Transcript

October 27, 2025, 11:07PM

Meeting Hosts 2:58

Hi everyone.
We are so sorry about that mix up. We had switched.
It's not really platforms, but ways of running the meeting so that we would have only the presenters and not have to.
Worry about the admitting people, and apparently that didn't work.
Plus, we sent two separate invites so entirely on us. We apologize.
But because I can't see.
Everyone who's in the meeting and I want to make sure that the stakeholders have made it from the lobby and I'm going to do an old fashioned roll call.
So just stay present.
Well, actually I can see you.
Laura Green.
Yep. Yep. Michelle Harris.

nate harris 3:52

Yes.

Meeting Hosts 3:54

Ian Jones.
You're on mute, but I see you, Ian. OK, native Lighthizer.

Nate Lighthizer 4:02

Present.

Meeting Hosts 4:03

Did I pronounce that correctly?

Nate Lighthizer 4:05

You did.

RB **Meeting Hosts** 4:07
Yay.
Jesselyn quint.

JQ **Jessilin Quint** 4:10
Present.

RB **Meeting Hosts** 4:12
Linda Schumacher, Farrow.

LF **Linda Feero** 4:14
Here.

RB **Meeting Hosts** 4:15
And Pat Smith, sorry, Pat Smith.
He's both OK. James. Pat Smith.

SJ **Smith, James** 4:19
Yeah, I'm here.
Made it.

LF **Linda Feero** 4:23
Don't work.

RB **Meeting Hosts** 4:23
All right.

SJ **Smith, James** 4:23
Thank you.

RB **Meeting Hosts** 4:25
Thank you so much. Again, my apologies on technology.
We love it and it hates us sometimes.
Any rate, I'll go very quickly.

Hopefully we can make up for lost time.
Thank you again for joining for the second of the three planned LD 1803 stakeholder meetings.
I'm gonna kick us off tonight and then turn it over to my colleague, Christina Lunner, who will run the rest of the meeting.
I just briefly want to say Christina has been appointed my Deputy Commissioner, so she has a new role, same person.
But in any rate, she will run the rest of the meeting.
As a reminder, the HCIFS committee asked the department to convene a stakeholder group to facilitate a discussion on LD 1803, as amended and prepare a Sunrise Lake study report for the committee.
Just want to take a moment to remind participants of the ground rules we discussed at the last meeting, basically, which are on the website, but basically be respectful, listen and allow all stakeholders the chance to speak.
Speak. In addition, I want to remind all stakeholders to remain on camera and mute themselves. If you would like to speak, please use the raise hand function and then unmute yourself to speak.
Reminder to lower your hand afterwards, please.
Please do not use the chat function unless you're experiencing technical difficulties and then definitely alert us to that.
And finally, while DPFR was under no obligation to treat this.
Or future stakeholder meetings as a public meeting, we've chosen to make the meeting available to interested parties also for full transparency.
All non stakeholder interested parties can listen and watch the proceedings through the webinar link, but interested.
And they can observe.
They can listen, but they cannot be seen or heard.
This is primarily a remote meeting, but pursuant to the Commissioner's Office.
Remote participation policy, which is on our website.
We do have a public location at our gardener office in the event someone does not have the technology to participate remotely.
No stakeholders are present at that location.
So as the agenda reflects, today's meeting is to focus on the proposed procedures in LD 1803 as amended.
And patient safety.

We appreciate the stakeholders efforts to collect and present information.
We are going to be moving through these topics pretty quickly and we also provided a 15 minute open forum at the end for stakeholders to ask any questions.
Share comments etcetera.
We are going to stop screen sharing now and do very brief introductions.
As I said, I'm Joan Cohen.
I'm the Commissioner of the Department of Professional and Financial Regulation.
And I'm joined tonight by my deputy Commissioner, Christina Lunner. Misty Robinson, who's running our technology, and Tyler Robinson, who's also helping with technology and attending the reception area. I'm going to turn it over to the stakeholders to make brief, very brief introductions.
Pleased to say your name and what you represent.
There's no need to state whether or not you have a conflict of interest.
I know some people did that last time.
All stakeholders are invited here as representatives of their profession.
So we'll start with Doctor Gleaton and we're going to go in alphabetical order.
Believe it or not, G is the beginning of the alphabet of the stakeholders.

GS **Gleaton, Maroulla S** 8:16
Hi, I'm marula gleaton.
I practice ophthalmology in Trenton, Maine, and I'm the immediate past chair of The Maine Board of Licensure in Medicine, and I'm representing them at this meeting.

RB **Meeting Hosts** 8:26
Thank you, doctor Greens.

LM **Laura Green, M.D.** 8:29
I'm Laura green.
I practice in Baltimore, MD.
I am the immediate past President of the Accreditation Council for graduate medical Education Ophthalmology Review Committee.
I am also a member of the Board of trustees of the American Academy of Ophthalmology and of the ACG ME and I'm representing my own personal views.
I'm not representing any particular organization.

RB **Meeting Hosts** 8:54
Thank you, Doctor Harris.

NH **nate harris** 8:57
Hi, I'm Michelle Harris.
I practice in Brunswick and I'm representing The Maine Society of I physicians and surgeons.

RB **Meeting Hosts** 9:05
Doctor Jones.
Oh, you're on mute.

I **ianjonesod@gmail.com** 9:15
Sorry, with that Ian Jones.
I'm an optometrist in Bangor.

RB **Meeting Hosts** 9:20
Thank you.
Doctor Lighthouse heiser.

NL **Nate Lighthizer** 9:25
Nate lighthizer. I'm an optometrist in Tahlequah, OK, representing the the main optometrist and then academia.

RB **Meeting Hosts** 9:34
Doctor quint.

JQ **Jessilin Quint** 9:36
Hi, I'm Jessalyn quint.
I practice optometry in Augusta, ME and I'm the current president of The Maine Optometric Association.

RB **Meeting Hosts** 9:45
Thank you, doctor Schumacher.

Linda Feero 9:48
Hi Linda fioreau.
I'm a comprehensive ophthalmologist.
I practice in Augusta.
I am a past President of The Maine Society of Eye Physicians and surgeons.

Meeting Hosts 9:56
And doctor Smith?

Smith, James 9:59
Hi lo I am Pat Smith.
I am the chief of Optometry for the VA Maine healthcare system and I am representing The Maine State Board of Optometry.

Meeting Hosts 10:09
Excellent. Thank you so very much.
I'm gonna turn this over to Christina.
Good evening everyone. As the Commissioner noted, we have got a full agenda and we're gonna jump right in the first we have 3 topics that we're gonna cover.
Tonight, we've asked opponents and proponents to be prepared to present 10 minutes on each of those topics.
We'll have 5 minutes of Q&A after each presentation.
And we're gonna start immediately with.
Proposed, authorized and unauthorized procedures proponents Europe give you 10 minutes.

Jessilin Quint 10:49
Awesome. I'll be taking this. Is it OK if I share my screen?

Meeting Hosts 10:52
Yes.

Jessilin Quint 10:53
All right, let me get that set up.

And.
Can everyone see that?

RB **Meeting Hosts** 11:03
Yes.

JQ **Jessilin Quint** 11:04
Awesome. Thanks.
So I'm kicking us off to really talk about what exactly is in LD 1803 when this bill was first proposed, it had only exclusionary language, meaning we listed out everything that optometrists would not be allowed to do. And we thought that was clear. But when we.
Introduced it, we realized that some people weren't too certain.
And so there was an amendment that was made before the public hearing, but then listed everything that optometrists would be allowed to do in addition to what would be specifically excluded if we look at that Bill amendment and we look at LD 1803 as a whole.
We see that the procedures that are allowed are. There's really only seven specific procedures.
These procedures, they're very limited.
They're very specific.
So we're going to walk through each of those.
The the first one is removal of benign skin lesions.
What's a benign skin lesion?
Something like a skin tag like you see in this top photo here, as well as the removal of a shalazi and a shalaisian is just a sty or clogged oil gland.
Which you can see in this bottom photo.
Here you can see that both the skin tag and and the sty can cause a lot of patients some discomfort. And so the point that we get to the point of removal of one is usually when eye is an optometrist, have already exhausted all of my other in.
Office procedures. Topical pharmaceutical agents to to move this kind of condition along. The risk for this procedure is considered very low because.
It's only involving superficial tissue.
Any risk that can happen is really aligned with other in office procedure risks at optometrist.

See every day, urgency is very high. As you can see that these can cause some discomfort to patients can also impact vision. And so when it's time to remove them, why make a patient wait?
Currently wait times for these procedures here in Maine are 12 to 18 months for a consultation, and then usually several months after that for when these.
These lesions are removed.
Very high or moderate frequency to statistically we see about 21% of patients are at risk for developing a stye and about 50% of adults are likely to experience a skin tag within their lifetime.
These are the CPT codes.
These are the CPT codes for the biopsy if needed for those lesions.
The second procedure in LD 1803 involves injecting a steroid into a stye so as you can see that sty is hot and inflamed and so a steroid shot essentially can make that inflammation go down.
Make that bump go away. This risk for this procedure is very low.
It's a, you know, doing the shot into that stye carries no greater risk than other in office procedures that optometrists currently have very high urgency.
Frequency is moderate. If left untreated, this can cause a lot of patient discomfort.
Pain can even distort the vision.
These are the CPT codes for that steroid shot.

RB **Meeting Hosts** 14:03
OK.

JQ **Jessilin Quint** 14:04
The third procedure in LD 1803 involves corneal collagen crosslinking, so this is a treatment that's used to treat keratoconus.
Keratoconus is where the clear part of the eye called the cornea.
That's the clear tissue that covers the colored part of the eye, often becomes cone shaped and can thin for patients. This means vision impairment. And So what?
Corneal collagen cross linking done.
There's a couple different types.
But essentially, you add some vitamin B12, a solution you cure it with the UV light to essentially kind of reshape the cornea to improve the patient's vision. Very low risk, especially with all of the advances in the automated technology that we have,

especially with Epiom Pro.
Very low risk, but very high urgency.
Keratoconus is a site threatening condition and if progresses can have a real impact on a patient's life.
Moderate frequency.
Keratoconus infects one in 667 patients.
The 4th procedure is involves a sub conjunctival injection, so the conjunctive is the clear tissue that sits on top of the white part of the eye and a sub conjunctival injection means applying medication just beneath that clear tissue above the white part of the eye. So this would.
Be used if the eye is inflamed.
And if it has an infection and this is a procedure of what it looks like, and you might see ah, scary needle syringe. But that same size needle and that syringe is something that I use an optometrist every day, especially for a treatment called lacrophil, which is where.
You put hyaluronic acid into the gel, into the punctum to cause punctal occlusion to to help the ocular surface.
So again, tools that I use every day.
A sub conjunctival injection has very low risk.
Has very high urgency and is considered moderate frequency.
The 5th procedure allowed an LD18O3 is a gag capsulotomy.
So this is an in office minimally invasive laser procedure that is used to clean the film off of an implant after cataract surgery.
So after when that film starts to grow on the implant that is put in at cataract surgery, that can really impact a patient's vision, making it so that they can't drive, they can't perform their daily activities.
Their they're unable to see.
And so this YAG procedure helps clear that off.
Very low risk.
This does not involve any incisions.
The actual procedure only takes a couple of minutes, very high urgency when a patient can't see.
That's a problem, right?
And so making a patient wait months for a referral for a consultation for one of these can have a real impact on their daily life.

Very high frequency.
Statistically, we see about 50% of patients that have cataract surgery will end up needing a YAG capsule out of me.
If we look at what this procedure looks like, you'll see here this is a procedure of it's done in an office. It's done behind a microscope called a slit lamp that I use every day.
There's no blood here, right?
There's no bloody tent around it.
This is done in a very in office minimally invasive way. Sometimes our ophthalmology colleagues like to use describe this laser as micro explosions, and while that description definitely makes it sound more exciting than it actually is.
The reality is that Microexposure is a very cinematic and dramatic description for what is actually happening with this procedure.
So this procedure uses focused energy pulses to separate the tissue at a Micron level in a very controlled, not in a chaotic way. But when we clean off the film, as you can see in this bottom photo here, it helps open that up and help clear up a.
Patient's vision.
The six procedure in LD 1803 is a YAG peripheral iridotomy which involves.
Using a YAG laser to create a little opening in the iris, the color part of the eye to essentially lower the eye pressure.
Very low risk.
Again, this is a minimally invasive procedure.
That's done in the office.
It is considered high urgency because when a patient needs it, they need it to prevent or further prevent a closed angle glaucoma, moderate low to moderate frequency.
Luckily, we don't see this a ton, but when a patient does need it, it becomes a very urgent situation.
That eroded me procedure with the YAG.
This is what it looks like.
So again, not done in an operating room, not done in a surgical center.
It's done behind the slit lamp.
It's done with lenses that I use everyday, seeing patients currently within my practice here in Maine.
The 7th procedure is a selective laser trabeculoplasty which involves targeting

pigmented cells in the drainage system of the eye to lower the eye pressure.
This is becoming a first line treatment for glaucoma.
There are numerous studies and the new research really does indicate that recently an ophthalmology group here in Maine actually hosted a big education webinar talking about how this is first line therapy. And so this is a laser procedure, but it has a very low risk for any complic.
Any complications that can arise are complications that are not unique to this procedure.
There complications that optometrists already treat.
Every day very high urgency and high frequency when a patient has glaucoma, they want to be able to have access to first in line treatment and currently in Maine this is not readily available.
This is what an SLT procedure looks like in the office.
So again, behind a microscope that I use every day using a lens that I use quite frequently, what procedures are not allowed in LD 1803?
So this is, you know, a pretty long list of things that are not allowed. But specifically I want to call out some of these procedures, right.
So if we see any of these photos, that's probably a clear indication.
That's not something that's gonna be allowed for optometrists to do an LD 1803. So optometrists will not be authorized to perform LASIK surgery or cataract surgery or intravitual injection, which means putting a shot into the eye, piercing the globe, or things like a corneal transplant. These.
Are all things look at how these are done in an operating room?
There's blood with these eyes.
These are done in a tent.
These are not procedures that are going to be allowed for an LD 1803 for optometrist to do any sort of retina surgery. If we go back to the list there's you know quite specifically implants vitrectomies, right?
So these are all very advanced seizures that are reserved for ophthalmologists, not optometrists. At this point in time.
These are currently the states that allow we call it lumps and bumps.
That's removal of like the skin tag and the sty within the eye.
These are the states that currently allow laser procedures.
Those would be things like cleaning the film after.
Cataract surgery, or SLT as first line treatment for glaucoma.

That's just a list of kind of breaking it up of which states have which or both. And again, you know in the stakeholder questions, it was like what are the pros and cons? Well-being very transparent is a real benefit.
We presented this bill to be very intentful.
We weren't trying to slide anything in.
And so that's why the amendment was made.
But of course, whenever we list very specific things out, it is very inefficient and sometimes it doesn't allow for new technology or new treatments as they emerge.
And that is all I have. I'll take any questions.

RB **Meeting Hosts** 21:57
Thanks, doctor quint.
Questions with regards to what was presented, any initial reactions?
Doctor Faro.

LF **Linda Feero** 22:10
Thank you.
So I'm a little confused.
You said that this is specific procedures and you listed 26 CPT codes and then you said there's this really long exclusionary list of maybe 12 things, but there's still about 125 things.
That aren't on the exclusionary list and that you didn't talk about.
Are you saying that you only want the 27 things or 26 things that you discussed today?
And everything else is excluded.
Or are you saying that there's an exclusionary list of just 12 things?

JQ **Jessilin Quint** 22:45
So.
So if you look at, yeah, great question.
So there's if you look at the bill, LD 1803, right?
You know on pages 1/2 as we kind of go through that that list very specifically everything that optometry would be allowed to do.
So it's only within those procedures to make it extra clear and to take it a step further.

So there was no confusion.
There's no ambiguity.
There's no question.
We also listed very specific exclusionary things.
To just kind of clear up any miscommunication or confusion that would be out there.

Linda Feero 23:21
So that actually actually makes it more confusing because I'm still confused here and I'm sure probably everybody else is too.
So do you have an exclusionary list with things listed on it and everything else is fair game? Or do you have a list of 26 CPT codes that are allowed and everything else is excluded?

Jessilin Quint 23:42
All I have is the bill here, and if you look at the bill under section two, number two practice of optometry between.
A and T.
Those are all the procedures that very specifically would be allowed to be performed.
So I guess I don't understand.

Linda Feero 24:02
OK.

Meeting Hosts 24:02
Can I just con?

Linda Feero 24:03
So that's a list of about 150.
Not the 27 that you.

Jessilin Quint 24:06
1.

Linda Feero 24:08
That you presented today.

Jessilin Quint 24:08
You're talking about 150 what CPT codes?

Linda Feero 24:11
CPT codes.

Jessilin Quint 24:13
Well, because I've seen the list that sometimes a lot of those CPT codes are already currently allowed under optometry scope.
So if we want to, you know, include that in addition to what's currently, this is an an amendment in addition to what the current scope or practice is here in Maine.

Linda Feero 24:29
Yeah, you've got a a few things that you're allowed to do, but they're still over 125 procedures. So, OK, I think I understand now that that the, the procedures that you talked about tonight are not the entire list that you're asking for.

Jessilin Quint 24:44
No, you're mishearing me the entire list and why I presented it is exactly those seven procedures.
Those are the only ones that are going to be allowed, so you know so.

Linda Feero 24:54
OK.

Jessilin Quint 24:56
So it's very specific.

Linda Feero 24:56
So are we striking?
The exclusionary list is that what what we're talking about here?

Jessilin Quint 25:01
We're not.

We're keeping exactly how it is verbatim written.
We're not changing anything with this bill.
It specifically lists what procedures are included, specifically what is excluded.
It's very black and white.
It's very black and white.
I don't know why you're trying to make it.
How much more black and white can you get?
Can you be when you say this is what we want to do?
This is exactly what we don't want to do.

LF **Linda Feero** 25:26
OK.
Well, maybe. Maybe what you should do is make a list of all the CPT codes that you think you are allowed to do. That would make it much clearer.

JQ **Jessilin Quint** 25:36
We did that and I presented those on the PowerPoints and we did submit that to the stakeholders.
So we we did that.
I'm sorry if you're having a difficult time accepting that those are the only CPT codes that we want to do.

LF **Linda Feero** 25:48
I.
I guess I just don't.
Don't understand why.
Why there's such a discrepancy?

RB **Meeting Hosts** 25:53
I'm gonna jump in here, so I think it this might be something that we say for a later discussion or even some in between meeting offline discussion.
Yes, things are black and white, but people are reading them differently.
And there may be very valid reasons why you know for that.
So I'm gonna suggest that we move on, but we have made note that we need to find a way to we may we may not get an alignment on what should be.

Proposed, but we need alignment on what we are proposing and it sounds like we aren't there yet.
So, Commissioner, anything else?
No, I was.
I was actually thinking that perhaps.
As a follow up, we could.
Have all of the items you know the 125 + 8 or something like that?
My math is bad, but identify, you know, Doctor Quint, what you think is currently within your scope in that list.
And.
We can just make sure that what's on that long list.
That there's clarity.
What you believe already is within the scope and what is being proposed.
Well, we'll work on that.

JQ **Jessilin Quint** 27:14
Yeah, we, we we can definitely you know we can definitely submit that.
I think that's why we wanted to clear that up is because there is miscommunication on that right.
There's there's this thought on the other side of trying to include more CPT codes and that's certainly not the case.
And so I also don't want it to get dramaticized, you know, in, in another direction and to not have very accurate CPT code.
So we did submit those within the stakeholder document, but we can submit that again if that would be helpful.

RB **Meeting Hosts** 27:43
And I think I'm just going to jump in before Doctor Fiora.
I think perhaps it's statutory clarity that might be needed, because if there's a difference in interpretation of how the statute would read and would allow certain procedures or not.
Then you know then that calls for some clarity, Dr. Ferra.

LF **Linda Feero** 28:07

Thank you. I would like to ask for a definition of urgent because what I define as urgent and what Doctor Quint defines as urgent don't match either.

RB **Meeting Hosts** 28:19
OK, we can.
We can try to seek alignment on that.
We may not know that we can.
If that wasn't clear, in the request, we can make sure that we share that doctor Glaton and then we'll move to the opponents presentation on this topic.

GS **Gleaton, Maroulla S** 28:42
I think it also might be helpful for her to define risk.
Buckets of risk and maybe percentages would be even more helpful.
Thank you.

RB **Meeting Hosts** 28:55
Thank you.
OK, that gets us.
To.
Opponents of LTLD 1803.

NH **nate harris** 29:08
Yes, good evening again.
Thank you, Christina and Commissioner Cohen, once again for allowing me to speak on this important topic.
Linda, were you going to pull up the slides? You're working on it there.
Thank you.
So tonight we're focusing on surgeries included in this bill and most importantly on patient safety.
So we just heard a detailed presentation from Doctor Quint regarding the types of surgeries being considered.
And now I'd like to fill in some blanks.
But first, some perspective.
On what's going to be important in assigning risk assessment with regards to the surgery.

So kind of what?
Doctor Leighton just mentioned it's important to keep in mind that we're discussing surgery to a very tiny, intricate organ that is essential for one of our most important senses. The eye is about an inch in diameter and you can think of it like a soccer team. It has.
About 11 key players, but in reality it's far more complex with over 2 million working components.
A few critical players, so to speak.
To keep in mind, these can all be damaged during the proposed surgeries.
The macula is the most important part of the retina, which is the layer in the back of the eye.
This area is only about 5mm across, which is roughly the size of a grain of rice. It is solely responsible for sharp, detailed vision of how we define our world.
The optic nerve is basically an extension of the brain, and it carries signals for interpretation.
This is damaged in glaucoma or cases of.
Sustained elevated eye pressure and then lastly the eyelids.
They are the thinnest skin on the body.
They measure about 2mm thick and this is about the width of two pennies.
Because.
The eye is also an end organ, which means it relies on the body's tiniest blood vessels for oxygen and nutrients, and ophthalmologists work on a microscopic scale, measuring structures in microns, which is one thousandth of a millimeter.
So there's very little room for error here.
So tikka a little bit more brief, more in detail.
About some of the details of these procedures with regard to the three laser eye procedures being discussed, these are very specialized and they do target precise structures in the eye.
Yes, they are done in the clinic and using a slit lamp that has a laser attached to it.
Both optometrists and ophthalmologists use slit lamps everyday to examine eyes.
So it is easy to assume that doing laser surgery is low risk.
But that is not the case.
Each laser surgery uses tiny bursts of energy to cut or open specific areas of the eye, and lasers are surgical tools.
And considered invasive surgery that carry the risk of some serious complications.

So let's talk a little bit more about these risks with YAG capsulotomies.
Creating an opening in the thin cloudy membrane behind the implanted lens at the time of cataract surgery.
The membrane is only about 3 microns.
Thick, so think of a spider web and oftentimes with the natural healing course. This membrane will stick to that intraocular lens.
Causing a risk of damage to the the lens during the procedure.
So here you see a picture of pitting on the lens which causes visual disturbance and may need to be explanted in the operating room in order to restore this patient's vision.
In addition, the retina can be damaged with this procedure.
It's rare, but it can happen.
The good news is that this laser treatment is usually only needed once in a person's lifetime.
And it is almost never urgent.
For laser peripheral iridotomies or lpis, these are performed for types of glaucoma.
Two major types, angle closure glaucoma, which is an emergency, but lasers or lpis for this condition are extremely challenging with high risks of complications such as bleeding in the eye, which can require emergent surgical EV.
And operating room.
Or the other.
Indication anatomic narrow angles.
These are almost never urgent and often times are observed in cases where there is a clear indication, most ophthalmologists are preferring cataract surgery in lieu of LP eyes, of which this is one of the excluded procedures on the optometrist list.
Can you go to SLT?
This is also a treatment for glaucoma. I'd like to highlight that it targets a specific area of the eye called the trabecular meshwork.
Angle umm this area is very difficult to view.
Umm it's it's viewed with a mirrored lens that is placed on the eye called gonioscopy.
And I have a picture of what the trabecular meshwork would look like if you if you just Scroll down here.
So this is a kind of a textbook view of the angle of the eye, but this is this is not the reality. Most views in the clinic, if you go to the next slide here.
Look like this.

So the point here is that although the procedure may be considered technically simple.
The diagnostics and the techniques to make sure you're treating the proper location can be very, very challenging.
And this fact was cited in a somewhat recent Optometry journal stating that.
Because of its challenging.
Nature. Most optometrists.
Will will stop performing this over over time.
Ophthalmologists end up mastering this this skill during residency.
It's not only used for performing SLT lasers and diagnostic exams in the clinics, newer procedures like microinvasive glaucoma surgery or Migs.
Are are kind of the on the forefront of glaucoma care?
These are performed in the operating room.
So like the other procedures, SLT also has risks.
And these do include.
Elevated eye pressure, inflammation, corneal abrasions, or even damage to the retina and in some types of secondary glaucoma, SLT can actually make things worse.
So if you're not very strong on the gonioscopy skills and determining which types of glaucoma you're treating, you could actually cause more harm.
Again, SLT is also not considered urgent.
And in Maine, Medicare data from 2023 shows that 192 SLT procedures were performed so relatively low volume.
So in office eye surgery is also delicate and precise.
Ophthalmologists are trained under direct one-on-one supervision to ensure that they can perform it safely on live patients. And actually this applies to the laser surgeries as well.
So you will hear about the training for optometrists through practice on plastic eye models and we do not consider this an adequate substitute for hands on experience to perform these procedures.
Safely.
To expand on the in office eyelid procedures that are being requested, so removing skin growth, treating styes or tulazia, or injecting kenalog which is a steroid.
These all involve a needle.
Again, keep in mind that eyelid skin is very, very thin.
So high risk of perforating the eye if not performed correctly and it's important to

note that most family physicians.
In some dermatologists, actually.
Prefer to refer these procedures to ophthalmologists because of the delicate anatomy in the eyelids.
Oftentimes, if you, if you look at this example showing a chalazione excision, this is a little bit more traumatic to a patient than they may realize.
So it's actually not uncommon to have patients experience vasovagal responses so low blood pressure.
Have I've had people lose consciousness?
And you want to be really cognizant of people.
That would be at risk.
Of things like heart attacks or falls, specifically older patients, which is typically our our patient population.
Again, the good news is the vast majority of do resolve and don't need any surgical intervention and in.
Can you just Scroll down there, Linda for me?
OK, I have I have Medicare data.
Later that I'll I'll point out to you for subconjunctival injections. Again, this does this involves placing medication adjacent to the eyelid wall underneath the the thin tissue called the conjunctiva, again using a a very sharp needle.
So risk of puncturing the eye is very possible and really not equivalent to using a blunt cannula for injecting lacrophil as as pointed out.
Additionally.
Medications that are placed against the eyewall if they need to be removed, they need to be surgically removed so they are are considered semi permanent.
So this shows 2023 Medicare data in Maine for with the numbers of procedures performed. So cataract surgery on the far left here.
Was by far the.
Procedure and then roughly a third of those patients needed yags and then you can see the relatively few number of patients that needed SLT LP is cheaper or even subconjunctival injections.
This is a a big topic to cover in 10 minutes and I see I am getting close to to time. I just want to point out on corneal cross linking.
This this is a very specific procedure.
One indication is keratoconus.

Very, very rare.
It affects less than 1% of the population and of those people, excuse me, affected.
Only about 20% might ever need surgical treatment.
This is not an urgent procedure and most surgeons that are performing this are tracking patients over long periods of time, years using specialized equipment to monitor corneal progression and this is typically performed by cornea specialists. So most ophthalmologists do not perform corneal crosslinking.
There was no data on the number of procedures performed.
In Maine for 20/23.
So I'd like to just conclude by stating that in question 1C.
There the the question asked. Describe the benefits or challenges to listing specifically authorized or unauthorized procedures in statute.
We just had a discussion on this being an exclusionary bill and you know, the field of ophthalmic surgery is always changing.
New tools and techniques come out all the time.
Some end up being more safe or effective than others, so figuring out the best approach for a particular surgeon or patient is not straightforward.
So this bill would allow optometrists to perform some of these new procedures because of its exclusionary nature. And that is extremely concerning.
And I am out of time, so I will.
I will end there. Thank you.

RB **Meeting Hosts** 41:06
Harris.
5 minutes for Q&A. Things that came up that were of particular interest or you would welcome further clarification.
Areas of disagreement.
Doctor Jones.

I **ianjonesod@gmail.com** 41:31
Just a question about the SLT, because in in your your what you were talking about, you said that the the.
SLT isn't really performed much here in Maine.
Is is that more because ophthalmologists aren't doing it or are not choosing not to do it?

Because if it's a first line of treatment, I'm wondering why that is not really a procedure that is done that often in in our state.

nate harris 41:58
Well, that was Medicare 2023 data. So I can't say that that you know applies to all patients, but I think what's more important is just the proportions.
So the ratios it it is, it is not performed you know nearly as much as say cataract surgery for example or yeah capsulotomies.

Meeting Hosts 42:25
Doctor lighthizer.

Nate Lighthizer 42:27
I'm just stating my opinion here. I think one could argue that it should be done more often.
We all have patients, whether you're an optometrist or an ophthalmologist that struggles with compliance. If you treat glaucoma at all, you have patients that struggle putting in their one drop or two drops or whatever it is for glaucoma, SLT. There's no ifs, ands, or buts about. It has been proven as a first line therapy.
And optometry treats glaucoma. First line.
The reason that that number is so low.
In my opinion, in Maine is your first line. Treatment providers are not allowed to do that.
There it has to be referred out, which for many patients that's not convenient and therefore they're being forced to put on an eye drop. The other point I would make out is this SLT and this difficult view. I've done thousands of SLT's here in Oklahoma, you know.
SLT is evolving tremendously. It is.
A fairly flexible and forgiving procedure.
Focus energy tremendously variable depending on the procedure to the point there is now a version of SLT called DSLT or direct SLT that doesn't even involve a lens on the eye and it just fires it right on the ocular surface.
So some of the leading glaucoma ophthalmologists out there have literature on the flexibility, the forgiveness, the energy, the focus, the placement.
You know, it's it's overly not critical in the vast majority of these procedures.

Certainly you want to perform this in the correct way, but the my my point is, is the flexibility of this procedure and the different applications bring a tremendous amount of benefit to patients?

RB **Meeting Hosts** 44:10
Thank you.

NH **nate harris** 44:12
Yes, just.

RB **Meeting Hosts** 44:12
Doctor.
Doctor Smith, then Doctor Harris.

SJ **Smith, James** 44:18
Hi I appreciated the presentation from both sides on the procedures involved and I understand that there are risks involved, but I it was was apparent to me there was no description of the actual complication rates for any of the procedures and I'm wondering if if that date is.
Not available, or if there's if, it should be reviewed.

RB **Meeting Hosts** 44:42
Thank you.
Doctor Harris.

NH **nate harris** 44:48
Yes. So doctor Leithiser, just to address the SLT comments, you know SLT is not a one-size-fits-all treatment for glaucoma.
And you know, there are lots of nuances that go into the decision to provide treatment.
I I will say that we we conducted a survey this year of our Members regarding scope expansion.
We allowed a a section for just kind of comments.
And the most common comment we received was.
Concerned for over treatment just based on some of the referrals for surgery and

and a lot of those concerns did stem around requests for SLT and and we provided testimony from glaucoma specialist who is now retired stating in his career you know he he's he's seen quite a.
Number of of requests to perform SLT in in. In his opinion, he felt.
You know the indication.
We're not clear. A lot of the time.
With regard to the direct SLT, that is very new technology.
The efficacy is still questionable and we also don't know the ramifications.
There's a lot of energy that is kind of sent anywhere, but to the to the targeted tissue, you know, where is that going?
What is the effect on the cornea with regard to complication percentages?
Doctor Smith.
Yes, that that could be more comprehensive to include that.
I I did not include that because I I think just thinking it from a patient safety perspective.
To a patient, they they really don't care if the risk is 1 or 99%, if it, if it happens to them and they don't feel like the person doing the procedure received the adequate training or didn't have the background, you know that.
That usually doesn't sit very well.
So you know, when I discuss risks with patients, you know, I I have to take into consideration what is my level of training, what is the patient's condition, you know and and what are we, what are we?
What are we looking at here as far as levels of success? That's gonna vary also in the hands of each provider.

RB **Meeting Hosts** 47:10
We are at overtime.
Doctor Faro, would you like to jump in quickly or is this something you can wait till the open forum time?

LF **Linda Feero** 47:22
I can wait.

RB **Meeting Hosts** 47:24
OK.

Great. Thanks.
All right, great discussion.
Want to move on to the second topic that's obtaining and maintaining proficiency?
This has come up earlier.
Now is the time to focus on it.
I'm going to turn to the proponents.
And give you 10 minutes to present on.
Proficiency.

NL **Nate Lighthizer** 47:57
Sounds good. I think that is me.
So I'm gonna share my screen here.
And.
Can you guys see my slides?

RB **Meeting Hosts** 48:07
We can.

NL **Nate Lighthizer** 48:09
OK. Again, I appreciate the opportunity to present and and have this very respectful professional dialogue on both sides about these in office procedures of optometrists in Maine.
Obviously both sides feel very passionate about their side and just wanna present kind of my experience.
Over the course of the last 16 years, doing these procedures in Oklahoma, both myself and supervising students, residents and traveling all across the country to all of those states that have laser procedures and injections.
So obtaining education, training, and proficiency, I'm talking optometry school here.
First, students today in optometry schools receive training on those procedures.
Those seven different procedures that.
Doctor Quint talked about whether it's YAG, capsulotomy, SLTPI, shalazian eyelid lesion removal, et cetera. During the four years of training.
Know this your during your optometry school.
Really, it starts in the classroom. You have classes, you have lectures, you have multiple semester courses, just like medical school, dental school.

You learn something in the classroom from experts watching videos, taking tests. But that's where it starts.
Understanding the theory, how things work, etcetera, then you have practical hands on lab training and our students get extensive practical hands on lab training again during during laboratories where they're working and learning the knobs and the buttons and the settings.
And here's how SLT works.
And here's how a YAG laser works for capsulotomy.
Or iridotomy or whatever it is.
And you start again. You'll notice there's not even a model I in this one.
This is just.
A piece of a of a business card firing at an eye as they're learning the knobs.
And the buttons and the settings and and how this works and that's the. That's the intro labs that they go through and that progresses to these model eyes that are made by an ophthalmologist. And I have multiple resources showing that ophthalmology trains on these simuli model eyes whether.
It's yag capsulotomy pislet.
Here's a couple of our students doing simulated SLT's on on model eyes and very realistic model eyes, again made by ophthalmology.
I know ophthalmology trains on these and it's again it's a part of the stepwise process to learn these procedures. So you start going back to the slide with Intro Labs and learning how the laser works.
Again, it's just like a slit lamp.
You learn the knobs, the buttons, the settings, and you go to to modelize and you're practicing your technique and gonioscopy and all that good stuff. And so that's where that starts.
And then our students are tested on both of that. They have written tests, they have proficiencies where they have to sit down in front of a laser.
And demonstrate proficiency in front of an attending doctor as they were just about to do the procedure. Then it moves on to treating patients in the clinic.
I was in laser clinic this afternoon and we had 13 patients scheduled this afternoon for YAG, CAPSULOTOMIES and SLT's and and procedures like that. Tuesday mornings I'm in OD surgery clinic optometry surgery clinic.
We're removing eyelid lesions, the skin tags, the chalazions, so they're actually doing this on patients and here you can see.

Some of our our students here doing.
Eyelid excuse me? Laser procedures.
There's a laser procedure, and here's a laser peripheral iridotomy.
And here's a an SLT again, doing these different procedures so you know you go through the different steps. This is just like medical school.
I would like to think our ophthalmology colleagues would agree. It starts in the classroom.
It goes to the laboratory.
Hands on training.
You're probably tested on both and. Then you do procedures.
Under the supervision of attending doctors as they're going through optometry.
Similar and analogous to dentists, you know I would.
I would, you know, dentists go to four years of dental school.
They don't go to medical school, they go to four years of dental school.
And yet your dentist, at least our dentist in Oklahoma, my brother-in-law in North Dakota, does all sorts of in office procedures injections after his four years of dental school.
So why can dentists do go to four years of dental school and do a wide variety?
Of in office procedures.
And yet, optometrists go to four years of optometry school.
And their question continuously about the procedures that they can do. So again at our school.
They are extensively trained at these 4 levels and doing procedures, doing procedures there.
So, you know, we're very fortunate that we're in Oklahoma, where our law allows our optometry school to do YAG, capsulotomies and SLT's and eyelid procedures, you know.
Your closest schools in Maine.
There's a couple in Massachusetts.
Sunnis in the northeast as well, so your closest three or four doesn't have a law that allows them to do that.
And I've heard the other side respectfully say, well, we can't change the law 'cause you're not properly trained.
Well, they can't get that 4th. We can't update the law because they don't have the proper training.

Well, you can't get the full proper training that that fourth step when the law doesn't legally allow them to do that in Massachusetts.
Well, we can't change the law because you don't have the proper training.
Well, you can't get the proper training 'cause the law doesn't allow it and you go round and round and round and round again.
So again, what we're fortunate in Oklahoma and Kentucky and and Indiana and a couple of the other schools where we can actually do these procedures and we take externs from a wide variety of of schools where they send externs to us to do these procedures. But again when.
The law doesn't allow them at their optometry school.
They can take it in the classroom.
They can do the laboratory hands on training.
They can be tested on it, but you can't get that final step during school of actually doing live procedures.
So that's during school.
So when I'm, you know, during school, going through optometry school, well, what if a doctor graduated 25 years ago?
You know, again this is this is me doing a procedure here and just showing that which has already been established.
It's a slit lamp like laser. The skills that you utilize, I promise you they are slit lamp skills.
They're gonioscopy skills, and they're differential diagnosis skills of knowing when to do a procedure, knowing when not to do a procedure.
What are the pitfalls?
What are the risks and the more you do something, the better you get at it. The more you do cataract surgery.
Our surgeons, I would.
I know they would.
Would admit that they're better on cataract surgery after doing 100 than they are on their first one.
And they're better after doing 1000, then on their 100th one and the same thing is true for foreign body removal, for laser procedures as well.
But what if you graduated 25 years ago?
You know, education continues.
After you graduate after your formal training, whether you're a dentist.

A pharmacist, a medical doctor.
We have training courses all over the country and our ophthalmology colleagues are not locked in to only doing what they could do on the day they finish their formal training, medical school and residency.
How did you add LASIK to your arsenal or Migs or intravitreal injection or whatever it was?
Well, you just started doing the procedure.
You had the laser Rep kind of show you how to do it, or you took some.
Continuing medical education, you went to a weekend course.
And Optometry is doing the exact same thing.
You know, I'm. I had our our 32 hour advanced procedures. Course we've been to 37 different states to put this course on this intensive 32 hour training course.
And you know from one of the laser reps at this course who attended for the first time.
Works extensively with optometry and ophthalmology, so that's the best SL treat T training that I've ever seen before.
And again, he has a extensive experience with both optometry and ophthalmology.
We worked with an ophthalmologist.
We did the course in the UK in December of 2021.
An ophthalmologist and he goes, you know what?
I wish we had had training like this when I started performing laser procedures.
This is so far and above any of the training that we had. And again this is postgraduate as you get your continuing education, your continuing medical education, if we were locked into doing what we could do only in the day we finished our school or our residency that.
Would be a disservice to our patients.
Dentistry is allowed to advanced medicine is allowed to advance and you add skills to your arsenal. You build upon your foundation and training and you add something to your arsenal.
You add something to your repertoire so it's the exact same thing as ophthalmology is doing.
You know, I know the ophthalmologist on this call.
They are doing things today that weren't around when they finished their formal training.
They didn't have to go do proctored cases.

They didn't have to go to A to a, you know, go back to the legislature.
And ask for the ability to do that.
You know, they're they.
They do those procedures, do they build upon their wonderful foundation and training and they add to their repertoire and optometry's gonna do the exact same thing here. So, you know, I think everybody in this call agrees.
Doing, how do you maintain? So that's obtaining proficiency.
How do you maintain proficiency?
You gotta do procedures.
You know I'm proficient in lasers because I do lasers on a weekly basis.
You have to do these procedures and some you do much more often than others. I did YAG, capsulotomies and SLT's today with our.
With our students and residents, I didn't do any Pis today, 'cause that's that's more rare procedure. You don't do that on a weekly basis. You go to continuing education or continuing medical education, additional training, and you further your skills.
You select your patients wisely.
All of our surgeons know that you know your first, your first cataract surgery ever.
I bet wasn't maybe on a lawyer. That's a triple type a personality. You know, you schedule your patients wisely.
You schedule your procedures wisely.
You know if and when this ever passes in Maine, you're probably not going to make your first eyelid procedure a shalazing incision.
Keratos you you make it a little skin tag removal that's that's hanging there by a thread by a stock to set yourself up for success and having confidence in doing these procedures.
You know YAG my story in YAG laser vitriol lysis, that's not even one of the procedures they're asking for in Maine. So I want to be very clear on that.
I started doing this procedure in 2019 and some ophthalmologists do this and some ophthalmologists are very against that.
And I'm very, very, I understand that I've done over 900 of these in the last six years.
I didn't do my first one until I was 10 years into my career and I had hundreds and hundreds and thousands of lasers under my belt.
I was trained in part by an ophthalmologist on this and and have hundreds and hundreds of patients that are happy.
My point is is I obtained and maintained proficiency long after my education and

training through.
Pushing myself and learning a new craft and skill so.
You know, I had an ophthalmologist friend that was doing a procedure a while back and he goes, I was just.
I had to read up on it the night before to figure out exactly how I was gonna do this procedure.
So all of our surgeons know that we do some procedures more often and some procedures less often and we study up and we we review things and we build upon our education and training.
You get CE afterwards after you're done with your training. We continue our education and we add to our repertoire, so.
I'm gonna pause there.
I think I'm out of my.
10 minutes.
I will stop my sharing.

RB **Meeting Hosts** 59:16
Thank you so much, doctor Lightheiser, questions, comments areas requesting clarification. Dr. Ferrell.

LF **Linda Feero** 59:27
Yes, thank you.
Can you tell us about the minimum requirements for your students, for all the procedures that would be allowed in LD 1803?

NL **Nate Lighthizer** 59:38
Yeah. So we don't a number on our minimum requirements 'cause, we have 28 students in our class and some of them have have no interest in doing that. We have students that do 50 to 75 of these during their schooling, which is way above.
The requirements for ophthalmology, we have some that do.
Less than five because that's not their interest.
So it just depends on the student.
For example, my wife is an OD.
She's never done one in 16 years of practice.
She fits scleral lenses all day.

That's not her interest.
Optometry is very broad, so some students do quite a few and some students will do just a handful do just a couple.
So it just depends on the procedure and it depends on the students and their interest.
But we don't have a set number of. Everybody has to have this many because not everybody has an interest and I'm going to give a YAG capsulotomy to a student that wants to do YAG capsulotomies and somebody that's scheduled in laser clinic and doesn't. I'm going to let.
Them pass on that and give it to the student that wants to do it.

RB **Meeting Hosts** 1:00:43
Doctor Farah.

LF **Linda Feero** 1:00:45
Do you think that some of them, when they actually get out into practice, might change their mind and want to do it? But now they haven't had the experience?

NL **Nate Lighthizer** 1:00:53
Well, certainly that's possible. And I think that goes back to well, they've had the didactic education, they've had the laboratory training.
They've been tested on that.
And they are doctors and can get the postgraduate education and training needed to make themselves comfortable in the guidance and help. I'm sure you've had help along the way in your career. Post formal training and I've had help along the way in mind from both Optometry and OP.
To add procedures. And yeah, they've had the didactic training during school, the laboratory.
They've been tested on that, and if they change their mind 10 years from now and say I would like to do YAG capsulotomies they have the means to go ahead and do that.

RB **Meeting Hosts** 1:01:39
Thank you.
Doctor Farrow was added.

Do you have another question?
I OK.
Go ahead.
Oh, doctor Harris.

LF **Linda Feero** 1:01:48
Doctor Harris was first.

RB **Meeting Hosts** 1:01:49
Sorry. Yes. Sorry, doctor Harris.

NH **nate harris** 1:01:54
This this is more of a comment than than a question, but.
Doctor Lighthizer, you you highlighted the training of dentists.
We we did have.
I I would like to to highlight to the Commissioner that we did have a dentist provide testimony.
Who provided a really in-depth description of the dentist's training, which involves every single student in their second year beginning procedure.
On live patients and continuing through till graduation.
With demonstrations multiple times on live patients.
This is vastly different than what every single optometry student would get, especially the ones that are not training in states.
And, you know, 11 might say, well, they would just do rotations in states that allow surgery. But part of the reason of me providing.
The volume of these procedures that are being requested is to just show that it would be mathematically impossible for every optometry student to obtain training on a live patient through those rotations to establish a level of proficiency.

RB **Meeting Hosts** 1:03:15
Thank you. Doctor Harris, Dr. Farah.

LF **Linda Feero** 1:03:18
Yeah. My question is of the students that you're training in Oklahoma, are you

tracking how many of them go on to continue to do these kind of advanced procedures?

Nate Lighthizer 1:03:32
Currently we don't track them about 60 percent, 70% of our students stay in Oklahoma.
But we don't track how many of them are doing procedures.
I do.
I do not know that answer.
My guess is it's a fairly high number, but I I don't.
I don't have a definitive data for you on that.

Meeting Hosts 1:03:54
Thank you.
Any other?
Questions before we move to opponents presentation.
If not.
Thank you, doctor Lightheiser.

Laura Green, M.D. 1:04:30
OK.
Thank you.
So we have submitted a comparison of optometry and ophthalmology education and you can see in the chart below that ophthalmologist certainly have more time that they spend in training. But it's not just the time, it's about the quality and how that time is spent.
Ophthalmology education is in small groups, not in large lecture halls, and all surgery is taught one-on-one with a surgeon who has been certified by the American Board of Ophthalmology, a university and a hospital as being fit to practice and to teach.
Next slide.
In the information that was also submitted by the proponents of LD 1803, we can see that there was.
A summary of how much time is spent clinically in each of the four years of optometry school in total that comes up.
To 2138, which is very much in line with what we have here. Based off of the Sunni

Optometry school and this amounts to if we're thinking about 55 hours per week, which is I can't speak for optometry school, how many hours.
They work, but that's the average for ophthalmology.
That's 38 weeks, and so even with four weeks of vacation, that's still 10 weeks short.
Of a full year.
Of clinical experience. Next slide.
And we'll go on to the next slide.
Just in the interest of time.
In the Acme Review Committee has defined procedural categories that are required for resident education and ophthalmology, and it's really important to understand that ophthalmologists have a plenary license because of the foundational medical school curriculum, which is much more similar to dental school.
In many ways than it is to optometrics school.
And so the review committee uses the case logs and the minimum numbers, which were also submitted by the proponents.
In full chart form from the ACGme.
The numbers are used for the accreditation of the training environment, not for the individual, and so these are an acceptable minimum experiment experience. They are not at all the maximum.
And in fact, if we look to this, we can actually see that the ACGme is also tracking residents through a national data capturing process.
This is used with your general surgeon, a family practice doctor, a dermatologist or an ophthalmologist.
This is not an ophthalmology system.
This is a House of medicine system and through this for office based procedures.
Any of the areas of medicine that do office based procedures.
Have listed competencies and their residents must be assessed on these.
Twice a year. This is not an individual assessment.
This is an aggregate assessment from all of the one-on-one interactions that are accumulated over the prior six months. These aggregate data then give us an opportunity to see the normal progression of how people learn these office based procedures. And so this is one year.
Of that where you see your first year residence, what we call PGY 1.
123 and four, and so we can see that if level 4 is competent, 312 is OK. Five is expert.
That really it does take several years of being around these procedures starting to

see them starting to do parts of them and starting to do them independently before you really are assessed on multiple occasions of being able to do them independently.
And that's how we define competence.
Next slide please.
And then this is data showing that that if we actually track individuals, so we we have. The overall data, so the we're tracking years of residents. So we're tracking the people who graduated in 2020, two, 2123 and 24.
So year one is actually, you know, back when they were in their first year and so we can see for these cohorts tracking forward just as an aside, the reason why the folks from 2000.
20 to 21 don't have year one is because of a change in the program requirements where internship had been separate versus now. Internship is united with everything. Also lower because of the pandemic, but the point is that we can see that it actually takes several years in these national aggregate data sets of thousands of trainees to acquire proficiency around these procedures.
It's not something that can be demonstrated after a 32 hour course.
Next slide.
Also, if we look at the average numbers that are actually done from the national databases, we can see that the total numbers are far in excess of the minimum numbers.
The minimum numbers were set at around the 20th percentile and get reviewed periodically.
And so you know, while that is the minimum, that's certainly not what's most common.
For graduates of ophthalmology, residency programs and this was a report that I pulled from just last month. For the people who just graduated in 2025.
So only three optometry schools are in states that allow the procedures that are requested in LD 1803.
And so we have serious concerns around how there's a lack of standardization in the type and hours of training on surgery. There are lectures in all schools and that is great to build familiarity. But it is not a replacement and certainly doesn't necessitate the need to legislate the.
Permission that is earned from building the trust with society in a plenary LIC.
Ense, like a medical degree.

There's just a fundamental difference.
In a plenary type degree.
The curriculum for optometry demonstrates excellence in creating primary eye care providers that are our partners in patient care.
But even if we look to the NECO curriculum, we see that in the four year curriculum hours, there's only 457 hours of patient care and a very small percentage of that is actually on anything surgical.
Most of which is didactic.
There's six hours of lecture and hands on lab instruction, and again, simulation is definitely something that we use in ophthalmology.
Simulation is something that can prepare you for the next step, but really to be able to be granted free license to practice. We believe that you need to have that one-on-one tutelage and the verification of competency assessments.
And then the next slide please.
And so if we look overall from all the different data sources that we've been able to find, ophthalmology has 144 weeks of surgical training and on average optometry has cumulatively of hands on surgical training one week.
So you know, it's important to look at what is most common and not what are just the outliers in ophthalmology.
This is a unified standard of care.
When we come up with our ophthalmology standards and accreditation, there are primary care doctors, family practice doctors, actually one from Maine was in our committee.
We also have neurologist, pediatricians, and then it has to be approved by several layers of committees within the ACG. Me that don't have ophthalmologists. So we can't just make up our own standards.
Our standards are very uniform and consistent.
Whether you're talking about what a pediatrician can do.
Or what a neurosurgeon can do across the House of medicine.
Very unified in building trust with patients and their caregivers and with society.
And with that, I'm I've concluded, ready for questions.

RB **Meeting Hosts** 1:13:16
Thank you.

Thank you.
Doctor quint.

Jessilin Quint 1:13:22
I thank you, Doctor Green.
I just. I had a question.
So you had mentioned that only three optometry schools were in states that allowed these procedures.
Can you tell us what those three are?

Laura Green, M.D. 1:13:34
I know that one is in Oklahoma and one is in Kentucky.
The Pikeville College of Optometry.
And I don't recall off the top of my head the name of the third one.

Jessilin Quint 1:13:50
Is the data that you presented what like? How recent is that? What year?

Laura Green, M.D. 1:13:59
On which data are you talking about?

Jessilin Quint 1:14:02
I guess any of it, either in the schools or any of the Acme data that you provided.

Laura Green, M.D. 1:14:09
Sure, it's all in the report that I think was also shared with you. But if we start at the top.
The Sunni Optometry School was based off of.

Jessilin Quint 1:14:21
Not not not. The Optometry school curriculum, but the three states being able to do.
I just was wondering like when when that was pulled from you guys and then specifically when you gave a lot of the procedural reports that were very specific to Acme, what were like when were those from what time time frame?

Laura Green, M.D. 1:14:42
Sure, the data with the the aggregate competency data on patient care at the top of the graph, it says 2020 to 2024 and you'll see in the top right corner one of the lines is for 20/20 to 20/21, one is for 20.
One to 22 one is for 22 to 23 and one is for 23 to 24.
The average data.
For the national resident report.
In terms of the total experience?
Was a report that I pulled on September 16th of this year.
So it was the the Acme calendar year runs July 1st to June 30th. So even though I pulled it on July on September 16th, it was the data for the year that concluded June 30th of 2025.

Jessilin Quint 1:15:21
OK.
Thank you for clarifying.
I just know five different optometry schools that you know, Oklahoma, Indiana, Kentucky, Oregon and Tennessee all have advanced procedures.
And so I was just, you know, making sure that we weren't looking at data from a number of.

Laura Green, M.D. 1:15:48
Oh well, there's a different rate.
So what I said was the ones.
There's only three that allow what is proposed in LD 1803.

Jessilin Quint 1:16:00
Like as a whole, you mean not specifically breaking it up.

Laura Green, M.D. 1:16:04
There are only three schools that train people to perform all of the things that are listed in LD18O3.

Jessilin Quint 1:16:12
Thank you for clarifying.

Meeting Hosts 1:16:22
Can I just ask a follow up?
Which are the three schools Doctor Green mentioned?
Oklahoma. Kentucky doctor Quinn. What would or doctor Lighthizer? What might be the third school that trains for all of the procedures?
That are proposed in 18 O3.

Nate Lighthizer 1:16:43
The answer for that would be if it's. If you're looking at all-encompassing that has all like laser states that have lasers and injections eyelid procedures, it would be Oklahoma, Kentucky and Indiana.
Those are the three that are both laser states as well as have injections and eyelid procedures now for example.
Excuse me? Southern College of Optometry, SCO in Memphis.
They have injections there but.
They do not have lasers.
Well, that's right. On the border of Mississippi, which does. So they have laser clinics established there.
So if you're an SCO student, yes, you're not in a state that allows Lasers Tennessee, but you're very close to one where they get laser privileges.
Same thing for like the University of Houston College of Optometry in Houston.
They can't do lasers or surgical procedures in Texas.
But they're very close to Louisiana.
Vienna, where you can so they send a number, a good chunk of their students there or to Oklahoma.
So again, is it all of their students? Probably not.
Is it a good chunk of them?
Yes. So again, it gets a little bit the answer is three. When those three schools, but you can see the nuances of that.

Meeting Hosts 1:17:58

OK.
That's great.
Thank you.

NL **Nate Lighthizer** 1:18:03
Yep.

RB **Meeting Hosts** 1:18:06
Doctor Lighthizer, you had your hand up before.
The Commissioner asked the question.

NL **Nate Lighthizer** 1:18:10
Sure. I was just curious to our our fine ophthalmologist, Doctor Green, Dr. Harris, Dr. Fierro, Dr. Gleaton.
So when when something new came up after you finished your residency, how did you add that to your repertoire?
I mean, I know there's procedures that you that you do today that weren't available back then and that they're new and you no longer have that.
Residency that yet that residency attending Doctor.
There you. How did you add that to your repertoire?
You didn't have that one-on-one. You talked to colleagues.

LM **Laura Green, M.D.** 1:18:45
I did.
Actually, I would never dream of doing something on a patient without having a Proctor there.
And I've had colleagues.
Yes, you learn on model eyes. You practice Migs on model eyes.

NL **Nate Lighthizer** 1:18:55
Mm-hmm.

LM **Laura Green, M.D.** 1:18:57
But I would never personally dream of doing something on a live patient without someone being there with me.

I can't speak for the other doctors.
Doctor fioro. Dr. Harris, do you have any comment?

nate harris 1:19:15
Yeah.
So the I mentioned Migs, these microindecsional glaucoma surgeries, that is something that was not available to me during residency.
It is something that is now taught in residency, and that does involve this interoperative gonioscopy that I mentioned.
So the way that the way that I learned that was starting on a wet lab which which frankly I did not feel was representative of of human tissue.
And then I was proctored I had.
Colleagues who were performing these and they sat with me for my first couple cases. I did a lot of practice gonioscopy in the operating room.
I, you know, relied on my foundation of of training.
You know the extensive training that I got in residency.
So you know we we build on the the foundation and it's just so important building on the foundation to then take the next next step to do these procedures.
I I did have I I had my hand up and just a follow on question.
I'm just curious which states are allowing optometrists to perform crosslinking corneal crosslinking, and then which schools are are specifically teaching this?

Nate Lighthizer 1:20:28
I.
I know Oklahoma does.
I know Colorado does.
I I don't have the list of cross linking states right off the top of my head.
You know, certainly that's going to be an interesting debate and dialogue as EPI on was just FDA approved within the last week.
You know where that will go.
Where there's no longer, you know, epithelial debridement associated with that. So we shall see where that goes as there's a a new technique now FDA approved for cross linking. But there's there's numerous states more than two or three.
I know the exact number on cross linking Alaska is one of them, so there's a there's

numerous ones. West Virginia, things like that.
There's numerous states that allow EPI off corneal cross linking.

RB **Meeting Hosts** 1:21:14
Doctor Farrell.

LF **Linda Feero** 1:21:16
Sure. I I wanna echo what Laura and Michelle said. Depending on the level of what kind of procedure you're doing. Certainly anything intraocular like Migs, it was precisely that I had learned something similar to Migs while I was a resident for treatment of angle structures.
But we did.
Proctoring you had to do a certain number of observed procedures before you were even allowed to go ahead and do them with.
On your own, without anyone being there.
So yes, it's not just, oh, I think I've watched a lecture and I'll think I'll go do this on somebody.
That's not how it works.
It's not how it should work.

RB **Meeting Hosts** 1:22:00
Doctor Quinn.

JQ **Jessilin Quint** 1:22:02
Doctor Ferret you mentioned make specifically as in NI.
What about SLT 'cause?
I think that that probably wasn't taught in your school curriculum.
How did you learn how to do that?

LF **Linda Feero** 1:22:12
So yeah, so we used to do something called alt argon laser trabeculas before SLT was allowed.

GS **Gleaton, Maroulla S** 1:22:17
1.

Linda Feero 1:22:20
And it's the same procedure, but with a smaller.
Smaller laser size, so it's actually harder to do than SLT.
Doing SLT was easy compared to doing Alt.

Nate Lighthizer 1:22:33
Yeah, no doubt about it.

Gleaton, Maroulla S 1:22:34
OK.

Meeting Hosts 1:22:37
Doctor lighthouser. Then drive Glee.

Nate Lighthizer 1:22:39
Yeah, I was just gonna comment.
You mean your what?
Your comments are I agree with you know it.
It takes mentoring and I was on the phone with a doctor today who who's less seasoned on laser procedures than me in Oklahoma and just discussing different techniques and way to do that. We continually evolve in advance.
I've been to numerous practices in Oklahoma where they were early in their laser experience and just wanted me in the room for them.
So you know Optometry's doing the exact same thing of you know.
Going to continue education and hearing lectures and and and furthering your education and and having proctoring and mentoring if needed and desired as well.
So I agree with that.
And that's that's exactly what Optometry is doing in a variety of states.

Meeting Hosts 1:23:25
Before I call on Doctor Quinn, I just want to note that we are considering adjusting the agenda slightly.
We may be moving the prescriptive authority topic to the the next meeting in December so that we have more time to talk tonight about these two important

topics.
With that doctor Quint.

Jessilin Quint 1:23:45
Well, it sounds like both sides.
Are you know when we talk about the new advancement, new things, treatments, new technology that comes out, these are able to be done in a very efficient way in a very patient safety informed way because of that foundation, right?
And so optometry school has 10,000 hours.
We have 2000 patient encounters.
We have that very clear foundation that has been very specific to the eye. If we get into comparing hours to hours.
You know.
It's it's different because at medical school covers multiple organs during their residency training.
They do a number of different procedures that aren't an LD18O3 things like cataract surgery, things like retina surgery. And so it is going to be a little bit different. But if we tease out some of those numbers and those hours and we focus exactly on.
What is very specific to the eyes optometry's four years of being very focused on the eyes.
The visual system.
Creates that very strong foundation for advanced procedures to be done.

Meeting Hosts 1:24:51
Thank you, Doctor Green.
Then doctor Joan. Excuse me, Doctor Jones and drive green.
You're on mute.

ianjonesod@gmail.com 1:25:03
I'll get this right, right one of these times.
Yeah. Well, I just want to throw too.
Basically that as we all know and we throw in the stats out, we as optometrists since Oklahoma got this bill, we've done 146,000 of these cases with a .001% complication rate.
So this is not something that that's new. This is not something we have not done

very many on.
So I want to make sure that stat was put out there.

RB **Meeting Hosts** 1:25:28
Thank you.
Doctor Green, before I call on you, I want to just check with Doctor Gleaton.
Your hand has been up and down a few times.
I just want to make sure.
Would you like to jump in?

GS **Gleaton, Maroulla S** 1:25:41
Well, I don't think I had a whole lot more to add than the other ophthalmologists did about how we take on new procedures.
It's easier to take on certain procedures based on your experience with very similar procedures that you have already done for many years.
I can't stress enough how I think experience makes a better surgeon and a surgeon that is less likely to do any harm. The other thing that I might want to add is it's not just doing a procedure that counts.
Here it's understanding Preoperatively who should have this procedure.
Why should they have the procedure, which is what requires months of training in a residency program with rotations?
And if you do the procedure, what are you likely to encounter?
How will you handle that no matter what you encounter and how will you follow that patient afterwards?
Those are the critical things that surround.
Being able to do procedures.
Thank you.

RB **Meeting Hosts** 1:26:40
Thank you, Doctor Glayton, doctor Green.

LM **Laura Green, M.D.** 1:26:45
I really have nothing out further to say Doctor Gleaton.
I agree with what you said 100%.

Meeting Hosts 1:26:53
Doctor lighthouser.
Like Heiser, sorry.
Changing your name? Oh, you're a mute.

Nate Lighthizer 1:26:59
There we go.
Sorry, I was gonna say the exact same thing and and optometry is trained on that and at our school we go deep into that.
You know, I always have the saying, doctor Gleaton.
Any captain can sail the seas when the waters are calm and the winds not blowing.
But when it gets stormy, that's when you really want your expertise in there.
And yeah, if you've done procedures that just go smooth as can be.
And then there's other ones where you go and we got to adapt and we've got to pivot and we trained on that.
These are your indications.
These are your contraindications.
Here's how you go through your procedural techniques.
You know we're doing a multi focal IOL for this one and this here's why we change our technique for a Jag capsulotomy. For this here's an SLT and what might be indicated what might be contraindicated.
Your point is exactly correct and and that is what's trained and taught.
To that level, at our school and to the doctors that I trainer on the country.

Meeting Hosts 1:27:59
Thank you, Doctor Quinn.

Jessilin Quint 1:28:03
Doctor Glton, you're exactly right. And I think that as optometrists, we're already doing that.
So here in Maine, like if I have somebody that has APCO, I'm monitoring that. I'm. I'm basically kind of deciding when they're a good candidate for that. Yeah, procedure.
So I monitor up until the point of actually pressing the button, which right now here in Maine, I send out to one of my ophthalmology colleagues and then that patient

winds up back in my chair and I'm managing what happens after that procedure.
To see if there's any complications that could pop up, and so you're exactly right.
But thanks to my very extensive optometry training and education, I'm able to decide who's a good candidate and I'm able to manage any complications that could potentially arise with any of these in office procedures.

RB **Meeting Hosts** 1:28:57
Actor Farah.

LF **Linda Feero** 1:28:59
Thank you.
So in Oklahoma, where they've been doing this for a long time now, optometrists have.
You don't have any minimums and you don't track how many residents are doing any of these procedures, and you don't track what they do after they leave your program.
And that's where we've been doing it the longest.
What is happening in all the other States and all the other schools where they're not getting experience on live patients or if they're going to Oklahoma and doing a couple of these?
There's a whole lot of variability here right there.
There's not continuity across the curriculum of all optometrists learning exactly the same thing and being taught to the same level of proficiency.

NL **Nate Lighthizer** 1:29:53
Yeah, every every state is different.
We're a legislated profession that the laws are determined by the state legislature.
You know, I can't remember if it was.
I think it was Doctor Jones mentioned earlier.
It was the study that we put out 146,000 procedures.
That's actually a way of it.
Way an underestimate because Doctor Farou I've been in Oklahoma since 2009.
The first laser was done in 1988 in in Oklahoma by an optometrist.
So 1988, they actually stopped tracking.
For the first 16 years, they had to every time you renewed your optometry license,

you had to turn in how many laser procedures that you had done for, like the 1st 16 years they they stopped that. As I said, we've done 6070 thousand lasers and it's it. It's part of what we do in Oklahoma Optometry.
So that there's never been lasers tracked in Oklahoma since 2004.
So that number's incredibly higher. To address that one point than 146,000.
But every state is different.
I mean, for example, in the state of South Dakota, when they passed their law, they have to do 10 YAG capsulotomies.
They have to do 10 proctored cases.
Of 10 YAG caps in South Dakota.
In West Virginia, they have to do 5 YAG Capsulotomies 5 SLT's.
Or pis. So every state is a little bit different.
On what the numbers have to be for, you know, proctored cases or your experience as you do these in lives, patients.
So everyone's a little bit different 'cause. We're a legislative profession and the rules are different in every state.

RB **Meeting Hosts** 1:31:22
Track track your lighthizer.
That's a perfect segue.
One of the questions that we asked.
In the many in the list of many questions we asked was about.
For the states with expanded scopes of practice, what's required?
Could you tell us a little bit more about?
As you just noted, states take different approaches.
Some require a separate certification, some require some.
This is a mandate.
Everyone has to be trained within a few years. Whether they do it or not.
Some require the the proctoring. Can you give us a little insight into your your thoughts about those different types of criteria?

NL **Nate Lighthizer** 1:32:09
Sure. So yeah, every state has been different.
Oklahoma did not require proctored cases.
Louisiana did not require proctored cases.

Alaska did not. As I mentioned, West Virginia and South Dakota did.
Wyoming required a couple of proctored cases.
So all of the states required a training or certification course.
And so if you're graduated five years ago or 15 years ago or 25 years ago, you have to take a.
A training or education course and that has been a a 32 hour training or education course that involves laser and surgical procedures.
So every state that has had this all 14 laser States and the injections states have required to take a training course.
The certification course that you've taken this education and training from a College of Optometry that performs these procedures.
Often us or Kentucky or things like that.
So the states require that training and education course, and then depending on the state.
Whether they had proctored.
Or not is going to just depend on depend on what was negotiated during that that passage of the law in the said state. So it's usually.

RB **Meeting Hosts** 1:33:21
Help. Yeah. What would be helpful is to get specifics on that. So like if you could do a spreadsheet that had the state, the requirements.

NL **Nate Lighthizer** 1:33:22
A.

RB **Meeting Hosts** 1:33:33
Specifics about what is permitted.
I mean, I there were laser States and tag States and some both states.
So to know which state is states are state or states are identical to what's being asked here.
And if not, you know, how do they differ and how does how does the how do the requirements differ?

NL **Nate Lighthizer** 1:34:00

Jeslyn I'm assuming the the MOA would be easily able to provide that.
Is that correct?

Jessilin Quint 1:34:07
We did.
I was under the understanding that we did submit that, Caroline. I I thought I saw that as a spreadsheet that clearly outlined it.
So if it wasn't included, we can definitely get that to you. Or if you look at that document and there's more information that we need, we can definitely go through that.
But I was under the impression submitted, yeah.

Meeting Hosts 1:34:25
And if we miss, and if we missed it, my apologies.

Jessilin Quint 1:34:29
Yeah, that's OK.

Nate Lighthizer 1:34:32
For example, you know Oklahoma, we have an exclusionary law it. It tells us what we can't do.
Corneal crosslinking is not on our exclusionary list, so we can do crosslinking.
There's numerous optometrists doing crosslinking, obviously, among ophthalmologists do it as well in the state just to our E Arkansas, they have an inclusionary law in the state of Arkansas, it says they can do laser capsulotomy.
Selective or excuse me, laser trabeculoplasty and injections of anesthesia.
Asia for benign eyelid lesions.
Full stop.
It tells them what they can do, and that's their law.
Notice that's different.
It's not as broad as the law in Oklahoma, where it says what we can't do, so everyone's a little bit different, and I'm sure that they'll be able to provide you.
What each law says and I can assist them with that.

Meeting Hosts 1:35:22

Lighthizer, thank you for that. With regards to exclusionary statutes, if there's something new that's not listed.

Nate Lighthizer 1:35:31
Mm-hmm.

Meeting Hosts 1:35:32
How is it handled?
It's not listed in the statute or the regulations, but yeah, it's not explicitly excluded.

Nate Lighthizer 1:35:40
Mm-hmm.

Meeting Hosts 1:35:40
Something new comes out.
How is that handled in?
I believe you said it was in Oklahoma, so I assume you're familiar with that, yeah.

Nate Lighthizer 1:35:47
Yeah, in in Oklahoma that would be handled if it's not on the exclusionary law, we would discuss with our Board of Examiners.
We have a an optometry board that regulates what we do that gives us an optometry license and we have to report to them.
So that would be a a question to the Oklahoma Optometry Board.
Is procedure X that's new.
Is that within our scope of practice?

Meeting Hosts 1:36:12
Mm-hmm.

Nate Lighthizer 1:36:14
Ractice. So that's how.
That's how we would go about that.
That answer the question.

Meeting Hosts 1:36:21
It does, but I'm just thinking this through the it's the.
But does that allow?
There would potentially be a period of time where it was unclear.

Nate Lighthizer 1:36:33
Again, if it's, if it's not on the exclusionary list.

Meeting Hosts 1:36:37
You can.
You can do it.

Nate Lighthizer 1:36:38
It's a procedure.
We have a very well defined law that we can't do cataract surgery. We can't do retinal lasers and we can't do these procedures.
So, for example, IPL intense pulse light therapy, that's not even a surgical procedure.
But it's not on the exclusionary list.
So when that came about in the last five to 10 years, there were some states that had to go to their optometry board and say, can we do this?
For us, it was just well within our procedures, so.

Meeting Hosts 1:37:04
Got it, Doctor Quinn.

Jessilin Quint 1:37:07
I just confirmed with our executive director that it was in the packet the spreadsheet that lists the states so that you have that.
And then on the exclusion and inclusion, I feel like our current bill has a little bit of both.
It was originally proposed as an exclusionary, just as as Doctor Lighthizer had described, and then for to clear up any, you know, ambiguity. We went back and and added very specific inclusionary language.
So LD 1803 is a little bit unique because it has both of those and and there's pros

and cons of doing that.
That I think you know our neighbors in New Hampshire, they have an inclusionary law with pharmaceutical drops.
So anytime a new drug comes out, they have to go to their legislature and, you know, go through.
All right, all the insurance and outs to be able to describe that medication and you know that can be really limiting. That can really access patient care.
It can really delay treatment and it doesn't allow.
You know to keep.
It's not an efficient way to keep up with the advancements that we have.
So so that is, you know, one big step back forward and you know for having a very specific inclusionary law.
Doctor lighthizer. You also brought up how the the Board and and that's why LD 1803 has those, the language about the board authority and I know we you know we're not probably going to get into that tonight but that was designed so that optometrists this board.
That's appointed by the governor that's appointed by legislators.
You know who better to know if this new procedure?
This new technology, if this new treatment is, you know, can be done safely for patients under the current epidemic or education, then those are the, you know, those that are the most familiar with it.
So just kind of a call out.
I just wanted to to showcase that with our bill because we have a little bit of exclusionary language and inclusionary as well.

RB **Meeting Hosts** 1:39:01
What would be helpful for me?
I'm looking at the amendment on the what's permitted and what's excluded.
And I see a through T whoops, accept it all disappeared.
A through T for what's included and so.
I'm curious about the.
I think Doctor Fiora, you had mentioned the 150.
The procedures that were not mentioned so are is that I'm wondering if that's because of H ophthalmic surgery, except for those excluded.
So there might be some that weren't specifically called out or. I'm trying to figure out

where.
Where the longer list is.
And I'm I we will get to.
But I would ask the doctor Firo.
1st please.

LF **Linda Feero** 1:40:01
Yeah. So we gave you the list for the first meeting that we had together of what we believe are all the the CPT codes that would be allowed and it's about 150.
But we've only talked about 26 or 27 tonight, different CPT codes.
And there's a whole bunch of others. So that's why I'd ask that, you know, if maybe. Doctor quint. Or they could work to create a list of all the CPT codes that they think that would be allowed. If that's different than the one that we submitted.
Ended.

RB **Meeting Hosts** 1:40:39
So we can find that and make sure it's shared with Doctor Quint and others.
To have you identify specifically which procedures would or would not be included.
And so now I'll turn it to Doctor Lighthouser.

NL **Nate Lighthizer** 1:40:59
I was just going to comment on that.
Can I share my screen or is that not allowed?

RB **Meeting Hosts** 1:41:04
Go ahead.

NL **Nate Lighthizer** 1:41:05
I was just gonna to me. When?

RB **Meeting Hosts** 1:41:06
Long as it's long as it's appropriate to this discussion.

NL **Nate Lighthizer** 1:41:10

Yeah, it's actually was.
Can you guys see my screen?

Meeting Hosts 1:41:13
Yes.

Nate Lighthizer 1:41:14
You know, to me this was the was the difference in we talked or jeslyn talked about 7 procedures and here they are.
And then it was mentioned 26 or 27 CPT code. Most of these procedures have one CPT code. For example a YAG capsulotomy has one CPT code.
There's procedure number 5A, YAG capsulotomy and it's 66821. That's where the discrepancy that we're getting here for these seven.
Procedures is when you do an eyelid procedure when a patient has that skin tag or that sty. If you look on the left here, you know there is just under this category of an eyelid procedure. Removing a lump or a bump, a skin tag, a verruca, a se.
Keratosis a cyst.
Look at all these different CPT codes just for biopsy and just for procedure codes.
For example the.
One diagnosis scholarship where you can have is it a single chelation?
Is it multiple shalazing on the same eyelid?
Is it multiple shalazing on different eyelids?
Is it multiple shalazing on both eyes so that right there?
One procedure removing a shalazian has four different CPT codes there. So that's to me when I heard that original.
That's the discrepancy is, is all of our colleagues know when you work on the eyelids, there's you have different codes for the number of skin tags they have and things like that based on the size, which you can see here.

Meeting Hosts 1:42:27
Yeah.

Nate Lighthizer 1:42:38
So to me, when I saw this based on my working with many other states, looking at inclusionary laws, exclusionary laws, this is both as Jeslyn said, but leaning more

towards the inclusionary because it's clearly got 7 procedures defined here now.
Again, one of them has multiple CPT codes.
But that's just to the nature of different sizes, same lid, different lid, etc.

RB **Meeting Hosts** 1:43:02
Right. Yeah. No, thank thank.
That's a great reminder of that difference. I do believe though, that based on tonight's conversation, there's still confusion as to what exactly would be in and out.
We will find a way to get alignment on that.
We are coming up closer to time.
Doctor Harris, Dr. quint.
Doctor Harris.

NH **nate harris** 1:43:30
So the the the problem with trying to put a number in listing exactly what would be included and wouldn't be included is that again as technologies and surgeries advance and new things come out.
The decision as to whether or not optometrists and Maine are going to be able to adopt these new technologies and surgeries is going to be solely up to the Board of Optometry.
This is a body that is independent of any medical.
Or surgical input and that is that is very concerning.
The other thing that you know, I think we'll get into this more when we talk about.
The the medicines, the systemic medicines that want to be prescribed, but just keep in mind the, you know.
The strength of optometry school having four years focused solely on the eye and not having to go through four additional years of medical school.
Is could be perceived as a strength.
But we have to remember the I is an end organ and is not independent of the body.
It is affected by everything downstream.
So having that foundation of of medicine and systemic diseases and then applying that knowledge to the eye is is extremely important. And then the last point that I did forget to mention because of time in my talk is lots of focus on benign eyelid lesion removal.
It is almost impossible to tell whether an eyelid lesion is benign just by looking.

So there, there has to be other steps involved.
Biopsies, discussions, interactions with pathologists who are again under this House of Medicine.
So this this is an area that is, you know, outside the purview of of of most optometrists.
Because they haven't undergone that medical training.

RB **Meeting Hosts** 1:45:27
Thank you.
Real quick question before I get to Doctor Quint is the I believe based on my apologies.
Ingested a lot of information on this topic.
I believe my recollection is that.
States maybe won, but most states don't do not in their statute of regulations require.
Biopsies to be sent to the lab.
Is that? And yet I saw several people.
Doctor Jones, Dr. Lighthizer.
Shaking your head affirmatively to the idea that you know we need. You need to take the biopsy. Needs to go to the lab to determine.
If it's a bad lesion.
And so.
Tell me briefly if it'd be great to get a sense of how the involvement of labs.
The involvement of you know you've done a biopsy. Then what?
Doctor lighthizer.

NL **Nate Lighthizer** 1:46:35
Yep, in our clinic, we evaluate an eyelid lesion, just like optometrists do all across the country and analyze it for a variety of features.
It's called the ABCD. Ease of lesions of skin lesions.
You look for hair loss, ulceration.
How long has it been there? Bleeding things like just a variety of features to make a determination.
How likely is this?
Is this eyelid lesion benign versus how likely is this something malignant?

Like basal cell or squamous cell or variety of others.
Umm, I tell patients and our students and residents and doctors I can never be 100% sure of what an eyelid lesion is.
There's many that I look at and I go I'm 99% sure that this is benign based on the history and the appearance, but I won't 100% know what this is unless we biopsy and I give every patient that option.
If some of the times you know much of the time we don't do a biopsy because it's been there for quite some time and and based on the features, I'm nearly certain it's it's benign and we will remove it.
And I'm not forced to biopsy it.
I don't have to biopsy it in Oklahoma, and most states don't require you to biopsy it.
If I do I remove the lesion and I throw it in the biopsy container and I fill out the form and it goes to our our local path lab where they analyze it and they tell me what what this is in in five to seven business days I.
Get a path report back of what? This is, whether it's a squamous papilloma, benign, whether it's something else, you know, basal cell.
Usually it's benign.
But we get a path report back, so that's how the process works.
X.

RB **Meeting Hosts** 1:48:06
Thank you.
We have 5 minutes left.
Before we wrap up, we want to remind folks of next steps. But before we do that, any since we took we we got rid of, we used the repurpose, the Open Forum are there before we wrap up.
Are there any suggestions? Outstanding questions?
Other than getting the technology right?
Thoughts on the process?

SJ **Smith, James** 1:48:39
I have a comment and it has to do with the data submitted by the two groups and they're very disparate and I and I wonder what kind of fact checking is being done and you know how, how true everything is is being submitted, not that that, you know.

Anybody's trying anything underhanded, but I just think that there's there's a lot of, there's a lot of differences and it would be nice to compare notes.

RB **Meeting Hosts** 1:49:07

That is a bit on you.
We are not data scientists.
You know, we are doing a little bit of follow up and either by doing a little bit of our own research, a little bit of our own outreach.
Following up with some of you all eventually.
But we are not in a position to be doing a deep dive.
To dive on this information so.
You know, if if we're not able to.
Independently verify something within our capacity which is small.
Then you know it's possible that we might just identify that there's, you know, varying differences in data submitted.
There are times where we may make a judgment.
But again.
We're not data scientists.
So if you, you know.
Anyone any of the stakeholders?
Want to share additional information and response?
I mean, as as you've noticed, from missing a few things and we are kind of getting a data overload, but we're willing to take the information and do our best.
I encourage you to, you know, you are free to respond to anything.
Anything.
And.
And also as and I think we've asked this in our emails, you know if there are questions that we're not asking.
You know, feel free to, you know, let us know what what we might be missing in our questioning.
We've got particular concerns for data.
Feel free to let us know we're not using all data that's been submitted.
We're we're trying to make our, you know, best judgment on what's the best data.
Obviously peer reviewed type data is we consider safe and we're not.
We are not medical providers, you know, that's the other thing.

Nor let most legislators so.
You know, we're looking at the information with.
Our best non medical thinking and trying to translate it to legislators who also aren't medical providers.
Happy to offline if you've got any particular questions or comments with that. We are at time as before we we plan on, we'll spend time reviewing this data.
Thank you everyone for all the effort it took to collect and present the information.
Tonight was a great conversation.
Clearly people feel very passionately about.
This topic, our third and final meeting, is scheduled for the 15th of December.
We've had to move it a few times because of availability, but thank you everyone.
We'll be able to kick off the the winter holidays with the final meeting that will focus on. As previously discussed, the board of Optometries or the the board related.
Topics as well as the topic that we delayed today, the table today, which was the prescriptive authority we will send discussion questions in the next couple weeks.
Definitely before Thanksgiving.
As we've said, let us know if you have any suggestions or questions and have a great rest of the evening.
Bye everyone.

LM **Laura Green, M.D.** 1:52:54
Thank you.

NL **Nate Lighthizer** 1:52:54
Thank you all. Enjoy your evening.

RB **Meeting Hosts** 1:52:56
You too.

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