Approved: 03/26/08
Date

MINUTES OF THE SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

The meeting was called to order by Chairman James Barnett at 1:30 P.M. on March 11, 2008 in Room 136-N of the Capitol.

All members were present.

Committee staff present:
Emalene Correll, Kansas Legislative Research Department
Terri Weber, Kansas Legislative Research Department
Nobuko Folmsbee, Revisor of Statutes
Renae Jefferies, Revisor of Statutes
Jan Lunn, Committee Secretary

Conferees appearing before the committee:
Linda Merrill, CEO, Envision, Inc.
Sam Williams, Vice Chair, Envision, Inc.
Gary Robbins, Executive Director, Kansas Optometric Association
Kendall Krug, OD, Hays, Kansas
David Westbrook, representing Kansas Optometric Association
Jerry Slaughter, Kansas Medical Society
Michael Byington, Kansas Association for the Blind and Visually Impaired

Others attending:
See attached list.

SB - 568 - Optometrist's and Kansas nonprofit low vision rehabilitation centers.

Renae Jefferies, revisor, briefed those attending on **SB 568**. The proposed legislation amends the current optometry law to allow a licensed optometrist to practice in a non-profit, low-vision center. In addition, a non-profit, low-vision center is defined. Ms. Jefferies indicated the fiscal note projects expenditures increasing $10,000 annually due to the increase in complaints the Kansas Board of Examiners would receive. Ms. Jefferies briefing is attached to these minutes. (Attachment 1).

Chairman Barnett recognized Senator Schodorf who, along with Senator Wagle, introduced this legislation. Senator Schodorf spoke to those attending regarding the work that had been done to provide a non-profit, low-vision clinic (no written testimony).

Chairman Barnett recognized Linda Merrill, CEO, of Envision, Inc., who, in turn, recognized Sam Williams, Vice Chair of the Board of Directors, Envision, Inc. Mr. Williams indicated Envision is non-profit, low-vision company offering a "one-stop shop" to low-vision clients providing services from a multi-disciplinary team encompassing evaluation, diagnosis, disease management, rehabilitation, and education/support. Mr. Williams spoke in support of **SB 568**. (No written testimony).

Ms. Linda Merrill, President and CEO, of Envision, Inc. rose to speak in support of **SB 568.** Ms. Merrill distributed a comprehensive folder containing information about the company, letters of support, a graphic detailing the model of service delivery, a list of low-vision optometrists in Kansas, a communication from the Federal Trade Commission relative to competition, and a list of non-profit agencies for the blind. Also included was a sheet on frequently asked questions, a "Legislative Advisory from Envision," and a fact sheet entitled "Envision Senate Bill 568 Fact Sheet." Ms. Merrill indicated Envision, Inc., has worked with Kansas optometrists for the last twelve months to come to a mutually beneficial resolution. Unfortunately, resolution has been unsuccessful for fear of competition as the barrier, Ms. Merrill stated. Ms. Merrill emphasized the company's mission is to provide comprehensive services (pediatric and geriatric) and to enhance access to care for an underserved population. (See Attachments 2-10).

Senator Haley questioned what type of complaints might be generated (refer to Ms. Jefferies testimony relative to the fiscal note) to warrant an additional $10,000 expenditure? Ms. Merrill

responded that, in her opinion, the projection was too high in that the majority of the 54 complaints generated in the previous year related to contractual issues, not patient-care issues.

Chairman Barnett recognized Gary Robbins, executive director of the Kansas Optometric Association, who spoke in opposition to **SB 568**. Mr. Robbins indicated the legislation was unnecessary citing approximately 40 low-vision optometrists currently practice in the state. In addition, the legislation would provide for unregulated optometry practice as well as expanding the pool to include outpatient rehabilitation facilities certified to participate in the Medicare program. Mr. Robbins testimony is attached, and therefore, becomes part of this record. (See Attachment 11).

Kendall Krug, doctor of optometry from Hays, Kansas, was recognized to provide testimony. Dr Krug has served on the Low-Vision Section Council of the American Optometric Association, the Medical Advisory Committee of Blue Cross and Blue Shield of Kansas as well as serving on the Envision Medical Advisory Committee. Dr. Krug spoke in opposition to **SB 568** indicating the legislation could have the unintended effect of reducing quality as a non-regulated, non-medical entity providing medical care. Dr. Krug's testimony is attached and incorporated into these minutes. (Attachment 12)

Chairman Barnett introduced David Westbrook, president of the Corporate Communications Group. Mr. Westbrook's company works closely with the Eye Care Council and Kansas Optometric Association, and he spoke in opposition to **SB 568**. Mr. Westbrook, speaking not only from the perspective of a business-owner consulting with these organizations, but also as a Kansan who is totally blind (Attachment 13), elaborated that his concerns were not with expanding resources but related to the centralization of resources in an unregulated environment where optometrists are hired and report to a corporation rather than a medical professional.

Jerry Slaughter, executive director of the Kansas Medical Society, began his testimony by recognizing Wesley H. Sowders, a senator for ten years, who passed away recently. Mr. Slaughter recognized his contributions to the Public Health and Welfare Committee and the Health Care Stabilization Fund. Mr. Slaughter indicated that **SB 568** affects Kansas law principles and holds the risk of spilling over into the Kansas Healing Arts Act. The Medical Society supports the principle that patient care is the responsibility of a medical provider who makes independent decisions without oversight by a corporation. Mr. Slaughter urged rejection of the proposed legislation. (Attachment 14)

Michael Byington, representing the Kansas Association for the Blind and Visually Impaired (KABVI), was recognized to provide testimony opposing **SB 568.** Mr. Byington provided a brief history of the KABVI organization emphasizing its all-volunteer staff dedicated to improving services to the blind and low-vision consumer. Mr. Byington indicated that after spirited discussion, KABVI cannot support **SB 568** due to lack of participation by blind and low-vision clients. Proposed legislation of this type should include components of consumer input, peer support, and consultation relative to credentialing low-vision practitioners. (Attachment 15)

Chairman Barnett called committee members' attention to written testimony from Pat Hall and Bob Chaffin from the Northwest Kansas Association for the Visually Impaired in Hays, Kansas. Their testimony opposing **SB 568** is attached and should be considered part of this record. (Attachment 16)

The minutes of the March 5 and 6, 2008, Public Health and Welfare Committee were reviewed by committee members. Senator Haley moved to accept the minutes as submitted, Senator Wagle seconded the motion; the motion passed.

The meeting was adjourned at 2:30PM.

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE GUEST LIST

DATE: March 11, 2008

NAME	REPRESENTING
Gary Robbins	Ks Optometric Assn
Dan Morin	KS Medical Society
Jerry Slaughter	" " "
RANDY FORBES	KS. BOARD OF OPTOMETRY
Bill Brady	KS Optometric Assoc.
Todd Fleischer	Ks Optometric Assoc
Amy Campbell	Envision
Mary Ellen Conlee	Envision
Scott Heidner	Luxottica
Lori Morton	Envision
Gail Jordan	Envision
Jennifer Barclay	ENVISION
Sam Williams	ENVISION
Linda Merrill	ENVISION
Steve Stambaugh	ENVISION
MICHAEL EPP	ENVISION
Michael Byington	KABVI
Dan Kelly	KS Optometric Assn
David Westbrook	KS Optometric Assn

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MEMORANDUM

To: Senate Committee on Public Health and Welfare

From: Renae Jefferies, Assistant Revisor

Date: March 11, 2008

Subject: SB 568

SB 568 amends current optometry law to allow a licensed optometrist to practice in a nonprofit low vision center.

Specifically, section one of the bill amends K.S.A. 65-1501a's definition of "medical facility" to include "an outpatient rehabilitation facility certified to participate in the medicare program and a nonprofit low vision rehabilitation center. (Page 2, line 43; page 3, lines 1 through 3.)

A nonprofit low vision rehabilitation center is defined to include any nonprofit corporation which is tax exempt under the federal internal revenue code and which provides low vision rehabilitation services. (Page 3, lines 30 through 33.)

Sections 2 and 3, amend K.S.A. 65-1502 and 65-1522 to allow an optometrist to practice as an agent or an employee of any nonprofit low vision rehabilitation center. (Page 4, lines 15, 16, 29, 30 and 31.)

Section 4 amends K.S.A. 65-1524 to except a nonprofit low vision rehabilitation center from the prohibition against a corporation or limited liability company practicing, offering or undertaking to practice or holding itself out as practicing optometry.

The fiscal note on the bill estimates that the Kansas Board of Examiners expenditures would increase by $10,000 annually due to the increase in complaints they would receive.

The bill would take effect upon publication in the statute book.

PUBLIC HEALTH AND WELFARE
ATTACHMENT: 1
DATE: 03/11/08

Testimony on SB 568
Presented to the Senate Committee on Public Health and Welfare
by
Linda K. Merrill
President and CEO, Envision, Inc.
March 11, 2008

Good morning and thank you for your time and interest in SB568.

This bill was brought forward by Envision in order to amend the KS optometric law to allow Envision, a nonprofit charitable KS corporation, the ability to hire an optometrist for the provision of low vision eye exams for pediatric and geriatric Kansans seeking vision rehabilitation services.

SB568 is a PINPOINT SOLUTION FOR A PINPOINT PROBLEM.

It is important to note, that in this country, interdisciplinary, comprehensive, low vision rehabilitation is primarily found in universities, Veterans Administration, and nonprofit agencies for the blind and visually impaired, such as Envision. Interdisciplinary, comprehensive, low vision rehab is rarely found as a full time practice in a private optometric office, yet the studies by the National Eye Institute, Prevent Blindness America, and the Centers for Disease Control predict an epidemic of vision loss by the year 2020. Why don't more optometrists practice full time low vision optometry?

Envision, a 75 year old organization which serves people who are blind or low vision in employment, low vision and blind rehabilitation and public education, has attempted numerous times to find a compromise position with the organized optometrists. Each attempt has only resulted in stalling and more stalling by the organized optometrists and obstinate resistance toward any compromise other than "do it their way or no way". This is evidenced in their many documented suggestions of "become a medical facility or medical care facility." According to the Kansas statutes, Envision cannot "employ" an optometrist unless it is licensed as a medical facility or a medical care facility. A medical facility includes public health centers; psychiatric hospitals; health maintenance organizations; adult care homes, or kidney disease treatment centers, including centers not located in a medical care facility… (K.S.A. 65-411) A medical care facility means a hospital, ambulatory surgical center or recuperation center, but shall not include a hospice… (K.S.A. 65-525) Envision is not in the business of psychiatry, or adult care homes, or kidney disease treatment or hospitals. Seeking to become medical facility has been the wild goose chase the organized optometrists sent us on since February 9, 2007 ultimately leading to the shut down of low vision rehabilitation services at Envision since September 2007.

Many nonprofit agencies for the blind across the country are employing optometrists for the purpose of low vision rehabilitation. To name only a few:

Chicago Lighthouse for the Blind *
Lighthouse International, New York City*
Diecke Center for Visual Rehabilitation, Wheaton, IL
Houston Lighthouse for the Blind and Visually Impaired
Center for Visually Impaired, Atlanta, Georgia*
Community Services for the Blind and Partially Sighted, Seattle, WA*

*Letters enclosed.

My purpose in mentioning these nonprofit agencies for the blind is not to claim that nonprofit status qualifies a corporation to hire optometrists, but rather to demonstrate that an industry of low vision rehabilitation exists in the nonprofit sector. Many more exist in addition to the above mentioned nonprofit agencies – some in states where optometric laws prohibit the employment of optometrist, but the corporate practice of medicine is not enforced.

According to the American Optometric Association's last survey on Employment of Optometrists, dated May 29, 1998, twenty-eight percent (28%) of the states in our nation allow optometrists to be employed by "lay persons". If SB 568 passed, Kansas would join the ranks of the other states in the country that recognize the significant value of optometrists working for nonprofit agencies for the blind who provide low vision rehabilitation.

The organized optometrists argue that Envision is not a licensed medical facility. However, any optometrist employed by Envision would function as a Medical Director, could report to a Medical Advisory Committee, and is licensed and regulated by the Kansas Board of Examiners in Optometry.

Beyond the bogus suggestion by the organized optometrists to become a medical facility or a medical care facility, two other models have been suggested by the organized optometrists in the provision of interdisciplinary comprehensive low vision rehabilitation. First, the side by side model and second the no optometrist/ provide only rehabilitation model. In the side by side model, optometrists work as private practitioners located adjacent to, but physically separated from the rehabilitation team, such as Wal-Mart. This "ne'r shall the two meet" model substantially limits the communications between the optometrist and the therapist team, thereby impacting the quality of patient care and eliminating the value of the interdisciplinary model. Furthermore, the side by side model totally eliminates the ability to inform the public on the availability of a one-stop, interdisciplinary comprehensive low vision rehabilitation center.

The major weakness of the second model is the absence of an expert low vision optometrist. The ability to select the optometrist that our occupational therapists will work incident to allows Envision the opportunity to select the very best of the best. The optometrist Envision is bringing to Kansas for private practice or as an employee of Envision has 20 years experience in low vision optometry. In addition he is a Fellow of the American Optometric Association and a soon to be Fellow of the NeuroOptometric

Rehabilitation Association. Additionally, the new Kansas optometrist has published his research at vision science conferences and in optometric and ophthalmologic trade journals. His research background along with our research staff will help Envision establish protocols and measure outcomes to determine the value of our vision rehabilitation services. Envision is raising the bar on what constitutes a qualified low vision optometrist. Without expert low vision optometrists, some deserving individuals may never get the opportunity to receive proper and adequate low vision rehabilitation.

It has been a well known fact within the Kansas low vision and blindness field that the number of optometrists in Kansas who practice low vision could be counted on one hand. In the October 2007 issue of the Kansas Optometric Association's Light Rays, an article titled, *Low Vision Committee Update*, appeared. The two sentence article read, "In response to requests by KOA members, the Low Vision Committee is updating their list of KOA members who **offer** comprehensive low vision services in their office. Please complete and return the enclosed Low Vision Service Provider Update Form and return it to the KOA office by November 15." The low vision service **provider** update form included a definition of comprehensive level of service. However, the last sentence within the definition stated, "**Coordination** with occupational or other certified therapists is made available when needed to include ADL, CCTV, bioptic and field limitation instruction." Apparently this wordsmithing (Do you offer, provide, coordinate comprehensive low vision services?) led to 31 new optometrists who offer, provide, or coordinate comprehensive low vision rehabilitation in Kansas! According to the American Optometric Association, Kansas only shows 3 optometrists providing low vision in their offices.

Why do the organized optometrists so adamantly oppose SB 568? We suspect it is pure and simple competition. Why else would four Kansas optometrists threaten that Envision will never get another referral from another optometrist if we introduce a bill to change the optometric statute? However, Kansas organized optometry has claimed competition by Envision is not the cause of their opposition of our bill. Perhaps it's their fear of competition from commercial optometry. If so, that is not Envision's fight. We simply want to carry out our mission by providing interdisciplinary comprehensive low vision rehabilitation services to Kansas in need of the service.

We appreciate the market forces that are threatening the traditional optometric business model, e.g., big box retail chains, etc., and we are not trying to add to these threats or the difficulties of running a small business today. While we are highly specialized to provide services for people who are blind and low vision, we advocate quality eye care for all Kansas and we salute KOA as the first line of defense for making quality care a reality.

We believe that optometrists should be in the driver's seat for our "whole person" rehabilitation philosophy. Our model puts the optometrist in charge of prescribing services for the patient. Because the demand for these services will far exceed the supply, and because we lose money on every client we serve, we are motivated to return the client to the primary care of the referring optometrist so that we can serve more

people. Our model is not static; it is in a state of continuous improvement, driven by research related to patient outcomes.

The last thing we want is for Envision to be viewed as a competitor to the private optometric practice. We are not interested in general optometry. It is not our mission and therefore the narrow language of SB 568 only applies to nonprofit low vision rehabilitation centers. Instead we want to function and be viewed as a plethora of services for an important, underserved category of patients. The reaction to our bill by the organized optometrists demonstrates a greater concern for increased competition rather than concern for the low vision patient. The October 29, 2007 issue of the American Optometric Association NEWS, included a commentary by the President, Dr. Alexander. His commentary addresses the concerns of optometrists over too many optometric schools and an oversupply of optometrists. In 1999, the AOA released a manpower study by Abt Associates that concluded that there would be an oversupply of optometrists through 2030. In fact, they concluded that even if we closed 10 percent of the schools and colleges of optometry, there would still be an oversupply. Dr. Alexander said many optometrists complain that they can't make a living at optometry. They fear that the corporate and chain optometrists are taking over what was once a "nice little profession" and that increasing the number of optometrists will only make their fears reality. Dr. Alexander adds that one optometrist told him it used to be as easy as falling off a log to make a living optometry. Now I really have to work at it—there are just too many optometrists. The AOA President states, "Some of you have taken the protectionist's position and demanded that the AOA take a stand against the opening of new schools. May I remind you that we live in a country that protects free enterprise?"

SB 568 is a PINPOINT SOLUTION FOR A PINPOINT PROBLEM.

Without your support of SB568, our ability to serve people in the most desired way is extremely diminished. Please help us.

Frequently Asked Questions

A Supplement to the Testimony
on SB 568
Presented by
Linda K. Merrill
Envision President and CEO

1. **What is the mission of Envision?** The mission of Envision is to enhance the personal independence of people who are low vision or blind through employment or vision rehabilitation.

2. **How many people who are blind or low vision does Envision serve?** Currently Envision employs 200 individuals with vision impairments. In addition to employment, we serve approximately 1500 individuals with vision impairments through our various rehabilitation programs.

3. **Can Envision legally bill Medicare?** Yes. Envision worked closely with CMS to complete the appropriate applications. Envision has a provider number.

4. **Has Envision committed Medicare fraud?** Absolutely not.

5. **Why does Envision feel it must employ an optometrist?** Primarily for two reasons. First, to ensure continuity of care. The side by side model suggested by the organized optometrists creates a "never shall the two meet" scenario and thereby eliminating the benefits of the interdisciplinary model. Second, the ability to educate the public on vision rehabilitation services is significantly reduced if we cannot mention the presence of an experienced low vision optometrist.

6. **Are there other low vision rehabilitation services in the state of Kansas?** There are no other interdisciplinary comprehensive low vision service providers in Kansas.

7. **Doesn't the Rehab Center for the Blind provide low vision rehabilitation?** No it does not. It serves people who are employment bound in need of adjustment to blindness and rehabilitation for

individuals with blindness. Additionally, the troubling policy at the Rehab Center for the Blind is that all individuals must undergo rehabilitation under sleep shades regardless of their remaining vision.

8. **Doesn't the VA provide low vision rehabilitation?** Yes it does. Veterans Administration services are only available to veterans. The VA in Wichita often refers patients to Envision for rehabilitation services.

9. **What makes Envision's rehabilitation therapists special?** Envision's therapists are dual certified as occupational therapists and ACVREP low vision therapists and/or orientation and mobility therapist. ACVREP stands for the Academy for Certification of Vision Rehabilitation Educators and Professionals.

10. **What are low vision therapists and specialists most concerned with?** A true low vision specialist is dedicated to evaluating the entire patient. They are more interested in finding useful vision in the patient and teaching the patient to use it than just selling some form of visual aid. Specialists also recognize that they're treating a whole patient with fears, goals, desires for independence and perhaps limited time left in their life to experiment with useless aids.

11. **What is the goal of low vision rehabilitation?** To improve the quality of life for people that have decreased visual function that is interfering with their activities of daily living.

12. **Is the corporate practice of medicine a concern of Envision?** Yes it is. Envision prefers to find a solution to the employment of optometrists in existing statutes. However, that has not been possible. Envision would be amenable to discussions with the Kansas Board of Examiners and/or the Kansas Optometric Association to develop a reasonable process or some type of oversight to prevent and ensure the nonexistence of corporate involvement at Envision.

13. **Does the American Optometric Association support the interdisciplinary approach to low vision rehabilitation?** Yes it does. In fact, the "A Team" comprised of the American Academy of Ophthalmology (AAO), the American Optometric Association (AOA), Association for Education and Rehabilitation of the Blind and Visually

Impaired (AER), and the American Occupational Therapist Association (AOTA) developed a model

14. **What is a comprehensive low vision rehabilitation service system?** It is a system of care for people with low vision that includes clinical, educational, and social components.

15. **Does Envision have a comprehensive low vision rehabilitation service system?** Yes it does.

16. **Does Envision "keep" patients that are referred to it by other doctors?** Absolutely not. It is in the best interest of the patient and in Envision's best financial interest that we refer patients back to their optometrist or ophthalmologist for routine eye care.

17. **Does Envision provide general optometric services?** Absolutely not.

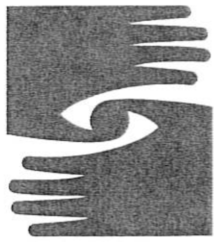
18. **Has Envision been notified by the Board of Examiners of complaints by patients against Envision?** No we have not.

19. **Have any of the optometrists who practiced within Envision been notified by the Board of Examiners of complaints by patients against them or Envision?** Not to our knowledge.

20. **Has Envision researched the possibility of becoming a medical facility or a medical care facility?** Yes, we have extensively researched the law, engaged legal counsel to pursue the possibility, and talked to KDHE.

21. **Is Envision involved in the national Medicare Demonstration Project?** Yes we are. Envision is the ONLY provider of low vision rehabilitation services in the state billing under the G codes for the demo project.

22. **What is the definition of low vision?** A visual impairment, not correctable by glasses, contact lenses, medicine or surgery that interferes with the ability to perform everyday activities.



Legislative advisory from

Envision®

Choices & resources for people who are blind or low vision

Envision: celebrating 75 years of service

The mission of Envision is to enhance the personal independence of individuals with low vision or blindness through employment and low vision rehabilitation.

Our roots go back to 1933, when the Wichita Workshop and

"Envision, celebrating 75 years of service" continued on Page 3

Take action for Kansans with impaired vision

Envision strongly supports Senate Bill 568, sponsored by Sen. Susan Wagle and Sen. Jean Schodorf, that would permit non-profit low vision rehabilitation centers to hire optometrists. Passage of this bill would greatly increase the availability of low vision services to Kansans living with low vision.

Envision is not asking for funds; there is no cost to the state if this bill becomes law. We are only asking for the legal right to hire staff essential to fulfilling our mission. Please read on to see why this small issue has an important role in our health care system.

An epidemic of vision loss

It would be easy to assume that vision loss is a disability from the past, largely conquered through sophisticated technology and an attentive health care system.

How many Americans will be affected? By 2020, we expect 7.2 million cases of diabetic retinopathy, the leading cause of blindness in the U.S. More than 3.3 million cases of

"Take action for Kansans..." continued on Page 2

But it's not.

Vision loss and blindness are on the increase, and sharply so. The number of people living with vision impairment is expected to increase 60 percent by the year 2020, as today's "baby boomer" generation – 77 million strong – becomes the largest senior group in history.

A patient with low vision learns to use a CCTV (closed circuit television) at the Envision low vision rehabilitation center.

PUBLIC HEALTH AND WELFARE
ATTACHMENT: 4
DATE: 03/11/08

Envision is a regional resource

While most of Envision's patients come from south-central Kansas, a significant number come from across the state. In fact, patients from 24 states and 270 cities have received services at Envision.

Envision® Rehabilitation Center

"Take action for Kansans with impaired vision, cont."

glaucoma. Almost three million cases of macular degeneration, with twice again that number at risk for the disease. And still others with vision loss from inherited diseases, such as retinitis pigmentosa, or from injury, or as a symptom of stroke.

In Kansas, the picture is even bleaker. Our state has the fifth-highest rate of vision impairment in the U.S., with 3.43 percent of Kansans affected. That translates into almost 40,000 Kansans with vision impairment, according to the 2000 census. By 2020, there will be more than 63,000 Kansans who are blind or vision impaired.

More than one-fifth of Envision's patients are children with vision impairments.

What can we do?

About half of all cases of vision impairment could be prevented, according to the National Eye Institute. Most of the 30 million Americans expected to have cataract by 2020 can have surgery and expect greatly improved vision. Others can save their sight through early detection and management of eye disease. A patient with glaucoma, for example, can take medicine that controls its effect on vision. For people with diabetes, healthy living techniques can slow or stop vision loss. Doctors and optometrists are fighting on these front lines, saving sight every day.

"When you hear the term low vision rehabilitation, I think immediately that there is hope, supported by science, that there's an opportunity to learn to maximize your remaining vision, supported by your other senses; I think it's a head, heart and eye journey."

Tracy Williams, OD
Executive Director, Deicke Center for Visual Rehabilitation, Wheaton, IL

If vision loss isn't stopped, then the patient will have to learn to live with the impairment. Through a process called low vision rehabilitation, patients can learn to make the best use of remaining vision. Then they can learn new skills to replace the lost vision. The result is a safer, more independent life. The National Eye Institute strategic plan says: "low vision rehabilitation helps people maintain their independence, live safely, and enjoy life, even if they have a visual impairment that cannot be corrected with standard eye glasses, contact lenses, medicine or surgery."

Low vision rehabilitation is not a well-known process. Only about six percent of the people who would benefit from these services actually receive them. In Kansas, only a handful of optometrists do some low vision work. The Envision Rehabilitation Center, with a full staff of certified low vision rehabilitation professionals, is unique in providing multi-disciplinary comprehensive low vision rehabilitation services.

A multi-disciplinary comprehensive low vision rehabilitation program has two components: medical and rehabilitation. In low vision rehabilitation, an optometrist or ophthalmologist generally delivers the medical component. The low vision assessment may include:

- examining the retina for patterns of vision loss
- conducting a refraction
- teaching a skill called "eccentric viewing" to help the patient find the best acuity
- making sure the two eyes work together properly
- assessing contrast, glare, lighting, and other factors that influence how well the eyes function
- selecting, fitting and evaluating optical devices

The rehabilitation component is delivered by professionals certified to work in low vision rehabilitation, including occupational therapists, certified low vision rehabilitation teachers, orientation & mobility specialists and low vision therapists. The focus here is on:

- activities of daily living
- reading
- learning how to use adaptive or optical devices
- learning how to navigate with a white cane or guide dog
- adapting and learning to use a computer
- external resources, such as support groups, audio reader services and transportation

"The building block of low vision rehabilitation is the evaluation by the physician, the prescription of low vision aids and devices, and the continuing care with a multidisciplinary team approach. . .I think we all need to be aware of the wonderful benefits it provides in helping people to maintain independence and continue to live their life as full as they can."

Dr. Gwen Sterns
Medical Director, Association for the Blind and Visually Impaired, Rochester, NY

Throughout the low vision rehabilitation process, the doctor is available to answer questions, try new approaches, and assess the efficacy of optical devices.

But does it work?

While low vision rehabilitation can seem like a lot of effort, the payoff can be huge. For a child, getting appropriate services can keep him or her from falling behind a grade level, helping assure success in school. For seniors, it may mean staying in the family home instead of going into assisted living. Being able to pay your own bills and read the newspaper.

4-2

And knowing how to safely cook, clean and maintain your home.

At Envision, we see success stories every day. But this observed success is also borne out by research.

Lighthouse International, an agency with a services model similar to that delivered by Envision, surveyed 149 patients who had gone through low vision rehabilitation services. They found that 94.1 percent reported satisfaction with their service and had improved function in daily life.

Studies conducted by Community Services for the Blind and Partially Sighted, a sister agency to Envision located in Seattle, found that patients with age-related macular degeneration who received access to multi-disciplinary low vision rehabilitation services had better outcomes than patients who received optical devices without additional support.

Economic factors

Why don't more doctors, therapists or agencies provide these services? Economic barriers to entry are high. Low vision rehabilitation is a time-consuming process. At the Envision Rehabilitation Center, an initial assessment takes three hours. And several repeat visits may be required to learn some new skills. Medicare and insurance reimbursements don't begin to cover the costs of these services.

Here's what one Colorado optometrist said: "Let's be honest about it. Doesn't make much money. Doesn't pay my mortgage ... and that's why for me to take on low vision isn't worth my while. I'm going to send it out."

Because of the complexity and multidisciplinary nature of low vision rehabilitation, currently over 200 physicians refer their patients to Envision. Patients come from 213 cities in Kansas as well as 24 states for low vision rehabilitation. Since we are referral based, that means we report back to the referring doctor on the patient's progress and the

Envision: celebrating 75 years of service cont...

Training School for the Adult Blind was chartered. Initially the agency focused on employment, with an emphasis on broom manufacturing, sewing and light manufacturing. As the agency grew, it branched first into low vision rehabilitation services, and then public education.

Today, Envision advances its mission in three areas:

Envision operates the Envision Low Vision Rehabilitation Center, the only comprehensive clinic in Kansas serving the needs of people living with vision impairments.

Envision works to reduce the more than 70 percent unemployment rate among people who are blind through its employment division. Envision is one of the largest employers of people who are blind in the region, with almost 200 employees (about half of all employees) who are legally blind. We offer jobs in manufacturing, retail sales, commercial printing, administration, management and information technology. In Kansas, our employment program has locations in Wichita, Pittsburg, Kansas City, Fort Riley and Leavenworth.

Envision public education works to promote eye health and safety, and awareness of low vision rehabilitation services. We produce

Envision is a leading employer of people who are blind or low vision.

public service announcements for radio and television which run statewide throughout the year. Topics include macular degeneration, diabetic eye disease, glaucoma, vision loss and stroke, and healthy vision. Envision produces a newsletter for doctors and health care professionals and a general-audience newsletter that addresses eye health and safety issues. Envision produces the national Envision Conference, which is the premier training event for medical and rehabilitation staff that work in the blindness and low vision field.

Learn more about Envision at ***www.envisionus.com***.

Who provides low vision care in Kansas?

The American Optometric Association reports 461 optometrists working in Kansas. But only eight – less than two percent – are members of the Low Vision Rehabilitation Section. And only three – less than one percent – report low vision rehabilitation as a practice emphasis.

When you think about the almost 40,000 Kansans age 40 and older who are blind or vision impaired, you can see that there are not nearly enough doctors working in low vision.

Envision has the capacity to see more than 1,500 patients a year. What's more, we're uniquely qualified with a multi-disciplinary comprehensive staff of low vision rehabilitation specialists, from occupational therapists to Braille teachers.

Leading agencies use this model

What do the Lighthouse International (New York), Community Services for the Blind and Partially Sighted (Seattle) and the Center for the Visually Impaired (Atlanta) have in common?

They're leaders in the field of low vision rehabilitation. They're private, not-for-profit corporations. And they employ optometrists, so they can provide comprehensive low vision services to their patients.

Under this model, the optometrist conducts the low vision evaluation, then follows the patient's progress through the plan of care. Because low vision rehabilitation is a process, the optometrist can intervene as needed. For example, if the patient has difficulties with a particular optical device, the optometrist can prescribe an alternative.

Only through this integrated model can we assure the best possible care for our patients. And this one-stop model is also easier for our patients, many of whom require transportation assistance and other support.

"Take action for Kansans with impaired vision" continued from page 3

patient returns for follow-up treatment and regular eye care to their referring physician.

Envision is uniquely qualified to offer these services. As a non-profit agency dedicated to enhancing the independence of people who are blind or low vision, providing these services is basic to our mission. In order to close the gap between cost of services and revenue, we utilize revenue from our mission-oriented employment division and engage in fundraising activities.

A beacon of hope: the Envision Low Vision Rehabilitation Center

Envision has purchased a building in downtown Wichita and is currently renovating it to become the future home of the Envision Low Vision Rehabilitation Center. When completed, it will become a state-of-the-art facility for providing low vision rehabilitation services. Designed from the ground up to be low vision- and blind-friendly, the facility will include exam rooms, an adaptive aids store, meeting places for support groups and educational events, a pediatric area, an activities of daily living area, and much more. Future plans will include a driving assessment and training center and a day program for children with vision impairments. We're building today to meet the needs of Kansas tomorrow.

"Daily I have the satisfaction of giving people a little bit of hope where there was none when they came in. If I speak to the average consumer who hadn't had low vision rehabilitation, I would tell them there is good reason for hope."

Dr. Donald C. Fletcher
Smith-Kettlewell Eye Research Institute,
San Francisco, CA

Our ability to provide these services is compromised if we can't hire the medical personnel needed to serve our patients. Your support of Senate Bill 568 will ensure a truly comprehensive low vision rehabilitation center for Kansas.

Quick Summary:

- Low vision and blindness affects 40,000 Kansans today, and the number is expected to grow to 63,000 by 2020.
- Research shows that low vision rehabilitation services can help improve independence and quality of life for people living with vision impairment.
- Only a small handful of Kansas optometrists provide low vision services.
- Current law prohibits a private non-profit agency like Envision from hiring an optometrist. The bill advanced by Sen. Wagle would allow non-profit agencies to hire an optometrist.
- Envision is making a significant investment in a regional low vision rehabilitation center. Having an optometrist on staff is an essential part of offering comprehensive services for Kansans.
- Senate Bill 568 is a pinpoint solution to a pinpoint problem.

To learn more about how Envision can better serve Kansans with vision impairment, contact:

- Mary Ellen Conlee
  Conlee Consulting Group
  316-619-2683
- Linda K. Merrill
  President and CEO, Envision
  316-267-2244

2301 S. Water • Wichita, KS 67213-4819 • 316.682.4646 • 866.319.4646 (toll free)
www.envisionus.com • envision@envisionus.com

Envision
Choices & resources for people who are blind or low vision

Senate Bill 568 Fact Sheet

1. "Low Vision" is vision loss that significantly impairs the daily functioning of the patient and cannot be adequately corrected with medicine, surgery, therapy, conventional eyewear or contact lenses. Low vision may be caused by macular degeneration, cataracts, glaucoma, or other eye conditions and/or diseases. Low vision may occur as a result of birth defects, injury, the aging process, or as a complication of disease.

2. "Vision Rehabilitation" includes counseling, training in use of optical devices, rehabilitation teaching and orientation and mobility training. Vision Rehabilitation is intended to provide patients with a richer, safer, more independent life. Because people suffering from low vision cannot have their vision adequately corrected, the availability and participation in a vision rehabilitation program is vital.

3. Envision Inc. is a Kansas non-profit corporation and tax-exempt charity. Envision has provided services to the blind and those with low vision in the State of Kansas for more than 70 years. Envision is the largest employer of individuals who are blind or low vision in a six-state region employing 175 people in Kansas City, Pittsburg and Wichita.

4. Envision is the only nonprofit low vision rehabilitation center in south-central Kansas providing low vision rehabilitation services. Previously, Via Christi Regional Medical Center provided these services, but transferred the low vision rehabilitation center to Envision.

5. Because people suffering from low vision require substantial time with their OD and therapists, providing low vision rehabilitation services is not a profitable endeavor. Since Envision took over the low vision rehabilitation center in 2003, Envision has incurred losses equal to $1.8 million. Envision is willing to continue to incur such losses because the provision of low vision rehabilitation services is vital to its charitable mission. Envision does not deny services to any low vision or blind individual, regardless of ability to pay.

PUBLIC HEALTH AND WELFARE
ATTACHMENT: 5
DATE: 03/11/08

6. The Kansas Board of Examiners in Optometry believes the "Regulation of Optometrists" statute, K.S.A. 65-1501 et seq., and specifically K.S.A. 65-1524, prohibits Envision, Inc. from entering into a contract with an optometrist to enable Envision to provide low vision rehabilitation services.

7. SB 568 limits the activities of a nonprofit low vision rehabilitation center to "low vision rehabilitation services" as currently defined by the Optometry Act.

   The existing definition from the Optometry Act states that "Low vision rehabilition services means the evaluation, diagnosis, management and care of the low vision patient including low vision rehabilitation therapy, education and interdisciplinary consultation under the direction and supervision of an ophthalmologist or optometrist."

8. SB 568 narrowly defines "nonprofit low vision rehabilitation center" as a "nonprofit corporation which (1) is exempt from tax pursuant to Section 501(c)(3) of the Internal Revenue Code of 1986, as amended, and (2) provides low vision rehabilitation services as defined in K.S.A. 65-1501a(u)." See new K.S.A. 65-1501a (p).

9. Under K.S.A. 65-1502, the Board believes Envision would be "deemed to be practicing optometry" if Envision provided low vision rehabilitation services through a contractual relationship with an optometrist. Senate Bill 568 would amend K.S.A. 65-1502 as follows: "(c) Nothing herein contained shall be construed to prohibit a licensee from entering into leases, agreements, mortgages or other types of debt instruments not in violation of this section or any other section of the optometry law or from practicing optometry as an agent or employee of any nonprofit low vision rehabilitation center."

10. For consistency, Senate Bill 568 would amend K.S.A. 65-1522(c) as follows: "(c) A licensee may practice in a medical facility, medical care facility or a governmental institution or agency or a nonprofit low vision rehabilitation center."

11. Allowing Envision the legal right to hire optometrists is completely consistent with practices in other states (i.e. Washington, New York, Illinois, Texas, Georgia) where nonprofits employ optometrists in their comprehensive low vision rehabilitation centers.

12. For more information, contact Mary Ellen Conlee at 316-619-2683 or maryellen@conleeconsulting.com.

Envision
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Wichita, KS 67213
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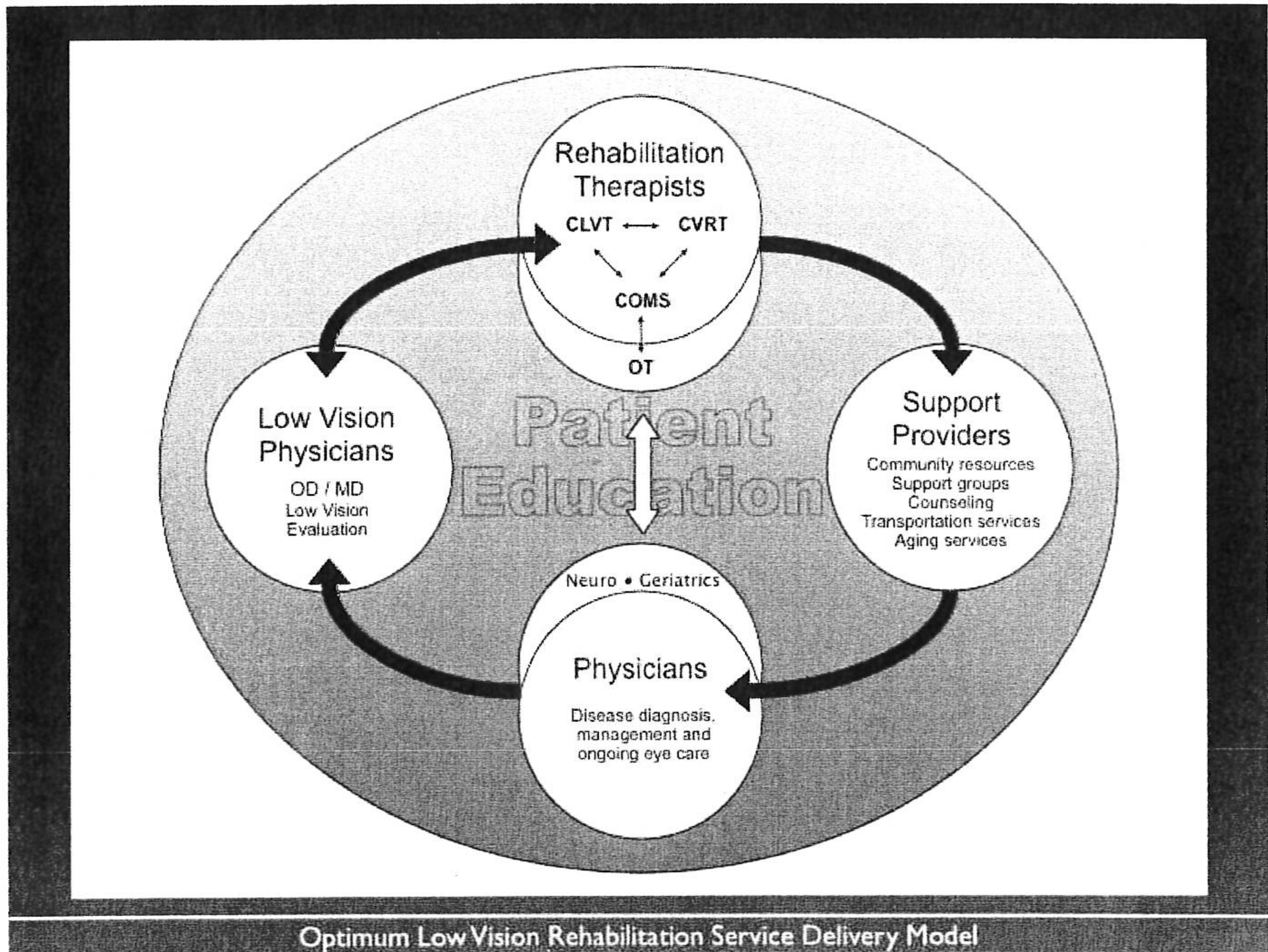
www.envisionus.com

THE "A TEAM" MODEL

Description of the Low Vision Rehabilitation Delivery Model

Home: www.mdsupport.org/lvrehab.html

Here is the graphic representation of the Low Vision Rehabilitation Delivery Model. Below it is a description of each step in the continuum of care it represents. With this information, you hold the key that will open the doors to the care you deserve. You may want to print it and discuss its content with your family and doctor.



Optimum Low Vision Rehabilitation Service Delivery Model

©AER_AOTA_AOA_AAO Study Group

The four services are joined in a circle by arrows, representing the paths to follow for optimum low vision rehabilitation service. These images overlay a background labeled "Patient Education," which is the driving force behind the model. Here are the steps you should expect to take along this road to low vision rehabilitation:

1. The continuum of care may be entered at any point in the circle. The process actually begins, however, when your diagnosing physician (usually an optometrist or ophthalmologist) refers you to a low vision physician for evaluation.

2. The low vision physician (a specially-trained medical doctor or optometrist) will evaluate your needs and refer you, if necessary, to the most appropriate rehabilitation professional/s. You may be referred to one or more of the following:

6-2

- Certified Low Vision Therapist (CLVT)
- Certified Vision Rehabilitation Therapist (CVRT)
- Certified Orientation and Mobility Specialist (COMS)
- Occupational Therapist (OT)

It could be that you do not need to move further through the system at this time. If not, you will at least know what is available to you if your vision declines further.

3. If you are referred on, rehabilitation professionals will consult and collaborate to provide multi-disciplinary care to meet your needs and goals. At the same time, they should refer you to appropriate ancillary and support services, including:

- Community resources
- Support groups
- Counseling
- Transportation services
- Aging services

4. The support services will provide you with ongoing assistance once formal rehabilitation services have ended. They will ensure that you have the resources to continue the gains made in therapy.

5. If your vision declines, the physician will reinitiate the referral process beginning with a new low vision examination, and the model will progress forward.

Your care providers should be putting this protocol into practice wherever possible. Sufficient manpower and physical resources, however, may not be available in some geographical areas. Hopefully, that situation will improve, as more professionals realize the increasing importance of such care to the quality of life and the health of our low vision community.

Close this window

OPHTHALMOLGY

The University of Kansas Medical Center

School of Medicine
Department of Ophthalmology

Faculty
John E. Sutphin, MD, Chair
Blake Cooper, MD
David Dyer, MD
Gregory Fox, MD
William A. Godfrey, MD
Martin A. Mainster, PhD, MD
Ann Stechschulte, MD
Michael Stiles, MD
Beatty Suiter, MD
George T. Timberlake, PhD
Thomas J. Whittaker, MD

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Glaucoma and Anterior Segment
Michael Stiles, MD

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Martin A. Mainster, PhD, MD
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David Dyer, MD
Gregory Fox, MD
King Y. Lee, MD
Beatty Suiter, MD

Uveitis
William A. Godfrey, MD

March 1, 2008

Kevin Yoder
Capitol
300 SW 10th Ave, Room 142-W
Topeka, KS 66612-1504

Dear Representative Yoder,

I am writing to ask for your support of Senate bill 568 which is crucial to Kansans with low vision. The National Eye Institute defines low vision as a visual impairment, not correctable by standard eyeglasses, contact lenses, medicine, or surgery, that interferes with the ability to perform everyday activities. The majority of those with low vision are considered legally blind and are unable to drive, read with facility, shop for groceries, recognize faces, or a host of other necessary activities of daily life. Almost 40,000 Kansans age 40 and older are blind or visually impaired and this number can be expected to increase dramatically as our population ages. As a faculty member in the Department of Ophthalmology at the University of Kansas Medical Center and as a researcher in the field of low vision, I see those struggling with low vision every day.

Kansas is fortunate to have *Envision,* one of the top non-profit providers of blind/low-vision services and rehabilitation in the United States. I collaborate with researchers at *Envision* to improve services and rehabilitation to those with low vision. I believe that *Envision's* mission will be jeopardized unless Senate bill 568 is passed. This bill seeks to allow *Envision*, a 75 year old, Kansas 501 (c) (3) nonprofit corporation the legal right to employ optometrists in its interdisciplinary, comprehensive, low vision rehabilitation center. The bill was introduced by Senators Susan Wagle and Jean Schodorf on February 6, 2008.

Envision is not seeking state funding. There is no cost to the state if this bill becomes law. *Envision* is only asking for the legal right to hire optometrists essential to fulfilling its mission. The Kansas Optometric Association (KOA) is opposing this bill. The KOA is unable to provide a rational explanation of their opposition to the bill, but I suspect the real reason for their opposition is the desire to eliminate any perceived or potential competition. In Kansas, employment of optometrists is unfairly restricted through laws that only allow optometrists to work in private practice, in a medical facility, a medical care facility, or a governmental institution or agency. The consequence of such law is that an optometrist can not be employed by a non-profit institution such as *Envision* that provides services and employment to Kansans with low vision or blindness. Oddly, in Kansas, *Envision* could

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freely hire M.D.'s, but is prohibited from hiring O.D. optometrists. Other states do not have such restrictive laws.

Envision does not compete with optometrists, but rather seeks to serve only those individuals with low vision. *Envision* does not serve individuals with vision that can be corrected by eyeglasses, contact lenses, medicine or surgery. In fact, *Envision* serves only individuals with low vision *that have been referred by optometrists* for advanced rehabilitative care. Without *Envision*, low-vision Kansans have very few options since there are only 3 optometrists in the entire state that have low vision rehabilitation as their practice emphasis. The paucity of low vision optometrists not only in Kansas, but nationwide is most likely due to the need for labor-intensive examination and relatively poor reimbursement. As a charitable nonprofit corporation, *Envision does* provide time-consuming, labor-intensive examinations and does not turn away patients without the ability to pay.

Please understand that I have the greatest respect for the profession of optometry and Kansas optometrists. In fact, I work with optometrists in both Missouri and Kansas and I also publish frequently in the American Academy of Optometry journal *Optometry and Vision Science* and review scientific articles for them. I am proud of my work with optometry. However, the opposition of the Kansas Optometric Association to the employment of optometrists by *Envision* is unproductive and against the best interests of the people of Kansas.

In summary, *Envision* is the only comprehensive low vision rehabilitation center in Kansas. It provides unique services to the people of Kansas, services that can only be accomplished with staff optometrists. Please help to continue *Envision's* charitable services to Kansans by supporting Senate Bill 568 which will allow it to employ full-time low vision optometrists for full-time low vision practice.

Sincerely,

George T. Timberlake, Ph.D.
Associate Professor
Director of Research

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COMPETITION

Federal Trad[illegible]ommission
Protecting Ame[illegible]'s Consumers

UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

Bureau of Consumer Protection
Office of the Director

February 10, 1995

The Honorable Gary A. Merritt
Kansas House of Representatives
State Capitol, Room 175-W
Topeka, Kansas 66612-1504

Dear Mr. Merritt:

The staff of the Federal Trade Commission(1) is pleased to respond to your request for comment on House Bill No. 2164. The bill would clarify the conditions under which optometrists and non-optometrists could enter into lease agreements. Thus, the bill would affect the conditions under which optometrists could practice in conjunction with optical goods companies.

I. Interest and experience of the Federal Trade Commission.

The Federal Trade Commission is empowered to prevent unfair methods of competition and unfair or deceptive acts or practices in or affecting commerce.(2) Pursuant to this statutory mandate, the Commission encourages competition in the licensed professions, including the health care professions, and in the delivery of health care services to the maximum extent compatible with other state and federal goals. For several years, the Commission and its staff have investigated the competitive effects of restrictions on the business practices of state- licensed professions, including dentists, physicians, pharmacists, and other health care providers.(3) In addition, the staff has submitted comments about these issues to state legislatures and administrative agencies and others.(4) As one of the two federal agencies with principal responsibility for enforcing antitrust laws, the Commission is particularly interested in restrictions that may adversely affect the competitive process and raise prices (or decrease quality) to consumers. And as an agency charged with a broad responsibility for consumer protection, the Commission is also concerned about acts or practices in the market that injure consumers through unfairness or deception.

II. Description of H.B. 2164.

H.B. 2164 would clarify the conditions under which an optometrist could lease office space from an optical company. Kansas statutes prohibit someone who is not a licensed optometrist from "maintaining an office for the practice of optometry," from directly or indirectly controlling or attempting to control a licensee's professional judgment or practice, and from bearing any expenses or having any interest in the licensee's practice, books, records, or materials.(5) The law permits a licensee to enter into leases and debt instruments not otherwise in violation of the law.(6)

H.B. 2164 would specify terms that would not be construed as "maintaining an office for the practice of optometry" in violation of the law. Payment of rent to an optical company would be permitted (as long as it did not depend on the number of patients, prescriptions, or referrals), as would lease agreements about hours of operation, insurance, equipment and furnishings, and utilities.(7) In addition, leases between optometrists and optical companies could include agreements about participation in third-party programs and noncompetition agreements about product sales.(8) Leases would have to recite that the optical company landlord will not interfere with the optometrist's exercise of professional judgment and acknowledge the ownership of the optometrist's patient records.(9)

The optometrist would have to post an appropriate sign at the office entrance indicating that the optometrist is independent.(10) Similar design and decor in adjoining optometry and optical company offices would be permitted, as long as the required sign shows that the optometrist is an independent practitioner.(11)

III. FTC studies and rulemaking proceedings concerning eye care.

Regulations that restrict the business aspects of professional practice can impose costs on consumers. Studies have often found little relationship between restrictions on professionals' business practices and the quality of service or care they provide.(12) Restrictions on their business practices can limit professionals' ability to compete effectively with each other and can also increase their costs. If restrictions impose costs that are passed on in the form of higher prices or reduced services, then consumers can be harmed. These potential adverse effects of

regulation should be considered along with its intended benefits.

The FTC and its staff have considerable e[illegible]nce with the competitive impact of restraints on b[illegible]ss practices in the eye care industry. Two kinds of practices, restraints on advertising [illegible] failures to release prescriptions, were the subject [illegible] FTC rulemaking proceeding in the 1970's.(13) That proceeding revealed that other common restraints on eye care providers also appeared to limit competition unduly, increase prices, and reduce the quality of eye care provided to the public.

To examine the effects of restraints on business practices in the eye care industry, the staff of the FTC conducted two comprehensive studies. The first, published in 1980 by the FTC's Bureau of Economics, compared the price and quality of optometric goods and services in markets where commercial practices were subject to differing degrees of regulation.(14) This study, conducted with the help of two colleges of optometry and the Director of Optometric Services of the Veterans Administration, found that commercial practice restrictions in a market resulted in higher prices for eyeglasses and eye examinations but did not improve the overall quality of care in that market. The second study, published in 1983 by the Bureaus of Consumer Protection and Economics, compared the price and quality of the cosmetic contact lens fitting services of commercial optometrists and other provider groups.(15) It concluded that, on average, "commercial" optometrists (for example, optometrists who were associated with chain optical firms, used trade names, or practiced in commercial locations) fitted cosmetic contact lenses at least as well as other fitters, but charged significantly lower prices.

During the 1980's, the FTC conducted a second rulemaking proceeding about restraints on commercial eye care practice.(16) Based on the evidence assembled in the rulemaking proceeding, the FTC concluded that restrictions on commercial practices by eye care providers have resulted in significant consumer injury, in the form of monetary losses and less frequent vision care, without providing consumer benefit.(17) The Commission found that a substantial portion of the consumers' costs for eye examinations and eyewear was attributable to the inefficiencies of an industry protected from competition.(18) The FTC thus adopted a rule(19) to prohibit state-imposed restrictions on four types of commercial arrangements: affiliating with non- optometrists, locating in commercial settings, operating branch offices, and using nondeceptive trade names.(20) Although the Eyeglasses II rule was vacated on appeal (on the ground that the FTC lacked the statutory authority to make rules declaring state statutes unfair), the FTC's substantive findings, that the restrictions harmed consumers, were not disturbed.(21) The evidence from the FTC's rulemaking record remains a compelling argument for eliminating restraints on commercial practice.

IV. Effects of location restrictions and regulation of employment relationships.

In general, restrictions on affiliations with non- professionals and on associations with other businesses prevent business corporations or non-professionals from employing professionals and prevent partnerships and franchise agreements with non-professionals. Such restrictions may deny professionals access to sources of capital and thereby tend to inhibit the development of large-scale practices that can take advantage of volume purchase discounts and other economies of scale. The likely result of excluding high-volume practitioners from the market and preventing practitioners from operating at the most efficient level is higher prices for optometric goods and services.(22)

We encourage the removal of provisions prohibiting eye care providers from working for lay persons or other professionals or entering into partnerships or other associations with them. Restrictions on these types of business formats may prevent the formation and development of forms of professional practice that may be innovative or more efficient, provide comparable or higher quality services, and offer competition to traditional providers.(23) We also support efforts to remove restrictions on practicing in commercial locations. We question whether such restrictions serve any purpose other than inhibiting the formation of high-volume commercial practices.(24)

H.B. 2164, which would make it easier for optometrists to locate in space leased from optical goods stores, represents a step toward eliminating a restriction on commercial forms of practice. We believe that making it clear that the business relationships outlined in H.B. 2164 are permitted could benefit consumers.

We note, however, that potentially significant constraints may remain in place. Kansas law apparently continues to ban employment of optometrists by non-professionals, and thus could prevent some potentially efficient forms of collaboration. Other forms of economic collaboration between optometrists and optical goods companies, such as coordinated promotions or pricing, could also benefit consumers. Because H.B. 2164 is limited to the subject of leases, its failure to include such promotions or other kinds of relationships may not necessarily mean they are not permitted, of course.

V. Conclusion.

Relaxing constraints on commercial practices is consistent with the direction the Commission took in its Eyeglasses II rulemaking. The proposal to clarify conditions under which optometrists may lease space from optical goods stores could benefit consumers through greater competition and efficiencies in operation.

Sincerely,

Christian S. White
Acting Director

(1) These comments represent the views of the staff of the Federal Trade Commission, and not necessarily the views of the Commission or any individual Commissioner.

(2) 15 U.S.C. §§ 41 *et. seq.*

(3) See, e.g., American Medical Ass'n, 94 F.T.C. 701 (1979); Iowa Chapter of American Physical Therapy Ass'n, 111 F.T.C. 199 (1988) (consent agreement); Wyoming State Bd. of Chiro[illegible] Examiners, 110 F.T.C. 145 (1988) (consent orde[illegible] nnecticut Chiropractic Ass'n, 114 F.T.C. 708 (1991); American Psychological Ass'n, [illegible]406 (consent order issued December 16, 1992), 5[illegible] [illegible]d. Reg. 557 (January 6, 1993)); Texas Bd. of Chiropractic Examiners, C-3379 (consent order issued, April 21, 1992, 57 Fed. Reg. 20279 (May 12, 1992)); National Ass'n of Social Workers, C-3416 (consent order issued March 3, 1992, 58 Fed. Reg. 17411 (April 2, 1993)); California Dental Ass'n, D-9259 (administrative complaint issued July 9, 1993); and McLean County Chiropractic Ass'n, C- 3491, 59 Fed. Reg. 22163 (April 29, 1994) (consent order).

(4) See, e.g., Comments to South Carolina Legislative Audit Council, February 26, 1992 (Boards of Pharmacy, Medical Examiners, Veterinary Medical Examiners, Nursing, and Chiropractic Examiners); same, January 8, 1993 (Boards of Optometry and Opticianry, Dentistry, Psychology, Speech and Audiology, Physical Therapy, Podiatry, and Occupational Therapy); Texas Sunset Advisory Commission, August 14, 1992 (Boards of Optometry, Dentistry, Medicine, Veterinary Medicine, Podiatry, and Pharmacy); Missouri Board of Chiropractic Examiners, December 11, 1992; Massachusetts Division of Registration, April 20, 1993 (Board of Optometry); and New Jersey Board of Medical Examiners, September 7, 1993; see also testimony to the Maine House of Representatives, May 3, 1993 (Board of Optometry); same, January 8, 1992, and the Washington State Legislature's Joint Administrative Rules Review Committee, December 15, 1992 (opticians and optometrists).

(5) K.S.A. 65-1502(b)(1) and (2).

(6) K.S.A.65-1502(c).

(7) H.B. 2164, §1, proposed K.S.A. 65-1502(c)(2)(A), (B), (C), (E) and (F).

(8) H.B. 2164, §1, proposed K.S.A. 65-1502(c)(2)(D) and (G).

(9) H.B. 2164, §1, proposed K.S.A. 65-1502(c)(2). Under Kansas decisions, a corporation cannot engage in the practice of optometry. This concept includes maintaining an office, K.S.A. 65-1502(a)(1), which in turn includes controlling professional judgment, K.S.A 65-1502(b)(1), and having any interest in books, records, or materials, K.S.A. 65-1502(b)(2). Thus, the records must be the property of the optometrist.

(10) H.B. 2164, §1, proposed K.S.A. 65-1502(c)(2).

(11) H.B. 2164, §1, proposed K.S.A. 65-1502(c)(2).

(12) See C. Cox and S. Foster, The Costs and Benefits of Occupational Regulation, FTC Bureau of Economics Staff Report, October 1990 (reviewing studies reported in economics literature).

(13) Advertising of Ophthalmic Goods and Services, 16 CFR Part 456 ("Eyeglasses Rule"). The FTC found that prohibiting nondeceptive advertising by vision care providers and failing to release eyeglass lens prescriptions to the customer were unfair acts or practices in violation of section 5 of the FTC Act. The Eyeglasses Rule prohibited bans on nondeceptive advertising and required vision care providers to furnish copies of prescriptions to consumers after eye examinations. On appeal, the Eyeglasses Rule's prescription release requirement was upheld but the advertising portions were remanded for further consideration in light of the Supreme Court decision Bates v. State Bar of Arizona, 433 U.S. 350 (1977) (finding state supreme court rules against attorney advertising violated the First Amendment). American Optometric Association v. FTC, 626 F.2d 896 (D.C. Cir. 1980). Rather than reinstate the advertising portions of the Eyeglasses Rule, the FTC has addressed advertising restrictions through administrative litigation. See, e.g., Mass. Bd. of Registration in Optometry, 110 F.T.C. 549 (1988).

(14) Bureau of Economics, Federal Trade Commission, The Effects of Restrictions on Advertising and Commercial Practice in the Professions: The Case of Optometry (1980) ("Bureau of Economics Study").

(15) Bureaus of Consumer Protection and Economics, Federal Trade Commission, A Comparative Analysis of Cosmetic Lens Fitting by Ophthalmologists, Optometrists, and Opticians (1983) ("Contact Lens Study").

(16) In the course of the "Eyeglasses II" rulemaking, the FTC received 287 comments and heard testimony from 94 witnesses. The commenters and witnesses included consumers and consumer groups, optometrists, sellers of ophthalmic goods, professional associations, federal, state and local government officials, and members of the academic community. See Ophthalmic Practice Rules ("Eyeglasses II"), Statement of Basis and Purpose, 54 Fed. Reg. 10285, 10287 (March 13, 1989) ("Commission Statement").

(17) Commission Statement, *supra* note 16, at 10285.

(18) Commission Statement, *supra* note 16, at 10285-86.

(19) Commission Statement, *supra* note 16, at 10285.

(20) In addition, the Commission decided to retain, with modifications, the prescription release requirement from the original Eyeglasses Rule.

(21) *California State Board of Optometry v. FTC,* 910 F.2d 976 (D.C. Cir. 1990).

(22) Commission Statement, *supra* note 16, at 10288-10289.

(23) Commission Statement, *supra* note 16, at 10288-10289.

(24) For a general discussion of the effects of restricting locations in mercantile settings, *see* Commission Statement, *supra* note 16, at 10289.

Last Modified: Monday, 25-Jun-2007 12:21:00 EDT

KANSAS LOW VISION PROVIDERS AS SUGGESTED BY KOA

Kansas Optometric Association

Issue No. 9
October 2007

Light Rays

Fall Eyecare Conference Well Attended

The 23rd Annual Fall Eyecare Conference was successful with 240 ODs and 155 assistants in attendance. The Exhibit Hall was outstanding with 26 exhibitors.

We extend our thanks and appreciation to Dr. Steven Bryant, Chairman of the Fall Eyecare Conference Committee, and Dr. Jeffry Gerson, Chairman of the Education Committee for planning an outstanding Fall Eyecare Conference program. The Education Committee is already planning and coordinating the education courses for the spring convention and the next Fall Eyecare Conference. They would welcome suggestions for topics and speakers for future programs.

The KOA Board of Directors wishes to thank our 2007 Fall Eyecare Conference exhibitors. Special thanks go to the following:

- Alcon Laboratories, Inc.
- Allergan Pharmaceuticals
- Blue Cross and Blue Shield of Kansas
- Burdett & Associates
- Carl Zeiss Meditec
- Carl Zeiss Vision
- Ciba Vision
- Duffens Optical
- Envision Rehabilitation Center
- Europa International
- Firestone Optics, Inc.
- Hawkins Optical Lab., Inc.
- Kansas City Ophthalmics
- Kenmark Optical
- Kowa Digital Cameras
- Latham & Phillips
- Lombart Instrument
- Maui Jim USA, Inc.
- Midwest Lens
- Oculus, Inc.
- Optos North America
- Optovue
- Sutherlin Optical
- Synemed
- Vistakon
- Walman Optical

We also want to thank Allergan; Bausch & Lomb; Blue Cross & Blue Shield of Kansas; Carl Zeiss Meditec; CIBA Vision; Fry Eye Associates; Pech Optical Corp.; Shamir Insight, Inc., Tura LP, Kansas City Ophthalmics; Vision Care Direct; Vitreo Retinal Consultants; VSP and the Wichita Airport Hilton for sponsoring speakers and breaks.

Children's Vision and Learning Conference Successful

The eighth annual Children's Vision and Learning Conference took place October 5, 2007 at the Airport Hilton in Wichita. The conference included presentations by Sally Cauble, Andrea Baker, OD, Karen Aldridge, OD and Jennifer Kordonowy.

More than 40 individuals attended the conference, including school nurses, teachers, school administrators, school psychologists, occupational therapists, optometrists, optometric assistants and others. The conference explored early literacy and the role of vision as it relates to learning and was designed to help parents, educators, and health care professionals identify the warning signs of vision problems and understand how they can affect a child's behavior and ability to learn.

Updating the Keyperson List

In light of major challenges to the Kansas Optometry Law next session, we are attaching a form to update our records on your contacts with legislators. We have also attached a list of legislators for your reference. Even if you are currently a keyperson, we are asking you to update the last time you have seen the legislator or a member of their family. If you are not a keyperson for a particular legislator, but are aquainted with the legislator, please let us know that as well.

The KOA is in the process of scheduling regional training sessions to thoroughly brief the membership on the latest legislative developments within the next 30 days. There will be a special mailing for members within the next 10 days with more details. There will also be training for members on how to visit with legislators and assist in their campaigns.

Currently, many candidates are hosting fund raisers and members should contribute and attend to support the candidates of their choice. This is also an excellent time to volunteer to assist candidates as they prepare for the 2008 elections.

Many times, volunteering a little of your time to help with mailings or other details is more valuable than money.

Third Party Update

Kansas Medicare released a MLN SE0743 on their list serve in regard to the new COBA lists. The COBA replaced what was the NAIC list. This MLN caused a lot of confusion as it talked about 2 different COBA lists. We have received clarification. For the most part, nothing is required on the part of the provider. There is no requirement to change the NAIC/COBA number on your claims for the companies on the "big list." Those claims should still automatically cross to the supplement. One of the lists was a "short list" and the numbers all started with a 5. Those companies are the only ones that Medicare will NOT cross-over UNLESS that COBA is on the claim. The COBA went into effect 10/1/07.

The KOA Board of Directors contracts with our Third Party Consultant Elaine Schmidt, CPC, to track third party issues and address problems. If you experience a third party problem or question, we need you to provide an explanation of the problem with your specific question and e-mail it to thirdparty@kansasoptometric.org. The KOA office will review your inquiry and provide an answer if it is a previously addressed issue. New inquiries will be sent directly to Elaine for response and research if needed. She may request more information and copies of the claims/RAs if needed.

We will also be asking Elaine to provide Third Party Updates at the Fall Eyecare Conference and the KOA Convention as needed. This will allow you and your staff to have the opportunity for an update every six months. In addition, the KOA staff in consultation with Elaine will provide Third Party updates by e-mail and through the "Light Rays."

Volunteers Sought for Special Olympics

The KOA will again be participating in the Fall Special Olympics event in Overland Park. In an effort to reach more athletes we will be conducting the exams at the Kansas City Gift Mart (115th and Metcalf) from 3 to 9 pm on Friday, November 16. The coordinators hope that this single day afternoon/evening will make it easier on those wanting to volunteer, minimizing time out of the office while still allowing time to enjoy the weekend. Please consider volunteering for this event. Staff and spouses are also welcome and encouraged to participate. Please contact Dr. Bill Hefner at 785-235-2374 or bill.hefner@kansasoptometric.org

2008-09 KOA Committee Appointments

KOA President-Elect Dr. Jeannette Holland, Oskaloosa, is reviewing the KOA committee structure for next year. She requests that anyone willing to serve on any KOA committee return the enclosed form to the KOA office by December 31, 2007, if you have not already done so.

Low Vision Committee Update

In response to requests by KOA members, the Low Vision Committee is updating their list of KOA members who offer comprehensive low vision services in their office. Please complete and return the enclosed Low Vision Service Provider Update Form and return it to the KOA office by **November 15**.

Kansas Optometric Foundation Scholarships Awarded

The 2007-2008 Kansas Optometric Foundation Scholarships were awarded to Jessica Mai, University of Missouri-St. Louis and Brent Wichert, Northeastern State University.

In addition to optometric scholarships, KOF contributions can also be used for other charitable purposes and optometric research. If you wish to make a voluntary, tax-deductible contribution, please fill out the enclosed form and return to the KOA office.

FAX numbers, e-mail addresses and address changes needed

If you have moved (home or office), changed marital status, have a new telephone number (home or office), fax number or new e-mail address, please contact the KOA office by **December 31, 2007.** We will be printing the 2008 KOA Roster in January and would appreciate your updated information. Please call, FAX or e-mail your changes to the KOA. Call the KOA at 785-232-0225, FAX at 785-232-6151 or send e-mail to debbie@kansasoptometric.org. Don't forget to send updated photos as well.

KOPAC Update

We wish to express our thanks and appreciation to all current KOPAC members. Attached is the 2007 KOPAC Honor Roll along with an enrollment form. Please note that new levels of giving have been added. We are facing a direct assault on the optometry law next session and the demands on KOPAC will be great. Currently there are numerous fund raisers by legislators for the 2008 elections. It is essential that members make an effort to contribute and attend these events along with volunteering to help the candidates of your choice.

9-3

Kansas Optometric Association

Low Vision Service Provider Update Form

The KOA Low Vision Committee is updating the list of providers who provide low vision services in their practice. Please complete and return a copy of this form for each practice location by November 15.

Name ____

Address ____

City ________________ State ________________ Zip ________________

Phone ________________ Fax ________________ E-Mail ________________

Please indicate the level of low vision services offered by your practice.

- ☐ **Comprehensive Level:** Includes yearly continuing education specific to low vision care and/or prior residency training. Equipment would include multiple acuity and contrast sensitivity assessment tools, trial frame refraction, reading and other functional evaluations, along with maintaining a complete inventory of hand held and spectacle mounted microscopes and telescopes. Coordination with occupational or other certified therapists is made available when needed to include ADL, CCTV, bioptic and field limitation instruction.

- ☐ **Intermediate Level:** Include low level care plus basic networking with the services and agencies serving the low vision and blind population. More complex cases need to be referred when CCTV training, O & M instruction and/or assistive technology is indicated. A broad spectrum of optical devices should be available, when needed. Trial frame refraction should be incorporated on all but the simplest cases.

- ☐ I refer all patients in need of low vision services.

- ☐ I do not want to be on a list, regardless whether or not I provide low vision services in my practice.

Please return this form to:

Kansas Optometric Association
1266 SW Topeka Boulevard
Topeka, KS 66612
FAX: 785-232-6151

9-4

Engel & Geier, P.A.

ATTORNEYS

February 14, 2008

Mr. Scott C. Palecki
FOULSTON & SIEFKIN
1551 N. Waterfront Pkwy, Suite 100
Wichita, Kansas 67206-4466

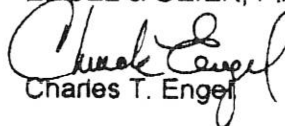
Dear Scott:

During our telephone conversation Tuesday regarding Envision and the Kansas Optometric Association, you requested me to provide you the number of Kansas optometrists practicing low vision rehabilitation in our state. The KOA reports that 37 of its members practice in that area. The number and cities where these optometrists practice all across Kansas is as follows:

Wichita	8
Topeka	2
Johnson County	3
Salina	2
Parsons	2
Hutchinson	2
Emporia	2
Dodge City	2
Wamego	2
Leavenworth	1
Scott City	1
Hays	1
Hiawatha	1
Ellsworth	1
Neodesha	1
Arkansas City	1
Augusta	1
Oskaloosa	1
Beloit	1
Washington	1
	36

Very truly yours,

ENGEL & GEIER, P.A.



Charles T. Engel

800 SW Jackson, Suite 1000 • Topeka, KS 66612
phone 785-233-6700 • fax: 785-233-6701 • www.EngelGeierLaw.com

NONPROFIT AGENCIES FOR THE BLIND

The Chic o Lighthouse
for People who are Blind
or Visually Impaired

February 12, 2008

Envision
2301 South Water Street
Wichita, Kansas
67213

Dear Ms. Merrill,

We recently learned of the challenges facing Envision's low vision rehabilitation service in being able to employ optometrists for the purpose of low vision rehabilitation.

I am writing to emphasize the importance of optometrists being included in the process of low vision rehabilitation. Optometrists have unique educational training allowing them to diagnose ocular disease while simultaneously having advanced competency in ophthalmic lenses. This combination allows an optometrist to prescribe appropriate ophthalmic aids for specific ocular conditions, and to understand the effects of such optical aids. In certain cases prescription modifications need to be made and only optometrists and ophthalmologists are qualified to amend such prescriptions.

Rehabilitation services are of vital importance in adjustment to vision loss. Comprehensive visual rehabilitation services are the most effective in addressing all of the needs of a person with vision impairment. Firstly social services and adjustment counseling must be provided to gain understanding and perspective on living with permanent vision loss. Then optical aids to improve vision must be evaluated. An optometrist or ophthalmologist must do this. Spectacles, magnifiers and telescopes share optics that may be combined for improved results and to relieve coexisting conditions of

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www.thechicagolighthouse.org • Please remember the Chicago Lighthouse in your will.

prescription glasses severe fatigue and decreased effectiveness may result. Imagine enlarging an out of focus image, it would be harder to see than without magnification. This is a common occurrence when low vision aids are dispensed without appropriate prescription.

Low vision optometrists are able to provide information to other rehabilitation professionals to improve outcomes. Some examples include:

- providing the extent of remaining visual fields and or depth perception when referring for Orientation and Mobility instruction;

- providing location and density of scotomas to a vision rehabilitation professional in order to train with eccentric viewing techniques and reading rehabilitation;

- providing optical information on low vision aids such as the focal length to be used with spectacle microscopes during rehabilitation training.

In looking at all providers of low vision rehabilitation services, Optometrists are needed to convey important information to the providers to obtain favorable outcomes.

At the Chicago Lighthouse Low Vision Rehabilitation service, optometrists and a staff ophthalmologist examine patients referred by their local eye doctors. We do not duplicate care or assume management of the patient's ocular disease; we simply manage the vision impairment caused by the ocular disease.

Many eye care providers do not provide low vision services in practice as they recognize the multi-disciplinary nature of successful low vision rehabilitation is cost prohibitive to private practice. This is why not-for-profit entities assisting persons with vision impairment are ideally positioned to provide complete vision rehabilitation services to their clients. If an agency simply gets a person a job but fails to recognize that their pathology will cause fatigue without prescriptive glasses, that client will likely lose their position. By adding optometric services to the agency, the client can be

prescribed glasses to relieve such fatigue and again outcomes are improved.

I strongly encourage the state to allow optometrists to be employed by rehabilitation centers so that citizens with vision impairment achieve their rehabilitation goals efficiently and effectively.

Sincerely,

Kara Hagerman, O.D.
Director of Clinical Services

January 29, 2008

Linda Merrill
Envision, Inc.
2301 S Water St.
Wichita, KS 67213

Dear Linda,

Community Services for the Blind and Partially Sighted has employed optometrists for many years now to provide low vision clinical services. We have had optometrists that were independent contracts and optometrists who were paid employees of the agency. Our current optometrist has been a paid employee for the past 6 years.

We are not aware of any regulation in the State of Washington that prohibits us from hiring an optometrist. Nor are we aware of any specials conditions that would be attached to the hiring of an optometrist. We have never had any contact by the Washington State Board of Optometry regarding our employment of an optometrist.

However, should there be conditions such as requiring the optometrist to have a separate entrance or phone line, etc. we would be unable to continue to offer low vision services. As you know, most private not-for-profit agencies need to subsidize the low vision clinic due to the low reimbursement rates received from Medicare and other insurance companies. Burdensome requirements such as separate entrances would not be practical and would make it impossible for us to continue to offer such a service. That would be a shame, as we are the only operating low vision clinic in Northwestern Washington. It is true in many states that only the local not-for-profit organization offers low vision services as most private practices do not want to undertake an activity with such low reimbursement.

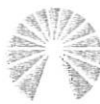
At a minimum, I would hope that any state having stringent requirements for optometrists offer a waiver program for the hiring of an optometrist at a not-for-profit organization.

Sincerely,

June W. Mansfield
President/CEO

10-5

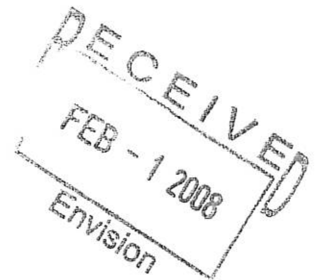
COMMUNITY SERVICES FOR THE BLIND AND PARTIALLY SIGHTED
9709 THIRD AVE NE #100 • SEATTLE WA 98115-2027 • (206) 525-5556 [v/tdd] • (206) 525-0422 [fax] • (800) 458-4888 [toll free]
www.csbps.com • www.sightconnection.com • email: csbps@csbps.com



LIGHTHOUSE.
INTERNATIONAL

Tara A. Cortes, PhD, RN
President and CEO

January 30, 2008



Linda K. Merrill
Envision, Inc.
2301 S. Water
Wichita, KS 67213-4819

Dear Linda,

Since 1905, Lighthouse International has been dedicated to preserving vision and to providing critically needed vision and rehabilitation services to help people of all ages overcome the challenges of vision loss. Through clinical services, education, research, and advocacy, the Lighthouse enables people with low vision and blindness to enjoy safe, independent and productive lives.

Naturally, optometrists are a critical and central part of our comprehensive approach to treating patients with vision loss. Lighthouse International employs two full-time, three part-time and one per diem optometrist across Manhattan and Westchester counties. In addition we have a resident optometrist in partnership with SUNY College of Optometry.

We hope that Kansas will soon provide legislation that would allow Envision to employ optometrists so that citizens of its state can get quality low vision care. Please do not hesitate to contact me if I can be of any further assistance.

Very truly yours,

Tara

Tara A. Cortes

10-6

The Sol and Lillian Goldman Building 111 East 59th Street, New York, NY 10022-1202
Tel: (212) 821-9568 Fax: (212) 821-9701 www.lighthouse.org

www.cviatlanta.org

January 28, 2008

Ms. Linda Merrill
President and CEO
Envision
2301 South Water Street
Wichita, Kansas 67213

Dear Linda:

The Center for the Visually Impaired in Atlanta, Georgia has had contracts with optometrists specializing in low vision in our Low Vision Clinic for more than 25 years. At present our contracts are with Timothy G. Spence, O.D. and Robert L. Elwell, Jr., O.D. Here is a brief description of our contractual arrangement with them:

1. The contract with each optometrist clearly identifies them as a contractor in private practice elsewhere, and state that they are not entitled to any of the benefits provided to employees of the Center.

2. Each states the services each optometrist is expected to provide, including documentation of the services.

3. Each states a capitated (per head) rate of compensation, times and conditions for compensation, and terms for review and revision of compensation.

4. Each states that the individual optometrist is responsible for any labor, equipment, applicable taxes, bonding, workers compensation insurance, unemployment compensation insurance, and general liability insurance necessary to the practice of optometry, as well as acquiring and maintaining the state licensure required.

5. The contracts are self-perpetuating, and can be terminated by either party at any time.

In response to the requirements that Kansas has established for optometrists, in Georgia we do not lease space in our building to our optometrists and we are not required to have the contracts approved between CVI and our contracted optometrists. We have no restrictions to advertising nor do the optometrists require a separate entrance in our building.

We see the partnership between our Certified Low Vision Therapists and the two contracted optometrists as an essential ingredient to the excellent results that our Low Vision Clinic achieves in helping people with low vision regain their independence.

If you have any questions or concerns, I encourage you to contact me, our Low Vision Clinic staff, or our contracted optometrists.

We wish you every success in your efforts.

Sincerely,

Susan B. Green
President

C: Harvey A. Clark, Director, Florence Maxwell Low Vision Clinic
Center for the Visually Impaired

739 West Peachtree St. NW
Atlanta, GA 30308

Ph: 404.875.9011
Fax: 404-607-0062

Accredited Member
National Accreditation Council

A United Way Agency

10-7

The Chi[illegible]go Lighthouse
for People Who are Blind
or Visually Impaired

February 11, 2008

Linda Merrill
President
Envision, Inc.
3201 S. Water
Wichita, KS 67213-4819

Dear Linda Merrill,

I am the President and Executive Director of The Chicago Lighthouse for People Who Are Blind or Visually Impaired. I have been legally blind all of my life due to Cone Rod Dystrophy. My visual acuity is less than 10/600. My visual field is also restricted. I mention these facts because of my strong feelings about any laws that "hurt" people who are blind or severely visually impaired.

At age 13, my ophthalmologist referred me to the Low Vision Clinic at The Chicago Lighthouse. Our clinic was established in the mid 1950's and has always been staffed by an optometrist employed by The Chicago Lighthouse. Our agency operates the oldest Low Vision Clinic in existence. We operate 7 low vision clinics including our main clinic at our corporate headquarters where the vast majority of our rehabilitation services are provided. Our facilities are similar to Envision's. Our optometrists are specialists in low vision rehabilitation. I want you to know that the most important event of my life was that referral by my ophthalmologist to

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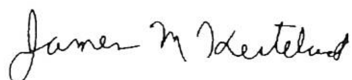
www.thechicagolighthouse.org • Please remember the Chicago Lighthouse in your will.

The Chicago Lighthouse clinic. As a freshman in high school, I could not read any regular size print, only one inch high thick headline size print. In grammar school, I never had a book that I could read. My school district did not provide any Braille or large print books. When my optometrist, employed by The Chicago Lighthouse, placed a low vision microscopic lens in front of my face, the result was a miracle to me. I was able to read regular print for the first time.

As a child, my parents took me to dozens of doctors before I was referred to The Lighthouse where appropriate specialists in low vision handled my case. The Chicago Lighthouse serves thousands of blind and severely visually impaired adults and children each year. Unfortunately very little has changed since my childhood. Patients still are misdirected to those who do not have the expertise in low vision rehabilitation. Patient's time is wasted.

Agencies like The Chicago Lighthouse and Envision dedicate and focus their mission and resources on low vision rehabilitation and nothing else. It is stunning to me that Kansas can deny Envision, its most vital resource to people who are blind or visually impaired the means to carry out its mission. I would be happy to provide any testimony to any hearings or legislators regarding this matter. I can be reached at The Chicago Lighthouse at 312-997-3661.

Sincerely,



James Kesteloot
President and Executive Director

KANSAS
OPTOMETRIC
ASSOCIATION

1266 SW Topeka Blvd. • Topeka, KS 66612
(785) 232-0225 • (785) 232-6151(FAX)
www.kansasoptometric.org

TESTIMONY
SENATE PUBLIC HEALTH AND WELFARE COMMITTEE
MARCH 11, 2008

Thank you for the opportunity to express our opposition to Senate Bill 568. This legislation is simply not necessary for Envision to meet its goals. Instead, it jeopardizes patient care and turns longstanding public policy on its ear. Envision wants you to enable unlicensed corporations to practice optometry without any state oversight or regulation, simply because Envision is a tax-exempt, non-profit organization. That's simply not in the best interests of the citizens of Kansas.

Since last April representatives of Envision and the Kansas Optometric Association met six times to discuss our differences on the merits of this bill. We stressed repeatedly several options are already available to Envision under existing law that get them where they want to go. Those options include Envision becoming a medical facility licensed by the Department of Health and Environment; leasing space separate and apart from Envision's other operations to an optometrist; and reinforcing the optometric patient referral model from doctors who wish to refer patients to Envision for rehabilitation services. Unfortunately, none of those options have been acceptable to Envision as recently as our last meeting in Wichita one week ago.

This bill simply isn't necessary. That point is underscored by the fact that there are nearly 40 optometrists practicing low vision rehabilitation all across Kansas, and there are adequate options where doctors refer patients for low vision therapy. Our concern is finding better ways to coordinate all of the existing services, which doesn't require legislation.

Envision believes that its non-profit status implies exemption from Kansas optometry laws. To validate that misconception Envision showcases Lighthouse International, a non-profit organization located in New York City that Envision wants to emulate here in Kansas. Envision argues that since the Lighthouse is non-profit and permitted to hire optometrists in New York, Envision is entitled to hire optometrists in Kansas. That argument is both illogical and factually incorrect.

Dr. Bruce Rosenthal of Lighthouse International wrote the letter attached to my testimony. It carefully notes that Lighthouse International, while a non-profit, is regulated as a "health care facility" by the New York State Department of Health, the

Affiliated with
American Optometric Association

New York City Department of Health and Mental Hygiene and other public entities. The Lighthouse's non-profit status is as irrelevant to public regulation of its operations in New York as Envision's tax exempt status is in this debate. Envision is not a regulated health care provider under Kansas law. This bill legitimizes what is now illegal, i.e., an unlicensed corporation hiring an optometrist. If Envision wants to be Lighthouse International, then Envision should submit to state regulation and follow state statutes like the Lighthouse.

This bill not only allows nonprofit low vision rehabilitation centers to hire optometrists without state regulation, but expands the pool to include outpatient rehabilitation facilities certified to participate in the Medicare program. Those types of facilities are neither recognized under Kansas law nor regulated by the Kansas Department of Health and Environment.

For well over 80 years it has been the public policy of this state to protect the public's health by not only licensure of all health care practitioners, but also by providing safeguards to ensure that each practitioner's independent professional judgment is free from interference or intimidation from unlicensed and unregulated entities. This policy serves our citizens well particularly those most vulnerable, including the blind, children and those with disabilities.

We respectfully ask that you reject S.B 568 as both unnecessary and harmful to Kansas citizens. It just makes no sense to entrust anyone's sight to an unlicensed or unregulated entity however well intended.

March 4, 2008

Kendall Krug, OD
2203 Canterbury Drive
Hays, KS 67601

Dear Dr. Krug:

The following is a description of the Lighthouse International Low Vision Clinical Practice, as well as the strict guidelines that must be adhered to, in order to be in compliance with the laws of New York State, New York City Board of Health, as well as by the New York State Professional regulatory boards.

After being in operation for 48 years, The Lighthouse, The New York Association for the Blind (now known as the Lighthouse International) opened the first low vision service in the United States in 1953. It quickly set the standards for the "best medical practices" for low vision services as well as for the vision rehabilitation team throughout the country and world. Eleanor Faye, M.D. the Medical Director asked me to become the first optometrist to join The Lighthouse Clinical Staff in 1975. She realized that low vision was primarily in the domain of Optometry not ophthalmology.

I succeeded Dr. Faye as the Chief of the Low Vision Clinical Practice in l994. We now have 7 optometrists (no ophthalmologists) practicing low vision in our headquarters in Manhattan and Westchester. In addition we have a very large vision rehabilitation team that includes CLVT's (Certified Low Vision Therapists), Occupational Therapists, O&M instructors, Vision Rehabilitation Teachers, nurses, a large team of Social Workers, Educators, and a Psychiatrist. We are continuing to expand our services and are opening a center for Diabetic Excellence on March 25th that will include internists and nurses specializing in diabetes.

11-3

The low vision staff includes a Chief of the Low Vision Clinical Practice (myself), a Medical Director to be incompliance with Article 28 of the Public Health Law (see below), the low vision optometric clinical staff and manager of the low vision service. All fall under the umbrella of a Nursing Administrator.

All professionals employed by The Lighthouse, including optometry, are strictly enforced by New York State's:

Article 28 Public Health Law

Article 28 is divided into many subsections including:

- **Article 28 - (2800 - 2818) HOSPITALS**
- **Article 28-A - (2850 - 2869) NURSING HOME COMPANIES**
- **Article 28-B - (2870 - 2883) HOSPITAL MORTGAGE LOAN CONSTRUCTION**
- **Article 28-C - (2890 - 2892) NURSE MANPOWER CENTER**
- **Article 28-D - PRACTICE OF NURSING HOME ADMINISTRATION**
    - **Title 1 - (2895 - 2895-A) GENERAL PROVISIONS AND PUBLIC POLICY**
    - **Title 2 - (2896 - 2896-H) LICENSING AND REGISTRATION**
    - **Title 3 - (2897 - 2897-D) VIOLATIONS; PENALTIES**
    - **Title 4 - (2898 - 2898-A) CONSTRUCTION**

The low vision optometrists employed by The Lighthouse, whether they are full time (such as myself), part-time, or independent contractors come under the Office of Professions of the University of the State of New York Education Department. As such they are required to take courses in infection control and child abuse as well as TPA courses (therapeutic pharmaceutical agents) to maintain their TPA privileges.

The Lighthouse Low Vision Service is also required to comply with the regulations of The New York City Department of Health and Mental Hygiene (DOHMH). The following, for example, was sent to The Lighthouse as a health care provider: The DOHMH "requests that ophthalmologists, optometrists and other medical providers be on the alert for cases of fungal keratitis, and report cases immediately to the Bureau of Communicable Disease at 212-788-9830. Please distribute to staff in the Departments of Ophthalmology, Optometry, Emergency Medicine, Internal Medicine, Pediatrics, Family Medicine, Infectious Disease, and Laboratory Medicine."

As a health care provider The Lighthouse is also subject to period medical record review and unannounced inspections by the New York City Board of Health as well as audits to ensure that there is no Medicare or Medicaid fraud.

Optometrists in New York State are also required to take Low Vision Certification examinations to see patients referred by the New York State Commission for the Blind and Visually Impaired. This is to insure that a high level of competence be met to evaluate and prescribe for low vision patients.

In summary The Lighthouse must be in compliance with all New York state, New York City, and the Optometry professional regulations.

Regards,

Bruce P. Rosenthal, O.D., F.A.A.O.
Chief of the Low Vision Clinical Practice
LIGHTHOUSE INTERNATIONAL
111 E. 59th Street
New York, NY 10022
1-212-821-9624

Testimony Senate Bill 568
Kendall L. Krug, OD, Hays, KS

Thank you for the privilege of testifying before this committee about low vision care in KS, and specifically in opposition to Senate Bill 568.

My Name is Kendall Krug. I practice optometry and low vision rehabilitation in Hays, KS. Before moving to Hays, I was the director of the low vision clinic at St Francis Hospital here in Topeka from 1992-97 and was a staff optometrist at the Vision Rehabilitation Center in Wichita. In 2004, I was elected to a two-year term on the Low Vision Section Council of the American Optometric Association, the main low vision policy making committee of the 33,000 member national association of optometrists. I currently serve on the Medical Advisory Committee of Blue Cross and Blue Shield of KS and on the Envision Medical Advisory Committee.

Low Vision describes vision loss that cannot be improved with medical treatment, surgery or conventional eyeglasses. Visually disabled people have a reduced level of vision that makes ordinary tasks difficult or impossible. Generally, people with best corrected vision of worse than 20/60 are considered visually handicapped. When a person's vision is worse than 20/200, they are considered legally blind, but over 90% of these individuals can be helped with low vision care. Low vision rehabilitation helps improve the person's ability to function in the visual sense.

2000 US Census numbers, in Kansas, estimated the number of "visually impaired" at 12,200, with an incidence of new low vision cases of around 10% per year (or 1,200 new cases).

Vision rehabilitation is the process of treatment and education that helps individuals who are visually disabled attain maximum function, a sense of well being, and optimum quality of life. Function is maximized by evaluation, diagnosis and treatment including, but not limited to, the prescription of optical, non-optical, electronic and/or other treatments. The rehabilitation process includes the development of an individual rehabilitation plan specifying clinical therapy and/or instruction in compensatory approaches. In addition to the evaluation, diagnosis and management of visual impairment by an eye doctor (optometrist or ophthalmologist), vision rehabilitation may include optometric, medical, allied health, social, educational and psychological services.

In 1999, the Medicare Region 7 (KS, NE, Western MO) Medical Director, Dr. Pat Price, asked the KS Optometric Association's Low Vision Committee for assistance in developing a local medical policy for the coverage of low vision rehabilitation services. I was the chair of this committee. At the time this policy was written, there were only three other states that had coverage for low vision rehabilitation. Our policy was so comprehensive that it has gone on to serve as a

model for other regions. In 2002, a Medicare Program Memorandum allowed all beneficiaries with visual impairments, to be eligible for low vision rehabilitation services.

Excluding state services for the blind agencies, current models of low vision delivery are dictated by insurance and Medicare coverage. The emerging model appears to be utilizing occupational therapists (OTs) as the preferred provider of the rehabilitation services. And in June 2006, Medicare published changes in the Federal Register stating that coverage for low vision rehabilitation services incident to the physician's service would only be allowed if provided by occupational therapists.

Currently there are two ongoing research projects looking at low vision rehabilitation:

The CMS **Low Vision Demonstration Project** is a government funded, five-year (2005-2010) study comparing the outcomes of low vision rehabilitation provided by occupational therapy, low vision therapists, orientation and mobility specialists, and vision rehabilitation therapists. The project is being conducted in KS, NH, NC, WA, Atlanta, GA and New York City.

A second research project: **"A Model Transdisciplinary Health Care Team for Low Vision Rehabilitation"** is a five-year National Eye Institute funded study to determine best practices for low vision rehabilitation. There are 5 clinical sites in Kansas for this project, and the principal investigator, Lori Grover, OD of Johns Hopkins University, has offered to share her data with policy makers in Kansas.

Again, Kansas appears to be at the front of low vision policy for the country, based on Medicare coverage, numbers of knowledgeable low vision providers and policy makers at both the state and national level. Is this a good time to allow a non-regulated, non-profit corporation with no medical background to change what has become a recognized state for low vision policy?

Regulation of any health care profession is a must for proper delivery of appropriate care, and low vision rehabilitation is no exception. Back in 1999, Dr. Price had the concern that coverage for low vision rehabilitation, if not supervised and regulated, could result in fraud and misuse.

The privacy of patient records, especially if maintained by a non-medical entity, is a cause for concern. If Envision were allowed the small exception in the optometry law, how could they comply with HIPPA standards? Public safety should also be a concern to state legislators. In Kansas, state law allows visually impaired persons (vision worse than 20/60) to drive with a restricted license, if a behind the wheel test can be passed. Most if not all of these cases will be seen by a low vision doctor (optometrist or ophthalmologist) and the eye doctor must

sign off on the license. Again, proper regulation and oversight is required to maintain the safety of the public.

In Kansas, we have functioning state services for the visually impaired: Kansas Services for the Blind (SRS - vocational rehabilitation) and the KanSAIL Program (KS Seniors Attaining Independent Living) both maintain a good referral network with low vision providers across the state. The Kansas State School for the Blind, under the Kansas State Board of Education, also utilizes a network of low vision providers statewide. Kansas veterans have access to world class low vision rehabilitation programs at the Kansas City and Wichita Veterans Administration hospitals. As an independent low vision provider, I can refer my patients to these programs for assistance.

In summary, I can say to this committee, that Kansas has top quality low vision care, and Kansas is consistently at the front in low vision policy for the entire country. The change in the optometry law to allow the small exception for Envision, in my opinion, may have the unintended effect of reducing quality as a non-regulated, non medical entity providing medical care. I think Kansas citizens deserve better than that.

Thank you for the opportunity to testify before this committee.

PROJECT TITLE

"A Model Transdisciplinary Health Care Team for Low Vision Rehabilitation" sponsored by the National Eye Institute of the National Institutes of Health

PRINCIPAL INVESTIGATOR

Lori L. Grover, OD, FAAO

PROJECT START DATE

June 1, 2007

SPECIFIC AIMS OF THE PROJECT

The aims of this five-year funded research project are:

Develop a consensus model for a transdisciplinary low vision rehabilitation team and identify the details of a model approach to team care that maximizes the outcomes of individuals with low vision via the development of a novel Low Vision Rehabilitation Team Clinical Practice Guideline (LVRCPG).
Develop and validate testing and measurement tools for professional knowledge, attitudes and practices (KAP), with respect to low vision of professionals representing various disciplines involved in the LVRCPG, to assess current rehabilitation practice patterns, attitudes about existing programs for individuals with vision impairment, and the roles of individual health care team members in the low vision rehabilitation process.
Implement the LVRCPG model into practice through Clinical Performance Sites.
Measure outcomes of the clinical model network on patient care and its economic impact on performance sites, using the Activity Inventory (AI) and relevant site data.

PARTICIPATION AS A CLINICAL PEFORMANCE SITE

We are recruiting eye care physicians and practice settings who are currently providing some low vision rehabilitation services and/or have a strong interest in developing a comprehensive service delivery model to serve as Clinical Performance Sites (CPS). The Clinical Practice Guideline (LVRCPG) will be implemented by participating CPS participants. Prior to implementation of the clinical guideline, outcomes data will be gathered by interviewers at Hopkins from each site and the cost-effectiveness of customary low vision rehabilitation practice patterns will be evaluated by the PI at baseline. The LVRCPG will be presented to each CPS via on-line educational programs and implementation training. As low vision patients are identified and recruited to participate in the pilot study, pre-treatment patient data will be gathered on-site and via phone interview. Site data will be collected by the PI during site visits during the project. Low vision rehabilitation patient care will then follow the LVRCPG model as determined by the CPS physician. Upon completion of the patient's low vision rehabilitation care plan, post-treatment patient and site data will be gathered and analyzed.

The objective is to meet the aims of the study using the least disruptive methods available for each CPS while providing as much education and feedback as possible to the eye care physician and team.

AVAILABLE RESOURCES FOR PARTICIPATING EYE CARE PHYSICIANS & CPS

There are many benefits available at no cost to those who participate as a CPS. These include, but are not limited to, the following:

On-line continuing education modules for eye care physicians (COPE approval included), and training courses for staff members and vision rehabilitation team service providers
On-line continuing education specifically geared to team professionals (i.e. O&M, RT, OTR/L) pursuing ACVREP certification for CLVT, CVRT and COMS
Teleconferencing and telementoring platforms
Provision of patient data (via the Activity Inventory) for eye care physician use in rehabilitation planning and CPS care considerations
Assistance in participating in the CMS Demonstration Project currently underway (Kansas is one of five participating locals)
Advice on how to establish relationships with other care providers and receive payment within demonstration project guidelines
Identification of regional team professionals for networking and service delivery considerations
Study participation and completion certificates suitable for in-office use
Direct web-site access for FAQ's, comments and other communications

ADDITIONAL INFORMATION

For more information, please contact;

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Baltimore, MD 21205
Direct phone: (410) 502-6850
E-mail: HYPERLINK "mailto:lgrover3@jhmi.edu" lgrover3@jhmi.edu

The Multiple District 22

Lions Vision Research and Rehabilitation Center

at the Johns Hopkins Wilmer Eye Institute

12-6

David S. Dyer, M.D., F.A.C.S.
Gregory M. Fox, M.D., F.A.C.S.
Blake A. Cooper, M.D., F.A.C.S.
Ernest D. Kovarik, M.D., F.A.C.S.
Beatty G. Suiter, M.D.

Diseases and Surgery of the Retina, Vitreous and Macula

March 6, 2008

KENDALL KRUG OD
2203 CANTERBURY DRIVE
HAYS KS 67601

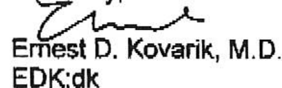
Dear Kendall,

I am writing in response to your telephone call and inquiry regarding availability of low vision care in Topeka and eastern Kansas. Our practice, consisting of four retinal specialists, have patients who benefit from low vision assessment, counseling, and training in the use of optical devices as well as rehabilitation training. My associates and I feel these services are adequately available within a 100-mile range of our multi-practice sites. My personal area, as you know, is in Topeka and Manhattan and surrounding areas. In addition, as we discussed on the telephone, the Kansas Division of Services for the Blind provides an outstanding source for vocational rehabilitation with an excellent rehabilitation center for the blind with rehab teaching along with industrial business and opportunities.

Briefly, Kendall, I also want to respond to the upcoming Senate bill that you apprised me of which is currently under consideration in committee as to whether a non-profit organization can hire medical and optometric eye care specialists without regulatory responsibility as required by the Kansas State Medical Board of Healing Arts and Kansas State Board of Examiners in Optometry. Although I am certainly not familiar with the details of the proposed bill, just the consideration of such legislation seems entirely irresponsible to me. It is my opinion that this would expose danger in the care of patients' welfare without regulatory standards required by the Kansas examining boards mentioned above. I believe this would be a liability risk to patients and would probably introduce practice fraud.

Kendall, these are my brief thoughts regarding your questions and concerns. Have a great day, and I hope all is well with you and your family.

Sincerely,



Ernest D. Kovarik, M.D.
EDK:dk

FAXED 785-625-7490

CORPORATE
COMMUNICATIONS
GROUP, INC.

March 10, 2008

I am here today to express opposition to Senate bill 568, the legislation that would set aside regulatory requirements for the operation of Envision's low-vision rehabilitation services located in Wichita, Kansas. My name is David H. Westbrook. I speak to you today as an individual who—for more than 17 years now—has served as a communications consultant to the Eye Care Council and the Kansas Optometric Association. I have done this with passion; for although I am totally blind, I owe much of what I have gained in business and personal fulfillment throughout my life to the so-called "handicap" of blindness. It was an optometrist who discovered my juvenile glaucoma, whick took me to the Mayo Clinic in the early 1960s where I participated as one of the first patients who ever was diagnosed with that disease. Although the physicians at Mayo could not arrest the blindness caused by that disease, it was the unbridled devotion of an optometrist who finally performed the proper diagnosis and who made arrangements for me immediately to be treated by one of the finest health care institutions in the world.

As president of Corporate Communications Group, I and my firm work closely with the Eye Care Council and KOA. When I started our assignment with them some 17 years ago, I was immediately impressed by the broad public purposes and the passionate devotion to civic engagement that are demonstrated by the mission of the KOA and the Eye Care Council and the actual performance of optometrists throughout the state. These are eye care medical professionals who not only practice the Hippocratic Oath—"Above all else, do no harm"—but also devote countless hours of their uncompensated time toward programs that are intended to detect eye problems in early childhood which—if undetected—could create chronic problems. These are the kinds of problems that are treated when individuals suffer from so-called low vision; and for the hard work done by optometrists in this state, many individuals are prevented from having low vision because early diagnosis leads to proper treatment, and proper treatment leads to functional vision.

Optometrists throughout the state not only work hard to be excellent diagnosticians. These optometrists also participate in a robust referral network, sending their patients to areas of excellence and care when the local optometrist does not have the resources (much as with the case with me, when my glaucoma was detected) to treat that patient. As you have heard from others who have testified, there are many centers throughout the state where optometrists team up with occupational therapists and other professionals to make sure patients who suffer from so-called receive the treatment and the rehabilitation they need. One of those centers, of course, is the center operated by Envision in Wichita.

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What troubles me about the proposition in front of you, though, is not that it would enlarge the resources that are available to rehabilitate those who suffer from low vision. What troubles me is that it is an effort to centralize those resources in an unregulated environment where optometrists could be hired and controlled by corporate rather than individual, medical professional-driven policy. People who are in need of low-vision therapeutic services are customarily people who are less empowered to be resourceful, to have political influence or political capital, to be able to demonstrate the skills of negotiability necessary when services seem unresponsive or when resources seem unavailable. As a blind man who owns his own company and who has led a self-sufficient life for all of his adult years, I am quite fortunate. Seventy-four percent of the blind and visually disabled people of this country are unemployed. Rehabilitation is critically important to the blind and visually impaired. The criticality of that importance insists that such rehabilitation, diagnosis, and treatment take place in a highly regulated environment. That's why this bill is so offensive to those of us who are blind and who do know what it's like not to get the kind of services that would be assured under a regulated system.

I would also be concerned about Envision's motives here. Forgive me for being provocative. But I really must question this constellation of organizations—some for-profit, some not-for-profit—organized around a holding company and operating for a variety of reasons and serving a variety of purposes. This is not just one organization that enjoys a nonprofit status, but several organizations who are linked together and operated by common leadership. I question in fact whether the mission of Envision really meets the obligations of its original charter.

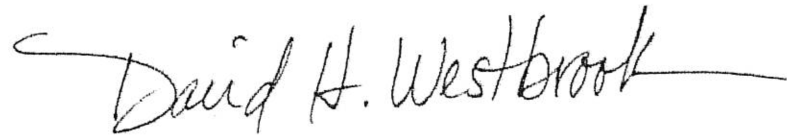
While Envision uses its charitable mission as the primary premise for this bill, it omits telling you that its tax-exempt purposes do not include provision of medical care. Since 1961, Envision's nonprofit purposes are to: counsel, educate, rehabilitate, support and assist blind and visually handicapped persons; operate training schools, workshops and facilities for the manufacture, distribution and sale of blind-made products in order to provide gainful employment for blind and visually handicapped persons; and to provide vocational and personal counseling, training and direct financial assistance. This is alarming for several reasons.

First, even nonprofit corporations are only permitted to operate for the purposes approved by the state. Second, you can expect other Kansas nonprofit corporations to follow Envision's lead, ignore their charitable purposes, hire optometrists and get into low-vision rehabilitation as an ancillary business without state licensure or regulation.

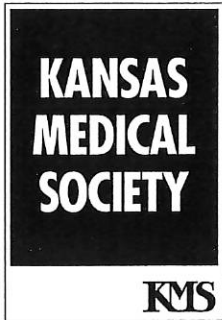
I respectfully ask that you reject this legislation as poor public policy and that you remain ever vigilant regarding similar proposals that might be in front of this legislature aimed at achieving the same purpose. I daresay that if my friends at the Mayo Clinic were to come to Kansas as they have done so in Arizona or Florida, the state would absolutely insist that the organization be regulated as a medical facility. Even Mayo's prestigious name would not earn it the right to have such regulation set aside simply because the Mayo Clinic is a nonprofit organization. I thank you

for your consideration of my request and for the thoroughness of due diligence you are exercising in regard to this important, poorly conceived public policy proposal.

Sincerely,



David H. Westbrook
President & CEO



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To: Senate Public Health and Welfare Committee

From: Jerry Slaughter
Executive Director

Date: March 11, 2008

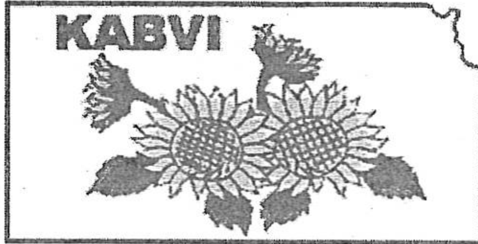
Subject: SB 568; Concerning the Optometry Act and Low Vision Rehabilitation Facilities

The Kansas Medical Society appreciates the opportunity to appear today and express some concerns about SB 568, which would amend the Optometry Act to allow certain non-profit corporations to practice optometry by employing optometrists. While this legislation does not directly affect physicians or the practice of medicine and surgery, *per se*, it could be seen as a precedent which expresses legislative intent on the issue of corporate practice by physicians.

Kansas has a long standing prohibition on the corporate practice of medicine, as well as similar prohibitions for the other health professions such as optometry. Generally stated, that prohibition forbids lay individuals and non-physician organizations from employing physicians. There are some limited exceptions, such as hospitals, who are also licensed health care providers. The prohibition against non-physician employment grew out of a number of concerns, namely that non-physician organizations would use the employment relationship to interfere with medical decision-making, and potentially create an environment of divided loyalty which would threaten the integrity of the patient-physician relationship.

There is no question that the structure of the health care system and the modes of delivery are continuing to evolve. However, the principle embodied in the prohibition on corporate practice remains relevant, and important to patient care. Patients want their caregivers to be in a position to make independent clinical decisions about what is best for them, not the employing corporation.

The concerns we are expressing should not be interpreted in as criticism of Envision, the corporation that is seeking this change in the optometry law. Rather, it is our desire to encourage the legislature to use care in making changes to the doctrine of corporate practice in this area, because it may establish a precedent that could have implications for other health care providers and their patients. Thank you.



Kansas Association for the Blind And Visually Impaired

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March 11, 2008

TO: Senate Health and Welfare

FROM: Michael Byington, C.E.O. (Volunteer)

SUBJECT: Senate Bill 568 – Opposition

Senate Bill 568 is a difficult issue for us. We support the good work Envision, the principle proponent of the bill, has done, and wishes to continue to do, in the field of low vision rehabilitation. We want them to be able to continue and expand that work. At the same time, we want the quality work being done in the field of low vision in some other parts of the State to continue.

PUBLIC HEALTH AND WELFARE
ATTACHMENT: 15
DATE: 03/11/08

Although the intent of Senate Bill 568 may be good, we are not convinced that it is the vehicle to bring about the Statewide picture of low vision rehabilitation that we desire for the State. Before that overall picture is described, please allow us to remind you all about who we are and what we feel our role should be within this controversy.

The Kansas Association for the Blind and Visually Impaired (KABVI) was founded in 1920 by blind and low vision adults for the purpose of giving blind and low vision Kansas citizens a voice concerning the treatment, rehabilitation, education, employment, and other programming to bring about self-sufficiency that is provided to the blind and low vision populations of Kansas. We continue to be the oldest and largest organization of and for people who are blind and visually impaired in Kansas. We have existed for 88 years as an all volunteer organization. We wrote and carried the first legislation to create categorical services for blind and low vision Kansas adults, and we have actively monitored and attempted to improve those services ever sense. We quite frankly do not believe that a bunch of professionals need to be deciding what will happen with services to low vision adults without consumer representation being at the table.

We knew that this legislation was coming, and we expressed our interest in it to all major parties involved.

The guidance our Board of Directors has given us is as follows:

- We want the people practicing low vision Rehabilitation in Kansas to have expertise in that field. Low vision rehabilitation is a definite specialty within the field of optometry and rehabilitation, and before we can adopt legislation to define who can practice it and who can supervise such a practice, we need to deal with a legal definition and credentialing for low vision rehabilitation practitioners.

* Such a definition should include, however, expertise by low vision people themselves, and not just that developed by the optometric field or by people working in the rehabilitation field, most of whom are fully sighted. Peer support and consultation is of incredible importance.

- We want services to be conveniently located throughout the State. We do not support any one service provider creating a monopoly in terms of low vision services in Kansas.

- We do find it odd that hospital or medical Corporations can supervise low vision rehabilitation in Kansas while not-for-profits with an interest in low vision can not. Our experience has been that hospital corporations who have gotten into the low vision field in both Wichita and Topeka have pulled out of the field only a

few years later, thus disrupting services, largely because comprehensive low vision services take time and one on one interaction to provide, and are thus not particularly lucrative services to provide.

The essence of the controversy about who shall be able to deliver low vision services in Kansas boils down to an issue of control. The credentialing entity in the State for optometry has told Envision that there were problems with their operations because they are a not-for-profit, and not a medical service corporation. Envision has responded in 568 by saying, "Then let not-for-profits supervise low vision. The field of optometry has taken the position that the optometrist themselves are always the folks who are best qualified to be in charge of low vision rehabilitation. Hospital corporations seem to still want to be in the mix even though they have failed in Kansas to provide stable, focused, comprehensive low vision rehabilitation for any length of time. Now here KABVI is, the major entity representing low vision consumers in the State, and we are not sure that any of these big dogs need to have as much control as they seem to want. We believe that low vision rehabilitation must first be better defined as a credentialed area, and then must be addressed as a partnership between medical professionals, rehabilitation professionals, and the consumers. If any of those three legs are missing, the service fails to stand and grow in a stable, consumer responsive manner.

We are frustrated at the posturing that is being taken concerning the delivery of low vision services in Kansas. If the major provider groups in the State fail to get along and work together, service quality and quantity will suffer. KABVI has thus made the offer to the major parties involved that we are willing to serve as a mediator, to help all parties start to communicate together and work together more amicably. So far, this offer has not been accepted, and it would obviously be a difficult task, but our interest is only that low vision consumers have the most conveniently located, comprehensive, and peer supported rehabilitation possible throughout Kansas.

NKAVI

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1105 Centennial Blvd
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March 1, 2008

TO WHOM IT MAY CONCERN

RE: SENATE BILL 568

As low vision consumers, we are not in favor of supporting Senate Bill 568.

We feel that both state and private services for Kansans who are visually impaired must be maintained at a high level of quality. Therefore, we support the current rules and regulations controlling health care's important role in rehabilitative care for low vision and blind individuals.

We are aware during this session of the Kansas legislative, Envision of Wichita, Kansas is seeking exemption to the Kansas law regulating the professional conduct of licensed optometrists. We object to this request.

Envision offers services to low vision consumers; however many promises have been made in the past which never materialized. Therefore, we do not feel an exemption to the current law would be appropriate.

SRS of Topeka has an outreach program, Kan-Sail, which is very helpful to those in Northwest Kansas. It is very difficult (since most of us do not drive) to travel to Topeka for services. Therefore, it is very helpful to have training work shops in our local areas. Northwest Kansas is fortunate to have optometrists who specialize in low vision services.

We appreciate your consideration and feel if this exemption was granted that the services we are now receiving would be affected.

Sincerely,

Pat Hall, President