncommercial drivers has been a topic of interest to my agency, and I think this hearing has been very interesting.

Mike has actually stolen some of what I'd say. So, I'm going to be a little bit brief, I think, to not repeat things.

DR. MARSHALL: Dr. Compton, excuse me.

DR. COMPTON: Yes?

DR. MARSHALL: Could you pull your mike a little bit closer?

DR. COMPTON: Okay.

DR. MARSHALL: Thank you.

DR. COMPTON: Is that better?

DR. MARSHALL: Okay.

DR. COMPTON: Let me just state at the outset that, you know, my agency has no regulatory authority over noncommercial drivers. That's a state function. Essentially what we do is

conduct research and try to identify risks and causal factors that contribute to the occurrence of crashes, and we also try to conduct research to identify effective programs that can reduce or eliminate many of these identified risks.

As Mike said, almost virtually from the beginning of our agency, we have worked with AAMVA to try to improve licensing practices of the states.

In terms of the specific question, I'll just respond by saying I think there is room to improve the way we identify people at potential risk due to medical conditions and their treatments. I think there's room for improvement in how we assess these people who are potentially at risk, to identify those who are a threat to public safety.

There's also room for improvement in how we deal with them. As Mike said, it's not simply a case of denying a license or giving a license. As we heard over the last two days, the states vary considerably as to how they deal with people who have been identified as potentially at risk in terms of restrictions. I don't think we fully understand how effective some of those restrictions are.

Clearly, there is a need for better education and training of almost all of the parties that are involved in this process, starting with the physicians who deal with these people as patients. Probably there's a need for better training for the licensing officials. Law enforcement, as we heard, could use more

education and training in this area. They receive very little information on how to identify people with medical conditions that might impair their driving.

I think there is a need for more programs to counsel people who should restrict or perhaps cease driving. You know, the heavy hand of the state in denying a license isn't the only approach. There's ample evidence that many groups do restrict their exposure. They restrict their driving, and I think a lot can be gained by doing more in that area.

I'll stop at that point.

DR. PRICE: Thank you.

The next question is on a somewhat different topic. It's on funding, and I just would like each of you in turn to address the idea of, first of all, the amount of funding that's currently committed to medical oversight and medical issues in your organizations, and then, also, based on the descriptions you've heard today about -- and the suggestions that you've made just now on how the system needs improvement, what is your estimate of the kinds of costs and funding issues that are associated with these suggestions?

I guess Mr. Calvin, if we could start with you again. Thank you.

MR. CALVIN: As I said earlier, we do have a formal working agreement with NHTSA. Actually, it is a cooperative agreement. The bulk of the funds that we have to work in this

particular area come from federal funding through our cooperative agreement with NHTSA. In many cases, you know, it's not enough, but it is more than what we would have without it.

Right now, in our budget for the coming year, the focus is on a number of areas, in particular identification security, and this has kind of taken a back seat, whether that's good or bad, I don't know, but that happens to be the case. So, basically, what we're looking at are programs that we are working on jointly and cooperatively with NHTSA, where we receive funding from them.

One of the areas that really -- I mentioned identification security -- that really ties in with the topic here today and that is the movement of data and the movement of information. There was a discussion in the last panel on that very subject. We have a network, an electronic network that's in place right now on the commercial side of things. Our network is called AAMVAnet and is a pointer system, but it does allow information to be moved from one jurisdiction to the next electronically, but it is set for the commercial driver.

We are looking at and hoping, possibly through the reauthorization of TEA-21, to receive funding for a driver record information verification system, the acronym being DRIVERS, that basically would be the counterpart to this system that I've talked about for the commercial driver. It would be an all-driver pointer system that would include again the movement of records

and information from one jurisdiction to the next electronically.

The records, however, do reside within the individual states. We don't have a database of records, but we do, with the system that we currently have, we have the capability of electronically going from jurisdiction to jurisdiction to inquire about a commercial driver. There are a lot of loopholes, and I think primarily the loopholes are with the automobile, the regular passenger driver, and this system hopefully would close those loopholes, and it would quite possibly absorb the National Driver Register, Problem Driver Pointer System, and our Commercial Driver License Information System as we know it today, and I think it would lend itself to a variety of uses. It's not cheap, however, and we are looking in the terms of in excess of $70 million currently is request to put a system like this in place and to run it and that is without any biometric identifier information.

So, that is a big ticket item, but I think it is something that, when we're talking about moving of information and moving of data, can be beneficial to a variety of programs, this one included.

DR. PRICE: Thank you.

Dr. Compton?

DR. COMPTON: I'm going to give you the long answer rather than the short answer since the question isn't actually that easy to address in terms of how much funding we spend currently on the issue of medical oversight.

Let me frame it by saying we spend approximately $12 to $14 million a year on impaired driving. That's research and program activity. There are additional funds spent on maintaining some of our national databases that contribute to our understanding of impaired driving. Of that 12 to 14 million, 80 percent is probably spent on the problem of alcohol-impaired driving. It's clearly the biggest issue in impaired driving that we're facing in this nation. It's clearly understood. Over 17,000 people lost their lives last year in alcohol-related crashes, 275,000 serious injuries. I mean, that's a clear known problem. That's where the bulk of our resources go.

I would say somewhere between one to two million is spent on the general issue of driver licensing, our agreement with AAMVA. Some of that's spent on graduated licensing, looking at the younger drivers. Some of it's spent on older drivers. We do research in the impaired driving area. Again, the majority of resources go towards the alcohol-impaired driving problem. In this case, probably a quarter of what we spend is on other drugs than alcohol, illegal drugs, prescription drugs, and over-the-counter medications.

In terms of research, I would say something on the order of 500,000 to a million dollars a year are spent on things like licensing and medical conditions.

In terms of the future, I would anticipate, absent reauthorization legislation, that the funding available to us will

stay roughly the same. I wouldn't predict what Congress will put in our reauthorization bill.

DR. PRICE: Is it your opinion that -- if you had the ability to estimate how much additional funding would be needed to address some of the suggestions that you made, what kinds of estimates would you make or in what areas from those that you've outlined would you suggest that there would be needs for more?

DR. COMPTON: We could easily spend sums many orders of magnitude larger than are available to us on these topics. There's a tremendous need for research.

Now just to sort of make the record clear, we always like to cite that I think some 95 percent of transportation-related crashes occur on our highways, about 98 percent of all fatalities, transportation-related fatalities occur on our nation's highways. My agency, the safety agency, gets less than one percent of the funds made available to the Department of Transportation. We do what we can with the resources provided to us, and we direct those towards the priority problems that have been clearly identified.

DR. PRICE: Understood. Okay. My final question is also a very general one and it's directed to both of you. It has to do with evaluation. We've heard about many programs discussed today and in terms of public policy perspectives.

I'd like to ask you both what kind of methods should be used to evaluate the success of various programs designed to

address medical oversight of noncommercial drivers.

Mr. Calvin?

MR. CALVIN: Thank you.

I think the goal of medical oversight is to reduce crashes in which a driver's physical or mental impairment is a contributing factor. The Department of Motor Vehicles-related programs that we feel can impact success in overseeing persons with such impairments include some of the things that I have already mentioned, screening and assessment, assessing drivers which includes anything from visual screening at the time of renewal to conducting functional assessments, such as road tests, knowledge tests, or sign recognition tests, medical review process, conducting medical reviews which include monitoring medical reports, driver histories, to assess continuing or restoring driving privileges, referring individuals for training or remediation, restricting or customizing the license for the individual to keep drivers driving safely where possible, establishing renewal requirements, and establishing partnerships with the medical community, area agencies on aging and so forth.

How can we tell if each individual program is successful in reducing crashes? I don't know. I don't know if we can or not since occurrence of crashes is not in itself proof of critical impairment and any improvement or worsening of crash rates cannot easily be attributed to an individual program. I think it's a combination of things.

But with the slate of programs that I've mentioned, jurisdictions can monitor crash rates of subject populations and look for improvements, and I think that's what we try to do, try to do on a daily basis, to the best of our ability.

DR. PRICE: Dr. Compton?

DR. COMPTON: Okay. I guess in answer to your question, how would you evaluate these programs, it really -- I think there are a number of issues here. I think we need to better understand the risks involved with certain medical conditions and there are methods of determining relative risk.

There are also issues about how different medical conditions are being treated by statute, by regulation, by process, by the licensing authorities. There are clear differences between them, and I think it is possible to again try to relate these practices and procedures and regulations to outcomes, specifically crash involvement.

None of this kind of research is easy to do. There are complexities involved. Determination of the cause of crashes is rarely done. Most of the data -- we know involvement. We don't know exactly what the cause of the crash is. Normally something like the Safety Board that makes an actual formal determination of contributing factors really does not occur for most crashes.

Therefore, it's necessary to control for all sorts of things that can confound your understanding of the relationship.

Probably the Number 1 thing in this area is exposure and that means just how much driving a person does because the probability of getting in a crash is related to the amount of driving. There's all sorts of co-morbidity factors that have to be controlled for. Just simple demographic factors that are known to relate to crash risk, gender, age. There are environmental factors, rural, urban, suburban, different traffic patterns.

These things can all be controlled for. They add a level of complexity and they add to the expense of conducting this kind of research, but it can be done.

DR. PRICE: I'm going to add the comments that Jim Reed sent along, a few of them, and then I'm just going to ask a little bit of a follow-up.

He suggested from the NCSL's perspective that the possibility of performance audits that may be taken by state legislatures to mostly ensure that any given agency or program or department is conducting the types of activities that are authorized by that program, and the way I understand that is more of a check or an evaluation to make sure that the program is doing what it's intended to do, perhaps more than looking at the validity of that program in terms of reducing the risk of drivers on the road.

I understand that determining relative risk and some of these kinds of things would be fairly complex undertakings, but I also wonder if there's some way that baseline measures could be

taken when programs are started and tracked throughout their completion to -- as they progress to try to understand, for example, if drivers are being correctly identified for whether they should continue driving or whether restricting was the correct choice for those drivers and even furthermore perhaps surveying or talking to individuals that are affected by this to try to understand the cost-benefit of having somebody lose their ability to drive.

So, if you have any further comments on that, please feel free to add them; otherwise, I'll defer.

DR. COMPTON: I'll make a comment. I think you've heard mention of a study we initiated, actually I started about two years ago, as issues came up about how people with medical conditions were being treated in the different states, and it became evident that we really didn't even know how medical advisory boards and the different states were dealing with issues of people with these different medical conditions, and so we funded a contract which is being conducted in conjunction with AAMVA. They basically conducted a survey of all 50 states to document how people with medical conditions, you know, what the rules, regulations, procedures and not all states have medical advisory boards, and we want to understand how they deal with people with these conditions. We want to understand the composition of the board, whether they're paid, unpaid, how long they serve, how many cases they typically deal with and of what

type, what age, and how they deal with them, what sort of restrictions do they normally apply.

We're going to do a second stage to that study once this information, which is practically all in, has been assembled and analyzed. We intend to do some in-depth work in at least 15 states that sort of span the diversity of the practices of the states where we'll actually be paying visits to the states and talking to members of the medical advisory or review boards to get a better understanding of just how they're working.

MR. CALVIN: We've had all but three jurisdictions out of the 51 here in the United States respond to that survey. So, as far as getting responses back from states, that's excellent, and we hope to get the remaining three jurisdictions as well, and there is a list of basically 23 items that -- items of information or pieces of information that we're trying to get information on, and I can provide that. I know a number of them were mentioned, but I provide that to the docket as well, which really -- it's a one-pager, but it describes the information that we're hoping to obtain by this survey.

DR. PRICE: Thank you.

I'll ask if Mr. Quinlan, do you have any follow-up questions to my questions?

MR. QUINLAN: Yes.

Dr. Compton, if I understood you correctly, you said $12 to $14 million per year is spent on impaired driving or is

that impaired driving research and programs?

DR. COMPTON: That's impaired driving research and programs.

MR. QUINLAN: How much of that is research?

DR. COMPTON: About $1.5 to $2 million.

MR. QUINLAN: Okay. Thank you.

And Mr. Calvin, I was unsure. You said that you had an estimate of $70 million for the Driver Records System that you described. However, I didn't hear a funding level that you apply to medically-related licensing issues. Do you have a specific level?

MR. CALVIN: Within the association, particularly for this at the association level, no, you know, we do not. The programs that we work on, some of which I had described, are -- basically get the funding that we use through our federal partnerships, and of course, each individual state does spend and have funding for this on an individual state basis, but association-wide, we do not.

MR. QUINLAN: Thank you.

DR. PRICE: Ms. Roeber?

MS. ROEBER: Yes, I have two questions.

One is to both panel members. It's the hypothetical. Bear with me, I'm an attorney, so we deal in hypotheticals.

If someone tomorrow would grant you a certain pot of money, essentially unlimited, but where would you focus that money

on? You know, what one project would you ask them to focus that money on this issue, and how much do you think it would cost?

Would you like to go first, Dr. Compton?

DR. COMPTON: Okay. The one thing I would probably take as a priority is better understanding the risk associated with the medical conditions because that's the underpinning of all the actions that the licensing agencies take.

Risk and how one could assess that risk for people subject to that condition, because clearly for almost any medical condition, there are people who may have that diagnosis who can drive perfectly safely. So, it's not an issue of a diagnosis but assessing the risk.

How much would that cost? There are lots of conditions, and I guess, you know, ultimately, you'd want to understand the risk with all of them. So, I think it would cost a substantial amount of money. I mean, we're probably talking $50 to $100 million ultimately.

I mean, this kind of research would take years. It would be very complex and difficult, but it's doable.

MS. ROEBER: Thank you.

Mr. Calvin?

MR. CALVIN: I wouldn't disagree with Dr. Compton, but I think once we have done that work, get back to our jurisdictions being able to understand what the other jurisdictions are doing from state to state, and in our case actually from province to

province.

In Canada, in this driver system that I talked about would allow us to do that, and I would hope, I think in any program that we would put in place, that we would have the ability then to communicate from jurisdiction to jurisdiction, and this would provide us that opportunity.

MR. QUINLAN: I have a follow-up question for Dr. Compton.

The ballpark figure you gave of $50 to $100 million seems reasonable. Mindful of the very small budget that NHTSA has, what would be the appropriate agencies to fund this research besides NHTSA, and should it be a special provision in some federal legislation, perhaps HHS?

DR. COMPTON: Let me answer that by saying we always try to leverage whatever funds we have available by involving partners in our mission to make the roads safer. We've been working with the American Medical Association for many years in this area. We've worked with AAAM. They've just completed a very extensive literature review which Dr. Dobbs talked about yesterday morning. We work with various of the National Institutes of Health to try to get them interested in this.

In terms of a public health issue and injury prevention, a lot of people die and are injured in automobile crashes, and it has to be an issue on the forefront for a lot of other people than just our agency. So, we try to involve a lot of

people. I mean law enforcement has a role, and we try to provide information to them and training, education materials. That's why we brought Sgt. Ticer in this year.

So, we work with a lot of different groups to try to get them involved in this issue.

MR. QUINLAN: My question really goes to perhaps it's the reverse of your trying to get them involved, but it's a motivating factor for other organizations to get you involved because it bridges gaps between departments and agencies within departments, and there's nothing more motivating than a budget line item, and would you -- what would be a share between your two agencies, let's say DOT and HHS, of this 100 million?

DR. COMPTON: I'm not sure. I'm not really in a position to answer that kind of question.

MR. QUINLAN: Okay. Thank you.

MS. ROEBER: One more question for Mr. Calvin.

Does AAMVA have a committee or an internal grouping of the medical advisory boards? Is there some way for them to interact with each other and maybe exchange best practices or problems that they've run into?

MR. CALVIN: We have an active group actually which we call Driver Screening and Assessment. It is a working group that falls under one of our 10 committees under the Driver Licensing and Control Committee. This group basically deals with and looks at the medical review process.

As far as us having some sort of a group that focuses strictly on the medical review or medical advisory boards, we do not. However, you know, within the last 12 months, we have kind of reconstituted this Driver Screening and Assessment Group. We have participated with NHTSA and their contractor in the survey that Dr. Compton mentioned and that we helped with, and I think there is a need to coordinate an activity around the medical advisory boards, and we are looking into that right now.

The information that we get from the survey will help us, I think, in determining in many respects the direction that we need to go in that area.

MS. ROEBER: Thank you.

If no one else has questions, I'm going to turn it over to Mr. Quinlan.

MR. QUINLAN: Thank you, Ms. Roeber.

Again, I want to thank you for being here. You've been here a long time. I'm going to make this as brief as possible. I'd like to step back for a second and try to get some perspective.

Given the statistics that you heard yesterday in terms of population covered with the different diseases and what we may have heard today about the aging population in the United States, what is your understanding of the medically-related crash problem in the United States? Try to give it some perspective. I'd like to start with Dr. Compton.

DR. COMPTON: I'd love to be able to put numbers on it, but they don't really exist. Most of our data comes from police-reported crashes, and as we've already learned here, police do not have information about medical conditions that may have contributed to these crashes. So, it's basically that kind of information is not available.

Based on all the experience we have, I think clearly alcohol is our Number 1 problem. You rarely see crashes that can be attributed to these other conditions. In part, I think that suggests that the state licensing authorities are doing a reasonably good job of screening and assessment and dealing with these people.

Are there crashes due to medical conditions? Yes, I'm sure there are. We know there are. They're relatively few. I would say probably, if I had to -- and this is just a wild guess, probably we're talking five percent or less of all crashes, maybe two percent or less.

MR. QUINLAN: Okay. Thank you.

MR. OSTERMAN: Hold on. I just want to clarify that.

Dr. Compton, you believe that five percent of all crashes are medically related or attributable?

DR. COMPTON: Or less.

MR. OSTERMAN: Is that what you said?

DR. COMPTON: Or less.

MR. OSTERMAN: Or less.

DR. COMPTON: I was trying to put an upper bound on it.

MR. OSTERMAN: Right. And the question that I have --

DR. COMPTON: Could be substantially less.

MR. OSTERMAN: Right. The question I have associated with that is, is that because -- is that based on what you can see in the current statistics?

DR. COMPTON: Yes.

MR. OSTERMAN: Or is that with information beyond just what the statistics tell you?

DR. COMPTON: It goes a little bit beyond what the statistics tell us, but we're always confronted with the problem that if you don't look, you're not going to find it and that's not something that's typically looked for as a causal factor in a crash.

MR. OSTERMAN: Okay.

MR. QUINLAN: That said, Dr. Compton, one of our original questions was, should this issue be of concern to us and that implies resources and other programs that could be applied to this issue.

Should this issue be of concern to us?

DR. COMPTON: Yes. Most traffic crashes are preventable. I think there are things that can be done to prevent them, and I don't mean to belittle the issue of medical conditions. There are lots of medical conditions that can

potentially result in someone being unable to operate a vehicle safely, and I think, you know, improvements can be made in handling that. I mean, our goal is to eliminate virtually all crashes.

I think it has to be kept in perspective of known risks and one has to devote the appropriate attention to it.

MR. QUINLAN: Thank you.

Mr. Calvin, again what's your understanding of the problem as it relates to your organization, the issue of medically-related crashes?

MR. CALVIN: We know it's a problem. It is a concern of ours. Statistically, I would have to yield to Dr. Compton and his comments.

The responsibility, I think, to deal with this issue is a shared one, both with the Department of Motor Vehicles, law enforcement for sure, the medical community and the driver, the drivers themselves.

I think one of the big concerns that we have right now and that we're dealing with and our jurisdictions are dealing with in this regard is we are getting bombarded by countries outside of the United States that are wanting our jurisdictions to sign bilateral agreements that would allow them to exchange reciprocity of driving privileges here in the United States from wherever they're coming and that is -- I think it compounds the problem that we're seeing, at least domestically, here in the United

States and probably throughout North America, and we are dealing with that particular issue as well on a number of fronts, particularly working closely with our sister organization in Canada, the Canadian Council of Motor Transport Administrators, with the EU countries, European Commission as well, in trying to help educate our individual licensing authorities in this area.

So, I think it really is a problem that does go beyond the boundaries of the United States and some people say, well, we have our problem here and we shouldn't be dealing with other countries, but we're being confronted on a state-by-state basis almost daily from other countries, and medical conditions of drivers that are coming into this country causing crashes is a problem in that regard as well.

MR. QUINLAN: Thank you.

I'd like to recap very quickly Mr. Reed's comment in regard to whether this is an issue of concern. I think the first sentence is most telling, also the last. It says, "Yes, it's a concern but an independent study of the extent of the problem is needed beyond the anecdotal incidence." He goes into more detail and identifies NHTSA as a source of funding for such a study and as well as a resource for statistics, and I think we may have identified some difficulties with that statement that perhaps we ought to look at in terms of the larger picture.

I'd like to move on to state laws, a subject near and dear to my heart because it's part of my job. We've heard about

different state laws licensing people with -- licensing or not licensing people with the same condition, and I believe, Mr. Calvin, you talked about the difficulties there.

I'd like to move on, rather than talking about licensing and enforcement, because I believe you've addressed the issue. Mr. Archer from NCUTLO mentioned this morning about the need to standardize, and in that regard, is there a need to standardize state laws? What would the elements of a state law be or a model law, and how is this best accomplished? I'd like to start with Mr. Calvin.

MR. CALVIN: As I said earlier, I've worked basically my whole working life with AAMVA in trying to put together programs, model programs that would create or help the uniformity and interoperability issue from state to state, province to state and province -- state to province. So, I do think there is some benefit in establishing some standards. That word is misused quite often as well and there are several different meanings for that word, but I talked about best practices. I talked about model laws being made based upon best practices. I think that is something that probably needs to be done, and what is the best way to go about doing that?

I mentioned uniformity with flexibility earlier. I saw some smiles, I think, out there with that. But I think short of any federal requirements, federal legislation, federal mandate, which right now I would not be for, that we need to establish and

work towards establishing as many of these model programs that we can around this particular subject that would lend itself to best practices and be able to promote that within the jurisdictions and build in some flexibility. Trying to get a hundred percent uniformity, a hundred percent of all state laws to look alike and be the same in this regard is virtually impossible, but to have a common goal and to set our sights on an area that we're working toward and then try to build programs around it and promote it, short of mandates, I think, is the best way of going about doing this. We've done it in a number of different areas before.

Graduated licensing is an area that we've been very active in and trying to promote some semblance of uniformity, based upon model programs that were developed. Is it fool-proof? Can you get a hundred percent participation? No. But with a plan and working towards that plan and building in some flexibility, I think we can make inroads in this particular area.

MR. QUINLAN: The second element of the question was, what are the elements that you believe should be in a model law? We have heard discussions of mandatory reporting versus not having mandatory reporting. Could you address that?

MR. CALVIN: Yes. Again, states that we represent and that I represent, that the association represents, it's very difficult to find any two states that do anything alike. Having just said what I said earlier, it is an uphill battle.

Many of our states or a number of our states have

mandatory reporting requirements. Many don't. I think I can see benefits there for the mandatory reporting requirements. I think there are some drawbacks as well. I think there is research that needs to be done to fill out the list, I guess if you will, of these elements, and other than that, Dr. Compton, he might have a list, but right now, I don't.

MR. QUINLAN: Actually, the question goes to you next, Dr. Compton, anyways.

So, could you address the need for a standardized law or a model law, what elements might be in there, and how it could best be accomplished?

DR. COMPTON: I guess I would respond by saying much as Mike did. I think greater uniformity has some benefits. I think we've heard some things during this hearing that would perhaps suggest somewhat greater uniformity would be appropriate.

Generally, the conditions on which a state denies someone license is that they present a risk to public safety on the road, and they have to identify an essential eligibility requirement, I guess, to use a legal term, that presumably is based on solid evidence, and one presumes the evidence speaks fairly clearly. There should be some consensus on it. So, a couple of examples that I've just observed today, you know, the dealing of loss of consciousness and how long someone should be seizure-free. I don't think that should be a matter of opinion, should not be subjective. I mean, a few states have it enacted in

statute, others have it as a matter of policy or procedure, but there aren't five right answers to that question. So, to me, that raises an issue.

In the same sense, how you would deal with some of these conditions. Most states attempt to allow someone to continue driving as long as possible safely. They may limit restrictions like within, we've heard, 10 miles of home or 25 miles of home, but I heard one or two witnesses say if the person can't drive safely, I don't care if it's five miles from home or 50 miles from home, either they can drive safely or not. So, again, it's not clear that both of those approaches can be correct or can reduce risk to the motoring public equally, but we don't have clear answers to what is the best practice, what does reduce risk. So, there's a need for more research.

I can't propose to you a model law without knowing the efficacy of these approaches, and we don't know that yet.

MR. QUINLAN: Thank you.

What you're saying, as I interpret, then is it's premature?

DR. COMPTON: Yes.

MR. QUINLAN: A model law is premature. Therefore, I know Mr. Calvin's already addressed my next question, which was, state laws versus a federal law. Without getting into agency positions, what would be more advisable from your point of view?

DR. COMPTON: I think experience has suggested where

voluntary guidelines are based on clear evidence of effectiveness, they are typically adopted. Most states are trying to do the best possible job they can to protect their citizens on their roads and to prolong driving. So, I think if you present them clear evidence of a good approach, a practice that's been shown to work.

You know, ultimately, a lot of this involves some sort of regulatory activity, whether at the state level or even at the federal level, and it has to be based on good science, either way, and if the science isn't there, it doesn't matter. It's not going to work either way any better.

MR. QUINLAN: Thank you, Dr. Compton.

Mr. Reed had a somewhat similar view. He said, "Some uniformity of state laws, particularly regarding physician reporting, may be desirable. NCSL recommends against a federal law mandating the states to do something", and he also supports a working group approach which begs the question of who's going to call the first meeting.

That concludes my questioning. Dr. Price, do you have any questions?

DR. PRICE: No, I don't.

MR. QUINLAN: Ms. Roeber?

Thank you.

MS. ROEBER: Let me play clean-up, and I'm going to start off with probably a precarious question.

Is a driver's license a right or a privilege? Gee,

which one of you would like to jump on that one?

DR. COMPTON: I'll give you a short answer. It's a privilege. I think most states would treat it as a privilege. There's no federal right to drive, and I don't think most states consider a person as having a right.

MR. CALVIN: Do I believe it is a privilege? Yes, very much so.

MS. ROEBER: With that in mind, how does that affect your decision making, recognizing that you may not have all the research you want, but this kind of ties into a question about due process and what due process people are entitled to when they have medical conditions? Mr. Calvin?

MR. CALVIN: Each state, as we said earlier, goes about it in a little bit different fashion, but they do have different processes and procedures for protecting the rights and offering recourse for medically-disqualified persons, and certainly if a person is reported to be a danger to himself or others, a DMV may suspend the license immediately and then investigate to determine whether it's safe to restore the driving privilege. The investigation may include a driver interview, review of the driving history of the individual, review of the medical history and/or referring the client for medical evaluation, and conducting functional assessments, such as road tests, the knowledge test, sign test and so forth.

I think due process for medically-disqualifying a

driver would include having DMVs document why the driver has been disqualified and providing such documentation to the driver in writing. If a person is medically disqualified, the DMV and/or the physician should suggest that the client seek training or remediation, where possible, so that their driving privileges might be restored.

There are appeals processes that are built into the whole system. Obviously a decision to medically disqualify a driver is not taken lightly by the DMVs, but things can change. Medical conditions sometimes improve and impairments are sometimes remediated. Provided that lapses of consciousness or control, use of alcohol or other medical factors are not a continuing concern, an individual should be allowed to demonstrate their ability to drive safely and that would be a part of this due process.

If there's still a disagreement, then we do leave it to the state's discretion to implement an appropriate appeals process which they do, which could include a legal appeal. As I said, each jurisdiction's program process is a little bit different. I think this is another area that it would help to work towards some semblance of uniformity or have some sense of the direction that we want to go as a group and then work towards promoting that within the individual jurisdictions.

MS. ROEBER: Thank you.

To kind of summarize, your response is very similar to Mr. Reed's, that he pointed out the driver's license is a property

interest that does entitle you to some due process constitutionally protected, similar to what Mr. Compton mentioned.

That pretty much answers all the questions I have. I guess I would ask the -- is there anything else you can think of that you would want to add before we go to the party tables? No is a viable answer.

Okay. Any questions? I'm sorry. In that case, the Technical Panel is done at this time.

CHAIRMAN GOGLIA: Okay. Since we've been at it for just a few minutes short of two hours, why don't we take a facilities break? Let's come back at 4:00.

(Whereupon, a recess was taken.)

CHAIRMAN GOGLIA: Thank you.

Okay. Lori, you can lead off the questions.

MS.COHEN: I have no questions. Thank you.

CHAIRMAN GOGLIA: Okay. Thank you.

MR. ARCHER: Two questions, one for Mike and one for Dr. Compton.

Hi, Mike. I was struck very much by your conversation where you talked about the need for uniformity but flexibility and some smiled but most didn't. I think most people didn't because actually that's probably a pretty politically-savvy remark in the context of all this can of worms kind of situation.

It strikes me, also, that, as it happens, I was pretty involved in the graduated licensing thing, particularly the

development of a model law that ultimately was endorsed by a number of organizations and in some substance or other has been enacted in a number of places, and at the beginning, when we got involved in that, a lot of people told us the same thing, you know. You sit down and you get 80 good suggestions but nobody would agree with anybody else, that kind of thing, and at some point, we decided are there any minimum things that everyone can agree, a consensus that must be in the model law, and we came up with two things with graduated licensing, and one was that you had to have some kind of restricted license and you couldn't call it that, and the second thing is when you had a restricted license, you then had to have some kind of limit on night-time driving for that restricted licensee, and then later on, as these things evolved over time, you began to have limitations with respect to kids in the car besides the driver.

But anyway, the point was, we had two minimum requirements and then we had a laundry list, very long, of possible things a state might do and in a way that hopefully that's drafted so it would be a good practice way, and I'm wondering, would that type of approach work in this area? If you sat down with a lot of people and said, what would you have to do, and everyone would agree you should do it, we call those minimums, and then everything else is sort of a laundry list of recommendations of language if but only if a state would want to do it?

MR. CALVIN: Thanks, John.

Yes, I think that the programs that I have worked on over the years with the association, with the states, and as I said earlier, in trying to get jurisdictions to adopt model programs, best practices, so that we can strive toward uniformity in different areas, that's how we went about it. We'd sit down with a working group, with a committee, whatever you would want to call it, and come up with those core items.

I think in this case, we talked about concerns earlier, concerns are shared and there are a number of organizations, number of individuals that need to be at the table, you know, to do that very thing. But I think, you know, short of some sort of a federal requirement or mandate, that's the way to go about attacking this problem and not only this but other areas as well that we deal with to get results, and we've had pretty good results when you put your mind to it and you get people at the table, and where there is an understanding that there is going to be some semblance of flexibility that would allow -- that wouldn't pitch in the whole states and require them to do to the letter, but where the end goal, where that end core item, let's say, whatever it might be, there might be a couple ways to reach that. Maybe two or three ways, I don't know, but the key would be to build in some flexibility but maintain the focus on the core items.

So, yes, I would agree with it.

MR. ARCHER: Thank you very much.

One other question for Dr. Compton. I was also interested in this whole debate as to how much impaired, medically-impaired driving, what does that relate into causation, whether it's five percent or less than five percent, and no one knows, and if you can study that, you indicate you probably could, then God bless because that's a struggle, but I was wondering, do you think that part of the problem that makes this so difficult is the whole issue of multiple causation; i.e., if you get into this situation where you've got somebody that's taking a drug for perfectly valid medical reasons, but in some way that interacts with alcohol, so that the person's had two drinks that normally given their body size would not be an impaired driver, that person might in fact become impaired.

It seems to me that that's one thing that complicates this and makes it more difficult, and it also seems to me, to give you some anecdotal suggestions that I've had from more than one member of the trial bar, is that if you are in any way involved with drugs and you're about to be pulled over by the police, the fastest way to avoid it is to take a drink, just a couple sips. If you're under 21, routinely what will happen is that you'll be charged with violating the under 21 mandate of complete temperance, and so the effect is that you avoid the larger charge, and I think that that -- those kinds of things, while they're incredibly hard to document, are things that muddy the waters and

make record keeping difficult, particularly in light of the fact that in the real world case, the cop is really concerned about things like getting the traffic moving and protecting the injured and that's right, but I just was wondering to the extent you would agree or disagree with that and if you had any comments about that.

DR. COMPTON: I have some comments about that, yes.

Let me respond to your first issue and that is, that most crashes do involve multiple contributing factors. Actually, there is something I just would like to put on the record. From the study of traffic crashes, very few are actually due to a person's inability to operate a motor vehicle safely in the sense that they can't control the basic functions of their vehicle. Most crashes involve bad judgment, risk-taking, impairment, and I think it's one of the drawbacks of sort of a functional ability approach to determining if someone can operate a motor vehicle. Even novice drivers who are 16-year olds very rapidly learn to control the motor vehicle, and as someone else mentioned, they have probably the highest crash involvement rate of any group. It's not due to an inability to control the vehicle, it's due to poor judgment and risk-taking, and yes, many factors are often involved in a single crash that contribute to it, inattention, distraction, various degrees of impairment.

The specific issue you were raising about, you know, some of the difficulties law enforcement faces, I think those are

real. We have information, for example, that repeat DUI offenders often will feign injury if they're involved in a crash simply because they know that when the police respond to the scene of a crash, the first priority is probably attending to any potential injuries, then EMS responds and transports those who may be injured to the hospital, and in, I would say many if not most, jurisdictions, their chances of prosecution drop when they're transported to the hospital.

We've done some research and in fact have shown that very few impaired drivers who are transported to hospital ever get prosecuted, and there's a variety of reasons for that. I mean, as we heard other people testify, some hospitals, they don't do a test for alcohol. There's problems with payment because of contributory negligence. In many jurisdictions, people at the hospital emergency departments don't want to share if a test is done with the police because they don't want to get involved in a legal matter.

Traditional law enforcement approach to impaired driving, you know, when they make an arrest, they see someone driving in a suspicious fashion, they're typically violating a motor vehicle law, they give an appearance of impairment, they pull the person over, they speak to them through the car window, they gain a reasonable suspicion that this person may be impaired by alcohol, they'll invite them outside of the car, they'll conduct field sobriety tests. They will establish probable cause

that the person is driving under the influence of alcohol. That is a requirement to perform an alcohol test. An alcohol test has been deemed by the Supreme Court to be a search and in order to do a warrantless search, they must have probable cause.

An officer that appears at the scene of a crash has not seen the person driving. They often may not even interview the victim if they're carted off to the hospital. So, where is the probable cause in order to get a subpoena, to have a BAC test done? It's very difficult.

MR. ARCHER: Right. Thank you very much.

I just -- I should clarify that. When I was talking about this zero tolerance statute, the reason why that's such a trigger is that all you have to do is find out that the kid has been drinking at all and it's an easy slam dunk kind of conviction and everything else is more difficult. So, what happens is you get that easy conviction and that's the end of it and sometimes that's difficult because it could be masking some other problems that never arise.

Thank you very much.

CHAIRMAN GOGLIA: Advocacy Group I?

MS. STRAIGHT: Mr. Compton, I just want to say I've worked over the years with personnel at National Highway Traffic Safety Administration as from the Public Policy Institute at AARP, and I have found the folks there helpful and positive and really very interested in this whole recognizing that age is an indicator

of the possibility of a problem but not the cause of accidents and that's been -- I want to say that I appreciate that attitude from NHTSA.

I think, I hope, I misunderstood you. Did you just say that you have a problem with this functional assessment approach to driver testing or using that as a way to reduce crashes?

DR. COMPTON: I think there are grounds for improvement in testing drivers to determine whether they're safe to drive. Our ability to predict who is likely to get in a crash, based on any sort of screening or assessment protocol, leaves a lot to be desired.

We've funded research and we will continue to fund research in this area because there's a clear need for improvement in that area.

MS. STRAIGHT: This is addressed to Mike Calvin.

Are you aware and could you talk a little bit about the new statute in Oregon and say does AAMVA have any feelings about that as sort of a direction for driver regulation statute? If you're not, you can say no and I'll just -- okay.

Just for the record, it is in James Reed's responses at Number 4, and it's the Oregon Medically At-Risk Driver Program, and I hope everybody will take a look at it because it was developed with sort of a consortium approach. Many people had much input and a lot of professional expertise and it looks like

something that AAMVA might want to be looking at for -- to assist other states as they approach this, if the states will turn to AAMVA for help.

MR. CALVIN: Oregon through the years has been very progressive in this area and many others. I mentioned earlier about the one-on-one interviews, conducting hearings and being able to conduct interviews.

We worked with Oregon a couple of years ago. Actually, it was in a driver improvement area, but they had developed, along with the States of Washington and California, a training program that would help hearing officers and examiners in helping them to conduct interviews and hearings, and we made that actually kind of a cornerstone of our training at the time for various jurisdictions around the country, of which again worked hand-in-hand with NHTSA in that area. So, they have been very active, and we do deal with Oregon quite a bit, although we haven't in this area.

MS. STRAIGHT: Would you say that the training should be a public policy training of personnel that works on this issue in the motor vehicle administrations, should be a high priority, public policy priority?

MR. CALVIN: It is very expensive and very time-consuming. I will preface my remarks, you know, by that, and where -- does it need to be a part or should it be a part of any program? I think certainly when you're putting together and

you're talking about, you know, what we should have, yeah, I think it is. I think that is important.

Being administratively feasible to do right now, given the financial climate within a lot of states, it's problematic, but yes, the concept and the training, the one-on-one approach, but getting to the practitioners, the people that are dealing with this hands on on a day-to-day basis, they need that, and we would support that and do support it, but we run into problems again with funding and with priorities within the individual states.

MS. STRAIGHT: Another issue that's come up as far as public policy goes during this is the interval at which people come in for renewal, both the interval and whether they come in in-person at all.

Does AAMVA have a take on that?

MR. CALVIN: Actually, we do. We have a policy. It's been on the books for a number of years. I said earlier we aren't a regulatory body and we can't make jurisdictions do anything. But yes, we would like to see ideally everybody every four years in the office at least, and for many years, I mean, that was kind of the norm, a four-year renewal cycle, and people coming into the office, so that they could be seen by an examiner.

In the last, let's say, five to 10 years, where budgets have been tight, states have been asked to do more with less, trying to cut down on lines, in many states, field offices are closing or being consolidated, states have looked at

alternative ways. They've gotten creative on how to renew individuals, and what we've seen, and you're probably all aware of this, is that renewal periods are going up. They're not stabilizing. They're not going down. They're going up, and various means are being used, various different technologies, whether it's the Internet, kiosk in a mall, ATM-type machines, that sort of thing, and that's compounded by the fact that there are many, many other programs that are being shoved down the throats almost of the DMVs that aren't driver-related, that are really outside the scope of their business.

So, even the definition of the business that the motor vehicle agencies are in is being reshaped by a number of things. So, yes, we do have a policy. Most jurisdictions have gotten away from that for a variety of reasons, a lot of them financial, you know, in the last, say, five to 10 years. A lot of states now are going to five-year cycles, some eight, some 10. In the case of Arizona, they, for all practical purposes, have a lifetime license where you have to come in, I believe, every 10 years to refresh a photograph.

So, really, the trend right now is going kind of the opposite direction that we would like to see, and this comes into play in this ID security area, you know, as well. We're grappling with that now.

MS. STRAIGHT: Thank you very much.

MR. COHEN: Hello. I'm Perry Cohen from the

Parkinson's Disease Foundation.

I don't really -- I have more of a comment than a question I would like you to respond to, since we're at the conclusion stage here, I think.

From what I've heard and seen, there's no -- although there's evidence of impairment with, say for example, Parkinson's Disease, there's not -- I don't think there's any evidence that it causes a great deal of motor vehicle accidents because of probably, due in part, large part, because the patients regulate themselves to some extent or perhaps it's not picked up on the records or something.

I think that that doesn't mean there's no role for public safety here because I know patients are interested in getting information and making the determination of should I drive, shouldn't I drive, when should I drive, and help from medical advisory boards and doctors and the whole system would be beneficial.

So that, the medical approach, I mean, states, I guess, differ from each other in the extent to which they take a medical public health approach versus, I don't know whether the other approaches would be termed maybe a little less user friendly, that the medical approach, if there's anything that was uniform, it would be more of a philosophical issue of trying to help the patients and help the public safety and using the medical approach, and in that regard, the voluntary health organizations

could contribute to this public health effort by getting the word out to our members and getting the AARP guide, updating it or supplementing it, where necessary, using the Epilepsy Foundation Guide to State Licensing Agencies to -- for people to know what they're dealing with in their own states, and we would like to play that kind of role because there is a need for this kind of information, and so I would like to get your reaction to that conclusion from -- that I've drawn from this two days of intensive information overload.

Thank you.

DR. COMPTON: I'll go ahead. I'll make several comments in response to your statement.

Let me comment first on you raised the issue of self-regulation and there is evidence that many people who are suffering deficits from a variety of causes do in fact appear to self-regulate. They limit their exposure. They reduce their driving typically at night time and in congested locations and roadways, congested time of day. They often stay off of high-speed roads.

I think for the one group where there's a real issue about their ability to self-regulate are those suffering from cognitive deficits and dementia, where there's some evidence they're not as good at self-regulating.

So, the second issue you raised, I guess, was of better awareness, and I think you'll find no one disagreeing that

there's a lot more that could be done to educate people, and I wish my agency had all the resources in the world so we could, you know, provide funding to do that but we don't. We are willing to work with most agencies that would like to help in that regard.

MR. COHEN: I understand that there's going to be a report from this conference or newsletter article that we could drop into our newsletters, and I'd like to encourage that to come out as soon as possible.

DR. COMPTON: From this hearing?

MR. OSTERMAN: Well, that's to me essentially, not to you.

Yes, we will provide a series of suggestions for articles for your periodicals and publications after this hearing. I don't think we've mentioned that to everybody at this point.

MR. FLAHERTY: Gerald Flaherty, Alzheimer's Association.

To Dr. Compton. We heard earlier about an insurance industry study indicating that less than 50 percent of police stops at sobriety checkpoints fail to identify alcohol-impaired drivers.

If that's the case, might it be even more difficult for police to identify a crash triggered by a medical condition? The second part of that question, of course, is, if there were better data, would that five percent or less estimate that you gave earlier for medical causes of crashes significantly rise?

DR. COMPTON: I think the law enforcement case is a particular challenge in trying to identify medical conditions that may have contributed to the cause of a crash. Essentially that information would probably have to come either from a physician, from some sort of medical record, and I think because of the privacy issues that's very problematic. It's an uphill challenge. They don't typically ask those questions. They don't investigate. So, I think you'd probably do a little bit more.

Of course, the fact that someone suffers from a medical condition would not necessarily mean that it contributed to a crash that they got into. People can be innocent victims of others or can get into crashes for a lot of other reasons. So, yes, I think it would be very difficult.

My five percent or less was speculation clearly. There's no data. So, it could be less or more.

MR. FLAHERTY: For Mr. Calvin. We heard yesterday some conflicting reports about the effectiveness of testing functional ability cheaply and in an unbiased way. One of the afternoon -- some of the afternoon testimony came from Dr. Soderstrom about a project in which Dr. Raleigh is working with the Maryland Medical Advisory Board. It's a test called the Functional Capacity Test. Others asked questions about it. Apparently it's a 15-20-minute test that can be conducted by staff at Registry of Motor Vehicles according to Dr. Soderstrom in an aside conversation I had with him.

Given the trends that you've talked about with regard to the economy and the difficulty of spending any more money on driver evaluation and assessment, would this be something, this sort of test that would be unbiased by age or diagnosis, well, relatively by age but certainly by diagnosis, would that be something that the Departments of Motor Vehicles might adopt uniformly?

MR. CALVIN: It's something that we have certainly talked about and discussed, you know, over the last several months, several years. I think administratively right now for DMVs to implement such a test would -- there would be some difficulty, I think, in doing it, not performing or doing it, but just getting it to the point where they would make a decision to do, you know, the test or put a program like this in.

The first thing that goes or the first thing that is cut in our agency and probably in many others is the training, it's the training piece, and we're fighting that now. I've worked with Dr. Raleigh a little bit, my staff has as well, and I think that we believe in the test that you described, but getting it implemented is a different story for us right now.

MR. FLAHERTY: Thank you.

MS. ENGLEHARDT: Christin Englehardt, American Sleep Apnea Association.

A few issues in this public policy arena to raise, and I'm sorry Mr. Reed got snowed in because I would like to ask him

about NCSL's stated support in its submission for mandatory reporting which the ASAA wants to go on record as opposing.

We don't think the diagnosed and treated should be reported because that will lead to fewer people being diagnosed, when the undiagnosed are a greater risk to public safety, not to mention the fact that most fall-asleep crashes are more likely to be caused by people who are sleep deprived, not sleep disorders treated or not, and I'm curious to know what the panel thinks about -- it's not a medical cause, but it's a common cause of crashes, the non-alcohol-related crashes, and if the panel thinks that there's anything that NTSB can do about reducing sleep-deprived and circadian rhythm crashes. First question.

DR. COMPTON: I guess I'll respond by saying we are aware that sleep disorders and sleep deprivation do play a role in crashes. There have been estimates of up to 18 to 20 percent of crashes may involve people with sleep deprivation. It seems to be a particular problem for certain types of individuals.

MS. ENGLEHARDT: Young males.

DR. COMPTON: Young males, yes. Shift workers and some others.

MS. ENGLEHARDT: Hm-hmm.

DR. COMPTON: Unfortunately for the sleep-deprived, the best antidote, of course, is to get some sleep, get off the road and get some sleep, which is not necessarily an easy sell.

MS. ENGLEHARDT: I agree.

DR. COMPTON: And yes, it interacts with other things. It interacts with central nervous system depressants, alcohol and medications that tend to be sedative in nature. This compounds the problem for those who are sleep deprived.

MR. CALVIN: I've been involved in this area, basically in the commercial area, with truck drivers, and I know that it has been studied and continues to be studied. The Motor Carriers Safety Administration has been involved with this as an association and in working in this area, we've done very little of any work in sleep deprivation, sleep apnea and so forth.

MS. ENGLEHARDT: I think it's a larger societal issue, but I'm going back to the sleep disorder issue. Our concern about mandatory reporting by chronic diseases, it's not supported by current data showing the efficacy of medical oversight boards, the known variations, the severity, plus we also don't know which patient's more likely to fall asleep at the wheel. There's the likelihood of discrimination and punitive outcomes based upon problems with access. There aren't sleep centers everywhere. There aren't home studies available everywhere. You need parity in mind-disease states and there could be over-reporting and over-testing by certain -- by multiple providers if the patient's being seen by different physicians, and there's some concern, we're starting to see now, too, and I'm curious about the panel's opinion on this, is that there's actually too much testing, when we don't know what the validation of those testing requirements

are.

There's the maintenance of wakefulness test and the multiple sleep latency test and CPAP machines that actually monitor the compliance and how often someone's using it and how effective it is, and should the medical board actually require these tests? Should the physician require these tests when we don't know if they're valid, when there's an issue with access and cost issues?

DR. COMPTON: We have not taken a position on mandatory testing. So, I really can't comment, other than to say that most of these testing procedures have not in fact been validated as relating to risk.

MR. CALVIN: We, too, have no formal position on mandatory reporting. We have a number of states that have that requirement, a number that don't, but we do have no formal position nor will we probably ever have one in that area, as I see it now.

As far as the validation, I think in the research, I think there is a lot lacking and a lot more that needs to be done before we would even entertain maybe coming out at least with some formal policy to include the mandatory reporting.

MS. ENGLEHARDT: Thanks.

And another similar related concern that we have, that sleep apnea is very common. As you saw in the slide yesterday, it affects millions of people, but at least 80 percent of them are

undiagnosed, in part, because physicians don't always recognize it. They weren't taught about it in medical school and they don't have time to actually assess for the presenting symptoms and the risk factors, and how do we expect physicians to be able to counsel their patients about driving privileges with sleep disorder breathing when they can't always diagnose and treat sleep disorder breathing?

DR. COMPTON: You're calling for more training and education of physicians, and I can't really comment on that.

The only thing I could add is, you know, the role of sleep disorders and sleep deprivation in causing crashes may be another case of under-reporting. When a police officer responds to the scene of the crash, if the driver is unconscious, she or he is wide-awake by the time the police get there. It's difficult for them to develop evidence that the person, you know, had a loss of consciousness, other than just the physical characteristics of the crash that someone drove off the road.

MS. ENGLEHARDT: And sometimes you can reconstruct them, especially if it's a commercial driver, you can see errors in the log books and so on, but I want to point out that a loss of consciousness is neurologically different than falling asleep.

DR. COMPTON: Yes.

MS. ENGLEHARDT: So.

DR. COMPTON: But the position of an officer investigating a crash, trying to determine what went on right

prior to the crash, is very difficult.

MS. ENGLEHARDT: I agree, and I think that is why they are under-reported.

This is my last comment. We obviously support more research in this area because I don't think we know the answers to what will make our roads safer. I mean, we don't want people who are sleepy driving, but we also want regulations written so that people aren't afraid to be diagnosed and treated, especially when there is evidence that the treatment normalizes their risk.

Thanks.

MR. FLAHERTY: I would also just restate more for the record than anything that the Alzheimer's Association position vis-a-vis mandated reporting is that it runs the risk of inhibiting early diagnosis and treatment, especially as we develop new methods of identifying people earlier and earlier in the disease process.

Thank you.

MS. WARD: Julie Ward with the Epilepsy Foundation.

I, too, have to state that the history of epilepsy as a condition that has been singled out for reporting and for automatic restrictions is a very long history and one that may actually help guide some of the discussions that we've heard the last two days and the policy that might be developed.

We have opposed mandatory reporting since, I believe, 1974 and have spent considerable time and energy trying to turn

this around in states. There are still, of course, the six states that require mandatory reporting. We embrace self-reporting as better medicine, as better compliance with the law as a more reasonable way to allow for determinations based on individual situations.

People with epilepsy, it's especially difficult in light of the data that documents that accidents for people with epilepsy are statistically very small in comparison to other conditions that are much more likely to cause traffic accidents.

We are not aware of any evidence that mandatory reporting of the diagnosis has improved safety. In fact, we may have some anecdotal evidence to the contrary. My intent was to ask Mr. Reed what evidence he has to support that it improves safety and will ask the other panelists if they're aware of evidence or studies that we may not be aware of.

MR. CALVIN: I'm not.

MS. WARD: The studies regarding mandatory reporting improving safety.

DR. COMPTON: I'm not. I'm not aware of any good research. There are pros and cons on both sides.

MS. WARD: I did want to ask a follow-up question to Mr. Calvin regarding the movement of records electronically, the proposal that was discussed in conjunction with the possible reauthorization of the Transportation bill.

I would assume that that may help get at some of the

issues of when people move from jurisdiction to jurisdiction, that their medical information or their licensing information does not move with them. Is that the intent to deal with that issue, and how have you dealt with the privacy concerns around that kind of electronic availability or database that might be developed?

MR. CALVIN: Well, there is no and there would be no central database. It would simply be a pointer-type system. The data resides in the individual jurisdictions and would remain there. What we're talking about would be -- and actually, to give you an idea on the commercial side of things, the commercial driver license information system, when an individual comes in to apply for a license, there is a CDLIS check that is run and that would point to another jurisdiction, if there was a possible hit or hit that that individual had a license in that jurisdiction, and then it would be up to the state that was making the inquiry then to go to that state to ask questions.

This would work in a similar way, only in dealing with -- instead of 10 million drivers, 10 million records, approximately or so, between 10 and 12 million commercial drivers, looking at 300 million records for the entire driving population. So, no central database anywhere would reside in the states and simply would be electronic means actually to query another state about a potential problem or about a potential applicant for a license.

MS. WARD: Would the information available go beyond

whether the person had been licensed in another state?

MR. CALVIN: It depends on how you design the system. It could. It could be also used for vehicle information as well. The system has not been designed.

MS. WARD: Okay. Thank you.

Another question for Mr. Calvin. Are you aware of any state -- is there required reporting of accidents to DMV by anyone, the individual, the police, in any state?

MR. CALVIN: I am not sure. I could find that out for you. I don't know.

Dr. Compton?

DR. COMPTON: You're asking by someone other than law enforcement?

MS. WARD: Or even is law enforcement required to report to DMV accidents?

DR. COMPTON: I believe in some states, yes, there is a reporting requirement and there are reporting thresholds. So, not all crashes are going to be reported. Usually injury crashes and tow-away crash perhaps, but certainly not all of them.

MS. WARD: And then, in terms of the individual, I guess it would be probably at application, there would be a question required on the form or at renewal whether you've had any accidents, whether that's required in any state, and you're not aware of that requirement?

MR. CALVIN: On almost all applications, there will be

a question whether or not you have anything wrong with you physically or mentally that would prevent you from driving safely. Whether or not on the application, they ask you to disclose if you've been involved in any accidents, I don't know. I don't think so, but I don't know that a hundred percent either.

MS. WARD: Thank you.

MS. STRAIGHT: One issue that hasn't -- that I don't remember coming up here at all, and I'm going to take advantage of Dr. Compton being here to ask this question.

I know that a great deal of money has been devoted to research and development in intelligent transportation systems by the Federal Government over the last number of years. I wonder if you could tell us whether any of that money has gone to developing technologies that can help improve safety for medically-impaired drivers.

DR. COMPTON: I don't have a great deal of expertise with that program, but I think it's probably accurate to say that none of it has been specifically directed at the issue of medical conditions. Some of the money in the IVI, the Intelligent Vehicle Initiative, has been directed at developing technologies to help prevent crashes that would presumably be of assistance to everyone, including people suffering from conditions.

Some of this has looked at run-off-the-road crashes, so there's early departure warning systems that are being tested. Rear-end crashes, also, with radar-type systems that will in fact

provide someone a warning when the closing rate indicates to a system that the collision is imminent. So, any of those type of technological features, I would assume, would make any driver -- would assist any driver in preventing a collision.

MR. FLAHERTY: Just a quick -- Gerald Flaherty, Alzheimer's Association.

Just a quick clarifying point, so that I'm consistent and what I say is consistent with what our National Board of directors has indicated, and that is, that we have very serious concerns about mandated reporting based on a diagnosis, and so if I could change what I said earlier to indicate that it's very serious concerns. There is no official position that I know of in direct opposition to mandated reporting, but the concerns for all the reasons I stated are very, very serious.

CHAIRMAN GOGLIA: Okay. Thank you.

Advocacy Group II, any questions?

MR. SNYDER: Thank you, Mr. Chairman.

Dave Snyder, American Insurance Association.

Let me try to encapsulate some of what we've heard and then try to see where this can take us in terms of a question principally to you, Mike, about how to better authorize the DMVs to be safety enforcement agencies, a role which I think you all take very, very seriously and yet for reasons which you indicated earlier, the pressure seems to be in exactly the opposite direction. How many people can you move through the system? How

few times can you see them? How little frankly safety enforcement can you really do? I think that's probably the wrong trend, but enough there.

So, using that as the focus, first data. Let's assume that for reasons which you've heard from advocacy groups and doctors and emergency rooms and others that they don't really like mandatory reporting, so the amount of data that you're basically getting from those sources would remain the same, and let's assume as is true, you've heard the same thing from insurers, that there are privacy law issues, there are immunity issues, there's a question about how valuable the data is, but let's assume that, as we heard from the police and the emergency medical services, that they might be willing to provide the data and that it could be done fairly cost effectively if they had some additional authority and perhaps some immunity.

So, I think, let's assume a bit more data than you have today but basically the same amount of data coming from more crashes and that would probably be helpful in the context of those who can provide it, who seemed during the course of this hearing, unlike the others, and who would be supportive of that, mostly the police and the emergency medical services, and let's assume that you were accepting the position that you didn't want to disqualify or take other action purely on the basis of someone having a medical condition, which is a debatable point but let's assume that for the present time, and then let's assume that we wanted to

maximize your capability to get bad drivers off the road; that is, those individuals which, because of various medical conditions that we've talked about, alcoholism, seizure disorders, whatever, we've identified those individuals to do that.

What are the kinds of authorities that would be helpful to maximize the DMV's ability to, under these circumstances, to identify unacceptably high-risk drivers and then to take effective action against them and argue effective action is suspension or revocation because that authorizes us to add to that in terms of either rating action or cancellation or non-renewal which can be a very powerful economic incentive, if we have the information to act on it?

So, let's assume all that. What are the kinds of things that we could collectively work on to give you the ability to perform the enforcement role under those circumstances?

MR. CALVIN: Well, first of all, I would like to say that we don't and most motor vehicle administrators don't endorse or embrace the trends that I've been talking about, but there's not a lot right now that they can do, that we can do as an association, and that is a problem that we see.

We are interested in keeping safe drivers on the roadways, not taking drivers off, but keeping, to the degree we can, safe drivers on the roadway. What we can do to better make that happen, I think some of the things, David, that we've talked about already in forming coalitions, in getting something that we

as an association can get our hands around and support to our members. Funding is obviously a basic issue in this day and age, and priorities, and as I have said earlier, since September 11th, the ID security, that whole arena, has preoccupied everybody's time, in particular the association.

I think we're willing to take action and willing to act. I'm not sure what the right circumstances now would be to allow us to do that. I know I probably haven't answered your question at all.

MR. SNYDER: No. I think you've made a very good effort to try to answer a fairly long question. Let me try to drill down a little more into details.

What I'm trying to do is assuming, you know, sort of -- at least I've tried to accurately sort of assume the real world is various groups here represented.

How can we maximize your role in that using basically the data that you have now and with perhaps some addition from police and EMS, and assuming that you want to identify individuals and assuming that suspension and revocation will continue to be an option but that, although I don't and insurers don't generally agree, that you want to sort of allow limited driving circumstances, and how can you enforce that, and how can you create a system that would be as effective as it could be under these circumstances?

I know it's a tough question and maybe there could be

an opportunity to supplement the record later, but I'm really interested in focusing on your role and how to give you the tools, the technical tools and the organizational tools you need to perform the critical role because I think you are in large measure the key enforcement agency.

MR. CALVIN: I wouldn't disagree with that statement at all.

Do we have the expertise in many of these areas, particularly the medical area and setting standards? No, we don't. Do we make the licensing decisions? Yeah, we do. I think we get back to the state-type solution, short of federal mandates, that would -- where we would have basic program that probably would be made up of a number of pieces that would be supported by the various groups that are here at this hearing.

MR. SNYDER: Hm-hmm. Ideas on those pieces at this point or would you prefer to reserve that?

MR. CALVIN: The individual detail of pieces, you know, we could provide that, I think, at a later date, but I'd rather not now.

MR. SNYDER: Okay. Thank you.

MR. CALVIN: Hm-hmm.

MR. SNYDER: Richard, yesterday, we heard some sort of -- and I think you were here. Some interesting commentary by the police and the emergency medical services that when you start to look at single-vehicle accidents and -- which are fairly

significant percentage of accidents and then you look at some of the multiple vehicle accidents, examples of that are in the materials, the Maryland, the three Maryland accidents where there was a medical condition somehow involved, and then you start to include, you know, the various medical conditions that may be contributing in one way or another, their sense was that this was a very, very -- I forget exactly their terms, but significant to a large degree.

I mean, is it really a definitional issue here? I mean, if it's accidents where there's been a medical diagnosis made and a conclusion that that was a causative factor, I suspect that's a low percentage. Is that really your best way of understanding this issue or should we understand it more in the larger context? What's your advice in terms of defining issues? You know, just your sense about how we determine an order of magnitude here.

DR. COMPTON: To have confidence in understanding the relationship, you typically will look for complementary information that comes from different sources and different methods.

I mean, what we heard yesterday was anecdotal reports. When you look in the available data, I mean, you see information about the role of alcohol. You see relatively little information about other drugs. I can't say they're not involved. There's very little testing for substances other than alcohol, and there's

very little reporting of medical conditions and --

DR. MARSHALL: Dr. Compton, could you pull the mike closer?

DR. COMPTON: I'm sorry. Understanding, you know, the role of these conditions in crashes because a lot of people, you know, have these conditions, millions of people, and they're going to get in some crashes by chance alone. They may be innocent victims of crashes. So, there needs to be some understanding of the role in which these conditions played in causing the crashes, if they contributed at all, and there are ways to try to establish that linkage from relative risk estimates, over-representation.

I mean, there are ways to show impairment of driving-related skills. You know, one looks for sort of complementary information that would suggest you have a serious problem.

MR. SNYDER: Thank you.

CHAIRMAN GOGLIA: Okay. The Medical Group?

DR. BREWER: Phil Brewer from the American College of Emergency Physicians.

Couple of points. First of all, ACEP or the American College of Emergency Physicians does have an official position, an official policy on reporting, and the policy is that ACEP is opposed to mandatory or voluntary reporting of alcohol-impaired drivers to law enforcement, and I emphasize to law enforcement.

That leads to a second issue, and that is, that I would hope, in my ideal world, that we begin to -- that we make a

divergence between reporting to police, such as in Illinois where physicians are required by law to call the police when they receive an injured drunk driver, and to call that reporting and to call the process that we've been talking about a referral process instead.

I've had hours and hours and hours of arguments and debates with my colleagues about this, and when you use the word "reporting", a lot of people in the room just assume you're talking about calling the police, instigating a criminal investigation, and what I'm talking about is a medical referral to a medical advisory board asking them to please evaluate this person and determine whether they can drive or not. In my writing now, I try to use the word "referral" instead of "reporting".

The question. We've heard that the data, the criteria which licensing agencies use, which medical advisory boards use, in making their recommendations to the licensing agencies need to be clear, objective and validated, and yet for most of the things we're talking about, those criteria don't actually exist at this point. It's very much a judgment call.

At the same time, in Mr. Reed's materials, he points out that drivers do have a right to due process, including the right to appeal of the decision, if there's a restriction or suspension of their license.

My question is, is there currently -- what is the current state of affairs as far as the number of appeals that

these decisions result in, and are there any trends towards an increased number of appeals?

It seems to me that it's just a matter of time before some lawyers who are outside of this room become expert in this whole issue and take this up as a specialty, the way many attorneys practice DUI defense as a specialty, and if and when that happens, they're going to be in a pretty strong position to challenge the findings of the review process because of the lack of these criteria.

So, is there -- does this happen very frequently? If so, is it happening -- is there any trend, and what are we doing to try to make it a more objective and legally-defensible process? Because obviously every time this happens, somebody from DMV has to go and be there for the duration of whatever review and appeals process there is. That costs money and that takes away time from other things.

DR. COMPTON: I have no information on appeals, beyond the administrative system, in the states.

I can tell you, people occasionally, not that frequently, will file discrimination complaint or civil rights action under the federal statutes. ADA, the Rehabilitation Act, and other civil rights acts, do prohibit discrimination based on disabilities, and if someone feels their state DMV in essence discriminated in violation of the federal law, they can file a complaint and that does come to NHTSA and our Civil Rights and

Legal offices will investigate that, and they're not common but they do occur.

MR. CALVIN: Specific numbers I don't have. I could possibly find that out, would have to go back and -- but I think that's probably doable on a state-by-state basis or at least to have a better idea.

As far as trends, I have no idea either which way, if they are increasing, I just have no way right now of answering that. You know, as far as the process and what the process is based upon, I think we've said that before, I think that is important, that it be looked at, and that we entertain the idea to create as level a playing field as we can from jurisdiction to jurisdiction and that's -- you know, that's no easy task, but it is something that we have looked at.

Our Driver Screening and Assessment Working Group has discussed that and looked at that as well and we will continue to do that. Are we going to have a definitive process through this group any time soon? Probably not. But it is something that, you know, we feel is important and that we are looking at, but it is a monumental task.

DR. BREWER: And I wanted to clarify a point that you made previously, Dr. Compton, concerning the five percent or less of crashes caused by medical impairment.

You're not including alcohol as a medical impairment?

DR. COMPTON: Obviously, I mean, because right now, it

looks a little over 40 percent of fatal crashes involve alcohol.

DR. BREWER: Okay. Thank you.

DR. WANG: Claire Wang, American Medical Association.

This is a question for Dr. Compton. Dr. Compton, NHTSA has cooperative agreements with the American Medical Association, AAMVA, law enforcement agencies, and many other key players in the field of medically-impaired driving.

I was wondering if NHTSA has any plans in the future to bring together all these key players so we can share our products, research findings, best practices, so that we can help further each other's projects and perhaps even work towards answering some of the questions that were brought up today.

DR. COMPTON: I guess the short answer is nothing specific. Based on what I've learned from this hearing, I will certainly give that some consideration. Yes, I think it would probably be a good idea.

DR. WANG: Thank you.

MS. WATSON: Miriam Watson from the Association of Driver Rehabilitation Specialists.

My question is directed to Mr. Calvin. First of all, I want to just applaud you in terms of the training that's going to be going -- you know, that's being advocated to different Department of Motor Vehicles regarding physical adaptations to vehicles, and as Dr. Compton mentioned, often the greatest impairment to driving isn't actually physically being able to take

control of the vehicle but more if there's a cognitive disability, lapses in attention, concentration, executive functioning of judgment and insight are often more the cause of a crash than some of the physical issues, and I was wondering what AAMVA is actually doing in terms of training in that light, in addition to more specifically, you know, how that's going to go about it and maybe how our organization can interface with yours as far as we are an organization that has certified driver rehab specialists that actually look at evaluating and training.

The other thing is, once someone does complete an evaluation or test done at the DMV, is there ever recommendations that would be made or at least do you see that in the future, recommendations to be made to a driver rehab program, and also, in terms of whether the Maryland program was/is looked at as sort of a model situation where the referrals go to a driver rehab program?

MR. CALVIN: I'll try to remember all that.

First of all, I think we are working with you, I'm not positive, but I think we are. We have -- actually are in the process of putting this program together, and it was voted on unanimously by our Certification Board of Directors, the IDEC Board of Directors, to include it as part of the Certification Program, and let me just, if I can, read to you some of the things that are a part of that -- that will be a part of that program, in addition to the familiarity with adaptive devices.

This says, "We are working on a fourth IDEC Program called Examining Drivers with Disabilities. The training acquaints the examiner with the types of disabilities that may be acquired during an individual's life span, their symptoms, impacts on the decisionmaking and motor control, and their effects on driver assessment, training and licensing. The training also covers common driver licensing restrictions and the role the medical advisory boards play in determining the effect various conditions may have on the driving task. The training covers specific disabilities that are acquired, congenital, progressive or developmental."

There's also a special chapter on visual deficits.

"For each of the four disability categories that training covers, defining the disability, its stages and any associated motor controls, sensory, cognitive, intrapersonal or interpersonal problems, and understanding the effects the disability may have on driving assessment, training and licensing."

So, it's going to be a fairly comprehensive program. It's information and that's a part of this training that our folks don't have now, and many of our examiners are under-trained. I will say that now. It's one of the reasons we started the whole Certification Program to begin with, to lend some professional qualities to the program, to the training and so the examiners

could feel good about themselves and have that transfer over into their jobs.

Quite frankly, now when examiners see a van coming in that's equipped with different devices, let's say for example, adaptive devices, they want to go run and hide for the most part, and a lot of them are afraid because in many cases, they haven't seen the equipment. They're not familiar with the individuals that -- the causes for the individuals that would be there operating the equipment. So, we want to get kind of their mindset so they're starting to have the education and the training and the knowledge that will allow them to feel more comfortable, to be able to interact and to have some basic core things that they can put their hands around and help them.

So, I think the program, when we started talking about it to our jurisdictions, you know, they were very, very excited on it, and it is something that, as I said, is in the developmental stages. It is -- once it's complete, we will be doing a round, maybe more than one round, of train-the-trainer-type sessions in the jurisdictions with their examiner pools.

One of the things that we hope that will come about as a result of this training is more interaction, more referrals, to the professionals in your organization that would be able to help, and as I said, I think -- I don't have names right now, but we have been working with Louisiana State University in this program, Mike Schipp has been involved, and I would hope probably the early

part of next calendar year, that we would have something that we could move out or roll out to jurisdictions. We'll see. We'll see what happens, but we're very excited about the entire program.

CHAIRMAN GOGLIA: Is that it from the Medical Group?

(No response.)

CHAIRMAN GOGLIA: Okay. Back to the Technical Panel. Any wrap-up questions?

MS. ROEBER: I have one question. It's directed primarily to Mr. Calvin.

We've heard a lot of opposition to the idea of mandatory reporting by physicians. In his written testimony, Jim Reed also made another suggestion that I was wondering what you would think about, and it's kind of additional encouragement for self-reporting. It's on Page 2, and he says, "The problem of deception by an individual may be solved by including a liability disclaimer on each questionnaire which imposes upon the individual liability in the event that any of the information proves to be false."

I guess I want your reaction to that or the idea of criminal prosecution or some type of extra fine if you have a medical condition, you don't report it, you're in a crash, and it can be attributed to that.

MR. CALVIN: I personally would not be opposed at all to that. As far as the position from the association, you know, we would have none now.

I think self-reporting and trying to strengthen that piece, we would be supportive of. How it would be strengthened, I'm not sure whether or what Mr. Reed has in his remarks would be looked upon favorably, I don't know. But I think basically right now, the self-reporting on the applications, I mean, it is there. It works sometimes, but there are problems with it.

MS. ROEBER: That's it.

Dr. Compton, you look like -- did you have a comment? Oh, okay.

No more questions.

CHAIRMAN GOGLIA: Okay. Thank you.

To the panel. Elaine?

MS. WEINSTEIN: No questions.

CHAIRMAN GOGLIA: Dr. Ellingstad?

DR. ELLINGSTAD: Just a couple of areas.

Dr. Compton, you remarked that you felt that the ceiling for the proportion of medically-related crashes was about five percent, and in some other comments, you talked about the difficulties in terms of defining these conditions in accidents.

Let me understand specifically what you base your assumption of this five-percent figure on. Is this from some statistical review of fatal accident data? Is it from particular studies that NHTSA has commissioned?

DR. COMPTON: I should probably know better. So, let me withdraw that speculation as just being professional judgment,

and I'll go with the fact that the data are not clear.

DR. ELLINGSTAD: Has NHTSA taken any steps to try to refine the basis for making that kind of an assessment, either in terms of the data elements that are captured with respect to FARS or any other data system?

DR. COMPTON: There is a data element or two in FARS for medical conditions. I do not -- I probably wouldn't rely -- I shouldn't say that.

The information available to the FARS analysts might not always be what you'd want to have great confidence in the reporting of that information, based on the information that's available to the FARS analysts.

DR. ELLINGSTAD: Just give us an idea of specifically how data pertinent to a medical condition would be recorded in FARS, for example.

DR. COMPTON: I think it would be relatively rare. I don't know what the precise --

DR. ELLINGSTAD: I'm not talking about what proportion of cases that it might be recorded in, but specifically what kind of data fields convey that information.

DR. COMPTON: You know, there are data fields for the vehicle, for the crash and for the person, and the FARS analyst gets the police crash report. They will get a death certificate. They'll get an autopsy or medical examiner report, test reports if an alcohol test is done, and it is not inconceivable, if

there's a medical examiner's report or an autopsy, it will list some conditions that would be apparent during those examinations. So, I believe there's a field for illness. But that would either be picked up from those reports or from the police --

DR. ELLINGSTAD: No. I understand what the origin of the information might be, but in terms of treating those data in the aggregate to try to get a risk assessment from them, I don't pretend to be as familiar as the folks in your shop are with respect to the FARS data fields, but the one data field that was pointed out to me combined categorical levels for physical/mental condition as one category, drowsy/sleepy/sleep fatigue as another, drugs as another, inattentive as yet another, all in the same dimension.

Is this the kind of resolution that's available to make this kind of a risk assessment from that data source?

DR. COMPTON: I believe so. I have not looked at those fields in many, many years.

DR. ELLINGSTAD: So you feel that it is important, given the gravity of some of these kinds of conditions, to try to develop a better epidemiological basis for determining what the risk is?

DR. COMPTON: It would be useful. I'm not sure how easy it would be to do that. I mean, a FARS analyst basically has to rely on the information contained in official reports that are made available to them, and I'm not sure how, given privacy laws

and other things, how you would get information to them that would be relevant in this case.

DR. ELLINGSTAD: Okay. Let me approach another issue very quickly.

Both you and Mr. Calvin talked about limited funding and we appreciate that kind of a situation. You'd also indicated that about 80 percent of your funding was allocated to alcohol-impaired driving programs. Is that a correct recollection?

DR. COMPTON: Yes, that was an estimate for impaired driving.

DR. ELLINGSTAD: Okay. I understand.

DR. COMPTON: Yes.

DR. ELLINGSTAD: And yesterday, we heard from at least several of the states that a very large proportion of their medical advisory board or medical review board activity was also necessarily allocated to that as a significant source of their kind of problem.

The question in this respect is, is the magnitude of the alcohol driving problem such as to overwhelm the proper consideration of other sources of medical impairment, either at a federal level or, Mr. Calvin, with respect to the operation within the states?

DR. COMPTON: you know, we try to spend our money where the identified problems are. We do spend funds on other, you know, medical conditions. We've been funding research for a

long time and we will continue to do that. We work with a lot of organizations to try to address these issues and working with AAMVA and others. So, it's not something that we're ignoring by any means.

DR. ELLINGSTAD: No, my question wasn't intended to criticize, you know, your decisions about spending but just a matter of we have, you know, one very large player is that elephant that's associated with alcohol overshadowing other important issues.

DR. COMPTON: I mean, clearly, we feel like we're making an appropriate judgment of addressing the problems as they exist. There are many other medical conditions one could look at and, you know, there's literally hundreds, and so I guess in a nutshell, our answer is I think we're devoting resources appropriately.

DR. ELLINGSTAD: Mr. Calvin, do you have the sense with respect to the operation of the -- within the states that just the overwhelming size of the alcohol problem prevents a thorough consideration of other medical conditions?

MR. CALVIN: I don't think it prevents a thorough consideration. Should there be more done? Yeah. Probably. There obviously is emphasis in the alcohol area, but I would, even from a state perspective, tend to agree with Dr. Compton.

DR. ELLINGSTAD: Okay. Thank you.

CHAIRMAN GOGLIA: Okay. Mr. Osterman?

MR. OSTERMAN: No.

CHAIRMAN GOGLIA: Okay. Thank you, panel members, for your time and helping to shed some light on this whole area.

Closing Remarks

CHAIRMAN GOGLIA: Well, we have reached the conclusion of this hearing, but we will not close the docket at this point. Witnesses therefore are encouraged to submit any additional information they consider appropriate. Submissions should be transmitted within the next 30 days to the Director, Office of Highway Safety, National Transportation Safety Board, Washington, D.C.

The factual record from this public hearing will assist the Safety Board in making recommendations to improve highway safety and the Board will consider pertinent information gathered during this hearing in developing such recommendations.

On behalf of the National Transportation Safety Board, I thank all the panelists who have participated so actively and cooperatively during these proceedings. By sharing your knowledge and insight into these important issues, you have greatly assisted our deliberations on major safety concerns.

As a result of this public hearing, the American public is much better informed about the medical oversight of noncommercial drivers.

This public hearing is now in recess.

(Whereupon, at 5:27 p.m., the hearing was adjourned.)