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Legislative Day 2011 — A Time of Change
On November 1st, the California Optometric Association (COA) Legislative and Affairs Division sent out a blast email that asked you to write letters to the director of the Department of Consumer Affairs (DCA), urging him to approve the proposed regulations for implementation of a glaucoma certification pathway currently under SB 1406. To each of you who responded quickly to this call to arms, I thank you. Admirably, some of you contacted ophthalmologic colleagues and enlisted their help for our cause, while others wrote your own letters. I was tremendously impressed by students who faxed half of all letters sent to DCA on behalf of optometry. Realize the regulations already allow optometrists who graduate after 2008 to receive licenses with glaucoma certification. Therefore, this act was not impressive because of the volume of students who responded (while concurrently studying for finals), more notably because these regulations will not directly impact the prescriptive authority of graduating ODs. For our future colleagues to selflessly rally around a letter-writing campaign reinforces the bright future that optometry holds for promoting public health policy.

During a long weekend in October, the COA leadership and members from our Legislation and Regulation Committee and Health Care Delivery Systems Committee attended the AOA’s Third Party Center and State Government Relations Committee Conference in Denver, CO. Along with COA Board members and student representatives, each affiliate state listened to hours of tactical lectures and presentations designed to prepare us for health care reform, including state-based exchanges and health information exchanges. Feel free to review all of the presentations on AOA Connect at www.aoa.org. The information was enlightening and overwhelming as we came to realize our state has a significant amount of work to do as we ensure optometry will play a vital role in California’s health care.

A few years ago, many may recall articles in CO discussing incentives for participating in the Physician Quality Reporting Initiative (PQRI), yet the submission by eligible professionals in optometry is still lacking. Recognize such a task in the future will likely penalize ODs for being unable to demonstrate to third parties a measurable level “quality” care. If you are not already doing so, I would ask that you begin submission of PQRI data, not for the financial incentive or because it’s the right thing to do, but because it provides decision-makers with a measurable outcome of the professional care that we deliver. If you’re not certain what to do or how to report, visit www.aoacodingtoday.com.

The same need for data holds true for InfantSEE™ and the California Vision Project (CVP). These programs provide forms for ODs to submit valuable data about utilization and outcomes that allows for continued funding from outside agencies and grants. The incorporation of an Electronic Health Record (EHR) system is another process offering incentives to ODs. Many of you have already adopted while others are waiting. We learned in Denver that EHR participation will be vital in Health Information Exchanges by 2014.

This will be my last Leadership Corner column as president of the California Optometric Association. It has been a tremendous pleasure and honor to serve at this level within organized optometry. We have many challenges ahead and a remarkable team of volunteers to help us achieve our mission. Bear in mind, we need members to provide all hands on deck as part of COA’s advocacy efforts. In 2011, COA will review and develop the next steps into our strategic plan.

I thank each of you for allowing me to serve as your president. I do ask that each of us do our part to preserve the future of optometry. Whether it is obtaining certification to practice at the highest level, volunteering to serve in the committee structure, ensuring our inclusion on the state health exchanges, or providing the information needed to demonstrate the quality of optometric care. As we move forward I look to our members and future colleagues and ask that you get motivated, stay involved, and, most importantly, be a member for life!
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BOARD OF TRUSTEES
MEETING HIGHLIGHTS

On November 4, 2010, the Board of Trustees had a meeting at the Marriott Hotel in Monterey, CA. The Board discussed a number of issues and topics, with motions:

• To ratify the September 27, 2010, board fax vote to appoint Dr. David Redman as the interim chair of the Legislation and Regulation Committee for the remainder of the 2010 COA governance year.
• To approve the Revised Volunteer Expense Reimbursement Policy as proposed by the Finance Committee.
• To approve the Revised 2011 Budget and the Proposed 2012 Budget as amended.
• To adopt the COA Legislative Fund Assessment Expenditures Policy as presented.
• To approve the revised CVF Bylaws as presented.
• To appoint the following six individuals as the CA representatives for the AOA PAC for the term of November 4, 2010, through the 2012 COA House of Delegates:
  o Stacy Gin, OD
  o Gregory Hom, OD, MPH
  o Steve Langsford, OD
  o Tommy Lim, OD
  o Bruce Mebine, OD
  o Jennifer Ong, OD

The next meeting of the COA Board of Trustees was scheduled to take place on February 3, 2011, at the Marriott Hotel in Visalia, CA.
Are you prepared?

Today, the WCIRB submitted a pure premium rate filing to the California Insurance Commissioner recommending a 27.7% increase in workers’ compensation pure premium rates effective January 1, 2011. Pure premium rates are a benchmark that insurers may use as a tool for determining their own rates.

The positive loss history of the California Optometric Association’s Workers’ Compensation Program has resulted in consistent and competitive rates for members. Plus, members receive first-class customer service from Marsh and claims service from Republic Indemnity to assist them whenever they need it.

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MAKING THE MOST OF MEETINGS

I go to a lot of meetings in a week. On average, I probably go to 20 hours of meetings in a normal work week. That sounds so much worse when I say it in print. Yikes! Some meetings are so worthwhile and time well spent. Other meetings make me want to poke my eyes out. What ends up differentiating these two experiences? Let me try to distill my observations for you so that you do not suffer a similar fate.

Be organized. An agenda is really crucial to any worthwhile meeting. It allows all the participants to see what topics are going to be addressed prior to the meeting. This gives participants an opportunity to already come somewhat pre-loaded to the meeting with information and opinions. It helps focus the topics and the discussions.

Be concise. If you are running the meeting or serving as a participant, limit your speech to items that are salient to the discussion — do not babble, do not go off on tangents. Stay focused on the topic at hand. Take a moment to ask if you are monopolizing the conversation, and rather, spend time drawing the opinions out of the unheard minority. Think before you speak, and then deliver the well-crafted word on the topic.

Don’t allow babbling. Some people make their point with clarity. One sentence and their opinion is stated and summed up. Then on the other hand you can have the ramblers. The point they are making never goes from point A to point B, but rather it meanders around and when they get to the end, you really still don’t know what point they are making. Try to corral and limit these people in their comments. They waste time and often do not bring anything additional to the discussion.

Don’t invite too many people. Select participants as representatives or as strategic contributors, but don’t include everyone and their uncle when crafting a meeting or committee. The sheer numbers make action and moving forward often unwieldy. Discussion times on topics are extended due to larger numbers. Smaller and smarter will lead to more concrete results.

Do your best to include everybody in attendance. If you have been strategic about who is at your meeting, then you should go out of your way to make sure that they weigh in on topics. Everyone has a different personal style. Some people will willingly contribute all the time and others you will have to purposefully draw out. Do your best to solicit the opinions of your meeting members.

Make sure people walk away with one of the following: action, assignment or accomplishment. One of the biggest complaints I hear about meetings is the lack of results. Participants will walk out of a meeting and say, “Well, that was a huge waste of time.” Don’t let it happen! People are willing to contribute the precious commodity of time if they feel that the expenditure was worth it. Work hard for people to walk away with a course of action, an assignment to be completed, or the acknowledgement that a task was accomplished from previous actions or assignments. The sense of forward movement in meetings is really a key ingredient in inspiring vitality in the group dynamic.

Don’t waste people’s time. Finally, the cardinal rule of meetings for me — don’t waste people’s time. If it is a staff meeting, an optometric society meeting, or a Rotary meeting, make the time that people spend in the meeting worthwhile. Start on time, end when you say you will, keep on task, get results, and make people feel valued and engaged.

We all participate in a wide array of meetings in a number of different capacities. I hope that these lessons constantly echo in my head as I organize and participate in meetings. I hope that by applying these guidelines your time in meetings will be time well spent in the New Year.
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Eye Openers

are a quick look at the latest headlines and news surrounding optometry and eye care in the last few months.

LEGISLATIVE DAY 2011
A Time of Change

As with the rest of California, it is also a time of change for COA and its Keyperson Program. SAVE THE DATE for COA’s 2011 Legislative Day (formerly known as Keyperson Day), Wednesday, March 23, 2011. Come and meet Kristine Shultz, new director of COA’s Government and External Affairs Division. Although Kristine has been on staff since May 2010, this will be her first Legislative Day with you and the first opportunity for many of you to meet her face-to-face. We will also be welcoming newly-elected Legislative and Regulatory Committee Chair Dr. David Redman — past president of COA.

We need COA representatives (Keypersons) to begin developing relationships with Governor-Elect Jerry Brown and newly-elected legislators. And as always, it is vitally important that we foster those relationships we already enjoy with our friends at the Capitol.

Even the venue of Legislative Day has changed! Legislative Day 2011 will be held at the Sheraton Grand in Sacramento on Wednesday, March 23, 2011 — more details and information to follow. The agenda will include among other things, discussions on implementation of federal health care reform and the importance of gaining access to health panels.

One thing certainly remains the same — COA’s great Keypersons! With your commitment we will continue to grow and be an even stronger voice for the profession of optometry within the Capitol. We look forward to seeing you at Legislative Day! Please watch your email for registration links and information.

CALIFORNIA OPTOMETRY CASE STUDY CONTEST DEADLINE EXTENDED!

California Optometry magazine’s Case Study Contest is back for 2011! The contest is open to recent graduates participating in residency programs and fourth-year optometry students who have current COA student membership for 2010-2011. Only case studies may be submitted, and submissions can be on any topic related to optometry. Case studies will be evaluated and the winner is expected to be announced in the May/June 2011 issue of CO. And the grand prize winner will be asked to rework their winning case study into a CE@Home article for an upcoming issue of the magazine.

All case study submissions are due no later than Saturday, January 15, 2011. For more information or to submit your case study, contact Corrie Pelc at cpelc@coavision.org.

COMPANY NEWS

- Bausch + Lomb recently announced a patient rebate program for Crystallens® intraocular lens (IOL). Those who have the IOL implanted between November 1, 2010, and January 31, 2011, are eligible for up to $250 per eye rebate from B+L. Visit www.crystallens.com for more information.
• Essilor of America, Inc., has launched the first personalized lenses available in the United States designed to meet the unique visual needs of patients of Chinese and Eastern Indian ethnicity.
• SynergEyes® has launched a new educational Web site, www.treatkeratoconus.com, for patients seeking information and treatment options for the eye disease.
• MingSight Pharmaceuticals announced in October it acquired exclusive worldwide rights from Pfizer to develop, manufacture, and commercialize two preclinical stage new chemical entities for the prevention and treatment of human diseases, including diabetic retinopathy, uveitis, and dry eye.
• In October, Wells Fargo unveiled its Wells Fargo Practice Finance brand from its previous Matsco identity.
• Marchon3D™, a division of Marchon Eyewear, announced in October the US Patent and Trademark Office issued an official Notice of Allowance on one of Marchon3D’s patent applications relating to its curved M3D™ 3D lenses, signifying that a patent will issued shortly.

GENERAL NEWS

• In September, CNNMoney.com ranked “optometrist” number 56 in its top 100 list of the best jobs in America.
• While 82% of Americans fear losing their vision the most of all their senses and the majority say they get an annual eye exam, 86% of those who have (or are at-risk for) an eye disease fear losing their vision and do not get an annual eye exam, according to a new survey conducted in September for Lighthouse International.
• A new study suggests older adults who wear multifocal contact lenses to correct problems with near vision may have greater difficulty driving at night than their counterparts who wear glasses, according to a study in the September issue of Investigative Ophthalmology and Vision Science.
• New research indicates video game therapy can improve the vision of adults, according to an article on WebMD.com in September. The study was published in the September issue of PLoS Biology.
• Anorexia nervosa causes potentially serious eye damage, according to a study published online in the British Journal of Ophthalmology in October. Analysis showed the macular and retinal nerve fiber layer were significantly thinner in the eyes of women with anorexia nervosa compared to healthy women, and there was also significantly less firing of the neurotransmitter dopamine in the eyes of the women with the disease.
• A push-pull training method in which the weak eye is made to work while vision in the strong eye is actively suppressed is a better way to correct sensory eye dominance, according to a report published in October in Current Biology.
• Men experience almost three times as many eye injuries as women, according to a study conducted by the American Academy of Ophthalmology and American Society of Ocular Trauma.
• A nationwide study in Taiwan compared glaucoma patients with people who did not have the eye disease and found the glaucoma patients were significantly more likely to have other serious health problems, including high blood pressure, diabetes, ulcers and/or liver disease. The study was published in the November issue of Ophthalmology.

FDA NEWS

• In September, the FDA issued a final rule that clarifies what safety information must be reported during clinical trials of investigational drugs and biologics, requiring certain safety information that previously had not been required to be reported to the FDA within 15 days of becoming aware of an occurrence.
• Allergan, Inc., received FDA approval for its Ozurdex® (dexamethasone intravitreal implant) 0.7 mg for the treatment of uveitis affecting the posterior segment of the eye.
• Abbott announced in September it received FDA market clearance for RevitaLens Ocutec™ next-generation multi-purpose disinfecting solution for silicone hydrogel and conventional soft contact lenses.
• The FDA announced in October a clinical trial of LASIK procedures was slated to begin at the Naval Medical Center San Diego during the next three months to serve as a template for a national study looking at the safety and effectiveness of the procedure.
• Heidelberg Engineering received FDA clearance for its new Spectralis® age-adjusted RNFL thickness normative database in October.
• ISTA Pharmaceuticals announced in October it received FDA approval for its supplemental new drug application for Bromday™ (bromfenac ophthalmic solution) 0.09% as a prescription eye drop for the treatment of postoperative inflammation and reduction of ocular pain in patients who have undergone cataract extraction.
• Carl Zeiss Meditec received marketing clearance from the FDA for its IOLMaster® 500 biometer used to calculate all necessary eye measurements for optimal lens selection for cataract surgery procedures.
AMD NEWS

• A new Irish study has found a strong correlation between changes in body composition and macular pigment levels found in the back of the eye, increasing the risk of developing AMD. The study was conducted by the Waterford Institute of Technology and supported by the Irish charity Fighting Blindness.
• Concerns that some drugs for AMD may increase patients’ risk for heart attack, bleeding, stroke and death have been allayed by researchers at Duke University Medical Center, whose comparison of the most popular therapies shows all are relatively safe. The study was published in the October 2010 issue of Archives of Ophthalmology.
• A study has failed to show a difference in efficacy between Bevacizumbab (Avastin) and Ranibizumab (Lucentis) for the treatment of AMD. The study was published in the online edition of Eye, the official journal of The Royal College of Ophthalmologists, in October.
• People with end-stage AMD have improved visual acuity and quality of life after receiving an intraocular implant containing a tiny telescope in one eye, according to an article on Medscape Medical News (www.medscape.com). Results of the unpublished study were presented at the American Academy of Ophthalmology and Middle East Africa Council of Ophthalmology 2010 Joint Meeting in October.
• Researchers at the American Academy of Ophthalmology and Middle East Africa Council of Ophthalmology 2010 Joint Meeting in October presented reports on a two-phase clinical trial of fenretinide — a synthetic derivative of vitamin A — showing risk of developing wet AMD decreased almost two-fold in dry AMD patients who took the medication.
• A new study has found the number of older Americans undergoing treatment for retinal conditions like AMD and diabetic retinopathy has nearly doubled between 1997 and 2007, with a significant shift in the types of procedures being performed, according to an article in October on HealthDay (consumer.healthday.com). The study was published in the October issue of Archives of Ophthalmology.

CATARACT NEWS

• Research presented at the American Academy of Ophthalmology and Middle East Africa Council of Ophthalmology 2010 Joint Meeting in October says cataract surgery not only improves vision and quality of life for older people, but also helps reduce the number of car crashes.
• Drinking one to two alcoholic beverages a day may be associated with a 50% decrease in long-term cataract surgery risk, according to an article on OSNSuperSite.com. The study was published in the September issue of the American Journal of Ophthalmology.
• Also on OSNSuperSite.com, a study has found a low risk of mortality within 90 days after cataract surgery. The study was published in the October issue of Ophthalmology.

KIDS & VISION NEWS

• A new study says young Hispanic children are more likely to develop astigmatism than their African-American peers. The study was published in the September issue of Ophthalmology.
• Researchers have found kids may actually see the world differently than adults, according to an article on HealthDay (consumer.healthday.com) in September. The two studies — published in the September issue of the Proceedings of the National Academy of Sciences — found the ability to blend perspective and binocular depth information is not present until about age 12, and kids younger than six years old were able to keep perspective and binocular visual information separate, while adults did not have this ability.
• A “surprisingly” large proportion of children with central nervous system (CNS) brain tumors have visual field deficits that go unnoticed by patients, parents, and clinicians, according to an article on Medscape Medical News.

DIABETIC RETINOPATHY NEWS

• A new study has found high serum levels of prolactin are associated with a decreased risk for diabetic retinopathy, according to an article on MedWireNews.com in September. The study was published in the September issue of the journal Diabetes.
• Vitamin D deficiency could be associated with diabetic retinopathy, according to an article on Doctor’s Guide (www.docguide.com) in October. The study was presented at the American Academy of Ophthalmology (AAO) annual meeting in October.
• Many long-term survivors with diabetes show little or no progression of retinopathy after a certain point and this resistance has nothing to do with glycemic control, according to an article on MedPageToday.com in October. The study was presented at a poster session at the American Academy of Ophthalmology’s annual meeting in October.
• People who are blind from birth are able to detect tactile information faster than people with normal vision, according to a study in the October issue of *The Journal of Neuroscience*.

• Researchers from the University of Houston have found that lead, or a new drug that acts like lead, could transform human embryonic retinal stem cells into neurons that would be transplanted into patients to treat retinal degenerations. The study was published in the October issue of *Environmental Health Perspectives*.

• A newly-developed retinal implant has allowed three blind people to identify shapes and objects just a few days after the devices were installed, according to an article on WebMD.com in November. The study was published in the October issue of *The Proceedings of the Royal Society*.

• A new survey from Anthem Blue Cross’ parent company and Transitions Optical, Inc., says many participants rarely consider the potential risks the sun can have on their eyes or their children’s eyes. Of survey participants, 41% reported when outside they rarely thought about protecting their eyes from the sun, and 55% said they wished they had taken better care of their eyes when they were younger.

• More than half of optometrists feel it is appropriate to introduce a child to soft contact lenses between the ages of 10 to 12, with daily disposable contact lenses being the most frequently prescribed contacts for this age group, according to a new American Optometric Association (AOA) study released in October.

• Photoscreening can be a cost-effective way to detect amblyopia in preschool children, according to an article on Medscape Medical News (www.medscape.com). The study was published in the October issue of *Ophthalmology*.

• HealthyWomen is offering a new educational resource, *Fast Facts for Your Health: Contact Lenses for Children*, to help parents, caregivers, and others better understand options and benefits for fitting children in contacts. Developed with the support of Vistakon®, Division of Johnson & Johnson Vision Care, Inc., the resource can be downloaded at www.healthywomen.org/children-and-contacts.
Once again, the Monterey Conference Center and Monterey Marriott Hotel welcomed almost 1,000 optometrists, optometric students, paraoptometric staff, and opticians from all across the U.S. for Monterey Symposium 2010, held November 5-7, 2010.

This year’s event featured a combined 94 hours of continuing education for optometrists and paraoptometrics. Highlights included the Friday evening Welcome Reception, and the return of past favorites such as the Food for Thought Breakfast Series and Monterey Symposium Exhibit Hall Raffle.
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Dr. Curtis Froid —
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Dr. Katherine Harano —
Modern Optical Summit Parts Kit
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Dr. Roger Hayashi —
Kindle 3G Wireless Reading Device + WiFi
(sponsored by Marsh)

Dr. David Jew —
COB Snapp Digital Camcorder
(sponsored by Primary Eyecare Network)

Dr. Peter Klem —
Portable GPS Device: Magellan Roadmate 3045
(sponsored by Essilor Laboratories of America)

Dr. Grace Kuo —
Choice of books, up to $200 in value
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Dr. Gary Louie —
Sony Bloggie High-Definition Digital Camcorder
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Sarah Melendez —
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(sponsored by Vision West, Inc.)

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Dr. Carl V. Nicholson —
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Delia Patino —
$500 AMEX Gift Certificate
(sponsored by Review of Optometry)

Antwanett Ragland, ABOC —
Clarity H2O Gift Bag and iPod Touch
(sponsored by Hydrogel Vision Corporation)

Dr. Frederick Stellhorn —
Pair of Dolce & Gabbana Sunglasses
(sponsored by EyeMed Vision Care)

Dr. Sukh Takher —
Kindle Wireless Reading Device
(sponsored by Younger Optics)

Dr. Denton Wells —
Pair of Dolce & Gabbana Sunglasses
(sponsored by EyeMed Vision Care)

Dr. Sharon Yurko —
Apple iTouch
(sponsored by Haag-Streit USA)
WELCOME RECEPTION

At 6pm on Friday, Monterey Symposium attendees made their way over to the San Carlos Ballroom in the Monterey Marriott Hotel for a family-friendly evening of appetizers, desserts, interactive games, and raffles generously donated by Walman Optical and VSP Vision Care.

THANK YOU MONTEREY SYMPOSIUM 2010 EXHIBITORS!

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Shamir Insight Inc.
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Synemed
US Optical LLC
Vision West, Inc.
Vistakon, Inc.
VSP Vision Care
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Western University School of Optometry
Younger Optics
ZeaVision, LLC

WE’LL SEE YOU NEXT YEAR AT MONTEREY SYMPOSIUM 2011!

NOVEMBER 11-13, 2011

www.montereysymposium.com
A LOOK INTO TELEMEDICINE

By now most optometrists have heard of the term “telemedicine.” Some California optometrists work with telemedicine on a daily basis, particularly those who work in the Veteran’s Administration, Kaiser, and some community clinics. Telemedicine, as defined by the American Telemedicine Association, is: “… the use of medical information exchanged from one site to another via electronic communications to improve patients’ health status. Closely associated with telemedicine is the term ‘telehealth,’ which is often used to encompass a broader definition of remote health care that does not always involve clinical services. Videoconferencing, transmission of still images, e-health including patient portals, remote monitoring of vital signs, continuing medical education and nursing call centers are all considered part of telemedicine and telehealth.”

Telemedicine is often considered a high-tech innovation and its adoption in eye care is sometimes viewed in the same way as scanning laser imaging, wave-front technology, or microperimetry. For this article, however, consider telemedicine a response to social and organizational changes within health care that reflect how people interact in general. Communication and collaboration are increasingly central to our professional lives, as well as in our personal lives. Health care is more subspecialized, multidisciplinary and integrated, requiring more efficient collaboration within a wide health care network. In recent years, not only do we communicate more frequently with our eye care colleagues and patients, but also with primary care physicians and many other clinical professionals. Enrico Coeira, a prominent medical information scientist, noted that clinical referrals, reports and “curbside consults” account for about 40% of all information transactions in health care. Telemedicine facilitates these information transactions, and this article will explore how it can be used in optometry.

Telemedicine and Diabetic Retinopathy

By far, the most prevalent use of telemedicine in eye care is in detection of diabetic retinopathy. The process begins by capturing images with a digital retinal camera in a primary care setting, such as a general medical clinic or a community center. Images and clinical data are then transmitted through communication software to appropriately credentialed telemedicine consultants (mostly optometrists and ophthalmologists). The telemedicine consultants then review the retinal images and interpret retinal findings to generate reports that are transmitted back to the originating site. Several million diabetic retinopathy screening encounters have been logged worldwide and this mode of performing retinal exams is becoming increasingly common.

Telemedicine-based retinal screening detects sight-threatening diabetic retinopathy with sensitivity and specificity that is comparable to the face-to-face encounter, but it does not take the place of a regular face-to-face eye exam. The screenings should be considered as a precursor to a full eye exam and not as a replacement. Even so, for many diabetic patients,
particularly those who are indigent and underserved, these encounters are often the only way to get recommended annual retinal exams. The lack of compliance with regular retinal exams for patients with diabetes often leads to vision impairment, which is costly to society. A recent cost-benefit analysis for the State of California found that the state would save $2,500 for every patient that is examined through telemedicine-based retinopathy screening. This calculation does not include the indirect costs of disability and the considerable social and personal burden of vision impairment.

promise to offer reimbursement for optometrists who perform telemedicine consults in the near future.

While telemedicine becomes more prevalent in eye care in California, optometrists will need to address important issues. Telemedicine consultants require certification and quality assurance to ensure that appropriate care is being provided through this new modality. Quality of care should not be compromised for the sake of convenience.

Optometry schools and optometric continuing education needs to be proactive to incorporate telemedicine into their curricula to prepare students and optometrists to practice in this new area. It is important for clinicians to be aware of the advantages and limitations of working in the telemedicine environment and how diagnostic skills and clinical goals differ from face-to-face consults.

Clinical tasks performed through telemedicine should be validated to ensure predictable outcomes. Further research and clinical trials will be essential to the sustainability of this mode of practice. So far, only diabetic retinopathy detection has been rigorously validated. The future for broader blindness prevention will need to include validation for other conditions, such as glaucoma and macular degeneration.

Telemedicine & EHR
Integration of telemedicine services with electronic health records at the acquisition site (i.e. where the imaging occurs) is also essential to the long-term sustainability of the service. Interoperability with electronic medical records systems in primary medical care settings is actually more important than interoperating with eye care health records. The

FIGURE 2. Primary care physicians photographing a diabetic patient in Guanajuato, Mexico.

Telemedicine in California
UC Berkeley’s Optometric Eye Center has been actively involved in telemedicine since 1994, starting with simple demonstration projects with local eye care providers and later in China, India and Latin America. EyePACS, a license-free software program, was developed at UC Berkeley and UC San Francisco to provide an easily accessible platform for clinical communication in eye care. To date, the EyePACS program has logged over 90,000 encounters, making it one of the largest ocular telemedicine programs in the United States. UC Berkeley’s program also prompted legislation to correct disparities in telemedicine practice between medical doctors and optometrists in California. These disparities were overcome with the support and guidance of the California Optometric Association. Assembly bills 1224 and 175, which passed in 2007 and 2009 respectively, assured that optometrists have equal access to reimbursement for telemedicine services. Third-party payers, however, have been slow to implement reimbursement policies for telemedicine. Recent policy changes in Medi-Cal

FIGURE 3. Credentialed retinal telemedicine consultants viewing a retinal image at Castle Optometry Clinic in Atwater, CA.
information from the primary care setting should be readily available to the remote consultant. Major electronic medical record vendors, such as e-Clinical Works and NextGen have well-established protocols for interfacing telemedicine, yet many ocular telemedicine systems are "stand-alone" programs that do not communicate with other programs. Optometrists need to consider interoperability when embarking in telemedicine.

Interoperability and adaptability should also be considered when acquiring the imaging hardware used in telemedicine. The imaging requirements are different for telemedicine than they are for in-office imaging. Medical assistants and other ancillary personnel usually perform the imaging in medical practices, so operating the cameras needs to fit easily into their workflow. In this setting, ease of use is more important than sophisticated camera features. Image enhancement and file compression are also handled differently in telemedicine. New retinal cameras specifically designed for telemedicine that incorporate these features are beginning to emerge on the market.

Specific guidelines and "how-to" information for getting started in ocular telemedicine are available online through the American Telemedicine Association’s Ocular Telehealth Special Interest Group, the California Telemedicine and eHealth Center’s Diabetic Retinopathy Screening Practice Guide and “Teleophthalmology” — a Springer publication that has recently become available online.

**Conclusion**

Telemedicine in eye care emerged long ago from the "early adopters" phase of home grown and experimental programs, to programs that are highly developed and meet regulatory and usability requirements. The question is not whether or not telemedicine will be practiced in optometric care, but how will it be incorporated in our day-to-day lives. Many questions still need to be answered. Your comments and your input are welcome in shaping the future of telemedicine.

For a list of references, please contact Dr. Cuadros at jcuadros@berkeley.edu.
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Associate Professor
Chief, Cornea Center
Illinois College of Optometry

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UNDER THE DOME

GLAUCOMA REGULATIONS APPROVED; TAKE EFFECT JANUARY 8, 2011

COA is pleased to announce that the glaucoma regulations will become effective January 8, 2011. Thanks to everyone who sent letters of support and helped make this possible.

To view a copy of the glaucoma regulations, visit www.optometry.ca.gov/lawsregs/1571_order_adopt.pdf.

As you know, SB 1406 (Correa) and the regulations that implement the measure were met with strong opposition at every turn. Approval of the regulations marks a major victory as well as a major advancement for the practice of optometry. We congratulate all of COA’s volunteers, keypersons and members who helped make SB 1406 a reality.

“These efforts have been a culmination of collaboration and development of regulations that will ensure continued quality of expanded eye care and greater access for Californians,” says COA President Dr. Harue Marsden.

The regulations will allow glaucoma certified optometrists to treat the most common forms of glaucoma. To become glaucoma certified, TPA certified optometrists must take a 24-hour didactic course in the management of glaucoma and complete a “Case Management Requirement” where a minimum of 25 individual patients are each prospectively treated for a minimum of 12 consecutive months. Optometrists have three different options for completing the 25 patient requirement: a “Case Management Course,” “Grand Rounds Program” or “Preceptorship Program.”

Now that the regulations are approved, the accredited California schools and colleges of optometry will cooperatively develop the Case Management Course and Grand Rounds Program, which must then be approved by the Board of Optometry. If you have questions, please contact Kristine Shultz at kshultz@coavision.org.
DRS. ED HERNANDEZ, BOOZMAN ELECTED TO SENATE

The November 2, 2010 General Election saw two “firsts” in optometry. COA past-president Dr. Ed Hernandez (D-Baldwin Park) was the first optometrist elected to state Senate and Dr. John Boozman (R-Arkansas) was the first optometrist elected to the U.S. Senate. COA congratulates both lawmakers on their decisive wins!

ADVICE ON INCLUDING PD MEASUREMENT ON A PRESCRIPTION

COA has received several questions from members asking if they must include the PD measurement on the eyeglasses prescription they are required by law to release to the patient. Usually the PD is not part of the prescription. Having said that, remember that a patient is entitled to a copy of their complete medical records. The PD may be recorded in those records for a few different reasons. From a business perspective, there are good reasons to always release the information the patient is entitled to up front without a hassle. Certainly you or your staff can educate the patient as to why they should purchase their eyeglasses from you. But if the patient has decided to purchase glasses elsewhere, there are only two outcomes that can occur. The patient will either go away angry and you lose the sale and the patient forever, OR you lose that sale and the patient returns for additional services and materials in the future.

TAX RULES — MAKE SURE YOU ARE FOLLOWING THE LAW!

Representatives from the Board of Equalization (BOE) are stepping up enforcement of California’s tax law and may perform an on-site audit of your practice. COA is providing the following general information to make our members aware of their possible tax responsibilities. This is not intended to be legal advice. You should always consult a tax professional to determine your specific tax liability.

1. The vast majority of private practice optometrists need to have a seller’s permit (www.boe.ca.gov/pdf/boe400spa.pdf). A licensed optometrist does not need a seller’s permit if he or she is only selling ophthalmic materials furnished in the performance of his or her professional service in the diagnosis, treatment or correction of conditions of the human eye (Cite: Rev & Tax Code Section 6018 and 18 CCR 1592). Anything else you sell in your office (including sunglasses without a prescription, contact lens solution or dietary supplements) requires a seller’s permit. The BOE asks that you display a copy of the permit in a public location.

2. If you have a seller’s permit, you do not need to register with the BOE to pay “use” tax. If you don’t have a seller’s permit and receive at least $100,000 in gross receipts from business operations, you probably need to register with the BOE to report your use tax liability. An example of a use tax liability is when you purchase something out-of-state and didn’t pay California sales tax. Find out if you are required to register by reading the criteria on Form 404-A (www.boe.ca.gov/pdf/boe404a.pdf). If you meet the criteria on this form, complete and mail it to your local BOE field office to get registered. Once registered, your account will be set up so that you can file your returns electronically (Cite: Rev & Tax Code Section 6225).

3. From this point forward, be sure to keep all instrument and equipment receipts. The BOE may ask to see the invoice on any equipment (no matter how old) to determine if the price of that piece of equipment included the proper sales tax.

If you have questions, please contact Kristine Shultz at kshultz@coavision.org.
How do you eat an elephant? Yum, sounds delicious! I hear elephant is great this time of year.

Just thinking about this concept is mind-boggling. Where do I start? How do I progress? What goes with elephant anyway? I haven’t seen that one on the cooking TV channel yet. This entire concept seems just fraught with problems from beginning to end. Besides, who has ever cooked anything this big before, let alone try to eat it?

In March of 2010, with the passage of the Affordable Health Care Act, optometry was handed their “elephant” to eat: an elephant in the form of inclusion as full scope providers in this new National Health Plan.

In California, it is expected that over 4 million new patients will be covered initially with insurance. Those patients will be eligible for services starting January 1, 2014.

The problem is that new structures, organizations and systems have to be in place by that date. At the AOA Third Party Conference in Denver during October 21 - 23, 2010, one presenter made the analogy that “we jumped on board a plane, and the engineers and designers are still building it after take-off.”

The new health care plan language states that optometrists have to be treated equally, just as other practitioners who provide the same service (Harkin Amendment). The California Insurance Exchange is the agency that will structure, govern and regulate how health care will be dispensed to these new patients. It is in the formation of exchange regulations that has optometry worried, because what the law giveth, the regulations can taketh away.

Besides these regulations is the other key element to our overall success in practicing full scope. Currently, in California, our access to health care medical panels is poor to fair. Our lack of panel inclusion is rooted in many areas and not necessarily just provider discrimination.

First of all, most of the panel structures were set up before California optometry had therapeutics. We are relatively new to medical panels. So the insurance plan administrators are not completely used to us being around.

Another major element to our lack of access is the fact that eye care, in total, only accounts for less than three percent of the total health care budget. This includes primary, secondary and tertiary eye care. Furthermore, optometric services account for less than one percent of all of the money spent. Consequently the insurance companies think about optometry less than one percent of the time. We are just not on their mind.

As was brought out at the AOA conference in Denver, the biggest reason for full scope non-inclusion is that plan administrators, benefits administrators, brokers, and managers are unaware of exactly what optometrists can do. In other words they are ignorant of our scope. Therefore education is a great part of the solution to access problems.

This leads us back to the original question — how do you eat an elephant? The answer is obvious — one bite at a time.

As you read this, COA is contacting the major players who are going to shape the Affordable Health Care Act as it is applied to California. The goal for these meetings is education to gain access. This is a humongous undertaking. But it has started.

Each COA member is not powerless. There are some things that we as individual optometrists can do to show segments of the industry we are players in medical management. Independently, we can help this education process. So here are some bites of that elephant that all of us can chew on:

1. **Stop using the S codes.** These are codes without guidelines. The S codes do not define the elements of the exam that it takes to make a diagnosis. When the insurers see these codes, they think of the kind of exam the optometrist did in 1975. So don’t use them.

2. **PQRI report.** The PQRI codes are additional codes that we need to use on our HICFA 1500 forms when we examine a patient with diabetes, macular degeneration or glaucoma. This tells the insurer that we have been medically following those patients and that we are players. Any time you medically bill for these diseases you need to use the additional PQRI codes. (The AOA will soon be publishing PQRI for Dummies for those who need help on these codes.)

3. **Send a report back to the patient’s PCP when a medical diagnosis is found.** This lets those MD’s know that we are in the game and that we can help with the management of those patients. And who knows — at one point, that same PCP might be referring patients to you.

Good luck and keep on coding!

Dr. Rogoway can be reached for questions or comments at wmrogoway@yahoo.com
Three Santa Clara County Optometric Society members with guests attended a luncheon in support of Assemblyman Ira Ruskin in Palo Alto in October — Drs. Jennifer Hsieh, Ron Seger, and Debra Cheung. Pictured here (from left) Dr. Cheung, Assemblyman Ruskin, and Dr. Hsieh.

COA and Senator Lou Correa Team Up for Health Fair

Senator Lou Correa has been a champion for increased access to quality eye care and a dynamic advocate of optometrists. As you all know, Senator Correa was the author of SB 1406 — landmark legislation that now allows California optometrists to diagnose and treat glaucoma, and allows vulnerable Californians to obtain greater access to primary health care.

As part of an educational endeavor aimed to thank Senator Correa for his support of optometry, and to enhance our brand amongst consumers, the California Optometric Association and our members helped organize a free Community Health Expo in Anaheim on September 25. Thousands of Orange County residents showed up, including neighbors from a variety of socio-economic backgrounds.

Orange County residents who would otherwise go without received free vision screenings from California Optometric Association members. Many of them received free eye glasses.

COA assisted not only with eye screenings at the event, but with helping to educate neighbors about the Community Health Expo. We coordinated direct mail invites, radio commercials, television commercials, and even did outreach to Vietnamese and Spanish-speaking Californians.

Thank you to Senator Lou Correa and all COA members who attended and contributed to this important community event — furthering COA’s commitment and relationship with Senator Lou Correa and our neighbors in California.
VU POINT 91

I hope everyone had a safe and joyous holiday season. 2011 will again be a challenging and exciting year as the Medi-Cal Program transitions to a new Fiscal Intermediary, prepares for Health Care Reform, and begins implementation of the Medicaid waiver. I will try my best to keep you informed of any new developments that will impact optometry in California. In the meantime, below are a couple of questions for you to review.

DEAR DR. VU: Do you know if CA optometrists will be eligible for the Electronic Health Record (EHR) Incentive Program?
—Laura, Berkeley, CA

DEAR LAURA: Optometrists are eligible to participate in the EHR Incentive Program, which was established by the Health Information Technology for Economic and Clinical Health (HITECH) Act of the American Recovery & Reinvestment Act of 2009. The program aims to transform the nation’s health care system and to improve the quality, safety and efficiency of patient health care through the use of electronic health records. Currently, the Medi-Cal program is in the process of developing a system to manage incentive payments for eligible professionals. To be eligible, providers must be fully licensed and credentialed in California and may not be excluded from federal funding. In addition, providers must demonstrate adoption, implementation or upgrade of a certified EHR system and “meaningful use” of the technology in order to qualify for the incentive payments. “Meaningful use” is defined as using certified EHR technology to improve quality, safety, efficiency and reduce health disparities; engage patients and families in their health care; improve care coordination; improve public health; all the while maintaining privacy and security.

Medicaid eligible professionals must also meet one of the following patient volume criteria and not be hospital-based (may not perform 90% or more of their services in a hospital inpatient or emergency room setting):

- Have a minimum 30% Medicaid patient volume
- Have a minimum 20% Medicaid patient volume if they are a pediatrician
- Practice predominantly in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) and have a minimum 30% patient volume attributable to needy individuals

Maximum incentives for the EHR incentive program are $63,750 over six years. Eligible professionals can qualify for $21,250 in the first participation year for adopting, implementing, upgrading or demonstrating meaningful use of certified EHR technology and must demonstrate meaningful use in each subsequent year to qualify for additional payment. Incentive payments are the same regardless of starting year; however, eligible professionals must participate by 2016 to receive the maximum incentive payment.

Comment: Effective January 1, 2011, Medi-Cal will begin the enrollment of qualified providers. At this time, all providers must register with the National Level Repository (NLR) through the Centers for Medicare & Medicaid Services (CMS). There will be additional registration required with Medi-Cal once CMS reports on registered providers. More details about the registration and payment process for Medi-Cal providers will be published in future Medi-Cal Updates. For additional information on the EHR Incentive Program, please refer to the CMS Web site at the following link: http://www.cms.gov/EHRIncentivePrograms. You can also read more about the Department of Health Care Services (DHCS) Office of Information Technology (OHIT) who will be coordinating the Medi-Cal EHR Incentive Program on the DHCS Web site at http://www.dhcs.ca.gov/Pages/DHCSOHIT.aspx. Additional questions for OHIT can be sent via e-mail to Medi-Cal_Incentive@dhcs.ca.gov.

DEAR DR. VU: Can optometrists bill for telemedicine services? Thank you.
—Ashley, Fresno, CA

DEAR ASHLEY: Yes. Assembly Bill 175 (Chapter 419, Statutes of 2009) amended Welfare and Institutions (W&I) Code section 14132.725 recognizing optometrists with physicians as providers able to provide and to be reimbursed by Medi-Cal for teleophthalmology services by store and forward. As a result, effective for dates of service on or after November 1, 2010, teleophthalmology by store and forward are now reimbursable for optometrists under the Medi-Cal program. Teleophthalmology by store and forward refers to an asynchronous transmission of medical information to be reviewed at a later time by a licensed optometrist or physician. Asynchronous telecommunications system (store and forward telemedicine) in single media format does not include telephone calls, images transmitted via facsimile machine, and text messages without visualization of the patient (electronic mail). Audio clips, video clips, still images, and photographs must be specific to the patient’s condition and adequate for rendering or confirming a diagnosis and/or treatment plan.
Comment: Optometrists may submit claims to Medi-Cal for teleophthalmology services by store and forward using office consultation CPT-4 codes 99241 – 99243 along with modifier GQ (service rendered by store and forward telecommunications system). When billing these CPT-4 codes, providers must enter the name and National Provider Identifier (NPI) of the referring provider in Box 17 (Name of Referring Provider or Other Source) and Box 17b (NPI), respectively, on the CMS-1500 claim form. In addition, providers should enter a statement in the Reserved for Local Use field (Box 19) of the CMS-1500 claim form or include an attachment that documents the barrier (geographic or other) that prevented an in-office visit by the recipient (e.g., local provider unavailable, local provider wait time unacceptable, local provider would not accept Medi-Cal, etc.). For additional information on policy including documentation and security requirements for teleophthalmology by store and forward, please refer to Medi-Cal bulletin article at http://files.medi-cal.ca.gov/pubsdoco/bulletins/artfull/vc201010.asp#a5 or to the Professional Services section in Part 2 of the Medi-Cal Vision Care Manual, which can be accessed on the Medi-Cal Web site at www.medi-cal.ca.gov.

If you have suggestions, comments, or would like to submit questions to VU POINT, please use the addresses below:

Department of Health Care Services
Pharmacy Benefits Division
Vision Services Branch
1501 Capitol Avenue, Suite 71.3041
PO Box 997413, MS 4604
Sacramento, CA 95899-7413
Attn: Cory N. Vu, O.D.
Phone: (916) 552-9539
E-mail: cory.vu@dhcs.ca.gov

STAY CONNECTED TO GOVERNMENT AFFAIRS!

Government Affairs Weekly Update
For weekly information on COA’s government and external affairs activities, including the latest on the glaucoma regulations, watch your e-mail inbox each Friday for the “GA Weekly Update.” Archives are available on COA’s Web site (in the Members’ Only section, click Advocacy, then Legislative News).

COA Government Affairs Twitter
Follow @kristineshultz on Twitter to be among the first to hear announcements about legislative issues important to the optometric profession, as well as provide insider information about COA’s government affairs activities on a daily basis.

Logged on Yet? COA Needs You!

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

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

www.coavision.org january/february 2011
HERE’S LOOKING AT YOU!

A round-up of recent accolades and news about COA members:

- The family of Dr. James Gregg, posthumous member of the Orange County Optometric Society, has donated his collection of optometric books and journals to the Southern California College of Optometry’s (SCCO) M.B. Ketchum Memorial Library. The donation includes copies of the 15 books he authored that focused primarily on the profession of optometry. Dr. Gregg passed away in September 2009 at the age of 94.

- Dr. Joseph Mallinger of the San Diego County Optometric Society was awarded the Great Western Conference of Optometry (GWCO) Optometrist of the Year Award in October.

- COA Trustee Dr. Barry Weissman of the Los Angeles County Optometric Society was awarded the University of California, Berkeley School of Optometry’s Alumnus of the Year Award in October.

- In October, Dr. Benny Shao of the Santa Clara County Optometric Society was one of 29 ODs inducted as a Board Certified Fellow (FCOVD) of the College of Optometrists in Vision Development (COVD). And CPS members Karen Gwen Stowers and Helen Welsh — staff members of COA member Dr. Carole Hong — were two of 25 optometric vision therapists that completed the COVD certification process at this year’s annual meeting to be inducted as Certified Optometric Vision Therapists (COVT).

- Student member Jason Egbert was awarded the 2010 Thriving Student Achiever scholarship in November. Awarded by CFCareForward, the scholarship goes to a student with cystic fibrosis who demonstrates exceptional academic achievement, community service, creative and artistic talent, and passion for inspiring others.

SDCOS NEWS

The San Diego County Optometric Society (SDCOS) welcomed Dr. Mel Shipp, dean of the Ohio State University College of Optometry and president-elect of the American Public Health Association, to their October membership meeting. Dr. Shipp spoke to SDCOS members about safety on the highways of America.

Also in October, 27 SDCOS members, friends and staff raised more than $5,000 as they walked in the Step Out San Diego walk to fight diabetes (pictured here). SDCOS members walking included Drs. David Sherman, Lisa Weiss, Byron Newman, Barbara Smith, Dawn Pewitt, and Carrie Haare Turley.
COA IN THE MEDIA

News sightings of COA members during the past few months.

- Dr. Kimberlee Sakai of the San Joaquin Optometric Society was pictured as part of CNNMoney.com’s report on the Best Jobs in America for 2010.
- A number of COA members were mentioned in the September issue of Women in Optometry:
  - Dr. Carol Alexander of the Orange County Optometric Society
  - Dr. Elise Brisco of the Los Angeles County Optometric Society
  - Dr. Amanda Kay Dexter of the San Diego County Optometric Society
  - Dr. Kimberly Haw of the Alameda Contra Costa Counties Optometric Society
  - COA Immediate Past President and AOA Board Member Dr. Hilary Hawthorne of the Los Angeles County Optometric Society
  - Dr. Heather Jones of Emeryville, CA
  - COA President Dr. Harue Marsden of the Orange County Optometric Society
  - Dr. Patrick Jason Scott of the Central California Optometric Society
- Dr. Jonathan Gording of the Los Angeles County Optometric Society was mentioned in an article on cosmetic contact lenses in The Signal in September.
- Dr. Jeanette Lee of the Santa Clara County Optometric Society was interviewed for an article on new technologies in eye care practices in the September 6th issue of Vision Monday.
- Dr. Rebecca Kammer of the Orange County Optometric Society was interviewed in articles on the Shared Visions Art Exhibit at the Eye Care Center at the Southern California College of Optometry (SCCO) in The Daily Breeze and The Orange County Register in September.
- Dr. Roger Phelps of the Tri-County Optometric Society was interviewed in an article on computer vision syndrome in The Orange County Register in October.
- California State Board of Optometry President Dr. Lee Goldstein of the Tulare Kings Optometric Society was featured in a video on the dangers of cosmetic contact lens use without a prescription on the State Board’s Web site, www.optometry.ca.gov.
- Dr. Timothy Robertson of the Golden Empire Optometric Society was interviewed for a story on diabetic retinopathy on KNVN (Chico/Redding) in November.
- Drs. Scott Daly and Cammie Hunt of the Monterey Bay Optometric Society were featured in an article on Infant-SEE® in the Santa Cruz Sentinel in November.
- COA had articles on children’s vision and dry eye published in the “Vision Health & Wellness” supplement in the November 4th issue of the Los Angeles Times.
- San Diego County Optometric Society members Drs. Jennifer Tabibzadeh, Dr. Greg Hayes, and Dr. Steve Klein, along with COA, were all featured in two articles in The Sun Signature in November — Dr. Tabibzadeh on sun protection and Drs. Hayes and Klein on 3D and vision.

I Want My COA-TV!
COA has compiled a number of television media hits by members in the “What’s New” section of EyeHelp.org. Or tune in and subscribe to COA’s YouTube channel, www.youtube.com/user/CAOptometricAssoc, to watch a compilation of COA’s public relations campaign videos from House of Delegates 2010, and more!

WELCOME! New COA Members

Alameda Contra Costa Counties Optometric Society
- Stephanie C. Jaso, OD
- Nadia S. Samii, OD

Inland Empire Optometric Society
- Vanessa N. Shaw-McMinn, OD
- Andrea W.Y. Wong, OD

Los Angeles County Optometric Society
- Sheila Tehrani, OD

Mojave Desert Optometric Society
- Kenneth T. Bracken, OD

Orange County Optometric Society
- David Norman Cler, OD
- Joanna K. Hsia, OD
- Jane Ann Munroe, OD

Redwood Empire Optometric Society
- Casey A. Thompson, OD
- Cheng-Yu A. Wang, OD

Sacramento Valley Optometric Society
- Mei Z. Huang, OD
- Nancy Nguyen, OD
- Brady Rembleski, OD

San Diego County Optometric Society
- Andrew J. Fasciani, OD
- Susan A. Ung, OD
- Brenda Yeh, OD

San Francisco Optometric Society
- Bradford Karl Chang, OD
- Laura Inger, OD

San Gabriel Valley Optometric Society
- Elda Mehrabian, OD

San Joaquin Optometric Society
- Sean West, OD

Santa Clara County Optometric Society
- Pei-Chen Jennifer Hsieh, OD
- Melody A. Zargharmi, OD

South Bay Optometric Society
- Danny H. Ngo, OD
- Alan N. Sands, OD

Tri-County Optometric Society
- Taylor D. Tedder, OD
An Eye for Shooting

When Dr. Norman Wong of the San Francisco Optometric Society isn’t examining his patients from behind a slit lamp, he’s busy examining his next bullseye from behind a pistol.

After graduating from the University of California, Berkeley School of Optometry (UCBSO), Dr. Wong entered military service as an optometrist in the United States Navy. It was here where he discovered his skill for shooting pistols and became one of the best shooters on base. He enjoyed the sport for only six months before finishing his military service and returning to civilian life to continue his optometric career in California.

Fast forward 26 years later, Dr. Wong resumed the sport of Bullseye Pistol shooting after friends introduced him to the various shooting facilities in the Bay Area. With increased interest and enthusiasm, Dr. Wong attended the National Matches held in Camp Perry, OH, where he made the prestigious Presidents’ Hundred List in 2004 and again in 2005. He later became an NRA classified master in 2005.

“Optometrists have natural talent for Bullseye Shooting because of superior knowledge in vision and because we are technically inclined,” says Dr. Wong. “Bullseye shooters enjoy the mental and physical challenges as well as the highly technical aspects of their equipment and ballistics.”

As a shooter and an eye doctor, Dr. Wong has become well-known amongst shooters. Most recently, he placed third in the 2010 California State Conventional Pistol Match. He has also earned the Distinguished Pistol Shot Badge, which is considered one of the highest honors that civilians can earn. He has also written articles for Shooting Sports USA magazine, has examined shooters from across the country, and is an NRA-certified instructor.

“I have found the level of character amongst shooters of organized sports to be extremely high, totally unlike what we read and hear in the media when firearms are mentioned,” explains Dr. Wong.

Anyone interested in further information regarding Bullseye Pistol shooting may reach Dr. Wong at drnhwong@yahoo.com. He believes there may be hundreds of optometrists in California with a hidden desire and talent to participate, but have never come across a friendly, knowledgeable initial contact source.

In Memoriam

Dr. Bernard Harris, of San Francisco, CA
Dr. James Moses, of Indio, CA
I’m a pushover. You wouldn’t think it just by looking at me, but alas, it’s true. In fact, I felt a very odd familiarity when watching Jim Carrey’s movie Yes Man. I’m not sure when or how it first started, but I am the Yes Man.

So where am I going with this, you say? Getting involved as an optometrist in your community is as easy as saying yes! Opportunities for community service and outreach are everywhere, and they often come to us unsolicited. Just be willing to accept them.

Case in point: I’m a new doctor and dreaming of the day when I’ll have enough patients to work full-time. When my kind employers in Davis asked if I would be willing to write an article for the local newspaper to get my name out in print, I said yes. It was the beginning of summer so I chose eye care topics related to summer activities.

Getting it published simply involved a phone call to the newspaper asking them if they would like a free article written by a local doctor about topics relevant to their readers. Not surprisingly, they said yes. Two months later, when I said yes to a second event after hearing they were having trouble finding available doctors, she sounded very surprised.

We have participated in a business fair at UC Davis, allowing us to introduce our practice while simultaneously educating students about services we provide, as well as their vision benefits. We have also been in contact with student health services to make them aware of optometry’s scope of practice in order to increase student access to optometrists.

Look at your own community and see where the opportunities are to increase awareness about optometry. The next time you’re approached to volunteer your time or participate in an event, consider it mutually beneficial for you and your current and prospective patients. Lastly, if you’re wondering why I’m writing this article, it’s because COA simply asked, and you can probably guess what I said.

Let California Optometry know about your experiences in the community – where you presented, what topics you discussed, what materials were effective, and any other suggestions to inspire others to increase optometry’s visibility in the community.

Please send submissions for “Public Awareness in Your Community” to Corrie Pelc, managing editor of California Optometry, via e-mail at cpelc@coavision.org or by fax at 916-448-1423.
CVF SPOTLIGHT
CVF ACKNOWLEDGES CVP DONORS
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The California Vision Foundation (CVF) would like to thank everyone who contributed services, materials or funding to the California Vision Project (CVP) in 2010. It was a very successful year, with approximately 3,000 individuals assigned to volunteer providers to receive a free comprehensive eye exam and glasses. We gratefully acknowledge the following individuals, organizations and companies for their generous contributions to the California Vision Foundation:

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The following optometrist made the largest individual donation to CVF in 2010:
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Osamu Ikeda, OD
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END-OF-YEAR LOCAL SOCIETY EVENTS

Over the holiday season, some local societies took the time to let loose and celebrate the holidays with each other. From holiday parties to membership recruitment events, here’s a look at what some local societies did!

Alameda Contra Costa County Optometric Society
On December 5th, ACCCOS held a membership recruitment event using monies they received from a COA grant. They hosted an ice cream social at a local creamery, and invited society members in private practice to bring any non-member ODs they employ in their practice. ACCCOS board members were on hand to convey the benefits of membership, answer questions, and to disseminate information about being a part of COA.

Orange County Optometric Society
On Tuesday, December 14th, OCOS hosted its Holiday Mixer at the Irvine Hyatt Hotel. Free for members and up to three guests, the mixer had dinner, drinks, a DJ, and a photo booth.

Rio Hondo Optometric Society
RHOS had its annual end-of-year holiday party on Saturday, December 11th at the White House in Anaheim. Free for members and one guest, the party included a sit down dinner, DJ, magician, group trivia, and a white elephant gift exchange. Raffle prizes were also donated from vendors, and attendees were asked to bring in food items to donate to the local food bank.

Sacramento Valley Optometric Society
SVOS held its end-of-year holiday party on December 5th at a restaurant in downtown Sacramento called The Waterboy Restaurant. Fifty members attended for drinks, appetizers and lunch. It again was a great success!
CONGRATULATIONS 2010 MEMBERSHIP MATTERS SOCIETY GRANT WINNERS!

The COA Membership Committee would like to congratulate the following four local societies who were awarded a Membership Matters! Society grant for recruitment events in 2010!

Take a look at the creative ways they used their grant award to recruit members:

- **Alameda Contra Costa County Optometric Society** — Hosted an ice cream social and encouraged society members to bring any ODs they employ who are not members. The goals for their event was to educate and enhance non-members understanding on the advantages of membership, update their contact information and facilitate their membership.

- **Sacramento Valley Optometric Society** — Invited non-members in their area to a wine tasting event. Their goal was to meet non-members in a relaxed setting to highlight the importance of membership in COA.

- **Orange County Optometric Society** — Hosted a BBQ and softball game between OCOS members, faculty, SCCO students and Western University students. The goals for their event was to sign-up students at the beginning of the school year and reinforce that COA membership be a part of their career plan.

- **San Diego Optometric Society** — Encouraged society members to invite non-member colleagues to a social hour where COA board member Dr. James Dallas was invited to make a presentation on the importance of organized optometry. Their goal for their event was not only to recruit new members but to promote camaraderie to help with membership retention.

The Orange County Optometric Society (OCOS) held its first annual softball challenge recruitment event on October 16th. Teams included OCOS members and a few students from the Southern California College of Optometry (SCCO) against students from the Western University of Health Sciences.

The Sacramento Valley Optometric Society (SVOS) invited non-members in their area to a wine tasting event to highlight the importance of COA membership.

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UNDERSTANDING THE IMPORTANCE OF HEALTH INFORMATION EXCHANGES

You are probably very familiar with the incentive payments being made available through the HITECH extension grant program. This is the program that makes you eligible for up to $44,000 if you become a meaningful user of a certified electronic health record (EHR) in your office. These incentives are to help you, and every other health care provider, the financial means to make the health information you gather on your patients electronic. Providers are the first step in our new health care delivery system, which is based on having electronic patient health information. The next step is to create communication networks to allow the exchange of this electronic health information between providers and the rest of the health care system. Once health information is electronic, it can then be used in many new and innovative ways to improve patient health outcomes and to control the cost of health care.

Health Information Exchanges (HIEs) are being set up in every state to create the communication network that will allow the sharing of patient electronic health information. For you as a provider to receive your HITECH incentive payment, you have to be a “meaningful user.” You will need to make a certified statement, and ultimately prove that you are using an EHR and that you are able, and in reality, sharing your electronic patient health information with the HIEs.

For you as an individual optometrist, and for our profession, it is critically important that we understand and are actively involved in the creation process that is forming the HIEs. You need to make sure that your EHR can communicate with the local HIE, but just as importantly, you must make sure the HIE in your state has a communication portal to allow you to participate as an equal with all other health care providers. Optometry must be involved in the development of all state HIEs in order for this to occur. To do that, you must understand the process.

The first thing to understand is that the HIEs are being created state-by-state and every one will be different. It is up to you, your state association, and your colleagues in California to make sure that the HIE set-up in California works for you and for optometry. Every state has received a financial award through the State Health Information Exchange Grant Program. This program was funded through the same HITECH act that funds the incentive payments for providers to use EHRs. California received its award for $38,752,536 through the California Health and Human Services Agency. This money is to be used to create a statewide HIE that will allow health care providers in the state to communicate with all other health care providers and the rest of the health system. Ultimately, each state HIE will be connected to create a national health information exchange.

There is a process going on now in California to design your HIE and all stakeholders, including optometry, are being asked to participate. Your state association needs your
support and participation now, probably more than at any
time in the past, to advocate for optometry in this process.
While $38 million sounds like a lot of money, it isn’t anywhere
near enough to create a statewide HIE from scratch. It is only
even to coordinate existing health systems to be able to
communicate with each other. The result is that we see a trend
developing in almost all states. The process is being domi-
nated by the large health systems in each state, which have a
vested interest in creating a statewide exchange that helps
their business model. Since there are few federal guidelines,
and the HITECH grant isn’t large enough to create a whole
new system, these large health organizations are able to exert
considerable influence in the design of how the state system
will function. In an ideal world, each participant in the process
would be primarily interested in creating a fair and open
system for everyone. It is unlikely that is actually the process. It
is more likely that the dominant health systems are just as
interested in using the exchanges to extend their business
model and influence. Optometry needs to make sure that our
business model and potential involvement in the new health
care delivery system isn’t jeopardized by the way access to the
HIE is created.

The business of medicine over the past couple of decades has
been for health systems to absorb most private independent
primary care physicians into their system. In the process of cre-
ating a statewide HIE, optometry is unique in that there are
not a lot of other independent health care providers that need
to be represented in the process. It is easy for the large health
systems to design a statewide system that includes how each
of the large systems will communicate with each other, but
without your direct involvement in the process, the design
may not include how individual independent health care
providers can also communicate effectively within the state
system. It is not uncommon to see large health systems
propose that the statewide system be simply a connection
between the existing large health system EHRs, and that all
local providers gain access to the state system through a
portal into the local large health care system. Whether that is
the best design of your state system, for your office and for
optometry, and how that portal is designed, becomes very
important for your ability to participate effectively in the new
health care system.

There are other alternatives to simply having a portal that
requires you to feed your information into the local health
system. You may want to have the ability to communicate
directly with other independent optometrists, ophthalmolo-
gists and physicians. You may want the ability to communicate
directly with the primary care physicians that are being certified
to be the medical homes in your community, and will ultimately
control the referral system and coordinate all referrals for
specialty care for any patients that have chronic illnesses. You,
and optometry as a profession, need to be clear on how you
want to participate in the new delivery system before you can
effectively suggest how the HIE should be designed.

The design of your statewide HIE is happening now and will
significantly affect your professional and financial future. Your
opportunity to affect the design is right now. Hopefully this
article and your California Optometric Association can help
you understand the process. It is up to you to make sure your
individual office is going to be able to effectively participate in
all aspects of the new health care delivery model, and access
to the statewide HIE is an important component of the system
that will shape your future.
Sitting on the bus, he views the scenery and using the distance mode, captures an electronic snapshot to show his friends later.
HELPFUL TIPS ON VENDOR RELATIONS AND BILLING FROM THE VISION WEST CUSTOMER SERVICE TEAM

One of the many roles of the Vision West Customer Service Team is assisting our members when they have billing questions. After receiving your Vision West monthly statement, if you believe there is a vendor billing error, please notify our Customer Service Team at 800-640-9485 as soon as you can. We are here to assist you in correcting the error with the vendor.

In most instances, once you notify us of the error, we can handle it from there and will contact the vendor to make sure you receive the proper credit/adjustment. However, if the billing error involves product you received in error, you will need to contact the vendor for a call tag to return it. Once you have received the call tag, let us know and we will follow up with the vendor. Our Customer Service Team will obtain the credit memo from the vendor, apply it to your account, and call you with a new amount to pay. If there is a delay in getting the credit memo from the vendor, we can extend your payment due date. Many billing questions we receive are the result of vendor return and exchange policies. Therefore, an important recommendation we make to all of our members is to make sure you know the return and exchange policies of the vendors you work with and if you do not, our Customer Service Team will be more than happy to help you find out.

For example, when you bring in a new frame line, it is important for you to know what policies are in place if the product does not sell well. Will the vendor give you the tools you need to sell the product? Will the vendor trade the product out for one that appeals more to your patient base? These are important things to know and the vendor sales rep is there to assist you in understanding their company’s policies.

One of the most common complaints we receive from our members is the delay of credit memos from vendors when a product exchange has occurred. Vendors typically process the invoice for the new product before the original merchandise has been received for credit. Therefore, we recommend that our members ask the vendor sales rep for net 60 terms on these new invoices, thus allowing time to have the credit memo come through in the same billing period.

Vision West partners with more than 250 vendors and our Customer Service Team has the expertise in expediting and resolving billing questions for you. Working with Vision West can save your staff time and we are committed to assisting members and working with our vendor partners to achieve the best possible resolution to your billing questions.
Health Savings Accounts – 2011*

While health care reform is now underway, it is a long road to travel until 2014, when many of the changes in the health insurance marketplace are projected to take place. Until then, you still have to actively manage your health insurance premium expenses. Since health insurance is not a “one size fits all” proposition, you need to look at a wide range of options. One of those options is the use of a qualified high deductible health plan combined with a health savings account.

Health Savings Accounts (HSAs) and qualified high deductible health plans can help you lower health insurance premiums, save on taxes, and fund current and future medical, dental and vision related expenses on a federally tax-free basis. And these benefits are continued under reform.

Among the advantages of opening a Health Savings Account are:

- Contributions to the health savings account are federally tax deductible. In 2011, individuals may contribute up to $3,050; with family coverage you may contribute up to $6,150.
- Individuals between the ages of 55 and 64, can make “catch up” contributions of an additional $1,000 to the above amounts.
- Contributions may be made by an individual, an employer or both.
- Amounts in an HSA belong to the individual and are fully portable.
-Amounts in an HSA earn federally tax-free interest.
- Unused amounts in the account at year-end roll over for future years.
- Distributions are not federally taxed if used for qualifying medical, dental and vision expenses.

In order to qualify for a health savings account, you must:

- Be covered under a qualifying high deductible health plan (HDHP).
- Not be covered under any health plan that is not a high deductible health plan.
- Not be enrolled in Medicare.
- Not claimed as a dependent on another person’s tax return.

Regardless of when in 2011 you open your health savings account, you’re able to make the full year’s contribution. For example, if you implement your high deductible health plan for your family on April 1, 2011, you may contribute the full $6,150 if you want. Any funds remaining in your account at year-end roll over for use in future years.

For assistance with selecting a qualified high deductible health plan, please call a Marsh Client Service Representative at 800-775-2020.

* Marsh and the COA do not render tax or legal advice. You should consult your advisors regarding applicable tax or legal considerations.
A Potential Income Source for the Risk-Averse
A survey of investors 65 and older found that 17% were unwilling to take on any investment risk. Another 19% said they were willing to take only below-average risk, even though they knew it meant they were giving up the opportunity to pursue higher-than-average investment gains.

Yet 58% of people in this same group also said their investment goals included generating current income. How is it possible to generate a retirement income without taking on too much risk? One way is by investing in fixed-income instruments, usually debt securities. But even these instruments pose some risks that investors may not be comfortable with.

An alternative is to purchase a long-term retirement income vehicle from an insurance company. Although no financial instrument is entirely without risk, the guarantees offered by a fixed annuity can help address the concerns of even the most risk-averse investors.

Fixed for Life:
An annuity is a contract with an insurance company that provides a guaranteed income at some point in the future, after the contract has been funded with premium payments. If you are interested in a guaranteed income or a guaranteed interest rate, you may want to consider the role an annuity could play in your portfolio.

Annuities are flexible and can be shaped to help meet your individual needs. For example, you could choose an income that lasts for a specified period, for the rest of your life, or for the lives of you and another person. Or you might choose to earn a specific rate of return for a guaranteed period.

The amount of income paid by an annuity depends on variables that include the amount paid in premiums, the contract’s rate of return, the age and gender of the contract holder, and the number of years over which income payments will be received.

Annuities have contract limitations, fees and expenses. Any guarantees are contingent on the claims-paying ability of the issuing insurance company. Most annuities have surrender charges that are assessed during the early years of the contract if the contract owner surrenders the annuity. Withdrawals prior to age 59½ may be subject to a 10% federal income tax penalty. The earnings portion of annuity withdrawals is subject to ordinary income tax.

A source of guaranteed income may help remove some of the uncertainty associated with volatility in the financial markets. It’s possible that annuitizing a portion of your savings may allow you to enjoy your retirement years with less concern that you might outlive your money.
PREGNANCY AND VISION: WHAT TO WATCH FOR IN THE EXAM ROOM

Many expectant mothers don’t include a comprehensive eye exam during pregnancy because of the fear that it may not be safe or effective to undergo an eye exam at that time. Eye examinations before or during pregnancy are, under some conditions, necessary to maintain ocular health. During pregnancy, changes in hormones, glucose levels and blood pressure can cause vision changes that signal ocular complications that should be co-managed with the patient’s prenatal care provider. During an exam, the mom-to-be also has the opportunity to discuss new and existing eye and general health conditions, and provide her doctor with the opportunity to identify additional medical issues or complications.

A comprehensive eye examination should be included in every woman’s prenatal plan. Tests for the evaluation of ocular health, particularly in the patient with diabetes, hypertension, multiple sclerosis, and dry eye, as well as refractive status, contact lens fit assessment, and intraocular pressure, should be performed. This baseline data is necessary to compare to any ocular changes the patient may experience during her pregnancy. Spectacle and contact lens prescriptions should be updated at this time. Any changes in existing refractive and contact lens fit should be made prenatally, so that changes that may occur during the pregnancy will seem minimal.

Too often a pregnant woman is told during her pregnancy that she should wait to address any changes in her vision until after the baby is born. If subsequent changes are significant, prescriptions should be changed at the patient’s request and provider’s discretion. The patient should be reminded that the prescription may return to normal postpartum, requiring additional changes. The mom-to-be doesn’t need the additional stress of inadequate visual acuity or contact lens discomfort.

Since changes in vision may also signal changes in health conditions, a comprehensive eye exam is important for your pregnant patients. A prenatal exam is optimal, since the possibility of complications can be discussed proactively.

Hormonal Changes Causing Ocular Complications During Pregnancy

- A change in corneal curvature and increased corneal thickness due to edema can result in contact lens intolerance.
- Alterations in the tear structure, resulting in dry eyes. This, in combination with puffy eyelids due to fluid retention, can make contact lens wear uncomfortable and in some cases intolerable.
- Deposition of pigment on the corneal endothelium has been noted, taking the form of Krukenberg spindles. By the third trimester, an increase in progesterone and aqueous outflow often result in decreased or absence of the deposits.
- A decrease in intraocular pressure can occur and persist for several months postpartum. This may have implications for pregnant women with preexisting glaucoma, since improvement of the disease during pregnancy has been reported.
Ophthalmic Medications in Pregnancy

It is important to remember that the incidence of systemic absorption and toxicity can be reduced by using two techniques. First, prescribe the patient the lowest dosage recommended. Patients can also be instructed to apply nasolacrimal duct and punctual occlusion, which will reduce the amount of medication absorbed systemically. The National Registry of Drug-Induced Ocular Side Effects published a comprehensive review of their findings. The following is a summary:

**DIAGNOSTIC AGENTS**

**Mydriatic** Tropicamide is safe to use for the purposes of ocular examination. Because of its vasopressive effect, Phenylephrine is contraindicated during pregnancy. Instillation can result in Pregnancy-Induced Hypertension (pre-eclampsia). Due to the anticholinergic and hypertensive effects of mydriatics on the infant, they are contraindicated in mothers who are breastfeeding.

**Fluorescein** has shown no teratogenic effects. The effect of fluorescein in mothers who are breastfeeding is not known.

**Topical anesthetics** should be used with caution since they have not been studied to show contraindications.

**GLAUCOMA MEDICATIONS**

**Beta-blockers** should be avoided or used in the lowest possible dose in the first trimester of pregnancy and be discontinued 2-3 days prior to delivery to avoid beta-blockade in the new born. Beta-blockers should also be avoided in mothers who are breastfeeding; although Timolol has been reported by the American Academy of Pediatrics (AAP) to be compatible with lactation.

**Topical and systemic carbonic anhydrase inhibitors** are contraindicated during pregnancy because of potential teratogenic effects. They should also be avoided during breastfeeding, although acetazolamide has been reported by the AAP to be compatible with lactation.

**Miotics** appear to be safe during pregnancy, but the toxicity during lactation is not known. One exception is demecarium, which is toxic and is contraindicated during pregnancy and breastfeeding.

**Prostaglandin analogs** (latanoprost) are not well studied. Prostaglandins are used systemically for labor induction and termination, so the topical use for glaucoma during pregnancy raises concern. Caution should be used when prescribing latanoprost in women who are pregnant or breastfeeding.

**Adrenergic agonists** have not demonstrated any fetal risk in animal studies. Whether it is excreted in human breast milk is not known. Caution should be used during breastfeeding since, when given to infants aged younger than two months, topical Brimonidine has been reported to cause bradycardia, hypertension, hypothermia, and apnea.

**CORTICOSTEROIDS**

Systemic corticosteroids are contraindicated in pregnancy, but there are no known teratogenic effects of topical steroids. Since there is little known about the risk of topical corticosteroids during lactation, it should be avoided in mothers who are breastfeeding.

**ANTIBIOTICS**

Erythromycin, polymyxin B, and the quinolones can be used during pregnancy. Polymyxin B and sulfonamides are safe to be used while breastfeeding. Antibiotics that should be avoided during pregnancy include Chloramphenicol, Gentamycin, Neomycin, Rifampin, Tetracycline, and Tobramycin.

**ANTIVIRALS**

Antivirals should be avoided during pregnancy because of teratogenic effects. They should also be avoided in mothers who are breastfeeding, although the AAP has reported that acyclovir is safe during breastfeeding.

**Health Conditions That Should be Followed During Pregnancy**

**DIABETIC RETINOPATHY**

Preexisting diabetic retinopathy can be affected by pregnancy. The change in the retinopathy depends on the severity of retinopathy at conception, the duration of the
diabetes, glycemic control, and presence of coexisting hypertension. There is a very low risk of developing diabetic retinopathy in gestational diabetes, but since the risk of developing diabetes later in life is increased, patient education at this time is beneficial.

PITUITARY ADENOMAS
Previously undiagnosed pituitary adenomas may enlarge during pregnancy, resulting in headaches, visual field change, and reduced visual acuity. Visual field changes should be monitored throughout the pregnancy.

MULTIPLE SCLEROSIS
Multiple sclerosis is episodic and can cause symptoms of blurred vision, diplopia and visual field defects, but it has been known to stabilize and improve during pregnancy. The episodes of MS can increase and become more severe postpartum.

PREGNANCY-INDUCED HYPERTENSION (Preeclampsia)
Pregnancy-Induced Hypertension is described as the onset of hypertension (>140/90) after the 20th week of gestation in an otherwise normotensive pregnant woman, accompanied by proteinemia (>300 mg/24 h). Ocular symptoms include blurred vision, scotomata, and diplopia. Ocular manifestations include optic neuropathy, serous detachments, retinal vascular occlusion, and retinopathy similar to hypertensive retinopathy.

OCCLUSIVE VASCULAR DISORDERS
Disseminated Intravascular Coagulation (DIC) can occur along with complications of pregnancy such as pregnancy-induced hypertension and complicated abortion. The choroid is the most common location in the eye for DIC to be found, notably by hemorrhages due to small vessel thrombosis. The patients may notice mild vision changes.

GRAVE’S DISEASE
Grave’s disease may become worse during the first trimester of pregnancy, and then lessens later in pregnancy. Patients with Grave’s orbitopathy are treated as they would be if they were not pregnant. The provider should also be aware of signs of thyrotoxicosis (tachycardia, weight loss, tremor and diaphoresis) since it signals an endocrinological emergency.

HIGH MYOPIA
There is no increased risk of retinal tears or detachments in pregnant women with high myopia. There was concern that spontaneous vaginal delivery could increase this risk in women with preexisting retinal pathology, but studies have shown this not to be the case.

CO-MANAGEMENT WITH PRENATAL CARE PROVIDER
During the pregnancy, communication with the mom-to-be’s obstetrician, nurse practitioner or midwife should be ongoing if ocular disease or complications are noted. The patient’s prenatal care provider should be notified of changes in ocular health and prescribed treatment, preferably by a phone call followed by written communication. Keeping them in the loop is not only in the best interest of the patient, but provides an opportunity to prove the value of optometry’s involvement in integrated medical eye care.

PRE-NATAL RISKS
The risks associated to general health and pregnancy by mothers who smoke or use drugs is well-known. However, there is also data to suggest that these risky behaviors, along with prematurity, increase the possibility of amblyopia (lazy eye), strabismus (crossed eyes) and other refractive errors in these infants.

Pregnancy is an excellent time to discuss the importance of comprehensive eye examinations for infants. Information regarding the InfantSEE® program can be provided to the mother-to-be along with a reminder to schedule an appointment for her baby at age six months, unless ocular problems are noted before then.

Finally, patients should be reminded that a healthy pregnancy means holistic health care and healthy habits, including caring for your eye health and sight.

Multiple sclerosis is episodic and can cause symptoms of blurred vision, diplopia and visual field defects, but it has been known to stabilize and improve during pregnancy.
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HIGH INDEX:

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<td>Single Vision 1.67 Super High Index Anti-Reflective (-4.00 cyl)</td>
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CE Questions

1. Hormonal changes during pregnancy can cause all of the following except:
   a. increased corneal thickness
   b. alterations in the tear structure
   c. Krukenberg spindles
   d. an increase in intraocular pressure
   
2. The choroid is the most common location in the eye for Disseminated Intravascular Coagulation (DIC) to be found.
   a. True
   b. False

3. Ocular manifestations of Pregnancy-Induced Hypertension include all but:
   a. optic neuropathy
   b. increased intraocular pressure
   c. serous detachments
   d. retinal vascular occlusion

4. There is a marked risk of developing diabetic retinopathy in gestational diabetes.
   a. True
   b. False

5. Multiple sclerosis during pregnancy:
   a. has been known to increase and become more severe during pregnancy
   b. can stabilize and improve post partum
   c. can cause symptoms of blurred vision and headaches
   d. is episodic

6. Pituitary adenomas may shrink during pregnancy.
   a. True
   b. False

7. Signs of thyrotoxicosis include all except:
   a. tachycardia
   b. edema
   c. tremor
   d. diaphoresis

8. There is no increased risk of retinal tears or detachments in pregnant women with high myopia.
   a. True
   b. False

9. Which of the following agents are contraindicated during pregnancy:
   a. topical and systemic carbonic anhydrase inhibitors
   b. miotics
   c. adrenergic agonists
   d. topical fluorescein

10. Pregnancy is an excellent time to discuss the importance of comprehensive eye examinations for infants and the InfantSEE® program.
    a. True
    b. False

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Transcripts will be mailed out after the submission deadline.

CE@Home January/February 2011 issue

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House of Delegates 2011
Visalia Marriott, Visalia, CA • www.coavision.org

March 23, 2011
Legislative (KP) Day 2011
Sheraton Grand, Sacramento, CA • www.coavision.org

April 7-10, 2011
OptoWest 2011
Hyatt Grand Champions Resort & Conference Center, Indian Wells, CA • www.OptoWest.com

JANUARY

8-11
22nd Annual Berkeley Practicum (CE Hours: 20)
Double Tree Hotel, Berkeley Marina
Contact: 510-642-6547, OptoCE@berkeley.edu

18
SVOS CE Meeting (CE Hours: 2)
Radisson Hotel, Sacramento, CA
Contact: Jerry Sue Hooper, 916-446-2331, jerrysue@svos.info

20
SDCOS CE Meeting (CE Hours: 2)
Handlery Hotel, San Diego, CA
Contact: Nancy-Jo Sinkiewicz, 619-663-8439, nancy-jo@sdcos.org

20
SCCOS CE Meeting (CE Hours: 1.5)
5131 Stars & Stripes Drive, Santa Clara, CA
Contact: Dr. Linda Hur, 650-967-6649, hurlindak@gmail.com

FEBRUARY

11-13
San Diego Specialty Contact Lens Symposium
Hilton San Diego Bay Front Hotel, San Diego, CA
www.specialtycontactlens.org

13
14th Annual Bay Area Optometric Council CE Meeting
(CE Hours: 4)
David’s Banquet & Conference Center, Santa Clara, CA
Contact: 800-675-3937, info@baoc.com

15
SVOS CE Meeting (CE Hours: 2)
Radisson Hotel, Sacramento, CA
Contact: Jerry Sue Hooper, 916-446-2331, jerrysue@svos.info

MARCH

5-7
27th Annual See & Ski Conference (CE Hours: 17)
Harvey’s Resort & Casino, South Lake Tahoe, NV
Contact: Gail Conkey, 702-220-7444, gail@nvoptometric.com

6
24th Annual SVOS Ocular Symposium (CE Hours: 8)
Marriott Sacramento Rancho Cordova Hotel, Rancho Cordova, CA
Contact: Jerry Sue Hooper, 916-446-2331, jerrysue@svos.info

APRIL

19
SVOS CE Meeting (CE Hours: 2)
Radisson Hotel, Sacramento, CA
Contact: Jerry Sue Hooper, 916-446-2331, jerrysue@svos.info

20
SGVOS CE Meeting (CE Hours: 2)
Coco’s Bakery Restaurant, Arcadia, CA
Contact: 310-717-4504, sangabrieloptometricsociety@gmail.com
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IS IT TIME FOR ANOTHER REVOLUTION?

Most citizens are proud of their state and tout the uniqueness of their homeland. Coming from the Midwest, I am confident in claiming that California is indeed different from the other 49. Texans may boast about their Alamo and the world’s largest rattlesnake festival, but Californians have Hollywood and a giant artichoke in Castroville! California is a place of unexpected occurrences.

Not only is California’s topography distinctive, but its politics are equally peculiar. Who would have dreamed that voters would have the chance to decide Proposition 19 (also known as the Regulate, Control and Tax cannabis Act of 2010) the same year a Republican governor signed legislation (AB 1602 and SB 900) implementing a national health care reform agenda pushed by the Democrats?

Although many Democrats and Republicans are divided over the anticipated effectiveness of the Patient Protection and Affordable Care Act of 2010, the concept of state-based health insurance exchanges appears to have bipartisan appeal in California. We should be proud that California was the first state to establish a health insurance exchange under the new federal health reform law. Our legislature and governor stepped up and had the courage to take the lead in implementing some critical elements of the widely contested federal health reform legislation.

There will be many hurdles to overcome if California’s Health Benefit Exchange is to be effective. The insurance market itself is a complicated mess. Products vary widely and policies are anything but transparent. Traditionally, health plans have focused on risk selection rather than on the provision of service, benefits and value. That being the case, provider nondiscrimination has not been a major issue for the health plans. However, the underlying assumption for health reform legislation is that healthy competition among the carriers will level the playing field and increase access to health care for most Americans.

Another hurdle to the implementation of health care reform is the monopoly that medicine holds over other health professions as THE designated primary health care profession. The American Medical Association’s infamous 2006-to-present Scope of Practice Campaign (SOPC) supports and organizes opposition to scope expansion of all other health professions including optometry using “patient safety” as its rationale. It is also worth noting that the AMA opposes the anti-discrimination portion (Section 2706) of the Patient Protection and Affordable Care Act ostensibly for the same reason.

A peculiar characteristic of the current US health care system is that organized medicine owns the means by which all other health care providers get reimbursed by third party payers. It has been estimated that the American Medical Association earned $70 million in royalties from the Current Procedural Technology (CPT) codes in 2009. Oh, and that $70 million does not include the estimated $47 million in revenue that the AMA reportedly received from the sale of CPT database products in that year. The point here is that the AMA, through its ownership of the CPT codes, controls the ability of optometry to create any new codes that better reflect the scope of optometric practice for the purpose of reimbursement.

These are interesting times indeed. And it will just get more interesting as time goes by. It is impossible to imagine real health care reform without having a major shift in how health care providers are reimbursed by third party providers. Maybe we need a revolution to topple organized medicine’s control over the health care system.
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