California State Board of Optometry

COMMENTS

CALIFORNIA CODE OF REGULATIONS 1571

REQUIREMENTS FOR GLACUOMA CERTIFICATION

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Comment 1

Curtis Knight, O.D.

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Ms. Andrea Leiva
California State Board of Optometry
2420 Del Paso Blvd., Suite 255
Sacramento CA 95834

Dear Ms. Leiva:

I am writing you in response to the opposition facing California optometry in our attempt to implement the decision by the California legislature; a decision paving the way for optometrists in our great state to treat and manage glaucoma. I support this decision.

I was glaucoma certified on August 25, 2005 under SB 929 requirements, through the mentorship of a local community concerned ophthalmologist.

My colleagues from other states often ask why so few of my California colleagues are glaucoma certified. I have to explain that it is not from lack of desire or effort. The answers I frequently get when I ask are:

- The inability to find an ophthalmologist who would agree to mentor them **for two years**.
- Those optometrist and patients living in rural areas had to travel long distances to find and ophthalmologist willing to participate, creating a hardship.
- There was confusion concerning the acceptance by the State Board of Optometry of credentialing provided by the schools of optometry. Those who were eager to start never did because they didn't know if the work would be credited.

Optometrist can now treat glaucoma in 49 of the 50 states. I am certain that the residents of these states appreciate the time, and money saved by not having to be referred to another doctor. I know that in my own practice, when patients are transferred to ophthalmologists by their insurance (capitation). Those patients, who can afford it, are willing to pay out of pocket rather than change their provider.

These referrals:

- Result in duplicate testing and payments
- Unnecessary time from work

- In many cases, long drives or bus rides

The need to recognize glaucoma is important but the need to have the patient recognize the importance of treatment and follow-up care is just as important. This will often take time; time not found in the office of many busy ophthalmologists. It is well known throughout the eyecare industry that optometrist devote more time to each patient. This difference in patient interaction is essential when faced with the task of explaining disease, and the important role the patient has to play in their own care. A patient came to me several weeks ago; she explained, that her reason for seeing me; was that during her last visit, to her ophthalmologist he entered the exam room, sat down and wrote a prescription, handed it to her and said "you have glaucoma, have this prescription filled" he then turned and left the room. A friend suggested that she see me.

The fact, that someone did not take the necessary time, is evident when patients enter the office for the first time with moderate to advanced glaucoma. The story usually goes like this:

- I was told that the pressure in my eyes was too high and given a bottle of drops to take but no one told me that I needed to come back for follow-up.
- I missed my first follow-up appointment and just never went back.
- I used all the medicine in the bottle and though that was I was finished.
- I was told to come back for tests and never went back.

The above actions or lack of action take place because primary open angle glaucoma, until the late stages, is an asymptomatic disease. The difficulty is convincing someone that they are sick when they don't <u>feel</u> sick. I am certain that my colleagues will devote the necessary time, with each patient, to avoid these unnecessary outcomes.

Many of these patients and their families have been seen by the same optometrist for many years and have come to know and trust him or her absolutely. It is confidence and trust that is most necessary when informing and later treating someone for a disease like glaucoma.

The requirements agreed upon by the panel of ophthalmologist and optometrist to fine tune my, already, well trained colleagues will more than suffice to prepare them to care for their glaucoma patients.

Thank you for allowing my input into this important issue.

Respectfully Submitted,

Curtis Knight, O.D.

Comment 2

NORTH CAROLINA STATE BOARD OF
EXAMINERS IN OPTOMETRY

December 7, 2009

To: Ms. Andrea Leiva
Policy Analyst
California State Board of Optometry

By US Postal Service to:
2420 Del Paso Road, Suite 255
Sacramento, CA 95834

By E-Mail to: andrea_leiva@dca.ca.gov

From: North Carolina State Board Of Examiners In Optometry
John D. Robinson, O.D., Executive Director

Re: The Board's 32 ½ years experience in the licensing and regulation of the practice of optometry in a state where optometrists are licensed and ***certified*** by the Board to use and prescribe pharmaceutical agents in the diagnosis, treatment and management of diseases and injuries of the eye and its adnexa

Today, North Carolina has the largest population of optometrists in the nation who, over a 32 year period, have been actively engaged in the use and prescribing of both topical and systemic pharmaceutical agents in the practice of optometry. Beginning in July of 1977, with the enactment of the therapeutic law, fewer than 300 licensed optometrists were serving some 5 million North Carolina citizens. Today, the profession has grown to over 1,200 licensees who serve a population now approaching 10 million. From the effective date of the amendment to the North Carolina optometry practice act, July 1, 1977, granting the use and prescribing of pharmaceutical agents in the practice of optometry in North Carolina to all optometrists meeting the qualifications set forth in the new law **no** optometrists have been licensed to practice optometry in North Carolina who are not ***"certified"*** by the Board to the use and prescribe pharmaceutical agents in the practice of optometry. Following the enactment of this new law patient access to services previously rendered only by ophthalmologists in North Carolina has been enhanced immeasurably, particularly access to primary eye care providers by those patients who

suffer from sight threatening diseases such as glaucoma, diabetes and systemic hypertension to mention the more common ones where access, early diagnosis and intervention are key elements in preservation of vision.

Over this period there has been no credible evidence presented, nor have there been any cases documented to either this Board or, to the best of our knowledge, to the Medical Board where the use or prescribing of pharmaceutical agents by an optometrist in the diagnosis, treatment or management of diseases of the eye or its adnexa resulted in death or irreversible harm to a patient. In January 2006 the Board ***credentialed*** and ***certified*** the first of over 150 of its licensees to perform peri-ocular and chalazion injections, procedures that have been performed without incident reported to the Board over a nearly four year period. A very conservative estimate is that patient encounters with optometrists performing procedures or in their use or the prescribing of some type of pharmaceutical agent for their patients now range somewhere between 60 and 70 million patient encounters. This is a record that speaks for itself.

Allegations of mis-management made by spokespersons for the North Carolina Society of Ophthalmology (now known as the North Carolina Society of Eye Physicians and Surgeons or SEPS) surfaced in the early 1980s at a legislative hearing in Nebraska. A subpoena was timely issued by this Board for any documentation in the Society's possession that would be credible evidence that such mis-management had indeed occurred and patient harm had resulted.

After lengthy hearings before the Board, on appeal by the Ophthalmology Society the case was heard before the Superior Court of Wake County when the Board's subpoena authority was called into question. On appeal by the Board the case moved to the North Court of Appeals where the Board's authority to issue subpoenas in such matters became the sole issue before the Court. A long story made short, the North Carolina Court of Appeals upheld the Board in its authority to issue subpoenas in such matters, and the case was once again before the Board. In the end no credible evidence of mismanagement was ever forthcoming, and the Board ended its hearings with findings of fact and final judgment based upon the findings, "that no credible evidence of mis-management ever existed". A copy of the Board's Order dated January 28, 1986 is available upon request. In the years that have followed there have been no further public allegations made against North Carolina optometrists by the North Carolina Society of Ophthalmology or its successor organization, the North Carolina Society of Eye Physicians and Surgeons (SEPS) that have come to the Board's attention.

Finally, over the 32 ½ year period that North Carolina licensed optometrists have been using and prescribing pharmaceutical agents in the practice of optometry, including both topical and systemic medications, there have been fewer than sixteen malpractice law suits filed against optometrists in this state, none of which went to trial. Monetary settlements were made in fewer than ten cases. Every suit that was filed against an optometrist was based on that optometrist's failure to 'diagnose' and did not involve the use or prescribing of pharmaceutical agents.

This memorandum is an attempt to present a brief summary or overview of the North Carolina State Board of Optometry's experience in matters involving the licensing, credentialing and regulation of optometrists who, once licensed and ***certified*** by the Board, have perhaps the broadest prescriptive authority in the nation when needed in the diagnosis, treatment and management of diseases and injuries of the eye and its adnexa. As stated earlier this authority was granted by the North Carolina General Assembly in May of 1977 with the amending of the North Carolina Optometry Practice Act, said amendments becoming effective on July 1, 1977. However, if further information is needed, or if there is a need to go into greater detail as to this Board's experiences over the past thirty two and a half years, July 1, 1977 through December 8, 2009, feel free to contact the Board at the address below.

North Carolina State Board of Examiners in Optometry\
John D. Robinson, O.D., Executive Director
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cc: Board and Attorney
Members of the California State Board of Optometry: Dr. Lee Goldstein, President, Dr. Alex Arrendondo, Vice President, Ms. Monica Johnson, Secretary, Dr. Susy Yu, Dr. Kenneth Lawenda, Mr. Fred Naranjo, Ms. Katrina Semmes and Mr. Edward Rendon.
Ms. Mono Maggio, Ex. Dir., California State Board of Optometry
Mr. Tim Hart, Dir. of Government & Ext. Affairs, California Optometric Association.

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Russell Y. Hosaka, O.D.

Certified in Treatment of Glaucoma

Doctorate:
Illinois College of Optometry

Chief of Optometry
UCLA-Harbor Hospital

Expert Examiner:
California State Board of Optometry

Research Consultant:
Physiological Optics Corporation
Clinical Director Total Vision Care

Comprehensive eye healthcare

Comprehensive vision & eye health testing for adults & children

Medical management of eye disease

Laser vision correction consultant

Glaucoma testing and treatment

Same day appointment for eye infections

Dry eye treatment

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Hundreds of frames in stock from budget to designer

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Specializing in overnight vision correcting lenses

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The convenience you deserve

Vision plans / PPO plans welcome

Open 6 days
evening and Saturday hours

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Bi-lingual Spanish speaking staff

12/08/2009

Dear Sirs:

I am writing this letter in support of Optometrists treating glaucoma. I was glaucoma certified on February 2, 2005. I co-managed some patients in my Torrance office but I had difficulty Finding Ophthalmologist to co-manage with me. Those that did Often stole my patients from me. I became frustrated and when an opportunity arose to opening a county clinic in clinic in Long Beach I jumped at the chance. I found an Ophthalmologist that was willing to co-manage my patients. When he signed off on My certification he told he feared reprisal from his colleagues.

Ophthalmologists have stacked the deck against Optometrists by insisting co-management and then refusing to co-manage with us. They effectively closed down the co-management pipeline. Many of my colleagues "gave up" because co-managing 50 patients seemed out of reach. When they found out many MD's would co-manage with OD's that discouraged them further.

The average person does not seek an Ophthalmologist and asks to be tested for glaucoma. The average person does know about eye glasses and contact lenses. Many vision plans require a screening visual field, tonometry(eye pressure check) and examination of the fundus(back of the eye). As optometrists we are in the ideal position to detect and diagnose glaucoma as well as other eye diseases. Since there are potentially 430,000 people in the state of California who have glaucoma and many of these people live in remote rural areas Optometrists are the most convenient option for these patients. Those optometrists who choose to be certified to treat glaucoma would be become better clinicians and will become better at detecting glaucoma. The public will benefit and many eyes can be saved.

My patients are comfortable with me. They do not wish to see another doctor and they certainly don't want to wait 3 hours to be seen by an Ophthalmologist. Many times when patients are

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Russell Y. Hosaka, O.D.

Certified in Treatment of Glaucoma

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referred out for testing there is a disconnect and they never get the tests they need. When I see the patient the next year and they report they never made it to the ophthalmologist risking a year of peripheral vision loss.

For the above reasons. I urge support for the State Board of Optometry proposed Glaucoma certification.

Best regards,

Russell Hosaka, OD

22809 Hawthorne Blvd., Torrance, CA 90505 • (310) 373-9993
www.AdvancedFamilyEyeCare.net

Comment 4

desert eyecare center
Greg McFarland, O.D.
Optometrist

December 8, 2009

Andrea Leiva
California State Board of Optometry
2420 Del Paso Blvd., Suite 255
Sacramento CA 95834

Dear Ms Leiva.:

As one of 77 COA members who became certified to diagnose, treat, and manage glaucoma patients independently under the SB 929 regime that was in place from 2003-2008, I'm writing to ask for your help in getting new glaucoma certification regulations in place that will help my peers who were licensed before 2008 to become certified more fairly and efficiently. I support the State Board of Optometry's proposed glaucoma certification regulations (which have been published for public comment).

The following points I feel are valid:

- I was glaucoma-certified on under the old SB 929 regime on December 16 2006, through a local preceptor ophthalmologist by the name of Tamela Martin, MD.
- The SB 929 process in place between 2003-2009 discouraged most of my qualified colleagues from seeking certification because the requirements imposed made it too expensive or inconvenient, especially for those located far from either of the two schools of Optometry. Several of my colleagues just stopped the process altogether as it was too cumbersome. Many ophthalmologists wouldn't participate in the program as they felt optometry was encroaching upon their "territory".
- My peers who practice elsewhere, know that California is one of a few remaining states with unfair obstacles in allowing optometrists to meet their glaucoma patients' needs without unnecessary and costly referrals. With the advancement of prescription eye drops over the past decade, most patients can be easily managed by their optometrist, with few patients in need of ophthalmological surgical care to control their glaucoma.
- Because California is a populous and diverse state, the public health need is great – more than 430,000 Californians with glaucoma are unaware they have it. Many of my patient's simply can't afford their medication, let alone a doctor's visit, and ophthalmological care by an MD or DO can be expensive. This is one reason patients choose optometry, as we are truly more affordable with lower fee schedules.
- Today, like never before, health care is in transition. Optometry is the most cost-effective choice for Californians when it comes to primary eye care.

I appreciate your valued time, and hope we can count on your support in optometry's efforts in providing Californians with improved access to primary eye care and managing patients with glaucoma.

Respectfully yours,

Dr. Gregory McFarland, OD

cc: Tim Hart
Director, Government & External Affairs
California Optometric Association

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Desert Hot Springs, CA 92240

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Comment 5

Clearview Eyecare Optometry

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Clifford A. Silverman, O.D.
Keith A. Simon, O.D.
Doctors of Optometry

December 8, 2009

Andrea Leiva
California State Board of Optometry
2420 Del Paso Blvd., Suite 255
Sacramento CA 95834
Tel: (916) 575-7176
Fax: (916) 575-7972
Email: Andrea_Leiva@dca.ca.gov

Dear Ms. Leiva,

I am a glaucoma-certified optometrist in California and I am writing this letter to state my strong support for the California State Board of Optometry's published proposed glaucoma certification regulations.

I was glaucoma-certified on December 19, 2005 under the old SB 929 regime, through a local preceptor ophthalmologist. The SB 929 process in place between 2003-2009 discouraged most of my qualified colleagues from seeking certification because of the unreasonable requirements imposed by this bill made it too expensive or inconvenient, especially for those located far from either Optometry school. I was very fortunate to have found a local ophthalmologist willing to work with me and to have a relationship with a local medical group based on an appreciation of my skills as an eye care provider.

The proposed glaucoma certification regulations as developed under the guidance of one of California optometry's leaders, Dr. Tony Carnivalli, are fair and reasonable. These regulations provide for adequate education of glaucoma diagnosis and treatment concepts. They also allow for a means of demonstrating adequate glaucoma treatment skills under the supervision of experienced glaucoma-certified California optometrists and schools of optometry.

As a local leader with Vision Source, a national organization of premier optometry providers, I know that California is one of only a few remaining states with unfair obstacles to allowing optometrists to meet their glaucoma patients' needs without unnecessary and costly referrals. It is time to allow optometrists in California to practice at a level equivalent to our colleagues around the United States and to provide all California residents with access to convenient, cost effective and excellent quality eye and vision care.

Sincerely,

Clifford A. Silverman, O.D.

Comment 6

FAMILY EYECARE
Andrew C. Balfour, O.D.
Robert L. Shapiro, O.D., F.A.A.O.
213/628-7359 • 213/627-5911
555 S. Broadway • Los Angeles, CA 90013

December 9, 2009

Andrea Leiva
California State Board of Optometry
2420 Del Paso Blvd., Suite 255
Sacramento, CA 95834

Dear Ms. Leiva:

I would like to take this opportunity to convey my strong support of the proposed glaucoma regulations that were developed due to the passage of SB1406. As a glaucoma-certified optometrist since 2006 I have had experience treating hundreds of patients with glaucoma. Furthermore I served on the Glaucoma Diagnosis and Treatment Advisory Committee. In reviewing and evaluating the proposed regulations, I firmly believe the requirements for certification will ensure that the future certified glaucoma treating optometrists will have had the training and experience to safely and expertly treat glaucoma.

I practice in Downtown Los Angeles, treating many patients that are underserved and have difficulty accessing proper health care. It has been gratifying that for the past 7 years since I started glaucoma management that I have been able to help many patients maintain their vision that surely would have been lost in the past. Unfortunately there are insufficient numbers of optometrists certified to treat glaucoma in many areas similar in demographics to my office. The new regulations will facilitate more doctors to obtain certification. Currently many optometrists that would like to become certified have been unable to due to the many difficulties with the previous law, SB 929.

Optometrists outside of California have been treating patients safely and effectively for years without the obstacles that have prevented OD's in California from treatment privileges. There is no logical reason that California doctors should be prevented from doing the same. Ironically California has two of the finest Optometry schools in the nation. In summary, passage of the proposed regulations will facilitate easier access of glaucoma patients for treatment and the regulations will ensure that those patients are treated safely and appropriately. I urge you to support the regulations in their current form.

Sincerely,

Robert L. Shapiro OD. FAAO

Robert L. Shapiro, O.D., F.A.A.O.

Comment 7

ELLIS MILES, O.D.

9617 WYSTONE AVE.

NORTHRIDGE, CA. 91324

December 9, 2009

Andrea Leiva

California State Board of Optometry

2420 Del Paso Blvd. Suite 255

Sacramento, CA 95834

Dear Ms Leiva,

I have been a Glaucoma-Certified Optometrist since December 9, 2004 under the old SB 929 regime through a local preceptoring ophthalmologist. The SB 929 process in place between 2003-2009 discouraged most of my qualified colleagues from seeking certification. There are many reasons for this. If they lived too far from a school or could not find an ophthalmologist to be their Preceptors due to geography or refusal by their local ophthalmologists to help, they were out of luck.

I personally was very lucky to have an ophthalmologist in my neighborhood who was willing to be my preceptor. He did everything by the books, but, let me work with him to fulfill my requirements for my certification at the ripe old age of 72.

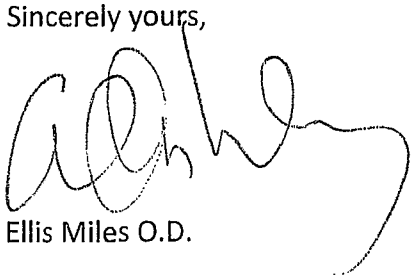
Since the time of my certification, I have found many patients who had glaucoma and didn't know it. I feel so blessed to be able to take these patients and help them. I have also seen many patients who were being treated incorrectly or at least with no real control over the disease. After my treatment, we saw more positive response in many of these patients. This is not a letter trying to say that ophthalmologists are not doing the right thing. Rather It is a letter trying to let you know that a properly certified optometrist will do a good job treating these patients.

California is such a large State and we need as many professionals as possible treating this disease including optometrists as well as ophthalmologists to take care of the vast numbers of

patients who don't even know that they have this blinding disease.

I am begging you to support the new regulations now on your desk so that Californians can have the best care when and where they need us.

Sincerely yours,



Ellis Miles O.D.

SD 04525-TLG

EVANS OPTOMETRY CLINIC INC.

California State Board of Optometry
2420 Del Paso Blvd. Ste. 255
Sacramento, CA 95834

I am writing in support of the Board's proposed glaucoma certification guidelines. As a glaucoma certified Optometrist since 2004 I have had the privilege to treat glaucoma patients and to serve fellow Californians for a significant time. In my community of Palm Desert (greater Palm Springs) we serve patients from outlying areas including 29 Palms, Idlywild, the Salton Sea and as far east as Blythe. Three of four of these communities do not have ophthalmogists present and patients are convenienced by my ability to provide care.

Within my current practice I have an ophthalmology partner. He performs both surgical management (scleral fistulation for glaucoma) as well as laser management (Selective Laser Trabeculoplasty) for glaucoma. The medical management is deferred to me.

Until recently, (2009) I was the only glaucoma certified OD in our service area of 450,000 plus patients. I seems very inappropriate that my peers did not share the same ability to complete the certification process and I commend the board for it's efforts to change the previous process. I would not have had the ability to complete the boards SB 929 certification process had it not been for Robert Herrick M.D. who was, and has always been, supportive of Optometry. Of note, the other glaucoma certified optometrist in my service area is in a joint Ophthalmology/Optometry practice. Without this type of practice mode the SB929 process is inconvenient for both patients and for the practitioners. It also leads both to more expense (for the patient) and lost revenue (for the practitioners). The proposed certification guidelines do well to address the inequities of the current process while ensuring practitioners are properly prepared for this privilege.

Sincerely,

Greg Evans O.D.

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Ms. Andrea Leiva

California State Board of Optometry

2420 Del Paso Blvd., Suite 255

Sacramento, CA 95834

Re: Glaucoma Certification

Dec, 14, 2009

Dear Ms. Andrea,

I am a glaucoma-certified optometrist licensed in the state of California under the old SB 929 legislation about 8 years ago. I still remember how difficult it was to receive the certification and I strongly believe that the 50 cases of glaucoma co-management with an ophthalmologist were excessive and unnecessary.

The SB 929 process discouraged most of my qualified colleagues from seeking certification because the requirements imposed made it too expensive or inconvenient. I was fortunate at the time to have a preceptor practicing near my office so that my patients were able to visit both offices without too much of an inconvenience.

I know that California is one of a few remaining states with unfair obstacles to allowing optometrists to meet their glaucoma patients' needs without unnecessary and costly referrals.

Because California is a populous and diverse state, the public health need is great – more that 430,000 Californians with glaucoma are unaware they have it. Almost every week in my office, I can "discover" one or 2 cases of undiagnosed glaucoma.

I therefore strongly support these regulations (glaucoma certifications) in their current form and any deviation from it will simply do a disservice to all the people in California, particularly to those who can least afford healthcare in the State.

Sincerely yours,

_____

C K CHAN, O.D.

EATON OPTOMETRIC GROUP
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FRANK G. BALESTRERY, O.D., M.S.
DAVID W. HARTZELL, O.D.

December 14, 2009

Andrea Leiva
California State Board of Optometry
2420 Del Paso Blvd., Suite 255
Sacramento, CA 95834

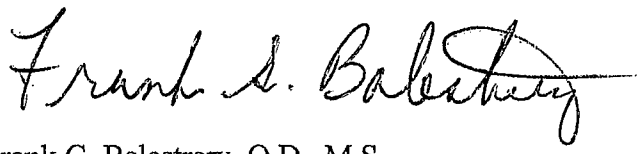
Dear Ms. Leiva,

I am certified to treat glaucoma in the State of California and in the State of Washington, having been certified for glaucoma in California for over four years. I obtained this certification under the regulations that required a minimum of 50 glaucoma patients to be followed for two years under the supervision of an Ophthalmologist. I elected to be certified through the UC Berkeley School of Optometry process because the logistical burden was otherwise completely impractical, and the process was available to me as a faculty member. In nearly identical circumstances, my colleague (who is not associated with UCBSO) with whom I have practiced for 25 years, Dr. David Hartzell, found the requirements literally impossible even though he had co-managed hundreds of glaucoma patients in his career. The goal of the process was never to pass a law with no practical means of implementation. A change in the glaucoma certification process for California Optometrists was acutely in need of remedial action.

I support the recently enacted SB 1406 glaucoma certification requirements as they are to be implemented by the California State Board of Optometry. Clearly, the legislative purpose and intent was to create a process that ensures clinical competence without the imposition of a draconian co-management and regulatory burden. Relative to other states, California has one of the most comprehensive glaucoma certification requirements for Optometrists who graduated under the former regulations. Glaucoma affects hundreds of thousands of Californians, many of whom are medically underserved. As the legislature well knows, California Optometry has always been well represented geographically in the State, and its commitment to serve the underserved is a matter of record. Epidemiological studies indicate that as many as 50% of all people with glaucoma are unaware they have the disease. This is a powerful argument that the practitioner base relative to glaucoma diagnosis and treatment is in dire need of expansion, and vigilance on the part of all vision care providers is necessary.

In summary, the California legislature and Governor have passed into law a new glaucoma certification process for Optometrists who wish to expand their licensure. It corrects the impractical and unnecessary co-management provisions that prevented virtually all Optometrists from being able to obtain certification. It corrects the unfair restrictions that prevented the implementation of legislative intent. The proposal of the California State Board of Optometry is fair and reasonable. I urge the California State Board of Optometry to move forward in implementing the new law.

Respectfully Yours,



Frank G. Balestrery, O.D., M.S.
Associate Clinical Professor, University of California, Berkeley School of Optometry
Private Practice, Tracy, CA

Cc: Tim Hart, California Optometric Association
Dennis Levi, Dean, UC Berkeley School of Optometry

SIERRA EYECARE ASSOCIATES
Optometry & Ophthalmology

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JERRY L. JOLLEY, O.D. Optometry | STEVEN J. FRONK, O.D. Optometry | JOANNE GIBSON, O.D. Optometry | RICHARD VAN BUSKIRK, O.D. Optometry | H. DOUGLAS COOPER, M.D. Ophthalmology | JANICE M. MC GEORGE, O.D. Optometry

12/15/09

Andrea Leiva
California State Board of Optometry
2420 Del Paso Blvd., Suite255
Sacramento, CA 95834

RE: Glaucoma Certification

Dear Ms. Levia,

I am writing the Board of Optometry regarding the effort of organized medicine to continue the very restrictive glaucoma certification for optometry. I am one of only 77 optometrists in the state of California that was able to qualify for glaucoma therapy treatment under the old legislation. I was fortunate to be associated with an ophthalmologist who was very supportive of my efforts. I was also fortunate that I live in a rural community that does not have easy access to ophthalmology. So I have many patients in my practice that have glaucoma.

There are many optometrists in California who are well qualified to manage glaucoma but cannot qualify under the onerous restrictions of the previous legislation. It must be obvious to even the most casual observer that the legislation is seriously flawed to have only 77 doctors qualify in a six year period of time.

The new regulations will allow the doctors who are truly interested and committed to treating glaucoma to do so with reasonable requirements. I support the new legislation and the terms that were agreed to at that time. It would be a disservice to patients and doctors of optometry to have to revert back to the requirements of the previous legislation.

Yours truly,

Steven J. Fronk, O.D.

Comment 12

December 15, 2009

HERITAGE VALLEY EYE CARE
OPTOMETRIC CENTER

Chris L. Bartelson, O.D.
Kevin Ikeda, O.D.
Aaron M. Luekenga, O.D.

Ms. Andrea Leiva
California State Board of Optometry
2420 Del Paso Blvd., Suite 255
Sacramento, CA 95834
VIA FACSIMILE: (916) 515-7972

RE: Support of Proposed Glaucoma Certification Regulations

Dear Ms. Leiva:

I am writing in support of the State Board's proposed glaucoma certification regulations. I have been glaucoma certified since November 30, 2006, under the SB929 requirements. I was fortunate to have a strong working relationship with a local ophthalmologist who was both willing and encouraging to help me complete the preceptorship required. My certification has been a great help in serving the many underserved people in our area. I practice in two rural communities, Santa Paula and Fillmore, neither of which has full time ophthalmological care. Patients have to travel 15-25 miles respectively. For many this creates a real hardship with their transportation. Compliance with proper use of medications and follow-up procedures is therefore difficult at best. Convenience has improved care for our patients dramatically. We are able to diagnose the condition and treat the patients without the patients having to leave their home town. Our situation is not unique; patients receive better care and are more likely to be compliant if they are taken care of by their local optometrist, who they have a relationship with and trust.

Most states have already made glaucoma certification available to optometrists without all the obstacles that I had to overcome. Most of my colleagues have had difficulty finding an ophthalmologist willing to be a preceptor or have had difficulty with the 50-patient requirement. So even though they see the need and would like to serve their patient population with this much needed service, they see the obstacles as unsurmountable. They look forward to the new regulations that are more achievable to go into effect. With so many people who have undetected glaucoma, this increase in glaucoma-certified optometrists will go a long way in helping these citizens retain their eyesight.

For the vision welfare of all California, I support the new regulations and ask for their passage.

Sincerely,

Chris L. Bartelson, O.D.

CLB:lr

400 E Santa Barbara St #C
Santa Paula, CA 93060
(805) 525-6603
(805) 525-6115 fax

429 Central Ave
Fillmore, CA 93015
(805) 524-2552
(805) 524-2558 fax

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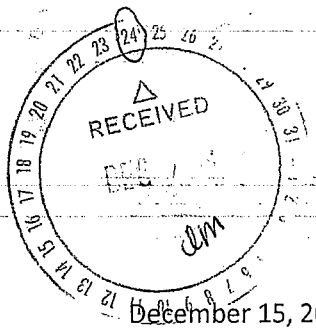

December 15, 2009

HERITAGE VALLEY EYE CARE
OPTOMETRIC CENTER

Chris L. Bartelson, O.D.
Kevin Ikeda, O.D.
Aaron M. Luekenga, O.D.

Ms. Andrea Leiva
California State Board of Optometry
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Sacramento, CA 95834
VIA FACSIMILE: (916) 515-7972

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For the vision welfare of all California, I support the new regulations and ask for their passage.

Sincerely,

Chris L. Bartelson, O.D.

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Comment 13

Pismo Beach
Optometric Center
MICHAEL E. JACOBS OD

Andrea Levia
California Board of Optometry
2429 Del Paso Blvd., Suite 255
Sacramento, Ca 95834

December 16, 2009

Dear Ms. Levia:

I am an optometrist and have practiced in Pismo Beach for 26 years. I was certified to treat glaucoma in October 2007. I was able to become glaucoma certified because I had on-going professional relationships with two large ophthalmological practices, not one, like many of my colleagues. I also have a large Medicare patient population and have a greater exposure to glaucoma patients than my colleagues. Even so, becoming certified was very time consuming and disruptive to my practice.

Unfortunately, the requirement to co-manage 50 patients over two years under ophthalmological supervision prohibits my colleagues on the Central Coast from becoming certified. There is simply not access to patients and supervising ophthalmologists.

Why 50? Why any? The diagnosis and treatment of glaucoma is a core part of our optometric curriculum and clinical training. Optometrists in almost every other state are qualified and licensed to diagnose and treat glaucoma with the same education and training that California optometrists have received.

How do my patients benefit from my ability to independently diagnose and treat glaucoma? First, they continue to receive care from a single doctor with whom they have an established relationship and history rather than being shuffled between multiple doctors. Independently, I provide care less expensively than co-managed patients. Patients are not lost to follow-up care as sometimes happens on co-managed patients when communication breaks down between the doctors. Finally, patients rarely have to wait 15 minutes in my office but frequently wait for over an hour in the ophthalmological offices I co-manage with.

Care is simply better coordinated, less expensive, more accessible and more convenient for my patients.

The 50 patient requirement guarantees that qualified optometrists will not be able to become certified and circumvents the whole intent of SB1406.

For the benefit of patients in California, many with undiagnosed glaucoma, it is time to come out of the Dark Ages and acknowledge the education and training of today's doctors of optometry. It is time to establish a sensible plan that allows the optometric profession to credential optometrists to diagnose and treat glaucoma.

Sincerely,

Michael E. Jacobs, OD
Cc: Tim Hart

573 Five Cities Drive, Pismo Beach, California 93449 • (805) 773-4700

"Alan Lubanes, O.D."
<drlubanes@sbcglobal.net>
12/16/2009 11:45 AM

To Andrea_Leiva@dca.ca.gov
cc
bcc
Subject comment; glaucoma certification standards

Dear Ms. Leiva,

I would like take this opportunity to provide comment on the proposed glaucoma treatment certification standards.

As an optometrist who is already glaucoma-certified, I feel that the proposed requirements are more than adequate to ensure competence to treat glaucoma. Any insistence from ophthalmology to return to a requirement for O.D. - M.D. co-management of any number of glaucoma cases is disingenuous at best. When that requirement was in place under SB929, most of my colleagues were unable to find an M.D. who would be willing to co-manage glaucoma. Most ophthalmologists used that requirement as an opportunity to stonewall the process entirely and prevent O.D.s from gaining certification to the greatest possible extent. Therefore, I request that the board adopt the proposed certification standards as submitted, so as not to be dependent on ophthalmology in any way.

Sincerely,
Alan Lubanes, O.D.
Georgetown, CA

Comment 15

ADVANCED EYE CARE ASSOCIATES
Trajan J. Soares, O.D. F.A.A.O.

12/16/09

To whom it may concern,

I have practiced optometry in the state of California for 20 years and have been licensed to treat glaucoma in California since November 2004 (and I have done so without incident). I have always maintained my license to the limit of what California allows. I have been therapeutically (including the treatment of glaucoma) licensed in Oregon & Washington states since 1990.

I feel the requirement set forth by SB 929, which requires comanagement of 50 glaucoma cases for a period of two years, is unrealistic and unnecessary. It is virtually impossible for the typical optometrist to attain 50 glaucoma cases and manage them with a willing ophthalmologist for a two year span. This requirement is inefficient for both the physicians involved, and for the patients being asked to participate. The only way I was able to accomplish this feat was that I was working with an ophthalmology group at the time.

The intent of such a requirement is to insure proper training of the optometrist seeking licensure. There are no safeguards in this scenario to guarantee that proper training is indeed taking place. Simply having any medical doctor, with a residency in ophthalmology, mentor an optometrist does not ensure that proper glaucoma management is being taught. Nor do these credentials make one a competent instructor. This requirement accomplishes nothing more than providing a brick wall to those seeking licensure.

I strongly urge the California State Board of Optometry to do all in its power to amend this requirement.

Sincerely,

Trajan J. Soares, O.D., F.A.A.O.

Phone: (209)826-1434 1028 6th Street, Los Banos, California 93635 Fax: (209)826-8375
advanced_eyecare@sbcglobal.net
VisionSource!

Comment 16

Robert H. Meisel, O.D.
Doctor of Optometry

7850 Broadway
Lemon Grove, CA 91945
(619) 697-2020

3950 30th Street
San Diego, CA 92104
(619) 296-6361

17 December 2009

I have been licensed to practice optometry in California for over thirty years and on 9 December 2004, I became certified to treat my patients for glaucoma. My colleagues in other states have been treating their patients with glaucoma for over a decade, so I was very pleased to have earned that privilege under SB 929. California has lagged behind most every state in allowing optometric care for glaucoma patients by having unfair obstacles for certification.

All of my glaucoma patients were especially pleased to not have to be referred to another doctor and could stay under my care. However, it was a true test of my dedication and perseverance to manage fifty patients with a cooperating preceptor ophthalmologist. My local colleagues were not so fortunate.

The vast majority of the members of the San Diego Society who wished to become certified were not able to accomplish that goal due to the fact that they were not geographically close to the colleges of optometry and they could not find an ophthalmologist to preceptor them. They were forced to then continue to refer their glaucoma patients, which was costly and unnecessary based on their training.

Now that SB 1406 has passed and ophthalmology agreed last year to repeal the burden of managing fifty patients within two years under their supervision, the Academy of Eye Physicians and Surgeons is still insisting this year that this rule be continued for optometric glaucoma certification. California has many undiagnosed patients with glaucoma and needs all qualified doctors, no matter what doctoral degree they have earned, to treat them, especially in rural areas of the state.

I am adamantly opposed to this attempt to discourage qualified optometrists from becoming certified under SB 1406! I strongly support the State Board of Optometry's proposed glaucoma certification regulations in their current format.

Please feel free to contact me if you need any further information.

Sincerely,

R.H. Meisel OD

Robert H. Meisel, OD, FAAO

License # 5905TPG

Member American Optometric Association

Comment 17

Beach Vision Center
AN OPTOMETRIC CORPORATION

WAYNE JOHNSON, O.D., F.A.A.O.
A. CORY THIES, O.D.

10900 LOS ALAMITOS BLVD., SUITE 102
LOS ALAMITOS, CALIFORNIA 90720

PH. (562) 431-1301
(562) 430-7505
FAX (562) 594-0624

December 17, 2009

Andrea Leiva
California State Board of Optometry

I was certified on February 28th, 2008 under the old SB929 regime, through a sponsored program at the Southern California College of Optometry. The process of certification under SB929 in the time frame of 2003-2009 has discouraged most of my qualified colleagues from seeking certification because the requirements implemented proved to be extremely inconvenient and far too expensive. Especially, for those located far from either learning institution.

My partner and I began the process mid 2002. It took us over 4 years to complete, a considerable amount of time and expense to fill the requirements. One major obstacle was completing the 2-year requirement for following 50 glaucoma patients. Unfortunately, the first 50 glaucoma patients don't walk into your office on day one. By the time we both diagnosed 50 glaucoma patients each more than 1 year had elapsed. The other problem was that not all patients returned for follow up care, for a variety of reasons, death, illness, moving out of area, change of insurance, change of doctors or just failure to return for treatment.

By the time we completed the 50 patients we needed at least 80 patients each to complete the 2-year requirement. This requirement is absurd. Ophthalmology isn't required to follow the same guidelines in their residency programs. At the time we commenced the program we were unable to locate a local ophthalmologist as a preceptor. We chose S.C.C.O even though it was a long commute for our patients as well as us.

I believe a better way to achieve a solid learning foundation would be in small groups of optometrists (4-10) in grand round clinics where each optometrist can discuss diagnosis, treatment plans and options. A great deal more would be learned in one session than a one on one visit with a patient, the same procedure that is utilized by interns and residents in hospitals and clinics.

Beach Vision Center
AN OPTOMETRIC CORPORATION

WAYNE JOHNSON, O.D., F.A.A.O.
A. CORY THIES, O.D.

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FAX (562) 594-0624

In discussions with my colleagues in other states, California is one of the few states remaining with extremely unfair obstacles in allowing optometrists to treat and manage their glaucoma patients without costly and unnecessary referrals. It is estimated that more than 430,000 Californians have undiagnosed glaucoma and need required treatment. In our practice we see more of this type of patient who is completely unaware they have a serious problem. I urge the implementation of SB1406 immediately, especially for my peers who were licensed before 2008 to become certified more efficiently and fairly.

Regards,

Dr. Wayne Johnson, O.D., F.A.A.O.

Statement of Tony Carnevali, O.D., F.A.A.O.
to the State Board of Optometry
December 22, 2009

Since the last time I appeared before this Board on July 16, 2009 to present my report on glaucoma certification commissioned by the Office of Professional Examination Services, I have been the focus of controversy as the author of that report. At that meeting, Dr. Craig Kliger, M.D., the Executive Vice President of the California Academy of Eye Physicians and Surgeons (CAEPS), stated that these attacks were "not personal." I beg to differ; criticisms which attack my credibility, my competence, and above all my personal ethics are personal.

In addition to addressing several letters to you criticizing me before I presented my findings and recommendations, CAEPS, the California Medical Association (CMA), and the American Glaucoma Society (AGS) filed two petitions with the Director of the Department of Consumer Affairs, suggesting that the process used by OPES to select me as their Special Consultant was flawed; that I was not an expert in glaucoma; and that I have several conflicts of interest that should have disqualified me from consideration. Using these charges as their only basis, they requested that this regulatory process be suspended. My alleged conflicts of interest are my past and present service to the California Optometric Association (COA) and that I am currently a member of the faculty at the Southern California College of Optometry. They contend that these factors somehow clouded my judgment and objectivity in performing my duties as Special Consultant to OPES.

It is apparent that these attacks are designed to divert the focus from the message to the messenger. The report and recommendations that I submitted were well researched and documented. To my knowledge, the Petitioners have never addressed any of my specific findings and recommendations presented in the report to you. Specifically, CAEPS, CMA and AGS claim:

- I am not glaucoma certified under SB 929;
- I am an employee of the Southern California College of Optometry which would stand to benefit financially from the conduct of glaucoma courses;
- I am President of the Board of Directors of the Public Vision League.-the litigative arm of COA; and
- I am a past president and was a long-time member of the COA's Board of Trustees.

These facts, they claim, render me unfit and anything produced by me as Special Consultant is therefore tainted and should be discarded as invalid and unreliable.

Allow me to set the record straight. The facts are these.

1. The Petitioners claim that I am not glaucoma certified and therefore not an expert in glaucoma. (In previous communications CAEPS representatives have even suggested that I may in fact be treating glaucoma illegally.) What is interesting is that while CAEPS, CMA, and AGS make this point in the petition, they also suggest that an "educator" with no such expertise would have been a better choice as Special Consultant.

Since my expertise regarding glaucoma and perhaps even the legality of my actions have been questioned, I must respond. It is correct that I am not currently certified to treat glaucoma under the law in effect between January 2001 and this year. The reality, however, is that within the context of clinical practice and education over the past 34 years I have acquired significant knowledge and skill in the diagnosis, treatment and management of glaucoma: Starting in private practice and working with local ophthalmologists in the diagnosis and management of glaucoma patients -including monitoring for intra-ocular pressure (IOP) and optic nerve changes, progression of visual fields, compliance with medications, etc., but not including treatment, and culminating with my experiences in the diagnosis, treatment and management of glaucoma patients at the Optometric Center of Los Angeles (OCLA), an affiliate teaching clinic of SCCO, within the scope of practice authorized by SB 929. With regard to this experience at OCLA, in my letter of July 25, 2009, forwarding my report to Sonia Merold, Chief of OPES, I did state:

> Since coming to OCLA, I have been deeply involved in the diagnosis, treatment, and management of glaucoma patients both directly and in grand-rounds and in teaching all clinical aspects of glaucoma to the Interns on rotation at our Center. Over the years, I have seen and worked with hundreds of patients with all types of glaucoma and at different stages and severities of glaucoma progression.

The Petitioners have taken this comment out of context to assert that I am treating glaucoma illegally. Had they considered this statement in the context of Tab 7 of my report, I am certain they would have a better appreciation of when and how I treat and manage glaucoma. I am attaching Tab 7 for your information.

One further clarification needs to be made. It is apparent that CAEPS, CMA, and AGS have misinterpreted SB 929 to mean that ODs cannot treat glaucoma. That is not correct. ODs can treat glaucoma with a co-managing ophthalmologist using up to two medications and following a very specific protocol detailed in SB 929. The prescribed protocol is as follows: The OD makes the initial diagnosis, refers the patient for an initial evaluation to an OMD, consults with the primary care physician if the patient is diabetic, and then initiates treatment and follows the patient for two years. During this time the OD may perform additional testing, monitor for glaucoma progression and change medications. Only in the event that a third medication is necessary, secondary glaucoma develops or upon patient request, is the patient required to be transferred to the care of an ophthalmologist. A report is required in one year to the consulting ophthalmologist as to the status of the patient. Once the OD reaches 50 patients, each followed for two years, the OD is certified by the State Board of Optometry to diagnose, manage, and treat glaucoma patients independently of any co-managing ophthalmologist.

That is exactly the protocol we follow at OCLA and that is the basis for my statement regarding the treatment and management of glaucoma.

As a further point, none of the tasks assigned to me by OPES required expertise in glaucoma diagnosis, treatment, or management. What was required was an ability to

evaluate and assess laws regulating the practice of optometry in other states, curriculum content and review process, accreditation process for optometric programs, and evaluating the National Board Examinations with regard to content and testing of entry level knowledge and skills in glaucoma. My past and current activities and experiences have given me the necessary expertise to conduct thorough and thoughtful evaluations and analyses as required by my OPES assignment.

2. The Petitioners also claim that my being on the SCCO faculty means that I may benefit financially from any glaucoma courses resulting from my recommendations - also a disqualifying conflict of interest. It is true that I have been a full time member of the faculty at SCCO since 1994, have enjoyed tenure as an Associate Professor since 2005, and have served as Clinic Director of the Optometric Center of Los Angeles, a teaching clinic of the college, since 1995. Petitioners are wrong however that these relationships create a conflict of interest. I am a salaried employee of the college. My salary depends neither on involvement with SCCO external teaching programs, nor whether SCCO makes money from these programs. It is a fixed salary based on my teaching performance at OCLA; scholarship contributions; service to the college, community and profession; and on my administrative responsibilities and accomplishments. The fact that SCCO may participate and benefit financially from conducting glaucoma courses as proposed in my recommendations has no bearing on my salary nor would it provide me with any further compensation-in any form, directly or indirectly.

   In point of fact, the schools of optometry in California have been providing Continuing Education programs throughout the state and have been charged by the Legislature in the past to conduct training and certification programs for ODs in California. When the law was first changed in 1976 to permit ODs to use diagnostic drugs, the schools were charged with conducting a 55 hour course on general and ocular pharmacology. When the law was changed in 1996 to allow ODs to treat some medical eye conditions the schools were charged with conducting an 80 hour course to certify ODs in the use of therapeutic pharmaceutical agents. When the law was changed in 2001 to permit ODs to first treat glaucoma, the schools were charged with conducting a 24 hour course in glaucoma. So what is different now? Why would any course required under SB 1406 exclude optometry schools in the state? The Ophthalmology Report of the Glaucoma Diagnosis and Treatment Advisory Committee had proposed a 16- hour advanced case management course; who was going to conduct the course? Would ophthalmology prohibit the participation of the schools of optometry in California in conducting such courses? Of course not! California's optometry schools are charged in the proposed regulations to develop for the State Board's approval the curriculum for the patient case management and grand-rounds courses, so it stands to reason that they would be significant providers of these courses.

   Additionally, my conclusions and recommendations about the adequacy of the didactic curriculum and clinical training programs at schools of optometry were not solely based on data from SCCO and UCB, but from several other schools and colleges of optometry in the country.

3. Finally, the Petitioners suggest that I should have been disqualified as Special Consultant because of conflict of interest resulting from past and current service to the COA, of which I am an active member. I did serve on the Board of Trustees from 1982 to 1992 and served as its President in 1991-1992. I have not been directly involved with the Board of Trustees of the association since that time; nor have I been directly involved as an advocate for scope of practice issues and legislation. However, I am a member of and currently serve as President of the Board of Directors of the Public Vision League. PVL is an independent entity constituted as a social welfare organization whose purpose is to promote and legally protect the visual welfare of the public. The organization is not involved in any political or legislative activity of the association. Incidentally this is a volunteer position, not a paid one. Except for reimbursements for travel expenses to attend meetings, I do not receive any payment from PVL. Moreover, as a member of the PVL Board, I have recused myself from any activity, discussion or communication pertaining to the glaucoma issue or certification process.

   In the letter to Sonja Merold I did make the following disclosure:

   > I have been and continue to be an active member of the California Optometric Association-a past president and member of the COA Board of Trustees and deeply passionate and committed to the evolution of the profession of optometry in California and on the national scene. That is who I am; therefore, I am not certain that I can completely divorce myself from this bias.

   Given this background and given the controversy of the issue, I can tell you that in preparing the report I acted autonomously and to the best of my ability tried to put aside my personal views and opinions and generate a report that was thorough, well researched and documented, and fair in addressing public needs while ensuring public safety.

When I was hired by OPES, I was given a list of very specific tasks to perform, including:

- Evaluating other state laws and regulations pertaining to the licensure of ODs with regard to glaucoma diagnosis, treatment and management;
- Evaluating didactic curriculum and case management training at various optometry schools; and
- Evaluating the National Board of Examiners in Optometry's three-part national examination regarding the integration of glaucoma diagnosis, treatment and management in their content.

In fulfilling these tasks I relied on information provided by other state boards of optometry; a number of optometry schools throughout the U.S.; data provided by the American Optometric Association; and data available from other sources, as well as the individual reports submitted by the members of the Glaucoma Diagnosis and Treatment Advisory Committee. In all instances, data gathering and analysis was performed only by me with no input from COA or the schools of optometry in California. I sought no counsel and none was offered from any of these organizations. I did my utmost to maintain my independence and objectivity throughout. The content of the report and its conclusions and recommendations were mine alone; my recommendations were based strictly on a thorough and critical assessment of all information at my disposal. At no time during the entire process did I violate the confidentiality agreement that

I signed for OPES. Upon completion of the report, I did not distribute nor share any part of the report, conclusions, or recommendations with anyone except for OPES. And as instructed by DCA's Office of Personnel I filed Form 700, my Statement of Economic Interest. A copy is attached for your information.

In conclusion, I have nothing for which to apologize. I performed my assigned duties and responsibilities to the best of my ability and I did so with full understanding of the implications of my actions. Consistent with the Legislature's charge to OPES, my goals were to –

- Ensure that optometrists have the necessary knowledge and skills to competently and safely diagnose, treat and manage glaucoma as specified under SB 1406;
- Suggest ways that optometrists be certified within a timely basis; and
- Most importantly to serve the public good by increased access to care, thus reducing the public health consequences of glaucoma.

As Senator Correa stated in his letter of March 31, 2009, to Sonja Merold, Chief of OPES:

> We wanted to guarantee that SB 1406 would make it possible for more optometrists to be treating vulnerable populations in the state of California…At a time when health care is expensive to the point of being prohibitive, this bill will allow more people at risk for vision loss to receive much needed attention.

Tab 7

Glaucoma Clinical Care at the Optometric Center of Los Angeles: A Personal Perspective

Allow me to describe the glaucoma clinical experience at the Optometric Center of Los Angeles, an affiliate teaching clinic of the Southern California College of Optometry. About 60% of all senior Interns from SCCO rotate through our facility and work under the supervision of 13 outstanding part-time clinical faculty members who are full time in private practice with other optometrists, ophthalmologists, hospital-based, etc.

Our Center is located in the South Los Angeles area, populated by 70% Hispanics, 25% African-Americans, and 5% of other ethnicities. It is also the third most densely populated area of the County and the one of the poorest with over 1/3 of its population below the federal poverty level. As is well documented African Americans have over 4-5 times greater incidence of glaucoma and the Hispanics over 3 times the prevalence of Caucasians. Not only are there great numbers of patients with great need; but the resources in this area are extremely limited. Our Clinic is one of the few in the area that is available to provide for the visual welfare of this segment of the population.

OCLA is a comprehensive eye and vision care facility. The services provided are Primary Care throughout the week with specialty services such as Low Vision Rehabilitation, Vision Therapy, Contact Lenses, and Ocular Disease superimposed on Primary Care. Ocular Disease Clinic is scheduled on a grand-rounds format and is conducted by a fellowship-trained ophthalmologist in comprehensive ophthalmology and glaucoma.

With regard to glaucoma, the clinic sees all different kinds and all degrees of severity…In addition to POAG, Pseudoexfoliation, Pigmentary, and Narrow Angle Glaucoma as authorized under SB 1406, other types are seen as well: normal tension glaucoma, ocular hypertension, neovascular glaucoma, uveitic glaucoma, traumatic glaucoma, congenital glaucoma, steroid-induced glaucoma, postlaser IOP spikes, etc. We are prepared to diagnose and treat most of these glaucomas, including performing laser procedures such as laser trabeculoplasties (SLT, Argon), laser iridotomies, iridectomies, and iridoplasties. Surgical procedures and neovascular glaucomas requiring anti-VEGF treatment are referred out to local ophthalmologists specializing in glaucoma or retina.

Types of Glaucoma patients seen: new patients who do not know they have glaucoma, new patients who have glaucoma and want to transfer to our clinic for further care; and established patients who are being followed as glaucoma suspects, or who eventually develop glaucoma. We also see patients who are referred by local doctors specifically for glaucoma work up, for co-management with our ophthalmologist, or for laser procedures; and those with end-stage glaucoma are referred to our Low Vision Clinic for visual rehabilitation. Approximately 5 to 7 new cases of glaucoma are seen per clinician and about 50 cases in grand-rounds for 8 clinicians per rotation. All examinations and services are provided first by Interns in consultation with Attending Staff Doctors. Most of our faculty is not glaucoma-certified, therefore all of the glaucoma patients are referred to Ocular Disease Clinic for co-management with ophthalmology as required by SB 929.

The protocol for glaucoma patients is as follows:
Each patient is generally given a comprehensive primary care exam by an Intern-with an initial assessment made and a treatment plan recommended by that Intern. If there is an indication for glaucoma or any suspicion of glaucoma, the type of glaucoma and the risk factors are considered in the proposed treatment plan with recommendations for medical/laser/surgical treatment or for further work up which may include-OCT/HRT, Pachymetry, Gonioscopy, Serial Tonometry, Threshold Visual Fields, Stereo Optic Disc Imaging, etc. After all testing is completed by the Intern a final treatment plan is developed by the Intern and coordinated with the Attending Staff-the plan includes recommended target IOPs, medications to be used, and frequency of follow-up visits. If the patient has POAG and the Attending Staff is glaucoma certified, treatment is initiated and the patient followed in Primary Care. If the Attending Staff is not glaucoma certified, the patient is scheduled with the Ophthalmologist in Ocular Disease Clinic for a consultation; the patient is presented in a grand-rounds format. After the EyeMD exams the patient and the EyeMD approves treatment plan, the initial prescription is written, and the patient later followed in Primary Care Clinic by the Intern and Attending Staff Doctor. If the patient also has diabetes, the patient's PCP is consulted as well. The grand-rounds program is supplemented with frequent lectures and discussions on glaucoma related topics.

In Primary Care Clinic, the patient is followed very closely-usually every 3 to 4 months or even more frequently during the first year of diagnosis. (However, during any rotation, an Intern would see the patient for the initial examination and work-up for perhaps 1-3 visits; subsequent visits would usually involve another clinician during the following rotation.) The patient is returned to Ocular Disease Clinic if any of the following occurs: the patient develops a secondary form of glaucoma; the patient needs a third medication; the patient requests treatment by an ophthalmologist; the optic nerve damage and visual field loss progress despite IOP control; or the patient needs a laser procedure. If the patient needs any surgical procedure, or any treatment beyond the scope of practice of optometry or beyond the clinic's capabilities, the patient is referred to an appropriate EyeMD for further care.

(E) D

CALIFORNIA FORM 700
FAIR POLITICAL PRACTICES COMMISSION

STATEMENT OF ECONOMIC INTERESTS
COVER PAGE COPY

Date Received
Official Use Only

Please type or print in ink. 2009 SEP 10 PM 2:31 *A Public Document* 09 SEP -9 AM 8:16

NAME (LAST)	(FIRST)	(MIDDLE)	DAYTIME TELEPHONE NUMBER
CARNEVALI	TONY		(323) 234-9137

MAILING ADDRESS (May use business address) STREET	CITY	STATE	ZIP CODE	OPTIONAL FAX / E-MAIL ADDRESS
3916 S. BROADWAY	LOS ANGELES	CA	90037	

1. Office, Agency, or Court

Name of Office, Agency, or Court:
CONSUMER AFFAIRS

Division, Board, District, if applicable:
OFF of PROFESSIONAL EXAMINATION SERVICES

Your Position:
SPECIAL CONSULTANT (Limited Term)

► If filing for multiple positions, list additional agency(ies)/ position(s): (Attach a separate sheet if necessary.)

Agency: _____

Position: COPY

2. Jurisdiction of Office *(Check at least one box)*

- ☒ State
- ☐ County of _____
- ☐ City of _____
- ☐ Multi-County _____
- ☐ Other _____

3. Type of Statement *(Check at least one box)*

- ☒ Assuming Office/Initial Date: 04 / 06 / 09
- ☐ Annual: The period covered is January 1, 2008, through December 31, 2008.

-or-

- ○ The period covered is ___/___/___, through December 31, 2008.
- ☒ Leaving Office Date Left: 07 / 31 / 09 (Check one)
  - ○ The period covered is January 1, 2008, through the date of leaving office.

-or-

  - ○ The period covered is ___/___/___, through the date of leaving office.
- ☐ Candidate Election Year: _____

4. Schedule Summary

► Total number of pages including this cover page: 3

► Check applicable schedules or "No reportable interests."

I have disclosed interests on one or more of the attached schedules:

- Schedule A-1 ☐ Yes – schedule attached
  Investments (Less than 10% Ownership)
- Schedule A-2 ☐ Yes – schedule attached
  Investments (10% or greater Ownership)
- Schedule B ☐ Yes – schedule attached
  Real Property
- Schedule C ☒ Yes – schedule attached
  Income, Loans, & Business Positions (Income Other than Gifts and Travel Payments)
- Schedule D ☐ Yes – schedule attached
  Income – Gifts
- Schedule E ☒ Yes – schedule attached
  Income – Gifts – Travel Payments

-or-

☐ No reportable interests on any schedule

COPY

5. Verification

I have used all reasonable diligence in preparing this statement. I have reviewed this statement and to the best of my knowledge the information contained herein and in any attached schedules is true and complete.

I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date Signed 9/2/09
(month, day, year)

Signature _____
(File the originally signed statement with your filing official.)

SCHEDULE C
Income, Loans, & Business Positions
(Other than Gifts and Travel Payments)

CALIFORNIA FORM 700
FAIR POLITICAL PRACTICES COMMISSION

Name
T. CARNEVALI

1. INCOME RECEIVED

NAME OF SOURCE OF INCOME
SOUTHERN CALIF. COLLEGE OF OPTOMETRY

ADDRESS
2575 YORBA LINDA BLVD
FULLERTON, CA 92831-1699

BUSINESS ACTIVITY, IF ANY, OF SOURCE
OPTOMETRIC EDUCATION

YOUR BUSINESS POSITION
CLINIC DIRECTOR/ASSOCIATE PROFESSOR

GROSS INCOME RECEIVED
- ☐ $500 - $1,000
- ☐ $1,001 - $10,000
- ☒ $10,001 - $100,000
- ☐ OVER $100,000

CONSIDERATION FOR WHICH INCOME WAS RECEIVED
- ☒ Salary
- ☐ Spouse's or registered domestic partner's income
- ☐ Loan repayment
- ☐ Sale of _____
- ☐ Commission or
- ☐ Rental Income,
- ☐ Other _____

1. INCOME RECEIVED

NAME OF SOURCE OF INCOME
PUBLIC VISION LEAGUE

ADDRESS
2415 K STREET
SACRAMENTO, CA 95816

BUSINESS ACTIVITY, IF ANY, OF SOURCE
SOCIAL WELFARE
PROMOTING VISION WELFARE OF PUBLIC

YOUR BUSINESS POSITION
PRESIDENT

GROSS INCOME RECEIVED
- ☐ $500 - $1,000
- ☒ $1,001 - $10,000
- ☐ $10,001 - $100,000
- ☐ OVER $100,000

CONSIDERATION FOR WHICH INCOME WAS RECEIVED
- ☐ Salary
- ☐ Spouse's or registered domestic partner's income
- ☐ Loan repayment
- ☐ Sale of _____
- ☐ Commission or
- ☐ Rental Income
- ☒ Other REIMBURSEMENT FOR ACTUAL TRAVEL EXPENSES

2. LOANS RECEIVED OR OUTSTANDING DURING THE REPORTING PERIOD

* You are not required to report loans from commercial lending institutions, or any indebtedness created as part of a retail installment or credit card transaction, made in the lender's regular course of business on terms available to members of the public without regard to your official status. Personal loans and loans received not in a lender's regular course of business must be disclosed as follows:

NAME OF LENDER*

ADDRESS

BUSINESS ACTIVITY, IF ANY, OF LENDER

HIGHEST BALANCE DURING REPORTING PERIOD
- ☐ $500 - $1,000
- ☐ $1,001 - $10,000
- ☐ $10,001 - $100,000
- ☐ OVER $100,000

INTEREST RATE
_____% ☐ None

TERM (Months/Years)

SECURITY FOR LOAN
- ☐ None
- ☐ Personal residence
- ☐ Real Property
- ☐ Guarantor
- ☐ Other

Comments:

CALIFORNIA FORM 700
FAIR POLITICAL PRACTICES COMMISSION

Name

T. CARNEVALI

SCHEDULE E
Income - Gifts
Travel Payments, Advances, and Reimbursements

- Reminder – you must mark the gift or income box.
- You are not required to report "income" from government agencies.

► NAME OF SOURCE
PUBLIC VISION LEAGUE

ADDRESS
2415 K STREET

CITY AND STATE
SACRAMENTO, CA 95816

BUSINESS ACTIVITY, IF ANY, OF SOURCE
SOCIAL WELFARE
PROMOTING VISION WELFARE OF PUBLIC

DATE(S) 1/16/09 - 7/31/09 AMT $1089.00

TYPE OF PAYMENT (must check one) ☐ Gift ☒ Income

DESCRIPTION REIMBURSEMENT FOR ACTUAL TRAVEL EXPENSES SUCH AS AIRLINE, TAXI, PARKING & LODGING FOR ATTENDING MEETINGS.

► NAME OF SOURCE

ADDRESS

CITY AND STATE

BUSINESS ACTIVITY, IF ANY, OF SOURCE

DATE(S) __/__/__ - __/__/__ AMT $

TYPE OF PAYMENT (must check one) ☐ Gift ☐ Income

DESCRIPTION

► NAME OF SOURCE

ADDRESS

CITY AND STATE

BUSINESS ACTIVITY, IF ANY, OF SOURCE

DATE(S) __/__/__ - __/__/__ AMT $

TYPE OF PAYMENT (must check one) ☐ Gift ☐ Income

DESCRIPTION

► NAME OF SOURCE

ADDRESS

CITY AND STATE

BUSINESS ACTIVITY, IF ANY, OF SOURCE

DATE(S) __/__/__ - __/__/__ AMT $

TYPE OF PAYMENT (must check one) ☐ Gift ☐ Income

DESCRIPTION

Comments:

Comment 19

Hershel B. Welton, O.D. • Tim Welton, O.D.
www.drwelton.com
303 W Lincoln Ave Ste 120
Anaheim CA 92805-2928
+1.714.535.8404 • +1.714.687.9848 [Fax]

December 21, 2009

To whom it may concern:

I am a glaucoma-certified optometrist in the state of California since 7/16/2005. I am writing to support the State Board of Optometry's proposed glaucoma certification regulations under SB 1406.

The glaucoma certification process under SB 929 was not realistically obtainable for the majority of optometrists because of the inability to find preceptors willing to supervise them. Indeed, even the California Academy of Eye Physicians and Surgeons agreed to repeal this standard last year.

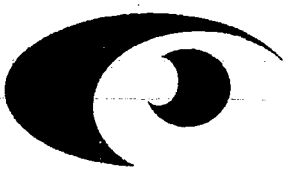
The glaucoma-certification process under SB 1406 will be of great benefit to state of California by providing the realistic ability for optometrists to help provide for the public health needs of their patients which are great given the size, population and diversity of its population.

Optometrists have a proven track record across the United States of providing excellent care, including the diagnosis, treatment and management of glaucoma. There is a pretty broad spectrum of skills among optometrists, but my experience has been that they clearly are able to decide for themselves what they are capable for diagnosing and treating and know when to refer cases they are not. The ability of those optometrists to provide care will help control medical costs by reducing unnecessary and costly referrals.

In closing, SB 1406's proposed glaucoma certification regulations will be a enormous while safe benefit to the residents of the state of California and look forward to its inaction.

Sincerely,

Tim WELTON, OD



UNIVERSITY EYE INSTITUTE

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College of Optometry
University of Houston
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Houston, Texas 77004

Phone: 713.743.1886
Fax: 713.743.0965

www.opt.uh.edu

Nicky R. Holdeman, O.D., M.D.
Executive Director of University Eye Institute
Chief of Medical Services

nrholdeman@uh.edu

December 21, 2009

Andrea Leiva
California State Board of Optometry
2420 Del Paso Road, Suite 255
Sacramento, CA 95834

RE: Proposed Amendments, 16 C.C.R. §1571

Dear Ms. Leiva:

I write to you today in support of proposed amendments to Section 1571 of Division 15 of Title 16 of the Code of California Regulations, as published for public comment on November 6. I understand that these amendments are the culmination of a process specified in Senate Bill 1406, to adopt standards for licensees who graduated prior to May 2008 in order to certify them to diagnose and manage glaucoma patients independently. It is also my understanding that, effective January 1 of this year, SB 1406 provided that any licensee who graduated on or after May 1, 2008 is certifiable by operation of law, without additional education or training.

Please let me clarify at the outset that some of my observations are based on review of information and data that was provided to the Legislature by the sponsors of SB 1406, furnished by members of the Glaucoma Diagnosis and Treatment Advisory Committee to the Office of Professional Examination Services (OPES), and presented to the Board by OPES's Special Consultant. I would also like to stipulate that the opinions expressed in this letter are my own and are not intended to represent the position of the College or of the University of Houston on any specific issue.

I am currently Professor and Associate Dean for Clinical Education, Executive Director of the University Eye Institute, and Chief of Medical Services at the University of Houston College of Optometry. I received my Doctor of Optometry degree from the University of Houston in 1976 and my Doctor of Medicine degree from the Health Sciences Center at Texas Tech University School of Medicine in 1987. I joined the College in 1989 as an Associate Professor, Chief of Medical Services, and Executive Director of the University Eye Institute, where I have served for two decades. I chaired the College's residency programs from 1993-1999 and became Associate Dean for Clinical Education in 2003 and a full tenured Professor in 2007. Given my background, I believe I am capable to comment on optometric training in general and with respect to the diagnosis and management of glaucoma in particular.

My *curriculum vitae* is attached for your information.

I note from submitted material, that both the legislative and certification debates have involved comparisons of optometric training and licensure to ophthalmology (or the medical model), as though the professions are in competition and thus should be measured by the same standards. True, there are similarities – both O.D.s and M.D.s must receive four years of postgraduate training at an accredited school or college and must pass a multipart, uniform, national board examination, to become eligible for state licensure.

Both optometrists and ophthalmologists are skilled in refracting and correcting vision abnormalities. Both disciplines are capable of diagnosing a wide range of ophthalmic disorders and systemic conditions that might manifest in the eye or be detected by various ancillary tests or imaging modalities. Where both professions are trained and examined appropriately, it makes good public health policy to have both optometrists and ophthalmologists use the diagnostic instrumentation and skills that they have acquired. This rational is already reflected in most state's optometric laws with respect to the diagnosis and management of glaucoma.

I discern that in California and elsewhere, that these comparisons, at times, become misguided. Optometry is a single system specialty that emphasizes *noninvasive* detection and therapeutic management of diseases and conditions of the eye and ocular adnexa. Ophthalmology is a *surgical* subspecialty that focuses on correction or treatment of ophthalmic disorders that cannot be effectively managed by less invasive means. Ophthalmologists are "eye physicians and surgeons." Optometrists are eye "generalists," and as such, can provide comprehensive primary eye care to most patients, most of the time. Optometrists serve as an accessible and efficient conduit to secondary and tertiary levels of intervention when needed. It has been my experience that optometrists will often practice in areas that might not support an ophthalmologist and that optometrists are very conscientious, deliberate, and ardently aware of their limitations. They do their best to diagnose and treat patients up to those limits, at which time they will readily refer a patient, along with tests, images and other information that serves to facilitate the specialist's consultation. These differences in practice strategy should be kept in mind when policy is made.

The curricular comparisons of four years' postgraduate work at three California colleges of medicine, dentistry, and optometry, which are on public record, illustrate a point. Optometrists, like dentists, focus on a single bodily system, so their specialized training begins first year. In contrast, medical students spend their first four years in classroom and clinical training studying the entire human body. They have rotations in selected disciplines, in what will become medical and surgical specialties after graduation, via internships and residencies. A recent editorial in the Journal of the American Academy of Ophthalmology noted that "[t]he number of medical schools requiring a formal ophthalmology rotation has declined significantly during the first years of the 21st century—down from 68% in 2000 to 30% in 2004". (*Ophthalmology* 2005; 112-11:1867 - 1868). Like other physicians, ophthalmologists receive their specialty training in residencies and fellowships that focus heavily on disease and surgery, which is entirely appropriate. The fact that optometrists do not receive the same training in regards to a skill set they are not legally authorized to perform, does not seem to be a substantial concern; again, much akin to dentistry.

On an individual basis, the two eye care professions work well together, a concept that is frequently proposed and endorsed by many prominent ophthalmologists. Optometrists and ophthalmologists collaborate daily in providing quality care, and work as a team to maximize individual time and talents. Optometrists diagnose and treat eye disorders when they can (or are permitted to), and refer to other medical and surgical subspecialists, such as ophthalmology, when more invasive treatment—surgery, injection, etc—is indicated or when a second opinion is appropriate. Optometrists identify and assess ocular surgical candidates, frequently in the same office, and co- manage these patients post-operatively with the assistance and oversight of the surgeon.

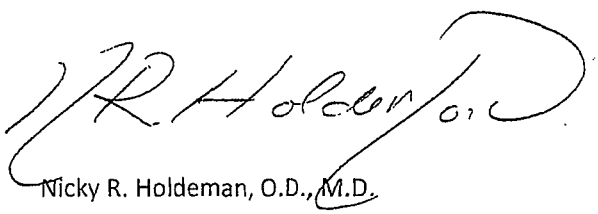
By definition, optometrists do not engage in the same level of risk as eye surgeons, but they are legally held to the same standard of care as their medical counterparts. Consequently, optometric examinations and the medical records generated must be clear, concise, and comprehensive. To my knowledge, the professional liability data for states who have bestowed optometrists the authority to diagnose and manage glaucoma, has not revealed an increase in disciplinary action or litigation as a result. Texas passed its optometric glaucoma law almost 10 years ago, and I am not aware of any legal action stemming from the increased scope of practice. This is a point to consider when meeting our highest duty, which is protection of the public.

I believe the proposed regulations, as drafted, will provide an appropriate foundation for optometrists to diagnose and manage glaucoma. Based on my experience, the proposed requirements for certification are consistent with the requirements of other states, such as Texas, where certified optometrists have been successfully diagnosing and treating patients with glaucoma for several years.

I am impressed by the fact that in SB 1406 and in these proposed regulations, California appears to be taking a more collaborative approach to governing the delivery of eye care. We have taken this approach in Texas and I believe it will serve the citizens of California well, particularly when it comes to meeting the public health challenges posed by an asymptomatic, yet serious disease like glaucoma. With the ageing of the "baby boomers', eye diseases in general will be increasing in record numbers. It will take all eye care providers, ODs and MDs, working together to efficiently accommodate the needs of our patients.

Thank you for your time and attention.

Respectfully submitted,



Nicky R. Holdeman, O.D., M.D.

CURRICULUM VITAE

December 2009

NAME: Nicky Ray Holdeman

TITLE: Professor and Associate Dean for Clinical Education
Executive Director, The University Eye Institute
Chief of Medical Services

ADDRESS: University of Houston
College of Optometry
4901 Calhoun Blvd
505 J. Davis Armistead Bldg.
Houston, Texas 77204-2020

HOME ADDRESS: 1813 Nantucket Drive
Houston, Texas 77057

EDUCATION:

A.S. - 1972	Amarillo College
B.S. - 1974	University of Houston
O.D. - 1976	University of Houston College of Optometry
M.D. - 1987	Texas Tech University Health Sciences Center School of Medicine
1987 - 1988	Internship, Internal Medicine Texas Tech University University Medical Center
1988 - 1989	Resident, Ophthalmology University of Texas Southwestern at Dallas

PROFESSIONAL EXPERIENCE:

1975 - 1976	Ophthalmological Assistant, Sylvan Brandon, M.D., Houston, Texas
1976 - 1977	Clinical Instructor, University of Houston College of Optometry, Houston, Texas

1977 - 1986	Doctor of Optometry, Drs. Pettey, Dean, Bowen, and Holdeman, Lubbock, Texas
1978 - 1986	Doctor of Optometry, Bill H. Wilson, M.D., Lubbock, Texas
1983 - 1986	Doctor of Optometry, William David Boothe, M.D., Lubbock, Texas
1989 - present	Associate Professor Chief of Medical Services Executive Director, The University Eye Institute University of Houston College of Optometry, Houston, Texas
1993 – 1999	Chair of Residency Programs University of Houston College of Optometry
2003 – present	Associate Dean for Clinical Education University of Houston College of Optometry
2007 – present	Professor University of Houston College of Optometry

HONORS AND AWARDS:

1972	Recipient of Eldon Durrett Scholarship for Outstanding Achievement, Amarillo College.
1974	Graduated Cum Laude, Bachelor of Science, University of Houston.
1976	Beta Sigma Kappa Honor Graduate, Doctor of Optometry, University of Houston.
1977	Best Article Award for Contribution of Significant Scientific Material to the Journal of the Texas Optometric Association.
1978	Best Article Award for Contribution of Significant Scientific Material to the Journal of the Texas Optometric Association.
1982-83	Who's Who in America, South and Southwest Edition.
1983	Outstanding Young Men of America.

1987	Lange Award for Outstanding Achievement in Medical School.
1990	Who's Who in Health and Medical Services.
1991	Who's Who Among Rising Young Americans.
1991	Recognition Award for Career Accomplishments presented by the Mayor and the City Council, City of Houston.
1992	Two Thousand Notable American Men.
1992	Men of Achievement - 16th Edition.
1993	Recognition Award for Career Accomplishments presented by the Mayor and the City Council, City of Houston.
1995	Who's Who, National Directory of Executives and Professionals, 1995-1996.
1996	Who's Who in Medicine and Healthcare, First Edition
2001	National Registry of Who's Who in Executives and Professionals, 2001-2002.
2001	Life Member – National Registry of Who's Who (#180341), 2001
2007	Selected as the 7th President at the Southern California College of Optometry (SCCO)

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Holdeman, N.R., Sable, G. M., Gurrola, M., Tang, R.A., "Diabetic Papillopathy: The Disc Edema Dilemma" Clinical and Refractive Optometry, 2009; Vol 20, Number 5, 150-154 (Reprint #2)

PUBLICATIONS: Book Chapters

Holdeman, N.R., Piccolo, M., "Detection, Diagnosis, and Management of the Uveitides," In: Onofrey, B.E. (ed.) Clinical Optometric Pharmacology and Therapeutics, Philadelphia, J.B. Lippincott Co., 1991, Chapter 49, pp. 1-26.

Holdeman, N.R., "Metabolic Disease," In: Blaustein, B.H.(ed), Ocular Manifestations of Systemic Disease. New York, Churchhill Livingstone, Inc., 1994, Chapter 7, pp. 99-115.

Holdeman, N.R., "Diabetes Mellitus," In: Onofrey, B.E. (ed.) Clinical Optometric Pharmacology. and Therapeutics, Philadelphia, J.B. Lippincott Co., 1994, Chapter 75 C, pp. 1-17.

Holdeman, N.R., Bartlett, J.D., "Analgesics for Treatment of Acute Ocular Pain," In: Bartlett, J.D., Jaanus, S.D. (eds.) Clinical Ocular Pharmacology, 3rd edition. Boston, Butterworth Publishers, 1994, Chapter 7.

Holdeman, N.R., "Systemic Disease Section," In: Hofstetter, Griffin, Berman (eds) Dictionary of Visual and Clinical Science, Butterworth - Heinemann, 2000.

Holdeman, N.R., "Analgesics for Treatment of Acute Ocular Pain," In: Bartlett, J.D., Jaanus, S.D. (eds.) Clinical Ocular Pharmacology, 4th edition. Boston, Butterworth Publishers, 2001, Chapter 7.

Bartlett, J.D., Holdeman, N.R., "Analgesics for Treatment of Acute Ocular Pain," In: Bartlett, J.D., Jaanus, S.D. (eds.) Clinical Ocular Pharmacology, 5th edition. St Louis, Butterworth, Heinemann, Elsevier Publishers, November 2007, Chapter 7.

PUBLICATIONS: Books

Onofrey, B.E., Skorin, L., Holdeman, N.R., (eds.) Ocular Therapeutics Handbook: A Clinical Manual, Philadelphia, J.B. Lippincott Co., December 1997.

Section Editor of Part III (Ocular Drugs in Clinical Practice, Chapters 19 - 35) In: Bartlett, J.D., Jaanus, S.D. (eds) Clinical Ocular Pharmacology, 4th edition. Boston, Butterworth Publishers, 2001.

Onofrey, B.E., Skorin, L., Holdeman, N.R., (eds.) Ocular Therapeutics Handbook: A Clinical Manual, 2nd edition. Philadelphia, Lippincott, Williams and Wilkins, May 2005.

Section Editor of Part III (Ocular Drugs in Clinical Practice, Chapters 19 - 35) In: Bartlett, J.D., Jaanus, S.D. (eds) Clinical Ocular Pharmacology, 5th edition. St Louis; Butterworth, Heinemann, Elsevier Publishers; November 2007.

Onofrey, B.E., Skorin, L., Holdeman, N.R., (eds.) Ocular Therapeutics Handbook: A Clinical Manual, 3rd edition. Philadelphia, Lippincott, Williams and Wilkins. Anticipated publication Q2 2010.

INVITED LECTURES and CONTINUING MEDICAL EDUCATION:

"Lyme Disease," Association for Women in Science, Rice University, Houston, Texas, October 4, 1989.

"Ocular Emergencies and Urgencies," University of Houston College of Optometry Continuing Education, Houston, Texas, December 2, 1989; 1990; 1991; 1992.

"Lyme Disease for the Eyecare Practitioner," University of Houston College of Optometry Continuing Education, Houston, Texas, December 3, 1989.

"Laboratory Culturing for Ocular Disease," Institute for Optometric Practice, Houston, Texas, April 22, 1990.

"Ocular Emergencies and Urgencies," Eyes of Texas Ophthalmology Clinic, Odessa, Texas, July 28, 1990.

"Gonioscopy and 3-Mirror Fundus Examination," University of Houston College of Optometry Ocular Health Assessment Course, Houston, Texas, August 16, 1990.

"Collagen Implants and Double Lid Eversion," Houston Concentrated Ocular Therapeutics, Houston, Texas, April 3, 1991.

"Culturing for Corneal Ulcers," Houston Concentrated Ocular Therapeutics, Houston, Texas, April 4, 1991; 1992.

"Cranial Nerve Examination and Assessment," Houston Concentrated Ocular Therapeutics, Houston, Texas, April 5, 1991; 1992.

"Gonioscopy and Peripheral 3-Mirror Fundus Evaluation," South Plains Optometric Society, Lubbock, Texas, June 14, 1991.

"Lid Retraction and Lid Eversion," Institute for Optometric Practice Instrumentation Workshop, Houston, Texas, July, 1991.

"Dilation and Irrigation of the Lacrimal System," Institute for Optometric Practice Instrumentation Workshop, Houston, Texas, July, 1991.

"Temporary and Permanent Punctal Occlusion," Institute for Optometric Practice Instrumentation Workshop, Houston, Texas, July, 1991.

"Corneal Foreign Body Removal," Institute for Optometric Practice Instrumentation Workshop, Houston, Texas, July, 1991.

"BIO with Scleral Depression," Institute for Optometric Practice Instrumentation Workshop, Houston, Texas, July, 1991.

"Faculty Credentialing and Quality Assurance," Association of Clinic Directors/Administrators of Schools and Colleges of Optometry, Chicago, Illinois, September 21, 1991.

"Treatment and Management of Ocular Disease: A National Board Panel Review," UHCO Alumni Association, Houston, Texas, October 20, 1991.

"Systemic Diseases Associated Uveitis," Institute for Optometric Practice, Santa Fe, New Mexico, January 18, 1992.

"The Comprehensive History, Physical Examination, and Complexity of Medical Decision Making," The 1992 Texas Optometric Association Third Party Conference, Dallas, Texas, April 5, 1992.

"Treatment and Management of Ocular Disease: A National Board Panel Review," UHCO Alumni Association, Houston, Texas, April 15, 1992.

"Systemic Medicine and the Eye," Annual Convention of the New Mexico Optometric Association, Albuquerque, New Mexico, June 14, 1992.

"Subtle Signs You Can't Afford to Miss," Contact '92, Anaheim, California, July 11, 1992.

"Diagnostic Lab Testing," Contact '92, Anaheim, California, July 12, 1992.

"AIDS and the Eye," Texas Society to Prevent Blindness, 37th Annual Scientific Session, Houston, Texas, March 14, 1992.

"Ocular Manifestations of Systemic Disease," Institute for Optometric Practice/ John H. Sheets, M.D., Lubbock, Texas, August 18, 1992.

"Ocular and Medical History/ Review of Systems," UHCO Advanced Therapeutics, Houston, Texas, November 5, 1992.

"Diabetes Mellitus," UHCO Advanced Therapeutics, Houston, Texas, November 5, 1992.

"Systemic Arterial Hypertension," UHCO Advanced Therapeutics, Houston, Texas, November 6, 1992.

"Thyroid Disorders," UHCO Advanced Therapeutics, Houston, Texas, November 7, 1992.

"Microbial Keratitis," Texan Eye Center, Austin, Texas, March 6, 1993.

"Ocular Emergencies: Case Reports," Institute for Optometric Practice, Houston, Texas, June 27, 1993.

"Ocular Emergencies and Urgencies," Contact '93, Anaheim, California, July 16, 1993.

"Diagnosis of Systemic Disease," Contact '93, Anaheim, California, July 17, 1993.

"How to Avoid Malpractice Traps," Southwest Contact Lens Society, San Antonio Texas, September 16, 1993.

"Diagnosis and Management of Ocular Trauma," Minnesota Association of Optometrists, St. Paul, Minnesota, October 8, 1993.

"Uveitis," Minnesota Association of Optometrists, St. Paul, Minnesota, October 9, 1993.

"Review of Systems," Advanced Therapeutics, Houston, Texas, November 4, 1993.

"Thyroid Disorders," Advanced Therapeutics, Houston, Texas, November 5, 1993.

"Hypertension," Advanced Therapeutics, Houston, Texas, November 5, 1993.

"Diagnosis and Management of Hypertension," Vision Institute of Canada, Toronto, Canada, November 13, 1993.

"Diabetes Mellitus," Vision Institute of Canada, Toronto, Canada, November 14, 1993.

"Physical Diagnosis," American Academy of Optometry, Boston, Massachusetts, December 9 & 10, 1993.

"Diagnosis and Management of Bacterial Corneal Ulcers," American Academy of Optometry, Boston, Massachusetts, December 10, 1993.

"Ocular and Systemic Implications of Thyroid Disorders," Institute of Optometric Practice, Santa Fe, N.M., January 14, 1994.

"Systemic Laboratory Assessment: Decisions in Ocular Disease," Institute of Optometric Practice, Santa Fe, N.M., January 16, 1994.

"Arterial Hypertension," Oklahoma Optometric Association 1994 Congress, Tulsa, Oklahoma, April 28, 1994.

"Diabetes Mellitus," Oklahoma Optometric Association 1994 Congress, Tulsa, Oklahoma, April 29, 1994.

"Danger Signals You Can't Afford to Miss," Kansas Optometric Association Annual Convention and Educational Seminar, Overland Park, Kansas, May 12, 1994.

"Danger Signals You Can't Afford to Miss," New Mexico Optometric Association Annual Convention, Albuquerque, New Mexico, May 19, 1994.

"Corneal Ulcers," International Academy of Optometry, Amsterdam, Netherlands, May 28, 1994.

"Diagnosis, Lab Analysis, and Treatment of Bacterial Corneal Ulcers," Utah Optometric Association Annual Convention, Park City, Utah, June 10, 1994.

"Medical Case History and Review of Systems," Utah Optometric Association Annual Convention, Park City, Utah, June 11, 1994.

"Physical Diagnosis: Lecture and Workshop," Oklahoma Chapter of the American Academy of Optometry, Oklahoma City, Oklahoma, August 19, 1994.

"Ocular and Systemic Implications of Thyroid Disorders," Panhandle Optometric Society, Amarillo, Texas, September 11, 1994.

"Systemic Laboratory Assessment," Panhandle Optometric Society, Amarillo, Texas, September 11, 1994.

"Diagnosis, Lab Analysis, and Treatment of Bacterial Corneal Ulcers," Southwest Contact Lens Society, San Antonio, Texas, September 30, 1994.

"Medical History and Physical Diagnosis: Lecture and Workshop," University of Houston College of Optometry Advanced Therapeutic Course, Houston, Texas, November 4 and 5, 1994.

"Injections and Suturing Techniques: Lecture and Workshop," University of Houston College of Optometry Advanced Therapeutic Course, Houston, Texas, November 4 and 5, 1994.

"Diagnosis, Lab Analysis, and Treatment of Bacterial Corneal Ulcers," Minnesota Association of Optometrists, Minneapolis, Minnesota, November 19, 1994.

"Ocular and Systemic Implications of Thyroid Disorders," Minnesota Association of Optometrists, Minneapolis, Minnesota, November 19, 1994.

"Medical History and Physical Diagnosis: Lecture and Workshop," American Academy of Optometry, San Diego, California, December 10, 1994.

"Diagnosis, Lab Analysis, and Treatment of Bacterial Corneal Ulcers," American Academy of Optometry, San Diego, California, December 11, 1994.

"Diagnosis, Lab Analysis, and Treatment of Microbial Keratitis," Heart of America Congress, Kansas City, Missouri, February 10, 1995.

"Detection and Clinical Management of Systemic Hypertension," Heart of America Congress, Kansas City, Missouri, February 11, 1995

"Systemic Etiologies and Laboratory Analysis of Uveitic Syndromes," University of Houston College of Optometry Concentrated Therapeutic Course, Houston, Texas, March 29, 1995.

"Systemic Medicine," University of Houston College of Optometry Concentrated Therapeutic Course, Houston, Texas, March 30, 1995.

"Ocular Emergencies and Urgencies," University of Houston College of Optometry Concentrated Therapeutic Course, Houston, Texas, March 31, 1995.

"Cranial Nerve Testing," University of Houston College of Optometry Concentrated Therapeutic Course, Houston, Texas, April 3, 1995.

"Rationale and Techniques of Ocular Cultures," University of Houston College of Optometry Concentrated Therapeutic Course, Houston, Texas, April 3, 1995.

"Subtle Signs and Symptoms You Can't Afford to Miss," University of Houston College of Optometry Concentrated Therapeutic Course, Houston, Texas, April 4, 1995.

"Corneal Ulcers and Infiltrates," Queensland Optometrical Association Ocular Therapeutics Course, Brisbane, Australia, May 13, 1995.

"Corneal Abrasions, Erosions and Foreign Bodies," Queensland Optometrical Association Ocular Therapeutics Course, Brisbane, Australia, May 13, 1995.

"Advanced Diagnostic Procedures Workshop," Queensland University of Technology, Brisbane, Australia, May 13, 1995.

"Uveitis - Classification, Lab Testing and Treatment," Queensland Optometrical Association Ocular Therapeutics Course, Brisbane, Australia, May 14, 1995.

"Ocular Emergencies and Urgencies," Southern Regional Conference, Melbourne, Australia, May 20, 1995.

"The Comprehensive Ocular and Medical History and Review of Systems," Southern Regional Conference, Melbourne, Australia, May 21, 1995.

"Lacrimal Procedures: Dilation, Irrigation, and Occlusion," Southern Regional Conference, Melbourne, Australia, May 21, 1995.

"Ocular Manifestation of Systemic Disease," Southern Regional Conference, Melbourne, Australia, May 22, 1995.

"Corneal Ulcers and Infiltrates," Victorian Optometrical Association Ocular Therapeutics Course, Melbourne, Australia, May 27, 1995.

"Corneal Abrasions, Erosions and Foreign Bodies," Victorian Optometrical Association Ocular Therapeutics Course, Melbourne, Australia, May 28, 1995.

"Advanced Diagnostic Procedures Workshop," Victorian University College of Optometry, Melbourne, Australia, May 28, 1995.

"Uveitis - Classification, Lab Testing and Treatment," Victorian University College of Optometry, Melbourne, Australia, May 29, 1995.

"Lacrimal Procedures: Evaluation and Indications for Dilation, Irrigation, and Occlusion," South Plains Optometric Society, Lubbock, Texas, July 22, 1995.

"Diagnosis and Management of Corneal Abrasions, Erosions, and Foreign Bodies," South Plains Optometric Society, Lubbock, Texas, July 22, 1995.

"Diagnosis and Management of Bacterial Keratitis," Northwest Pathology Forum, Portland, Oregon, September 9, 1995.

"Uveitis, Classifications, Detection and Diagnosis," Northwest Pathology Forum, Portland, Oregon, September 9, 1995.

"Systemic Emergencies in an Office Based Practice," Institute for Optometric Practice, Houston, Texas, September 24, 1995.

"When the Diagnosis is in the Blood," Rio Grand Optometric Society, Weslaco, Texas, October 5, 1995.

"Diagnosis, Lab Analysis, and Treatment of Bacterial Keratitis," Arizona Optometric Association, Sedona, Arizona, November 11, 1995.

"Physical Diagnosis," American Academy of Optometry, New Orleans, Louisiana, December 9, 1995.

"Physical Diagnosis," Dallas County Optometric Society, Dallas, Texas, December 14, 1995.

"Medical News From Around the World," Institute for Optometric Practice, Santa Fe, New Mexico, January 12, 1996.

"Update on the Management of Corneal Abrasions," Institute for Optometric Practice, Santa Fe, New Mexico, January 13, 1996.

"Update on Hypertension," Harris County Optometric Society, Houston, Texas, March 26, 1996.

"Early Detection of Glaucoma," Harris County Optometric Society, Houston, Texas March 26, 1996.

"Update on the Detection, Diagnosis, and Management of Hypertension," New Mexico Optometric Association, Albuquerque, New Mexico, April 27, 1996.

"Laboratory Testing for the Eyecare Practitioner," New Mexico Optometric Association, Albuquerque, New Mexico, April 27, 1996.

"Ocular Emergencies and Urgencies," Uniformed Services University of the Health Sciences and Office of the Surgeon General. AMEDD/MSC Clinical Specialty Symposium, Garmisch, Germany, June 10, 1996.

"Systemic Emergencies," Uniformed Services University of the Health Sciences and Office of the Surgeon General. AMEDD/MSC Clinical Specialty Symposium, Garmisch, Germany, June 11-12, 1996.

"Laboratory Investigation and Treatment of Bacterial Keratitis," Uniformed Services University of the Health Sciences and Office of the Surgeon General. AMEDD/MSC Clinical Specialty Symposium, Garmisch, Germany, June 13, 1996.

"Systemic Emergencies In An Optometric Practice," Institute for Optometric Practice, Estes Park, Colorado, June 27-28, 1996.

"Systemic Emergencies In An Optometric Practice," DeHaven Eye Center, Tyler, Texas, September 19, 1996.

"Systemic Emergencies In An Optometric Practice," Institute for Optometric Practice, San Antonio, Texas, September 21, 1996.

"Laboratory Investigation and Treatment of Bacterial Keratitis," Institute for Optometric Practice, Cozamel, Mexico, October 12, 1996.

"Lacrimal Procedures and Dry Eye Syndrome," Vision Institute of Canada, Toronto, Canada, November 23, 1996.

"Medical History and Physical Diagnosis," Vision Institute of Canada, Toronto, Canada, November 23, 1996.

"Update on the Management of Corneal Abrasions," Vision Institute of Canada, Toronto, Canada, November 23, 1996.

"Physical Diagnosis Lecture and Workshops," American Academy of Optometry, Orlando, Florida, December 5 - 8, 1996.

"Diagnosis, Lab Analysis and Treatment of Bacterial Keratitis," Pacific University, Maui, Hawaii, January 17, 1997.

"Systemic Emergencies," Pacific University, Maui, Hawaii, January 17, 1997.

"Uveitis: Classifications, Detection, Diagnosis, and Management," Pacific University, Maui, Hawaii, January 18, 1997.

"Update on the Detection, Diagnosis and Management of Hypertension," California Optometric Association, Palm Springs, California, March 7, 1997.

"Medical History and Physical Diagnosis," California Optometric Association, Palm Springs, California, March 8, 1997.

"Convergence of Optometry and Medicine," the Meredith Morgan Lecturer; Meredith Morgan Symposium, University of California, Berkeley, Berkeley, California, June 7, 1997.

"Medical History and Physical Diagnosis," the Meredith Morgan Lecturer; Meredith Morgan Symposium, University of California, Berkeley, Berkeley, California, June 7, 1997.

"Systemic Emergencies in an Office Based Practice," MSCO/COA, Snowmass, Colorado, July 25, 1997.

"Detection, Diagnosis and Treatment of Uveitis," International Vision Expo," Anaheim, California, September 11, 1997.

"Update on Systemic Hypertension," International Vision Expo, Anaheim, California, September 12, 1997.

"Update on Managing Corneal Abrasions," International Vision Expo, Anaheim, California, September 12, 1997.

"Preparing for Systemic Office Emergencies," International Vision Expo, Anaheim, California, September 13, 1997.

"Diagnosis, Laboratory Procedures and Treatment of Bacterial Keratitis," University of Houston/Pacific University Alaskan Cruise, September 23, 1997.

"Preparing for Systemic Emergencies in an Office Based Practice," AOSA National Meeting, Houston, Texas, January 7, 1998.

"Systematic Approach to the Dry Eye Patient," Alcon Laboratories - Americas Best Conference, Dallas, Texas, January 12, 1998.

"Hypertension Practice Guidelines," UHCO Nussenblatt Lecture, Houston, Texas, February 8, 1998.

"Ocular Emergencies and Urgencies," British Columbia Association of Optometrists, Vancouver BC, Canada, February 17, 1998.

"Review and Update of High Blood Pressure," California Optometric Association, Sacramento, California, March 8, 1998.

"Cranial Nerve Assessment," California Optometric Association, Sacramento, California, March 8, 1998.

"Systemic and Ocular Manifestations of Thyroid Disease," California Optometric Association, Sacramento, California, March 9, 1998.

"Classification, Detection, Diagnosis, and Treatment of Uveitis," California Optometric Association, Sacramento, California, March 9, 1998.

"Ocular and Systemic Manifestations of Thyroid Disorders," Institute of Optometric Practice, University of Houston College of Optometry, Estes Park, Colorado, June 12, 1998.

"Physical Diagnosis," American Optometric Association, Orlando, Florida, June 26, 1998.

"Ocular Emergencies and Urgencies," San Joaquin Optometric Society, Lake Tahoe, Nevada, August 14, 1998.

"Medical History and Physical Diagnosis," San Joaquin Optometric Society, Lake Tahoe, Nevada, August 14, 1998.

"Thyroid Disease: Systemic and Ocular Manifestations," University of Houston / Pacific University, Alaskan Cruise Book Tour, September 21, 1998.

"Red Eye Rapid Fire Session: Iritis," University of Houston / Pacific University, Alaskan Cruise Book Tour, September 21, 1998.

"Thyroid Disease: Systemic and Ocular Manifestations," Institute for Optometric Practice, University of Houston College of Optometry, Houston, Texas, November 7, 1998.

"Red Eye Rapid Fire Session: Iritis," Institute for Optometric Practice, University of Houston College of Optometry, Houston, Texas, November 7, 1998.

"Thyroid Disease: Systemic and Ocular Manifestations," North Carolina Optometric Association, Ashville, North Carolina, November 13, 1998.

"Review and Update on Hypertension," North Carolina Optometric Association, Ashville, North Carolina, November 13, 1998.

"Thyroid Disease: Systemic and Ocular Manifestations," British Columbia Optometric Association, Vancouver, British Columbia, February 2, 1999.

"Review and Update on Hypertension," British Columbia Optometric Association, Vancouver, British Columbia, February 2, 1999.

"Thyroid Disease: Systemic and Ocular Manifestations," California Optometric Association, Spring Congress, Santa Clara California, March 13-14, 1999.

"Review and Update on Hypertension," California Optometric Association, Spring Congress, Santa Clara California, March 13-14, 1999.

"Thyroid Disease: Systemic and Ocular Manifestations," Iowa Optometric Association, Des Moines, Iowa, April 18, 1999.

"Review and Update on Hypertension," Iowa Optometric Association, Des Moines, Iowa, April 18, 1999.

"Thyroid Disease: Systemic and Ocular Manifestations," EyeQuest '99, Rosemont Convention Center, Chicago, Illinois, May 22, 1999.

"A Systematic Approach to Uveitis," EyeQuest '99, Rosemont Convention Center, Chicago, Illinois, May 23, 1999.

"The Medical History and Physical Examination," AOA 102nd Annual Congress, San Antonio, Texas, June 24-24, 1999.

"Houston Concentrated Therapeutics Course," University of Houston College of Optometry, Houston, Texas, July 14, 1999.

"Analgesics and the Treatment of Acute Ocular Pain," 1999 Oklahoma Chapter of the American Academy of Optometry, Oklahoma City, Oklahoma, August 20 & 21, 1999.

"Systematic Evaluation of Patients with Uveitis: A Case Approach," 1999 Oklahoma Chapter of the American Academy of Optometry, Oklahoma City, Oklahoma, August 20 & 21, 1999.

"Review and Update of High Blood Pressure," 1999 Oklahoma Chapter of the American Academy of Optometry, Oklahoma City, Oklahoma, August 20 & 21, 1999.

"Thyroid Disease: Systematic and Ocular Manifestations," 1999 Oklahoma Chapter of the American Academy of Optometry, Oklahoma City, Oklahoma, August 20 & 21, 1999.

"Review and Update of Diabetes Mellitus," 1999 Oklahoma Chapter of the American Academy of Optometry, Oklahoma City, Oklahoma, August 20 & 21, 1999.

"Thyroid Disease: Systemic and Ocular Manifestations," Minnesota Association of Optometrists and Opticians, Woodbury, Minnesota, October 30, 1999.

"Review and Update on High Blood Pressure," Minnesota Association of Optometrists and Opticians, Woodbury, Minnesota, October 30, 1999.

"Thyroid Disorders: Ocular and Systemic Manifestations," Manitoba Optometric Association, Winnipeg, Canada, April 16, 2000.

"Review and Update of Diabetes Mellitus," Manitoba Optometric Association, Winnipeg, Canada, April 16, 2000.

"Physical Diagnosis," North Carolina State Optometric Society, Myrtle Beach, South Carolina, June 3, 2000.

"The Medical History, Review of Systems, and Physical Diagnosis," Washington Association of Optometric Physicians, Winthrop, Washington, June 22, 2000.

"The Medical History, Review of Systems and Physical Diagnosis," National Association of Optometrists, Washington, D.C., August 12, 2000.

"Review and Update of Diabetes Mellitus," Nebraska Optometric Association, Kearney, Nebraska, October 14, 2000.

"Systematic Evaluation of Uveitis," Nebraska Optometric Association, Kearney, Nebraska, October 14, 2000.

"Review and Update of Diabetes Mellitus," Minnesota Optometric Association, Minneapolis, Minnesota, October 28, 2000.

"Systematic Evaluation of Uveitis," Minnesota Optometric Association, Minneapolis, Minnesota, October 28, 2000.

"Glaucoma Case Profiles, I, II, III, IV," Institute of Optometric Practice, Santa Fe, New Mexico, January 11-14, 2001.

"Infectious Keratitis Case Profile," Institute of Optometric Practice, Santa Fe, New Mexico, January 11-14, 2001.

"Review and Update of Diabetes Mellitus," Canadian Optometric Congress, Vancouver British Columbia, February 15, 2001.

"Internal Medicine Update - Panel Discussion," Heart of America Congress, Kansas City, Missouri, February 16, 2001.

"Systemic and Ocular Manifestations of Thyroid Disease," Heart of America Congress, Kansas City, Missouri, February 16, 2001.

"Review and Update of High Blood Pressure," Heart of America Congress, Kansas City, Missouri, February 16, 2001.

"Review and Update of Diabetes Mellitus," Institute for Optometric Practice / University of Houston College of Optometry, El Paso, Texas, March 4, 2001.

"Systemic and Ocular Manifestations of Thyroid Disease," Institute for Optometric Practice / University of Houston College of Optometry, El Paso, Texas, March 4, 2001.

"Most Commonly Prescribed Drugs in the United States: Systemic and Ocular Implications," Vision 2001 Spring Meeting, UTMB Department of Ophthalmology, Galveston, Texas, March 24, 2001.

"Glaucoma Case Profiles," University of Houston College of Optometry, Banff, Canada, August 3, 2001.

"Glaucoma Case Profiles," Vision Expo West, Las Vegas, Nevada, September 20, 2001.

"Infectious Keratitis Case Profile," Vision Expo West, Las Vegas, Nevada, September 21, 2001.

"Glaucoma Case Profiles," University of Houston Homecoming Weekend, Houston, Texas, October 20, 2001.

"Glaucoma Case Profiles," State of Washington Department of Health, Seattle, Washington, March 23, 2002.

"Glaucoma Case Profiles," South Plains Optometric Society, Lubbock, Texas, April 28, 2002.

"The Medical History, Review of Systems, and Physical Diagnosis," Florida Optometric Association, Orlando, Florida, July 13-14, 2002.

"Glaucoma Case Profiles," Texas Optometric Association, University of Houston College of Optometry, Glaucoma Certification Course, Houston, Texas, August 11, 2002.

"Glaucoma Case Profiles," De Haven Eye Center, Tyler, Texas, September 25, 2002.

"Infectious Keratitis Case Profile," Homecoming Faculty Showcase 2002, University of Houston College of Optometry, Houston, Texas, November 10, 2002.

"Nutritional Supplements – Bad, Benign, Beneficial, or Bogus," CIBA/Novartis Educators Meeting, Scottsdale Arizona, March 29, 2003.

"Review and Update of Diabetes Mellitus," University of Houston, CE at Sea, November 2, 2003.

"Review and Update of High Blood Pressure," Southwest Council of Optometrists, Dallas, Texas, March 6, 2004.

"What's New in the Most Popular Systemic Medications," Southwest Council of Optometrists, Dallas, Texas, March 6, 2004.

"Review and Update of Diabetes Mellitus," Texas State Optical Regional Conference, Houston, Texas, May 5, 2004.

"Review and Update of Diabetes Mellitus," North Carolina State Optometric Society, Spring Congress, Myrtle Beach, South Carolina, June 6, 2004.

"Review and Update of High Blood Pressure," European Army Optometry Conference, Sonthofen, Germany, June 16, 2004.

"Review and Update of Diabetes Mellitus," European Army Optometry Conference, Sonthofen, Germany, June 16, 2004.

"Ocular and Systemic Manifestations of Thyroid Disorders," European Army Optometry Conference, Sonthofen, Germany, June 17, 2004.

"Ocular and Systemic Manifestations of Thyroid Disorders," Inland Empire Health Plan, San Bernardino, California, October 17, 2004.

"Review and Update of Diabetes Mellitus," Inland Empire Health Plan, San Bernardino, California, October 17, 2004.

"Vascular Disease for the Practicing O.D.," Heart of America Congress, Kansas City, Missouri, February 11, 2005.

"Review and Update of High Blood Pressure," Heart of America Congress, Kansas City, Missouri, February 11, 2005.

"Review and Update of Diabetes Mellitus," Heart of America Congress, Kansas City, Missouri, February 12, 2005.

"Coding and Billing: The Houston Experience" ASCO Clinic Directors / Practice Management Educators Joint Meeting, Jacksonville FL, May 3, 2006.

"There's Nothing Sweet About Diabetes: What Every OD Should Know Personally and Professionally" Institute for Optometric Practice, Estes Park, CO, July 6, 2006.

"Vascular Diseases for the Practicing Optometrist" Institute for Optometric Practice, Estes Park, CO, July 7, 2006.

"There's Nothing Sweet About Diabetes: What Every OD Should Know Personally and Professionally" Institute for Optometric Practice, Alcon Pharmaceutical, Fort Worth, TX, August 26, 2006.

"Oral Medications and Ocular Sequeale" Primary Care Optometry News Symposium, Philadelphia, PA, November 18, 2006

"The Many Faces of Thyroid Disease" Primary Care Optometry News Symposium, Philadelphia, PA, November 18, 2006

"Contemporary Management of Macular Disease" Primary Care Optometry News Symposium, Philadelphia, PA, November 18, 2006

"Current Concepts & Controversies in Systemic Medicine" Primary Care Optometry News Symposium, Philadelphia, PA, November 19, 2006

"Clinical Integration as a Key Component of Optometric Education" Optometric Education Section Symposium, American Academy of Optometry, Denver CO December 8, 2006

"There's Nothing Sweet About Diabetes: What Every OD Should Know Personally and Professionally" Oklahoma Association of Optometric Physicians Spring Conference Oklahoma City, OK, April 14, 2007

"The Many Faces of Thyroid Disease" Harris County Optometric Society, Houston, TX, September 25, 2007

"Vascular Diseases for the Practicing Optometrist" Harris County Optometric Society, Houston, TX, September 25, 2007

"Diabetes Mellitus" Part 1 and Part 2, Vision Expo West, Las Vegas NV, October 6, 2007

"Vascular Diseases for the Practicing Optometrist", Vision Expo West, Las Vegas, NV, October, 6, 2007

"The Many Faces of Thyroid Disease", Vision Expo West, Las Vegas, NV, October, 6, 2007

"There is Nothing Sweet About Diabetes", Minnesota Association of Optometrists, Minneapolis, Minnesota, October 27. 2007

"There is Nothing Sweet About Diabetes", University of Houston – CE in Austin, Austin, TX November, 17, 2007

"Americas Alarming Health and Metabolic Issues: Today and in the Future" UC Berkeley Practicum Program, Berkeley, CA, January, 12, 2008

"Diabetes: There is Nothing Sweet About It" UC Berkeley Practicum Program, Berkeley, CA, January, 12, 2008

"Cardiovascular Diseases and Diabetes: It's Feast of Famine" UC Berkeley Practicum Program, Berkeley, CA, January, 13, 2008

POSTER SESSIONS:

Westin, E., Holdeman, N.R., "Bulbar conjunctival pigmentation secondary to tetracycline therapy," American Academy of Optometry, 1990.

Pate, L, Holdeman, NR, Tran, T, 'Hydroxychloroquine Retinopathy: A Practical Approach to Retinal Evaluation" American Academy of Optometry, December, 2005

BOOK REVIEWS:

Haesaert, S.P., "Clinical Manual of Ocular Microbiology and Cytology." Reviewed in: Doody's Health Sciences Book Review Journal, 1993, Vol., No. 1

Hom, M.M., "Mosby's Ocular Drug Consult" Mosby Elsevier, St. Louis Missouri, 2006

CONSULTING / SERVICE:

Curriculum Revision Consultant for the National Board of Examiners in Optometry and the Association of Schools and Colleges of Optometry, 1990.

Medical Consultant for Fisher, Patterson, Sayler, and Smith: Attorneys at Law, Topeka, Kansas, 1991-present.

University of Houston Health Center Policy Board, 1991; 1994; 1995; 1997.

High School for the Health Professions: Community Advisory Board, A Subsidiary of Baylor College of Medicine, 1991-1996.

National Board of Examiners in Optometry - Consultant Item Writer, 1991-present.

National Board of Examiners in Optometry - Examination Construction Committee, 1991-1996.

National Board of Examiners in Optometry - Chair - Human Anatomy and Systemic Conditions, 1992-1994. Member 1991-1998.

Clinical Eye and Vision Care, Butterworths Publishers, Editorial Board Member, 1991-2001.

Foundation for Education and Research in Vision, Board of Directors, 1991-present.

Medical Consultant for Talbot, Sottle, Carmouche, Marchand, and Marcello: Attorneys at Law, Donaldsonville, LA. 1992-present.

Review of Optometry, Chilton Publications, Contributing Editor and Member of the Editorial Review Board, 1992-present.

Texas Southern University Research Journal - External Referee for the TSU School of Pharmacy, 1992-present.

Texas Society to Prevent Blindness - Texas State Board of Directors, 1991-1997.

Texas Society to Prevent Blindness - Texas State Board of Medical Advisors, 1991-present.

Medical Consultant for Rolling, Tillery and Perrilloux: Attorneys at Law, Hammond, LA. 1993.

Alcon - Optometric Advisory Board, 1993-present.

Johnson Space Center (NASA): Medical Operations Consultant for Telemedicine Project via the Advanced Communications Technology Satellite (ACTS), 1995.

Medical Consultant for E. Thomas Bishop, P.C.: Attorneys at Law, Dallas, TX. 1994.

Optometry Clinics, Appleton and Lange Publishers, Participant of the Journal Review Board, 1994.

Medical Consultant for Lorance and Thompson: Attorneys at Law, Houston, Texas, 1995.

Allergan Teleconference Participant on "The Effective Use of Anti-Infectives in the Treatment of Corneal and External Disease, Roy S. Rubinfeld, M.D., Moderator, February 28, 1995.

American Schools of Colleges of Optometry, Clinical Affairs Committee, 1994–2000; 2002–2004.

University of Houston, Protection of Human Subjects Committee; Advisor, 1995-present.

International Vision Expo Advisory Board, 1996-2001.

Medical consultant for Giessel, Barker & Lyman: Attorneys at Law, Houston, Texas, 1995.

Medical advisor for Slack Incorporated, Primary Care Optometry News, 1996.

Allergan - Medical Advisory Board for Instil, Atlanta, Georgia, February 28, 1996.

Medical Consultant for House and House: Attorneys at Law, Houston, Texas, 1996.

Prevent Blindness Texas; Member - Strategic Planning Committee, October 1996-2000.

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Optometry and Vision Science, Williams and Wilkins Publishers, External Reviewer.

Chair, ASCO Critical Issues Seminar on Residency, Houston, Texas, March 20-22, 1998.

Medical Consultant for Rodey, Dickason, Sloan, Akin and Robb, PA: Attorneys at Law, Albuquerque, New Mexico, 1999.

Medical Consultant for Irelan and Associates: Attorneys at Law, Houston, Texas, 2000.

Medical Consultant for Miller, Norman and Associates, Ltd. Attorneys at Law, Moorhead, Minnesota, 2001.

Diabetes Coalition of Houston; Charter Member of the Steering Committee, 2002–2004.

University of Houston – University Health Center Policy Board, 1999-present.

University of Houston – Sexual Harassment Board, 2002–present.

National Board of Examiners in Optometry – Member Basic Science Item Re-engineering Task Force, 2003.

MedPointe Pharmaceuticals – Consultants Roundtable February 2006

University of Houston – Transportation and Parking Advisory Board 2006 – present

University of Houston – Substance Abuse Prevention Advisory Board, 2006 – present

Clinical and Surgical Ophthalmology Editorial Board; Department Editor in Clinical Consultations 2007-present

CIVIC, FRATERNAL, AND PROFESSIONAL ASSOCIATIONS:

American Optometric Association, Member 1972-present.

Texas Optometric Association, Member 1972-present, Associate Editor of the Journal of the Texas Optometric Association, 1978-1983.

Beta Sigma Kappa Honor Fraternity, Member, 1975-present.

South Plains Optometric Society, Honorary Member, 1977-present, Past President.

Lubbock Jaycees, Member 1977-1979.

United Way of Lubbock, Chairman, Professional Division, 1978.

Lubbock Chamber of Commerce, Member 1980-1988, Leadership Lubbock Participant 1980; Chairman Leadership Lubbock 1981; Health, Medical and Related Sciences Committee; Governmental Affairs Committee.

Lubbock Business Association, Member 1980-1983, Board of Directors 1981-82, 1982-83.

City of Lubbock, City Council appointment to Zoning Board of Adjustments, 1982-83.

University of Houston Alumni Association, Member, Regional Coordinator 1982-83.

Texas Tech University Health Sciences Center School of Medicine Alumni Association, Member, Founding Committee.

American Heart Association, Instructor in Cardiopulmonary Resuscitation, Certified Advanced Cardiac Life Support, 1983–1989.

American Medical Association, Member 1983-present.

Texas Medical Association, Member 1983-present, 1986 appointed to Committee on Alcoholism and Drug Abuse.

Lubbock, Garza, Crosby, Medical Society, member 1983-1988.

Dallas County Medical Society, member 1988-1990.

Harris County Medical Society, member 1990-present.

Association of Clinic Directors/Administrators of Schools and Colleges of Optometry, Executive Board Member 1990-1997.

American College of Physician Executives, Member 1990-2000.

Houston Academy of Medicine, 1991-present.

Fellow American Academy of Optometry, 1993-present.

Editorial

Medical Student Education in Ophthalmology: Crisis and Opportunity

David A. Quillen, MD - *Hershey, Pennsylvania*
Richard A. Harper, MD - *Little Rock, Arkansas*
Barrett G. Haik, MD, FACS - *Memphis, Tennessee*

The number of medical schools requiring a formal ophthalmology rotation has declined significantly during the first years of the 21st century—down from 68% in 2000 to 30% in 2004 (Association of University Professors in Ophthalmology 2004 Survey on Medical Student Teaching). At first glance, this seems shocking. How can it be that the specialty we love so much receives so little attention in the overall scheme of medical education? But the explanations are numerous. The explosive growth of scientific information dictates that more time be devoted to the core areas of medical education. Because the Liaison Committee on Medical Education does not specifically require ophthalmology training in medical school, ophthalmology rotations are vulnerable. And frankly, many academic departments of ophthalmology have disengaged from the medical student education process for a variety of reasons, including limited financial support for medical student teaching and inability—or unwillingness—to devote sufficient resources to the task.

As a result of limited ophthalmology education in medical schools and primary care residency programs, medical students and primary care physicians are inadequately trained to deal with the initial management or appropriate referral of even the most basic ophthalmic problems.[1,2] They have an insufficient understanding of ocular anatomy, fundamental eye examination skills, common causes of vision loss, and the relationship between the eye and systemic disease. An equally disturbing possibility is that the best students may not consider a career in ophthalmology because of their limited exposure to the field in the formative years of medical school.

There is a clear need to improve ophthalmology education for medical students and primary care physicians.[3,4] Our challenge—we would argue, our obligation—is to optimize existing educational programs and develop new teaching and learning activities to address specifically the needs of our medical student and primary care colleagues. How might we bring about such a change? In simplistic terms, change occurs because it is either required or seen as value added. There is reason to believe that each of these forces for change may be applicable to medical student and primary care physician education. Although the Liaison Committee on Medical Education does not specifically require ophthalmology education in medical school, the United States Medical Licensing Examination does contain ophthalmic content (http://www.uslme.org); it is likely that the new Clinical Skills Examination will require students to perform eye examination skills competently. The fact that vice-deans of medical education and curriculum committees are highly motivated to insure that medical students pass the United States Medical Licensing Examination and Clinical Skills Examination should provide strong motivation to reintroduce ophthalmology in medical school curriculums. Our impression is that, although there are considerable constraints within medical school curriculums and residency training programs, vice-deans, residency program directors, and other educational leaders are receptive to expanding the role of ophthalmology—provided the commitment is real and the educational offerings are sound. We believe we can positively impact ophthalmology education using these fundamental concepts: prioritize, advocate, integrate, and innovate.

Prioritize. What do students and primary care physicians *really* need to know? Consider the Association of University Professors in Ophthalmology policy statement on medical student education.[1] Adopted in 1990, it provides suggestions for the minimum level of competence expected of general physicians when dealing with ophthalmologic problems. All students should be able to measure and record visual acuity, evaluate a red eye, evaluate a traumatized eye, detect strabismus and abnormal eye movements, detect abnormal pupillary responses, perform direct ophthalmoscopy to detect abnormalities of the optic nerve and fundus, and initiate management and/or referral for detected or suspected abnormalities of the eye and visual system. While teaching these specific skills, we can incorporate discussions on ocular anatomy, common causes of vision loss, ophthalmic emergencies, the eye and systemic disease, and the humanistic aspects of our profession. Let us get back to basics and adopt the Association of University Professors in Ophthalmology policy statement as our minimum standard and develop reliable and valid educational programs to achieve teaching and learning in these critical areas.

Advocate. A formal ophthalmology rotation provides the best opportunity to train students. Studies have shown that experiences outside a formal ophthalmology rotation are limited, and non-ophthalmologists are less effective than ophthalmologists in teaching ophthalmic knowledge and skills to students.[5] There is clear evidence that active medical student education programs improve the knowledge and skill levels of students.[6,7] In addition, dynamic medical student education programs may increase the number and quality of students applying to ophthalmology residency programs, ensuring that the next generation of ophthalmologists remains the best and brightest of our medical school graduates. In the absence of significant external mandates, it is vital that we demonstrate the value of ophthalmology education in medical school and primary care residency programs. This effort would provide additional educational research opportunities for our faculty members and allow

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the clinician–educators among us to develop even more rewarding academic careers.

Integrate. The possibilities to incorporate ophthalmology into the existing medical school curriculum are endless: anatomy, physiology, pathology, pharmacology, neurosciences, endocrinology, physical diagnosis, medicine, pediatrics, surgery. We can play a role in many of the core basic and clinical science courses throughout the medical school years. Because of our limited financial and human resources, participating in existing courses allows us to improve ophthalmology education without significantly increasing the administrative burden of coordinating an entire course or rotation. There are secondary benefits as well: we can reengage with the medical school curriculum (it's fun to work with medical students!) and strengthen our ties with other departments (which provides additional opportunities to collaborate in patient care and research).

Innovate. Ophthalmology is a profession recognized for its creativity and innovation. We must apply these attributes to our education mission. There are many opportunities to develop extracurricular programs for medical students. For example, ophthalmology interest group meetings conducted by enthusiastic ophthalmologists—including faculty members and private practitioners—provide an ideal forum to highlight ophthalmology as a career option and teach ophthalmic content. Participation in community service programs enables students to enhance their knowledge and eye examination skills while improving the quality of life in the communities we serve. We should develop continuing medical education programs specifically targeting the needs of primary care physicians or incorporate eye-related presentations into primary care conferences. In addition to mobilizing our faculty, ophthalmology departments should promote the role of ophthalmology residents as teachers and unleash the underutilized power of resident–student and resident–resident teaching and learning. In doing so, we have the opportunity to address many of the general competencies outlined in the Accreditation Council on Graduate Medical Education Outcomes Project: practice-based learning and improvement ("facilitate the learning of students and other health care professionals"), professionalism ("a commitment to excellence and on-going professional development"), interpersonal and communication skills ("work effectively with others as a member or leader of a health care team"), and systems-based practice ("partner with health care providers to assess, coordinate, and improve health").[8,9]

This is a time of great challenge for ophthalmology in medical school education. With challenge comes opportunity. We have the chance to reverse the current trend of ophthalmology's declining role in medical education. By prioritizing our educational programs, we can ensure that students and primary care residents master the basics. We must develop and strengthen formal ophthalmology teaching experiences offered by ophthalmologists. Integration of ophthalmology into the existing medical school curriculum and supplementation of this experience with innovative extracurricular programs are natural and readily available steps that can be implemented within any medical school. All of these goals can be accomplished as long as we are willing to commit the time and necessary resources to the task. Faculty support from deans and department chairs will be critical to the success of this effort. By reestablishing medical school education as a priority, we can reconnect with the greater medical school community and demonstrate our commitment to enhancing the education of all physicians.

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WITH EXPERIENCE, COMES VISION

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Southern California College of Optometry

December 21, 2009

Ms. Andrea Leiva
California State Board of Optometry
2420 Del Paso Blvd., Suite 255
Sacramento, CA 95834

Re: Glaucoma Certification Regulations

Dear Ms. Leiva:

Thank you for the opportunity to provide supportive input to the State Board of Optometry as it seeks to establish rules for the certification of optometrists in the treatment of glaucoma.

By way of background, I hold the O.D. and Ph.D. degrees from The Ohio State University College of Optometry (OSU) where I also completed a post-graduate fellowship in vitreoretinal disease. I have been a full-time faculty member at OSU, Dean of the Michigan College of Optometry and currently President of the Southern California College of Optometry. I have over 20 year's experience in private and medical group practice actively treating patients. I have served as President of the Ohio Optometric Association and the American Optometric Association. I am a Fellow in the American Academy of Optometry.

I submit this letter to the Board in my capacity as President of the Southern California College of Optometry and I offer the following comments based on a diverse 30-year career that includes my direct, personal treatment and management of glaucoma patients.

1) **Optometrists are appropriately educated and trained to care for glaucoma patients.**

As a faculty member at The Ohio State University where I taught Ocular Disease and Ocular Pharmacology and later as Dean of the Michigan College of Optometry and now as President of the Southern California College of Optometry (SCCO), I have first-hand knowledge of the educational background of optometrists in the area of glaucoma management. Additionally, having served on the American Optometric Association Accreditation Council on Optometric Education, I have seen the "best practices" among the nation's optometry schools in this area. I can unequivocally state that optometrists receiving their degree from the early 1990's on, are appropriately trained to treat glaucoma upon graduation.

2) **The proposed Case Management Requirement goes far beyond what the majority of other states require.**

I have been licensed to treat glaucoma in Ohio since 1992. At that time, after completing a prescribed didactic course and passing the Treatment and Management of Ocular Disease examination (TMOD—now part of the NBEO exam), I was fully authorized by the State of Ohio to medically treat all

presentations of anterior segment disease—including all glaucomas. Ohio, as with the majority of other states, does not require "clinical case management" nor is there a requirement to be "supervised" by an ophthalmologist. Having served on the 5-year oversight committee (composed of ODs and MDs) monitoring the implementation of Ohio's therapeutic bill in the 90's, I can definitively state that there were no adverse consequences to this approach.

3) **In considering the proposed regulation it is useful to remember that this is not about "optometry taking over glaucoma care".**

During my full-time clinical practice, spanning care in a private setting and delivering medical eye care in a large anterior segment referral practice and large retina service, I have treated thousands of glaucoma patients; and importantly, referred hundreds more on to fellowship-trained glaucoma specialists when treatment beyond medical therapy was appropriate. In adopting these regulations, Californians will have access to many more doctors who, like many general ophthalmologists, will care for glaucoma on a primary care level, referring patients to fellowship-trained ophthalmologists for advanced care when appropriate.

4) **Authorizing optometrists to treat glaucoma is not something new.**

In my experience as President of the American Optometric Association, I have seen first-hand how incorporating glaucoma privileges into state law across the country has improved patient care in states like Ohio, Michigan, and 47 other states for as far back as 1976. California's reluctance to embrace an appropriate scope of optometric practice given the advanced education of today's optometrist is wasteful, shortsighted and withholds access to care for Californians.

Given the generally accepted description of a "learned profession" – having advanced knowledge in a field of science or law involving a prolonged course of specialized intellectual education—optometry certainly is a learned profession. Considering the virtually unrestricted scope of practice enjoyed by professions such as Medicine and Dentistry, one wonders how such a restrictive approach to statutory authority for such well trained professionals makes sense in the 21st century.

In closing, I encourage the California State Board of Optometry to adopt the proposed language for section 1571. While I believe the proposal represents "over-kill" relative to how most other states have addressed the glaucoma issue, the regulations, if adopted represent a step in the right direction.

Sincerely,

Kevin L. Alexander

Kevin L. Alexander, O.D., Ph.D., F.A.A.O.
President

COMMUNITY EYE CENTER OPTOMETRY

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December 21, 2009

Ms. Andrea Leiva
California State Board of Optometry
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Sent via email: Andrea_Leiva@dca.ca.gov

Re: Notice of Proposed Action to Adopt 16 CCR §1571

My name is Dr. Hilary Hawthorne, O.D. I received my Doctor of Optometry degree from Pacific University College of Optometry in Forest Grove, OR and have been licensed to practice in California since 1993. I am in private practice in Los Angeles and am certified to prescribe both Diagnostic and Therapeutic Pharmaceutical Agents and to perform lacrimal dilation and irrigation.

I am the current President of the California Optometric Association, representing its 2,632 member ODs actively practicing in California.

Our association sponsored Senate Bill 1406 (Correa), the legislation that created the mandate for this process of creating glaucoma certification standards, for several reasons:

- To provide optometrists with broader use of ophthalmic medications, devices, procedures and laboratory testing for diagnosis and treatment of eye disease.
- To allow ODs to treat patients as we have been educated and trained to do.
- To legislate for better access to safe, quality patient care from optometrists that desire to serve public welfare without harm.
- To expand the optometric scope of practice to ensure more optometrists will be able to properly treat patients for primary open angle, exfoliation, and pigmentary glaucomas, as well as acute cases of angle closure glaucoma.

I practice optometry in a family-based community in south Los Angeles. Although I serve predominantly black and Hispanic working class families, the area also has a dense population of underserved patients in half-way homes, recovery programs, etc. and their lifestyles pose a high risk for disease. Others in the vicinity have physically disabilities, developmental delays, and/or emotional disorders and are living on limited resources.

My patients tend to seek care locally. The expanded access to eye care will be welcomed, especially for those limited by transportation. I foresee glaucoma patients who were reluctant to travel to another eye doctor's office when referred for care, will now be more educated and compliant as they receive treatment within their optometrist's office.

I envision this law changing care. The Optometric Practice Act now represents broader scope territory for my profession. I take ownership of its contents because it symbolizes everything I have a legal right to become certified to do.

The new regulations for Section 3041 reflect a slow gain of independence for optometry. I feel empowered by my profession's new state privileges. It puts an end to unnecessary referrals and flaws in co-management, as well as other impediments to the full use of optometric expertise. Patients diagnosed with primary open angle glaucoma will be treated without generating redundant billings or unneeded referrals between two examining eye doctors.

Enhanced primary care is at stake. It is my hope that all of my qualified colleagues and I will soon become glaucoma certified optometrists under these proposed regulations. There has not been a day that has gone by that I could not have exercised the prescriptive authority granted to me for this level of glaucoma care. Believe me, I've been waiting since I was first licensed 16 years ago.

I ask that the State Board act as soon as possible to adopt these recommendations, as published, and move on to finalize them. As desired by the Legislature in enacting SB 1406, the proposed regulations allow the creation of both didactic and case management training options that will both protect the public and get more optometrists certified within a reasonable time. Please continue your work to allow California optometrists with training and skills to help and serve the public rightfully as a primary care asset.

It is regrettable that many patients are being underserved by the present eye care delivery system. As an optometrist, I want to thank California's ophthalmologists for negotiating to enact legislation that truly places our patients first. Scare tactics aside, this regulatory action is an opportunity to close one of the gaps in health care delivery; we ODs will enhance our training to provide broader, more appropriate care, and will do so in a manner that does not put our patients at unnecessary risk.

California optometrists are grateful to the members and staff of the Board and Department of Consumer Affairs for your assistance. Promoting access to health care, providing communities another means to meet a fundamental need, and protecting the public in a primary eye health capacity will serve everyone.

Respectfully submitted,

Hilary L. Hawthorne O.D.

Hilary L. Hawthorne, O.D.
CA License Number 10080 TPL
President, California Optometric Association

HLH/hlh

Elizabeth Hoppe
<ehoppe@westernu.edu>
12/21/2009 08:33 AM

To "Andrea_Leiva@dca.ca.gov" <Andrea_Leiva@dca.ca.gov>
cc "timh@coavision.org" <timh@coavision.org>
bcc
Subject for board meeting tomorrow

History: This message has been replied to.

This communication is for submission as a written comment for the meeting on Tuesday, December 22, 2009.

It is clear that the state legislature intended for the people of the state of California to benefit from expanded access to the treatment of glaucoma. It is clear that the people of the state of California deserve access to treatment that is on par with individuals residing in other states across the country.

However, it is apparent that special interest groups have become involved to try to obstruct the intention of the legislature and to try to restrict and limit access to care.

The purpose of this communication is to provide information regarding the qualifications of doctors practicing in the state of California, and to assure the board that doctors in California are as well-educated and as well-qualified as their professional colleagues across the nation.

The members of the board should be well aware of, and extremely familiar with, the details of the National Board of Examiners in Optometry (NBEO). The NBEO sets a standard that ensures the same level of competency regardless of the state in which an optometric practice is located.

In 1980 the NBEO shifted to an objective style examination, which was criterion referenced and content outline driven. Since those early days, and continuing to the present, the NBEO has worked diligently to keep the examination content outline in line with the contemporary practice of optometry. This involves annual changes to the examiantion content and periodic major shifts in the examination material. In 1984 the NBEO introduced a separate examination entitled the Treatment and Management of Ocular Disease (TMOD), in 1986 the NBEO expanded parts I and II, in 1991 the Clinical Skills Examination (CSE) was added along with the Visual Recognition and Interpretation of Clinical Signs (VRICS), in 1992 the TMOD became an embedded portion of the exam, in 1993 Patient Management Problems (PMPs) were added, and in 2000 the NBEO constituted Part III of the examination. As you can see, the national examination has certainly kept pace with new advancements in the science and practice of the profession of optometry.

Specifically related to glaucoma, candidates for the NBEO must use information from intra-ocular pressure measurement, gonioscopy, scanning laser ophthalmoscopy, fundus photography, and visual field analysis to diagnose and manage primary and secondary glaucomas.

As the Dean of one of California's three Colleges of Optometry, I have been actively engaged in

hiring faculty members to educate the next generation of optometrists. On several occassions, I have hired a well-qualified and experienced doctor of optometry who has been a long time practitioner in another state. These doctors have been actively treating patients with glaucoma in other states, and in federal facilities, and have never had a single problem with the management of patients in need of care. The minute that they join my faculty and move to California, the talent and experience of these doctors can no longer be utilized. This is a serious detriment to patients who need treatment.

I urge the board to enact appropriate regulations, as have already been recommended and testified to, to enable the people of California to have the care that they deserve.

Sincerely,

Elizabeth Hoppe, OD, MPH, DrPH, FAAO
Founding Dean
College of Optometry
Western University of Health Sciences
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Comment 24

David A. Cockrell, O.D.
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California State Board of Optometry

December 22, 2009

Proposed Glaucoma Regulations

Thank you very much for this opportunity to present testimony at this hearing. I am David Cockrell. I am a currently practicing Optometrist in Oklahoma. I have served on the Oklahoma State Board of Examiners in Optometry since 1996. I have served in all positions on the board including, board member, Vice President and President of the Board.

Technology and education have continued to broaden the field of healthcare providers who are capable of safely and responsibly practicing all areas of healthcare. Optometric treatment of Glaucoma is an excellent example of the increased access to care for our patients that has occurred as a result of these changes.

As a practicing optometric physician in Oklahoma, I have treated Glaucoma for over 25 years. I along with all other Oklahoma licensed Optometrists are responsible for diagnosing and treatment of this disease. I am certain that we have some OD's that do not treat Glaucoma, however the great majority do treat glaucoma and do so very effectively, to the benefit of the citizens of Oklahoma. The Oklahoma State Board of Examiners in Optometry currently licenses 780 Optometrists. Between 550 and 580 are in active clinical practice in Oklahoma, the remainder include academicians at the Oklahoma College of Optometry and Optometrists that live and practice in other states and also hold an Oklahoma license. The majority of the out-of-state licensees practice in federal settings, including the Public Health Service, Indian Health Service, the Veterans Administration and all branches of the Armed Services. The reason for the number of federal practitioners holding Oklahoma licenses is the broad scope of practice law allowed by Oklahoma is suited to the scope of practice required of those practitioners.

Boards and regulating bodies are frequently asked to support legislation or promulgate rules regarding legislation, with little or no long term study of the effects or outcomes for patients, of the newly enacted legislation or regulations. The boards consider many variables in these decisions; among those variables are educational background, efficacy of proposed treatment, as well as the capabilities of the applicants, and as in this case, the specific education of an Optometrist on the management of glaucoma and the eventual outcome of the legislation for the

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citizens of California. Regarding the treatment of Glaucoma, Optometry can point to a 30 year, successful track record across the United States.

The timeline of glaucoma treatment by Optometry began in the late 1970's. In Oklahoma glaucoma has been treated by Optometrists since 1982. While the current regulations for glaucoma treatment being studied here are quite specific, the types of glaucoma treated by Optometrists as well as treatment modalities in Oklahoma are much more expansive and therefore the results should be valid as a metric for successful treatment of Glaucoma by Optometrists. The practice act In Oklahoma allows Optometric treatment of glaucoma including all forms of topical pharmaceuticals, with no restrictions on treatment regimen or length of treatment. In the early 1990's we began to utilize all current oral pharmaceutical treatment for Glaucoma available when appropriate and in the best interest of the patient. In addition to pharmaceutical treatment, Optometrist's also utilize laser surgical treatment as well including Argon Laser Trabeculoplasty (ALT), Peripheral Iridotomy (PI); those procedures have been performed for almost 20 years by Optometry in Oklahoma. Within the past few years Selective Laser Trabeculoplasty has been developed for surgical treatment of Glaucoma and is now a part of Optometric treatment as well. As you can see our treatment of Glaucoma has expanded as new pharmaceutical treatments have been developed and as new technological advances are brought into play.

During the twenty five plus years that Optometry has treated glaucoma in Oklahoma, we have demonstrated an excellent record of safety for the public. During this period of glaucoma treatment including both pharmaceutical and laser surgical treatment, the Oklahoma State Board of Examiners in Optometry has had **no** formal or informal complaints from the public, any Oklahoma State Agency, or any state or national medical society during that time, concerning pharmaceutical treatment or laser surgery for glaucoma.

One rough measure of the efficacy of a procedure or successful treatment by a practitioner is, is the rate or cost of Professional Liability Insurance. In Oklahoma we are still at the lowest rate for PLI for Optometry in the United States. Since 1990 the National Practitioner Data Bank has identified 21 cases of Medical Malpractice by Optometry in Oklahoma, none of those have been reported to the Oklahoma Board of Examiners as a result of failed treatment plans for glaucoma.

To move from Oklahoma to a "national" view of glaucoma treatment; glaucoma is now treated by Optometrist in 49 states, one territory (Guam) and the District of Columbia. I have had a unique perspective to view pharmaceutical treatment by Optometry, as the changes in the scope of practice of Optometry have occurred. Of the 49 states that treat Glaucoma only 8 have required co-management with Ophthalmology for glaucoma, the requirement for those 8 occurred as a result of Legislative negotiation. I have served as the Chairman of the State

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Government Relations Center for the American Optometric Association and have seen first-hand the same arguments expounded by opponents of Optometric treatment of Glaucoma in every state that has expanded the scope of practice to include pharmaceutical treatment. In all instances I have been involved with, Optometric education and experience have been portrayed as inadequate and dangerous to the public. As you might imagine because of these allegations Optometric treatment has been extensively reviewed for error, inappropriate treatment or negative outcomes.

To this date there still is not a verifiable, documented study that proves any of the allegations of lack of training, qualifications, limited education or experience, let alone that has shown inferior outcomes for our patients.

In summation, Optometrists are well qualified to treat Glaucoma and have a proven track record of success.

Thank you very much for this opportunity to present testimony.

Respectfully Submitted

David A. Cockrell

David A. Cockrell O.D., F.A.A.O

Comment 25

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December 21, 2009 **Via FAX: (916) 575-7292**

Andrea Leiva
California State Board of Optometry
2420 Del Paso Blvd., Suite 255
Sacramento CA 95834

Dear Board of Optometry:

I strongly support the State Board of Optometry in its revision of glaucoma certification.

As a four-year glaucoma certified optometrist under the old SB 929 protocol, I know the tremendous and unnecessary difficulty of jumping through the hoops of the SB 929 certification protocol. The ridiculous paperwork demands of the old certification process were very difficult, even for those of us who worked with a cooperating OMD preceptor. It is vital that new certification protocol be adopted to allow every licensed OD in California to treat glaucoma.

Californians concerned about the public health of our citizens should be outraged by those in political ophthalmology who work to block optometry from treating patients with glaucoma. While these ophthalmologists fight to protect their pocketbooks, thousands of Californians are unable to afford costly referral and expensive travel to an ophthalmologist when their glaucoma could and should be managed by their primary care optometrist.

Almost all other states have embraced the public health-benefits of having optometrists treat glaucoma. Optometrists are well-distributed throughout our state, and they are well equipped, both educationally and in their practices, to diagnose and treat glaucoma. In my rural practice I annually help over one hundred patients manage their glaucoma, resulting in great cost savings to my patients, their insurance companies, and Medicare.

The State Board must adopt regulations which will eliminate the unfair obstacles of glaucoma certification for my peers. My only issue with your proposed revisions are that they still do not recognize the extensive training in glaucoma which has been part of every OD's basic education for years and years. I believe the section below should be modified to say "after May 1, 1990"

> "Licensees who completed their education from an accredited school or college of optometry on or after May 1, 2008, are exempt from the didactic course and case management requirements of this Section"

The health of California's citizens will be best served when all optometrists are able to meet their glaucoma patients' needs without unnecessary and costly referral.

Sincerely,

Jerry L. Jolley, O.D., M.P.H., F.A.A.O.

SIERRA EYECARE ASSOCIATES
Optometry & Ophthalmology

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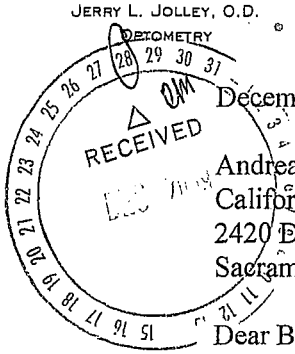

December 21, 2009

Via FAX: (916) 575-7292

Andrea Leiva
California State Board of Optometry
2420 Del Paso Blvd., Suite 255
Sacramento CA 95834

Dear Board of Optometry:

I strongly support the State Board of Optometry in its revision of glaucoma certification.

As a four-year glaucoma certified optometrist under the old SB 929 protocol, I know the tremendous and unnecessary difficulty of jumping through the hoops of the SB 929 certification protocol. The ridiculous paperwork demands of the old certification process were very difficult, even for those of us who worked with a cooperating OMD preceptor. It is vital that new certification protocol be adopted to allow every licensed OD in California to treat glaucoma.

Californians concerned about the public health of our citizens should be outraged by those in political ophthalmology who work to block optometry from treating patients with glaucoma. While these ophthalmologists fight to protect their pocketbooks, thousands of Californians are unable to afford costly referral and expensive travel to an ophthalmologist when their glaucoma could and should be managed by their primary care optometrist.

Almost all other states have embraced the public health-benefits of having optometrists treat glaucoma. Optometrists are well-distributed throughout our state, and they are well equipped, both educationally and in their practices, to diagnose and treat glaucoma. In my rural practice I annually help over one hundred patients manage their glaucoma, resulting in great cost savings to my patients, their insurance companies, and Medicare.

The State Board must adopt regulations which will eliminate the unfair obstacles of glaucoma certification for my peers. My only issue with your proposed revisions are that they still do not recognize the extensive training in glaucoma which has been part of every OD's basic education for years and years. I believe the section below should be modified to say "after May 1, 1990"

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The health of California's citizens will be best served when all optometrists are able to meet their glaucoma patients' needs without unnecessary and costly referral.

Sincerely,

Jerry L. Jolley, O.D., M.P.H., F.A.A.O.

Comment 26

SIERRA EYECARE ASSOCIATES
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H. DOUGLAS COOPER, M.D. Ophthalmology
JANICE M. MC GEORGE, O.D. Optometry

December 21, 2009 **Via FAX: (916) 575-7292**

Andrea Leiva
California State Board of Optometry
2420 Del Paso Blvd., Suite 255
Sacramento CA 95834

Dear Board of Optometry:

I strongly support the State Board of Optometry in its revision of glaucoma certification regulations.

As a first-year glaucoma certified optometrist, I know the difficulty in becoming certified to treat glaucoma. It took me almost eight years! The onerous paperwork and the difficulty of finding an ophthalmologist willing to work with optometrists to meet the demands of the old certification process were too punitive. It is essential that the new certification protocol be adopted to allow every licensed optometrist in California to treat glaucoma patients.

The State Board must adopt regulations which will eliminate the unfair obstacles of glaucoma certification for my peers. My only issue with your proposed revisions are that they still do not recognize the extensive training in glaucoma which has been part of every OD's basic education for years and years. I believe the section below should be modified to say "after May 1, 1990"

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The health of California's citizens will be best served when all optometrists are able to meet their glaucoma patients' needs without unnecessary and costly referral.

Sincerely,

Richard Van Buskirk, O.D., F.A.A.O.

COA RESPONSE TO CAEPS AMENDMENTS TO STATE BOARD'S PUBLISHED REGULATIONS

"We have reviewed the proposed amendments to the draft regulations and believe that they constitute a substantive change.

"This is the most recent attempt by medicine to derail the adoption of the proposed regulations. If you will recall, there have been two petitions filed with the Department of Consumer Affairs requesting that the regulation proceeding be halted. Since that request was denied, we now have a last ditch attempt to rewrite the regulations.

"SB 1406 was adopted unanimously by the legislature in order to remedy the perceived deficiencies that existed in the prior law relative to the optometric treatment of glaucoma. The prior law was too cumbersome, too complex and there were too many barriers preventing optometrists from becoming certified.

"These proposed amendments do nothing more or less than perpetuate the problems that previously have existed.

"I urge you to disregard this last minute attempt to disrupt the regulation making process."

Optometric Specialties, Inc.
Eric E. Gaylord, O.D.
Raymond E. Gaylord, O.D.
www.optometricspecialties.com
323-294-7517

Andrea Leiva
California State Board of Optometry
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Sacramento CA 95834
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Email: Andrea_Leiva@dca.ca.gov

December 23, 2009

Re: Senate Bill 1406

Dear Ms. Leiva,

I write this letter to express my opinion about the development of certification standards for Senate Bill 1406, and to support the State Board of Optometry's proposed glaucoma certification regulations. I was certified to treat primary open angle glaucoma in 2005 under SB 929. I can attest to the difficulty and time-consuming nature of the certification requirements in SB 929, and I am certain that SB 929 prevents most Optometrists from gaining a certification to treat glaucoma.

I began the SB 929 certification process in 2001 with local preceptoring Ophthalmologists shortly after taking the didactic course. Because I practice in an area of Los Angeles with a high incidence of glaucoma, I was able to accumulate a long list of patients quickly—more than 200. I found that I was not able to follow many of these patients due to several factors including assignments to insurance plans, normal attrition of patients for death or moving away, and lack of cooperation with local Ophthalmologists. Who did not return documents in a timely fashion or, usually, not at all: Thus, the list of patients had to grow, which began to delay the certification process. Fortunately for me, two Ophthalmologists were quite cooperative, and I was able to manage my last patient four years later.

The fifty patient-two year certification process is prohibitive and unreasonable. There will be little change in California to the number of Optometrist treating glaucoma without an amendment to the law. Patients who suffer from glaucoma will continue to have fewer choices for good care and deal with needless delays in diagnosis and treatment. I strongly urge the support and passing of the proposed changes to this law in SB1406.

Sincerely,

Eric E. Gaylord, O.D.
Optometrist

Cc: Tim Hart

Spectrum Eye Physicians
EyeMD

Martin L. Fishman, M.D., M.P.A.
General Ophthalmology, Cataract & Refractive Surgery

431 Monterey Avenue, #3, Los Gatos, CA 95030
408-354-9510 Fax 408-395-1610
www.spectrumeye.com

December 14, 2009

California Board of Optometry
2420 Del Paso Road, Suite 255
Sacramento, CA 95834

RE: SB 1406 Regulations

Dear Members of the California Board of Optometry:

I am writing you as an individual and a recent member of the Glaucoma Diagnosis and Treatment Advisory Committee (GDTAC), which was designated by SB 1406 to provide the Department of Consumer Affairs (DCA) and the California State Board of Optometry (SBO) with appropriate training requirements for optometrists wishing to treat glaucoma. The Legislature's mandate in SB 1406 [Sec. 2.3041.10. (a)] was clear: the Public is to be protected as optometrists treat and manage glaucoma patients.

During the many days of GDTAC meetings, the ophthalmologist members consistently asked one primary question: **"What experience in diagnosing and treating glaucoma was present in previous and current optometric training, and was this adequate to protect the public?"** It was our opinion that practical, hands-on experience was necessary to learn to properly diagnose, treat and manage glaucoma patients. The diagnosis and treatment of this group of diseases cannot be learned simply from textbooks and lectures. As practicing ophthalmologists, we had each seen many examples of patients with glaucoma inappropriately misdiagnosed by optometrists, with resultant delays in diagnosis, injury, and significant loss of vision. We knew that patients could be injured and blinded by the incorrect diagnosis, treatment and management of glaucoma. The recent Palo Alto Veterans Administration Hospital revelations confirm this concern.

We asked the optometric representatives on the GDTAC for specific information on optometric training in glaucoma, including the number of glaucoma patients diagnosed, treated and managed by optometric students, and the numbers of contacts and time frames. Glaucoma is actually dozens of diseases, with complex presentations, variable response to medication, subtle signs of progression, and the risk of serious visual loss. Ophthalmologists see thousands of such patients in their three or four years of residency, initially diagnosing hundreds of cases and managing patients though many visits and years of treatment. **They refused to provide data, in part because there do not appear to be minimal requirements in the optometric curricula for numbers of glaucoma patients diagnosed, treated or managed. This is a serious deficiency in the training of optometrists in California programs.**

In the past, SB 929 established very minimal requirements for optometrists wishing to treat glaucoma, requiring them to manage at least 50 patients over two years with an ophthalmologist preceptor. We attempted to address some of the complaints about these requirements, by allowing the substitution of some patient requirements by case management and lecture courses, and allowing preceptors to be glaucoma certified optometrists. Nonetheless, we strongly believed that some minimal number of patients should be treated in a supervised manner prior to certification.

We also felt that recent graduates of optometric training in California should demonstrate at least this same degree of experience in actually individually diagnosing, treating and managing glaucoma patients. We attempted to obtain from the optometric representatives the actual statistics of such training, but they were unwilling to provide this information. For this reason, we could not conclude that current graduates should be assumed to have had adequate training and clinical experience in glaucoma. **We therefore recommended that current optometric graduates (since 2008) demonstrate the equivalent experience requirements of SB 929, or that their experience be supplemented if necessary.** We have each known recent California optometry school graduates who have never primarily diagnosed a case of glaucoma, nor devised and managed a treatment plan for a significant number of patients over a reasonable length of time.

The DCA took the two differing recommendations from the GDTAC and chose, incredibly, an optometrist for this role who was not glaucoma certified, who practiced the treatment of glaucoma without a proper license from the SBO, and who was directly in a position to benefit personally and through his institution from allowing the broadest possible licensing for optometrists to treat glaucoma. I would urge the SBO to reconsider basing regulations on a report lacking even basic objectivity.

As a member of the GDTAC, an ophthalmologist who treats glaucoma patients daily, and as a citizen simply concerned about the safety of patients, I urge the SBO to obtain information and objectively examine the past and current glaucoma diagnosis and management experience in optometric training prior to issuing regulations.

The primary goal of SB 1406 is to protect the public, and not simply to license optometrists to treat glaucoma. <u>The SBO 1406 Proposed Regulations clearly allow optometrists to diagnose and treat glaucoma without any significant required direct patient management experience, putting the public at risk for injury and visual loss</u>. I hope the SBO will recognize its role as an agent of the Department of Consumer Affairs, and truly protect the public with appropriate regulations based on truly objective standards.

Sincerely,

Martin L. Fishman MD

Martin L. Fishman, MD, MPA

MLF/bf

Comment 30

LightHouse for the Blind and Visually Impaired

Via Facsimile (916) 575-7292
State Board of Optometry
2420 Del Paso Road, Suite 255
Sacramento, CA 95834

Re: Draft Regulations: 1571 Requirements for Glaucoma Certification – *OPPOSE*

Dear Board Members:

I am writing to oppose the regulations currently before the Board related to glaucoma certification.

As we understand it, a pathway to complete the certification process for those currently out in practice would allow them to do so without actually managing a single glaucoma patient themselves.

Furthermore, it is our understanding the regulations impose no additional requirements on graduating students even though the committee charged with establishing the standards was specifically refused information (by the optometrist members of the committee) that would have allowed the committee to make an informed decision on the subject. SB 1406 required the committee to review such data.

Lastly, it is our understanding that the Director of the Department of Consumer Affairs recently honored the portion of the Administrative Petition we supported calling for a thorough investigation of the treatment of glaucoma patients at the Palo Alto Veterans Administration Hospital. We believe that investigation should be completed and considered by your Board in developing the regulations in question ***before*** proceeding with the enactment of standards that might endanger the public.

The LightHouse for the Blind and Visually Impaired is the largest agency serving individuals who are blind or visually impaired in Northern California. Our primary purpose is providing individuals with vision loss the skills they need to live successfully in their communities. Training includes rehabilitation, teaching, orientation and mobility training, Braille instruction and assistive technology classes.

Many of our clients are individuals who have lost their vision due to glaucoma. Due to the precarious nature of glaucoma, it is crucial that an individual be seen regularly by an ophthalmologist. As you are aware, ophthalmologists are physicians and medical school graduates, while optometrists earn their degrees after completing four years of optometry school and, in some cases, a residency. We are dismayed by the recent events at the Palo Alto VA where several patients experienced severe vision loss after being treated by a team of Optometrists. Ophthalmologists have historically treated glaucoma.

The evidence suggests a glaucoma patient's outcomes may be better when treated by an Ophthalmologist.

I urge you to reconsider these regulations in light of the fact the process developing them appears to be tainted, and the fact that the investigation should be completed such that its outcome can be rationally considered in this process.

Respectfully,

Anita S. Aaron
Executive Director/CEO

cc: Craig H. Kliger, M.D.

214 Van Ness Avenue, San Francisco, CA 94102 / Voice: 415 **431-1481**
Fax: 415 863-7568 / TTY: 415 431-4572 / www.lighthouse-sf.org

December 17, 2009

Via Facsimile (916) 575-7292
State Board of Optometry
2420 Del Paso Road, Suite 255
Sacramento, CA 95834

RE: Section 1571 – Glaucoma Certification Requirements -- ***Oppose***

Dear Members of the Board:

I am writing as a recent member of the Glaucoma Diagnosis and Treatment Advisory Committee (GDTAC), which was designated by SB1406 to recommend appropriate training requirements for optometrists seeking certification to treat glaucoma in California. I am respectfully asking you reject the above mentioned regulations and redevelop them so as to allow 1) an objective appraisal of the current clinical education in glaucoma provided by optometric training, 2) the selection of an appropriate and unbiased consultant for DCA to reevaluate the recommendations of the GDTAC, 3) development of reasonable requirements for the safe treatment of glaucoma patients by optometrists.

As you know, our committee came to a deadlock on the recommendations to be transmitted to the Board of Optometry via the Office of Professional Examination Services. The ophthalmology committee members felt that the current didactic portion of optometric glaucoma education is minimally adequate, but that the clinical training -- the supervised one doctor-one patient encounters where a provider gains experience in the nuances of diagnosing and managing a disease under a provider experienced in the science and art of glaucoma management – is currently lacking. For the majority of optometry students, the Veterans Administration (VA) is where they obtain the bulk of their clinical experience. ***It is extremely concerning that many of California's optometry students have trained in an institution (the Palo Alto VA) where the very educators providing them training are now being investigated for patients under their care losing vision and/or going blind from glaucoma.*** Furthermore, this information was not known to us until it became public ***after*** the GDTAC held its meetings. I believe that all these facts warrant a further look into the adequacy of optometric training for the disease of glaucoma.

Glaucoma is a complex disease with a slow but irreversible progression to blindness. The understanding of glaucoma management cannot be achieved with a one-year crash course because, most likely, no changes in vision will occur within the one particular year that the optometrist is training. A good comparison is to that of a pilot. A pilot must log above a certain number of hours of actual flying (after their didactics) in order to increase the chances that they will encounter and manage dangerous conditions as a trainee, before they are licensed to fly actual passengers on their own. In glaucoma, under the management of someone inexperienced without proper training and education, it is very likely that a patient's vision will (sadly) irreversibly slip away from under them.

The previous mechanism by which optometrists wishing to manage glaucoma for their patients could become certified was established by SB 929. This certification process mandated a minimally rigorous one patient-one doctor management program of 50 patients over 2 years each under the supervision of a board-certified ophthalmologist (Eye MD). This previous certification process attempted to guarantee a certain level of experience with "dangerous conditions" for optometrists to improve their clinical judgement as regards glaucoma, something that does not appear to be achieved by the regulations before you. As a clinical educator, I have personally seen the learning curve of health care providers, and the apprenticeship type of training (supervised one patient-one doctor encounters under a specialist that takes place over an extended period of time) cannot be underestimated in its efficacy.

Again, I hope that you will reject the regulations and have them redeveloped in a more appropriate fashion. I am confident that the Board will do what is necessary to protect the public and optometric patients.

Sincerely,

JoAnn Giaconi, MD
Assistant Clinical Professor of Ophthalmology
David Geffen School of Medicine, UCLA

December 21, 2009

Andrea Leiva
Department of Consumer Affairs
California State Board of Optometry
2420 Del Paso Road, Suite 255
Sacramento, CA 95834

My name is James Brandt. I am a Professor of Ophthalmology at the University of California, Davis and for the past twenty years have served as the Director of the glaucoma service at UC Davis. In that role I wear many hats – Most of the time I am a clinician, taking care of patients with glaucoma. I am a researcher, running laboratory and clinical studies in my field, and most relevant to the topic at hand, an educator, teaching medical students, residents and fellows about glaucoma. Finally, as an associate examiner for the American Board of Ophthalmology, I conduct oral examinations of candidates for board certification in ophthalmology, so I have the added perspective of someone who sees the end product of American ophthalmic and specifically glaucoma education from around the country.

I will not address how the Board of Optometry arrived at their proposed regulations. Let the lawyers and lobbyists argue about process. My comments focus instead on how clinicians learn and how clinicians are educated.

Before I address clinical education, allow me to make some observations about glaucoma, based on two decades of focusing my entire career on this disease. First, this is a complicated disease, one which presents differently in each patient and requires a nuanced and individualized approach to treatment. In many ways I feel I understand glaucoma less well now than I did when I finished my training, or at least it is not as simple as I thought when I started my career. I say this to emphasize that this is not a disease that can be treated according to a simple algorithm, flow chart or guidelines propagated by a specialty organization. Indeed, all such treatment guidelines contain the disclaimer that "these are guidelines only and do not substitute for clinical judgment."

So where does clinical judgment come from? The hallmark of modern medical education is the combination of graded responsibility with breadth, depth and length of patient care. Let me explain how this plays out in the training of an ophthalmology resident at UC Davis, which is typical of ophthalmology residencies around the US. When our brand new first year residents arrive, we focus first on the skills needed to properly diagnose glaucoma. We do this on *real* patients with *real* disease presenting in a myriad of ways, hundreds of them, with direct one-to-one supervision of examination skills. These are patients who come in with early disease and end-stage disease, comorbidities as diabetes and heart disease that interact with their glaucoma and all the social and personal issues that affect treatment

decisions. This is what I mean by breadth. In the second year of the residency, during a full time rotation on the glaucoma service, the resident will see thirty to forty glaucoma patients a day, 3 or 4 days a week, combined with graded experience in the operating room and laser suite. By the end of a their second year, therefore, a resident will have personally seen, examined and cared for as many as two thousand (yes, thousand) patients, across the very large spectrum of the several diseases we call "glaucoma." This is what I mean by both breadth and depth. At the beginning of the second year the resident has 'training wheels' and does little without direct supervision. By the end of the second year the training wheels come off and the resident does more with less direct supervision. In their final year the whole package comes together, with the residents acting with increasing independence but still with the safety net of an experienced clinician at hand to offer suggestions, consultation or gentle correction. By the time they complete a residency and sit for board certification, an ophthalmology resident will have cared for thousands of patients with glaucoma and have provided glaucoma care for a few hundred patients over the course of three years. Breadth, depth and length.

This is where clinical judgment comes from. There is a saying that good judgment comes from experience, but that experience comes from bad judgment. Nowhere is this more important than in medicine. The whole goal, in fact the whole *design* of medical education is to allow trainees to gradually gain experience while being supervised so that the patients don't pay the price of a trainee's bad judgment. Patients are protected and high quality clinicians are trained. The public at large wins.

Board certification serves as a final quality check, with oral examination by experienced clinicians designed to test clinical judgment. These are not *pro forma* exams – some 20% or more fail the exams and must re-take them, and board certification is time-limited with ongoing testing required to maintain.

Now let's contrast this with what the Board of Optometry is proposing.

First, it is proposed that current and future graduates of schools of optometry have already received training sufficient to treat glaucoma without additional training requirements. If one looks at this from the standpoint of medical education, graded responsibility and breadth, depth and length of patient care, one can see how dangerous this proposal is. Optometry students see mostly healthy patients. In their eye disease clinics the glaucoma patients are mostly those who are 'glaucoma suspects' or with ocular hypertension. They may see only a handful of patients with moderate to advanced disease and are rarely given graded responsibility for their long-term care. They are supervised in most cases by other optometrists, and given the recent experience at the Palo Alto VA, we see how well that works out.

Second, it is proposed that practicing optometrists gain certification by one of three mechanisms, none of which require the optometrist to have a therapeutic relationship with more than a token number of patients. There is no breadth, depth or length and certainly no graded responsibility. In fact it is possible under the

proposed regulations to receive credit for seeing patients from a lecture course in which no hands-on contact with a patient even occurs. Optometrists can satisfy the requirement of 'treating' patients by participating in grand rounds and patient discussion. Lectures, seminars and grand rounds all have their place in medical education, but they only work when added to a foundation of direct patient care of breadth, depth and length.

Remarkably, under the proposed regulations it would be possible for an optometrist to gain certification to independently treat glaucoma without ever having treated a single patient. Common sense surely tells us that this doesn't make sense and is not in the public interest.

Finally, the proposed regulations fail to incorporate any semblance of a requirement for ongoing continuing education or any mechanism to verify that glaucoma-certified optometrists are staying up with the field. Glaucoma management in 2010 is completely changed from what it was when I entered practice in 1989, with new medications, diagnostic tools and surgical treatments. The public is ill-served, and quite honestly placed in harm's way if clinicians are not forced to stay on top of their field. Ophthalmologists are required to re-test to maintain board certification and the Medical Board of California requires ongoing continuing medical education. In 2015, who do you think will be on top of their field, an optometrist five years after graduation with no ongoing continuing education requirement specific to glaucoma or the ophthalmologist five years after board certifications studying for her recertification?

In closing I would like to remind you of Sir William Osler, who helped revolutionize medical education in the early part of the last century, in large part by helping shut down diploma mills that granted medical degrees without any clinical experience. He stated that *"He who studies medicine without books sails an uncharted sea, but he who studies medicine without patients does not go to sea at all."* In the 21st century, despite dazzling Powerpoint lectures, YouTube videos, online collaboration, virtual reality and educational media yet to be invented, his words still ring true.

Thank you.

James D. Brandt, M.D.
Professor of Ophthalmology & Director, Glaucoma Service at the University of California, Davis

California Medical Association
Physicians dedicated to the health of Californians

December 21, 2009

Via Email: andrea_leiva@dca.ca.gov
Andrea Leiva
Department of Consumer Affairs
California State Board of Optometry
2420 Del Paso Road, Suite 255
Sacramento, CA 95834

RE: Requirements for Glaucoma Certification Proposed Regulations

Dear Ms. Leiva:

The California Medical Association (CMA) appreciates the opportunity to comment on the Board of Optometry's (Board) proposed regulations regarding optometric glaucoma certification requirements. CMA is a professional organization that represents more than 35,000 California physicians. Dedicated to the health of Californians, CMA is active in the legal, legislative, reimbursement and regulatory areas on behalf of California physicians and their patients.

While CMA values the Board's efforts to promulgate regulations to implement the legislative intent of Senate Bill 1406 (Chapter 352, Statutes of 2008, Correa) the proposed regulations violate tenets of California's Administrative Procedures Act requiring that regulations be authorized and uphold the appropriate statutory reference. (*See* Government Code §11349.1.)

First, we describe our general objections in response to the methods in which these regulatory standards were developed. These fundamental objections apply to the regulatory proposal as a whole. Below the objections, we provide additional comments as to why the specific proposed language fails to comply with the Administrative Procedures Act.

I. Glaucoma Diagnosis and Treatment Advisory Committee Bias

The Glaucoma Diagnosis and Treatment Advisory Committee (GDTAC) was established as a result of the enactment of SB 1406 in order to develop appropriate requirements by which optometrists may be certified to treat glaucoma. However, CMA believes that the process by which these recommendations were developed was plagued with bias and lacked maintenance of good faith negotiations.

After a decision making stalemate within the committee resulted in the submission of two separate reports of findings and recommendations, the former Director of the Department of

Consumer Affairs (Department) hired Tony Carnevali, OD to act as an unbiased, third-party consultant to reconcile the competing reports and make recommendations on certification requirements for glaucoma. The Department hired Dr. Carnevali without being directed to do so by specific legislative authority.

The neutrality of process laid out in the final version of SB 1406 was essential to all parties' agreement to the bill's passage. Contrary to the clear intent of the Legislature to have unbiased recommendations from the GDTAC, the hired consultant had significant conflicts of interest. Dr. Carnevali was found to be a) an optometrist who is **not** certified to treat glaucoma, b) an employee of the Southern California College of Optometry - one of two schools of optometry that would benefit economically by efforts to reduce clinical training requirements, c) the President of Public Vision League – the litigation arm of the California Optometric Association, and d) a past President and longtime member of the Board of Trustees of the California Optometric Association, which sponsored SB 1406.

After learning of these fundamental biases included in the proposed regulations, current Director of the Department, Mr. Brian Stiger, asked that the Board reevaluate its decision to proceed with these regulations. Even after receiving this request, the Board refused to postpone and reevaluate this regulatory package.

II. Current Department of Consumer Affairs-Mandated Investigation Highlights the Dangers of Glaucoma Treatment by Optometrists without Adequate Training

In January 2009, doctors at the Veterans Affairs Palo Alto Health Care System (VAPAHCS) discovered that a 62-year-old male veteran had significant visual loss in one eye as a result of poorly controlled glaucoma, a disease which had been managed solely in the hospital's optometry unit since June 2005. This prompted the review of 381 medical charts which resulted in finding that eight veterans with glaucoma suffered blindness, 16 others had experienced "progressive visual loss" short of blindness and 87 others were at high risk of losing their sight.

As a result of these events, Department Director Stiger granted a request petitioned by CMA, the California Academy of Eye Physicians & Surgeons, and the American Glaucoma Society that the Board of Optometry and the Medical Board of California hold a formal investigation regarding these events at VAPAHCS.

Because this investigation is currently underway, it would be unwise for the Board to continue with the promulgation of these regulations as written until a final determination is made. The available evidence in this investigation suggests that the proposed standards for glaucoma certification could be detrimental to patient safety, counter to Business and Professions Code §3041.10(a) statutory reference.

III. Section 1571

The proposed regulations violate California statute by threatening patient safety. Business and Professions Code §3041.10(a) states that "it is necessary to ensure that the public is adequately protected during the transition to full certification for all licensed optometrists who desire to treat and manage glaucoma patients."

The proposed regulations cut the minimum Case Management Requirement in half from current standards which require those seeking glaucoma certification to manage 50 patients in collaboration with a physician over two years. The current requirement is minimal to begin with as compared to the extensive glaucoma training met by ophthalmologists. The Department's hired consultant had a substantial influence in watering down these requirements, as previously mentioned in reference to Dr. Carnevali's conflicts of interest.

The complicated three-option certification process detailed in §1571(a)(4) of the proposed language endorsed by the Department of Consumer Affairs could place glaucoma patients in grave danger. The proposed regulation would authorize glaucoma certification after simply completing a lecture requirement and "interacting" in a group with as few as 10 glaucoma patients over a single year or less without actual treatment. This process claims to require each applicant to follow 25 "patients" over one year. However, it allows an applicant to obtain 15 patient credits for a lecture course involving no patients as well as an additional 15 patient credits from a course where live patients are "seen" in a large group setting where they are discussed with faculty. By combining these two options (the "Case Management Course" and the "Grand Rounds Program") an optometrist seeking glaucoma certification can completely satisfy the requirement to treat a minimum of 25 patients within a 12-month period without ever personally treating a glaucoma patient.

It is difficult to imagine that the public will be adequately protected by proposed regulations which do not require **any** training involving supervised treatment of patients. Under the proposed regulations, an optometrist ***could actually become certified to independently treat glaucoma without having ever treated a single glaucoma patient.***

The third option provides a Preceptorship Program where an applicant actively manages glaucoma patients with a supervisor authorized to treat glaucoma. However, because of the complexity and level of difficulty involved with undertaking this third option, it is irrational for anyone to voluntarily choose this course of action when seeking glaucoma certification.

Aside from this, the regulations fail to incorporate additional training requirements for future optometry graduates. Because the regulations assume that "licensees who completed their education from an accredited school or college of optometry on or after May 1, 2008 are exempt

from the didactic course and case management requirements," ophthalmologist members of the GDTAC hoped to consider additional necessary training requirements.

However, because negotiations within the committee faltered, GDTAC optometrist members ***refused*** to provide vital information to their colleagues regarding the number of glaucoma patients an average student at the UC Berkeley School of Optometry and the Southern California College of Optometry managed under supervision and for how long. As illustrated by the events at VAPAHCS, extensive clinical glaucoma training is essential to maintaining patient safety. The mandate of Business and Professions Code §3041.10(a) is not upheld in the current proposed regulations because the GDTAC did not have the necessary information available to ensure that the correct safeguards were included regarding glaucoma training of recent optometric graduates.

Again, CMA appreciates the efforts of the Board of Optometry in promulgating regulations to increase patient access to glaucoma treatment. However, sacrificing patient safety by proposing insufficient training requirements for certification is not the solution. CMA also has serious concerns over the mechanisms through which these regulations were developed, especially considering the current allegations against optometrists from VAPAHCS. For these reasons, we urge the Board of Optometry to significantly amend the proposed regulations or better, have them redeveloped through the SB 1406 process in a manner consistent with its legislative intent.

Respectfully submitted,

Veronica Ramirez

Veronica Ramirez
Research Associate, Center for Medical and Regulatory Policy
California Medical Association

Comment 34

STATE AND CONSUMER SERVICES AGENCY - *Department of Consumer Affairs* Arnold Schwarzenegger, *Governor*

MEDICAL BOARD OF CALIFORNIA
Executive Office

December 21, 2009

Andrea Leiva
Board of Optometry
2420 Del Paso Road, Suite 255
Sacramento, CA 95834

Proposed Rulemaking: Requirements for Glaucoma Certification

Dear Ms. Leiva:

The Medical Board of California (Medical Board) appreciates the opportunity afforded by the Board of Optometry to review the proposed rulemaking addressing "Requirements for Glaucoma Certification" and we would like to share our concerns.

On July 1, 2009, the Office of Professional Examination Services (OPES) submitted to the Board of Optometry a report, "Glaucoma Certification for Optometrists – Report and Recommendations," with modifications.

The recommendations of the consultant hired by the Department of Consumer Affairs (DCA) and the modifications offered by OPES, regarding the case management requirements state: *"California schools and colleges of optometry will work cooperatively to develop uniform curriculum and procedures and obtain approval by the State Board of Optometry."* Later in the same document, it is written: *"The accredited optometry schools and colleges in California could develop and recommend to the State Board of Optometry for approval the specific format and content of a case management course and/or a grand rounds program."*

However, the proposed language in the rulemaking for both the Case Management Course and the Grand Rounds Program only requires that both be "developed by an accredited California school or college of optometry."

Section 3041.10 of the California Business and Professions Code, as added by SB 1406 (Chap. 352, Stats of 2008) states that the Board of Optometry "shall adopt the findings of the office and shall implement certification requirements . . . "

Thus, the Medical Board believes two key elements of the recommendations are missing: (A) the requirement for uniform curriculum and procedures established cooperatively by California schools and universities of optometry and (b) the uniform curriculum and procedures be granted approval by the Board of Optometry. Failure to include these elements in the proposed language would seem to indicate that the Board of Optometry has not met one of the six standards required under the Administrative Procedures Act, that of **consistency**.

Thus, the Medical Board posits that to ensure consistent and equal educational opportunities for all optometrists seeking glaucoma certification, and to ensure equal patient safety for all Californians, regardless of where their optometrist is educated, the two recommendations of the DCA consultant and OPES that were omitted should be included in the proposed rulemaking language in Section 1571 (a) (4) (A) and (B).

The Medical Board also notes that the consultant's and OPES' recommendations address changes which the Board of Optometry should make to the continuing education requirements. Since we are certain that the Board of Optometry and the Medical Board share a common interest in improved patient safety, we look forward to reviewing a future rulemaking which implements these recommendations.

We thank you for the opportunity to comment on this rulemaking.

If you have any questions, please contact Kevin A. Schunke, the Medical Board's Regulations Manager, or me at (916) 263-2389.

Sincerely,

Barb Johnston
Executive Director

Jane Vogel, JAC Chairperson Emeritus
35 Granada, Irvine, CA 92602

Kathy Goodspeed, JAC Treasurer
856 Amber Lane, Anaheim, CA 92807

December 21, 2009

California State Board of Optometry
2420 Del Paso Road, Ste 255
Sacramento, CA 95834

RE: Section 1571 OPPOSE

Dear Board of Optometry Members:

We are writing this letter to you as members of a statewide organization comprised of most major organizations in the state that provide services or work on behalf of Californians who are blind or visually impaired. This 28-year-old organization is *Joint Action Committee of Organizations Of and For the Visually Impaired (JAC).*

Our professions and our involvement in JAC have allowed us to work directly with people who are blind or visually impaired, including individuals who have glaucoma. We have worked with consumers, eye care providers, educators, rehabilitation workers, and others who want to help prevent blindness and who want to help individuals who have lost their vision. We have over 65 years between us, of doing this.

We are very concerned that the current proposed regulations (section 1571), pertaining to Senate Bill 1406 (Correa), have not been formulated in a manner that is in the best interest of consumers. Having an optometrist draft the regulations does not reflect the spirit of the bill that was passed, and is a conflict of interest. The regulations do not offer the protection to consumers that we would like to see. We would like to see more authentic training of optometrists, with hands-on experience with patients who have glaucoma (not just patients with elevated pressure). We want to know that when we refer people to optometrists they will receive the level of care that would be received if they had gone to an ophthalmologist. In our field of helping people with vision loss the incident with the veterans at the VA in Palo Alto is alarming. Several veterans placed their trust in an optometrist who was supposed to be an expert in glaucoma treatment, yet the treatment they received caused them to lose their vision. We are very much afraid that more consumers will suffer a similar fate, should the proposed regulations be adopted.

Please think of the consumer, rather than your profession. There should be no rush to pass these regulations. Please consider using a new non-biased consultant who can draft meaningful regulations to protect the consumer. If this is not a consideration we hope that Director Brian Stiger will veto the regulations. This issue is too serious to ignore. We know, we see those individuals who live with glaucoma every day of their lives. Their only hope is quality eye care, provided by competent, well-trained eye care providers. We do not feel that these regulations are sufficient to ensure the type of eye care that these individuals deserve.

Respectfully,

Jane Vogel, M.A. and Kathy Goodspeed

California Academy of Eye Physicians & Surgeons
425 Market St., Suite 2275, San Francisco, CA 94105 o Phone: (415) 777-3937 o Fax: (415) 777-1082
e-mail: CaEyeMDs@aol.com o web: www.CaliforniaEyeMDs.org

December 21, 2009

Lee A. Goldstein, OD, MPA
President
California Board of Optometry
2420 Del Paso Road, Suite 255
Sacramento, CA 95834

RE: Proposed Requirements for Glaucoma Certification – 45-day Comment Period

Dear Dr. Goldstein:

The California Academy of Eye Physicians and Surgeons (CAEPS) appreciates the opportunity to comment on the proposed adoption of Title 16, California Code of Regulations Section 1571, which promulgates requirements for the certification of optometrists to treat glaucoma. We believe the proposed regulations create a "glaucoma treatment loophole" not authorized by SB 1406 that virtually ***eliminates*** any actual "hands-on" clinical training in treatment for practicing optometrists and thus threaten patient safety. They also are based on a process that failed to include a legitimate Legislatively-mandated "backstop" review of optometric student training (to balance the "presumption" of sufficient experience to be certified ***without an advance review***), and therefore unreasonably conclude additional training is ***not*** required for graduates after May 1, 2008. Furthermore, subsequent reports of optometric mismanagement of glaucoma patients at the Palo Alto Veterans Affairs Hospital call into question both the lack of referral requirements for optometrists treating glaucoma and the adequacy of training received by students.

SB 1406 delegated the responsibility to protect patients from blindness and loss of vision to the Department of Consumer Affairs (DCA, Department), the Board of Optometry, and the Glaucoma Diagnosis and Treatment Advisory Committee (GDTAC). SB 1406 mandated a fair and balanced approach to resolving issues pertaining to optometric glaucoma certification requirements. The Department under former Director Carrie Lopez compromised the fair and balanced SB 1406 process and in effect turned key rulemaking authority over to a former President of the California Optometric Association in flagrant violation of the intent of the Legislature. It took considerable courage for the current DCA Director Brian Stiger to ask the Board to "re-evaluate its decision to proceed" with these regulations so that their tainted history could be expunged through re-doing key parts of the legislatively-mandated process.[1] Unfortunately, the Board has chosen to rush these tainted regulations through the process, defying the Director's "suggestion" and risking the exercise of his veto power or the Office of Administrative Law's inevitable rejection.

The Board's primary responsibility is to ***protect the public*** and since we believe it is clear that patient protection has not been achieved, CAEPS respectfully asks the Board of Optometry to withdraw the regulations and have them redeveloped in a manner consistent with patient safety and the legislative intent of SB 1406 or consider proposed amendments.

[1] November 10, 2009 letter from DCA Director Brian Stiger re: joint Revised Administrative of CAEPS, the California Medical Association, and the American Glaucoma Society dated October 12, 2009, pg. 4 [Attach. 1]

INTRODUCTION:
The law is on a collision course with blindness...

On August 29, 2008, the Legislature sent Senate Bill 1406 relating to optometry to the Governor who approved it on September 26, 2008. (Stats. 2008, Ch. 352.) The Senate Business, Professions and Economic Development Committee's analysis of the final amendment dated August 20, 2008, describes the measure as follows:

> "SUMMARY: Revises and recasts the scope of practice for optometrists to specify permissible procedures for certified optometrists; creates, until January 1, 2010, a Glaucoma Diagnosis and Treatment Advisory Committee to ***establish*** glaucoma certification requirements." [Emphasis added.]

Unfortunately, the subsequent regulatory action taken by both the Board of Optometry and the DCA does not comply with the Legislature's intent in two fundamental areas, and fails to take into account a third:

1. **Content: The content of the regulations violates the statutory purpose to protect glaucoma patients and exceeds the statute's authority regarding the permissible scope of clinical training requirements.**

   By a nearly unanimous vote the Legislature authorized a ***balanced*** compromise approach to the establishment of new clinical training requirements for optometrists who seek certification to treat glaucoma without going to medical school. However, the implementation regulations reflect an unlawful one-sided approach supported by the California Optometric Association to dramatically expand optometrists' scope of practice without requiring the clinical training necessary to protect patients against blindness and loss of vision. The legislative history of SB 1406 clearly sets forth the expectation that new glaucoma certification requirements would be promulgated with an "appropriate curriculum" that adequately protects glaucoma patients [B&P Section 3041.10 (d) (1) and (f) (1) (A)].

   The Legislature never seriously considered ***exempting*** practicing optometrists from the requirement for "hands-on" clinical training requirements regarding treatment. Long hearings wrestled about differences between optometrists and physicians about how much training should be required, but no one ever envisioned a couple of 16-hour classroom courses and a multiple-choice test covering "case management" would authorize an optometrist to treat glaucoma independently.

2. **Process: The process by which the regulations were developed does not conform in key respects to the process mandated by the Legislature.**

   SB 1406 clearly outlined a process whereby the GDTAC – made up of a balanced number of physicians (ophthalmologists) and optometrists – was expected to establish the clinical training requirements. The DCA was given unusual regulatory rule making authority (normally given to the Board) to modify the Advisory Committee's findings and recommendations to primarily protect patient safety. The Board was given ministerial duties to adopt the new clinical training requirements. However, lack of consensus reached by the 3 optometrist-3 ophthalmologist committee resulted in the issuance of two sets of proposed certification requirements, contrary to the Legislature's mandate.

   To make matters worse, subsequent actions by both the DCA and the Board of Optometry were undertaken without statutory authority. In particular, the DCA hired an optometrist activist and former President of the California Optometric Association as a "Special Consultant" to turn the two sets of recommendations into one. No surprise, the Legislature required that optometrists

serving on the Advisory Committee be certified to treat glaucoma. But surprisingly former DCA Director Carrie Lopez hired a consultant who was not certified to treat glaucoma. This simply illustrates the near total disregard former Director Lopez had for the intent of SB 1406. The Board is only authorized to adopt regulations proposed by the Committee itself and modified by the Department. However, it has now unlawfully proposed the DCA's optometrist Consultants' recommendations.

3. New Information Directly Impacts Subject of Regulations

Within days of the Board of Optometry adopting the DCA's tainted recommendations, published reports revealed that eight veterans were blind and more than 20 others suffered significant loss of vision as a result of treatment by at least two California-licensed optometrists at the Palo Alto Veterans Affairs Hospital. At particular issue was the failure of the optometrists to comply with a VA policy requiring "all patients with glaucoma seen in the Optometry section should have their cases overseen and reviewed by the Ophthalmology section."[2]

Stephen C. Ezjei-Okoye, MD, Deputy Chief of Staff, Palo Alto Heath Care System, Department of Veterans Affairs on February 27, 2009, wrote to a partially blind veteran who has lost a very substantial portion of his eyesight due to mismanaged glaucoma while under the care of the Optometry Department at the Palo Alto VA Hospital:

> "...We have recently reviewed your eye care and have determined that some of the vision loss you suffered may have been preventable had you received a different course of therapy. We deeply regret that you did not receive the very best possible care. I want to let you know that we are reviewing our system of eye care and are making changes to ensure that every veteran receives care of the highest possible standard."[3]

News reports clearly indicate that ***lack of training*** was a problem with at least one optometrist involved in this tragic incident.[4] VA officials are reported saying that one of the two optometrists involved in the blinding of eight veterans "has returned to clinical duties after ***receiving training***."[5] [Emphasis added.]

DCA Director Brian Stiger has since authorized a joint Medical Board of California-Board of Optometry investigation into whether state laws have been violated. Patient safety is being jeopardized by the Board's decision to charge ahead with regulations to reduce clinical training requirements for glaucoma treatment ***before*** the results of the investigation are available.

CONTENT: REGULATIONS VIOLATE THE LEGISLATURE'S CLEAR INTENT AND FAIL TO PROTECT THE PUBLIC

A. "Glaucoma Treatment Loophole" Buried in Impermissibly Vague Language

The proposed new language for the requirements for glaucoma certification would be contained in Section 1571 of Division 15 of Title 16 of the California Code of Regulations.

Section 1571 as proposed lists four requirements that must be met before an optometrist can treat glaucoma. The first three are consistent with the history of SB 1406 and present no problems.

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[2] Statement, Palo Alto Veterans Affairs Hospital, July 2009 [Attachment 2]
[3] See attached letter. [Attachment 3]
[4] Jessica Bernstein-Wax, "Physicians demand investigation of Palo Alto VA optometry department," Palo Alto Daily News, September 24, 2009
[5] Ibid.

At first glance, the fourth requirement, Section 1571 (a)(4) also appears to advance the goals and intentions of SB 1406. It says that to be certified to treat glaucoma, an optometrist shall:

> " ...Complete a Case Management Requirement where a minimum of **25 patients** are prospectively treated in a consecutive **12-month period**."[6] [Emphasis added]

When compared to existing law, this clinical training requirement appears to only cut in half the number of glaucoma patients who must be treated (from 50 to 25) and the length of supervised training (from two years to one). It could be interpreted as a "reasonable simplification" in a spirit of compromise under SB 1406. And it has the apparent benefit of being clear and unambiguous: treat 25 patients over the course of 12 consecutive months under prescribed oversight and supervision.

However, the remaining language in 1571 (a) (4) makes a ***mockery*** of the whole concept of clinical training. It opens a loophole that makes it possible for an optometrist to become certified to manage glaucoma patients ***without ever treating or co-managing a single glaucoma patient.***

It opens by stating:

> "The following options may be chosen ***in any combination*** to fulfill this requirement:" [Emphasis added]

Options to fulfill this are then spelled out, the first two of which are:

> (A) **Case Management Course** from an accredited California school or college of optometry. In just 16 hours, the course would "present" 15 cases of glaucoma and include a one-hour "final competency examination". But the course could be conducted live, over the Internet or by the use of telemedicine, which means no live patients need be seen. For completing this course, an optometrist would receive "... ***a 15 patient credit towards the Case Management Requirement.***" [Emphasis added]
>
> (B) **Grand Rounds Program**, which would also take just 16 hours and would require participants to evaluate and create a management plan for live patients. This option says patients must simply be "evaluated" in person, but does not mandate the optometrist actually treat them. Yet this program, too, " ...***will count as a 15-patient credit towards the Case Management Requirement.***" [Emphasis added]

Since the options may be chosen ***in any combination***, simply choosing Option (A) and Option (B) together would allow the candidate for glaucoma certification to receive not just 25, but a ***full 30*** patient credits. The candidate would thus complete the Case Management Requirement in just 32 hours, the equivalent of less than a single week of work, and ***without ever having to treat a single real patient. This loophole directly contradicts the regulation's "minimum of 25 patients...treated in a consecutive 12-month period" standard.***

Now compare that to Option (C), the only option that actually has the candidate actually ***treating real*** patients:

> (C) **Preceptorship Program**, in which the optometrist evaluates a patient and co-manages the patient's care under a preceptor who would be either a licensed, board-certified ophthalmologist or a licensed optometrist who has been glaucoma certified for two or more years. In this case, the

[6] Note, this language *deviates* from that in the OER/DCA Report, which *more clearly* indicates that actually anticipated to treat/manage 25 patients for one year: "The case management requirement will consist of, at minimum, 25 patients prospectively treated/managed for one year..."

patients would be prospectively treated for at least 12 consecutive months and "each patient that is seen by the optometrist in the program will count as a 1-patient credit towards the Case Management Requirement."

Option (C) is thus the ***only*** one of the three options that embodies some of SB 1406's spirit of compromise agreed to by optometrists and physician groups. It is the only one option that actually requires a candidate to treat ***real*** people. Yet it has, in effect, been made ***voluntary*** by the language of the proposed regulation. And it seems highly unlikely that any practicing optometrist who wants glaucoma certification would "bother" with treating live patients for a full year under the oversight of a preceptor by deliberately choosing option (C) when the combination of Options (A) and (B) is available.

Public health cannot be served if optometrists can be certified to treat a complex disease without ever making clinical decisions under appropriate supervision to develop the thought processes required for independent practice. *Would we ever allow an airline pilot to fly a commercial flight to Los Angeles based solely on two 16-hour lecture courses?* Yet under this proposed language, the Board of Optometry wants to allow an optometrist to "fly solo" on his or her first glaucoma patient without ever before having treated an actual glaucoma case. ***Who among us would want to be that first patient?***

Because of this giant loophole, the overall requirement is inconsistent, misleading and deceptive on its face. Because of this loophole, the proposed regulation fails in its primary duty of protecting the public and ***must not stand***.

B. Legislative Intent Not Complied With

Key provisions of the proposed regulations are not authorized under SB 1406 or any other statute. The "compromise" nature of SB 1406 is not represented in the regulations.

The statute represents a compromise measure agreed to by optometrists and physician groups. Regulation by law must be in the public interest. The Legislature has mandated public safety and public health as the highest priorities for the Board. The proposed regulation fails to uphold the legislative mandate to protect public health and safety.

The legislative history of SB 1406 is crystal clear.

As introduced, this California Optometric Association-sponsored measure sought to grant optometrists with four years of optometry school training the ***same*** legislatively-mandated authority accorded to physicians with at least eight years of medical training. By giving absolute authority to the Board of Optometry regarding optometric scope issues, optometrists would have been able to diagnose and treat virtually all eye diseases – glaucoma included – as well as perform "minor surgical procedures" (undefined) on the visual system (also undefined) that did not require general anesthesia.[7] Stringent clinical training requirements for optometrists to treat glaucoma patients, which had been in place since 2000, were repealed.

When it was noted that the bill's language to authorize "minor surgical procedures" on the visual system in effect allowed "small" brain surgeries, that provision was permanently dropped. Put simply, the as introduced February 22, 2008 version of the bill proved to be too open-ended a grant of legislative authority and the measure was amended down to a "spot bill" and moved out of Committee while optometrists and physician groups agreed to negotiate a compromise bill in a "collaborative process"[8] that

[7] Senate Business, Professions and Economic Development Committee analysis of SB 1406, as introduced.
[8] The intent language from the July 1, 2008 version of SB 1406 stating "It is the intent of the Legislature that interested parties come to resolution on a collaborative process..."

eventually was diluted to one that would make it easier for optometrists to become certified to treat glaucoma patients without compromising patient safety.[9]

The California Optometric Association argued for a minimum standards which would virtually "grandfather" the older of practicing optometrists and allow optometrists to treat glaucoma patients without any of the stringent clinical training required by law since 2000. While unsuccessful in the Legislature arena, this idea of holding recent optometry school graduates to one clinical training standard while providing a loophole for older practicing optometrists found itself buried in the vagaries of the proposed regulation. Physician groups have been and remain adamant that actual supervised (or co-managed), "hands-on" clinical training with glaucoma patients was necessary if optometrists are to be allowed in essence to practice medicine on the grounds that one-patient, one-trainee, one-supervisor encounters actively promote the decision making necessary for the ***independent*** practice of glaucoma treatment.

Existing law in 2008 required that optometrists seeking glaucoma certification complete a clinical training requirement involving co-managing 50 glaucoma patients over a two-year period each with an ophthalmologist. Review of the amended versions of the bill from June to August 2008 reveals that several different specific numbers of glaucoma patients and time frames were considered. It is important to note, however, at no time during the passage of SB 1406 did the Legislature ever seriously consider allowing a practicing optometrist to treat glaucoma patients without ***any*** actual co-management of glaucoma patients under treatment.

A compromise was finally reached and on August 11, 2008 the bill was amended to remove all the numbers and specific clinical training requirements, and a "Glaucoma Diagnosis and Treatment Advisory Committee" was authorized to resolve the dispute between optometrists and physician groups over the special clinical training requirements. The August 11, 2008 amendments revealed the safeguards and priorities of the compromise:

> "The Legislature hereby finds and declares that it is necessary to ensure that the public is adequately protected during the transition to full certification for all licensed optometrists who desire to treat and manage glaucoma patients."

While SB 1406 repealed clinical training safeguards in place for almost a decade, the statute gives no hint that ***all*** co-management of actual glaucoma patients under treatment would ever be eliminated for any category of optometrist seeking to treat glaucoma. On the contrary, the only "directive" aspect of the statute authorizes the Advisory Committee to ***add*** additional clinical training requirements:[10]

> "After reviewing training programs for representative graduates, the committee in its discretion may recommend additional glaucoma training to the Office of Examination Resources pursuant to subdivision (f)..." (B&P Section 3041.10 (2))

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[9] The March 22, 2008 amendment read in part: SEC. 5. It is the intent of the Legislature that in order to facilitate access to eye care in keeping with appropriate regard for the health, safety, and welfare of patients in California, the parties who are interested in the scope of practice of optometrists shall continue negotiations during the current legislative session on any proposed changes to the law governing this practice..."

[10] Also see Sen. Lou Correa's August 29, 2008 clarifying letter to the Senate Journal: "Amendments made to Business and Profession Code Section 3041.10 (d) (1) and Section 2041.10 (d) (2) as contained in SB 1406 as passed by the State Senate today clarify the purpose of the Glaucoma Diagnosis and Treatment and Advisory committee in its discretion ***may recommend additional glaucoma training to be completed before a license renewal application for any licensee described in this subdivision is approved.***" While the committee has been ***directed to presume*** that licensees who apply for glaucoma certification and who graduated from an credited school of optometry on or after May 1, 2008, possess sufficient didactic and case management training in the treatment and management of patients diagnosed with glaucoma to be certified, the intent of this addition to the law is to clarify the authority of the committee ***to recommend to the Office of Examination Resources additional educational requirements to those specified in Section 3041 (f)(1)*** for glaucoma certification as are deemed necessary by the committee." [Attachment 4]

Further, the August 20, 2008 amendments sought to clarify the intent and details of the compromise agreement. While the Board of Optometry was given formal appointing authority, the Legislature limited the role of the Board in choosing the members and mandating that optometrists and physician groups be equally represented by three members each. The August 20, 2008 amendments clarified that the Board could appoint the GDTAC, but it was not to be considered "within the Board of Optometry." In addition, the intended role of the Board was further statutorily reduced by removing the August 11, 2008 language that describes the Advisory Committee as "**assisting the Board**" in establishing certain requirements for glaucoma certification. The August 20, 2008 amendments made it crystal clear that the decisions on clinical training requirements were in the hands of the Advisory Committee not the Board of Optometry.

In keeping with the "collaborative process" envisioned by the compromise, the Legislature inserted a virtually unprecedented role for the DCA and its Director into SB 1406 rulemaking. The committee's final findings and recommendations were to be submitted to the Office of Examination Resources within the DCA; **not the Board of Optometry**:

> "The office [within the DCA] shall examine the committee's recommended curriculum requirements to determine whether they will do the following:
>
> - "**Adequately protect glaucoma patients**.
> - "Ensure that defined applicant optometrists will be certified to treat glaucoma on an appropriate and timely basis.
> - "Be consistent with the department's and board's examination validation for licensure and occupational analyses policies..." [Emphasis added.]

The August 11, 2008 amendments gave the Department more than its normal ministerial duties. The Department was given unprecedented rulemaking duties to ensure that glaucoma patients were adequately protected from the more one-sided, special interests of the involved professions. Again, the statute allowed the Department to modify the Advisory Committee's to protect glaucoma patients:

> "The office [of Examination Resources within the DCA] shall present the recommendations **and any modifications necessary to meet the requirements**" including to adequately protect glaucoma patients. [Emphasis added]

The near unanimous votes of 74 to 0 in the Assembly and 38 to 0 in the Senate reflect the compromise nature of the legislation. The physician groups, CAEPS and the California Medical Association joined with the California Optometric Association in supporting a ***neutral,*** expert-based advisory process to determine what the clinical training requirements should be for optometrists who in essence were being authorized to practice medicine without having to go to medical school.

Precisely because SB 1406 represented a compromise agreement, no one ever dreamed there would be a loophole whereby thousands of practicing optometrists seeking certification could avoid ***all*** co-management of glaucoma patients under active treatment.

PROCESS: PROCEDURAL ERROR AND BIAS PRODUCE "SPECIAL INTEREST" REGULATIONS

SB 1406 put in place a fair and balanced process that should have been able to produce clinical training requirements that both protected patients and at the same time expanded the scope of optometric practice. However, that fair and balanced process was twisted and compromised by DCA's former Director Carrie Lopez.

New Section 3041.10 of the Business and Professions code mandates an unusual form of rulemaking. Unfortunately, the mandated requirements were not followed.

SB 1406 required:

(1) The formation of the "Glaucoma Diagnosis and Treatment Advisory Committee" by the Board of Optometry with a balance of optometrist and physician interests represented in the best interest of the public.[11]

(2) The committee produce a set of recommendations by April 1, 2009.

(3) The committee submit its final recommendations to the DCA's Office of Examination Resources which would review & revise it as necessary to meet requirements including protecting patients.

(4) DCA to submit its final "findings and any modifications necessary" to the Board of Optometry by July 29, 2009.

(5) The Board to then "adopt the findings of the office and shall implement certification requirements pursuant to this section on or before January 1, 2010."

Unfortunately, the Board's "process" for formulating the regulations was ***tainted*** by bias and the perception of conflict of interest, and violates the spirit[12] of the voter approved Political Reform Act.[13]

This view is strongly supported by DCA Director Brian Stiger who in his November 10, 2009 letter responding to our joint Administrative Petition[14] challenging the Department's selection of a "Special Consultant," acknowledged the tainted regulatory record of the proposed regulations:

> "I understand your concern with the process by which the [Special Consultant] recommendations were made." [*No* emphasis added]

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[11] Subdivision (a) establishes the intent to protect the public: "The Legislature hereby finds and declares that it is necessary to ensure that the public is adequately protected during the transition to full certification for all licensed optometrists who desire to treat and manage glaucoma patients."

Subdivisions (b) and (c) require the Board of Optometry to appoint a "Glaucoma Diagnosis and Treatment Advisory Committee" with specified membership, balancing the interests involved between optometrists and physicians.

Subdivision (d) requires the Committee to "establish requirements for glaucoma certification" as specified, including an "appropriate" curriculum" with the possibility of recommending "additional glaucoma training".

Subdivision (f) sets out other key requirements:

For the Committee: "The committee shall submit its final recommendations to the Office of Examination Resources of the department on or before April 1, 2009."

For the Office: (1) "The office shall examine the committee's recommended curriculum requirements to determine whether they will do the following:

"(A) Adequately protect glaucoma patients.

"(B) Ensure that defined applicant optometrists will be certified to treat glaucoma on an appropriate and timely basis.

"(C) Be consistent with the department's and board's examination validation for licensure and occupational analyses policies adopted pursuant to subdivision (b) of Section 139.

"(2) The office shall present its findings and any modifications necessary to meet the requirements of paragraph (1) to the board on or before July 1, 2009. The board shall adopt the findings of the office and shall implement certification requirements pursuant to this section on or before January 1, 2010."

[12] The state's Political Reform Act states: "Public officials, whether elected or appointed, should perform their duties in an impartial manner, **free from bias caused by their own financial interests or the financial interests of persons who have supported them**;"[Emphasis added.] Government Code Section 81001 (b).

[13] Brian Joseph, "Optometry Board speeds up vote on controversial rule," Orange County Register, December 10, 2009

[14] Revised Administrtrative Petition of CAEPS, the California Medical Association, and the American Glaucoma Society dated October 12, 2009. [Attachment 5]

The "process" that produced these special interest regulations was contrary to the clear intent of the Legislature that these regulations ***protect patients*** and be crafted with the ***neutrality*** required by law. SB 1406 outlined a carefully balanced process to develop certification standards for optometrists desiring to treat glaucoma.

Each step built on each other in a carefully layered manner and none were optional: (1) One set of proposed regulations by the specially constituted GDTAC would be submitted to the DCA's Office of Examination Resources. (2) That office would then review and modify the single set of recommendations as necessary to conform to the limited statutory criteria (e.g., adequate protection of glaucoma patients, etc.). (3) The Board of Optometry would then adopt those recommendations without change.

Clearly the Legislature intended for the Board of Optometry to only play a ministerial role in the regulatory process and for the DCA's final submission to the board to operate as the board's de facto proposal. However, because the statutorily prescribed steps were not followed, the resulting regulations are invalid.

This outcome is akin to what befalls "the Fruit of the Poisonous Tree" – a well established legal doctrine in criminal law whereby evidence gathered with the aid of information obtained illegally is also "poisonous" or tainted. ***Substantive errors made at any step in the process similarly invalidate the fruit of those labors.***

A. Two Set of Recommendations Were Not Authorized

The Advisory Committee deadlocked on all of the clinical training issues by a vote of 3-3. Instead of forwarding a ***single set of recommendations*** to the DCA as required by the Legislature, **two** competing sets of recommendations were submitted. However, the language of 3041.10 (f) (1) is clear:

> The ***committee*** shall submit its final recommendations to the Office of Examination Resources of the department on or before... [Emphasis added.]

As a body that utilizes typical rules of parliamentary procedure, the Legislature can reasonably be expected to understand the potential consequences of forming a body with equal representation on both sides. This is supported by a letter submitted by Sen. Mark Wyland in support of an Administrative Petition related to this process in which he states:

> "It was my understanding that by appointing a committee of 3 optometrists and 3 ophthalmologists to develop ***the recommendations*** we would ***assure an outcome that had to be acceptable to both sides***, and would thus protect the public."[15] [Emphasis added]

Furthermore, his comments suggest and indeed the actual processes of normal committees and the Legislature (which those agreeing to SB 1406 would be most familiar with and therefore have "legislative expectations" of) do not permit something to "advance" that does not have a bona fide majority. Thus, any forwardable "recommendation" would require at least ***4 votes***.

In addition, while the committee "agreed" to submit two reports, it had no statutory authority to make that decision. The concept of "final" cannot be embodied in two separate diametrically-opposed sets of recommendations. According to *dictionary.com*, the applicable definition of "final" is "conclusive or decisive." Submission of two reports with two sets of recommendations achieves ***neither*** criterion and therefore does not comport.

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[15] See attached letter. [Attachment 6]

We therefore conclude there was no legislative intent for the submission of two reports and all subsequent products of this process are invalid.

B. The "Special Consultant" Hired by DCA was Not Authorized by Statute.

At no time did the Legislature provide the DCA with authority to hire an outside consultant to reconcile any potential competing reports that were generated by the committee. Unlike its exquisitely detailed direction with respect to the composition and duties of the committee, the Legislature was silent on the issue of hiring of an outside consultant and therefore provided ***no safeguards*** to guide such an individual's discretion. In the absence of such legislative direction, serious questions are raised as to whether the hiring of the consultant to reconcile the reports, or otherwise make independent recommendations was concordant.

Such unauthorized activity nullifies the recommendations made to the DCA and ***all subsequent products of this process are invalid.***

C. Education of Optometric Students was Not Addressed.

The fact that one of the optometrists involved in the blinding of 8 veterans at the Palo Alto VA Hospital taught at one of the state's two optometry schools raises a fundamental question about the adequacy of glaucoma clinical training at the optometry schools. In addition, it may be significant that a number of students from the UC Berkeley School of Optometry rotate through the Palo Alto VA facility. Questions about the adequacy of optometry school clinical training appear to have been on the minds of the Legislature when it approved SB 1406.

On the one hand, [SB 1406 3041.10 (d) (2)] the Legislature directed the advisory committee to "presume" the recent optometry school graduates had sufficient "*case management training in the treatment and management of patients diagnosed with glaucoma to be certified.*" ***However, the very next sentence directs the Advisory Committee to review optometry school training and require additional training if necessary:***

> "***After reviewing*** training programs for representative graduates, the committee [GDTAC] **in its discretion may recommend additional glaucoma training** to the Office of Examination Resources pursuant to subdivision (f) to be completed before a license renewal application from any licensee described in this subdivision is approved." [Emphasis added.]

However, members of the Advisory Committee were repeatedly denied any information as to exactly what the clinical training experience (e.g. encounters with glaucoma patients on treatment in a one-trainee, one-patient, one-supervisor setting) are for optometry students. Robert DiMartino, OD, MS, an optometrist member of the committee selected because of his status as an educator, after agreeing to provide specific information regarding actual clinical exposure of optometry students at the conclusion of the first GDTAC meeting, upon arriving at the second meeting is recorded as having changed his mind, stating:

> "I'm reluctant to give you a number [of specific patients seen by our students] because your *modus operandi* in the past has been to say 'that's not adequate.'"... "It will never be adequate because [it's] not ophthalmology training."...[16]

Despite clear legislative direction, former DCA Director Lopez allowed this refusal to produce key rule-making information by the three optometrists on the committee stand. The Legislature's direction to add

[16] Recording of second GDTAC meeting, February 26, 2009

additional clinical training if needed is made ***moot*** by the refusal to even discuss what that training actually entails. This refusal to follow clear legislative direction is just another case of total ***disregard*** for the statutorily-directed role of the Advisory Committee. The number of glaucoma patients optometry students examine and for what time period, and the quality of that experience should ***not*** be a secret.

The refusal to turn over key clinical training data was again echoed in the former California Optometric Association President's "Special Consultant" report. When faced with specific optometry schools' refusal to respond to his survey questions, he explained the importance of keeping the details of optometry school glaucoma clinical training requirements secret:

> "There is an apparent reluctance on the part of many of the schools [of optometry] to provide or share specific numbers because of their prior experience with ophthalmology in their state's own attempts to expand scope of practice."[17]

The only reasonable conclusion was that ophthalmologists in other states were successful at using the data provided by optometry to ***prevent*** expansion in some area – a ***political***, not patient care issue.

Unfortunately, in a situation where it is REQUIRED that data be examined, the only reasonable conclusion must be that on its face the data is ***inadequate***. But one would think that if optometry students truly had significant amounts of training in the treatment of glaucoma, the schools (and even the optometrist committee members) would be jumping at the chance to demonstrate it.

Therefore the legislative "presumption" that optometry student training is adequate will remain just that – an unverified presumption.

It should be noted that the fact the "Special Consultant" attempted to review similar information to what the committee sought is ***not*** an acceptable substitute. ***The statute gave the authority to review and make decisions on such information specifically to the Committee***.

Other attempts to confound the process can be pointed to throughout. In particular, when asked by JoAnn Giaconi, MD, the glaucoma-specialist ophthalmologist member of the committee, why the optometrist members appeared against the involvement of a glaucoma-specialist ophthalmologist in the development of courses under consideration, Dr. DiMartino replied:

> "I would understand why you [who are "new" to such issues] wouldn't understand that...It once again says 'there's the king, and I don't know why you don't like being my subjects.'"[18]

Ophthalmologists have been treating glaucoma essentially since medical licensure has existed, far longer than the time that optometrists in any US jurisdiction have done so. To suggest that an ophthalmologist should not be involved for what would appear to be purely political or "image" reasons defies comprehension. If indeed optometrists desire the best training to practice what has traditionally been medicine, they should reasonably welcome such training from the most knowledgeable sources, ***including*** ophthalmology ones.

We believe the ophthalmology members were therefore correct in concluding that if the necessary and statutorily mandated information was ***not*** provided sufficient to make an informed decision, ***public protection demanded*** that additional education ***must*** be imposed on the graduates after May 1, 2008.

Based on the limited information that was provided throughout the legislative process, we continue to find it not credible that two optometry schools in California graduating 150 optometry students per year

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[17] Special Consultant's Report to the Office of Professional Examination Services, June 25, 2009, page 18.
[18] Recording of second GDTAC meeting, February 26, 2009

(with the bulk of clinical training presented over 1.5 years) can provide a uniformly adequate experience to ALL its trainees, particularly when compared to the approximately 45 graduating ophthalmology residents per year (with clinical training presented over a minimum of 3 years) in California that are trained by ***EIGHT*** institutions. Adequate numbers of one-trainee, one-patient supervised exposures just don't seem possible.

For example, we cited a small study at the West Los Angeles Veterans Affairs Medical Center that we presented at the first meeting of the GDTAC.[19] VA facilities have long been touted by optometry as places that they get significant exposure to patients with disease, including glaucoma. That study documented an ***extremely variable*** experience in the glaucoma exposure of the optometry students rotating through that just that facility (one student actually only saw two "glaucoma" patients in two months). But more important, only a few of the patients ***were actually on anti-glaucoma medications***, strongly suggesting that the educational component regarding treatment – which is the ultimate goal of the certification process under SB 1406 – ***was just not there.***

This situation might be remedied if optometric educators would consider creating "glaucoma tracks" whereby a certain percentage of optometry students (likely 15-20%) declare an interest in glaucoma at the onset of clinical training and then be enrolled in specific rotations that might provide appropriate experience. This would recognize that, as we have acknowledged, ***properly trained*** optometry students ***can*** treat glaucoma independently. We conclude, however, there is insufficient evidence that all optometry students can reasonably be trained during optometry school.

While the committee was required to "presume" that the graduates after May 1, 2008 had sufficient education and training to be "certified," we are confident the legislature would never admit to legislative intent requiring a statutorily mandated committee to ultimately honor such a "presumption" if it can be reasonably concluded it ***threatens patient safety.***

Thus, in the absence of real evidence to the contrary, ***it is irrational to conclude that additional training should not be imposed on optometric graduates after May 1, 2008 desiring to treat authorized glaucoma.***

D. The "Special Consultant" Hired by DCA Admitted His Bias.

To reconcile the competing reports and make recommendations on certification requirements for glaucoma, contrary to the clear intent of the Legislature, the DCA hired a consultant, Tony Carnevali, OD who was:

- An optometrist who was ***not*** certified to treat glaucoma.
- An employee of the Southern California College of Optometry, one of two optometry schools in California that would be an **economic beneficiary**[20] of the effort to reduce clinical training requirements;
- The President of the litigation arm of the California Optometric Association – the Public Vision League; and
- A past President and long-time member of the Board of Trustees of the California Optometric Association, which sponsored SB 1406.

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[19] Documented on recording of first GDTAC meeting, February 5, 2009.

[20] by offering the related courses created by Dr. Carnevali's recommendations

We will state up front that because of the reports regarding optometric mismanagement of glaucoma patients at the Palo Alto Veterans Affairs Hospital, ***all the language offered is predicated on a "consultation" with an ophthalmologist under specified conditions***, which we believe provides a "safety net" for patients and therefore might compensate for some streamlining of standards. Therefore, we do not consider them subject to negotiation.

We understand the California Optometric Association is likely to re-raise its argument that optometrists have a "professional standard" to refer when appropriate. However, we believe it is clear that did ***not*** occur at the Palo Alto VA Hospital. Furthermore, in order to "know" you need to refer requires a certain ***minimum*** level of education, which we argue is not imparted by the clinical experience embodied in the regulations. Therefore, achieving patient protection demands that we err on the side of safety.

Major points of the proposal include:

1) Establishing a specific set of standards for consultation

2) Increasing the number of cases of the Case Management Course form 15 to 50 (note these are anticipated to be "vignettes," and it is not anticipated this be a difficult task from an educational standpoint), as well as inclusion of an academic glaucoma specialist ophthalmologist in course development).

3) Acceptance of the 25-patients followed for 1 year standard for the Preceptorship option (renamed Co-Management option)

4) Modification of the Grand Rounds option to allow a group of up to 20 optometrists seeking certification to form a group, such that each follows a minimum of 5 patients in his or her own practice and these patients are "pooled" to provide an educational base for the group. The group would initially and two other evenly spaced times spanning 12 months, and each time each participant would present two of his patients (selected in advance by Faculty), followed by discussion led by faculty (one of which would be an academic glaucoma specialist ophthalmologist). Patients followed by the participants would be monitored by a program established by the schools administering these courses under the same conditions as a Co-Management arrangement with individual preceptors.[27]

5) Imposing a 10 "patient credit" requirement on graduates after May 1, 2008 to be completed under either the "Co-Management" or revised "Grand Rounds" option, allowing for retrospective review of existing patients to satisfy the requirement and ***exempting*** graduates (functionally graduating May 1, 2011 or after to allow for the development of a documentation system) who can document 75 one-patient, one-supervisor, one-trainee encounters with patients on (or begun on) active medication treatment for authorized glaucoma (thus establishing a "meet it or not" standard based on actual individualized educational experience).

6) Other minor requirements as indicated in the Attachment.

It should be carefully noted that ***<u>without</u>*** the referral requirement, ***we would <u>not</u> consider the <u>numbers</u> of patients indicated in the amendments to be realistic to provide an adequate experience to protect patient safety***.

[27] It should be noted that this is very similar to a course proposal made by the Southern California College of Optometry approximately 2 year prior to the passage of SB 1406 as an attempt to "expedite" the certification of optometrists, but which we indicated would not comport with the law ***at that time***. However, we believe it has merit in comparison to the current proposed regulations and would consider a similar version in conjunction with the referral requirement.

Exhibit A

CAEPS AMENDED BOARD OF OPTOMETRY PROPOSED LANGUAGE

Adopt section 1571 of Division 15 of Title 16 of the California Code of Regulations to read as follows:

§ 1571. Requirements for Glaucoma Certification and Treatment.

(a) Only optometrists meeting the requirements of this Article may apply for certification for the treatment of glaucoma as described in subdivision (j) of Section 3041, in patients over 18 years of age. The optometrist shall:

(1) Hold an active license as an optometrist in California in good standing with the State Board of Optometry (Board);

(2) Be certified to use Therapeutic Pharmaceutical Agents (TPA) pursuant to Section 3041.3;

(3) Complete a didactic course of no less than 24 hours in the diagnosis, pharmacological and other treatment and management of glaucoma. The following topics may be covered in the course:

(A) Anatomy and physiology of glaucoma

(B) Classification of glaucoma

(C) Pharmacology in glaucoma therapy

(D) Diagnosis of glaucoma including risk factors analysis

(E) Medical and surgical treatment

(F) Participant performance assessment; and

(4) Complete a Case Management Requirement ~~where a minimum of 25 patients are prospectively treated in a consecutive 12-month period~~. The following options may be chosen in any combination to ~~fulfill this requirement~~achieve 25 patient credits:

(A) **Case Management Course:** Completion of a 16-hour case management course developed by an accredited California school or college of optometry approved by the board and developed in collaboration with a board certified academic ophthalmologist with fellowship training in glaucoma. The Board may require collaboration of institutions to ensure a uniform experience.

~~, with at~~ The course would include least ~~15~~ 50 cases of moderate to advanced complexity. The course may be conducted live, over the Internet, or by use of telemedicine. One hour of the program will be used for a final competency examination. The program will count as a 15-patient credit towards the Case Management Requirement. The full course must be completed to receive the 15-patient credit. The course must include the following topics/conditions:

(1) Presentation of conditions/cases that licensees may treat:

(a) All primary open-angle glaucoma

(b) Exfoliation and pigmentary glaucoma

(2) Presentation of conditions/cases that licensees may not treat, but must recognize and refer to the appropriate physician and/or surgeon such as:

(a) Pseudoglaucoma with vascular, malignant, or compressive etiologies.
(b) Secondary glaucoma.
(c) Traumatic glaucoma
(d) Infective or inflammatory glaucoma.
(e) Appropriate evaluation and analysis for medical or surgical consultation.
(f) In an emergency, if possible, stabilization of acute attack of angle closure and immediate referral of the patient.

~~(B) **Grand Rounds Program:** Completion of a 16-hour grand rounds program developed by an accredited California school or college of optometry, wherein participants will evaluate and create a management plan for live patients. The program will count as a 15-patient credit towards the Case Management Requirement. The full program must be completed to receive the 15-patient credit. Patients must be evaluated in person. The program must include the following:~~

~~(1) Presentation of various patient types such as: glaucoma suspects, narrow angle, primary open angle glaucoma (early, moderate, late); and secondary open angle glaucoma such as pigment dispersion and pseudoexfoliation. Patient data, including but not limited to, visual acuities, intra-ocular pressures, visual fields, imaging, and pachymetry, will be available on-site and presented upon request.~~
~~(2) Examination of patients, evaluation of data and test results, and commitment to a tentative diagnosis, treatment, and management plan.~~
~~(3) Participation in group discussion of the cases with instructor feedback.~~
~~(4) Attendance of follow-up meetings (within the 16-hour program requirement) where the same or different patients will be used via serial data from visual fields, imaging photos, and etc.~~

(~~C~~B) ~~**Preceptorship**~~ **Co-Management Program:** Completion of a ~~preceptorship~~ co-management program where ~~each~~ patients with the diagnosis of authorized glaucoma must be initially evaluated by the optometrist and co-managed with a preceptor. Each patient must be prospectively treated in a minimum consecutive 12-month period each. A preceptor for purposes of this section is defined as:

(1) A California licensed, Board certified ophthalmologist in good standing; or
(2) A California licensed optometrist in good standing, who has been glaucoma certified for two or more years.

A monitoring program established by an accredited school or college of optometry utilizing qualifying preceptors may also be employed.

Preceptors shall confirm the diagnosis and treatment plan, and then approve the therapeutic goals and management plan for each patient. Consultation with the preceptor (or program) must occur at appropriate clinical intervals or when the therapeutic goals are not achieved. Clinical data will be exchanged at appropriate intervals determined by the preceptor and the licensee. Patients must be informed of the training arrangement and must be seen by the preceptor (or referred to a geographically-appropriate ophthalmologist or glaucoma-certified optometrist as appropriate as directed by the preceptor or program). Telemedicine and electronic exchange of information may be used as agreed upon by the preceptor or program and the licensee. Each patient that is seen by the optometrist in the program will count as a 1-patient credit towards the Case Management Requirement. A participant in a Co-Management program shall file a Statement of Intent to participate in this process with the Board, which shall then authorize (without fee) said participant to prescribe anti-glaucoma medications solely in connection with this process. The Board will develop a suffix to the license number of the participant that will identify him or her as having such authority. This authority is automatically revoked if the participant ceases participation in the process or for any other reason at the discretion of the Board.

(C) Grand Rounds Program. Completion of a 16-hour (total) program developed by an accredited California school or college of optometry and approved by the Board. One faculty member shall be a board certified academic ophthalmologist with fellowship training in glaucoma.

Each participant will follow a minimum of five patients for minimum consecutive period of 12 months each governed by the terms of (B) above under a monitoring program established by that school or college utilizing qualifying preceptors. Each participant shall identify five patients for inclusion in this process. Additional patients may be followed under the supervision of the program at the discretion of the program.

Up to 20 participants shall form a "class" that meets initially and then at least two additional times at approximately evenly-spaced intervals spanning a total time of 12 months to review examination and testing data from at least 40 of the identified patients selected by the course faculty before each meeting. This shall include at least two patients being followed by each participant, who shall present the data for his or her patients. Each case shall be followed by discussion led by course faculty.

The program will count as a 15-patient credit towards the Case Management requirement. The full course must be completed to receive the 15-patient credit.

(b) Licensees who completed their education from an accredited school or college of optometry on or after May 1, 2008, are exempt from the didactic course~~, and case management requirements of this Section, provided they submit proof of graduation from that institution to the Board~~. As soon after [DATE

OF ENACTION OF REGULATIONS] as practicable, such licensees desiring to treat authorized glaucoma shall enter into a Co-Management arrangement under (a) (4) (B) or a Grand-Rounds Program under (a) (4) (C) for all glaucoma patients under their management and shall achieve at least ten patient credits. Where applicable, retrospective review by a preceptor or program indicating adequate prior care for patients with authorized glaucoma shall qualify retroactively to satisfy the 12-month requirement. Treatment authority for glaucoma is automatically revoked if the participant fails to actively participate in this process towards its successful completion. The licensee shall submit evidence of satisfactory completion of the minimum ten patient credits to the Board upon completion of the appropriate process. Licensees who can document evidence of 75 one-student, one-supervisor, one-patient encounters involving active medical treatment of patients with authorized glaucoma (i.e., the patient is started on or taking anti-glaucoma agents) during enrollment in an accredited school or college of optometry shall be exempt from this requirement.

(c) Licensees who graduated from an accredited school or college of optometry prior to May 1, 2000, and who have not completed a didactic course of no less than 24 hours will be required to take the 24-hour course indicated in subsection (a). Licensees who graduated from an accredited school or college of optometry after May 1, 2000, are exempt from the didactic course requirement of this Section.

(d) Licensees who graduated from an accredited school or college of optometry prior to May 1, 2008, and who have taken a didactic course of no less than 24 hours, but not completed the case management requirement under SB 929 [Stats. 2000, ch. 676, § 3], will be required to complete the ~~25-patient~~ case management requirement indicated in subsection (a).

(e) Licensees who started the process for certification to treat glaucoma under SB 929 [Stats. 2000, ch. 676, § 3] but will not complete the requirements by December 31, 2009, may apply all patients who have been co-managed prospectively for at least one consecutive year towards the ~~25-patient~~ case management requirement, or may continue to follow them until the 12 month requirement is met.

(f) all optometrists certified under this section to treat glaucoma shall consult with an ophthalmologist if while evaluating or treating glaucoma a patient is noted to have:

(1) For a newly-diagnosed or initially evaluated glaucoma patient not having prior ophthalmic consultation explaining finding(s) documented in chart:

(A) Visual Field Parameters

(i) Any paracentral defect of -5dB or worse by any method

(ii) Humphrey Visual Field: Mean Deviation worse than -5.2 dB (not attributable to cataract) and/or Pattern Deviation worse than 3 dB

(iii) Octopus Visual Field: Cumulative defect curve below 95%; Mean Defect worse than -5.2 dB (not attributable to cataract); Corrected Loss Variance worse than 3 dB
(iv) Humphrey FDT Matrix: Mean Deviation at or below 2% normal probability level; Pattern Standard Deviation at or below 2% normal probability level
(v) Other Devices: Reasonable crosswalk to the devices listed in (ii)-(v).

(B) Optic Nerve Parameters:
(i) Cup to Disc ratio (C/D) ≥ 0.7
(ii) focal notch
(iii) Disc hemorrhage
(iv) any pallor
(v) <5% probability on any optic nerve imaging device
(vi) presence of a relative or absolute pupillary defect

(C) Intraocular Pressure (IOP) greater than 26 mmHg
(D) Age < 45 years
(E) Monocularity
(F) Presentation on 2 medications without control to target IOP (combination drops to be considered as the number of individual medications contained)

(2) For established glaucoma or glaucoma suspect patients:
(A) Visual Field Parameters
(i) Worsening by 2 dB on general indices
(ii) Worsening of any paracentral point by 5 dB or more

(B) Optic Nerve Parameters:
(i) new notches/focal defects, especially if accompanied by visual field change; (ii) new disc hemorrhages
(iii) increase of C/D by 0.2
(iv) any change in percentile probability scores on optic nerve imaging (i.e. drop from on HRT Moorsfield Regression Analysis from "green" to "yellow" or "yellow" to "red" and similar changes on optical coherence tomography and scanning confocal microscopy
(v) development or change in character of a relative or absolute pupilary defect

(C) IOP greater than 26 mmHg on treatment or if target IOP isn't achieved with 2 medications (combination drops to be considered as the number of individual medications contained), either after three appropriately spaced visits.

NOTE: Authority cited: Section 3025, 3041, 3041.10, Business and Professions Code. Reference: Section 3041.3, Business and Profession Code.

ATTACHMENT 1

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

STATE AND CONSUMER SERVICES AGENCY • ARNOLD SCHWARZENEGGER, GOVERNOR
EXECUTIVE OFFICE
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November 10, 2009

James B. Ruben, MD
President
California Academy of Eye Physicians & Surgeons
425 Market Street, Suite 2275
San Francisco, CA 94105

RE: Revised Administrative Petition and The Department of Consumer Affairs and its Response Thereto

Dear Dr. Ruben:

The Department of Consumer Affairs (Department) is in receipt of a Revised Administrative Petition (Petition) from the California Academy of Eye Physicians and Surgeons, the California Medical Association, and the American Glaucoma Society (hereinafter "Petitioners") dated October 12, 2009 and received by the Department on that date. Petitioners submitted the Petition under the auspices of section 11340.6 of the Government Code (section 11340.6), which provides in pertinent part:

> "Except where the right to petition for adoption of a regulation is restricted by statute to a designated group or where the form of procedure for such a petition is otherwise prescribed by statute, any interested person may petition a state agency requesting the adoption, amendment, or repeal of a regulation as provided in Article 5 (commencing with Section 11346). This petition shall state the following clearly and concisely:
> (a) The substance or nature of the regulation, amendment, or repeal requested.
> (b) The reason for the request.
> (c) Reference to the authority of the state agency to take the action requested."

The petition revolves around the treatment of patients with glaucoma by duly licensed optometrists, not ophthalmologists. Petitioners strongly suggest that the Board of Optometry's (Board) rulemaking to implement the provisions of Senate Bill 1406 (SB 1406) (Ch. 352, Stats.2008) will result in a loss of public protection, especially given the events that allegedly occurred at the Palo Alto Veterans Hospital. Generally, SB 1406 authorizes the Board to adopt certification requirements that would enable certified and licensed optometrists to treat patients suffering from glaucoma.

Specifically, the Petition contains the following requests for relief from the Department:

1. "Investigate the blinding of eight veterans and the harm to others at the Veterans Affairs Palo Alto Health Care System (VAPAHCS) to determine whether state laws governing the California-licensed optometrists have been violated.

2. Withdraw the Department's Findings and Recommendations on clinical training requirements for glaucoma certification required by SB 1406 pending the results of the requested investigation of the blinding of the veterans.

3. Suspend any further watering down or elimination of clinical training requirements until a thorough investigation of the Palo Alto Veterans Affairs (VA) scandal is complete and its finding and recommendations can be included in the implementation of SB 1406."

Response to Petition

1. Investigate the Events at the Palo Alto Veterans Hospital.

While section 11340.6 is aimed at a party petitioning a state agency to adopt, amend or repeal its regulations and not the commencement of investigations, section 310 of the Business and Professions Code does authorize the Director of the Department to investigate matters of concern to consumers. As the events at the VA hospital do concern consumers, I am formally requesting that the Board of Optometry, together with the Medical Board of California, investigate the occurrences at the Palo Alto Veterans Affairs Hospital regarding the eye care provided to veterans, including the role of optometrists and physicians in that care. To the extent permitted by existing state and federal law, I am also requesting that those boards make public the findings of the investigation. Accordingly, any information that petitioners could provide on this matter would be helpful and should directed to the Board of Optometry and the Medical Board of California

2. Withdrawal of the Department's Finding and Recommendations for Clinical Treatment Requirements for the Glaucoma Certification.

Petitioners request the Department withdraw the findings of its Office of Examination Resources (OER) pending the results of the investigation referenced above. OER had previously reviewed the findings of the Glaucoma Diagnosis and Treatment Committee (Committee) and provided its findings and modifications regarding the proposed certification requirements to the Board of Optometry.

The Department respectfully denies this part of the petition.

It would be premature at this time to withdraw the Department's findings in the absence of sufficient evidence establishing that the events at the VA hospital are substantially linked to the implementation of SB 1406. If an optometrist failed to follow appropriate policies and departed from the established standard of care, he or she may be subject to discipline by the Board of Optometry. (See Bus. & Prof. Code, § 3090.) But there is no basis for assuming that the

regulations proposed to be adopted are causally connected to the events at the hospital simply because of alleged bad acts by a small number of licensees. It may be that the established VA policies are flawed or inappropriate; however, prudent public policy dictates that an investigation be completed so that any action taken by the Department is based upon solid evidence.

Once the requested investigations are completed and the results made available to the public, petitioners may petition the appropriate boards within the Department to adopt, amend or repeal regulations. (See Gov. Code, §11340.6 et seq.) Of course, nothing in this response prevents petitioners from undertaking efforts to change the treatment policies at other federal facilities. Petitioners are encouraged to submit oral and/or written comments to the Board of Optometry as the SB 1406 rulemaking process proceeds, and such comments and the responses thereto will be included in file submitted to me and thereafter to the Office of Administrative Law for approval.

3. Suspension of Watering Down or Elimination of Clinical Training Requirements Until VA Hospital Investigation Completed

The Department presumes this part of the requested relief is directed at the Board of Optometry's regulatory proposal to implement the provisions of SB 1406, as that board is the state agency charged with the responsibility of that enacted legislation. The Department is not so charged. Petitioners presume the Department is statutorily authorized or somehow otherwise empowered to intervene in a constituent board's regulatory processes. That presumption is inaccurate.

The Board of Optometry is a constituent agency within the Department. (See Bus. & Prof Code, §101.) The Legislature has established the functions of a board with the Department, as follows:

> "The boards, bureaus, and commissions in the department are established for the purpose of ensuring that those private businesses and professions deemed to engage in activities which have potential impact upon the public health, safety, and welfare are adequately regulated in order to protect the people of California.
> To this end, they establish minimum qualifications and levels of competency and license persons desiring to engage in the occupations they regulate upon determining that such persons possess the requisite skills and qualifications necessary to provide safe and effective services to the public, or register or otherwise certify persons in order to identify practitioners and ensure performance according to set and accepted professional standards. They provide a means for redress of grievances by investigating allegations of unprofessional conduct, incompetence, fraudulent action, or unlawful activity brought to their attention by members of the public and institute disciplinary action against persons licensed or registered under the provisions of this code when such action is warranted. In

> addition, they conduct periodic checks of licensees, registrants, or otherwise certified persons in order to ensure compliance with the relevant sections of this code. (Bus. & Prof. Code, § 101.6.)

The Legislature has also established the organizational structure for the Department, as follows:

> Each of the boards comprising the department exists as a separate unit, and has the functions of setting standards, holding meetings, and setting dates thereof, preparing and conducting examinations, passing upon applicants, conducting investigations of violations of laws under its jurisdiction, issuing citations and holding hearings for the revocation of licenses, and the imposing of penalties following those hearings, insofar as these powers are given by statute to each respective board." (Bus. & Prof., Code, § 108.)

The Legislature has granted the authority to the Board to adopt regulations regarding the admissions of applicants to the optometric licensing examinations and the practice of optometry itself. (See Bus. & Prof. Code, § 3025.) The Board may also adopt regulations regarding the minimum standards for optometric services, optometric equipment, and sanitary conditions. (See Bus. & Prof. Code, § 3025.5.) As stated *supra*, the Board may discipline licensees who engage in unprofessional conduct. The Legislature has granted the Board the powers specified in section 108 and those powers do not reside with the Department.

Admittedly, section 313.1 of the Business and Professions Code (section 313.1) does require that the Director approve regulations adopted by a board. However, section 313.1 contemplates that a board has adopted the proposed regulation. Such is not the case here, as the rulemaking process is still in its infancy. A fair reading of section 313.1 does not authorize the requested intervention, suspension or postponement.

Petitioners suggest two additional reasons supporting suspension of the Board of Optometry's rulemaking: 1) The provisions of sections 109 and 155 of the Business and Professions Code, and 2) The "additional unprecedented responsibilities granted to the Department for the establishment as clinical training requirements." (See Petition, page 17, lines 19-21.)

These reasons do not authorize the relief requested. Section 109 by its own terms limits the power of the Director to review decisions made by a board. There are two exceptions: licensing decisions and examination scoring and potential criminal conduct. (See Bus. & Prof. Code, §109, subds. (b) & (c).) Section 155 of the Business and Professions Code authorizes the Director to employ investigators for the purpose of investigating and prosecuting violations of any law.

I was not the Director at the time that OER submitted its recommendations to the Board. However, I understand your concern with the process by which the recommendations were

made. Therefore, by copy of this letter, I am asking the Board of Optometry to re-evaluate its decision to proceed with these regulations. If the board agrees to postpone its efforts, I will immediately direct OER to secure a consultant who has not been an advocate with respect to the issue of glaucoma and the scope of practice of optometry.

To the request for a joint investigation of the events that transpired at the VA hospital, by copy of this letter, I formally request that Board of Optometry and the Medical Board of California commence said investigation.

Please contact me if you have any questions.

Sincerely,

Brian J. Stiger

Brian J. Stiger
Director
Department of Consumer Affairs

cc: Barb Johnston, Executive Director, Medical Board of California
Mona Maggio, Executive Officer, Board of Optometry

Dev GnanaDev, MD
President
California Medical Association
1201 K Street, Suite 200
Sacramento, CA 95814

Theodore Krupin, MD
President
American Glaucoma Society
655 Beach Street
San Francisco, CA 94109

Doreathea Johnson, Deputy Director, Legal Affairs Division
Anita Scuri, Supervising Senior Counsel, Legal Affairs Division
Kurt Heppler, Senior Staff Counsel, Legal Affairs Division
Michael Santiago, Staff Counsel, Legal Affairs Division

ATTACHMENT 2

Eye Care Issue at the VA Palo Alto Health Care System

As you may have heard or read, a recent news story covered an issue regarding the care of Veterans with glaucoma in VA Palo Alto Health Care System's (VAPAHCS) optometry section. The VAPAHCS has a policy that all patients with glaucoma seen in the Optometry section should have their cases overseen and reviewed by the Ophthalmology section and we found this was not done in all cases. After an extensive review of patients, it was found that seven patients may have had their clinical care compromised. We contacted the patients and/or their families immediately and acknowledged the inadequate oversight.

It only took one Veteran to trigger massive investigations and medical evaluations that have now ensured the proper care for every other Veteran receiving eye care at the VAPAHCS. We deeply regret that any Veteran under our care received less than care of the highest quality. We are confident that we have taken the necessary steps to ensure that our Veterans are now receiving the best possible eye care.

VAPAHCS has contacted and evaluated all the patients with glaucoma or at risk for glaucoma, who were seen by Optometry alone. Optometry and Ophthalmology are working closely together and any patients who are identified needing further evaluation by an ophthalmologist will be called and brought in for further care.

VAPAHCS encourages any Veteran who is concerned about their eye care to speak with their physician or provider to ensure they have been appropriately evaluated and treated, or call the Patient Advocate at **650-493-5000, extension 63543**.

July 2009

ATTACHMENT 3

DEPARTMENT OF VETERANS AFFAIRS
Palo Alto Health Care System
3801 Miranda Ave.
Palo, Alto, CA 94304

FEB 2 7 2009

Dear Mr. [redacted]

I am writing to follow up on our phone call of February 26, 2009. As we discussed, we have recently reviewed your eye care and have determined that some of the vision loss you suffered may have been preventable had you received a different course of therapy. I deeply regret that you did not receive the very best possible care. I want to let you know that we are reviewing our system of eye care, and are making changes to ensure that every veteran receives care of the highest possible standard.

As a result of this injury you are eligible to apply for compensation from VA by filing a benefits claim with the Veterans' Benefits Administration (VBA) and/or by filing a claim based on the Federal Tort Claim Act (FTCA). If your benefits claim is granted by the VBA you would be eligible for monthly benefit payments. On the other hand, if you decide to file an administrative tort claim based on the FTCA, the claim will need to be investigated and granted by the Office of the VA Regional Counsel and the Facility Director. A benefits claim may be filed at anytime to the VBA, but an administrative tort claim based on the FTCA must be filed within 2 years of the date of discovery of your injury. I hope the enclosed pamphlet provides you with additional information that you may find useful.

I wish again to express my regret over your vision loss and to assure you that we will do all we can to provide you with the best possible treatment. If you wish to meet personally for any further discussion or you have unanswered questions, please contact Terri Monisteri, the VAPAHCS Risk Manager, at 650-496-2592.

Sincerely,

Stephen C. Ezeji-Okoye, MD
Deputy Chief of Staff

ATTACHMENT 4

Roll Call

The roll was called and the Senate concurred in Assembly amendments by the following vote:

AYES (21)—Senators Alquist, Calderon, Cedillo, Corbett, Ducheny, Kehoe, Kuehl, Lowenthal, Machado, Migden, Negrete McLeod, Oropeza, Padilla, Perata, Ridley-Thomas, Romero, Simitian, Steinberg, Torlakson, Vincent, and Wiggins.

NOES (15)—Senators Aanestad, Ackerman, Ashburn, Battin, Cogdill, Correa, Cox, Denham, Harman, Hollingsworth, Maldonado, Margett, McClintock, Runner, and Wyland.

Above bill ordered enrolled.

Senate Bill 1406—An act to amend Sections 3041 and 3152 of, and to add and repeal Section 3041.10 of, the Business and Professions Code, relating to optometry.

Bill presented by Senator Correa.

The question being: Shall the Senate concur in the Assembly amendments to SB 1406?

Roll Call

The roll was called and the Senate concurred in Assembly amendments by the following vote:

AYES (38)—Senators Aanestad, Ackerman, Alquist, Ashburn, Battin, Calderon, Cedillo, Cogdill, Corbett, Correa, Cox, Denham, Ducheny, Dutton, Florez, Harman, Hollingsworth, Kehoe, Kuehl, Lowenthal, Machado, Maldonado, McClintock, Migden, Negrete McLeod, Oropeza, Padilla, Perata, Ridley-Thomas, Romero, Runner, Scott, Simitian, Steinberg, Torlakson, Vincent, Wyland, and Yee.

NOES (0)—None.

Above bill ordered enrolled.

UNANIMOUS CONSENT TO PRINT IN JOURNAL

Without objection, the following letter was printed in the Journal.

August 29, 2008

Honorable Don Perata,
Chair, Senate Rules Committee

Dear Senator Perata,

This letter is to state my intent regarding three issues contained in SB 1406 as it was passed by the State Senate today, August 29, 2008.

Those three issues are as follows:

Amendments made to Business and Professions Code Section 3041 (e)(3) as contained in SB 1406 (Correa) as passed by the State Senate today eliminate any reference to the use of cautery by optometrists in the performing punctal occlusion. The intent of this amendment to

existing law, as indicated by its removal from the section, is to prohibit the use of cautery by optometrists in performing punctual occlusion.

Amendments made to Business and Profession Code Section 3041 (b) (1) (C) and Section 3041 (b) (1) (F) as contained in SB 1406 as passed by the State Senate today include the phrase "nonsurgical in cause except when comanaged with the treating physician and surgeon" when authorizing optometrists to diagnose and treat ocular pain and inflammation, as specified. The intent of this change to existing law is to assure that when an optometrist diagnoses or treats ocular inflammation or pain due to surgical causes, such diagnosis and/or treatment should be comanaged by the surgeon who performed the surgery resulting in the pain or inflammation.

Amendments made to Business and Professions Code Section 3041.10 (d) (1) and Section 3041.10 (d) (2) as contained in SB 1406 as passed by the State Senate today clarify the purpose of the Glaucoma Diagnosis and Treatment Advisory Committee. Specifically 3041.10 (d)(2) provides that "the committee in its discretion may recommend additional glaucoma training to be completed before a license renewal application for any licensee described in this subdivision is approved." While the committee has been directed to presume that licensees who apply for glaucoma certification and who graduated from an accredited school of optometry on or after May 1, 2008, possess sufficient didactic and case management training in the treatment and management of patients diagnosed with glaucoma to be certified, the intent of this addition to the law is to clarify the authority of the committee to recommend to the Office of Examination Resources additional educational requirements to those specified in Section 3041 (f)(1) for glaucoma certification as are deemed necessary by the committee.

I appreciate the opportunity to state the intent of these statutory changes.

Sincerely,

LOU CORREA
State Senator, 32nd District

MOTION TO RECONSIDER (AB 2948)

Senator Hollingsworth moved to reconsider the vote whereby AB 2948 passed by a favorable vote.

Roll Call

The roll was called and reconsideration was granted by the following vote:

AYES (40)—Senators Aanestad, Ackerman, Alquist, Ashburn, Battin, Calderon, Cedillo, Cogdill, Corbett, Correa, Cox, Denham, Ducheny, Dutton, Florez, Harman, Hollingsworth, Kehoe, Kuehl, Lowenthal, Machado, Maldonado, Margett, McClintock, Migden, Negrete McLeod,

ATTACHMENT 5

BEFORE THE DEPARTMENT OF CONSUMER AFFAIRS OF THE STATE OF CALIFORNIA

California Academy of Eye Physicians & Surgeons California Medical Association American Glaucoma Society PETITIONERS.	DOCKET NO.

***REVISED* ADMINISTRATIVE PETITION**

REQUESTING AN INVESTIGATION AND WITHDRAWAL OF THE DEPARTMENT'S SB 1406 FINDINGS AND RECOMMENDATIONS

(GOVERNMENT CODE SECTION 11340.6, BUSINESS & PROFESSIONS CODE SECTIONS 3041.10, 155(a), 100, et. al., 109)

PURPOSE OF THE PETITION

We urge the Department of Consumer Affairs to convene a joint investigation into whether any state licensing laws have been violated in the blinding of eight glaucoma cases by optometrists at the Veterans Affairs Palo Alto Health Care System (VAPAHCS). This investigaton should utilize the resources and expertise of the State Board of Optometry and the Medical Board of California in consultation with the California Department of Veterans Affairs. In addition, we urge that the Department withdraw its Findings and Recommendations to the Board of Optometry mandated by SB 1406 of 2008 pending a full investigation into the blinding of eight veterans by uncertified optometrists in violation of VAPAHCS policy. At the conclusion of this investigation, the records obtained and any recommendations or conclusions derived there from should be made available to the State Board of Optometry and incorporated in the regulatory record for any future implementation of SB 1406.

INTRODUCTION

Glaucoma is a vision threatening disease. (See www.nei.nih.gov/health/glaucoma/glaucoma_facts.asp.) A lack of early diagnosis and proper treatment can result in blindness. (*Id.*) In January of this year, officials at the US Department of Veterans Affairs Hospital in Palo Alto discovered that eight patients suffering from glaucoma had apparently been blinded by mismanagement of their disease at the hands of two optometrists who had violated the Veteran's Affairs' policies. The Veterans Affairs (VA) hospital policies prohibit optometrists from treating glaucoma patients without consulting with a medical doctor/ophthalmologist. And Neither of these California licensed optometrists were certified under California law to independently treat glaucoma. This tragic incident occurred at the very time California was in the final stage of deciding whether to eliminate its stringent clinical training requirements and allow the state's 6,000 optometrists to treat glaucoma patients with only four years of optometry school and **no** actual "hands-on" clinical training. The issue the Department of Consumer Affairs grappled with was whether optometrists would be required to have any supervised experience

with glaucoma patients under their own management prior to certification. These reduced clinical training requirements contrast with the eight years required for a licensed medical doctor/ophthalmologist. In short, even as the role of uncertified optometrists in the VA blindness cases was being uncovered, California was in the process of scrapping the very certification safeguards that, had they been followed, might have protected the VA patients. The regulatory process authorized under SB 1406 of 2008 proceeded without knowledge of the VA Hospital scandal, which has only recently been made public in a series of published reports.

The Legislature's clear SB 1406 mandate to the Department to employ a neutral consensus building approach to establishing clinical training requirements for optometrists to treat glaucoma patients without going to medical school was violated by the Department of Consumer Affairs' former Director. (For details see pages 11-12.) When the glaucoma advisory committee created by the Legislature deadlocked, the Department's former Director, in the absence of any legislative authority, hired a Special Consultant to in effect break the deadlock. The Department's former Director set in motion a tainted regulatory scheme with the intent to implement a predetermined conclusion:

> Optometrists were to be allowed to treat glaucoma patients with minimal clinical training.

The state's Political Reform Act states:

> "Public officials, whether elected or appointed, should perform their duties in an impartial manner, **free from bias caused by their own financial interests or the financial interests of persons who have supported them**;"[Emphasis added.][1]

[1] Government Code Section 81001 (b)

Instead of hiring a consultant "free from bias," the Department hired the President of the litigation arm of the California Optometric Association -- the Public Vision League – who has freely admitted his bias:

> "... I have been and continue to be an active member of the California Optometric Association – a past president and member of the COA Board of Trustees and deeply passionate and committed to the evolution of the profession of optometry in California and on the national scene. That is who I am; therefore, **I am not certain that I can completely divorce myself from this bias ...nonetheless I have tried."** [Emphasis added.][2]

The Department's former director waived or simply ignored the Department's Conflict of Interest Code, which required the consultant to file a Form 700 Statement of Economic Interests.

The consultant, as expected, recommended scrapping clinical requirements that have protected glaucoma patients for almost a decade and replacing them with minimal clinical standards. This recommendation set in motion a regulatory process that would permit an optometrist who seeks certification to complete the process ***without having managed an actual glaucoma patient.*** The Department of Consumer Affairs signed off on those recommendations with only minor revisions and regulations finalizing those decisions are imminent. **After** the consultant's recommendations were received and used to shape the Department's final decision, the Department required the consultant to file a Form 700 Statement of Economic Interests pursuant to the Department's Conflict of Interest Code.[3]

The vision of California consumers will be placed at risk if optometrists are allowed to, in

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[2] Tony Carnevali, O.D., F.A.A.O. Special Consultant, Office of Professional Examination Services, Department of Consumer Affairs, letter to Sonja Merold, Chief, Office of Professional Examination Services, Department of Consumer Affairs, June 25, 2009, p. 2

[3] See Department of Consumer Affairs Conflict of Interest Code

essence, expand further into the practice of medicine without having to go to medical school. These decisions were made without public knowledge of the blinding of eight veterans and harm to dozens of others, These events demand proper investigation prior to any final decision on reducing existing clinical training requirements for optometrists who wish to treat glaucoma patients.

The California Academy of Eye Physicians & Surgeons, the California Medical Association and the American Glaucoma Society are filing this formal Administrative Petition under California Government Code Section 11340.6 to protect the vision of California consumers.

Petitioners urge investigation of the Department of Consumer Affairs licensees to determine whether any state licensing laws have been violated and suspension of current regulatory efforts to further reduce the clinical training requirements for optometrists who seek to treat patients with glaucoma without consulting medical doctors/ophthalmologists.

STATEMENT OF FACTS

1. According to published reports, while under the care of two California-licensed optometrists, eight veterans at the Palo Alto Veterans Affairs Hospital were blinded.[4] Another 16 veterans experienced "progressive visual loss" and a total of 87 others were determined to be at high risk of losing their sight. What all of these veterans had in common, besides their record of service to their country, was that they were suffering from glaucoma, and that they were being treated – not by medical doctors whose consultation was required by VA policy – but by less trained optometrists whose standard of care is overseen by the State Board of Optometry within the Department of Consumer Affairs.

[4] Jessica Bernstein-Wax, "VA Says Glaucoma Patients at Palo Alto Facility Suffered Severe Vision Loss Due to Mistreatment, San Jose Mercury News, July 22, 2009. Jessica Bernstein-Wax, "Physicians demand investigation of Palo Alto VA optometry department," Daily News, September 24, 2009; Juliana Barbassa, "Groups want review after vets lose vision," Associated Press, September 23, 2009

2. What makes this tragedy more painfully significant is that even as the US Department of Veterans Affairs was learning of the scope of injury to the veterans under its care, the California State Board of Optometry was deliberating on how much more to relax the clinical training required of the state's 6,000 optometrists before they can treat glaucoma patients without consulting a physician.

3. The Department of Consumer Affairs maintains that this relaxation of glaucoma standards was authorized by SB 1406, passed in 200 at the behest of the California Optometric Association. The Optometric Association believes that reduced minimum clinical standards for the management and treatment of glaucoma will provide "access to cost effective and quality eye care for all Californians."[5] That claim is now called into tragic question by the events in Palo Alto.

I. Veterans Affairs Policy Violated: Possible Violations of State Law

4. In January of 2009, doctors at the Veterans Affairs Palo Alto Health Care System (VAPAHCS) discovered that a 62-year-old male veteran had significant visual loss in one eye as a result of poorly controlled glaucoma. What triggered particular alarm was the fact that the man had been managed ***solely*** in the hospital's optometry unit since at least June of 2005, despite the fact clinic notes showed optometrists suspected he had glaucoma.[6]

5. "Ophthalmology Service became concerned that optic nerve damage and visual loss might have been avoided if the patient had been referred to ophthalmology sooner," a VA statement said.[7]

[5] "State Board Approves Standards for Optometrists to Become Glaucoma Practitioners," California Optometric Association, July 16, 2009
[6] Op. Cit. "VA Says Glaucoma Patients at Palo Alto Facility Suffered Vision Loss..."
[7] Ibid

6. That discovery triggered a review of 381 medical charts and resulted in the finding that eight veterans with glaucoma suffered blindness, 16 more had experienced "progressive visual loss" short of blindness and 87 others were at high risk of losing their sight.

7. Especially disturbing was the fact that while VA policy requires optometrists to consult with medical doctors on glaucoma cases, the policy had apparently been ignored by the optometry service. As a result of the probe, the chief of optometry was removed from his clinical and administrattive duties and has since retired;[8] A second optometrist was reassigned.

8. Dr. Stephen Ezeji-Okoye, deputy chief of staff at the facility, said: "It was identified that there were treatment options available that potentially could have prevented their loss. We felt that they didn't get optimal treatment."[9]

9. The VA hospital moved all glaucoma cases to the care of the ophthalmology department, which will now supervise the optometry department.

II. Optometry vs Ophthalmology

10. Ophthalmologists must have eight years of training: four years of medical school, a one-year internship and a three-year residency before they are permitted to practice independently.

11. Optometrists, on the other hand, complete only four years of optometry school.

12. Nonetheless, for the past 30 years, the California Optometric Association has been on a quest to gain for its members the right to operate as eye physicians and surgeons without having to go

[8] Juliana Barbassa, "Groups want review after vets lose vision," Associated Press, September 23, 2009
[9] Jessica Bernstein-Wax, "Optometrists Association Defends Palo Alto VA Optometry Chief", San Jose Mercury News, July 23, 2009

to medical school.[10] Included in that quest has been the goal to gain licensure to treat glaucoma with minimal or no supervision from licensed ophthalmologists.

III. State Law: On a Collision Course With Blindness

13. Optometrists have had a steady string of political victories in the California legislature, which has tended to view the important distinction between medical doctors and optometrists as nothing more than a 'turf war.' But as the eight cases of blindness at the Palo Alto Veterans Hospital clearly demonstrate that the so-called 'turf' is much more than a mere political prize. ***Patient safety is at stake.***

14. Glaucoma is a group of diseases that can damage the eye's optic nerve and result in permanent vision loss and blindness. It is one of the main causes of blindness in the United States, according to the National Eye Institute of the National Institutes of Health.

15. Until 2000, optometrists were not authorized to treat glaucoma, and therefore had to refer those who they suspected had the disease to medical doctors/ophthalmologists. (In that respect, until 2000, state law closely resembled the Veterans Affairs policy that appears to have been ignored in the case of the blinded veterans at Palo Alto.)

16. However, in 2000, SB 929 (Polanco), sponsored by the California Optometric Association, authorized optometrists to independently treat certain glaucoma patients over 18 years of age provided the optometrist underwent a special certification process. An optometrist was required to treat a total of 50 glaucoma patients for two years each under the supervision of an ophthalmologist before being authorized to treat a patient. After almost a decade, only about 110 optometrists of California's 6,000 licensed optometrists had completed the certification by

[10] Last year the California Optometric Association sought legislative approval to perform undefined "minor surgery". The bill was re-written when the analysis noted that the bill would have authorized brain surgery. See Senate Committee on Business, Professions, and Economic Development Analysis of SB 1406, April 14, 2008.

November 2007. [11]

17. The California Optometric Association then sponsored SB 1406 (Correa) in 2008, which eliminated the previous stringent certification requirements, and in their place established what came to be known as the "Glaucoma Diagnosis and Treatment Advisory Committee." This committee, composed of three ophthalmologists and three optometrists, was to work out a final compromise on the required clinical training for glaucoma certification.

18. SB 1406 (2008) delegated unprecedented authority to the Department of Consumer Affairs to make key Findings and Recommendations as to the regulatory requirements for optometrists who seek certification to independently treat glaucoma patients without having to go to medical school. One of the last amendments to the bill removed the Board of Optometry's authority to make the key Findings and Recommendations about the adequate level of clinical training required for patient safety and placed that responsibility squarely with the Department of Consumer Affairs to protect patient safety. As the plain language of the SB 1406 reveals the ability for optometrists to treat and manage glaucoma patients was expressly conditioned on Section 2 of the bill, adding Business & Professions Code §3041.10. This Section requires the Board of Optometry to appoint a committee that was balanced between the professions, with an equal number of physicians and optometrists, so that the public would be assured that whatever curricula and certification requirements were adopted, patients were adequately protected. The neutrality of process laid out by this bill was key to the parties' agreement to the bill's passage. Further, the law only authorized the committee to submit and the Department of Consumer Affairs to receive **a single** recommendation. (See Business & Professions Code §3041.10(f).)

19. SB 1406 required the newly formed committee to "presume" that all optometrists who had graduated from optometry school after May 1, 2008 had received the necessary glaucoma training

[11] Analysis of SB 1406, Assembly Committee on Business and Professions, June 24, 2008

in school and would therefore be eligible for certification. But the law left open the door for the committee to impose additional requirements on thousands of other practicing optometrists should a review of the training given in California's two optometry schools warrant it.

20. Following that premise, the three ophthalmologists on the panel sought information from the optometrist members regarding how many glaucoma patients the average student at the UC Berkeley School of Optometry and the Southern California College of Optometry managed under supervision, and for how long. At first, the three optometrists on the panel agreed to provide the information, but later changed their minds and refused to make the data public. The very necessity of clinical optometry training is illustrated by the facts of the Palo Alto VA case. It is extremely significant that the VA hospital's chief of optometry involved in the cases of blindness also supervises the training of optometry students at the UC Berkeley School of Optometry. A proper investigation of the details of the Palo Alto VA cases of blindness may call into question the quality of the optometry school training and necessitate additional requirements as provided by SB 1406. UC Berkeley's School of Optometry is one of the state's two teaching schools of optometry. It is also worth noting that neither optometrist involved in the Palo Alto VA hospital scandal appears to have been certified under California law to treat glaucoma patients.

IV. A Clinical Deadlock and a Tainted Compromise

21. The advisory committee deadlocked on all of the clinical training issues by a vote of 3-3. Instead of forwarding a **single** unified report to the Department of Consumer Affairs as required by the Legislature, two competing reports were submitted. Among the differences, the three optometrists in their report argued that previous strict glaucoma certification requirements should be eliminated and replaced with a 16-hour lecture course and ***no*** supervised treatment of patients at all. Imagine licensing an airline pilot to fly 200 passengers from Sacramento to Los Angeles who had only passed a written exam, but never flown an airliner before?

22. To reconcile the competing reports and make recommendations on certification requirements for glaucoma, contrary to the clear intent of the Legislature, the Department of Consumer Affairs hired a consultant who was:

- An optometrist who was **not** certified to treat glaucoma.
- An employee of the Southern California College of Optometry, one of two optometry schools in California that would be an **economic beneficiary**[12] of the effort to reduce clinical training requirements;
- The President of the litigation arm of the California Optometric Association---the Public Vision League[13] and
- A past President and long-time member of the Board of Trustees of the California Optometric Association, which sponsored SB 1406.

Although the published job description for the position claimed to be willing to consider either an optometrist or an ophthalmologist, other listed requirements could ***only*** be filled by an optometrist.

23. Once the appointment had been made, the Department ignored correspondence from the California Academy of Eye Physicians and Surgeons (supported by correspondence from the California Medical Association)[14] expressing concern about the statutory authority for the consultant, but requesting that if one were used the Department instead employ a qualified educator (neither an optometrist or a physician) or other more neutral party to address this obvious procedural flaw.

[12] In retaining Tony Carnevali, OD as a consultant the Department of Consumer Affairs failed to follow its own Conflict of Interest Code that requires consultants to file a Statement of Economic Interest. The director could have waived the requirement. However, the Conflict of Interest Code requires the director to make a finding as the reasons for the waiver and place the findings in the public review file. The department now says it will require Dr. Cornevali to file a Form 700 Statement of Economic Interest weeks after he was retained and his recommendations were made a part of the regulatory record. See Fax Message Mike Newbert, Office of Professional Services, August 18, 2009

[13] See Form 700, Tony Carnevali, OD and Form 990, Tax Return for Exempt Organization for Public Vision League (Provided upon request).

[14] CAEPS letter to Sonja Merold, Chief, Office of Professional Examination Services, Department of Consumer Affairs, May 28, 2009, and CMA letter to Ms. Merold, May 29, 2009.

24. The consultant supported the position of the California Optometric Association in his SB 1406 Findings and Recommendations that directly involved decisions affecting his major employer, the Southern California College of Optometry. He recommended scrapping clinical requirements that have protected glaucoma patients for almost a decade and replacing them with minimal clinical standards. These recommendations set in motion a regulatory process that would permit an optometrist who seeks certification to complete the process ***without having managed an actual glaucoma patient.*** The Department of Consumer Affairs signed off on those recommendations with only minor revisions and regulations finalizing those decisions are imminent.

25. **After** the consultant's recommendations were received and used to shape the Department's final decision, the Department discovered it had failed to require the consultant to file a Form 700 Statement of Economic Interests pursuant to the Department's Conflict of Interest Code. So after the fact the Department required the consultant to file the required disclosure.

26. As noted earlier, the consultant optometrist is **not** certified to treat glaucoma. This is particularly significant because the Department's own ***published requirement for the position***, required that the consultant have "personal experience in ***treating*** more than 50 cases (patients) diagnosed with glaucoma."(Emphasis added).[15] (The 50-glaucoma case standard was one of the key requirements for glaucoma certification prior to the passage of SB 1406. The consultant couldn't have ***treated*** glaucoma patients prior to performing his duties as the consultant because it was illegal.)

27. It was not surprising; therefore, that the Department of Consumer Affairs' consultant recommended watering down the requirements to allow optometrists to be certified to treat glaucoma patients. The final recommendation was to authorize glaucoma certification after

[15] Item H, "Special Consultant Tasks and Responsibilities," (Tab 1, Appendix), Office of Professional Examination Services Report from Special Consultant, June 25, 2009.

simply completing a lecture requirement and "interacting" in a group with **as few as 10 glaucoma patients** over a single year or less. Incredibly, under this new California Optometric Association-Department of Consumer Affairs recommended process, an optometrist ***could actually become certified to independently treat glaucoma without having ever treated a single glaucoma patient.***[16] Furthermore, all optometrists who graduated after May 2008 were "presumed" to have sufficient training under SB 1406. Not surprising, the consultant agreed with the position of the optometry school where he is employed – namely that current graduates are well qualified to independently treat glaucoma -- and decided that optometrists who graduated after 2008 would ***not*** be required to have any additional clinical training.

28. The California State Board of Optometry accepted the recommendations and will enact regulations in January of 2010.

29. At no time did the Legislature provide the Department of Consumer Affairs with authority to hire an outside consultant to reconcile any potential competing reports that were generated by the committee. Had the Legislature wanted to do so, it clearly could have. See People v. Cole (2006) 38 Cal.4th 964.

30. Further, serious Constitutional implications are raised. Unlike the Legislature's direction with respect to the composition and duties of the committee, the Legislature was silent on the issue of

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[16] The complicated three-option certification process endorsed by the Department of Consumer Affairs claims to require each applicant to follow 25 "patients" over a year. However, it allows an applicant to obtain:

1. 15 "patient credits" for a lecture course involving *no* patients.
2. 15 "patient credits" from a course where live patients are "seen" in a large group setting where they are discussed with faculty.

However, options 1 and 2 can completely satisfy the "25 patients over a year" requirement ***without ever treating a patient with glaucoma.*** And then there is option 3 that no one expects applicants to voluntarily choose.

3. This option provides a "preceptorship" where the applicant actively manages glaucoma patients with a supervisor authorized to treat glaucoma.

hiring of an outside consultant, and therefore provided no safeguards to guide such an individual's discretion. In the absence of such legislative direction, serious questions are raised as to whether the hiring of the consultant to reconcile the reports, or otherwise make independent recommendations, constitutes an unlawful delegation of legislative power. See, for example, *Blumenthal v. Board of Medical Examiners* (1962) 57 Cal.2d 228 (a statute, which conferred upon licensed dispensing opticians unlimited power to exclude optician applicants was an invalid delegation of legislative discretion); see also *State Board of Drycleaners v. Thrift-D-Lux Cleaners* (1953) 40 Cal.2d 436 (statute which authorized State Board of Dry Cleaners to establish just and reasonable minimum prices for services of drycleaners was unconstitutional where Board included active members of the industry and the Legislature failed to establish an ascertainable standard to guide the administrative body).

31. This unauthorized activity nullifies the recommendations made to the Department of Consumer Affairs and subsequently adopted by the Board of Optometry. As a result, any regulation adopted authorizing optometrists to treat and diagnose glaucoma is void as being in excess of statutory authority and in violation of the criminal provisions prohibiting the unlicensed practice of medicine. See Business & Professions Code §2052.

PARTIES

Petitioners

1. Petitioner, California Academy of Eye Physicians & Surgeons, is a leading physician-based organization committed to serving the total visual health care needs of the people of California through public and professional education, membership services, and legislative advocacy.

2. Petitioner, California Medical Association, is the state's leading physician organization representing more than 35,000 members in all modes of practice and specialties representing the patients of California.

3. Petitioner, American Glaucoma Society is a national organization of glaucoma specialists and related scientists. Its mission is to promote excellence in the care of patients with glaucoma and preserve or enhance vision by supporting the advancement of education and research in the field.

JURISDICTION

This Administrative Petition[17] is filed pursuant to California Government Code Section 11340.6, which provides that "[A]ny interested person may petition a state agency requesting the adoption, amendment, or repeal of a regulation as provided in Article 5 (commencing with Section 11346)...." Government Code section 11340.7 further provides:

> (a) Upon receipt of a petition requesting the adoption, amendment, or repeal of a regulation pursuant to Article 5 (commencing with Section 11346), a state agency shall notify the petitioner in writing of the receipt and shall within 30 days deny the petition indicating why the agency has reached its decision on the merits of the petition in writing or schedule the matter for public hearing in accordance with the notice and hearing requirements of that article.
>
> (b) A state agency may grant or deny the petition in part, and may grant any other relief or take any other action as it may determine to be warranted by the petition and shall notify the petitioner in writing of this action.
>
> (c) Any interested person may request a reconsideration of any part or all of a decision of any agency on any petition submitted. The request shall be submitted in accordance with Section 11340.6 and include the reason or reasons why an

[17] This code section originated from the advocacy of Consumers Union USA. For a discussion of its use in consumer advocacy see: Harry Snyder, Consumers Union West Coast Regional Office, with Carl Oshiro and Ruth Holton, Getting Action How to Petition Government and Get Results. Updated and Expanded - 2nd Edition 2002, http://www.consumersunion.org/other/g-action1.htm

agency should reconsider its previous decision no later than 60 days after the date of the decision involved. The agency's reconsideration of any matter relating to a petition shall be subject to subdivision (a).

(d) Any decision of a state agency denying in whole or in part or granting in whole or in part a petition requesting the adoption, amendment, or repeal of a regulation pursuant to Article 5 (commencing with Section 11346) shall be in writing and shall be transmitted to the Office of Administrative Law for publication in the California Regulatory Notice Register at the earliest practicable date. The decision shall identify the agency, the party submitting the petition, the provisions of the California Code of Regulations requested to be affected, reference to authority to take the action requested, the reasons supporting the agency determination, an agency contact person, and the right of interested persons to obtain a copy of the petition from the agency.

The authority and responsibility of the Department of Consumer Affairs to investigate its licensees is unquestioned. Business and Professions Section 155 (a), states:

"In accordance with Section 159.5, the director may employ such investigators, inspectors, and deputies as are necessary properly to investigate and prosecute all violations of any law, the enforcement of which is charged to the department or to any board, agency, or commission in the department."

Furthermore, Business and Professions Code Section 100. et. al. authorizes the Department of Consumers Affairs to oversee and evaluate the 39 licensing boards and bureaus for the protection of the public. Business and Professions Code Section 109 limits the power of the Department of Consumer Affairs Director over decisions of the licensing boards "comprising the department

with respect to setting standards, conducting examinations, passing candidates, and revoking licenses, are not subject to review by the director, but are final within the limits provided by this code..." However, ***this limitation is silent with respect to intervening in regulatory matters.*** Further, Subsection (c) provides the following exception:

> (c) ***The director may intervene in any matter of any board where an investigation by the Division of Investigation discloses probable cause to believe that the conduct or activity of a board, or its members or employees constitutes a violation of criminal law.*** [Emphasis added.]

> The term "intervene," as used in paragraph (c) of this section may include, but is not limited to, an application for a restraining order or injunctive relief as specified in Section 123.5, or a referral or request for criminal prosecution. For purposes of this section, the director shall be deemed to have standing under Section 123.5 and shall seek representation of the Attorney General, or other appropriate counsel in the event of a conflict in pursuing that action.

However, the Legislature in SB 1406 of 2008 granted the Department of Consumer Affairs additional unprecedented responsibilities for establishing clinical training requirements for glaucoma certification:

> Section 3041.10. (a) The Legislature hereby finds and declares that it is necessary to ensure that the public is adequately protected during the transition to full certification for all licensed optometrists who desire to treat and manage glaucoma patients.

SB 1406 Business and Professions Code 3041.10 (f) grants the Department of Consumer Affairs unique regulatory authority over the issue of setting clinical requirements for certifying optometrists to treat glaucoma patients. The Department of Consumer Affairs is mandated to, among other things, examine the committee's recommendation to determine whether it will (a) adequately protect patients, and (b) ensure that optometrists are able to treat glaucoma on an appropriate and timely basis. Clearly, the Legislature intended that Department of Consumer Affairs utilize the resources of the State Board of Optometry and the ophthalmologists, licensees of the Medical Board of California for the protection of the public to prevent the unlicensed practice of medicine and protect patients. The Petition's requested withdrawal of the Department's SB 1406 Findings and Recommendations and a defacto suspension of the clinical training requirements regulatory process pending completion of the requested investigation are consistent with the Legislature's mandate to the Department to "to ensure that the public is adequately protected during the transition to full certification for all licensed optometrists who desire to treat and manage glaucoma patients."

Neither of the two optometrists involved in the VA hospital tragedy appears to have been certified to treat glaucoma patients under California law.

"Department of Consumer Affairs is a regulator. DCA consists of more than 40 bureaus, programs, boards, committees, commission, and other entities that license more than 2.4 million practitioners in more than 255 professions. **DCA works with professions throughout the State to protect licensees from unfair competition and to protect consumers from unlicensed practitioners.**"[18] [Emphasis added.]

[18] Department of Consumer Affairs, "What We Do and How We Do it", p. 4 http://www.dca.ca.gov/about_dca/index.shtml

RELIEF REQUESTED

Petitioners request that the Department of Consumer Affairs:

1) Investigate the blinding of eight veterans and the harm to others at the Veterans Affairs Palo Alto Health Care System (VAPAHCS) to determine whether state laws governing the California-licensed optometrists have been violated.

2) Withdraw the Department's Findings and Recommendations on clinical training requirements for glaucoma certification required by SB 1406 pending the results of the requested investigation of the blinding of the veterans.

3) Suspend any further watering down or elimination of clinical training requirements until a thorough investigation of the Palo Alto VA scandal is complete and its findings and recommendations can be included in the implementation of SB 1406.

CONCLUSION

The mission statement of the California Department of Consumer Affairs says, "We are the primary consumer protection resource for California residents."

Speaking to the issue of health care professionals shortly after the new Director of the Department of Consumer Affairs Brian J. Stiger was appointed, he stated:

> "The existing model protects licensees. The new model makes the protection of consumers paramount."

The California consumers treated at the Palo Alto Veterans Hospital who are now blind or suffering from failing eye sight might legitimately question how much protection they received

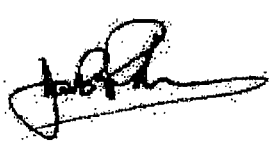
from our state's licensing process.

At the very least, their cases deserve investigation of the kind we have outlined in this Petition. At the very least, further attempts to water down clinical training requirements should be placed on hold pending that investigation. At the very least, our state should be aware of the admonishment from the American Glaucoma Society that: "Vision lost to glaucoma is lost forever."[19]

The California Optometric Association's political might does not make it right. Increased risk of blindness to the public is simply unacceptable.

For the reasons set forth above, Petitioners request that this Administrative Petition be granted and this matter be scheduled the matter for public hearing in accordance with the rulemaking provisions of the California Administrative Code. Petitioners further request the withdrawal of the Department's Finding and Recommendations required by SB 1406 pending the results of the investigation of the blinding of 8 veterans. Petitioners request that the Department and the Board of Optometry stay any further proceedings on SB 1406 implementation pending final resolutions of the requested investigation.

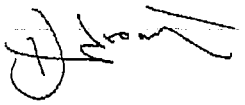
Respectfully submitted,



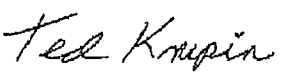
Dated: October 12, 2009

James B. Ruben, MD
President
California Academy of Eye Physicians & Surgeons
425 Market St., Ste. 2275, San Francisco
Clinical Professor, University of California, Davis
(916) 614-4305

[19] Theodore Krupin, M.D., President, American Glaucoma Association letter to Sonja Merold, Chief, Office of Professional Examination Services, July 15, 2009



Dev GnanaDev, MD
President
California Medical Association
1201 K St., Ste. 200, Sacramento
(916) 444-5532



Theodore Krupin, MD
President
American Glaucoma Society
655 Beach St., San Francisco
Professor, Northwestern University
(415) 561-8587

cc: The Honorable Susan Lapsley, Director, Office of Administrative Law, 300 Capitol Mall, Suite 1250, Sacramento, California 95814-4339

The Honorable Lee A. Goldstein, OD, MPA, President, California Board of Optometry, 2420 Del Paso Road, Suite 255, Sacramento, CA 95834

The Honorable Barbara Yaroslavsky, President, Medical Board of California, 2005 Evergreen Street, Suite 1200, Sacramento, CA 95815

Acting Secretary Roger Brautigan, California Department of Veterans Affairs, 1227 O Street, Sacramento, California, 95814

The Honorable Jerry Brown, Attorney General, California Department of Justice P.O. Box 944255 Sacramento, CA 94244-2550

The Honorable Arnold Schwarzenegger, Governor, State Capitol, Sacramento, 95814

ATTACHMENT 6

STATE CAPITOL
SACRAMENTO, CA 95814
(916) 651-4038
(916) 445-7262 FAX

DISTRICT OFFICES
1910 PALOMAR POINT WAY
SUITE 105
CARLSBAD, CA 92008
(760) 931-2455
(760) 931-2477 FAX

27128A PASEO ESPADA
SUITE 1021
SAN JUAN CAPISTRANO, CA 92675
(949) 489-9555
(949) 489-8354 FAX

California State Senate

SENATOR
MARK WYLAND
THIRTY-EIGHTH SENATE DISTRICT

COMMITTEES
BUSINESS & PROFESSIONS
VICE-CHAIR
LABOR & INDUSTRIAL RELATIONS
VICE-CHAIR
APPROPRIATIONS
BUDGET & FISCAL REVIEW
EDUCATION
GOVERNMENTAL ORGANIZATION
VETERANS AFFAIRS

November 3, 2009

Director Brian Stiger
Department of Consumer Affairs
1625 N. Market Blvd., Suite S-309
Sacramento, CA 95834

Re: ***Administrative Petition from Medical Groups related to Blindness Cases at Palo Alto VA***

Dear Mr. Stiger:

As a Senator who supported the compromise legislation (SB 1406, Correa) calling for a carefully balanced process for the development of revised certification standards for optometrists to treat glaucoma, it is very important to me that the resulting process be credible and the intended process respected.

It is my understanding that you have been petitioned by the American Glaucoma Society, the California Medical Association, and the California Academy of Eye Physicians and Surgeons to investigate events related to the blinding of eight Veterans under the care of California-licensed optometrists at the Palo Alto Veterans Affairs Hospital, which came to light immediately after your Department submitted its report on the matter to the State Board of Optometry.

They have questioned the appropriateness of having a single optometrist with potential bias toward the bill's sponsor as your "Special Consultant" to assist the Department in developing its Findings and Recommendations, which were accepted with only minor changes. It was my understanding that by appointing a committee of 3 optometrists and 3 ophthalmologists to develop the recommendations, we would assure an outcome that had to be acceptable to both sides, and would thus protect the public.

While I will not prejudge the issue, I strongly encourage you to consider these concerns carefully so that the Department's credibility cannot be called into question by a flawed result.

Sincerely,

MARK WYLAND
Senator, 38th District

MW:ab

Assemblymember Ed Hernandez, O.D.
Representing the 57th Assembly District

Senator Lou Correa
Representing the 34th Senate District

Lang | Hansen | O'Malley | Miller
Governmental Relations

ATTACHMENT 7

GOVERNMENTAL ADVOCATES

AARON READ & ASSOCIATES, LLC.

March 2, 2009

Ms. Sonja Merold, Acting Chief
Office of Professional Examination Services
California Department of Consumer Affairs
2420 Del Paso Blvd., Suite 265
Sacramento, CA 95834

Dear Ms. Merold:

First, we'd like to let you know how much we appreciate all of the work you have done and the extraordinary patience you have displayed as we worked together toward the final implementation of SB 1406 (Correa).

During the seemingly endless and oftentimes difficult negotiations, the stakeholders involved in SB 1406 absolutely agreed that OPES was the best place for the final glaucoma discussion to be held. We believe that the parameters inherent with the legislation and the key individuals chosen from all sides to participate in the discussion, will ultimately lead to vulnerable Californians receiving the kind of quality eye care that is currently outside their grasp.

Not surprisingly, there are still strong emotions involved when discussing glaucoma. We support OPES with their decision to have an arbiter in place if the six doctors at the table cannot come to a clear resolution. The problem, however, is that after hundreds of hours of discussion, there remains a real concern that the final choice for arbiter be someone who not only has the experience and background to understand the issue, but clearly be someone without any bias.

We are hopeful that you are open to the suggestion of hiring former longtime consultant to the Senate and Assembly Business & Professions Committees, Jay DeFuria. There is no one in government who has navigated more scope of practice issues, has a greater understanding of the process to guarantee the minimum competency required by the Department of Consumer Affairs, is able to access in a credible manner those with the expertise on the issues at hand, and can deal fairly with all of the stakeholders.

We make this suggestion in good faith and with the full understanding that the final decision is yours.

Sincerely,

Assemblyman Ed Hernandez, O.D.
Representing the 57th Assembly District

Senator Lou Correa
Representing the 34th Senate District

Joe Lang
Lang, Hansen, O'Malley & Miller

Terry McHale
Aaron Read & Associates

Cliff Berg
Governmental Advocates

ATTACHMENT 8

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

STATE AND CONSUMER SERVICES AGENCY • ARNOLD SCHWARZENEGGER, GOVERNOR
OFFICE OF PROFESSIONAL EXAMINATION SERVICES
2420 Del Paso Road, Suite 265, Sacramento, CA, 95834
P (916) 575-7240 F (916) 575-7291

June 10, 2009

James B. Ruben, MD; President
Craig H. Kliger, MD; Executive Vice President
California Academy of Eye Physicians & Surgeons
425 Market Street, Suite 2275
San Francisco, CA 94105

Dear Doctors Ruben and Kliger:

This is in response to your letter of May 28, 2009 in which you suggest that the Office of Professional Examination Services (OPES) either hire an educator or hire an ophthalmologist to restore balance, as a result of OPES hiring optometrist Tony Carnevali, OD as a Special Consultant.

As I have indicated in previous correspondence, curriculum review is not one of our core competencies. We determined that the State would be best served by hiring a Special Consultant to assist us meeting our responsibilties under Senate Bill (SB) 1406. Prior to making the appointment of Dr. Carnevali, OPES verified with our legal office that SB 1406 does not preclude us from seeking assistance from an outside source.

A Special Consultant is a civil service classification often used by departments when they seek expert assistance for a project on a limited-term basis. OPES followed the advertising and hiring methods used by State departments to fill civil service positions. The duty statement with minimum qualifications was developed, the position was advertised on the State Personnel Board's Vacant Position database, and candidates were selected to interview based on their meeting the minimum qualifications. A selection was made by a three-person panel consisting of a member of my staff, the Department of Consumer Affairs' Assistant Personnel Officer, and the Equal Employment Opportunity manager for the California Department of Forestry and Fire Protection. The panel members were unbiased in their selection of Tony Carnevali, OD, to serve as the Special Consultant. Due to the short timeframe of this project, it was imperative that OPES hire someone by the first of April 2009 in order to allow sufficient time to research and prepare a report to OPES before July 1, 2009. The Legislature intended that we review one report. We instead received two.

OPES acknowledges the concerns expressed in your letter. However, we feel that Dr. Carnevali will be objective in his assessment of both reports submitted by the Glaucoma Committee. There is a balance and equal representation inherent in the two reports.

Thank you for bringing your concerns to my attention.

Sincerely,

Sonja Merold

Sonja Merold, OPES Chief

cc: Mona Maggio, Executive Officer, State Board of Optometry

ATTACHMENT 9

California Academy of Eye Physicians & Surgeons
1201 J Street, Suite 200, Sacramento, CA 95814 o Phone: (916) 529-8795 o Fax: (415) 777-1082
Accounting: 425 Market St., Suite 2275, San Francisco, CA 94105 o Phone: (415) 777-3937
e-mail: CaEyeMDs@aol.com o web: www.californiaeyemds.org

May 28, 2009

Via Facsimile (916) 575-7291
Sonja Merold, Chief
Office of Professional Examination Services
Department of Consumer Affairs
State of California
2420 Del Paso Blvd., Suite 265
Sacramento, CA 95834

Dear Ms. Merold:

We believe the interests of California's consumers would be best served if your department would seek neutral and unbiased expertise to ensure fulfillment of the mandates of SB 1406. As you may be aware, critical to the bill's passage was the creation of the Glaucoma Diagnosis and Treatment Advisory Committee (GDTAC) that was balanced – a factor we believe was vital to the protection of glaucoma patients in this state. Now it appears your office is securing the services of a consultant that cannot be objective, contrary to the letter and spirit of SB 1406.

While we question whether this action is authorized under this law, earlier this year we wrote to express our strong desire that any such consultant utilized in this process have both expertise and neutrality. Although we did receive your reply indicating you would extend the deadline for submission of candidates, and we had been actively searching for appropriate candidates, your letter arrived after the extended deadline.

Shortly thereafter, however, the name of Jay DeFuria was agreed to by a number of stakeholders, including ourselves, and he appeared to be your likely choice. With Mr. DeFuria's withdrawal from consideration for health reasons we learned at the Board of Optometry meeting held May 15, 2009 (just over a week ago) that you have apparently elected to proceed with an optometrist, specifically Tony Carnevali OD FAAO. Unfortunately, as suggested above, Dr. Carnevali appears to have ***several conflicts of interest*** that would lead one to question his lack of bias in making recommendations to your office.

As you are aware Dr. Carnevali is on the faculty of the Southern California College of Optometry (SCCO). That institution is already on record as having the position that its graduates are "qualified" to independently treat glaucoma. Since one of the charges of the ongoing process is to determine whether there is a need for "additional glaucoma training...pursuant to subdivision (f) [of 3041]

to be completed before a license renewal application from any licensee described in this subdivision is approved," Dr. Carnevali would appear to have an ***inherent bias to support his institution's claim.***

In addition, Dr. Carnevali's employer SCCO ***would potentially benefit financially from being one of the institutions conducting the course*** suggested by the optometrist members of the GDTAC as adequate training in and of itself for prior graduates.

Furthermore, according to the website of the state Board of Optometry, Dr. Carnevali is ***not himself currently certified to treat glaucoma in California.*** He would therefore have an inherent conflict to make the criteria as minimally demanding as possible because he would potentially need to qualify under them himself.

Lastly, Dr. Carnevali is a Past President and served more than ten years on the Board of Trustees of the California Optometric Association, which sponsored the bill that created the process being carried out. One would be hard pressed to think that he can ***easily separate the goals of an organization to which he has devoted such significant amounts of time and energy,*** particularly if he is not balanced by anyone with an alternate view.

Of course similar comments could likely be made if you had solely selected someone with a strong affiliation with organized medicine/ophthalmology.

As we pointed out in our last letter, the committee established by this legislation was specifically composed of an equal number of optometrists and ophthalmologists (3 of each with specific backgrounds) so as to ensure balanced representation. Abandoning that balance at this point only serves to create the bias the legislation so painstakingly attempted to avoid.

Although for the reasons previously outlined we did not submit additional names for your consideration before Mr. DeFuria became the likely candidate, we had been working on this. However, rather than concentrate on an ophthalmologist or an optometrist, we attempted to identify an educator (i.e., someone with a Doctor of Education degree) whose neutral and unbiased experience in "educational process," would serve California consumers well. While we cannot be certain you would find our suggestions acceptable, should you be willing to consider them (and they remain willing to serve) we would be happy to forward their names.

Alternatively, you could consider also involving an ophthalmologist to again restore balance. However, we again ask that the previously indicated requirement for such a person to "actively treat optometry students" be reconsidered as that would appear to have nothing to do with the ability to evaluate what is a suitable "standard" of training. Californians deserve a single standard of care, regardless of which practitioner provides such care.

Thank you in advance for addressing our concerns and considering our request.

Sincerely,

James B. Ruben, MD
President

Craig H. Kliger, MD
Executive Vice President

cc: Mona Maggio, Executive Officer, State Board of Optometry

ATTACHMENT 10

California Medical Association
Physicians dedicated to the health of Californians

May 29, 2009

Sonja Merold, Chief
Office of Professional Examination Services
Department of Consumer Affairs
State of California
2420 Del Paso Road, Suite 265
Sacramento, California 95834

Re: Implementation of SB 1406 (Ch. 352, Stats. 2008)

Dear Ms. Merold:

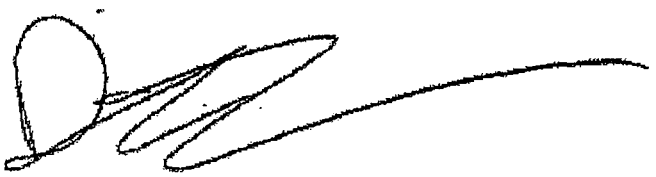
The California Medical Association (CMA) understands that your office has contracted with an optometrist, Tony Carnevali, OD, FAAO, to advise on the requirements for glaucoma certification for optometrists. The California Academy of Eye Physicians and Surgeons (CAEPS), in their letter dated May 26, 2009, has set forth a number of reasons why this appointment is ill-advised, given the numerous conflicts of interest which he appears to have. The CMA writes this letter to support the CAEPS' objections to Dr. Carnevali's appointment, as well as to provide additional reasons why this activity was never envisioned by the Legislature or the interested parties when the Bill was enacted.

As you may recall, given the significant increased scope of practice and attendant patient care considerations raised by SB 1406, the bill was the product of extensive debate, negotiations, and compromise. As the language of the bill makes clear, the ability for optometrists to treat and manage glaucoma patients was expressly conditioned on the Board appointing a Glaucoma Diagnosis and Treatment Advisory Committee that was balanced between the professions. Equal numbers of physicians and optometrists would assure the public that whatever curriculum and certification requirements were adopted, patients would be adequately protected. The neutrality of process laid out by this bill was key to the parties' agreement and the subsequent passing of the bill. The hiring of an outside consultant, particularly one with potentially significant conflicts of interest, does not appear to be authorized by SB 1406.

There are serious questions as to whether the hiring of any consultant, let alone one with potential conflicts of interest, is appropriate given the lengths the Legislature went to in SB 1406 to define the committee, its responsibilities, and the process for its composition. Indeed, in addition to defining the committee member qualifications, the Legislature went so far as to expressly identify those professional organizations that were entitled to recommend committee member appointments. At no time did the Legislature provide the Office with authority to hire an outside consultant to reconcile any potential competing reports that were generated by the committee. Had the Legislature wanted to do so, it clearly could have.

Regardless of the Office's statutory authority here, there is no question that any consultant hired by the Office must be free of conflicts that could comprise objectivity. Based on the information we have received from the California Academy of Eye Physicians and Surgeons, significant concerns have been raised with respect to Dr. Carnevali's ability to maintain that core requirement that is so essential to protect the patients in this State. Under these circumstances, we urge that you consider other consultants whose neutrality is assured, and who, in the end, would better serve California consumers. Thank you for your attention to this matter.

Sincerely,



Dustin Corcoran
Senior Vice President
California Medical Association

ATTACHMENT 11

ENCLOSURE A

OPES' MODIFICATIONS

OPES adopts all of Dr. Carnevali's recommendations with the following modifications. Underlined = Additions and changes; ~~Strikethrough~~ = Deleted text.

RECOMMENDATIONS:

1. New graduates of an accredited school or college of optometry after May 1, 2008, are well trained in all aspects of glaucoma diagnosis and management, and therefore are fully qualified to receive glaucoma certification without any additional didactic or case requirements.

   This is also consistent with the wishes of the Legislature and the co-authors of SB 1406.

2. Those graduating from an accredited school or college of optometry prior to May 1, 2000, who have not completed a didactic course of not less than 24 hours in the diagnosis, pharmacological, and other treatment and management of glaucoma, ~~who have not yet taken a 24-hour glaucoma course~~, will be required to take the 24-hour course. Those graduating from an accredited school or college of optometry after May 1, 2000, are exempt from further didactic courses.

3. Those graduating from an accredited school or college of optometry prior to May 1, 2008, who have taken the 24-hour course but not completed the case management requirement under SB 929, will be required to complete a minimum 25- patient case management requirement.

   The case management requirement will consist of, at minimum, 25 patients prospectively treated/managed for one year. This case requirement may be fulfilled by any combination of the following:

   a. Fifteen-patient credit for taking a 16-hour advanced case management course conducted live, web-based, or by use of telemedicine and passing a course examination. California schools and colleges of optometry will work cooperatively to develop uniform curriculum and procedures and obtain approval by the State Board of Optometry. ~~The course is to be developed by an accredited school of optometry in California and approved by the State Board of Optometry.~~

      The 16-hour case management course should be structured in such a way that it will maximize the learning experience. The following are some suggestions:

      1) Case-based course similar to the NBEO Part II examination on patient assessment and management including a specified number of common treatment scenarios, complex

cases and confounding disease processes (similar to the proposal by ophthalmology); including an

~~(2) Course based on~~ individual analysis and presentation by each candidate of at least 10 patient case scenarios most likely to be encountered in clinical practice (as proposed by optometry).

2) ~~3)~~ A written examination administered to each candidate at the conclusion of the course (as recommended by both ophthalmology and optometry).

b. Fifteen patients credit by participating in a 16-hour grand-rounds program with live patients developed by an accredited school of optometry in California and approved by the State Board of Optometry.

A grand-rounds program with live patients that are individually examined by doctors would better mimic real life glaucoma management. Here is an example of such a program:

1) Live patients to include: Glaucoma suspects, narrow angle, POAG (early, moderate, late), and secondary open angle glaucoma like pigment dispersion and pseudoexfoliation. The patient data would be available on site and presented upon request: VA's, IOP, VFs, imaging and pachymetry
2) The doctors would exam the patient (optic nerve, gonioscopy), evaluate data and test results, and commit to a tentative diagnosis and management plan.
3) Conduct a group discussion of the cases with instructor feedback.
4) Follow-up meetings involving the same doctors - could use the same patients or different patients with serial data from VF, imaging, photos, etc.

The accredited optometry schools and colleges in California could develop and recommend to the State Board of Optometry for approval the specific format and content of a case management course and/or a grand rounds program. ~~The specific format and content of a case management course and/or a grand rounds program would most appropriately be decided and approved by the State Board of Optometry.~~

~~c. Ten patients credit may be completed on a retrospective basis by writing a case report, to include a treatment plan and appropriate tests, on currently co-managed patients from the OD's practice...to be reported and conducted in a manner approved by the Board of Optometry.~~

~~This would most likely require the use of experts (i.e. glaucoma certified ODs, glaucoma certified ophthalmologists, faculty members at schools of optometry) to evaluate the written case reports. An appropriate per case fee could be charged of the OD submitting the case report to the Board for processing and expert evaluation.~~

c. ~~d.~~ Those ODs who began the credentialing process under SB 929 but will not be completing the requirement by December 31, 2009, may apply all patients who have been co-managed prospectively for at least one year towards the 25-patient requirement. Full credit should be given for a~~A~~ll these patients that have been or are currently being co-

managed with an ophthalmologist and the optometrist. ~~should therefore be given full credit for that experience.~~

d.~~e.~~ And finally, any or all of the 25 patients may be seen under a preceptorship arrangement with a glaucoma certified OD or ophthalmologist. This preceptorship may all be accomplished by the use of telemedicine/ electronic submission of information, etc., as mutually agreed to by the consulting and treating doctors.

4. Present CE requirement of 50 hours for two years with 35 hours in ocular disease is sufficient for all ODs already certified to treat glaucoma. However, the State Board of Optometry may at its discretion consider specifying a given number of hours (perhaps eight ~~12~~ hours) of glaucoma treatment and management continuing education courses every two years for those who are glaucoma certified ~~ODs who will be going through the glaucoma certification process~~. (This should be part of the 50 hours currently required, not an additional number of hours...perhaps even with an automatic sunset provision for this requirement after 4-6 years.)

OPES' RATIONALE FOR MODIFICATIONS

1. Added "accredited school or college of optometry" to make sure that it was clear that schools need to be accredited by the Accreditation Council on Optometric Education.

2. Added specific text from the California Optometry Law Book about the 24 hour didactic course because no changes were made to this requirement and it keeps with the recommendations given by the glaucoma advisory committee. The current didactic course offered by California schools/colleges of optometry is sufficient and meets the standards necessary for licensure.

3. Added "a minimum" to the 25 patient case management requirement description in order to indicate that if more patients are seen during a course, the course must be completed despite the additional patient credits received. OD's cannot drop out of any course they choose in order to meet these requirements when they reach the 25 patient cut off.

a. OPES recommends that a "uniform curriculum" be developed with the schools/ colleges of optometry in California working together. The Board will approve the final curriculum.

1) & 2) Have been combined in order to facilitate curriculum development. OPES also feels that students should have both 1) and 2) in their training, not just one or the other.

b. OPES recommends that the schools/colleges of optometry in California should develop the format for the grand rounds course and then the Board of Optometry will approve.

c. OPES felt that this recommendation should be removed because it would require statutory and regulatory amendments if a fee is required. Currently, there is nothing in the B&P Code established that would permit the Board to collect fees for expert evaluations. A fee cap would be required in statute in order to ensure that all experts are charging a fair amount to graduates. Also, it would be difficult to determine who would be qualified as an "expert" for the evaluation of the written case reports. The Board would need the schools/colleges of optometry to recommend experts, but again, the question remains on how to establish who is qualified. The evaluations would be subjective depending on the expert and it would be difficult to develop a standard to which each evaluator should be held to in order to ensure that each student is getting the same evaluation.

d. editorial changes only

e. no changes

4. OPES feels that 8 hours are sufficient instead of 12 because OD's are already required to take 35 hours of ocular disease in order to treat glaucoma. Additionally,

courses are usually in 6-8 hour increments. For example, subject matter experts who attend workshop at OPES in order to develop the California Law Examination for optometry receive 8 CE credits for 2-day workshops.

Finally, OPES conferred with Board staff in regards to CE record keeping and the case management process because this process will essentially mirror what is already in place. Thus, it was found necessary to remove the fifth sentence referencing whether OD's will be going through the certification process. It would be difficult for the Board to keep track of these individuals since the Board currently does not have a tracking mechanism in place in order to determine who is in the glaucoma certification process. The only way Board staff will know this information is when an OD has completed the process and turned in their application for evaluation and approval.