Transcript

September 30, 2025, 11:15PM

Robinson, Misty B started transcription

0:03

Right issue.

LF **Linda Feero** 0:07

She says she's called in as well, so hopefully it's just gonna show up somewhere.

0:12

OK great.

Continuing with the rules as commissioner said limit the chat.

We don't want an actual conversation but if you've got something to add.

Reference document or technology you know issue.

Let us know via the chat.

Attack the problem not the person.

We intend to make this a very respectful conversation.

We understand we're going to do our best to keep us focused.

On the topics at hand but we understand other topics may come up during the conversation and if they do we'll just staff will create a list a parking lot list to do that and we'll keep those under consideration for future discussions.

And then finally.

In the for the emails if you could just.

Not reply all on the e-mail exchanges.

Just direct your e-mail to DPFR.

Staff.

Any questions about the ground rules before we get going?

Doctor Harris it's great to see you.

And and doctor Harris I we have unmuted you.

So hopefully that has worked and if you could just lower your hand that 'd be great.

John Harris 1:40
Are you able to hear me OK?

1:43
Yes perfect.

John Harris 1:44
Yes, perfect. OK, perfect. Thank you.

1:47
Technology is great until it isn't.
OK.
Well.
We had.
Planned on spending some time this evening.
Initially we had planned on spending some time this evening reviewing some of the primary components of LD 18 O 3 as amended by the sponsors amendment but in reviewing the agenda and prepared for tonight particularly after receiving all the data.
That you collectively sent us in the last 24 hours.
We wanted to make sure that we had as much time as possible for discussion around data.
So instead of us reviewing the highlights the primary components of the proposal which you received.
In pre meeting materials on its posting on the meeting website we just want to pause and ask does you know the in summary this is a proposal to expand scope of practice for optometry.
Interests in Maine to include some surgical procedures expand some prescriptive authorities.
Are there any particular questions about the proposal or do people feel like they have a pretty good handle on what the bill as amended seeks to achieve?
All right hearing none.
We wanted to start.
The tonight's discussion by providing the stakeholders an opportunity to present

their thoughts.
And so we've given the plan here is to give optometrists an ophthalmologist.
Each 20 minutes to provide their perspective I'll serve as time keeper.
But and with that I'm going to turn it.
I'm going to ask the optometrist representative to take the floor.

JQ **Jessilin Quint** 3:52
Thank you, Christina, and thank you, Commissioner, and thank you all for being here.
So LD 1803 is essentially about aligning optometry's education and training to Maine's scope of practice.
To really just meet the needs of our state optometry scope of practice here in Maine has not been updated in over 30 years and we can all probably agree that life today looks very different than it did 30 years ago.
Education, technology, techniques and patient needs have all changed within this time.
The training, the education and the expertise of optometrists have changed as well.
Frontline treatments have also changed. What was once best in class 30 years ago is now dramatically different.
Patients here remain deserve access to the best of the best treatments by qualified providers.
Optometrists should be allowed to grow with these advancements just as other professions have been allowed to grow.
And it especially makes sense when growing can be done safely and for the benefit of the patient. Optometrists are educated, trained, and certified to perform the procedures that are outlined in LD 1803.
Patients shouldn't have to face delay in treatment or have to have unnecessary travel time to just have easy access to an ophthalmologist.
Many other states have allowed optometrists to do the procedures that are outlined in LD18O3.
And some have allowed optometrists to do this for over 30 years without compromising patient safety. And while increasing access to safe patient care.
This bill should not be about turf wars.
It's about access to timely and safe patient care.
The procedures in LD 1803 have been taught by every optometry school in the nation for over the last 10 years.

The procedures in LD 1803 are taught in a variety of ways.
Through classroom work, these procedures are integrated into basic clinical and science courses. They're developed in labs and workshops, and they're observed and performed under the supervision of qualified faculty and clinicians.
Competency in these procedures is also demonstrated through both national and state written and practical board examinations. The training and education for an optometrist includes over 10,000 of doctorate level education.
That is specific to the body. The eyes in the visual system during my time in optometry school, I performed procedures on over 2000 patients and I learned the procedures that are in LD18O3 training for the procedures in LDA. 2O3 has also been.
Part of the standard curriculum for accredited optometry schools since at least 2015, this education is standardized and it's specifically standardized under the Accreditation Council of Optometric Education.
And the procedures in LD 1803, they're very specific.
They're limited.
They're all considered minimally invasive.
None of the procedures in this bill require an operating room.
They're all done under topical anesthesia.
None of them pierced the globe.
These are all front of the eye procedures. One of the procedures in this bill, the selective laser trabeculoplasty and SLT, is now becoming the first line treatment for glaucoma to reduce the eye pressure in the eye.
And this approach, and SLT, is sometimes for many patients a better method than eye drops and can often help extend the time that's needed before an invasive glaucoma surgery would need to be done by an ophthalmologist.
So to be clear, LD18O3 does not allow an optometrist to perform cataract surgery invasive glaucoma surgeries.
Lasik retina surgeries.
No intravitreal injections, despite what opponents to this bill have tried.
To lead misinformation on the reality is that the procedures in LD 1803 are safe and they're well established.
This bill outlines some other procedures that are currently allowed by The Maine State optometry scope of practice, but it was put in this bill to resolve any ambiguity that could potentially pop up down the road. Optometrists have been performing

these.
Procedures that are in LD 1803 since 1990.
Without unforeseen complications to date, over 100,000 procedures have been performed by optometrists with the same education and training that I have and other optometrists here in Maine have. Now, these procedures could have complications, and while these complications are rare, these complications that come from these pro.
Are not unique to these procedures, optometrists.
Are used to treating very simpler complications, and we do this on a daily basis.
Within our current scope of practice, main optometrists have the training. We have the expertise. Should these complications arise right now here in Maine, we are patients are experiencing unnecessary delays, duplications and services and rising medical costs to receive care that could be provided efficiently in an optometrist's.
Office optometrist currently serves 92% of Maine's population across.
15 of the 16 counties.
3 counties have no ophthalmologist at all, and two of those counties only have one ophthalmologist, even if that county has one or few ophthalmologists, there's no guarantee that that ophthalmologist is the specialty that's needed to perform some of the procedures that are outlined in LD18O3.
There's also no guarantee that that ophthalmologist is accepting new patients to shed a little more light on the current status of ophthalmology here in Maine.
Earlier this year, there was an ophthalmology practice in Lewiston that closed, leaving patients scrambling for care.
There's a large ophthalmology practice with multiple locations that serves Bangor and northern Maine.
They've recently filed for Chapter 11 bankruptcy.
There are several ophthalmology practice that I've sent letters saying they're not accepting new patients and a large ophthalmology practice in central Maine stated that as of September this month.
They're no longer accepting new glaucoma patients.
Doctors of Optometry are the only local eye care providers for two main counties.
Specifically, this provides access to approximately 10,000 urban residents, 79,000 rural residents, while the one main county that doesn't have an optometrist also does not have an ophthalmologist.
And unfortunately that counts for about 17,000 rural residents without access to local

eye care.
Maine continues to be the oldest state in aging. The access to care for these procedures is only going to get worse as Maine's population continues to age. More than 22% of Maine's residents are over the age of 65.
EU.
The US Census Bureau estimates that that number will continue to grow more than 31% within the next five years.
This is the highest percentage of any state, and it's putting strain on our healthcare services, especially for treatments.
For common eye conditions that are associated with aging like glaucoma, glaucoma and cataracts.
Main currently has about 258 optometrists with an active license. Of those, 200 and 58239 practice in Maine, nine practice out of state but hold the main state license and at least 30% of those optometrists have taken.
Extra steps outside what?
Is outside of passing boards outside of licensing to show competency.
And advanced procedures like those that are outlined in LD 1803 in 2024, our organization, the main Optometric Association, surveyed members what their patients average wait times were for some of the procedures that were outlined in LD18O3. Depending on the procedure and.
The location within the state Maine citizens are having to wait anywhere from three to 18 months for procedures that could safely be completed.
Often within weeks.
By their local optometrists to add some perspective on this, because three months might not sound like a lot, but a few weeks ago I was at an Advisory Board meeting, which was comprised mostly of ophthalmologists, specifically cataract and refractive surgeons. And while this meeting was focused more about.
The pre and post care of the patient, the general wait time of what was considered an appropriate amount of wait time for some of these procedures that are in LDA 1803 was two weeks, right.
So 2 weeks is what's considered average and main is 3 to 18 months, right?
So a big discrepancy there. It's hard to pull specific data for national wait times because so much of the US has underserved areas just like Maine. And this is also why there's thirteen different states that have proposed optometry bills similar to LD18O3.

There are multiple articles from the Journal of the American Medical Association.
That show that the national ophthalmology workforce in the US is shrinking.
Projections show the ophthalmologist will decline by 12% by 2035, while the demand for eye care rises by 24%.
That's expected to be worse in rural communities like Maine.
So Maine is likely going to continue to feel the shortage now expanding optometry scope is certainly not going to solve this workforce crisis.
Alone.
But it's a definite, vital step in ensuring that mayors get the care that they need and that they deserve.
So LD18O3 should not be about competing professions.
It's about bringing safe, proven and efficient care closer to home for main residents, it's about updating Maine's law to reflect the current education and training of optometrists, while improving access to care and doing so in a safe and educated way.

14:05
Thank you jesslyn.
Fabulous presentation.
You're the first of the series so well done kudos to you.
We will now turn to the ophthalmologist representative to present their perspective on the proposed legislation.

JH **John Harris** 14:27
Hi there.
Thank you.
Thank you, Christina.
Thank you, Commissioner.
And thanks again to everybody for being here and apologies for my technical issues.
So tonight I'm here to expand on the testimony previously submitted in opposition to LD 1803 as a representative of the main eye physicians and surgeons, I have no financial disclosures, related industry, medical devices or pharmaceuticals to report that are relevant to LD 1803.
So msup's, which is the main eye physicians and surgeons shortened.
Our opposition is multifaceted to LD 1803.

It does send around a few core components, so access to care, lack of adequate educational training, and the complexity surrounding the surgeries requested in this bill.
The legislature last updated lodge regarding optometry in 2023.
And since then, there really have been no substantial changes in the education and training of optometrists that would justify the need to modernize outdated laws.
Mainers can be proud of the quality and timely access to surgical care available across our states.
Currently, many individuals do express concerns with access to General Medical eye care and it is essential to distinguish between.
These two very different issues.
So access to selected surgical eye care services as addressed in LE 1803, such as the laser and eyelid procedures and access to medical care, which is not meaningful, meaningfully addressed in this bill.
So Meseps argues that current access to surgical eye care in Maine is excellent.
The surgery is referenced in LD 1803 are already accessible, so 83% of Mainers live within 30 minutes of an ophthalmologist in 96.
6% within an hour, Maine currently has 76 practicing ophthalmologists in 14 out of 16 counties, and this coverage aligns with Maine's population density, the number of ophthalmologists in Maine also aligns with the national average of five to six ophthalmologists per 100,000 people.
In 2023, a national study found no improvement in patient access or drive times in states that do allow optometrists to perform laser eye surgeries.
As discussed in LD 1803, in fact in some states.
Patients were sometimes closer to an ophthalmologist than the optometrist actually performing the procedure.
The surgeries referenced in LD 1803 are also performed timely, according to a survey of Mesa's members completed this year, over 75% of ophthalmologists are able to perform to provide these laser eye and eyelid surgeries within a month of referral.
And lastly, the surgeries referenced in LD 1803 are non urgent and considered to be low volume.
These surgeries are typically needed only once.
Or maybe a few times in a person's lifetime, the number of 2023 Medicare Part B services performed in Maine for laser eye surgeries is as follows.
So these are the three lasers that are requested shortened YAG yad.

There were 2834 procedures.
For SLT, which is a glaucoma procedure, 192 and for LPI also a glaucoma procedure, there were 19.
This is compared to 41% of Americans who need treatment for near sightedness, which is usually treated with glasses or contacts, or the 3rd, roughly 38 million Americans with diabetes who need annual eye exams.
Surgical rates for the lasers requested in Lt. 1803 differ significantly across States and numbers of procedures.
Indicating that only a small proportion of the population requires these operations.
And furthermore, data shows that relatively few optometrists perform these procedures despite scope expansions in other U.S. states.
So, LDA 2O3 we feel is a solution in search of a problem. It proposes to address surgical access that is not currently lacking in Maine and expanding surgical privileges to optometrists is not necessary and poses serious safety concerns due to significant differences in training the OR.
Medications requested also carry the risk of significant systemic side effects and are not commonly prescribed by most ophthalmologists.
Hydrocodone prescribing privileges requested stipulate no annual CME.
Or prescription drug monitoring program requirements as mandated for MD's and DO's currently.
The training between optometrist and ophthalmologist is very different.
Ophthalmologists are medical doctors that complete four years of medical school and a four to six year surgical residency.
They receive 17,000 to 22,000 hours of clinical training on live patients under the supervision of experienced surgeons.
Optometrist hold a doctor of Optometry degree. After four years of education, which is mostly non-surgical and they receive limited surgical experience via short externships or lectures.
So very few optometrists actually trained to do the specific procedures requested.
Those that do receive training may consist their surgical training may consist of a 32 hour course using plastic models with no live patient experience.
And limited, if any, supervision by a surgeon.
On these surgical training standards would not meet our current accreditation of.
The the medical surgery standards that we have are HGME eye surgery is considered high risk, according to the American Medical Association.

Surgery includes any treatment that alters live human tissue, and this does include lasers and scalpels.
As you might imagine, eye surgery is invasive.
It is extremely delicate and it carries risks that do include vision loss.
It not only requires extensive technical skill, but clinical judgment and complication management, and we argue that these last two entities are in many ways even more important than knowing how to perform these procedures.
And it is the focus of a surgical residency under experience surgeons, again training that optometrists do not receive.
In a msubs member survey completed last year, if optometric expansion were to take place in Maine, members expressed concerns of poor diagnosis judgment.
That could result in unnecessary procedures or missed serious pathology maps.
Members also noted that complications with the reportable or not would likely need to be managed by an ophthalmologist who takes call after hours and this may put us also put a strain on emergency room resources.
A few additional considerations.
LD18O3 is an exclusionary bill that would actually grant authority for over 150 surgeries, including on minors, with no surgical oversight.
The Board of Optometry, which does not have surgical members, would control the expansion of any future procedures as well.
And there's an absence of any of an adverse event reporting system, which is also not mandatory in all states that allow optometrists to perform surgery. This fact makes evaluating the safety surrounding this expansion effort flawed. Ophthalmic state societies in Oklahoma, which was the first state to allow opt.
Laser surgery in 1998 in Kentucky in 2011 are aware of at least 11 cases reporting adverse outcomes, a few resulting in vision loss as a result of optometric expansion.
LD83 is part of the American Optometric Association's national lobbying campaign.
So if eye surgery were truly central to the future of optometry and public health, one might expect corresponding reform to optometric education on a national level.
However, only one of the five new optometry schools opened since 2020.
Is in a state that allows laser or eyelid surgery.
This disconnect suggests that leaders in optometric education are not aligned with the American Optometric Association's legislative push to expand surgical scope.
And to just clarify, the Veterans Health Administration does not allow optometrists to perform surgery.

This is referenced in the federal VA Policy Directive 1121-2, which does only allow ophthalmologists to perform these laser surgeries.
So access to medical eye care is a separate issue.
Meaners struggle with access to quality, routine eye care and LD 1803 again does not address the broader challenges related to medical eye care access, especially in rural areas.
Expanding surgical privileges without adequate training does not solve this problem.
So in conclusion, LD 1803 is a high risk proposal that offers no meaningful benefit to main patients.
It expands surgical privileges to providers who are not adequately.
Adequately trained and opens the door to future expansions without appropriate oversight and sets. Supports collaboration with optometrists, but not at the expense of patient safety.
Thank you.

24:00
Thank you doctor Harris.
We had requested in advance of this meeting if at all possible for the parties to submit data.
And some of the data that you we we in the last 24 hours received a lot of data we've reviewed it at a high level.