Association of Regulatory Boards of Optometry 2019 Annual Meeting (ARBO & NBEO):

Looking Back/Seeing Ahead-20/20 Vision for the Next Century, June 16-18, 2019, St. Louis, MO

2019 is a landmark year as ARBO commerates its 100-year anniversary. It is one of the oldest continuously operating organizations in optometry and their mission of assisting regulatory boards hasn't changed since they began. They began as the International Association of Boards (IAB) in 1919 to create a venue to bring boards of optometry to create uniformity, share knowledge, and advance optometric regulation for the benefit of the public.

The name was changed to the Association of Regulatory Boards of Optometry or ARBO in 1999. For over 100 years, ARBO has served its member boards by developing programs to help ease the burden on regulatory boards and by being a conduit of information regarding licensure and regulation. They do point out that continuing efforts at deregulation and ever-diminishing resources in government budgets and all of health care will continue to have an impact on their future progress.

Reports from States, Provinces of Canada, and New Zealand, and Australia

Every year ARBO sends out a request to have the various Boards send in a report listing how many licensees they have, what their licensing fees are, what type of continuing education is required to maintain licensure, and what issues are of current concern to their jurisdiction. As has happened in most years, ARBO also asks Member Boards about what they deem a pertinent issue affecting the contemporary practice of optometry. This year there were 5 questions titled "Member Board Survey on Telehealth 2019". Q1 "What is the extent of telehealth (optometry) in your jurisdiction?" Q2," Has your Board addressed this issue in a formal way? How so?" Q3 "What resources is your Board using to help make decisions about telehealth?" Q4 "Has your Board any complaints regarding tele-optometry? What was the nature of the complaint?" Q5 "Do you know if other health professions boards in your jurisdiction have addressed this issue in any formal way? How?"

The following is a quick synopsis of the responses from the various Boards.

USA: (35/50 states reported)

Alabama: 5/2 OD/public member board/5 yr terms. $500 app fee/$270 renewal fees/biennium. 20 hrs CE/biennium. 100% OET CE audit. Injectables allowed.

Alaska: No report was given but because of passage of their new law, it is included here. The big change is that the Alaska Board of Optometry regulates the profession of Optometry. Since other professions in Alaska are regulated by their respective boards, Optometry now is as well. Their scope of practice is limited to what the Schools and Colleges of Optometry are currently teaching. This eliminates the need for costly legislative scope changes.

Arizona: 5/2 OD/public member board/No specified terms. $450 app & renewal fees/biennium. 100% OET CE audit. No amount of CE specified.

Arkansas: 5/2 OD/public member board. $438.50 app fee/$200.00/annum. 100% OET CE audit. No amount of CE specified.

California: 6/4/1 OD/public member/optician board. $364/441/biennium. 5% CE audit (only 60%/40% compliance in last audit!) Has license registration & fees for Opticians, Spectacle Lens dispenser, CL Dispenser, Non-resident CL Seller. Injectables allowed. Just passed a law that prohibits those with minor offenses to still get an OD license. Anaphylaxis injections allowed.

Connecticut: 4/3 OD/public member board. $565/$380/annum. CE audits only when a complaint is filed. Anaphylaxis injections allowed.

District of Columbia: 4/1 OD/public member board. $433/348/biennium. <20% CE audits.

Georgia: 5/1 OD OD/public member board. $300/$125/biennium. Injectables allowed.

Hawaii: 6/3 OD/public member board. $270/$270/biennium. 100% CE audit.

Idaho: 2/3 OD/public member board. $100/$150/annum. 10% random CE audits. DOB renewal. Injectables allowed.

Illinois: 6/2 OD/public member board. $500/$400/biennium. No CE audits. ALL OD's are TPA!

Kansas: 4/1 OD/public member board. $150/$450/biennium. 100% CE audit.

Kentucky: 4/1 OD/public member board. Licenses renewed annually but no fee given. 100% CE audit. Legislation did not pass that was an attempt to restructure boards given the 2015 US Supreme Court ruling in the NC Dental Board vs. FTC. LASER-yes.

Maine: 5/2 OD/public member board. $300/$350/annum. 10% CE audit annually.

Maryland: 5/2 OD/public member board. $300/$600/biennium. 10% annual w/"select" record review annually.

Michigan: 9 member board, make up not specified. $202.80/$222.80/biennium w/additional $88.40 for controlled substances permit. 1% CE audit annually. New telehealth rule but not enumerated.

Minnesota: 5/2 OD/public member board. $160/$135/biennium. 99.9% OET CE audit. A 2-hr opioid education bill is before the governor now.

Mississippi: 5 OD board. $325/annum. 20% CE audit.

Missouri: 5/1 OD/public member board. $225/$150/biennium. 33% CE audit q 2 yrs.

Montana: 5/1 OD/public member board. $250/$250/biennium. 36 hours CE required. Working on implementation of OET.

Nebraska: 3/1 OD/public member board.

New Hampshire: 4/1 OD/public member board. $300/$300/biennium. 10% CE audit.

North Carolina: 5/2 OD/public member board. $800/$300/biennium. Additional costs for multiple offices. 100% OET CE audit. Now requires a 2-hr webinar on opioids.

North Dakota: 5/2 OD/public member board. $200/$200/biennium(?). 100% CE audit. Requires CPR.

Oklahoma: 4/1 OD/public member board. $300/annum. 25 hours "CME"/annum. 100% CE audit. Background check on all applicants required. CPR required. LASER-yes. (They have been performing LASIK, YAG, LPI, SLT since 1988. Have one of the lowest malpractice rates in the country with NO adverse outcomes since 1988.) Passed the following rule this past year, O.S. 59 Section 581, Part E, "Nothing in this title shall be construed as allowing any agency, board, or any other entity of this state other than the Board of Examiners in Optometry to determine what constitutes the practice of Optometry."

Oregon: 4/1 OD/public member board. $325/annum includes $25 PDMP charge. 10% CE audit. CPR required.

Pennsylvania: 7/2 OD/public member board. $25/$135/biennium. 2% CE audit. Opioid education now required. LASER & Injectables-yes.

South Carolina: 3/2 OD/public member board. $425/$230/biennium. LASER & Injectables-yes.

South Dakota: 4/1 OD/public member board. $200/325/annum. 100% CE audit/annum.

Texas: 6/3 OD/public member board. $230/$224.50/annum. Requires 16 CE hours for renewal annually. Anaphylaxis injections.

Utah: 5/2 OD/public member board. $140/$93/biennium. 10% CE audit.

Vermont: 3/2 OD/public member board. @225/$425/biennium. Seeking to add "Advanced Procedures Endorsement" for their OD's. This is just at the committee stage. Injectables-yes.

Virginia: 5/1 OD/public member board. $350/$250/biennium. 5-10% CE audit. Just had a license fee reduction.

Washington: 5/1 OD/public member board. $146/$166/biennium. 2% CE audit done each month.

West Virginia: 5/2 OD/public member board. $700/$400/annum. Injection Certificate is an additional $200/annum. 100% CE audit.

Wyoming: 3 OD's on board. $250/$175/annum. 100% CE audit. Just lowered licensure fees. Involved in a "Rules Rewrite Project" now.

Canadian Provinces: (4/10 Provinces reported)

Alberta: 8/1 OD/public member board. $110/annum. 100% CE audit. All OD's must have TPA and be "Advanced Scope" or don't get a license. May apply non-ionizing radiation. LASERs are "not prohibited".

British Columbia: 6/3 OS/public member board. $1390/annum. 100% OET CE audit.

Ontario: 10/8 OD/public member board. $1365/annum. 70 hours CE/3 yrs. Their board just settled a lawsuit with Essilor-Quebec and their subsidiaries, Clearly Contacts, Ltd., and Coastal Contacts, both out of British Columbia. The Board felt that by NOT having an OD as part of the verification process IN ONTARIO, selling of contact lenses across provincial borders from BC violated their "Regulated Health Professions Act". They lost this case. Ontario is now accepting the NBEO in addition to the OEBC for their licensure.

Saskatchewan: 10/2 OD/public member board. $3195/annum. 19% CE audit.

Southern Hemisphere:

Australia: 6/3 OS/public member board. Many levels of registration. Range is $100-$300/annum. They perform CE audits, but this number is "confidential". CPR is required.

New Zealand: 4/2/2 OD/Dispensing optician/public member board. $265 NZ/$813.50 NZ/annum. 100% CE audit. Have a "cultural competency" CE requirement.

Current issues of greatest concern for all these jurisdictions include, but are not limited to:

- License portability. There is no Uniform Practice Act in Canada although some provinces are working towards that.
- Telehealth
- CE compliance and keeping the public protected.
- Regulating Scope expansions
- Corporations "taking over optometric practices"
- Online "eye exams" and public protection
- Online contact lens sellers not verifying Rx.
- How does evolving technology balance public safety with the Optometry Board mission?

NBEO Workshop

Reviewed test psychometrics with the statisticians. The NBEO tests are NOT like the ACT or SAT which are "Normal Reference Testing" exams. These reference a "norm" only. The NBEO tests are "Criterion Reference Tests". These types of tests set an absolute standard of performance to establish initial minimal competency in an effort to ensure the knowledge and ability for safer and effective independent practice.

Nursing has their tests where AI will actually base your next question on how well you do not the previous question. This is not what medicine, podiatry or optometry do at the present time.

NBEO is looking for the MQC (minimally qualified candidate). This definition can and does change every 5 to 7 years based on scope of practice for optometrists. The definition of a MQC cannot be changed quickly or you lose relevancy. It has been determined that 5 to 7 years is an appropriate time to reassess and change the definition minimally if necessary. 80% of students must pass the NBEO exams to be accredited.

Of note, most professions' regulatory boards OWN their national board examinations. Veterinary and chiropractic currently are the only ones who do not own their tests. NBEO is separate from ARBO and this is beginning to cause friction. SIX MILLION DOLLARS is generated by NBEO exams yearly! This has doubled since 2006! Soooo, it is all about the money...

NBEO Board is comprised of 4 ARBO members, 3 ASCO members, and 1 public member.

Dearth of solid optometry school candidates. Peak of good candidates was in 2006. 6 schools in 2017 DECREASED their class sizes in an effort to keep the number of qualified candidates up. In 2018 13 schools

reduced their class sizes anywhere from 3 to 11 seats. (A strong candidate has an OAT score of 330 and a GPA of 3.4.)

In an effort to "get the word out about optometry," SCO has developed a program to introduce optometry to high school students. Any OD can request this and use this to stir interest in our field. ASCO has started a program to introduce the field of optometry to college juniors called "Optometry Gives Me Life". Essilor is funding this 5-yr program. Programs like these are needed to develop students in STEM curricula and get them thinking of optometry as a great career path. Dental schools had this problem many years ago and found going into MIDDLE SCHOOLS yielded better results. I have personally seen this decline in the MQC as MANY graduates were not passing the TMOD and expecting to get a license here in Wisconsin. I have also seen the average scores going down on the applicants I see as Credentialing Liaison in my 12 years on the Board.

Average debt load per student is $174K for last year's graduating class.

The TMOD examination was constructed in 1985.

Board Training with Dale Atkinson, esq.

He noted that since the 2015 NC Dental Board lawsuit, 35 lawsuits have been filed against boards for antitrust issues.

He recommends that for EVERY Board meeting, send the Agenda to the Governor & key legislators with an invitation to our meeting. They probably will not come but they will know what we do and value us more. Send them the approved minutes after the meeting to say that we missed them and that this is what we accomplished. He also suggests that we bring our meetings to different venues so our citizens will know government is transparent. He also recommends that NO trade group has anything to do with CE approval.

He recommends that we, as a Board should always be affirming any decisions made by staff when NOT in session by a motion every meeting that follows.

Also recommended that Boards have retreats for long-range planning and have joint meetings with other medical boards. "Find the common ground". This ensures efficiency, transparency, and effectiveness.

Optometric Education Tracker (OET)

Australia, New Zealand, and 3,700 practitioners in Canada use OET. 10 states in the USA do not use OET. Ontario pointed out that their audit of 2500 OD's took 2 days where it had taken 6 months before. Many states include the cost of OET in the license fees.

OET came on the scene in 2004. In 2012, the OET app came out.

Council on Optometric Education (COPE)

COPE has a new governing body comprised of ASCO, ARBO, and AAO. The AOA declined to participate. COPE provides an independent review of educational activities based on specific criteria. They maintain that accredited CE is the only way to ensure that our licensees are maintaining the education required to

meet rules set forth by our legislature. The universally accepted CE standards have been shown to be equivalent to other healthcare professions since 2017.

They have been busy this year with 4,400 courses approved so far and 550,000 credits being entered in OET by staff this year.

Autorefraction & Telehealth, Melissa D. Bailey, OD, PhD, FAAO

This professor at the Ohio State University, College of Optometry is seeking multiple patents for autorefraction and a digital cover test. This encompasses refractive error measurement without patient input. While this could ultimately be used for online purposes, she will only be "selling" it to practitioners with a vested interest in special needs patients, i.e. non-communicative pts, those unable to participate , and pediatric pts. This has demonstrated good repeatability and reliability.

Telehealth and AI to Engage Patients and Prevent Blindness, Jorge Cuadros, OD, PhD

From the first telehealth consult in 1993 to now, the growth has been exponential in the numbers of just active retinal imaging sites. It seems to work well with DR. He says we define our practice by our ability to communicate and engage our pts to do what is best for them. We will increasingly deal with statistics, uncertainty, excess information and complexity. We have the technology explosion, genome implementation, artificial intelligence to deal with. HOW will we incorporate this into our practice?

Telehealth Innovation and DigitalOptometrics, Howard S. Fried, OD

"The Best Way to Predict the Future is to Help Create It" Abraham Lincoln

Benefits from a comprehensive, remote eye examination include remote locations are never without the coverage of a licensed Optometrist. Exams are readily available to pts in the evening and on weekends during high demand. Optometrists can focus more time on eye health and vision analysis in review of testing and data analysis. Exams become more readily available to pts who seek corrective lenses and eye health exam with capability for early detection of disease.

He points out the 70% of graduating ODs are women who work in the profession for 2-3 years before returning home to raise families and no longer practice optometry Retiring ODs are not replaced in the marketplace by newly licensed ODs. Since demand for ODs is high, ODs locate in urban areas where population is dense rather than in remote areas of the USA.

This is a internet-connected OD with a technician using the slit lamp and performing the refraction with the OD looking on while the data is collected. The video of an exam was provided and it was STUNNING in its accuracy and how the pt responded.

Makes you think about the future as the future is HERE. What will our Board do to make sure this type of exam and all other emerging technologies satisfy the criteria the State of Wisconsin has set forth as a minimum examination? What is public perception of said on-line "exams" and other disruptive technology? In the discussion of telehealth and disruptive technologies, both the optometrist and Executive Director of some Boards were rather at odds as to what to "do" about this. Some ED's were adamant that no more Rules or Statutes were needed as a minimum comprehensive examination is a minimum comprehensive examination no mater how or where it is performed. But that still begs many

questions. Where should the practitioner be licensed? How does a relationship first get established with the pt? Is it Face-to-Face?

Attached are several reports for your review, discussion, and reference.

Respectfully submitted,

Ann Meier Carli, OD

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ARBO
Association of Regulatory Boards of Optometry, Inc.

Telehealth Model Language – General Concepts and Decision Points

Background

Advancements in technology offer opportunities for improved access to care at a lower cost. At the same time, boards of optometry have an obligation to ensure quality standards are met and the public is protected.

	Recommended Policy	Impact
Definitions	Telehealth – broad definition • Practice of health care using electronic communications, information technology or other means between a licensee in one location, and a patient in another location with or without an intervening healthcare provider. • Includes telemedicine, telepractice, teleophthalmology, etc.	
Establishing patient-provider relationship	Relationship begins when the patient seeks assistance from an optometrist and the optometrists agrees to undertake diagnosis and treatment • Internet/online questionnaire qualifies • Supervised technician qualifies • Initial in-person physical exam not required Provider is required to: • Validating and authenticating location of the patient • Disclosing and validating the licensing credentials of the clinician • Obtain appropriate consents	Provides most flexibility for patients
Consent Issues	Require informed consent regarding use of telemedicine technologies, including delivery methods and limitations • Patient agrees that provider determines whether or not condition being diagnosed and/or treated is appropriate for telemedicine encounter • Hold harmless clause for information lost due to technical failures	
Live Video (Real Time)	Acceptable • High resolution video/camera • Secure encryption • Multi-factor authentication	
Store and Forward (Asynchronous)	Acceptable • High resolution video/camera • Secure encryption • Multi-factor authentication	
Remote Monitoring	With potential restrictions: • Limited clinical conditions	

	• Limited monitoring devices • Limited information collection • FDA approved devices only	
Supervision of Technicians/Assistants	Documentation of training programs for any technician who is capturing clinical images	
E-Mail/Phone	Acceptable only in conjunction with some other type of system Direct to patient eye and vision health related application, including online vision test must comply with standard of care	
Licensure	• Provider must be licensed in the jurisdiction where the patient is located. • Practice of optometry begins where the patient is located at the time telemedicine technologies are used • No separate license or certificate related to telehealth: such a separate license could allow an out-of-state provider to render services via telemedicine in a state where they are not located or have a full license	
Location of Services	No geographical restrictions Practitioner must be licensed in the same jurisdiction of the patient	Uniform access to care, across rural and urban areas
Online Services	Prescriptions limited selectively Disclosures, including: • Specific services provided • Contact information for provider • Licensure and qualifications of provider • Appropriate uses and limitations of the site • Uses and response times for communications • Financial interests, other than fees charged, in any information, products, or services	
Prescribing	Consider measures to limit medication formularies for telehealth exams (no opiods) Appropriate clinical considerations documented	
Practice Standards	• Same standard of care as an in-person exam • Same scope of practice as an in-person exam • Require adoption of practice standards, including documentation and diagnosis prior to providing treatment • Online questionnaire alone is not acceptable standard of care • Provider remuneration or treatment recommendations should not be based on prescription, referral, or utilization of telehealth technologies • Local Referrals: urgent care, emergency services, facilitate continuity of care	
Medical Records	Patient record from telehealth exam should be available to both provider and patient, and be consistent with established laws and regulations governing patient healthcare records. • Patients' relevant health history must be collected as part of the provision of eye and	

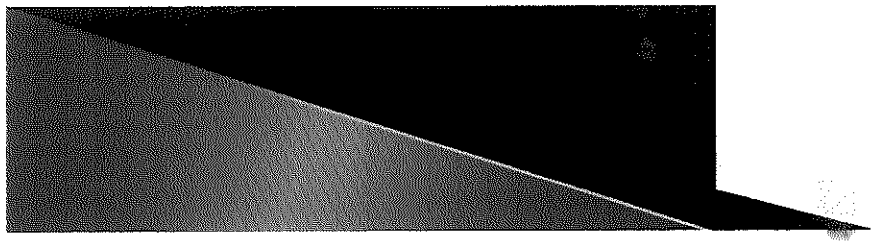
	vision telehealth services
Privacy of Patient Data	Protect patient confidentiality • Requirement for express patient consent to forward patient-identifiable information to a third party • Ensure HIPAA compliance • Inform patients that asynchronous telehealth involves their health information traveling by electronic means
Private Payers	Require same reimbursement as in-person exam for same services Prohibit payers from restricting use of telehealth to specific companies
Crossing State Lines	Practitioner must be licensed in the state the patient resides
Disclaimer	Not intended to establish legal, medical or other standard of care Does not replace or supersede local, state, or federal laws

Contemporary Issues Committee Report

ARBO 2019 Annual Meeting

• *Celebrating 100 Years* •

ARBO



2018-2019 Contemporary Issues Committee Members

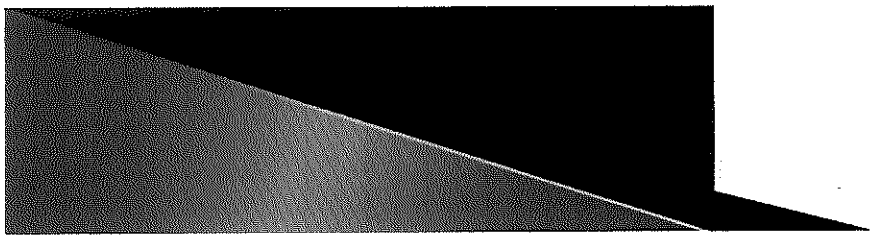
- Coby Ramsey, OD, Co-Chair
- Susy Yu, OD, MBA, FAAO, Co-Chair
- Chris Cooper, OD
- Emily Cronbaugh
- Mary Lou French, OD
- Fred Goldberg, OD
- Caren Jenkins, Esq.
- Jeff Kraskin, OD
- Rick Orgain, OD, *Ex-officio*
- Lisa Fennell, Staff

Celebrating 100 Years
ARBO

2018 House of Delegates Motion

Motion approved by the delegates at the 2018 ARBO annual meeting:

- That the ARBO Board of Directors establish a committee to do research into telemedicine and develop resources to assist the Member Boards.

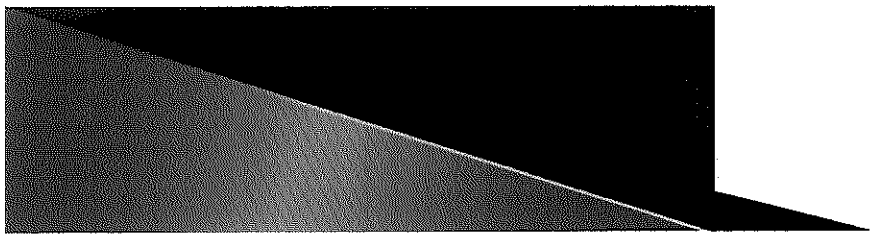


Celebrating 100 Years
ARBO

ARBO Member Survey

What is the extent of optometry telehealth in your jurisdiction?

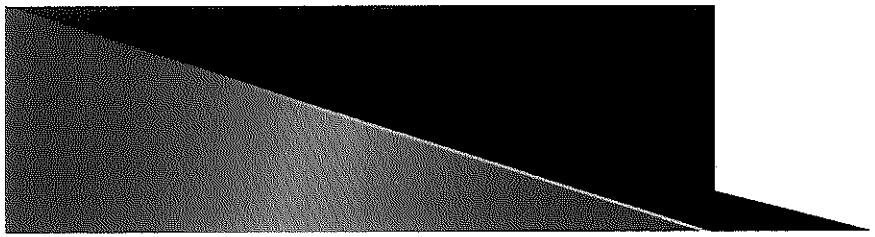
- 5 responses: internet sources, co-management, online refractions and eyewear sales, video in remote locations, etc.
- 9 responses: None, unknown, not defined, in discussion
- 1response: Guidelines adopted
- 1response: Pending legislation
- 3 responses: Defined or prohibited by statute



ARBO Member Survey

Has your board addressed this issue in a formal way? How so?

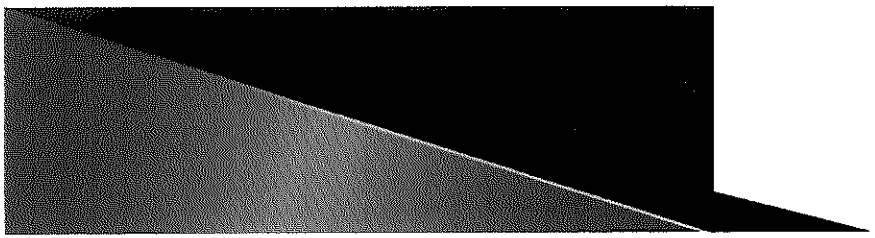
- 5 responses: No
- 15 responses: Yes
  - Rules, regulations, legislation, policy, guidelines, etc.



ARBO Member Survey

What resources is your board using to help make decisions about telehealth?

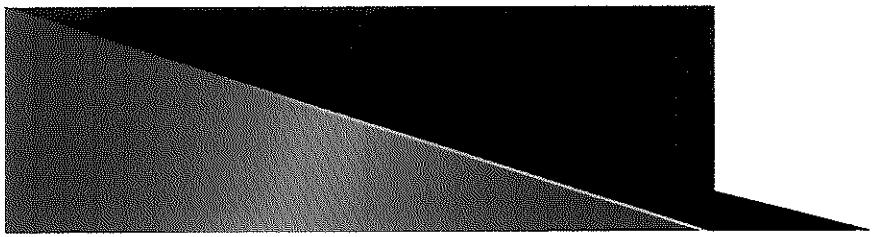
- State Associations and AOA
- Other boards' actions, policies, rules, etc.
- ARBO and Canadian regulatory authority
- Board council
- Guidelines and policies of other professions



ARBO Member Survey

Has your board received any complaints in regards to tele-optometry?

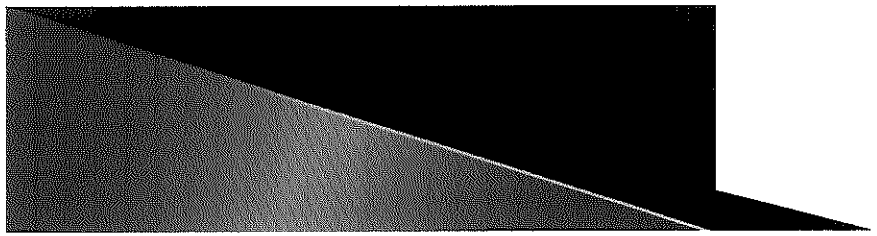
- 14 responses: No
- 3 responses: Yes, remote exams
- 2 responses: Complaints from ODs
- 1 response: Against an ophthalmologist (referred to medical board)



ARBO Member Survey

Do you know if other health profession boards in your jurisdiction have addressed this issue in any formal way?

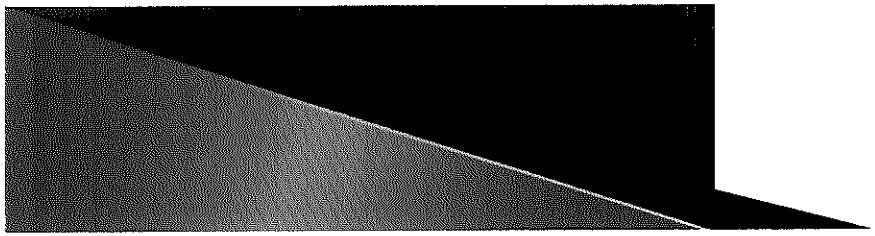
- 4 responses: No/unknown
- 17 responses: Yes, medical and/or other health professions boards have adopted policies, rules, statutes, etc.



ARBO Member Survey

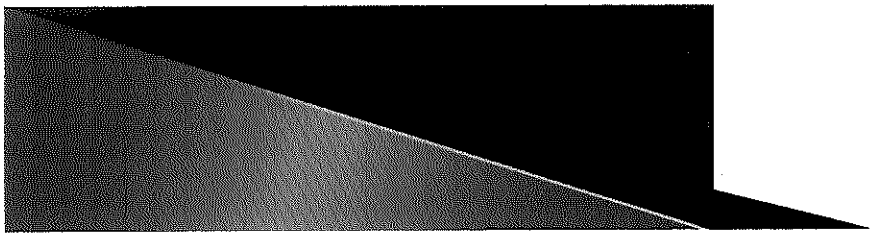
What can ARBO do to help your board with this issue?

- Collect and share information from other regulatory boards
- Education at annual meeting



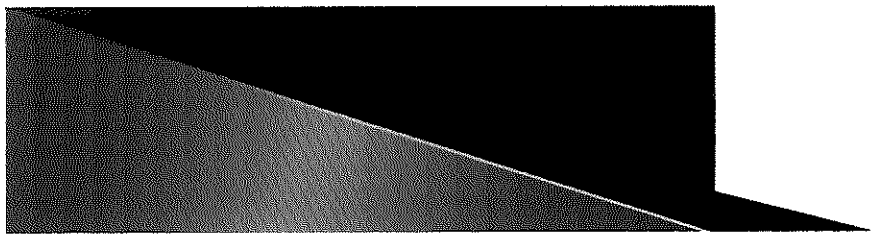
Committee Research

- Reviewed the Federation of State Medical Boards (FSMB) Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine: https://www.fsmb.org/siteassets/advocacy/policies/fsmb_telemedicine_policy.pdf



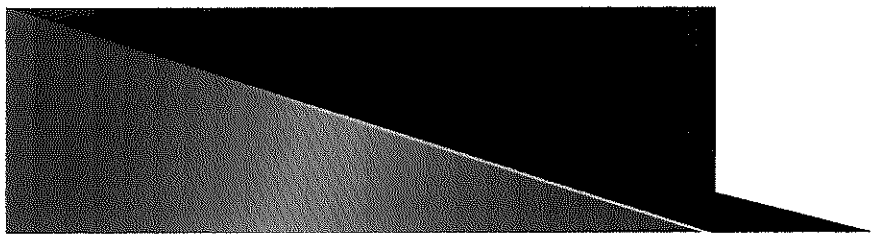
Committee Research

- Reviewed various state telemedicine rules, regulations, and policies regarding telehealth in optometry.
  - Alabama, Arkansas, California, Colorado, Kentucky, Michigan, New Jersey, Ohio, Rhode Island, Virginia, Wyoming
  - ARBO is collecting a library of telehealth rules/regulations/policies.
  - If you have one and you're not listed please email it to Lisa Fennell: Lfennell@arbo.org



General Concepts to Consider

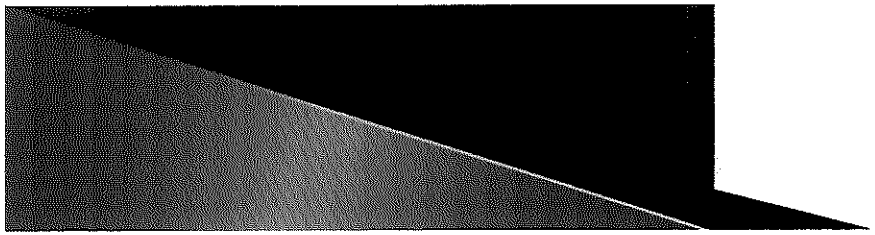
- Definition of telehealth
- Patient-Provider Relationship
- Consent Issues
- Licensure
- Location of Services
- Prescribing
- Practice Standards
- Medical Records
- Privacy



Recommendations

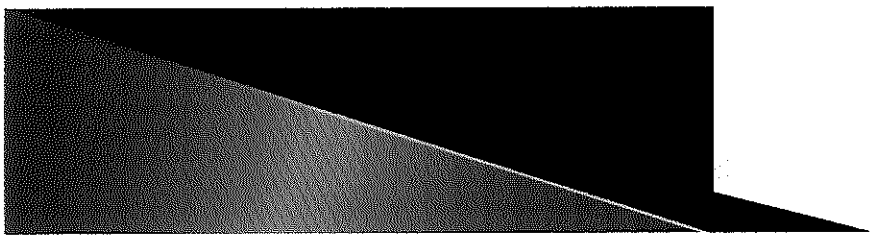
TN Board of Optometry:

- Establish a Task Force
- Review "global" laws governing telehealth
- Review rules/regulations from other health related boards.
- Understand managed care reimbursement laws in your jurisdiction.
- Consider your practice act.
- Consider definitions and exclusions.



Questions?

Thank You!



· Celebrating 100 Years ·
ARBO