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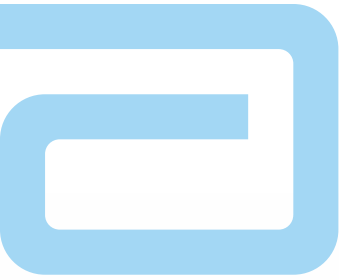
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NOVEMBER / DECEMBER 2012
VOL. 39 NO. 6



Departments

- 4 LEADERSHIP CORNER
- 6 COA BOARD HIGHLIGHTS
- 8 EDITOR'S NOTE
- 10 EYE OPENERS
- 12 MEMBERSHIP MATTERS
- 17 PRODUCT & SERVICES SUPPLEMENT
- 18 NEWS & VIEWS
- 26 ALL EYES ON YOU
- 30 HEALTH CARE REFORM
- 34 MEMBER SERVICES
- 36 CE@HOME
- 42 MARKET PLACE
- 44 WHEN & WHERE
- 46 THE BACK PAGE

We have to engage with our local legislators



When my two kids were little, I often had to repeat my words to them over and over again for them to understand my message, even though they heard me the first time. But the repetition made their responses a habit, and eventually I didn't have to constantly tell them what they needed to do.

I certainly don't mean to imply that any of you are kids, but it bears repeating what is important to our association and the profession of optometry in California.

Elections will be held in November, and by the time you read this, we will know who will be president for the next four years, and whether we have a doctor of optometry — Jennifer Ong — in the California Assembly to complement another optometric doctor serving in the Legislature, Senator Ed Hernandez.

Leadership Corner

However, whatever the outcome, our game plan doesn't change. We have to engage with our local legislators. We have to engage with our local legislators. We have to engage with our local legislators. Get the message?

Now, here are a few easy things you should do:

- Visit your state assembly member and senator's websites and sign up for their newsletter. Most lawmakers have newsletters that notify constituents of events they are holding and provide occasional legislative updates. This is an easy way to find out about events that you could attend to meet your state representative. It also provides an easy way to lead into a conversation to show your legislator that you are an engaged constituent. For example: "I read in your newsletter that you sponsored bill xyz...."



We have to engage with our local legislators. We have to engage with our local legislators. Get the message?

- Most legislators hold open houses or constituent nights in the district after they are sworn into office. Look online or in the newsletter e-mail you signed up for and find out when your legislators' next event will be held. Introduce yourself as a doctor of optometry and a member of COA.
- Some lawmakers will create local constituent advisory boards on different policy topics like health care. Volunteer to serve on the board and offer your assistance in providing information on health issues or giving a small business perspective on various topics.
- Write a letter congratulating your recently elected (or re-elected) assembly member and senator (half of the Senate was up for election in 2012, the other half is up for election in 2014). Be sure to personally sign the letter, identify yourself as a doctor of optometry and include your address to show that you are indeed a constituent.

The reality is that optometry is a legislated profession. We are in the process of redefining optometry in California. Thus, we need to start building new and enhancing existing relationships with our legislative representatives to protect and expand our profession. Like I said before, *we have to engage with our local legislators!*



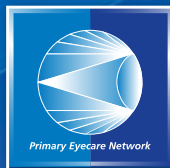
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COA Board of Trustees meeting highlights

On **June 7, 2012**, the COA Board of Trustees (BOT) met at the COA office in Sacramento. The BOT discussed a number of issues and topics that included motions:

- Motion: To accept the 2011 COA audit report as presented.
- Asked that consideration be given to hosting three students at the COA Presidents' Council and Leadership Conference from each California-located school and college of optometry.
- Motion: To appoint Dr. Cory Vu to serve on the COA Healthcare Delivery Systems Committee.
- Motion: To appoint Dr. Davey Pinakin to serve on the COA Education and Clinical Practice Committee.
- Motion: To approve the proposed COA Anti-Trust Compliance Policy.
- Motion: To approve the proposed COA Member Contact Information Sharing Policy.
- Motion: To approve the proposed amendments to the COA Low Vision and Rehabilitation Section bylaws and to forward the approved amendments to the 2013 COA House of Delegates for consideration.
- Motion: To approve the proposed resolution offered by the COA Low Vision and Rehabilitation Section for submission to the 2013 COA House of Delegates.
- Referred to the 2013 Speaker of the COA House of Delegates (HOD) the implementation of 2012 COA Policy Resolution Number Two relating to HOD procedures and agenda.
- Motion: To submit Dr. Jeffery Calmere as the COA nominee for the 2012 Great Western Council of Optometry Optometrist of the Year.

COA Board Highlights

The COA BOT met on **September 7, 2012**, in Fullerton. Minutes from this meeting are pending approval by the BOT and will be released in the next edition of *California Optometry*. The next meeting of the COA BOT is scheduled for November 8, 2012, at the Monterey Marriott Hotel.



MISSION STATEMENT

The mission of the California Optometric Association is to assure quality health care for the public by advancing all modes of optometry and by providing members with the resources and support to practice at the highest levels of ethics and professionalism.

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Calendar of Commitment

Las Vegas, NV
September 21-24, 2011

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Portland, OR
October 6-9, 2011

American Academy of Optometry



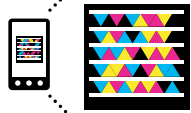
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Collective power



Editor's Note

During our orientation program at the college of optometry for the brand new first year optometry students, I was standing in line for a food function. I started to chat up one of the fresh-faced first year students next to me about life in general. He looked just a slight bit older than your classic first year optometry student and his story bore that out. He told me about his personal journey that had led him to optometry as a profession. He told me how he had started off in law school. From the first moment he stepped foot on the law school campus, they made it clear that every student was pitched against every other student for grades, class position and possible future clerkships and jobs. This student recalled how when he sat in group study sessions in law school, the thought often crossed his mind that his contributing knowledge to the group was possibly not in his best interest. By elevating the knowledge of the group, he was potentially improving the performance of another classmate. In most spheres, this would be viewed positively — in law school it might be perceived as a liability. He relayed that this constant looking over your shoulder and questioning your actions and motives in group activities eventually wore him down and he chose to leave law school because of his discontent with the educational environment and the emphasis on individual performance rather than group excellence.

This student went back to school and pursued a more scientific endeavor. He became certified as a laboratory technician but ultimately wanted more autonomy and more patient contact. He did his research and came to the profession of optometry. He believed that optometry was an ideal profession for providing him with extended and long-term patient relationships and he was struck by the spirit of camaraderie in both our student population and among the profession at large. He related how just based upon the orientation activities of the weekend and the interactions he had with his newfound classmates, he knew that he had found a home.



The profession is too small to harbor splinter groups or pockets of malcontent. We need to work together to resolve differences and present a unified voice.

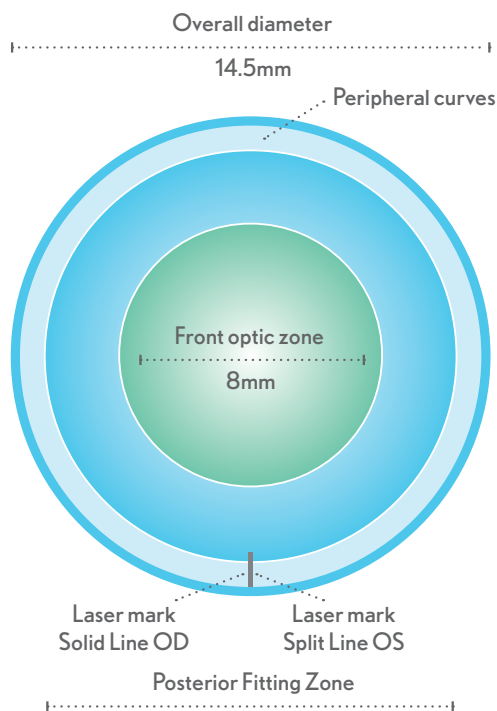
This interaction has had a profound impact on me and I have thought about it several times since the beginning of the school year. I have thought about how it is so valuable and desirable to have a profession that is unified and respectful of our similarities and differences. The profession has always had issues that bring about debate and dialogue. Ultimately, our internal issues should be resolved so that we can work collectively to great ends.

The profession is too small to harbor splinter groups or pockets of malcontent. We need to work together to resolve differences and present a unified voice. It is that unified voice that brings us clarity in direction for the profession. As we move forward in legislation, health care reform implementation, specialty care and access to patients, I hope for that unified spirit and collective power that the student in this story sensed and embraced.

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Eye Openers

Eye Openers gives a quick look at the latest headlines and news surrounding optometry and eye care.

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Health care law ensures consumers get clear, consistent information about health coverage

Beginning September 23, 2012, insurance companies are required to provide consumers in the individual health insurance market with an easy-to-understand summary about a health plan's benefits and coverage. For enrollees in group health plans enrolling during an open enrollment period, employers are to make it available during the next open enrollment period that starts on or after that date. Part of the federal Affordable Care Act, the new regulation is designed to help consumers better understand and evaluate their health insurance choices and to assist employers in finding the best coverage for their business and employees.

Available to health insurance consumers are the following forms:

- A short, plain language standard Summary of Benefits and Coverage (SBC): Includes a comparison tool, called Coverage Examples, which helps consumers compare coverage options by providing information on covered health benefits out-of-pocket costs, and the network of providers, in addition to showing a standardized sample of what each health plan will cover for common medical situations.
- Uniform Glossary: A listing of terms commonly used in health insurance coverage, such as "deductible" and "copayment."

HealthCare.gov

Study: Docs increasingly using social media to share medical info

The e-newsletter *FierceHealthIT* (fiercehealthit.com) reports that research published in a recent edition of the *Journal of Medical Internet Research (JMIR)* finds a growing number of physicians use social media to share medical information and stay up to date. In the *JMIR* survey of 485 practicing oncologists and primary care physicians, 24.1 percent used social media daily or many times daily to scan or explore medical information, while 61 percent did so weekly. Just 14.2 percent contributed new information daily, though 46 percent added material weekly. The survey found that more than half of those responding said that social media had helped them to care for patients more effectively, while 60 percent said it improved the quality of patient care they delivered. Ease of use and usefulness were cited as the determining factors in doctors' use of social media for sharing information among peers. The study's authors contend that with colleagues pointing them toward relevant research and other information, social media can effectively be part of physicians' continuing professional development. To read the study, go to jmir.org/2012/5/e117/.



Court upholds ABO board certification

Phase-in rules toward certification expire June 30, 2013

The United States District Court for Central California recently dismissed the American Optometric Society's (AOS) claims against the American Board of Optometry (ABO) alleging the use of the terms "board certification" and "board certified" constituted false advertising under federal law. The court ruled that in four of the six elements of law required to be proved in making its case, AOS failed on the following four: "(1) the ABO made a false statement of fact about its own product; (2) the statement actually deceived or had the tendency to deceive a substantial segment of its audience; (3) the deception was material in that it was likely to influence the purchasing decision; and (4) the AOS or one or more of its members has been or is likely to be injured by the false statement."

ABO has in place phase-in rules that modify the post-graduation requirements necessary to earn the board certification which expire **June 30, 2013**. These rules allow for the use of professional designations and education toward the 150 points of post-graduate requirements needed to qualify to sit

for the certification exam. In addition to Category 1 and 2 education requirements, to qualify under the phase-in rules, doctors must do the following:

- Apply to be an active candidate for certification by **April 30, 2013**
- ACOE Accredited Residency — 150 points (regardless of date of completion)
- Fellow, American Academy of Optometry — 50 points completed by **June 30, 2013**
- Fellow, College of Optometrists in Vision Development — 50 points completed by **June 30, 2013**
- Experience in Active Clinical Practice — 5 points per year of active clinical practice
- Submit postgraduate requirements for verification by the ABO by **June 30, 2013**
- Complete the examination by **January 2014**

After the expiration of the phase-in rules, the qualification requirements change. For more information, visit americanboardofoptometry.org.

Eye proteins have germ killing power

The UC Berkeley News Center recently reported that UC Berkeley vision scientists have found that small fragments of keratin protein in the eye play a key role in warding off pathogens. The researchers also put synthetic versions of these keratin fragments to the test against an array of nasty pathogens. The synthetic molecules effectively zapped bacteria that can lead to flesh-eating disease and strep throat (*Streptococcus pyogenes*), diarrhea (*Escherichia coli*), staph infections (*Staphylococcus aureus*) and cystic fibrosis lung infections (*Pseudomonas aeruginosa*).

The study authors wrote "The findings could lead to a great new weapon in the battle against disease-causing invaders. These keratin fragments are relatively easy to manufacture, making them good candidates for low-cost therapeutics."

Illegal contact lens sales reporting

The U.S. Food & Drug Administration (FDA) published a consumer health information update warning consumers about the dangers of purchasing decorative, noncorrective contact lenses. A growing number of websites and small retailers continue to illegally offer decorative, noncorrective contact lenses



for sale without prescription. The AOA Advocacy Group encourages doctors of optometry to report all adverse events associated with these lenses to the FDA MedWatch Safety Information and Adverse Event Reporting Program. Information may be reported to the FDA's MedWatch program by phone at 800-FDA-1088, by fax at 800-FDA-0178 or online at fda.gov/medwatch.



COA PCLC recommends solutions on key optometric, COA issues

Representatives from 22 COA societies gathered on the campus of the Southern California College of Optometry in Fullerton on September 8, 2012, for the annual day-long COA Presidents' Council & Leadership Conference (PCLC). PCLC serves as a forum for local society leadership and members to discuss, debate and develop recommended solutions on key opportunities and challenges facing societies, COA and the optometric profession.

This year's meeting covered updates on health care reform, i.e., the federal Affordable Care Act, which included the definition of the "essential" benefits that now must be covered, new optometry-specific patient access standards, the status of stand-alone vision plans and what impact each of these decisions will have on optometry. Attendees discussed other issues such as board certification, membership and COA governance. Below is a short summary of each of the items considered:

Membership Matters

Optometry in Health Benefit Exchanges

- **Essential benefits** — The pediatric vision essential benefit will include an annual comprehensive eye exam, eyeglasses, contact lenses and treatment of low vision. While specific details have yet to be confirmed, COA believes that an annual adult eye examination also will be covered under medical insurance, but adults will not have a materials benefit. As a result, doctors of optometry can expect the demand for eye care to increase beginning in 2014, the implementation date for health care reform.
- **New optometry access standards** — As a result of the COA Healthcare Delivery Systems Committee's advocacy efforts, the California Exchange included a provision in its recently issued standards that health plans must contract with an adequate number of optometrists. While it's a significant and positive first step, it is still unclear what this really means. COA will continue to fight for an expanded role for doctors of optometry in California's health care delivery system.



PCLC attendees enjoy lunch on the campus of the Southern California College of Optometry.



Harue Marsden, OD, MS, FAAO, moderates important topics submitted by societies for discussion.

- **Stand-alone vision plans** — Over the objections of VSP and COA, the Exchange Board decided to not allow stand-alone vision plans to provide the pediatric vision essential benefit.* Stand-alone plans also cannot offer supplemental coverage within the Exchange for individuals. However, stand-alone plans will be allowed to offer supplemental coverage in the Exchange for small businesses. It was discussed that COA had attended every state Exchange meeting, submitted written and oral testimony, and had met with Exchange staff to advocate for stand-alone plan inclusion. VSP has studies that show not including stand-alone plans in the individual Exchange will result in fewer eye exams. The Presidents' Council made the following recommendation relative to this issue:

Recommendation A: Stand Alone Vision Plans. The 2012 Presidents' Council recommends that the COA Board continue to work with VSP. If VSP is willing to offer resources to the efforts of getting stand alone vision plans included in the state health exchange that the COA Board continue to work with VSP to that end.

Board certification — COA supported board certification because it is optional and it will help doctors of optometry compete against other providers when health care reform is fully implemented. The American Board of Optometry (ABO) has qualified for purposes of the Physician Quality Reporting System (PQRS) Maintenance of Certification (MOC) Program Incentive, which provides a 0.5 percent additional incentive payment as an add-on to the standard PQRS incentive payments. In addition, **June 30, 2013**, is the **final date** to use points from FAAO (50 points) and SCOVD (50 points) certification toward the board certification requirement.

Governance

- **Society Communications** — Societies decided to participate in quarterly conference calls coordinated by COA staff to improve communication between societies.
- **Delegates to AOA House of Delegates** — There was discussion of how to achieve a full complement of COA delegates to the AOA House of Delegates (HOD) meeting. COA will look to revise the form delegates and alternate delegates to the COA House of Delegates complete indicating whether those delegates and alternates wished to be considered for an AOA HOD delegate appointment, as well as explore putting the form online. In addition, the Presidents' Council made the following recommendation on this matter:

Recommendation B: COA Delegates to AOA House of Delegates. The 2012 Presidents' Council recommends that each year the process for selecting prospective California delegates and alternate delegates to the AOA House of Delegates begin with the COA House of Delegates.

Membership

- **Project Keep** — There was agreement that COA should work to increase awareness of COA's Project Keep program where a young doctor of optometry can qualify for an extended graduated dues schedule if they become a COA officer or committee member in a local society.
- **Students of Optometry** — There was discussion of COA being represented on the campuses of California schools and colleges of optometry earlier than the fourth year to underscore earlier in the students' education the value and importance of COA membership and involvement with organized optometry.
- **Students and Organized Optometry** — There was agreement that COA should refocus its efforts on exposing students of optometry to organized optometry and opportunities to network with optometric doctors with the goal of generating life-long



Dr. Jennifer Tu (l) and Melissa Moore, third year student at UC Berkeley School of Optometry, share in the bright future for their chosen profession painted at PCLC.



SCCO President Kevin Alexander, OD, PhD, welcomes COA PCLA attendees.



2012 COA PCLC co-chairs Drs. Steve Langsford and Derron Lee brought great enthusiasm to the program.



Dr. Linda Hur, president of the Santa Clara County Optometric Society, shares a light moment with her husband and 2011 COA Optometrist of the Year, Dr. Jeffery Calmère.



Dr. Kierstyn Napier-Dovorany, president-elect of the Inland Empire Optometric Society, networks with a colleague.



More than a dozen students of optometry joined doctors in experiencing firsthand the power of organized optometry.

members. The Presidents' Council made the following recommendation on this matter:

Recommendation C: Increasing Student Involvement at COA Meetings. *The 2012 Presidents' Council recommends to the COA Membership Committee to realign the focus of its student membership programs to emphasize the programs in which the*

students can be exposed to the legislative events/activities and governance of optometry.

* Since PCLC, the California Health Exchange Board voted to reconsider the inclusion of stand-alone vision plans in the individual Exchange. COA will continue to aggressively advocate for their inclusion and will keep members apprised as decisions unfold.

The new COA Member Resource Center has the answers for you

Ever have a billing problem with an insurance company, have a question about scope of practice, or want to find an employment law? Look no further, COA has the answers for you. Countless member doctors have found that one of the best returns on COA membership investment is the COA Member Resource Center. While COA does not provide legal advice, COA employs a staff person with a legal background who answers common practice-related questions that include:

- working through a health plan problem;
- rules governing ownership of a separate business by an OD, such as a sunglass shop;
- optometric advertising requirements;
- permit requirements for selling over the counter vitamins;
- rules governing patient eye examination payment in order to receive a prescription;
- certification of legally blind patients;
- employment and workers' compensation issues;
- and so many more.

COA has the knowledge and authoritative contacts to answer your questions quickly. There are two methods to access the COA Member Resource Center:

1. Call the COA Member Resource Center at 916-266-5043. As a COA member doctor, your staff or you may call from 9 a.m. to 5 p.m., Monday through Friday. Any other time, just leave a message and your call will be returned.

COA MEMBER RESOURCE CENTER



Phone: 916-266-5043
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2. E-mail the COA Member Resource Center at jgabhart@coavision.org.

The COA Member Resource Center maintains a vast library of optometric-specific fact sheets covering virtually every area of your practice. These fact sheets can be e-mailed, or, many of them can be downloaded from the password-protected COA website. If, in the rare event that staff does not have the answer, it will be fully researched until the answer is found.

Among its other benefits, the COA Member Resource Center has one constant — it returns dividends time and again on your dues dollar investment. Your practice will save time and money when you utilize the Center. Program the COA Member Resource Center telephone number on your staff's and your speed dials and put the e-mail address in your address book.

COA adds membership, grassroots development staff

The California Optometric Association hired two professionals to build COA membership and develop COA's political grassroots network.

national non-profit representing more than 23,000 merit shop construction and construction-related firms.



Dana Brooks, COA membership development director

COA is proud to announce Dana (pronounced "Donna") Brooks as its membership development director. Brooks will spearhead COA's campaign to recruit new members and further strengthen the nation's largest state optometric association.

"Dana is a vital new part of COA's team," said Bill Howe, COA executive director.

"With special focus on membership development and retention, she will ensure that COA remains strong and doctors of optometry can continue to serve patients at the highest level possible."

Brooks brings to COA a wealth of experience in sales and association membership recruitment. Most recently, she was membership director for ABC Northern California Chapter, a



COA Grassroots and Fundraising Manager Kara Corches

Kara Corches has been tapped as COA's grassroots and fundraising manager. Corches will develop and implement a strategic plan to mobilize COA members, their patients and the public in support of COA's legislative and political action campaigns.

"We are thrilled Kara has joined COA's team," said Kristine Shultz, COA government and external affairs director. "She

will play a major role in building local networks of doctors of optometry and raising funds to bolster awareness of optometry's vital role in California's health care system."

Corches brings to COA valuable political experience having worked in a congressional office at the U.S. Capitol. Most recently, she served in the political affairs department of the California Farm Bureau Federation in Sacramento.

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Dr. Linda Hur

Get involved and make a difference!

By Dr. Linda Hur, President, COA Santa Clara County Optometric Society

Every day you and I are reminded of how privileged we are to live in a country that models democracy and provides three branches of government for checks and balances. You would have to be in summer hibernation not to acknowledge the U.S.

Supreme Court's landmark decision upholding most of President Barack Obama's Affordable Care Act (ACA). When many citizens and lawmakers took issue with the passage of this controversial legislation, they did not take the issue to the streets, rioting and setting cars on fire. Rather, we as Americans used the avenues established by our forefathers, with civility and due respect. Now, if "We the People" don't agree that this is indeed the best way of approaching health care as a nation, we have the upcoming presidential election to voice that opinion. Moreover, if "We the People" wish to affirm our current president's leadership in the economy, national security, health care and more, then we have that privilege too.

You would have to be in double hibernation not to be paying attention to the emerging "playing rules" for California optometry as it applies to health care reform. You would have to be closer to a coma for not paying attention to the fact that initial ACO concepts don't have optometrists on the list as providers. Finally, you would have to be near death not to know that the federal model of health care will not include stand-alone vision plans, though in California we have an opportunity to revise the rule. "What's ACO"* you might be asking? "Linda, didn't you mean, ACA?" Whether it's confusion on stand-alone or ACO or ACA or anything else, we start clarifying and talking amongst our peers at the local society level.

At those meetings, we even have continuing education: perhaps we allot too much time for the CE portion of our general membership meetings. When the early founding doctors of the Santa Clara County Optometric Society got together, it wasn't for CE per se, but to talk about the future of optometry. In fact, nearly 60 years ago, California optometrists



It is not solely up to your AOA leaders to protect and maintain the dignity of your profession.

As doctors of optometry practicing in California, we have three formal entities in which we work to voice our vision of optometry among our colleagues: COA local societies, COA and AOA. While it's not three branches to offer checks and balances, it is three avenues in which to make change happen. Never for a moment underestimate your individual voice and vote in organized optometry at the local, state and national levels, just like your individual vote affects outcomes in local, state and national politics. It is not solely up to your AOA leaders to protect and maintain the dignity of your profession. Nor is it up to your COA leaders. Nor is it up to me as Santa Clara County Optometric Society president or the other 24 local society presidents. It is up to you and me. If we all as California ODs would exercise the privilege of actively participating in organized optometry, just think what we could accomplish!

frustrated at being shut out of medical insurance plans took matters into their own hands. California ODs formed their own insurance plan. They called it VSP. Today it is a national company, 56 million members, successful, responsible for changing the way the public perceives vision and eye health care.

These are wild times. Let's work all this out together. I don't have all the answers. I don't even have all the questions! We all need each other to navigate the murky waters of health care reform. Finally, don't go this month without asking a disenfranchised optometric colleague to join COA and make their voice and vote count. We live in a great nation and we have a great profession. We have a voice in both.

*Accountable Care Organizations



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News & Views

Some relief from disabled access 'demand letters' approved

A bill that brings some relief to small businesses, including optometric practices by regulating Americans with Disabilities Act-related "demand" letters, which an attorney will use to order a business to pay a set amount, plus their exorbitant legal fees, in exchange for dropping a disability access lawsuit, has been signed by Governor Jerry Brown. COA strongly supported Senate Bill 1186, jointly authored by Senators Darrell Steinberg, D-Sacramento, and Bob Dutton, R-Rancho Cucamonga, which additionally reduces small business' liability from \$4,000 to \$2,000 for each "construction-related," i.e., disability access, violation that is corrected within 30 days of being served with a demand letter or complaint. The measure also specifies what must be included in an attorney demand letter or complaint, including the defendant's (small business') legal rights, the way the alleged barrier interfered with the individual's access, the dates of each occasion on which the individual encountered the specific access barrier, and prohibit

pre-litigation demands for money from an attorney to prevent the filing of a court complaint, i.e., lawsuit. Further, the bill requires a commercial property owner to state on the lease form or rental agreement if the property was inspected by a certified access specialist.

Doctors of optometry, along with other small businesses, have been victims of unscrupulous alleged disability access demands by a few attorneys. Members' dues investment has returned some relief from those demands, as well as a 50 percent reduction in the fine.



Exchange to reconsider stand-alone vision plan inclusion

In mid-September, the California Health Benefit Exchange (Exchange) Board voted to direct its staff to revisit the issue of dental and vision plans at its October meeting, including the possibility of allowing stand-alone vision plans in the individual Exchange. This is a big win for optometry! As readers will recall, over the strenuous objections of COA and VSP, the Exchange initially voted to exclude these plans from the Exchange for individuals. COA will continue to work with VSP to convince the Exchange to allow stand-alone vision

plans within the Exchange. For more information on broader aspects of the 2014 health care reform implementation and its impact on optometry, see "Health care reform implementation — essential information for optometry" in this edition of *California Optometry*.

**CALIFORNIA HEALTH
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Governor signs legislation on retired license status, temporary practice

Governor Jerry Brown signed into law Senate Bill 1215 by Senator Bill Emmerson, R-Riverside, which was sponsored by the State Board of Optometry (SBO) and supported by COA. The bill creates a retired license status, a retired license status with a volunteer designation, as well as defines temporary practice. The new law takes effect January 1, 2013. The specific provisions include:

- **Retired License Status:** A doctor of optometry will be permitted to obtain a retired license status by paying a one-time fee of \$25, and will not be required to complete any continuing education. The doctor of optometry will not be permitted to practice optometry; however, he or she will earn the more positive designation of "retired" versus "inactive," "cancelled" or "delinquent." (*Business and Professions Code Section 3151*)
- **Retired License Status with a Volunteer Designation:** SB 1215 also creates a category for those doctors of optometry who are retired but would still like an opportunity to volunteer their services. The new law permits an optometric doctor to obtain a retired license status with a volunteer designation by paying a \$50 initial fee and a \$50 renewal fee biennially. Upon renewal, the doctor will have to complete a total of 50 hours of continuing education, 35 of which must be on the diagnosis, treatment and management of ocular disease. Under this license designation, doctors of optometry may only practice optometry on a volunteer basis providing free services. The designation received will be "retired volunteer" versus "inactive," "cancelled" or "delinquent." (*Business and Professions Code Section 3151.1*)
- **Definition of Temporary Practice:** Under current law, before engaging in the practice of optometry, a doctor

must notify the State Board of Optometry in writing of any addresses where he or she practices optometry and obtain a Statement of Licensure (SOL) to be placed in all practice locations other than a doctor's principal place of practice. The new law clarifies that a holder of a Branch Office License is not required to obtain an SOL to practice at those branch offices, deletes the previous five exceptions for posting an SOL, and newly defines temporary practice as "[T]he practice of optometry at locations other than the optometrist's principal place of practice for not more than five calendar days during a 30-day period, and not more than 36 days within a calendar year. This limitation applies to all practice locations where the doctor is engaged in temporary practice, not to each location individually." For example, if you are performing relief work at another practice for an optometrist who is sick, you don't have to notify the SBO unless it goes longer than five days in a month or adds up to more than 36 days within a calendar year spent away from your principal place of practice. If you go over this limitation, you must obtain an SOL. The purpose of this change is to let doctors clearly know when they need to notify the SBO of a new location and when an SOL is needed. Many doctors found the previous rules unclear and confusing. (*Business and Professions Code Section 3070*)



Stay connected to government affairs!

Government Affairs Weekly Update

For weekly information on COA's government and external affairs activities, watch your e-mail inbox each Wednesday for the *Government Affairs Weekly Update*. Archives are available on COA's website (in the Members' Only section, click Government Affairs, then Weekly Updates).

December 13, 2012, deadline for HIPAA 5010 compliance

The state Department of Health Care Service (DHCS) has identified **December 31, 2012**, as the final date that providers can submit claims in the ASC X12N 4010A1 and NCPDP 5.1/1.1 formats.

Effective on and after **January 1, 2013**, all 4010/401A1, NCPDP 5.1 or 1.1 batch transactions submitted will be rejected due to HIPAA non-compliance and will not be processed. This will result in non-payment of claims.

Doctors of optometry who have not yet converted over to the ASC X12N 5010 and NCPDP D.O/12 formats are strongly advised to do so before the December 31, 2012, deadline.

Xerox State Healthcare, LLC (Xerox) will mail a letter notifying all providers/submitters who have not yet been certified nor converted to ASC X12N 5010 and NCPDP D.O/12 formats to contact the Computer Media Claims (CMC) Help Desk at 1-800-541-5555, option 4 then option 2, to schedule testing.

Additional information can be located on the Medi-Cal website at www.medi-cal.ca.gov/ under "HIPAA 5010/4010/NCPDP."



Noridian to replace Palmetto as Medicare contractor

The Centers for Medicare & Medicaid (CMS) Services has named Noridian Administrative Services as the new Medicare administrative contractor (MAC) for California, replacing Palmetto GBA. The new contract, awarded on September 20, 2012, covers Jurisdiction E (formerly Jurisdiction 1) A/B MAC which administers Medicare Part A and Part B claims for covered services, including optometric. Palmetto GBA will continue to administer provider claims for up to six months as CMS oversees the transfer of the Medicare contract responsibilities to Noridian. COA will keep members apprised of contract transition developments as they become available.

ICD-10 compliance date: October 2014

The US Health and Human Services Department released a rule that makes final a proposed one-year delay—from October 1, 2013, to October 1, 2014—for the compliance date for the profession's transition to ICD-10 codes.

The transition to ICD-10 is occurring because ICD-9 is outdated and produces limited data about patients' medical conditions and hospital inpatient procedures. Doctors of optometry should develop an implementation strategy that includes an assessment of the impact on their practice and a detailed timeline and budget. Check with your billing service, clearinghouse or practice management software vendor about their compliance plans. Doctors who handle billing and software development internally should plan for medical records/coding, clinical, IT and finance staff to coordinate on ICD-10 transition efforts (see "Steps to Assess How the ICD-10 Transition Will Affect Your Practice" in the July 18, 2012, issue

of *e-Government Affairs Weekly* that can be found on the COA website under the "Government Affairs" tab).

Resources to keep up to date on ICD-10

Visit often and sign-up for the below ICD-10 resources for the latest news and information to help you prepare for the ICD-10 transition:

- CMS ICD-website: cms.gov/Medicare/Coding/ICD10/index.html?redirect=/ICD10
- CMS ICD-10 Industry Updates e-mail : Sign up at cms.gov/Medicare/Coding/ICD10/CMS_ICD-10_Industry_Email_Updates.html



Passion, involvement, results

by Kara Corches, COA Grassroots and Fundraising Manager



Kara Corches,
COA grassroots
and fundraising
manager

I was working in Washington, DC in a congressional office during the weekend of the final vote on the Affordable Care Act. Stepping outside my office and seeing the sheer power of grassroots advocacy was fascinating. There were thousands of people on both sides of the health care debate who traveled from all over the country and lined up along the streets surrounding the Capitol; their energy and enthusiasm was electric.

I fielded hundreds of calls, e-mails and office visits from citizens from all walks of life voicing support or opposition to the bill. While I did answer some hostile and just plain weird phone calls, most callers were civil and described how the legislation would impact them in an either positive or negative way. Although every phone call was different, one thing remained the same: *each individual calling was personally invested in the fate of the measure.*

I remember speaking with some activists at a Capitol Hill restaurant that weekend. They told me that they were from the Midwest and packed up their car with their kids and drove to Washington, DC because they heard about the grassroots movement and decided that they wanted to be a part of democracy.

You certainly don't have to drive thousands of miles to be engaged in the political process. It starts locally. Meet your legislators in their district office. Write a personalized letter telling your legislator how a bill will impact your profession and cost of doing business. Call your lawmaker about a key bill. Attend an open house at your state senator or assembly member's office. There are many simple ways to engage with your elected representative, but the most influential of all is to show them that you - as a constituent - are personally invested in the future of your profession. I will always remember working that weekend in Congress because that is what ignited my passion for grassroots advocacy.

While I may have met some of you already, many of you may not know me. I started at COA in August of this year. My job at COA as grassroots and fundraising manager is to strengthen and expand our political action committee (PAC) fundraising and doctor of optometry grassroots network. If we want to continue to have a seat at the table in Sacramento, we have to strengthen our political program.

Here are some goals that I have for COA's political program:

- Expand the COA Key Person Program to at least five key persons per Assembly/Senate district

- Build more relationships between ODs and legislators
- Raise funds for COA's independent expenditure committee (see below)
- Get more optometry-friendly candidates elected to the State Legislature

As new legislators are elected into office this month, it is very important to start building relationships with them immediately. After they are sworn into office, many of these new lawmakers, along with those re-elected, will open up their Capitol and district offices for constituent meet-n-greets. Attending one of these events is a great way to start building a key relationship with your legislator. Remember, the best advocate for your profession is none other than you!

“ You certainly don't have to drive thousands of miles to be engaged in the political process. It starts locally.

While our COA Key Person Program has experienced success in the past, it is important to remember that the saying is true ... "there is indeed strength in numbers." Just imagine the difference we could make if we had at least five Key Persons per district with relationships with his or her state Senate and Assembly representatives: 5 COA Key Persons x 120 Senate/Assembly Districts = Major Legislative Success!

Being a COA Key Person is easy! COA notifies the Key Person network when urgent action is needed on legislation. We may ask you to call, write or meet with the lawmakers with whom you have established a relationship. Each of these activities takes no longer than 30 minutes. A 15 minute meeting with your legislator in their district office may result in legislation that saves you and your practice thousands of dollars a year.

In California politics, money plays a huge role. There are Assembly races in California that raise more money than United States Congress races in other states! The fact of the matter is that with close to 3,000 bills introduced just in the Assembly in 2011-2012, there are many special interests that are all fighting to get their voices heard. Labor unions and other trade groups have PACs that raise millions of dollars each year. If the optometric profession wants a seat at the table, we need to pool our resources to work to get strong candidates elected who will make our profession more visible in Sacramento.

Independent expenditure committees are now the game changers in political races. COA will be working to build up funds for our independent expenditure committee since we can greatly impact races by purchasing campaign mailers, television ads and other forms of political advertisements and will not be subject to limits because we will be working independently of candidates' campaigns. Contributions to COA's independent expenditure committee are not subject to campaign contribution limitations. By implementing a strong independent expenditure fundraising effort, we will be able to help get more optometry-friendly candidates elected to office.

Just as you invest in new equipment and technology for your office, please consider personally investing in the future of your profession by getting involved in the COA Key Person Program and/or contributing to the COA independent expenditure committee. The time is now for us to step up to the plate and work together to make a real and lasting impact for the future of the optometric profession and the patients it serves.

Contributions to Doctors of Optometry for Better Health Care in support of Dr. Ong for Assembly 2012, sponsored by California Optometric Association Political Action Committee are not tax deductible.

2012 — COA and organized optometry score huge legislative victories

Enactment of an ACA pediatric vision essential benefit that includes an annual comprehensive eye examination, eyeglasses and contact lens benefit, and more. Establishment of California's benchmark plan that defines "essential" benefits that all individual and small group health plans must cover that includes routine adult eye examinations for refraction and preventative care. Legal authority for doctors of optometry to conduct diagnostic tests ("CLIA Waived") in the office rather than having to order tests from a lab. Prohibition on Americans with Disabilities Act-related "demand" letters from attorneys that seek exorbitant amounts of money in exchange for preventing the filing of a disability access lawsuit. **By virtually all measurements, 2012 was a hugely successful year in the State Capitol for COA, organized optometry and patients served.** These legislative victories and the return on members' dues investment they represent were expertly guided by the COA Legislation and Regulation Committee chaired by Dr. David Redman. COA Government and External Affairs Director Kristine Shultz and Julie Andrade, COA legislative relations manager, are to be thanked for carrying out COA's winning legislative strategies. And, COA thanks its longtime legislative advocates, Cliff Berg of Governmental Advocates and Terry McHale of Aaron Read & Associates, for pounding the halls of the Capitol to help secure these tremendous gains. Finally, COA thanks the member doctors of optometry and students of optometry for their support of organized optometry; without you, none of these achievements would have been possible.

Below is a recap of legislation on which COA advocated this year and their final disposition.

Measures signed:

Assembly Bill 761 by Roger Hernández, D-Baldwin Park.

Sponsored by COA, allows optometrists to use CLIA Waived diagnostic tests in the office rather than having to order tests from a lab. The California Academy of Eye Physicians and Surgeons supported this measure and the bill received overwhelming support in the Legislature. COA's proactive initiative with this measure gains for optometric doctors the legal authority to build upon the optometric practice skills and knowledge they have and enhances the realm of services available to their patients. **COA position:** Sponsor.

AB 1083 by Bill Monning, D-Santa Cruz. Prohibits a health care service plan contract or health insurance policy, on or after January 1, 2014, from imposing any pre-existing condition provision upon any individual, except as specified. The bill also enacts provisions that apply to nongrandfathered and grandfathered plans with respect to plan years on or after January 1, 2014, consistent with the federal Affordable Care Act, i.e., health care reform, including the availability of plans to small employers, open enrollment periods, and the use of age, geographic region, and whether the plan covers an individual or family for purposes of establishing rates. This bill is intended to revise California law to conform to the federal law in order to bring more uninsured into coverage. **COA position:** Support.

AB 1526 by Bill Monning, D-Santa Cruz. Permits the state Major Risk Medical Insurance Board (MRMIB) for the period from January 1, 2013, through December 31, 2013, to further subsidize Major Risk Medical Insurance Program (MRMIP)

subscriber contributions so that the amount paid by each MRMIP subscriber is below 125 percent, but no less than 100 percent, of the standard average individual risk rate for comparable coverage. **COA position:** Support.

AB 1588 by Assembly Member Toni Atkins, D-San Diego. Requires boards under the state Department of Consumer Affairs, including the State Board of Optometry, to waive professional license renewal fees and continuing education requirements for any licensee called to active duty with the United States Armed Forces or California National Guard.

“ By virtually all measurements, 2012 was a hugely successful year in the State Capitol for COA, organized optometry and patients served.

Prohibits licensees from practicing while the waiver is in effect, except as specified, and specifies when a licensee is required to report his or her discharge from active duty to the appropriate board. **COA position:** Support.

AB 1761 by Speaker John Pérez, D-Los Angeles. Prohibits individuals and entities, including those regulated by the state Department of Managed Health Care and the state Department of Insurance, from holding themselves out as representing, constituting or otherwise providing services on behalf of the California Health Benefit Exchange (Exchange) unless the individual or entity has a valid agreement with the Exchange to engage in those activities. This measure is intended to provide consumer protection when purchasing health insurance. **COA position:** Support.

SB 951 by Senator Ed Hernandez, OD, D-Los Angeles, and AB 1453 by Assembly Member Bill Monning, D-Santa Cruz. Both measures establish the Kaiser Foundation Health Plan Small Group HMO 30 plan contract as California's benchmark plan that defines the “essential” benefits that all individual and small group health plans must cover in implementing the federal Affordable Care Act. For adults, coverage includes routine eye examinations for refraction and as preventative care. The bills also defines the “pediatric vision” essential benefit as the largest vision plan for federal workers — the FEP Blue Vision plan — and includes an annual comprehensive eye examination, eyeglasses and contact lens benefit, and pre-authorized low vision services (see “Health care reform implementation: essential information for optometry” in this publication edition for more information). **COA position:** Support.

SB 1186 by Senators Darrell Steinberg, D-Sacramento, and Bob Dutton, R-Rancho Cucamonga. Regulates Americans with Disabilities Act-related “demand” letters which an attorney will use to order a business to pay a set amount, plus their exorbitant legal fees, in exchange for dropping a disability access lawsuit by, among other things, prohibiting pre-litigation demands for money to prevent the filing of a lawsuit and reducing small business financial liability for disability access violations corrected within 30 days of a complaint (see “Some relief from disabled access ‘demand letters’ approved” in this edition for more information). **COA position:** Support.

SB 1215 by Senator Bill Emerson, R-Riverside. Sponsored by the State Board of Optometry, creates a retired license status, a retired license status with a volunteer designation, as well as defines temporary practice. (see “Governor signs legislation on retired license status, temporary practice” in this edition for more information). **COA position:** Support.

SB 1301, by Senator Ed Hernandez, OD, D-Los Angeles. Allows a pharmacist to dispense a 90-day supply of a dangerous drug other than a controlled substance if there is a valid prescription that specifies an initial quantity of less than a 90-day supply followed by periodic refills of that amount, the patient has completed an initial 30-day supply and the total quantity of dosage units dispensed does not exceed the total quantity authorized by the prescriber on the prescription, including refills. **COA position:** Support.

SB 1410 by Senator Ed Hernandez, OD, D-Los Angeles. Makes revisions to the operation of independent medical review organizations effective July 1, 2015. Among those revisions is to revise the minimum qualifications of medical professionals conducting IMRs to require those individuals to be a clinician knowledgeable in the treatment of the enrollee's medical condition, knowledgeable about the proposed treatment, and familiar with guidelines and protocols in the area of treatment under review. Requires IMR decisions adopted by the state Department of Managed Health Care and the California Department of Insurance be made available at no charge on a searchable database. **COA position:** Support.

Measures vetoed

AB 1461 by Bill Monning, D-Santa Cruz. Would have prohibited health care plans and insurers from denying insurance coverage to individuals based on pre-existing health conditions.

SB 961 by Senator Ed Hernandez, OD, D-Los Angeles. Would have prohibited health care service plan contracts and health insurance policies from imposing any pre-existing condition provision upon any individual.



William Rogoway,
OD, DABFE

Secrets of coding Back to Basics

Mastering Medicare billing codes is an important skill to know because most all insurance carriers base their compensation system on that which Medicare has established. The need to diagnose and treat the patient is often shrouded with thousands of carrier rules. Consequently, the practitioner might be left confused and forget basic coding rules and end up with claim troubles. Even the simplest of Medicare billing requires knowledge of these basic rules as well as a sense of its billing logic to complete the agency's claims submission requirements. If doctors of optometry keep in mind a few of the most essential rules and have an idea of what Medicare is looking for, their billing outcomes improve. In the case of Medicare billing, knowledge of the coding system is directly related to your reimbursement levels.

Each CPT procedure code has its own guidelines for their use. Medicare has rules as to what constitutes a 92xxx Comprehensive Examination, for example, as well as rules for the proper code to use for special diagnostic tests. Furthermore, Medicare always wants an ICD Diagnostic Code attached to each CPT Procedure to explain why that particular code was billed. The documentation that the practitioner provides in the patient's chart will also set the level of billing which will in turn provides the level of reimbursement. In other words, the chart has to defend and prove the insurance claim.

Additionally, the patient's chart documentation has to show the need for further specialized testing based on disease, not wellness. Threshold fields, fundus photos and OCT, for example, cannot be billed as "a well patient" procedure, cannot be billed as a screening test, or used to "rule out" a disease. Medicare wants the disease diagnosed through your dilated fundus exam, and the specialized tests used to aid in the management and treatment of the disease. Furthermore, a written request for these special tests has to be logged into the chart prior to beginning those tests.

The chart documentation needed to initiate those specialized tests should include information based on a careful inquiry into the patient's chief complaint, clinical findings, patient and family history, signs, symptoms and observations. The chart has to establish that there is enough evidence existing to support the need for further tests. In addition, when these special tests are completed, usually an "Interpretation and Report" has to be included as part of the chart. This report should state how the test results would affect treatment and management.

"Red Flags" and "Triggers" are some billing circumstances to avoid when submitting claims because they can prompt audits. Red Flags are those codes used that are frequently abused like codes 99201, 99211, as well as codes 99205 and 99215. Triggers are claims submitted that grossly defy coding logic, like billing a Comprehensive Exam code (92xxx) and a Medical Management Exam (99xxx) for dry eye on the same day.

“ The need to diagnose and treat the patient is often shrouded with thousands of carrier rules.

Coding experts recommend that doctors of optometry keep abreast of coding developments by attending coding classes and keeping in contact with their carriers on coding issues. This is especially true this year with the upcoming rollout of the ICD-10 codes in 2014.

Hope this helps and keep on coding.

Dr. Rogoway can be reached at wmrogoway@yahoo.com.

The News & Views segment of *California Optometry* magazine is sponsored by Vision West, COA's preferred buying group.



Logged on Yet? COA Needs You!



Contact Julie Andrade at jandrade@coavision.org to be linked up!

Medi-Cal update

By Donny Shiu, OD, Medi-Cal Vision Care Program Consultant

With a blink of an eye, we are near the end of 2012. I hope it has been a good year so far for readers of this column and I wish everyone a better 2013. It has been said that change is the only constant. To help you manage some of the Medi-Cal vision program changes, I remind everyone that the Healthy Families Program (HFP) transition to Medi-Cal remains on course to begin in 2013. Most providers will not be severely impacted since the children involved in Phase 1 are already enrolled in Healthy Families plans that are also Medi-Cal managed care plans. Your existing HFP patients may continue to seek your care under Medi-Cal. With regard to the difference in benefits, under HFP, eye exam, frame and lens benefits are covered once every 12 months; this will change to once every 24 months under Medi-Cal. In addition, the optical lens fabrication will all be done through the CalPIA optical labs for these new Medi-Cal patients. The labs are already making preparations to address the expected increase in volume. Low vision services and medically necessary contact lenses remain covered with authorization. I know the patients are always well taken care of by the great eye care providers we have in California regardless of which plan covers them. Have a safe and wonderful Holiday Season. As always, I have answered a couple provider questions below that may provide answers for you as well.

Q DEAR DR. SHIU: Recently one of our opticians retired and we don't know who to contact when we encounter questions, problems related to eyeglasses orders online or an address change. Can you help us?

—Leslie from Santa Ana

A DEAR LESLIE: Anytime you have problems with placing an order, tracking an existing order, are in need of shipping labels or any other issues related to CalPIA lab services, you can contact:

- Customer Service at 1-877-437-9188
- VSPW lab in Chowchilla at 1-559-665-5531 ext. 7428
- CSP-Solano lab in Vacaville at 1-800-700-9861
- You can also e-mail the lab for help at:
OpticalHelpDesk@calpia.ca.gov

Reminder: Although shipping address change requests are available online via your account's "Maintain Profile" link, the optical lab cannot change addresses without state Department of Health Care Services' (DHCS) approval. To be in compliance with Medi-Cal rules and regulations, providers are responsible for reporting any modifications to information previously submitted to DHCS **within 35 days of the change**. You can find information and applications on the Medi-Cal website (medi-cal.ca.gov) under the heading "Provider Enrollment." The direct link to Provider Enrollment can be found on the PIA Optical On-Line website at <https://optical.pia.ca.gov/pool>. For Medi-Cal and other non-lab questions, contact the Medi-Cal Telephone Service Center (TSC) at 800-541-5555.

Q DEAR DR. SHIU: The patient's eyeglass order was rejected because of Other Health Coverage (OHC). Why? What do I do if the patient denies having OHC?

—Henry from Stockton

A DEAR HENRY: The order was rejected because the Medi-Cal Eligibility Verification Confirmation System indicates that the patient has OHC with vision benefits included, i.e., Scope of Coverage (COV): "V" or "Comprehensive." Since Medi-Cal is the payer of last resort, the patient must obtain his/her eyeglasses through the other insurer. To supply the patient with eyeglasses, providers should contact the other insurer for authorization or refer the patient back to the other insurer for services.

The Medi-Cal Eligibility Verification Confirmation System is responsible for the identification of all health insurance belonging to Medi-Cal beneficiaries. The system identifies health insurance resources through referrals from county offices and the Social Security Administration. This information is also obtained by conducting data exchanges with various health insurance companies. When the health insurance information is received, the system is updated to ensure that Medi-Cal is the payer of last resort.

Individuals may choose one the following methods to request updates or removal of an OHC indicator that may be erroneous:

1. Use the new **OHC Processing Center** that allows you to update commercial health insurance for Medi-Cal beneficiaries: www.dhcs.ca.gov/services/Pages/TPLRD_OCU_cont.aspx. (The OHC Processing Center provides a secure means of transmitting the least amount of personal health information required to process your request.)
2. Contact the Department of Health Care Services Third Party Liability Recovery Division via secure e-mail: WATS@dhcs.ca.gov
3. If you cannot use the OHC processing center link or send a secure email, you may submit your request via fax to 916-440-5675.
4. Patients may contact their county social services office or social workers for assistance.

If you have suggestions, comments or would like to submit questions to COA Medi-Cal, please use the contact information below:

**Department of Health Care Services
Pharmacy Benefits Division/Vision Services Branch
1501 Capitol Avenue, Suite 71.5144
P.O. Box 997413, MS 4604
Sacramento, CA 95899-7413
Attn: Donny Shiu, O.D.
Phone: 916-552-9539 • E-mail: Donny.Shiu@dhcs.ca.gov**



All Eyes on You

COA Key Persons at work for optometry

The establishment and maintenance of relationships by member doctors of optometry with state lawmakers is an invaluable investment in the shaping of public policy governing optometry. Personal connections between COA Key Person doctors and their state elected officials are critical to the achievement of the legislative goals of the optometric profession. Read below about your peers connecting with California elected officials on behalf of optometry.

COA Los Angeles County Optometric Society (LACOS) Key Person Coordinators **Jay Messinger, OD**, and **Richard Hoffman, OD**, attended a fundraiser for state **Insurance Commissioner Dave Jones** at the home of television personality Lisa Ling and Paul Song, MD, in Santa Monica. Commissioner Jones will be very important in the formation of the new insurance Exchanges under the health care reform that will impact the practice of optometry for decades. Dr. Hoffman said that Jones understands optometry's role in health care delivery because of COA's involvement and interaction with him. During his remarks to fundraiser attendees, Jones recognized and thanked COA for being a co-sponsor of the event.



State Insurance Commissioner Dave Jones pictured with Richard Hoffman, OD (l) and Jay Messinger, OD (r).

All Eyes on You features the latest news about COA members.



Assembly Member Holly Mitchell (center) is joined by Jay Messinger, OD, and Corey Hodes, OD.

Corey Hodes, OD, and **Jay Messinger, OD**, from LACOS recently attended an event for **Assembly Member Holly Mitchell**, D-Culver City, in Los Angeles. Assembly Member Mitchell is a member of the Senate Health, Appropriations and Budget committees.

"The event was held at a local convalescent community and the medical community was well represented," stated Dr. Messinger. "Holly Mitchell was amongst friends having grown up in this community and having worked as a service provider. She was grateful for our attendance and spent some time conversing about health care reform and issues close to her heart."



(L-R) Rick Ideta, OD, Jay Newsome, OD, Assembly candidate Bob Whalen, Tony Baudonnet, OD, and John Barrón, OD at Whalen fundraising event.

COA Central California Optometric Society (CCOS) doctors attended a fundraising event for Assembly District 23

Republican candidate Bob Whalen in Clovis. Covering parts of Fresno County, AD 23 includes the cities of Fresno, Clovis and Three Rivers.

COA SFVOS-supported MEND named non-profit of the year

MEND — Meet Each Need with Dignity — has been honored with the 2012 Governor's Volunteering and Service Award as California's Nonprofit of the Year. The COA San Fernando Valley Optometric Society (SFVOS) has been very active with MEND, a San Fernando Valley-based organization dedicated to breaking the bonds of poverty by providing basic human needs and a pathway to self-reliance. MEND was recognized for its "service and innovation while addressing the increasing needs of the state of California."

“ [COA SFVOS] been able to offer comprehensive optometric services to more than 700 patients per year.

The COA SFVOS has played a major role in MEND's success serving the poor, staffing a thriving volunteer vision clinic for the past 10 years. The (vision) clinic began after discussion with Los Angeles City Councilman Richard Alarcon. He suggested that SFVOS get involved with MEND, and within a year, the first vision clinic was built as a small closet-sized facility furnished with used equipment funded by the Lions Club. Today, it's a large, two-lane facility with a large frame selection supplied by K-Mars Optical. The clinic typically opens for a half day per week and serves up to 15 patients in the San Fernando area with low income and no medical insurance. With the start of the

new academic year, MEND is now a two day per week externship site for a fourth year optometry student from Western University. This development has greatly increased the number of eye exams that can be provided.

"I am really proud of the work the San Fernando Optometric Society has done with MEND," said Stevin Minie, OD, COA trustee and SFVOS past president. "Thanks to our volunteer doctors, Lions Club and K-Mars, we have been able to offer comprehensive optometric services to more than 700 patients a year in our community who would have had no other place to go."

In the last year, the following doctors of optometry have volunteered at MEND:

- Dr. Stevin Minie
- Dr. Lee Dodge
- Dr. Adolphus Lages
- Dr. Jay Schlanger
- Dr. Gina Shao
- Dr. John Nelson
- Dr. Francisca Escobar

MEND serves as many as 30,000 poverty-level clients each month. It is the largest, most efficient and most comprehensive poverty-relief organization in the San Fernando Valley. MEND's mission is to break the bonds of poverty by providing basic human needs and a pathway to self-reliance. For more information about MEND, please see their website; www.mendpoverty.org. If you are interested in donating time as an optometrist, please email Dr. Minie at mineye@earthlink.net.

Dr. Christopher J. Orenic passes away

COA and South Bay Optometric Society member Dr. Christopher J. Orenic passed away unexpectedly on September 17.

Dr. Orenic was widely known in the South Bay for having built a successful optometry business, Advanced Eyecare Center of Manhattan Beach, and for his active involvement in the community. He participated in and contributed to numerous school and sporting events. He also served on the Manhattan Beach Chamber of Commerce Board of Directors.

A gourmet chef, Dr. Orenic loved cooking for family and friends. He was dedicated to his family, wife Mary Claire, and their son, Christopher.

Born December 12, 1957, in Joliet, Illinois, he was an outstanding student who was active in athletics and band. He went to

Barry University in Miami, Florida, and graduated *cum laude* in 1983 with a bachelor's degree in biology and a minor in chemistry. In 1985, while working in Chicago, he met his wife-to-be, Mary Claire Van Bree. They moved to California, married on July 16, 1988, and were inseparable throughout their marriage.

Dr. Orenic graduated with distinction from the Southern California College of Optometry in 1992. He was in private practice for more than two decades, helping thousands of patients improve their vision and protect their eye health. Chris is survived by his wife of 24 years, Mary Claire; their son, Christopher Kenneth; five brothers and three sisters, and 26 nieces and nephews. In lieu of flowers, the family requests that donations be made to the Christopher Kenneth Orenic Education Fund at The Bank of Manhattan, 2141 Rosecrans Ave., Suite 1100, El Segundo, CA, 90245.



CVF Spotlight Get involved!

California Vision Foundation, COA's charitable foundation, needs your help. If you would like to become involved in the California Vision Project and provide free eye exams to eligible low-income families, or contribute financially to the Foundation, please contact Michelle Harvey, California Vision Foundation administrator, at (800) 877-5738 ext. 222, via e-mail at mharvey@coavision.org or mail checks payable to the "California Vision Foundation," 2415 K Street, Sacramento, CA 95816.

To find out more, visit our website at californiavision.org.



WELCOME! New COA Members

Alameda/Contra Costa Counties Optometric Society

Stephanie Lynn Tom, OD
Avanti Ghanekar, OD
Sheryl L. Guillory, OD
Cheyenne A. Huber, OD
Mary Q. Nguyen, OD
Celia A. Futch, OD
Kathleen K. Mai, OD
Melissa Owyong, OD
Stephen Page, OD
Jeffrey A. Lewis, OD

Central California Optometric Society

Hong Luu, OD

Cahuilla Optometric Society

Kailee K. Watson, OD
Gabriela Avila, OD

Inland Empire Optometric Society

Lauren N. Tang, OD

Kern County Optometric Society

Randell P. Canaya, OD
Matthew W. Oblad, OD
Lisa J. Higson, OD

Los Angeles County Optometric Society

Anna Baycher
Melody Huang, OD

Monterey Bay Optometric Society

Anh Truong, OD

Orange County Optometric Society

Rodney Tahran, OD, FFAO
Marian Masoud, OD
Charles Luu, OD
Lynne Dianne Louie, OD
Terra J. Barnes, OD
Debon A. Crews, OD
Jennifer J. Che, OD
Paul D. Chappelle, OD
Lynn F. Marran, OD,
PhD, FFAO
Stephanie L. Mulick, OD
Reena A. Patel, OD
Anny Y. Lai, OD
Michelle N. Kirk, OD
Jamie Lam, OD
Ketan B. Patel, OD

Rio Hondo Optometric Society

Anh Trinh, OD

Santa Barbara Optometric Society

Irene C. Flores, OD
Amanda Powers, OD
Tiffany Q. Liu, OD
Hripsime G. Shirvanian, OD

Santa Clara Optometric Society

Stephanie L. Wong, OD
Chelsia Leong, OD
Yin-Yin Aung, OD
Jesley Johnson, OD
Kelly H. Kageyama, OD
Shirley F. Quicho, OD
Aileen Chang, OD

San Diego County Optometric Society

John B. Vinh, OD
Melody Fitch, OD
Simona Grosu, OD
Nishi Mehdiratta, OD
Maria Theresa G.
Alfonso, OD
Jennifer C. Koh, OD
Thu T. Nguyen, OD

San Francisco Optometric Society

Helen J. Yang, OD
Linda Ngo, OD
Jenny O. Cheung, OD
Stacie M. Low, OD

San Fernando Valley Optometric Society

Laura Uyen K. Ha, OD
Cathy L. Nguyen, OD
Thanh V. Mai, OD
Dennis R. Jorge, OD
Theresa T. Nguyen, OD

San Gabriel Valley Optometric Society

Jan Tung, OD
Julie C. Kao, OD
Veronica L. Woi, OD

San Jose Optometric Society

Janice M. McGeorge, OD

San Mateo Optometric Society

Neda Moshasha, OD
David J. Border, OD

Sacramento Valley Optometric Society

Jessica Huynh, OD
Cory N. Vu, OD
Jennie Nguyen, OD

Tri-County Optometric Society

Nicole V. Le, OD
Barry C. Mast, OD
Asuman Unal, OD
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Supported by educational grants from Alcon and Zeiss, and contributions of faculty and staff from Berkeley Optometry.

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Health care reform implementation: essential information for optometry

This year, California has been feverishly working to implement the new federal health care reform law, the Affordable Care Act (ACA). Said and written many times, ACA represents the most far-reaching change to the health care delivery system since the 1965 establishment of Medicare — and arguably is far more extensive. COA has been representing the optometric profession in every step of ACA's rollout. The ACA has three main parts that will take effect in 2014: **1)** expands Medi-Cal, **2)** requires individuals to obtain health insurance and **3)** creates a new California Health Benefit Exchange. Though admittedly long, this article reviews the three main parts of the law, the pediatric essential benefit, special contracting for optometry within the state Exchange, efforts being pursued by COA to ensure the widest patient access to doctors of optometry, tips for doctors to succeed in the new health care arena and the significant provisions of the law that will affect your patients and practice — all, COA believes, essential to a doctor's basic understanding of ACA and how he or she can best benefit.

Health Care Reform



Children now with Healthy Families insurance coverage will be transferred into Medi-Cal in four phases beginning 2013.

1. Expands Medi-Cal

Starting in 2014, the current Medi-Cal eligibility income threshold will increase from about 100 to 138 percent of the federal poverty level. Additionally, eligibility will be expanded to include poor adults without dependent children. Millions of Californians (estimates range from 1.7 million to more than 3 million) could gain access to coverage through Medi-Cal expansions under the ACA. Children now with Healthy Families insurance coverage will be transferred into Medi-Cal in four phases beginning 2013.

2. Requires individuals to obtain health insurance

Beginning in 2014, uninsured individuals must buy coverage — on their own, through an employer's plan or through a health insurance exchange — or else pay a tax penalty. In 2014, the penalty is capped at \$285 per family, or 1 percent of income, whichever is greater. By 2016, it will jump sharply to \$2,085 per family, or 2.5 percent of income, whichever is greater. Individuals will pay penalties of \$95 in 2014 that will climb to \$625 in 2016.

By 2014, companies with 50 or more full-time employees must start providing health insurance or face penalties. There is no requirement for small business owners (less than 50 employees) to provide health insurance coverage for their employees.

3. Creates a California Health Benefit Exchange

An Exchange is a marketplace where people and small businesses can shop for health insurance. It will begin offering coverage in January 2014. Simply stated, an Exchange is a regulated marketplace, where the Exchange selects the insurers allowed to sell policies and sets the minimum benefits those insurers must provide.

There are really two Exchanges: one for individuals and one for small businesses with less than 50 employees. Beginning in 2017, states have discretion to open its small business Exchanges to larger employers.

Subsidies in the form of tax credits will be available to people in the individual Exchange who earn up to 400 percent of the federal poverty level. This year, that would be up to \$44,680 for an individual and \$92,200 for a family of four.

How many patients are impacted by the ACA?

Between 1.8 and 2.1 million Californians are expected to enroll in subsidized coverage through the Exchange. Millions more will be guaranteed the ability to purchase coverage

without subsidies in the individual market. An additional 300,000 small business employees are expected to obtain coverage in the Exchange.

According to some estimates, up to 30 percent of small employers who currently purchase health insurance for their employees may drop coverage and instead encourage their employees to purchase health coverage through the individual Exchange. This is more likely to happen with lower paying employers because their employees can qualify for subsidies within the Exchange.

“Essential benefits” under the new law

Senator Ed Hernandez and Assembly Member Bill Monning jointly authored the legislation that established the “essential benefits” in California. For most services, benefits are modeled on the Kaiser Foundation Health Plan Small Group HMO 30 plan. It’s important to note that the choice of Kaiser as the benchmark plan for most services only applies to the benefit levels; **they do not have any impact on payment or contracting rules with providers.**

Adult vision — The Kaiser plan includes routine eye examinations for refraction and as preventative care.

Exclusions include:

- Industrial frames
- Eyeglass lenses and frames
- Contact lenses, including fitting and dispensing (except for special contact lenses to treat aphakia or aniridia)
- Eye exams for the purpose of obtaining or maintaining contact lenses
- Low-vision devices

It is unclear if vision therapy and low vision devices and services would be covered under the “rehabilitative and habilitative services and devices” essential benefit that is required under federal law. We won’t know until we receive further guidance from the federal government.

Pediatric vision — In addition to the Kaiser benefits, the pediatric vision essential benefit will be based on the largest vision plan for federal workers. According to a report supported by the California Healthcare Foundation, that plan is FEP Blue Vision — High. Beginning in 2014, all health plans will be required to provide coverage for pediatric vision at this level. Below is a description of that coverage:

- **Comprehensive vision exam** — No cost in network every calendar year.
- **Lenses** — One pair per calendar year; Polycarbonate lenses covered for children. Additional copays for progressive, photochromic, polarized and other special lenses.

Between 1.8 and 2.1 million Californians are expected to enroll in subsidized coverage through the Exchange.



- **Frames** — Covered once every calendar year. No charge for standard “collection” or \$150 credit.
- **Contact lenses** — \$130 allowance for contacts every calendar year; \$600 allowance if medically necessary with prior authorization. Medically necessary includes: Keratoconus, Pathological Myopia, Aphakia, Anisometropia, Aniseikonia, Aniridia, Corneal Disorders, Posttraumatic Disorders, Irregular Astigmatism.
- **Low vision care** — Pre-authorized low vision services include one comprehensive low vision evaluation every five years, with a maximum charge of \$300; maximum low vision aid allowance of \$600 with a lifetime maximum of \$1,200 for items such as high-power spectacles, magnifiers and telescopes; and follow-up care consisting of up to four visits in any five-year period with a maximum charge of \$100 each visit.

These essential benefits apply to individual and small group health plans inside and outside the Exchange. However, self-insured group health plans, large group market health plans, and grandfathered health plans are not required to offer essential health benefits.

Special contracting requirement for optometry

The Exchange is expected to transform the broader health insurance industry. State lawmakers made the Exchange an “active purchaser,” meaning that it can set criteria, negotiate with insurers and decide which plans can offer coverage. As a result of the COA Healthcare Delivery Systems Committee’s advocacy efforts, the California Exchange included a provision in its recently issued standards that health plans that wish to participate within the Exchange must contract with an adequate number of optometrists. The specific provider network standards have yet to be determined; however, COA will continue working closely with the Exchange as the provider contracting rules for health plans are developed in the next few months.

Stand-alone vision plans

COA has been working closely with VSP to advocate that stand-alone vision plans be included in all segments of the Exchange. Initially, the Exchange board voted to only allow stand-alone plans in the Exchange for small businesses.

However, the Exchange board recently agreed to reconsider its position on stand-alone plans at its next meeting.

What COA is doing to prepare doctors for 2014?

- **Meetings with health plans** — COA has initiated several meetings with health plans to address billing and other issues and concerns. Member doctors who have problems getting access to medical panels should contact Jason Gabhart, COA external affairs manager, at jgabhart@coavision.org to share your concerns to assist COA in this advocacy.
- **Meetings with medical groups, IPAs** — COA is working with the medical director for the association representing IPAs and medical groups in California to expand the role of optometry in California's health system.
- **Meetings with primary care groups** — COA has met with the California Primary Care Association to see how community clinics can be expanded to include access to optometry.
- **Meetings with other provider organizations** — COA is part of a coalition of non-physician providers that support expanded roles for non-MDs.
- **Sponsoring legislation to prohibit discrimination** — COA plans to reintroduce Senate Bill 690, by Senator Ed Hernandez, OD, which would prohibit health plans from discriminating in contracting.

Addressing issues that would limit patient access to optometry — California is trying to move patients who are dual-eligible for Medicare and Medi-Cal into managed care. This sometimes interferes with the doctor-patient relationship when a patient who previously had Medicare is now getting coverage through an HMO or other plan with closed participating provider panels. COA is opposed to the demonstration projects being considered for making this

transfer and is working with a coalition of health care providers to stop the transfer of these patients.

What should doctors do to get ready for 2014?

Things are changing and the doctors who can adapt to the new environment will be the most successful. Here are some ideas to prepare yourself:

- Get glaucoma certified. Doctors should strive to practice to the fullest extent of their licensure to meet the increased demand.
- Sign up for California Healthline (californiahealthline.org) and keep track of the provider contracting arrangements that may be changing in your community.
- Try approaching health plans and provider organizations that may have denied you access to their medical panels in the past. They may be looking for ways to reduce costs and improve patient outcomes with better utilization of optometry.
- Learn about accountable care organizations (ACOs) and reach out to newly forming provider groups; information on ACOs can be found at the following website: www.kaiserhealthnews.org/stories/2011/january/13/aco-accountable-care-organization-faq.aspx.
- Educate yourself with AOA webinars on how to evaluate a provider contract.
- Take a billing course and prepare your practice to convert to ICD-10 billing codes (see "ICD-10 compliance date: October 2014" in this edition).
- Participate in the Physician Quality Reporting Initiative (PQRI), a voluntary pay-for-reporting program in Medicare. It offers a financial incentive to doctors of optometry and other eligible professionals who successfully report quality measures.
- Convert to electronic health records and "meaningful use" standards.

Health care reform timeline

On March 23, 2010, President Barack Obama signed the comprehensive health reform measure, the Patient Protection and Affordable Care Act ("ACA"), into law. Some of its provisions are in effect now, and most of the balance will take effect in 2014. In planning for your practice, there is value in knowing its key elements. Below is a chronologic summary of the major requirements of the sweeping law:

Now in Effect

- Insurers are barred from imposing exclusions on children with pre-existing conditions.
- Young adults are able to stay on their parents' insurance until their 26th birthday.

- Insurers are not able to rescind policies to avoid paying medical bills when a person becomes ill.
- Lifetime limits on benefits and restrictive annual limits are prohibited.
- New plans must provide coverage for preventive services without co-pays (all plans must comply by 2018).
- New plans are required to provide for an appeals process for coverage determinations and claims.
- Small businesses with fewer than 25 full-time equivalent (FTE) employees and average annual wages of \$50,000 or less that purchase health insurance for employees will be eligible for a sliding scale tax credit of up to 35 percent of the employee's premium. The full credit is

available to employers with 10 or fewer FTE employees and average annual wages of \$25,000 or less. To be eligible for a tax credit, the employer must contribute at least 50 percent of the total premium cost.

- Laws strengthened for anti-kickback, false claims, beneficiary inducement, etc. Example: Intent no longer required for convictions under anti-kickback laws.
- The Independent Payment Advisory Board has been created to seek ways to cut wasteful spending by Medicare and reduce per capita health care expenditures.
- Patient Centered Outcomes Research Institute has been created to research clinical effectiveness of treatments.
- Accountable Care Organizations (ACOs) are being formed. An ACO is a network of doctors and hospitals that share responsibility for providing care to patients. ACOs agree to manage all of the health care needs of a minimum of 5,000 Medicare beneficiaries for at least three years.

Effective January 2013

- Health plans must implement uniform standards for electronic exchange of health information to reduce paperwork and administrative costs.
- Disclosure required for financial relationships between pharmaceutical/device companies and physicians.
- Bundled payment pilot projects begin.
- Contributions to flexible savings accounts (Section 125 plans) will be limited to \$2,500 per year, indexed by the Consumer Price Index in subsequent years.
- There will be increases to the income threshold from 7.5 percent to 10 percent of adjusted gross income for the purpose of health care expense income tax deduction eligibility. Those older than 65 will be able to claim the 7.5 percent deduction through 2016.
- A 2.9 percent excise tax on the first sale of medical devices will be established. **Excepted are eyeglasses, contact lenses, hearing aids or other items for individual use.**

Effective January 2014

- Most individuals will be required to have health insurance.
- Individuals who do not have access to affordable employer-sponsored coverage will be able to purchase coverage through a health insurance Exchange with premium- and cost-sharing credits available to some people to make coverage more affordable. Small businesses will also be able to purchase coverage through the Exchange. Large employers will

be able to purchase coverage through the Exchange beginning in 2017.

- Eligible employers purchasing coverage through an Exchange for their employees can receive a tax credit for two years of up to 50 percent of the individual employee's premium.
- Employers of 50 or more who do not offer health insurance will be required to a pay penalty of \$2,000 per FTE employee who receives tax credits for health insurance through the Exchange, e.g., "Shared Responsibility Requirement." In recognition of the fact that employee health care coverage is unaffordable for many small businesses, employers with fewer than 50 employees are exempt from this penalty.
- Plans must cover a defined essential health benefits package, **including pediatric vision care.**
- No health plan or insurer may discriminate against any health provider acting within the scope of that provider's license or certification under applicable state law. The provision is a federal protection applicable to ERISA and other plans established or regulated under the bill, including both insured and self-insured health plans. This provision is sometimes referred to as the "Harkin amendment." **Note:** COA sponsored this year SB 690, Hernandez, which mirrored federal law, which would prevent provider discrimination in contracting with health plans. The measure will be re-introduced in 2013.
- New regulations will be imposed on all health plans that will prevent health insurers from denying coverage to people for any reason, including health status, and from charging higher premiums based on health status and gender.
- Medicaid eligibility will be expanded to 138 percent of the federal poverty level (\$14,404 for an individual and \$29,327 for a family of four as of 2011) for all individuals under age 65.

January 2018

- An excise tax will be imposed on high-cost, employer-provided health plans beyond \$27,500 for family coverage and \$10,200 for single coverage.

As noted above, some provisions of the ACA are already in place. Most others take effect in the next two years but, before they do, additional laws and regulations must be developed. COA and AOA will continue to vociferously advocate for the profession and its patients as ACA is put in place. Please continue to keep-up-to-date by reading COA and AOA's publications, attending seminars and society meetings.



Take advantage of special pricing or services offered to COA members. For more information on these member services, visit the Member Resources section of COA's website at www.coavision.org.

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Minimize threatened rate hikes with COA's Workers' Compensation Program

Are you one of the members who participate in the California Optometric Association (COA) sponsored workers' compensation program who:

- This year paid almost 11 percent less than non-members in the COA program?
- Save \$228 in workers' compensation premium per year on average?
- Enjoy consistently low, competitive rates over time, providing stability year in and year out because rate changes are reviewed and approved by COA's Sponsored Services Committee?
- Are protected from policy non-renewal simply because you had a claim?
- Are protected against being singled out for a rate increase?

There are many things to consider when purchasing your workers' compensation protection each year. Certainly the rate you pay is one of the most important, especially in these difficult economic times. But there are other factors that should be included in any evaluation.

For instance, you may have heard that workers' compensation insurance companies are losing money in California and rates are on the rise again. According to the most recent report by the Workers' Compensation Insurance Rating Bureau (WCIRB), the combined loss and expense ratio for workers' compensation insurers totaled 122 percent in calendar year 2011; that means for every dollar in premium paid by an employer, the carriers are paying \$1.22 in benefits and other expenses. They are recommending an overall average increase in rates of 11.5 percent for January 1, 2013.

At times like these, it is important to be protected by the formidable buying power of your association to minimize rate hikes. The last time workers' compensation insurance became a problem for California doctors of optometry, COA provided a stable, long-term solution for members.

If you want to get the best rate, don't wait until the last minute. Contact us now to get a workers' compensation premium indication from Zenith Insurance Company,* COA's sponsored program insurer. Call a Marsh client advisor at 800-775-2020 or email COA.Insurance@marsh.com.



*ZNAT Insurance company, a wholly owned subsidiary of Zenith Insurance Company, is the underwriter for the California Optometric Association program.

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Pediatric Cerebral Visual Impairment

Keywords: blindness, cortical visual impairment, pediatric cerebral visual impairment



CE@Home

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Defining pediatric cerebral visual impairment

The definition of brain-related visual impairment had been and even today is often confusing, misunderstood and imprecise. It is now, however, frequently referred to as pediatric cerebral visual impairment (PCVI). Initially, pediatric cerebral visual impairment had also been referred to as pediatric cortical visual impairment and mistaken for delayed visual development.¹ Commentary in the *Journal of Visual Impairment and Blindness*² noted that in North America the phrase "cortical visual impairment" was frequently used while elsewhere "cerebral visual impairment" was considered the preferred terminology.

The story of the development of the concepts of visual impairment due to brain injury begins in the 19th century. Later, during World War I, wounded veterans with brain injury displayed an ability to perceive motion in the "blind, non-seeing" visual field. This ability to sense motion, lights, and colors even though the individual has brain injury-induced blindness may be conscious or subconscious. This is also referred to as statokinetic dissociation or the Riddoch phenomenon when discussing adults.³ The ability to sense such motion was called blindsight,⁴ which also appeared to include the ability to "sense" objects in one's way so that these could be avoided when walking into a room or down a hallway.

Prior to the 1980s, adults with bilateral insult to the occipital cortex were referred to as having cortical blindness. At this time, this term was also applied to children. Cortical visual impairment was used in the late 1980s onward with the definition of CVI being injury between the lateral geniculate nucleus and the visual cortex with reduced visual acuity being the identifying feature. When it was noted that many children had damage to the white matter surrounding the ventricles of the brain (periventricular leukomalacia PVL), the term cerebral visual impairment was coined and used to describe the condition (especially in Europe).

Cerebral visual impairment is a more inclusive term that allows for not only significantly reduced visual acuity, but also the frequently associated oculomotor anomalies, visual field loss and vision information processing problems seen in children.³ Some researchers suggest that the phrase cognitivevisual dysfunction (CVD) be used to identify the many visual perceptual anomalies associated with this condition.⁵

Colanbrander classified the various areas associated with CVI. These included:

1. Ocular visual impairment: Anomalies of refractive state, optics and eye health.
2. Cerebral visual impairment: Abnormalities associated with pathway problems, cortical problems and oculomotor dysfunction, as well as vision information processing anomalies (dorsal and ventral streaming processing mechanisms).⁶

Delayed visual maturation (DVM)

DVM type I describes infants who appear to be visually impaired, but usually demonstrate improved visual abilities by the age of 6 months, often without treatment. At this point the children frequently then go on to mirror more normal infant visual development.⁷ Even though infants with DVM were first described in the 1920s, there is little consensus as to the etiology of this disorder. There are several types of DVM, with type I being described earlier in this para-



graph. DVM type II is characterized by problems with attention and fixation but is also usually associated with other neurological and/or learning abnormalities. Improvement in the infant's vision takes longer and the end point visual acuity is typically not of the same quality as in DVM type I. Many in this category have intellectual disability, seizures and other developmental issues. In DVM type III, the children frequently have congenital nystagmus and albinism. Their vision starts to improve later than infants with DVM type I and can improve to low-normal levels. When delayed visual maturation is associated with retinal, optic nerve and macular anomalies, it is referred to as being Type IV.⁸

Defining PCVI

Variability with defining various disorders is not all that uncommon. For instance autism used to be a relatively rare anomaly. Once this definition was altered to reflect a spectrum of individuals with behaviors that have autistic-like characteristics, the number of those on the *Spectrum* is now considered — by some — to have reached almost epidemic status.^{9,10,11} Interestingly the neurological/brain changes associated with this disorder can even mimic many of the behaviors seen in those with PCVI as well.¹²

Should we be concerned about how PCVI is defined? Absolutely. There are instances where not only do the number of individuals with the diagnosis increase exponentially (like that which occurred for autism), but can also decrease significantly. When the American Association on Intellectual and Developmental Disabilities changed the definition of mental retardation by decreasing the IQ cut off point from 80 to 70 and adding adaptive behavior qualifications, they instantly cured hundreds of thousands of those with mental retardation overnight.¹³ The AAIDD has not only changed the

definition of mental retardation, but also the words used to describe the condition. Many years ago the classifications used such derogatory terms as "idiot" and "moron"; then "mental retardation" and now, the preferred terminology in this area is either "developmental disability" or "intellectual disability."

What we call a thing is very important for to name it is to have power over it.

After the American Conference on Pediatric Cerebral Visual Impairment (sponsored by the Children's Hospital of Omaha) was held in April 2012, the group of presenters met to review all that was discussed. It was decided that the term "*pediatric cortical visual impairment*" was the preferred terminology to use since this is very specific about the group of individuals being discussed — those with cortical visual impairment only and no other developmental, cognitive or developmental issues. I noted that most practitioners, therapists and teachers see children with additional issues such as motor challenges, vision information dysfunction and other non-cortical anomalies. For these individuals, at least one of the presenters suggested that the term pediatric "*cerebral visual impairment*" was much more appropriate because we seldom see cortical visual impairment isolated from other factors.

Determining visual function in children with pediatric cortical visual impairment

There are numerous areas that require a significant number of assessment procedures to ascertain the level of ability of those with pediatric cerebral/cortical visual impairment. We need to assess *vision function* as well as *functional vision*.

An assessment of vision function can include determination of the clarity of vision (visual acuity, contrast sensitivity, refractive error), oculomotor ability (pursuits and saccades, convergence and divergence), accommodation, depth perception and eye health.^{14,15,16} It is also often appropriate to use special diagnostic tools such as the EOG (electrooculogram), ERG (electroretinogram) and the VER (visually evoked response; VEP, visual evoked potential) to determine the level of ability present. Those with a wide range of disability tend to show many anomalies in the various areas of vision function noted above.^{17,18,19,20}

An assessment of functional vision should then be conducted as well. Those with disability tend to have *functionally induced disability* that often overlays *pathologically induced disability*, so that the end result is often greater than one might expect from either anomaly individually. For instance, a large amount of uncorrected refractive error could cause amblyopia that magnifies any vision loss due to cerebral/cortical impairment. The amblyopia also induces numerous vision information processing anomalies that impede a child's daily living skills development and his or her ability to navigate the world about them. Children with Down's syndrome, for example, have very poor accommodative abilities that can interfere with all near-point activities, from using a computer to reading a book.^{21,22,23} Those with cerebral palsy will display oculomotor, visual motor integration and accommodative problems along with high refractive errors as well.^{24,25,26}

Another area of concern is that of vision information processing (VIP) and the development of appropriate visual perceptual skills.²⁷ Laterality/directionality, visual motor integration, non-motor perceptual skills and auditory perceptual/processing skills all have a role to play in child development. Unfortunately, those with disability tend to have both functional vision and vision function anomalies that interfere with the development of appropriate vision and auditory information processing ability.²⁸



Laterality/directionality, visual motor integration, non-motor perceptual skills and auditory perceptual/processing skills all have a role to play in child development.

It should be noted that some presenters at the conference thought that the use of electro-diagnostics — VEP, ERG, EOG — were not needed and only confirmed what you already knew. These tests added to the costs involved in managing patients and used valuable resources unwisely. At least one presenter however, noted that the use of VEPs could establish a valuable objective baseline of vision function that could be utilized to confirm improvement once therapy was begun and could help guide the therapist in what approaches worked best.

Therapeutic strategies for the treatment of pediatric cerebral visual impairment

All treatment should begin by paying attention to the basics. These basics include the various areas of vision function and eye health discussed above. Any problems that need to be



addressed to insure the best possible eye health should be instituted. If uncorrected refractive error is present, it should be diagnosed and a prescription for glasses given to the child. It has been noted that even correcting a relatively small

amount of refractive error for those with traumatic brain injury can improve these individuals' quality of life.²⁹ Remember that spectacles are not only corrective in nature, they can also be therapeutic as well.

Children with high amounts of hyperopia and those with accommodative dysfunction, including individuals with Down's syndrome, cerebral palsy and brain injury, often benefit from a multi-focal prescription where an added "+" power is given either in a multifocal prescription, e.g., bifocal, or as a secondary pair of spectacles to use for specific tasks. Individuals with significantly decreased vision at near can also benefit from high "+" adds and the magnification that results.

Once the refractive prescription is determined and corrected, and any therapeutic applications addressed appropriately for

use with a spectacle prescription, e.g., bifocals, prism, sector occlusion, etc., then it is time to determine other therapeutic interventions required for any additional vision function anomalies present. It was suggested that Facebook can be a unique resource for therapeutic ideas, as well as other Internet resources, e.g., Thinking Outside the Box,³⁶ Mainos-Memos,³⁷ Pinterest.³⁸ Therapeutic procedures to improve eye movement and hand-eye, accommodation, convergence/divergence, and other aspects of both vision function and functional vision, as well as visual stimulation activities were presented as well.

Although children with cortical/cerebral visual impairment have significant neurological impediments, the principles of neuroplasticity can be applied to the various therapeutic approaches utilized for this population.³⁰ In most instances the therapy is not rehabilitative in nature, rather habilitative. This difference is important to remember when caring for those with PCVI. Teachers of those with cortical visual impairment often rely on texts such as that by Christine Roman Lantzy, Ph.D., *Cortical Visual Impairment: An Approach to Assessment and Intervention*, as the best way to determine various levels of function and to treat PCVI.³¹

How do environmental factors, medications and non-visual handicaps affect the evaluation and treatment of pediatric cerebral visual impairment?

Individuals with a handicap tend to be prescribed many more medications than those not demonstrating a disability. They also often have a slightly higher affinity for the development of adverse effects due to various environmental factors. A paper in *Optometry* discussed adults with not only a developmental disability, but also a psychiatric illness that noted many of these individuals were taking 10 or more high powered neurotropic and systemic medications. Interestingly, seldom did any of these individuals complain of symptoms related to their disability, systemic anomalies or medication side effects.³² Certainly those who are significantly younger than the population described above may also find it difficult to communicate their needs, wants and symptoms as well.

Various medications, alternative and complementary medical therapies³³ and even more traditional allopathic approaches to health care can result in adverse, unintended events. (See Table 1.) Although you may think that a child is too young for many of these major drugs, you should realize that various psychiatric anomalies, such as pediatric bipolar disorder, is now one of the most frequently diagnosed mental illnesses in children. Pediatric depression is also being diagnosed often, let alone all the medications currently being used for behavioral issues such as attention deficit hyperactivity disorder.³⁴

	SYSTEMIC SIDE EFFECTS	OCULOVISUAL SIDE EFFECTS
Antipsychotics	Bone marrow depression	Blurred vision
	Muscle spasms/twitches	Light sensitivity
	Breast enlargement (M & F)	Visual disturbances
	High body temperature	Mydriasis
Antidepressants	Abdominal pain/constipation	Blurred vision
	Abnormal dreams/thinking	Increased risk of glaucoma
	Abnormal ejaculation/orgasm	Visual disturbances
	Anxiety	Photophobia
Anticonvulsants	Memory problems/amnesia	Blurred vision
	Sedation	Dimming of vision
	Insomnia	Diplopia
	Bronchitis	Involuntary eye movements
	Fluid retention	Dry eye
Anti-Parkinson's	Abnormal dreams/insomnia	Vision abnormalities
	Increased muscle tone/weakness	Blurred vision
	Involuntary movements	Mydriasis
	Hallucinations	Decreased accommodation
Tranquilizers	Breast development in men	Risk of narrow angle GLC
	Breathing problems	Cycloplegia/mydriasis
	Insomnia	Decreased vision
	Tardive dyskinesia	Capsular cataract
Antianxiety	Anemia	Decreased accommodation
	Seizures	Nystagmus
	Blood disorders	Diplopia
	Unusual excitement	Mydriasis

Table 1: Medication Side Effects adapted from RJ Donati RJ, Maino DM, Bartell H, Kieffer M. Polypharmacy and the Lack of Oculo-Visual Complaints from those with Mental Illness and Dual Diagnosis. *Optometry* 2009; 80:249-254.

One of the major environmental hazards those with disability encounter are *people*. Many do not know how to respond to an individual with a disability. They may make assumptions that are false and then act on those assumptions. This is true not only for lay individuals but also for teachers and health care professionals.³⁵

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CE Questions

1. Pediatric cortical visual impairment is defined as:
 - a. Abnormalities associated with pathway problems, cortical problems, oculomotor dysfunction and vision information processing anomalies
 - b. Cortical visual impairment not associated with other problems
 - c. Delayed visual impairment type II
 - d. Delayed visual impairment type III
2. Statokinetic dissociation is also known as:
 - a. Riddoch phenomenon in adults
 - b. Blind motor sight
 - c. Blind sense
 - d. Riddick Chronicle Blind-Sight
3. Cognitive visual dysfunction includes:
 - a. Anomalies of refractive state and optics and eye health
 - b. Abnormalities associated with pathway problems, cortical problems, oculomotor dysfunction and vision information processing problems
 - c. Delayed visual impairment type Ia
 - d. A and B
4. Delayed visual maturation type I describes an infant who:
 - a. Shows visual impairment that does not get better over time
 - b. Demonstrates improved visual abilities by the age of 6 months only with treatment
 - c. Shows improved vision by 6 months of age often without treatment
 - d. Has visual impairment due to trauma
5. Children with delayed visual maturation type III frequently have:
 - a. Corneal anomalies
 - b. Nystagmus
 - c. Albinism
 - d. B and C
6. When delayed visual maturation is associated with retinal, optic nerve and macular anomalies, it is referred to as being:
 - a. Type V
 - b. Type IV
 - c. Type III
 - d. Type II
7. When we examine those with pediatric cerebral/cortical visual impairment, we need to assess:
 - a. Vision function
 - b. Functional vision
 - c. A and B
8. Treatment of those with PCVI should include:
 - a. Refractive care
 - b. Intervention that involves improving vision function
 - c. Intervention that involves visual stimulation
 - d. All of the above
9. True or False: It is also often appropriate to use special diagnostic tools such as the EOG (electrooculogram), ERG (electroretinogram) and the VER (visually evoked response; VEP, visual evoked potential) to determine the patient's level of ability.
 - a. True
 - b. False
10. A major hazard that those with disability encounter includes:
 - a. People
 - b. Animals
 - c. Raised curbs
 - d. Stop lights

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To place any ad, simply contact Bill Howe at bhowe@coavision.org or call 916-266-5037.

OPHTHALMOLOGY PRACTICE FOR SALE: Atlanta Suburb, GA

This 50-year-old practice is located in an upscale suburban community just outside of Atlanta, GA. Practice provides full-scope eye care (ophthalmology, optometry and retail optical) customer service. \$800K revenue without any surgeries. (ID#75349)

OPTOMETRY PRACTICE FOR SALE: San Fernando Valley, CA

This practice was established over 56 years ago in the heart of the San Fernando Valley. The office is located on the corner of a busy main street in town with high visibility. Annual gross revenue is over \$410K with plenty of room for expansion. (ID#73243)

NEW LISTING! OPTOMETRY PRACTICE FOR SALE: Atlanta, GA

Location, location, location! This great practice was opened cold 3 1/2 years ago in the Midtown area of Atlanta. Annual gross revenue was over \$725K in 2011, and is currently on the rise. The practice is well designed with stylish and modern furnishings and an upscale optical boutique. The doctors and staff are known for their exceptional customer service and personal care. Seller is moving abroad, but will assist in transition. (ID#76564)

OPTOMETRY PRACTICE FOR SALE: Dallas-Fort Worth Metro Area, TX

Location, location, location! This growing practice is situated in a prime retail strip center in the Dallas-Fort Worth metro area of Texas. Well-designed with upscale finishes, the space includes 1 exam room, a large, stylish dispensary and an extensive inventory collection including Chanel, which no other practice in the area carries. Gross revenue was just over \$200K in 2011. (ID#75350)

OPTOMETRY PRACTICE FOR SALE: Near Houston, TX

This turnkey, 32-year-old practice is situated in a prime location about 30 minutes from Houston. The well-designed office boasts an average gross revenue of over \$950K. Situated in front of a popular mall in town, the practice is highly visible from the street and main highway. The seller also owns the building, which may be available for sale. (ID#71876)

OPTOMETRY PRACTICE FOR SALE: Upstate NY

This practice was started cold 71 years ago and has been family owned since. This office is situated in a historic area with high visibility and high foot traffic. Over \$285K gross. Plenty of room for growth. Practice offers easy weekday hours. Doctor only works about 20 hours average per week. Current owner will assist in transition. (ID# 71028)

OPTOMETRY PRACTICE FOR SALE: Northern CA

Location, location, location! Gross over \$800K, this great, retail oriented optometry practice is located in an upscale shopping center. Boasting exclusive eyewear collections, this practice is the place to go for fashionable frames and excellent customer service. Annual gross revenue is over \$800K with strong net income of almost 50%. (ID# 73063)

OPTOMETRY PRACTICE FOR SALE: Los Angeles County, CA

This great, 23 year old practice was opened cold by the current owner. Located across the street from a popular strip mall with excellent visibility in Los Angeles County, CA. Annual gross revenue is over \$445K. Includes a new Nidek refracting unit and a computer network. (ID#75328)

NEW LISTING! OPTICAL PRACTICE FOR SALE: Near Philadelphia, PA

This Sterling Optical franchise is located near Philadelphia in a busy strip center with high visibility. Well known in the community as the go to place for eye exams and stylish eyewear. Annual gross revenue is over \$915K with a strong net. Sale includes one exam lane, a fully equipped finishing lab and an extensive inventory. (ID#76602)

OPTOMETRY PRACTICE FOR SALE: Central CA

This well-established practice started cold 17 years ago. Annual average gross revenue is \$300K. The current owner chose this location due to the affluence of area and beautiful location. Located in a strip center, surrounded by restaurants, a gym and retail stores. (ID#70531)

COMING SOON! OPTOMETRY PRACTICE FOR SALE: Los Angeles – South Bay Area, CA

Over \$290K annual gross revenue. More details coming soon. (ID#76486)

COMING SOON! OPTOMETRY PRACTICE FOR SALE: Central Coast, CA

Over \$400K gross. Recent equipment upgrades. More details coming soon. (ID#76487)

COMING SOON! OPTOMETRY PRACTICE FOR SALE: Atlanta, GA

Newly established, turnkey practice. More details coming soon. (ID#76488)

COMING SOON! Optometry Practice For Sale: San Francisco, CA - Richmond District

\$1MM + practice in a prime location. Strong net, upscale office, fully automated, EMR, lots of upgrades. Beautiful interior recently remodeled. Owner must sell for personal reasons. Very motivated and priced to sell. (ID#76489)

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COA Events

November 8-11, 2012

Monterey Symposium

Monterey Marriott Hotel & Conference Center, Monterey

February 8-9, 2013

COA House of Delegates Meeting

Sheraton Universal Hotel, Universal City

February 27, 2013

COA Legislative Day

Sheraton Grand Hotel, Sacramento

If you have an event you would like to promote, please send your listing to Bill Howe at bhowe@coavision.org.

View more upcoming events at: www.coavision.org.

When & Where

November

4

CE Clinical Chief's Optometry Update

SCCO, 2575 Yorba Linda Boulevard, Fullerton, CA 92831
714-449-7442 • satkinson@scco.edu

8

Monterey Symposium Management & Business Academy™

Monterey Marriott Hotel & Conference Center, Monterey
800-877-5738 • events@coavision.org

8-10

COA Glaucoma Track

Monterey Marriott Hotel & Conference Center, Monterey
800-877-5738 • events@coavision.org

8-11

Monterey Symposium

Monterey Marriott Hotel & Conference Center, Monterey
800-877-5738 • events@coavision.org

13

SFOS Meeting and COA Town Hall Meeting —

1 CE Hour TBA

Queen Anne Hotel, 1590 Sutter Street, San Francisco
RSVP Carrie Lee, OD • carinya5@hotmail.com

15

SDCOS Presents: Glaucoma by Robert Weinreb, MD

Handlery Hotel, 950 Hotel Circle North, San Diego, CA 92108
Jason Tu, OD • jastontuod@gmail.com

18-19

Glaucoma Grand Rounds with Live Patients

SCCO, 2575 Yorba Linda Boulevard, Fullerton, CA 92831
714-449-7442 • satkinson@scco.edu

20

SVOS General Meeting & Glaucoma and Eye Disease in Immigrant Populations by Aaron Lech, OD (2 CE Hours) and COA Town Hall Meeting

Red Lion Woodlake Hotel, 500 Leisure Ln., Sacramento, CA 95815
Jerry Sue Hooper • 916-447-0270 • jerrysue@svos.info

December

1-2

Glaucoma Grand Rounds with Live Patients

Western University College of Optometry, Pomona
909-706-3493 • ceoptometry@westernu.edu

2

GP Lens Specialty Practice — Today & Tomorrow

SCCO, 2575 Yorba Linda Boulevard, Fullerton, CA 92831
714-449-7224 • satkinson@scco.edu

2-3

Glaucoma Grand Rounds with Live Patients

SCCO, 2575 Yorba Linda Boulevard, Fullerton, CA 92831
714-449-7442 • satkinson@scco.edu

January

12

Launching a Successful Glaucoma Practice — Session #2

SCCO, 2575 Yorba Linda Boulevard, Fullerton, CA 92831
714-449-7442 • satkinson@scco.edu

12-14

**UC Berkeley School of Optometry:
24th Annual Berkeley Practicum**
Doubletree Hotel, Berkeley Marina, 200 Marina Boulevard,
Berkeley, CA 94710
510-642-6547 • optoce@berkeley.edu

15

SVOS General Meeting & 2 CE Hours TBA
Red Lion Woodlake Hotel, 500 Leisure Ln., Sacramento,
CA 95815
Jerry Sue Hooper • 916-447-0270 • jerrysue@svos.info

27

Jules Stein Eye Institute & SCCO Annual Symposium
SCCO, 2575 Yorba Linda Boulevard, Fullerton, CA 92831
714-449-7442 • satkinson@scco.edu

February

8-9

COA House of Delegates Meeting
Sheraton Universal Hotel, Universal City
916-266-5022 • mharvey@coavision.org

19

SVOS General Meeting & 2 CE Hours TBA
Red Lion Woodlake Hotel, 500 Leisure Ln., Sacramento,
CA 95815
Jerry Sue Hooper • 916-447-0270 • jerrysue@svos.info

27

COA Legislative Day
Sheraton Grand Hotel, Sacramento
916-266-5031 • jandrade@coavision.org

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Steps and Leaps



The Back Page

I remember well sitting with my best friend and his parents watching astronaut Neil Armstrong's historic first steps on the moon on a 13" black and white portable television powered by "rabbit ears." Who would have believed it at the time when then-President John F. Kennedy challenged the American public in 1961 to send a man to the moon and bring him safely back? Though I was a kid, I knew the world had changed by observing and listening to my parents and their peers who were raised in the 1920s and 30s, and their parents born in the late 19th century when powered flight was just a dream of two brothers from Ohio.

In the pages of this edition of *California Optometry*, you will read of steps forward made in this year by the optometric profession for the benefit of doctors and their patients. With the 2014 launch of federal Affordable Care Act (ACA) on the horizon, your professional association has won the definition of the pediatric essential benefit required to be offered by all health plans to include a comprehensive vision examination, lenses and frames, contact lenses and low vision care. Further, the California Health Benefit Exchange agreed with COA and voted to require health plans that offer coverage through the exchange to contract with an adequate number of doctors optometry. Up to six million new lives are expected to be newly insured through the exchange beginning in 2014. And a bill sponsored by COA permits optometric doctors to perform certain diagnostic tests in office, rather than ordering them from a lab will allow doctors to treat and be paid to a fuller extent of their education and offer greater convenience to the patient. (**Note:** COA is offering a course on how to code and bill for these tests, called "CLIA Waived," at its Monterey Symposium on November 11, 2012.)



That's one small step for [a] man, one giant leap for mankind.

—Neil Armstrong, 1930-2012

Being paid for the treatment of strabismus. Authorization to perform dilation and lacrimal irrigation. Ability to use diagnostic pharmaceutical agents. Treatment of eye disease through therapeutic pharmaceutical agents. Ability to treat glaucoma. How many of your forbearers licensed for the first time in 1913 would have dreamed of these steps advancing optometric care of the public?

As I wrote in my last column, COA is embarking on the next steps toward capturing the optometric ultimate dream: "Guarantee all Californians use optometrists as the primary providers of quality eye and vision care." In cooperation with COA local societies, COA will be holding a series of town hall meetings in November (and maybe December) to discuss the next step in achieving that dream — redefining optometry in such a way as to be able to take advantage of new technologies and modalities in caring for the eye and any of its appendages. Your viewpoints and observations are an essential part of the dialog that shapes this next step. Please watch your e-mail and society newsletters for upcoming dates and locations or contact Julie Andrade, COA legislative relations manager, at jandrade@coavision.org or 916-266-5031.

Neil Armstrong had it right. Many small (and some medium) steps have been taken by COA on behalf of the California optometric profession over more than a century to advance optometry. When added together, these steps represent a giant leap toward patient access to optometric care delivered at the highest level of the profession's education and training. Please invest in yourself and your profession and take the relatively little time to attend a town hall meeting to share your thoughts on the next steps for the profession and its patients.

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