Transcript

December 15, 2025, 11:57PM

RB **Lunner, Kristina** 0:16

OK.
Everybody in the lobby is in.
Meeting is started OK.
I just wanted them.
Good evening everyone.
We'll just give Doctor Smith a chance to join.
Joined. OK, Craig.
I understand he's joined.
Good evening everyone.
I'm here in the DPFR offices.
It's Christina lunner.
You all know me well by now. I'm gonna turn it to the Commissioner.

CJ **Cohen, Joan** 3:20

Hi everyone and welcome.
It is our pleasure to launch the 3rd and final of the three planned meetings of the LD 1803 Stakeholder Group.
I am Commissioner Joan Cohen speaking to you today from my vacation in Sunny Palm Beach, FL. As fate would have it, the camera on my computer just failed.
So I am joining by phone.
So sorry that you know, I know that's never as pleasant to an experience.
So I am gonna kick it off tonight and then turn it over to my colleague Christina. Just as a brief 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 study like.
Report for the committee the board's impacted by the legislation.
The board's optometry, licensure and medicine and osteopathic Catholic licensure are all licensing boards affiliated with the department.
I would like to take a moment to remind participants of the ground rules we discussed at previous meetings.

Those rules are available on our website, but basically be respectful, listen and allow all stakeholders the chance to talk.
In addition, I'd like 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 and then please also try to lower your hand after speaking.
Please do not use the chat function unless you are experiencing technical difficulties.
Finally, while DPFR was under no obligation to treat this or future stakeholder processes as a public meeting, we have chosen to make the meeting available to all interested parties to be fully transparent.
All non stakeholder interested parties can listen and watch the proceedings through a webinar link. While interested parties can observe, they can listen but cannot be seen or heard.
This is primarily a remote meeting, but pursuant to the Commissioner office remote participation policy, which is posted on our website, we have a public location at the Gardener Office in the event someone does not have the technology to participate remotely.
No stakeholders are present at that public location.
So with that part of the opening comments completed, as the agenda reflects today's meeting, we'll focus on primarily on prescriptive authority and the Board of Optometry.
We appreciate the stakeholders efforts to collect and present this information.
Stakeholders will have 15 minutes to present their comments, followed by 5 minutes of question and answer.
Any questions about the agenda before I move to the introductions and I actually can't see everyone on my tiny little phone, so please unmute yourself if you have any questions.

RB **Lunner, Kristina** 6:31
I don't see any questions, Commissioner.

CJ **Cohen, Joan** 6:33
OK.
Thank you.
So Christina, if you could stop screen sharing at this time, as I said, I'm Commissioner

Joan Cohen and I am joined tonight by Christina Lunner, my deputy Commissioner, Misty Robinson, who is assisting with the technical aspects of the meeting, and Tyler Robinson, who's been helping in a vari.
Of ways, including serving as the receptionist in the event any public comes to the office.
I will now turn it over to stakeholders to make brief introductions.
There's no need to state whether or not you have a conflict of interest, as all stakeholders are invited here today as representatives of their profession.
Please briefly state your name where you work and who you are representing.
We are going to go in alphabetical order starting with Doctor Murula Gleaton.

GS **Gleaton, Maroulla S** 7:23
Hi, I'm marula esleaton.
I'm an ophthalmologist practicing in Trenton, ME.

CJ **Cohen, Joan** 7:30
Thank you.

GS **Gleaton, Maroulla S** 7:30
And I represent the main board of licensure in medicine.

CJ **Cohen, Joan** 7:34
Thank you very much, Doctor Green.

LM **Laura Green, M.D.** 7:37
Laura Green, ophthalmologist in Baltimore, MD, representing the American Academy of Ophthalmology.

CJ **Cohen, Joan** 7:44
Doctor Harris.

RB **Lunner, Kristina** 7:48
You're on mute, Doctor Harris.

MH **Michelle Harris** 7:51

Thank you. Michelle Harris, ophthalmologist in Brunswick. And I'm here representing The Maine Society of I physicians and surgeons.

Cohen, Joan 8:00
Doctor Jones.

ianjonesod@gmail.com 8:02
Hi Ian Jones, optometrist in Bangor representing the main optometric association.

Cohen, Joan 8:08
Doctor lighthizer.

Nate Lighthizer 8:11
Hi everyone.
Nate Lighthizer, optometrist in Oklahoma.
I'm here representing the main optometric association.

Cohen, Joan 8:18
Doctor quint.

Jessilin Quint 8:20
Hi, I'm Jesselyn, quint optometrist, practicing in Augusta. ME and I'm here representing The Maine Optometric Association.

Cohen, Joan 8:28
Doctor fiora.

Linda Feero 8:30
Hi, Linda Schumacher Farrow. I'm ophthalmologist.
I practice in Augusta, ME and I'm here representing The Maine Society of Eye physicians and surgeons.

Cohen, Joan 8:40
And doctor Smith?

PS **Pat Smith** 8:42
Hi, Pat Smith.
I'm an optometrist in Augusta, ME, and I'm representing The Maine State Board of Optometry.

CJ **Cohen, Joan** 8:48
Thank you all very much.
I am now going to turn the meeting over to Deputy Commissioner Lonnar.

RB **Lunner, Kristina** 8:54
Good evening everyone.
We're going to jump right into our first agenda item.
I will turn to the proponents of LD 1803 to present their thoughts on prescriptive authority.

I **ianjonesod@gmail.com** 9:11
OK.
I'm just gonna share.
There we go.
Perfect. Can you see that?

RB **Lunner, Kristina** 9:29
We can.

I **ianjonesod@gmail.com** 9:30
Perfect. OK.
Well, my name's again.
Doctor Jones from Bangor, Representative, Maine Outreach Association.
What? We're gonna start off with today is just really the big thing with LD 1803 is that optimists are not asking for any new prescribing, right?
What what we're asking for is to once again be able to prescribe hydrocodone from the 1990s until 2014 of Thomas were allowed to prescribe hydrocodone and Maine.
For teen US Drug Enforcement Administration rescheduled hydrocodone from Schedule 3 to the more restrictive schedule.

Two under the Control Substance Act, this reclassification restricted optometrists main to no longer have prescriptive authority to prescribe hydrocodone right now, because it's only 36 states now. Allow optometrists to prescribe hydrocodone. There's requirements to hold Adea license to prescribe that the opioid hydrocodone in the state of Maine is the same for every type of healthcare provider.
No matter what type of provider you are, the DEA requires A1 time, 8 hour training on managing and treating patients with opioids and other substances orders. And in addition, the state of Maine also requires practitioners to complete 3 hours of opioid training every two years. So we.
Been so as you can see in the LDA 1803 patients are not asking for any new prescriptive authority, just asking to once again be able to prescribe hydrocodone. This is a medication that we were able to describe for over 20 years as you can see like.
I said basically we're at 36 states that can prescribe this right now and that's really what we're looking at. And this is what we presented for the for the prescriptive authority.
Perfect. And that's all we have.

RB **Lunner, Kristina** 11:30
Questions for Doctor Jones?
I have one I was not aware of the reclassification.
Do you, Doctor Jones know why that? What prompted that?

I **ianjonesod@gmail.com** 11:52
No, I don't know why they end up making that decision that for the DEA to to reschedule hydrocodone.
I don't know if there was any any real reason for that.
Unless anybody else knows on this panel.

LF **Linda Feero** 12:07
Yeah, I can speak to that.
It was reclassified because of the addictive potential that ended up being higher. And so it was reclassified into the appropriate category from 3:00 to 2:00.

RB **Lunner, Kristina** 12:22

Thank you, doctor Farah.
Doctor Harris.

Michelle Harris 12:33
Doctor Jose, do you have any numbers on the How many optometrists prescribed hydrocodone in those twenty years that they were allowed to do so?

ianjonesod@gmail.com 12:46
But we don't need data on how many subscribed patients during that period.

Lunner, Kristina 12:57
Doctor Faro.

Linda Feero 12:58
How about in the other states that have allowed optometrists to prescribe it?
Do you have any data from those states?

ianjonesod@gmail.com 13:06
No, but we could probably through the AOA be able to get that information.
So I can after this be able to get that information for you.

Lunner, Kristina 13:36
Doctor Jones, it's Christina.
Oh, go ahead, Doctor Harris.

Michelle Harris 13:43
I'm just also curious the indications for use.
How would mean optometrist plan to utilize the prescriptive rights?

ianjonesod@gmail.com 13:57
So you're right, it's very rarely used.
I think it probably in three years I've used it maybe three times.
I had a patient just recently.
Recently, when we first were allowed to prescribe it with acampa keratitis that we ended up in severe pain that we prescribed before they could go into to Boston to

see the corneal specialists.
So there are very rare reasons, but like I said, there are those potential times where the patient needs it because of a, you know, extreme pain and.
You know, for, for, for patient comfort, you know, to use it, we like to have that prescription back like you. But like you said, it's very rarely used. Like I said, I can't imagine how many times I've ever had to except maybe 3 * 3 or four times.

MH **Michelle Harris** 14:50
Yeah. Thanks.
Thanks for the answer, Doctor Jones.
I didn't actually say that.
It was rarely used, but it it is rarely used by ophthalmologists.
Do you ever liaison with primary care physicians?

I **ianjonesod@gmail.com** 15:06
Yes. Yeah, I have because I with staff with the Sebasta hospital.
So you know, we work a lot with the primary care's for a lot of different reasons, but yes.
If there is a reason for us to be able to for a question with it, a lot of times we can reach out to our primary care colleagues to to help.

RB **Lunner, Kristina** 15:31
Doctor quint.

JQ **Jessilin Quint** 15:34
In Doctor Jones, you did a really great job of of kind of showcasing where where the journey has gone with optometry and like specifically hydrocodone.
Hopefully this is something a medication that I never have to use, you know, but it's it's like that one case once in your lifetime or a couple in your lifetime where it really comes down to the patient being in pain. And obviously there's a there's a lot of. Awareness of the.
You know, risks and the addictive nature of these medications.
We're very aware of this and of course, you know, anytime you are prescribing something of that, you have to take that with a great responsibility. And so are, you know, we look at this of when we were introducing LD 1803 is this was included

really to.
Kind of LD18O3 was written in the spirit of including everything that optometrists are trained and educated to do.
So we have extensive pharmacology classes all optim.
To practice and maintain, to serve on insurance panels have to hold adea license, which does include extra opioid, you know, continuing education involved in that.
And so hopefully we never have to use these medications because using them is at a time when a patient is in extreme pain.
But making a patient wait and while we do Co collaborate with a lot of primary care physicians and providers.
Sometimes you know, getting into those individuals or making those connections because we all know.
How thin spread they can be that can sometimes delay the care delay, that patient being able to to have some pain management and so that's why it was included.
We, you know, we didn't really think of hydrocodone necessarily as something new with LD18O3 like some of the other CPT codes, but really to just expand upon what optometrists are trained and educated to do so and to really just keep the forefront of our pat.
Comfort and vision at the top of the line.

RB **Lunner, Kristina** 17:41
Doctor Jones, it's Christina. I'm curious.
The because of the reclassification, do you do you know how many other states had to make changes to reflect the new classification?
How many actually went through and made the update?

I **ianjonesod@gmail.com** 17:59
36 states did.

RB **Lunner, Kristina** 18:03
Thank you.
Doctor quint.

JQ **Jessilin Quint** 18:10
Yeah, I just have one other point. Before 2014, when optometrists could prescribe

this, there, there weren't any negative experiences reported, right?
There weren't any complaints with the board and so this wasn't something that was abused by optometrists before 2014.
There's there's no track record of that. And so I think that that's important to also include when we're when we're looking at this within LD18O3.

RB **Lunner, Kristina** 18:38
Thank you, Doctor Quinn.
Doctor lighthizer.

NL **Nate Lighthizer** 19:00
I was just going to partly answer that one question, for example one.
One example is Oklahoma.
Our law read in in 2014. We could prescribe Schedule 3 narcotics when it changed to schedule 2 hydrocodone.
Are the changes were made in Oklahoma in 2014 or early 2015, so it was within six months of when this change that that's when Oklahoma changed their law to allow us to again prescribe hydrocodone.

RB **Lunner, Kristina** 19:37
Thank you, doctor Lightheiser.
Any other questions or comments about?
Hydrocodone.
OK.
We can always come back, but if we if we have time, why don't we turn to opponents of LD 1803 and welcome your thoughts on prescriptive authority.

LF **Linda Feero** 20:29
I'll be presenting.
I'm going to go through not just the the opioids, but the other drugs that were on the list of of requested things. The first one were contact lenses impregnated with medications or drug eluting contact lenses.
This is a technology that's not available in the United States or anywhere in the world currently. The first drug, the first contact lens that had a drug in it, was Acuvue Thera vision with.

Ketofin.
Which is a drug approved in 2022 to treat ocular allergies.
This was released in in Europe and then was withdrawn from the market before it could be released in the United States. Although it had been FDA approved for release here.
There have been other drugs that have been trialled, but none of those have been approved for use.
They've tried with the antibiotic meloxicam, impregnating with a steroid, dexamethasone, and anesthetic Tetra cane and with a prostaglandin.
In an analog bermatopross to treat glaucoma.
At this time, it's really unclear what medications will be able to be delivered by contact lenses in the future, and whether any of those drugs would be falling within the training of an optometrist at this point so.
That's where we are with contact lenses and medications. Category number two were antihistamines.
Antihistamines are a class of drugs that are used to treat allergies.
They're considered generally a safe class.
Many of them are available over the counter.
Optometrists can prescribe topical antihistamine drops already.
And other prescription forms of antihistamines include some oral and some nasal spray medications, but generally are considered pretty safe.
The third category that they asked for was very nonspecific and it said anti-inflammatory medications.
This is a huge category and has a lot a lot of drugs in it.
The first group is aspirin, which is available over the counter. The second category is non steroidal anti-inflammatory medications or NSAID's, many of which are over the counter like ibuprofen and naproxen or.
They're effective for pain relief, for fever and for inflammation.
Topically prescribed NSAID or can already be prescribed by optometrists, and stronger oral prescription NCG's are available as well. These drugs, when they're used long term in oral form, increase the risk of gastrointestinal bleeding and ulcers.
And they should not be used during pregnancy, but generally can be used especially in the short term.
In a relatively safe manner.
The next category is disease modifying antirheumatic drugs.

Dmard's things like methotrexate, hydrochloroquine, azathioprine, sulfazalazine.
These are drugs that modify the immune system.
They use various different mechanisms.
They slow disease progression. They're used for rheumatoid arthritis and other autoimmune diseases.
And and for lupus, side effects vary.
Among the different drugs, but they also cause gastrointestinal problems, rashes.
They can cause bone marrow suppression.
The biologics are a group of drugs that specifically target conventional, particular molecule inside the body and specific proteins or immune cells.
Biologics include targets or tumor necrosis factor inhibitors, limumumab. Lots of them.
They're hard to say.
Interleukin inhibitors B cell depletes T cell modulators.
These are all given by.
Cutaneous injections, or by intravenous infusions.
The most worrisome potential complications of this class of drugs is infection from immune suppression.
You can reactivate latent infections that might be laying hidden in the body. You have to screen patients for infections like hepatitis B and tuberculosis before you start therapy. You can have in injection site reactions because you have to inject these. You can get fevers, blood disorders and.
Certain cancers can be increased in in.
Some of the medications.
These two groups, the Dmars and the biologics, are generally prescribed by oncologists and by rheumatologists rarely prescribed by ophthalmologists, unless they have additional fellowship training in ocular inflammatory diseases or in retina.
And they're often administered in conjunction with a rheumatologist or an oncologist.
So it's hard to see for us how an optometrist would really have the the scope of training to be using.
Biologics and demarts.
The next drug is acetazolamide, which is a carbonic anhydrous inhibitor.
This is a drug that's infrequently used to treat glaucoma.
There's a topical form of it that's used more commonly to treat glaucoma. The most

common use of this drug orally is for a disease called idiopathic intracranial hypertension.
It's often prescribed by either an ophthalmologist or by a neurologist for that disease.
It has a pretty moderate safety profile cost some gastrointestinal side effects.
You can get a funny taste in the mouth. You can get paresthesias or tingling in the extremities with higher doses of the medication. You can get metabolic acidosis, an electrolyte imbalances, and it can cause kidney stones.
The next class is oral corticosteroids.
These are medicines that mimic the hormone cortisol. They have an immunosuppressant effect in addition to being anti-inflammatory. The most common example that that is prescribed is Prednisone.
But also hydrocortisone, triamcinolone dexamethasone, they come as eye drops.
Which optometrists can already prescribe?
They can also be administered as creams.
They come as nasal spray oral pills. They can be injected.
They can be injected into a lesion.
They can be injected intravenously.
They can be even injected into the eye.
Depending on the steroid you're using, they vary in their duration of action and how potent they are.
There's a lot of conditions that are treated with steroids. Anything from X amount to multiple sclerosis.
Is autoimmune conditions, cancers, organ transplants? They have a lot of side effects as well. Appetite and weight changes, mood changes, particularly anxiety, depression and insomnia. At high doses, they can cause fluid retention.
Gastrointestinal problems, osteoporosis, avascular necrosis of the hip, high blood sugars.
They cause adrenal insufficiency when used for longer than a week.
Ocular side effects include development of cataracts.
And the creation of glaucoma.
For ocular disease, steroids can be used in several forms.
You can use them.
Creams or ointments are put on the skin, injections into or around the eye that can be used orally or they can be given intravenously. For some diseases,

ophthalmologists often will manage the side effects of steroids with the patients primary care physician. When a chronic use is necessary.
And then we'll talk about.
About narcotics, hydrocodone is a semi synthetic opioid.
It's created from codeine.
Was rescheduled in 2014 because of the high potential for abuse.
Historically, it was developed as a cough suppressant, but it's much more commonly prescribed for moderate to severe pain.
Pharmaceutical related opioid deaths a third of all the opioid deaths remain mostly stable.
However, the number caused by hydrocodone increased substantially from two in 2015 to 18 in 2016 in Maine, before being then overtaken by a surge of illicit fentanyl that continues to drive overdose deaths now.
As far as we can see, there's no strong reasons from from our perspective to expand optometry prescriptive authority for really any of these medication.
But we don't have any objection to the use of oral antihistamines, don't object to a Zeta zolamide either when there's a adequate monitoring for electrolyte imbalances, kidney and liver function, and screening for blood dysrhiasis. This may require the optometrist to partner with the PCP to make sure that.
The medication is used safely.
When it's used on a chronic basis.
Among the anti-inflammatory medications, we don't object to the use of aspirin.
NSAID's, with appropriate monitoring in elderly patients with a history of gastric ulcers or with renal insufficiency.
Again, partnering with the PCP to ensure safe use if it's chronically used.
Cortico steroids, we think, could be used within guidelines. The use of topical creams and ointments is acceptable.
We'd recommend doses of oral Prednisone not in excess of about 80 milligrams a day and not more than seven days at a time.
Patients who require steroids at higher doses or for longer periods of time should be referred to a physician for ongoing care, whether that's an ophthalmologist or a primary care doctor, rheumatologist, oncologist, whoever is appropriate. We don't think that optometrists need to use intravenous or injected steroids. Dmard's.
Biologics.
And these drugs are best managed by rheumatologists and oncologists.

We don't think that optometrists need to be authorized to prescribe hydrocodone, the governor's opioid strategic action plan strategy. #13 under public safety is to improve the safety of opioid prescribing. The first question to ask is, what conditions are they treating that require a highly addictive op?
The main PMP program indicated that between 2019 and 2024 for ophthalmologists, 13% of all narcotic prescriptions were for hydrocodone.
This was behind Tramadol, which is schedule 4 oxycodone, which is also schedule 2 and about equal with codeine, which is about which is scheduled 3 drug.
This is a table from the data from the main PMP for ophthalmologist. The number of patients treated and the number of prescriptions.
And for for reference, this is a a table showing the difference in potency between the various different opioids.
Showing that hydrocodone and morphine are about equal as far as their their.
Potential for for for causing.
Or causing difficulties.
The PMP doesn't have any data that they can give you.
Why? Why a particular narcotic was chosen so I can't attach a diagnosis to any of that data.
All I can tell you is that's the data that we have for the state.
But far and away the the main 'cause.
That for an ophthalmologist to prescribe an opioid is for postoperative pain.
The use of narcotics for postoperative pain is limited in duration.
But 6% of patients who are given a narcotic for postoperative pain control will be go on to become chronic users of narcotics, a rate that is 15 times higher than a patient who was never prescribed narcotics.
So it's really incumbent, as Doctor Quinn said earlier, that surgeons minimize the need for the use of narcotics whenever that is possible.
Pain management is generally in a stepwise fashion, preserving the use of narcotics for pain that cannot be controlled with any less dangerous therapies.
I'm going to show you a study that was done at a large teaching institution where 2.2% of the surgical ophthalmic cases.
Generated a narcotic prescription.
These are the diagnosis that are associated with those opioids, and you'll see that over half of the people who had corneal crosslinking got an opioid medication, a nucleation or evisceration is removal of an eye or removal of the contents of an eye,

and about half of those people.
Need a narcotic?
A tantalum ring is placed for treatment of an ocular cancer and about one in four of those patients.
Patients needed one preparing a ruptured globe, 17%, then going down stabiliser surgery, which is moving the muscles on the eye to align an eye that's turning in or out.
Cyclophoto coagulation is a treatment for glaucoma and can be quite painful.
Orbital fracture repair eyelid procedures and I need to talk a little bit about eyelid procedures.
5% of them needed a narcotic and these are not the eyelid procedure.
That are in this bill.
These are eyelid procedures like blepharoplasty. Removing all the excess skin in the upper lids.
It's pitis repair, raising an eyelid that's drooping.
It's it's fixing an entropy, or an entropy an eyelid that turns in or turns out.
And it's not shalazian removal or removal of small lesions from the eye.
Surgery on the nasolacrimal duct system.
Retinal detachment surgery and a very small number, but not zero of cataract cases.
For those cases, the breakdown of the narcotics prescribed, and I can't tell you exactly which narcotics for which particular case, but this is the breakdown. Most of them were given oxycodone and hydrocodone was the second most common narcotic that was prescribed for those particular procedures of the list.
That's above.
I'm going to scroll back up. The only thing that's on the list for our bill is the top one, corneal crosslinking.
And this is because they remove the entire epithelium of the whole surface of the eye. To do that procedure, exposing all of the nerve endings on the cornea.
And I think that for people that do corneal crosslinking, they will say yes, it's not uncommon to use narcotics, but it probably in most cases isn't 50% of them.
That's probably a a high, but that's what this study reported.
I won't belabor.
Yes, the FDA has the one time requirement 8 hours of training.
You have to do that either when you initially apply for your DEA license or your first renewal of your DA license after June 27th, 2023.

The main board of Licensure and Medicine, the osteopathic board and the nursing boards require 3 hours of training on opiate prescribing every two years.
And you have to do that regardless of whether you use those medications or not.
Diversion and Dr. Shopping account for 40% of drug overdose deaths in the United States.
So to minimize the chance of prescribing additional narcotics for a patient who's neglected to disclose that they're using one or neglected to disclose that they're on other sedatives, that could be dangerous when used in conjunction, you have an obligation to utilize the prescription monitoring program, and optometrists are.
If they're using narcotics required to use the PMP.
Can't see any reason why? Why optometrists need to prescribe chronic narcotics.

RB **Lunner, Kristina** 36:32
Doctor Farah.

LF **Linda Feero** 36:40
Furthermore.
If they're prescribing narcotics within the postoperative surgical time of a procedure done by an ophthalmologist, they really should be communicating with the primary surgeon about the need for why that patient needs narcotics.

RB **Lunner, Kristina** 37:04
Thank you, Doctor Farrow.
I was going to ask.
I see you have more before you move on, before you move on.

LF **Linda Feero** 37:09
But I'll stop.
Yep.

RB **Lunner, Kristina** 37:12
I I just would.
We've got time are there.
Let me just check are there any objections with Doctor Farrow continuing?
Seeing none.

Jessilin Quint 37:28
I guess does it fall outside of the the time allotted, I guess.
So that it's balanced and equal, are we at the 15 minute mark?

Lunner, Kristina 37:38
We are at the 15 minute mark.

Linda Feero 37:40
OK.
I'm happy to stop.

Jessilin Quint 37:40
OK.

Lunner, Kristina 37:42
OK.
Great. Thank you.
Doctor quint.

Jessilin Quint 37:55
Doctor Ferrar, you did a really good job of outlining things and you know most of the things that you outlined, optometrists are actually already allowed to do in the state of Maine.
All but two of those categories. Main optometrists can already do, of course. One of those was the, you know, the Demarge and the biologics. If there was a, you know, our intent is not to to do anything in that category, right.
We that's outside of.
What we want to do?
And if there was the word biologic and LD 1803 it was pertaining possibly to a topical biologic which again optometrist domain can already do.
I'm thinking of like ox survey.
That's a topical biologic.
You know, we're fine with not having that category.
We don't need it.

We don't want it and I'm not quite sure actually how that was inferred from LD18O3. I'm not sure if if we're reading maybe the the same bill there the other one.
That isn't currently allowed by optometrists is the hydrocodone, which we've had, you know, a discussion on. And you're right that we don't have to have that for a lot of the other procedures in ALDI 1803, which is great, especially with the corneal crosslinking. You know the.
The new technology allows an EPI on, which also significantly decreases the need for for hydrocodone.
But you know.
When it would be used were cases that were already seeing maybe that corneal pathology case.
That is rare that we would need to be able to prescribe it to keep that patient out of pain.
I think we also agree with you that being able to prescribe chronic use of this is maybe outside what we want to do.
So we kind of anticipate with hydrocodone that those would be very short stints and possibly set up to something of how we already can prescribe oral steroids with maybe a time limit with on that.
And even with hydrocodone, you know whether we look at Maine's history of Optometry being able to prescribe it. Prior to 2014, we didn't see any abuse of situations.
We didn't see any problems with it. Even if we look at the other 36 states in across the US that currently can prescribe hydrocodone even as rare as it may be, we don't have any statistics that show that that is a problem. There's any danger with that.
That that's caused any.
Harm in those other states that that currently.
Allow it with that change of moving to a different scheduling class.

RB **Lunner, Kristina** 40:39
Doctor Farah, I'd like to follow up on Doctor Quint's comment.
Would would welcome.
More clarity or perspective on?
Where some of the you know the those.
Medications outside of other than hydrocodone that you listed.
Do you see that in Ldat 3 referenced?

Linda Feero 41:08
Yes.
Yes, they were all listed.

Lunner, Kristina 41:11
And where do you see?

Linda Feero 41:13
That's why we we brought them up.
They were on the list of of things that they wanted.

Lunner, Kristina 41:24
Thank you.
Should have the amendment right, right with me and I, of course I don't. But I don't want that to delay Q&A.
But I think I do think we need to get alignment on this doctor Harris.

Michelle Harris 41:47
It would be under M to independently prescribe oral and topical anti-inflammatory.
Says also including steroids.
But the fact that it's oral anti-inflammatory is the is the concerning aspect because we we can't.
We can't know what every optometrist in the state of Maine aspires to.
And and I will say that's that, that same thought process applies to corneal crosslinking.
There is a newer category of of EPI on crosslinking, which should in theory reduce discomfort. It's it's very new.
But that doesn't negate the fact that EPI off cross linking still exists.
And that may be someone's preference.
Maybe not the preference of the group here, but again, we we we don't know the intent of all the optometrists in Maine.

Lunner, Kristina 42:44
Thank you, Doctor Harris. Doctor Quinn.

Jessilin Quint 42:48

Yeah, just to clarify, these are outlined in ALDI 1803, but they're not new.
When we wrote LD 1803, it was to be very transparent.
We wanted to be very clear about everything that was in here, so there was no Gray area.
So yes, they are in LD 803 really just for the specification that this is exactly we're not trying to sweep anything under the rug. We're trying to be very transparent.
But if you look at the current optometry bill.
Even page 7, if you.
Look at the current downtrend bill at the end of Page seven, Section B talks about how we can prescribe even oral immunopreressive agents.
It just is limited to the five day supply, so it's currently written out in our bill.
It's also reflected in LD18O3, but just specifically because something is spelled out on LD18O3, that's not a category that we're asking for.
That's really just us being very clear.
Of you know of, of everything that optometry would be allowed.
Out to do so, just to kind of get everybody on the same page there.
Yes, it's spelled out, but it's also currently spelled out on our currently on our current optometry law.

Lunner, Kristina 44:06

So Doctor Quint to confirm the only new prescriptive authority.
Is related to hydrocodone, which you would argue is not new because you had that prescriptive authority when it was under a different schedule.

Jessilin Quint 44:23

Exactly, yes.

Lunner, Kristina 44:56

Any other questions or comments about prescriptive authority?
If not, why don't we go ahead and move to the next topic?
The second this is on the Board of Optometry. This is an area the implications to the board and it was an area that the committee requested that we look at specifically.
So I will it's 742.

We'll turn to the proponents.
Give you an your 15 minutes to present.

Jessilin Quint 45:47
Yeah. So I can kick us off and then I'm sure we'll hear from pat with our, with our licensing board.
So the the reason why board authority was really included in the LD18O3 was to really be mindful of as new technology comes out to make patient care a little bit more efficient, it wasn't put in place to underwrite any guardrails.
You know, legislators with the best of intent and Commissioner, with the best of intent.
You guys are amazing at what you do, but it's not always super well known exactly what the education of optometrists are. And so this was put in place to to really kind of offer that insight or licensing board is made-up of individuals that are appointed by the.
Governor.
These individuals and a lay person are tasked with the sole mission to protect the public and to make decisions and.
Lead within within that sole purpose and within certain guardrails. And so when we think about, you know, what can optometrists do safely?
What can optometrists do based on their education and their training? And you know their experience?
We you know who better than to ask optometrists that are tasked with the with the sole mission of of protecting the public.
So the way that this was written out was was really with that kind of oversight.
In mind and that intent, you know to further ensure public safety within this, there can definitely be statute verbiage that's added that prevents the licensing board from writing any new regulations or procedures that are taught, you know, outside of optometry school. We could also add in the process.
Of substantial rulemaking to again kind of keep those guard rails within place. And if we look across the country, there's a number of other.
That have had board authority and have had their states really involved in this different licensing and this kind of oversight with the optometry profession.
So that's kind of the intent of why the board authority was put there. If we look at licensing specifically, whether it's looking at states like South Dakota, Montana,

Louisiana, Oklahoma, Colorado.
You know how they've rolled out being able to do advanced procedures.
They, while they might have some nuances, there's kind of three big themes they really could have really dictate exactly what education requirements are mandated and required.
They talk about what competency verification is needed and then some also have a a proctored skill evaluation assessment that is similar to reflect the same number that ophthalmology residents do have.
So if we look at these states that when they do help, look at how they roll out these advanced procedures, different licensee, what we do see is that those state licensing boards don't require a substantial new infrastructure.
They don't have significant new spending. They don't have to bring on, you know, a lot of extra people to put on their payroll. They don't have to make huge.
Organizational sweeps to to restructure different components.
They're able to really incorporate these advanced procedures in an efficient way in a low cost way, but still ensuring patient safety. And so there's a number of different ways that this licensing board can certainly roll this out. But just to kind of get like, take a big picture.
Of what this would entail would likely be an advanced therapeutic license. We'd have to really kind of dictate some.
Board approved education, a competency exam. Whether it's something.
Thing like signing off on a laser injection therapy training skill mastery course, or in a course, it's equivalent to that. Possibly a proctored clinical skills assessment.
And then, of course, there will likely be some extra educational hours in the continuing education aspect.
But when I look at our main state licensing board, they are well within the rounds.
They have the infrastructure, they have the people in place in order to make this licensure happen. If LD18O3 was to go through.

RB **Lunner, Kristina** 50:25
Thank you, Doctor Quinn.

LF **Linda Feero** 50:34
Pat, you're muted.

Pat Smith 50:45
Sorry about that.
Can you guys hear me?

Lunner, Kristina 50:47
Yes.

Pat Smith 50:48
OK.
Yeah, sorry.
Yeah. Doctor Quint, thanks for that nice explanation of things.
Now we, the State Board's happy to participate in this process.
We understand it's not our job to take sides in it, but we are.
We do need to be prepared to implement it if it does become law.
Because much of the implementation will fall to the state board.
We've used the Sunshine Review as an opportunity to to get familiar with all of the the the licensing processes used by other states.
We've reviewed statutes and rules, we've spoken with state board members.
We've begun to look closely at the licensing and monitoring processes. We recognize the components that Dr. Quint mentioned as integral to.
Adding these procedures to the scope of optometry, the collective experience of other states suggests that the the processes are very front end heavy. That rulemaking can be time consuming that designing the application processes.
Is involved a significant amount of work.
And that a clear statute and clear rules are critical to a well run program.
We're very confident that the research we've done will allow the board to establish a robust and credentialing and monitoring process that will ensure the delivery of quality eye care and guarantee public safety.
We've submitted our responses for this meeting and we're happy to discuss them further.
Thank you.

Lunner, Kristina 52:25
Thanks Doctor Smith.

Questions.
For the board or the proponents?
Doctor Clayton.

GS **Gleaton, Maroulla S** 53:15
Doctor Smith.
What are your thoughts about how to ensure competency of optometrists, who have not received any kind of residency sort of training?
Since there really is no program anywhere around the northeast.
And that there are optometries currently in the state that might be interested in expanding but have not had any access to those kinds of training programs.
How would you go about assuring competency as a board?

PS **Pat Smith** 53:53
If you look at the models that the other states have used, they are comprised of a didactic classroom component.
That is.
Finalized by passing a test and then after that there's some demonstration of competency that's required, and that's where the variability really takes place.
Some some state boards run their own test.
Other states.
Have proctored.
Situations.
Where after people complete the education component, they receive a credential and that credential allows them to perform procedures under a proctored setting.
The Proctor would be either an ophthalmologist or an optometrist.
It's already certified to do the procedures.
I think that that process has been shown effective in the states where the procedures are being done and I think.
Think for us.
Well, we haven't discussed it in in depth at the state board level.
I personally would be.
In favor of the proctored process, where we make sure that there's a number of cases done.
And for various reasons, I think the state board wouldn't necessarily incur a lot of

expense in that process that would be cheaper for us to do.
And.
I think.
It ensures more, more cases.
More practice.

RB **Lunner, Kristina** 55:32
Thank you, Doctor Smith, Dr. Harris.

MH **Michelle Harris** 55:37
So under the requirement for proctoring or even the the education, I think the the 32 hour courses, I think we've been mentioning it.
I mean where?
Where is it specifically stated that in optometrist must perform these on on live patients?
So I I'm not seeing that clear requirement and and I'm also not aware of specific numbers of cases that would.
Online patients.
Because it's, you know, I think it was mentioned.
Well, it wasn't mentioned, but I think Doctor Lee's question was how.
How? How could this possibly be similar to an ophthalmology residency which you know we've covered in in Session 2 where we've we've outlined the different training aspects of an optometrist and an ophthalmologist.

PS **Pat Smith** 56:37
I can answer this, but one of the proponents may be better versed in the different state requirements.

NL **Nate Lighthizer** 56:46
Yep I can.
I can help answer that if you want me to help Pat.

PS **Pat Smith** 56:51
Yeah, go ahead.

Nate Lighthizer 56:51

You said every state is a little bit different in Oklahoma, we are required to take the 32 hour laser and surgery course.
I had that course now and teach that in Oklahoma as well as across the nation.
And then we have to sit for our Oklahoma Board of Examiners examination, which includes a written examination and a practical exam.
So doctors that have been performing these procedures.
Are a Proctor, I should say are a they a greater where you have to demonstrate proficiency on model eyes.
In Oklahoma, we do not have live eyeball requirements.
In Oklahoma, that's why we don't have a live proctored cases in Oklahoma that is different. In Wyoming, for example, in Wyoming, they have to have two proctored live cases.
For each procedure in South Dakota, they have to have 10 proctored cases for YAG CAPSULOTOMIES and five for SLT. When they're doing these procedures. So you can see the numbers are a little bit different in terms of how many live proctored cases that you have to do under.
The supervision of a an optometrist or an ophthalmologist that has a history of doing these procedures so.
Every states a little bit different.
Kentucky have had Procter dies Louisiana.
Did not.
Oklahoma does not.
Colorado does not. Wyoming does.
So everyone is a little bit different, but at the core it's you take an education and training course that has a didactic component, a hands on laboratory component.
There then is a demonstration of competency in terms of performing these procedures, either on modelize or live eyes and or live eyes, as I just outlined.
And then you are then granted a license to perform these procedures.
So that's how it's been done.
In other states, I will like to emphasize a point that competency of procedures and learning procedures does not only just happen during school and during residency.
If it did, then even our ophthalmology friends on the call, they would not be able to do procedures that came out after residency.

So things are learned and trained upon, not just in residency, but after residency as well.
So that's how it's currently done in optometry.

RB **Lunner, Kristina** 59:22
Thank you, Doctor Lighthizer.
Any other questions or comments about?
How this would impact the board?
Doctor lightheiser.

NL **Nate Lighthizer** 1:00:12
I just wanted to mention you know I I've have been fortunate to see this process in pretty much all of the 14 states that authorized optometrists to do, lasers and most of them that authorizes currently 20 that authorize them to do injections and eyelid procedures, things like that.
Optometry has been very, very strong at regulating what optometry does.
We're actually a very conservative profession.
They're very conservative. And optometrists?
Medical judgment. They go to optometry school and they go through four years of intense schooling and some go through residencies and have clinical experience to make the judgment going. Even though I have a law in Oklahoma that allows me to do a procedure on this patient for one.
Reason or another I'm I'm going to pass on this one optometrist. Have medical judgment to make the decisions on who should get a treatment that I can do and who should not get a treatment even though I do that and I've seen that first hand that medical Dec.
Making I just wanted to make that point, that optometrists have incredibly sound judgment and good medical decision making doesn't mean mistakes are not made.
Certainly in every profession, mistakes are made.
But they've had a really strong track record of regulating themselves.
By the Optometry board and through their sound medical decision making.

RB **Lunner, Kristina** 1:01:44
Doctor glayton.

Gleaton, Maroulla S 1:01:49
Doctor Smith, can you kind of give me a a feel for the number of staff that you have on your Optometry Board, number one. And then #2, do you feel like you have the staff to be able to do rulemaking and do anticipate having to raise Fe?
Or hire more people.

Pat Smith 1:02:09
We currently have.
One administrative office specialist who runs the office and the board is comprised of.
Five different board members.
I think it should be 65 practicing optometrists, although we have one vacancy at this point in time and one member of the public.
And as far as you know, do we have the resources to do this?
Yeah, we definitely have the resource to resources to do it.
The the path has been paved.
You know the the rulemaking process has been done in other states. We would rely heavily on those those to model what we did.
It's really only making up one rule and we have 15 other states to model ours after, you know this is coming on the heels of us redoing our entire statute which.
Which is comprised of seven chapters.
There's in six additional rules.
We did that without without an abundance of extra resources.
That took us about four years to do and cost the board about $11,000.
We did that independently and we think that in this case we would have, if needed, assistance from public sources, the Association of Regulatory boards of Optometries of resource for us, as is the.
American Optometric Association and the main optometric association.
So yeah, we definitely think this is, well, significant lift.
It's not an, it's it's. It's a doable thing and and we're ready if tasked.

Lunner, Kristina 1:03:59
Man, doctor phyll.

Linda Feero 1:04:02
Yeah, of the four optometrists who are on your board. How many of them have experience doing surgical or laser procedures on live patients?

Pat Smith 1:04:16
Can only speak for myself.
But I can say that 22 years ago, before I moved to the state of Maine, I lived in Arkansas.
Where we were doing minor lit procedures on patients without.
Without a lot of without, you know, without a problem.
I think that speaks to the length of time that this has been happening. I mean, this has been going on for a while successfully in other places.
I think that.
You know and and that being said, there hasn't been a ton of in talking to other state boards.
There hasn't been a lot of complications or complaints or any of these fears that you know are realistic, but they're not.
They haven't materialized in years of years of advance procedures being done by optometrists.
So I think that that would.
It suggests to me that.
The impact on our state board would be.
Would be minimal.

Lunner, Kristina 1:05:22
Commissioner Cohen.

Cohen, Joan 1:05:26
Thank you, Doctor Smith.
The repeal and replace that you mentioned was that a reorganization of existing statute and rules or was it?
Did it involve implementation of new authorities and responsibilities?

Pat Smith 1:05:45

It was both.
The the statue was a lot of organization, but the rules there were a couple new rules.
We added.
We added the telehealth rule and and an ethics.
I have it here.
I think it's ethics code of ethics.
So it was a little bit of both.

RB **Lunner, Kristina** 1:06:06
Doctor lighthizer.

NL **Nate Lighthizer** 1:06:08
I was just going to mention to Pat in the group, you know that's you know when something new comes out in the state, you know, I wouldn't expect the main optometric board of four or five eye doctors to have extensive laser or eyelid procedures when it's not current.
Authorized and permitted in that state.
And that's why you utilize colleagues and other doctors from other states.
I would be happy to be a resource.
I sit as the liaison for our school, for our optometric board.
I've helped assist them put on their.
Their exam numerous times again, and their job is to protect the public.
I want optometrists to safely and effectively do these procedures.
So again, there's there's a blueprint, a track record of success in numerous other states, and tap into that knowledge. And that experience of here's how you would lay out a main optometric board exam.
Here's the components that you need.
Here's how it's done. Here's how many.
Live cases I would recommend.
And when you do this, things like that. So you tap into that experience.
That exists already.

RB **Lunner, Kristina** 1:07:22
Doctor Harris.

Michelle Harris 1:07:26

I would just give some perspective on performing surgeries when there's been.
A.
A.
A large gap between either learning or performing them and.
Often times when surgeons are being credentialed. So this goes beyond just the training residency.
This is like for my my case credentialing in a hospital when you ask for those privileges. If you have not performed them.
Within the last couple years, typically those credentials will not be approved until you go through a period of retraining, which typically involves sitting with a trained surgeon to make sure that you are still competent. The same thing would apply to a procedure that you are maybe asking to.
Perform that you maybe only saw during your your training and you haven't actually practiced.
They don't just say well.
You're a doctor. And so I guess you did the training so.
Oh, sure, go ahead.
Go ahead and do that even though you haven't done it for, you know, 20 plus years.
And there are certainly surgeries that I have dropped off because I I did them and I did a lot of them in residency.
But I I didn't do them at all once I graduated.
And so, you know, I've self selected out and said I don't feel safe to do that.
That's not not fair.
And this this also ties into the volumes that we're presenting in presenting and that is a concern that there would be an adequate.
Number of cases that would allow either an optometrist to become competent in the state of Maine and then to also maintain competency throughout their careers.

Lunner, Kristina 1:09:11

Doctor Clint.

Jessilin Quint 1:09:14

I'd like to say that with Doctor Fierro, you're right. And so that's why sometimes a lot

of other states, if we look at the blueprints that they set, that they require, you know, the 32 hour lasers within the five years of of when they apply for this.
Advance license.
So I think it's certainly appropriate to create some guardrails in place because of that.
And I also think that you know that 32 hour kind of.
Just re demonstrating your skill set.
That's able to be done because of the.
Really broad foundation that we've all had through our educational training.
So if it's a retraining that might be a different, I would maybe pick a different word choice for this, because it's not. So retraining it's building upon that extensive knowledge and background that you that you already have.
You the licensing board, they have, they did a great job with LD with the repeal and replace and they do have the everything in place.
Place in order to to do something very similar with LD18O3. The other thing to really point out is that this doesn't have to happen overnight, right when the licensing board is is setting this when when LD 1803 goes through, they can sit with.
This and while that would delay the patient access part of it, they can take their time to get everything that's needed to.
Safely put in place the licensing requirements as proctoring waiting for those number of cases.
You know they can take as much time as needed to basically make sure that we have sound rules in place and we feel very confident that the mainstay Optometry licensing board would be able to do that.

RB **Lunner, Kristina** 1:11:05
Doctor Faro.

LF **Linda Feero** 1:11:07
I just want to state that I object strongly to the assertion that optometrists are are rigorously trained as surgeons in their residency training and all that they need is 32 hours to refresh them and they be competent.

RB **Lunner, Kristina** 1:11:42
Doctor Harris.

Michelle Harris 1:11:44
Yeah, the, I mean, the entirety of the main there are the mseps organization supports that that statement, Linda.
That that's, you know, taking a 32 hour course on on on a non live patients and calling yourself competent is it's it's concerning.

Lunner, Kristina 1:12:13
Doctor lighthizer.

Nate Lighthizer 1:12:15
Yeah. So I guess how I would would counter that is there is a very different surgical skill set for doing a selective lasers trabeculasi as there is for cataract surgery as there is for retinal detachment surgery, there's a very big difference between heart surgery and removing a skin.
Tag in somebody's armpit.
Both of those would technically be considered surgery or a procedure, but there's a different skill set for that.
So I think we need to be careful that we're bundling all procedures and.
Calling them surgery while they are defined as surgery based on codes and things like that. There's different levels of surgical procedures and SLT and YAG capsulotomy are a different skill set than some of the wonderful skills that these ophthalmologists possess when they're repairing a retinal detachment or taking.
A cataract out or or operating and putting a a certain Migs device into the trabecular meshwork when they're actually.
Inside the eyes, with tools manipulating delicate tissue.
You. So there there's differences in surgical procedures and I can speak on that. From my experience, I've had different surgical set doing a chalazine incision in cure Taj versus an SLT.
Those carry different surgical sets. When I'm behind my surgical microscope for an Inc versus behind an SLT laser. That is a very, very similar skill set to gonioscopy and slit lamp.
So I think we need to be careful on there's different levels of surgical skills.

RB **Lunner, Kristina** 1:13:52
Doctor Faro.

LF **Linda Feero** 1:13:55
I don't disagree, and I'd say that there's as much difference, if not more difference between removing a skin tag and doing open heart surgery than between using a slit lamp and using a laser.

RB **Lunner, Kristina** 1:14:19
Doctor Harris.

MH **Michelle Harris** 1:14:25
I mean I I understand.
The analogy that you're trying to make, but, but the fact remains that there is the possibility of causing harm to a patient with any of these surgeries.
And to the patient, it doesn't matter to them if you're opening up their chest where you're firing a laser into the eye if you have the potential to hurt somebody.
It needs to be taken very seriously and the standards need to be the same.

RB **Lunner, Kristina** 1:15:09
Doctor quint.

JQ **Jessilin Quint** 1:15:12
I would say that as an optometrist I took an an oath to do no harm to patients and I do surgical procedures. However, we want to define that currently when I remove a foreign body from a patient's cornea that can have some negative implications.
So any anything that we do within an within the healthcare system is never to harm the patient. And unfortunately a lot of these procedures do have complications.
But the fact of the matter is, is that currently within Maine, when I have a patient in my chair, I'm making the diagnosis.
I'm educating the patient on different treatments that are available alternatives.
I'm prepping the patient.
I'm doing everything up until the point of literally clicking a button, and then I'm which I'm referring out to currently, which is delaying care and then a patient is

coming back to me for me to manage any complications or.
Things that could have gone and happened.
So yes, unfortunately things can happen within that, but no optometrist sets out to do harm to a patient in anything we do is is to improve the patient's vision, make them more comfortable, improve the quality of life.
So to say that these procedures that are in LD 1803 would be done with the intent to harm the patient is just really out of, you know, just very out of the line because they're gonna be done with the intent to help the patients and they.
Gonna be done with the right safety measurements in place and any complications that can arise which could possibly arrive.
Optometrists are trained and educated to manage those complications. Should any now negative outcomes do potentially pop up.

RB **Lunner, Kristina** 1:17:03
Thank you, Doctor Quint, Dr. Lighthizer.

NL **Nate Lighthizer** 1:17:05
My my point was going to be a similar point. You know, we can cause harm of the foreign body removal.
I believe some of these same arguments were made when optometrists fought for the ability to put eye drops in the eyes is yes, you can cause harm when you're putting eye drops in the eyes versus prescribing glasses and contact lenses, and then some of the same arguments were.
Made when you prescribe oral medications because now it's another level when you're putting, you're taking a medication via the mouth that goes through obviously systemic absorption.
That can affect them system wide and the same arguments are being made now. I mean I I've done thousands of. Yeah. Glaser capsulotomies. I will tell you, I have had one patient that developed a retinal detachment after a YAG laser capsulotomy the ophthalmologist, the fine ophthalmologist on this.
Call know that is a risk.
Retinal tears.
Retinal brakes.
Retinal detachment is a risk. And yes, that had happened in one patient and we referred them up to retina.

They were repaired very quickly and had a good outcome, but that doesn't stop that 99 plus percent.
Of the YAG capsulotomies that I have done, patients have been extremely thrilled and happy with that. There are risks with anything and that's our job as the doctor is to explain the the possible benefits, the benefits and the possible risks of this.
So yeah, there's risks with anything from putting contact lenses into the eye to prescribing drops, prescribing oral medications to doing injections procedures and lasers.
Absolutely there is.

RB **Lunner, Kristina** 1:18:30
Thanks, Doctor Lightheiser, Dr. quint.

JQ **Jessilin Quint** 1:18:34
I'd also like to point out that optometrists are held to the same standards as ophthalmologists. If something unfortunately doesn't go quite as planned or held, you know, retails to the fire just as much as you are, there's no, you know, exemption of that because we're optometrists so for.
That standard of care we're held to the same standard as our colleagues.

RB **Lunner, Kristina** 1:19:04
Thank you, Doctor Quinn.
We're only at 8:15, but we have completed the discussion of the two topics that were planned for this evening.
We wanted to give you an opportunity.
This is our last meeting to make any.
Closing comments share any observations? Share any aha moments you might have had?
Ask any final questions, just it's an open floor.
Doctor Quinn.

JQ **Jessilin Quint** 1:19:44
Well, we've had some great discussion right over these the course of these three meetings, but I want to bring it back to you know why we're here with LDA eighteen O 3.

This shouldn't be a turf war.
This shouldn't be a fight against ophthalmology.
We all are in this to better our patients. LD 18, O3 is is really patient focused.
It's thinking about our patients that are having delay in care delay in access to the care.
For procedures that can be done safely.
And effectively in an Otometrics office.
And what happens when a patient has a condition that they have a delay in care?
Well, either they're possibly in pain or they can't see. And if you can't see, what does that mean, right?
You can't drive.
You have to rely on others to be able to transport you.
Possibly you can't work.
I you know, I've had patients that were waiting for a YAG that had to take a leave of work absence because they've had some.
They're just not able to to see.
It affects their quality of life. If you can't see, you can't do the hobbies that you love.
You can't see your loved ones and so not being able to have prompt care is is a real issue for a patients. We've talked about how the workforce is changing, right?
So nationally we see the number of ophthalmologists, there's significant decline in that and that's only going to hit Maine a little bit harder here in Maine, we've already seen.
Some ophthalmologists stop taking new patients.
We've seen some leave the state. It's been a hard time recruiting some new ophthalmologists.
So that workforce issue is is not going to go away. Maine's an aging population.
The need for these procedures is only going to continue to go up, so we've got a real discrepancy there when we don't have the workforce to meet the demand, but that demand is definitely increasing.
So what's the solution to that?
Well, why not use optometrists? That have extensive education training?
We've talked significantly about what goes into that, that who in a lot of other states have a great track record of being able to do these procedures very safely.
Why not allow them to be able to offer that solution for here in Maine, right?
Safety is is at the front of all of our minds, but these procedures are very low risk.

They can be done very safely. We've seen extensive examples. We've looked at other states where where this is statistically very true.
Are these procedures completely free of complications? No.
And we're definitely not saying that. But we've also seen how implementing advanced procedures like this can be done in a very efficient and in a very anomic economical way.
And we know that our state licensing board can definitely already have blueprints from other states to be able to have the example of how to be able to to blueprint this and to be able to roll this out.
LD18O3 is very specific.
You know, there's been a lot of discussion about what's in LD18O3.
But if we look back to how it was first proposed, it was with exclusionary language.
When we saw that that had a little bit of questionable, what does this really mean?
We revised it to be more transparent to also have inclusionary language of everything.
That's laid out. So it's not just all these thousands upon thousands of CPT codes.
We've been very transparent about what would be allowed within LD 1803.
Board authority was put into place, really, so we don't have to keep having fights like this.
Right, this is very similar to the glaucoma battle that we endured a number of years ago where our opponent colleagues so that everybody was going to go blind.
Everybody was going to die. And unfortunately that came at a cost to patients, right?
And we've, we've seen how that trickled out that none of those bad things did happen. So board authority can, especially with proper guardrails, be put in place can make it so that our patients have the best access to care.
But also that these procedures can be done in a very Safeway.
So that's I feel like our summary of kind of where we're at and I just want to call mind that the reason why we're here is because of that patient access issue. And we have an ample solution for that by allowing optometrists to just be allowed with their.
Trained and educated to do so.

RB **Lunner, Kristina** 1:24:08
Thank you, Doctor Quinn.
Doctor phyro.

Linda Feero 1:24:13
Thank you. I want to get back to the access question. One of the questions that came up during our first meeting and I'm hoping that they have answers for today because we had talked about presenting this at this meeting. Is the average wait time for routine eye exam.
New patients and existing patients for optometrists in Maine.
Do we have any data on that?

Lunner, Kristina 1:24:45
Doctor quint.

Jessilin Quint 1:24:48
We did submit some data to the Commissioner and and Christina on that to summarize it. It's very variable. So and this data is coming from. We pulled our Members, our main optometric association members across the state. So and it varies.
Some optometrists are booking two weeks out.
Some are booking two months out, some are booking six months out depending on.
How many days a week they work and kind of what part of the state that we're in?
But there were no trends that central Maine had a three month wait time, or southern Maine had a, you know, there weren't any trends with that.
It was very variable and just varied so much between provider between practice.
So I hope that answers your question.

Linda Feero 1:25:37
Yeah. Thank you.
So I also presented some data to them on my practice and the wait time for an existing patient in my practice is just over seven weeks in my practice. The wait time for a laser or a minor lid procedure.
Is 3 weeks.
So half the time to get in for a routine exam.
From the data that the main optometric association submitted to the legislature for YAG hop salotamy's, the average wait time was just over just over seven weeks.
So the same as the time for getting in for a routine exam in my practice and well

within the time of two to six months for your optometrist for routine exams.
So it's hard for me to see how.
Access is an issue when the times are roughly the same.

RB **Lunner, Kristina** 1:26:42
Doctor quint.

JQ **Jessilin Quint** 1:26:44
Well, Doctor Ferr, you talked a lot about at your practice and and your schedule.
Do you have any data from your other ophthalmology colleagues?

LF **Linda Feero** 1:26:54
I just told you the data that you actually submitted.
To the legislature on yeah, capsulotomies that the average wait time is just over seven weeks.

JQ **Jessilin Quint** 1:27:02
We don't.
For some procedures, but not every L, not every procedure in LD 1803.
So if we look at things.

LF **Linda Feero** 1:27:13
Right. You didn't give us all the data for all those things. I could only present what you gave.

JQ **Jessilin Quint** 1:27:29
When we looked at the data and we can verify that maybe you were able to receive the complete extent of it, the wait times do vary a lot. And so I think when we look at this, we can't look at just what doctor Farrow's practice is we.
Do have to look at the whole and we have to look at what, what procedure it is.
Especially for our Portland colleagues in southern Maine, which is the most urban part of Maine, they actually had the longest wait times for having the most ophthalmologist for.
Per you know, square capital, however, we want to categorize that.
So it does.

It does vary, but I you know, with being able to expand those procedures and allow optometrists to do so on average to be able to see an optometrist versus a lot of these advanced procedures, it would be much quicker with an optometrist.

RB **Lunner, Kristina** 1:28:25
Doctor Harris.

MH **Michelle Harris** 1:28:29
Yes, doctor. Quinn. I, I mean, I agree.
This is this is a really hard topic to kind of nail down consistent facts across the state.
But we have.
We have presented data.
We we did perform a survey amongst our members unanimously.
We all are feeling the burden of providing routine eye care.
We feel like we're doing a pretty good job with addressing the surgeries that are requested in LD18O3 with offering services on average.
Within about a month, the offices in Portland, it's important for Christine and the Commissioner to know these are our sub specialists and they typically are not performing routine care.
So they're only offering these surgeries as well as more advanced things like retina, retina surgeries, glaucoma surgeries.
And oculoplastics surgeries.
So it's, you know, we're kind of mixing apples and oranges. I know at my practice in Brunswick.
Which is a large area.
We will typically get we we have kind of a fast track if you will for these surgeries.
I did not present this data formally, but just kind of anecdotally we we do have a a special phone number where the optometrist can call and we know that that's the question and we we make an effort to get these patients in and if insurance and patient pre.
Allows. We will even try to do these on the same day.
The number one question I get from all patients.
And in talking with our front desk staff is routine care. Patients have a great concern about the access for routine care in our area.

Lunner, Kristina 1:30:15
Thank you, Doctor Harris.
Any other closing comments?
Doctor Harris.

Michelle Harris 1:30:32
Christina and our Commissioner and Christina, on behalf of Mseps, we would like to thank you for your time and attention on this important issue.
We truly appreciate.
Appreciate your efforts to bring our groups together and for listening thoughtfully on our differing perspectives for LD 1803. I am going to sound a little bit like a broken record, but I think I should just summarize Mcepp's position.
We do oppose LDA 1803 due to concerns about patient safety.
Safety. We recognize that optometrists are well trained in primary eye care, but their surgical training is limited.
It is not standardized.
It's often restricted to brief course work using models. Encompass competency is, as we're finding out, defined by state boards.
Which contain no surgeons or physicians.
I think you know our thoughts that no eye surgery should be considered simple or low risk.
Depending on how or yeah, simple or low risk given the eyes.
Delicate nature and critical role in vision and then expanding oral prescribing authority, particular for opioids, would just increase means prescription monitoring burden with little benefit. As we've already pointed out, these medications are rarely needed for most eye conditions or even after most eye surgeries.
And lastly, Lea two no three will not improve.
The type of access to eye care that maynors need.
We've already presented Medicare data that shows low surgical volume volumes for these requested surgeries among mean ophthalmologists and these volumes would also be insufficient for optometrists to gain or maintain surgical competency.
So what we would propose is, rather than passing LDA 1803, our efforts would be better utilized focusing on improving access to routine eye care and strengthening collaboration between our professions.

Lunner, Kristina 1:32:32
Thank you, Doctor Harris.
With that, I will turn it to the Commissioner.
Doctor Jones, any last comments?

ianjonesod@gmail.com 1:32:46
I just wanted to say same thing. Want to thank the Commissioner and you, Christina, for, for, for bringing us all together with this important topic. I think it's been.
Very productive and you know we as the main objective association.
Would like to thank everybody that was here.
It took a lot of work and anyway we'll hopefully be seeing everybody soon.

Lunner, Kristina 1:33:14
Thanks Doctor Jones.

Cohen, Joan 1:33:19
So with that, I would like to thank all the stakeholders for their involvement in this process and for the information that you have provided. We ask for a lot of data and we appreciate the time you all spent researching and organizing the information for us and also for.
Keeping it.
At a.
A language level that the non medical expert could understand.
Thank you.
This is an important patient access and public safety issue and we greatly appreciate each of your contributions. I would also like to thank Deputy Commissioner Christina Lunner. She has been dedicating a lot of time to organizing these meetings, developing the agendas and the requests for information, reviewing all.
Your responses and undertaking additional research.
Thank you Christina for your diligence and hard work.
So for the next steps, we will continue to digest and summarize the information provided.
We will undertake additional research as needed and draft a report which is due January 15th.

We don't anticipate that the report will be available in advance of the 15th, given the amount of time, amount of work there is still to do.
According to the health coverage insurance and Financial Services Committee's directive.
The report will include the department's findings and recommendations for the committee's consideration.
So with that, again, I thank you for your time and commitment to this process and I wish you all a happy and healthy holiday season.
Thank you so much.

GS **Gleaton, Maroulla S** 1:35:10
To you as well.

RB **Lunner, Kristina** 1:35:10
Thanks everyone.

NL **Nate Lighthizer** 1:35:11
Thank you.

LM **Laura Green, M.D.** 1:35:12
Thank you.

CJ **Cohen, Joan** 1:35:13
Have a nice weekend.

NL **Nate Lighthizer** 1:35:14
Yep.

CJ **Cohen, Joan** 1:35:16
Aye.

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