VA National Standards of Practice (NSP) Listening Session 2: Transcript

August 31, 2023

0:01

Moderator: Good afternoon. Thank you for joining the Veterans Affairs National Standards of Practice Listening Session. Today's session will run from approximately 2:05 to 4:30 PM Eastern Daylight time. We will be starting in about four minutes. We are giving a little extra time for those who registered to join our session. Thank you.

1:21

Moderator: Good afternoon. Thank you all for attending the Veterans Affairs. National Standards of Practice Listening Sessions. We will begin our session in approximately two minutes. Thank you.

2:17

Moderator: Good afternoon. Thank you for joining the Department of Veterans Affairs National Standards of Practice Listening Session 2. We will be starting our session in approximately two minutes.

3:38

Moderator: Good afternoon. Thank you for joining the Department of Veterans Affairs National Standards of Practice Listening Session number 2. Our session will run until 4:30 PM Eastern Daylight time.

3:53

Moderator: My name is Elizabeth, and I will be your moderator for this session. I will now go over a few housekeeping items to keep in mind during the session. The session will be recorded and closed

captioning is available at the bottom left corner of your webinar platform. The session recording and transcript of the recording will be made available on the Veterans Affairs, National Standards of Practice website at a later date upon completion of all five listening sessions. If you experience any technical difficulties at any time, during the session, you may notify our technical team using the Q and A function located at the bottom right-hand corner of the webinar platform. Speaking time will be allocated based on the number of people who requested to comment. During the session, all attendees will be placed on mute. If you indicated upon registration your intent to present, a representative will turn the mic over to you during your allotted time to provide comment. You will be unmuted during your period of comments and muted upon completion. Each speaker will be allocated four minutes to present. Allocation time is based on the number of people who requested to present. If you send any materials to us ahead of this listening session to support your comments, they will be displayed on the webinar platform. If you are scheduled to present and use a phone to join today session, we will call your name during your allocated speaking time and request you to raise your hand by dialing star 3 to identify yourself on the line. I will then give you the capability to unmute your phone line and you will hear a prompt to press star 6 to unmute your mic. Please announce your name and affiliation upon being unmuted. We will mute your microphone upon completion of your allocated time. If you did not indicate your interest to share a comment upon registration, but are still interested in doing so today, please write it in the Q and A function located at the bottom right-hand corner of the webinar platform. Time will be allotted as available at the end of the session. Any participants unable to speak during today's session may submit written comments after the session to VA.NSP@va.gov. Participants have until September 30, 2023, to submit comments. We ask everyone to please be respectful during your period of comment and while others are speaking.

6:46

Moderator: I will now turn it over to Dr. Erica Scavella to begin our session. Dr. Scavella, the floor is yours. Good afternoon, everyone.

6:58

Dr. Erica Scavella: Thank you for joining us my name is Dr Erica Scavella, and I serve as the Assistant Under Secretary for Health for Clinical Services, and Chief Medical Officer for Veterans Health Administration. Thank you for joining today's second VA National Standards of Practice Listening Session focused on Optometrists, Respiratory Therapists, Podiatrists, Perfusionists, Genetic Counselors, Therapeutic Radiological Technologists, Acupuncturists, and Massage Therapists. We greatly appreciate your input today on variance between State licenses for these health care occupations and your recommendations on what should be included in their VA standard of practice. Your comments today will inform and guide our decisions moving forward. We would like to note that during these sessions, VA will not directly respond to your presentations for we are actively listening. Additionally, please note that the proposed national standard of practice for each occupation will be posted on the National Federal Register once ready for a 60-day public comment period. We have also several clinical representatives on the line who may ask clarifying questions. I'd like to welcome Mr. Ethan Kalett, the Executive Director for the Veterans Health Administration Office and Regulations Appeals and Policy, Dr. Jeffrey Robbins, our National Pediatric Medical Director for the Podiatrist Service. Dr. Varanelli, the Tele Specialty Care Chief. Sanjay Patel, our Perfusion Supervisor at the Michael E DeBakey VA Medical Center. Crystal Reynolds, the Chief Therapist, Radiation Oncology at Durham VA Medical Center. Paul Seim, Chief Respiratory Care Services. Jane Peredo, the Research Coordinator to Licensed Genetic Counselor. Dr. Sharon Weinstein, the National Lead from Massage Therapy at the Integrative Health Coordinating Center. And finally, Dr, Juli Olson, the National Lead for Acupuncture at the Integrative Health Coordinating Center. If anyone I just mentioned would like to introduce others from their office, please do so at

this time. Hearing none and seeing no hands raised, I will proceed. Thank you once again for attending today's Listening Session. Your participation and attendance demonstrates your commitment and enabling VA health care professionals to provide the best care coordination Veterans. I will now hand it back over to our moderator.

9:53

Moderator: Thank you. As a reminder, if you indicated upon registration your intent to present, we will turn the mic over to you during your allocated time to provide comments. You will be unmuted during your period of comment and muted upon completion. Please note, there may be a delay during this unmute process and your patience is appreciated. Each speaker will be allocated four minutes to present. Allocation time is based on the number of people who requested to present. If you sent any materials to VA ahead of this Listening Session to support your comments, they will be displayed on the webinar platform. If you are scheduled to present and use a phone to join to these sessions, we will call your name during your allocated speaking time and request you to raise your hand by dialing star 3 to identify yourself on the line. I will then give you the capability to unmute your phone line and you will hear a prompt to press star 6 to unmute your mic, please announce your name and affiliation upon being unmuted. We will mute your microphone upon completion of your allocated time. If you did not indicate your interest to share a comment upon registration, but are still interested in doing so today, please write it in the Q and A function located at the bottom right-hand corner of the webinar platform. Time will be allotted as available at the end of the session. Any participants unable to speak during today's session written comments after the session to VA.NSP@va.gov. Participants have until September 30, 2023, to make comments. We ask everyone to please be respectful during your period of comment. And while others are speaking, speaker should be fully aware that you may experience delays during the unmuting/muting process.

11:49

Moderator: We will begin with optometrist. I will now call upon Joe Chenelly from AMVETS to present their comments.

12:12

Joe Chenelly: Thank you. My name is Joe Chenelly, I am the National Executive Director for AMVETS. I appreciate you including AMVETS in this important discussion. It's of the utmost importance to me and the millions of Veterans AMVETS represents that VA gets the Optometrist National Standard of Practice right. With vision and eye health care ranking as the third most requested service by Veterans, what VA decides to include, or exclude, from the optometry standards will have a significant impact and Veteran access to need to care. VA Optometrists right now provide three-quarters of all eye and vision care within the VA. And in many locations across the country optometrists are the only independent eye care practitioner available. AMVETS feels strongly that the Optometry National Standard of Practice must include all care and services an optometrist is trained and licensed to provide in any State. As with other health care providers, the VA's rigorous privileging and credentialing process will ensure that these doctors have the license, skills, training and ongoing competency to serve Veteran patients with a wide range of care. Right now, Americans with health care coverage under Medicare, Medicaid, in all major, private insurers have access to local optometrists for the full range of care that is included under their State's license. We believe Veterans should be treated no differently. Well, optimistic that the new standards will boost access to need to care, we should be concerned if the standards did not include some eye care services provided by optometrists simply because these types of eye doctors are not authorized to provide those services in the majority of States. Should VA take the approach of only including healthcare services in the standards, which are authorized in a significant number of States, AMVETS is worried that Veterans in some States may needlessly be denied access to essential healthcare services solely because States, other than their own, have failed to act. Again, we feel strongly that VA should take

the same approach. We see now, under all other federal health care programs, and all major, private insurers to ensure access to all healthcare services included in an optometrist's State license. Thank you again for including me and us on this important discussion, and we look forward to continuing to work with to ensure that Veterans across the country of access to the care they need when, and where they need it. Thank you.

14:35

Moderator: Thank you so much. I will now call upon Julie DeKinder from the Accreditation Council on Optometric Education.

15:05

Julie DeKinder: Hello, my name is Julie DeKinder and I'm here today representing the Accreditation Council on Optometric Education, or the ACOE. We appreciate VA providing us this opportunity to participate in this listening session and appreciate all the VA has done to ensure a transparent and fair process. The ACOE is the only accrediting body for professional optometric degree programs, optometric residency programs and optometric technician programs in the United States and Canada, and is recognized by the U.S. Department of Education in the Council on Higher Education Accreditation. The ACOE's mission is to serve the public and profession of optometry by establishing, maintaining, and applying standards to ensure the academic quality and continuous improvement of optometric education that reflect the contemporary practice of optometry. The ACOE values the important and long-standing role that the VA plays in the education of our nation's optometry students and residents and in the provision of eye and vision care for America's Veterans through externship and residency programs in partnership with the schools and colleges of optometry. According to the Association of Schools and Colleges of Optometry (ASCO), 41% of all optometry residency positions nationally are sponsored by the VA. The ASCO also reports that nearly 75% of the

1,735 fourth-year students received training at one or more VA sites in the 2021 academic year for a total of 1,310 externship rotations completed at 377 VA sites. The ACOE believes the national standard of practice consistent with the most advanced State scope of practice would be best to serve the educational objectives of the VA and the health care needs of our Veterans while minimizing the operational challenges of providing that care. The ACOE standards of accreditation require that professional optometric degree programs prepare graduates for independent, contemporary practice of optometry as a condition of accreditation. As the VA develops national standards of practice for optometry, it must ensure that the new standards ensure access to the full range of care that Doctors of Optometry are trained and licensed by their States to provide. A growing number of States have passed laws authorizing their State's Doctors of Optometry to provide a wide range of medical eye care, including injections, removal of foreign bodies and therapeutic laser eye care. We anticipate more States will approve this authority in the months and years to come. In one State, optometrists have been authorized to provide this care since the 1980s. To implement a national standard that does not ensure access to the full range of care that Doctors of Optometry are trained and licensed by their States to provide would not only be detrimental to the care to our Veterans, to our Veterans, but also would negatively impact the clinical education and training of the nation's future optometric workforce and exasperate the access to care and efficiency issues with which the VA has struggled over the last decade. Thank you again for including us today and we look forward to continuing to work with the VA to ensure the best care for our Nation's Veterans when, and where they need it.

18:50

Moderator: Thank you so much. I will now call upon Roman Krivochenitser from the American Glaucoma Society.

19:07 [MATERIALS: American Glaucoma Society]

Roman Krivochenitser: I'm a glaucoma surgeon practicing in the State of Michigan. I'm a young ophthalmologist. I graduated from my training less than four years ago. This training included four years of undergraduate work, four years of medical school, four years of surgical residency, and four years of specialized training afterwards in glaucoma. Given my youthful experience and appearance, I'm often asked by my patients how long it took me to get to this point. To which I can reply, well over a decade, 13 years to be exact. With training with hundreds of hours of direct supervised oversight on every procedure that I performed today. I'm speaking on behalf of the American Glaucoma Society, a group of over 1,600 glaucoma specialists, and researchers dedicated to improving the lives of people with glaucoma. As a society, we have published an official position paper on glaucoma, laser eye surgeries to be performed by surgeons. Next slide. Glaucoma is an aggressive disease that affects the optic nerve in the back of the eye. It is one of the leading causes of universal blindness in the world with a substantial impact to patient quality of life. Once you lose vision from glaucoma, you do not get it back. Subsequent presentation will further dive into the training differences between optometry and ophthalmology. Next slide. Many of the laser surgical procedures in discussion today are treatments for glaucoma. One of the treatments uses heat to coagulate tissue inside the eye changing its structure. The second, a laser punctures a hole through the iris, the colored part of the eye. Well, the third laser is intended to physically cut and obliterate scar tissue from behind the lens. Next slide. These are not benign procedures and have real world consequences if not properly done. Each person's anatomy is different. And it is impossible to pick up the subtle nuances that are often the difference between successful and unsuccessful surgery by only practicing a handful of times on a model eye. Complications are real and can be devastating. Next slide. The research also bears this out. A study published in 2016 in the Journal of the American Medical Association by Stan et. all compared the outcomes of laser trabecular plasti done by optometrist versus ophthalmologist in the State of Oklahoma. They showed that 35.9% of eyes treated by optometrist needed a repeat laser surgical treatment in the same eye compared to only

15% treated by ophthalmologists. That is a 189% increase in risk of repeat laser surgery when done by optometrists. Not only is this not cost effective, but actually dangerous to the patients undergoing these procedures. There is a reason that 41 States and D.C. do not allow optometrists to perform these anterior laser surgeries. The rest of the studies in this presentation, or for documentation purposes, to be submitted for the record that will not go through in the interest of time. But essentially my discussion blows down to simple principle: and that's the Hippocratic Oath. At the beginning of medical school, we all took the Hippocratic Oath to do no harm and we are here. precisely because of that oath. Because of the fact that changing these standards will do direct harm to the Veterans that have risked their lives protecting us. Optometrists are our colleagues, our team members, our friends, but they are not surgeons and they're not physicians with medical school training. Being around a plane, makes you very knowledgeable about it, but it does not mean you know how to land it. It does not mean you know all the nuances that can go wrong if conditions are not 100% optimal. The eyeball is quite similar to that. Being always around it is certainly helpful, but it does not mean you're able to operate inside it. The consequences, complete vision loss in this case, are simply too high. Ask yourself, if you are your loved one needed surgery, whom would you want it done by? A trained surgeon with four plus years of surgical residency, or an optometrist who spent a weekend practicing the surgery on a model? This question was posed to the general population, and it was no surprise that well over 80% of the participants wanted surgery to be done by a surgeon. Our Veterans deserve the highest standard care for their sacrifice, and we are here to protect that. The American Glaucoma Society is firmly opposed to changing the national standards of practice at the VA for optometrists to perform laser surgery. Surgery should be done by surgeons. That is the least that our Veterans deserve.

23:01

Moderator: Thank you, thank you very much for your comment. I will now call upon Greg Smith from the Association of Armed Forces and Federal Optometric Services.

23:28

Greg Smith: Good afternoon. Can you hear me okay?

Moderator: Yes, we can hear you.

Greg Smith: Oh, great. Thank you. Good. Thank you for the opportunity to speak and support Veteran care.

23:39

Greg Smith: My name is Dr. Greg Smith and I'm the President of the Association of Armed Forces and Federal Optometric Services, otherwise knows AFOS. And we represent federal service optometrists. I am a Navy Veteran and an optometrist that provides rural healthcare to a vulnerable and underserved population. I am speaking in support of the national standards of practice reflecting at all professions, including optometry, be able to practice to the full extent of their training certification and licenses. As a Veteran, I cherish the VA health care system and expect that after serving the Department of Defense where their optometrist practices at the highest level of their training to licensure that my optometrist in the VA would also be able to practice at the highest level of their training and licensure. Due to my rural location myself and many of my patients who are also Veterans must travel up to five hours one way to the nearest VA that offers eye care. At times this is in adverse cold, sometimes being 35 or 40 below zero or more and on treacherous roads. Veterans have earned the rights of streamlined care within a health care system that is expected to create a work environment in which all its employees are working to the fullest extent of their training and ability. Each referral to community care for Veterans I serve results in additional 10 hour round trip. That would not be necessary when health care professionals, including optometrist, are credentialed and privileged according to their highest level of training certification licensure. And therefore, would then be able to complete all services within one visit within the VHA health care system. Regarding the national standards of practice review process, we are all medical professionals seeking

to provide the best and most sufficient care for our patients. And especially for our Veterans. During the process to establish the national standards of practice, no medical profession and especially optometry, would approach VA leadership to request privileging that we were not trained for, or board tested on, or licensed to practice. As a Veteran and for the care of my Veteran patients, I respectfully request VA leadership to grant full credentialing privilege to optometrists, as well as all of its health care providers, according to each professions level of licensure and training. I would like to thank the VA leaders on this call for the opportunity to speak. And look forward to continuing dialogue and full support of the national standards of practice when released would support all practitioners, including Doctors of Optometry, to provide care to Veterans to the fullest extent of their training and licensure. I thank you very much for your time.

26:26

Moderator: Thank you so much next. I will call upon Lindsey Wright also from the Association of Armed Forces and Federal Optometric services.

27:00

Lindsey Wright: And thank you for allowing me a few minutes. My name is Dr. Lindsey Wright, and I am the Executive Director for the Association of Armed Forces and Federal Optometric Services. Our organization represents all federal services optometrists across the military branches, Indian Health service, and of course the VA. Doctors of Optometry have proven to be an essential provider of primary eye and medical care in the VA. Over 1,000 optometrists are currently practicing at 95% of the VA sites where eye care is offered, and of those facilities, often they're the only licensed independent eye care practitioner. As we stated earlier, eye and vision care are the third most requested services by Veterans and VA optometrist care for nearly 70% of the total unique eye care visits for Veterans annually with more than 1.7 million unique and 3.1 million overall patient visits.

My colleagues on the call have explained the significant education and training that is placed on Doctors of Optometry and all the optometry schools. Doctors of Optometry have been practicing to a higher level of eye care in the community and DoD for decades. More importantly, the VA is paying for Veterans to receive the standard of care in the community. We all know access to care is critical for our Veterans. Veterans should not have to seek better or higher quality eye care in the community rather than having the option to receive the services at the facility. I stated the VA currently has policies in place to ensure that the Doctors of Optometry have appropriate qualifications and clinical abilities to the credentialing and privileging process. This will ensure that only those with the required skills and continuing competency will be able to offer these services to the Veterans in need. We need to shift the focus to the Veterans and how quality eye care can be delivered to them effectively and safely. Doctors of Optometry have been doing lasers for decades. Over 130,000 laser procedures have been safely performed across the country. Therefore, the national standards of practice should reflect this and allow optometry doctors enough time to practice to the highest level of their education, training, and licensure. I'd like to thank the VA leaders on this call for the opportunity to speak.

29:49

Moderator: Hi, I will now call upon Marrie Read from the Association of Armed Forces and Federal Optometric Services. As a reminder, if you dialed in to today's call, please press star 3 to raise your hand and we will call in, we will unmute you and press star 6 to unmute.

30:21

Marrie Read: Sorry, thank you.

30:29

Marrie Read: Are you able to hear me? It was still talking.

Moderator: Oh, are you, are you there Ms. Read?

Marrie Read: Umm, yes, are you able to hear me?

Moderator: Yes, we can now hear you.

Marrie Read: Okay. Great. Thank you.

30:42

Marrie Read: Okay, so I, I am a Navy optometrist, and I have served in the United States maybe for 26 years. And I have been able to practice to the fullest extent of the license that I've had in my particular State. I'm also a past president of the Association of Armed Forces and Federal Optometric services. And I want to share that back when I first was within the Navy, I was selected for a competitive duty under instruction program that sent me to complete a residency program in the civilian world, rather than within the military. I chose to do this residency at a VA and the reason why I did was at the time, optometrist at the VA practiced to the highest level. And I really wanted to be able to use the education and licensing that I had learned to be able to practice at the highest level and be able to hone these skills within the residency program. My concern is that since then many of the States have surpassed what optometrists are allowed to do and residencies are going unfilled as new graduates are choosing to go to residency programs that allow them to practice to the fullest extent of their education and licensing. This affects the access to care of Veterans in these facilities that these residencies are going unfilled. It is also concerning that patients are being seen the patients beings inside the VA may not have the same access to the same care as those receiving care in the community care providers. Referring patients for procedures at a separate date, time, and with a different provider that are well within an optometrist's education, certification and licensing is a time-consuming disservice to our Veterans. Today is my last day on active duty,

tomorrow I will be a Veteran myself, and I will be receiving care within the VA. I strongly encourage the VA to allow those optometrists, with, to allow optometrists within the national standards of practice to practice at the top of their license education certifications to ensure Veterans, including me, have access to the care when, and where we need it. Thank you for the opportunity to speak with you today.

33:04

Moderator: Thank you for your comments we will now call upon Dr. Mary Lawrence with the American Academy of Ophthalmology.

33:32 [MATERIALS: AMERICAN ACADEMY OF OPHTHALMOLOGY]

Dr. Mary Lawrence: Can you hear me?

Moderator: Yes, ma'am. You may proceed.

33:38

Dr. Mary Lawrence: Yeah, thank you Dr. Erica Scavella and the entire national standards of practice team. Next slide. My name is Dr. Mary Lawrence, I am an eye surgeon and have been performing eye surgery since 1987. I've had the honor and privilege of working for nearly two decades, culminating in an appointment by Secretary Eric Shinseki as the level Deputy Director of the DoD VA Vision Center of Excellence. During my time in D.C. I served on the trauma team at Walter Reed, National Military Medical Center. I have no financial interest to disclose. Next slide. I will cover three topics: a recent history of laser eye surgery policy in VA, military medicine eye surgery requirements, and designations of eye care providers in Minnesota. Next slide. In 2003, the American Academy of Ophthalmology, the AMA, and other medical organizations worked closely with VA to enact a policy that ensured that Veterans would have the best standard of eye health care that non-VA patients

across the United States had. In December 2004, VA released Directive 2004-070 specifying that quote, "therapeutic laser eye procedures only be performed by ophthalmologists with the requisite training and expertise," end quote. This directive was renewed in 2009, 2015, and 2020. Next slide. Current VA policy, per Directive 1121 reiterates and unambiguously states, quote, "therapeutic laser eye procedures in VA are currently performed by only ophthalmologists and ophthalmology residents," end quote. Next slide. Military medicine. If a super majority of States allows the specialty to engage in the practice of a specific medical intervention, the U.S. Army Medical command recommends privileging. Military optometrists are not privileged to perform laser eye surgery. Next slide. May I describe the distinct responsibilities of optometrist and surgeons in Minnesota? In my home State, only surgeons, that is ophthalmologists, are allowed to perform surgery, including surgery using lasers. Optometrists are also prohibited from prescribing or administering any drugs for which a medical degree is properly needed. This law has been challenged repeatedly by optometry. After careful consideration and hearings with multiple expert witnesses, including testimony from many optometrists, the Minnesota legislature has maintained these requirements for eye health care. The Mayo Clinic has weighed in strongly in support of Minnesota's current optometric allowances. We highly value the work of optometrists in Minnesota, and we certainly need them to do the work they've been properly trained to do. Next slide. Minnesota health care is commonly referenced as the gold standard of health care in the U.S. Only a few States representing approximately 11% of the U.S. population have chosen to allow optometrists to do surgical eye procedures, including lasers. We want health care for our Veterans, those who have raised their hands to go into harm's way for our freedoms to be at the equivalent level of our country's best health care systems. That is, surgery, including laser surgery, should be performed by surgeons. Surgery should be performed by surgeons. Thank you.

37:33

Moderator: Thank you so much. Next, I will call upon Dr. John Peters with the American Academy of Ophthalmology. Once again, if you dialed in using a telephone today, please star 3 so we can identify you and we will and then press star 6 to unmute. Please also, you could raise your hand using the raise-hand function at the bottom screen of your webinar platform.

38:26

Moderator: We will move on to our next individual and go back to anybody that we could not identify as being unmuted. I will now call upon Michael Mittleman with the Pennsylvania College of Optometry at Salus University and the American Optometry Association.

39:05 [SALUS University's materials]

Michael Mittleman: Appreciate the time to address this August body. I am a Former Deputy Surgeon General of the Navy after having served 33 years in Navy medicine. I am a graduate of the Pennsylvania College of Optometry. Next slide please. As you already heard, optometrists really provide about a third, 70% of eye and vision care to Veterans every year. And for us, as a Veteran myself, it's so important that Veterans have access to great eye care wherever they are. Also, as an educator, I'm also concerned about the quality of education that our optometric interns and our optometric residents are getting. And as you've already heard, the Department of Veterans Affairs provides lion share of that type of training for our budding doctors. There are roughly 22 VA optometric residencies in primary care disease, brain injury, low vision in geriatrics and which is extremely important. In April 2020, the VA issued Directive 1899, which urged all of its facilities to fully utilize optometrists and others to the full extent of their license. Once again, with the end result of providing full access to care to quality care to our Veterans. Next slide please. We believe that the national standards of practice must ensure that all of our Veterans have full access to the full range of services that optometrists are trained to and are licensed to provide. And this is by allowing

providers to practice at their highest level of training and licensure, enabling the national standard of practice to meet VA's goals of ensuring that every Veteran has access to high quality care independent of their location. And you heard that if somebody is located in a very, very rural area, it's very difficult for them to seek care safely. Of note, all schools and colleges of optometry teach medical eye care to include therapeutic laser surgery injections, removal of foreign body. And a growing number of States have passed laws authorizing Doctor of Optometry to provide these services. Patients served internally with the VA have to be treated the same way as those who are accessing community care, or every other citizen has with coverage under the current federal health programs to include Medicare and Medicaid as well as private health insurers. Individual provider credentialing within the VA and privileging is designed to ensure a competency, quality, and safety and we believe that works extremely well. Next slide please. As you have already heard the current State of optometric laser utilization, currently, 10 States allow optometrists to provide minor laser eye surgeries. This is included in the scope and we feel that Veterans should have substantial access to this type of care to meet their needs. As you already heard, Oklahoma Doctors of Optometry, providing optometric therapeutic laser eye procedures for 30 years they've provided over 50,000 eye procedures just in that State alone, and they have had no registered complaints, and this is similar in most other States that have these same privileges. Next slide please. So, our bottom line, well, you might hear some detractors saying that such a move could be harmful to Veterans. The reality is that optometrists are fully trained to provide this care. We believe that creating national standards of practice for optometry, based on their education, the national and State certification, national assessments, and licensure is essential. We also believe that the national standards of practice should include as taught language to ensure that they remain current and don't become a barrier to care that future Doctors of Optometry, or any other profession, can provide to Veterans. We also will reiterate that relying on individual provider, credentialing privileges and State licensing will help to ensure competence moving forward. I thank you so very much for your time.

43:31

Moderator: Thank you so much for your comments. We will now go back to call upon Dr. John Peters with the American Academy of Ophthalmologists. Dr Peters can you raise your hand with star 3 and then our team can unmute you. And you will press star 6. In the interest of time, we'll come back to you.

44:20

Moderator: I will now call upon Dr. Rich Castillo with the American Optometric Association.

44:50

Dr. Rich Castillo: Hello?

Moderator: Yes. Hello.

44:52

Dr. Rich Castillo: Okay, thank you. So, my name is Dr. Rich Castillo. Thank you for allowing me to speak today. I'm speaking on behalf of the American Optometric Association. So, as we've heard, eye and vision care is now the third most requested service by Veteran patients behind on the primary care, and mental health care. VA Doctors of Optometry provide according to the statistic, I have nearly 73% of that care, including nearly 99% of services in low vision clinics and blind rehab centers. The services the VA decides to include in the forthcoming optometric national standards of practice will significantly impact how, when, and where Veterans across the country can access the vision and eye health care services, they need and deserve. I believe that as both an optometrist and an ophthalmologist, I have a valuable perspective to bring to this conversation. I'm currently the Senior Director for Clinical Examination Development and Administration at the National Board of Examiners in Optometry. I'm a graduate of the Northeastern State University College of Optometry

and the Oklahoma State University College of Osteopathic medicine and surgery where I completed a residency in ophthalmology. I am and have been on the front lines of educating the next generation of eye doctors. I've been NSU principal surgeon and clinical professor since the late 1990s. I've served as an assistant dean overseeing the surgical training program in NSU which, by the way, begins on day one of the four-year core optometric curriculum. It's not done over just the weekend as it was alluded to earlier. It takes four years to produce a Doctor of Optometry. I've trained optometrists, optometry students, optometry residents, medical students, family medicine residents from OSU College of Osteopathic Medicine that rotate through NSU and Cherokee Nation's outpatient health center. I also routinely train, by the way, Army Special Forces trainees from the third special forces group at Fort Bragg, North Carolina who rotate through my supervised clinics at the Cherokee Nation Health Care center. And I trained them in emergent field procedures, such as ocular trauma management, including lateral canthotomy, and acantholysis. So, over the past 30 years, an increasing number of States, including my home State of Oklahoma have amended in modernized laws, reflective of modern educational and contemporary practice standards within the nation's schools and colleges of optometry, postgraduate training programs, authorizing the States Doctors of Optometry to provide a wide range of needed medical eye care, including injections as alluded to earlier: removal of foreign bodies on, or around, the eye and therapeutic laser eye care. These States cite that this authority has increased -increased- access to needed eye care, particularly in underserved and rural areas. I can speak to that directly because I practice in the very rural part of the country. Oklahoma, for example, I have been providing this care since the 1990s with little, or no reported complaints. Now practice rates for States with this authority are roughly identical to those without highlighting the safety and efficacy of this care provided by optometrists for decades. Medicare, Medicaid, and the Indian Health Service have covered an insured patient access to the wide range of medical care services and procedures. Doctors of Optometry are trained and licensed to perform from treating glaucoma diabetic retinopathy and other site threatening conditions to administering injections and performing laser and other types of office based surgery. All major

private payers cover and pay for these services provided by optometrists operating within their State authorized scope of practice. The VA's community care program recently removed language that had limited private practice optometrist from providing Veteran access to these contemporary procedures, including injections and lasers placing it with language, asserting that these services may be provided by ophthalmologist or optometrist, based on the State licensure of the provider. So, my message today is that our Veterans deserve nothing less than national standards of practice, guaranteeing access to all services that their Doctors of Optometry are trained and licensed to provide. Patients covered by Medicare, Medicaid and private insurance, have access to the full range of care that optometrist training and professional licensure provides. Our Veterans deserve at least the same choices with regards to providers and services as every other citizen in their State. And for the sake of time, I will echo the statements that Mr. Joe Chenelly from AMVETS made earlier today. Thanks for your time. And thank you for inviting me to participate in this important discussion.

49:55

Moderator: Thank you so much. I will now call upon Dr. J Michael Jumper with the American Society of Retina Specialist.

50:23

Michael Jumper: My name is Dr. Michael Jumper. I serve on the Executive Committee of the American Society of Retina Specialists. I'm a Veteran and come from a family of Veterans. Starting with my father, someone from my family has served in the Army Corps, or the United States Air Force since 1944. After graduating from college, I spent 10 years obtaining a medical degree, an internship in internal medicine, residency training and ophthalmology and fellowship training as a retina specialist. I was a recipient of a health profession scholarship through the military and served in the United States Air Force as a retina specialist. I have since worked and volunteered in the VA health system in the San Francisco Bay area where I practice. In my current practice, and in the VA

system I've had the opportunity to work with many optometrists. Their work is important in their role in disease screening, prescription for glasses and contact lens and providing low vision care is vital for our Veterans. However, they are not surgeons, and their depth and breadth of medical knowledge is limited. In my training, I have worked on medical and surgical hospital wards in intensive care units from neonates and adults, and in the operating room. In the 10 years of my training, I have obtained extensive knowledge and the many diseases that result in blindness, including common conditions, like diabetes and hypertension as well as the myriad rare diseases, including cancers like ocular, melanoma, infectious diseases like Neuro syphilis, inherited diseases such as Von Hippel–Lindau disease. All these rare diseases I have mentioned are not only blinding but also potentially fatal and require expertise and diagnosis and knowledge of other specialties to make appropriate medical referral and obtain specific testing. The surgery that a retina specialist performs requires six years of training beyond medical school to be credentialed by hospitals and surgical centers. In the operating room, I insert microscopic instruments into the eye and peel scar tissue from the surface of the retina to treat retinal detachment. Diabetic eye disease and complications of injury with no training whatsoever and performing retinal surgery optometrists have no business in the OR. In the clinic, I use lasers and cryotherapy to treat retinal tears, retinal detachment and causes of bleeding in the eyes such as stroke in diabetes. I also treat chronic blinding conditions such as age-related macular degeneration with expensive medications that I inject into the eye. I take the responsibility of determining who needs such treatment, which drug to use, and when it is appropriate to continue or stop treatment very seriously. Our clinic has many mechanisms in place for infection control and to prevent laser injury. It is these procedures, lasers, and injections that the scope of practice legislation has been proposed in various States of what optometrists are most likely to be interested in performing. It's my opinion that these procedures are as complex as intraocular surgery performed in the operating room and the same level of training is required. Speaking for myself, and the Veterans of my family, there is an incredible trust in the VA system that the best interest of our nation's most cherished servants are always first and

foremost. I would not want my care or the care of my father, two brothers, three nieces and two nephews, all Veterans with combined 155 years of active-duty service to be provided by someone with inadequate training, not only to perform the procedure, but also to deal with the complications that may occur. I ask that you continue to prioritize ensuring Veterans have access to the highest quality of care. Thank you again for this opportunity and the American Society of Retina Specialist is available to assist in the development of these vital standards. Thank you.

54:21

Moderator: Thank you so much next I will call upon Laura Green with the Association of University of Professors of Ophthalmology.

54:39

Laura Green: Can you hear me?

Moderator: Yes, ma'am. Please proceed.

54:44 [MATERIALS: Association of University Professors of Ophthalmology]

Laura Green: Thank you, thank you so much for this opportunity, Dr. Scavella and other VA officials. I'm Dr. Laura Green, representing the Association of University Professors of Ophthalmology, which is the society that governs academic ophthalmology where I am the past president of the program director's council. I'm also the chair of the Accreditation Council for Graduate Medical Education Review Committee for Ophthalmology, which governs Ophthalmology residency accreditation and I'm a past chair of the American Academy of methodology committee for resident education. I have been deeply involved in training ophthalmologists and development of educational standards for our methodology for 17 years. And I'm a clinical associate professor at the George Washington Medical School. My comments here are my own and represent my own thoughts and opinions. Please

proceed to slide seven. Even though most optometrists—thank you—and even though both optometrists and ophthalmologist are eye doctors, only ophthalmologists train as medical physicians and surgeons. Where, and how these practitioners train has a big impact and what they are competent to do, whether they know when to cut and when to not cut. Whether they know how to counsel patients in pre and post operative care, whether they know, and really understand the tools that they're using. It's important to know the differences and to think about the clinical experiences they have. And whether they justify doing certain things on our Veterans. Next slide. Part of why there are no national optometry training standards for laser surgeries because over 95% of optometry students do not study laser in surgery States. 7,036 optometry students do not study laser if they don't practice, and they don't learn in laser surgery States. Surgical training requires consistency not just one weekend of brief exposure, all sorts of studies from the surgical literature across the house of medicine, validate this. No one learned surgery in a weekend. Next slide please. Of all of the optometry students in the United States, only 4.7%, around 346, are currently enrolled in schools that permit laser surgery. Next. The National Board of Examiners in Optometry's optional, laser and surgical procedures examination, tests surgical skills on plastic model eyes and skin. Not live living, moving, breathing, anxious patients who need to be comforted and comfortable while you're doing a delicate laser on a five-micron thick structure inside their eye. This exam does not ensure surgical competence by ophthalmology standards, or by the house of medicine standards. Ophthalmology requires that residents learn side by side one-on-one with a board-certified ophthalmologic surgeon. First, watching, assisting and observing through the microscope as a surgeon operate and does the laser procedure. Then doing parts of the laser surgery before finally being able to be competent to do a full laser surgery under the direct watchful eye of a board-certified expert who not only must be approved by their hospital and university, but also by the National Accreditation Council for Graduate Medical Education. These educators are deemed competent as surgical educators, and then they sit for written and oral board certifications. So, they have the medical knowledge for decision making. Next slide. Only nine States out of 50, not

including Indiana, which was noted earlier, allow the optometrists. Only 11% of Americans are exposed to this. Next slide. Only two States, Oklahoma and Kentucky have optometry schools, only two of the laser surgery States. Next slide. Ophthalmology residents do not learn surgery in a lecture hall on YouTubers, or in the lab. Next slide. This is an example of the clinical training environments at two Optometry schools. You'll notice the absence of patients. Next slide. These are results of a laser in glaucoma. You're actually seeing holes made in human structures to allow for the outflow. These are high stakes surgeries that are very delicate. Next slide. Additionally, the training numbers don't add up when you look at the number of procedures that would need to be performed, in order to train 707,000 optometry students. There just aren't enough of these procedures to go around and if you were to train the optometrist, there wouldn't be enough to train the ophthalmologist. Thank you.

59:38

Moderator: Thank you so much for your comment. I will now call upon Craig Kliger with the California Academy of Eye Physicians and Surgeons.

1:00:06

Craig Kliger: Hello can you hear me? I can't unmute myself. No, there, thank you.

Moderator: Thank you. Hello, we can hear you.

Craig Kliger: Thank you very much. Thank you for the opportunity to provide input and I apologize for any duplication of what might have already been said.

1:00:18

Craig Kliger: My name is Craig Kliger. As I said, I'm a board-certified ophthalmologist and Executive Vice President of the California Academy of Eye Physicians and Surgeons. I believe I offer a unique

perspective given I've been the primary discussant for ophthalmologists on this issue in California for about 15 years. As you may be aware, we in California faced legislation, just last year, they could've authorized essentially all of the surgical procedures being considered. However, our governor vetoed the bill based on inadequate training, despite the fact that it did require some training on live human patients. In his opinion, that wasn't enough to protect California's residents. Let me say, I'm confident optometric educators truly believe their educational processes yield graduates that are well trained to do the procedures under discussion. Unfortunately, those educational processes leverage an accreditation structure that the optometrist themselves created to defend training they also created. So, any representation of adequacy should be viewed through a critical lens. The reality is that providing substantial supervised training on live human patients, which is the gold standard for training ophthalmologists, is essentially impossible given the number of potential optometric trainees. As was alluded to earlier, only two of the existing 24 optometry schools are located in States where it is currently legal to do any of the surgical procedures we were talking about. Furthermore, these two schools only train about 90 of the 1,750 annual optometric graduates nationwide. The other person described multiplying by four for the four years. For comparison, the U.S. trains about 450 ophthalmologist residents per year in settings that do have training cases. That is because ophthalmologist training programs are usually located at tertiary referral hospitals that concentrate patients with pathology that needs treatment. On the other hand, optometric training programs are at usually largely community-based schools that can concentrate healthy patients that occasionally have pathology. In short, the idea of identifying sufficient training cases to acquire all the necessary skills to perform surgery to a standard that matches the surgical skill level that Veterans currently receive from ophthalmologists for these procedures seems virtually undoable. So, lacking the needed patient populations, optometrists, primarily, train on plastic models and cadaveric and non-human tissue, not on live patients with real conditions requiring surgical treatment. Advocates allowing these procedures point to the exams by the NBEO as evidence of competence, and as was said earlier, these are done exclusively on plastic or rubber models. Their

ability to meaningfully test clinical skills seems totally inadequate for the privileges sought. Having done all these procedures myself, I can assure you human tissue reacts far differently. It bleeds and as you might guess, eyes and eyelids move. So, they are far less easy to suture, or laser compared to inanimate materials. So, and, I mean, this respectfully, the reality is that the first human being an optometric surgeon might treat could be a Veteran who might experience a complication that optometrist just couldn't possibly be prepared to address based on work on a plastic model or other inanimate object. This comes down to a pretty simple question and it was sort of alluded to earlier: Would you want yourself a loved one or the Veterans under your care to receive surgery with potentially blinding consequences from an optometrist if that optometrist had performed no, or almost no surgical training cases on human beings? The governor of California apparently didn't, and I strongly suspect you wouldn't either. Our Veterans deserve quality care, and at least currently the training received by optometrists for the procedures under discussion would not allow them to deliver such care and therefore ask you to recognize that fact in developing any practice standard you may establish. Thank you for your time.

1:03:54

Moderator: Thank you. Next, I will call upon Kurt Heitman with the South Carolina Society of Ophthalmology.

1:04:13 [MATERIALS: South Carolina Society of Ophthalmology]

Kurt Heitman: Dr. Scavella, Elizabeth, and team, my name is Kurt Heitman. I'm a private practice ophthalmologist from Greenville, South Carolina. I am a Veteran. I'm the son of a Veteran, and I have a father who is currently a captain in 101st airborne, who is currently deployed overseas. I'm a partner in a vertically integrated eye practice of ophthalmologists and optometrists who work together as an efficient eye care team delivering high quality eye care to the people of our

community. And I know the differences in training between the two professions, and I respect the profession of optometry. Next slide please. As the VA develops itss national standard of practice for optometry, I humbly asked the VA, as a Veteran, to prioritize what ophthalmologists do every day. Please protect the eye. Eye tissue is extremely delicate. Once it's damaged, it's often impossible to fix. Among surgeons, eye surgery is considered one of the most difficult and delicate surgeries that are performed. Next slide please. Despite this, some optometrists are seeking an expanded scope with the national standards of practice based on the misplaced perception that eye procedures are inherently of low risk. All procedures carry a higher risk profile when attempted by an inexperienced provider. Moreover, the notion that the VA will become more efficient and save money by hiring lower priced providers of eye surgery must be dispelled given the higher risk and liability incurred. I refer you to the Palo Alto VA debacle of several years ago, where multiple millions of dollars in lawsuits were levied against the VA due to optometrists practicing outside their area of expertise. Next slide please. Furthermore, having more providers performing surgery at the VA greatly amplifies the risk to Veterans. Surgery is a practice skill. More persons performing surgery increases the risk of skilled dilution and skill atrophy. This is especially true in the case of entry segment laser surgeries where surgical volumes relative to the population are low, while the requirement for precision for each surgery remains high. In contrast, having optometrists just focus on primary care would be a boon to Veterans. Access to primary eye care is a known bottleneck to advance medical and surgical care that Veterans need. Next slide please. And this brings me to my main point, is the highly variable optometric scopes of practice in the States will lead to confusion amongst Veterans who expect a consistent standard of care. And what I mean by that is only nine States authorize optometrists to perform anterior segment laser surgeries. And even this small minority of States do not necessarily authorize optometrists to perform the same laser surgeries. The States scopes of practice, or even more variable for non-laser surgical procedures. Some State statutes or regulations that authorized optometrist to perform, non-laser surgical procedures, contain an exclusionary list of surgical procedures. These exclusionary lists are not all the same. This variable nature of optometric

scope of practice, is really, do more to political accomplishment and not to educational consistency. Next slide please. Optometrists may voice concern that the best and the brightest will not be attracted to the Veterans Administration. If their national standard practice is written broadly. We found these career choice arguments are invalid. Optometrists have not flooded into States with expanded scopes to perform laser surgery. Next slide please. Similarly, we do not see recent optometry school graduates avoiding States with more restrictive scopes of practice. And the reason it's simple, the overwhelming majority of young optometrists do not perform laser surgery in the States in which they're authorized. Final slide please. In conclusion, the scope of necessary surgical knowledge has expanded exponentially over the last 40 years, not decrease, the number of possible surgical approaches to the same eye disease has increased as well and to suggest that traditional surgical training is no longer necessary to safely perform eye surgery strikes me as misguided. I'm asking that the ophthalmologists be allowed a stake in the determination of the standards of practice for VA Optometrists as a Veteran. Thank you so much.

1:08:54

Moderator: Thank you for your comments. I will now call upon Ben Harvey with the Oklahoma Academy of Ophthalmology.

1:09:13

Ben Harvey: Can you hear me?

Moderator: Yes, sir. You may proceed.

1:09:18

Ben Harvey: Okay, thank you. Good afternoon, everyone. My name is Ben Harvey, I'm representing the Oklahoma Academy of Ophthalmology serving as its current Counselor and immediate Past-

President. I'm a board-certified ophthalmologist, and a fellowship trained glaucoma specialist at the Dean McGee Eye Institute. So, as a clinical associate professor at the University of Oklahoma College of Medicine, involved deeply in educating medical students, residents, and fellows, I've been tasked to speak about safe, about patient safety. I'm not here to bash optometry. In fact, they are an important part of the eye care profession team, but here are some examples of when those not properly trained to perform surgery create undue patient harm. So, in Oklahoma, we have a variety of examples. I am limited by time, so I will skip to the most pertinent. The following is a patient who after months of evaluation for a painful red eye by two different optometrists was finally sent to the emergency room for pain relief. The emergency room doctor, not the optometrist, diagnosed chronic angle-closure glaucoma and referred to ophthalmology. A peripheral iridotomy would have been an early treatment but due to delay in diagnosis and scar formation, she required glaucoma filtration surgery. The two optometrists that repeatedly saw the patient and failed to properly diagnose the patient were, quote-unquote, laser certified by the optometry board. The patient filed lawsuit against optometrists but when she'd soon died from a ruptured cerebral aneurysm, the lawsuit died as well. There was also a VA patient who came from a community optometrist to ophthalmology with hyphemia in both eyes. Optometrist diagnosed the narrow angle and recommended laser peripheral iridotomy in both eyes. The laser procedure was started in the first eye and soon the patient experienced bleeding in the anterior chamber, and he was not clear enough to complete the iridotomy. The optometrist moved to the other eye and attempted the same procedure. The same thing occurred bleeding in the anterior chamber, in neither eye was the procedure completed due to the bleeding. The patient's eye pressure increased due to the blood in the eye, and the patient was referred to the VA hospital where he had to be hospitalized for control of eye pressure. He was also on potent blood thinners. When the blood cleared, it was noted that the patient did not actually have narrow angles and the procedure which caused the complication was not needed. Again, we have another patient who had vision issue and saw an optometrist that recommended peripheral iridotomy, and this was done in both eyes. This did not resolve her visual

issue and she sought a second opinion. Review of the records described no visual compliance and no physical findings of narrow angles. It did document insurance coverage. The ophthalmologist diagnosed an epiretinal membrane as the source of visual complaint. The patient asked, “Was I harmed?” Patient did not need a procedure, did not have complications, but the insurance did have to pay for the procedure because the insurance cannot deny payment when a State allows optometrist to perform surgery. However, if the records were audited, the payment would be recouped. So, these are some examples of when and when not to do surgery. Either way, the wrong call is due to lack of education and experience. More examples include a patient who’s told by corneal specialist, an ophthalmologist who specializes in the cornea, that he is not a good candidate for LASIK surgery. He was, the patient was however, encouraged by his girlfriend to see an optometrist. The optometrist also told the patient he was not a good candidate, but he would watch to see if the patient would be in the future. Two weeks later, the optometrist told the patient he could have LASIK surgery. He underwent the procedure, and the vision was worse than prior than to the procedure he called and complained without any response to the optometrist office. Someone from the office did call the patient back and said if he wanted his records, he needs to come get them out of the dumpster because the optometrist threw them away. The patient went and retrieved records and saw the same cornea specialist that said he was not a good candidate. However, unfortunately, there was no good way to correct the vision. Other examples we have encountered are suggesting a YAG capsulotomy when, one, the capsule was clear, and the problem with the vision was uncorrected astigmatism. Two, the capsule was clear and age-related macular degeneration was the cause of vision loss. Three, the capsule was already open, that is, had already been lasered. All would have been obvious with proper slit lamp examination by a skilled and medically trained physician. The most startling example of optometric laser complication involved a patient who is supposed to receive a YAG capsulotomy from an optometrist. However, the optometrist could not adequately visualize the poster capsule with the slit lamp. Therefore, a special lens was utilized for improved visualization of and laser administration to the posterior capsule.

Unfortunately, the optometrist selected the wrong lens, so the laser was focused on the retina instead of the posterior capsule...

1:13:57

Moderator: I apologize Mr. Harvey, unfortunately, your time has been completed.

1:13:59

Ben Harvey: Okay I want to thank you all for allowing me to speak, and, everyone have a good day.

Moderator: Thank you so much for your comments.

1:14:13

Moderator: I will now call upon Dr. John Peter, from the American Academy of Ophthalmology.

1:14:36

Moderator: Dr. Peter you are good. Thank you.

1:14:54

Dr. John Peter: Are you able to hear me now?

Moderator: Yes sir. You may proceed.

Dr. John Peter: Great. Thank you. I apologize for the technical difficulties. Thank you for allowing me to speak today.

1:15:03 [MATERIALS: American Academy of Ophthalmology]

Dr. John Peter: Afternoon, my name is John Peter's MD I'm a practicing ophthalmologist from Omaha, Nebraska, and I serve as a Secretary for State Affairs at the American Academy of Ophthalmology. Please move to my next slide. Ophthalmologists who work in the VA provide consistent and high-quality surgical care to Veterans. Ophthalmologists have provided that surgical care for generations of Veterans. Next slide please. Optometrists also play an important role, providing services to Veteran patients. However, I'm speaking here today to convey our concerns that, as the VA develops its national standards of practice for optometry, we must not relinquish the high standards for surgical eye care Veterans expect and deserve. Next slide. In 2004, the VA restricted laser eye surgery to ophthalmologists. The VA has reviewed and reaffirmed this policy three times over the last two decades. We support keeping this patient safeguard in place to protect Veterans. Next slide. Forty-one States and the District of Columbia prohibit optometrists from performing anterior segment laser surgeries, encompassing 89.5% of the U.S. population. The Academy is concerned the VA might adopt a lower standard resulting in Veterans facing an unsafe and lower level of care. Notably, my rural State of Nebraska, and the much larger State of California, the State with the most Veterans, both prohibit optometrists from performing laser surgery. Next slide please. Speaking of California, as mentioned earlier, in 2022, optometry failed to pass the surgery bill that included various laser procedures. California Governor Gavin Newsom, who vetoed the legislation, wrote: "I am not convinced that the education and training required in the bill is sufficient to prepare optometrists to perform the surgical procedures identified." Physicians who perform these procedures must complete at least a three-year residency program. We know of no compelling reason for the VA to conclude otherwise. Next slide please. An ophthalmology study from France examined YAG laser capsulotomy outcomes when performed by ophthalmologists, revealing an adverse event rate of approximately 13% within the first year. Around the country, we have heard claims from optometrists and several State optometry boards of no adverse outcomes from their performance of these surgeries. And we find this would be extremely unlikely as shown

by this study. This raises serious concerns for us about optometry's recognition reporting and addressing complications. We worry that optometrists may not recognize or handle these situations properly, thereby subjecting Veterans to harm. Next paragraph please. Earlier it was mentioned, there's a study in JMA ophthalmology in 2016 with a much higher likelihood of patients needing repeat glaucoma laser treatments if the original was done by an optometrist, rather than an ophthalmologist. The potential reasons for the difference are concerning. There's the potential for inadequate training, unfamiliarity with essential tests to evaluate and treat the patient, and lack of understanding possibly of the time needed for the treatment to take effect. The study underscores our concerns about patient safety as well as increased costs. Next paragraph, or next slide, I'm sorry. We have not seen any scientific study in the medical literature that would alleviate our concerns regarding the surgical competence of optometrists. Our Veterans most often have comorbidities and preexisting injuries to place them at greater risk than the general population. Next slide. In conclusion, eye surgery is not simple or minor. It's not merely a technical skill. It requires intense, incremental, and arduous development of skill and judgment that is not obtainable on a weekend course. Surgeons must consider the unique qualities of each patient and tissue and anticipate potential circumstances that may develop and then have the experience to address them. This careful consideration and approach applies to lasers, scalpels, and other surgical instruments, such an approach also applies to the VA's decision when taking into consideration who will be allowed to be a surgeon with their facilities. I encourage the VA to place proven skill and patient safety as top priorities, and thereby maintain the current eye surgical standards in this national standard of practice. Thank you very much for your time.

1:19:20

Moderator: Thank you for your comments. At this time, I will ask if any clinical representatives on the line would like to ask any clarifying questions in regard to optometry to please do so now.

1:19:43

Moderator: Hearing none, we will move to the next occupation. We do not have a list of pre-registered individuals to present on Respiratory Therapist. If you would like to comment on this occupation, trying to, during today's session, please use the Q and A function to indicate your interest to do so. Time will be allotted at the end of the session.

1:20:08

Moderator: We will now move to Podiatrist. I will now call upon Benjamin Wallner, from the American Podiatric Medical Association to present their comment.

1:20:24

Benjamin Wallner: You hear me?

Moderator: Yes, sir. Please proceed.

Benjamin Wallner: Perfect. Thank you. My name is Benjamin, and I represent the American Podiatric Medical Association, and the profession of podiatric medicine and surgery.

1:20:36

Benjamin Wallner: Thank you for the opportunity to provide comments on behalf of doctors of podiatric medicine also known as DPMs regarding the VA national standards of practice project. We commend the VA for its focus to more effectively and efficiently utilize medical professionals and to improve access to quality healthcare in the VA. Similar to other physicians training, current podiatric medical school curriculum focuses on medicine, surgery and patient encounters. Residency is mandated for all graduating podiatric physicians. It is standardized comprehensive and is a three-year medicine and surgery model with enough positions to satisfy all of our graduates. There are currently 235 podiatry residents working to complete a broad curriculum, equitable to allopathic and

osteopathic residency training. Additionally, there are three new fellowships housed within the VA. Today's podiatrists are appointed as medical staff at the vast majority of hospitals across the country, including many facilities nationwide. And many podiatrists served in leadership roles within those institutions. Podiatrists at that these facilities enjoy admitting privileges and many are also responsible for emergency and trauma call. The competency skill and scope of today's pediatric physicians and surgeons aligns with our allopathic and osteopathic colleagues. Because of this CMS recognizes today's podiatrist as physicians and TRICARE recognizes us as licensed independent practitioners. Veteran populations often plagued by socio-economic challenges and psychosocial conditions are ailing, have more comorbidities and experience disproportionately poor health status and outcomes compared to their non-Veteran counterparts. These factors contribute to an increase in diabetic foot ulcers and amputations, burdening patients, and the health care system. Almost two million Veterans are at risk of amputation with underlying diabetes, sensory neuropathy, and non-healing foot ulcers. The Veteran population is far more complex to treat than patients in the private sector as a whole. One of podiatry's major missions within is amputation prevention and limb salvage, which provides cost savings to the VA and plays an integral role in the Veteran quality of life. As part of the interdisciplinary team, podiatrists independently manage patients within our scope of practice and assume the same clinical surgical and administrative responsibilities as any other independent medical or surgical specialty. It is the position of APMA that the national standard of practice for podiatrist should read as follows, quote, "Podiatric medicine and surgery is the specialty that addresses the diagnosis and treatment of pathologies and conditions of the lower leg with special emphasis and the diagnosis and treatment of the foot, ankle, and their governing and related structures of the leg by any and all means. Osseous surgical treatment is limited to that part of the lower leg distal to the tibial tubercle," unquote. At present, there are 48 States as well as the District of Columbia and Puerto Rico that allow DPMs to perform medical and surgical treatment of the ankle. Likewise, the vast majority of States make no specific reference to requirements for specialized training in skin, subcutaneous, or wound care. APMA believes that the podiatric

physicians, and surgeons should enjoy scope of practice language commensurate with education and training. And as with our osteopathic and allopathic colleagues, that there should not be specific limitations in place related to board qualification or certification, as part of scope of practice language. An individual provider's privileges should be determined at the facility level by a panel of practitioners, empowered to review privilege requests based on education, training, and experience. Occam's razor is a problem-solving principle whereby the simplest solution is often the best. APMA's promote, proposed scope would permit qualified podiatrist the opportunity to perform to the highest levels of their education, training, and experience. This concludes my remarks; once again, on behalf of APMA and the nation's expert foot and ankle, medical and surgical providers, we thank you for the opportunity to participate in the process of developing a national standard of practice for podiatry.

1:24:51

Moderator: Thank you for your comment.

1:24:54

Moderator: We'll now move to the next occupation. We do not have a list of pre-registered individuals to present on perfusionist. If you would like to comment on this occupation during today's session. Please use the Q and A function to indicate your interest to do so. Time will be allotted at the end of the session is available.

1:25:16

Moderator: We will now move to the next occupation. We do not have a list of pre-registered individuals to present on therapeutic radiological technologist. If you would like to comment on this

occupation during today's session, please use the Q and A function to indicate your interest to do so. Time will be allotted at the end of the session if available.

1:25:41

Moderator: We will now move to the next occupation, acupuncturist. I will now call upon Amy Mager, Legislative Co-Chair, Acupuncture Society of Massachusetts, Board of Director for the Acupuncturist Without Borders to present their comments.

1:25:59

Moderator: As a reminder, please raise your hand if you join via web using the hand raising button at the bottom of your webinar platform. If you dialed in on phone, please press star 3 to identify yourself. Our technicians will call on you and press, and you will press star 6 to unmute.

1:26:31

Moderator: I will move on to the next individual. Next, I will call upon Mary Nolan to present their comment.

1:26:56

Moderator: As a reminder, Ms. Nolan, if you dialed in using a telephone, please press star 3 to identify yourself and our team will identify you to unmute press, and you will press star 6.

1:27:10

Mary Nolan: Wonderful. Can you hear me? Okay?

Moderator: Yes, Ms. Nolan, we can hear you. Please proceed.

1:27:15 [MATERIALS: Mary Nolan's "Acupuncture" materials]

Mary Nolan: Wonderful. Could you please display the material? I submitted the slides.

Moderator: Yes, I will be doing that right now.

Mary Nolan: Thank you so much, Elizabeth.

1:27:23

Mary Nolan: Good afternoon. My name is Mary Nolan. I'm presenting on behalf of Northwestern Health Sciences University as a graduate with a Doctorate of Acupuncture in Chinese Medicine. My focus for these 4 minutes is on the advocacy practice standards, specific to inpatient and acute care. Time doesn't allow for a deep dive on this today, but Minnesota has already laid the foundation implemented inpatient acupuncture programs and is seeing the positive results on patient care. So, I encourage the committee to reach out to the many experts on this topic for more information. Next slide please. The VA's already conducted extensive research on the merits of acupuncture in the outpatient settings so I won't belabor the value we add there, but I will emphasize our valuable role as integrated medicine providers in the inpatient and acute care settings for the purpose of these national practice standards. Bottom line up front, I'm recommending the VA's national practice standards for acupuncture include our role in inpatient and acute care specifically for the VA Medical Centers. A quick list of justifications for this recommendation I can speak to the Minnesota practice standards, which specifically support acupuncture in the hospital setting. More on that in the coming sides. Further, NCCAOM, our national board certifying body ensures that acupuncturists have completed rigorous hands on training and biomedical courses, such as pathophysiology, neurology, endocrinology, reproductive health, allowing us to work to the top of our scope of practice and importantly, communicate effectively. With all members across the health care team, including acupuncture in the VAMC is consistent with the whole health approach for patient centered care. The joint commission recommends acupuncture as a non-pharmacological pain management option

while research supports it reduces reliance on opioids. There's abundant research in literature on acupuncture disability to improve the inpatient experience and recovery. More on that to come as well. Lastly, introducing patients to acupuncture in the inpatient setting lends to continued care in the outpatient setting, reducing the burden on primary care. Next slide please. I'll go into the Minnesota acupuncture practice standards and their applicability to inpatient and acute care and the research as well. But first, next slide please. Very quickly—my name again, Mary Nolan, I'm a former U.S. Army Preventive Medicine Officer, Combat Veteran, West Point graduate, now with a Doctorate in Acupuncture and Chinese Medicine. My focus has been on hospital inpatient internships of which Minnesota currently supports many. Next slide please. The applicability of the Minnesota acupuncture practice standards and patient in acute care includes specifically reviewing patient diagnoses in medical history, obtaining informed consent for patients using sterilized equipment in accordance with CDC standards, independently assessing diagnosing and treating patients maintaining patient records and referring to other health care practitioners all of which are conducive to offering acupuncture in the VAMC settings. Next slide please how including inpatient acupuncture in the national practice standards will benefit VAMC patients again, it's a non-pharmacological pain management option. It helps to transition patients from the sympathetic trauma response to the parasympathetic response more conducive to healing. It can improve sleep, repair recovery in addition to helping reduce barriers to discharge further. It does a unique role in an integrated medicine team approach. Next slide please. Here are just several of the Minnesota hospitals that currently employee inpatient acupuncturists. Next slide please, and the supporting research, next slide please. The following sides go into great detail on how current research supports acupuncture as an inpatient therapy, including its use in the emergency department to reduce pain and anxiety. The research provides further justification for my recommendations today. Which is to include acupuncturists in the inpatient and acute care settings in the VHA national practice standards. Thank you so very much for your time.

1:31:49

Moderator: Thank you so much. I will now call upon Stephen Englehardt from the Minnesota Acupuncture Association.

1:32:10

Stephen Englehardt: On behalf of the Minnesota Acupuncture Association, I just want to quickly give an overview of the scope of practice and areas that we practice in starting with our training standards. All acupuncturists throughout the country, regardless of different State licensure do have a masters or doctorates accredited by the Accreditation Commission for Acupuncture Herbal Medicine. The board certification varies a little bit from State to State. California, having their own board exam and two States not having any regulation on the books, but every acupuncturist through all 50 States do have either masters or doctorates accredited by ACAM. Also, prenatal technique certification, which is a national certification to maintain safety in practice. Our scope of practice is a lot more than just acupuncture. We use that as our professional title just 'cause it's most recognizable. But it's important to make sure that any standard practice also includes the full scope of our practice, including cupping and dermal friction, manual manipulations, which we call tuina. Use of moxibustion, which is burning herbs depending on the logistics in different facilities. Herbal medicine, both topically and internal, and then dietary exercise and lifestyle recommendations based on DCM principles. Additionally, we are trained to read certain labs and use those within the scope of our practice. It's not the only thing we would be able to make a diagnosis on, but it is part of the things that we are trained to include in our diagnostic decision-making process and injection therapy is another therapy that is growing in popularity and becoming- is being added to scope of practice throughout the country, including currently in the works in Minnesota. Our range of practice includes pain medicine which is what most known for, but in Minnesota, we actually have quite a few acupuncturists operating in most if not all-I'm not sure if it's all, but most hospital

networks within the States- they work in emergency rooms, maternity wards, operating rooms-not sure if they're in Minnesota operating rooms or not, but there are acupuncturists not performing procedures obviously, but performing acupuncture during the operation physical or neurological rehabilitation, mental health addiction, reproductive care, cancer, and dermatological and allergy issues. We're able to help with all these different areas. So, it's critical to make sure that our standard of practice includes the ability to access patients in all areas of the health care system. I also want to just quickly highlight the importance that we are front line health care providers in most States. We do not need a referral from any other provider. Our training does include the ability to identify when referral to other providers is needed. We're not primary care providers. But we are front line providers who are able to practice without need for any referral. That's important because early intervention and inclusion of acupuncture early on in treatment is critical to maintaining the best possible outcomes. Especially when we're talking about opioids and mental health issues in particular. There's a lot of research showing that acupuncturists being brought in at the very beginning of that process leads to lower opioid addiction and better outcomes. Ah, thank you, that's all I have for you.

1:36:08

Moderator: Thank you so much. Next, I will call upon Mark McKenzie from the Accreditation Commission for Acupuncture and Herbal Medicine.

1:36:24

Moderator: As a reminder, if you dialed in via phone, please press star 3 so our team can identify you.

1:36:31

Mark McKenzie: This is Mark McKenzie.

Moderator: Hi Mark.

Mark McKenzie: Can you hear me okay?

Moderator: Yes, thank you.

Mark McKenzie: Great. Thank you so much.

1:36:40

Mark McKenzie: Uh, good afternoon. My name's Mark McKenzie. I'm the Executive Director of the Accreditation Commission for Acupuncture and Herbal Medicine. I have been so for the last 10 years. I'm also a licensed acupuncturist in Minnesota. Thank you for the opportunity to speak to you today and introduce you to the Accreditation Commission for Acupuncture and Herbal Medicine, a specialized accredited agency recognized by the U.S. Department of Education. ACAHM is the only specialized accreditor recognized by the Department of the Ed to accredited institutions and programs in the field of acupuncture and or herbal medicine. ACAHM was founded in 1982 and it's been continually recognized by the department since 1988. ACAHM has publicized- published educational standards for entry level masters and doctoral degrees, and advanced practice doctoral degree training programs. We currently accredit a total of 139 programs at 52 independent institutions with 62 different locations in 23 different States. Our total enrollment exceeds 6,000 students studying acupuncture and or herbal medicine. We are currently 82 master's degree programs, 33 professional doctoral degree programs, and 12 advanced practice, doctoral degree program. Each of these institutions can be found on our website. National and regional and specialized accreditors are reviewed every 5 years by the Department of Ed to ensure that the accrediting body meets specific standards established by Congress. ACAHM scope of recognition from the Department is the accreditation and pre-accreditation throughout the United States

professional non-degree and graduate degree programs, including professional doctoral programs in the field, as well, as freestanding institutions, and colleges of acupuncture that offer such programs, including programs offered by via distance education. We're 501(c)(3) nonprofit as such. We do not specifically advocate on behalf of federal or State legislation, however, we are available to answer any questions that you may have about accreditation standards. I did want to let you know that our standards, as they have been in place since the early 80s, are basically the baseline for almost all State practice apps so as the VA is looking to create standards of practice, I would encourage you to look at our standards, especially standard 7, which is program of study. That program of study indicates all of our various programs, but also includes all of the competencies that form the baseline training for all students throughout the United States. And with that, I'll go ahead and close. And again, thank you for the time.

1:40:02

Moderator: Thank you so much. We will now move on to Amy Mager, Legislative Co-Chair, Acupuncture Society of Massachusetts, Board of Director for Acupuncturists Without Borders to present their comments.

1:40:19

Amy Mager: Thank you so much for this opportunity.

1:40:32

Amy Mager: Thank you so much for the opportunity to speak with you today and I applaud the VA for working to acknowledge and create meaningful standards that are appropriate within the practice act of acupuncture. So, I want to thank Mark McKenzie for being here and presenting the standards for ACAHM. You know, as you may, or may not know every applicant for the National

Certification Commission for Acupuncture and Oriental medicine must complete a minimum of 1905, clinical and didactic hours instruction hours in acupuncture related courses. In the Commonwealth of Massachusetts there needs to be a minimum of 100 hours in which a provider is supervised, but responsible for their own patients. In order to sit for the national certification exams, we each need to not only have completed our accredited a program, we need to sit for the national certification exams, as well as take the clean needle technique course, and pass that exam as well as have at least 660 clinically supervised hours. In order to practice, we have training, we have to have at least 90 hours in counseling, communications, ethics, and practice management. 450 credit hours in biomedicine. We need to have at least 705 hours in acupuncture theory. We need to have 450 didactic hours in Oriental verbal medicine studies to sit for the herbal medicine exam. 870 hours in a clinic. 510 biomedicine hours. And these are the basic standards, we are all required to take continuing education requirements, 60 hours every four years in order to maintain our national certification standards. So, I want to invite the VA to use the skills and tools that we have within our practice act to support those who have served our country. We are able and willing to serve both in the VA and as community acupuncturists. Because in some States, like, in the Commonwealth of Massachusetts, there are not enough acupuncturists on staff at the VA to provide the amount of care that patients are seeking for treatment of pain, PTSD, opioid addiction, and nausea. And all of these things are things that our Veterans come in with when we work with them. We have a unique set of skills that makes us a valuable member of an integrative health team. Nothing is a panacea, and we are profoundly trained and examined to be good team members, right? There's significant research in the demonstration of the efficacy of acupuncture in the Nielsen paper. And we know that the VA covers acupuncture because it works. It is demonstrated to be efficacious in the treatment of pain, PTSD, nausea, and opioid addiction. In a Rhode Island study, they found that every dollar spent on acupuncture decreased overall health care costs by $2.31. That is significant and not only does do the financial pieces matter, but the intangibles matter about the companion of patients and our presence and support as part of an integrative team member for that patient's

care. Thank you so much for your time and willingness to listen and for your due diligence in this process.

1:44:35

Moderator: Thank you so much for your comment. I will now call upon Bonnie Bolash to present their comment.

1:44:52

Bonnie Bolash: I'm a licensed acupuncturist in Minnesota. I'm here today to be a representative of the history of acupuncture and Chinese medicine in the United States as well as Minnesota. I am here to say acupuncture is a separate, indistinct segment of medicine and not merely a technique to be used by the other healing arts. Thus, the separation of one effect of a technique from the entire practice of acupuncture seems unwarranted until further study can be made. That comment was made by the Michigan Attorney General in 1974. Acupuncturist as a profession has gone through many trials and tribulations. And I'm so incredibly thankful for the VA to include acupuncturists within their system as well as, as an acupuncturist out in the community, providing care to the Veterans. I have concerns as I addressed in the previous listening sessions regarding the rebranding of acupuncture and Chinese medicine. Acupuncture has been in the United States since the 1700s. There was a federal- there's a Food and Drug Administration article or report in May 1993 about the history of acupuncture as well as what the acupuncture treatment looks like. Throughout history, I found thousands of articles and documents. If you want to look at my newspaper.com account, I've collected over 1000 articles, just on acupuncture and acupuncturists and key words like, the first time acupuncture was used in U.S. newspapers was in 1825. The term acupuncturist appeared in 1887. We saw Janet Travell's work of acupuncture. In 1947, where she gave a presentation, and it was associated with acupuncture. When she provided dry needling technique, which is acupuncture

on John F. Kennedy, it was reported across the United States as acupuncture. We see in medical history for example, the annals of medical history in 1924 categorized Chinese medicine to include acupuncture, bone setting, cupping, herbal medicine, massage, medical gymnastics and moxibustion. There are many instances where acupuncture and Chinese medicine has suffered has been held back. And I hope anybody that hears this will support acupuncturist and not the rebranding of acupuncture and Chinese medicine. One of the ways in which acupuncture has been held back is medical literature. I tried to get a 1974 Minnesota Medical Association article into Pub Med. So, I reached out to Pub Met and I said, oh, my gosh, there's this acupuncture article. Can you put in the keywords that were in this article trigger point needling and things like that? Dry needling was in this article, and basically, I got a response that that this article isn't eligible for inclusion in the PMC because it isn't a journal that deposits into the PMC. And it was not funded by funding provided after 2008, when the public access policy began. Please don't make decisions on the rebranding without having a cultural competency discussion. I am willing. I have spent thousands of hours collecting thousands of pages of the history of acupuncture and Chinese medicine, and I'm available and I really appreciate the VA for including us acupuncturists and please don't rebrand the medicine. Thank you.

1:48:33

Moderator: Thank you for your comments.

1:48:37

Moderator: We will now move to the next occupation Massage Therapist. We do not have a list of pre-registered individuals to present a Massage Therapist. If you would like to comment on this occupation during today's session, please use the Q and A function to indicate your interest to do so. Time will be allotted at the end of the session, if available.

1:49:00

Moderator: We will now move to the next occupation, Genetic Counselor. I will now call upon Cassandra Williamson from the Transgender and Diverse Veterans of America to present their comments.

1:49:28

Moderator: If you joined in via phone, please press star 3 to raise your hand, and our team can unmute you and you will press star 6 to unmute. If you join via the webinar, you can unmute yourself once we identify you.

1:49:56

Moderator: We will move to the next presenter. We will now call upon Fuki Hisama from the American College of Medical Genetics and Genomics.

1:50:20

Fuki Hisama: Are you able to hear me?

Moderator: Yes, you may proceed.

1:50:26

Fuki Hisama: Thank you. Hello, I am a professor of Medical Genetics at the University of Washington, and I'm here today speaking on behalf of the American College of Medical Genetics and Genomics. The ACMG is the largest professional organization for all medical genetics healthcare professionals and is pleased to provide input today on the VA national standard practice for genetic counselors. The training of physicians who are certified by the American Board of Medical Genetics and

Genomics includes four years of medical school followed by 10,000 to 16,000 hours of supervised, clinical training, lasting four to 10 years during residency and fellowship. Physicians are trained to care for patients with complex and multiple medical problems. The practice of medicine for physician geneticist encompasses diagnosis, physical examination, ordering genetic as well as non-genetic diagnostic testing, prescribing medications, managing patients with complex diseases, and counseling patients with, or at risk for genetic conditions. Genetic counselors are master's level professionals whose education lasts 18 to 24 months and includes 1,000 hours of supervised clinical training. Genetic counselors provide risk assessment, information on inheritance, guidance, and pre- and post-test counseling services for patients. There is considerable variance among the different United States in the licensing and scope of practice for genetic counselors. Some States license genetic counselors to practice, others have no genetic counselor licensing. The majority of States that license genetic counselors include identifying and coordinating genetic testing in the scope of practice. Some States require a written, collaborative agreement with a physician for genetic counselors, in order to order genetic testing. One State prohibits genetic counselors from ordering genetic testing. Some genetic testing laboratories require a physician to be the ordering provider for genetic testing. At the Federal level, Medicare does not recognize genetic counselors as health care providers. The ACMG supports recognition and reimbursement for genetic counseling services for genetic counselors, but not for the practice of medicine. The ACMG's recommendation for the VA national standards of practice is that genetic counselors should work as part of a health care team led by qualified licensed physicians. This should be documented formally by a written, collaborative agreement, in order to provide the highest quality and safest care for the Nation's Veterans. Thank you.

1:53:43

Moderator: Thank you so much for your comment. We will now move to the individuals who may

have had experienced technical difficulties. I will now call upon Cassandra Williamson again from the Transgender and Diverse Veterans of America present their comments.

1:54:05

Cassandra Williamson: Thank you so much for having me. I appreciate it. My name is Cassandra. Williamson. I'm the Executive Director for Transgender and Diverse Veterans of America, and for Transgender Diverse Veterans of American Action Group. I am not a geneticist. I am not a genetic counselor, but I do want to express how important it is to make sure that whenever you're doing the studies on genetics and asking our Veterans to participate that you include inclusive language in the surveys. That the surveys don't conflate sex and gender and things like that because it's important to know that and we do want to know who we are and how we got here. Let me see if I've got a written thing here for you anyway. So, one of the ways that we can ensure that everyone is treated inclusively is by asking inclusive questions on your intake forms records, research studies programs. For example, instead of asking for a person's gender, you could ask for their sex assigned at birth and their gender identity. This allows people to self identify in a way that is comfortable to them. We need understanding to understand the difference between sex and gender, but they are related. But different inclusive questions are also important for the research. When we ask a list of questions, we get a more accurate picture of the experiences of our Veterans and their families. This information can then be used to improve those services are available to them. Primarily, I just wanted to mention that to our geneticist and our genetic counselors is, and anyone to please consider making sure that all your intake forms all your information in your records across the country, whatever your State level or Federal levels, please include inclusive language. Please do that. So that we know who we're dealing with, and that way, we can get appropriate treatment and care. So, with that, I will turn it back over to you. Thank you.

1:56:03

Moderator: Thank you so much for your comment. We will now open the mic up to any individuals who indicated their interest to present using the Q and A function of the chat. You may also raise your hand now, using the Webex platform at the bottom of your screen. If you've dialed in on your phone, you may press star 3 on your phone to raise your hand, to indicate your interest to present. Once identified, you will press star 6 to be unmuted.

1:56:41

Moderator: I will now call upon Samuel Collins from the American Acupuncture Council.

1:57:00

Samuel Collins: *Inaudible*

Moderator: You're on mute. Yep, hello.

Samuel Collins: Hello? Hi. Can you hear me now?

Moderator: We can hear you, thank you. You have four minutes to present.

1:57:09

Samuel Collins: Okay. Hi, this is Samuel Collins. I'm with the American Acupuncture Council. I'm specifically a coding and billing expert when it comes to acupuncture and teach multiple seminars through all the accrediting agencies as well as State association and national for acupuncture. I want to applaud the VA, because myself, I was included in the WHO, World Health Organization, if you will, global summit, where Tracy Gaudet from the VHA presented to the world, the access of care for Veterans among the VA and how that is changing patient outcomes, and obviously giving patients outcomes with less cost. However, the thing I would like to address is when there's consideration of

the standard episode of care for acupuncture, there's often confusion among the providers to make sure they have the best and correct codes for the services they're doing. And to assure they have proper documentation. As a consequence, one that stands out is, of course, the standard episode of care does indicate cupping. But there's no direction as to which code to use, of course 97039, the unlisted CPT code, can well be used, but there's also a listing of 970106, which many believe to be for cupping. Of course, 970106 under the CPT is a vasopneumatic device, which is generically a compression device or sleeve that goes over an area. Now, if the VA is stating that that is the appropriate code, I would hope that they give some indication to make sure that acupuncturists can properly document their service and assure that they're always demonstrating the best in outcomes. I will continue to applaud the VA and its leadership, and Tracy Gaudet specifically, as she spearheaded this program, but there continues to need to create an access for acupuncturists to make sure that patients and Veterans have access. Because obviously, the outcomes with opioids have been somewhat of a disaster, uh, to an extent. And, of course, the acupuncture with pain relation has really made a nice change. Thank you.

1:59:10

Moderator: Thank you so much for your comment. I will now call upon Marilyn Allen with the American Acupuncture Council.

1:59:26

Marilyn Allen: Thank you for letting me speak. I also joined Sam in the Traditional Medicine Global Summit, but I worked with the WHO. I represent acupuncture to the World Health Organization from the United States. We have established a vocabulary list as well as now there is a set of diagnostic codes, which will include a Western diagnosis, an Eastern disorder, and pattern differentiation. This will give the acupuncturists the ability to mark custom tailor the treatment for the Veterans. I appreciate that acupuncture has been included so far. And would like to continue

that we expand the services for the Veterans using acupuncture. These codes will be, are released already from the World Health Organization and the United States is in the process of thinking about when they will adopt ICD-11. In the codes, these are called traditional medicine one, and are very specific about disorders and patterns which customize credements. Thank you for your interest in acupuncture and we appreciate your help in serving our Veterans across America.

2:00:52

Moderator: Thank you so much for your comment. We will now move to Jason Scull with the American Medical Association.

2:01:07

Jason Scull: Can you hear me?

Moderator: Yes sir, we can.

2:01:14

Jason Scull: The AMA has been aware of the Federal Supremacy project for several years. Our main concern has been that NSPs, like optometrists and respiratory therapist and podiatrists and other non-physician providers, may be allowed to provide services and perform procedures that are outside the scope of their knowledge and the license and to practice independently without the clinical supervision of physicians. This will undermine physician-led teams. And ultimately lead to a lower standard of care for Veterans. It also runs counter to research, showing that not only is care best delivered by physician-led teams. But additionally, four in five patients want and expect. No other occupation comes close to the four years of medical school, three to seven years of residency training, and 12,000 to 16,000 hours of advanced medical and surgical training that physicians must go through. A balanced NSP development process designed to get the best result for the

beneficiaries could include relevant positions, specialty representatives like ophthalmologists on workgroups that consult with a more diverse group of internal and external stakeholders. Before they are published in the Federal Register, we look forward to working with the VA as it moves through the NSP development process. Thank you.

2:02:47

Moderator: Thank you so much for your comment. We will now move to Chip Richardson with the American Academy of Ophthalmology.

2:03:11

Chip Richardson: Can you hear me?

Moderator: Yes sir. You may proceed.

2:03:16

Chip Williamson: Hello I'm Dr, William Richardson. I'm a general ophthalmologist with 15 years' experience, and a mixed medical doctor optometry private practice. I'm the immediate past president of the Kentucky Academy of Eye Physicians and Surgeons. I have two family members who are optometrists and have employed optometrists at the top of their class with contemporary optometric training. I'm able to provide the Kentucky experience, a State that allowed optometry expanded scope in 2011 when 80+ percent of the public was against it. I'd like to thank everyone for the opportunity to speak today as others have noted. I was surprised when I heard that the VA had embarked on this path to allow optometry to provide surgical service for our awesome Veterans as I mentioned. I have employed and interviewed brilliant optometrist who have graduated from U S. optometry schools who have themselves become expanded therapeutics or EPT certified in Kentucky. Shockingly, these important members of my care team or unified and that they lack the

confidence training experience to deliver these minor surgical procedures safely. Many were actually relieved that I would not ask them to do this in my practice. Relieved. We now have 11 years' experience with optometry expanded scope. My experience dispels the notion espoused by others, that medical school and residency are not important whether it's learning how it feels to pass a needle and various skin types, the sterile technique, delivering anesthesia complication management, or even the basic identification of those who lack the physical or mental capability to do surgery. Years of medical training do matter. Believing that one can squeeze the necessary didactic and experience into the same timeframe of a four-year general optometry program or a 32-hour course, as is the case in Kentucky, is not founded. Shockingly, it should be noted that in many cases optometry lacks the privileges or training to manage the known complications from many of the procedures they seek to perform. Optometry advocates may tell you that there have not been complications in our State of Kentucky, or that premiums haven't increased. I believe that the reason premiums haven't increased is that only about 33 or so of the 600 or so optometrists in our city actually do these procedures and expose insurers to claims. Being the past president of my society has given me insight into many optometry complications. All of these events are substantiated by our society's members employees who directly observe these events, or by members who have managed these complications. Number one, from Eastern Kentucky, while performing a needle injection of anesthesia into an eyelid, a Kentucky teacher of optometric surgery accidentally went through the eyelid and directly into the eye. As everyone knows, this is a grave complication. Also, from Eastern Kentucky, while attempting to perform an after cataract YAG laser procedure, another teacher of optometry surgery subjectively patient to a multi-hour procedure usually completed in minutes. These struggles often lead to multiple laser defects in the lens and cornea abrasions, not to mention anxiety. Again, from Eastern Kentucky, while attempting to remove a benign eyelid lesion, which is what statute allows a professor of Optometry surgery used another provider's magnifiers and proceeded to use the dull edge of the number 11 scalpel. Now, from central Kentucky, a patient who was subjected to a laser peripheral iridotomy on one eye, asked the practice to have the MD to

do the subsequent eye as she did not want to have the staff optometrist try the uncomfortable procedure multiple times in multiple visits to get it correct. From central Kentucky, an optometrist performed a laser peripheral iridotomy on a patient with neovascular glaucoma when this procedure isn't indicated. This delayed the patient's care causing further glaucoma damage. From central Kentucky, an adult patient who had pediatric cataract surgery, an optometrist lasered the vital capsule, separating the two chambers of the eye causing severe glaucoma. Fixing this tragedy took operations by ophthalmologist. In this case, having cataract surgery experience would have prevented the temptation to use that laser. And lastly, from central Kentucky, optometrists have recently been found by Medicare overstepping the optometrist's own statute by injecting glaucoma implants into the eye. Recent analysis of Medicare claims data suggests that 33 or so, of optometrists, notably all in Kentucky's urban areas, are outpacing the number of claims by MDs. This would suggest over-utilization as those populations' centers are well served by ophthalmology. The Oklahoma experience supports this. I'm confident that these types of experiences, and potentially unnecessary procedures are not the sort of experiences that we should be subjecting our Veterans to. Optometry is a vital part of the eye care team, but until their training resembles ophthalmologist training with the same minimum standards, required by our diverse accreditation council, our Veterans deserve to have MDs provide the surgical services that are now being requested by optometry. Thank you very much.

2:07:45

Moderator: Thank you so much for your comment. I will now call upon Deb Zurcher, licensed acupuncturist.

2:08:09

Deb Zurcher: *Inaudible*

Moderator: Hi, we can hear you.

2:08:22

Deb Zurcher: …from the Minnesota accupunture… I am a licensed acupuncturist… I wanted to speak to the research about chiropractic and how it can help both acute and chronic pain and we know that chronic pain with opioid addiction is really an epidemic in our nation and so just want to talk to you about the American College of Physicians recommending acupuncture for chronic low back pain as frontline treatment. That HHS recommends multi-disciplinary approach to the treatment of chronic pain, including acupuncture. As well as addressing bio, psycho, social aspects of pain. These are in the foundations of our education in Minnesota. Medicaid has a wide variety of conditions that are covered by Medicaid for acute pain; anxiety, chronic pain, depression, schizophrenia, post-traumatic stress disorder, insomnia, helps with smoking cessation, menstrual disorders. So, you can see that it's a very broad, um, listing of information and research that supports the use of acupuncture. Medicare is now covering acupuncture for chronic low back pain. And one of the biggest things that really is that with Fulcrum Health, we have three physical medicine networks and health care organizations are really looking for that conservative care approach first, in order to decrease opioid use, and not only stop early opioid use, but the long-term use of opioids. Thank you very much.

2:10:13

Moderator: Thank you so much for your comment. I will now call on Mina Larson with the National Certification Commission for Acupuncture and Oriental Medicine.

2:10:36

Mina Larson: Yes, hello. Can you hear me?

Moderator: Yes ma'am. We can hear you.

2:10:41

Mina Larson: Thank you so much. Good after…uh…thank you… Thank you so much. *Inaudible*… standards of practice…the VA. I'm the Executive Officer of the National Commission for Acupuncture Herbal Medicine, NCCAOM. The only national certification organization in the U.S. In 2019, the Department of Veterans required NCCAOM certification as one of the qualifications to work within the Veterans health care system. Since 1982, the NC examinations have served as a gateway for the profession of acupuncture and herbal medicine and 98% of States that regulate acupuncture require the NC examinations or certification as a prerequisite for State licensure. Today, the value of NCCAOM national examinations and certification is demonstrated by its acceptance in 46 States, plus D.C. that regulate acupuncture. All NCCAOM programs are also accredited by the National Commission for Certifying Agencies, the NCCA Standards for Accreditation of Certification Programs, where the first standards developed by credentialing industry for professional certification programs. The NCC standards were developed to help ensure the health welfare and safety of the public, and then highlight the essential elements of a high-quality program. The mission of the NCCAM is to ensure the safety and wellbeing of the public and to advance and advocate for the professional practice of NCCAM board certified acupuncturist by promoting, established national standards, focused on competence and credentialing. Our mission makes us partners with the VA and the important role of protecting the public and most importantly, our Veterans. I'm here to testify that licensed acupuncturists go through an extensive national education, training, and assessment process to become licensed. To qualify for NCCAM certification, licensed acupuncturists are required to meet extensive, academic, and clinical standards. The following are required- are the requirements the applicants for certification in herbal medicine must require. Number one, they have to graduate from full time formal school or college accredited by ACAHM, which my colleague,

Mark McKenzie, testified earlier. ACAHM is the only agency recognized for the purpose of accreditation by the United States Department of Education. Then they must complete a minimum of 2,625 hours of which represents four years of graduate school education. This includes 870 hours of acupuncture and Chinese herbal medicine clinical training, 705 hours of Oriental medicine foundations acupuncture theory, 450 hours of didactic Oriental herbal studies, and 90 hours of counseling, communication, ethics, and practice management. In addition, acupuncturists also complete 510 hours of education and biomedical clinical sciences. These hours ensure that an acupuncturist has necessary skills to perform, identify, and diagnose ailments. Finally, applicants must pass four separate examinations: foundations of medicine, acupuncture with point location, biomedicine, and Chinese herbology. The NCCAM biomedicine exam assesses for the knowledge skills and abilities for acupuncture to perform diagnostic examination, which includes understanding the clinical assessment process, clinical decision-making, and standard of care. The NCCAM considers due standards of eligibility as well as successful performance on our examinations to be the minimum requirements for the safe practice of acupuncture. Nationally board-certified acupuncturists get additional training and all active NCCAM certified practitioners must complete a rigorous continuing education requirement every four years, comprised of 60 hours of professional development activity hours, which includes completing an ethics, safety, and CPR course. The NCCAM professional development activity process ensures that practitioners have completed the recertification process have met continued competencies in our field. The practice of acupuncture is more than merely placing needles at various points for different conditions. Assurance of safe and effective therapeutic outcomes from acupuncture treatments relies on having a practitioner who is applying a system of medicine that uses a diagnostic treatment approach. It is from such a knowledge base that acupuncturists full efficacy and value can be realized by our valued Veterans. At the U.S. federal level licensed acupuncturists are widely recognized for their advanced education and training but the U.S. government to the U.S. Department of Bureau Labor and Statistics to the standards of classification code, which states that acupuncturist can diagnose, treat, and prevent

disorders and develop individual treatment plans on strategies. And of course, the Department of Veterans recognition in 2018 as well. I would also like to add that the NCCAM does an extensive job analysis process every five years where we survey our practitioners and are able to update a content outline and really be able to glean very important data that shows the competency and the knowledge…

2:15:46

Moderator: I do apologize. In the interest of time your time has been concluded.

2:15:55

Moderator: We will now open the mic up to any individuals who indicated their interest to present using the Q and A function of the chat. You may also raise your hand now using the Webex platform at the bottom of your screen. If you have dialed in on your phone, you may press star 3 on your phone to raise your hand to indicate your interest to present. Once identified, you press star 6 to be unmuted.

2:16:23

Moderator: I would also like to remind you, if any participant's unable to speak or if you would like to submit a written comments after the session you may do so by emailing VA.NSP@va.gov. Participants have until September 30th, 2023, to submit comments. At this time, I will also ask if any VHA clinical representatives on the line would like to ask any clarifying questions or comment please do so now.

2:17:21

Jane Paredo: Hi, this is Jane Paredo. I'm a genetic counselor at the VA. I would like to ask Dr. Hisama to please clarify how or what would constitute genetic counselors practicing medicine?

2:17:48

Moderator: Thank you our technical team are seeing if that individual is still on the line.

2:18:14

Dr. Hisama: Hello, this is Dr. Hisama. Can you hear me?

Moderator: Yes, we can.

2:18:22

Dr. Hisama: Okay, so the question was, what constitutes the practice of medicine? For a, so, the practice of medicine includes diagnosis, physical examination, treatment of disease and managing conditions, and managing medical conditions.

2:18:46

Jane Paredo: Thank you.

2:18:52

Moderator: Thank you both.

2:19:03

Moderator: Again, if any individuals who indicated their interest to present using Q and A function,

or if you have interest to do so you may please raise your hand now using the Webex platform at the bottom of your screen. If you dialed in on the phone, you may press star 3 on your phone to raise your hand, and we will call on you, once identified you will press star 6 to be unmuted.

2:20:55

Moderator: It looks like we do have a new representative wanting to ask a clarifying question. Dr. Weinstein?

2:21:02

Dr. Weinstein: Thank you, I'm not sure if there are any external stakeholders with further comments regarding the Massage Therapy National Standard of Practice. If so, I would encourage you to take the time before September 30th to submit those comments as indicated to the website. Thank you very much.

2:21:32

Moderator: Thank you so much. Once again, if you would like to write in comment using the Q and A function you may do so now. You may also raise your hand if you would like to provide your comments.

2:22:30

Moderator: We will now conclude the open comment section during this listening session. We commend each of you for your steadfast dedication and continued support and enabling VA health care professionals to provide the best care to our Nation's Veterans. As a reminder, all suggestions made through these listening sessions will be used to improve and inform the content included in proposed national standards of practice across all 51 occupations. All VA proposals for each

occupation VA national standard of practice will still occur through the Federal Register during the 60-day open comment period. For more information on VA's national standards of practice visit the VA National Standards of Practice website and sign up for our newsletter at https://www.va.gov/standardsofpractice/. Thank you again for attending the Veterans Affairs National Standards of Practice Listening Session 2, number 2. A recording and transcript of this listening session will be available on the VA National Standards of Practice website upon conclusion of all scheduled listening sessions. Have a wonderful day. Thank you. And goodbye.

NOTE: *All listening sessions conducted ran 2.5 hours in duration—audio recordings have been edited to remove pauses. Please contact presenters directly to request presented materials referenced in each session.*