CALIFORNIA STATE BOARD OF OPTOMETRY

Sunset Review Report 2012

Presented to the California Legislature
Senate Committee on Business, Professions and Economic Development

November 1, 2012

STATE OF CALIFORNIA
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DEPARTMENT OF CONSUMER AFFAIRS

California
State Board of Optometry

Board Members

Alejandro Arredondo, OD, President, Professional Member
Monica Johnson, Vice President, Public Member
Alexander Kim, MBA, Secretary, Public Member
Kenneth Lawenda, OD, Professional Member
Donna Burke, Public Member
Madhu Chawla, OD, Professional Member
Fred Dubick, OD, MBA, Professional Member
Glenn Kawaguchi, OD, Professional Member
William H. Kysella Jr., Public Member

Executive Officer

Mona Maggio

Additional copies of this report can be obtained from www.optometry.ca.gov

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BOARD OF OPTOMETRY
BACKGROUND INFORMATION AND OVERVIEW OF THE CURRENT REGULATORY PROGRAM
As of November 1, 2012

Section 1 – Background and Description of the Board and Regulated Profession

History and Function of the Board

Provide a short explanation of the history and function of the board. Describe the occupations/professions that are licensed and/or regulated by the board (Practice Acts vs. Title Acts).

The Board of Optometry (Board) is one of the forty regulatory entities within the Department of Consumer Affairs (DCA). The Board licenses and regulates the profession of optometry. The Board is funded solely by the fees of applicants, licensees, certifications, business licenses, and other related fees.

The Board's mission is to serve the public and optometrists by promoting and enforcing laws and regulations which protect the health and safety of California's consumers, and to ensure high quality care in optometric services. In order to accomplish this mission, the Board performs the following duties and responsibilities:

- Promulgate regulations governing procedures of the Board, admission of applicants for examination for an optometric license; minimum standards of optometric services offered or performed, the equipment or sanitary conditions, in all locations where optometry is practiced;
- Investigate consumer complaints and criminal convictions which may include substance abuse and patient abuse, unprofessional conduct, incompetence, fraudulent action, and unlawful activity;
- Institute disciplinary action for violations of laws and regulations governing the practice of optometry when warranted.
- Accredit schools and colleges of optometry;
- Establish educational requirements to ensure the competence of candidates for licensure;
- Establish examination requirements to ensure the competence of candidates for licensure;
- Develop and administer a laws and regulations examination;
- Set and enforce standards for continued competency of existing licensees;
- Establish educational and examination requirements for licensed optometrists seeking certification to use and prescribe certain pharmaceutical agents and other procedures; and
- License branch offices, issue statements of licensure and fictitious name permits.

The Board's statutes and regulations require a license before an individual may engage in the practice of Optometry. These statutes and regulations set forth the requirements for registration and licensure and provide the Board the authority to discipline a license.

On March 20, 1903, California became the third state to pass a law recognizing the profession of Optometry, and regulating its practice (Optometry Act of 1903 (California Statutes of 1903, Chapter CCXXXIV) later repealed by Statutes of 1913, Chapter 598). In 1913, a new Optometry Practice Act (Statutes of 1913, Chapter 598, derived from the 1903 Act as amended by enactments of 1907 and 1908) was enacted creating the Board, defining its duties and powers, and prescribing a penalty for a violation of the Act. The Act of 1913 was later incorporated in the Business and Professions Code (BPC) (Chapter 7, Division 2, healing arts). Empowered with rulemaking authority (BPC Sections 3025 and 3025.5), the Board promulgated the first rule

for the practice of optometry in 1923. In the same year, the legislature passed a law (Chapter 164, Statutes of 1923) requiring all applicants for licensure to meet certain educational requirements, i.e., graduate from an accredited school or college of optometry. The Board was charged with the responsibility of accrediting these schools. Prior to this time, individuals desiring to practice were not required to have any specific formal education.

Today, the Board is responsible for the regulatory oversight of approximately 9,000 optometrists, the largest population of optometrists in the United States. The Board is also responsible for issuing certifications for optometrists to use Diagnostic Pharmaceutical Agents (DPA), Therapeutic Pharmaceutical Agents (TPA), since 2009 TPA with Lacrimal Irrigation and Dilation (TPL), and since 2011 TPA with Glaucoma Certification (TPG), and TPA with Lacrimal Irrigation and Dilation and Glaucoma Certification (TLG). The Board continues to license branch office licenses, and issue statements of licensure and fictitious name permits. In 2007, the Board enacted legislation to remove its jurisdiction over the licensure of optometric corporations.

Current law provides for eleven board members; six licensees and five public members. Nine members are appointed by the Governor, one public member is appointed by the Speaker of the Assembly, and one public member is appointed by the Senate Rules Committee.

Board Committees

Describe the make-up and functions of each of the board's committees.

The Board currently has four committees all composed of professional and public members:

1. Legislation and Regulation
   Responsible for recommending legislative and regulatory priorities to the Board and assisting staff with drafting language for Board-sponsored legislation and recommending official positions on current legislation. The committee also recommends regulatory additions and amendments.

2. Practice and Education
   Advises Board staff on matters relating to optometric practice, including standards of practice and scope of practice issues. Reviews staff responses to proposed regulatory changes that may affect optometric practice. Also reviews requests for approval of continuing education courses, and offers guidance to Board staff regarding continuing education issues.

3. Consumer Protection
   Oversees the development and administration of legally defensible licensing examinations and consulting on improvements/enhancements to licensing and enforcement policies and procedures.

4. Public Relations – Outreach
   Assists with the development of outreach and development of educational materials to the Board's stakeholders.

Due to a change in Board leadership and the addition of seven new members, the Board is still determining the composition of the members in each committee for 2012-2013. The committees meet on an "as needed" basis pursuant to the Board's Administrative Procedure Manual. The current committee structure provides multiple opportunities for consumers, licensees, professional organizations, and educational institutions to actively participate and comment on topics before the Board. All Committee recommendations are presented to the Board for consideration.

Board Member Meeting and Committee Attendance

Table 1a. Attendance

CURRENT MEMBERS

Alejandro Arredondo, O.D., Professional Member, President			
Date Appointed:	November 1, 2007		
Date Reappointed:	June 15, 2012		
Term Expires:	June 1, 2015		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Board Meetings 2012	October 19	Teleconference	Y
	August 31	Teleconference	Y
	August 10	Fullerton	Y
	May 18	Sacramento	Y
	March 30	Fullerton	Y
	March 2	Pomona	Y
Board Meetings 2011	December 2	Fullerton	Y
	September 16	Sacramento	Y
	June 21	Los Angeles	Y
	April 11	Fullerton	Y
	January 11	Oakland	Y
Legislation and Regulation Committee 2011	November 18	Fullerton	Y
	May 10	Teleconference	Y
Board Meetings 2010	October 22	Teleconference	Y
	October 4	Teleconference	Y
	September 24	Pomona	Y
	July 28	Sacramento	Y
	May 11	Teleconference	Y
	March 25-26	San Diego	Y
	March 16	Teleconference/Fullerton	Y
	January 21	Los Angeles	Y
Board Meetings 2009	December 1	Sacramento	Y
	October 22-23	Oakland	Y
	August 24	Fullerton	Y
	July 16	Sacramento	Y
	May 15	Fullerton	Y
	March 23	Teleconference	N
	February 27	Oakland	Y
Practice and Education Committee 2009	December 17	Fullerton	Y
Board Meetings 2008	November 20	Los Angeles	Y
	September 3	Pomona	Y
	June 17	Sacramento	Y
	April 25	Sacramento	Y
	March 3	Sacramento	Y
Board Meetings 2007	November 15	San Jose	Y

Monica Johnson, Public Member, Vice President			
Date Appointed:	December 20, 2005		
Date Reappointed:	May 5, 2010		
Term Expires:	June 1, 2013		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Board Meetings 2012	October 19	Teleconference	Y
	August 31	Teleconference	Y
	August 10	Fullerton	Y
	May 18	Sacramento	N
	March 30	Fullerton	Y
	March 2	Pomona	Y
Board Meetings 2011	December 2	Fullerton	N
	September 16	Sacramento	Y
	June 21	Los Angeles	Y
	April 11	Fullerton	Y
	January 11	Oakland	Y
Legislation and Regulation Committee 2011	November 18	Fullerton	N
	May 10	Teleconference	N
Board Meetings 2010	October 22	Teleconference	Y
	October 4	Teleconference	Y
	September 24	Pomona	Y
	July 28	Sacramento	N
	May 11	Teleconference	Y
	March 25-26	San Diego	N, Y
	March 16	Teleconference/Fullerton	Y
	January 21	Los Angeles	N
Legislation and Regulation Committee 2010	September 24	Pomona	Y
Board Meetings 2009	December 1	Sacramento	Y
	October 22-23	Oakland	Y
	August 24	Fullerton	Y
	July 16	Sacramento	Y
	May 15	Fullerton	Y
	March 23	Teleconference	Y
	February 27	Oakland	Y
Legislation and Regulation Committee 2009	December 17	Fullerton	N
Board Meetings 2008	November 20	Los Angeles	Y
	September 3	Pomona	Y
	June 17	Sacramento	Y
	April 25	Sacramento	Y
	March 3	Sacramento	Y
Board Meetings 2007	November 15	San Jose	N
	August 17	Irvine	N
	July 12	Teleconference	N
	May 17	LA	Y
	February 7-8	Sacramento	Y
Legislative Committee 2007	May 16	Los Angeles	Y
	January 31	Los Angeles	Y
Board Meetings 2006	November 16	San Diego	Y
	August 24	Sacramento	Y
	June 8	Fullerton	Y
	March 13	Various	N/A
	February 2	Fullerton	Y

Alexander Kim, Public Member, Secretary			
Date Appointed:	December 27, 2010		
Term Expires:	June 1, 2014		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Board Meetings 2012	October 19	Teleconference	Y
	August 31	Teleconference	Y
	August 10	Fullerton	Y
	May 18	Sacramento	Y
	March 30	Fullerton	Y
	March 2	Pomona	Y
Board Meetings 2011	December 2	Fullerton	Y
	September 16	Sacramento	Y
	June 21	Los Angeles	Y
	April 11	Fullerton	Y
	January 11	Oakland	Y
Public Affairs Committee 2011	October 18	Teleconference	Y

Kenneth Lawenda, O.D., Professional Member			
Date Appointed:	November 1, 2007		
Date Reappointed:	December 2, 2010		
Term Expires:	June 1, 2014		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Board Meetings 2012	October 19	Teleconference	Y
	August 31	Teleconference	Y
	August 10	Fullerton	Y
	May 18	Sacramento	Y
	March 30	Fullerton	N
	March 2	Pomona	Y
Board Meetings 2011	December 2	Fullerton	Y
	September 16	Sacramento	Y
	June 21	Los Angeles	Y
	April 11	Fullerton	Y
	January 11	Oakland	Y
Board Meetings 2010	October 22	Teleconference	Y
	October 4	Teleconference	Y
	September 24	Pomona	Y
	July 28	Sacramento	Y
	May 11	Teleconference	Y
	March 25-26	San Diego	N
	March 16	Teleconference/Fullerton	Y
	January 21	Los Angeles	Y
Board Meetings 2009	December 1	Sacramento	Y
	October 22-23	Oakland	Y
	August 24	Fullerton	Y
	July 16	Sacramento	Y
	May 15	Fullerton	Y
	March 23	Teleconference	Y
	February 27	Oakland	Y
Practice and Education Committee 2009	December 17	Fullerton	Y
Board Meetings 2008	November 20	Los Angeles	Y
	September 3	Pomona	Y
	June 17	Sacramento	Y
	April 25	Sacramento	Y
	March 3	Sacramento	Y
Board Meetings 2007	November 15	San Jose	Y

Donna Burke, Public Member			
Date Appointed:	October 11, 2010		
Term Expires:	June 1, 2015		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Board Meetings 2012	October 19	Teleconference	Y
	August 31	Teleconference	Y
	August 10	Fullerton	Y
	May 18	Sacramento	Y
	March 30	Fullerton	Y
	March 2	Pomona	Y
Board Meetings 2011	December 2	Fullerton	Y
	September 16	Sacramento	Y
	June 21	Los Angeles	Y
	April 11	Fullerton	N
	January 11	Oakland	Y
Public Affairs Committee 2011	October 18	Teleconference	N
Board Meetings 2010	October 22	Teleconference	Y

Madhu Chawla, O.D., Professional Member			
Date Appointed:	June 15, 2012		
Term Expires:	June 1, 2015		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Board Meetings 2012	October 19	Teleconference	Y
	August 31	Teleconference	Y
	August 10	Fullerton	Y

William H. Kysella Jr., Public Member			
Date Appointed:	July 25, 2012		
Term Expires:	June 1, 2015		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Board Meetings 2012	October 19	Teleconference	Y
	August 31	Teleconference	Y
	August 10	Fullerton	Y

Fred Dubick, O.D., MPA, Professional Member			
Date Appointed:	August 10, 2012		
Term Expires:	June 1, 2013		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Board Meetings 2012	October 19	Teleconference	Y
	August 31	Teleconference	N
	August 10	Fullerton	Y

Glenn Kawaguchi, O.D., Professional Member			
Date Appointed:	August 10, 2012		
Term Expires:	June 1, 2015		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Board Meetings 2012	October 19	Teleconference	Y
	August 31	Teleconference	Y
	August 10	Fullerton	Y

PREVIOUS MEMBERS

Lee A. Goldstein, O.D., Professional Member, Past President			
Date Appointed:	April, 2003		
Date Reappointed:	November 1, 2007		
Term Expired:	June 1, 2011 (served during 1-year grace period until June 1, 2012)		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Board Meetings 2012	May 18	Sacramento	Y
	March 30	Fullerton	Y
	March 2	Pomona	Y
Board Meetings 2011	December 2	Fullerton	Y
	September 16	Sacramento	Y
	June 21	Los Angeles	Y
	April 11	Fullerton	Y
	January 11	Oakland	Y
Legislation and Regulation Committee 2011	November 18	Fullerton	Y
	May 10	Teleconference	Y
Board Meetings 2010	October 22	Teleconference	Y
	October 4	Teleconference	Y
	September 24	Pomona	Y
	July 28	Sacramento	Y
	May 11	Teleconference	Y
	March 25-26	San Diego	Y
	March 16	Teleconference/Fullerton	Y
	January 21	Los Angeles	Y
Legislation and Regulation Committee 2010	September 24	Pomona	Y
Board Meetings 2009	December 1	Sacramento	Y
	October 22-23	Oakland	Y
	August 24	Fullerton	Y
	July 16	Sacramento	Y
	May 15	Fullerton	Y
	March 23	Teleconference	Y
	February 27	Oakland	Y
Legislation and Regulation Committee 2009	December 17	Fullerton	Y
Practice and Education Committee 2009	December 17	Fullerton	Y
Board Meetings 2008	November 20	Los Angeles	Y
	September 3	Pomona	Y
	June 17	Sacramento	Y
	April 25	Sacramento	Y
	March 3	Sacramento	Y
Enforcement Committee 2008	March 4	Sacramento	Y
Board Meetings 2007	November 15	San Jose	Y
	August 17	Irvine	Y
	July 12	Teleconference	Y
	May 17	LA	Y
	February 7-8	Sacramento	Y
Legislative Committee 2007	May 16	Los Angeles	Y
	January 31	Los Angeles	Y
Board Meetings 2006	November 16	San Diego	Y
	August 24	Sacramento	Y
	June 8	Fullerton	Y
	March 13	Various	N/A
	February 2	Fullerton	Y

Dr. Lee A. Goldstein, O.D., Professional Member, Past President Continued

Board Meetings 2005	November 17	San Diego	Y
	August 18	Fullerton	Y
	March 19	Sacramento	Y
	February 17	San Francisco	Y
Enforcement Committee 2005	November 16	San Diego	Y
	August 17	Fullerton	Y
	March 18	Sacramento	Y
	February 16	San Francisco	Y
Task Force on Licensure for Graduates of Foreign Schools of Optometry 2005	March 17	Oakland	Y
Board Meetings 2004	November 5	Fullerton	Y
	July 9	Sacramento	Y
	April 16	Oakland	Y
	February 23	Arcadia	Y
	January 16	Los Angeles	Y
Enforcement Committee 2004	November 4	Fullerton	Y
	July 8	Sacramento	Y
	April 15	Oakland	Y
Board Meetings 2003	November 14	Berkeley	Y
	September 8	Sacramento	Y
	June 14	San Diego	Y
	May 22	Sacramento	Y
Continuing Education Committee 2003	August 22	N/A	Y

Martha Burnett-Collins, O.D., Professional Member			
Date Appointed:	November 1, 2007		
Term Expires:	June 1, 2009		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Board Meetings 2009	May 15	Fullerton	Y
	March 23	Teleconference	Y
	February 27	Oakland	Y
Board Meetings 2008	November 20	Los Angeles	Y
	September 3	Pomona	Y
	June 17	Sacramento	Y
	April 25	Sacramento	N
	March 3	Sacramento	Y
Enforcement Committee 2008	March 4	Sacramento	Y
Board Meetings 2007	November 15	San Jose	Y

Fred Naranjo, Public Member			
Date Appointed:	April, 2003		
Date Reappointed:	November 1, 2007		
Term Expired:	June 1, 2011 (served during 1-year grace period until June 1, 2012)		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Board Meetings 2012	May 18	Sacramento	Y
	March 30	Fullerton	Y
	March 2	Pomona	Y
Board Meetings 2011	December 2	Fullerton	Y
	September 16	Sacramento	Y
	June 21	Los Angeles	Y
	April 11	Fullerton	Y
	January 11	Oakland	Y
Board Meetings 2010	October 22	Teleconference	N
	October 4	Teleconference	Y
	September 24	Pomona	Y
	July 28	Sacramento	N
	May 11	Teleconference	Y
	March 25-26	San Diego	Y
	March 16	Teleconference/Fullerton	Y
	January 21	Los Angeles	N
Board Meetings 2009	December 1	Sacramento	N
	October 22-23	Oakland	Y
	August 24	Fullerton	Y
	July 16	Sacramento	Y
	May 15	Fullerton	Y
	March 23	Teleconference	N
	February 27	Oakland	Y
Practice and Education Committee 2009	December 17	Fullerton	N
Board Meetings 2008	November 20	Los Angeles	Y
	September 3	Pomona	Y
	June 17	Sacramento	Y
	April 25	Sacramento	N
	March 3	Sacramento	Y
Enforcement Committee 2008	March 4	Sacramento	Y
Board Meetings 2007	November 15	San Jose	Y
	August 17	Irvine	Y
	July 12	Teleconference	Y
	May 17	LA	Y
	February 7-8	Sacramento	Y
Board Meetings 2006	November 16	San Diego	Y
	August 24	Sacramento	Y
	June 8	Fullerton	N
	March 13	Various	Y
	February 2	Fullerton	N
Board Meetings 2005	November 17	San Diego	Y
	August 18	Fullerton	N
	March 19	Sacramento	Y
	February 17	San Francisco	Y
Enforcement Committee 2005	November 16	San Diego	Y
	August 17	Fullerton	Y
	March 18	Sacramento	Y
	February 16	San Francisco	Y

Fred Naranjo, Public Member Continued

Task Force on Licensure for Graduates of Foreign Schools of Optometry 2005	March 17	Oakland	Y
Board Meetings 2004	November 5	Fullerton	Y
	July 9	Sacramento	Y
	April 16	Oakland	Y
	February 23	Arcadia	N/A
	January 16	Los Angeles	Y
Enforcement Committee 2004	November 4	Fullerton	Y
	July 8	Sacramento	Y
	April 15	Oakland	Y
Board Meetings 2003	November 14	Berkeley	Y
	September 8	Sacramento	Y
	June 14	San Diego	Y
	May 22	Sacramento	Y

Katrina Semmes, Public Member			
Date Appointed:	May 16, 2007		
Term Expires:	June 1, 2010		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Board Meetings 2010	October 22	Teleconference	Y
	October 4	Teleconference	N
	September 24	Pomona	N
	July 28	Sacramento	Y
	May 11	Teleconference	Y
	March 25-26	San Diego	Y
	March 16	Teleconference/Fullerton	Y
	January 21	Los Angeles	Y
Board Meetings 2009	December 1	Sacramento	N
	October 22-23	Oakland	Y
	August 24	Fullerton	Y
	July 16	Sacramento	Y
	May 15	Fullerton	N
	March 23	Teleconference	N
	February 27	Oakland	Y
Board Meetings 2008	November 20	Los Angeles	Y
	September 3	Pomona	Y
	June 17	Sacramento	Y
	April 25	Sacramento	Y
	March 3	Sacramento	Y
Board Meetings 2007	November 15	San Jose	Y
	August 17	Irvine	N
	July 12	Teleconference	Y
	May 17	Los Angeles	N

Susy Yu, O.D., Professional Member, Past Vice President			
Date Appointed:	April 25, 2003		
Date Reappointed:	May 24, 2007		
Term Expired:	June 1, 2010 (served during 1-year grace period until June 1, 2011)		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Board Meetings 2011	April 11	Fullerton	Y
	January 11	Oakland	Y
Legislation and Regulation Committee 2011	May 10	Teleconference	Y
Board Meetings 2010	October 22	Teleconference	Y
	October 4	Teleconference	Y
	September 24	Pomona	Y
	July 28	Sacramento	Y
	May 11	Teleconference	N
	March 25-26	San Diego	Y
	March 16	Teleconference/Fullerton	Y
	January 21	Los Angeles	Y
Legislation and Regulation Committee 2010	September 24	Pomona	Y
Board Meetings 2009	December 1	Sacramento	Y
	October 22-23	Oakland	Y
	August 24	Fullerton	Y
	July 16	Sacramento	N
	May 15	Fullerton	Y
	March 23	Teleconference	Y
	February 27	Oakland	Y
Legislation and Regulation Committee 2009	December 17	Fullerton	Y
Board Meetings 2008	November 20	Los Angeles	N
	September 3	Pomona	Y
	June 17	Sacramento	Y
	April 25	Sacramento	Y
	March 3	Sacramento	Y
Board Meetings 2007	November 15	San Jose	Y
	August 17	Irvine	Y
	July 12	Teleconference	N
	May 17	LA	Y
	February 7-8	Sacramento	Y
Board Meetings 2006	November 16	San Diego	Y
	August 24	Sacramento	N
	June 8	Fullerton	Y
	March 13	Various	Y
	February 2	Fullerton	Y
Board Meetings 2005	November 17	San Diego	N
	August 18	Fullerton	Y
	March 19	Sacramento	Y
	February 17	San Francisco	Y
Continuing Education Committee 2005	March 18	Sacramento	Y
Board Meetings 2004	November 5	Fullerton	Y
	July 9	Sacramento	Y
	April 16	Oakland	Y
	February 23	Arcadia	Y
	January 16	Los Angeles	Y
Board Meetings 2003	November 14	Berkeley	Y
	September 8	Sacramento	Y
	June 14	San Diego	Y
	May 22	Sacramento	Y
Continuing Education Committee 2003	August 22	N/A	Y

Edward Rendon, Public Member			
Date Appointed:	January 6 , 2009		
Term Expires:	June 1, 2011		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Board Meetings 2012	May 18	Sacramento	Y
	March 30	Sacramento/Fullerton	N
	March 2	Pomona	N
Board Meetings 2011	December 2	Fullerton	N
	September 16	Sacramento	N
	June 21	Los Angeles	N
	April 11	Fullerton	Y
	January 11	Oakland	N
Legislation and Regulation Committee 2011	November 18	Fullerton	N
	May 10	Teleconference	Y
Board Meetings 2010	October 22	Teleconference	Y
	October 4	Teleconference	N
	September 24	Pomona	Y
	July 28	Sacramento	Y
	May 11	Teleconference	Y
	March 25-26	San Diego	Y, N
	March 16	Teleconference/Fullerton	Y
	January 21	Los Angeles	Y
Board Meetings 2009	December 1	Sacramento	N
	October 22-23	Oakland	N
	August 24	Fullerton	N
	July 16	Sacramento	Y
	May 15	Fullerton	Y
	March 23	Teleconference	N
	February 27	Oakland	Y
Legislation and Regulation Committee 2009	December 17	Fullerton	N

Richard Simonds, O.D., Professional Member			
Date Appointed:	December 1, 2005		
Term Expired:	June 1, 2009		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Board Meetings 2009	May 15	Fullerton	N
	March 23	Teleconference	Y
	February 27	Oakland	N
Board Meetings 2008	November 20	Los Angeles	Y
	September 3	Pomona	Y
	June 17	Sacramento	N
	April 25	Sacramento	Y
	March 3	Sacramento	Y
Board Meetings 2007	November 15	San Jose	Y
	August 17	Irvine	Y
	July 12	Teleconference	Y
	May 17	Los Angeles	N
	February 7-8	Sacramento	Y
Legislation Committee 2007	January 31	Los Angeles	Y
	May 17	Los Angeles	N
Board Meetings 2006	November 16	San Diego	Y
	August 24	Sacramento	Y
	June 8	Fullerton	Y
	March 13	Various	N/A
	February 2	Fullerton	Y

Mary Galvan-Rosas, Public Member			
Date Appointed:	April 10, 2003		
Date Reappointed:	June 6, 2007		
Term Expired:	June 1, 2011 – Resigned June 25, 2008		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Board Meetings 2008	June 17	Sacramento	Y
	April 25	Sacramento	Y
	March 3	Sacramento	Y
Board Meetings 2007	November 15	San Jose	N
	August 17	Irvine	Y
	July 12	Teleconference	Y
	May 17	Los Angeles	Y
	February 7-8	Sacramento	N
Board Meetings 2006	November 16	San Diego	Y
	August 24	Sacramento	Y
	June 8	Fullerton	N
	March 13	Various	N/A
	February 2	Fullerton	Y
Board Meetings 2005	November 17	San Diego	Y
	August 18	Fullerton	Y
	March 19	Sacramento	Y
	February 17	San Francisco	Y
Board Meetings 2004	November 5	Fullerton	Y
	July 9	Sacramento	N
	April 16	Oakland	Y
	February 23	Arcadia	N/A
	January 16	Los Angeles	N
Enforcement Committee 2004	November 4	Fullerton	Y
	July 8	Sacramento	N
	April 15	Oakland	Y
Board Meetings 2003	November 14	Berkeley	N
	September 8	Sacramento	Y
	June 14	San Diego	Y
	May 22	Sacramento	Y

Lupe De La Cruz, Public Member			
Date Appointed:	April 25, 2003		
Term Expired:	June 1, 2005 (February 2005 – Resigned; moved out of state)		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Board Meetings 2005	February 17	San Francisco	Y
Board Meetings 2004	November 5	Fullerton	Y
	July 9	Sacramento	Y
	April 16	Oakland	Y
	February 23	Arcadia	N/A
	January 16	Los Angeles	Y
Board Meetings 2003	November 14	Berkeley	Y
	September 8	Sacramento	Y
	June 14	San Diego	Y
	May 22	Sacramento	Y

Daniel Pollack, O.D., Professional Member			
Date Appointed:	April 25, 2003		
Date Reappointed:	October 1, 2003		
Term Expired:	June 1, 2007		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Board Meetings 2007	November 15	San Jose	N
	August 17	Irvine	Y
	July 12	Teleconference	Y
	May 17	Los Angeles	N
	February 7-8	Sacramento	Y
Board Meetings 2006	November 16	San Diego	Y
	August 24	Sacramento	N
	June 8	Fullerton	Y
	March 13	Various	N/A
	February 2	Fullerton	Y
Board Meetings 2005	November 17	San Diego	N
	August 18	Fullerton	Y
	March 19	Sacramento	Y
	February 17	San Francisco	Y
Continuing Education Committee 2005	March 18	Sacramento	Y
Board Meetings 2004	November 5	Fullerton	Y
	July 9	Sacramento	Y
	April 16	Oakland	Y
	February 23	Arcadia	N/A
	January 16	Los Angeles	Y
Board Meetings 2003	November 14	Berkeley	Y
	September 8	Sacramento	Y
	June 14	San Diego	Y
	May 22	Sacramento	Y
Continuing Education Committee 2003	August 22	N/A	Y
Finance Committee	October 17	Oakland	Y

Page Yarwood, O.D., Professional Member			
Date Appointed:	April 25, 2003		
Term Expired:	June 1, 2005		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Board Meetings 2005	November 17	San Diego	Y
	August 18	Fullerton	Y
	March 19	Sacramento	Y
	February 17	San Francisco	Y
Task Force on Licensure for Graduates of Foreign Schools of Optometry 2005	March 17	Oakland	Y
Exam Committee 2005	November 16	San Diego	Y
Board Meetings 2004	November 5	Fullerton	Y
	July 9	Sacramento	Y
	April 16	Oakland	Y
	February 23	Arcadia	N/A
	January 16	Los Angeles	Y
Board Meetings 2003	November 14	Berkeley	Y
	September 8	Sacramento	Y
	June 14	San Diego	Y
	May 22	Sacramento	Y
Finance Committee 2003	October 17	Oakland	Y

Edward Hernandez, O.D., Professional Member			
Date Appointed:	April 25, 2003		
Term Expired:	June 1, 2006		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Board Meetings 2006	November 16	San Diego	N
	August 24	Sacramento	Y
	June 8	Fullerton	Y
	March 13	Various	Y
	February 2	Fullerton	Y
Board Meetings 2005	November 17	San Diego	Y
	August 18	Fullerton	Y
	March 19	Sacramento	Y
	February 17	San Francisco	Y
Board Meetings 2004	November 5	Fullerton	Y
	July 9	Sacramento	Y
	April 16	Oakland	Y
	February 23	Arcadia	Y
	January 16	Los Angeles	Y
Board Meetings 2003	November 14	Berkeley	Y
	September 8	Sacramento	Y
	June 14	San Diego	Y
	May 22	Sacramento	Y

Gregory Kame, O.D., Professional Member			
Date Appointed:	November 4, 2003		
Term Expired:	June 1, 2005		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Board Meetings 2006	November 16	San Diego	N
	August 24	Sacramento	N
	June 8	Fullerton	N
	March 13	Various	N/A
	February 2	Fullerton	Y
Board Meetings 2005	November 17	San Diego	Y
	August 18	Fullerton	N
	March 19	Sacramento	N
	February 17	San Francisco	Y
Board Meetings 2004	November 5	Fullerton	Y
	July 9	Sacramento	Y
	April 16	Oakland	Y
	February 23	Arcadia	N/A
	January 16	Los Angeles	Y
Board Meetings 2003	November 14	Berkeley	Y

Roberto Vellanoweth, Public Member			
Date Appointed:	November 14, 2006		
Term Expired:	June 1, 2010 (separated March 27, 2007)		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Board Meetings 2007	November 15	San Jose	N
	August 17	Irvine	N
	July 12	Teleconference	N
	May 17	Los Angeles	N
	February 7-8	Sacramento	Y
Board Meetings 2006	November 16	San Diego	Y

Audrey Noda, Public Member			
Date Appointed:	November 12, 2003		
Term Expired:	June 1, 2006 (separated August 24, 2006)		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Board Meetings 2006	August 24	Sacramento	Y
	June 8	Fullerton	Y
	March 13	Various	N/A
	February 2	Fullerton	Y
Board Meetings 2005	November 17	San Diego	Y
	August 18	Fullerton	Y
	March 19	Sacramento	N
	February 17	San Francisco	Y
Task Force on Licensure for Graduates of Foreign Schools of Optometry 2005	March 17	Oakland	Y
Board Meetings 2004	November 5	Fullerton	Y
	July 9	Sacramento	Y
	April 16	Oakland	Y
	February 23	Arcadia	N/A
	January 16	Los Angeles	Y

Board Member and Committee Roster

Table 1b. Board/Committee Member Roster						
Member Name (Include Vacancies)	Date First Appointed	Date Re-appointed	Date Term Expires	Appointing Authority	Type (public or professional)	Committee
Alejandro Arredondo*	11/01/2007	06/15/2012	06/01/2015	Governor	Professional	Leg/Reg, Practice/Education (Past: Outreach)
Monica Johnson**	12/20/2005	05/05/2010	06/01/2013	Governor	Public	Leg/Reg, Consumer Protection*** (Past: Finance, Executive)
Alexander Kim	12/27/2010		06/01/2014	Governor	Public	Public Relations
Kenneth Lawenda	11/01/2007	12/02/2010	06/01/2014	Governor	Professional	Leg/Reg, Consumer Protection (Past: Practice, Exam)
Donna Burke	10/01/2010		06/01/2015	Senate	Public	Public Relations, Consumer Protection
Madhu Chawla	06/15/2012		06/01/2015	Governor	Professional	Leg/Reg, Practice/Education
William Kysella, Jr.	07/25/2012		06/01/2015	Assembly	Public	Leg/Reg
Fred Dubick	08/10/2012		06/01/2013	Governor	Professional	Practice/Education
Glenn Kawaguchi	08/10/2012		06/01/2015	Governor	Professional	Leg/Reg
Vacant			06/01/2009	Governor	Professional	
Vacant			06/01/2011	Governor	Public	
Lee A. Goldstein	04/01/2003	11/01/2007	06/01/2011	Governor	Professional	Leg/Reg, Consumer Protection, Practice, Executive
Martha Burnett-Collins	11/01/2007		06/01/2009	Governor	Professional	Enforcement, Exam
Fred Naranjo	4/01/2003	11/01/2007	06/01/2011	Governor	Public	Consumer Protection, Practice
Katrina Semmes	05/16/2007		06/01/2010	Governor	Public	Strategic Planning, Practice, Fiscal
Susy Yu	04/25/2003	05/24/2007	06/01/2010	Governor	Professional	Leg/Reg, Exam, Strategic Planning, Executive
Edward Rendon	01/06/2009		06/01/2009	Assembly	Public	Leg/Reg, Consumer Protection
Richard Simonds	12/01/2005		06/01/2009	Governor	Professional	Legislation, CE
Mary Galvan-Rosas	04/10/2003	06/06/2007	06/01/2011	Senate	Public	Outreach, Exam, Enforcement
Lupe De La Cruz	04/25/2003		06/01/2005	Governor	Public	Leg/Reg, Outreach
Daniel Pollack	04/25/2003	10/01/2003	06/01/2007	Governor	Professional	CE, Finance, Enforcement
Page Yarwood	04/25/2003		06/01/2005	Governor	Professional	Leg/Reg, Outreach, Enforcement, Finance
Edward Hernandez	04/25/2003		06/01/2006	Governor	Professional	Leg/Reg
Gregory Kame	11/04/2003		06/01/2005	Governor	Professional	CE
Roberto Vellanoweth	11/14/2006		06/01/2010	Governor	Public	n/a
Audrey Noda	11/12/2003		06/01/2006	Governor	Public	Leg/Reg
Bold denotes current board members ***Current Board President; 1**Current Board Vice President;*** ****Consumer Protection Committee = Enforcement Committee***						

Please Note: Due to a change in Board leadership and the addition of seven new members, the Board is still determining the composition of the members in each committee for 2012-2013. The above indicates committees that the current members are interested in participating in. The committees will be finalized at the Board's December 2012 meeting.

In the past four years, was the board unable to hold any meetings due to lack of quorum? If so, please describe. Why? When? How did it impact operations?

- February 24, 2012: This Board meeting was cancelled because a quorum could not be established due to scheduling conflicts. The meeting was successfully re-scheduled for March 2, 2012.
- January 5, 2012: This Board meeting was cancelled because a quorum could not be established due to scheduling conflicts. The meeting was re-scheduled for February 24, 2012 (see above), and then re-scheduled again for March 2, 2012.

None of the above meeting cancellations and re-schedules affected the Board's operations adversely.

Major Changes since the Last Sunset Review

Describe any major changes to the board since the last Sunset Review, including: Internal changes (i.e., reorganization, relocation, change in leadership, strategic planning)

Reorganization

Since the last sunset review in 2002, the Board has attempted to restructure its organization to meet its operational needs more efficiently.

Prior to 2002, the management composition consisted of one Executive Officer (EO), with the assistance of two Associate Governmental Program Analysts (AGPA), managing the daily activities related to program administration, licensing, examination, and enforcement, in addition to policy decisions and implementing the direction of the board members. Following a change in the EO in 2008 and an informal evaluation of the Board's operational needs and desire to improve efficiency, the Board gained three Staff Services Analysts (SSA) and a Limited Term Office Technician (LT OT) for its enforcement unit to implement legislatively mandated fingerprint requirements, and a probation monitoring program. These positions were obtained through various Business Change Proposals (BCP), and promotion and/or re-classification of positions (i.e., blanket, interchangeable positions). An SSA in the licensing unit was promoted to an AGPA and transferred to the administration unit to directly assist the EO with policy decisions, legislation, and regulation. This allowed the EO to focus on implementing the direction of the board members, take on personnel responsibilities, and provide oversight and management of the daily activities of the Board's licensing, enforcement and administrative units.

A 30% increase in licensees and business licenses, the addition of an improved glaucoma certification process, and a push from DCA to improve enforcement processes starting in 2009, initially resulted in a 50% increase in total staffing since 2002. Also as a result of these changes, the EO attempted to obtain through a BCP a Staff Services Manager I (SSMI) to serve as the Assistant Executive Officer, to assist the EO with the oversight and management of the daily activities of the Board's units, and further improve efficiency. Although this BCP was approved by the Department of Finance (DOF), it was later rejected by DCA because it did not meet the Department of Personnel Administration's allocation criteria (required positions).

Starting in 2010, the Board has lost almost all the much needed positions it gained throughout the years (six positions total) due to expiration of limited term positions, DCA policy changes, and directives from the State and Consumer Services Agency and Governor. The current management and staff structure does not provide for ongoing review of processes to identify areas for process improvements and staff development.

The composition of the Board's staff since 2002 is noted in the chart below.

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Total Authorized Staff Positions	7	7	7	7	7	7	8	9	13	14	10.4
Total Staff	6	6	6	6	6	6	7	8	11	16*	11.4**
Managers	0	0	0	0	0	0	0	0	0	1	0
AEO	0	0	0	0	0	0	0	0	0	0	0
EO	1	1	1	1	1	1	1	1	1	1	1

* This figure includes authorized position approved through BCPs but not filled, and two positions paid from blanket funds.
** This figure includes one position paid from blanket funds.

Relocation

In 2011, the Board relocated from 2420 Del Paso Road, Sacramento, California to its current location at 2450 Del Paso Road, Sacramento, California.

Change in Leadership

From 2002 to 2012 the Board has consisted of eleven board members. Six are professional members and five are public members.

Prior to 2002, the Board consisted of nine members. Six were professional members and three were public members. This composition of a two-to-one ratio of professional to public members was argued, by the Sunset Review Committee in 2002, to result in professional bias, and less focus on consumer protection. In order to ensure a balanced approach to decision-making, ensure the Board was in line with other DCA Boards, and enhance public protection, the Sunset Review Committee recommended adding two additional public members. This recommendation was implemented in 2002 through sunset review legislation when the Board was sunseted and reconstituted with entirely new members effective January 1, 2003.

Board Members elect a President, Vice President, and Secretary annually. Current Board policy provides that in the event the President of the Board is unable to continue his or her role as President, the Vice President shall immediately assume the duties of the President until the next election of officers.

Since 2002, the Board has had two Executive Officers. The previous incumbent served from 2002-2008. The current Executive Officer was appointed in 2008.

Strategic Planning

The Board revised its Strategic Plan in 2004, at which time the Board's mission statement read - *The mission of the California Board of Optometry is to assure that Californians have access to appropriate high quality eye and vision care and to implement and promote fair and just laws and regulations protecting the health and safety of consumers.* The goals are very general in this plan.

The 2004 Strategic Plan was updated in 2007, at which time the Board's mission statement was changed to read - *The mission of the California State Board of Optometry is to implement and promote just laws and regulations protecting the health and safety of consumers and to assure that Californians have access to appropriate high quality eye and vision care.* The vision statement, values and goals had very minor changes between the 2004 Plan and the 2007 Plan.

The 2007 Strategic Plan was most recently updated in 2010. This revision further defined the Board's goals with the inclusion of objectives which included tasks and projects to be completed. The Board's current mission statement was changed to read - *To serve the public and optometrists by promoting and enforcing*

laws and regulations which protect the health and safety of California's consumers and to ensure high quality care. The Board is currently working on completion of all objectives before the next update slated for 2013-2014.

Legislative Activity

Legislation Sponsored by or Affecting the Board of Optometry
A number of legislative changes relevant to the Board's duties have been enacted since the last sunset review in 2002. These changes are listed below in chronological order.

Senate Bill 1955 – Sunset Legislation to Sunset and Reconstitute the Board of Optometry (Figueroa, Ch. 1150, Stats. 2002)
Terminates the existence of the board and the executive officer on January 1, 2003, and, as of that date, provides for the formation of a new board and employment of a new executive officer both of which would be terminated on July 1, 2005. Grants the new board certain authority parallel with the authority of the previous board. Provides for the appointment and staggering of terms of board members. Also authorizes the board to adopt regulations clarifying the level of training and supervision of assistants to optometrists.

Assembly Bill 2020 – Prescriptions (Correa, Ch. 814, Stats. 2002)
Prohibits the expiration date of a contact lens prescription from being less than one to two years from the date of issuance, with certain exceptions. Requires a prescriber or registered dispensing optician to provide the patient with a copy of his or her prescription, subject to certain exceptions. Prohibits the prescriber or optician from conditioning the release of the prescription on the patient paying a fee or purchasing contact lenses. Makes the prescriber's willful violation of these requirements unprofessional conduct. Provides that it is a deceptive marketing practice to represent by advertisement or sales presentation that contact lenses may be obtained without confirmation of a prescription. Provides that a violation of the laws regulating prescription lenses is punishable by a fine, not to exceed $2,500.

Assembly Bill 269 – Protection of the Public is the Highest Priority (Correa, Ch. 107, Stats. 2002)
Makes consumer protection the highest priority of licensing boards, commissions, and bureaus, in performing their licensing, regulatory, and disciplinary functions.

Assembly Bill 2464 - CE Requirements and Lens Dispensing Receipts (Pacheco, Ch. 426, Stats. 2004)
Revises the authority of the Board to adopt regulations, and would define and alter certain terms. Deletes the prohibition on a board member having a financial interest in a prospective board purchase or contract. Revises the recordkeeping requirements of the Board. Deletes the provisions authorizing the payment of expenses for the Board secretary and requiring the Board to publish and distribute certain information. Requires the Board to publish its notices on its Internet Website. Deletes the Board's authority to visit and examine optometric educational institutions. Revises the application requirements and the standards for examination and licensure as an optometrist. Requires an optometrist to post specified information at each place of practice. Revises the continuing education requirements for optometrists performing certain functions. Revises the information that must be provided on a receipt and would require any licensed optometrist who fits or supplies a patient with lenses to provide the patient with a receipt.

Assembly Bill 370 - Changes in the Board's Enforcement Program (Aghazarian, Ch. 186, Stats. 2005)
Requires the Board to file an accusation against a licensee within three years after the Board discovers the act or omission that is the subject of the proceeding, or within seven years after the act or omission occurred, whichever comes first, subject to certain exceptions.

Assembly Bill 488 - Repeal of the 30 day grace period & payment receipt requirements (Bermudez, Ch. 393, Stats. 2005)
Requires optometrists to provide a receipt to patients making a specified payment to them and it would also revise the information that is required on the receipt. Authorizes the Board to issue a probationary license to an applicant, subject to specified terms and conditions. Revises and recasts provisions relating to unprofessional

conduct. Authorizes the Attorney General to prosecute a licensee for unprofessional conduct under the Administrative Procedure Act. Deletes reporting requirements when the Board raises a fee to certain committees in the Legislature. Makes various fee changes.

Senate Bill 231 - Reporting of Settlements or Arbitration Awards Over $3,000 (Figueroa, Ch. 674, Stats. 2005)
Requires that any judgment in a malpractice action against a licensee to be reported to the appropriate licensing board by the licensee or the claimant, or their counsel, and would make a failure to comply with this requirement a crime.

Senate Bill 579 - Elimination of CPR Requirement, Advertising Free Eye Exam and Licensure by Endorsement (Aanestad, Ch. 302, Stats. 2006)
Authorizes the Board to issue a license to a person that, among other things, has passed a licensing examination for an optometric license in another state. Eliminates the Board's authority to adopt regulations requiring licensees to maintain current certification in cardiopulmonary resuscitation. Makes it unlawful to advertise as being free or without cost the furnishing of optometric services where the services are contingent upon payment or other exchange of consideration unless the contingency is fully disclosed.

Assembly Bill 2256 - Certificate of Registration for Optometric Corporation Repealed (Ch. 564, Stats. 2006)
Deletes the provisions requiring an optometric corporation to obtain this certificate from the Board and file these reports with it. Deletes the provisions that give the Board the powers of suspension, revocation, and discipline against an optometric corporation as it has against individuals. Also deletes the requirement that the Board comply with Administrative Procedure Act as they pertain to optometric corporations.

Assembly Bill 1382 - Deceptive Marketing Practices (Nakanishi, Ch. 148, Stats. 2006)
Prohibits a person, other than a physician, surgeon or optometrist from measuring the powers or range of human vision or determining the accommodative and refractive status of the human eye or scope of its functions in general or prescribe ophthalmic devises, as defined. Makes it a deceptive marketing practice for any individual or entity who offer for sale plano contact lenses to represent by any means that those lenses may be lawfully obtained without an eye examination or confirmation of a valid prescription, or may be dispensed or furnished to a purchaser without complying with prescribed requirements.

Senate Bill 1406 - Changes in Scope of Practice (Correa and Aanestad, Ch. 352, Stats. 2009)
Revises and recasts the Optometry Practice Act to further allow an optometrist who is certified to use therapeutic pharmaceutical agents to, among other things, treat glaucoma, as defined, under specified certification standards, order X-rays necessary for the diagnosis of conditions or diseases of the eye or adnexa, perform venipuncture for testing patients suspected of having diabetes, administer oral fluorescein to patients suspected of having retinopathy, prescribe lenses or devices that incorporate a medication or therapy the optometrist is certified to prescribe or provide, and use specified instruments within the central three millimeters of the cornea. Allows optometrist to perform lacrimal irrigation and dilation if they meet certain criteria and changes referral requirements. Also creates the Glaucoma Diagnosis Advisory Committee for the creation of regulations to establish the training required to obtain glaucoma certification.

Assembly Bill 2683 - The Practice of Optometry in Health Facilities and Optometric Assistants (Hernandez, Chapter 604, Stats. 2010)
Requires the Board to consult with the Military Department before adopting rules and regulations to provide for methods of evaluating education, training, and experience obtained in the armed services, if applicable, to the requirements to become an optometrist.

Senate Bill 1489 Omnibus - Strengthening of Licensing Laws (Senate Business, Professions and Economic Development Committee, Chapter 653, Stats. 2010)
Amends various licensing provisions for clarity purposes only.

Assembly Bill 2699 - Exemption for Out-of-State Provider Participating in Sponsored Event Where Free Services Provided (Bass, Chapter 270, Stats. 2010) Provides an exemption from licensure and regulation requirements to optometrists, licensed or certified in good standing in another state or states, which offer or provide eye care services through sponsored free health care events.

Assembly Bill 2500- Reinstatement of Optometry for Licensees in Military Service (Hagman, Chapter 389, Stats. 2010)
Authorizes a licensee whose license expired while the licensee was on active duty as a member of the California National Guard or the United State Armed Forces to, upon application, reinstate his or her license without a penalty and without examination, if those requirements are satisfied, unless the Board determines that the applicant has not actively engaged in the practice of optometry while on active duty, as specified.

Assembly Bill 2783 - Military Personnel (Committee on Veterans Affairs, Chapter 214, Stats. 2010)
Requires the Board to develop rules and regulations that provide methods of evaluating education, training, and experience obtained in the armed services, if applicable, to the requirements of the practice of optometry. These rules and regulations shall also specify how this education, training and experience may be used to meet the licensure requirements for optometrists. The Board must consult with the Department of Veterans Affairs and the Military Department before adopting any rules and regulations.

Senate Bill 850 - Electronic Medical Records: Confidential Information (Leno, Chapter 714, Stats. 2011)
Requires an electronic health or medical record system to automatically record and preserve any change or deletion of electronically stored medical information, and would require that record to include, among other things, the identity of the person who accessed and changed the medical information and the change that was made to the medical information.

Assembly Bill 1424 - Franchise Tax Board: Delinquent Tax Debt (Perea, Chapter 455, Stats. 2011)
Authorizes all State licensing entities, including boards and bureaus under DCA other than the Contractor's State License Board (CSLB), to deny, suspend, or revoke a license if the licensee or applicant appeared on the Franchise Tax Board or the State Board of Equalization's certified lists of top 500 largest tax delinquencies over $100,000. This bill would also authorize the Department to suspend a license in the event that the board fails to take action.

Regulation Activity

Regulations Initiated by the Board

A number of regulatory changes have been enacted since the last sunset review in 2002. The changes are listed below in chronological order.

National Board of Examiners in Optometry: Effective January 28, 2002, section 1531 of Title 16 of Division 15, of the California Code of Regulations (CCR) was amended to adopt the licensure examination developed by the National Board of Examiners in Optometry.

Continuing Education Requirements: Effective January 21, 2005, 16 CCR section 1536 was amended to reflect the change in the license renewal cycle from annual to biennial, amends the self-study continuing education requirements, and the initial licensure exemptions.

Therapeutic Pharmaceutical Agents: Effective January 19, 2005, 16 CCR sections 1567, 1568 and 1569 were amended to incorporate language from the BPC to increase clarity regarding what optometrists can and can't prescribe. Language also deletes outdated protocols for certain conditions.

Deletion of Advertising Violations: Effective March 13, 2006, 16 CCR section 1515 was repealed. This regulation provided that optometrists who violated BPC sections 651, 651.3, or 17500 were subject to revocation or suspension of their certificate or registration. The impetus for this section was eliminated by Assembly Bill 488 (Bermudez, Chapter 393, Stats. 2005), which provided specific statutory authority.

Deletion of 75% Passing Score - Change Without Regulatory Effect (technical or editorial changes): Effective March 14, 2006, 16 CCR section 1530 was repealed. This regulation required candidates for optometric licensure to obtain a passing score of at least 75% in each required examination section listed in CCR section 1531. The need for this section was eliminated via Assembly Bill 2464 (Pacheco, Chapter 426, Stats. 2004) which replaced the 75% passing score criteria with language requiring that passing grades for California licensure exams be based on "psychometrically sound principles for establishing minimum qualifications and levels of competency."

Release of Prescriptions: Effective April 9, 2006, 16 CCR sections 1566 and 1566.1 were amended to make it clear that optometrists must release both spectacle prescriptions and contact lens prescriptions following either an exam or fitting. The amendment also corrected the title of the consumer notice and the physical address, e-mail address and internet address of the Board.

Citable Offenses: Effective October 26, 2006, 16 CCR section 1579 was amended to update the fines the Board could issue for citable offenses. Also, this amendment eliminated the specificity of the old language and created categories of violations, thus eliminating the need for ongoing amendments in response to future changes in optometry law.

Out-of-State Optometrists – 18 Years of Age Requirement to Apply: Effective November 7, 2007, 16 CCR section 1523 was amended to add a provision regarding applications from out-of-state optometrists who must be at least 18 years of age and apply for California licensure on two forms which are incorporated by reference.

Out-of-State Optometrists – Waiver of 65 Hour Preceptorship Requirement: Effective July 3, 2008, 16 CCR section 1568 added a subsection on Therapeutic Pharmaceutical Agents (TPAs). This new subsection enabled out-of-state licensed optometrists, who wish to be licensed in California and to use topical TPAs on patients to obtain a waiver of the BPC section 3041.3(b) 65-hour preceptorship requirement.

Fee Increase: Effective April 28, 2009, 16 CCR section 1524, was amended to increase various application, renewal and penalty fees collected by the Board to fund its administration of the optometry licensing program. Fees had not been raised since 1993.

Notification to Engage in Practice - Change Without Regulatory Effect (technical or editorial changes): Effective January 6, 2010, 16 CCR section 1505 was amended to replace the words "certificate holder" with "licensee." Referring to an optometrist licensed by the Board as a licensee is a more appropriate term used by staff and throughout the Board's laws and regulations.

Fingerprinting Requirements: Effective June 21, 2010, Article 5.1 with 16 CCR sections 1525, 1525.1, 1525.2 were adopted to require licensees who had not previously submitted fingerprints to the Department of Justice (DOJ) to complete a state and federal level criminal offender recording information search through the DOJ before renewal of a license. Also clarifies that prior to renewal, a licensee has to disclose whether there has been any disciplinary action against them and if they have any criminal convictions during the renewal cycle.

Scope of Practice Repeal: Effective August 20, 2010, 16 CCR section 1569 was repealed because the regulation duplicates BPC section 3041.

Glaucoma Certification Requirements: Effective January 8, 2011, 16 CCR section 1571 was adopted to implement Senate Bill 1406, Chapter 352, Stats. 2008, by establishing the requirement for the certification of optometrists to treat all primary open-angle glaucoma and exfoliation and pigmentary glaucoma. Continuing education requirements for glaucoma certified-optometrists are also specified, and the exemption of didactic instruction and case management requirements for certification for optometrists who completed their education from accredited schools and colleges of optometry on or after May 1, 2008. In February 2011, this regulation was challenged in court by the California Academy of Eye Physicians and Surgeons (CAEPS) and the California Medical Association (CMA). The parties claimed that the regulation did not afford the appropriate training needed for California optometrists to treat glaucoma. The courts upheld that the regulation was valid and that the Board acted within its rulemaking authority under BPC section 3025, and no abuse of discretion

was shown. The ruling also stated that CAEPS and CMA did not demonstrate adequate standing that their claims were correct. This ruling ended the case and this regulation continues to be implemented without further issues.

Infection Control Guidelines: Effective January 19, 2011, 16 CCR section 1520 was amended to set forth "Infection Control Guidelines" for optometrists. The principal provisions of the regulation pertain to: proper hand hygiene, use of personal protective equipment, handling of sharp instruments, and disinfection requirements.

Fictitious Name Permits and Licensing Requirements: Effective March 10, 2011, 16 CCR sections 1518, 1523, 1531, 1532, 1533, 1561 were amended to clarify information for requirements regarding licensure and examination, permit fees for creating a fictitious business names, and usage of topical pharmaceutical agents.

Continuing Education: Effective June 17, 2011, 16 CCR section 1536 was amended to add new continuing optometric education opportunities, including credit for attending a Board meeting, earning certification in cardiopulmonary resuscitation (CPR) and completing course work in the ethical practice of optometry. This amendment also provides for utilization of the Association of Regulatory Boards in Optometry's Optometric Education Tracker system as proof of course attendance.

Renting Space and Fingerprints: Effective October 25, 2012, 16 CCR sections 1514 and1525.1 further clarify that signage is required at commercial/mercantile location to indicate that it is owned by an optometrist and the practice is separate and distinct from other occupants. This proposal also clarifies that fingerprints are to be submitted upon renewal of an optometric license if the licensee has not had their fingerprints taken by the Department of Justice and the Federal Bureau of Investigation.

Pending Regulations

Uniform Standards Related to Substance Abuse and Disciplinary Guidelines: (CCR section 1575) This proposal adds the Uniform Standards Related to Substance Abuse pursuant to Senate Bill 1441 (Ridley-Thomas, Ch. 548, Stats. 2008) to the Board's disciplinary guidelines. Also updates the Board's disciplinary guidelines, which have not been revised since 1999, to be in line with the current probationary environment. This rulemaking file will be submitted to the Office of Administrative Law (OAL) for final review prior to the file's expiration on October 21, 2012.

Sponsored Free Health Care Events: (CCR sections 1508, 1508.1, 1508.2, 1508.3) This proposal provides exemption from licensure and requirements to optometrists, licensed or certified in good standing in another state or states, that offer or provide eye care services through a sponsored event. Requirements are also established for the sponsoring entity, and registration forms are incorporated by reference. This proposal was initiated pursuant to Assembly Bill 2699 (Bass, Ch. 2070, Stats. 2010). This rulemaking package will be submitted to OAL for final review by the end of this year.

Consumer Information Change without Regulatory Effect (technical or editorial changes): (CCR section 1566.1) This proposal updates the Board's address because the current language in the Consumer Notice regulation contains the old address. This change without regulatory effect will be submitted to OAL before the end of this year.

Consumer Protection Initiative Regulations: (CCR sections TBD) This proposal stems from an effort by DCA to implement certain provisions of its legislation Senate Bill 1111 that do not require statutory authority. Senate Bill 1111 failed to pass the legislature in 2010. These regulations will propose delegation of certain functions to the Executive Officer, required actions against registered sex offenders, and additional professional conduct provisions to aid in streamlining the Board's enforcement process. The Board anticipates meeting in December 2012 to discuss these regulations and possibly submit them for notice to OAL by the end of this year.

Major Studies

Describe any major studies conducted by the board.

2009 – Comprehensive Audit of the National Boards of Examiners in Optometry:
As part of the Board's responsibility to ensure that examination programs being used in the California licensure process comply with psychometric and legal standards, the Board contracted with the DCA, Office of Professional Examination Services (OPES) to complete a comprehensive review of the NBEO licensing examinations for continued use in California. The purpose of the review was to determine if the NBEO examinations assess competencies relevant to practice in California and whether the examinations meet professional guidelines and technical standards outlined in the *Standards for Educational and Psychology Testing (APA Standards)* and BPC section 139. OPES found that that the procedures used to establish and support the validity and defensibility of the NBEO examination meet the professional guidelines and technical standards outlined above.

Occupational Analysis – Office of Professional Examination Services:
An occupational analysis (survey) is a required component in the examination development process. Professional guidelines and testing standards recommend conducting an occupational analysis every five to seven years. This survey of licensees is conducted to determine the current practice of the profession. The survey becomes the foundation for the examination plan which is utilized to develop the laws and regulation examination for optometrists. This process ensures the Board's laws and regulation examination is fair, job-related, and legally defensible. Since the last sunset review, the Board conducted an occupational analysis in 2009 with the assistance of OPES.

National Association Activity

List the status of all national associations to which the board belongs.

The Board is a current member of the Association of Regulatory Boards of Optometry. This membership includes voting privileges.

To date, despite Board member interest, the Board has not participated in any committees, workshops, work groups, or task forces related to its membership in this national association. This is due to constraints, specifically restrictions on travel, associated with California's ongoing budget shortfalls.

Although not a member, the Board does have a good working relationship with the California Optometric Association (COA), which is an affiliate of the American Optometric Association. Board staff is invited to three events held by the COA yearly:

- Monterey Symposium – Optometrists have the opportunity to obtain continuing optometric education, network with colleagues, and explore an exhibit hall filled with optometry's latest products and services. The Board is given a table in the exhibit area to distribute information about the licensing and enforcement of the profession, and answer questions. Historically, two staff members were permitted to attend, but in the last few years, budget constraints have precluded staff from attending.

- Legislative Day – More than 180 optometrists from around the state rally at the State Capitol to meet legislators and promote the practice of optometry. The Board is represented and has the opportunity to share projects they are working on, statistics pertaining to licensure and enforcement, and answer questions. Since this is held in Sacramento, two staff members attend.

- House of Delegates – The COA House of Delegates and a ten member board of trustees govern the COA and consist of COA members from each of the local optometric societies, California optometry schools and colleges, and COA sections. Delegates meet once a year to debate and vote on COA policy resolutions and bylaws amendments; adopt the COA budget; and elect COA's trustees and

- officers. Historically two Board staff members are permitted to attend. In the past few years, staff has not attended due to budget restraints. This event is held in a different part of the state each year.

If the board is using a national exam, how is the board involved in its development, scoring, analysis, and administration?

In 2001, the Board voted to use the National Board of Examiners in Optometry (NBEO) examination for licensure. This became effective upon the passage of CCR section 1531 on January 28, 2002. The examination is developed and administered by the NBEO, which is located in North Carolina. The NBEO was established in 1951 and is an organization that develops, administers, and scores examinations, and reports the results that state boards utilize in licensing optometrists to practice eye care. Currently, all 50 states, the District of Columbia and Puerto Rico use this examination for licensure.

The Board conducted an assessment of the NBEO examination in 2001, and again in 2009. The purpose of the assessments as to ensure that the examination met professional guidelines and technical standards outlined in the *Standards for Educational and Psychological Testing* and the DCA *Examination Validation Policy*. The Board's assessments determined the examination meets the prevailing standards for validation and use of the examination for licensure in California.

Applicants for an optometrist license can apply to take the NBEO examination without first applying to the Board. This is permitted because the NBEO is divided into three parts, and applicants must take the first two parts while still in optometry school. Upon applying with the Board, applicants must ensure that the NBEO submits their scores to the Board. The Board and the NBEO have arranged for the scores to be transmitted electronically for examination security purposes. There are two administrations of this examination a year, and this takes place at the NBEO testing center in North Carolina.

The NBEO is aware that the Board may take the following steps to ensure they are current with California optometrist practice, and meet the national and California testing standards.

- The Board and/or its psychometric vendor may audit the NBEO program every five to seven years;
- California optometrists will be involved in future occupational analyses and the examination development process;
- Upon notification of any potential or actual adjustments of the national passing score by another state, the Board may voice its concerns or adapt, as necessary;
- The Board and/or its designated examination expert may conduct site visits of testing centers on an annual basis;
- Require detailed content outlines of the examination be provided by the NBEO to candidates for the examination;
- Require that pass/fail rates be provided to the Board on a monthly basis. The NBEO posts scores online for Parts I, II, III, TMOD, and ISE as soon as the scores are released to the candidates;
- Require that detailed statistics such as number of attempts and pass/fail rates per school be provided;
- Require the NBEO to continue to provide examination scores electronically for examination security purposes;
- Ensure the NBEO is in compliance with the American Disabilities Act by providing special testing accommodations to examination candidates.

Section 2 –
Performance Measures and Customer Satisfaction Surveys

Quarterly and Annual Performance

Provide each quarterly and annual performance measure report as published on the DCA website
The Board's quarterly and annual performance measures as published on the DCA website are located in Section E.

Customer Satisfaction Survey

Discussion of customer satisfaction survey data

The Board began using three customer satisfaction surveys (general, licensing, and enforcement) in April 2009. Therefore, the fiscal year 2009/10 survey data reflects responses since that time. All other fiscal years represent responses for a full fiscal year, with the exception for fiscal year 2011-12 in the enforcement survey (see below). Customer satisfaction surveys were not conducted prior to April 2009.

The surveys were distributed as follows:

- In paperwork mailed to individuals who were served by the Board's licensing or enforcement units, including applicants for licensure, renewal, or certification changes, and individuals who had filed complaints against a licensee;
- A link on the Board's website;
- A link on all staff's e-mail signature blocks;
- A link on follow-up e-mails to licensees/consumers, that had been recently assisted by staff, requesting completion of the survey; and
- A link in every e-mail sent to the Board's website subscribers.

In 2011, DCA created an enforcement customer satisfaction survey and the Board's enforcement unit began using this survey instead of the 2009 Board enforcement survey. In addition to including a postcard sized survey in correspondence to complainants, Board staff continued the use of e-mail signature blocks that include the link to the electronic version of the survey. Since implementation of the survey, a total of six people have viewed the DCA survey online.

In an effort to increase responses for all surveys, the Board is researching other options for contacting potential survey respondents. One option that is being researched is requesting that the Employment Development Department include copies of the survey in the licensure packets that are mailed out once applications are completed. While this would require significant staff time and financial resources to implement, it may result in more survey responses.

While response rates are low, survey results indicate that the Board's performance is consistent with satisfaction scores ranging from 70% to 85%, and a rating average of 4.5. The Board will continue to research additional methods to increase response rates, and provide excellent service to consumers and licensees. This is an important component to the Board's mission and strategic goals.

Provide results for each question in the customer satisfaction survey broken down by fiscal year. Discuss the results of the customer satisfaction surveys.

Board General Customer Satisfaction Survey Fiscal Years (FY) 09/10* - 11/12				
Are you a(n):	**Answer Options**	**Response Count**		
		FY 09/10	**FY 10/11**	**FY 11/12**
	Applicant	0	0	0
	Licensee	2	12	4
	Consumer	0	0	2
	Government Agency	0	0	7
	Optometric Association	0	2	0
	Other	2	3	1
	Total Respondents	4	17	14
On average, how many times do you contact the Board per month?	**Answer Options**	**Response Count**		
		FY 09/10	**FY 10/11**	**FY 11/12**
	0-1 times	3	16	7
	2-3 times	0	1	1
	4-5 times	0	0	4
	6 or more times	1	0	2
What was your purpose for contacting the Board? Choose all that apply.	**Answer Options**	**Response Count**		
		FY 09/10	**FY 10/11**	**FY 11/12**
	Board Meetings	1	1	0
	Board Member Contact	0	0	0
	Executive Officer	1	0	0
	Forms	2	7	2
	Laws and Regulations	0	6	2
	Law Exam Workshops	0	1	0
	Newsletter	0	5	0
	Public Records Act Request	0	0	3
	Request for Information	0	8	12
	Subject Matter Expert Info	0	1	0
	Other	0	2	4
Were you transferred to the appropriate individual if you were unable to get a response from your initial contact with the Board?		**Response Percent**		
		FY 09/10	**FY 10/11**	**FY 11/12**
	Yes	50%	82%	71%
Based on your contact with the Board, please rate the following:	**Answer Options**	**Rating Average** (1=Unacceptable, 5 = Excellent))		
		FY 09/10	**FY 10/11**	**FY 11/12**
	Staff Courteous/Helpful	4.3	4.2	4.1
	Staff Knowledgeable	4.0	4.5	4
	Staff Accessible	4.0	4.2	3.8
	Staff Responsiveness	4.0	4.2	4.1
	Overall Satisfaction	4.0	4.3	4.1
Prior to contacting the Board, did you visit the Board's website at www.optometry.ca.gov?		**Response Percent**		
		FY 09/10	**FY 10/11**	**FY 11/12**
	Yes	50%	88%	79%
Did you receive the service you needed as a result of your contact with the Board?		**Response Percent**		
		FY 09/10	**FY 10/11**	**FY 11/12**
	Yes	75%	88%	93%

The first survey conducted by the Board was in April 2009

Board General Customer Satisfaction Survey Additional Comments:

FY 11/12

- I worked with the receptionist and she did a great job handling my complicated case and being aware of the time limit I was under.
- The Board should provide interpretation and advice on California law as it pertains to optometry. I was advised to contact my attorney when I contacted the Board.

- The receptionist and licensing staff who handle business licenses are the best people in the world!! So nice and extremely helpful.
- Specifically, I requested the citation of the rules governing the dispensing of eyeglasses on an *expired* prescription. Initial call: I was transferred to someone who would be expected to have an answer to my question, but for whom I was to leave a voice message. I did leave a voice message requesting a response either by phone or by e-mail and provided my contact information. I received no response at all.... and this survey is the first I've heard back!

FY 10/11

- I called to request information regarding optometry law, and was told to contact my attorney.
- The few times I have contacted the Board of Optometry, everyone that I met was courteous and very knowledgeable. This is probably why I do not have to contact them as much. They are very efficient!
- Not all the information is presented on the website, but I am glad to know that all my questions are answered with a single phone call.

FY 09/10

- None.

Board Licensing Customer Satisfaction Survey Fiscal Years (FY) 09/10* - 11/12				
Are you a(n):	**Answer Options**	**Response Count**		
		FY 09/10	**FY 10/11**	**FY 11/12**
	Applicant	3	10	12
	Licensee	1	6	5
	Consumer	1	4	5
	Total Respondents	5	20	22
Based on your initial contact with the Board, please rate the following:	**Answer Options**	**Rating Average** (1 = Unacceptable, 5 = Excellent)		
		FY 09/10	**FY 10/11**	**FY 11/12**
	Staff Courteous/Helpful	4.8	4.6	4.6
	Staff Knowledgeable	4.2	4.4	4.5
	Staff Accessible	4.4	4.4	4.2
	Staff Responsiveness	3.8	4.4	4.3
	Overall Satisfaction	4.4	4.4	4.4
During your initial contact with the Board, were you transferred to the appropriate individual in the Licensing Unit?	**Answer Options**	**Response Percent**		
		FY 09/10	**FY 10/11**	**FY 11/12**
	Yes	80%	85%	82%
On average, how many times do you contact the Board's Licensing Unit per month?	**Answer Options**	**Response Count**		
		FY 09/10	**FY 10/11**	**FY 11/12**
	0-1 times	3	14	14
	2-3 times	2	3	3
	4-5 times	0	0	2
	6 or more times	0	2	2
What was your purpose for contacting the Licensing Unit? Choose all that apply.	**Answer Options**	**Response Count**		
		FY 09/10	**FY 10/11**	**FY 11/12**
	Address Change	0	1	1
	Application for Licensure (CA)	0	5	2
	Application for Licensure (out-of-state)	2	7	9
	CLRE	0	1	5
	Business Licenses	0	2	1
	Laws and Regulations	0	4	2
	Optometry License Renewal	0	2	3
	Verification of Licensure	0	3	3
	Other	3	6	5
Based on your contact with the Board's Licensing Unit, please rate the following:	**Answer Options**	**Rating Average** (1 = Unacceptable, 5 = Excellent)		
		FY 09/10	**FY 10/11**	**FY 11/12**
	Staff Courteous/Helpful	4.8	4.5	4.3
	Staff Knowledgeable	4.4	4.3	4.4
	Staff Accessible	4.2	4.4	4.2
	Staff Responsiveness	3.6	4.3	4.3
	Overall Satisfaction	4.2	4.4	4.4
Prior to contacting the Board's Licensing Unit, did you visit the Board's website at www.optometry.ca.gov?		**Response Percent**		
		FY 09/10	**FY 10/11**	**FY 11/12**
	Yes	100%	85%	86%
Did you receive the service you needed as a result of your contact with the Board Licensing Unit?		**Response Percent**		
		FY 09/10	**FY 10/11**	**FY 11/12**
	Yes	100%	85%	77%

The first survey conducted by the Board was in April 2009

Board Licensing Customer Satisfaction Survey Additional Comments:

FY 09/10

- How very sad it is that at the same time so many names of those certificated in 1959 no longer appear on the roster, the name of one long deceased, whose license had been revoked, remains. Despite

many petitions to change the status to deceased, the Board of Optometry refuses to respond. I knew Dr. Gerald Albert and his family very well. I pursued the attempts to change the status to deceased, to honor the memory of the very significant good that he and his late wife did for the community, which is carried on by their very accomplished children. If the status of Dr. Albert's license will not be changed, I request a written explanation from the Board so that I can show the evidence to his children.

- E-mail petitions to the Board office during the previous year, and to the Vice-President. Received no response. I could not find a direct e-mail address for the President.
- Out-of-state optometrist: The process has been very slow and I received a letter requesting information that had been sent more than three months ago. The staff is not as organized as I would have expected and it has taken a long time to process the application.
- In regards to the Board's website: All very useful indeed.

FY 10/11

- The staff is helpful & very knowledgeable.
- The board personnel work very hard to cover the needs of the licensed optometrists.
- I appreciate the prompt reply and provision of requested form.

FY 11/12

- I attempted to obtain written verification of a provider's optometry license. I received a letter stating there was no fee for the service along with my check and this survey. The letter did not indicate whether or not your company will provide written verifications or if WE MUST USE the information we obtain on your website. So I am sending a second request via fax.
- I have been e-mailing the licensing analyst about my license for over two weeks and have not gotten a response. Every time I call his direct number, he states that he is unavailable. I would like to get a response about my application. The person I contacted stated that he was not able to be reached on his voicemail. I am still waiting to be contacted
- Still waiting for our FNP. It has been over 2 months.
- I am impressed.
- No response regarding my TPL application until I contacted them 2 months later, then I was left hanging until I contacted them 2 and a half months after that. Was told the supervising doctor that signed off my TPL was not an "ophthalmologist" even though he practices ophthalmology in California and is a board certified ophthalmologist.
- The licensing analyst is very knowledgeable and extremely helpful.

Board Enforcement Customer Satisfaction Survey Fiscal Years (FY) 09/10* - 11/12**				
Are you a(n):	**Answer Options**	**Response Count**		
		FY 09/10	**FY 10/11**	**FY 11/12**
	Applicant	0	0	
	Licensee	1	2	
	Consumer	2	19	
	Total Respondents	3	21	
Based on your initial contact with the Board, please rate the following:	**Answer Options**	**Rating Average** (1 = Unacceptable, 5 = Excellent)		
		FY 09/10	**FY 10/11**	**FY 11/12**
	Staff Courteous/Helpful	5.0	4.8	
	Staff Knowledgeable	5.0	4.8	
	Staff Accessible	4.7	5.0	
	Staff Responsiveness	4.3	4.7	
	Overall Satisfaction	4.7	4.8	
During your initial contact with the Board, were you transferred to the appropriate individual in the Enforcement Unit?	**Answer Options**	**Response Percent**		
		FY 09/10	**FY 10/11**	**FY 11/12**
	Yes	100%	100%	
On average, how many times do you contact the Board's Licensing Unit per month?	**Answer Options**	**Response Count**		
		FY 09/10	**FY 10/11**	**FY 11/12**
	0-1 times	2	13	
	2-3 times	0	1	
	4-5 times	1	1	
	6 or more times	0	1	
What was your purpose for contacting the Licensing Unit? Choose all that apply.	**Answer Options**	**Response Count**		
		FY 09/10	**FY 10/11**	**FY 11/12**
	Disciplinary History	1	14	
	Laws and Regulations	1	6	
	Request to File a Complaint	0	2	
	Pending Complaint	0	1	
	Probation	0	0	
	Other	2	4	
Based on your contact with the Board's Enforcement Unit, please rate the following:	**Answer Options**	**Rating Average** (1 = Unacceptable, 5 = Excellent)		
		FY 09/10	**FY 10/11**	**FY 11/12**
	Staff Courteous/Helpful	5.0	4.4	
	Staff Knowledgeable	5.0	4.5	
	Staff Accessible	4.7	4.5	
	Staff Responsiveness	4.3	4.5	
	Overall Satisfaction	4.7	4.5	
Prior to contacting the Board's Enforcement Unit, did you visit the Board's website at www.optometry.ca.gov?		**Response Percent**		
		FY 09/10	**FY 10/11**	**FY 11/12**
	Yes	100%	71%	
Did you receive the service you needed as a result of your contact with the Board Enforcement Unit?		**Response Percent**		
		FY 09/10	**FY 10/11**	**FY 11/12**
	Yes	100%	76%	

The first survey conducted by the Board was in April 2009
***** In 2011, the Board began using the DCA Enforcement Survey***

Board Enforcement Customer Satisfaction Survey Additional Comments:

FY 09/10

- An observation: the Enforcement Unit takes their roles and responsibilities seriously ensuring consumer protection. Took a couple of days for staff to respond to my calls and e-mails, but after they called me back the staff was helpful and knowledgeable.
- Enforcement staff is kind, helpful and professional.

- When I e-mailed your website for help. I did not get any reply for over a week. When I called an analyst directly, I was helped promptly and she is great.
- I called the Enforcement Unit to obtain some info on CA rules for optometrists. They are extremely helpful. Thanks again.
- Extremely helpful, went the extra mile to identify which of my providers will be affected by the new fingerprint requirement.

FY 10/11

- None.

Department of Consumer Affairs Enforcement Customer Satisfaction Survey Fiscal Years (FY) 11/12*		
Complaint number?	**Answer Options**	**Response Count**
	Answered question	2
	Skipped question	1
	Total Respondents	2
Which DCA Board or Bureau did you file a complaint with?	**Answer Options**	**Response Count**
	Optometry, Board of	100%
	Total Respondents	3
How did you contact our Board/Bureau?	**Answer Options**	**Response Count**
	Website	0
	Regular Mail	2
	E-mail	0
	Phone	1
	In-person	0
How satisfied were you with the format and navigation of our Web site?	**Answer Options**	**Response Count**
	Very satisfied	0
	Somewhat satisfied	0
	Neither satisfied nor dissatisfied	0
	Somewhat dissatisfied	0
	Very dissatisfied	0
How satisfied were you with the information pertaining to your complaint available on our Web site?	**Answer Options**	**Response Count**
	Very satisfied	0
	Somewhat satisfied	0
	Neither satisfied nor dissatisfied	0
	Somewhat dissatisfied	0
	Very dissatisfied	0
How satisfied were you with the time it took to respond to your initial correspondence?	**Answer Options**	**Response Count**
	Very satisfied	0
	Somewhat satisfied	0
	Neither satisfied nor dissatisfied	0
	Somewhat dissatisfied	0
	Very dissatisfied	1
How satisfied were you with our response to your initial correspondence?	**Answer Options**	**Response Count**
	Very satisfied	0
	Somewhat satisfied	0
	Neither satisfied nor dissatisfied	0
	Somewhat dissatisfied	0
	Very dissatisfied	1
How satisfied were you with the time it took to speak to a representative of our Board/Bureau?	**Answer Options**	**Response Count**
	Very satisfied	1
	Somewhat satisfied	0
	Neither satisfied nor dissatisfied	0
	Somewhat dissatisfied	0
	Very dissatisfied	0

Department of Consumer Affairs Enforcement Customer Satisfaction Survey Fiscal Years (FY) 11/12* Continued

How satisfied were you with our representative's ability to address your complaint?	**Answer Options**	**Response Count**
	Very satisfied	1
	Somewhat satisfied	0
	Neither satisfied nor dissatisfied	0
	Somewhat dissatisfied	0
	Very dissatisfied	0
How satisfied were you with the time it took for us to resolve your complaint?	**Answer Options**	**Response Count**
	Very satisfied	0
	Somewhat satisfied	0
	Neither satisfied nor dissatisfied	0
	Somewhat dissatisfied	1
	Very dissatisfied	1
How satisfied were you with the explanation you were provided regarding the outcome of your complaint?	**Answer Options**	**Response Count**
	Very satisfied	0
	Somewhat satisfied	0
	Neither satisfied nor dissatisfied	0
	Somewhat dissatisfied	0
	Very dissatisfied	2
Overall, how satisfied were you with the way in which we handled your complaint?	**Answer Options**	**Response Count**
	Very satisfied	0
	Somewhat satisfied	0
	Neither satisfied nor dissatisfied	0
	Somewhat dissatisfied	0
	Very dissatisfied	2
Would you contact us again for a similar situation?	**Answer Options**	**Response Count**
	Definitely	0
	Probably	0
	Maybe	0
	Probably Not	1
	Absolutely Not	1
Would you recommend us to a friend or family member experiencing a similar situation	**Answer Options**	**Response Count**
	Definitely	0
	Probably	0
	Maybe	0
	Probably Not	1
	Absolutely Not	1
Thank you for taking the time to complete this survey. Your opinion matters to us and will help us improve our enforcement processes. Please add any comments you with to provide:	**Answer Options**	**Response Count**
	Answer questions	2
	Skipped question	1

The first enforcement survey conducted by the DCA was in 2011.

Section 3 – Fiscal and Staff

Fiscal Issues

Describe the board's current reserve level, spending, and if a statutory reserve level exists.

The Board ended FY 2011/2012 with a reserve balance of $617,000 which equates to 4.3 months in reserve. The Board estimates FY 2012/2013 reserve balance to be approximately $571,000 equaling 3.9 months in reserve. A decrease to the Board's reserve balance is due to the $1 million dollar loan to the General Fund in FY 2011/2012. Additionally, the Board anticipates further decreases to its reserve fund due to the increase in Operating Expenses & Equipment (OE&E), a rent increase based on the Board's relocation to a larger office, and the DCA BreEZe Budget Change proposal (See Section 9 for more information on the BreEZe Project).

In FY 2011/2012, the Board reverted $247,615 due to spending $1,270,684 (81%) of its $1,564,598 budget. The Board's statutory reserve fund limit is six months (BPC section 3145).

Table 2. Fund Condition

(Dollars in Thousands)	FY 2008/09	FY 2009/10	FY 2009/10	FY 2011/12	FY 2012/13	FY 2013/14
Beginning Balance	742	813	1226	1514	617	571
Revenues and Transfers	1118	1573	1648	664	1671	1670
Total Revenue	$1118	$1573	$1648	$1664	$1671	$1670
Budget Authority	1489	1489	1658	1571	1714	TBD
Expenditures	1055	1167	1357	1554	1714	1748
Loans to General Fund				1000		
Accrued Interest, Loans to General Fund						
Loans Repaid From General Fund						
Fund Balance	$804	$1218	$1514	$617	$571	$493
Months in Reserve	8.3	10.7	11.6	4.3	3.9	3.3

Describe if/when a deficit is projected to occur and if/when fee increase or reduction is anticipated. Describe the fee changes (increases or decreases) anticipated by the board.

Current Board projections do not indicate a future deficit. The last fee increase became effective April 28, 2009. The Board had not sought a fee increase since FY 1996/1997. The fee increase was necessary for the Board to maintain core business functions (licensing, enforcement and consumer protection) in the regulatory program, to rebuild the reserve funds, and absorb the anticipated and necessary increases in the operating budget in future years. The Board does not have immediate plans to increase or reduce fees. (BPC sections 3152, 3152.5, and CCR section 1524)

Describe history of general fund loans. When were the loans made? When were payments made? What is the remaining balance?

In FY 2011/2012, the Board made a $1 million dollar loan to the General Fund. To date, the Board has not received any repayment leaving the balance due at $1 million dollars. The lack of repayment has constrained the Board's ability to maintain adequate reserve funds that can assist the Board in emergency situations.

Describe the amounts and percentages of expenditures by program component. Use *Table 3. Expenditures by Program Component* to provide a breakdown of the expenditures by the board in each program area. Expenditures by each component (except for pro rata) should be broken out by personnel expenditures and other expenditures.

The chart below reflects the Board's expenditures by program component. On average, during the last four fiscal years, the Board's enforcement program accounts for 41.5% of the Board's expenditures, the examination program 3.5%, the licensing program accounts for 15%; administration 24%, and 16% for pro rata.

Table 3. Expenditures by Program Component

(Dollars in Thousands)	FY 2008/09		FY 2009/10		FY 2010/11		FY 2011/12	
	Personnel Services	OE&E	Personnel Services	OE&E	Personnel Services	OE&E	Personnel Services	OE&E
Enforcement	110	208	183	286	313	358	306	290
Examination	11	41	9	26	11	19	9	31
Licensing	165	71	160	97	106	35	94	40
Administration *	231	66	198	77	278	66	245	69
DCA Pro Rata		207		172		216		238
Diversion (if applicable)								
TOTALS	$517	$593	$550	$658	$708	$694	$654	$668

*Administration includes costs for executive staff, board, administrative support, and fiscal services.

Describe license renewal cycles and history of fee changes in the last 10 years. Give the fee authority (Business and Professions Code and California Code of Regulations citation) for each fee charged by the board.

Table 4. Fee Schedule and Revenue

Fee	Current Fee Amount	Statutory Limit	FY 2008/09 Revenue	FY 2009/10 Revenue	FY 2010/11 Revenue	FY 2011/12 Revenue	% of Total Revenue
Duplicate or replacement	$25	$25	$6,925	$6,400	$6,225	9,400	.55%
Cite & Fine Recovery	Various	Various	---	$454	$1,100	$5,692	.33%
Optometrist License - Application	$275	$275	$64,075	$73,450	$73,700	$75,075	4.37%
Statement of Licensure - Application	$20	$20	$3,500	$20	---	---	---
Statement of Licensure – Application	$40	$40	$440	$7,540	$9,240	$10,160	.59%
Therapeutic Pharmaceutical Agent Certification - Application	$25	$25	$375	$7,425	---	---	---
Therapeutic Pharmaceutical Agent Certification - Application	$50	$50	---	---	$6,515	$6,675	.39%
Lacrimal Irrigation and Dilation Certification – Application	$50	$50	---	$7,050	$6,725	$7,200	.42%
Glaucoma Certification - Application	$35	$50	---	$10,085	$9,685	$33,380	1.94%
Fictitious Name Permit - Application	$10	$10	$250	---	---	---	---
Fictitious Name Permit - Application	$50	$50	---	$5,520	$7,400	$7,650	.45%
Branch Office - Application	$60	$75	$3,900	$3,660	$760	$160	.01%
Branch Office - Application	$75	$75	$1,715	$3,450	$4,500	$4,575	.27%
Continuing Education Course Provider - Application	$50	$100	---	$5,015	$5,600-	$6,400-	.37%-
Optometrist License - Biennial Renewal	$300	$300	$963,900	$40,976	$4,260	$4,500	.26%
Optometrist License - Biennial Renewal	$425	$500	$945	$1,324,725	$1,400,308	$1,490,475	87%
Statement of Licensure – Biennial Renewal	$40	$40	---	---	$12,000	$13,000	.76%
Fictitious Name Permit – Annual Renewal	$10	$10	$354	$1,330	---	---	---
Fictitious Name Permit – Annual Renewal	$50	$50	$10,280	$20,375	$54,700	$592	.03%

Table 4. Fee Schedule and Revenue Continued							
Fee	**Current Fee Amount**	**Statutory Limit**	**FY 2008/09 Revenue**	**FY 2009/10 Revenue**	**FY 2010/11 Revenue**	**FY 2011/12 Revenue**	**% of Total Revenue**
Branch Office License – Annual Renewal	$60	$60	$20,460	---	$840	---	---
Branch Office License - Annual Renewal	$75	$75	$135	$25,375	$25,350	$24,883	1.45%
Delinquent Optometrist License – Biennial Renewal	$25	$25	$2,710	$1,400	$375	$400	.02%
Delinquent Optometrist License – Biennial Renewal	$50	$50	$2,050	$5,750	$7,425	$6,410	.37%
Delinquent Fictitious Name Permit – Annual Renewal	$25	$25	$925	$365	$1,150	$1,050	.06%
Delinquent Statement of Licensure – Biennial Renewal	$20	$40	$520	---	---	---	---
Delinquent Statement of Licensure – Biennial Renewal	$20	$20	---	$580	$440	$1440	.08%
Miscellaneous Service to the Public	Various	Various	$15,532.79	$1,269.20	---	$1,575	.09%
Income from Surplus Money Investment	Various	Various	$19,103.16	$6,832.25	$7,304.23	$4,041.88	.24%
Miscellaneous Revenue	Various	Various	$14.95	$1,065	$2,403	$836	.05%
Unclaimed Property	Various	Various	$125	$215.20	$304	$910	.05%
Total Revenue			$1,118,235.40	$1,572,776.65	$1,648,345.23	$1,716,931.88	100%

Fee	Date Repealed	Date Amended	Date Added
Professional Corporation Application ($100)	01/1/2007		
Professional Corporation Renewal Application ($50)	01/1/2007		
Professional Corporation Special Report ($25)	01/1/2007		
Renewal of Optometric License ($300 to $500)		01/01/2008	
Delinquency Fee Renewal of Optometric License ($25 to $50)		01/01/2008	
Application –- Certificate to Treat Lacrimal Irrigation & Dilation ($50)			01/01/2008
Application – Certificate to Treat Glaucoma ($50)			01/01/2008
Application – Approval of Continuing Education Course ($100)			01/01/2008
Application – Issuance of Statement of Licensure ($40)			01/01/2008
Biennial Renewal – Statement of Licensure ($40)			01/01/2008
Delinquency Fee – Statement of Licensure ($20)			01/01/2008
Application – Fictitious Name permit ($50)			01/01/2008
Annual Renewal – Fictitious Name Permit ($50)			01/01/2008
Delinquency Fee – Fictitious Name Permit ($25)			01/01/2008

(BPC sections 3044, 3152, 3152.5, 3161, 3075, 3077, 3078, and CCR sections 1524, and 1549)

Describe Budget Change Proposals (BCPs) submitted by the board in the past four fiscal years.

Table 5. Budget Change Proposals (BCPs)								
BCP ID#	FY	Description of Purpose of BCP	Personnel Services				OE&E	
			# Staff Requested	# Staff Approved	$ Requested	$ Approved	$ Requested	$ Approved
1110-30	09-10	Comprehensive Healing Arts Boards Fingerprinting Augmentation	2.0 SSA 1.0 OT (T)	2.0 SSA 1.0 OT (T)	146	146	128	1110-30
1110-1A	10-11	Consumer Protection Enforcement Initiative	0.5 AGPA [2yr LT]	0.5 AGPA [2yr LT]	32	32	10	1110-1A
*1110-25	10-11	Licensing Position Increase	Denied					1110-25
1110-38	10-11	Office Relocation	Denied					1110-38
1110-15	11-12	Staff Services Manager I Position	1.0 SSM I	1.0 SSM I	93	Position Authority only	17	1110-15

Staffing Issues

Describe any staffing issues/challenges, i.e., vacancy rates, efforts to reclassify positions, staff turnover, recruitment and retention efforts, succession planning.

In FY 2007/2008 the Board consisted of 7.5 authorized positions and by FY 2011/2012, the Board doubled in size with authorization for 14 positions and one blanket position. Currently, the Board has authorization for 10.4 positions and one blanket position.

Past and current Executive Orders for personnel reductions and furlough programs are adversely impacting the Board's recruitment efforts and operations:

- *1110-25 FY 10/11 – Licensing Position Increase was authorized; however it was never realized as it was used to comply with Governor Schwarzenegger's Executive Order for a Permanent Reduction in Staff (i.e., Workforce Cap) in FY 2011/2012. Executive Order S-01-10 required state agencies to ensure an additional 5% salary savings in FY 2010/2011. This was converted to a 5% workforce cap that required permanent staff reductions in FY 2011/2012.

- BCP 1110-15 authorized the Staff Services Manager I (SSM I) position; however, after submitting a Request for Personnel Action, the Board was informed by the DCA, Office of Human Resources that the Board's current position authority (staffing delegation) did not meet the Department of Personnel Administration's (DPA) allocation criteria to support a SSM I. The Board was denied moving forward on hiring the SSM I. The Board considered reclassifying the SSM I to an Associate Governmental Program Analyst (AGPA); however, a limited term office technician (OT) (typing) position as support staff in the Board's enforcement program was slated to expire on July 11, 2012 and could not be extended. This position was vital to the improvements in the enforcement program and ongoing efforts of the Board in meeting its mandate of consumer protection. The Board determined that this critical position must be filled. To establish this position, the Board has reclassified a 0.9 PY from a full-time SSMI position to a 0.9 Office Technician (Typing) classification. The Board was directed by Budget Letter 12-03 to reduce positions by 0.6 PY. To meet this directive, the Board lost 0.1 PY from the SSM I position and 0.5

PY from a 1.0 PY at the Management Services Technician classification that is currently filled with a part-time (0.5) employee.

- Originally the Board had a permanent tenured employee at the AGPA classification housed in the Board's enforcement program. This was an authorized position through the State Controllers Office (SCO). At the same time, the Board had a permanent tenured employee also housed in the enforcement program. This position was not authorized through SCO but the Board was permitted to have the position funded as a blanket position. Subsequently, the AGPA position became vacant, was downgraded to a SSA and the employee in the blanketed position was redirected to the authorized position. The overall result was the loss of one position. The Board has been informed that it can no longer create a blanket position for a permanent classification.

The Board provides a work environment that is flexible, positive, and supportive of staff development. The longevity of employment with the Board by current staff speaks well of the Board's retention efforts. The Board recognizes the importance of institutional knowledge and succession planning. Enforcement program staff meets weekly to discuss complaint handling of complex cases as a means of training and sharing of knowledge. Development of a resource and procedure manual are under development by the enforcement program. Licensing program staff meets monthly to discuss issues/concerns related to licensure. Staff is currently revising the procedure manuals for this program. The manuals and regularly scheduled meetings provide the staff members with the necessary tasks and an understanding of the Board objectives and goals.

Staff development and mentoring is vital to succession planning. In addition to the training available, staff is afforded the opportunity to participate when special project arise. These opportunities provide staff the experience necessary to qualify for promotional opportunities within the Board.

Describe the board's staff development efforts and how much is spent annually on staff development. Provide year-end organizational charts for the last four fiscal years.

Work-related and professional development training opportunities are afforded to all Board staff. Staff may enroll in training courses available through a vast number of resources, including courses offered through the DCA, SOLID Training Office. Enforcement staff has completed the week long Enforcement Academy that consists of seven modules. The Academy provides a solid, standard baseline of knowledge and practices for employees who perform enforcement functions.

All analytical staff is participating in the newly developed Analyst Certification Training (ACT) program. The training helps individuals build indispensable analytical skills through training that focuses on the critical core abilities essential to successful analysts.

The Board has spent approximately $4,030 in staff development efforts:

Fiscal Year	Cost
2008/09	$752.01
2009/10	$418.70
2010/11	$1,070
2011/12	$1,790

In addition to training, the Executive Officer conducts an annual review of staff. The review includes a discussion regarding work-related training as well as training related to professional development.

Organizational Charts

The Board's organizational charts for the past four fiscal years are located in Section 12 D.

Section 4 – Licensing Program

Performance Measures

What are the board's performance targets/expectations for its licensing program? Is the board meeting those expectations? If not, what is the board doing to improve performance?

During FY 2011-2012, the Board was able to meet and, in some areas, surpass its previous performance standards in the processing and issuance of optometrist licenses, statements of licensure (for a licensee's additional places of practice), and license certifications. The Board was able to accelerate the issuance of optometrist licenses due to a revision of its forms, policies and procedures, and the assistance of staff which includes one full-time analyst, one seasonal office assistant, and one student assistant that the Board was able to employ for a two-month period.

With the addition of the seasonal office assistant, the Board has been able to maintain its standard for the issuance of Statement(s) of Licensure (SOL) and license certifications (TPA, TPL, TPG, TLG), which has become a full-time job, but has not been able to meet its goal for the completion of branch office licenses (BOL) and fictitious name permits (FNP). This is due to an increase in workload and lack of staff. The Board recently requested, and received permission via BCP 1110-25 FY 10/11 to establish a 0.5 PY Management Services Technician (MST) position. This would have allowed the current 0.5 MST to be an authorized 0.5 position and enable the Board to hire a full-time MST to add to the licensing unit's staff. The Board "lost" both BCP 1110-25 and the 0.5 PY of the full time MST position to meet the Governor's directives of personnel reduction.

The Board's licensing staff is working diligently to maintain its current standards but with a limited staff and a growing profession, there are concerns as to whether staff can continue its current pace.

In previous years, Board staff was able to sufficiently handle the processing of SOLs, BOLs, FNPs and, corporations (CORs) due to the employment of two half-time MSTs. On January 1, 2007, CORs no longer had to register with the Board. This eliminated that duty, but soon thereafter the Board had to relinquish one of the half-time MST positions. This increased the workload of the remaining position and required the assigned job duties among the licensing staff be restructured. The workload backlogged and it became evident a seasonal office assistant was necessary. As an example, optometrists are required by law to obtain a FNP and/or BOL prior to opening or purchasing an optometric business. During recent compliance checks conducted to ensure optometrists possess current optometric and business licensure, and follow advertising laws and regulations, it was found that a number of optometrists are not complying with FNP and BOL licensure requirements. Enforcement staff began notifying optometrists of the requirements and requiring the completion and submission of the appropriate applications. This generated a spike in applications for FNPs and BOLs which led to an unprecedented increase in workload. A half-time employee is responsible for the evaluation of FNP and BOL applications. This individual also serves as the in-house cashier for the Board. Consequently, the application processing time exceeds performance measures and the processing times (CCR sections 1564-1564.1).

The Board recently revised its forms and applications to promote a more streamlined application review process. Also the Board's enforcement unit's newly implemented project has the capability to locate licensed optometrists who are non-compliant with the laws and regulations. This has helped improve licensing staff operations.

Application and Licensure Processing Times

Describe any increase or decrease in average time to process applications, administer exams and/or issue licenses. Have pending applications grown at a rate that exceeds completed applications? If so, what has been done to address them? What are the performance barriers and what improvement plans are in place? What has the board done and what is the board going to do to address any performance issues, i.e., process efficiencies, regulations, BCP, legislation?

The average time needed to issue optometrist licenses largely depends on the receipt of the items required for the issuance of the license which are, for the most part, outside of Board control. Prior to FY 2009-2010, the process could take anywhere from 60 to 365 days to complete. The Board's acceptance in 2002 of all parts of the NBEO examination as the Board's licensure examination, greatly streamlined the testing process for applicants. Not having to develop and manage the testing of its own licensure examination permitted the Board to focus on decreasing the processing times to issue an optometric license. In FY 2011-2012, the minimum amount of time needed is 12 days, the median, 108 days, and the maximum, 365 days (this average includes applications from recently graduated optometrists and out-of-state optometrist license applicants). Since the California Laws and Regulations examination (CLRE) can now be taken at almost any time, applicants for licensure no longer have to wait for one of the two days the CLRE used to be administered, thereby eliminating a significant portion of the processing time.

The average processing time for statement(s) of licensure (SOL) and optometrist license certifications (TPA, TPL, TPG, TLG) remains unchanged due to the addition of a temporary office assistant. Without this individual, pending applications would almost assuredly have exceeded completed applications. The hiring of a permanent office assistant or management services technician would greatly improve the processing time and prevent any potential backlog of pending applications.

Optometrist applications that are left pending are those that we have yet to confirm completion. The number of pending applications has decreased by as much as 50% in the past two fiscal years.

How many licenses or registrations does the board issue each year? How many renewals does the board issue each year?

On average, the Board issues 243 optometrist licenses and renews 3,449 optometric licenses each year.

Table 6. Licensee Population

		FY 2008/09	FY 2009/10	FY 2010/11	FY 2011/12
Optometrist	Active	6860	6936	6994	7070
	Out-of-State	962	934	872	858
	Out-of-Country	42	43	44	42
	Delinquent	1497	1485	1482	1496
Statement of Licensure (SOL)	Active	878	800	829	856
	Out-of-State	n/a	n/a	n/a	n/a
	Out-of-Country	n/a	n/a	n/a	n/a
	Delinquent	477	439	320	254
Branch Office License (BOL)	Active	364	353	363	367
	Out-of-State	n/a	n/a	n/a	n/a
	Out-of-Country	n/a	n/a	n/a	n/a
	Delinquent	69	73	69	70
Fictitious Name Permit (FNP)	Active	1094	1126	1169	1210
	Out-of-State	n/a	n/a	n/a	n/a
	Out-of-Country	n/a	n/a	n/a	n/a
	Delinquent	89	89	74	71

Table 7a. Licensing Data by Type

	Application Type	Received	Approved	Closed	Issued	Pending Applications			Cycle Times		
						Total (Close of FY)	Outside Board control*	Within Board control*	Complete Apps	Incomplete Apps	combined, IF unable to separate out
FY 2009/10	OPT License	279	279	-	223		-	-	-	-	75
	OPT Renewal	3327	3327	-	3369		-	-	-	-	6
	SOL Initial	199	199	-	149		-	-	-	-	82
	SOL Renewal	306	306	-	290		-	-	-	-	6
	FNP Initial	119	119	-	115		-	-	-	-	165
	FNP Renewal	1023	1023	-	1033		-	-	-	-	6
	BOL Initial	46	46	-	40		-	-	-	-	111
	BOL Renewal	341	341	-	327		-	-	-	-	6
FY 2010/11	OPT License	271	271	-	258		-	-	-	-	141
	OPT Renewal	3468	3468	-	3430		-	-	-	-	5
	SOL Initial	247	247	-	181		-	-	-	-	93
	SOL Renewal	313	313	-	297		-	-	-	-	5
	FNP Initial	154	154	-	99		-	-	-	-	105
	FNP Renewal	1137	1137	-	1092		-	-	-	-	4
	BOL Initial	65	65	-	42		-	-	-	-	114
	BOL Renewal	351	351	-	331		-	-	-	-	4
FY 2011/12	OPT License	282	282	-	249	100	-	-	-	-	148
	OPT Renewal	3569	3569	-	3547		-	-	-	-	6
	SOL Initial	226	226	-	259	55	-	-	-	-	88
	SOL Renewal	320	320	-	328		-	-	-	-	5
	FNP Initial	158	158	-	131	44	-	-	-	-	121
	FNP Renewal	1129	1129	-	1116		-	-	-	-	6
	BOL Initial	63	63	-	59	20	-	-	-	-	106
	BOL Renewal	363	363	-	338		-	-	-	-	5

* Optional. List if tracked by the board.
NOTE: Exams are integrated in the License Application Process

Table 7b. Total Licensing Data

	FY 2009/10	FY 2010/11	FY 2011/12
Initial Licensing Data:			
Initial License Applications Received	643	737	729
Initial License Applications Approved	643	737	729
Initial License Applications Closed	527	580	698
License Issued	527	580	698
Initial License/Initial Exam Pending Application Data:			
Pending Applications (total at close of FY)	-	-	219
Pending Applications (outside of board control)*	-	-	-
Pending Applications (within the board control)*	-	-	-
Initial License/Initial Exam Cycle Time Data (WEIGHTED AVERAGE):			
Average Days to Application Approval (All - Complete/Incomplete)	57	59	61
Average Days to Application Approval (incomplete applications)*	-	-	-
Average Days to Application Approval (complete applications)*	-	-	-
License Renewal Data:			
Licenses Renewed	5019	5150	5329
* Optional. List if tracked by the board.			

Applicant Information Verification and Requirements

How does the board verify information provided by the applicant?

School/college transcripts, examination score reports, and fingerprint reviews are sent directly to the Board from their place of origin. Applicants provide information on a form created by the Board, where they declare that, under penalty of perjury under the laws of the State of California, all the information provided is true and correct.

What process is used to check prior criminal history information, prior disciplinary actions, or other unlawful acts of the applicant?

The Board uses the following processes to check prior criminal history information, prior disciplinary actions, or other unlawful acts of applicants:

- Automated Tracking System (ATS);
- Record of Arrest and Prosecution (RAP) sheets; and
- Subsequent Arrest Reports (SAR).

Applicants for optometrist licensure are required to be fingerprinted and have their prints reviewed and cleared by the California State Department of Justice (DOJ) and the Federal Bureau of Investigation (FBI). If the applicant was licensed in another State, they are required to have that State submit a letter of verification of their license status and history directly to the Board. If the applicant's fingerprints or license history are "flagged" because of unlawful acts, their applications are forwarded to our Enforcement Unit for further review.

Does the board fingerprint all applicants?

The Board does require all applicants to fingerprint as part of the licensure process. The application is held until both the DOJ and the FBI have issued fingerprint clearances (BPC section 144).

Have all current licensees been fingerprinted? If not, explain.

All licensees have been fingerprinted but those who were issued licenses prior to April 1, 2007 are currently being reprinted due to a regulatory change in June 2010 that requires their fingerprints be cleared by the DOJ and the FBI. Prior to April 1, 2007, background checks were only processed through the DOJ. All licensees will have been contacted and informed of the fingerprint requirement and should have complied with the fingerprint requirement by November 2012, after which time an audit will be conducted in the first quarter of 2013 to ensure all licensed optometrists are compliant. (BPC sections 144, 3010.1, 3010.5, and CCR section 1525.1)

Is there a national databank relating to disciplinary actions? Does the board check the national databank prior to issuing a license? Renewing a license?

There are two national databanks related to disciplinary actions:

1) National Practitioners Data Bank (NPDB): Established by Title IV of Public Law 99-660, the Health Care Quality Improvement Act of 1986, as amended (Title IV). Final regulations governing the NPDB are codified in 45 CFR Part 60. In 1987 Congress passed Public Law 100-93, Section 5 of the Medicare and Medicaid Patient and Program Protection Act of 1987 (Section 1921 of the Social Security Act), authorizing the Government to collect information concerning sanctions taken by State licensing authorities against all health care practitioners and entities. Congress later amended Section 1921 with the Omnibus Budget Reconciliation Act of 1990, Public Law 101-508, to add "any negative action or finding by such authority, organization, or entity regarding the practitioner or entity."

Title IV is intended to improve the quality of health care by encouraging State licensing boards, hospitals, professional societies, and other health care organizations to identify and discipline those who engage in unprofessional behavior; to report medical malpractice payments; and to restrict the ability of incompetent physicians, dentists, and other health care practitioners to move from State to State without disclosure or discovery of previous medical malpractice payment and adverse action history. Adverse actions can involve licensure, clinical privileges, professional society membership, and exclusions from Medicare and Medicaid (http://www.npdb-hipdb.hrsa.gov/topNavigation/aboutUs.jsp).

2) Health Integrity and Protection Data Bank (HIPDB): The Secretary of HHS, acting through the Office of Inspector General (OIG) and the U.S. Attorney General, was directed by the Health Insurance Portability and Accountability Act of 1996, Section 221(a), Public Law 104-191, to create the Healthcare Integrity and Protection Data Bank (HIPDB) to combat fraud and abuse in health insurance and health care delivery. The HIPDB's authorizing statute is more commonly referred to as Section 1128E of the Social Security Act. Final regulations governing the HIPDB are codified at 45 CFR Part 61.

   The HIPDB is a national data collection program for the reporting and disclosure of certain final adverse actions taken against health care practitioners, providers, and suppliers. The HIPDB collects information regarding licensure and certification actions, exclusions from participation in Federal and State health care programs, health care-related criminal convictions and civil judgments, and other adjudicated actions or decisions as specified in regulation (http://www.npdb-hipdb.hrsa.gov/topNavigation/aboutUs.jsp).

The Board does not check HIPDB and NPDB prior to issuing or renewing a license due to the following:

- Cost: In order to initiate and maintain continuous queries when issuing and renewing licenses, the Board would need to raise the licensing fee. It is estimated that it would cost $6.50 per licensee per year.
- Staffing: It is estimated that the Board would need an additional full time, limited term staff person to manually enter licensees and applicants into the databanks.

Does the board require primary source documentation?

Yes. Optometrist license applicants are required to have the school/college of optometry where they received their degree as a professional eye care provider submit a transcript to the Board prior to being issued a license. In addition, the Board requires fingerprint results directly from FBI and DOJ and examination results directly from PSI and NBEO.

Does the board send No Longer Interested notifications to DOJ on a regular and ongoing basis? Is this done electronically? Is there a backlog? If so, describe the extent and efforts to address the backlog.

The Board does not send No Longer Interested notification to the DOJ on a regular basis. The form must be completed online and mailed or faxed to the DOJ. Currently, there is no backlog.

Out-of-State Applicant Requirements

Describe the board's legal requirement and process for out-of-state and out-of-country applicants to obtain licensure.

California laws and regulations require optometrist license applicants from out-of-state and out-of-country (international graduates) to meet the same requirements as those that are in-state. The differences for out-of-state applicants not considered to be recent graduates of schools/colleges of optometry are that they must meet the experience requirements desired by the Board. International graduates must meet the educational

requirements desired by the Board which, in many cases, are incomparable to in-state and out-of-state applicants. International graduate applicants are required to prove that they have a similar, if not more advanced, degree for a provider of eye care and must request sponsorship from the Board that will allow them to apply for and take the national examinations.

Examinations

What are the pass rates for first time vs. retakes in the past four fiscal years?

The table below reflects the pass rates for first time examination candidates and those who retake the examination.

Table 8a. Examination Data			
California Laws and Regulations Examination - APPLICANTS			
	Exam Title	California Laws and Regulations Examination (CLRE) – English Only	
		# of candidates	**Pass rate**
FY 2008/09	First attempt	297	65%
	Second attempt	44	95%
	Third attempt	0	
FY 2009/10	First attempt	166	84%
	Second attempt	9	78%
	Third attempt	2	100%
FY 2010/11	First attempt	229	87%
	Second attempt	21	95%
	Third attempt	0	
FY 2011/12	First attempt	244	89%
	Second attempt	22	82%
	Third attempt	4	75%
	Date of Last OA	2009	
	Name of OA Developer	Office of Professional Examination Services	
	Target OA Date	2016	

Table 8b. Examination Data			
California Laws and Regulations Examination - PROBATIONERS			
	Exam Title	California Laws and Regulations Examination (CLRE) – English Only	
		# of candidates	**Pass rate**
FY 2010/11	First attempt	3	67%
	Second attempt	0	
	Third attempt	0	
FY 2011/12	First attempt	6	33%
	Second attempt	3	67%
	Third attempt	0	
FY 2012/13	First attempt	0	
	Second attempt	1	0%
	Third attempt	1	100%
	Date of Last OA	2009	
	Name of OA Developer	Office of Professional Examination Services	
	Target OA Date	2016	

* The first CLRE examination for probationers was conducted in 2011. Probationers take the same examination as applicants for licensure.

Table 8c. Examination Data						
National Examination - APPLICATIONS						
			Exam Title	National Board of Examiners in Optometry (NBEO) Licensing Examination– English Only		
Year	**Part I**		**Part II**		**Part III**	
	N	**Pass**	**N**	**Pass**	**N**	**Pass**
2002	2000	66%	1569	86%	1473	90%
2003	1977	61%	1549	85%	1513	88%
2004	2068	60%	1531	85%	1452	93%
2005	2133	68%	1490	87%	1423	90%
2006	1996	70%	1582	83%	1380	92%
2007	2025	66%	1632	87%	1427	94%
2008	590	47%	1645	86%	1443	92%
2009	1694	82%	1659	87%	1494	91%
2010	1691	80%	1606	88%	1491	95%
2011	2063	66%	1598	91%	1413	97%
2012	2198	73%	n/a		1616	86%
			Date of Last OA	2009		
			Name of OA Developer	Office of Professional Examination Services		
			Target OA Date	2016		

The above data provided by the National Board of Examiners in Optometry (NBEO) reflects all the candidates that took each part of their examination across the country. They do not have a record of which candidates became licensed in California. Refer to Table 7a to view the number of applicants licensed per year. The Board will not issue a license to any applicant who has not successfully passed Parts I, II, and III of the NBEO examination. The following Part I, II, and III pass rates and number of candidates (N) statistical information is consolidated for calendar year. Complete data for Part II is not included since the December 2012 exam has yet to be administered.

Describe the examinations required for licensure. Is a national examination used? Is a California specific examination required?

All applicants for licensure must take and pass the National Board of Examiners in Optometry's (NBEO) Applied Basic Science (Part I), Patient Assessment and Management and Treatment and Management of Ocular Disease (Part II), and Clinical Skills (Part III) examinations. In addition, they must also take and pass the California Laws and Regulations Examination (CLRE). Part I of the NBEO examination measures the fundamental knowledge and understanding of the scientific principles upon which optometric practice is based. Part II provides cases of patients that challenge the examinee to properly manage them. Part III provides the examinee with a "real" patient on which to assess. The Treatment and Management of Ocular Disease (TMOD) component of the examination is comprised of cases extracted from the Patient Assessment and Management (PAM) section. The CLRE is a 50-question, multiple-choice jurisprudence examination.

Is the board using computer based testing? If so, for which tests? Describe how it works. Where is it available? How often are tests administered?

Yes, the Board is using computer bases testing for its CLRE. The Board's vendor is Psychological Services, LLC (PSI). "Paper and pencil" examinations are available to those candidates who require special accommodation. Examination candidates contact PSI to schedule their examination after submitting an Application for Licensure as an Optometrist. Submission of an application to the Board is required first in order to designate the candidate eligible to take the CLRE. Candidates may use the online feature to schedule their examination or use a toll free number. Candidates may select from PSI's 13 California testing sites and 10 out-of-state sites to schedule their examination. Each test site proctors the examination and provides candidates a

designated space with a computer terminal to take their examination. Proctors at the test site monitor the examination candidates to ensure the security and integrity of the examination is preserved. PSI offers testing six days a week (Monday-Saturday), year round, except for major holidays. If candidates fail the examination, they must wait 180 days to re-examine.

The NBEO administers the licensing examination for California optometrist candidates. There are three parts to the examination. The first two portions are administered in a paper pencil format, and the third portion, which is a clinical portion, is hands-on. The NBEO has only one testing site in North Carolina. Candidates may register for the examination online, or by calling a toll free number. The examinations are offered twice a year.

Are there existing statutes that hinder the efficient and effective processing of applications and/or examinations? If so, please describe.

None of the existing statutes appear to hinder the effective processing of the optometrist license applications or the NBEO or CLRE examinations.

School Approvals

Describe legal requirements regarding school approval. Who approves your schools? What role does BPPE have in approving schools? How does the board work with BPPE in the school approval process?

BPC section 3023, Accreditation of Schools, states: “For the purpose of this chapter, the board shall accredit schools, colleges and universities in or out of this state providing optometric education, that it finds giving a sufficient program of study for the preparation of optometrists.”

The Board uses the Accreditation Council on Optometric Education (ACOE) to conduct audits and reports of compliance as the approval of the schools/colleges of optometry. The ACOE is the only accrediting body for professional optometric degree (O.D.) programs, optometric residency programs and optometric technician programs in the United States and Canada. Both the U.S. Department of Education and the Council on Higher Education Accreditation recognize the ACOE as a reliable authority concerning the quality of education of the programs the Council accredits.

The Bureau of Private Post-Secondary Education (BPPE) does not play a role in approving the schools/colleges of optometry; therefore the Board does not work with the BPPE in the approval process.

How many schools are approved by the board? How often are schools reviewed? What are the board’s legal requirements regarding approval of international schools?

The ACOE has accredited or pre-accredited 21 schools and colleges of optometry. California has two schools that are fully accredited; The University of California, Berkeley, School of Optometry and the Southern California College of Optometry, Fullerton. There is a college in California, Western University of Health Sciences, College of Optometry, Pomona, which is pre-accredited. This college will very likely be fully accredited in Spring 2013 shortly before the graduation of its first class if the program is found to meet the standards of accreditation.

The Board considers the didactic courses offered by the other 19 schools/colleges of optometry accredited by the ACOE to be equivalent to those in California.

Schools/colleges of optometry that are in the pre-accreditation process are reviewed each year until the program has its first graduating class at which time it becomes fully accredited. The Board has participated in each yearly review of Western University, College of Optometry. The ACOE conducts a formal reevaluation visit at least every eight years for professional optometric degree (O.D.) or optometric residency programs.

However, all accredited programs are reviewed annually through an annual reporting process, and the ACOE may visit more frequently if deemed necessary through the annual reporting process. The Board receives and reviews the copy of each report prepared by ACOE.

The Board has no legal requirement to approve international schools of optometry.

Continuing Education/Competency Requirements

Background

Current law requires all licensees of the Board, as a condition of biennial licensure renewal, to complete continuing education (CE) as required by the type of certification that the licensee holds. Licensees who are not certified in the use of therapeutic pharmaceutical agents must complete 40 hours of CE in the two years prior to the renewal of their certificate to maintain active licensure status. Licensees who are certified in the use of therapeutic pharmaceutical agents pursuant to BPC section 3041.3 must complete a total of 50 hours of CE in the two years prior to the renewal of the certificate. Thirty-five of the 50 hours must be in the diagnosis, treatment, and management of ocular disease in any combination of the following areas: glaucoma, ocular infection, ocular inflammation, topical steroids, systemic medication, and pain medication. Additionally, licensees certified to diagnose and treat primary open angle glaucoma are required to complete 10 hours of glaucoma specific CE in each renewal period. These 10 hours shall be part of the 35 hours on the diagnosis and treatment and management of ocular disease.

CE courses which are approved as meeting the required standards of the Board include those sponsored or recognized by any accredited US school or college of optometry, any national or state affiliate of the American Optometric Association, the American Academy of Optometry, or the Optometric Extension Program. Also acceptable are courses approved by the International Association of Boards of Examiners in Optometry known as COPE (Council on Optometric Practitioner Education). Licensees can earn a maximum of 20 hours of CE through the completion of acceptably documented and accredited self-study courses.

Statutory changes in 2001(SB 662), 2004(AB 2464), and 2011(SB 1406) further defined the specific study areas required for CE hours, but did not change the total hours required or the methods by which the hours could be obtained.

Verification of Continuing Education Requirements

Approximately 3,500 licensees renew with the Board every year. All licensees are required to complete CE coursework in each renewal cycle. In order to renew a license prior to biennial expiration, a licensee must certify that he or she has completed the required CE hours. If a licensee fails to certify completion of the required CE, the license renewal is held until the licensee certifies completion of CE. A licensee may not practice with an expired or delinquent license.

Continuing Education Audits

The Board began conducting random CE audits in December 2009; however, due to staffing issues, time constraints, furloughs, and more urgent projects, CE audits have not been consistently conducted. Currently, the CE audits are conducted by an Enforcement Analyst with the assistance of an office technician. CE audits are conducted monthly on a random selection of licensees who have renewed with an active status. The Board has established policy and procedures for conducting CE audits. The following is a general outline of the procedures for a CE audit:

- Determine the renewal period in which to audit.
- Of the licensees who renewed as active for the given audit period, randomly select 15% to be audited.

- Send initial letter to licensee. Once the letter has been sent, the licensee has 30 days to respond. The first letter sent requests the licensee to submit certificates of completion of the required CE.
- If licensee responds prior to the 30 days notice, document all of the courses and hours taken.
- If licensee has taken the required CE, the licensee has passed the audit.
- If the licensee didn't fulfill the CE requirements, then he/she has failed the audit.
- After 30 days, if a licensee hasn't responded to the initial audit letter, a second letter is sent stating that if he/she does not respond the case, the licensee will be referred to enforcement.
- After a licensee has submitted all of his/her CEU certificates and has passed the audit, a Passed Letter is sent to the licensee.
- If a licensee has submitted their CE certificates and is still missing either hours of CE or the required 35 hours of specific coursework, the licensee will be sent a letter stating that he/she needs to submit any other certificates to complete their requirements and have 15 days to respond.
- After 30 days, if a licensee hasn't respond to the first audit letter, a second letter is sent stating that if he/she does not respond then he/she shall be referred to enforcement after 15 days.
- If a licensee has failed to respond to an audit letter or he/she has no other CE to submit, then he/she is referred to enforcement.
- If a case is opened against a licensee that fails to comply, then a citation and fine will be issued.

Consequences of Failing a Continuing Education Audit

As noted above, licensees that fail to provide proof of completion of CE requirements are subject to fines (CCR section 1579). Depending on the severity of the violation, fines for failure to comply with CE requirements may be levied in an amount up to $2,500. If a licensee fails to remediate the deficiencies or pay the determined fine, an enforcement hold it placed on the license, making the license ineligible for renewal until all conditions are met.

Number of Continuing Education Audits for the Past Four Fiscal Years

Since December 2009, the Board has conducted approximately 270 CE audits. To date, all licensees have been found to be in compliance with the CE requirements.

What is the board's course approval policy?

CE course approval criteria is based on whether the course is likely to contribute to the advancement of professional skill and knowledge in the practice of optometry; whether the speakers, lecturers, and others participating in the presentation of the course are recognized by the Board as being qualified in their field; and whether the proposed course is open to all California-licensed optometrists.

Who approves CE providers? Who approves CE courses? If the board approves them, what is the board application review process?

CE providers and courses are reviewed by Board licensing staff and finalized by the Board member's CE Committee. Providers must submit their course on an application provided by the Board. The provider must submit a processing fee, their name, course title, date the course is scheduled to be offered, topical outline of the course subject matter, any announcements, notices, or advertisements about the course, and the curriculum vitae of all instructors and/or lecturers involved.

How many applications for CE providers and CE courses were received? How many were approved?

In FY 2011-2012, 129 requests for CE approval were submitted. Only three (3) of those potential providers were rejected.

Does the board audit CE providers? If so, describe the board's policy and process.

The Board does not currently audit its CE providers but only accepts those that meet the requirements of CCR section 1536(g-h).

Describe the board's effort, if any, to review its CE policy for purpose of moving toward performance based assessments of the licensees' continuing competence.

Board staff is currently in the process of reviewing a major provider of CE, the Association of Regulatory Boards of Optometry's (ARBO) Council on Optometric Practitioner Education's (COPE) performance based assessments of continuing competence and how it may aid the Board in its quest to provide the same.

Section 5 – Enforcement Program

Enforcement Performance Measures

What are the board's performance targets/expectations for its enforcement program? Is the board meeting those expectations? If not, what is the board doing to improve performance?

The board's performance targets/expectations coincide with those standards created by the DCA's Consumer Protection and Enforcement Initiative (CPEI). They are as follows:

- **Intake** – Average cycle time from complaint receipt to the date the complaint was assigned to an investigator. The Board has set a target of seven days for this measure.
    a. For the 2010-2011 Fiscal Year, the average cycle time was five days.
    b. For the 2011-2012 Fiscal Year, the average cycle time was 10 days.

  The performance measures published by DCA, as shown in Section E, reference complaints as well as conviction investigations and are, therefore, different than the statistics for complaint intake.

- **Intake and Investigation** – Average cycle time from complaint receipt to closure of the investigation process. Does not include cases sent to the Attorney General (AG) or other forms of formal discipline. The Board has set a target of 90 days for this measure.
    a. For the 2010-2011 Fiscal Year, the average cycle time was 89 days.
    b. For the 2011-2012 Fiscal Year, the average cycle time was 184 days.

- **Formal Discipline** – Average number of days to complete the entire enforcement process for cases resulting in formal discipline (Includes intake and investigation by the Board and prosecution by AG). The Board has set a target of 365 days for this measure.
    a. For the 2010-2011 Fiscal Year, the average number of days was 685 days.
    b. For the 2011-2012 Fiscal Year, the average number of days was 879 days.

- **Probation Intake** – Average number of days from monitor assignment to the date the monitor makes first contact with the probationer. The Board has set a target of six days for this measure.
    a. For the 2010-2011 Fiscal Year, the average number of days was one day.
    b. For the 2011-2012 Fiscal Year, the average number of days was one day.

- **Probation Violation Response** – Average number of days from the date a violation of probation is reported to the date the assigned monitor initiates appropriate action. The Board has set a target of eight days for this measure.
    a. For the 2010-2011 Fiscal Year, the average number of days was three days.
    b. For the 2011-2012 Fiscal Year, the average number of days was one day.

In order to improve performance in each category, the Board's enforcement unit has recently created internal timelines for each phase of a complaint. For example, after sending a case to the Division of Investigation, the analyst will follow-up with the investigator within five days of receiving notification of the assignment. In addition, Board staff has recently completed a training course with emphasis on effective time management. The enforcement unit is also promoting accountability in weekly enforcement meetings by reviewing and providing status updates for each pending complaint. The Board, through budget change proposals, has requested additional enforcement staff to help manage the case load and to act as the enforcement lead of the unit. These requests, however, continue to be denied.

Enforcement Statistics and Process Improvement

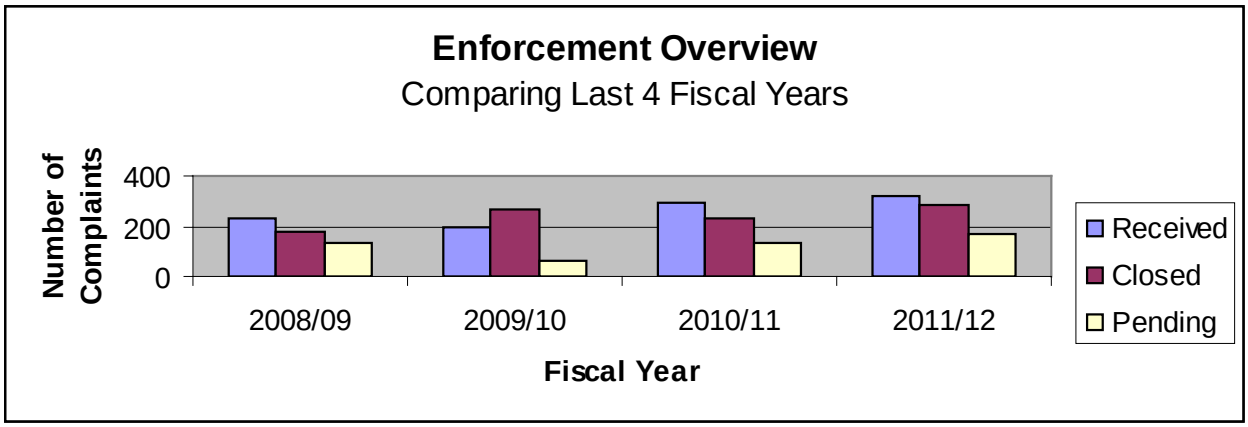
Explain trends in enforcement data and the board's efforts to address any increase in volume, timeframes, ratio of closure to pending, or other challenges. What are the performance barriers? What improvement plans are in place? What has the board done and what is the board going to do to address these issues, i.e., process efficiencies, regulations, BCP, legislation?

The Board receives an average of 260 complaints a year with the largest percentage (52%) of complaints filed by consumers. In addition, the Board closes an average of 238 complaints and maintains an average of 126 pending caseload per year. In the last fiscal year, the Board saw a 7% volume increase compared to FY 2010/2011 and a 38% increase since FY 2009/2010.

With the implementation of the fingerprint program, the Board encountered a challenge with receiving DOJ and FBI fingerprint results. Due to missing, incorrect, and/or duplicative data provided by the licensees, DOJ/FBI, and/or the Board, the majority of the fingerprint results did not transfer correctly into the Board's database. As a result, the cycle time to complete intake, intake and investigation, and formal discipline (in some cases) are negatively effected.

During Fiscal Year 2011/12, the enforcement unit operated with two less analysts than the previous year. In addition, the unit's enforcement lead analyst transferred outside of the Board, leaving the unit to function without the direction, guidance, and accountability a lead provides. The responsibilities are handled by the Executive Officer but due to a number of priorities, timely direction and guidance are not always available and cases have to wait.

To address these issues, the enforcement unit has implemented process timelines to increase efficiency, assisted in updating regulations for clarity and enforceability, and holds weekly enforcement meetings to review pending caseload. In addition, the implementation of BreEZe will help with case tracking and staff accountability. The Board has also made multiple requests for additional staffing through various budget change proposals.



	FY 2008/09	FY 2009/10	FY 2010/11	FY 2011/12
Complaints Received	229	197	295	318
Complaints Closed	180	264	227	281
Complaints Pending	133	66	134	171
Referred for Sworn Investigation	0	3	38	28
Accusation Filed	4	6	9	3
Disciplinary Action	0	4	6	7

Table 9a. Enforcement Statistics			
	FY 2009/10	FY 2010/11	FY 2011/12
COMPLAINT			
Intake (Use CAS Report EM 10)			
Received	173	239	224
Closed	0	37	22
Referred to INV	177	202	201
Average Time to Close	11	5	10
Pending (close of FY)	1	1	2
Source of Complaint (Use CAS Report 091)			
Public	134	131	140
Licensee/Professional Groups	21	23	28
Governmental Agencies	36	137	123
Other	6	4	25
Conviction / Arrest (Use CAS Report EM 10)	24	56	92
CONV Received	22	21	128
CONV Closed	13	3	189
Average Time to Close	3	38	2
CONV Pending (close of FY)	173	239	224
LICENSE DENIAL (Use CAS Reports EM 10 and 095)			
License Applications Denied	1	0	0
SOIs Filed	1	0	0
SOIs Withdrawn	0	0	0
SOIs Dismissed	0	0	0
SOIs Declined	0	0	0
Average Days SOI	330	0	0
ACCUSATION (Use CAS Report EM 10)			
Accusations Filed	6	9	3
Accusations Withdrawn	0	1	1
Accusations Dismissed	0	0	1
Accusations Declined	0	2	1
Average Days Accusations	612	410	623
Pending (close of FY)	6	9	3

Table 9b. Enforcement Statistics (continued)			
	FY 2009/10	FY 2010/11	FY 2011/12
DISCIPLINE			
Disciplinary Actions (Use CAS Report EM 10)			
Proposed/Default Decisions	1	2	1
Stipulations	3	3	6
Average Days to Complete	881	695	879
AG Cases Initiated	10	9	14
AG Cases Pending (close of FY)	13	12	16
Disciplinary Outcomes (Use CAS Report 096)			
Revocation	0	2	1
Voluntary Surrender	0	1	1
Suspension	0	0	0
Probation with Suspension	0	0	1
Probation	4	2	4
Probationary License Issued	0	1	0
Other	0	0	0
PROBATION			
New Probationers	5	3	5
Probations Successfully Completed	8	5	5
Probationers (close of FY)	18	16	15
Petitions to Revoke Probation*	2	1	1
Probations Revoked	0	2	1
Probations Modified**	0	2	1
Probations Extended	0	0	0
Probationers Subject to Drug Testing	5	7	9
Drug Tests Ordered	4	387	230
Positive Drug Tests***	0	0	0
Petition for Reinstatement Granted	1	1	0
DIVERSION			
New Participants	N/A	N/A	N/A
Successful Completions	N/A	N/A	N/A
Participants (close of FY)	N/A	N/A	N/A
Terminations	N/A	N/A	N/A
Terminations for Public Threat	N/A	N/A	N/A
Drug Tests Ordered	N/A	N/A	N/A
Positive Drug Tests	N/A	N/A	N/A

*Includes No. of Surrendered Probations
**Includes Granted Petitions for Early Termination of Probation
***Does not include positive drug tests resulting from authorized prescriptions

Table 9c. Enforcement Statistics (continued)			
	FY 2009/10	FY 2010/11	FY 2011/12
INVESTIGATION			
All Investigations (Use CAS Report EM 10)			
First Assigned	199	223	329
Closed	263	190	257
Average days to close	193	110	191
Pending (close of FY)	62	95	167
Desk Investigations (Use CAS Report EM 10)			
Closed	258	169	235
Average days to close	178	88	177
Pending (close of FY)	60	76	142
Non-Sworn Investigation (Use CAS Report EM 10)			
Closed	NA	NA	NA
Average days to close	NA	NA	NA
Pending (close of FY)	NA	NA	NA
Sworn Investigation			
Closed (Use CAS Report EM 10)	5	21	22
Average days to close	936	285	330
Pending (close of FY)	2	19	25
COMPLIANCE ACTION (Use CAS Report 096)			
ISO & TRO Issued	1	0	0
PC 23 Orders Requested	0	0	0
Other Suspension Orders	0	0	0
Public Letter of Reprimand	0	0	0
Cease & Desist/Warning	0	0	0
Referred for Diversion	0	0	0
Compel Examination	0	0	0
CITATION AND FINE (Use CAS Report EM 10 and 095)			
Citations Issued	5	2	2
Average Days to Complete	269	390	292
Amount of Fines Assessed	18250	13000	15501
Reduced, Withdrawn, Dismissed	5000	14250	0
Amount Collected	750	2500	5500
CRIMINAL ACTION			
Referred for Criminal Prosecution	0	0	2

Table 10. Enforcement Aging						
	FY 2008/09	FY 2009/10	FY 2010/11	FY 2011/12	Cases Closed	Average %
Attorney General Cases (Average %)						
Closed Within:						
1 Year	0	0	0	0	0	0
2 Years	0	1	3	3	7	41
3 Years	0	2	3	2	7	41
4 Years	0	1	0	2	3	18
Over 4 Years	0	0	0	0	0	0
Total Cases Closed	0	4	6	7	17	100
Investigations (Average %)						
Closed Within:						
90 Days	70	111	126	97	407	47
180 Days	38	53	31	59	181	21
1 Year	26	55	21	62	164	19
2 Years	14	39	12	35	100	11.5
3 Years	3	1	0	4	8	.5
Over 3 Years	7	4	0	0	11	1
Total Cases Closed	158	263	190	257	868	100

What do overall statistics show as to increases or decreases in disciplinary action since last review.

The Board cannot compare statistics from the last review with the current statistics because of inaccuracies and inconsistencies found in the last review's statistics. For example, in a graph demonstrating case aging data, the last review cited the following numbers, which should include all of the disciplinary actions taken during the given fiscal year:

AG CASES CLOSED WITHIN:	FY 1997/98	FY 1998/99	FY 1999/00	FY 2000/01	AVERAGE % CASES CLOSED
1 Year	7	6	6	1	**46%**
2 Years	4	1	6	4	**35%**
3 Years	4	0	1	0	**12%**
4 Years	0	0	1	2	**7%**
Over 4 Years	0	0	0	0	**0%**
Total Cases Closed	**15**	**7**	**14**	**7**	

Later in the report, however, the following numbers were cited:

ENFORCEMENT DATA	FY 1997/98	FY 1998/99	FY 1999/00	FY 2000/01
Disciplinary Actions	Total: 20	Total: 7	Total: 14	Total: 12
Revocation	8	1	7	7
Voluntary Surrender	1	2	0	0
Suspension Only	0	0	0	0
Probation with Suspension	2	2	1	0
Probation	9	1	6	5
Probationary License Issued	0	1	0	0
Public Reproval	0	0	0	1

Both sets of statistics are in conflict with information currently available regarding the time period. Below, the last review's disciplinary statistics were recalculated for the purposes of this report:

ENFORCEMENT DATA	FY 1997/98	FY 1998/99	FY 1999/00	FY 2000/01
Disciplinary Actions	Total: 12	Total: 5	Total: 11	Total: 9
Revocation	1	1	1	0
Voluntary Surrender	1	2	2	0
Suspension Only	0	0	0	0
Probation with Suspension	1	2	2	2
Probation	9	2	6	5
Probationary License Issued	0	0	0	0
Public Reproval	0	0	0	1
Based on information currently available for the same period				

As can be seen, even with the recalculation, there continues to be substantial discrepancies in the statistics provided in the last review. The reason for this is because it was also discovered that prior staff was inconsistently reporting data to CAS in years prior to 2009. Thus, at this time, it is impossible to accurately compare the two time periods without cleaning up the files and electronic data relating to the Board's disciplinary cases. The Board has begun working to clean up the files and electronic data and should have that project completed prior to the implementation of BreEZe. Accurate statistics and comparisons can be provided at that time.

Case Prioritization, Mandatory Reporting, and Statutes of Limitation

How are cases prioritized? What is the board's complaint prioritization policy? Is it different from DCA's *Complaint Prioritization Guidelines for Health Care Agencies* (August 31, 2009)? If so, explain why.

While the Board does follow DCA's *Complaint Prioritization Guidelines for Health Care Agencies* (August 31, 2009), the vast majority of the complaints received by the Board do not rise to the "Urgent" level as set by DCA's guidelines. The Board prioritizes the following as the most urgent complaints:

- Patient harm
- Potential patient harm
- Fraud
- Convictions
- Unlicensed Practice

Are there mandatory reporting requirements? For example, requiring local officials or organizations, or other professionals to report violations, or for civil courts to report actions taken against a licensee. Are there problems with receiving the required reports? If so, what could be done to correct the problems?

There are three mandatory reporting requirements.

- BPC section 801(a) requires every insurer providing professional liability insurance to a person who holds a license, certificate, or similar authority from or under any agency mentioned in subdivision (a) of section 800 shall send a complete report to that agency as to any settlement or arbitration award over three thousand dollars ($3,000) of a claim or action for damages for death or personal injury caused by that person's negligence, error, or omission in practice, or by his or her rendering of unauthorized

professional services. The report shall be sent within 30 days after the written settlement agreement has been reduced to writing and signed by all parties thereto or within 30 days after service of the arbitration award on the parties.

- BPC section 802 requires optometrists (or their attorney, if represented by counsel) to report any settlement, judgment, or arbitration award over $3,000 of a claim or action for damages for death or personal injury caused by the licensee's negligence, error or omission in practice, or by rendering of unauthorized professional services.

- BPC section 803 requires the clerk of the court to report, within 10 days after judgment made by the court in California, any person who holds a license from the Board who has committed a crime or is liable for any death or personal injury resulting from a judgment for an amount in excess of $30,000 caused by his or negligence, error or omission in practice or by rendering of unauthorized professional services.

Although these are mandatory reporting requirements, the Board only receives a very small number of these reports each year. During the last four fiscal years, the Board only received a total of eight reports. As the agencies charged with the submission of these reports are largely outside of the authority of the Board, correction of this problem has been challenging. The Board is researching the effectiveness of using outreach and education to these agencies in an effort to obtain more compliance.

Does the board operate with a statute of limitations? If so, please describe and provide citation. If so, how many cases were lost due to statute of limitations? If not, what is the board's policy on statute of limitations?

Yes. The Board operates with a statute of limitations under BPC section 3137. In general, the Board has three years from the date the Board discovers the act or seven years after the act occurs, whichever occurs first. Specific exemptions pertaining to fraud, willful misconduct, unprofessional conduct and sexual misconduct are provided.

The first recorded instance of a statute of limitations closure was in 2008. Since then, 101 cases have been closed due to statute of limitations. Of those 101 cases, the overwhelming majority involved past convictions discovered via the implantation of new fingerprinting requirements pursuant to BPC section 144.

Describe the board's efforts to address unlicensed activity and the underground economy.

The Board's enforcement unit works closely with the DCA, Division of Investigation to investigate allegations of unlicensed activity; this includes undercover sting operations and investigation of companies outside of California providing unlicensed services to California consumers. In addition, the Board has held press conferences around Halloween to advise the public of the potential harm of purchasing and wearing "plano" cosmetic contact lenses without the benefit of an examination and proper fitting by an optometrist, has participated in outreach events, distributed fliers, and created pamphlets related to the illegal distribution of plano contact lenses.

Cite and Fine

Discuss the extent to which the board has used it's cite and fine authority. Discuss any changes from last review and last time regulations were updated. Has the board increased its maximum fines to the $5,000 statutory limit?

In the last three fiscal years, the Board has issued a total of nine citations for violations of the Optometry Practice Act that did not rise to a level that warranted revocation, suspension, or imposition of probationary terms. While the $5,000 statutory fine limit has not increased, in 2006, CCR section1579 was amended to further define the Board's ability to issue fines for violations, and includes the ability for the Board to levy fines for additional violations, and an additional fine for multiple violations.

How is cite and fine used? What types of violations are the basis for citation and fine?

The citation and fine program provides the Board with an expedient method of addressing violations which do not warrant revocation, suspension, or imposition of probationary terms. The types of violations that are the basis for citations and fines include, but are not limited to, the following: advertising violations, failure to post license, failure to provide records, disciplinary actions in other states, using name other than registered name, and unlicensed practice.

How many informal office conferences, Disciplinary Review Committees reviews and/or Administrative Procedure Act appeals in the last 4 fiscal years?

Since July 1, 2008, the Board has conducted five informal citation conferences and has had one citation appealed to hearing per the Administrative Procedures Act.

What are the 5 most common violations for which citations are issued?

The Board's five most common violations for which citations are issued are advertising violations, failure to post license, failure to provide records, disciplinary actions in other states, and using a name other than a registered name.

What is average fine pre and post appeal?

Of citations that were appealed, the average fines pre appeal was $3,350, and the average find post appeal was $500.

Describe the board's use of Franchise Tax Board (FTB) intercepts to collect outstanding fines.

The Board sent one case to FTB to collect outstanding fines. Due to the low volume of fines issued, FTB has not been necessary. For those who are licensed, the Board will hold renewal until the fines are paid.

Cost Recovery and Restitution

Describe the board's efforts to obtain cost recovery. Discuss any changes from the last review.

When cost recovery is ordered, payment plans are implemented unless the probationer can pay the amount in one lump sum; probationers are not allowed to complete probation until all cost recovery is received.

As demonstrated in the table below, the Board had a 45% decrease in enforcement expenditures since the last review. In addition, the Board had a 44% decrease in potential cases for cost recovery, resulting in a 65% decrease in amount of cost recovery ordered. However, the cost recovery amount collected increased by 30% since the last review.

	Previous Sunset	Current Sunset
Total Enforcement Expenditures	1,367,430	748,467
Potential Cases for Recovery	34	19
Cases Recovery Ordered	28	14
Amount of Cost Recovery Ordered	232,747	$81,476
Amount Collected	101,021	$143,964

How many and how much is ordered for revocations, surrenders and probationers? How much do you believe is uncollectable? Explain.

According to Board records, $231,182 in cost recovery has been ordered for revocations, surrenders and cost recovery. Of that, only 21% ($49,387.71) is being actively collected through probationers on payment plans. Roughly 79% of that ($181,794.29) was ordered for revocations, surrenders, and probationers who are tolling and is believed to be uncollectable. These licensees only have to repay their cost recovery upon reinstatement or returning to practice in California. The majority of them never return to practice in California; therefore, they have no desire or requirement to pay their outstanding balance.

Are there cases for which the board does not seek cost recovery? Why?

The Board seeks cost recovery in most cases. Cost recovery is used as a negotiation tool in stipulated settlements. The board may agree to decrease or eliminate cost recovery if it expedites the disciplinary process through settlement.

Describe the board's use of Franchise Tax Board intercepts to collect cost recovery.

The Board has not used FTB for cost recovery in the past, but will be using it where appropriate in the future depending on order language.

Describe the board's efforts to obtain restitution for individual consumers, any formal or informal board restitution policy, and the types of restitution that the board attempts to collect, i.e., monetary, services, etc. Describe the situation in which the board may seek restitution from the licensee to a harmed consumer.

The Board has no jurisdiction to order restitution unless written into a disciplinary order or stipulated settlement. While the Board does not have a formal restitution policy, we have sought restitution in cases involving insurance fraud. In addition, if the Board obtains evidence of substantial financial harm from a consumer by a licensee, the Board would seek restitution at the hearing or in a stipulated settlement.

Table 11. Cost Recovery

	FY 2008/09	FY 2009/10	FY 2010/11	FY 2011/12
Total Enforcement Expenditures	160,974	175,929	258,806	152,758
Potential Cases for Recovery *	3	4	5	7
Cases Recovery Ordered	3	4	3	4
Amount of Cost Recovery Ordered	20,147.25	12,627.06	8,612.00	40,089.75
Amount Collected	49,000.06	28,599.14	31,332.44	35,032.75

"Potential Cases for Recovery" are those cases in which disciplinary action has been taken based on violation of the license practice act.

Table 12. Restitution

	FY 2008/09	FY 2009/10	FY 2010/11	FY 2011/12
Amount Ordered	0	1	0	0
Amount Collected	0	0	8,785.64	0

Section 6 –
Public Information Policies

How does the board use the internet to keep the public informed of board activities?

The Board's website was created in the 1990's and is constantly being updated and re-designed to provide a variety of information to applicants, licensees, and the public. The website features links to the Board's laws and regulations, forms and publications, online license verification, disciplinary actions against licensees, Board activity, and links to related professions and associations. The website also offers a feature for individuals to enroll in a Subscriber List which provides an e-mail notification to subscribers when new information is added on the website.

Does the board post board meeting materials online? When are they posted? How long do they remain on the website? When are draft meeting minutes posted online? When does the board post final meeting minutes? How long do meeting minutes remain available online?

The Board does post meeting materials online, typically a week before the meeting date. At this time, the materials remain on the website indefinitely.

Draft minutes are not posted on the website, only final meeting minutes. Final minutes are posted after they have been reviewed by the Board Secretary and approved at the next scheduled meeting of the Board. At this time, minutes remain available online indefinitely.

Does the board webcast its meetings? What is the board's plan to webcast future board and committee meetings?

The Board webcasts public Board and committee meetings at DCA in Sacramento. It is too expensive for the Board to pay for the travel and attendance of a DCA representative to webcast the meetings at off-site locations. In the future, the Board hopes to identify locations that have webcast capabilities throughout California.

Does the board establish an annual meeting calendar, and post it on the board's web site?

Yes. All board meeting dates for the upcoming calendar year are posted a couple of months prior to the end of the current calendar year. Committees meet on an "as needed" basis pursuant to the Board's Administrative Procedure's Manual, and if they are public, are noticed 10 days in advance of the meeting date in compliance with the Administrative Procedures Act.

Is the board's complaint disclosure policy consistent with DCA's *Recommended Minimum Standards for Consumer Complaint Disclosure*? Does the board post accusations and disciplinary actions consistent with DCA's *Web Site Posting of Accusations and Disciplinary Actions* (May 21, 2010)?

Yes.

What information does the board provide to the public regarding its licensees (i.e., education completed, awards, certificates, certification, specialty areas, disciplinary action, etc.)?

Consumers can access a licensee's information on the Board's website using the License Verification tool. A query can be performed by entering the licensee's name, license number, business name, city or county. A record will then appear with the licensee's name, address of record, optometrist license information (renewed, issued, expired), certifications held (i.e., TPA, TPG, etc.), disciplinary status if any, and other licenses held (BOL, FNP, SOL).

Upon written request and in compliance with the Public Records Act, information contained in the licensee's file that may be disclosed will be provided to the public.

What methods are used by the board to provide consumer outreach and education?

The Board uses the following methods to provide consumer outreach and education:

- Website;
- Brochures;
- Biennial press conference about the dangers of cosmetic contact lenses sold illegally at flea markets/jewelry stores in Sacramento; and
- Provide brochures to DCA outreach unit to distribute at health fairs.

Staff attended health related and other optometric events in previous years, but in order to reduce government spending, the Board can no longer participate in events that are not mission critical. Currently, the Board cannot attend any events that are not in Sacramento. Board publications for licensees and consumers remain available on the website.

Section 7 – Online Practice Issues

Discuss the prevalence of online practice and whether there are issues with unlicensed activity. How does the board regulate online practice? Does the board have any plans to regulate Internet business practices or believe there is a need to do so?

Online practices for health care purposes are starting to increase amongst consumers and health practitioners as technological advances make it possible to conveniently access information and services straight from home or one's place of practice. When it comes to the practice of optometry, pursuant to BPC section 3041(i), optometrists are permitted to practice telehealth. Telehealth is defined as the delivering of health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self management of a patient's health care while the patient is at the originating site and the health care provider is at a distant site (BPC section 2290.5). Effective January 1, 2013, optometrists that choose to practice telehealth must make certain disclosures, verbally, to the patient and note agreement from the patient in the patient's chart before services are rendered (BPC section 2290.5). Telehealth is beneficial in that it permits optometrists to reach underserved populations, who, due to geographic and/or economic barriers, cannot access health care. The downside to telehealth is the possibility of missing verbal, body, or language cues. Also, there is the possible lack of security when transmitting patient information and dealing with emergency situations.

To the Board's knowledge, optometrists are practicing telehealth as needed, but the Board does not have a mechanism to track the exact amount of licensees doing so, and to what extent. Examples of optometrists utilizing online practices include the use of Twitter, Facebook, Groupon and other similar discount advertisers, to reach out to current and potential patients. Some optometrists may use online contact and spectacle lens dispensers, while others might just simply e-mail a patient, or make a telephone call. The schools and colleges of optometry use various online tools in line with current technology so that students learn the most cutting edge optometric practices.

So far, there are only a couple of issues the Board has encountered related to unlicensed activity involving online practices. The first is the illegal sale of plano contact lenses without a prescription to consumers. The Board is already working with the Department of Investigation to investigate companies and distributors who do this. The second issue involves online dispensers of glasses and contact lenses. The Board may have to work to ensure that all prescribing laws related to glasses and contact lenses apply to online dispensers. There has not been an increase in the number of complaints received by the Board related to this practice, thus a change in policy is not necessary at this time.

The Board will be monitoring how online practices develop, keeping patient safety and quality of care in the forefront. The laws currently in place are sufficient to regulate this type of practice.

Section 8 –
Workforce Development and Job Creation

What actions has the board taken in terms of workforce development?

The Board's primary focus is to ensure that candidates for licensure entering the optometric health profession possess the required skills and knowledge to provide services to the diverse population of Californians who seek primary eye care. These efforts are listed below:

- Always, ensure that applications for a California optometrist license are processed quickly and efficiently;
- Starting in 2009 through 2010, the Board worked with the schools and colleges of optometry and successfully implemented Senate Bill 1406 (Correa & Aanestad, Ch. 352, Stats. 2009) so that California optometrist could become glaucoma certified in a more expedient manner;
- Yearly, visit the schools and colleges of optometry students and graduates to introduce them to the Board and how to navigate through the licensure process.

Describe any assessment the board has conducted on the impact of licensing delays.

Licensing delays can adversely affect the profession of optometry's workforce, the optometrist's ability to make a living, and the public's ability to have their eye care needs met in a swift and professional manner by a competent eye care professional. Board staff constantly seeks licensing measures that diminish and often prevent licensing delays.

Describe the board's efforts to work with schools to inform potential licensees of the licensing requirements and licensing process.

Part of the Board's outreach and education include visits to California's schools/colleges of optometry to provide third and fourth year students with an introduction to the Board's role and commitment to its stakeholders.

Provide any workforce development data collected by the board, such as:

a. Workforce shortages
b. Successful training programs.

The Board does not collect these data.

Section 9 – Current Issues

What is the status of the board's implementation of the Uniform Standards for Substance Abusing Licensees?

The Board is incorporating the Uniform Standards for Substance Abusing Licensee to its disciplinary guidelines. On September 21, 2012, the rulemaking package was submitted to DCA for final review. Upon its return, it will be submitted to the Office of Administrative Law (OAL). The Board had until October 21, 2012 to submit the package to OAL, but has requested an extension that also meets OAL's submission deadline.

What is the status of the board's implementation of the Consumer Protection Enforcement Initiative (CPEI) regulations?

In 2011, these regulations were originally a part of the rulemaking package that includes the Uniform Standards Related to Substance Abuse and Disciplinary Guidelines. The Board voted to remove the regulations from this joint rulemaking package so that staff could fully focus on implementing Senate Bill 1441 (Ridley-Thomas, Ch. 548, Stats. 2008), which is mandatory. At the August 10, 2012 meeting, the Board again discussed proposed amendments to add the provisions of the Consumer Protection Enforcement Initiative to its regulations. Because the Board has five new members that are not familiar with the proposal, the members requested that staff conduct more research specific to optometry to determine which of the regulations are suitable for the Board. The regulations will be considered before the end of this year.

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Describe how the board is participating in development of BreEZe and any other secondary IT issues affecting the board.

The Board currently has two employees working part time on the BreEZe project as subject matter experts; another employee has contributed to a forms and correspondence work group as part of BreEZe. The rest of the Board's employees assist with BreEZe on an as needed basis.

Section 10 –
Board Action and Response to Prior Sunset Issues

Include the following:

1. **Background information concerning the issue as it pertains to the board.**
2. **Short discussion of recommendations made by the Committee/Joint Committee during prior sunset review.**
3. **What action the board took in response to the recommendation or findings made under prior sunset review.**
4. **Any recommendations the board has for dealing with the issue, if appropriate.**

ISSUE #1: Should the licensing and regulation of optometrists be continued?

2002 Committee Recommendation
The Joint Legislative Sunset Review Committee (JLSRC) and DCA recommended that the profession of optometry continue to be regulated.

2002 Committee Comments
"Due to the highly technical procedures performed by optometrists and the health and safety implications for consumers, DCA and the JLSRC recommend continued regulation of the optometric profession."

Board Response and/or Recommendation
The Board agrees with the JLSRC's and DCA's recommendation.

ISSUE #2: Should the composition or membership qualifications of the Board be changed?

2002 Committee Recommendation
The addition of two public board members appointed by the Governor, for a total of eleven members (six professional, five public). The JLSRC states, "This new composition would provide more consumer representation while continuing to maintain the expertise needed for technical regulatory and enforcement issues. Two additional Board members would not substantially increase the Board's operational costs.

2002 Committee Comments
"The Board currently consists of nine members, six professional and three public. The majority of the Boards under the purview of DCA have a balanced composition with an equitable number of professional and public members. Unlike these other Boards, the Board of Optometry has a two-to-one ratio of professional to public members. It has been argued that this professional super majority necessarily results in professional bias, and less focus on consumer protection."

"Public participation on regulatory boards ensures a balanced approach to decision-making, and enhances public protection. In recent years, the JLSRC has expanded the number of public members on DCA regulatory boards."

Board Response and/or Recommendation
The Board agrees with the JLSRC's and DCA's recommendation. The Board was indeed reconstituted in 2002 with all new Board members and an Executive Officer, and has not had issues of this nature since then.

ISSUE #3: What actions should the Board take to resolve some of the ongoing problems between professional members and public members?

2002 Committee Recommendation
The JLSRC and DCA recommend that the Board needs to continue its efforts to reconcile conflicts between professional and public members.

2002 Committee Comments
"As reported in the Minority Report to the JLSRC and DCA, the Board's public members argue that they are treated differently than the professional members, suggesting the potential for a two-tiered approach by the Board staff in addressing the concerns of the public members."

"Significant conflict exists between the professional and public members of the Board. This is resulting in an inability to meet with a full quorum due to the public members' unwillingness to attend meetings under current conditions. The absence of Board meetings undermines the purpose of the Board – which in part is to engage in regular public discourse."

"This impasse and consistent inability to resolve difference is unprecedented. DCA has been asked on more than one occasion to facilitate conversations between the Board's two factions so that a Board meeting may be convened. DCA believes this is the responsibility of the Board's chair and executive officer."

"It was recommended that professional facilitators or conflict mediation expert be brought in to resolve the conflict so that the Board can carry out its business. While DCA was encouraged by the Board's recent decision to do so, it is disappointed by the plan engaged to effectuate conflict mediation. DCA has profound concerns about the Board leadership."

Board Response and/or Recommendation
The Board agrees with the JLSRC's and DCA's recommendation. The Board was indeed reconstituted in 2002 with all new Board members and an Executive Officer, and has not had issues of this nature since then.

ISSUE #4: What corrective steps should the Board take to comply with deficiencies found during a recent audit conducted by the Department of Finance?

2002 Committee Recommendation
The JLSRC and DCA recommend the Board should comply with corrective steps recommended in the Board's recent audit.

2002 Committee Comments
"The DOF's draft audit identified several areas needing improvement. These included the need to submit monthly bank statements on a timely basis, take physical inventories of and tag board property, process purchase invoices in a timely manner, and maintain independent leave balance report."

"The Board agreed with the audit findings and recommendations for remedial behavior in its response to DOF. DCA would like to underscore the importance of these corrective steps and the need to have sound internal fiscal controls in place prior to the next sunset review cycle."

Board Response and/or Recommendation
The monthly bank statement related to the Cal-Card is paid timely each month upon receipt. In FY 2008/2009 the Board implemented a purchasing tracking system to monitor its purchases and for comparison to the monthly statement. This made for a more efficient tracking of purchases which in turn expedited the review of the statement and approval of payment.

In July 2012, a physical inventory of all board equipment, furniture, and storage was completed. The inventory was taken after final closure of the Board's relocation to its new office to ensure that all newly purchased and

newly acquired items from other DCA boards/bureaus were accounted for and tagged according to the property criteria.

Each month the Executive Officer receives the Leave Activity & Balance Report (LAB) from the DCA Office of Human Recourses (OHR). This report is used by the Executive Officer to compare the monthly leave usage against the leave balances for each employee. Annually staff are given an accounting of their leave balances from DCA OHR and asked to compare these data against their own tracking so any discrepancies can be researched and changed if substantiated. Additionally employee direct deposit and pay check notifications from the State Controller's Office shows the employee his/her leave balance from the previous month, including credits/usage and the beginning balance for the month.

ISSUE #5: Should the Board adopt supervision and training standards for unlicensed optometric assistants?

2002 Committee Recommendation
The JLSRC and DCA recommend that the Board should conduct an occupational analysis for optometric assistants to identify the tasks they will perform, and the attendant training and skill level required. An occupational analysis should be developed before unlicensed assistants are permitted to engage in practices that until now require licensure as an optometrist. Following the occupational analysis, regulations clarifying the level of training and supervision of assistants should be promulgated.

2002 Committee Comments
"Senate Bill 929 (Polanco, Ch. 676, Stats. 2000) expanded the scope of practice for optometrists and expanded the duties that an unlicensed assistant may perform under the direct responsibility and supervision of an optometrist. This is a dramatic change in the delivery of optometric services."

"The provisions of SB 929 reclassified technicians, who previously were only authorized to fit contact lenses, to assistants who can perform various testing procedures including glaucoma testing, visual perception testing, measurement of the thickness of the cornea, screening of the corneal curvature, administering topical agents, and performing sonograms to measure the length of the eye and structures of the eye, generally used for surgical procedures and may involve direct contact with the eye. Clearly, this is a significant expansion of the tasks that unlicensed assistants were able to perform prior to the passage of SB 929, and consumers should not be placed at risk until duties of these assistants are clarified and regulations are adopted clarifying the level of training and supervision."

"Specifically, the Board needs to establish standards to ensure that unlicensed assistants demonstrate adequate knowledge and skill. In the absence of clarifying regulations, individual practitioners in the field could interpret the law in a variety of ways. To protect consumers, the Board should expedite the adoption of clarifying regulations."

Board Response and/or Recommendation
In an effort to comply with the JLSRC and DCA's recommendations, the Board submitted a budget change proposal (BCP) in 2003 to obtain spending authority to conduct an occupational analysis for optometric assistants. The BCP was denied; therefore the occupational analysis was never conducted. At the Board's January 16, 2004 meeting, the prior Executive Officer reported the denial of the BCP and indicated that due to the current budget situation, it was unlikely that the Board would be granted additional funds to conduct the analysis any time soon. Despite this set-back, the Executive Officer presented proposed regulatory language, and the Board voted to approve it and initiate the rulemaking process. A public hearing was conducted on November 16, 2004 to solicit comments from the public, and the Board received support from the California Optometric Association (COA). After two 15-day modified text comment periods prompted by comments from DCA in May 2005, and later, the COA in August 2005, the final proposed regulatory language would have been as follows:

Key - Regular text signifies the proposed language originally drafted by the Board.

Italic text signifies the recommendations from DCA
Underlined text signifies the recommendations from COA

Title 16, California Code of Regulation Section 1508. Optometric Assistants

As used in this regulation:
(a) An optometric assistant is an individual working in an office of an optometrist and acting under the optometrist's direct responsibility and supervision.
(b) Supervision by an optometrist of an optometric assistant means the supplying or providing of direction, control, instruction and evaluation, to include personal review of, and responsibility for the results of testing.
(c) Prior to the assignment of a task or procedure, an optometric assistant must first demonstrate to the satisfaction of the supervising optometrist that he/she possesses the necessary understanding of, and ability to perform such tasks that may lawfully be assigned in a safe manner. *There shall be* a written policy *outlining* what procedures can be done and by whom *that is approved by the supervising optometrist which is to be maintained in his/her office. The written policy* must also state that no exercise of professional judgment or interpretation of data by an optometric assistant which exceeds his/her scope of practice as authorized by Section 2544 of the Business and Professions Code is permitted.

Note: Authority cited: Section 3025, Business and Professions Code, Reference: Section 2544 and 3042, Business and Professions Code.

Also in April 2005, for the rulemaking package's fiscal analysis, the staff conducted a survey of 100 optometrists who utilized optometric assistants to determine the costs of supervising and training them. Based on the survey results, the average initial training time for procedures authorized in BPC section 2544 is 122.8 hours, with estimated optometrist/non-optometrist staff time costs of $4,882.65. Annual refresher training time totals 35.5 hours with related staff time costs of $1,169.93.

Unfortunately, the second 15-day modified text comment period to address COA's recommendations started on September 26, 2005 and ended on October 11, 2005. This rulemaking package was noticed on October 1, 2004, so pursuant to the Administrative Procedures Act, it expired October 1, 2005. After this date, the Board did not discuss this rulemaking package again.

This sunset review period has brought the issue back to the Board's attention. The Board plans to review the work that has already been done by prior staff, and discuss new proposed regulatory language before the end of this year.

The Board does want to note that the 2009 occupational analysis for the Board's California Laws and Regulations Examination and the National Board of Examiners in Optometry Examination included data related to the knowledge that an optometrist must have pertaining to what tasks an optometric assistant can perform. An optometrist's knowledge of what an optometric assistant can and can't do is important because the optometrist is fully responsible for all the actions taken by the assistant, who is not required to be licensed. In other words, the optometrist's license is in jeopardy if the assistant makes a mistake and patient harm takes place. With the inability to obtain a BCP to conduct an occupational analysis solely for optometric assistants, the Board used the resources it had available to them to at least educate optometrists on their responsibility as a supervisor of optometric assistants.

ISSUE #6: Should the profession of optometry continue to be regulated by the current Board, or should the Board be reconstituted, or become a bureau under the Department of Consumer Affairs?

2002 Committee Recommendation
The JLSRC recommends that current membership of the Board should be allowed to sunset.

2002 Committee Comments
"Since the last sunset review this Board has struggled with scope of practice issues, criticism of its enforcement efforts, an impasse between Board members that has effectively rendered the Board impotent, and a persistent perception that the profession exercises inordinate control of the Board."

"In 1999 the Director of DCA intervened in a Board dispute with the Department of Justice which has severely impaired the Board's relationship with the Department of Justice's licensing division."

"Following criticism that the Board was unlawfully permitting optometric exams to be conducted by unlicensed personnel…the Board being fully aware of the Department's interest in resolving the matter….amended late in the session optometry scope bill, SB 929, to permit unlicensed assistant personnel to perform optometric exams. …it was achieved with virtually no public discussion, and without even cursory notification to the Department."

"In 2001, the Department worked with the Board and the Office of Examination Resources (OER) to evaluate the national exam...however, the Board did not conduct an independent audit of the national exam in spite of the significant changes in their scope of practice that occurred as a result of SB 929…until the Department intervened."

Board Response and/or Recommendation
The Board agrees with the JLSRC's recommendation. The Board was indeed reconstituted in 2002 with all new Board members and an Executive Officer, and has not had issues of this nature since then.

Section 11 – New Issues

This is the opportunity for the board to inform the Committee of solutions to issues identified by the board and by the Committee. Provide a short discussion of each of the outstanding issues, and the board's recommendation for action that could be taken by the board, by DCA or by the Legislature to resolve these issues (i.e., legislative changes, policy direction, budget changes) for each of the following:

Issues that were raised under prior Sunset Review that have not been addressed.

New issues that are identified by the board in this report.

New issues not previously discussed in this report.

New issues raised by the Committee.

Board Operations

Current California budget issues requiring the Board to take cost saving measures such as cut much needed staff positions, participate in furlough programs, and reduce resources for staff to conduct their day-to-day tasks hinder the work of the Board. These constraints adversely affect the Board's operations, the profession the Board regulates, and most importantly, the public. Even though the Board is a "special fund" agency, which is funded solely by the fees of applicants, licensees, certifications and business licenses, the Board recognizes that it must support efforts to improve California's economic environment. Unfortunately, these efforts are preventing the Board from meeting its mission effectively. Since the 2002 sunset review period, the Board has demonstrated its fiscal responsibility by operating well within its budget allocation.

The Board is mandated to use its resources on the licensure, examination and regulation of the profession of optometry. This also includes educating and protecting consumers. Without sufficient staff, funds and resources, this may result in the Board failing to meet its mandate, and inadequately giving California consumers the protection they deserve.

National and California Association Attendance

One of the Board's goals in its strategic plan is to solidify the Board's national presence as a regulator of optometry. Without the ability to travel to meetings and events held by the Association of Regulatory Boards of Optometry (ARBO), in which the Board has voting privileges, the Board is not represented and cannot participate in discussions about possible developments and trends in the optometric profession. California has the highest population of optometrists nation-wide and is typically regarded as one of the most innovative states when it comes to health-care, yet the Board does not have a voice in the national arena.

The Board is aware that it can receive informational packets from meetings that take place, try to call-in during meetings, or use web casting, but it's not the same. Actually making the effort to attend gives the Board the opportunity to build relationships, establish credibility, learn of new ways to better protect consumers, and be part of the optometric world.

Likewise, the Board is restricted from traveling to different parts of California to participate in meetings and events held by the California Optometric Association, an affiliate of the American Optometric Association. The Board has strong concerns that these restrictions will perpetuate the perception that the Board does not care about national and state-wide issues. Also, it is particularly frustrating to the Board and its licensees because licensing fees, which do not impact the General Fund, could be used to accomplish this beneficial form of travel.

The Board is not requesting to attend all meetings, just one or two a year. The Board would pick the meetings that would most advance the Board's provision of its program and services.

Continued Competency

One of the Board's legal and regulatory goals in its strategic plan is to establish a process for assessing continuing competency of optometrists. In order to explore the options available for this type of assessment of health practitioners, at its January 2011 meeting, the Board invited David Swankin, President and CEO of the Citizens Advocacy Center (CAC), to provide an overview of the organization and their mission to research health professional continuing competency. Since the 1990's, the CAC has been a leader in the belief that from a consumer protection point of view, it does not make sense to assess a professional's competence only once in the course of a career. The CAC believes that it is the state's responsibility to assure continuing competence, just as they are responsible for assuring that the health practitioner meets minimum standards for licensure. The CAC discussed the challenges of implementing valid and reliable programs to accomplish continued competency (i.e., cost, professional associations) and how to reach the goals of state-based programs that assure the public of the ongoing competency of their health practitioners.

Additionally in 2011, the CAC scheduled meetings with DCA and various other health boards, prompting DCA to regularly discuss continuing competency at its monthly conference calls with health board chairs. This lead to the Board discussing the creation of a "Continuing Competency Pilot Program" to further explore this potential transition from the use of continuing education to continued competency. So far, a pilot program has not been developed due to a change in Board leadership, and acquisition of various new members in 2012.

Overall, along with other professions such as chiropractors, physical therapists, psychologist, and podiatrists, the Board has mainly remained as an observer of these discussions. Despite the fact that since the change in administration continuing competency is no longer a primary concern for DCA, the Board plans to continue monitoring the issue and gathering information to ensure the Board is ready for changes, if any, in the maintenance of licensure.

Registered Dispensing Optician Program

The Board has expressed its interest in requesting that the Medical Board of California (MBC) transfer the duties, powers, purposes, responsibilities and jurisdiction of the Registered Dispensing Optician (RDO) Program from the purview of the MBC to the Board. Since both the Board and the MBC are going through the sunset review process this year, this sunset review period may be the best possible method to make the transfer, if the legislature is in agreement. Board staff has been working with MBC staff in discussing the RDO Program and providing information about the administration of the Program. At its October 2012 Board meeting, the MBC agreed with the Board that the RDO program should not be under the purview of the MBC. While not opposed to the recommendation to transfer the RDO program to the Board, MBC members suggested another option, which is to transfer the RDO program to the DCA so that they may research and determine where the RDO program should be housed. While this solution has been mentioned at prior Board meetings by the Board's Past President and other agencies such as the Office of the Attorney General, this issue has yet to be discussed more thoroughly with the current Board and interested stakeholders. Board staff plans to present this issue in detail at an appropriate future committee meeting before the end of this year, and at its December 2012 meeting.

The Board has identified that its interest in regulating the RDO Program is because it may result in more complete and efficient regulation of individuals and businesses that are registrants of the RDO Program, and to possibly streamline the delivery of government services.

The Board receives about 20-30 calls a month from consumers who believe they received services from an optometrist, when in reality they received services from an individual or business that is a registrant with the MBC's RDO Program. Almost all of these calls are complaint related and many times include a combination of issues which also involve an optometrist and optometric assistant. With regard to these types of complaints,

The Board must refer all complaints related to the RDO Program to the MBC, forcing both agencies to discipline their respective licensee/registrant separately. If the Board had jurisdiction over the RDO Program, it's possible that a more efficient, joint investigation of these types of complaints could be conducted by Board. Further, many consumers do not understand that the functions of these two professions are different. Unfortunately, consumers incorrectly assume that optometrists and registrants of the RDO Program are the same profession, resulting in confusion as to which agency a complaint should be submitted.

The MBC believes that some of the consumer confusion may be due to the fact that an optometrist is often times located on or near the premises of an RDO business. This is the business set-up in at least 50% of the current RDO businesses. In FY 2011-2012 the MBC reported 1,170 current RDO businesses. Over 600 of these RDO businesses are made up of large optical companies and department store companies that also provide optometric services in or near the RDO business premises.

What may lead to further confusion is that current law does not allow optometrists and RDO registrants to have commingling business relationships. BPC section 655 provides that an optometrist shall not have any membership, proprietary, interest, co-ownership, landlord-tenant relationship, or any, profit-sharing arrangement in any form, directly or indirectly, with an RDO registrant and vice versa.

There have been lengthy legal battles regarding the validity of BPC section 655; both the California State and United States Federal Courts have made it clear that California law prohibits certain relationships between optometrists and RDO registrants and that these laws are valid and constitutional. The most recent ruling came from the United States Court of Appeals for the Ninth Circuit on June 13, 2012. The ruling affirmed the decision of April 2010 by a U.S. District Judge that the state acted well within its rights to prohibit these types of relationships. The Plaintiffs-Appellants, National Association of Optometrists & Opticians, Lenscrafters, Inc, and Eye Care Centers of America, Inc., could seek review by an enlarged circuit panel or at the Supreme Court.

AB 778 (Atkins, 2011) would have authorized a registered dispensing optician, an optical company, a manufacturer or distributor of optical goods, or a non-optometric corporation to own a specialized health care service plan that provides or arranges for the provision of vision care services. It would have also allowed these groups to share profits with the specialized health care service plan, contract for specified business services with the specialized health care service plan, and jointly advertise vision care services with the specialized health care service plan. This bill passed the Assembly and was referred to the Senate Business, Professions and Economic Development Committee. The hearing was cancelled by the author and therefore did not proceed through the legislature for passage.

It is the opinion of the Board that if they were to regulate the RDO Program, it may lead to more efficient investigation of complaints by eliminating the need for two agencies to investigate the same complaint when it involved an optometrist and an RDO Program registrant. With the Board administering the RDO Program, it may potentially have the ability to resolve emerging issues with regard to optometrists and opticians and the ability to amend laws and regulations within one agency when it affects both professions.

For the reasons discussed above, the Board is requesting transfer of the RDO Program from the MBC to the Board of Optometry.

Inspection Authority

The Board's enforcement unit is charged with investigating and ensuring compliance of the laws and regulations regarding optometry. However, these laws and regulations do not include the authority to audit and inspect an optometrist's practice location.

Currently, if an inspection is required, the Board must enlist the assistance of the Division of Investigation, who as peace officers, have inspection authority. These investigators may enter an optometric office and require the inspection of the premises including patient records, financial and billing information, infection control procedures, etc. However, the investigators often are not aware of the specifics in regards to optometric

offices, and may overlook important information, critical to the investigation. The Board of Pharmacy, Board of Barbering and Cosmetology, Board of Respiratory Care, Dental Board, and the Board of Physical Therapy are several of the health boards within DCA that have the authority to inspect the facilities in which their licensees practice. These inspections are to ensure the compliance of the laws and regulations of these boards, which in turn, protect California consumers.

Inspection authority will allow the Board the ability to inspect and ensure compliance in the following areas:

- Licensure - ensure that practicing optometrists have notified the Board of each practice location;
- License postings (usually posted in examination rooms, not visible to the general public);
- Infection Control -use of proper hand washing and other infection control procedures;
- Therapeutic and Ophthalmic Solutions -ensure expiration dates are being adhered to;
- Patient Charting -complete documentation, billing, and financial information; and
- Business and Financial information - ensuring proper ownership, fictitious name and branch office licensure.

The Board plans to explore the best way to implement this proposal in the future.

Scope of Practice Expansion

The practice of optometry has changed dramatically in the last 20 years, and is continuing to do so especially now with health care reform, a rapid increase in baby boomers requiring services, and technological advances.

The Board works to stay informed regarding scope of practice changes that may occur in other states, in order to evaluate if California patients would be better served if the Board initiated those changes in this state. The Board is also constantly monitoring scope of practice changes proposed by the California Optometric Association and the legislature to ensure that the Board has the resources to implement such expansions, if the Board is designated a role.

It is important to the Board that they be considered a stakeholder in any legislation to expand optometry's scope of practice. The Board will be working to join any scope expansion discussions in order to represent California consumers, and share the capabilities of the Board that may assist or hinder the implementation of potentially beneficial and innovative changes.

Outreach Efforts

The Board continues to bolster its outreach efforts to ensure licensees are receiving the information they need for licensure; and consumers are aware the Board exists, and are receiving the information they need to make informed decisions. Using the resources available, the Board has made the following efforts in recent years:

Licensees

- 2009 – Re-design of newsletter and issuance twice a year;

Consumers

- 2011 - Development of three brochures; 1) Focus on Your Eyes – What to expect at an eye examination; 2) Cosmetic Contact Lenses – Change the look of your eyes safely and legally; and 3) California State Board of Optometry – Focus on consumer protection. These are posted on the Board's website and distributed to optometrist's offices.
- 2009-2012 – Biennial press conference about the dangers of cosmetic contact lenses sold illegally at flea markets/jewelry stores in Sacramento.

Both

- 2012 - The Board's website was entirely re-designed to a more user friendly format. The design implemented won first place in the 2010 Best of the Web and Digital Government Achievement Awards. A usability study on the design was conducted to ensure the website continued to deliver citizens services despite tight fiscal constraints. This resulted in California beating all 50 states in the state portal category.
- 2011 - creation of Facebook and Twitter account.
- 2011 - DCA updated all Board's and Bureau's e-mail notification tool for interested parties to increase the ease of use;
- 2011 – creation of a public relations committee composed of two Board members.

If travel restrictions are removed so that the Board and its staff can participate in events, outreach efforts can increase. The Board also has experienced a reduction in staff, which is making it difficult for the Board to implement new ideas.

Section 12 – Attachments

A. Board's Administrative Procedure Manual

- Includes the Board Member Handbook.
- In 2011, these manuals were revised. The manuals are updated as processes are revised for enhanced productivity. These manuals are available upon request.

B. Board and Committee Member Organizational Chart

Current organizational chart showing relationship of committees to the board and membership of each committee.

- 2012 Board and Committee Member Organizational Chart

C. Major Studies

- 2009 Comprehensive Audit of the National Board of Examiners in Optometry
- 2009 Occupational Analysis

D. Year-end Organizational Charts

Year-end organization charts for last four fiscal years. Each chart should include number of staff by classifications assigned to each major program area (licensing, enforcement, administration, etc.).

- 2008/2009 Board Staff Organization Chart
- 2009/2010 Board Staff Organization Chart
- 2010/2011 Board Staff Organization Chart
- 2011/2012 Board Staff Organization Chart

E. Performance Measures

- Enforcement Performance Measures
  - First Quarter July – Sept 2010
  - Second Quarter Oct – Dec 2010
  - Third Quarter Jan – March 2011
  - Fourth Quarter April – June 2011
  - FY 2010-2011 Annual Report

  - First Quarter July – Sept 2011
  - Second Quarter Oct – Dec 2011
  - Third Quarter Jan – March 2012
  - Fourth Quarter April – June 2012
  - FY 2011-2012 Annual Report

- DCA Annual Report - Includes Board of Optometry information. The full report with all DCA Boards and Bureaus is available at http://www.dca.ca.gov/publications/annual_reports.shtml
  - 2008/2009
  - 2009/2010
  - 2010/2011
  - 2011/2012

A. Board's Administrative Procedure Manual

CALIFORNIA STATE BOARD OF

OPTOMETRY

BOARD MEMBER HANDBOOK

Introduction:

The purpose of this handbook is to provide guidance to future and incumbent Board Members regarding the general processes involved with their position on the Board of Optometry (Board). As a Board Member, you are typically asked to create and review policy and administrative changes, make disciplinary decisions, and preside over regular and special meetings.

In addition to the Bagley-Keene Open Meeting Act and the attached Administrative Procedures Manual, which provide public meeting laws, this handbook serves as a referential guide to help you understand further meeting requirements and Board procedures.

Mission Statement:

The Board of Optometry's mission is to serve the public and optometrists by promoting and enforcing laws and regulations which protect the health and safety of California's consumers and to ensure high quality care.

Vision Statement:

The Board of Optometry's vision is to be the leading health care profession board that continuously provides consumers and optometrists with effective, collaborative, and proactive services.

Values Statement:

The Board of Optometry values:

Integrity

Competence **A**ccountability **R**esponsiveness **E**fficiency

TABLE OF CONTENTS

Getting Started as a Board Member

The following information serves to inform Board Members of mandatory training requirements as well as the Board of Optometry's (Board) essential functions. Newly appointed members are also advised in this section on how to engage with Board staff and of their relationship with the Executive Officer.

Training Requirements

Within one year of assuming office, newly appointed members shall complete the following training:

1. Board Member Orientation, which is provided by the Department of Consumer Affairs
2. Ethics Training Course, which shall be completed within the first 6 months of office
3. Sexual harassment prevention, within the first six months of office

Additional training:

1. Members shall attend an ethics training course every two years

Upon assuming office, members will also receive a copy of the Bagley-Keene Open Meeting Act, which lists public meeting laws that provide the guidelines for Board Meetings. The 2011 version of this Act can also be found at the following:

http://www.dca.ca.gov/publications/bagleykeene_meetingact.pdf

Board of Optometry's Essential Functions

The Board's essential functions are comprised of licensing, examinations, legal and regulatory, and enforcement. As such, the following provide a brief understanding of staff procedures to uphold each function.

1. Licensing: Staff is responsible for such tasks as evaluating applications for initial licensure, license renewals, providing certifications (see page 16 this list), issuing Fictitious Name Permits, monitoring continuing education, and providing license verifications to consumers and customer service to licensees accordingly.
2. Examinations: Staff regulates the law and licensing exams, which are necessary to ensure proficiency to practice. Staff also develops examination procedures.
3. Legal and Regulatory: Administrative staff is responsible for implementing administrative changes, primarily by revising or introducing regulations and statutes.
4. Enforcement: Staff is responsible for ensuring consumer protection predominantly by processing consumer complaints, monitoring probationers, and providing customer service to licensees and consumers by providing information related to Board law.

Interactions with Board Staff

Employees of the Board, with the exception of the Executive Officer, are civil service employees. Their employment, pay, benefits, discipline, termination, and conditions of employment are governed by a myriad of civil service laws and regulations and often by

collective bargaining labor agreements. Because of this complexity, it is most appropriate that the Board delegate all authority and responsibility for management of the civil service staff to the Executive Officer. Board members shall not intervene or become involved in specific day-to-day personnel transactions.

The Executive Officer

The Executive Officer serves at the pleasure of the Board Members as a whole. As such, your role as a Board Member is to direct the Executive Officer to implement program administration, budget, strategic planning, and coordination of meetings.

Meetings

All Healing Arts Boards under the Department of Consumer Affairs, including the Board of Optometry, must meet in accordance with the provisions set forth by the Bagley-Keene Open Meeting Act and the Brown Act. A copy of the Bagley-Keene Open Meeting Act should be provided to each newly appointed Board Member (see web address on page 1).

For more information on Administrative Procedures, you may reference the attached Administrative Procedure Manual.

Attendance at Board Meetings

The Board's policy is such that Members attend each meeting of the Board. If a Member is unable to attend, he or she must contact the Executive Officer and ask to be excused from the meeting for a specific reason.

Quorum

In order to conduct a full Board Meeting, there needs to be a quorum of six board members. Either having members in attendance or attending the meeting via teleconference can accomplish this.

General Rules of Conduct

The following rules of conduct are taken from the attached Administrative Procedures Manual to detail expectations of your conduct as a Member. Be mindful that the Board is comprised of both public and professional members with the intention that, together, you can protect the public and regulate the profession of Optometry.

- Board members shall not speak or act for the Board without proper authorization.
- Board members shall maintain the confidentiality of non-public documents and information.

- Board members shall adequately prepare for Board responsibilities.
- Board members shall recognize the equal role and responsibilities of all Board members.
- Board members shall act fairly, be nonpartisan, impartial and unbiased in their role of protecting the public.
- Board members shall treat all applicants and licensees in a fair and impartial manner.
- Board members' actions shall serve to uphold the principle that the Board's primary mission is to protect the public.
- Board members shall not use their positions on the Board for personal, familial or financial gain.

Meeting Requirements

Pursuant to Government Code Section, 11121.9, the following are requirements for the various meetings that you, as a Board Member, may attend.

Open Meeting Requirements:

Regularly scheduled meetings generally occur throughout the year and address the usual business of the Board. There are no restrictions on the purposes for which a regularly scheduled meeting may be held.

The Board is required to give at least 10 calendar days for written notice of each Board Meeting to be held.

The meeting notice must include the agenda, which may have a brief description of the item. Note that no changes can be made to the agenda unless the notice is amended accordingly. If this occurs, it must be posted for 10 calendar days prior to the meeting. More information about notice requirements can be found in the Administrative Procedures Manual.

Committee Meeting Requirements:

Notice requirements are mandatory for committee meetings if the committee consists of three or more persons. Those committees with fewer members do not need to submit meeting notices.

Should the committee post notice for a meeting, it must match the requirements for open meetings wherein the notice must be posted on the Internet at least 10 calendar days prior to the meeting and be provided to interested parties upon request.

Special Meeting Requirements:

Though the purposes and instructions for special meetings are found in Government Code Section 11125.4, one such reason is in the instance that a 10-day notice period to the public would impose a hardship to the Board. However, should this occur, the Board must provide notice of the meeting to each member and those persons who have requested notice of board meetings. This notice needs to specify the time, place and purpose of this special meeting.

At the commencement of this meeting, the Board must make a finding (in the open session) that providing a 10-day notice of the meeting poses a substantial hardship or that immediate action is required to protect public interest. This finding must then be adopted by two-thirds vote of members present or by a unanimous vote if less than the two-thirds of members are present. Failure to do so terminates the meeting.

Closed Session Requirements:

Closed Sessions may take place in the following instances:

1. Personnel matters (i.e. appointments, employment, performance evaluations, etc.)
2. To conduct administrative disciplinary proceedings
3. Examination matters, such as when the Board administers or approves an exam
4. Pending litigation
5. In response to confidential audit reports
6. When matters discussed would be an invasion of privacy if conducted in open session
7. As a response to a threat of criminal or terrorist activity against personnel, property, buildings, facilities, or equipment.

Should a closed session take place, the Board must disclose in the open meeting a general statement about the closed session items (i.e. by mentioning it on the agenda). Additionally, all closed sessions must take place in a regularly scheduled or special meeting.

All material discussed in closed sessions must remain confidential. When such a session takes place, a staff person will be present to record and make available to members the discussion topics and decisions made.

Making a Motion

A Board Member should make a motion to introduce a new piece of business or to propose a decision or action. All motions must reflect the content of the meeting's agenda – the Board cannot act on business that is not listed on the agenda.

Upon making a motion, it is important to remember to speak slowly and clearly; bear in mind that the motion is being recorded. Members who opt to second the motion must remember to repeat the motion in question. Additionally, it is important to remember that once a motion has been made, it is inappropriate to make a second motion until the initial one has been resolved.

The basic process of a motion is as follows:

1. An agenda item has been thoroughly discussed and reviewed. If it is a new piece of business, see step 2.
2. The Board President opens a forum for a Member to make a motion to adopt or reject the discussed item.
3. A Member makes a motion before the Board.
4. Another Member seconds this motion.
5. The Board President puts forth the motion to a vote.
6. If it is a voice vote, those in favor of the motion say "aye" and those opposed say "no".
7. If it is a rising vote, those in favor of the motion will rise from their seats.

8. Upon completion of the voting, the President will announce the result of the vote (e.g. "the ayes have it and the motion is adopted" or "the no's have it and the motion fails").

The adjournment of each meeting is done via motion, seconded motion, and majority vote.

Reviewing Disciplinary Decisions

As previously mentioned under the purposes for a closed-session meeting, you will be asked to make a disciplinary decision based on a hearing that has taken place with an Administrative Law Judge. To learn more about the complaint and disciplinary process, you may consult with the overview provided on page 14 of this handbook.

Deciding to Adopt or Non-adopt a Proposed Decision

Upon being presented with a proposed disciplinary decision from an Administrative Law Judge (ALJ), you, as a Board Member, are asked to either adopt or non-adopt the action. Accordingly, consider the following when making your decision:

A. Factors for adopting an ALJ's proposed decision:
    1. The summary of the evidence supports the findings of fact, and the findings support the conclusions of law.
    2. The law and standards of practice are interpreted correctly.
    3. In those cases in which witness credibility is crucial to the decision, the findings of fact include a determination based substantially on a witness' credibility, and the determination identifies specific evidence of the observed demeanor, manner, or attitude of the witness that supports the credibility determination.
    4. The penalty fits within the disciplinary guidelines or any deviation from those guidelines has been adequately explained.
    5. If probation is granted, the terms and conditions of probation provide the necessary public protection.
    6. The costs of proceeding with non-adoption far exceed the severity of the offense and the probability is high that respondent will be successful.

B. Factors for non-adopting an ALJ's proposed decision:
    1. The proposed decision reflects the ALJ clearly abused his/her discretion.
    2. The ALJ made an error in applying the relevant standard of practice for the issues in controversy at the hearing.
    3. The witness's credibility is crucial to the decision and the findings of fact include a determination based substantially on a witness' credibility; but, the determination <u>does not</u> identify specific evidence of the observed demeanor, manner, or attitude, of the witness that supports the credibility determination.
    4. The ALJ made an error in interpreting the licensing law and/or regulations.
    5. The ALJ made correct conclusions of law and properly applied the standards of practice but the penalty is substantially less than is appropriate to protect the public.

Reviewing the Record and Preparing to Discuss and Render a Decision after Non-adoption

Should you, as a Member, choose to non-adopt a proposed decision by the administrative law judge (ALJ), he or she must review the factual and legal findings to render a determination. The following suggestions are intended to assist in reviewing the case record:

A. Reviewing the Administrative Record

1. The Accusation:

   - Make note of the code sections charged and brief description of the sections (e.g. B&P 3110(b) – gross negligence; B&P 3110 (d) – incompetence).
   - Read the facts that are alleged as they stand to prove or disprove the code violations. The burden to prove the violations by "clear and convincing evidence to a reasonable certainty" rests on the Board.

2. The Proposed Decision:

   - Factual Findings. Review the factual findings and determine if they and/or testimony prove violations. Note that expert testimony may be necessary to prove the violations.
   - Legal conclusions (determination of issues). Determine if any proven facts constitute a violation of the code section.
   - Order. Review the order and determine if the penalty is appropriate per the violations found and if it is consistent with the Disciplinary Guidelines. If not, determine if there is a basis for which the record deviated from the guidelines.

3. The Transcript

   - Sufficiency of the Evidence. You must determine if the evidence introduced is clear and convincing to a reasonable certainty to prove *each* factual allegation.
   - Lay Witnesses. You must determine if the testimony provided by witnesses prove factual allegations. In doing so, bear in mind the ALJ's credibility findings.
   - Expert Witnesses. Which expert's testimony was given the most weight by the ALJ? If you do not agree with the ALJ's findings, you must determine which evidence in the record supports your own conclusion.

B. Preparing for an Oral Argument Hearing

1. Review written arguments and determine if the burden of proof has been met.

   - The Deputy Attorney General's (DAG) argument will contend the facts are clearly proven and constitute a violation of the law.
   - The Respondent's argument will likely focus on the weaknesses of the Board's case and strength of the Respondent's case. It will force you to

answer if (a) facts are proven, (b) the law was violated, and (c) the penalty is appropriate.

2. Review the proposed decision
    - Note in the proposed decision where you agree and disagree with the ALJ in regards to factual findings, the legal conclusion, and proposed penalty. Also note the specific evidential findings which support your own conclusions.
3. Summary and Conclusion
    - Remember, that if you maintain your focus on the code sections alleged to have been violated and the facts that were alleged to have occurred, your decision should be made more easily and this will help your decision withstand judicial scrutiny.

Background Information of Various Board Processes

As a member, you may be asked to review material which you are not closely acquainted with. Therefore, you may wish to reference the following guides to attain a comprehensive understanding of items brought forth in Board Meetings.

This section provides a guide to the Legislative Process, Regulatory Process, Complaint and Disciplinary Process, and the various licenses and certifications provided by the Board.

Overview of California's Legislative Process

For a graphic overview of California's legislative process, see the attached diagram on page 10.

The California State Legislature consists of two houses: the Senate and the Assembly. The Senate has 40 members and the Assembly has 80 members.

All legislation begins as an idea or concept. Should the Board take an idea to legislation, it will act as its sponsor.

Next, in order to move the idea toward legislation the Board must attain a Senator or Assembly Member to author it as a bill. Once a legislator has established himself or herself as an author, he or she will proceed to the Legislative Council where a bill is drafted; it is then returned to the legislator for introduction in a house (if a Senator authors a bill, it will be introduced to the Senate; if an Assembly Member authors a bill, it will be introduced to the Assembly). This house is called the House of Origin.

Once a bill is introduced on the floor of its house, it is sent to the office of State Printing. At this time, it may not be acted upon until 30 days after the date which it was introduced. After the allotted time has lapsed, the bill moves to the Rules Committee of its house to be assigned to a corresponding Policy Committee for hearing.

During committee hearing, the author presents his or her bill to the committee and witnesses provide testimony in support or opposition of the bill. At this time, amendments may be proposed and/or taken. Bills can be amended multiple times. Additionally, during these

hearings, a Board representative (Board Chair, Executive Officer, and/or staffer) may be called upon to testify in favor of the bill.

Following these proceedings, the committee votes to pass the bill, pass it as amended, or defeat it. A bill is passed in committee by a majority vote.

If the bill is passed by committee, it returns to the floor of its House of Origin and is read a second time. Next, the bill is placed on Third Reading and is eligible for consideration by the full house in a floor vote. Bill analyses are prepared prior to this reading. During the third reading, the author explains the bill and members discuss and cast their vote. Bills that require appropriation or, that take effect immediately, generally require 27 votes in the Senate and 41 votes in the Assembly to be passed. Other bills require majority vote. If a bill is defeated, its author may seek reconsiderations and another vote.

Once a bill has been approved by the House of Origin, it is submitted to the second house where the aforementioned process is repeated. Here, if an agreement is not reached, the bill dies or is sent to a two-house committee where members can come to a compromise. However, if an agreement is made, the bill is returned to both houses as a conference report to be voted upon.

Should both houses approve a bill, it proceeds to the governor who can either sign the bill to law, allow it to become law without signature, or veto it. If the legislation is in session, the governor must act within 12 days; otherwise, he has 30 days to do so. A two-thirds vote from both houses can override the governor's decision to veto a bill.

Bills that are passed by the legislature and approved by the governor are assigned a chapter number by the Secretary of State. Chaptered bills typically become part of the California Codes and the Board may enforce it as statute once it becomes effective. Most bills are effective on the first day of January the following year; however, matters of urgency take effect immediately.

Positions on Legislation

As a regulatory body, the Board can issue its own legislative proposals or take a position on a current piece of legislation.

At Board Meetings, staff may present current legislation that is of potential interest to the Board, and/or which may directly impact the Board and the practice of optometry. When the Board attains research on legislation, it can take a position on the matter.

Possible positions include:

Neutral: If a bill poses no problems or concerns to the Board, or its provisions fall outside of the Board's jurisdiction, the Board may opt to remain neutral. Should the Board take this stance, it cannot testify against the bill.

Neutral if Amended: The Board may take this position if there are minor problems with the bill but, providing they are amended, the intent of the legislation does not impede with Board processes.

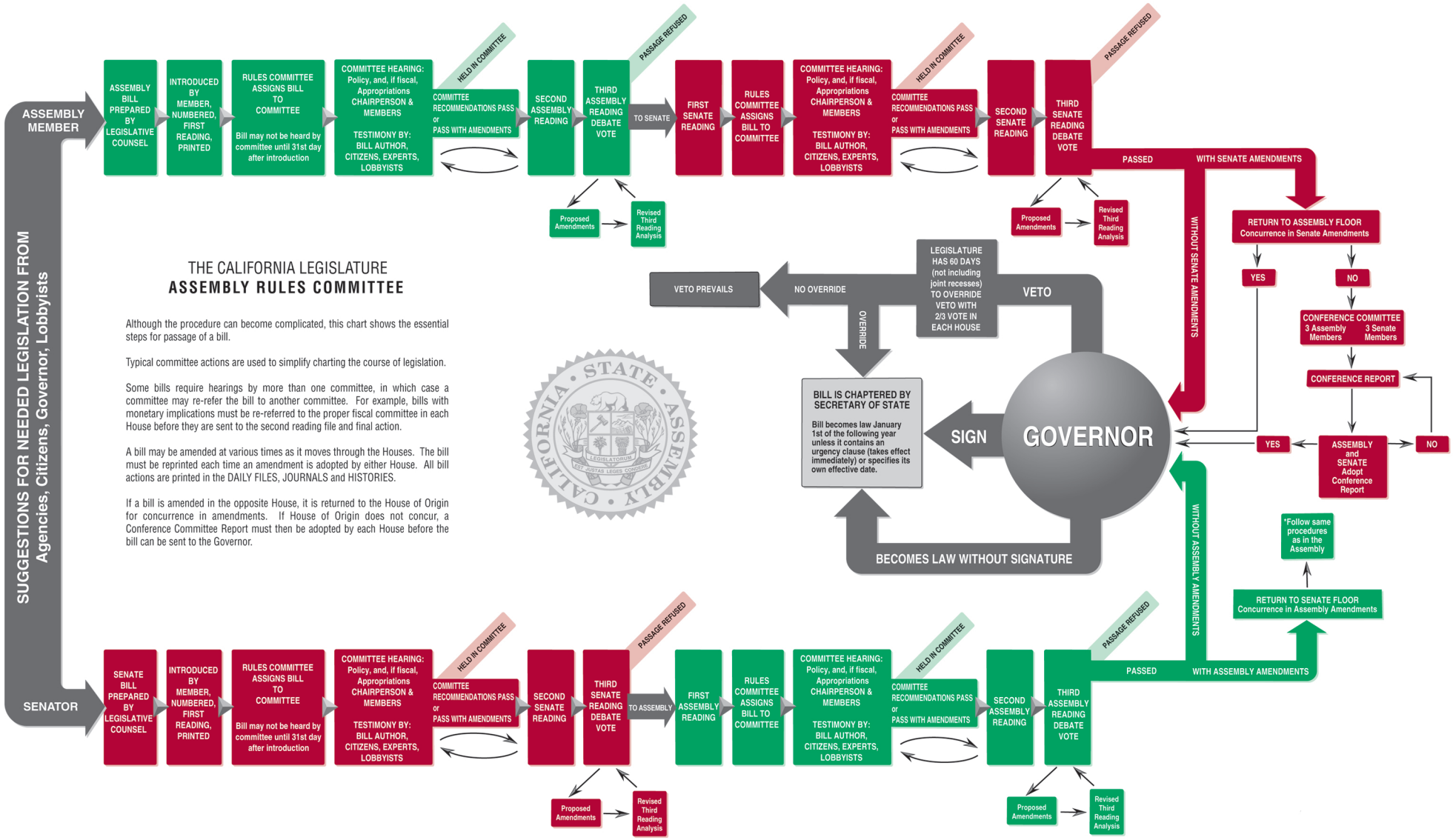
Support: This position may be taken if the Board supports the legislation and has no recommended changes.

Oppose: The Board may opt to oppose a bill if it negatively impacts consumers or is against the Board's own objectives.

Oppose Unless Amended: The Board may take this position unless the objectionable language is removed. This is a more common and substantive stance than Neutral if Amended.

THE LIFE CYCLE OF LEGISLATION

From Idea into Law



THE CALIFORNIA LEGISLATURE
ASSEMBLY RULES COMMITTEE

Although the procedure can become complicated, this chart shows the essential steps for passage of a bill.

Typical committee actions are used to simplify charting the course of legislation.

Some bills require hearings by more than one committee, in which case a committee may re-refer the bill to another committee. For example, bills with monetary implications must be re-referred to the proper fiscal committee in each House before they are sent to the second reading file and final action.

A bill may be amended at various times as it moves through the Houses. The bill must be reprinted each time an amendment is adopted by either House. All bill actions are printed in the DAILY FILES, JOURNALS and HISTORIES.

If a bill is amended in the opposite House, it is returned to the House of Origin for concurrence in amendments. If House of Origin does not concur, a Conference Committee Report must then be adopted by each House before the bill can be sent to the Governor.

Overview of Regulations

Regulations are administratively enforceable. They, along with statutes, govern the Board and comprise the Board's Practice Act. Succinctly, regulations interpret or make specific laws that are enforced or administered by the Board.

Should the Board wish to implement an administrative change, it may do so via statute or regulation. There are pros and cons to each of these routes. However, should the Board decide to implement a regulatory (also referred to as rulemaking) change or introduce a new regulation, it must follow direct procedures.

In order to prepare a rulemaking action, the Board is required to: (1) express terms of proposed regulation (the proposed text), (2) determine fiscal impact, (3) create a statement of reasons for that regulation, and (4) post notice of proposed rulemaking.

The issuance of a notice of proposed regulation initiates a rule making action. To do this, the Board creates a notice to be published in the California Regulatory Notice Register and mailed to interested parties. It must also post the notice, proposed text, and statement of reasons for the rulemaking action on its website.

Once the notice has been posted, the Administrative Procedures Act (APA) requires a 45-day comment period from interested parties before the Board may proceed further with the proposed regulation. During this time the Board can also decide if it wants to hold a public hearing to discuss the proposed rulemaking action. However, if it opts against this, but an interested person requests a hearing at least 15 days prior to the end of the written comment period, the Board must offer notice of and hold a public hearing to satisfy public request.

Following the initial comment period, the Board will often decide to revise its proposal. If it chooses to do so, APA procedures require that the agency assess each change and categorize them as (a) nonsubstantial, (b) substantial and sufficiently related, or (c) substantial and not sufficiently related. Any change that has been categorized as substantial and sufficiently related must be available for public comment for at least 15 days before the change is adopted in the proposal. All comments must then be considered by the Board.

Additionally, if the Board cites new material that has not been available to the public while revising the proposal, these new references must be presented to the public for 15 days.

The Board is also responsible for summarizing and responding on record to public comments submitted during each allotted period. These are to be included as part of the final statement of reasons. By doing so, the agency demonstrates that it has understood and considered all relevant material presented to it before adopting, amending, or repealing a regulation.

After the Board has fulfilled this process, it must adopt a final version of the proposed rulemaking decision. Once this has been accomplished, the rulemaking action must be submitted to the Office of Administrative Law (OAL) for review within a year from the date which the notice was published. OAL has 30 days to review the action.

During its review, OAL must determine if the rulemaking action satisfies the standards set forth by APA. These standards are: necessity, authority, consistency, clarity, nonduplication, and reference. It must also have satisfied all procedural requirements governed by the APA.

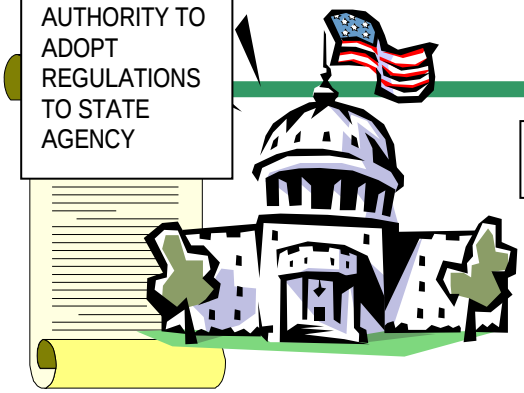
If OAL deems that the rulemaking action satisfies the aforementioned standards, it files the regulation with the Secretary of State and it is generally effective within 30 days. The regulation is also printed in the California Code of Regulations.

If OAL, however, determines that the action does not satisfy these standards, it returns the regulation to the Board, which can revise the text, post notice of change for another comment period, and, finally, resubmit the proposed regulation to OAL for review; or, the Board may appeal to the governor.

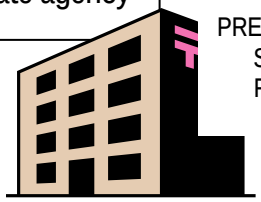
Diagrams on pages 13 and 14 provide graphical overview of the rulemaking process.

The Rulemaking Process

LEGISLATURE GRANTS AUTHORITY TO ADOPT REGULATIONS TO STATE AGENCY



State agency



PRELIMINARY ACTIVITIES
Special Considerations
Fiscal Impact

NOTICE OF PROPOSED RULEMAKING

INITIAL STATEMENT OF REASONS

TEXT OF REGULATIONS

RULEMAKING RECORD OPEN

PUBLISHES & ISSUES NOTICE

PUBLIC HEARING

Minimum 45 day public comment period

AGENCY HOLDS PUBLIC HEARING AS SCHEDULED OR BY REQUEST

AGENCY CONSIDERS COMMENTS

CHANGES MADE TO REGULATIONS?

Major Changes: New 45 day notice

substantial & sufficiently related

non-substantial or no changes

15 Day-Comment Period; Agency mails Notice of Proposed Changes

FINAL STATEMENT OF REASONS

SUMMARY & RESPONSE TO COMMENTS:

Changed to accommodate

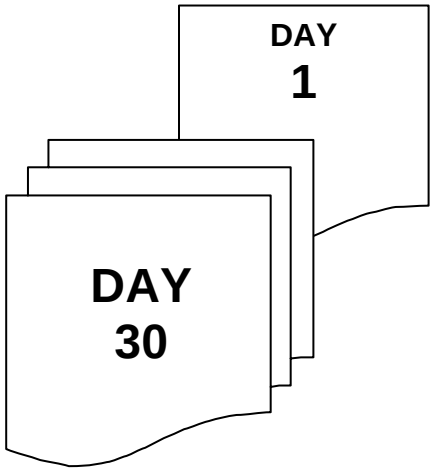
Agency adopts regulation

RULEMAKING RECORD CLOSED

OAL REVIEW

State agency must submit rulemaking record within 1 year of notice publication

OAL has 30 WORKING days to review a regulation



APA STANDARDS:

AUTHORITY
REFERENCE
CONSISTENCY
CLARITY
NON–DUPLICATION
NECESSITY

& PROCEDURAL REQUIREMENTS

DOES THE RULEMAKING SATISFY THE APA?

YES

OAL Files regulation with Secretary of State

USUALLY EFFECTIVE IN 30 DAYS

Regulation printed in California Code of Regulations

NO

OAL returns regulation to agency

Publishes disapproval in Notice Register and California Code of Regulations Decisions

Agency revises text; does 15-day notice; & resubmits to OAL w/in 120 days

NEW PUBLIC NOTICE

OR

APPEALS TO THE GOVERNOR

Complaint and Disciplinary Process

Under the Department of Consumer Affairs, the California Sate Board of Optometry (Board) conducts disciplinary proceedings in accordance with the Administrative Procedure Act, Government Code Section 11370, and those sections that follow. The Board conducts investigations and hearings pursuant to Government Code Sections 11180 through 11191.

Typically, the disciplinary process begins with a complaint case. Complaints can come to the Board via consumers, optometrists, and other agencies. Under Business and Professions Code 800 et seq., civil judgments or settlement against a licensee that exceeds three thousand dollars ($3,000) must be reported to the Board by an insurer or licensee. These will result in an enforcement investigation.

To begin an investigation, the Board's enforcement staff determines jurisdiction over a complaint case. If jurisdiction has been established, enforcement staff begins its investigation by requesting permission to review the patient's medical file (if this is pertinent to the complaint) and notifies the optometrist that a complaint has been made.

Enforcement staff determines if a violation of the Optometry Practice Act has occurred by verifying facts to validate a complaint allegation. This is generally done by gathering statements, patient records, billings, insurance claims, etc. The Board may also submit the case to the Division of Investigation (DOI) for further investigation as DOI investigators are given authority of peace officers by the Business and Professions Code while engaged in their duties. Therefore, these investigators are authorized more investigative privileges than Board staff.

The Board may also seek the aid of an expert witness when the enforcement team needs an expert opinion to determine if the licensee in question breached the standard of care.

If it is determined by enforcement staff, expert opinion, DOI, etc. that the subject's acts constitute a violation of law, the completed investigative report is submitted to the California Office of the Attorney General. The assigned Deputy Attorney General will review the case to determine if the evidence supports filing of an accusation against the subject for a violation of the law. If it is determined appropriate, an accusation is prepared and served upon the subject and he or she is given the opportunity to request a hearing to contest the charges.

Acts subject to disciplinary action – such as revocation, suspension, or probationary status of a license – include but are not limited to:

- Unprofessional conduct;
- Gross negligence;
- Sexual misconduct;
- Conviction of a substantially related crime;
- Substance abuse; and
- Insurance fraud.

After the Board files an accusation, the case may be resolved by a stipulated settlement: a written agreement between parties to which the person is charged admits to certain violations and agrees that a particular disciplinary order may be imposed.

Stipulations are subject to adoption by the Board. If a stipulated settlement cannot be negotiated, the Board holds a hearing before an Administrative Law Judge of the Office of Administrative Hearings. The hearing may last anywhere from one day to several months, depending on the complexity of the case and the defense. During the hearing, both sides may call expert witnesses

to support their views. After both sides have argued their case, the judge issues a proposed decision. This written proposal is submitted to the Board for adoption as its decision in the matter.

If the Board does not adopt the proposed decision, Board members obtain a transcript of the hearing, review the decision and decide the matter based upon the administrative record. If dissatisfied with the Board's decision, the respondent may petition for reconsideration or he or she may contest it by filing a writ of mandate in the appropriate superior court.

Licenses and Certification

The following chart provides an overview of the various licenses and certifications that the Board issues to its licensees.

TYPE	DESCRIPTION	Authority
Optometric License (OPT)	License to practice optometry in California at designated "principal place of practice." May be owner or an employee/independent contractor at the location.	B&P 3040
Statement of Licensure (SOL)	Required for every location where a licensee is employed or works as an independent contractor in addition to principal place of practice as designated by OPT license.	CCR 1506(d).
Branch Office License (BOL)	Required for each optometric practice owned by a licensed optometrist that is in addition to principal place of practice as designated by OPT license.	B&P 3077
Fictitious Name Permit (FNP)	Required if a fictitious name is used in conjunction with the practice of optometry.	B&P 3078 and CCR 1518
Therapeutic Pharmaceutical Agents (TPA) Certification	Required for optometrists who wish to treat patients with pharmaceutical agents as authorized by this category. To become TPA certified, an optometrist must meet one of seven category requirements.	B&P 3041.3 and CCR 1568
Glaucoma Certification	Effective January 8, 2011. In order to be certified to diagnose and treat Glaucoma, an optometrist must already be TPA certified.	B&P 3041(f)(5) and CCR 1571
Lacrimal Irrigation and Dilation Certification	Effective January 1, 2011. To be certified to perform these tasks, an optometrist must already be TPA certified.	B&P 3041(e)(6) and B&P 3041.3

State of California
State and Consumer Services Agency

CALIFORNIA STATE BOARD OF OPTOMETRY

Administrative Procedure Manual

California State Board of Optometry
2450 Del Paso Road, Suite 105
Sacramento, CA 95834
www.optometry.ca.gov

2011 Edition

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Chapter 1. Introduction

Overview

The California State Board of Optometry (hereafter Board) was created by the California Legislature in 1973 under the Department of Professional and Vocational Standards to safeguard the public's health, safety, and welfare. In 1923, the Board promulgated the first rules for the practice of optometry and the State Legislature first required all applicants for licensure to be graduates of an accredited school or colleges of optometry. The Board is responsible for accrediting these schools. To assure competent and ethical practitioners and protect the public from harm, no person may engage in the practice of optometry in California unless he or she possesses a valid and unrevoked license from the Board.

Today, the Board is one of the boards, bureaus, commissions, and committees within the Department of Consumer Affairs (DCA), part of the State and Consumer Services Agency under the aegis of the Governor. DCA is responsible for consumer protection and representation through the regulation of licensed professions and the provision of consumer services. While the DCA provides administrative oversight and support services, the Board has policy autonomy and sets its own policies, procedures, and initiates its own regulations.

Protection of the public shall be the highest priority for the Board in exercising its licensing, regulatory and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount (Business and Professions Code (BPC) Section 3010.1).

The Board is comprised of 11 members. By law, five must be public members and six must be optometry professionals (licensed optometrists of the State of California actually engaged in the practice of optometry at the time of appointment or faculty members of a school or college of optometry). No more than two faculty members may be on the Board at any one time and they may not serve as public members. No member of the Board shall have a financial interest in any purchase or contract under Board purview nor shall he/she have financial interest in the sale of any property or optical supplies to any prospective candidate for examination before the Board. The public members shall not be licensees of the Board or of any other Healing Arts Board. The Governor appoints three public members and the six professional members. The Senate Rules Committee and the Speaker of the Assembly each appoint one public member. Board members may serve up to two, four-year terms. Board members are paid $100 for each day actually spent in the discharge of official duties and are reimbursed travel expenses.

Board Responsibilities

With approximately 7,000 practicing optometrists and 500 optometric corporations, the largest population of optometrists in the United States, the Board is charged with the following duties and responsibilities:

- Accrediting the schools and colleges providing optometric education.
- Establishing educational requirements for admission to the examination for certificates of registration as California licensed optometrists.

- Establishing examination requirements to ensure the competence of individuals licensed to practice optometry in California and administering the examination.
- Setting and enforcing standards for continued competency of existing licensees.
- Establishing educational and examination requirements for licensed optometrists seeking certification to use and prescribe authorized pharmaceutical agents.
- Issuing certification to diagnose and treat glaucoma for patients over the age of 18.
- Licensing branch offices and issuing fictitious name permits.
    - Effective January 1, 2007, the Board of Optometry no longer registers Optometric Corporations. However, the Board has maintained the authority to regulate those in existence.
- Promulgating regulations governing:
    - Procedures of the Board
    - Admission of applicants for examination for licensure as optometrists
    - Minimum standards governing the optometric services offered or performed, the equipment, or the sanitary conditions
- Providing for redress of grievances against licensees by investigating allegations of substance and patient abuse, unprofessional conduct, incompetence, fraudulent action, or unlawful activity.
- Instituting disciplinary action for violations of laws and regulations governing the practice of optometry when warranted.

This procedures manual is provided to Board members as a ready reference of important laws, regulations, DCA policies, and Board policies in order to guide the actions of the Board members and ensure Board effectiveness and efficiency.

Definitions

ALJ	Administrative Law Judge.
AOA	American Optometric Association
APA	Administrative Procedure Act
BPC	Business and Professions Code
CLEAR	Council on Licensure Enforcement and Regulations
COA	California Optometric Association
DCA	Department of Consumer Affairs

EO	Executive Officer
OAH	Office of Administrative Hearings. This state agency provides neutral judges to preside over administrative cases.
OAL	Office of Administrative Law. This state agency reviews regulation changes for compliance with the process and standards set out in law and either approves or disapproves those regulation changes.
Regulation	A standard that implements, interprets, or makes specific a statute enacted by a state agency. It is enforceable the same way as a statute.
SAM	State Administrative Manual
Statute	A law passed by the legislature.
Stipulation	A form of plea bargaining in which a disciplinary case is settled by negotiated agreement prior to hearing.
President	Where the term "President" is used in this manual, it will be assumed to include "his or her designee"

General Rules of Conduct

- Board members shall not speak or act for the Board without proper authorization.
- Board members shall maintain the confidentiality of non-public documents and information.
- Board members shall adequately prepare for Board responsibilities.
- Board members shall recognize the equal role and responsibilities of all Board members.
- Board members shall act fairly, be nonpartisan, impartial and unbiased in their role of protecting the public.
- Board members shall treat all applicants and licensees in a fair an impartial manner.
- Board members' actions shall serve to uphold the principle that the Board's primary mission is to protect the public.
- Board members shall not use their positions on the Board for personal, familial or financial gain.

Chapter 2. Board Meeting Procedures

Frequency of Meetings

(BPC Section 3017)

The Board shall hold regular meetings every calendar quarter.

Special meetings of the Board may be held upon request of a majority of the members of the Board or upon the call of the President.

Six members constitute a quorum at a Board meeting.

Notice of each meeting and the time and place thereof shall be given to each member in the manner provided by the Bagley-Keene Open Meeting Act.

Board Member Attendance at Board Meetings

(Board Policy)

Board members shall attend each meeting of the Board. If a member is unable to attend, he or she must contact the Executive Officer and ask to be excused from the meeting for a specific reason.

Public Attendance at Board Meetings

(Government Code Section 11120 et seq.)

Meetings are subject to all provisions of the Bagley-Keene Open Meeting Act. This act governs meetings of the state regulatory boards and meeting of committees of those boards where the committee consists of more than two members. It specifies meeting notice and agenda requirements and prohibits discussing or taking action on matters not included in the agenda.

The Bagley-Keene act stipulates that the Board is to provide adequate notice of meetings to be held to the public as well as provide an opportunity for public comment. The meeting is to be conducted in an open session, except where closed session is specifically noted.

If the agenda contains matters that are appropriate for closed session, the agenda shall cite the particular statutory section and subdivision authorizing the closed session.

Closed Sessions at Board Meetings

(Government Code Section 11126 et seq.)

A Board may meet in a closed session to discuss: personnel matters (appointments, employment, evaluation of performances, etc.); examination matters wherein the Board prepares, approves, grades, or administers examinations; matters which would constitute an invasion of privacy if discussed in an open session; administrative disciplinary matters; pending litigation; as a response to confidential final draft audit report; and, as a response to threat of criminal or terrorist activity against the personnel, property, buildings, facilities, or equipment.

Closed Session Procedural Requirements

(Government Code Section 11126 et seq.)

The Board shall disclose in the open meeting a generalization of the items to be discussed in a closed session. This can be accomplished by those items on the agenda as a closed session item.

All closed sessions must be held during a regular or special meeting (section 11128). A staff person shall be designated to attend the closed session and record the discussion topics and decisions made, which will be available only to members.

All information discussed in the closed session is confidential and must not be disclosed to outside parties.

Quorum

(BPC Section 3010.1)

Six of the members of the Board constitute a quorum of the Board for the transaction of business. The concurrence of a majority of those members of the Board present and voting at a meeting duly held at which a quorum is present shall be necessary to constitute an act or decision of the Board.

Agenda Items

(Board Policy and Government Code Section 11125 et seq.)

Any Board member may submit items for a Board meeting agenda to the Executive Officer 15 days prior to the meeting.

No item shall be added to the agenda subsequent to the provision of the meeting notice. However, an agenda item may be amended and then posted on the Internet at least 10 calendar days prior to the meeting.

Items not included on the agenda may not be discussed.

Notice of Meetings

(Government Code Section 11120 et seq.)

According to the Opening Meeting Act, meeting notices (including agenda for Board meetings) shall be sent to persons on the Board's mailing list at least 10 calendar days in advance. The notice shall include a staff person's name, work address, and work telephone number so that he or she can provide information prior to the meeting.

Notice of Meetings to be Posted on the Internet

(Government Code Section 11125 et seq.)

Notice shall be given and also made available on the Internet at least 10 calendar days in advance of the meeting and shall include the name, address, and telephone number of any person who can provide information prior to the meeting. However, it need not include a list of witnesses expected to appear at the meeting.

Written notices shall include the address of the Internet site where notices required by this article are available.

Special Meetings

(Government Code Section 11125 et seq.)

A special meeting may be held where compliance with a 10-day meeting notice would impose a hardship or when an immediate action would be required to protect the public interest.

Notice for a special meeting must be posted on the Internet at least 48 hours prior to the meeting. Upon commencement, the Board must state the specific facts which necessitate special meeting as a finding. This finding must be adopted by a two-thirds vote; failure to adopt the finding terminates the meeting.

Record of Meetings

(Board Policy)

The minutes are a summary, not a transcript, of each Board meeting. They shall be prepared by Board staff and submitted for review by Board members before the next Board meeting. Board minutes shall be approved at the next scheduled meeting of the Board. When approved, the minutes shall serve as the official record of the meeting.

Tape Recording

(Board Policy)

The meetings may be tape-recorded if determined necessary for staff purposes. Tape recordings may be disposed of upon Board approval of the minutes.

Meeting by Teleconferencing

(Government Code Section 11123 et seq.)

Board Meetings held by a teleconference must comply with requirements applicable to all meetings.

The portion of the meeting that is open session must be made audible to the public present at the location specified in the meeting notice. Each teleconference meeting location must be identified in the meeting notice and agenda.

All votes taken during this meeting shall be by roll-call.

Use of Electronic Devices During Meetings

(Bagley-Keen Act)

Members should not text or email each other during an open meeting on any matter within the Board's jurisdiction.

Meeting Rules

(Board Policy)

The Board will use Robert's Rules of Order, to the extent that it does not conflict with state law (e.g., Bagley-Keene Open Meeting Act), as a guide when conducting the meetings.

Chapter 3. Travel & Salary Policies & Procedures

Travel Approval

(DCA Memorandum 96-01)

Board members shall have Board President approval for travel except for regularly scheduled Board and committee meetings to which the Board member is assigned.

Travel Arrangements

(Board Policy)

Board members should attempt to make their own travel arrangements and are encouraged to coordinate with the Executive Officer's Assistant on lodging accommodations.

Out-of-State Travel

(State Administrative Manual Section 700 et seq.)

For out-of-state travel, Board members will be reimbursed for actual lodging expenses, supported by vouchers, and will be reimbursed for meal and supplemental expenses. Out-of-state travel for all persons representing the state of California is controlled and must be approved by the Governor's Office.

Travel Claims

(State Administrative Manual Section 700 et seq. and DCA Travel Guidelines)

Rules governing reimbursement of travel expenses for Board members are the same as for management-level state staff. All expenses shall be claimed on the appropriate travel expense claim forms. The Executive Officer's Assistant maintains these forms and completes them as needed. It is advisable for Board members to submit their travel expense forms immediately after returning from a trip and not later than two weeks following the trip.

In order for the expenses to be reimbursed, Board members shall follow the procedures contained in DCA Departmental Memoranda which are periodically disseminated by the Director and are provided to Board members.

Salary Per Diem

(BPC Section 103)

Compensation in the form of salary per diem and reimbursement of travel and other related expenses for Board members is regulated by BPC Section 103.

In relevant part, this section provides for the payment of salary per diem for Board members "for each day actually spent in the discharge of official duties," and provides that the Board member "shall be reimbursed for traveling and other expenses necessarily incurred in the performance of official duties."

(Board Policy)

Accordingly, the following general guidelines shall be adhered to in the payment of salary per diem or reimbursement for travel:

1. No salary per diem or reimbursement for travel-related expenses shall be paid to Board members except for attendance at official Board or committee meetings, unless a substantial official service is performed by the Board member. Attendance at gatherings, events, hearings, conferences or meetings other than official Board or committee meetings in which a substantial official service is performed shall be approved in advance by the Board President. The Executive Officer shall be notified of the event and approval shall be obtained from the Board President prior to the Board member's attendance.

2. The term "day actually spent in the discharge of official duties" shall mean such time as is expended from the commencement of a Board meeting or committee meeting to the conclusion of that meeting. Where it is necessary for a Board member to leave early

from a meeting, the Board President shall determine if the member has provided a substantial service during the meeting and, if so, shall authorize payment of salary per diem and reimbursement for travel-related expenses.

For Board-specified work, Board members will be compensated for actual time spent performing work authorized by the Board President. That work includes, but is not limited to, authorized attendance at other gatherings, events, meetings, hearings, or conferences, and AOA or CLEAR committee work. That work does not include preparation time for Board or committee meetings. Board members cannot claim salary per diem for time spent traveling to and from a Board or committee meeting.

Chapter 4. Selection of Officers & Committees

Officers of the Board

(BPC Section 3014)

The Board shall elect from its members a President, Vice-President, and a Secretary to hold office for one year or until their successors are duly elected and qualified.

Election of Officers

(Board Policy)

The Board elects the officers at the last meeting of the fiscal year. Officers serve a term of one-year beginning July 1 of the next fiscal year. All officers may be elected on one motion or ballot as a slate of officers unless more than one Board member is running per office. An officer may be re-elected and serve for more than one term.

Officer Vacancies

(Board Policy)

If an office becomes vacant during the year, an election shall be held at the next meeting. If the office of the President becomes vacant, the Vice President shall assume the office of the President until the election for President is held. Elected officers shall then serve the remainder of the term.

Committee Appointments

(Board Policy)

The President shall establish committees, whether standing or special, as necessary. The composition of the committees and the appointment of the members shall be determined by the

Board President in consultation with the Vice President, Secretary and the Executive Officer. Appointment of non-Board members to a committee is subject to the approval of the Board.

Attendance of Committee Meetings

(Government Code Section 11122.5 (c)(6))

(a) As used in this article, "meeting" includes any congregation of a majority of the members of a state body at the same time and place to hear, discuss, or deliberate upon any item that is within the subject matter jurisdiction of the state body to which it pertains.

(b) Except as authorized pursuant to Section 11123, any use of direct communication, personal intermediaries, or technological devices that is employed by a majority of the members of the state body to develop a collective concurrence as to action to be taken on an item by the members of the state body is prohibited.

(c) The prohibitions of this article do not apply to any of the following:

(1) Individual contacts or conversations between a member of a state body and any other person.

(2) The attendance of a majority of the members of a state body at a conference or similar gathering open to the public that involves a discussion of issues of general interest to the public or to public agencies of the type represented by the state body, provided that a majority of the members do not discuss among themselves, other than as part of the scheduled program, business of a specified nature that is within the subject matter jurisdiction of the state body. This paragraph is not intended to allow members of the public free admission to a conference or similar gathering at which the organizers have required other participants or registrants to pay fees or charges as a condition of attendance.

(3) The attendance of a majority of the members of a state body at an open and publicized meeting organized to address a topic of state concern by a person or organization other than the state body, provided that a majority of the members do not discuss among themselves, other than as part of the scheduled program, business of a specific nature that is within the subject matter jurisdiction of the state body.

(4) The attendance of a majority of the members of a state body at an open and noticed meeting of another state body or of a legislative body of a local agency as defined by Section 54951, provided that a majority of the members do not discuss among themselves, other than as part of the scheduled meeting, business of a specific nature that is within the subject matter jurisdiction of the other state body.

(5) The attendance of a majority of the members of a state body at a purely social or ceremonial occasion, provided that a majority of the members do not discuss among themselves business of a specific nature that is within the subject matter jurisdiction of the state body.

(6) The attendance of a majority of the members of a state body at an open and noticed meeting of a standing committee of that body, provided that the members of the state body who are not members of the standing committee attend only as observers.

Chapter 5. Board Administration and Staff

Appointment of Executive Officer

(BPC Section 3027)

The Board shall employ an Executive Officer and other necessary assistance in the carrying out of the provisions of the BPC, Chapter 7.

The executive officer shall perform the duties delegated by the Board and shall be responsible to it for the accomplishment of those duties. The executive officer shall not be a member of the Board. With the approval of the Director of Finance, the Board shall fix the salary of the Executive Officer. The Executive Officer shall be entitled to traveling and other necessary expenses in the performance of his duties.

Board Administration

(DCA Reference Manual)

Board Members should be concerned primarily with formulating decisions on Board policies rather than decisions concerning the means for carrying out a specific course of action. It is inappropriate for Board Members to become involved in the details of program delivery. Strategies for the day-to-day management of programs, operations and staff shall be the responsibility of the Executive Officer. Board members should not interfere with day-to-day operations, which are under the authority of the Executive Officer.

Legal Counsel

The Board's legal counsel acts represents the Board for litigation and accordingly for services rendered by the Office of the Attorney General. The Board's legal counsel provides "in-house" counsel.

Board Budget

(Board Policy)

The Secretary shall serve as the Board's budget liaison with staff and shall assist staff in the monitoring and reporting of the budget to the Board. Staff will conduct an annual budget briefing with the Board with the assistance of the Secretary.

The Executive Officer or the Executive Officer's designee will attend and testify at legislative budget hearings and shall communicate al budget issues to the Administration and Legislation.

Press Releases

(Board Policy)

The Executive Officer may issue press releases with the approval of the Board President.

Strategic Planning

(Board Policy)

The Executive Committee shall have overall responsibility for the Board's strategic planning process. The Vice President shall serve as the Board's strategic planning liaison with staff and shall assist staff in the monitoring and reporting of the strategic plan to the Board. The Board will conduct an annual strategic planning session and may utilize a facilitator to conduct the strategic planning process.

Legislation

(Board Policy)

In the event time constraints preclude Board action, the Board delegates to the Executive Officer and the Board President the authority to take action on legislation that would affect the practice of optometry or responsibilities of the Board. The Board shall be notified of such action as soon as possible.

Communication with Other Organizations & Individuals

(Board Policy)

Any and all representations of the Board or Board policy must be made by the Executive Officer or Board President, unless approved otherwise. All correspondence shall be issued on the Board's standard letterhead and will be created and disseminated by the Executive Officer's Office.

Executive Officer Evaluation

(Board Policy)

Board members shall evaluate the performance of the Executive Officer on an annual basis.

Board Staff

(DCA Reference Manual)

Employees of the Board, with the exception of the Executive Officer, are civil service employees. Their employment, pay, benefits, discipline, termination, and conditions of employment are governed by a myriad of civil service laws and regulations and often by collective bargaining labor agreements. Because of this complexity, it is most appropriate that the Board delegate all authority and responsibility for management of the civil service staff to the Executive Officer. Board members shall not intervene or become involved in specific day-today personnel transactions.

Business Cards

(Board Policy)

Business cards will be provided to each Board member with the Board's name, address, telephone and fax number, and website address. A Board member's business address, telephone and fax number, and email address may be listed on the card at the member's request.

Chapter 6. Other Policies & Procedures

Board Member Orientation

(BPC section 453)

Newly appointed members shall complete a training and orientation program provided by DCA within one year of assuming office. This one-day class will discuss board member obligations and responsibilities.

Materials Provided to Incoming Board Members

(Government Code section 11121.9)

A copy of the Bagley-Keene Act must be provided to each new member upon his or her appointment.

Board Member Ethics Training

(Government Code sections 12950.1 and 11146.1)

Newly appointed board members shall attend an ethics training course within six months of assuming office and every two years thereafter.

Pursuant to Government Code section 12950.1, each member shall attend at least two hours of interactive training covering sexual harassment prevention within six months of his or her appointment.

Board Member Disciplinary Actions

(Board Policy)

The Board may censure a member if, after a hearing before the Board, the Board determines that the member has acted in an inappropriate manner. The President of the Board shall sit as chair of the hearing unless the censure involves the President's own actions, in which case the Vice President of the Board shall sit as chair. In accordance with the Public Meetings Act, the censure hearing shall be conducted in open session.

Removal of Board Members

(BPC Sections 106 and 106.5)

The Governor has the power to remove from office at any time any member of any Board appointed by him or her for continued neglect of duties required by law or for incompetence or unprofessional or dishonorable conduct. The Governor may also remove from office a Board member who directly or indirectly discloses examination questions to an applicant for examination for licensure.

Resignation of Board Members

(Government Code Section 1750)

In the event that it becomes necessary for a Board member to resign, a letter shall be sent to the appropriate appointing authority (Governor, Senate Rules Committee, or Speaker of the Assembly) with the effective date of the resignation. State law requires written notification. A copy of this letter shall also be sent to the director of DCA, the Board President, and the Executive Officer.

Conflict of Interest

(Government Code Section 87100)

No Board member may make, participate in making, or in any way attempt to use his or her official position to influence a governmental decision in which he or she knows or has reason to know he or she has a financial interest. Any Board member who has a financial interest shall disqualify him or herself from making or attempting to use his or her official position to influence the decision. Any Board member who feels he or she is entering into a situation where there is a potential for a conflict of interest should immediately consult the Executive Officer or the Board's legal counsel.

Contact with Candidates, Applicants and Licensees

(Board Policy)

Board members shall not intervene on behalf of a candidate or an applicant for licensure for any reason. Nor shall they intervene on behalf of a licensee. All inquiries regarding licenses, applications and enforcement matters should be referred to the Executive Officer.

Gifts from Candidates

(Board Policy)

Gifts of any kind to Board members or the staff from candidates for licensure with the Board shall not be permitted.

Request for Records Access

(Board Policy)

No Board member may access the file of a licensee or candidate without the Executive Officer's knowledge and approval of the conditions of access. Records or copies of records shall not be removed from the office of the Board.

Ex Parte Communications

(Government Code Section 11430.10 et seq.)

The Government Code contains provisions prohibiting *ex parte* communications. An *ex parte* communication is a communication to the decision-maker made by one party to an enforcement action without participation by the other party. While there are specified exceptions to the general prohibition, the key provision is found in subdivision (a) of section 11430.10, which states:

"While the proceeding is pending, there shall be no communication, direct or indirect, regarding any issue in the proceeding to the presiding officer from an employee or representative of an agency that is a party or from an interested person outside the agency, without notice and an opportunity for all parties to participate in the communication."

Board members are prohibited from an *ex parte* communication with Board enforcement staff while a proceeding is pending. Occasionally an applicant who is being formally denied licensure, or a licensee against whom disciplinary action is being taken, will attempt to directly contact Board members.

If the communication is written, the person should read only far enough to determine the nature of the communication. Once he or she realizes it is from a person against whom an action is pending, they should reseal the documents and send them to the Executive Officer.

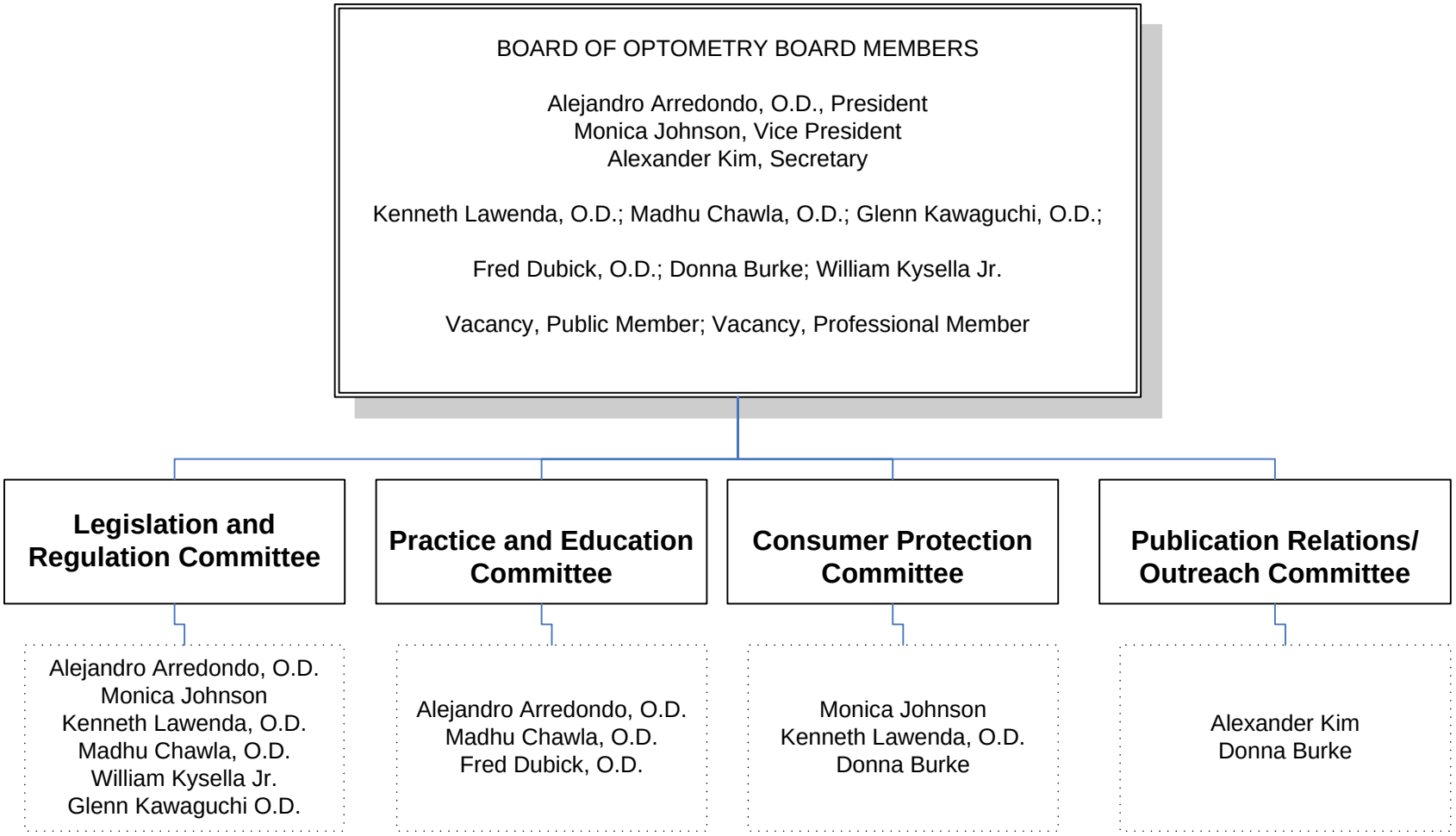
If a Board member receives a telephone call form an applicant or licensee against whom an action is pending, he or she should immediately tell the person they cannot speak to them about the matter. If the person insists on discussing the case, he or she should be told that the Board

member will be required to recuse him or herself from any participation in the matter. Therefore, continued discussion is of no benefit to the applicant or licensee.

If a Board member believes that he or she has received an unlawful *ex parte* communication, he or she should contact the Executive Officer.

B. Board and Committee Member Organizational Chart

BOARD OF OPTOMETRY BOARD AND COMMITTEE MEMBER ORGANIZATIONAL CHART



Please Note: Due to a change in Board leadership and the addition of seven new members, the Board will determine the final composition of the members in each committee for 2012-2013 at its December 2012 meeting. The above indicates committees that the current members are interested in participating in.

C. Major Studies

2009 Comprehensive Audit of the National Board of Examiners in Optometry

EXECUTIVE SUMMARY

Licensing boards and bureaus within the California Department of Consumer Affairs are required to ensure that examination programs being used in the California licensure process comply with psychometric and legal standards. The California State Board of Optometry (Board) requested that the Department of Consumer Affairs, Office of Professional Examination Services (OPES), complete a comprehensive review of the National Board of Examiners in Optometry (NBEO) licensing examination program for continued use in California and to develop a supplemental examination outline for the California laws and regulations examination.

OPES received and reviewed documents provided by NBEO. A comprehensive evaluation of the documents was made to determine whether (a) job analysis, (b) examination development, (c) passing scores, (d) test administration, (e) examination performance, and (f) test security procedures met professional guidelines and technical standards. OPES found that the procedures used to establish and support the validity and defensibility of the NBEO examination program components listed above meet professional guidelines and technical standards outlined in the *Standards for Educational and Psychological Testing (APA Standards)* and B&P Code section 139.

The Board convened a panel of licensed California optometrists who would serve as subject matter experts in reviewing the NBEO job analysis and examination content outlines and compare those to the description of practice determined for California optometrists. The subject matter experts were selected by the Board based on their geographic location, experience, and practice specialty.

The subject matter experts were asked to review and link the scope of practice for optometrists as determined by the 2009 California State Board Optometrist Occupational Analysis, performed by OPES, with the examination specifications for NBEO that were determined by the September 2006 occupational analysis performed by Soroka, Krumholz, Bennet, and The National Board of Examiners Conditions Domain Task Force. The results of the subject matter expert's linkage indicate that the competencies assessed in the NBEO examinations are relevant to optometric practice in California.

The subject matter experts were also asked to review the results of the Board's occupational analysis and identify the job task and knowledge statements that specifically relate to laws and regulations in California that should be included in the California laws and regulations examination outline. The subject matter experts selected task and knowledge statements based on the criteria that they relate to California laws and regulations, and not to clinical practice.

The subject matter experts linked the selected job task and knowledge statements to develop the examination outline for the California laws and regulations examination. A total of 43 task statements were selected to be included in the examination outline, and a total of 97 knowledge statements were selected to be included in the

examination outline. The examination outline is structured into seven content areas. Each content area is weighted proportionately relative to other content areas. The examination outline specifies the job tasks related to California laws and regulations an optometrist is expected to master at the time of licensure. Table 1 presents the seven content areas, a descriptive overview of the content areas, and the weight for each content area.

TABLE 1 – CONTENT AREAS FOR CALIFORNIA LAWS AND REGULATIONS EXAMINATION OUTLINE

Content Area	Content Area Description	Percent Weight
I. Patient Examinations	This assesses the candidate's ability to assess a patient's vision, ocular health, general health, and needs for care.	33%
II. Diagnoses and Treatment Plans	This area assesses the candidate's ability to make diagnoses and prepare treatment plans.	10%
III. Spectacles and Protective Eyewear	This area assesses the candidate's ability to analyze and prescribe eyewear according to the needs of the patient.	5%
IV. Contact Lenses	This area assesses the candidate's ability to provide and fit contact lenses and train patients in their handling, care, and use.	15%
VII. Management of eye disorders and referrals	This area assesses the candidate's ability to manage and treat eye disorders and/or refer patients.	26%
VIII. Patient Emergencies	This area assesses the candidate's ability to recognize and respond to patient emergencies.	4%
IX. Co-managing Patients	This area assesses the candidate's ability to co-manage patients who need or have received therapies provided by other specialists.	7%
TOTAL		**100**

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CHAPTER 1. INTRODUCTION

PURPOSE OF THE COMPREHENSIVE REVIEW

Licensing boards and bureaus within the California Department of Consumer Affairs are required to ensure that examination programs being used in the California licensure process comply with psychometric and legal standards. The public must be reasonably confident that an individual passing a licensing examination has the requisite knowledge and skills to competently and safely practice in the respective profession.

The California State Board of Optometry (Board) requested that the Department of Consumer Affairs, Office of Professional Examination Services (OPES), complete a comprehensive review of the National Board of Examiners in Optometry (NBEO) licensing examinations for continued use in California. The purpose of the review was to determine if the NBEO examinations assess competencies relevant to practice in California and whether the examinations meet professional guidelines and technical standards outlined in the *Standards for Educational and Psychological Testing (APA Standards)*[1] and Business and Professions (B&P) Code section 139. In addition to the review, OPES was asked to develop a supplemental examination outline for the California laws and regulations examination.

OPES, in collaboration with the Board, requested documentation from NBEO to determine whether (a) occupational analysis[2], (b) examination development (c) passing scores[3], (d) test administration, (e) examination performance, and (f) test security procedures met professional guidelines and technical standards outlined in the *APA Standards* and B&P Code section 139.

Soroka, Krumholz, Bennet, and The National Board of Examiners Conditions Domain Task Force conducted the occupational analysis entitled *The Practice of Optometry: National Board of Examiners in Optometry Survey of Optometric Patients* used in this review.

[1] American Educational Research Association, American Psychological Association, & National Council on Measurement in Education. (1999). Standards *for Educational and Psychological Testing*. Washington, DC: American Educational Research Association.

[2] An occupational analysis is also known as a job analysis, a practice analysis, or a task analysis.

[3] A passing score is also known as a pass point, cut score, or standard score.

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CHAPTER 2. JOB ANALYSIS

STANDARDS

The most relevant Standard from the *APA Standards* relating to job analyses, as applied to credentialing or licensing examinations, is:

> **Standard 14.14**
> The content domain to be covered by a credentialing test should be defined clearly and justified in terms of the importance of the content for credential-worthy performance in an occupation or profession. A rational should be provided to support a claim that the knowledge or skills being assessed are required for credential-worthy performance in an occupation and are consistent with the purpose for which the licensing or certification program was instituted. (p. 161)

The comment following Standard 14.14 emphasizes its relevance:

> *Comment:* Some form of job or practice analysis provides the primary basis for defining the content domain. If the same examination is used in the licensure or certification people employed in a variety of settings and specialties, a number of different job settings may need to be analyzed. Although the job analysis techniques may be similar to those used in employment testing, the emphasis for licensure is limited appropriately to knowledge and skills necessary for effective practice… In tests used for licensure, skills that may be important to success but are not directly related to the purpose of licensure (e.g., protecting the public) should not be included. (p. 161)

B&P Code section 139 requires that every board, bureau, commission, and program report annually on the frequency of their occupational analysis, examination validation and development. The Department of Consumer Affairs' Examination Validation Policy states:

> Occupational analyses and/or validations should be conducted every three to seven years, with a recommended standard of five years, unless the board, program, bureau, or division can provide verifiable evidence through subject matter experts or similar procedure that the existing occupational analysis continues to represent current practice standards, tasks, and technology.

FINDINGS

Soroka et al. conducted the occupational analysis for the NBEO licensing examinations. Soroka et al. documented this study in the report, *The Practice of Optometry: National Board of Examiners in Optometry Survey of Optometric Patients (2006)*.

Occupational Analyses – Mechanism, and Timeframe

The purpose of the occupational analysis was to obtain information about patients seen in general practice. The mechanism used to achieve the stated purpose of the occupational analysis study was through a survey completed by optometrists for all patients whom they saw over a two-day period.

> Finding 1. The timeframes in which the job analysis studies were conducted are considered to be current, valid, and legally defensible. The study began in 2003 and was completed in 2006.

Occupational Analyses – Development of Survey Instrument and Sampling Plan

"An encounter form entitled *Survey of Patient Conditions Encountered in General Optometric Practice Form* was developed with input from the NBEO Conditions Task Force." (Soroka et al. p. 626) The encounter form was used to collect information regarding clinical knowledge related to conditions seen in practice. The encounter form was piloted by ten practitioners and reviewed for appearance, structure, and format.

> Finding 2. The mechanism used to develop the survey instrument and sampling plan by Soroka et al meets professional guidelines and technical standards.

Soroka et al. then established a protocol for the sampling of licensees. "Lacking a single accurate listing of practicing optometrists, a database was developed using several sources." (Soroka et al p. 626) From this database licensees were selected at random and stratified by geographic region. A total of 2,719 practitioners from across the United States were sent letters asking for participation in the occupational analysis study. Participating practitioners received a $100 honorarium upon receipt of the completed encounter forms. 480 practitioners agreed to participate, 23.7% were from the West.

> Finding 3. The intent of the sampling plan was reasonable and meets professional standards. It is not clear how many respondents were from California.

Occupational Analysis – Survey Results

After administering the *Survey of Patient Conditions Encountered in General Optometric Practice Forms,* Soroka et al. collected the data and analyzed the survey results.

> Finding 4. The typical respondent was male, worked in a solo or group practice, and saw 23 patients within the two-day period the survey was administered.

> Finding 5. OPES facilitated a focus group with subject matter experts to review the findings of the *Survey of Patient Conditions Encountered in General Optometric Practice Form.* The group reviewed the results of the top eight types of examinations and the top eight types of diagnostic procedures performed in practice nationally and in California. The group concluded that the results from the *Survey of Patient Conditions Encountered in General Optometric Practice Form* were consistent with practice in California.

Occupational Analyses – Final Examination Plans/Specifications (content outline)

According to NBEO, content outlines for each of the NBEO examinations were developed based on the results of the *Survey of Patient Conditions Encountered in General Optometric Practice Form.* OPES facilitated a focus group to establish a linkage between the encounter form and the content outlines for the examinations.

> Finding 6. The focus group facilitated by OPES determined that the information within the *Survey of Patient Conditions Encountered in General Optometric Practice Form* is linked to the current content outlines used for the NBEO examinations. The linkage between critical job activities performed by optometrists and major content areas of the examination demonstrates a sufficient level of validity, meeting professional guidelines and technical standards.

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CHAPTER 3. EXAMINATION DEVELOPMENT

STANDARDS

Examination development includes many steps within an examination program, from the development and evaluation of an occupational analysis to scoring and analyzing questions or items following the administration of an examination. Specific activities evaluated in this section of the report include item writing, linking items to the content outline/blueprint, and developing examination forms.

The most relevant standards from the *APA Standards* relating to examination development, as applied to credentialing or licensing examinations, are:

> **Standard 3.6**
> The type of items, the response formats, scoring procedures, and test administration procedures should be selected based on the purposes of the test . . . The qualifications, relevant experiences, and demographic characteristics of expert judges should also be documented. (p. 44)
>
> **Standard 3.7**
> The procedures used to develop, review, and try out items, and to select items from the item pool should be documented. If the items were classified into different categories or subtests according to the test specifications, the procedures used for the classification and the appropriateness and accuracy of the classification should be documented. (p. 44)
>
> **Standard 3.11**
> Test developers should document the extent to which the content domain of a test represents the defined domain and test specifications. (p. 45)

FINDINGS

The NBEO examinations are developed by subject matter experts that represent "a broad geographic cross-section of the optometric community, which includes faculty members, state board members, and practitioners. These subject matter experts comprise test development committees that are responsible for developing a specific portion or section of an examination part. For written examinations, this activity consists of reviewing, editing, and selecting items written by the National Board's team of consultant item writers and case writers. All test items are scrutinized for accuracy, conformance to the specific test content outline, and appropriateness for entry-level difficulty." (www.optometry.org)

> Finding 7. The criteria used to select SMEs as item writers are consistent with professional guidelines and technical standards.

Finding 8. Item writers are required to sign confidentiality agreements and are instructed about examination security, which is consistent with professional guidelines and technical standards.

Examination Development – Linkage to Exam Content Outline and Use of References

Finding 9. SMEs are instructed to frame the item topic based on the exam content outline to ensure that the exam measures concepts relevant to day-to-day practice and different cognitive levels, consistent with professional guidelines and technical standards.

Finding 10. NBEO does not create a restricted list of references for item writers. Items are verified as entry-level through consensus by the test development committee and the examination councils.

Examination Development – Examination Forms

Examination forms are constructed according to the test blueprint summary. The forms are reviewed by the test development committee and the examination councils for final approval.

Finding 11. The criteria applied to create new exam forms meet professional guidelines and technical standards.

Finding 12. Given the information provided for item writers and reviewers, it appears items discriminating between minimally competent and incompetent candidates for licensure should result from examination development activities.

Examination Development – Size of Item Banks

NBEO recognizes the importance of having a sufficient number of items within its item banks. According to NBEO, each item bank has a sufficiently large number of items to select from. (NBEO, personal communication)

Findings 13. The number of items maintained within the item banks are consistent with professional guidelines and technical standards.

CONCLUSIONS

Given the findings, the examination development conducted by NBEO demonstrates a sufficient degree of validity, meeting professional guidelines and technical standards.

CHAPTER 4. PASSING SCORES

STANDARDS

The passing score of an examination is the score that represents the cut-off that divides those candidates for licensure who are minimally competent and those who are incompetent.

The most relevant standards from the *APA Standards* relating to passing scores, points, cut scores, or standard scores as applied to credentialing or licensing examinations, are:

> **Standard 4.21**
> When cut scores defining pass-fail or proficiency categories are based on direct judgments about the adequacy of item or test performance or performance levels, the judgmental process should be designed so that judges can bring their knowledge and experience to bear in a reasonable way. (p. 60)
>
> **Standard 14.17**
> The level of performance required for passing a credentialing test should depend on the knowledge and skills necessary for acceptable performance in the occupation or profession and should not be adjusted to regulate the number or proportion of persons passing the test. (p. 162)

The supporting commentary on passing or cut scores in the *APA Standards*, Chapter 4 – Scales, Norms, and Score Comparability, states that there can be no single method for determining cut scores for all tests and all purposes. The process used should be clearly documented and defensible. The qualifications of the judges involved, and the process of selection should be part of the documentation. A sufficiently large and representative group of judges should be involved, and care must be taken to assure that judges understand what they are to do.

In addition, the supporting commentary in the *APA Standards* – Chapter 14 – Testing in Employment and Credentialing, states that the focus of credentialing standards is on "levels of knowledge and performance necessary for safe and appropriate practice" (p. 156). "Standards must be high enough to protect the public, as well as the practitioner, but not so high as to be unreasonably limiting." (p. 157)

FINDINGS

NBEO describes its passing score methodology on its Web site. (www.optometry.org)

Passing Scores – Purpose, Use of Subject Matter Experts, and Methodology

The process of establishing passing scores for licensure exams relies upon the expertise and judgment of SMEs.

NBEO uses the passing score approach referred to as the "Nedelsky" technique for their multiple choice examinations, Parts I, II, and TMOD. SMEs are trained in the Nedelsky technique and facilitated in the development of the passing score. The Nedelsky technique begins with defining minimal acceptable competence for an entry level candidate. SMEs are then asked to determine the likelihood of eliminating obviously incorrect options. OPES uses a modified Angoff approach which also begins with defining minimal acceptable competence for an entry level candidate. The focus in Angoff is on the difficulty of the question as a whole and the likelihood of the candidate answering the question correctly. The Angoff and Nedelsky methods are both considered sound methods for determining passing scores.

> Finding 14. The training of the SMEs and the application of the Nedelsky technique is consistent with professional guidelines and technical standards.
>
> Finding 15. The number of SMEs used in the passing score study met professional guidelines and technical standards.

The passing score approach used for Part III of the NBEO examinations is determined by summing the minimally acceptable performance levels for the two component sections: Clinical Skills and Patient Assessment Management (PAM). Each section contributes a specific number of points to the overall passing score. (www.optometry.org)

The Clinical Skills section "is scored using differential item criticality weights. Candidates receive the full point value for items performed correctly, and no points (zero) for items either performed incorrectly, or omitted." (www.optmetry.org). "The PAM section is scored using, the item criticality scale of the Clinical Skills section." (www.optmetry.org)

CONCLUSIONS

Given the findings, the passing score process conducted by NBEO demonstrates a sufficient degree of validity, meeting professional guidelines and technical standards.

CHAPTER 5. TEST ADMINISTRATION

STANDARDS

The most relevant standards from the *APA Standards* relating to test administration, as applied to credentialing or licensing examinations, are:

Standard 5.1
Test administrators should follow carefully the standardized procedures for administration and scoring specified by the test developer, unless the situation or a test taker's disability dictates that an exception should be made. (p. 63)

Standard 5.2
Modifications or disruptions of standardized test administration procedures or scoring should be documented. (p. 63)

Standard 5.5
Instructions to test takers should clearly indicate how to make responses. Instructions should also be given in the use of any equipment likely to be unfamiliar to test takers. Opportunity to practice responding should be given when equipment is involved, unless use of the equipment is being assessed. (p. 63)

FINDINGS

NBEO publishes its *Chief Proctor Manual,* which contains the recommended administration polices and procedures for paper-pencil examinations.

Finding 16. The manual is detailed and comprehensive and includes the following subject areas:

- Introduction (exam structure, chief proctor responsibilities, Americans with Disabilities Act)
- Pre-exam (proctors, facility standards, testing conditions)
- Materials (receiving test booklets, answer sheets, test critique forms, rosters, seating charts)
- Security, Audit (suspicious behavior, preventing candidate misconduct)
- Exam Administration (registration, admission, personal belongings)
- Post-exam (check out, prepare to return materials, shipping exam materials)

Test Administration –Test Centers

NBEO administers each part of its three-part examination twice per year. The multiple choice portions and clinical portion of the examinations are administered at test centers located in 18 states across the United States. (www.optometry.org)

There are 18 test centers across the nation with one center in California (Berkeley).

> Finding 17. It appears that NBEO provides candidates access to test centers with trained proctors.

Test Administration – Registration of Candidates

NBEO has a detailed registration process that can be found on its Web site. (www.optometry.org)

> Finding 18. The NBEO registration process appears straightforward. The information available to candidates is detailed and thorough, stating NBEO policies when necessary.

Test Administration – Special Accommodations and Arrangements

NBEO and the respective jurisdiction approve any necessary accommodations under the Americans with Disabilities Act (ADA). (www.optometry.org)

> Finding 19. The special accommodation procedure appears to meet professional guidelines and technical standards.

Test Administration – Candidate Feedback

"The National Board has a formal procedure that allows and encourages all candidates to challenge the content of specific test items during written examinations, or procedural matters during the Clinical Skills section of Part III. For written examinations, space is provided on the back of each answer sheet for candidates to note possible ambiguities in individual test items or to make any other comments about examination quality issues. For Clinical Skills, candidates are given an incident report form, which they can complete at the end of the examination. Candidate comments are used by the appropriate examination council for review and possible action." (www.optometry.org)

Test Administration – Exam Security

NBEO's *Chief Proctor Manual* explains the administrative procedures that have been established to accommodate emergency closures, weather-related situations, and security-related incidents.

In addition, NBEO requires candidates to sign its *Cheating Statement.* By signing this statement the candidate affirms an understanding of what cheating entails and the consequences of those actions.

> Finding 21. The exam security protocols in place as they pertain to test administration appear to meet professional guidelines and technical standards (see Chapter 8: Test Security for additional information).

CONCLUSIONS

Given the findings, the test administration protocols in place by NBEO appear to meet professional guidelines and technical standards.

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CHAPTER 6. EXAMINATION PERFORMANCE

STANDARDS

The most relevant standards from the *APA Standards* relating to examination performance, as applied to credentialing or licensing examinations, are:

> **Standard 2.1**
> For each total score, subscore, or combination of scores that is to be interpreted, estimates of relevant reliabilities and standard errors of measurement or test information functions should be reported. (p. 31)

> **Standard 3.9**
> When a test developer evaluates the psychometric properties of items, the classical or item response theory (IRT) model used for evaluating the psychometric properties of items should be documented. The sample used for estimating item properties should be described and should be of adequate size and diversity for the procedure. The process by which items are selected and the data used for item selection, such as item difficulty, item discrimination, and/or item information, should also be documented. When IRT is used to estimate item parameters in test development, the item response model, estimation procedures, and evidence of model fit should be documented. (pp. 44-45)

FINDINGS

NBEO posts the results of the examinations on its Web site. (www.optmetry.org)

Examination Performance – Analyses

> Finding 22. Analyses are performed on the examinations to ensure all scored items are valid. NBEO uses classical item statistics to flag poorly performing items. Flagged items are then reviewed and a decision is made whether to retain the item(s) as scored.

> Finding 23. Descriptive test statistics (e.g., mean, standard deviation, standard error of measurement, test reliability, and decision consistency reliability) were calculated. Resulting statistics were typical for licensure examinations.

CONCLUSIONS

The steps taken by NBEO to evaluate examination performance are valid and legally defensible, meeting professional guidelines and technical standards.

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CHAPTER 7. INFORMATION AVAILABLE TO CANDIDATES

STANDARDS

The most relevant standards from the *APA Standards* relating to candidate information, as applied to credentialing or licensing examinations, are:

> **Standard 8.1**
> Any information about test content and purposes that is available to any test taker prior to testing should be available to *all* test takers. Important information should be available free of charge and in accessible formats. (p. 86)

> **Standard 8.2**
> Where appropriate, test takers should be provided, in advance, as much information about the test, the testing process, the intended test use, test scoring criteria, testing policy, and confidentiality protection as is consistent with valid responses. (p. 86)

FINDINGS

The NBEO Web site is located at www.optometry.org. It provides extensive information about NBEO as a central resource for information. NBEO staff have direct access to the Web site and can make changes and updates as necessary.

> Finding 24. On the NBEO Web site, candidates can locate extensive examination information by clicking on the following tabs located on the homepage:
>
> Exam Content (exam content outlines for each exam)
> Exam Information (schedules, State requirements, deadlines, fees, eligibility)
> Test Day (admissions, locations, candidate instructions)
> Scoring Information (view scores, scoring methods, statistical reports)
> Registering (register, instructions, information)
> Examiners (how to become an examiner and current examiners)
> General Information (message from NBEO President)
> Personal Directory (Board, staff, exam committee, exam council, college liaison, state board offices)

> Finding 25. The NBEO Web site provides extensive information to candidates regarding all aspects of the examinations and testing process.

CONCLUSIONS

Given the findings, the information provided to candidates about the NBEO examination program is comprehensive, meeting professional guidelines.

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CHAPTER 8. TEST SECURITY

STANDARDS

The most relevant standards from the *APA Standards* relating to test security, as applied to credentialing or licensing examinations, are:

Standard 5.6
Reasonable efforts should be made to assure the integrity of test scores by eliminating opportunities for test takers to attain scores by fraudulent means. (p. 64)

Standard 5.7
Test users have the responsibility of protecting the security of test materials at all times. (p. 64)

FINDINGS

NBEO's *Chief Proctor Manual* provides detailed information about security procedures for test administration. Candidates are also informed about test security during test administration on the NBEO Web site. (www.optometry.org)

Finding 26. The *Chief Proctor Manual* addresses the following areas regarding security:

- Proctor training
- Preventing candidate misconduct
- Confidentiality agreement
- Shipping and receiving test booklets and answer sheets

Finding 27. NBEO requires candidates to provide current and valid identification to sit for the exams. Acceptable forms of identification include a valid driver's license, a valid passport, or school ID with photo and signature imbedded into the card. Candidates are prohibited from bringing reference materials, books or notes, electronic devices, food, or purses into the testing room

CONCLUSIONS

Given the findings, the policies and procedures outlined in the NBEO *Chief Proctor Manual* meet professional guidelines and technical standards.

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CHAPTER 9. COMPARISON OF THE BOARD EXAMINATION PLAN AND NBEO EXAM CONTENT OUTLINE

UTILIZATION OF EXPERTS

A meeting was held on June 28-29, 2009 to critically compare and evaluate the California State Board of Optometry examination plan and the NBEO examination content outlines. The Board, with direction from OPES, recruited SMEs to participate in the meeting. Nine SMEs participated in the meeting.

The SMEs represented both northern and southern California, rural and urban areas, had been licensed from almost one year to 57 years (mean = 28 years licensed), and worked full-time as optometrists in various setting. SMEs completed security agreement and personal data forms which are on file with OPES and document additional SME information.

An orientation was provided by OPES stating the purpose of the meeting, the role of the SMEs, and the project background leading to the meeting. Once SMEs understood the purpose of the meeting, they independently reviewed both the Board examination plan and the NBEO exam content outlines.

After independent review of the documents, the OPES facilitator worked with the group to identify similarities and differences between the examination plan and examination content outlines.

FINDINGS

Finding 28. The SMEs performed a comparison of the documents and concluded that the Board examination plan and the NBEO exam content outlines are congruent in assessing knowledge required for entry-level practice in California.

CONCLUSIONS

Given the findings, the Board examination plan and the NBEO clinical exam content outlines are congruent. The NBEO exam content outlines meet professional guidelines and technical standards.

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CHAPTER 10 DEVELOPMENT OF THE CALIFORNIA LAWS AND REGULATIONS EXAMINATION OUTLINE

REVIEW OF CALIFORNIA OPTOMETRIST EXAMINATION SPECIFICATIONS

During the June 28-29, 2009 meeting the SMEs were asked to review the examination specifications developed by OPES in the 2009 California Optometrist occupational analysis and to identify task and knowledge statements relevant to California laws and regulations for optometric practice.

SELECTION OF TASK STATEMENTS

The SMEs determined that 43 task statements from the 2009 California Optometrist examination specifications should be included in the California laws and regulations examination outline. Of the eight original content areas only seven are covered in the examination outline. Content areas V. Low Vision and VI. Binocular Therapy and/or Vision Training were dropped due to low ratings and lack of content related to laws and regulations.

SELECTION OF KNOWLEDGE STATEMENTS

The SMEs determined that 97 knowledge statements from the 2009 California Optometrist examination specifications should be included in the California laws and regulations Examination outline.

LINKAGE OF KNOWLEDGE STATEMENTS TO JOB TASKS

The last step in the development of the California laws and regulations examination outline was to establish a linkage between job tasks and knowledge statements to define the content areas in examination outline. The SMEs achieved the linkage by assigning specific knowledge statements to specific job task so that every task had a set of knowledge statements associated with it, and every knowledge statement was associated with a task.

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CHAPTER 11. EXAMINATION OUTLINE

OVERVIEW OF EXAMINATION OUTLINE

The California laws and regulations examination outline is structured into seven content areas (Table 2). Each content area is weighted based on the task critical indices (Appendix B) established from the 2009 California Optometrist Occupational Analysis. Each content area is weighted proportionately relative to other content areas. The examination outline specifies the job tasks related to laws and regulations that a California licensed optometrist is expected to master at the time of licensure. The California laws and regulations examination should be based directly on the examination outline.

CONTENT AREA WEIGHTS

The relative weight of the content areas in the California laws and regulations examination outline represents the sum of the critical task indices for a content area divided by the overall sum of the critical task indices for all tasks. For example, if the sum of the critical task indices for "Patient Examination" in the examination outline is 238.83, the weight of the content area (33%) is calculated by dividing the sum of the critical task indices (238.83) by the overall sum of the critical task indices (730.95).

TABLE 2 – SUMMARY OF CONTENT AREAS

Content Area		Number of Tasks in Content Area	Task Indices in Content Area	Area Weight (%)
I.	Patient Examinations	12	238.33	33%
II.	Diagnoses and Treatment Plans	4	71.22	10%
III.	Spectacles and Protective Eyewear	2	37.17	5%
IV.	Contact Lenses	6	112.94	15%
V.	Management of eye disorders and referrals	13	190.86	26%
VI.	Patient Emergencies	2	27.94	4%
VII.	Co-managing Patients	4	51.99	7%
Totals		**43**	**730.95**	**100%**

TABLE 3 –EXAMINATION OUTLINE FOR CALIFORNIA LAWS AND REGULATIONS EXAMINATION

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I. Patient Examinations (33%) - This area assesses the candidate's ability to examine a patient's visual, ocular, and general health.

Job Task	*Associated Knowledge*
T1. Take a patient history including current health status [e.g., visual and medical history, personal and family history, presenting complaint(s)].	K1. Knowledge of the types of information that constitute a comprehensive, useful patient history. K2. Ability to communicate with a patient or a patient's caregiver so as to elicit a clearly stated presenting complaint, a useful account of symptoms, and adequately detailed ocular, medical, and family histories. K3. Knowledge of the ocular manifestations of systemic diseases [e.g., the susceptibility to dry eye and meibomitis of middle-aged, arthritic women (Sjogren's syndrome), the symptoms associated with sexually transmitted diseases such as syphilis]. K4. Knowledge of congenital and developmental syndromes (e.g., fetal-alcohol, Down's, cerebral palsy, and their characteristic effects on vision). K5. Ability to interpret a presenting problem in the light of the patient's ocular, medical, and family histories (e.g., to decide whether the current problem is new or an expected continuation of problems past).
T6. Document patient's initial visual acuities.	K11. Ability to determine the visual acuity of pediatric, illiterate, uncooperative, malingering, or low-vision patients as well as of normal adult patients.
T7. Test patient's pupillary light responses to determine neurological integrity.	K12. Ability to test a patient's pupillary responses to light for pupillary anomalies. K13. Knowledge of pupillary anomalies (e.g., afferent pupillary defect, and their underlying causes).
T8. Perform cover test to assess patient's binocular alignment and ocular movement (e.g., strabismus).	K14. Ability to recognize symptoms and clinical signs of binocular dysfunction. K15. Ability to perform and interpret tests for defects in binocular alignment, eye movement, or versions.
T9. Test patient's visual fields for gross deficits.	K16. Ability to perform confrontational visual-fields tests to detect gross visual-field defects and to distinguish malingering from hysterical patients.

I. Patient Examinations (33%) - This area assesses the candidate's ability to examine a patient's visual, ocular, and general health.

Job Task	*Associated Knowledge*
T11. Perform objective measurement (e.g., retinoscopy) to assess each eye's refractive status.	K20. Ability to use a retinoscope (e.g., to detect anomalies in the ocular media).
T12. Perform subjective refraction to assess each eye's refractive status at distance and near.	K21. Knowledge of interactive refraction procedure (i.e., of what to do or say after each response from a patient, of how to help the patient make choices). K22. Ability to use a phoropter to obtain subjective refractions at both distance and near. K23. Ability to use Jackson cross cylinders to refine axis and power measurements, noting barely observable differences.
T13. Perform binocular test(s) (e.g., phorias, ductions, tropias, suppression, and range of convergence and divergence at distance and near) to determine the degree of ocular coordination.	K24. Knowledge of the interaction between accommodation and convergence and its implications for prescribing lenses. K25. Ability to apply appropriate tests for detecting eye suppression. K26. Ability to determine a patient's near points of convergence and accommodation. K27. Ability to measure the range of a patient's clear vision at near.
T15. Measure patient's intraocular pressures to screen for pressure related conditions.	K30. Knowledge of topical anesthetics or dye/anesthetic mixtures useful in preparing a patient's eyes for Goldmann tonometry. K31. Knowledge of the possible adverse effects of instilling a dye, an anesthetic, or a dye/anesthetic mixture into a patient's eyes and of appropriate remedies. K32. Knowledge of Goldmann tonometry and other tonometric methods.
T17. Use diagnostic pharmaceutical agents (DPAs) as needed to facilitate refractive and ocular health assessments.	K32. Knowledge of Goldmann tonometry and other tonometric methods. K35. Knowledge of mydriatics and cycloplegics and their indications and contraindications, together with their possible adverse effects, and appropriate managements of those effects.

I. Patient Examinations (33%) - This area assesses the candidate's ability to examine a patient's visual, ocular, and general health.

Job Task	*Associated Knowledge*
T19. Perform keratometry as needed to determine the curvature of the cornea.	K40. Knowledge of keratometers and their uses in determining corneal toricity, corneal integrity, and tear film integrity.
T22. Perform visual-fields tests as indicated by history or prior test results.	K41. Ability to measure a patient's visual fields with perimeter and tangent screens, using static and kinetic stimuli, and to interpret the measurements.

II. Diagnoses and Treatment Plans (10%) - This area assesses the candidate's ability to make diagnoses and prepare treatment plans.

Job Task	*Associated Knowledge*
T30. Determine and provide a treatment plan, which may include, but is not limited to, spectacles or contact lenses, vision therapy, low-vision rehabilitation, medication, or observation, referral, and follow-up.	K70. Knowledge of the treatments available for specific common eye diseases and of treatment regimens appropriate to particular eye diseases and patient profiles. K71. Knowledge of treatment alternatives for specific common eye diseases and the risks, benefits, costs, and prognosis for each alternative. K72. Ability to explain all refractive treatment options, including their risks and relative costs, the prognosis with each, and the time required for each to succeed. K73. Ability to communicate treatment options clearly and effectively to a patient or the patient's parents or caregivers.
T31. Prepare treatment plans that provide patient options and explain the risks, benefits, prognoses, and relative costs with each option.	K70. Knowledge of the treatments available for specific common eye diseases and of treatment regimens appropriate to particular eye diseases and patient profiles. K71. Knowledge of treatment alternatives for specific common eye diseases and the risks, benefits, costs, and prognosis for each alternative. K72. Ability to explain all refractive treatment options, including their risks and relative costs, the prognosis with each, and the time required for each to succeed. K73. Ability to communicate treatment options clearly and effectively to a patient or the patient's parents or caregivers.
T32. Explain to a patient refractive treatment options (e.g., spectacles, contact lenses, orthokeratology, refractive surgery, and vision therapy).	K72. Ability to explain all refractive treatment options, including their risks and relative costs, the prognosis with each, and the time required for each to succeed. K73. Ability to communicate treatment options clearly and effectively to a patient or the patient's parents or caregivers.

II. Diagnoses and Treatment Plans (10%) - This area assesses the candidate's ability to make diagnoses and prepare treatment plans.

Job Task	*Associated Knowledge*
T65. Perform refractive examinations for both near and distance vision, using a phoropter, trial lenses, and/or low-vision devices.	K149. Knowledge of the etiology of low vision (e.g., genetic or acquired causes). K150. Ability to recognize the visual conditions typical of low-vision patients (e.g., retinitis pigmentosa, macular degeneration). K151. Knowledge of the extent to which the effects of the ocular pathologies associated with low vision are remediable. K152. Knowledge of the legal definition of blindness. K153. Ability to elicit a low-vision patient's goals in seeking the help of an optometrist and to determine what goals can be realized. K154. Knowledge of the psychosocial aspects of low vision. K156. Knowledge of how to modify refractive examinations as needed for low-vision patients.

III. Spectacles And Protective Eyewear (5%) - This area assesses the candidate's ability to analyze and prescribe eyewear according to the needs of the patient.

Job Task	*Associated Knowledge*
T40. Provide patient with a written spectacle prescription as required by law.	K95. Knowledge of ANSI standards for ophthalmic goods. K96. Knowledge of available lens choices and their inherent advantages and disadvantages (e.g., high-index lenses, polycarbonate lenses). K97. Knowledge of the availability, advantages, and disadvantages of particular lens types, designs, and materials for particular patients (e.g., severe myopes, severe hyperopes). K98. Knowledge of the types of multifocals available and the measurements and dispensing techniques needed for each type. K100. Knowledge of how base curve, thickness, and vertex distance affect image size and patient comfort. K103. Knowledge of available frame materials, types, and styles (i.e., sport, safety). K104. Knowledge of frame styles suitable for specific corrections and lens types (e.g., a high plus/minus, multifocal frame). K105. Knowledge of the care and limitations of specific lenses, tints, and coatings (i.e., that special lens cloths and cleaners may be needed, that most tints and coatings can be applied only during lens manufacture). K109. Knowledge of OSHA standards for safety eyewear. K111. Knowledge of common needs for protective eyewear (e.g., sports, vocations). K193. Knowledge of how lenses are fabricated and of how to verify that the prisms in new spectacles match the prescription.
T43. Explain the need for protective eyewear and eyewear alternatives (e.g., safety lenses, UV coating) to help a patient obtain adequate protection.	K109. Knowledge of OSHA standards for safety eyewear. K111. Knowledge of common needs for protective eyewear (e.g., sports, vocations).

IV. Contact Lenses (15%) - This area assesses the candidate's ability to fit and prescribe contact lenses and educate patients in their handling, care, and use.

Job Task	*Associated Knowledge*
T45. Review patient's history to evaluate problems with contact lenses and conditions, allergies, or medications that might affect contact lens use.	K112. Ability to judge whether a patient has the dexterity in handling lenses, inserting and removing lenses, and applying solutions that wearing contact lenses requires. K113. Knowledge of eye conditions, allergies, and sensitivities to medication that contraindicate contact lens wear. K114. Knowledge of common medications that affect contact lens wear (e.g., knowledge that birth control pills may adversely affect tear quality). K115. Knowledge of allergic reactions to contact lens materials and solutions and of how to minimize or prevent them. K116. Knowledge of the significance of environmental conditions for contact lens wear.
T51. Perform keratometry to measure a patient's corneas, corneal toricity, and the contribution of each cornea to total astigmatism and total refraction.	K122. Ability to take keratometric measurements appropriate to determining a contact lens prescription. K123. Ability to use keratometric measurements to evaluate corneal astigmatism and the contribution of the cornea to total astigmatism and total refraction.
T55. Determine the type of contact lens most appropriate for a patient (e.g., soft vs. RGP, spherical vs. toric).	K130. Knowledge of the types and characteristics of contact lenses currently available to patients (e.g., knowledge of the water content and chemical qualities of particular lens materials). K131. Knowledge of how each available type of contact lens improves vision (e.g., rigid as opposed to soft).
T56. Calculate the parameters of the lenses to be prescribed from diagnostic data.	K133. Knowledge that refractive, keratometric, and test measurements and diagnostic lens fittings can be used to determine lens choices for a patient. K135. Ability to determine parameters for contact lenses that will provide a patient with clear, comfortable, and safe vision.

IV. Contact Lenses (15%) - This area assesses the candidate's ability to fit and prescribe contact lenses and educate patients in their handling, care, and use.

Job Task	*Associated Knowledge*
T59. Evaluate the fit and movement of contact lenses.	K137. Ability to evaluate soft lenses with a slit lamp (e.g., centration, movement, and physiological response). K139. Knowledge of how to change contact lens parameters to improve the fit.
T62. Monitor and evaluate a patient's physiological response to contact lens wear with dyes and instruments.	K142. Knowledge of contact lens care products appropriate for particular patients and lenses and of how each should be used. K143. Knowledge of how to monitor and interpret a patient's histological and physiological responses to wearing contact lenses. K144. Ability to assess a patient's subjective responses to contact lens wear. K145. Knowledge of the causes of and remedies for common patient complaints about contact lenses.

VII. Management of Eye Disorders and Referrals (26%) - This area assesses the candidate's ability to manage and treat eye disorders and/or refer patients.

Job Task	*Associated Knowledge*
T79. Recommend lubricants (e.g., artificial tears) for patients with dry eyes).	K203. Knowledge of ocular lubricants (e.g., artificial tears as a palliative for eye dryness).
T80. Insert collagen punctal plugs to palliate eye dryness and to test whether permanent plugs might provide long-term relief.	K204. Knowledge of collagen punctal plugs as a way to impede tear drainage temporarily and relieve eye dryness. K205. Ability to apply temporary punctal plugs safely and effectively and to judge from the patient's response whether to refer for permanent plugs.
T81. Prescribe topical, nonsteroidal anti-inflammatories and topical antibiotics for eye diseases of the anterior segment (e.g., bacterial conjunctivitis).	K201. Knowledge of the therapeutic drugs that an optometrist may administer and of the conditions for which they may be used under California law. K202. Knowledge of the indications and contraindications for common therapeutic drugs; the appropriate dosages, administration schedules, and durations of use; the possible side effects; and the appropriate responses to side effects.
T82. Prescribe topical or oral antiallergenics (e.g., for allergic conjunctivitis).	K201. Knowledge of the therapeutic drugs that an optometrist may administer and of the conditions for which they may be used under California law. K202. Knowledge of the indications and contraindications for common therapeutic drugs; the appropriate dosages, administration schedules, and durations of use; the possible side effects; and the appropriate responses to side effects.
T83. Prescribe topical or oral medications for infectious peripheral corneal ulcers, corneal abrasions, and corneal-surface disease.	K201. Knowledge of the therapeutic drugs that an optometrist may administer and of the conditions for which they may be used under California law. K202. Knowledge of the indications and contraindications for common therapeutic drugs; the appropriate dosages, administration schedules, and durations of use; the possible side effects; and the appropriate responses to side effects.

VII. Management of Eye Disorders and Referrals (26%) - This area assesses the candidate's ability to manage and treat eye disorders and/or refer patients.

Job Task	*Associated Knowledge*
T84. Prescribe topical or oral medications to treat blepharitis.	K201. Knowledge of the therapeutic drugs that an optometrist may administer and of the conditions for which they may be used under California law. K202. Knowledge of the indications and contraindications for common therapeutic drugs; the appropriate dosages, administration schedules, and durations of use; the possible side effects; and the appropriate responses to side effects.
T85. Prescribe oral medication to treat chalazion if heat and digital massage are not effective.	K201. Knowledge of the therapeutic drugs that an optometrist may administer and of the conditions for which they may be used under California law. K202. Knowledge of the indications and contraindications for common therapeutic drugs; the appropriate dosages, administration schedules, and durations of use; the possible side effects; and the appropriate responses to side effects. K206. Knowledge of good eyelid hygiene as prophylaxis and part of therapy for lid diseases.
T86. Remove nonperforating foreign bodies from a cornea with appropriate instruments.	K209. Knowledge of instruments and procedures for removing a foreign body from an eye and of how to use them safely and effectively. K213. Knowledge of patient conditions for which a referral is legally necessary.
T87. Remove foreign bodies from the sclera, eyelid, or adenxa with appropriate instruments.	K209. Knowledge of instruments and procedures for removing a foreign body from an eye and of how to use them safely and effectively. K213. Knowledge of patient conditions for which a referral is legally necessary.
T88. Epilate eyelashes to treat trichiasis.	K210. Knowledge of instruments and procedures for epilating eyelashes to relieve trichiasis, of how to use a lid everter and epilation tweezers safely and effectively.

VII. Management of Eye Disorders and Referrals (26%) - This area assesses the candidate's ability to manage and treat eye disorders and/or refer patients.

Job Task	*Associated Knowledge*
T89. Monitor glaucoma suspects and glaucoma patients and refer them to specialists as needed.	K200. Knowledge of the disease processes that produce common eye disorders (e.g., conjunctivitis, iritis, uveitis, glaucoma, diabetic retinopathy). K223. Knowledge of ocular and systemic diseases that threaten eyesight, health, or life; and of appropriate preventive care.
T90. Refer disorders of the anterior segment and disorders of the posterior segment to appropriate specialists as the patient's needs dictate and as the law requires.	K213. Knowledge of patient conditions for which a referral is legally necessary. K214. Knowledge of appropriate referrals of particular eye or vision disorders. K216. Knowledge of recurrent symptoms or signs that call for referral (e.g., recurrent eye hemorrhages, recurrent headaches). K217. Ability to write appropriate referral letters, including the information about the patient that should accompany the referral. K218. Knowledge of the points in the development of particular conditions at which referral for surgery is appropriate (e.g., of appropriate timelines for referring a cataract or diabetic retinopathy). K223. Knowledge of ocular and systemic diseases that threaten eyesight, health, or life; and of appropriate preventive care.
T91. Refer newly suspected systemic diseases to appropriate specialists as the patient's needs dictate and as the law requires.	K217. Ability to write appropriate referral letters, including the information about the patient that should accompany the referral. K223. Knowledge of ocular and systemic diseases that threaten eyesight, health, or life; and of appropriate preventive care.

VIII. Patient Emergencies (4%) - This area assesses the candidate's ability to recognize and respond to patient emergencies.

Job Task	*Associated Knowledge*
T99. Perform examinations directed to the presenting ocular emergency (e.g., check for anterior-chamber reaction in a traumatized eye, dilate a traumatized eye and check for retinal detachment).	K224. Ability to judge from a patient's symptoms whether the patient should be seen immediately and to train office staff to make the same judgment and to err on the side of the patient's safety. K226. Knowledge of extended examination procedures for common ocular emergencies. K228. Knowledge of how to recognize true emergencies (i.e., conditions immediately threatening to a patient's eyesight, health, or life). K231. Ability to recognize or determine that a particular emergency requires an immediate referral. K232. Knowledge of lawful means of palliating and stabilizing a patient's condition to facilitate an emergency referral.

VIII. Patient Emergencies (4%) - This area assesses the candidate's ability to recognize and respond to patient emergencies.

Job Task	*Associated Knowledge*
T101. Refer a true emergency for immediate medical care.	K224. Ability to judge from a patient's symptoms whether the patient should be seen immediately and to train office staff to make the same judgment and to err on the side of the patient's safety. K227. Ability to recognize clinical signs of a potential emergency (e.g., in a patient who is diabetic, hypertensive, or glaucomatous). K228. Knowledge of how to recognize true emergencies (i.e., conditions immediately threatening to a patient's eyesight, health, or life). K229. Knowledge of the management of a patient who presents with a vasovagal reaction, low blood sugar level, or epileptic seizure. K230. Knowledge of the management of a patient with an adverse reaction (e.g., anaphylactic shock, breathing difficulties, anesthesia, dilating drops). K231. Ability to recognize or determine that a particular emergency requires an immediate referral. K232. Knowledge of lawful means of palliating and stabilizing a patient's condition to facilitate an emergency referral.

IX. CO-MANAGING PATIENTS (5%): This area assesses the candidate's ability to co-manage patients with other specialists.

Job Task	*Associated Knowledge*
T103. Co-manage patient with developing or advanced pathology (e.g., a patient with developing cataracts, background diabetic retinopathy).	K233. Ability to co-manage a patient with a developing or advanced ocular pathology. K234. Knowledge of indications for referral associated with developing eye disorders (e.g. diabetic retinopathy, glaucoma, macular degeneration).
T104. Establish a co-management protocol and refer patient for corrective surgery or other remedial therapy.	K233. Ability to co-manage a patient with a developing or advanced ocular pathology. K234. Knowledge of indications for referral associated with developing eye disorders (e.g. diabetic retinopathy, glaucoma, macular degeneration). K237. Knowledge of pre and post operative optometric care for patients referred for surgery (e.g., cataract, refractive, or glaucoma surgery). K240. Knowledge of therapeutic complications and of their remedies, where remedies exist.
T105. Co-manage patient following remedial therapy (e.g., check whether a prescribed medication is being used, whether the medication should be altered).	K239. Knowledge of the need to interview a returning referred patient regarding post-therapy discomfort, compliance with the therapeutic plan, and quality of vision. K241. Knowledge of common therapies for which referrals are made (e.g., for a cataract-removal case, refractive surgery). K242. Knowledge of appropriate intervals for follow-up checks of particular co-management patients. K243. Knowledge of appropriate medications for common conditions and of the California laws regulating optometrists' use of therapeutic drugs.
T107. Co-manage patients with systemic diseases (e.g., hypertension, diabetes) with their physicians.	K233. Ability to co-manage a patient with a developing or advanced ocular pathology. K235. Knowledge of indications for referral associated with systemic diseases (e.g., multiple sclerosis, Grave's disease). K244. Knowledge of common patient conditions requiring referral, of the signs and symptoms of a significant improvement or cure.

CHAPTER 12. CONCLUSIONS

COMPREHENISVE REVIEW OF THE NBEO EXAMINATION PROGRAM

OPES completed a comprehensive analysis and evaluation of the documents provided by NBEO. The procedures used to establish and support the validity and defensibility of the NBEO exam program components (i.e., practice analysis, examination development, passing scores, test administration, examination performance, and test security) were found to meet professional guidelines and technical standards outlined in the *Standards for Educational and Psychological Testing* and Business & Professions Code section 139.

Given the findings of the NBEO exam program, the California State Board of Optometry should continue use of NBEO examinations for licensure in California.

CALIFORNIA LAWS AND REGULATIONS EXAMINATION OUTLINE

By adopting the California laws and regulations examination outline contained in this report, the Board ensures that its examination program reflects specific areas of laws and regulations related to practice in California. This report provides all documentation necessary to verify that the analysis has been implemented in accordance with legal, professional, and technical standards.

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LIST OF APPENDICES

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APPENDIX A – SCALE MEANS AND CRITICAL INDICES FOR TASKS

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I. PATIENT EXAMINATION

	TASK	Mean Freq.	Mean Impt.	Mean Critical Index
1.	Take a patient history including current health status [e.g., visual and medical history, personal and family history, presenting complaint(s)].	4.74	4.82	23.22
6.	Document patient's initial visual acuities.	4.74	4.65	22.45
7.	Test patient's pupillary light responses to determine neurological integrity.	4.77	4.63	22.42
8.	Perform cover test to assess patient's binocular alignment and ocular movement (e.g., strabismus).	4.54	4.22	19.68
9.	Test patient's visual fields for gross deficits.	4.48	4.37	20.13
11.	Perform objective measurement (e.g., retinoscopy) to assess each eye's refractive status.	3.89	3.93	16.62
12.	Perform subjective refraction to assess each eye's refractive status at distance and near.	4.91	4.84	23.91
13.	Perform binocular test(s) (e.g., phorias, ductions, tropias, suppression, and range of convergence and divergence at distance and near) to determine the degree of ocular coordination.	3.36	3.31	12.44
15.	Measure patient's intraocular pressures to screen for pressure related conditions.	4.88	4.81	23.62
17.	Use diagnostic pharmaceutical agents (DPAs) as needed to facilitate refractive and ocular health assessments.	4.54	4.66	21.46
19.	Perform keratometry as needed to determine the curvature of the cornea.	3.67	3.57	14.20
22.	Perform visual-fields tests as indicated by history or prior test results.	4.10	4.28	18.68

II. DIAGNOSES AND TREATMENT PLANS

	TASK	Mean Freq.	Mean Impt.	Mean Critical Index
30.	Determine and provide a treatment plan, which may include, but is not limited to, spectacles or contact lenses, vision therapy, low-vision rehabilitation, medication, or observation, referral, and follow-up.	4.73	4.72	22.71
31.	Prepare treatment plans that provide patient options and explain the risks, benefits, prognoses, and relative costs with each option.	4.31	4.39	19.63
32.	Explain to a patient refractive treatment options (e.g., spectacles, contact lenses, orthokeratology, refractive surgery, and vision therapy).	4.46	4.43	20.35
65.	Perform refractive examinations for both near and distance vision, using a phoropter, trial lenses, and/or low-vision devices.	2.07	2.58	8.53

III. SPECTACLES AND PROTECTIVE EYEWEAR

	TASK	Mean Freq.	Mean Impt.	Mean Critical Index
40.	Provide patient with a written spectacle prescription as required by law.	4.57	4.22	19.93
43.	Explain the need for protective eyewear and eyewear alternatives (e.g., safety lenses, UV coating) to help a patient obtain adequate protection.	3.98	4.13	17.24

IV. CONTACT LENSES

	TASK	Mean Freq.	Mean Impt.	Mean Critical Index
45.	Review patient's history to evaluate problems with contact lenses and conditions, allergies, or medications that might affect contact lens use.	4.36	4.37	19.88
51.	Perform keratometry to measure a patient's corneas, corneal toricity, and the contribution of each cornea to total astigmatism and total refraction.	3.72	3.80	16.00
55.	Determine the type of contact lens most appropriate for a patient (e.g., soft vs. RGP, spherical vs. toric).	4.42	4.37	20.42
56.	Calculate the parameters of the lenses to be prescribed from diagnostic data.	4.06	4.09	18.03
59.	Evaluate the fit and movement of contact lenses.	4.60	4.51	21.60
62.	Monitor and evaluate a patient's physiological response to contact lens wear with dyes and instruments.	3.89	3.99	17.01

VII. MANAGEMENT OF EYE DISORDERS AND REFERALS

	TASK	Mean Freq.	Mean Impt.	Mean Critical Index
79.	Recommend lubricants (e.g., artificial tears) for patients with dry eyes).	4.62	4.50	21.12
80.	Insert collagen punctal plugs to palliate eye dryness and to test whether permanent plugs might provide long-term relief.	1.73	2.62	6.59
81.	Prescribe topical, nonsteroidal anti-inflammatories and topical antibiotics for eye diseases of the anterior segment (e.g., bacterial conjunctivitis).	3.83	4.40	17.52
82.	Prescribe topical or oral antiallergenics (e.g., for allergic conjunctivitis).	3.97	4.31	17.92
83.	Prescribe topical or oral medications for infectious peripheral corneal ulcers, corneal abrasions, and corneal-surface disease.	3.55	4.34	16.38
84.	Prescribe topical or oral medications to treat blepharitis.	3.40	4.03	14.72
85.	Prescribe oral medication to treat chalazion if heat and digital massage are not effective.	2.34	3.24	9.82
86.	Remove nonperforating foreign bodies from a cornea with appropriate instruments.	2.66	3.87	11.66
87.	Remove foreign bodies from the sclera, eyelid, or adenxa with appropriate instruments.	2.39	3.62	10.27
88.	Epilate eyelashes to treat trichiasis.	2.89	3.74	11.86
89.	Monitor glaucoma suspects and glaucoma patients and refer them to specialists as needed.	3.70	4.45	17.49
90.	Refer disorders of the anterior segment and disorders of the posterior segment to appropriate specialists as the patient's needs dictate and as the law requires.	3.90	4.64	18.42
91.	Refer newly suspected systemic diseases to appropriate specialists as the patient's needs dictate and as the law requires.	3.64	4.59	17.09

VIII. PATIENT EMERGENCIES

	TASK	Mean Freq.	Mean Impt.	Mean Critical Index
99.	Perform examinations directed to the presenting ocular emergency (e.g., check for anterior-chamber reaction in a traumatized eye, dilate a traumatized eye and check for retinal detachment).	3.37	4.36	15.75
101.	Refer a true emergency for immediate medical care.	2.59	4.49	12.19

IX. CO-MANAGING PATIENTS

	TASK	Mean Freq.	Mean Impt.	Mean Critical Index
103.	Co-manage patient with developing or advanced pathology (e.g., a patient with developing cataracts, background diabetic retinopathy).	3.34	4.04	14.90
104.	Establish a co-management protocol and refer patient for corrective surgery or other remedial therapy.	3.16	3.85	13.75
105.	Co-manage patient following remedial therapy (e.g., check whether a prescribed medication is being used, whether the medication should be altered).	2.66	3.49	11.19
107.	Co-manage patients with systemic diseases (e.g., hypertension, diabetes) with their physicians.	2.82	3.65	12.15

APPENDIX B – SCALE MEANS AND CRITICAL INDICES FOR KNOWLEDGE STATEMENTS

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I. PATIENT EXAMINATION

	KNOWLEDGE STATEMENT	Critical Index
1.	Knowledge of the types of information that constitute a comprehensive, useful patient history.	4.43
2.	Ability to communicate with a patient or a patient's caregiver so as to elicit a clearly stated presenting complaint, a useful account of symptoms, and adequately detailed ocular, medical, and family histories.	4.48
3.	Knowledge of the ocular manifestations of systemic diseases [e.g., the susceptibility to dry eye and meibomitis of middle-aged, arthritic women (Sjogren's syndrome), the symptoms associated with sexually transmitted diseases such as syphilis].	4.09
4.	Knowledge of congenital and developmental syndromes (e.g., fetal-alcohol, Down's, cerebral palsy, and their characteristic effects on vision).	3.26
5.	Ability to interpret a presenting problem in the light of the patient's ocular, medical, and family histories (e.g., to decide whether the current problem is new or an expected continuation of problems past).	4.13
11.	Ability to determine the visual acuity of pediatric, illiterate, uncooperative, malingering, or low-vision patients as well as of normal adult patients.	3.63
12.	Ability to test a patient's pupillary responses to light for pupillary anomalies.	4.40
13.	Knowledge of pupillary anomalies (e.g., afferent pupillary defect, and their underlying causes).	4.17
14.	Ability to recognize symptoms and clinical signs of binocular dysfunction.	3.64
15.	Ability to perform and interpret tests for defects in binocular alignment, eye movement, or versions.	3.64
16.	Ability to perform confrontational visual-fields tests to detect gross visual-field defects and to distinguish malingering from hysterical patients.	3.85
20.	Ability to use a retinoscope (e.g., to detect anomalies in the ocular media).	3.92
21.	Knowledge of interactive refraction procedure (i.e., of what to do or say after each response from a patient, of how to help the patient make choices).	4.58
22.	Ability to use a phoropter to obtain subjective refractions at both distance and near.	4.74
23.	Ability to use Jackson cross cylinders to refine axis and power measurements, noting barely observable differences.	4.35
24.	Knowledge of the interaction between accommodation and convergence and its implications for prescribing lenses.	3.80
25.	Ability to apply appropriate tests for detecting eye suppression.	3.24
26.	Ability to determine a patient's near points of convergence and accommodation.	3.51

27.	Ability to measure the range of a patient's clear vision at near.	3.95
30.	Knowledge of topical anesthetics or dye/anesthetic mixtures useful in preparing a patient's eyes for Goldmann tonometry.	4.31
31.	Knowledge of the possible adverse effects of instilling a dye, an anesthetic, or a dye/anesthetic mixture into a patient's eyes and of appropriate remedies.	4.09
32.	Knowledge of Goldmann tonometry and other tonometric methods.	4.59
35.	Knowledge of mydriatics and cycloplegics and their indications and contraindications, together with their possible adverse effects, and appropriate managements of those effects.	4.45
40.	Knowledge of keratometers and their uses in determining corneal toricity, corneal integrity, and tear film integrity.	3.61
41.	Ability to measure a patient's visual fields with perimeter and tangent screens, using static and kinetic stimuli, and to interpret the measurements.	3.35

II. DIAGNOSES AND TREATMENT PLANS

	KNOWLEDGE STATEMENT	Critical Index
70.	Knowledge of the treatments available for specific common eye diseases and of treatment regimens appropriate to particular eye diseases and patient profiles.	4.23
71.	Knowledge of treatment alternatives for specific common eye diseases and the risks, benefits, costs, and prognosis for each alternative.	3.93
72.	Ability to explain all refractive treatment options, including their risks and relative costs, the prognosis with each, and the time required for each to succeed.	4.11
73.	Ability to communicate treatment options clearly and effectively to a patient or the patient's parents or caregivers.	4.52
149.	Knowledge of the etiology of low vision (e.g., genetic or acquired causes).	3.08
150.	Ability to recognize the visual conditions typical of low-vision patients (e.g., retinitis pigmentosa, macular degeneration).	3.49
151.	Knowledge of the extent to which the effects of the ocular pathologies associated with low vision are remediable.	3.13
152.	Knowledge of the legal definition of blindness.	3.53
153.	Ability to elicit a low-vision patient's goals in seeking the help of an optometrist and to determine what goals can be realized.	2.56
154.	Knowledge of the psychosocial aspects of low vision.	2.41
156.	Knowledge of how to modify refractive examinations as needed for low-vision patients.	2.38

III. SPECTACLES AND PROTECTIVE EYEWEAR

	KNOWLEDGE STATEMENT	Critical Index
95.	Knowledge of ANSI standards for ophthalmic goods.	2.93
96.	Knowledge of available lens choices and their inherent advantages and disadvantages (e.g., high-index lenses, polycarbonate lenses).	3.89
97.	Knowledge of the availability, advantages, and disadvantages of particular lens types, designs, and materials for particular patients (e.g., severe myopes, severe hyperopes).	3.84
98.	Knowledge of the types of multifocals available and the measurements and dispensing techniques needed for each type.	3.75
100.	Knowledge of how base curve, thickness, and vertex distance affect image size and patient comfort.	3.34
103.	Knowledge of available frame materials, types, and styles (i.e., sport, safety).	3.40
104.	Knowledge of frame styles suitable for specific corrections and lens types (e.g., a high plus/minus, multifocal frame).	3.61
105.	Knowledge of the care and limitations of specific lenses, tints, and coatings (i.e., that special lens cloths and cleaners may be needed, that most tints and coatings can be applied only during lens manufacture).	3.37
109.	Knowledge of OSHA standards for safety eyewear.	2.95
111.	Knowledge of common needs for protective eyewear (e.g., sports, vocations).	3.36
193.	Knowledge of how lenses are fabricated and of how to verify that the prisms in new spectacles match the prescription.	3.03

IV. CONTACT LENSES

	KNOWLEDGE STATEMENT	Critical Index
112.	Ability to judge whether a patient has the dexterity in handling lenses, inserting and removing lenses, and applying solutions that wearing contact lenses requires.	3.95
113.	Knowledge of eye conditions, allergies, and sensitivities to medication that contraindicate contact lens wear.	4.18
114.	Knowledge of common medications that affect contact lens wear (e.g., knowledge that birth control pills may adversely affect tear quality).	4.07
115.	Knowledge of allergic reactions to contact lens materials and solutions and of how to minimize or prevent them.	4.07
116.	Knowledge of the significance of environmental conditions for contact lens wear.	4.07
117.	Knowledge of phorometric procedure, of what it can reveal, and of the significance of phorias and ductions for contact lens wear.	3.15

118.	Ability to recognize, through slit-lamp examination, eye anomalies that affect contact lens wear (e.g., dry-eye syndrome, corneal erosions, and dystrophies).	4.31
119.	Ability to assess the quality of a patient's tears and to relate the assessment to the patient's suitability for contact lens daily wear or for extended wear.	4.13
120.	Ability to perform and interpret a Schirmer test or phenol red thread test of tear production.	2.89
121.	Ability to measure patient parameters (e.g., corneal diameter, pupil size, that are relevant to prescribing contact lenses).	3.60
122.	Ability to take keratometric measurements appropriate to determining a contact lens prescription.	3.83
123.	Ability to use keratometric measurements to evaluate corneal astigmatism and the contribution of the cornea to total astigmatism and total refraction.	3.86
130.	Knowledge of the types and characteristics of contact lenses currently available to patients (e.g., knowledge of the water content and chemical qualities of particular lens materials).	4.05
131.	Knowledge of how each available type of contact lens improves vision (e.g., rigid as opposed to soft).	4.13
135.	Ability to determine parameters for contact lenses that will provide a patient with clear, comfortable, and safe vision.	4.27
137.	Ability to evaluate soft lenses with a slit lamp (e.g., centration, movement, and physiological response).	4.42
139.	Knowledge of how to change contact lens parameters to improve the fit.	4.15
142.	Knowledge of contact lens care products appropriate for particular patients and lenses and of how each should be used.	4.16
143.	Knowledge of how to monitor and interpret a patient's histological and physiological responses to wearing contact lenses.	4.04
144.	Ability to assess a patient's subjective responses to contact lens wear.	4.19
145.	Knowledge of the causes of and remedies for common patient complaints about contact lenses.	4.21

VII. MANAGEMENT OF EYE DISORDERS AND REFERRALS

	KNOWLEDGE STATEMENT	Critical Index
200.	Knowledge of the disease processes that produce common eye disorders (e.g., conjunctivitis, iritis, uveitis, glaucoma, diabetic retinopathy).	4.45
201.	Knowledge of the therapeutic drugs that an optometrist may administer and of the conditions for which they may be used under California law.	4.53

202.	Knowledge of the indications and contraindications for common therapeutic drugs; the appropriate dosages, administration schedules, and durations of use; the possible side effects; and the appropriate responses to side effects.	4.42
203.	Knowledge of ocular lubricants (e.g., artificial tears as a palliative for eye dryness).	4.58
204.	Knowledge of collagen punctal plugs as a way to impede tear drainage temporarily and relieve eye dryness.	3.43
205.	Ability to apply temporary punctal plugs safely and effectively and to judge from the patient's response whether to refer for permanent plugs.	3.08
206.	Knowledge of good eyelid hygiene as prophylaxis and part of therapy for lid diseases.	4.31
209.	Knowledge of instruments and procedures for removing a foreign body from an eye and of how to use them safely and effectively.	3.82
210.	Knowledge of instruments and procedures for epilating eyelashes to relieve trichiasis, of how to use a lid everter and epilation tweezers safely and effectively.	3.84
213.	Knowledge of patient conditions for which a referral is legally necessary.	4.29
214.	Knowledge of appropriate referrals of particular eye or vision disorders.	4.35
216.	Knowledge of recurrent symptoms or signs that call for referral (e.g., recurrent eye hemorrhages, recurrent headaches).	4.22
217.	Ability to write appropriate referral letters, including the information about the patient that should accompany the referral.	4.20
218.	Knowledge of the points in the development of particular conditions at which referral for surgery is appropriate (e.g., of appropriate timelines for referring a cataract or diabetic retinopathy).	4.27
223.	Knowledge of ocular and systemic diseases that threaten eyesight, health, or life; and of appropriate preventive care.	4.21

VIII. PATIENT EMERGENCIES

	KNOWLEDGE STATEMENT	Critical Index
224.	Ability to judge from a patient's symptoms whether the patient should be seen immediately and to train office staff to make the same judgment and to err on the side of the patient's safety.	4.20
226.	Knowledge of extended examination procedures for common ocular emergencies.	3.99
227.	Ability to recognize clinical signs of a potential emergency (e.g., in a patient who is diabetic, hypertensive, or glaucomatous).	4.20
228.	Knowledge of how to recognize true emergencies (i.e., conditions immediately threatening to a patient's eyesight, health, or life).	4.25
229.	Knowledge of the management of a patient who presents with a vasovagal reaction, low blood sugar level, or epileptic seizure.	3.64

230.	Knowledge of the management of a patient with an adverse reaction (e.g., anaphylactic shock, breathing difficulties, anesthesia, dilating drops).	3.72
231.	Ability to recognize or determine that a particular emergency requires an immediate referral.	4.17
232.	Knowledge of lawful means of palliating and stabilizing a patient's condition to facilitate an emergency referral.	3.65

XI. CO-MANAGING PATIENTS

	KNOWLEDGE STATEMENT	Critical Index
233.	Ability to co-manage a patient with a developing or advanced ocular pathology.	3.63
234.	Knowledge of indications for referral associated with developing eye disorders (e.g. diabetic retinopathy, glaucoma, macular degeneration).	4.20
235.	Knowledge of indications for referral associated with systemic diseases (e.g., multiple sclerosis, Grave's disease).	3.91
237.	Knowledge of pre and post operative optometric care for patients referred for surgery (e.g., cataract, refractive, or glaucoma surgery).	3.81
239.	Knowledge of the need to interview a returning referred patient regarding post-therapy discomfort, compliance with the therapeutic plan, and quality of vision.	3.54
240.	Knowledge of therapeutic complications and of their remedies, where remedies exist.	3.57
241.	Knowledge of common therapies for which referrals are made (e.g., for a cataract-removal case, refractive surgery).	4.02
242.	Knowledge of appropriate intervals for follow-up checks of particular co-management patients.	3.75
243.	Knowledge of appropriate medications for common conditions and of the California laws regulating optometrists' use of therapeutic drugs.	4.28
244.	Knowledge of common patient conditions requiring referral, of the signs and symptoms of a significant improvement or cure.	4.19

C. Major Studies Continued

2009 Occupational Analysis

EXECUTIVE SUMMARY

The California State Board of Optometry (Board) requested that the Department of Consumer Affairs' Office of Professional Examination Services (OPES) conduct a validation study to identify critical job activities performed by Optometrists licensed in California. This occupational analysis is part of the State Board of Optometry's comprehensive review of the practice of Optometry. The purpose of the occupational analysis is to define practice for Optometry in terms of actual job tasks that new licensees must be able to perform safely and competently. The results of this occupational analysis serve as the basis for the examination program for Optometry in California.

To develop a legally defensible examination plan for Optometrists in California, OPES conducted interviews with California licensed Optometrists, researched the profession, and facilitated a total of two focus group workshops with California licensed Optometrists between February 2009 and June 2009.

Working with an OPES examination development specialist, the first focus group of licensed Optometrists established a description of practice using a content validation strategy. This group reviewed task and knowledge statements developed by OPES based on the interviews. They were then asked to review, refine, and develop additional task and knowledge statements to assist in defining the practice of Optometry in California.

Following the review performed by the first focus group, OPES developed a questionnaire to be sent to Optometrists statewide that was composed of three parts. Part One consisted of demographic questions about the Optometrists themselves, their work setting, and practice. In Part Two, the Optometrists were asked to rate specific job tasks in terms of how often they performed the task and how important the task was to performance of their current job. Finally in Part Three, Optometrists were asked to rate specific knowledge statements in terms of how important that knowledge is to performance of their current job.

The State Board of Optometry distributed the questionnaire to a total of 1,975 licensees. The sample consisted of active California Optometrists in good standing with the State Board of Optometry. A total of 350 (18%) questionnaires were returned. The responding sample size included in the data analysis is 275 or 14% of the mailed questionnaires. This response rate reflects three adjustments. Eight questionnaires were excluded from the analysis because the respondents are not currently practicing as Optometrists in California. The second adjustment was due to 44 questionnaires being returned to the State Board of Optometry because of incorrect addresses. The final adjustment was due to 23 questionnaires being returned after the return deadline. Respondents represented 42 of the 58 counties in California.

Once the data from the questionnaires was entered, OPES used a multiplicative model to arrive at a critical index for each task statement. The importance rating was used as the critical index for each knowledge statement. These critical indices were then reviewed by a second focus group who evaluated the task indices and selected a mean critical index value of

6.57 as the boundary above which tasks would be retained and below which tasks would be eliminated in the examination outline. The same group also evaluated the knowledge indices and selected a mean critical index value of 2.37 as the boundary above which knowledge statements would be retained and below which statements would be eliminated in the examination outline. As a result, ten tasks and twenty-seven knowledge statements were eliminated from being included in the examination outline. For content area "Low Vision," only task 65 was retained since it had a critical index value of 8.53 and all other task statements were eliminated since they were below the cutoff value of 6.57. The focus group decided to move task 65 to content area "Diagnoses and Treatment Plans" thereby deleting content area "Low Vision." In addition, the same group also decided to move all knowledge statements for content area "Low Vision" that were above the cutoff value of 2.37 and were retained to content area "Diagnoses and Treatment Plans." The group of Optometrists were then asked to establish the linkage between job tasks and knowledge statements for the examination outline.

The examination outline is structured into eight content areas. Each content area in the examination outline is weighted proportionately relative to other content areas. The examination outline specifies the job tasks that a California Optometrist is expected to master at the time of licensure.

AN OVERVIEW OF THE OPTOMETRY PROFESSION

EXAMINATION OUTLINE

Content Area	Content Area Description	Percent Weight
Patient Examinations	This area assesses the candidate's ability to examine a patient's visual, ocular, and general health.	28
Diagnoses and Treatment Plans	This area assesses the candidate's ability to make diagnoses and prepare treatment plans.	11
Spectacles and Protective Eyewear	This area assesses the candidate's ability to analyze and prescribe eyewear according to the needs of the patient.	9
Contact Lenses	This area assesses the candidate's ability to fit and prescribe contact lenses and educate patients in their handling, care, and use.	22
Binocular Therapy and/or Vision Training	This area assesses the candidate's ability to evaluate the binocular status of a patient and provide therapy.	2
Management of Eye Disorders and Referrals	This area assesses the candidate's ability to manage and treat eye disorders and/or refer patients.	18
Patient Emergencies	This area assesses the candidate's ability to recognize and respond to patient emergencies.	4
Co-managing Patients	This area assesses the candidate's ability to co-manage patients with other specialist.	5
Total		**100***

*Note: Percentage does not add up to 100 due to rounding.

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CHAPTER 1. INTRODUCTION

PURPOSE OF THE OCCUPATIONAL ANALYSIS

The State Board of Optometry requested that the Department of Consumer Affairs' Office of Professional Examination Services (OPES) conduct a validation study to identify critical job activities performed by Optometrists. This occupational analysis is part of the State Board of Optometry's comprehensive review of the practice of Optometry in California. The purpose of the occupational analysis is to define practice for Optometry in terms of the actual tasks that new licensees must be able to perform safely and competently. The results of this occupational analysis serve as the basis for the examination program for the Optometrists.

CONTENT VALIDATION STRATEGY

To ensure that the occupational analysis reflects the actual tasks performed by Optometrists, OPES implemented a content validation strategy to describe the content of the job. The content validation strategy establishes the link between the job tasks and the knowledge statements utilizing the technical expertise of Optometrists.

ADHERENCE TO LEGAL STANDARDS AND GUIDELINES

Several statutes, guidelines, and case law serve as standards for the basis of licensure, certification, and registration programs in California. These include the Section 139 of the Business and Professions Code; Government Code, Section 12944; Federal Uniform Guidelines for Employee Selection; and the Civil Rights Act of 1991. For a licensure program to meet these standards, it must be based upon the job activities that Optometrists perform on the job. This report provides all documentation necessary to verify that the analysis has been implemented in accordance with legal, professional, and technical standards.

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CHAPTER 2. QUESTIONNAIRE

UTILIZATION OF EXPERTS

The State Board of Optometry identified California licensed Optometrists who would provide OPES with technical expertise in all phases of the occupational analysis. Some Optometrists participated in the interviews, and other Optometrists developed and refined job tasks and knowledge statements in the focus group workshops. A number of recently licensed Optometrists were included in the focus group workshops to ensure that the results of the occupational analysis reflect current practice for the entry-level candidate.

LIST OF JOB TASKS AND KNOWLEDGE STATEMENTS

OPES conducted telephone interviews with California licensed Optometrists. During these interviews, OPES asked licensees to identify the tasks specific to Optometrists that are performed on the job and the knowledge needed to perform these tasks.

Following the telephone interviews, OPES conducted two focus groups. During the first focus group, licensed Optometrists were asked to review and refine the information obtained from the interviews. The licensees were asked to identify major content areas of practice and the job tasks performed in each content area. The licensees were also asked to identify the knowledge necessary to perform each job task safely and competently. The focus group also evaluated the technical and conceptual accuracy and comprehensiveness of the content areas. The licensees determined whether the scope of the task and knowledge statements was independent and non-overlapping.

Following the review performed by the focus group, OPES developed a pilot questionnaire based on the demographic information and the list of job tasks and knowledge statements developed in the focus group. The pilot questionnaire was sent to thirteen Optometrists who participated in the interviews and the focus group workshop. Licensees were asked to evaluate the pilot questionnaire and provide feedback about the questionnaire before the State Board of Optometry mailed the final questionnaire out to all licensees. A total of nine licensees returned the pilot questionnaire.

Next, OPES developed a final questionnaire based on the demographic information, the list of job tasks and knowledge statements developed by the first focus group, and the information provided by licensees from the pilot questionnaire. Appendix A displays the questionnaire that the State Board of Optometry mailed to the California licensed Optometrists selected to receive this survey.

DISTRIBUTION OF QUESTIONNAIRE

The questionnaire was distributed to a sample of Optometrists who are actively licensed in California. The identified recipients of the questionnaire were Optometrists practicing in California who are in good standing with the State Board of Optometry. A total of 1,975 licensed Optometrists were selected as the target sample to receive the questionnaire in May 2009.

CHAPTER 3. SURVEY RESULTS

OVERVIEW SURVEY RESULTS

The California licensed Optometrists were asked to complete the three part questionnaire. In Part One the respondents answered general background questions about themselves, their work setting, and practice. In Part Two, the Optometrists were asked to rate specific job tasks in terms of: (1) how often they perform the task (FREQUENCY) and (2) how important the task is to performance of their current job (IMPORTANCE). Similarly in Part Three, Optometrists were asked to rate specific knowledge statements in terms of: (1) how important a knowledge (IMPORTANCE) is to performance of their current job.

RESPONSE RATE

A total of 350 (18%) questionnaires were returned. The responding sample size included in the data analysis is 275 (14%). This response rate reflects three adjustments. Eight questionnaires were excluded from the analysis because the respondents are not currently practicing as Optometrists in California. The second adjustment was due to 44 questionnaires being returned to the State Board of Optometry because of incorrect addresses. The final adjustment was due to 23 questionnaires being returned after the return deadline. Respondents represented 42 of the 58 counties in California. Appendix B presents the respondents by county and region.

RELIABILITY OF RATINGS

All ratings from the questionnaire were evaluated with a standard index of reliability called coefficient alpha (α). Coefficient alpha is an estimate of internal-consistency reliability of the respondents' ratings of job tasks and knowledge statements in the questionnaire. Coefficients were calculated for all respondent ratings and knowledge statements.

Table 1 displays the reliability coefficients for the task rating scales in each content area. The frequency for all content areas was highly reliable. The overall high reliability indicates that the responding Optometrists rated the task statements consistently throughout the questionnaire.

Table 2 displays the reliability coefficients for the knowledge statements rating scale in each content area. The importance for each content area was highly reliable. The high reliability indicates that the responding Optometrists rated the knowledge statements consistently throughout the questionnaire.

TABLE 1 –TASK SCALE RELIABILITY

Content Area	Number of Tasks	Frequency Scale	Importance Scale
Patient Examinations	25	.84	.86
Diagnoses and Treatment Plans	8	.83	.84
Spectacles and Protective Eyewear	10	.87	.88
Contact Lenses	20	.94	.95
Low Vision	8	.93	.96
Binocular Therapy and/or Vision Training	7	.92	.93
Management of Eye Disorders and Referrals	18	.93	.92
Patient Emergencies	5	.89	.83
Co-managing Patients	6	.89	.90
TOTAL	**97**	**.96**	**.97**

TABLE 2 – KSA SCALE RELIABILITY

Content Area	Number of KSAs	Importance Scale
Patient Examinations	53	.97
Diagnoses and Treatment Plans	41	.96
Spectacles and Protective Eyewear	17	.97
Contact Lenses	37	.98
Low Vision	20	.98
Binocular Therapy and/or Vision Training	31	.98
Management of Eye Disorders and Referrals	24	.96
Patient Emergencies	9	.96
Co-managing Patients	12	.96
TOTAL	**244**	**.99**

DEMOGRAPHIC RESULTS

Most of the responding California Optometrists can be described in terms of the following demographic data (see Figures 1 – 9 and Tables 3 – 27, starting on page 9):

- Have a private practice
- Have been licensed 0-5 years
- Work 31-40 hours a week

FIGURE 1 – NUMBER OF YEARS AS A LICENSED OPTOMETRIST

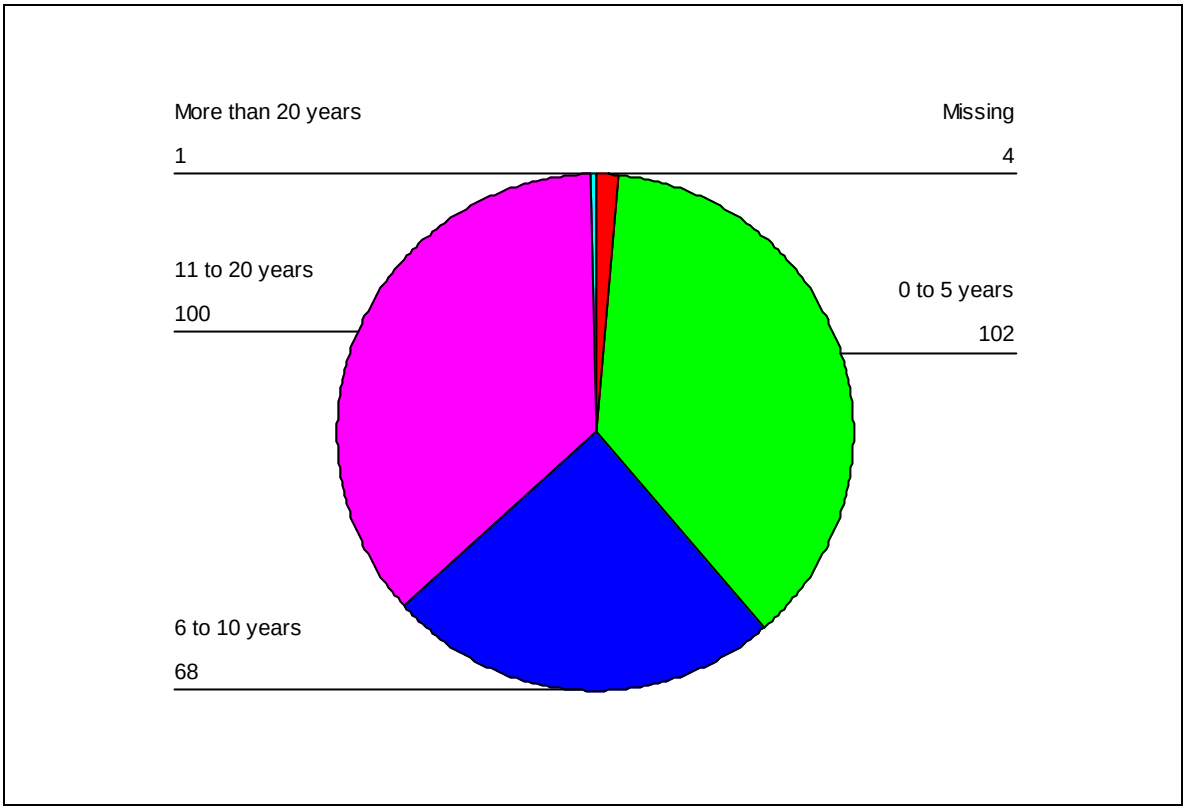

FIGURE 2 – CLASSIFICATION OF MAJORITY OF RESPONSIBILITIES AS AN OPTOMETRIST

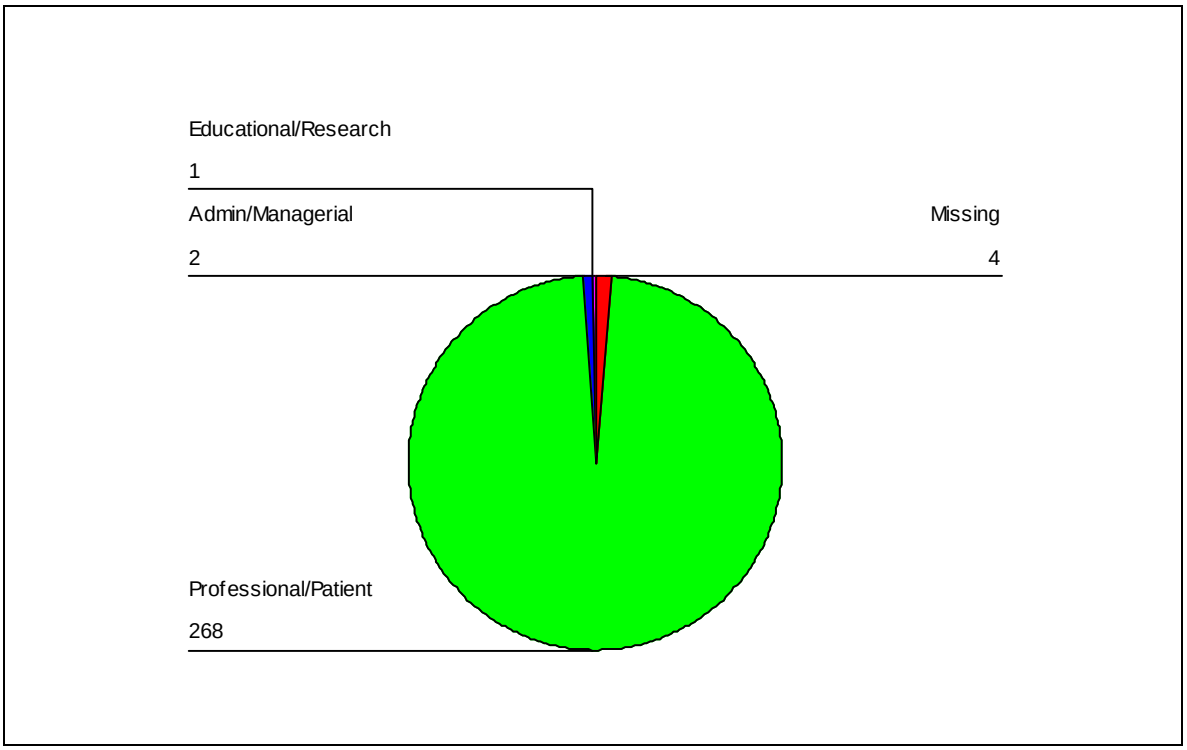

FIGURE 3 – LOCATION OF PRIMARY WORK SETTING

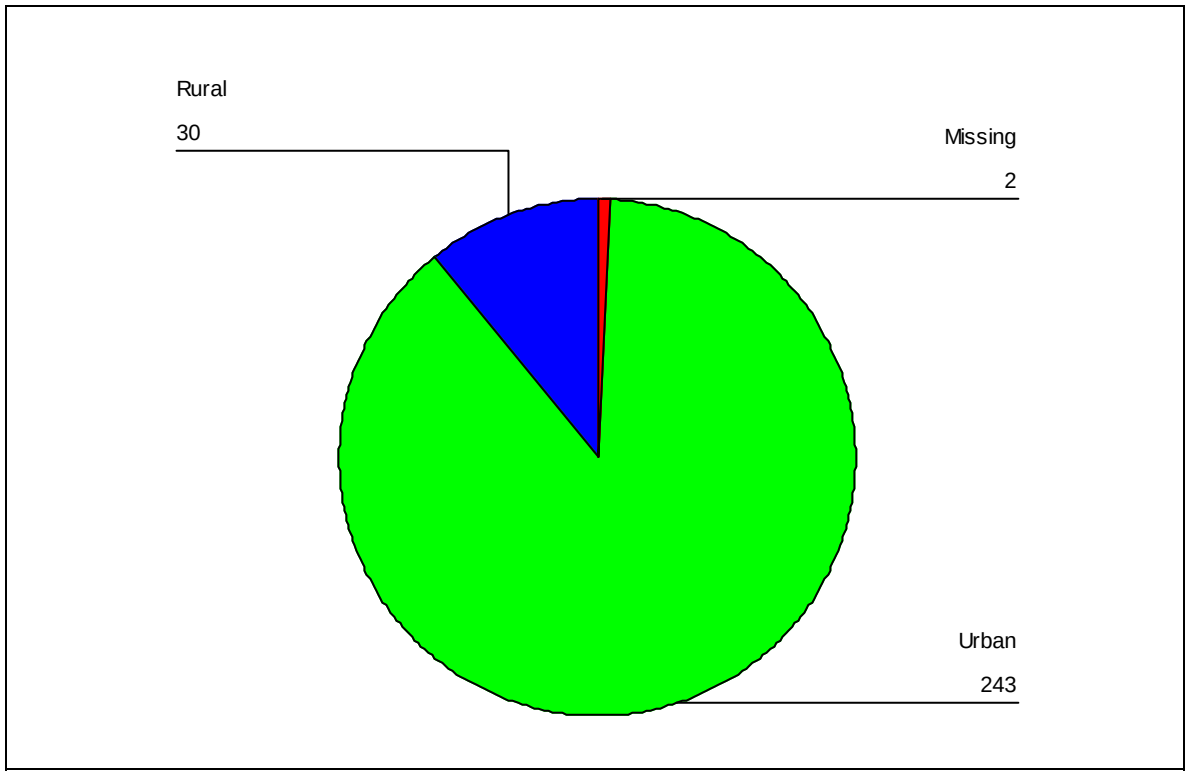

FIGURE 4 – STATE WHERE OPTOMETRY DEGREE WAS EARNED

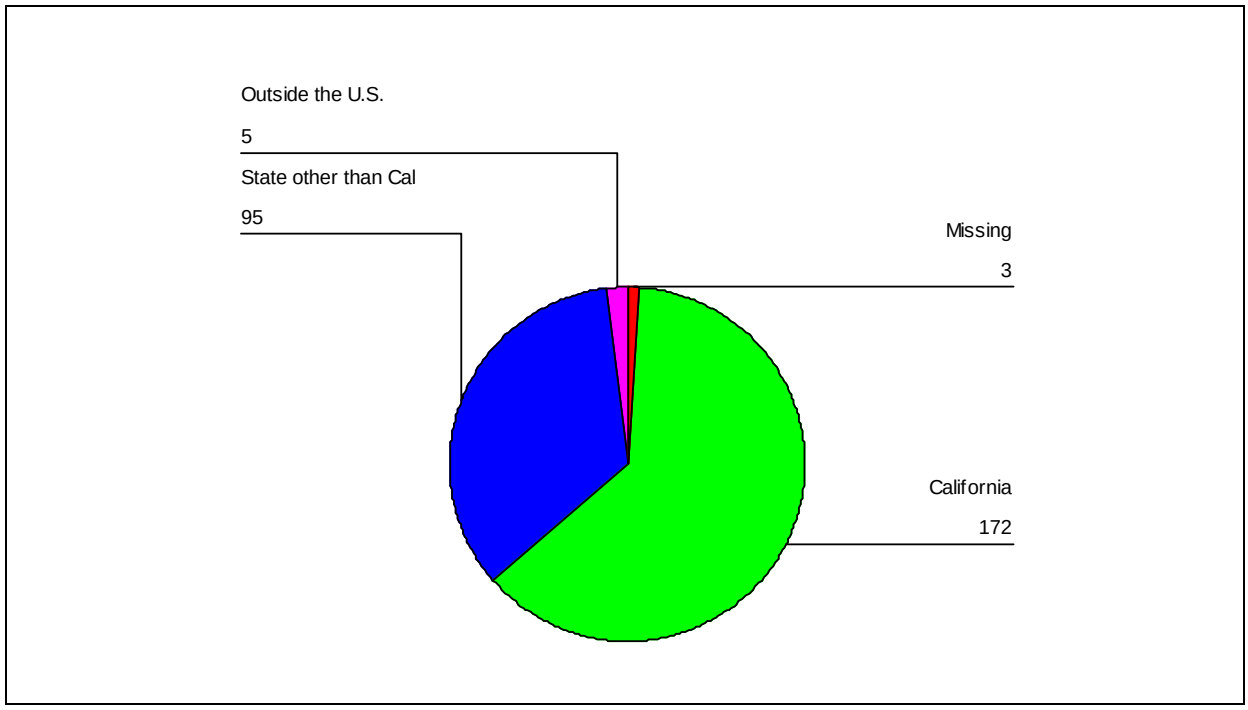

FIGURE 5 – JOB TITLE

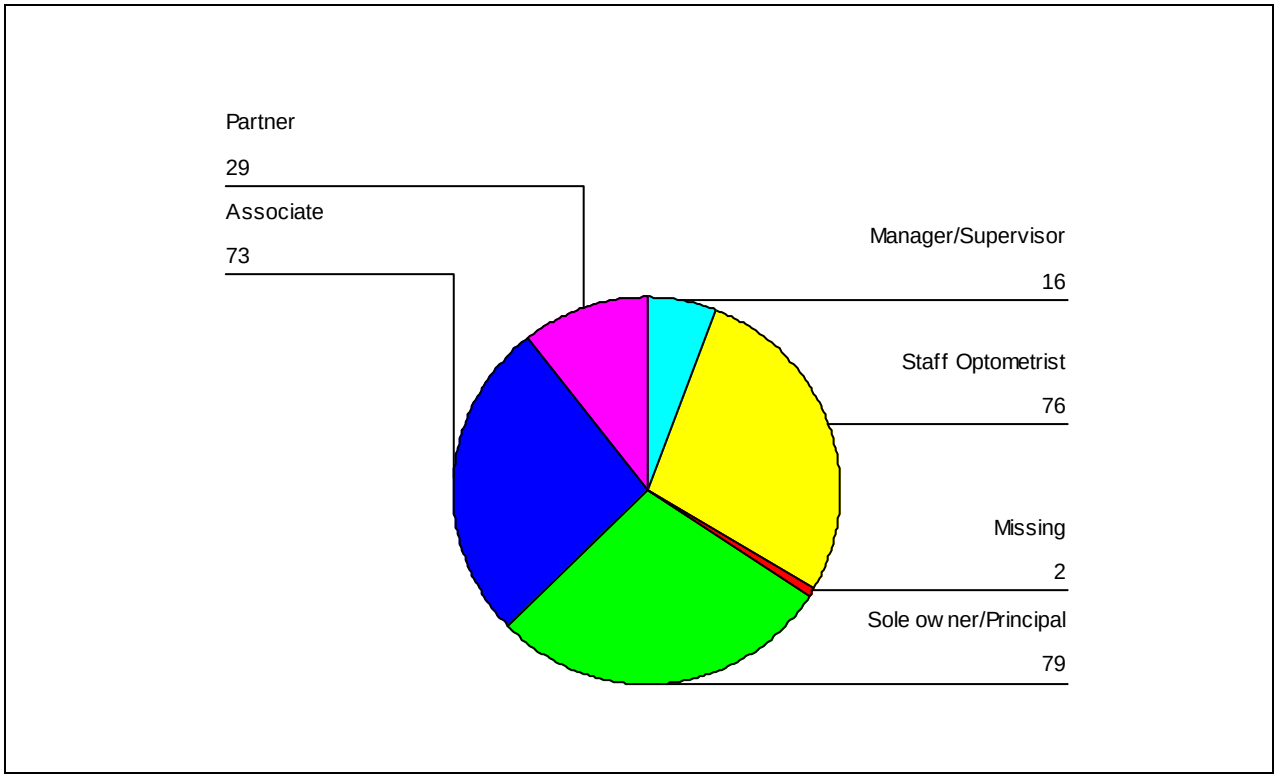

FIGURE 6 – NUMBER OF HOURS PER WEEK AS A LICENSED OPTOMETRIST

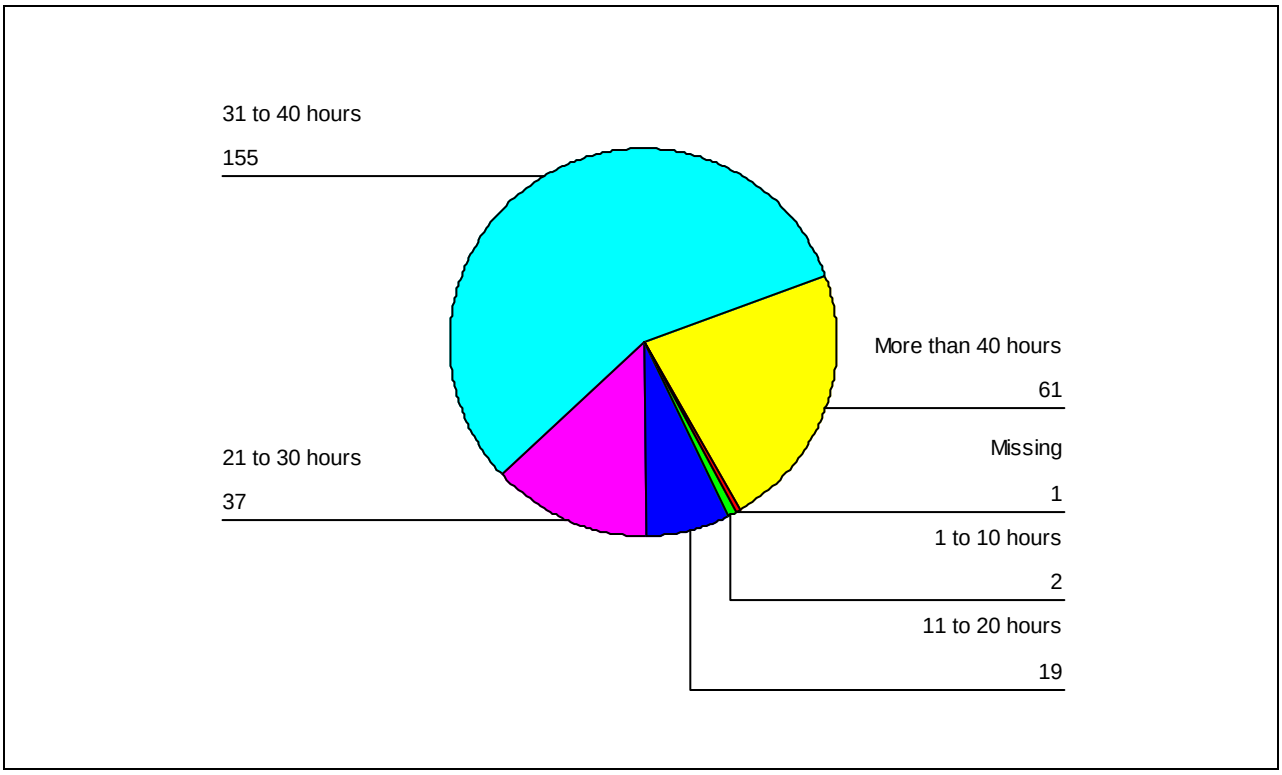

FIGURE 7 – PRIMARY WORK SETTING

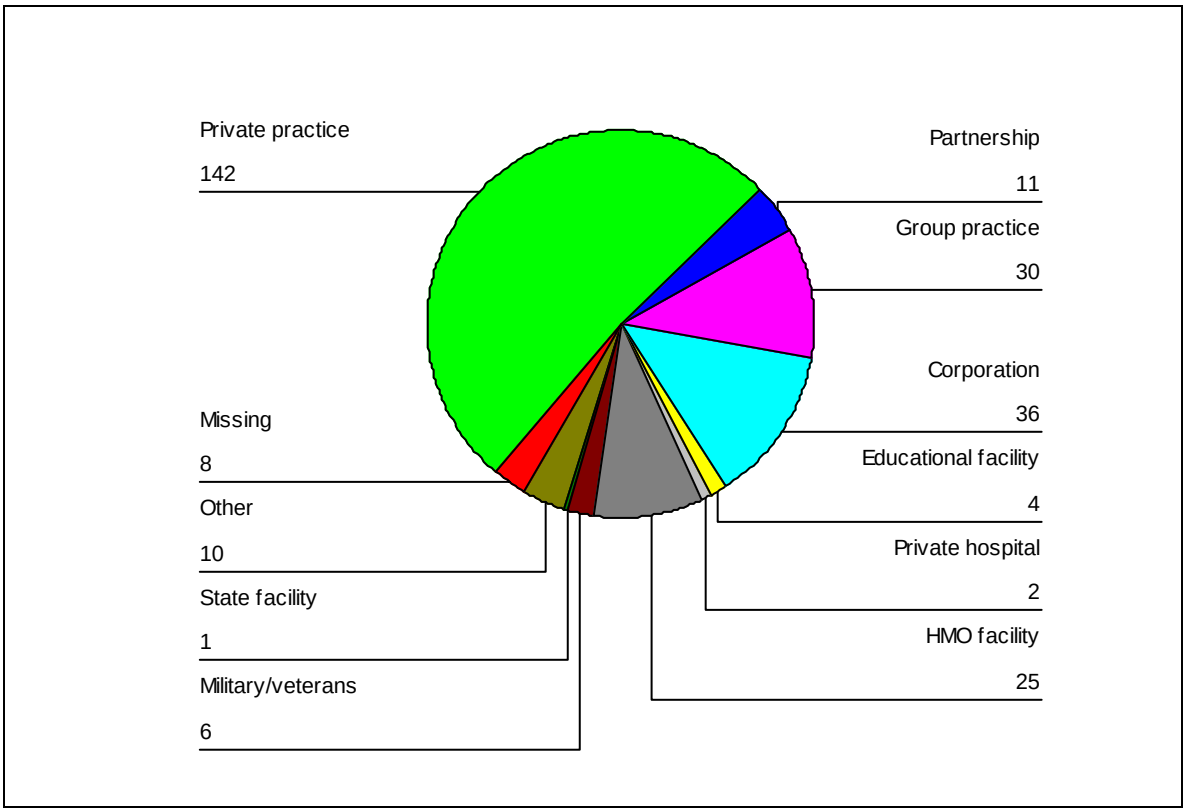

FIGURE 8 – REGION OF PRACTICE

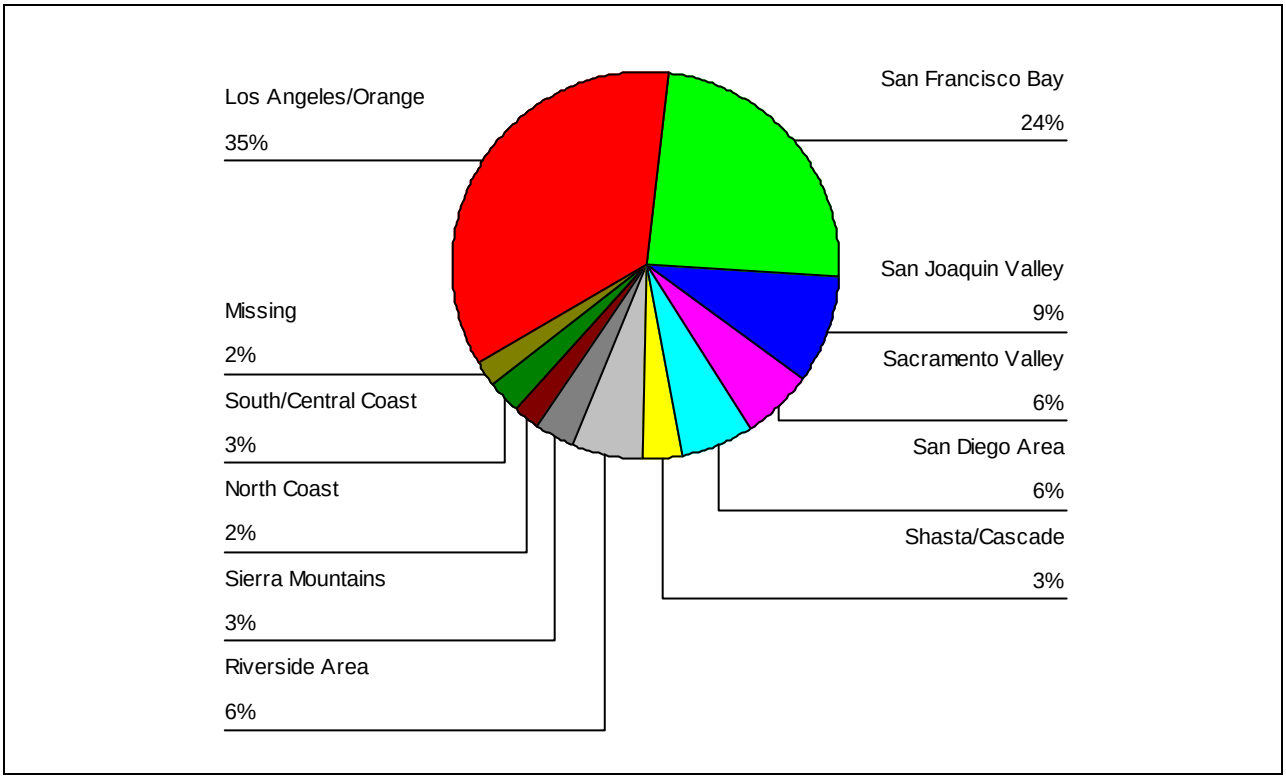

TABLE 3 – NUMBER OF YEARS AS A LICENSED OPTOMETRIST

Years	Number of Respondents	Percent
0 to 5 years	102	37
6 to 10 years	68	25
11 to 20 years	100	36
More than 20 years	1	1
Missing	4	1
Total	**275**	**100**

TABLE 4 – CLASSIFICATION OF MAJORITY OF RESPONSIBILITIES AS AN OPTOMETRIST

Responsibilities	Number of Respondents	Percent
Professional/Patient-oriented	268	97
Administrative/Managerial	2	1
Educational/Reseach-oriented	1	1
Missing	4	1
Total	**275**	**100**

TABLE 5 – LOCATION OF PRIMARY WORK SETTING

Location	Number of Respondents	Percent
Urban	243	88
Rural	30	11
Missing	2	1
Total	**275**	**100**

TABLE 6 – STATE WHERE OPTOMETRY DEGREE WAS EARNED

State	Number of Respondents	Percent
California	172	63
State other than California	95	34
Outside the U.S.	5	2
Missing	3	1
Total	**275**	**100**

TABLE 7 – Job Title

Job Title	Number of Respondents	Percent
Sole owner/Principal	79	29
Associate	73	27
Partner	29	10
Manager/Supervisor	16	6
Staff Optometrist	76	27
Missing	2	1
Total	**275**	**100**

TABLE 8 – NUMBER OF HOURS PER WEEK AS A LICENSED OPTOMETRIST

Hours	Number of Respondents	Percent
1 to 10 hours	2	1
11 to 20 hours	19	7
21 to 30 hours	37	13
31 to 40 hours	155	56
More than 40 hours	61	22
Missing	1	1
Total	**275**	**100**

TABLE 9 – PRIMARY WORK SETTING

Setting	Number of Respondents	Percent
Private Practice	142	52
Partnership	11	4
Group Practice	30	11
Corporation	36	13
Educational Facility	4	1
Private Hospital	2	1
HMO Facility	25	9
Military/Veterans Hospital or Clinic	6	2
State Facility	1	1
Other	10	4
Missing	8	3
Total	**275**	**100**

TABLE 10 – ACTIVITIES PERFORMED IN PRACTICE

Activity	Mean Percent
Patient examinations	48
Contact lenses	14
Diagnosis and treatment plan	13
Spectacles/protective eyewear	8
Treating eye disorders/referring for treatment	8
Co-management with medical specialists	5
Patient emergencies	3
Low vision	1
Binocular therapy and/or vision training	1

TABLE 11 – DIAGNOSTIC PROCEDURES PERFORMED IN PRACTICE

Procedure	Mean Percent
Refraction	41
Dilated fundus examination	22
Nondilated fundus examination	20
BV/sensorimotor evaluation	6
Fundus photos	5
Refractive surgery work-up	3
Corneal topography	2
Gonioscopy	2

TABLE 12 – TREATMENT PROCEDURES PERFORMED IN PRACTICE

Procedure	Mean Percent
Contact lens fitting/dispensing	55
Eyeglass dispensing	13
Any surgical postoperative	11
Foreign body removal	6
Epilation	5
Punctal plugs	3
Vision training	3
Low vision dispensing	1

TABLE 13 – REGION OF PRACTICE

Region	Number of Respondents	Percent
Los Angeles/Orange	97	35
San Francisco Bay Area	66	24
San Joaquin Valley	25	9
Sacramento Valley	16	6
San Diego Area	17	6
Shasta/Cascade	9	3
Riverside Area	16	6
Sierra Mountains	9	3
North/Central Coast	6	3
South Coast	8	2
Missing	6	2
Total	**269**	**100**

*Note: Percentages may not add to 100 due to rounding.

CHAPTER 4. DEVELOPMENT OF EXAMINATION OUTLINE

USE OF CRITICAL INDICES

The critical indices for job tasks and knowledge statements were used as guidelines by the second focus group of licensed Optometrists to establish the criticality of individual items and evaluate the consequences of selecting a particular "cutoff" value. Approximately ten tasks and twenty-seven knowledge statements were eliminated (See Appendices C and D).

CRITICAL TASK INDEX

To obtain a critical task index for each job task (j), the frequency (F_i) and importance (I_i), ratings for each individual (i) were multiplied and then averaged.

$$\text{Critical task index}_j = \text{mean } [(F_i) \times (I_i)]$$

Appendix C displays each task and the mean for each rating scale (i.e., "frequency" and "importance") as well as the critical task index for each task. The second focus group of Optometrists evaluated the tasks indices and selected a mean critical index value of 6.57 as the boundary above which tasks would be retained and below which tasks would be eliminated. Ten tasks were eliminated (see shaded items in Appendix C). For content area "Low Vision," only task 65 was retained since it had a critical index value of 8.53 and all other task statements were eliminated since they were below the cutoff value of 6.57. The focus group decided to move task 65 to content area "Diagnoses and Treatment Plans" thereby deleting content area "Low Vision."

CRITICAL KNOWLEDGE INDEX

To obtain a critical knowledge index for each knowledge statement, the mean importance (I_i) ratings for each knowledge statement was calculated.

$$\text{Critical knowledge index}_i = \text{mean } (I_i)$$

Appendix D displays each knowledge statement and the mean for each rating scale (i.e., "importance"). The second focus group of Optometrists who evaluated the task indices also evaluated the knowledge indices and selected a mean critical index value of 2.37 as the boundary above which knowledge statements would be retained and below which statements would be eliminated. Twenty-seven knowledge statements were eliminated (see shaded items in Appendix D). The second focus group decided to move all knowledge statements for content area "Low Vision" that were above the cutoff value of 2.37 and were retained to content area "Diagnoses and Treatment Plans."

LINKAGE OF KNOWLEDGE STATEMENTS TO JOB TASKS

The last step in the development of the examination outline was to determine which task and knowledge statements should be included in the outline. The second focus group of licensed Optometrists then established a linkage between job tasks and knowledge statements for the examination outline. The focus groups achieved the linkage by assigning specific knowledge

statements to specific job tasks so that every task had a set of knowledge statements associated with it, and every knowledge statement was associated with a task. The licensed Optometrists changed content area “Diagnosis and Treatment Plans” to “Diagnoses and Treatment Plans”; “Treating Eye Disorders/ Referring for Treatment” to “Management of Eye Disorders and Referrals”; and “Comanaging Patients” to “Co-managing Patients.”

CHAPTER 5. EXAMINATION OUTLINE

OVERVIEW OF EXAMINATION OUTLINE

The examination outline is structured into eight content areas (See Table 14). Each content area is weighted proportionately relative to other content areas. The examination outline specifies the job tasks that an Optometrist is expected to master at the time of licensure. Examinations should be based directly on the examination outline.

CONTENT AREA WEIGHTS FOR THE EXAMINATION

The relative weight of the content area in the examination outline represents the sum of the critical task indices for a content area divided by the overall sum of the critical task indices for all tasks. For example, if the sum of the critical task indices for "Patient Examinations" in the examination outline is 438.35, the weight of that content area (28%) is calculated by dividing the sum of the critical task indices (438.35) by the overall sum of the critical task indices (1551.63).

TABLE 14 – SUMMARY OF CONTENT AREAS

Content area	Number of Tasks in Content Area	Task Indices in Content Area	Area Weight (%)
I. Patient Examinations	25	438.35	28
II. Diagnoses and Treatment Plans	9	173.52	11
III. Spectacles and Protective Eyewear	10	142.10	9
IV. Contact Lenses	20	342.06	22
V. Binocular Therapy and/or Vision Training	4	32.32	2
VI. Management of Eye Disorders and Referrals	18	273.84	18
VIII. Patient Emergencies	5	67.75	4
IX. Co-managing Patients	6	81.70	5
TOTAL	**97**	**1551.63**	**100***

*Note: Percentages may not add to 100 due to rounding.

NARRATIVE DESCRIPTION OF CONTENT AREAS

Narrative descriptions were developed for each content area to provide a broad perspective of each area in terms of a defining theme. The examination outline presented in Table 14 includes these narrative descriptions.

TABLE 15 – OVERVIEW OF THE EXAMINATION OUTLINE

Content Area	Content Area Description	Percent Weight
Patient Examinations	This area assesses the candidate's ability to examine a patient's visual, ocular, and general health.	28
Diagnoses and Treatment Plans	This area assesses the candidate's ability to make diagnoses and prepare treatment plans.	11
Spectacles and Protective Eyewear	This area assesses the candidate's ability to analyze and prescribe eyewear according to the needs of the patient.	9
Contact Lenses	This area assesses the candidate's ability to fit and prescribe contact lenses and educate patients in their handling, care, and use.	22
Binocular Therapy and/or Vision Training	This area assesses the candidate's ability to evaluate the binocular status of a patient and provide therapy.	2
Management of Eye Disorders and Referrals	This area assesses the candidate's ability to manage and treat eye disorders and/or refer patients.	18
Patient Emergencies	This area assesses the candidate's ability to recognize and respond to patient emergencies.	4
Co-managing Patients	This area assesses the candidate's ability to co-manage patients with other specialist.	5
Total		**100***

*Note: Percentage does not add up to 100 due to rounding.

TABLE 16 - EXAMINATION OUTLINE FOR OPTOMETRY

I. PATIENT EXAMINATIONS (28%): This area assesses the candidate's ability to examine a patient's visual, ocular, and general health.

TASKS	KNOWLEDGE OR ABILITY
T1. Take a patient history including current health status [e.g., visual and medical history, personal and family history, presenting complaint(s)]. T2. Question patient to obtain additional information regarding history, current health status, and/or complaint(s). T3. Observe patient for abnormalities, (e.g., psychological, physical, ocular) to facilitate diagnosis and treatment. T4. Evert a patient's eyelids when indicated, (e.g., diseases, foreign bodies, allergies). T5. Verify patient's existing corrective lenses to expand patient history and refractive status. T6. Document patient's initial visual acuities. T7. Test patient's pupillary light responses to determine neurological integrity. T8. Perform cover test to assess patient's binocular alignment and ocular movement (e.g., strabismus). T9. Test patient's visual fields for gross deficits. T10. Measure patient's interpupillary distances. T11. Perform objective measurement (e.g., retinoscopy) to assess each eye's refractive status.	K1. Knowledge of the types of information that constitute a comprehensive, useful patient history. K2. Ability to communicate with a patient or a patient's caregiver so as to elicit a clearly stated presenting complaint, a useful account of symptoms, and adequately detailed ocular, medical, and family histories. K3. Knowledge of the ocular manifestations of systemic diseases [e.g., the susceptibility to dry eye and meibomitis of middle-aged, arthritic women (Sjogren's syndrome), the symptoms associated with sexually transmitted diseases such as syphilis]. K4. Knowledge of congenital and developmental syndromes (e.g., fetal-alcohol, Down's, cerebral palsy, and their characteristic effects on vision). K5. Ability to interpret a presenting problem in the light of the patient's ocular, medical, and family histories (e.g., to decide whether the current problem is new or an expected continuation of problems past). K6. Ability to identify any common facial anomaly (e.g., carcinoma, ptosis) and understand its health or ocular health implications. K7. Ability to perform a cranial-nerve assessment to determine a patient's neurological status. K8. Ability to recognize a patient's behavioral signs of communicative impairment (e.g., signs of hearing impairment). K9. Ability to evert a patient's eyelids safely and recognize diseases (e.g., giant papillary conjunctivitis). K10. Ability to determine all parameters of a patient's existing correction by measuring the corrective lenses with appropriate instruments. K11. Ability to determine the visual acuity of pediatric, illiterate, uncooperative, malingering, or low-vision patients as well as of normal adult patients. K12. Ability to test a patient's pupillary responses to light for pupillary anomalies. K13. Knowledge of pupillary anomalies (e.g., afferent pupillary defect, and their underlying causes). K14. Ability to recognize symptoms and clinical signs of binocular dysfunction. K15. Ability to perform and interpret tests for defects in binocular alignment, eye movement, or versions.

I. PATIENT EXAMINATIONS (28%): This area assesses the candidate's ability to examine a patient's visual, ocular, and general health.

TASKS	KNOWLEDGE OR ABILITY
T12. Perform subjective refraction to assess each eye's refractive status at distance and near. T13. Perform binocular test(s) (e.g., phorias, ductions, tropias, suppression, and range of convergence and divergence at distance and near) to determine the degree of ocular coordination. T14. Perform accommodative test(s) to assess ocular focus ability. T15. Measure patient's intraocular pressures to screen for pressure related conditions. T16. Perform biomicroscopy to aid in assessing patient's ocular health. T17. Use diagnostic pharmaceutical agents (DPAs) as needed to facilitate refractive and ocular health assessments. T18. Perform direct and/or binocular indirect ophthalmoscopy as needed to assess the health of each posterior segment. T19. Perform keratometry as needed to determine the curvature of the cornea. T20. Perform gonioscopy as needed to determine the integrity of angle structures. T21. Perform color deficiency tests as indicated.	K16. Ability to perform confrontational visual-fields tests to detect gross visual-field defects and to distinguish malingering from hysterical patients. K17. Ability to measure a patient's interpupillary distance, even if the patient is strabismic or exotropic. K18. Knowledge of methods used to test a patient's stereopsis. K19. Knowledge of the external and internal anatomy of the eye and of the normal range of variation in the appearance of each of its components (i.e., knowledge of what is normal and what is abnormal or anomalous. K20. Ability to use a retinoscope (e.g., to detect anomalies in the ocular media). K21. Knowledge of interactive refraction procedure (i.e., of what to do or say after each response from a patient, of how to help the patient make choices). K22. Ability to use a phoropter to obtain subjective refractions at both distance and near. K23. Ability to use Jackson cross cylinders to refine axis and power measurements, noting barely observable differences. K24. Knowledge of the interaction between accommodation and convergence and its implications for prescribing lenses. K25. Ability to apply appropriate tests for detecting eye suppression. K26. Ability to determine a patient's near points of convergence and accommodation. K27. Ability to measure the range of a patient's clear vision at near. K28. Ability to use a patient's clinical data and history to determine an appropriate prescription for corrective lenses. K29. Knowledge of topical ophthalmic dyes (e.g., fluorescein, useful in revealing corneal and conjunctival anomalies). K30. Knowledge of topical anesthetics or dye/anesthetic mixtures useful in preparing a patient's eyes for Goldmann tonometry. K31. Knowledge of the possible adverse effects of instilling a dye, an anesthetic, or a dye/anesthetic mixture into a patient's eyes and of appropriate remedies. K32. Knowledge of Goldmann tonometry and other tonometric methods. K33. Knowledge of common anomalies of the anterior segment (i.e., of their identifying characteristics and implications for vision and health).

I. PATIENT EXAMINATIONS (28%): This area assesses the candidate's ability to examine a patient's visual, ocular, and general health.

TASKS	KNOWLEDGE OR ABILITY
T22. Perform visual-fields tests as indicated by history or prior test results. T23. Use an Amsler grid to reveal central field irregularities. T24. Perform pinhole acuity tests as indicated. T25. Take and assess a patient's blood pressure.	K34. Ability to perform biomicroscopy to detect anomalies (e.g., anterior segment, adnexa, and vitreous). K35. Knowledge of mydriatics and cycloplegics and their indications and contraindications, together with their possible adverse effects, and appropriate managements of those effects. K36. Ability to perform direct and binocular indirect ophthalmoscopy (e.g., detection of posterior-segment anomalies). K37. Knowledge of the indications for indirect ophthalmoscopy with scleral depression. K38. Knowledge of common anomalies of the posterior segment, the clinical signs that identify them, and their implications for vision and health. K39. Ability to recognize eye anomalies that are potentially dangerous to the patient's eyesight, health, or life. K40. Knowledge of keratometers and their uses in determining corneal toricity, corneal integrity, and tear film integrity. K41. Ability to measure a patient's visual fields with perimeter and tangent screens, using static and kinetic stimuli, and to interpret the measurements. K42. Knowledge of gonioscopic equipment and procedure for evaluating angle structure and the fundus. K43. Knowledge of the cranial and facial nerves related to vision and of their lesions and defects. K44. Ability to localize the neural lesion causing a particular visual defect. K45. Knowledge of color-vision testing materials, procedures, and interpretation (e.g., of how to determine whether defective color vision is congenital or acquired). K46. Knowledge of Amsler-grid test procedure and interpretation. K47. Knowledge of pinhole acuity testing and of the significance of the results. K48. Knowledge of the adverse effects of ultraviolet light and other radiation on a patient's skin K49. Knowledge of adverse effects secondary to contact lens wear. K50. Knowledge of hypertension and its effects on systemic and ocular health. K51. Ability to take a patient's blood pressures with standard measuring equipment. K52. Ability to correlate ocular findings with systemic diseases (e.g., diabetes, STIs, hypercholesteremia).

I. PATIENT EXAMINATIONS (28%): This area assesses the candidate's ability to examine a patient's visual, ocular, and general health.

TASKS	KNOWLEDGE OR ABILITY
	K53. Knowledge of visual-system development (e.g., of the age at which to expect 20:20 vision in a young child, of the refractive status to expect at different ages, of the critical age for strabismus). K74. Knowledge that the treatment of minors requires the consent of parents or guardians.

II. DIAGNOSES AND TREATMENT PLANS (11%): This area assesses the candidate's ability to make diagnoses and prepare treatment plans.

TASKS	KNOWLEDGE OR ABILITY
T26. Make differential diagnoses based on symptoms, clinical examination, and history as indicated. T27. Select additional procedures or tests to confirm or rule out diagnoses as indicated. T28. Interpret diagnostic findings and consultative reports, using references as needed to confirm diagnosis. T29. Identify patients with systemic disorders that may affect the eyes or visual system (e.g., patients with vascular, neurological, endocrinological, or allergic disorders). T30. Determine and provide a treatment plan, which may include, but is not limited to, spectacles or contact lenses, vision therapy, low-vision rehabilitation, medication, or observation, referral, and follow-up. T31. Prepare treatment plans that provide patient options and explain the risks, benefits, prognoses, and relative costs with each option.	K54. Knowledge of the common causes and sequelae of particular eye disorders (e.g., Knowledge that the chief causes of amblyopia are anisometropia and strabismus; that the potential consequence of glaucoma is blindness). K55. Ability to apply differential diagnoses relevant to a patient's profile, which includes: age, habits, and behaviors. K56. Ability to recognize different diseases that produce similar ocular presentations. K57. Knowledge of ocular immunological responses to allergens, viruses, and bacteria. K58. Ability to perform differential diagnostic procedures and to choose treatments as the diagnostic findings indicate. K59. Knowledge of which ocular pathologies can be identified by their clinical signs and which require laboratory services for their identification. K60. Knowledge of when to order or refer for laboratory tests. K61. Ability to interpret laboratory test findings for a patient's symptoms and clinical signs. K62. Knowledge of optometric, ophthalmological, and other references as aids to diagnosis and treatment. K63. Knowledge of common drugs and medications and their potential for interactions and adverse reactions. K64. Knowledge of what each test applied to a patient is capable of revealing. K65. Ability to determine whether the etiology of a vision defect is genetic, pathological, or nonpathological. K66. Knowledge of chronic or recurrent systemic disorders that affect the eyes or vision, and of how to identify the disorders by their effects (e.g., knowledge that tuberculosis may produce phlyctenules). K67. Knowledge that ocular dysfunctions may induce symptoms (e.g., that a phoria may induce untimely drowsiness; that binocular, accommodative, or refractive dysfunctions may induce headaches). K68. Knowledge of psychosomatic visual disorders. K69. Ability to gather and evaluate all relevant information about a patient's disorder so as to achieve a definitive diagnosis. K70. Knowledge of the treatments available for specific common eye diseases and of treatment regimens appropriate to particular eye diseases and patient profiles.

II. DIAGNOSES AND TREATMENT PLANS (11%): This area assesses the candidate's ability to make diagnoses and prepare treatment plans.

TASKS	KNOWLEDGE OR ABILITY
T32. Explain to a patient refractive treatment options (e.g., spectacles, contact lenses, orthokeratology, refractive surgery, and vision therapy). T33. Educate patient about how to maintain visual health and integrity. T65. Perform refractive examinations for both near and distance vision, using a phoropter, trial lenses, and/or low-vision devices.	K71. Knowledge of treatment alternatives for specific common eye diseases and the risks, benefits, costs, and prognosis for each alternative. K72. Ability to explain all refractive treatment options, including their risks and relative costs, the prognosis with each, and the time required for each to succeed. K73. Ability to communicate treatment options clearly and effectively to a patient or the patient's parents or caregivers. K75. Knowledge of methods to diagnose astigmatism. K76. Knowledge of methods to diagnose myopia. K77. Knowledge of methods to diagnose presbyopia. K78. Knowledge of methods to diagnose hyperopia. K79. Knowledge of methods to diagnose nuclear sclerotic cataract K80. Knowledge of methods to diagnose hypertension. K81. Knoweldge of methods to diagnose dry eye syndrome. K82. Knoweldge of methods to diagnose pseudophakia. K83. Knoweldge of methods to diagnose diabetes, type 2. K84. Knowledge of methods to diagnose allergies. K85. Knowledge of methods to diagnose allergic congunctivitis. K86. Knoweldge of methods to diagnose cortical cataract. K87. Knowledge of methods to diagnose vitreous opacities/floaters. K88. Knowledge of methods to diagnose glaucoma, suspect. K89. Knowledge of methods to diagnose pinguecula. K90. Knowledge of methods to diagnose hypercholesterolestrolemia. K91. Knowledge of methods to diagnose glaucoma, open angle. K92. Knowledge of methods to diagnose arcus. K93. Knowledge of methods to diagnose arthritis. K94. Knowledge of methods to diagnose blepharitis, unspecified. K149. Knowledge of the etiology of low vision (e.g., genetic or acquired causes). K150. Ability to recognize the visual conditions typical of low-vision patients (e.g., retinitis pigmentosa, macular degeneration).
	K151. Knowledge of the extent to which the effects of the ocular pathologies associated with low vision are remediable.

II. DIAGNOSES AND TREATMENT PLANS (11%): This area assesses the candidate's ability to make diagnoses and prepare treatment plans.

TASKS	KNOWLEDGE OR ABILITY
	K152. Knowledge of the legal definition of blindness. K153. Ability to elicit a low-vision patient's goals in seeking the help of an optometrist and to determine what goals can be realized. K154. Knowledge of the psychosocial aspects of low vision. K156. Knowledge of how to modify refractive examinations as needed for low-vision patients.

III. SPECTACLES AND PROTECTIVE EYEWEAR (9%): This area assesses the candidate's ability to analyze and prescribe eyewear according to the needs of the patient.

TASKS	KNOWLEDGE OR ABILITY
T34. Educate patient about lens options (e.g., lens material, type, tint, coating, and multifocal style) to assist in making an informed decision. T35. Prescribe base curves and lens thicknesses that improve visual function, appearance, and comfort. T36. Prescribe spectacles for a contact lens wearer (e.g., to improve a patient's binocularity for driving, or to improve near vision for presbyopes). T37. Educate patient about spectacle frame options that meet the patient's needs (e.g., minimize lens thickness and weight). T38. Adjust a spectacle frame as needed to give a patient a secure, comfortable, pleasing, and optically correct fit. T39. Inform patient how to care for spectacles, recommending appropriate supplies and procedures. T40. Provide patient with a written spectacle prescription as required by law. T41. Analyze and address patient's complaints with newly prescribed spectacles.	K95. Knowledge of ANSI standards for ophthalmic goods. K96. Knowledge of available lens choices and their inherent advantages and disadvantages (e.g., high-index lenses, polycarbonate lenses). K97. Knowledge of the availability, advantages, and disadvantages of particular lens types, designs, and materials for particular patients (e.g., severe myopes, severe hyperopes). K98. Knowledge of the types of multifocals available and the measurements and dispensing techniques needed for each type. K99. Knowledge of preventive methods and first aid for laboratory injuries. K100. Knowledge of how base curve, thickness, and vertex distance affect image size and patient comfort. K101. Knowledge of supplemental spectacles for contact lens wearers. K102. Knowledge of critical concerns when a patient is changing from contact lenses to spectacles. K103. Knowledge of available frame materials, types, and styles (i.e., sport, safety). K104. Knowledge of frame styles suitable for specific corrections and lens types (e.g., a high plus/minus, multifocal frame). K105. Knowledge of the care and limitations of specific lenses, tints, and coatings (i.e., that special lens cloths and cleaners may be needed, that most tints and coatings can be applied only during lens manufacture). K106. Ability to explain to a patient the advantages and disadvantages: of lens and frame materials and types; lens options (tints, coatings, beveling, edge finish, press-ons). K107. Ability to adjust a frame so that it fits a patient securely and comfortably. K108. Ability to repair spectacles. K109. Knowledge of OSHA standards for safety eyewear. K110. Ability to identify safety lenses and frames. K111. Knowledge of common needs for protective eyewear (e.g., sports, vocations). K193. Knowledge of how lenses are fabricated and of how to verify that the prisms in new spectacles match the prescription.

III. SPECTACLES AND PROTECTIVE EYEWEAR (9%): This area assesses the candidate's ability to analyze and prescribe eyewear according to the needs of the patient.

TASKS	KNOWLEDGE OR ABILITY
T42. Repair spectacle frames (e.g., straighten bowed temples, replace lost screws, remove broken screws, change or replace nosepads and bridges). T43. Explain the need for protective eyewear and eyewear alternatives (e.g., safety lenses, UV coating) to help a patient obtain adequate protection.	

IV. CONTACT LENSES (22%): This area assesses the candidate's ability to fit and prescribe contact lenses and educate patients in their handling, care, and use.

TASKS	KNOWLEDGE OR ABILITY
T44. Evaluate patient's wants, needs, and goals in considering or requesting contact lenses. T45. Review patient's history to evaluate problems with contact lenses and conditions, allergies, or medications that might affect contact lens use. T46. Review examination records if available to identify patient's past or current corrective prescription. T47. Examine patient with a biomicroscope to check for current ocular health conditions (e.g., severe dry eyes, corneal damage) that affect contact lens wearability. T48. Assess the quality of patient's tears (e.g., measure tear break-up time). T49. Assess a patient's tear production (e.g., perform a Schirmer tear test or a phenol red thread test). T50. Measure patient parameters relevant to contact lens wear (e.g., corneal curvature). T51. Perform keratometry to measure a patient's corneas, corneal toricity, and the contribution of each cornea to total astigmatism and total refraction. T52. Perform an over-refraction with a contact lens in place.	K112. Ability to judge whether a patient has the dexterity in handling lenses, inserting and removing lenses, and applying solutions that wearing contact lenses requires. K113. Knowledge of eye conditions, allergies, and sensitivities to medication that contraindicate contact lens wear. K114. Knowledge of common medications that affect contact lens wear (e.g., knowledge that birth control pills may adversely affect tear quality). K115. Knowledge of allergic reactions to contact lens materials and solutions and of how to minimize or prevent them. K116. Knowledge of the significance of environmental conditions for contact lens wear. K117. Knowledge of phorometric procedure, of what it can reveal, and of the significance of phorias and ductions for contact lens wear. K118. Ability to recognize, through slit-lamp examination, eye anomalies that affect contact lens wear (e.g., dry-eye syndrome, corneal erosions, and dystrophies). K119. Ability to assess the quality of a patient's tears and to relate the assessment to the patient's suitability for contact lens daily wear or for extended wear. K120. Ability to perform and interpret a Schirmer test or phenol red thread test of tear production. K121. Ability to measure patient parameters (e.g., corneal diameter, pupil size, that are relevant to prescribing contact lenses). K122. Ability to take keratometric measurements appropriate to determining a contact lens prescription. K123. Ability to use keratometric measurements to evaluate corneal astigmatism and the contribution of the cornea to total astigmatism and total refraction. K124. Ability to use a patient's spectacle prescription or refraction and keratometric measurements to assess the patient's candidacy for corneal refractive therapy or other refractive treatment options. K125. Knowledge of corneal topography as a means of assessing an anomalous cornea (e.g., a keratoconic cornea). K126. Ability to interpret a patient's corneal topography and draw appropriate conclusions regarding the patient's candidacy for regular contact lens wear or corneal refractive therapy. K127. Knowledge that a patient's existing spectacle lens prescription can be used as a factor in choosing trial contact lenses if vertex distance is taken into account.

IV. CONTACT LENSES (22%): This area assesses the candidate's ability to fit and prescribe contact lenses and educate patients in their handling, care, and use.

TASKS	KNOWLEDGE OR ABILITY
T53. Verify the parameters for the most suitable rigid lenses with appropriate instruments. T54. Perform, or refer for, corneal topography as needed. T55. Determine the type of contact lens most appropriate for a patient (e.g., soft vs. RGP, spherical vs. toric). T56. Calculate the parameters of the lenses to be prescribed from diagnostic data. T57. Assess fluorescein patterns with a slit-lamp/Burton lamp to evaluate the fit of rigid lenses. T58. Evaluate the contact lens modality for patient (e.g., daily wear, extended wear, flexible wear). T59. Evaluate the fit and movement of contact lenses. T60. Educate patient or the patient's parents or caregivers as needed in the handling, insertion and removal, care, cleaning, disinfection, and use of contact lenses. T61. Analyze and address patient's problems with newly prescribed contact lenses. T62. Monitor and evaluate a patient's physiological response to contact lens wear with dyes and instruments.	K128. Knowledge of the need to consider the size of the palpebral fissure in fitting contact lenses. K129. Ability to determine the resultant correction by over-refraction while the patient wears trial contact lenses. K130. Knowledge of the types and characteristics of contact lenses currently available to patients (e.g., knowledge of the water content and chemical qualities of particular lens materials). K131. Knowledge of how each available type of contact lens improves vision (e.g., rigid as opposed to soft). K132. Knowledge of periodical publications as a means of keeping abreast of changes in contact lens types and availability. K133. Knowledge that refractive, keratometric, and test measurements and diagnostic lens fittings can be used to determine lens choices for a patient. K134. Ability to determine the characteristics of the contact lenses most appropriate to prescribe for a particular patient [e.g., for a presbyope, both near and far corrections by means of (a) bifocal lenses or (b) a combination of contact lenses for far vision and reading glasses for near vision]. K135. Ability to determine parameters for contact lenses that will provide a patient with clear, comfortable, and safe vision. K136. Ability to fit rigid lenses and assess their fit with a slit lamp and Burton lamp after instilling fluorescein (e.g., centration, movement, and for toric or bifocal lenses, orientation) from the fluorescein pattern the lens creates. K137. Ability to evaluate soft lenses with a slit lamp (e.g., centration, movement, and physiological response). K138. Knowledge of how to fit contact lenses after eye surgery (e.g., after keratoplasty, refractive surgery). K139. Knowledge of how to change contact lens parameters to improve the fit. K140. Knowledge of contact lens wear schedules appropriate for particular patients, lens types, and lens materials. K141. Ability to explain what a patient or a patient's caregivers should know about the handling, insertion and removal, care, cleaning, disinfecting, and use of the patient's contact lenses and about the adverse effects of inattention to proper procedures.

IV. CONTACT LENSES (22%): This area assesses the candidate's ability to fit and prescribe contact lenses and educate patients in their handling, care, and use.

TASKS	KNOWLEDGE OR ABILITY
T63. Explain the availability and benefits of prosthetic or therapeutic lenses.	K142. Knowledge of contact lens care products appropriate for particular patients and lenses and of how each should be used. K143. Knowledge of how to monitor and interpret a patient's histological and physiological responses to wearing contact lenses. K144. Ability to assess a patient's subjective responses to contact lens wear. K145. Knowledge of the causes of and remedies for common patient complaints about contact lenses. K146. Knowledge of preventive care for ocular diseases that derive from contact lens wear (e.g., for corneal abrasion and scarring, allergic reactions to lens solutions). K147. Knowledge that a troublesome lens should be inspected off the eye, under magnification. K148. Knowledge of available prosthetic and therapeutic contact lenses that improve the appearance or function of abnormal or damaged eyes.

VI. BINOCULAR THERAPY AND/OR VISION TRAINING (2%): This area assesses the candidate's ability to evaluate the binocular status of a patient and provide therapy.

TASKS	KNOWLEDGE OR ABILITY

Task	Knowledge or Ability
T72. Take and interpret a history oriented to a patient's presenting binocular condition. T74. Conduct an examination oriented to a patient's binocularity. T76. Decide whether to treat a patient with poor binocular performance and/or, refer the patient to a vision training specialist or refer the patient for surgery. T77. Educate a patient with a binocular problem or who needs vision training, regarding course of treatment, length of treatment, and intended outcomes.	K169. Ability to use a patient's history and relevant information from parents and educators to plan a problem-oriented eye examination and, later, to evaluate examination findings. K170. Ability to assess a muscle imbalance using cycloplegics when indicated. K171. Knowledge of examination procedures needed to find visual anomalies (e.g., to detect and measure binocular dysfunctions). K172. Ability to perform and interpret objective tests of binocularity as needed (e.g., a cover test, a Hirschberg test). K173. Ability to perform and interpret special tests as needed (e.g., stereoscopic "fly" and "reindeer," Worth 4 dot test). K175. Knowledge of objective tests for suppression (e.g., Worth 4 dot test). K176. Knowledge of subjective tests for eccentric fixation (e.g., Haidinger's brush and Maxwell's spot). K177. Knowledge of objective test for eccentric fixation (e.g., visuoscopy). K178. Knowledge of eccentric fixation treatment options. K179. Knowledge of motor and visual developmental milestones in children. K180. Knowledge of how good vision and poor vision affect and interact with the developing psychology of a child. K181. Ability to determine what therapy is appropriate, the prognosis, and whether or not to refer. K182. Knowledge of tests and of lens and prism corrections, for binocular misalignment, latent hyperopia, or aniseikonia. K185. Ability to determine a patient's fixation disparity and derive a prism prescription. K187. Knowledge of lenses for improving binocularity and focusing at near. K188. Knowledge of binocular tests with a phoropter (e.g., polaroid, red/green, Maddox, and vectograph tests).

VI. BINOCULAR THERAPY AND/OR VISION TRAINING (2%): This area assesses the candidate's ability to evaluate the binocular status of a patient and provide therapy.

TASKS	KNOWLEDGE OR ABILITY
	K189. Ability to use prisms to determine a patient's binocular status. K190. Ability to refract with a trial frame and the lenses to be prescribed. K191. Ability to recognize from symptoms the need to change a binocular prescription and to change it as needed to eliminate discomfort or diplopia. K192. Ability to improve a patient's vision and appearance with appropriate spectacle frames, lenses, and prisms (e.g., to optimize the cosmetic appearance and balance of new spectacles by splitting the prism power between lenses). K194. Knowledge of methods for sequential vision training. K196. Knowledge of home vision-training procedures and schedules appropriate for patients with particular needs after an appropriate lens correction. K197. Knowledge of how to monitor a vision-training patient's progress on tasks, to judge the need for additional training or a change in training. K198. Knowledge of learning-related visual functions and of how to train a patient to improve them. K199. Knowledge of dyslexia symptoms, tests, and treatments.

VII. MANAGEMENT OF EYE DISORDERS AND REFERRALS (18%): This area assesses the candidate's ability to manage and treat eye disorders and/or refer patients.

TASKS	KNOWLEDGE OR ABILITY
T79. Recommend lubricants (e.g., artificial tears) for patients with dry eyes). T80. Insert collagen punctal plugs to palliate eye dryness and to test whether permanent plugs might provide long-term relief. T81. Prescribe topical, nonsteroidal anti-inflammatories and topical antibiotics for eye diseases of the anterior segment (e.g., bacterial conjunctivitis). T82. Prescribe topical or oral antiallergenics (e.g., for allergic conjunctivitis). T83. Prescribe topical or oral medications for infectious peripheral corneal ulcers, corneal abrasions, and corneal-surface disease. T84. Prescribe topical or oral medications to treat blepharitis. T85. Prescribe oral medication to treat chalazion if heat and digital massage are not effective. T86. Remove nonperforating foreign bodies from a cornea with appropriate instruments. T87. Remove foreign bodies from the sclera, eyelid, or adenxa with appropriate instruments.	K200. Knowledge of the disease processes that produce common eye disorders (e.g., conjunctivitis, iritis, uveitis, glaucoma, diabetic retinopathy). K201. Knowledge of the therapeutic drugs that an optometrist may administer and of the conditions for which they may be used under California law. K202. Knowledge of the indications and contraindications for common therapeutic drugs; the appropriate dosages, administration schedules, and durations of use; the possible side effects; and the appropriate responses to side effects. K203. Knowledge of ocular lubricants (e.g., artificial tears as a palliative for eye dryness). K204. Knowledge of collagen punctal plugs as a way to impede tear drainage temporarily and relieve eye dryness. K205. Ability to apply temporary punctal plugs safely and effectively and to judge from the patient's response whether to refer for permanent plugs. K206. Knowledge of good eyelid hygiene as prophylaxis and part of therapy for lid diseases. K207. Knowledge of therapies for eye diseases that derive from contact lens wear. K208. Knowledge of possible interactions between ocular and systemic medications and of how to avoid or remedy interactions adverse to the patient. K209. Knowledge of instruments and procedures for removing a foreign body from an eye and of how to use them safely and effectively. K210. Knowledge of instruments and procedures for epilating eyelashes to relieve trichiasis, of how to use a lid everter and epilation tweezers safely and effectively. K211. Knowledge of the appropriate management of epithelial defects (e.g., corneal erosion or abrasion). K212. Knowledge of nutrition and nutritional supplements as they relate to ocular health. K213. Knowledge of patient conditions for which a referral is legally necessary. K214. Knowledge of appropriate referrals of particular eye or vision disorders. K215. Knowledge of appropriate referrals of systemic disorders discovered through providing optometric service. K216. Knowledge of recurrent symptoms or signs that call for referral (e.g., recurrent eye hemorrhages, recurrent headaches). K217. Ability to write appropriate referral letters, including the information about the patient that should accompany the referral.

VII. MANAGEMENT OF EYE DISORDERS AND REFERRALS (18%): This area assesses the candidate's ability to manage and treat eye disorders and/or refer patients.

TASKS	KNOWLEDGE OR ABILITY
T88. Epilate eyelashes to treat trichiasis. T89. Monitor glaucoma suspects and glaucoma patients and refer them to specialists as needed. T90. Refer disorders of the anterior segment and disorders of the posterior segment to appropriate specialists as the patient's needs dictate and as the law requires. T91. Refer newly suspected systemic diseases to appropriate specialists as the patient's needs dictate and as the law requires. T92. Treat and/or refer corneal diseases that derive from contact lens wear. T93. Recommend multivitamins and antioxidants that may help prevent eye diseases. T94. Advise patient about behaviors that can affect the eyes or vision (e.g., excessive exposure to the sun, smoking). T95. Advise patient about the side effects, particularly the ocular effects, of particular drugs and medications, and of preventive care. T96. Refer patient with a developing, threatening condition of the need for preventive care and medical attention.	K218. Knowledge of the points in the development of particular conditions at which referral for surgery is appropriate (e.g., of appropriate timelines for referring a cataract or diabetic retinopathy). K219. Knowledge of appropriate and inappropriate candidates for eye surgery. K220. Ability to recognize that eye surgery is needed; to explain to the patient the risks, benefits, alternatives, and possible complications; and to reassure anxious patients. K221. Knowledge of the detrimental effects of high-risk behaviors (e.g., excessive sun exposure, smoking) to a patient's vision and health. K222. Knowledge of common patient medications that may induce eye or other disorders as side effects and of prophylactic measures, if they exist. K223. Knowledge of ocular and systemic diseases that threaten eyesight, health, or life; and of appropriate preventive care.

VIII. PATIENT EMERGENCIES (4%): This area assesses the candidate's ability to recognize and respond to patient emergencies.

TASKS	KNOWLEDGE OR ABILITY

Task	Knowledge or Ability
T97. Train office staff to distinguish between telephoned descriptions of genuine and presumed ocular emergencies, to ask appropriate questions as needed, and to err on the side of the patient's safety. T98. Establish procedures for dealing with emergencies that arise in the office. T99. Perform examinations directed to the presenting ocular emergency (e.g., check for anterior-chamber reaction in a traumatized eye, dilate a traumatized eye and check for retinal detachment). T100. Determine whether patient's symptoms and clinical signs characterize a true emergency (e.g., acid or alkali burns, an angle closure glaucoma attack) or other condition(s) that acutely threatens the patient's eyesight, health, or life. T101. Refer a true emergency for immediate medical care.	K224. Ability to judge from a patient's symptoms whether the patient should be seen immediately and to train office staff to make the same judgment and to err on the side of the patient's safety. K225. Knowledge of the possible legal ramifications of allowing office staff to triage patient symptoms. K226. Knowledge of extended examination procedures for common ocular emergencies. K227. Ability to recognize clinical signs of a potential emergency (e.g., in a patient who is diabetic, hypertensive, or glaucomatous). K228. Knowledge of how to recognize true emergencies (i.e., conditions immediately threatening to a patient's eyesight, health, or life). K229. Knowledge of the management of a patient who presents with a vasovagal reaction, low blood sugar level, or epileptic seizure. K230. Knowledge of the management of a patient with an adverse reaction (e.g., anaphylactic shock, breathing difficulties, anesthesia, dilating drops). K231. Ability to recognize or determine that a particular emergency requires an immediate referral. K232. Knowledge of lawful means of palliating and stabilizing a patient's condition to facilitate an emergency referral.

IX. CO-MANAGING PATIENTS (5%): This area assesses the candidate's ability to co-manage patients with other specialists.

TASKS	KNOWLEDGE OR ABILITY
T102. Educate patient about recommended ocular procedures and their possible risks and benefits prior to making a referral. T103. Co-manage patient with developing or advanced pathology (e.g., a patient with developing cataracts, background diabetic retinopathy). T104. Establish a co-management protocol and refer patient for corrective surgery or other remedial therapy. T105. Co-manage patient following remedial therapy (e.g., check whether a prescribed medication is being used, whether the medication should be altered). T106. Assess whether patient satisfaction, symptoms, and clinical signs imply an improvement or cure of the condition for which the patient was referred. T107. Co-manage patients with systemic diseases (e.g., hypertension, diabetes) with their physicians.	K233. Ability to co-manage a patient with a developing or advanced ocular pathology. K234. Knowledge of indications for referral associated with developing eye disorders (e.g. diabetic retinopathy, glaucoma, macular degeneration). K235. Knowledge of indications for referral associated with systemic diseases (e.g., multiple sclerosis, Grave's disease). K236. Knowledge of testing to confirm the presence of a disorder associated with the eye (e.g., of blood panels, carotid tests). K237. Knowledge of pre and post operative optometric care for patients referred for surgery (e.g., cataract, refractive, or glaucoma surgery). K238. Knowledge of appropriate and workable nonsurgical co-management protocols. K239. Knowledge of the need to interview a returning referred patient regarding post-therapy discomfort, compliance with the therapeutic plan, and quality of vision. K240. Knowledge of therapeutic complications and of their remedies, where remedies exist. K241. Knowledge of common therapies for which referrals are made (e.g., for a cataract-removal case, refractive surgery). K242. Knowledge of appropriate intervals for follow-up checks of particular co-management patients. K243. Knowledge of appropriate medications for common conditions and of the California laws regulating optometrists' use of therapeutic drugs. K244. Knowledge of common patient conditions requiring referral, of the signs and symptoms of a significant improvement or cure.

CHAPTER 6. CONCLUSIONS

The occupational analysis of the Optometrists described in this report provides a comprehensive description of current practice in California. The procedures of the occupational analysis are based upon a content validation strategy to ensure that the results accurately represent the practice of Optometry in California.

By adopting the Optometry examination outline contained in this report, the State Board of Optometry ensures that their examination program reflects current practice. This report provides all documentation necessary to verify that the analysis has been implemented in accordance with legal, professional, and technical standards.

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LIST OF APPENDICES

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APPENDIX A – QUESTIONNAIRE

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OCCUPATIONAL ANALYSIS OF OPTOMETRIST

The Board of Optometry (Board) is currently conducting an occupational analysis of the Optometry profession. The purpose of the occupational analysis is to identify the important tasks that are currently performed by practicing Optometrists and the knowledge required to perform those tasks. Results of the occupational analysis will be used to update the definition of Optometry practice and to ensure that licensing examinations reflect important aspects of current practice.

The Board is requesting your assistance in this process. By completing this questionnaire as it relates to your *current* practice, you will contribute valuable information regarding the profession. Your responses on this questionnaire will be combined with the responses of other practitioners to determine the tasks and knowledge needed for independent practice. Your individual responses will be kept confidential.

Complete this questionnaire **only** if you are currently licensed **and** working as an Optometrist in California.

This questionnaire has four sections that address your professional experience during the past year.

PART I asks you for background information related to your practice. Information in this section will be used for demographic purposes only.

PART II asks you to rate tasks in terms of:
(a) HOW FREQUENTLY you perform each task in your practice relative to the other tasks you perform; and,
(b) HOW IMPORTANT the performance of each task is to your current practice relative to the other tasks you perform.

PART III asks you to rate knowledge statements in terms of:
(a) HOW IMPORTANT each knowledge is to your current practice.

The Board recognizes that every practitioner may not perform all of the tasks and use all of the knowledge contained in this questionnaire. However, your participation is essential to the success of this project, and your contributions will help establish standards for safe and effective Optometry practice in the state of California.

Please complete each item in the questionnaire and return it in the postage-prepaid envelope no later than June 3, 2009

THIS IS A TWO-SIDED DOCUMENT.
PLEASE READ AND COMPLETE BOTH SIDES OF EACH PAGE.

PART I
PERSONAL DATA

The information you provide here is voluntary and confidential. It will be treated as personal information subject to the Information Practices Act (Civil Code, Section 1798 et seq.), and it will be used only for the purpose of analyzing the ratings from this questionnaire.

For items 1-8, check **ONLY ONE** of the choices.

1. Are you currently practicing as a licensed Optometrist in California?
   - ☐ Yes
   - ☐ No (If No, please return this survey uncompleted in the enclosed postage paid envelope.)

2. How many years have you been licensed as an Optometrist in California?
   - ☐ 0 to 5 years
   - ☐ 6 to10 years
   - ☐ 11 to 20 years
   - ☐ More than 20 years

3. How would you classify the **majority** of your responsibilities as an Optometrist in California?
   - ☐ Professional/patient-oriented
   - ☐ Administrative/managerial
   - ☐ Educational/research-oriented

4. What describes the location of your primary work setting?
   - ☐ Urban (greater than 50,000 people)
   - ☐ Rural (less than 50,000 people)

5. Where were did you receive your Optometry degree?
   - ☐ In California
   - ☐ In a state other than California
   - ☐ Outside the U.S.

6. What title below most nearly matches your job title?
   - ☐ Sole owner/Principal
   - ☐ Associate
   - ☐ Partner
   - ☐ Manager/Supervisor
   - ☐ Staff Optometrist

7. How many hours per week do you work as a licensed Optometrist?
   - ☐ 1 to 10 hours
   - ☐ 11 to 20 hours
   - ☐ 21 to 30 hours
   - ☐ 31 to 40 hours
   - ☐ More than 40 hours

8. How would you describe your **primary** work setting?
   - ☐ Private practice
   - ☐ Partnership
   - ☐ Group practice
   - ☐ Corporation
   - ☐ Educational facility
   - ☐ Private hospital
   - ☐ HMO facility
   - ☐ Federal facility (nonmilitary)
   - ☐ Military/veterans' hospital or clinic
   - ☐ State facility
   - ☐ County facility
   - ☐ Municipal facility
   - ☐ Other (please specify)

9. Please indicate the percent of time you spend performing each activity listed below during a **typical work week**. The total must add up to **100%**.

Activity	**Percent of Time Spent**
Patient examinations	
Diagnosis and treatment plan	
Spectacles/protective eyewear	
Contact lenses	
Low vision	
Binocular therapy and/or vision training	
Treating eye disorders/referring for treatment	
Patient emergencies	
Co-management with medical specialists	
Total	**100%**

10. Please indicate the percent of time you spend performing each diagnostic procedure listed below during a **typical two-day period**. The total must add up to **100%**.

Diagnostic Procedure	**Percent of Time Spent**
BV/sensorimotor evaluation	
Corneal topography	
Dilated fundus examination	
Nondilated fundus examination	
Fundus photos	
Refraction	
Gonioscopy	
Refractive surgery work-up	
Total	**100%**

11. Please indicate the percent of time you spend performing each treatment procedure listed below during a **typical two-day period**. The total must add up to **100%**.

Treatment Procedure	**Percent of Time Spent**
Any surgical postoperative	
Contact lense fitting/dispensing	
Epilation	
Eyeglass dispensing	
Foreign body removal	
Low vision dispensing	
Punctal plugs	
Vision training	
Total	**100%**

12. In what California county is your **primary** practice located? _____

Please select **only one** of the two-digit codes below.

01	Alameda	16	Kings	31	Placer	46	Sierra
02	Alpine	17	Lake	32	Plumas	47	Siskiyou
03	Amador	18	Lassen	33	Riverside	48	Solano
04	Butte	19	Los Angeles	34	Sacramento	49	Sonoma
05	Calaveras	20	Madera	35	San Benito	50	Stanislaus
06	Colusa	21	Marin	36	San Bernardino	51	Sutter
07	Contra Costa	22	Mariposa	37	San Diego	52	Tehama
08	Del Norte	23	Mendocino	38	San Francisco	53	Trinity
09	El Dorado	24	Merced	39	San Joaquin	54	Tulare
10	Fresno	25	Modoc	40	San Luis Obispo	55	Tuolumne
11	Glenn	26	Mono	41	San Mateo	56	Ventura
12	Humboldt	27	Monterey	42	Santa Barbara	57	Yolo
13	Imperial	28	Napa	43	Santa Clara	58	Yuba
14	Inyo	29	Nevada	44	Santa Cruz		
15	Kern	30	Orange	45	Shasta		

YOU HAVE COMPLETED PART I OF THE SURVEY QUESTIONNAIRE.
GO ON TO PART II.

PART II
INSTRUCTIONS FOR RATING TASKS

In this part of the questionnaire, please rate each task as it relates to your current practice as an Optometrist. Your **Frequency** and **Importance** ratings should be separate and independent ratings. Therefore, the ratings that you assign from one rating scale should not influence the ratings that you assign from another rating scale. For example, you may perform a task frequently, but the task may not be important. If the task is NOT part of your current practice, rate the task "0" (zero) **Frequency**, and "0" (zero) **Importance**.

Circle ONE rating that best fits each task.

RATING SCALES FOR TASKS

FREQUENCY

This scale is designed to measure HOW OFTEN a task is performed in your current practice. In making this rating, consider all of the tasks you perform in your practice, and judge how often you perform each task in this section *relative* to all other tasks you perform. Use the following scale to make your rating.

0 **DOES NOT APPLY TO MY JOB.** I do not perform this task in my practice. (Note: If a task is marked "0" for Frequency, it must also be marked "0" for Importance.)

1 **RARELY.** This task is one of the tasks I perform least often in my practice relative to other tasks I perform.

2 **SELDOM.** This task is performed less often relative to other tasks I perform in my practice.

3 **OCCASIONALLY.** This task is performed somewhat often relative to other tasks I perform in my practice.

4 **OFTEN.** This task is performed more often than most other tasks I perform in my practice.

5 **VERY OFTEN.** This task is one of the tasks I perform most often in my practice relative to other tasks I perform.

IMPORTANCE

This scale is designed to measure HOW IMPORTANT a task is in the performance of your current practice. In making your rating, consider all of the tasks you perform in your current practice and judge the importance of each task in this section *relative* to all other tasks you perform. Use the following scale to make your ratings.

0 **NOT IMPORTANT; DOES NOT APPLY TO MY PRACTICE.** This task is not important to my current practice; I do not perform this task in my practice.

1 **OF MINOR IMPORTANCE.** This task is of minor importance for effective performance relative to other tasks; it has the lowest priority of all the tasks I perform in my current practice.

2 **FAIRLY IMPORTANT.** This task is fairly important for effective performance relative to other tasks; however, it does not have the priority of most other tasks I perform in my current practice.

3 **MODERATELY IMPORTANT.** This task is moderately important for effective performance relative to other tasks; it has average priority of all the tasks I perform in my current practice.

4 **VERY IMPORTANT.** This task is very important for performance in my practice; it has a higher degree of priority than most other tasks I perform in my current practice.

5 **CRITICALLY IMPORTANT.** This task is one of the most critical tasks I perform in practice; it has the highest degree of priority of all the tasks I perform in my current practice.

EXAMPLES OF TASK RATINGS

PLEASE REFER TO THIS PAGE TO MAKE YOUR IMPORTANCE RATINGS

This example shows how each task has a **Frequency** and **Importance** rating.

TASKS	FREQUENCY	IMPORTANCE
Take a patient history including current health status (e.g., visual and medical history, personal and family history, presenting complaint(s)).	0 1 2 3 4 (5)	0 1 2 3 4 (5)
Question patient to obtain additional information regarding history, current health status, and/or complaint(s).	(0) 1 2 3 4 5	(0) 1 2 3 4 5
Observe patient for abnormalities, (e.g., psychological, physical, ocular) to facilitate diagnosis and treatment.	0 1 2 3 (4) 5	0 1 2 3 4 (5)

NOTE: In *task number 2, the task is <u>not</u> performed (FREQUENCY=0; therefore, and the task IMPORTANCE is rated zero (IMPORTANCE=0).*

FREQUENCY	IMPORTANCE
HOW OFTEN do you perform this task in your current practice? If you do not perform the task, mark **Frequency** as "0."	HOW IMPORTANT is performance of this task in your current practice? If you do not perform the task, mark **Importance** as "0."
0 - Does not apply to my practice; task is not performed 1 - Rarely 2 - Seldom 3 - Occasionally 4 - Often 5 - Very often	0 - Does not apply to my practice; task is not performed 1 - Of minor importance 2 - Fairly important 3 - Moderately important 4 - Very important 5 - Critically important

	TASKS	FREQUENCY	IMPORTANCE
	I. PATIENT EXAMINATIONS		
1.	Take a patient history including current health status [e.g., visual and medical history, personal and family history, presenting complaint(s)].	0 1 2 3 4 5	0 1 2 3 4 5
2.	Question patient to obtain additional information regarding history, current health status, and/or complaint(s).	0 1 2 3 4 5	0 1 2 3 4 5
3.	Observe patient for abnormalities, (e.g., psychological, physical, ocular) to facilitate diagnosis and treatment.	0 1 2 3 4 5	0 1 2 3 4 5
4.	Evert a patient's eyelids when indicated, (e.g., diseases, foreign bodies, allergies).	0 1 2 3 4 5	0 1 2 3 4 5
5.	Verify patient's existing corrective lenses to expand patient history and refractive status.	0 1 2 3 4 5	0 1 2 3 4 5
6.	Document patient's initial visual acuities.	0 1 2 3 4 5	0 1 2 3 4 5
7.	Test patient's pupillary light responses to determine neurological integrity.	0 1 2 3 4 5	0 1 2 3 4 5
8.	Perform cover test to assess patient's binocular alignment and ocular movement (e.g., strabismus).	0 1 2 3 4 5	0 1 2 3 4 5
9.	Test patient's visual fields for gross deficits.	0 1 2 3 4 5	0 1 2 3 4 5
10.	Measure patient's interpupillary distances.	0 1 2 3 4 5	0 1 2 3 4 5
11.	Perform objective measurement (e.g., retinoscopy) to assess each eye's refractive status.	0 1 2 3 4 5	0 1 2 3 4 5
12.	Perform subjective refraction to assess each eye's refractive status at distance and near.	0 1 2 3 4 5	0 1 2 3 4 5
13.	Perform binocular test(s) (e.g., phorias, ductions, tropias, suppression, and range of convergence and divergence at distance and near) to determine the degree of ocular coordination.	0 1 2 3 4 5	0 1 2 3 4 5

FREQUENCY	IMPORTANCE
HOW OFTEN do you perform this task in your current practice? If you do not perform the task, mark **Frequency** as "0."	HOW IMPORTANT is performance of this task in your current practice? If you do not perform the task, mark **Importance** as "0."
0 - Does not apply to my practice; task is not performed 1 - Rarely 2 - Seldom 3 - Occasionally 4 - Often 5 - Very often	0 - Does not apply to my practice; task is not performed 1 - Of minor importance 2 - Fairly important 3 - Moderately important 4 - Very important 5 - Critically important

	TASKS	FREQUENCY	IMPORTANCE
14.	Perform accommodative test(s) to assess ocular focus ability.	0 1 2 3 4 5	0 1 2 3 4 5
15.	Measure patient's intraocular pressures to screen for pressure related conditions.	0 1 2 3 4 5	0 1 2 3 4 5
16.	Perform biomicroscopy to aid in assessing patient's ocular health.	0 1 2 3 4 5	0 1 2 3 4 5
17.	Use diagnostic pharmaceutical agents (DPAs) as needed to facilitate refractive and ocular health assessments.	0 1 2 3 4 5	0 1 2 3 4 5
18.	Perform direct and/or binocular indirect ophthalmoscopy as needed to assess the health of each posterior segment.	0 1 2 3 4 5	0 1 2 3 4 5
19.	Perform keratometry as needed to determine the curvature of the cornea.	0 1 2 3 4 5	0 1 2 3 4 5
20.	Perform gonioscopy as needed to determine the integrity of angle structures.	0 1 2 3 4 5	0 1 2 3 4 5
21.	Perform color deficiency tests as indicated.	0 1 2 3 4 5	0 1 2 3 4 5
22.	Perform visual-fields tests as indicated by history or prior test results.	0 1 2 3 4 5	0 1 2 3 4 5
23.	Use an Amsler grid to reveal central field irregularities.	0 1 2 3 4 5	0 1 2 3 4 5
24.	Perform pinhole acuity tests as indicated.	0 1 2 3 4 5	0 1 2 3 4 5
25.	Take and assess a patient's blood pressure.	0 1 2 3 4 5	0 1 2 3 4 5

II. DIAGNOSIS AND TREATMENT PLANS

26.	Make differential diagnoses based on symptoms, clinical examination, and history as indicated.	0 1 2 3 4 5	0 1 2 3 4 5
27.	Select additional procedures or tests to confirm or rule out diagnoses as indicated.	0 1 2 3 4 5	0 1 2 3 4 5

FREQUENCY	IMPORTANCE
HOW OFTEN do you perform this task in your current practice? If you do not perform the task, mark **Frequency** as "0."	HOW IMPORTANT is performance of this task in your current practice? If you do not perform the task, mark **Importance** as "0."
0 - Does not apply to my practice; task is not performed 1 - Rarely 2 - Seldom 3 - Occasionally 4 - Often 5 - Very often	0 - Does not apply to my practice; task is not performed 1 - Of minor importance 2 - Fairly important 3 - Moderately important 4 - Very important 5 - Critically important

	TASKS	FREQUENCY	IMPORTANCE
28.	Interpret diagnostic findings and consultative reports, using references as needed to confirm diagnosis.	0 1 2 3 4 5	0 1 2 3 4 5
29.	Identify patients with systemic disorders that may affect the eyes or visual system (e.g., patients with vascular, neurological, endocrinological, or allergic disorders).	0 1 2 3 4 5	0 1 2 3 4 5
30.	Determine and provide a treatment plan, which may include, but is not limited to, spectacles or contact lenses, vision therapy, low-vision rehabilitation, medication, or observation, referral, and follow-up.	0 1 2 3 4 5	0 1 2 3 4 5
31.	Prepare treatment plans that provide patient options and explain the risks, benefits, prognoses, and relative costs with each option.	0 1 2 3 4 5	0 1 2 3 4 5
32.	Explain to a patient refractive treatment options (e.g., spectacles, contact lenses, orthokeratology, refractive surgery, and vision therapy).	0 1 2 3 4 5	0 1 2 3 4 5
33.	Educate patient about how to maintain visual health and integrity.	0 1 2 3 4 5	0 1 2 3 4 5
	III. SPECTACLES AND PROTECTIVE EYEWEAR		
34.	Educate patient about lens options (e.g., lens material, type, tint, coating, and multifocal style) to assist in making an informed decision.	0 1 2 3 4 5	0 1 2 3 4 5
35.	Prescribe base curves and lens thicknesses that improve visual function, appearance, and comfort.	0 1 2 3 4 5	0 1 2 3 4 5
36.	Prescribe spectacles for a contact lens wearer (e.g., to improve a patient's binocularity for driving, or to improve near vision for presbyopes).	0 1 2 3 4 5	0 1 2 3 4 5
37.	Educate patient about spectacle frame options that meet the patient's needs (e.g., minimize lens thickness and weight).	0 1 2 3 4 5	0 1 2 3 4 5
38.	Adjust a spectacle frame as needed to give a patient a secure, comfortable, pleasing, and optically correct fit.	0 1 2 3 4 5	0 1 2 3 4 5

FREQUENCY	IMPORTANCE
HOW OFTEN do you perform this task in your current practice? If you do not perform the task, mark **Frequency** as "0."	HOW IMPORTANT is performance of this task in your current practice? If you do not perform the task, mark **Importance** as "0."
0 - Does not apply to my practice; task is not performed 1 - Rarely 2 - Seldom 3 - Occasionally 4 - Often 5 - Very often	0 - Does not apply to my practice; task is not performed 1 - Of minor importance 2 - Fairly important 3 - Moderately important 4 - Very important 5 - Critically important

	TASKS	FREQUENCY	IMPORTANCE
39.	Inform patient how to care for spectacles, recommending appropriate supplies and procedures.	0 1 2 3 4 5	0 1 2 3 4 5
40.	Provide patient with a written spectacle prescription as required by law.	0 1 2 3 4 5	0 1 2 3 4 5
41.	Analyze and address patient's complaints with newly prescribed spectacles.	0 1 2 3 4 5	0 1 2 3 4 5
42.	Repair spectacle frames (e.g., straighten bowed temples, replace lost screws, remove broken screws, change or replace nosepads and bridges).	0 1 2 3 4 5	0 1 2 3 4 5
43.	Explain the need for protective eyewear and eyewear alternatives (e.g., safety lenses, UV coating) to help a patient obtain adequate protection.	0 1 2 3 4 5	0 1 2 3 4 5
	IV. CONTACT LENSES		
44.	Evaluate patient's wants, needs, and goals in considering or requesting contact lenses.	0 1 2 3 4 5	0 1 2 3 4 5
45.	Review patient's history to evaluate problems with contact lenses and conditions, allergies, or medications that might affect contact lens use.	0 1 2 3 4 5	0 1 2 3 4 5
46.	Review examination records if available to identify patient's past or current corrective prescription.	0 1 2 3 4 5	0 1 2 3 4 5
47.	Examine patient with a biomicroscope to check for current ocular health conditions (e.g., severe dry eyes, corneal damage) that affect contact lens wearability.	0 1 2 3 4 5	0 1 2 3 4 5
48.	Assess the quality of patient's tears (e.g., measure tear break-up time).	0 1 2 3 4 5	0 1 2 3 4 5
49.	Assess a patient's tear production (e.g., perform a Schirmer tear test or a phenol red thread test).	0 1 2 3 4 5	0 1 2 3 4 5

FREQUENCY	IMPORTANCE
HOW OFTEN do you perform this task in your current practice? If you do not perform the task, mark **Frequency** as "0."	HOW IMPORTANT is performance of this task in your current practice? If you do not perform the task, mark **Importance** as "0."
0 - Does not apply to my practice; task is not performed 1 - Rarely 2 - Seldom 3 - Occasionally 4 - Often 5 - Very often	0 - Does not apply to my practice; task is not performed 1 - Of minor importance 2 - Fairly important 3 - Moderately important 4 - Very important 5 - Critically important

	TASKS	FREQUENCY	IMPORTANCE
50.	Measure patient parameters relevant to contact lens wear (e.g., corneal curvature).	0 1 2 3 4 5	0 1 2 3 4 5
51.	Perform keratometry to measure a patient's corneas, corneal toricity, and the contribution of each cornea to total astigmatism and total refraction.	0 1 2 3 4 5	0 1 2 3 4 5
52.	Perform an over-refraction with a contact lens in place.	0 1 2 3 4 5	0 1 2 3 4 5
53.	Verify the parameters for the most suitable rigid lenses with appropriate instruments.	0 1 2 3 4 5	0 1 2 3 4 5
54.	Perform, or refer for, corneal topography as needed.	0 1 2 3 4 5	0 1 2 3 4 5
55.	Determine the type of contact lens most appropriate for a patient (e.g., soft vs. RGP, spherical vs. toric).	0 1 2 3 4 5	0 1 2 3 4 5
56.	Calculate the parameters of the lenses to be prescribed from diagnostic data.	0 1 2 3 4 5	0 1 2 3 4 5
57.	Assess fluorescein patterns with a slit-lamp/Burton lamp to evaluate the fit of rigid lenses.	0 1 2 3 4 5	0 1 2 3 4 5
58.	Evaluate the contact lens modality for patient (e.g., daily wear, extended wear, flexible wear).	0 1 2 3 4 5	0 1 2 3 4 5
59.	Evaluate the fit and movement of contact lenses.	0 1 2 3 4 5	0 1 2 3 4 5
60.	Educate patient or the patient's parents or caregivers as needed in the handling, insertion and removal, care, cleaning, disinfection, and use of contact lenses.	0 1 2 3 4 5	0 1 2 3 4 5
61.	Analyze and address patient's problems with newly prescribed contact lenses.	0 1 2 3 4 5	0 1 2 3 4 5
62.	Monitor and evaluate a patient's physiological response to contact lens wear with dyes and instruments.	0 1 2 3 4 5	0 1 2 3 4 5
63.	Explain the availability and benefits of prosthetic or therapeutic lenses.	0 1 2 3 4 5	0 1 2 3 4 5

FREQUENCY	IMPORTANCE
HOW OFTEN do you perform this task in your current practice? If you do not perform the task, mark **Frequency** as "0."	HOW IMPORTANT is performance of this task in your current practice? If you do not perform the task, mark **Importance** as "0."
0 - Does not apply to my practice; task is not performed 1 - Rarely 2 - Seldom 3 - Occasionally 4 - Often 5 - Very often	0 - Does not apply to my practice; task is not performed 1 - Of minor importance 2 - Fairly important 3 - Moderately important 4 - Very important 5 - Critically important

	TASKS	FREQUENCY	IMPORTANCE
	V. LOW VISION		
64.	Assess low vision patient's needs and wants (i.e., what visual needs are essential to the patient's lifestyle or desired lifestyle) to determine treatment plan.	0 1 2 3 4 5	0 1 2 3 4 5
65.	Perform refractive examinations for both near and distance vision, using a phoropter, trial lenses, and/or low-vision devices.	0 1 2 3 4 5	0 1 2 3 4 5
66.	Evaluate low-vision patient's visual deficits and calculate the remedial magnifications needed.	0 1 2 3 4 5	0 1 2 3 4 5
67.	Assess low-vision patient's mobility and dexterity relative to possible remedies.	0 1 2 3 4 5	0 1 2 3 4 5
68.	Recommend optical aids to patient, (e.g., a monocular telescope, binoculars, high-add reading glasses) to increase visual quality.	0 1 2 3 4 5	0 1 2 3 4 5
69.	Recommend nonoptical aids, (e.g., felt-tip pens, electronic aids, large-print books) to improve patient's visual functioning.	0 1 2 3 4 5	0 1 2 3 4 5
70.	Train patient as needed in the use of the aids to vision that the patient chooses.	0 1 2 3 4 5	0 1 2 3 4 5
71.	Educate patient regarding support groups and services available to the visually impaired.	0 1 2 3 4 5	0 1 2 3 4 5
72.	Take and interpret a history oriented to a patient's presenting binocular condition.	0 1 2 3 4 5	0 1 2 3 4 5
73.	Evaluate information provided by patient, parents, educational psychologists, and teachers regarding binocular function.	0 1 2 3 4 5	0 1 2 3 4 5
74.	Conduct an examination oriented to a patient's binocularity.	0 1 2 3 4 5	0 1 2 3 4 5
75.	Evaluate whether binocular vision therapy is indicated for patient and, if so, what form of therapy is appropriate.	0 1 2 3 4 5	0 1 2 3 4 5

FREQUENCY	IMPORTANCE
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	TASKS	FREQUENCY	IMPORTANCE
76.	Decide whether to treat a patient with poor binocular performance and/or, refer the patient to a vision training specialist or refer the patient for surgery.	0 1 2 3 4 5	0 1 2 3 4 5
77.	Educate a patient with a binocular problem or who needs vision training, regarding course of treatment, length of treatment, and intended outcomes.	0 1 2 3 4 5	0 1 2 3 4 5
78.	Prepare a sequential vision training treatment plan for a patient with binocular problems.	0 1 2 3 4 5	0 1 2 3 4 5
79.	Recommend lubricants (e.g., artificial tears) for patients with dry eyes).	0 1 2 3 4 5	0 1 2 3 4 5
80.	Insert collagen punctal plugs to palliate eye dryness and to test whether permanent plugs might provide long-term relief.	0 1 2 3 4 5	0 1 2 3 4 5
81.	Prescribe topical, nonsteroidal anti-inflammatories and topical antibiotics for eye diseases of the anterior segment (e.g., bacterial conjunctivitis).	0 1 2 3 4 5	0 1 2 3 4 5
82.	Prescribe topical or oral antiallergenics (e.g., for allergic conjunctivitis).	0 1 2 3 4 5	0 1 2 3 4 5
83.	Prescribe topical or oral medications for infectious peripheral corneal ulcers, corneal abrasions, and corneal-surface disease.	0 1 2 3 4 5	0 1 2 3 4 5
84.	Prescribe topical or oral medications to treat blepharitis.	0 1 2 3 4 5	0 1 2 3 4 5
85.	Prescribe oral medication to treat chalazion if heat and digital massage are not effective.	0 1 2 3 4 5	0 1 2 3 4 5
86.	Remove nonperforating foreign bodies from a cornea with appropriate instruments.	0 1 2 3 4 5	0 1 2 3 4 5
87.	Remove foreign bodies from the sclera, eyelid, or adenxa with appropriate instruments.	0 1 2 3 4 5	0 1 2 3 4 5
88.	Epilate eyelashes to treat trichiasis.	0 1 2 3 4 5	0 1 2 3 4 5

FREQUENCY	IMPORTANCE
HOW OFTEN do you perform this task in your current practice? If you do not perform the task, mark **Frequency** as "0."	HOW IMPORTANT is performance of this task in your current practice? If you do not perform the task, mark **Importance** as "0."
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	TASKS	FREQUENCY	IMPORTANCE
89.	Monitor glaucoma suspects and glaucoma patients and refer them to specialists as needed.	0 1 2 3 4 5	0 1 2 3 4 5
90.	Refer disorders of the anterior segment and disorders of the posterior segment to appropriate specialists as the patient's needs dictate and as the law requires.	0 1 2 3 4 5	0 1 2 3 4 5
91.	Refer newly suspected systemic diseases to appropriate specialists as the patient's needs dictate and as the law requires.	0 1 2 3 4 5	0 1 2 3 4 5
92.	Treat and/or refer corneal diseases that derive from contact lens wear.	0 1 2 3 4 5	0 1 2 3 4 5
93.	Recommend multivitamins and antioxidants that may help prevent eye diseases.	0 1 2 3 4 5	0 1 2 3 4 5
94.	Advise patient about behaviors that can affect the eyes or vision (e.g., excessive exposure to the sun, smoking).	0 1 2 3 4 5	0 1 2 3 4 5
95.	Advise patient about the side effects, particularly the ocular effects, of particular drugs and medications, and of preventive care.	0 1 2 3 4 5	0 1 2 3 4 5
96.	Refer patient with a developing, threatening condition of the need for preventive care and medical attention.	0 1 2 3 4 5	0 1 2 3 4 5

VIII. PATIENT EMERGENCIES

97.	Train office staff to distinguish between telephoned descriptions of genuine and presumed ocular emergencies, to ask appropriate questions as needed, and to err on the side of the patient's safety.	0 1 2 3 4 5	0 1 2 3 4 5
98.	Establish procedures for dealing with emergencies that arise in the office.	0 1 2 3 4 5	0 1 2 3 4 5
99.	Perform examinations directed to the presenting ocular emergency (e.g., check for anterior-chamber reaction in a traumatized eye, dilate a traumatized eye and check for retinal detachment).	0 1 2 3 4 5	0 1 2 3 4 5

FREQUENCY	IMPORTANCE
HOW OFTEN do you perform this task in your current practice? If you do not perform the task, mark **Frequency** as "0."	HOW IMPORTANT is performance of this task in your current practice? If you do not perform the task, mark **Importance** as "0."
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	TASKS	FREQUENCY	IMPORTANCE
100.	Determine whether patient's symptoms and clinical signs characterize a true emergency (e.g., acid or alkali burns, an angle closure glaucoma attack) or other condition(s) that acutely threatens the patient's eyesight, health, or life.	0 1 2 3 4 5	0 1 2 3 4 5
101.	Refer a true emergency for immediate medical care.	0 1 2 3 4 5	0 1 2 3 4 5
	IX. CO-MANAGING PATIENTS		
102.	Educate patient about recommended ocular procedures and their possible risks and benefits prior to making a referral.	0 1 2 3 4 5	0 1 2 3 4 5
103.	Co-manage patient with developing or advanced pathology (e.g., a patient with developing cataracts, background diabetic retinopathy).	0 1 2 3 4 5	0 1 2 3 4 5
104.	Establish a co-management protocol and refer patient for corrective surgery or other remedial therapy.	0 1 2 3 4 5	0 1 2 3 4 5
105.	Co-manage patient following remedial therapy (e.g., check whether a prescribed medication is being used, whether the medication should be altered).	0 1 2 3 4 5	0 1 2 3 4 5
106.	Assess whether patient satisfaction, symptoms, and clinical signs imply an improvement or cure of the condition for which the patient was referred.	0 1 2 3 4 5	0 1 2 3 4 5
107.	Co-manage patients with systemic diseases (e.g., hypertension, diabetes) with their physicians.	0 1 2 3 4 5	0 1 2 3 4 5

YOU HAVE COMPLETED PART II OF THE SURVEY QUESTIONNAIRE.
GO ON TO PART III.

PART III
INSTRUCTIONS FOR RATING KNOWLEDGE AND ABILITIES

In this part of the questionnaire, rate each of the knowledge/ability statements based on how important you believe a knowledge/ability statement is to the performance of your tasks. If a knowledge/ability statement is NOT part of your practice, then rate the statement "0" (zero) for **Importance** and go on to the next item.

Circle ONE rating that best fits each knowledge/ability.

RATING SCALES FOR KNOWLEDGE AND ABILITIES

IMPORTANCE

HOW IMPORTANT is this knowledge/ability to performance of tasks in your current practice?

0 **DOES NOT APPLY TO MY PRACTICE; NOT REQUIRED**. This knowledge/ability does not apply to my practice; it is not required for performance.

1 **OF MINOR IMPORTANCE**. This knowledge/ability is of minor or incidental importance for performance; it is useful for some minor part of my practice.

2 **FAIRLY IMPORTANT**. This knowledge/ability is fairly important relative to other tasks; however, it does not have the priority of most other knowledges of my practice.

3 **MODERATELY IMPORTANT**. This knowledge/ability is moderately important for performance in some relatively major part of my practice.

4 **VERY IMPORTANT**. This rating indicates that this knowledge/ability is very important for performance in a significant part of my practice.

5 **CRITICALLY IMPORTANT**. This rating indicates that this knowledge/ability is critically important for performance.

EXAMPLE OF KNOWLEDGE RATINGS

PLEASE REFER TO THIS PAGE TO MAKE YOUR IMPORTANCE RATINGS

This example shows how each knowledge/ability statement has an **Importance** rating

KNOWLEDGE or ABILITY	IMPORTANCE
Knowledge of the types of information that constitute a comprehensive, useful patient history.	0 1 2 (3) 4 5
Ability to communicate with a patient or a patient's caregiver in order to elicit a clearly stated presenting complaint, a useful account of symptoms, and adequately detailed ocular, medical, and family histories.	0 1 2 3 4 (5)
Knowledge of the ocular manifestations of systemic diseases [e.g., the susceptibility to dry eye and meibomitis of middle-aged, arthritic women (Sjogren's syndrome), the symptoms associated with sexually transmitted diseases such as syphilis].	(0) 1 2 3 4 5

NOTE: In *knowledge number 3, the knowledge is <u>not</u> performed; therefore, the knowledge IMPORTANCE is rated zero (IMPORTANCE= 0).*

IMPORTANCE

HOW IMPORTANT is this knowledge/ability to performance of tasks in your current practice?

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1 - Of minor importance or incidental performance.
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4 - Very important for a significant part of my practice.
5 - Critically important to performance.

		KNOWLEDGE / IMPORTANCE
	I. PATIENT EXAMINATIONS	
1.	Knowledge of the types of information that constitute a comprehensive, useful patient history.	0 1 2 3 4 5
2.	Ability to communicate with a patient or a patient's caregiver so as to elicit a clearly stated presenting complaint, a useful account of symptoms, and adequately detailed ocular, medical, and family histories.	0 1 2 3 4 5
3.	Knowledge of the ocular manifestations of systemic diseases [e.g., the susceptibility to dry eye and meibomitis of middle-aged, arthritic women (Sjogren's syndrome), the symptoms associated with sexually transmitted diseases such as syphilis].	0 1 2 3 4 5
4.	Knowledge of congenital and developmental syndromes (e.g., fetal-alcohol, Down's, cerebral palsy, and their characteristic effects on vision).	0 1 2 3 4 5
5.	Ability to interpret a presenting problem in the light of the patient's ocular, medical, and family histories (e.g., to decide whether the current problem is new or an expected continuation of problems past).	0 1 2 3 4 5
6.	Ability to identify any common facial anomaly (e.g., carcinoma, ptosis) and understand its health or ocular health implications.	0 1 2 3 4 5
7.	Ability to perform a cranial-nerve assessment to determine a patient's neurological status.	0 1 2 3 4 5
8.	Ability to recognize a patient's behavioral signs of communicative impairment (e.g., signs of hearing impairment).	0 1 2 3 4 5
9.	Ability to evert a patient's eyelids safely and recognize diseases (e.g., giant papillary conjunctivitis).	0 1 2 3 4 5
10.	Ability to determine all parameters of a patient's existing correction by measuring the corrective lenses with appropriate instruments.	0 1 2 3 4 5
11.	Ability to determine the visual acuity of pediatric, illiterate, uncooperative, malingering, or low-vision patients as well as of normal adult patients.	0 1 2 3 4 5
12.	Ability to test a patient's pupillary responses to light for pupillary anomalies.	0 1 2 3 4 5
13.	Knowledge of pupillary anomalies (e.g., afferent pupillary defect, and their underlying causes).	0 1 2 3 4 5

IMPORTANCE

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	KNOWLEDGE	IMPORTANCE
14.	Ability to recognize symptoms and clinical signs of binocular dysfunction.	0 1 2 3 4 5
15.	Ability to perform and interpret tests for defects in binocular alignment, eye movement, or versions.	0 1 2 3 4 5
16.	Ability to perform confrontational visual-fields tests to detect gross visual-field defects and to distinguish malingering from hysterical patients.	0 1 2 3 4 5
17.	Ability to measure a patient's interpupillary distance, even if the patient is strabismic or exotropic.	0 1 2 3 4 5
18.	Knowledge of methods used to test a patient's stereopsis.	0 1 2 3 4 5
19.	Knowledge of the external and internal anatomy of the eye and of the normal range of variation in the appearance of each of its components (i.e., knowledge of what is normal and what is abnormal or anomalous.	0 1 2 3 4 5
20.	Ability to use a retinoscope (e.g., to detect anomalies in the ocular media).	0 1 2 3 4 5
21.	Knowledge of interactive refraction procedure (i.e., of what to do or say after each response from a patient, of how to help the patient make choices).	0 1 2 3 4 5
22.	Ability to use a phoropter to obtain subjective refractions at both distance and near.	0 1 2 3 4 5
23.	Ability to use Jackson cross cylinders to refine axis and power measurements, noting barely observable differences.	0 1 2 3 4 5
24.	Knowledge of the interaction between accommodation and convergence and its implications for prescribing lenses.	0 1 2 3 4 5
25.	Ability to apply appropriate tests for detecting eye suppression.	0 1 2 3 4 5
26.	Ability to determine a patient's near points of convergence and accommodation.	0 1 2 3 4 5
27.	Ability to measure the range of a patient's clear vision at near.	0 1 2 3 4 5
28.	Ability to use a patient's clinical data and history to determine an appropriate prescription for corrective lenses.	0 1 2 3 4 5
29.	Knowledge of topical ophthalmic dyes (e.g., fluorescein, useful in revealing corneal and conjunctival anomalies).	0 1 2 3 4 5

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	KNOWLEDGE	IMPORTANCE
30.	Knowledge of topical anesthetics or dye/anesthetic mixtures useful in preparing a patient's eyes for Goldmann tonometry.	0 1 2 3 4 5
31.	Knowledge of the possible adverse effects of instilling a dye, an anesthetic, or a dye/anesthetic mixture into a patient's eyes and of appropriate remedies.	0 1 2 3 4 5
32.	Knowledge of Goldmann tonometry and other tonometric methods.	0 1 2 3 4 5
33.	Knowledge of common anomalies of the anterior segment (i.e., of their identifying characteristics and implications for vision and health).	0 1 2 3 4 5
34.	Ability to perform biomicroscopy to detect anomalies (e.g., anterior segment, adnexa, and vitreous).	0 1 2 3 4 5
35.	Knowledge of mydriatics and cycloplegics and their indications and contraindications, together with their possible adverse effects, and appropriate managements of those effects.	0 1 2 3 4 5
36.	Ability to perform direct and binocular indirect ophthalmoscopy (e.g., detection of posterior-segment anomalies).	0 1 2 3 4 5
37.	Knowledge of the indications for indirect ophthalmoscopy with scleral depression.	0 1 2 3 4 5
38.	Knowledge of common anomalies of the posterior segment, the clinical signs that identify them, and their implications for vision and health.	0 1 2 3 4 5
39.	Ability to recognize eye anomalies that are potentially dangerous to the patient's eyesight, health, or life.	0 1 2 3 4 5
40.	Knowledge of keratometers and their uses in determining corneal toricity, corneal integrity, and tear film integrity.	0 1 2 3 4 5
41.	Ability to measure a patient's visual fields with perimeter and tangent screens, using static and kinetic stimuli, and to interpret the measurements.	0 1 2 3 4 5
42.	Knowledge of gonioscopic equipment and procedure for evaluating angle structure and the fundus.	0 1 2 3 4 5
43.	Knowledge of the cranial and facial nerves related to vision and of their lesions and defects.	0 1 2 3 4 5
44.	Ability to localize the neural lesion causing a particular visual defect.	0 1 2 3 4 5

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	KNOWLEDGE	IMPORTANCE
45.	Knowledge of color-vision testing materials, procedures, and interpretation (e.g., of how to determine whether defective color vision is congenital or acquired).	0 1 2 3 4 5
46.	Knowledge of Amsler-grid test procedure and interpretation.	0 1 2 3 4 5
47.	Knowledge of pinhole acuity testing and of the significance of the results.	0 1 2 3 4 5
48.	Knowledge of the adverse effects of ultraviolet light and other radiation on a patient's skin and eyes and of the means of patient protection.	0 1 2 3 4 5
49.	Knowledge of adverse effects secondary to contact lens wear.	0 1 2 3 4 5
50.	Knowledge of hypertension and its effects on systemic and ocular health.	0 1 2 3 4 5
51.	Ability to take a patient's blood pressures with standard measuring equipment.	0 1 2 3 4 5
52.	Ability to correlate ocular findings with systemic diseases (e.g., diabetes, STIs, hypercholesteremia).	0 1 2 3 4 5
53.	Knowledge of visual-system development (e.g., of the age at which to expect 20:20 vision in a young child, of the refractive status to expect at different ages, of the critical age for strabismus).	0 1 2 3 4 5

II. DIAGNOSIS AND TREATMENT PLANS

54.	Knowledge of the common causes and sequelae of particular eye disorders (e.g., Knowledge that the chief causes of amblyopia are anisometropia and strabismus; that the potential consequence of glaucoma is blindness).	0 1 2 3 4 5
55.	Ability to apply differential diagnoses relevant to a patient's profile, which includes: age, habits, and behaviors.	0 1 2 3 4 5
56.	Ability to recognize different diseases that produce similar ocular presentations.	0 1 2 3 4 5
57.	Knowledge of ocular immunological responses to allergens, viruses, and bacteria.	0 1 2 3 4 5
58.	Ability to perform differential diagnostic procedures and to choose treatments as the diagnostic findings indicate.	0 1 2 3 4 5
59.	Knowledge of which ocular pathologies can be identified by their clinical signs and which require laboratory services for their identification.	0 1 2 3 4 5

IMPORTANCE

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	KNOWLEDGE	IMPORTANCE
60.	Knowledge of when to order or refer for laboratory tests.	0 1 2 3 4 5
61.	Ability to interpret laboratory test findings for a patient's symptoms and clinical signs.	0 1 2 3 4 5
62.	Knowledge of optometric, ophthalmological, and other references as aids to diagnosis and treatment.	0 1 2 3 4 5
63.	Knowledge of common drugs and medications and their potential for interactions and adverse reactions.	0 1 2 3 4 5
64.	Knowledge of what each test applied to a patient is capable of revealing.	0 1 2 3 4 5
65.	Ability to determine whether the etiology of a vision defect is genetic, pathological, or nonpathological.	0 1 2 3 4 5
66.	Knowledge of chronic or recurrent systemic disorders that affect the eyes or vision, and of how to identify the disorders by their effects (e.g., knowledge that tuberculosis may produce phlyctenules).	0 1 2 3 4 5
67.	Knowledge that ocular dysfunctions may induce symptoms (e.g., that a phoria may induce untimely drowsiness; that binocular, accommodative, or refractive dysfunctions may induce headaches).	0 1 2 3 4 5
68.	Knowledge of psychosomatic visual disorders.	0 1 2 3 4 5
69.	Ability to gather and evaluate all relevant information about a patient's disorder so as to achieve a definitive diagnosis.	0 1 2 3 4 5
70.	Knowledge of the treatments available for specific common eye diseases and of treatment regimens appropriate to particular eye diseases and patient profiles.	0 1 2 3 4 5
71.	Knowledge of treatment alternatives for specific common eye diseases and the risks, benefits, costs, and prognosis for each alternative.	0 1 2 3 4 5
72.	Ability to explain all refractive treatment options, including their risks and relative costs, the prognosis with each, and the time required for each to succeed.	0 1 2 3 4 5
73.	Ability to communicate treatment options clearly and effectively to a patient or the patient's parents or caregivers.	0 1 2 3 4 5
74.	Knowledge that the treatment of minors requires the consent of parents or guardians.	0 1 2 3 4 5
75.	Knowledge of methods to diagnose astigmatism.	0 1 2 3 4 5

IMPORTANCE

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	KNOWLEDGE	IMPORTANCE
76.	Knowledge of methods to diagnose myopia.	0 1 2 3 4 5
77.	Knowledge of methods to diagnose presbyopia.	0 1 2 3 4 5
78.	Knowledge of methods to diagnose hyperopia.	0 1 2 3 4 5
79.	Knowledge of methods to diagnose nuclear sclerotic cataract	0 1 2 3 4 5
80.	Knowledge of methods to diagnose hypertension.	0 1 2 3 4 5
81.	Knoweldge of methods to diagnose dry eye syndrome.	0 1 2 3 4 5
82.	Knoweldge of methods to diagnose pseudophakia.	0 1 2 3 4 5
83.	Knoweldge of methods to diagnose diabetes, type 2.	0 1 2 3 4 5
84.	Knowledge of methods to diagnose allergies.	0 1 2 3 4 5
85.	Knowledge of methods to diagnose allergic congunctivitis.	0 1 2 3 4 5
86.	Knoweldge of methods to diagnose cortical cataract.	0 1 2 3 4 5
87.	Knowledge of methods to diagnose vitreous opacities/floaters.	0 1 2 3 4 5
88.	Knowledge of methods to diagnose glaucoma, suspect.	0 1 2 3 4 5
89.	Knowledge of methods to diagnose pinguecula.	0 1 2 3 4 5
90.	Knowledge of methods to diagnose hypercholesterolestrolemia.	0 1 2 3 4 5
91.	Knowledge of methods to diagnose glaucoma, open angle.	0 1 2 3 4 5
92.	Knowledge of methods to diagnose arcus.	0 1 2 3 4 5
93.	Knowledge of methods to diagnose arthritis.	0 1 2 3 4 5
94.	Knowledge of methods to diagnose blepharitis, unspecified.	0 1 2 3 4 5

III. SPECTACLES AND PROTECTIVE EYEWEAR

IMPORTANCE

HOW IMPORTANT is this knowledge/ability to performance of tasks in your current practice?

0 - Does not apply to my practice; not required
1 - Of minor importance or incidental performance.
2 - Fairly important for some minor part of my practice.
3 - Moderately important for a major part of my practice.
4 - Very important for a significant part of my practice.
5 - Critically important to performance.

	KNOWLEDGE	IMPORTANCE
95.	Knowledge of ANSI standards for ophthalmic goods.	0 1 2 3 4 5
96.	Knowledge of available lens choices and their inherent advantages and disadvantages (e.g., high-index lenses, polycarbonate lenses).	0 1 2 3 4 5
97.	Knowledge of the availability, advantages, and disadvantages of particular lens types, designs, and materials for particular patients (e.g., severe myopes, severe hyperopes).	0 1 2 3 4 5
98.	Knowledge of the types of multifocals available and the measurements and dispensing techniques needed for each type.	0 1 2 3 4 5
99.	Knowledge of preventive methods and first aid for laboratory injuries.	0 1 2 3 4 5
100.	Knowledge of how base curve, thickness, and vertex distance affect image size and patient comfort.	0 1 2 3 4 5
101.	Knowledge of supplemental spectacles for contact lens wearers.	0 1 2 3 4 5
102.	Knowledge of critical concerns when a patient is changing from contact lenses to spectacles.	0 1 2 3 4 5
103.	Knowledge of available frame materials, types, and styles (i.e., sport, safety).	0 1 2 3 4 5
104.	Knowledge of frame styles suitable for specific corrections and lens types (e.g., a high plus/minus, multifocal frame).	0 1 2 3 4 5
105.	Knowledge of the care and limitations of specific lenses, tints, and coatings (i.e., that special lens cloths and cleaners may be needed, that most tints and coatings can be applied only during lens manufacture).	0 1 2 3 4 5
106.	Ability to explain to a patient the advantages and disadvantages: of lens and frame materials and types; lens options (tints, coatings, beveling, edge finish, press-ons).	0 1 2 3 4 5
107.	Ability to adjust a frame so that it fits a patient securely and comfortably.	0 1 2 3 4 5
108.	Ability to repair spectacles.	0 1 2 3 4 5
109.	Knowledge of OSHA standards for safety eyewear.	0 1 2 3 4 5
110.	Ability to identify safety lenses and frames.	0 1 2 3 4 5
111.	Knowledge of common needs for protective eyewear (e.g., sports, vocations).	0 1 2 3 4 5

IMPORTANCE

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4 - Very important for a significant part of my practice.
5 - Critically important to performance.

		KNOWLEDGE / IMPORTANCE
	IV. CONTACT LENSES	
112.	Ability to judge whether a patient has the dexterity in handling lenses, inserting and removing lenses, and applying solutions that wearing contact lenses requires.	0 1 2 3 4 5
113.	Knowledge of eye conditions, allergies, and sensitivities to medication that contraindicate contact lens wear.	0 1 2 3 4 5
114.	Knowledge of common medications that affect contact lens wear (e.g., knowledge that birth control pills may adversely affect tear quality).	0 1 2 3 4 5
115.	Knowledge of allergic reactions to contact lens materials and solutions and of how to minimize or prevent them.	0 1 2 3 4 5
116.	Knowledge of the significance of environmental conditions for contact lens wear.	0 1 2 3 4 5
117.	Knowledge of phorometric procedure, of what it can reveal, and of the significance of phorias and ductions for contact lens wear.	0 1 2 3 4 5
118.	Ability to recognize, through slit-lamp examination, eye anomalies that affect contact lens wear (e.g., dry-eye syndrome, corneal erosions, and dystrophies).	0 1 2 3 4 5
119.	Ability to assess the quality of a patient's tears and to relate the assessment to the patient's suitability for contact lens daily wear or for extended wear.	0 1 2 3 4 5
120.	Ability to perform and interpret a Schirmer test or phenol red thread test of tear production.	0 1 2 3 4 5
121.	Ability to measure patient parameters (e.g., corneal diameter, pupil size, that are relevant to prescribing contact lenses).	0 1 2 3 4 5
122.	Ability to take keratometric measurements appropriate to determining a contact lens prescription.	0 1 2 3 4 5
123.	Ability to use keratometric measurements to evaluate corneal astigmatism and the contribution of the cornea to total astigmatism and total refraction.	0 1 2 3 4 5
124.	Ability to use a patient's spectacle prescription or refraction and keratometric measurements to assess the patient's candidacy for corneal refractive therapy or other refractive treatment options.	0 1 2 3 4 5

IMPORTANCE

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4 - Very important for a significant part of my practice.
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	KNOWLEDGE	IMPORTANCE
125.	Knowledge of corneal topography as a means of assessing an anomalous cornea (e.g., a keratoconic cornea).	0 1 2 3 4 5
126.	Ability to interpret a patient's corneal topography and draw appropriate conclusions regarding the patient's candidacy for regular contact lens wear or corneal refractive therapy.	0 1 2 3 4 5
127.	Knowledge that a patient's existing spectacle lens prescription can be used as a factor in choosing trial contact lenses if vertex distance is taken into account.	0 1 2 3 4 5
128.	Knowledge of the need to consider the size of the palpebral fissure in fitting contact lenses.	0 1 2 3 4 5
129.	Ability to determine the resultant correction by over-refraction while the patient wears trial contact lenses.	0 1 2 3 4 5
130.	Knowledge of the types and characteristics of contact lenses currently available to patients (e.g., knowledge of the water content and chemical qualities of particular lens materials).	0 1 2 3 4 5
131.	Knowledge of how each available type of contact lens improves vision (e.g., rigid as opposed to soft).	0 1 2 3 4 5
132.	Knowledge of periodical publications as a means of keeping abreast of changes in contact lens types and availability.	0 1 2 3 4 5
133.	Knowledge that refractive, keratometric, and test measurements and diagnostic lens fittings can be used to determine lens choices for a patient.	0 1 2 3 4 5
134.	Ability to determine the characteristics of the contact lenses most appropriate to prescribe for a particular patient [e.g., for a presbyope, both near and far corrections by means of (a) bifocal lenses or (b) a combination of contact lenses for far vision and reading glasses for near vision].	0 1 2 3 4 5
135.	Ability to determine parameters for contact lenses that will provide a patient with clear, comfortable, and safe vision.	0 1 2 3 4 5
136.	Ability to fit rigid lenses and assess their fit with a slit lamp and Burton lamp after instilling fluorescein (e.g., centration, movement, and for toric or bifocal lenses, orientation) from the fluorescein pattern the lens creates.	0 1 2 3 4 5
137.	Ability to evaluate soft lenses with a slit lamp (e.g., centration, movement, and physiological response).	0 1 2 3 4 5

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	KNOWLEDGE	IMPORTANCE
138.	Knowledge of how to fit contact lenses after eye surgery (e.g., after keratoplasty, refractive surgery).	0 1 2 3 4 5
139.	Knowledge of how to change contact lens parameters to improve the fit.	0 1 2 3 4 5
140.	Knowledge of contact lens wear schedules appropriate for particular patients, lens types, and lens materials.	0 1 2 3 4 5
141.	Ability to explain what a patient or a patient's caregivers should know about the handling, insertion and removal, care, cleaning, disinfecting, and use of the patient's contact lenses and about the adverse effects of inattention to proper procedures.	0 1 2 3 4 5
142.	Knowledge of contact lens care products appropriate for particular patients and lenses and of how each should be used.	0 1 2 3 4 5
143.	Knowledge of how to monitor and interpret a patient's histological and physiological responses to wearing contact lenses.	0 1 2 3 4 5
144.	Ability to assess a patient's subjective responses to contact lens wear.	0 1 2 3 4 5
145.	Knowledge of the causes of and remedies for common patient complaints about contact lenses.	0 1 2 3 4 5
146.	Knowledge of preventive care for ocular diseases that derive from contact lens wear (e.g., for corneal abrasion and scarring, allergic reactions to lens solutions).	0 1 2 3 4 5
147.	Knowledge that a troublesome lens should be inspected off the eye, under magnification.	0 1 2 3 4 5
148.	Knowledge of available prosthetic and therapeutic contact lenses that improve the appearance or function of abnormal or damaged eyes.	0 1 2 3 4 5

V. LOW VISION

149.	Knowledge of the etiology of low vision (e.g., genetic or acquired causes).	0 1 2 3 4 5
150.	Ability to recognize the visual conditions typical of low-vision patients (e.g., retinitis pigmentosa, macular degeneration).	0 1 2 3 4 5

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	KNOWLEDGE	IMPORTANCE
151.	Knowledge of the extent to which the effects of the ocular pathologies associated with low vision are remediable.	0 1 2 3 4 5
152.	Knowledge of the legal definition of blindness.	0 1 2 3 4 5
153.	Ability to elicit a low-vision patient's goals in seeking the help of an optometrist and to determine what goals can be realized.	0 1 2 3 4 5
154.	Knowledge of the psychosocial aspects of low vision.	0 1 2 3 4 5
155.	Knowledge of visual-field testing for low-vision patients, of how to interpret the results, and of how to provide visual aids for field modification.	0 1 2 3 4 5
156.	Knowledge of how to modify refractive examinations as needed for low-vision patients.	0 1 2 3 4 5
157.	Knowledge of the lighting appropriate for low-vision examinations and of home lighting appropriate for low-vision patients.	0 1 2 3 4 5
158.	Knowledge of eye charts (e.g., contrast sensitivity, for specific needs).	0 1 2 3 4 5
159.	Ability to assess a patient's responses to magnification and to telescopic and microscopic lenses.	0 1 2 3 4 5
160.	Knowledge of how to measure a patient's visual deficits and to use the measurements to calculate remedial magnifications.	0 1 2 3 4 5
161.	Ability to judge whether a patient has the mobility and dexterity needed to use a particular aid to vision.	0 1 2 3 4 5
162.	Knowledge of effective dual prescriptions for patients with difficulties at both distance and near (e.g., a monocular telescope with power appropriate to the patient's acuity at distance and a magnifier at near).	0 1 2 3 4 5
163.	Knowledge of the various optical aids available to help low-vision patients and of the advantages and disadvantages of each aid.	0 1 2 3 4 5
164.	Knowledge of the various nonoptical aids available to help low-vision patients.	0 1 2 3 4 5
165.	Knowledge of filters (e.g., CPF, NOIR, blue-blockers, for low-vision patients).	0 1 2 3 4 5
166.	Knowledge of common patient difficulties in using aids to vision.	0 1 2 3 4 5

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	KNOWLEDGE	IMPORTANCE
167.	Ability to train low-vision patients in the use of the aids they choose or accept.	0 1 2 3 4 5
168.	Knowledge of supplementary services for low-vision patients (e.g., of genetic counseling for patients with inherited conditions, of support groups and other services available to the visually impaired).	0 1 2 3 4 5

VI. BINOCULAR THERAPY AND/OR VISION TRAINING

169.	Ability to use a patient's history and relevant information from parents and educators to plan a problem-oriented eye examination and, later, to evaluate examination findings.	0 1 2 3 4 5
170.	Ability to assess a muscle imbalance using cycloplegics when indicated.	0 1 2 3 4 5
171.	Knowledge of examination procedures needed to find visual anomalies (e.g., to detect and measure binocular dysfunctions).	0 1 2 3 4 5
172.	Ability to perform and interpret objective tests of binocularity as needed (e.g., a cover test, a Hirschberg test).	0 1 2 3 4 5
173.	Ability to perform and interpret special tests as needed (e.g., stereoscopic "fly" and "reindeer," Worth 4 dot test).	0 1 2 3 4 5
174.	Knowledge of subjective tests for suppression (e.g., pola vision test).	0 1 2 3 4 5
175.	Knowledge of objective tests for suppression (e.g., Worth 4 dot test).	0 1 2 3 4 5
176.	Knowledge of subjective tests for eccentric fixation (e.g., Haidinger's brush and Maxwell's spot).	0 1 2 3 4 5
177.	Knowledge of objective test for eccentric fixation (e.g., visuoscopy).	0 1 2 3 4 5
178.	Knowledge of eccentric fixation treatment options.	0 1 2 3 4 5
179.	Knowledge of motor and visual developmental milestones in children.	0 1 2 3 4 5
180.	Knowledge of how good vision and poor vision affect and interact with the developing psychology of a child.	0 1 2 3 4 5
181.	Ability to determine what therapy is appropriate, the prognosis, and whether or not to refer.	0 1 2 3 4 5

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	KNOWLEDGE	IMPORTANCE
182.	Knowledge of tests and of lens and prism corrections, for binocular misalignment, latent hyperopia, or aniseikonia.	0 1 2 3 4 5
183.	Knowledge of contrast sensitivity testing and interpretation.	0 1 2 3 4 5
184.	Knowledge of Sheard's and Percival's criteria for the amount of prism to prescribe.	0 1 2 3 4 5
185.	Ability to determine a patient's fixation disparity and derive a prism prescription.	0 1 2 3 4 5
186.	Knowledge of optometric procedures that utilize flippers, prisms, and anaglyphs and of how and when to use them.	0 1 2 3 4 5
187.	Knowledge of lenses for improving binocularity and focusing at near.	0 1 2 3 4 5
188.	Knowledge of binocular tests with a phoropter (e.g., polaroid, red/green, Maddox, and vectograph tests).	0 1 2 3 4 5
189.	Ability to use prisms to determine a patient's binocular status.	0 1 2 3 4 5
190.	Ability to refract with a trial frame and the lenses to be prescribed.	0 1 2 3 4 5
191.	Ability to recognize from symptoms the need to change a binocular prescription and to change it as needed to eliminate discomfort or diplopia.	0 1 2 3 4 5
192.	Ability to improve a patient's vision and appearance with appropriate spectacle frames, lenses, and prisms (e.g., to optimize the cosmetic appearance and balance of new spectacles by splitting the prism power between lenses).	0 1 2 3 4 5
193.	Knowledge of how lenses are fabricated and of how to verify that the prisms in new spectacles match the prescription.	0 1 2 3 4 5
194.	Knowledge of methods for sequential vision training.	0 1 2 3 4 5
195.	Ability to educate, reassure, and motivate a patient and the patient's parents and caregivers regarding a patient's training.	0 1 2 3 4 5
196.	Knowledge of home vision-training procedures and schedules appropriate for patients with particular needs after an appropriate lens correction.	0 1 2 3 4 5
197.	Knowledge of how to monitor a vision-training patient's progress on tasks, to judge the need for additional training or a change in training.	0 1 2 3 4 5

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	KNOWLEDGE	IMPORTANCE
198.	Knowledge of learning-related visual functions and of how to train a patient to improve them.	0 1 2 3 4 5
199.	Knowledge of dyslexia symptoms, tests, and treatments.	0 1 2 3 4 5
	VII. TREATING EYE DISORDERS/REFERRING FOR TREATMENT	
200.	Knowledge of the disease processes that produce common eye disorders (e.g., conjunctivitis, iritis, uveitis, glaucoma, diabetic retinopathy).	0 1 2 3 4 5
201.	Knowledge of the therapeutic drugs that an optometrist may administer and of the conditions for which they may be used under California law.	0 1 2 3 4 5
202.	Knowledge of the indications and contraindications for common therapeutic drugs; the appropriate dosages, administration schedules, and durations of use; the possible side effects; and the appropriate responses to side effects.	0 1 2 3 4 5
203.	Knowledge of ocular lubricants (e.g., artificial tears as a palliative for eye dryness).	0 1 2 3 4 5
204.	Knowledge of collagen punctal plugs as a way to impede tear drainage temporarily and relieve eye dryness.	0 1 2 3 4 5
205.	Ability to apply temporary punctal plugs safely and effectively and to judge from the patient's response whether to refer for permanent plugs.	0 1 2 3 4 5
206.	Knowledge of good eyelid hygiene as prophylaxis and part of therapy for lid diseases.	0 1 2 3 4 5
207.	Knowledge of therapies for eye diseases that derive from contact lens wear.	0 1 2 3 4 5
208.	Knowledge of possible interactions between ocular and systemic medications and of how to avoid or remedy interactions adverse to the patient.	0 1 2 3 4 5
209.	Knowledge of instruments and procedures for removing a foreign body from an eye and of how to use them safely and effectively.	0 1 2 3 4 5
210.	Knowledge of instruments and procedures for epilating eyelashes to relieve trichiasis, of how to use a lid everter and epilation tweezers safely and effectively.	0 1 2 3 4 5
211.	Knowledge of the appropriate management of epithelial defects (e.g., corneal erosion or abrasion).	0 1 2 3 4 5
212.	Knowledge of nutrition and nutritional supplements as they relate to ocular health.	0 1 2 3 4 5

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	KNOWLEDGE	IMPORTANCE
213.	Knowledge of patient conditions for which a referral is legally necessary.	0 1 2 3 4 5
214.	Knowledge of appropriate referrals of particular eye or vision disorders.	0 1 2 3 4 5
215.	Knowledge of appropriate referrals of systemic disorders discovered through providing optometric service.	0 1 2 3 4 5
216.	Knowledge of recurrent symptoms or signs that call for referral (e.g., recurrent eye hemorrhages, recurrent headaches).	0 1 2 3 4 5
217.	Ability to write appropriate referral letters, including the information about the patient that should accompany the referral.	0 1 2 3 4 5
218.	Knowledge of the points in the development of particular conditions at which referral for surgery is appropriate (e.g., of appropriate timelines for referring a cataract or diabetic retinopathy).	0 1 2 3 4 5
219.	Knowledge of appropriate and inappropriate candidates for eye surgery.	0 1 2 3 4 5
220.	Ability to recognize that eye surgery is needed; to explain to the patient the risks, benefits, alternatives, and possible complications; and to reassure anxious patients.	0 1 2 3 4 5
221.	Knowledge of the detrimental effects of high-risk behaviors (e.g., excessive sun exposure, smoking) to a patient's vision and health.	0 1 2 3 4 5
222.	Knowledge of common patient medications that may induce eye or other disorders as side effects and of prophylactic measures, if they exist.	0 1 2 3 4 5
223.	Knowledge of ocular and systemic diseases that threaten eyesight, health, or life; and of appropriate preventive care.	0 1 2 3 4 5

VIII. PATIENT EMERGENCIES

224.	Ability to judge from a patient's symptoms whether the patient should be seen immediately and to train office staff to make the same judgment and to err on the side of the patient's safety.	0 1 2 3 4 5
225.	Knowledge of the possible legal ramifications of allowing office staff to triage patient symptoms.	0 1 2 3 4 5

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	KNOWLEDGE	IMPORTANCE
226.	Knowledge of extended examination procedures for common ocular emergencies.	0 1 2 3 4 5
227.	Ability to recognize clinical signs of a potential emergency (e.g., in a patient who is diabetic, hypertensive, or glaucomatous).	0 1 2 3 4 5
228.	Knowledge of how to recognize true emergencies (i.e., conditions immediately threatening to a patient's eyesight, health, or life).	0 1 2 3 4 5
229.	Knowledge of the management of a patient who presents with a vasovagal reaction, low blood sugar level, or epileptic seizure.	0 1 2 3 4 5
230.	Knowledge of the management of a patient with an adverse reaction (e.g., anaphylactic shock, breathing difficulties, anesthesia, dilating drops).	0 1 2 3 4 5
231.	Ability to recognize or determine that a particular emergency requires an immediate referral.	0 1 2 3 4 5
232.	Knowledge of lawful means of palliating and stabilizing a patient's condition to facilitate an emergency referral.	0 1 2 3 4 5

IX. CO-MANAGING PATIENTS

233.	Ability to co-manage a patient with a developing or advanced ocular pathology.	0 1 2 3 4 5
234.	Knowledge of indications for referral associated with developing eye disorders (e.g. diabetic retinopathy, glaucoma, macular degeneration).	0 1 2 3 4 5
235.	Knowledge of indications for referral associated with systemic diseases (e.g., multiple sclerosis, Grave's disease).	0 1 2 3 4 5
236.	Knowledge of testing to confirm the presence of a disorder associated with the eye (e.g., of blood panels, carotid tests).	0 1 2 3 4 5
237.	Knowledge of pre and post operative optometric care for patients referred for surgery (e.g., cataract, refractive, or glaucoma surgery).	0 1 2 3 4 5
238.	Knowledge of appropriate and workable nonsurgical co-management protocols.	0 1 2 3 4 5
239.	Knowledge of the need to interview a returning referred patient regarding post-therapy discomfort, compliance with the therapeutic plan, and quality of vision.	0 1 2 3 4 5
240.	Knowledge of therapeutic complications and of their remedies, where remedies exist.	0 1 2 3 4 5

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	KNOWLEDGE	IMPORTANCE
241.	Knowledge of common therapies for which referrals are made (e.g., for a cataract-removal case, refractive surgery).	0 1 2 3 4 5
242.	Knowledge of appropriate intervals for follow-up checks of particular co-management patients.	0 1 2 3 4 5
243.	Knowledge of appropriate medications for common conditions and of the California laws regulating optometrists' use of therapeutic drugs.	0 1 2 3 4 5
244.	Knowledge of common patient conditions requiring referral, of the signs and symptoms of a significant improvement or cure.	0 1 2 3 4 5

YOU HAVE COMPLETED PART III OF THE SURVEY QUESTIONNAIRE.

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE.

Please check to see that you have responded to every item and return the questionnaire in the prepaid envelope provided.

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APPENDIX B – RESPONDENTS BY REGION

1 – LOS ANGELES AND VICINITY

Los Angeles	70
Orange	27

TOTAL LOS ANGELES: 97

2 – SAN FRANCISCO BAY AREA

Alameda	13
Contra Costa	11
Marin	2
Napa	1
San Francisco	4
San Mateo	12
Santa Clara	22
Solano	1

TOTAL BAY AREA: 66

3 – SAN JOAQUIN VALLEY

Fresno	4
Kern	7
Kings	1
Merced	1
San Benito	1
San Joaquin	4
Stanislaus	4
Tulare	3

TOTAL SAN JOAQUIN: 25

4 – SACRAMENTO VALLEY

Butte	2
Sacramento	10
Sutter	2
Yolo	1
Yuba	1

TOTAL SACRAMENTO: 16

5 – SAN DIEGO AND VICINITY

San Diego	17

TOTAL SAN DIEGO: 17

6 – SHASTA/CASCADE

Plumas	1
Shasta	5
Siskiyou	2
Trinity	1

TOTAL SHASTA/CASCADE: 9

7 – RIVERSIDE AND VICINITY

Riverside	8
San Bernardino	8

TOTAL RIVERSIDE: 16

8 - SIERRA MOUNTAIN VALLEY

Amador	2
El Dorado	1
Nevada	1
Placer	2
Sierra	1
Tehama	2

TOTAL SIERRA MOUNTAIN VALLEY: 9

9 - NORTH/CENTRAL COAST

Mendocino	2
Monterey	1
Sonoma	3

TOTAL NORTH/CENTRAL COAST: 6

10 – SOUTH COAST

San Luis Obispo	2
Santa Barbara	1
Ventura	5

TOTAL SOUTH COAST: 8

11 – MISSING

Missing	6

TOTAL UNKNOWN: 6

TOTAL RESPONDENTS: 275

APPENDIX C – SCALE MEANS AND CRITICAL INDICES FOR ALL TASKS

I. Patient Examination

ITEM	JOB TASK	MEAN TASK		MEAN CRITICAL TASK INDEX
		FREQ (F)	IMP (I)	
16.	Perform biomicroscopy to aid in assessing patient's ocular health.	4.89	4.87	24.00
12.	Perform subjective refraction to assess each eye's refractive status at distance and near.	4.91	4.84	23.91
15.	Measure patient's intraocular pressures to screen for pressure related conditions.	4.88	4.81	23.62
1.	Take a patient history including current health status [e.g., visual and medical history, personal and family history, presenting complaint(s)].	4.74	4.82	23.22
18.	Perform direct and/or binocular indirect ophthalmoscopy as needed to assess the health of each posterior segment.	4.74	4.83	23.12
6.	Document patient's initial visual acuities.	4.74	4.65	22.45
7.	Test patient's pupillary light responses to determine neurological integrity.	4.77	4.63	22.42
17.	Use diagnostic pharmaceutical agents (DPAs) as needed to facilitate refractive and ocular health assessments.	4.54	4.66	21.46
2.	Question patient to obtain additional information regarding history, current health status, and/or complaint(s).	4.51	4.53	20.87
5.	Verify patient's existing corrective lenses to expand patient history and refractive status.	4.54	4.39	20.55
9.	Test patient's visual fields for gross deficits.	4.48	4.37	20.13
8.	Perform cover test to assess patient's binocular alignment and ocular movement (e.g., strabismus).	4.54	4.22	19.68
3.	Observe patient for abnormalities, (e.g., psychological, physical, ocular) to facilitate diagnosis and treatment.	4.30	4.23	18.90
22.	Perform visual-fields tests as indicated by history or prior test results.	4.10	4.28	18.68
4.	Evert a patient's eyelids when indicated, (e.g., diseases, foreign bodies, allergies).	3.95	4.19	17.26
11.	Perform objective measurement (e.g., retinoscopy) to assess each eye's refractive status.	3.89	3.93	16.62
19.	Perform keratometry as needed to determine the curvature of the cornea.	3.67	3.57	14.20
14.	Perform accommodative test(s) to assess ocular focus ability.	3.53	3.43	13.57

23.	Use an Amsler grid to reveal central field irregularities.	3.14	3.75	12.60
13.	Perform binocular test(s) (e.g., phorias, ductions, tropias, suppression, and range of convergence and divergence at distance and near) to determine the degree of ocular coordination.	3.36	3.31	12.44
24.	Perform pinhole acuity tests as indicated.	3.10	3.55	12.44
21.	Perform color deficiency tests as indicated.	3.25	3.16	11.28
10.	Measure patient's interpupillary distances.	2.80	2.82	10.55
25.	Take and assess a patient's blood pressure.	2.09	2.79	7.82
20.	Perform gonioscopy as needed to determine the integrity of angle structures.	1.83	2.71	6.58

II. Diagnosis and Treatment Plans

ITEM	JOB TASK	MEAN TASK		MEAN CRITICAL TASK INDEX
		FREQ (F)	IMP (I)	
26.	Make differential diagnoses based on symptoms, clinical examination, and history as indicated.	4.73	4.76	22.71
30.	Determine and provide a treatment plan, which may include, but is not limited to, spectacles or contact lenses, vision therapy, low-vision rehabilitation, medication, or observation, referral, and follow-up.	4.73	4.72	22.71
33.	Educate patient about how to maintain visual health and integrity.	4.54	4.60	21.14
32.	Explain to a patient refractive treatment options (e.g., spectacles, contact lenses, orthokeratology, refractive surgery, and vision therapy).	4.46	4.43	20.35
27.	Select additional procedures or tests to confirm or rule out diagnoses as indicated.	4.42	4.59	20.72
31.	Prepare treatment plans that provide patient options and explain the risks, benefits, prognoses, and relative costs with each option.	4.31	4.39	19.63
29.	Identify patients with systemic disorders that may affect the eyes or visual system (e.g., patients with vascular, neurological, endocrinological, or allergic disorders).	4.18	4.48	19.20
28.	Interpret diagnostic findings and consultative reports, using references as needed to confirm diagnosis.	4.08	4.35	18.54

III. Spectacles and Protective Eyewear

ITEM	JOB TASK	MEAN TASK		MEAN CRITICAL TASK INDEX
		FREQ (F)	IMP (I)	
40.	Provide patient with a written spectacle prescription as required by law.	4.57	4.22	19.93
41.	Analyze and address patient's complaints with newly prescribed spectacles.	4.13	4.37	18.61
34.	Educate patient about lens options (e.g., lens material, type, tint, coating, and multifocal style) to assist in making an informed decision.	3.99	4.06	17.11
43.	Explain the need for protective eyewear and eyewear alternatives (e.g., safety lenses, UV coating) to help a patient obtain adequate protection.	3.98	4.13	17.24
36.	Prescribe spectacles for a contact lens wearer (e.g., to improve a patient's binocularity for driving, or to improve near vision for presbyopes).	3.87	3.93	16.09
37.	Educate patient about spectacle frame options that meet the patient's needs (e.g., minimize lens thickness and weight).	3.40	3.63	13.81
35.	Prescribe base curves and lens thicknesses that improve visual function, appearance, and comfort.	2.75	3.21	10.46
39.	Inform patient how to care for spectacles, recommending appropriate supplies and procedures.	2.67	3.07	10.13
38.	Adjust a spectacle frame as needed to give a patient a secure, comfortable, pleasing, and optically correct fit.	2.54	3.22	10.45
42.	Repair spectacle frames (e.g., straighten bowed temples, replace lost screws, remove broken screws, change or replace nosepads and bridges).	2.19	2.70	8.27

IV. Contact Lenses

ITEM	JOB TASK	MEAN TASK		MEAN CRITICAL TASK INDEX
		FREQ (F)	IMP (I)	
47.	Examine patient with a biomicroscope to check for current ocular health conditions (e.g., severe dry eyes, corneal damage) that affect contact lens wearability.	4.72	4.68	22.86
59.	Evaluate the fit and movement of contact lenses.	4.60	4.51	21.60
44.	Evaluate patient's wants, needs, and goals in considering or requesting contact lenses.	4.46	4.41	20.57
55.	Determine the type of contact lens most appropriate for a patient (e.g., soft vs. RGP, spherical vs. toric).	4.42	4.37	20.42
45.	Review patient's history to evaluate problems with contact lenses and conditions, allergies, or medications that might affect contact lens use.	4.36	4.37	19.88
46.	Review examination records if available to identify patient's past or current corrective prescription.	4.35	4.28	19.56
58.	Evaluate the contact lens modality for patient (e.g., daily wear, extended wear, flexible wear).	4.34	4.28	19.60
61.	Analyze and address patient's problems with newly prescribed contact lenses.	4.30	4.40	19.92
60.	Educate patient or the patient's parents or caregivers as needed in the handling, insertion and removal, care, cleaning, disinfection, and use of contact lenses.	4.08	4.41	19.18
56.	Calculate the parameters of the lenses to be prescribed from diagnostic data.	4.06	4.09	18.03
52.	Perform an over-refraction with a contact lens in place.	4.05	3.94	17.18
50.	Measure patient parameters relevant to contact lens wear (e.g., corneal curvature).	3.99	3.90	17.21
57.	Assess fluorescein patterns with a slit-lamp/Burton lamp to evaluate the fit of rigid lenses.	3.98	4.23	18.31
62.	Monitor and evaluate a patient's physiological response to contact lens wear with dyes and instruments.	3.89	3.99	17.01
48.	Assess the quality of patient's tears (e.g., measure tear break-up time).	3.84	4.00	16.24
51.	Perform keratometry to measure a patient's corneas, corneal toricity, and the contribution of each cornea to total astigmatism and total refraction.	3.72	3.80	16.00

53.	Verify the parameters for the most suitable rigid lenses with appropriate instruments.	3.11	3.46	12.92
54.	Perform, or refer for, corneal topography as needed.	2.44	3.05	9.88
49.	Assess a patient's tear production (e.g., perform a Schirmer tear test or a phenol red thread test).	2.17	2.71	7.76
63.	Explain the availability and benefits of prosthetic or therapeutic lenses.	2.10	2.74	7.93

V. Low Vision

ITEM	JOB TASK	MEAN TASK		MEAN CRITICAL TASK INDEX
		FREQ (F)	IMP (I)	
65.	Perform refractive examinations for both near and distance vision, using a phoropter, trial lenses, and/or low-vision devices.	2.07	2.58	8.53
64.	Assess low vision patient's needs and wants (i.e., what visual needs are essential to the patient's lifestyle or desired lifestyle) to determine treatment plan.	1.44	2.22	5.48
71.	Educate patient regarding support groups and services available to the visually impaired.	1.20	2.05	4.53
68.	Recommend optical aids to patient, (e.g., a monocular telescope, binoculars, high-add reading glasses) to increase visual quality.	1.07	1.82	3.90
69.	Recommend nonoptical aids, (e.g., felt-tip pens, electronic aids, large-print books) to improve patient's visual functioning.	1.01	1.74	3.74
66.	Evaluate low-vision patient's visual deficits and calculate the remedial magnifications needed.	.95	1.75	3.54
67.	Assess low-vision patient's mobility and dexterity relative to possible remedies.	.86	1.62	3.23
70.	Train patient as needed in the use of the aids to vision that the patient chooses.	.66	1.44	2.45

VI. Binocular Therapy and/or Vision Training

ITEM	JOB TASK	MEAN TASK		MEAN CRITICAL TASK INDEX
		FREQ (F)	IMP (I)	
76.	Decide whether to treat a patient with poor binocular performance and/or, refer the patient to a vision training specialist or refer the patient for surgery.	2.51	3.22	9.83
77.	Educate a patient with a binocular problem or who needs vision training, regarding course of treatment, length of treatment, and intended outcomes.	2.00	2.64	7.72
74.	Conduct an examination oriented to a patient's binocularity.	1.98	2.49	7.60
72.	Take and interpret a history oriented to a patient's presenting binocular condition.	1.84	2.42	7.17
75.	Evaluate whether binocular vision therapy is indicated for patient and, if so, what form of therapy is appropriate.	1.72	2.24	6.34
73.	Evaluate information provided by patient, parents, educational psychologists, and teachers regarding binocular function.	1.63	2.27	6.15
78.	Prepare a sequential vision training treatment plan for a patient with binocular problems.	1.01	1.65	3.84

VII. Treating Eye Disorders/Referring for Treatment

ITEM	JOB TASK	MEAN TASK		MEAN CRITICAL TASK INDEX
		FREQ (F)	IMP (I)	
79.	Recommend lubricants (e.g., artificial tears) for patients with dry eyes).	4.62	4.50	21.12
90.	Refer disorders of the anterior segment and disorders of the posterior segment to appropriate specialists as the patient's needs dictate and as the law requires.	3.90	4.64	18.42
94.	Advise patient about behaviors that can affect the eyes or vision (e.g., excessive exposure to the sun, smoking).	4.07	4.30	18.11
82.	Prescribe topical or oral antiallergenics (e.g., for allergic conjunctivitis).	3.97	4.31	17.92
81.	Prescribe topical, nonsteroidal anti-inflammatories and topical antibiotics for eye diseases of the anterior segment (e.g., bacterial conjunctivitis).	3.83	4.40	17.52
89.	Monitor glaucoma suspects and glaucoma patients and refer them to specialists as needed.	3.70	4.45	17.49
96.	Refer patient with a developing, threatening condition of the need for preventive care and medical attention.	3.71	4.51	17.23
91.	Refer newly suspected systemic diseases to appropriate specialists as the patient's needs dictate and as the law requires.	3.64	4.59	17.09
92.	Treat and/or refer corneal diseases that derive from contact lens wear.	3.65	4.44	16.78
83.	Prescribe topical or oral medications for infectious peripheral corneal ulcers, corneal abrasions, and corneal-surface disease.	3.55	4.34	16.38
93.	Recommend multivitamins and antioxidants that may help prevent eye diseases.	3.63	4.05	15.58
95.	Advise patient about the side effects, particularly the ocular effects, of particular drugs and medications, and of preventive care.	3.56	4.09	15.28
84.	Prescribe topical or oral medications to treat blepharitis.	3.40	4.03	14.72
88.	Epilate eyelashes to treat trichiasis.	2.89	3.74	11.86
86.	Remove nonperforating foreign bodies from a cornea with appropriate instruments.	2.66	3.87	11.66
87.	Remove foreign bodies from the sclera, eyelid, or adenxa with appropriate instruments.	2.39	3.62	10.27
85.	Prescribe oral medication to treat chalazion if	2.34	3.24	9.82

	heat and digital massage are not effective.			
80.	Insert collagen punctal plugs to palliate eye dryness and to test whether permanent plugs might provide long-term relief.	1.73	2.62	6.59

VIII. Patient Emergencies

ITEM	JOB TASK	MEAN TASK		MEAN CRITICAL TASK INDEX
		FREQ (F)	IMP (I)	
99.	Perform examinations directed to the presenting ocular emergency (e.g., check for anterior-chamber reaction in a traumatized eye, dilate a traumatized eye and check for retinal detachment).	3.37	4.36	15.75
97.	Train office staff to distinguish between telephoned descriptions of genuine and presumed ocular emergencies, to ask appropriate questions as needed, and to err on the side of the patient's safety.	3.00	3.91	13.70
100.	Determine whether patient's symptoms and clinical signs characterize a true emergency (e.g., acid or alkali burns, an angle closure glaucoma attack) or other condition(s) that acutely threatens the patient's eyesight, health, or life.	2.88	4.36	13.41
98.	Establish procedures for dealing with emergencies that arise in the office.	2.82	3.88	12.69
101.	Refer a true emergency for immediate medical care.	2.59	4.49	12.19

IX. Co-managing Patients

ITEM	JOB TASK	MEAN TASK		MEAN CRITICAL TASK INDEX
		FREQ (F)	IMP (I)	
102.	Educate patient about recommended ocular procedures and their possible risks and benefits prior to making a referral.	3.66	4.29	16.34
103.	Co-manage patient with developing or advanced pathology (e.g., a patient with developing cataracts, background diabetic retinopathy).	3.34	4.04	14.90
104.	Establish a co-management protocol and refer patient for corrective surgery or other remedial therapy.	3.16	3.85	13.75
106.	Assess whether patient satisfaction, symptoms, and clinical signs imply an improvement or cure of the condition for which the patient was referred.	3.16	3.77	13.37
107.	Co-manage patients with systemic diseases (e.g., hypertension, diabetes) with their physicians.	2.82	3.65	12.15
105.	Co-manage patient following remedial therapy (e.g., check whether a prescribed medication is being used, whether the medication should be altered).	2.66	3.49	11.19

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APPENDIX D – SCALE MEANS AND CRITICAL INDICES FOR ALL KNOWLEDGE STATEMENTS

I. Patient Examination

ITEM	KNOWLEDGE STATEMENT	IMP (I)
34.	Ability to perform biomicroscopy to detect anomalies (e.g., anterior segment, adnexa, and vitreous).	4.78
36.	Ability to perform direct and binocular indirect ophthalmoscopy (e.g., detection of posterior-segment anomalies).	4.75
22.	Ability to use a phoropter to obtain subjective refractions at both distance and near.	4.74
33.	Knowledge of common anomalies of the anterior segment (i.e., of their identifying characteristics and implications for vision and health).	4.64
39.	Ability to recognize eye anomalies that are potentially dangerous to the patient's eyesight, health, or life.	4.62
32.	Knowledge of Goldmann tonometry and other tonometric methods.	4.59
21.	Knowledge of interactive refraction procedure (i.e., of what to do or say after each response from a patient, of how to help the patient make choices).	4.58
19.	Knowledge of the external and internal anatomy of the eye and of the normal range of variation in the appearance of each of its components (i.e., knowledge of what is normal and what is abnormal or anomalous.	4.49
2.	Ability to communicate with a patient or a patient's caregiver so as to elicit a clearly stated presenting complaint, a useful account of symptoms, and adequately detailed ocular, medical, and family histories.	4.48
28.	Ability to use a patient's clinical data and history to determine an appropriate prescription for corrective lenses.	4.48
35.	Knowledge of mydriatics and cycloplegics and their indications and contraindications, together with their possible adverse effects, and appropriate managements of those effects.	4.45
1.	Knowledge of the types of information that constitute a comprehensive, useful patient history.	4.43
38.	Knowledge of common anomalies of the posterior segment, the clinical signs that identify them, and their implications for vision and health.	4.43
12.	Ability to test a patient's pupillary responses to light for pupillary anomalies.	4.40
29.	Knowledge of topical ophthalmic dyes (e.g., fluorescein, useful in revealing corneal and conjunctival anomalies).	4.37
23.	Ability to use Jackson cross cylinders to refine axis and power measurements, noting barely observable differences.	4.35
49.	Knowledge of adverse effects secondary to contact lens wear.	4.35
10.	Ability to determine all parameters of a patient's existing correction by measuring the corrective lenses with appropriate instruments.	4.34
30.	Knowledge of topical anesthetics or dye/anesthetic mixtures useful in preparing a patient's eyes for Goldmann tonometry.	4.31
52.	Ability to correlate ocular findings with systemic diseases (e.g.,	4.26

	diabetes, STIs, hypercholesteremia).	
9.	Ability to evert a patient's eyelids safely and recognize diseases (e.g., giant papillary conjunctivitis).	4.17
13.	Knowledge of pupillary anomalies (e.g., afferent pupillary defect, and their underlying causes).	4.17
5.	Ability to interpret a presenting problem in the light of the patient's ocular, medical, and family histories (e.g., to decide whether the current problem is new or an expected continuation of problems past).	4.13
50.	Knowledge of hypertension and its effects on systemic and ocular health.	4.11
3.	Knowledge of the ocular manifestations of systemic diseases [e.g., the susceptibility to dry eye and meibomitis of middle-aged, arthritic women (Sjogren's syndrome), the symptoms associated with sexually transmitted diseases such as syphilis].	4.09
31.	Knowledge of the possible adverse effects of instilling a dye, an anesthetic, or a dye/anesthetic mixture into a patient's eyes and of appropriate remedies.	4.09
48.	Knowledge of the adverse effects of ultraviolet light and other radiation on a patient's skin and eyes and of the means of patient protection.	4.01
27.	Ability to measure the range of a patient's clear vision at near.	3.95
20.	Ability to use a retinoscope (e.g., to detect anomalies in the ocular media).	3.92
16.	Ability to perform confrontational visual-fields tests to detect gross visual-field defects and to distinguish malingering from hysterical patients.	3.85
24.	Knowledge of the interaction between accommodation and convergence and its implications for prescribing lenses.	3.80
46.	Knowledge of Amsler-grid test procedure and interpretation.	3.80
47.	Knowledge of pinhole acuity testing and of the significance of the results.	3.78
6.	Ability to identify any common facial anomaly (e.g., carcinoma, ptosis) and understand its health or ocular health implications.	3.74
53.	Knowledge of visual-system development (e.g., of the age at which to expect 20:20 vision in a young child, of the refractive status to expect at different ages, of the critical age for strabismus).	3.65
14.	Ability to recognize symptoms and clinical signs of binocular dysfunction.	3.64
15.	Ability to perform and interpret tests for defects in binocular alignment, eye movement, or versions.	3.64
11.	Ability to determine the visual acuity of pediatric, illiterate, uncooperative, malingering, or low-vision patients as well as of normal adult patients.	3.63
40.	Knowledge of keratometers and their uses in determining corneal toricity, corneal integrity, and tear film integrity.	3.61
26.	Ability to determine a patient's near points of convergence and accommodation.	3.51

18.	Knowledge of methods used to test a patient's stereopsis.	3.40
41.	Ability to measure a patient's visual fields with perimeter and tangent screens, using static and kinetic stimuli, and to interpret the measurements.	3.35
17.	Ability to measure a patient's interpupillary distance, even if the patient is strabismic or exotropic.	3.28
4.	Knowledge of congenital and developmental syndromes (e.g., fetal-alcohol, Down's, cerebral palsy, and their characteristic effects on vision).	3.26
25.	Ability to apply appropriate tests for detecting eye suppression.	3.24
45.	Knowledge of color-vision testing materials, procedures, and interpretation (e.g., of how to determine whether defective color vision is congenital or acquired).	3.22
51.	Ability to take a patient's blood pressures with standard measuring equipment.	3.21
37.	Knowledge of the indications for indirect ophthalmoscopy with scleral depression.	3.19
43.	Knowledge of the cranial and facial nerves related to vision and of their lesions and defects.	3.09
44.	Ability to localize the neural lesion causing a particular visual defect.	3.01
8.	Ability to recognize a patient's behavioral signs of communicative impairment (e.g., signs of hearing impairment).	3.00
42.	Knowledge of gonioscopic equipment and procedure for evaluating angle structure and the fundus.	2.89
7.	Ability to perform a cranial-nerve assessment to determine a patient's neurological status.	2.87

II. Diagnoses and Treatment Plans

ITEM	KNOWLEDGE STATEMENT	IMP (I)
76.	Knowledge of methods to diagnose myopia.	4.70
77.	Knowledge of methods to diagnose presbyopia.	4.70
78.	Knowledge of methods to diagnose hyperopia.	4.68
79.	Knowledge of methods to diagnose nuclear sclerotic cataract	4.59
81.	Knoweldge of methods to diagnose dry eye syndrome.	4.53
73.	Ability to communicate treatment options clearly and effectively to a patient or the patient's parents or caregivers.	4.52
88.	Knowledge of methods to diagnose glaucoma, suspect.	4.52
85.	Knowledge of methods to diagnose allergic congunctivitis.	4.51
91.	Knowledge of methods to diagnose glaucoma, open angle.	4.48
54.	Knowledge of the common causes and sequelae of particular eye disorders (e.g., Knowledge that the chief causes of amblyopia are anisometropia and strabismus; that the potential consequence of glaucoma is blindness).	4.47
87.	Knowledge of methods to diagnose vitreous opacities/floaters.	4.43
84.	Knowledge of methods to diagnose allergies.	4.42
86.	Knoweldge of methods to diagnose cortical cataract.	4.40
58.	Ability to perform differential diagnostic procedures and to choose treatments as the diagnostic findings indicate.	4.35
82.	Knoweldge of methods to diagnose pseudophakia.	4.35
83.	Knoweldge of methods to diagnose diabetes, type 2.	4.32
94.	Knowledge of methods to diagnose blepharitis, unspecified.	4.32
75.	Knowledge of methods to diagnose astigmatism.	4.31
89.	Knowledge of methods to diagnose pinguecula.	4.28
56.	Ability to recognize different diseases that produce similar ocular presentations.	4.26
55.	Ability to apply differential diagnoses relevant to a patient's profile, which includes: age, habits, and behaviors.	4.24
70.	Knowledge of the treatments available for specific common eye diseases and of treatment regimens appropriate to particular eye diseases and patient profiles.	4.23
74.	Knowledge that the treatment of minors requires the consent of parents or guardians.	4.23
57.	Knowledge of ocular immunological responses to allergens, viruses, and bacteria.	4.18
69.	Ability to gather and evaluate all relevant information about a patient's disorder so as to achieve a definitive diagnosis.	4.14
80.	Knowledge of methods to diagnose hypertension.	4.12
72.	Ability to explain all refractive treatment options, including their risks and relative costs, the prognosis with each, and the time required for each to succeed.	4.11
92.	Knowledge of methods to diagnose arcus.	4.06
90.	Knowledge of methods to diagnose hypercholesterolestrolemia.	4.01
64.	Knowledge of what each test applied to a patient is capable of revealing.	3.99

62.	Knowledge of optometric, ophthalmological, and other references as aids to diagnosis and treatment.	3.97
67.	Knowledge that ocular dysfunctions may induce symptoms (e.g., that a phoria may induce untimely drowsiness; that binocular, accommodative, or refractive dysfunctions may induce headaches).	3.95
71.	Knowledge of treatment alternatives for specific common eye diseases and the risks, benefits, costs, and prognosis for each alternative.	3.93
63.	Knowledge of common drugs and medications and their potential for interactions and adverse reactions.	3.91
65.	Ability to determine whether the etiology of a vision defect is genetic, pathological, or nonpathological.	3.86
66.	Knowledge of chronic or recurrent systemic disorders that affect the eyes or vision, and of how to identify the disorders by their effects (e.g., knowledge that tuberculosis may produce phlyctenules).	3.74
59.	Knowledge of which ocular pathologies can be identified by their clinical signs and which require laboratory services for their identification.	3.59
93.	Knowledge of methods to diagnose arthritis.	3.49
68.	Knowledge of psychosomatic visual disorders.	3.04
60.	Knowledge of when to order or refer for laboratory tests.	2.93
61.	Ability to interpret laboratory test findings for a patient's symptoms and clinical signs.	2.55

III. Spectacles and Protective Eyewear

ITEM	KNOWLEDGE STATEMENT	IMP (I)
96.	Knowledge of available lens choices and their inherent advantages and disadvantages (e.g., high-index lenses, polycarbonate lenses).	3.89
97.	Knowledge of the availability, advantages, and disadvantages of particular lens types, designs, and materials for particular patients (e.g., severe myopes, severe hyperopes).	3.84
102.	Knowledge of critical concerns when a patient is changing from contact lenses to spectacles.	3.80
101.	Knowledge of supplemental spectacles for contact lens wearers.	3.78
98.	Knowledge of the types of multifocals available and the measurements and dispensing techniques needed for each type.	3.75
104.	Knowledge of frame styles suitable for specific corrections and lens types (e.g., a high plus/minus, multifocal frame).	3.61
106.	Ability to explain to a patient the advantages and disadvantages: of lens and frame materials and types; lens options (tints, coatings, beveling, edge finish, press-ons).	3.53
103.	Knowledge of available frame materials, types, and styles (i.e., sport, safety).	3.40
105.	Knowledge of the care and limitations of specific lenses, tints, and coatings (i.e., that special lens cloths and cleaners may be needed, that most tints and coatings can be applied only during lens manufacture).	3.37
111.	Knowledge of common needs for protective eyewear (e.g., sports, vocations).	3.36
100.	Knowledge of how base curve, thickness, and vertex distance affect image size and patient comfort.	3.34
107.	Ability to adjust a frame so that it fits a patient securely and comfortably.	3.29
109.	Knowledge of OSHA standards for safety eyewear.	2.95
95.	Knowledge of ANSI standards for ophthalmic goods.	2.93
108.	Ability to repair spectacles.	2.92
110.	Ability to identify safety lenses and frames.	2.86
99.	Knowledge of preventive methods and first aid for laboratory injuries.	2.73

IV. Contact Lenses

ITEM	KNOWLEDGE STATEMENT	IMP (I)
137.	Ability to evaluate soft lenses with a slit lamp (e.g., centration, movement, and physiological response).	4.42
118.	Ability to recognize, through slit-lamp examination, eye anomalies that affect contact lens wear (e.g., dry-eye syndrome, corneal erosions, and dystrophies).	4.31
135.	Ability to determine parameters for contact lenses that will provide a patient with clear, comfortable, and safe vision.	4.27
134.	Ability to determine the characteristics of the contact lenses most appropriate to prescribe for a particular patient [e.g., for a presbyope, both near and far corrections by means of (a) bifocal lenses or (b) a combination of contact lenses for far vision and reading glasses for near vision].	4.23
145.	Knowledge of the causes of and remedies for common patient complaints about contact lenses.	4.21
146.	Knowledge of preventive care for ocular diseases that derive from contact lens wear (e.g., for corneal abrasion and scarring, allergic reactions to lens solutions).	4.20
141.	Ability to explain what a patient or a patient's caregivers should know about the handling, insertion and removal, care, cleaning, disinfecting, and use of the patient's contact lenses and about the adverse effects of inattention to proper procedures.	4.19
144.	Ability to assess a patient's subjective responses to contact lens wear.	4.19
113.	Knowledge of eye conditions, allergies, and sensitivities to medication that contraindicate contact lens wear.	4.18
140.	Knowledge of contact lens wear schedules appropriate for particular patients, lens types, and lens materials.	4.18
142.	Knowledge of contact lens care products appropriate for particular patients and lenses and of how each should be used.	4.16
139.	Knowledge of how to change contact lens parameters to improve the fit.	4.15
119.	Ability to assess the quality of a patient's tears and to relate the assessment to the patient's suitability for contact lens daily wear or for extended wear.	4.13
127.	Knowledge that a patient's existing spectacle lens prescription can be used as a factor in choosing trial contact lenses if vertex distance is taken into account.	4.13
131.	Knowledge of how each available type of contact lens improves vision (e.g., rigid as opposed to soft).	4.13
114.	Knowledge of common medications that affect contact lens wear (e.g., knowledge that birth control pills may adversely affect tear quality).	4.07
115.	Knowledge of allergic reactions to contact lens materials and solutions and of how to minimize or prevent them.	4.07
116.	Knowledge of the significance of environmental conditions for contact lens wear.	4.07
130.	Knowledge of the types and characteristics of contact lenses currently	4.05

	available to patients (e.g., knowledge of the water content and chemical qualities of particular lens materials).	
133.	Knowledge that refractive, keratometric, and test measurements and diagnostic lens fittings can be used to determine lens choices for a patient.	4.05
143.	Knowledge of how to monitor and interpret a patient's histological and physiological responses to wearing contact lenses.	4.04
129.	Ability to determine the resultant correction by over-refraction while the patient wears trial contact lenses.	4.03
112.	Ability to judge whether a patient has the dexterity in handling lenses, inserting and removing lenses, and applying solutions that wearing contact lenses requires.	3.95
123.	Ability to use keratometric measurements to evaluate corneal astigmatism and the contribution of the cornea to total astigmatism and total refraction.	3.86
122.	Ability to take keratometric measurements appropriate to determining a contact lens prescription.	3.83
136.	Ability to fit rigid lenses and assess their fit with a slit lamp and Burton lamp after instilling fluorescein (e.g., centration, movement, and for toric or bifocal lenses, orientation) from the fluorescein pattern the lens creates.	3.82
147.	Knowledge that a troublesome lens should be inspected off the eye, under magnification.	3.80
124.	Ability to use a patient's spectacle prescription or refraction and keratometric measurements to assess the patient's candidacy for corneal refractive therapy or other refractive treatment options.	3.69
132.	Knowledge of periodical publications as a means of keeping abreast of changes in contact lens types and availability.	3.67
121.	Ability to measure patient parameters (e.g., corneal diameter, pupil size, that are relevant to prescribing contact lenses).	3.60
128.	Knowledge of the need to consider the size of the palpebral fissure in fitting contact lenses.	3.38
125.	Knowledge of corneal topography as a means of assessing an anomalous cornea (e.g., a keratoconic cornea).	3.17
117.	Knowledge of phorometric procedure, of what it can reveal, and of the significance of phorias and ductions for contact lens wear.	3.15
138.	Knowledge of how to fit contact lenses after eye surgery (e.g., after keratoplasty, refractive surgery).	3.13
126.	Ability to interpret a patient's corneal topography and draw appropriate conclusions regarding the patient's candidacy for regular contact lens wear or corneal refractive therapy.	3.06
120.	Ability to perform and interpret a Schirmer test or phenol red thread test of tear production.	2.89
148.	Knowledge of available prosthetic and therapeutic contact lenses that improve the appearance or function of abnormal or damaged eyes.	2.74

V. Low Vision

ITEM	KNOWLEDGE STATEMENT	IMP (I)
152.	Knowledge of the legal definition of blindness.	3.53
150.	Ability to recognize the visual conditions typical of low-vision patients (e.g., retinitis pigmentosa, macular degeneration).	3.49
151.	Knowledge of the extent to which the effects of the ocular pathologies associated with low vision are remediable.	3.13
149.	Knowledge of the etiology of low vision (e.g., genetic or acquired causes).	3.08
153.	Ability to elicit a low-vision patient's goals in seeking the help of an optometrist and to determine what goals can be realized.	2.56
154.	Knowledge of the psychosocial aspects of low vision.	2.41
156.	Knowledge of how to modify refractive examinations as needed for low-vision patients.	2.38
157.	Knowledge of the lighting appropriate for low-vision examinations and of home lighting appropriate for low-vision patients.	2.30
158.	Knowledge of eye charts (e.g., contrast sensitivity, for specific needs).	2.15
155.	Knowledge of visual-field testing for low-vision patients, of how to interpret the results, and of how to provide visual aids for field modification.	2.02
168.	Knowledge of supplementary services for low-vision patients (e.g., of genetic counseling for patients with inherited conditions, of support groups and other services available to the visually impaired).	1.77
163.	Knowledge of the various optical aids available to help low-vision patients and of the advantages and disadvantages of each aid.	1.76
159.	Ability to assess a patient's responses to magnification and to telescopic and microscopic lenses.	1.73
164.	Knowledge of the various nonoptical aids available to help low-vision patients.	1.73
161.	Ability to judge whether a patient has the mobility and dexterity needed to use a particular aid to vision.	1.67
166.	Knowledge of common patient difficulties in using aids to vision.	1.67
160.	Knowledge of how to measure a patient's visual deficits and to use the measurements to calculate remedial magnifications.	1.61
162.	Knowledge of effective dual prescriptions for patients with difficulties at both distance and near (e.g., a monocular telescope with power appropriate to the patient's acuity at distance and a magnifier at near).	1.60
165.	Knowledge of filters (e.g., CPF, NOIR, blue-blockers, for low-vision patients).	1.54
167.	Ability to train low-vision patients in the use of the aids they choose or accept.	1.36

VI. Binocular Therapy and/or Vision Training

ITEM	KNOWLEDGE STATEMENT	IMP (I)
172.	Ability to perform and interpret objective tests of binocularity as needed (e.g., a cover test, a Hirschberg test).	3.66
173.	Ability to perform and interpret special tests as needed (e.g., stereoscopic "fly" and "reindeer," Worth 4 dot test).	3.24
181.	Ability to determine what therapy is appropriate, the prognosis, and whether or not to refer.	3.22
191.	Ability to recognize from symptoms the need to change a binocular prescription and to change it as needed to eliminate discomfort or diplopia.	3.21
171.	Knowledge of examination procedures needed to find visual anomalies (e.g., to detect and measure binocular dysfunctions).	3.20
192.	Ability to improve a patient's vision and appearance with appropriate spectacle frames, lenses, and prisms (e.g., to optimize the cosmetic appearance and balance of new spectacles by splitting the prism power between lenses).	3.16
169.	Ability to use a patient's history and relevant information from parents and educators to plan a problem-oriented eye examination and, later, to evaluate examination findings.	3.14
182.	Knowledge of tests and of lens and prism corrections, for binocular misalignment, latent hyperopia, or aniseikonia.	3.10
190.	Ability to refract with a trial frame and the lenses to be prescribed.	3.09
170.	Ability to assess a muscle imbalance using cycloplegics when indicated.	3.04
193.	Knowledge of how lenses are fabricated and of how to verify that the prisms in new spectacles match the prescription.	3.03
189.	Ability to use prisms to determine a patient's binocular status.	3.02
180.	Knowledge of how good vision and poor vision affect and interact with the developing psychology of a child.	2.96
179.	Knowledge of motor and visual developmental milestones in children.	2.83
187.	Knowledge of lenses for improving binocularity and focusing at near.	2.81
175.	Knowledge of objective tests for suppression (e.g., Worth 4 dot test).	2.52
188.	Knowledge of binocular tests with a phoropter (e.g., polaroid, red/green, Maddox, and vectograph tests).	2.51
174.	Knowledge of subjective tests for suppression (e.g., pola vision test).	2.28
195.	Ability to educate, reassure, and motivate a patient and the patient's parents and caregivers regarding a patient's training.	2.11
186.	Knowledge of optometric procedures that utilize flippers, prisms, and anaglyphs and of how and when to use them.	2.02
183.	Knowledge of contrast sensitivity testing and interpretation.	2.01
184.	Knowledge of Sheard's and Percival's criteria for the amount of prism to prescribe.	1.94
185.	Ability to determine a patient's fixation disparity and derive a prism prescription.	1.89
196.	Knowledge of home vision-training procedures and schedules appropriate for patients with particular needs after an appropriate lens	1.89

	correction.	
177.	Knowledge of objective test for eccentric fixation (e.g., visuoscopy).	1.80
194.	Knowledge of methods for sequential vision training.	1.77
176.	Knowledge of subjective tests for eccentric fixation (e.g., Haidinger's brush and Maxwell's spot).	1.76
197.	Knowledge of how to monitor a vision-training patient's progress on tasks, to judge the need for additional training or a change in training.	1.72
178.	Knowledge of eccentric fixation treatment options.	1.71
198.	Knowledge of learning-related visual functions and of how to train a patient to improve them.	1.70
199.	Knowledge of dyslexia symptoms, tests, and treatments.	1.63

VII. Treating Eye Disorders/Referring for Treatment

ITEM	KNOWLEDGE STATEMENT	IMP (I)
203.	Knowledge of ocular lubricants (e.g., artificial tears as a palliative for eye dryness).	4.58
201.	Knowledge of the therapeutic drugs that an optometrist may administer and of the conditions for which they may be used under California law.	4.53
200.	Knowledge of the disease processes that produce common eye disorders (e.g., conjunctivitis, iritis, uveitis, glaucoma, diabetic retinopathy).	4.45
202.	Knowledge of the indications and contraindications for common therapeutic drugs; the appropriate dosages, administration schedules, and durations of use; the possible side effects; and the appropriate responses to side effects.	4.42
214.	Knowledge of appropriate referrals of particular eye or vision disorders.	4.35
206.	Knowledge of good eyelid hygiene as prophylaxis and part of therapy for lid diseases.	4.31
213.	Knowledge of patient conditions for which a referral is legally necessary.	4.29
218.	Knowledge of the points in the development of particular conditions at which referral for surgery is appropriate (e.g., of appropriate timelines for referring a cataract or diabetic retinopathy).	4.27
207.	Knowledge of therapies for eye diseases that derive from contact lens wear.	4.26
216.	Knowledge of recurrent symptoms or signs that call for referral (e.g., recurrent eye hemorrhages, recurrent headaches).	4.22
223.	Knowledge of ocular and systemic diseases that threaten eyesight, health, or life; and of appropriate preventive care.	4.21
217.	Ability to write appropriate referral letters, including the information about the patient that should accompany the referral.	4.20
215.	Knowledge of appropriate referrals of systemic disorders discovered through providing optometric service.	4.18
221.	Knowledge of the detrimental effects of high-risk behaviors (e.g., excessive sun exposure, smoking) to a patient's vision and health.	4.10
219.	Knowledge of appropriate and inappropriate candidates for eye surgery.	4.09
220.	Ability to recognize that eye surgery is needed; to explain to the patient the risks, benefits, alternatives, and possible complications; and to reassure anxious patients.	4.07
211.	Knowledge of the appropriate management of epithelial defects (e.g., corneal erosion or abrasion).	4.03
208.	Knowledge of possible interactions between ocular and systemic medications and of how to avoid or remedy interactions adverse to the patient.	3.97
222.	Knowledge of common patient medications that may induce eye or other disorders as side effects and of prophylactic measures, if they exist.	3.97

210.	Knowledge of instruments and procedures for epilating eyelashes to relieve trichiasis, of how to use a lid everter and epilation tweezers safely and effectively.	3.84
209.	Knowledge of instruments and procedures for removing a foreign body from an eye and of how to use them safely and effectively.	3.82
212.	Knowledge of nutrition and nutritional supplements as they relate to ocular health.	3.76
204.	Knowledge of collagen punctal plugs as a way to impede tear drainage temporarily and relieve eye dryness.	3.43
205.	Ability to apply temporary punctal plugs safely and effectively and to judge from the patient's response whether to refer for permanent plugs.	3.08

VIII. Patient Emergencies

ITEM	KNOWLEDGE STATEMENT	IMP (I)
228.	Knowledge of how to recognize true emergencies (i.e., conditions immediately threatening to a patient's eyesight, health, or life).	4.25
224.	Ability to judge from a patient's symptoms whether the patient should be seen immediately and to train office staff to make the same judgment and to err on the side of the patient's safety.	4.20
227.	Ability to recognize clinical signs of a potential emergency (e.g., in a patient who is diabetic, hypertensive, or glaucomatous).	4.20
231.	Ability to recognize or determine that a particular emergency requires an immediate referral.	4.17
226.	Knowledge of extended examination procedures for common ocular emergencies.	3.99
225.	Knowledge of the possible legal ramifications of allowing office staff to triage patient symptoms.	3.79
230.	Knowledge of the management of a patient with an adverse reaction (e.g., anaphylactic shock, breathing difficulties, anesthesia, dilating drops).	3.72
232.	Knowledge of lawful means of palliating and stabilizing a patient's condition to facilitate an emergency referral.	3.65
229.	Knowledge of the management of a patient who presents with a vasovagal reaction, low blood sugar level, or epileptic seizure.	3.64

IX. Co-managing Patients

ITEM	KNOWLEDGE STATEMENT	IMP (I)
243.	Knowledge of appropriate medications for common conditions and of the California laws regulating optometrists' use of therapeutic drugs.	4.28
234.	Knowledge of indications for referral associated with developing eye disorders (e.g. diabetic retinopathy, glaucoma, macular degeneration).	4.20
244.	Knowledge of common patient conditions requiring referral, of the signs and symptoms of a significant improvement or cure.	4.19
241.	Knowledge of common therapies for which referrals are made (e.g., for a cataract-removal case, refractive surgery).	4.02
235.	Knowledge of indications for referral associated with systemic diseases (e.g., multiple sclerosis, Grave's disease).	3.91
237.	Knowledge of pre and post operative optometric care for patients referred for surgery (e.g., cataract, refractive, or glaucoma surgery).	3.81
242.	Knowledge of appropriate intervals for follow-up checks of particular co-management patients.	3.75
233.	Ability to co-manage a patient with a developing or advanced ocular pathology.	3.63
240.	Knowledge of therapeutic complications and of their remedies, where remedies exist.	3.57
238.	Knowledge of appropriate and workable nonsurgical co-management protocols.	3.56
239.	Knowledge of the need to interview a returning referred patient regarding post-therapy discomfort, compliance with the therapeutic plan, and quality of vision.	3.54
236.	Knowledge of testing to confirm the presence of a disorder associated with the eye (e.g., of blood panels, carotid tests).	3.08

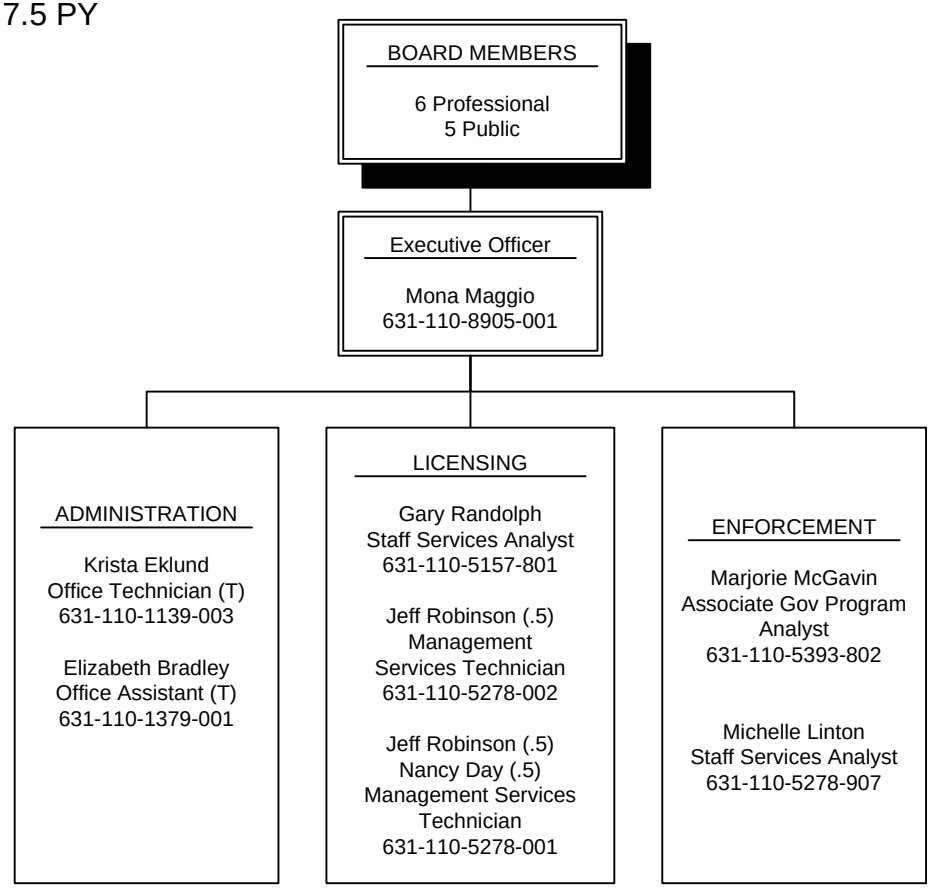
D. Year-end Organizational Chart

Department of Consumer Affairs

Board of Optometry

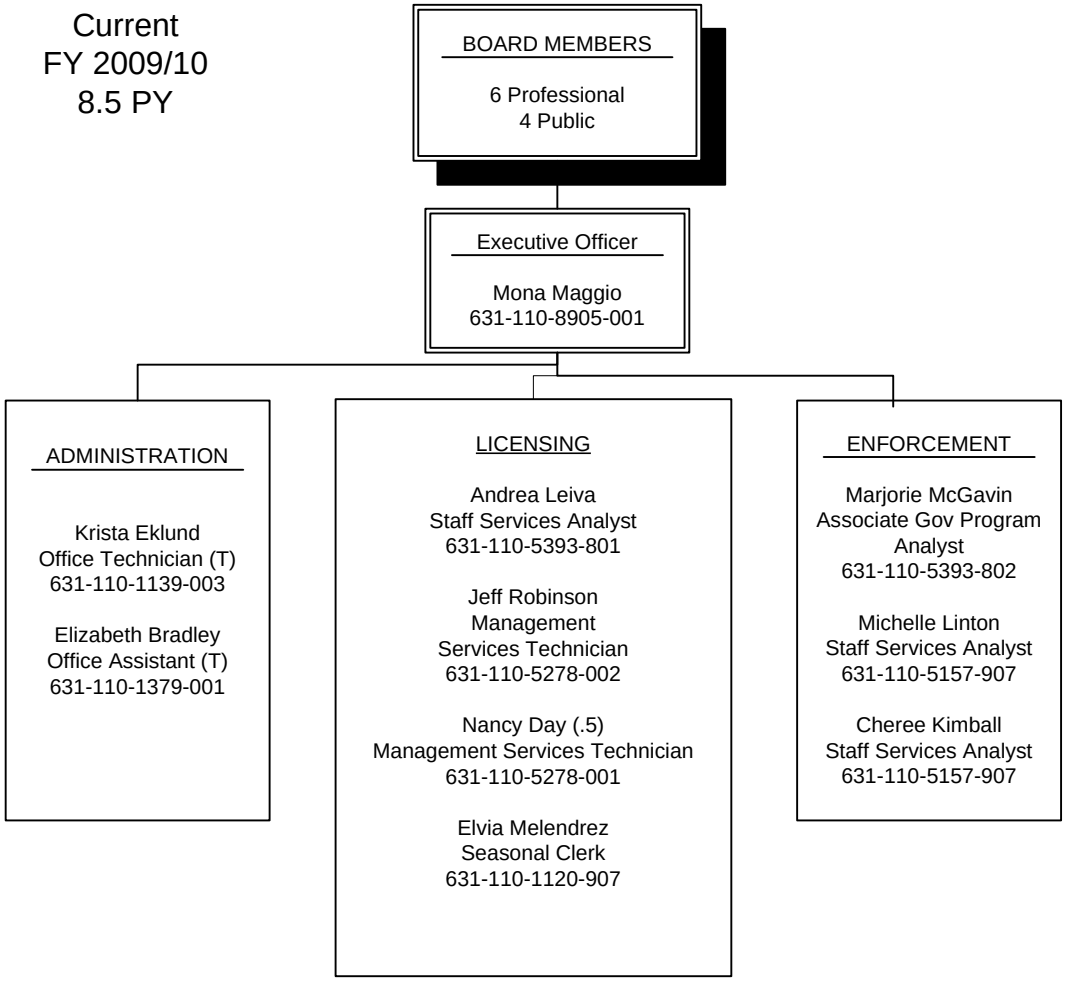
July 2008

FY 2008/09
7.5 PY



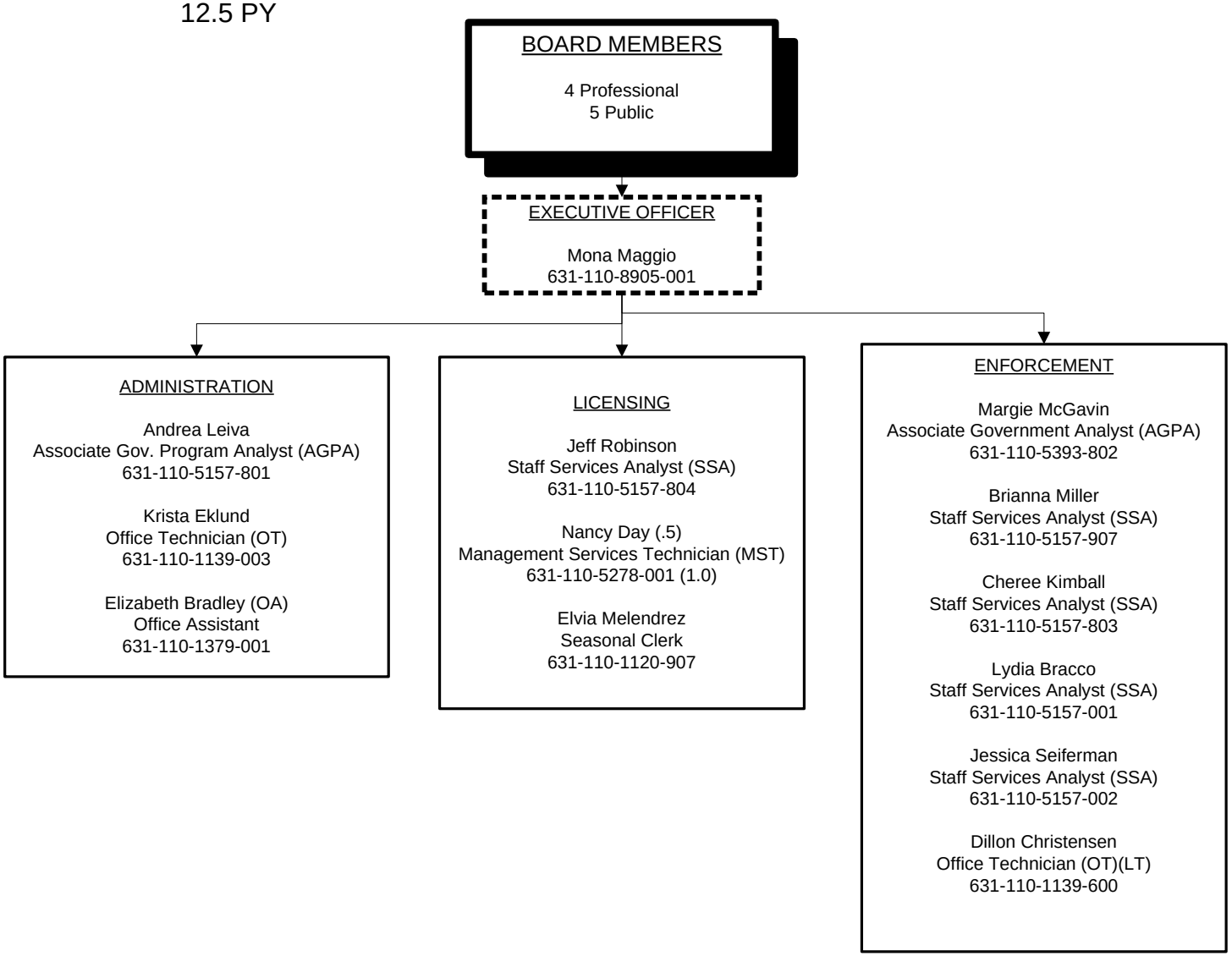
Department of Consumer Affairs
Board of Optometry
July 1, 2009

Current
FY 2009/10
8.5 PY

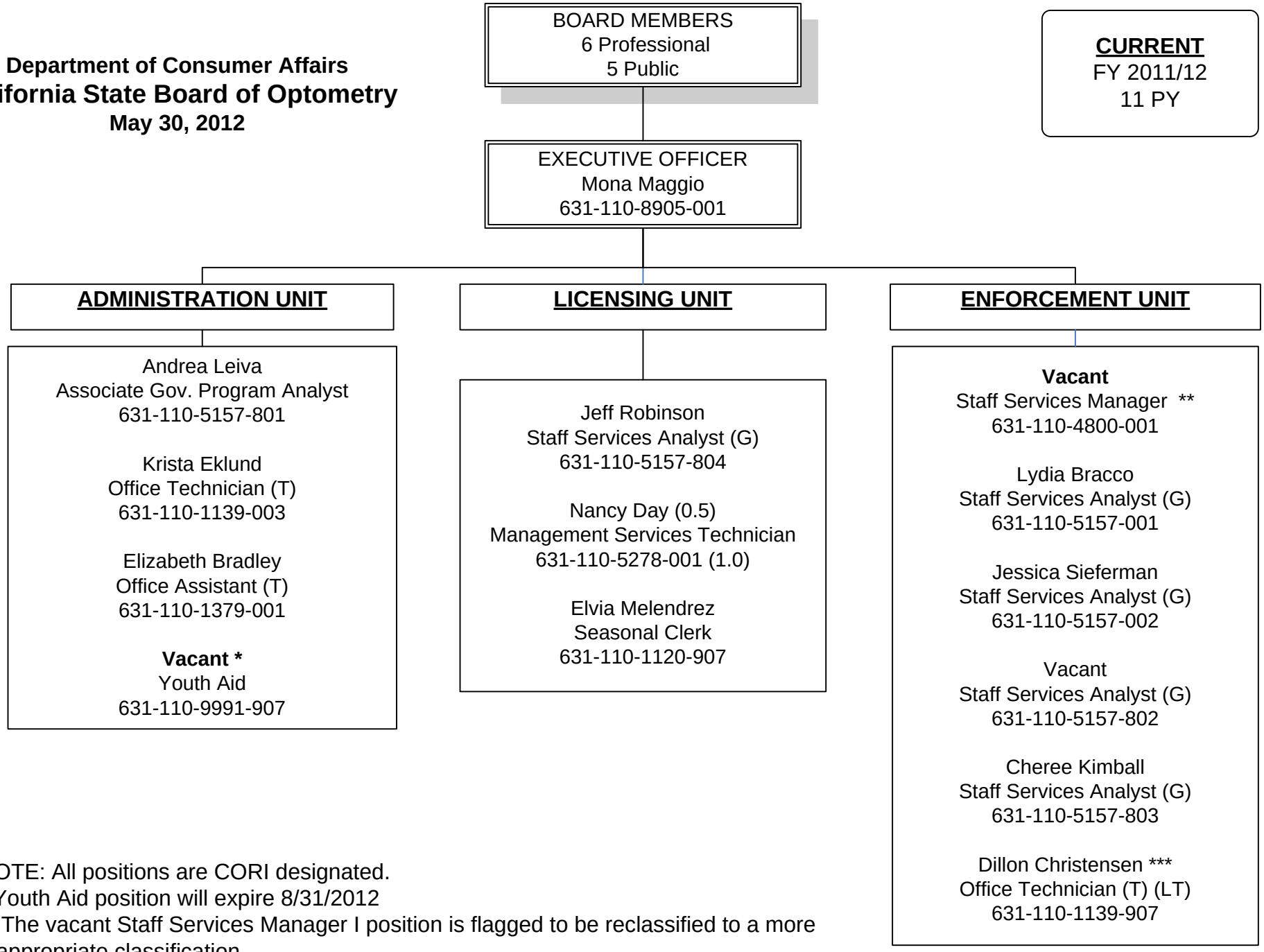


Department of Consumer Affairs
Board of Optometry
November 2010

Proposed
FY 2010/2011
12.5 PY



Department of Consumer Affairs
California State Board of Optometry
May 30, 2012



NOTE: All positions are CORI designated.
* Youth Aid position will expire 8/31/2012
** The vacant Staff Services Manager I position is flagged to be reclassified to a more appropriate classification.
*** Office Technicia (T)(LT) will expire 7/2012

E. Performance Measures

Department of Consumer Affairs

California State Board of Optometry

Performance Measures

Q1 Report *(July - Sept 2010)*

To ensure stakeholders can review the Board's progress toward meeting its enforcement goals and targets, we have developed a transparent system of performance measurement.

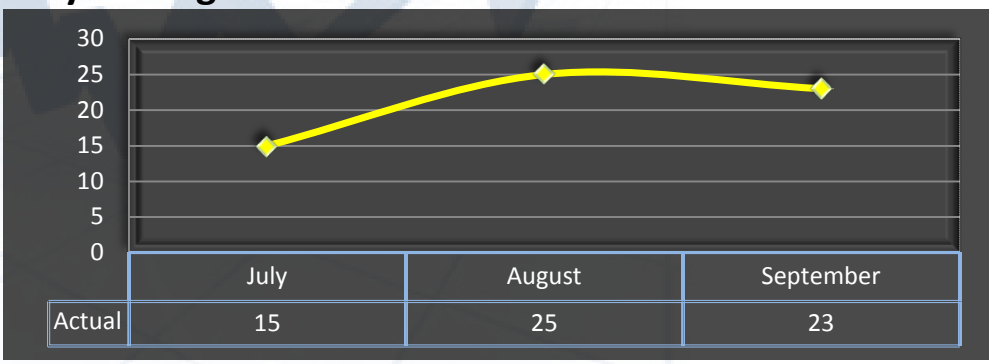
These measures will be posted publicly on a quarterly basis. In future reports, additional measures, such as consumer satisfaction and complaint efficiency, will also be added. These additional measures are being collected internally at this time and will be released once sufficient data is available.

Volume

Number of complaints received.*

Q1 Total: 63 (*Complaints: 59 Convictions: 4)*

Q1 Monthly Average: 21



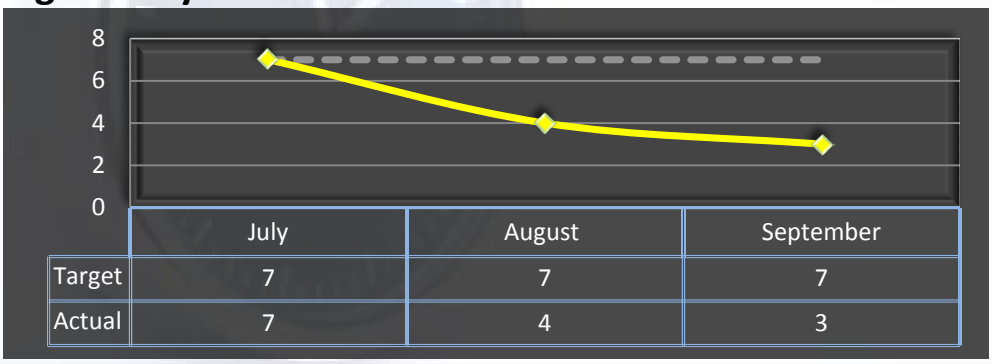
	July	August	September
Actual	15	25	23

Intake

Average cycle time from complaint receipt, to the date the complaint was assigned to an investigator.

Target: 7 Days

Q1 Average: 4 Days



	July	August	September
Target	7	7	7
Actual	7	4	3

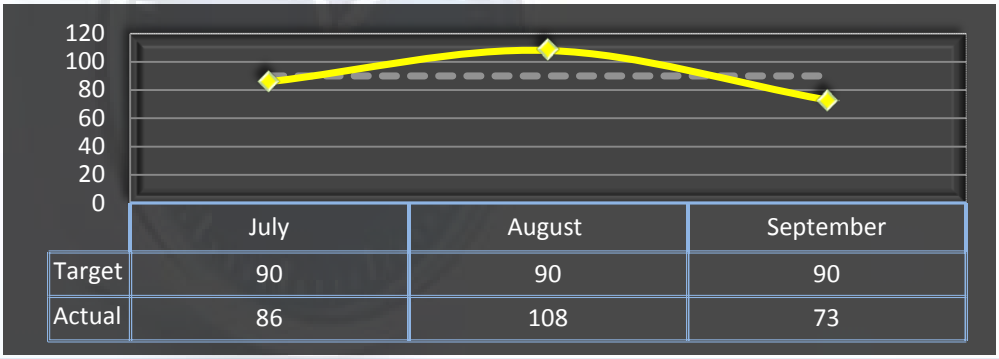
***"Complaints" in these measures include complaints, convictions, and arrest reports.**

Intake & Investigation

Average cycle time from complaint receipt to closure of the investigation process. Does <u>not</u> include cases sent to the Attorney General or other forms of formal discipline.

Target: 90 Days

Q1 Average: 94 Days



	July	August	September
Target	90	90	90
Actual	86	108	73

Formal Discipline

Average cycle time from complaint receipt to closure, for cases sent to the Attorney General or other forms of formal discipline.

Target: 365 Days

Q1 Average: 448 Days **(only 1 data point available)**

Probation Intake

Average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.

Target: 6 Days

Q1 Average: N/A

The Board did not report any probation monitoring data this quarter.

Probation Violation Response

Average number of days from the date a violation of probation is reported, to the date the assigned monitor initiates appropriate action.

Target: 8 Days

Q1 Average: N/A

The Board did not report any probation violation data this quarter.

Department of Consumer Affairs

California State Board of Optometry

Performance Measures

Q2 Report *(Oct - Dec 2010)*

To ensure stakeholders can review the Board's progress toward meeting its enforcement goals and targets, we have developed a transparent system of performance measurement. These measures will be posted publicly on a quarterly basis.

In future reports, the Department will request additional measures, such as consumer satisfaction. These additional measures are being collected internally at this time and will be released once sufficient data is available.

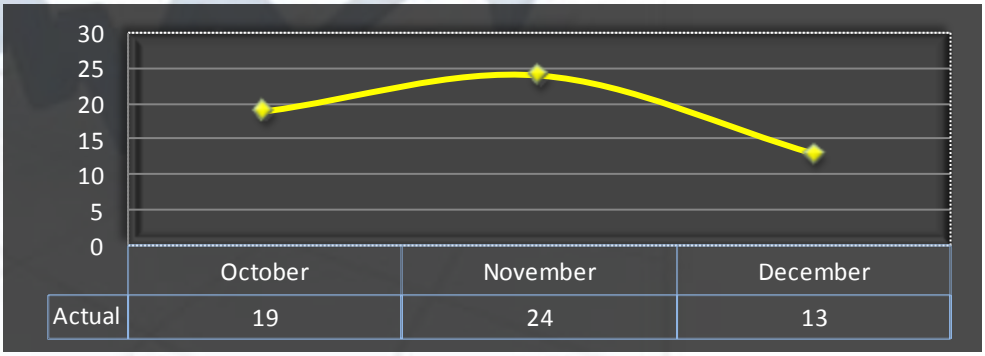
Volume

Number of complaints and convictions received.

Q2 Total: 56

Complaints: 55 Convictions: 1

Q2 Monthly Average: 19



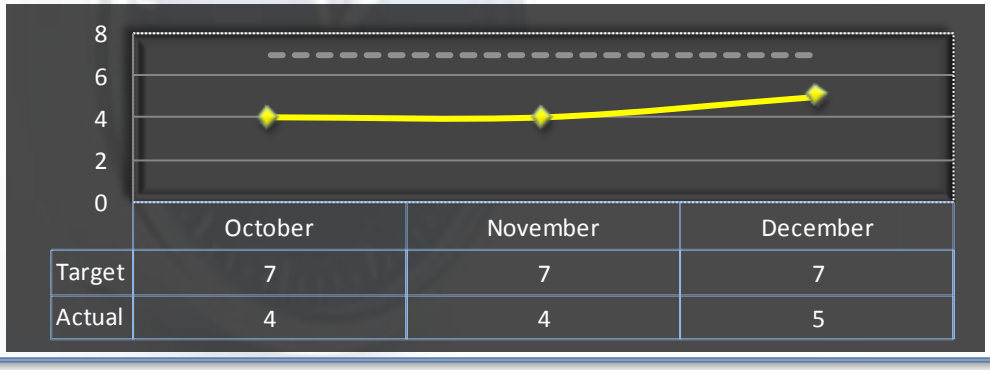
	October	November	December
Actual	19	24	13

Intake

Average cycle time from complaint receipt, to the date the complaint was assigned to an investigator.

Target: 7 Days

Q2 Average: 4 Days



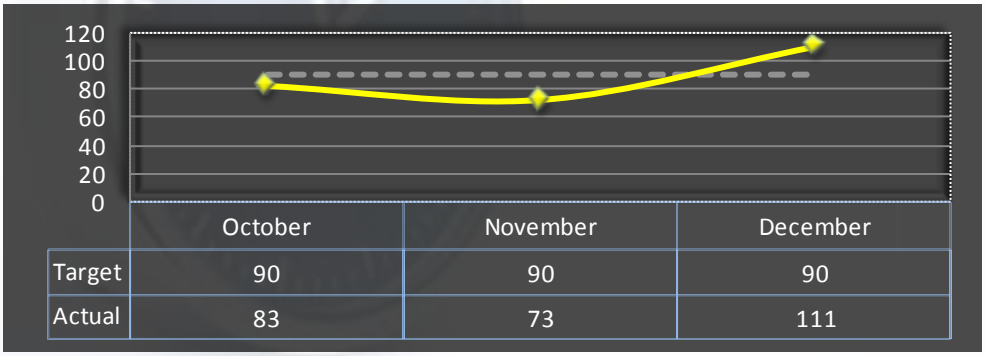
	October	November	December
Target	7	7	7
Actual	4	4	5

Intake & Investigation

Average cycle time from complaint receipt to closure of the investigation process. Does not include cases sent to the Attorney General or other forms of formal discipline.

Target: 90 Days

Q2 Average: 92 Days



	October	November	December
Target	90	90	90
Actual	83	73	111

Formal Discipline

Average number of days to complete the entire enforcement process for cases resulting in formal discipline. (Includes intake and investigation by the Board, and prosecution by the AG)

Target: 365 Days

Q2 Average: N/A

The Board did not close any disciplinary cases this quarter.

Probation Intake

Average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.

Target: 6 Days

Q2 Average: N/A

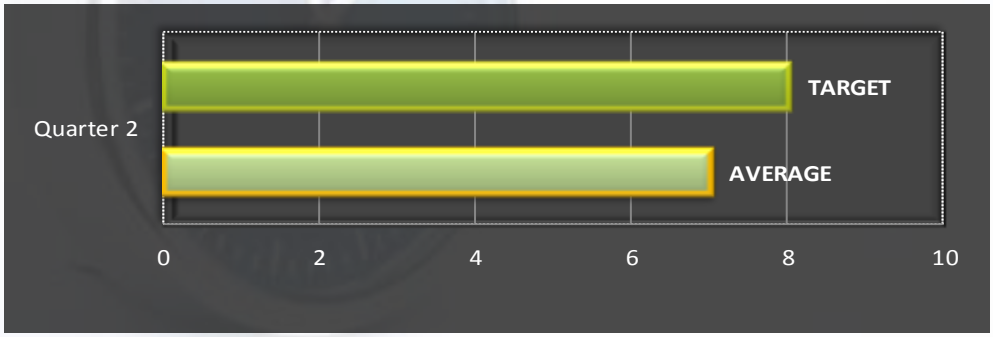
The Board did not contact any new probationers this quarter.

Probation Violation Response

Average number of days from the date a violation of probation is reported, to the date the assigned monitor initiates appropriate action.

Target: 8 Days

Q2 Average: 7 Days



Department of Consumer Affairs

California State Board of Optometry

Performance Measures

Q3 Report *(January - March 2011)*

To ensure stakeholders can review the Board's progress toward meeting its enforcement goals and targets, we have developed a transparent system of performance measurement. These measures will be posted publicly on a quarterly basis.

In future reports, the Department will request additional measures, such as consumer satisfaction. These additional measures are being collected internally at this time and will be released once sufficient data is available.

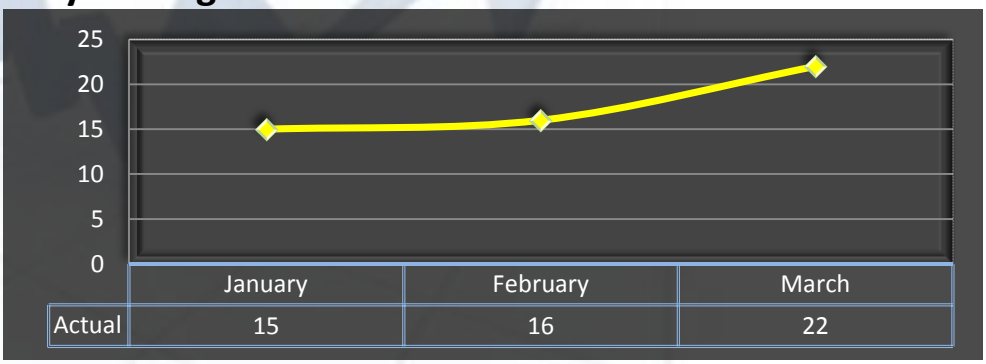
Volume

Number of complaints and convictions received.

Q3 Total: 53

Complaints: 46 Convictions: 7

Q3 Monthly Average: 18

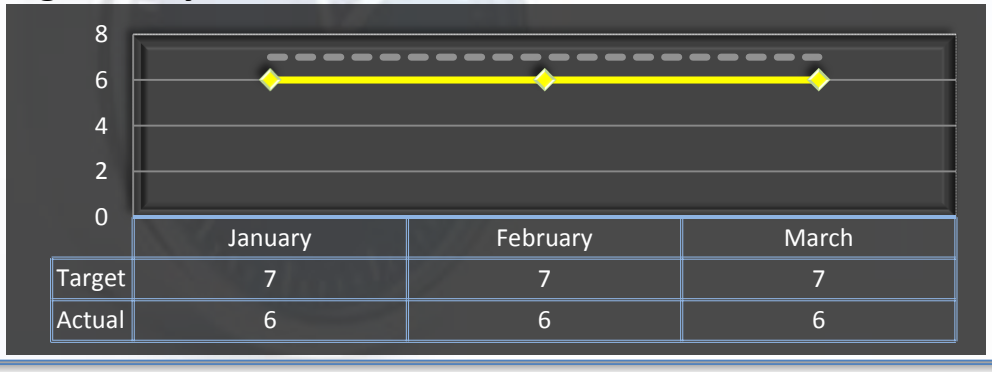


Intake

Average cycle time from complaint receipt, to the date the complaint was assigned to an investigator.

Target: 7 Days

Q3 Average: 6 Days

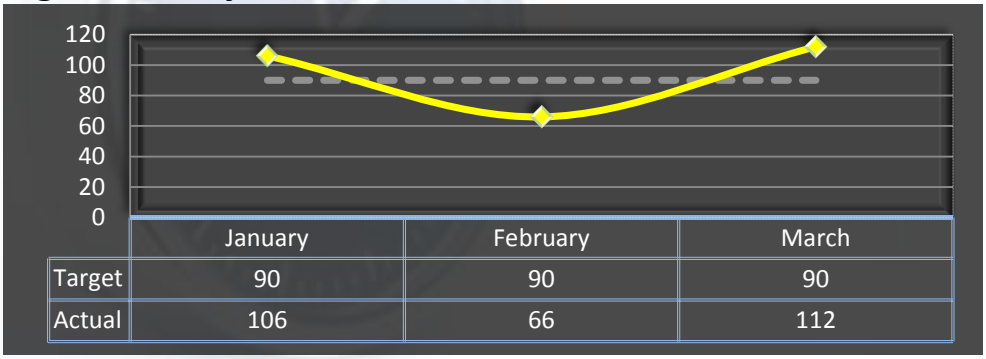


Intake & Investigation

Average cycle time from complaint receipt to closure of the investigation process. Does not include cases sent to the Attorney General or other forms of formal discipline.

Target: 90 Days

Q3 Average: 100 Days



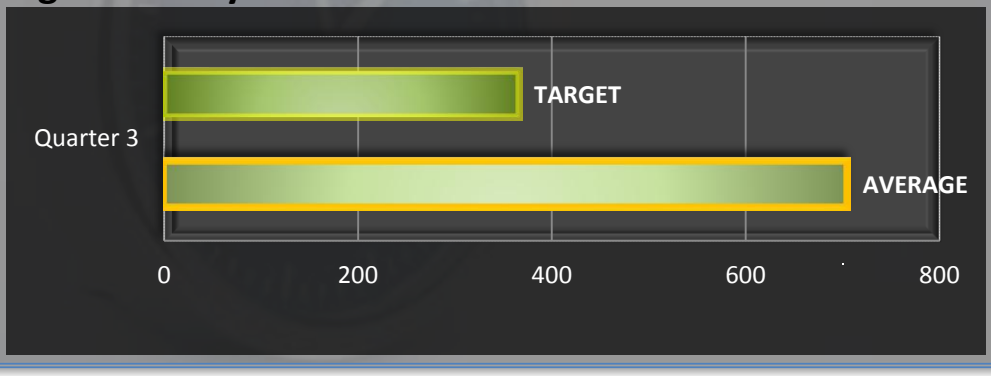
	January	February	March
Target	90	90	90
Actual	106	66	112

Formal Discipline

Average number of days to complete the entire enforcement process for cases resulting in formal discipline. (Includes intake and investigation by the Board, and prosecution by the AG)

Target: 365 Days

Q3 Average: 704 Days

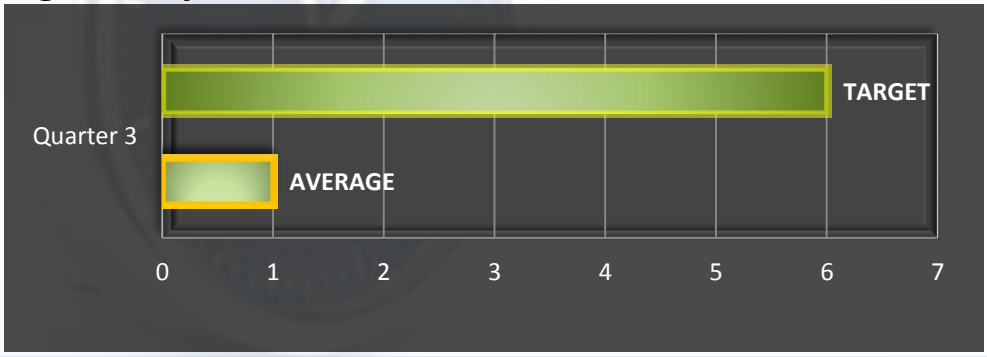


Probation Intake

Average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.

Target: 6 Days

Q3 Average: 1 Day

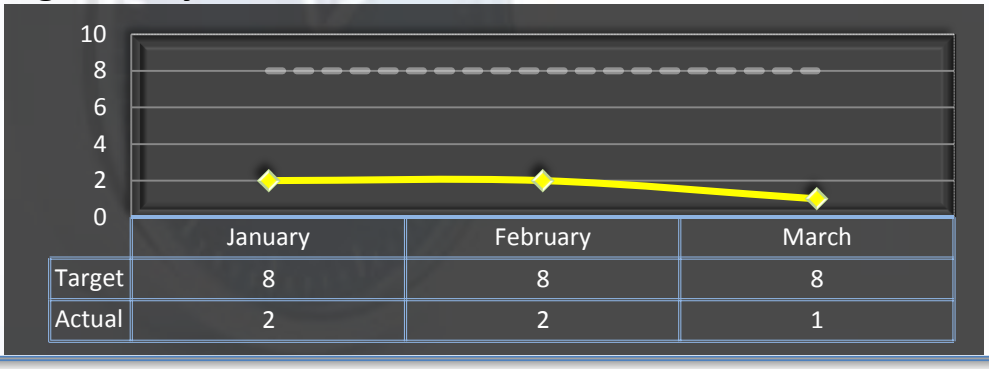


Probation Violation Response

Average number of days from the date a violation of probation is reported, to the date the assigned monitor initiates appropriate action.

Target: 8 Days

Q3 Average: 2 Days



	January	February	March
Target	8	8	8
Actual	2	2	1

Department of Consumer Affairs

California State Board of Optometry

Performance Measures

Q4 Report *(April - June 2011)*

To ensure stakeholders can review the Board's progress toward meeting its enforcement goals and targets, we have developed a transparent system of performance measurement. These measures will be posted publicly on a quarterly basis.

In future reports, the Department will request additional measures, such as consumer satisfaction. These additional measures are being collected internally at this time and will be released once sufficient data is available.

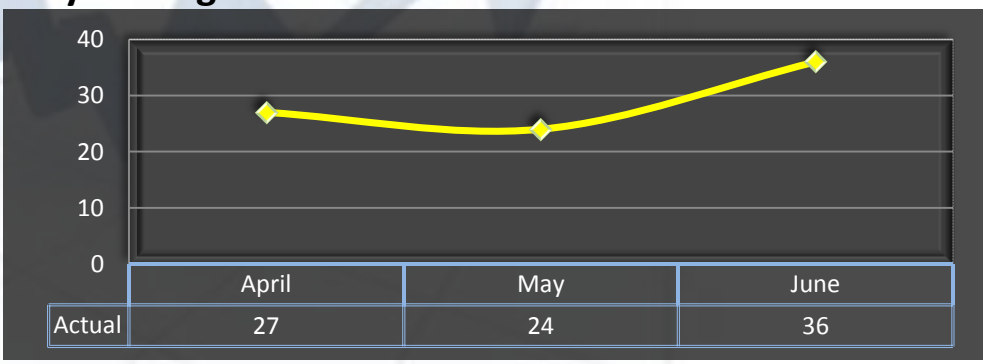
Volume

Number of complaints and convictions received.

Q4 Total: 87

Complaints: 78 Convictions: 9

Q4 Monthly Average: 29



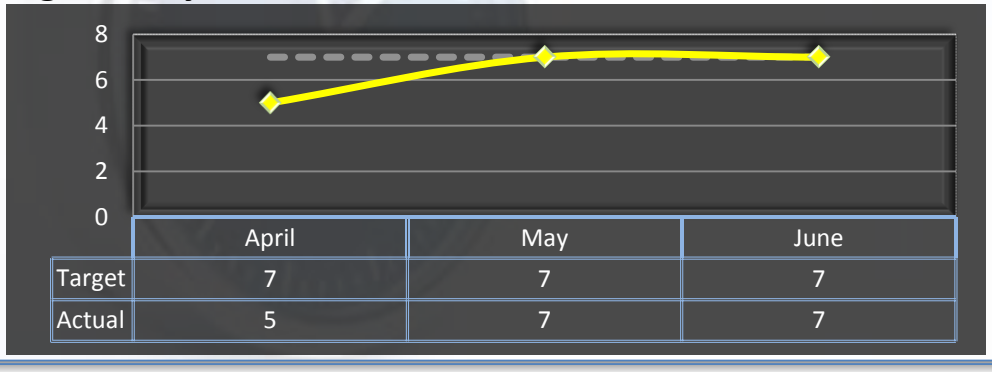
	April	May	June
Actual	27	24	36

Intake

Average cycle time from complaint receipt, to the date the complaint was assigned to an investigator.

Target: 7 Days

Q4 Average: 7 Days



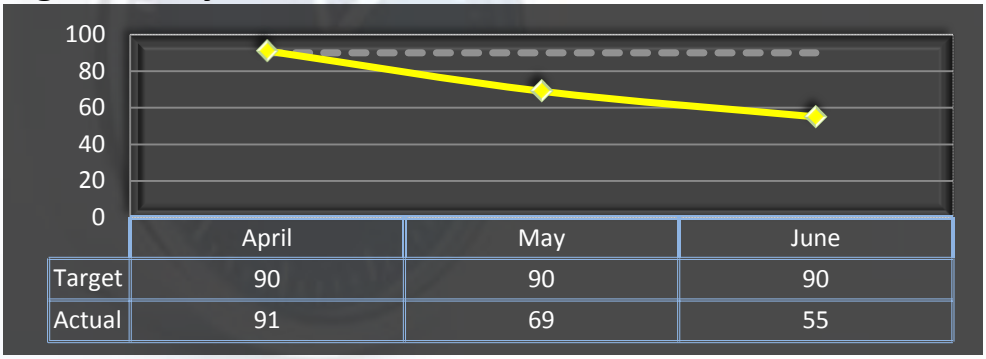
	April	May	June
Target	7	7	7
Actual	5	7	7

Intake & Investigation

Average cycle time from complaint receipt to closure of the investigation process. Does <u>not</u> include cases sent to the Attorney General or other forms of formal discipline.

Target: 90 Days

Q4 Average: 68 Days



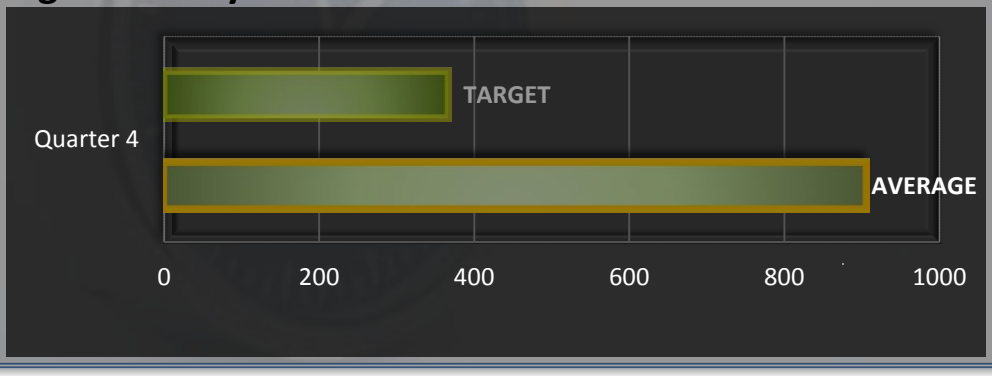
	April	May	June
Target	90	90	90
Actual	91	69	55

Formal Discipline

Average number of days to complete the entire enforcement process for cases resulting in formal discipline. (Includes intake and investigation by the Board, and prosecution by the AG)

Target: 365 Days

Q4 Average: 904 Days

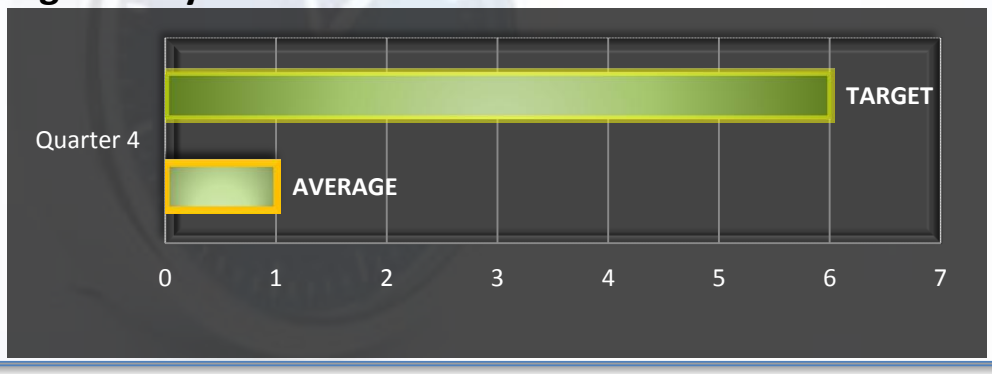


Probation Intake

Average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.

Target: 6 Days

Q4 Average: 1 Day

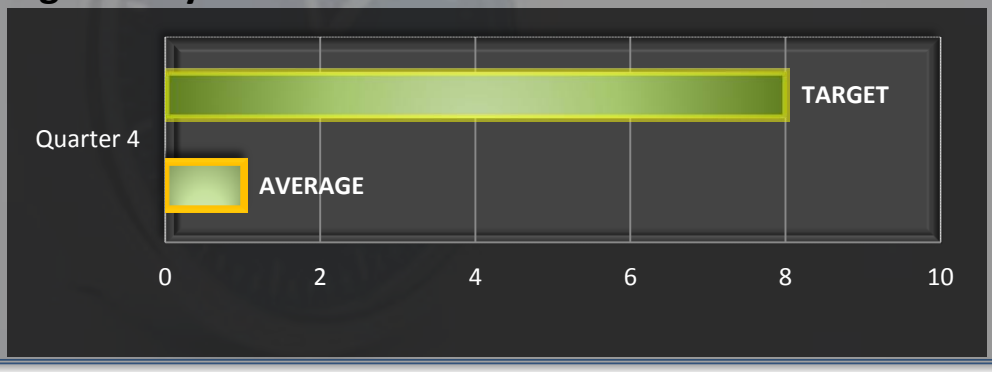


Probation Violation Response

Average number of days from the date a violation of probation is reported, to the date the assigned monitor initiates appropriate action.

Target: 8 Days

Q4 Average: 1 Day



Department of Consumer Affairs

California State Board of Optometry

Performance Measures

Annual Report *(2010 – 2011 Fiscal Year)*

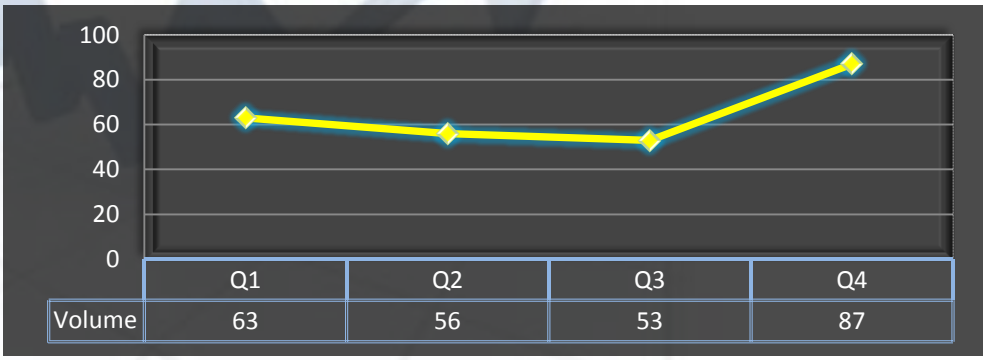
To ensure stakeholders can review the Board's progress in meeting its enforcement goals and targets, we have developed a transparent system of performance measurement. These measures are posted publicly on a quarterly basis.

This annual report represents the culmination of the first four quarters worth of data.

Volume

Number of complaints and convictions received.

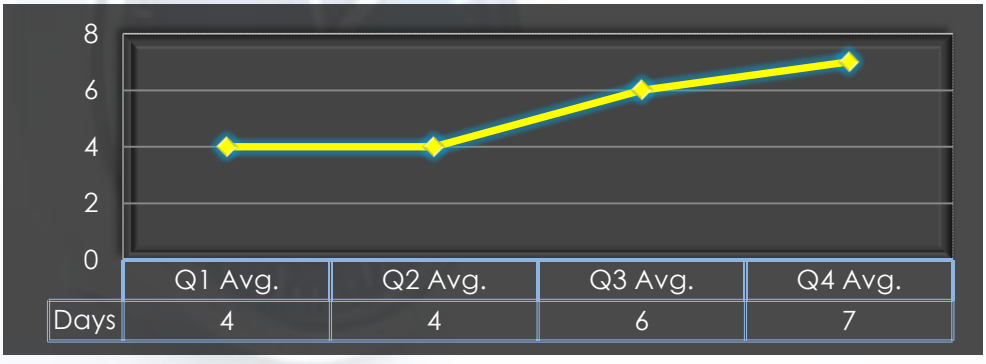
The Board had an annual total of 259 this fiscal year.



Intake

Average cycle time from complaint receipt, to the date the complaint was assigned to an investigator.

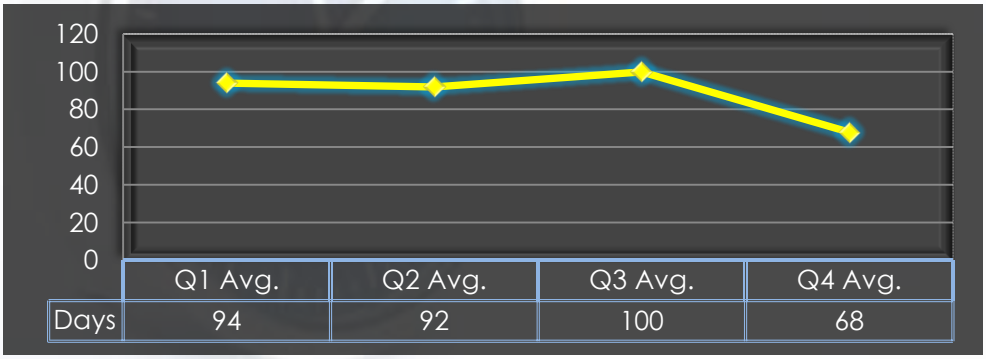
The Board has set a target of 7 days for this measure.



Intake & Investigation

Average cycle time from complaint receipt to closure of the investigation process. Does <u>not</u> include cases sent to the Attorney General or other forms of formal discipline.

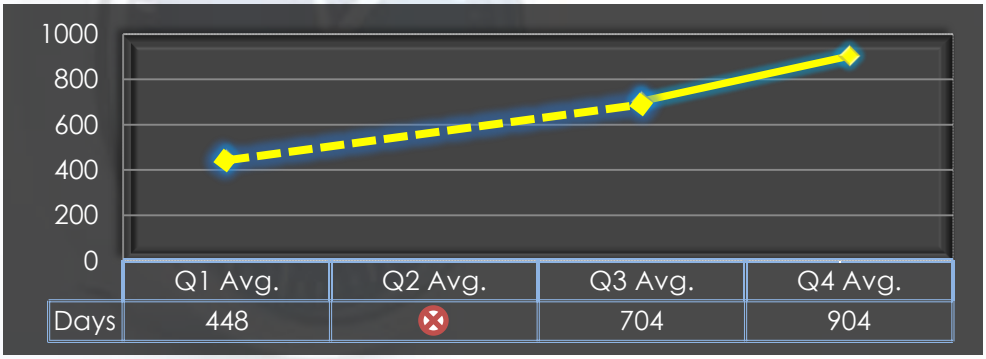
The Board has set a target of 90 days for this measure.



Formal Discipline

Average number of days to complete the entire enforcement process for cases resulting in formal discipline. (Includes intake and investigation by the Board, and prosecution by the AG)

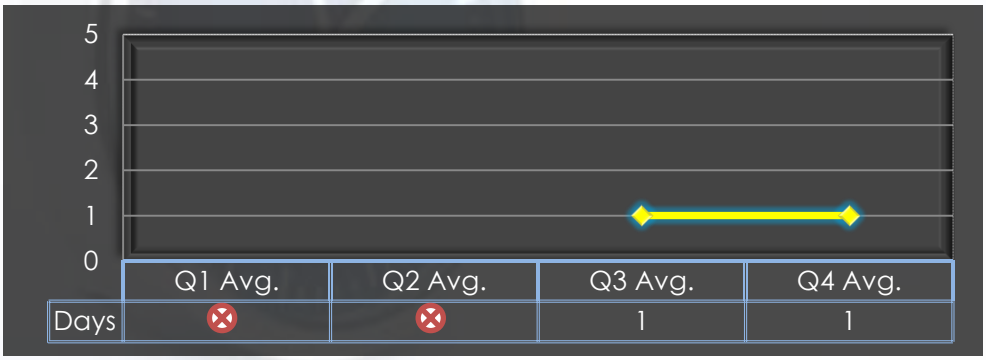
The Board has set a target of 365 days for this measure.



Probation Intake

Average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.

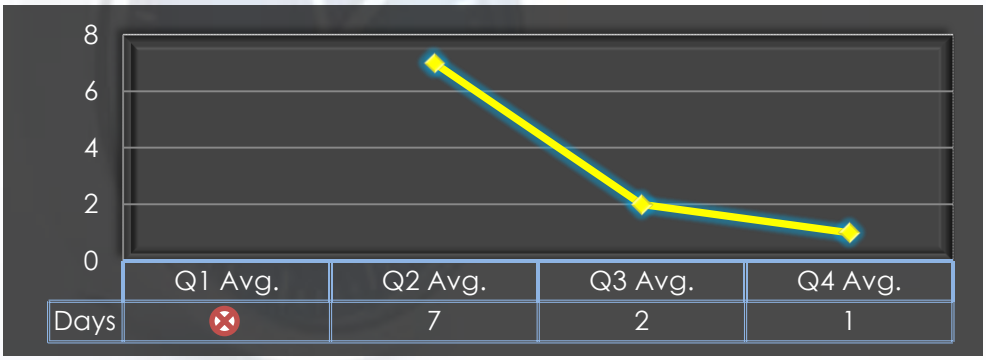
The Board has set a target of 6 days for this measure.



Probation Violation Response

Average number of days from the date a violation of probation is reported, to the date the assigned monitor initiates appropriate action.

The Board has set a target of 8 days for this measure.



Department of Consumer Affairs

California State Board of Optometry

Performance Measures

Q1 Report *(July - September 2011)*

To ensure stakeholders can review the Board's progress toward meeting its enforcement goals and targets, we have developed a transparent system of performance measurement. These measures will be posted publicly on a quarterly basis.

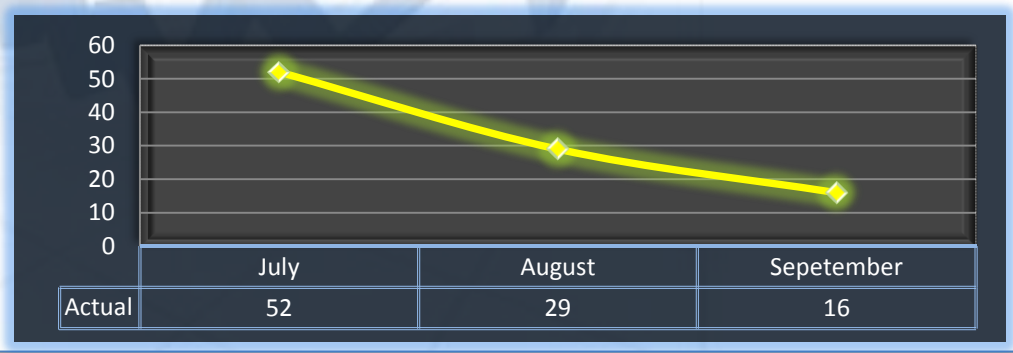
Volume

Number of complaints and convictions received.

Q1 Total: 97

Complaints: 76 Convictions: 9

Q1 Monthly Average: 32



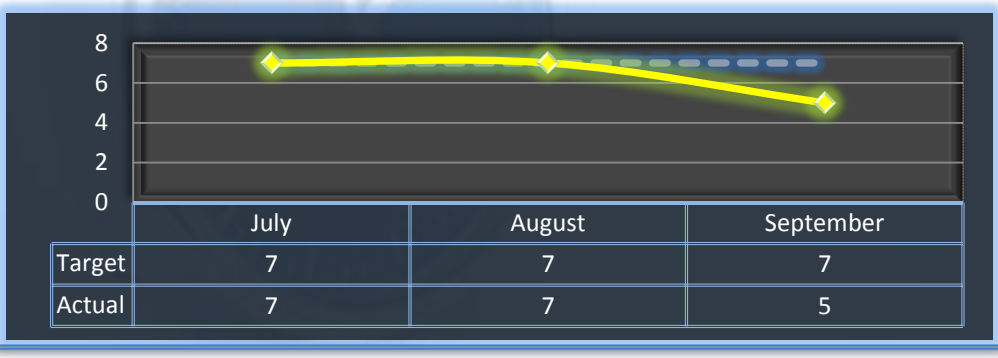
	July	August	Sepetember
Actual	52	29	16

Intake

Average cycle time from complaint receipt, to the date the complaint was assigned to an investigator.

Target: 7 Days

Q1 Average: 7 Days



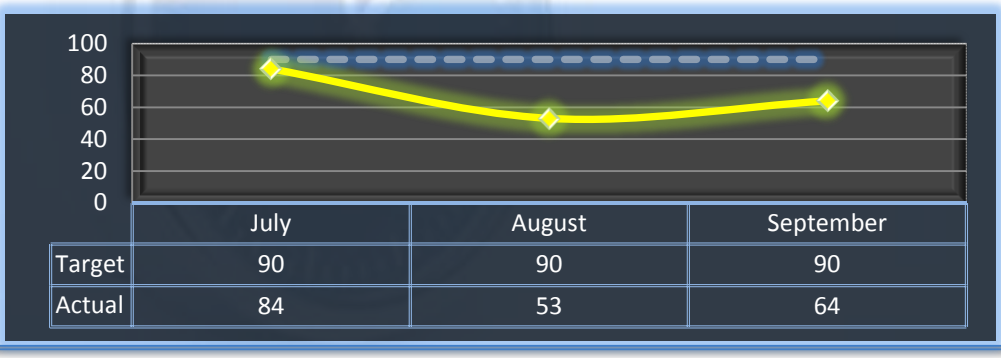
	July	August	September
Target	7	7	7
Actual	7	7	5

Intake & Investigation

Average cycle time from complaint receipt to closure of the investigation process. Does <u>not</u> include cases sent to the Attorney General or other forms of formal discipline.

Target: 90 Days

Q1 Average: 71 Days



	July	August	September
Target	90	90	90
Actual	84	53	64

Formal Discipline

Average number of days to complete the entire enforcement process for cases resulting in formal discipline. (Includes intake and investigation by the Board, and prosecution by the AG)

Target: 365 Days

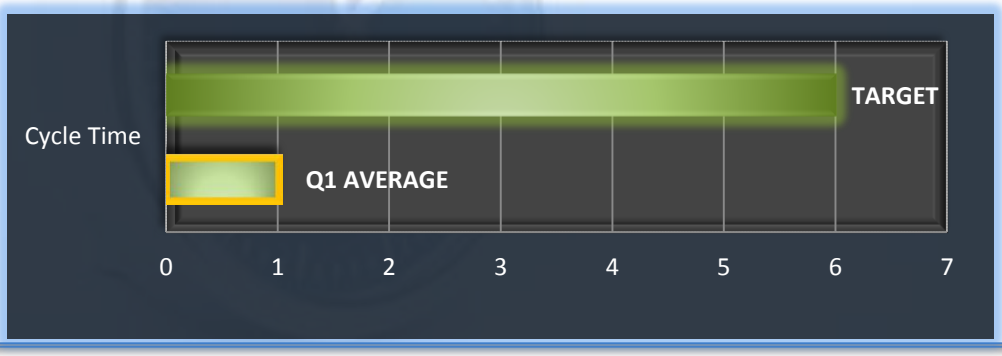
Q1 Average: 570 Days

Probation Intake

Average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.

Target: 6 Days

Q1 Average: 1 Day

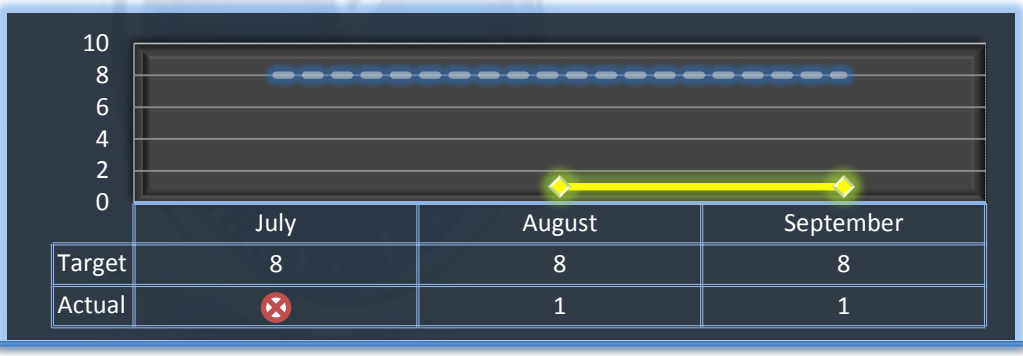


Probation Violation Response

Average number of days from the date a violation of probation is reported, to the date the assigned monitor initiates appropriate action.

Target: 8 Days

Q1 Average: 1 Day



	July	August	September
Target	8	8	8
Actual	⊗	1	1

Department of Consumer Affairs

California State Board of Optometry

Performance Measures

Q2 Report *(October - December 2011)*

To ensure stakeholders can review the Board's progress toward meeting its enforcement goals and targets, we have developed a transparent system of performance measurement. These measures will be posted publicly on a quarterly basis.

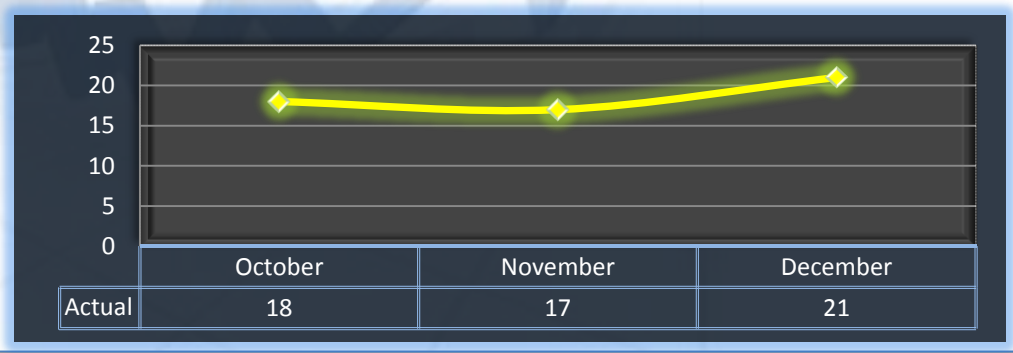
Volume

Number of complaints and convictions received.

Q2 Total: 56

Complaints: 37 Convictions: 19

Q2 Monthly Average: 19



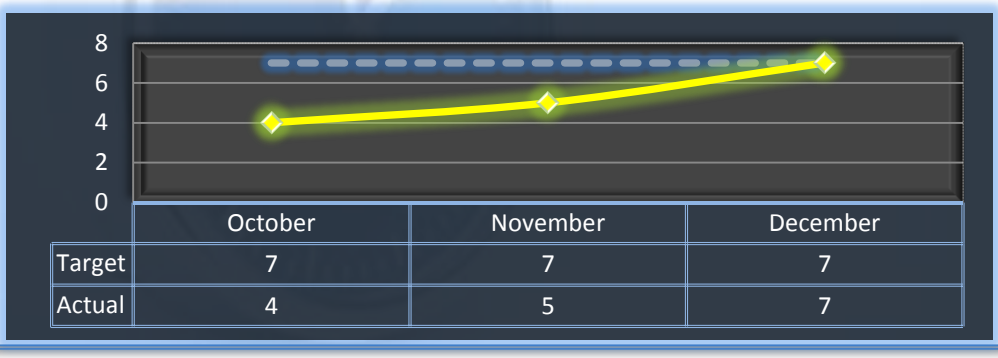
	October	November	December
Actual	18	17	21

Intake

Average cycle time from complaint receipt, to the date the complaint was assigned to an investigator.

Target: 7 Days

Q2 Average: 5 Days



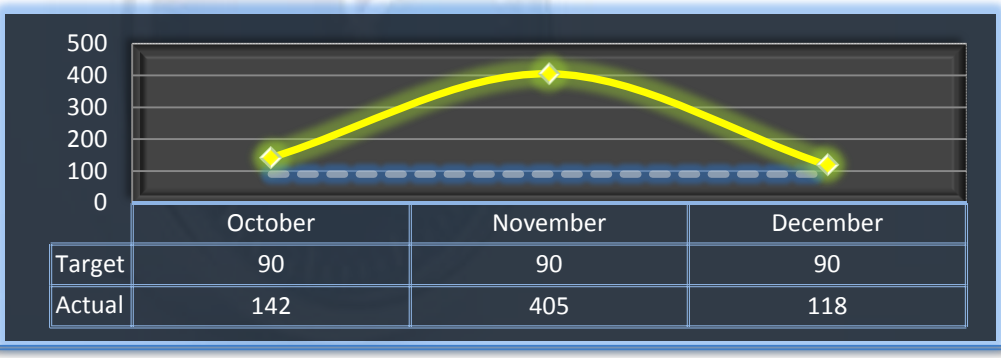
	October	November	December
Target	7	7	7
Actual	4	5	7

Intake & Investigation

Average cycle time from complaint receipt to closure of the investigation process. Does not include cases sent to the Attorney General or other forms of formal discipline.

Target: 90 Days

Q2 Average: 200 Days



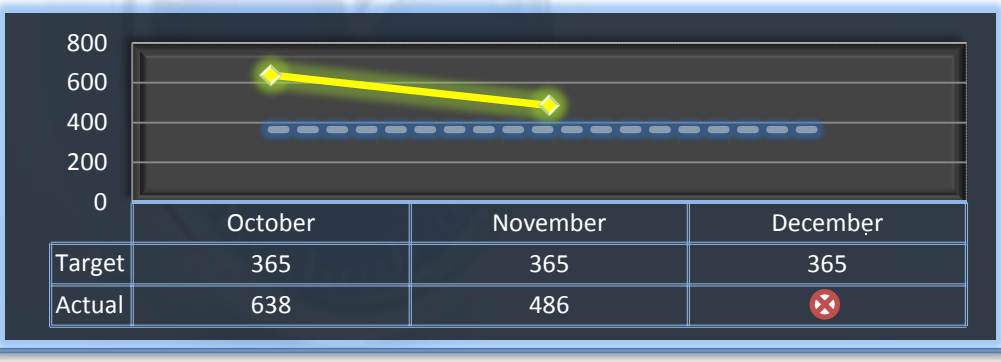
	October	November	December
Target	90	90	90
Actual	142	405	118

Formal Discipline

Average number of days to complete the entire enforcement process for cases resulting in formal discipline. (Includes intake and investigation by the Board, and prosecution by the AG)

Target: 365 Days

Q2 Average: 570 Days



	October	November	December
Target	365	365	365
Actual	638	486	⊗

Probation Intake

Average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.

Target: 6 Days

Q2 Average: N/A

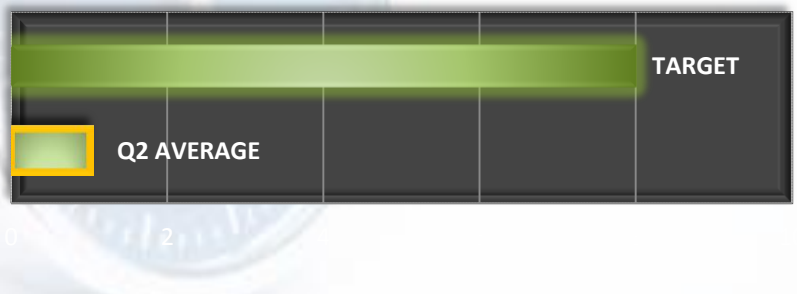
The Board did receive any new disciplinary cases this quarter.

Probation Violation Response

Average number of days from the date a violation of probation is reported, to the date the assigned monitor initiates appropriate action.

Target: 8 Days

Q2 Average: 1 Day



Department of Consumer Affairs

California State Board of Optometry

Performance Measures

Q3 Report *(January - March 2012)*

To ensure stakeholders can review the Board's progress toward meeting its enforcement goals and targets, we have developed a transparent system of performance measurement. These measures will be posted publicly on a quarterly basis.

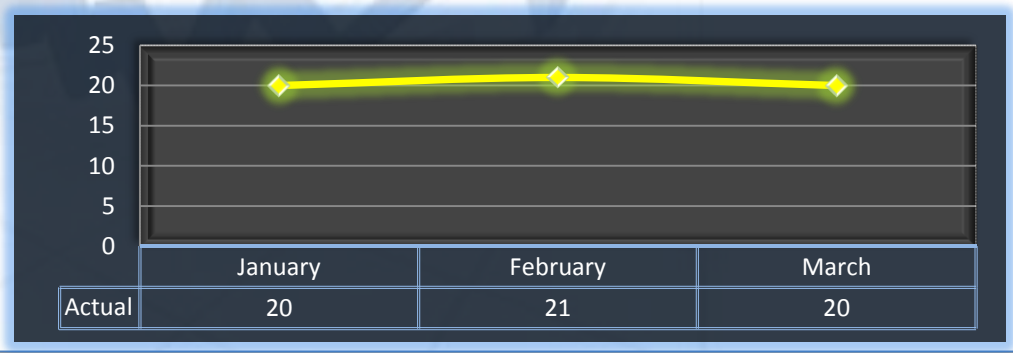
Volume

Number of complaints and convictions received.

Q3 Total: 61

Complaints: 48 Convictions: 13

Q3 Monthly Average: 20



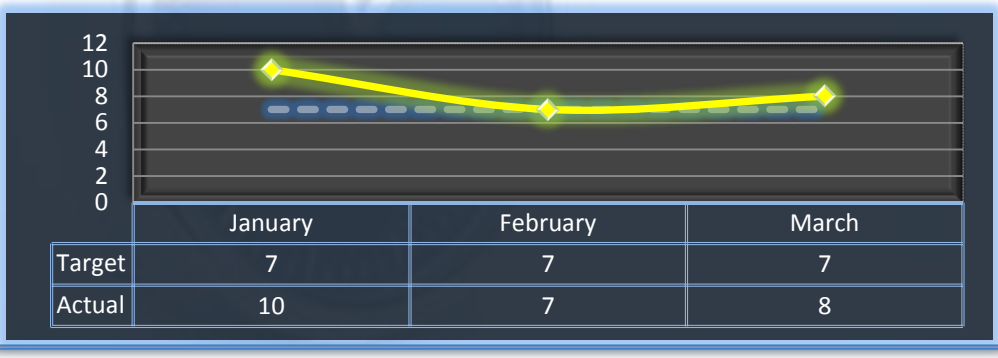
	January	February	March
Actual	20	21	20

Intake

Average cycle time from complaint receipt, to the date the complaint was assigned to an investigator.

Target: 7 Days

Q3 Average: 8 Days



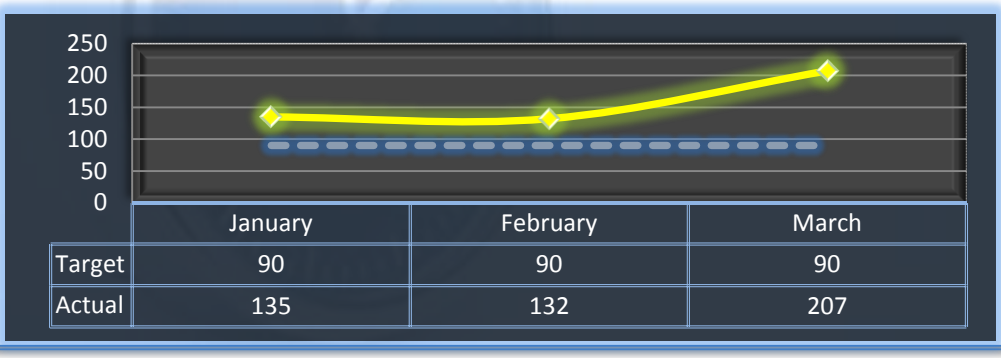
	January	February	March
Target	7	7	7
Actual	10	7	8

Intake & Investigation

Average cycle time from complaint receipt to closure of the investigation process. Does <u>not</u> include cases sent to the Attorney General or other forms of formal discipline.

Target: 90 Days

Q3 Average: 159 Days



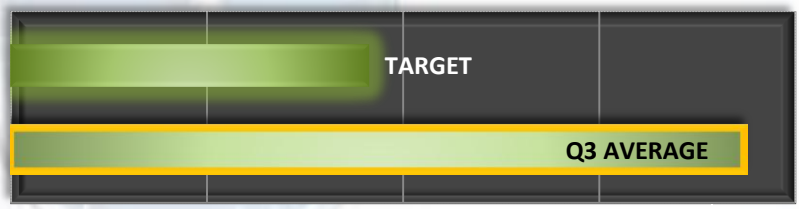
	January	February	March
Target	90	90	90
Actual	135	132	207

Formal Discipline

Average number of days to complete the entire enforcement process for cases resulting in formal discipline. (Includes intake and investigation by the Board, and prosecution by the AG)

Target: 365 Days

Q3 Average: 747 Days



Probation Intake

Average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.

Target: 6 Days

Q3 Average: N/A

The Board did receive any new disciplinary cases this quarter.

Probation Violation Response

Average number of days from the date a violation of probation is reported, to the date the assigned monitor initiates appropriate action.

Target: 8 Days

Q3 Average: N/A

The Board did not handle any probation violations this quarter.

Department of Consumer Affairs

California State Board of Optometry

Performance Measures

Q4 Report *(April - June 2012)*

To ensure stakeholders can review the Board's progress toward meeting its enforcement goals and targets, we have developed a transparent system of performance measurement. These measures will be posted publicly on a quarterly basis.

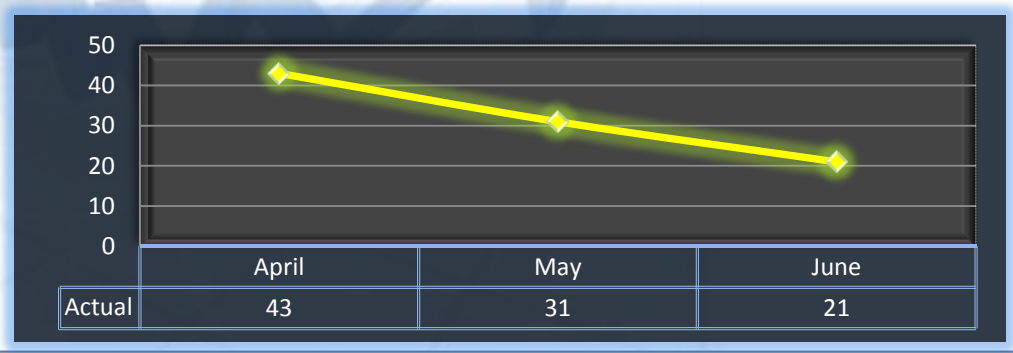
Volume

Number of complaints and convictions received.

Q4 Total: 95

Complaints: 61 Convictions: 34

Q4 Monthly Average: 32



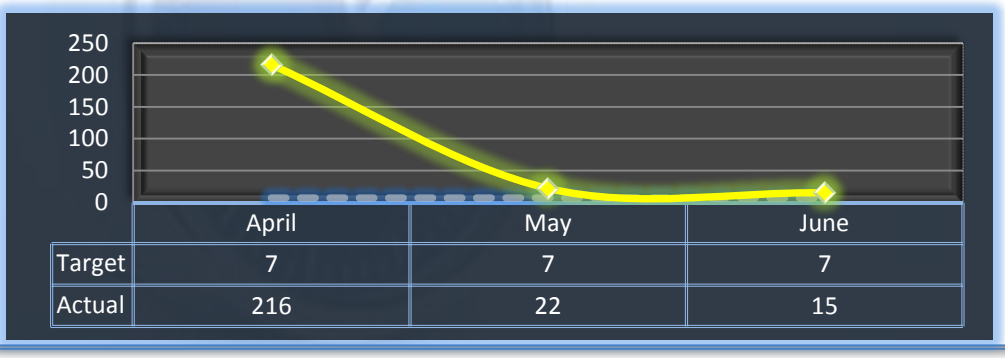
	April	May	June
Actual	43	31	21

Intake

Average cycle time from complaint receipt, to the date the complaint was assigned to an investigator.

Target: 7 Days

Q4 Average: 149 Days



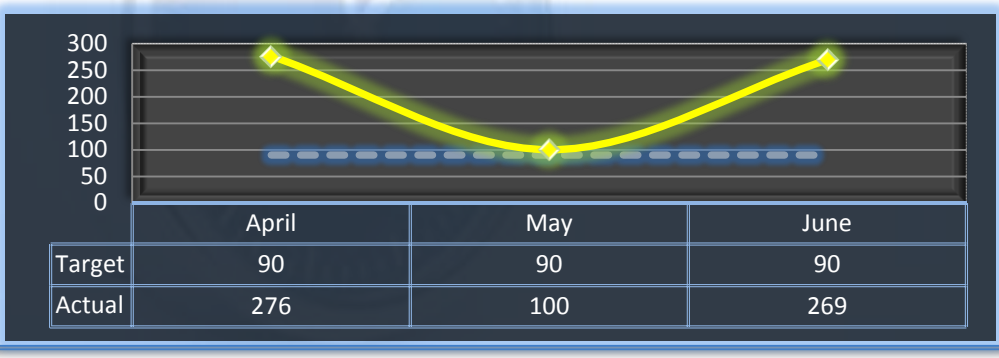
	April	May	June
Target	7	7	7
Actual	216	22	15

Intake & Investigation

Average cycle time from complaint receipt to closure of the investigation process. Does <u>not</u> include cases sent to the Attorney General or other forms of formal discipline.

Target: 90 Days

Q4 Average: 244 Days



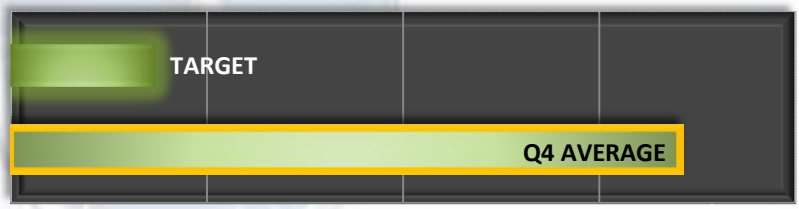
	April	May	June
Target	90	90	90
Actual	276	100	269

Formal Discipline

Average number of days to complete the entire enforcement process for cases resulting in formal discipline. (Includes intake and investigation by the Board, and prosecution by the AG)

Target: 365 Days

Q4 Average: 1,705 Days

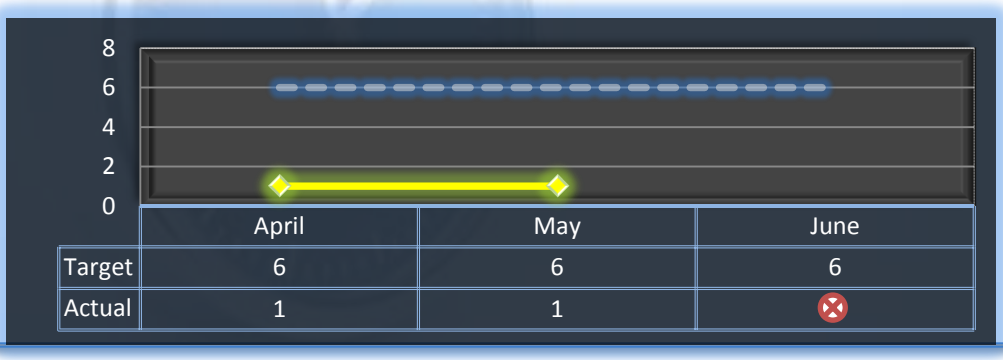


Probation Intake

Average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.

Target: 6 Days

Q4 Average: 1 Days



	April	May	June
Target	6	6	6
Actual	1	1	

Probation Violation Response

Average number of days from the date a violation of probation is reported, to the date the assigned monitor initiates appropriate action.

Target: 8 Days

Q4 Average: N/A

The Board did not report any probation violations this quarter.

Department of Consumer Affairs

California State Board of Optometry

Performance Measures

Annual Report *(2011 – 2012 Fiscal Year)*

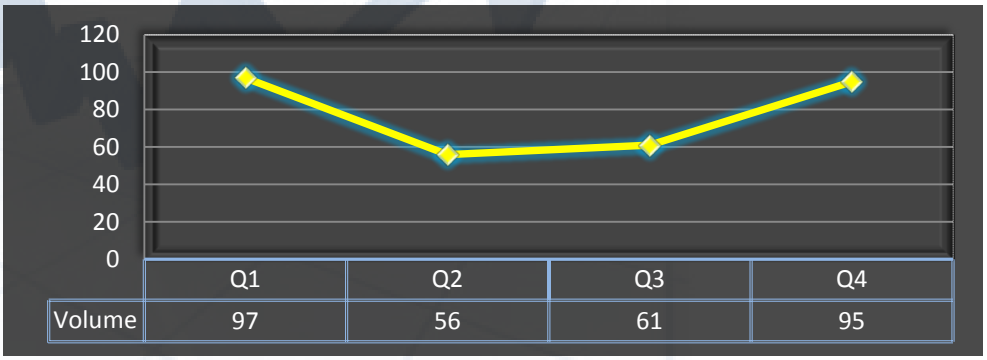
To ensure stakeholders can review the Board's progress in meeting its enforcement goals and targets, we have developed a transparent system of performance measurement. These measures are posted publicly on a quarterly basis.

This annual report represents the culmination of the four quarters worth of data.

Volume

Number of complaints and convictions received.

The Board had an annual total of 309 this fiscal year.

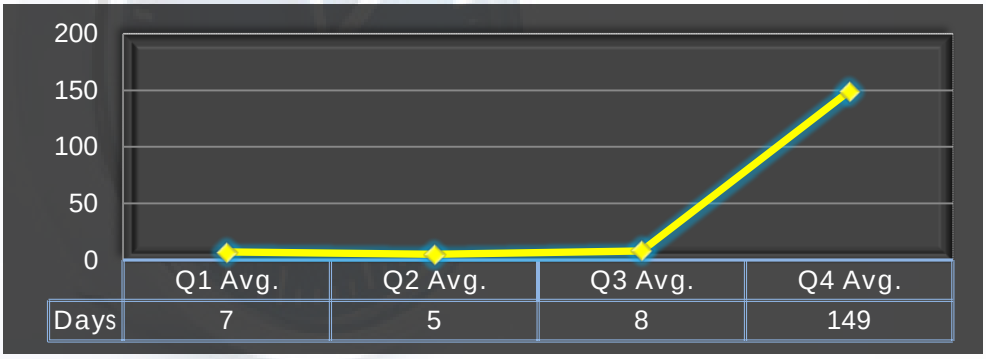


	Q1	Q2	Q3	Q4
Volume	97	56	61	95

Intake

Average cycle time from complaint receipt, to the date the complaint was assigned to an investigator.

The Board has set a target of 7 days for this measure.

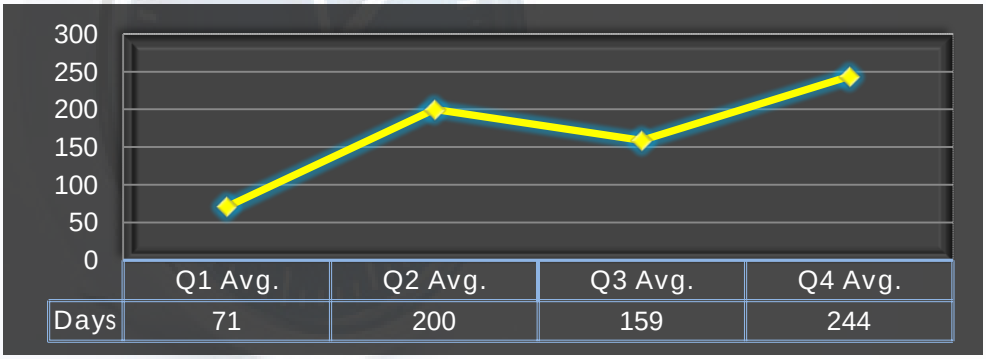


	Q1 Avg.	Q2 Avg.	Q3 Avg.	Q4 Avg.
Days	7	5	8	149

Intake & Investigation

Average cycle time from complaint receipt to closure of the investigation process. Does <u>not</u> include cases sent to the Attorney General or other forms of formal discipline.

The Board has set a target of 90 days for this measure.

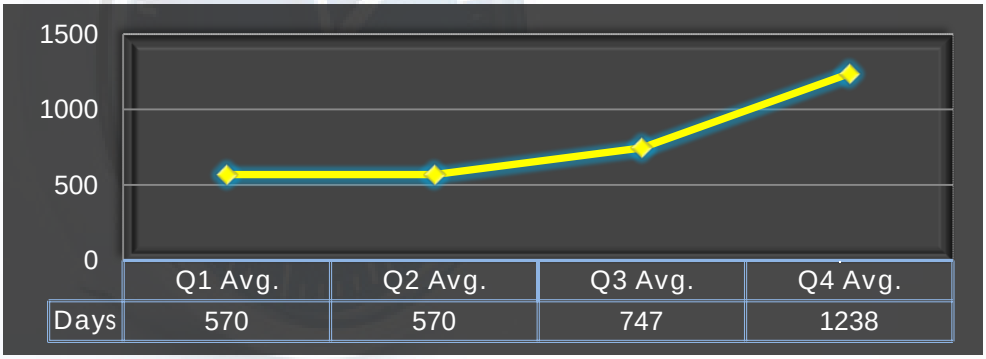


	Q1 Avg.	Q2 Avg.	Q3 Avg.	Q4 Avg.
Days	71	200	159	244

Formal Discipline

Average number of days to complete the entire enforcement process for cases resulting in formal discipline. (Includes intake and investigation by the Board, and prosecution by the AG)

The Board has set a target of 365 days for this measure.

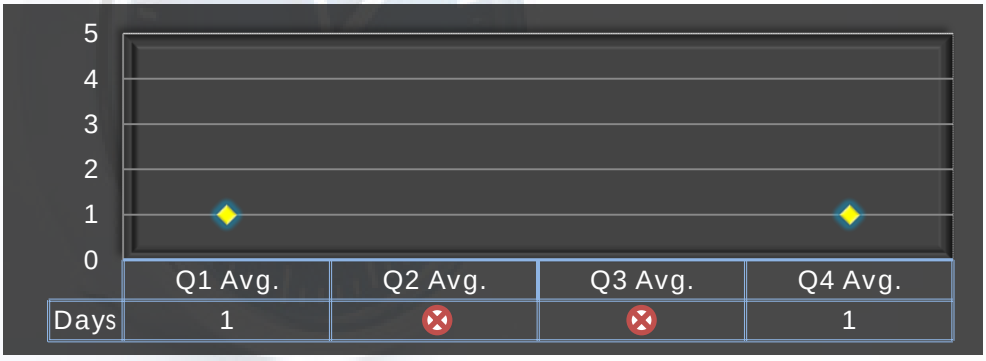


	Q1 Avg.	Q2 Avg.	Q3 Avg.	Q4 Avg.
Days	570	570	747	1238

Probation Intake

Average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.

The Board has set a target of 10 days for this measure.

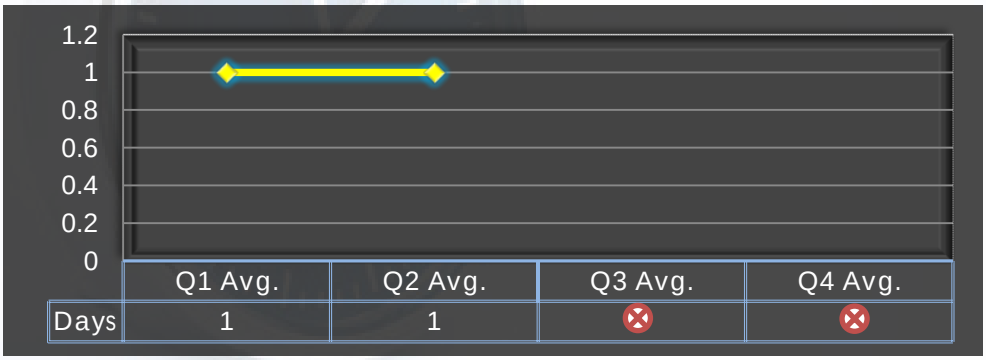


	Q1 Avg.	Q2 Avg.	Q3 Avg.	Q4 Avg.
Days	1	⊗	⊗	1

Probation Violation Response

Average number of days from the date a violation of probation is reported, to the date the assigned monitor initiates appropriate action.

The Board has set a target of 10 days for this measure.



E. Performance Measures Continued

DCA Annual Reports

CALIFORNIA STATE BOARD OF OPTOMETRY

www.optometry.ca.gov

The California Board of Optometry (Board) regulates the practice of optometry through licensing and enforcement. The Board's mission is to implement and promote laws and regulations that protect the health and safety of consumers and to ensure that Californians have access to appropriate, high-quality eye and vision care. The Board provides continuing education so that licensees can remain current on emerging trends and industry changes and conducts public outreach to inform consumers about the eye and vision care programs and services available to them.

MAJOR ACCOMPLISHMENTS FOR FISCAL YEAR 2008–09:

- Completed an occupational analysis for the practice of optometry required for the development of a new plan for the California Law Examination.
- Conducted law examination development and occupational analysis workshops and raised subject matter expert response rates dramatically by communicating with licensees via e-mail in addition to traditional mail. Eight hundred and fifty-eight registration forms were sent out to licensees who graduated between January 2005 and January 2009 in an effort recruit younger optometrists. The workshop schedule was posted online as an additional outreach effort.
- Created and published the Board's first newsletter. The new newsletter will assist the Board in its outreach to licensees by informing them about hot topic issues in the field of optometry and Board news. The publication will be distributed online and by mail on a quarterly basis.
- Updated applications on the Board's Web site, including the application for lacrimal irrigation and dilation certification, application for licensure as an optometrist and instructions and the application for inactive to active license status.

MAJOR LEGISLATION/REGULATIONS FOR FISCAL YEAR 2008–09:

- Adopted Title 16, California Code of Regulations (CCR) sections 1525, 1525.1, and 1525.2. CCR section 1525 clarifies the requirements for the renewal of a license to practice optometry, specifically the disclosure of the completion of the required continuing education courses and disclosure of any disciplinary action taken against any license and/or any conviction that occurred in the prior renewal cycle. CCR 1525.1 and CCR 1525.2 provide the Board with authority to take disciplinary action against a licensee who fails to provide requested information relating to a criminal conviction history during the course of a Board investigation.
- Amended Title 16, California Code of Regulations section 1524 which increases various types of licensing fees to better support Board operations. The last fee increase was implemented in 1993.
- Senate Bill 1406 (Chapter 352, Statutes of 2008, Correa) became effective January 1, 2009, and expanded the scope of practice for optometrists related to treating patients with glaucoma, treating children, prescribing authority, ordering laboratory tests. Changes were made to the requirements for consultation with ophthalmologists or an appropriate physician or surgeon.

ENFORCEMENT

Complaints

2008/2009	
221	RECEIVED Total received complaints from the following sources: public, government/ law enforcement, licensed professional groups, internal, other, or anonymous.
162	CLOSED Total number of complaints closed without going to formal investigation.
160	PENDING Total number of complaints which remained open and in progress at the end of the 2008–09 fiscal year, regardless of the fiscal year in which the complaint was received. Does not include complaints referred for formal investigation.

Number of Days to Close Complaints

2008/2009	
77	UP TO 90 DAYS
40	91 TO 180 DAYS
30	181 DAYS TO 1 YEAR
15	1 TO 2 YEARS
0	2 TO 3 YEARS
0	OVER 3 YEARS

Inspections

2008/2009	
0	TOTAL NUMBER OF INSPECTIONS

Formal Investigations

2008/2009	
0	OPENED Total number of formal investigations opened. Includes complaints referred to formal investigation only once, even if investigated by more than one entity.
2	CLOSED Total number of all investigations closed.
8	PENDING Total number of investigations which remained open and in progress at the end of the 2008–09 fiscal year, regardless of the fiscal year in which the investigation was initiated.

Number of Days to Close Investigations

2008/2009	
0	UP TO 90 DAYS
0	91 TO 180 DAYS
0	181 DAYS TO 1 YEAR
0	1 TO 2 YEARS
1	2 TO 3 YEARS
1	OVER 3 YEARS

* PLEASE REFER TO PAGE 3 FOR AN EXPLANATION OF THE DEFINITIONS AND CRITERIA FOR DATA REPORTED IN THE ENFORCEMENT SECTION

Office of the Attorney General

2008/2009	
4	REFERRED TO Total number of investigations referred to the Office of the Attorney General for disciplinary action. This is a subgroup of total investigations closed during the 2008–09 fiscal year.
3	RESOLVED
13	PENDING

Number of Years the Office of the Attorney General Took to Close a Case

2008/2009	
0	TOTAL NUMBER OF AG CASES THAT TOOK UP TO 1 YEAR TO CLOSE
3	TOTAL NUMBER OF AG CASES THAT TOOK 1 TO 2 YEARS TO CLOSE
0	TOTAL NUMBER OF AG CASES THAT TOOK 2 TO 3 YEARS TO CLOSE
0	TOTAL NUMBER OF AG CASES THAT TOOK 3 TO 4 YEARS TO CLOSE
0	TOTAL NUMBER OF AG CASES THAT TOOK OVER 4 YEARS TO CLOSE

Convictions

2008/2009	
29	RECEIVED
12	CLOSED
45	PENDING

Enforcement Actions

2008/2009	
0	STATEMENTS OF ISSUES Total number of statements of issues prepared and filed by the Office of the Attorney General, bureau, board, or program staff.
4	ACCUSATIONS Total number of accusations/petitions to revoke probation prepared and filed by the Office of the Attorney General, bureau, board, or program staff.
4	CITATIONS ISSUED Total number of citations issued, with or without an administrative fine. Does not include inspection citations.
0	REVOCATIONS Total number of licenses, registrations, or certificates revoked without stay of the order of revocation resulting from a disciplinary action.
0	SURRENDER OF LICENSE Total number of licenses, registrations, certificates, or permits surrendered resulting from a disciplinary action.
0	SUSPENSION ONLY Total number of licenses, registrations, certificates, or permits suspended resulting from a disciplinary action. Includes revocation stayed, with suspension only (probation is not included as part of the penalty).
4	PROBATION ONLY Total number of licenses, registrations, certificates, or permits placed on probation resulting from a disciplinary action. Includes suspension stayed, probation only; revocation stayed, probation only; revocation stayed, conditions, and probation; and initial licenses and reinstatements issued on probation.
0	PROBATION WITH SUSPENSION Total number of licenses, registrations, certificates, or permits suspended and placed on probation resulting from a disciplinary action. Includes revocation stayed, suspension, and probation; suspension stayed, suspension, and probation; revocation stayed, suspension, conditions, and probation.
0	NUMBER OF PC23s ISSUED
0	NUMBER OF ISOs ISSUED
4	NUMBER OF FINAL DECISIONS
21	NUMBER OF PROBATIONERS Total number of licenses, registrations, certificates, or permits placed on probation resulting from a disciplinary action. Includes suspension stayed, probation only; revocation stayed, probation only; revocation stayed, conditions, and probation; and initial licenses and reinstatements issued on probation.

* PLEASE REFER TO PAGE 3 FOR AN EXPLANATION OF THE DEFINITIONS AND CRITERIA FOR DATA REPORTED IN THE ENFORCEMENT SECTION.

LICENSING/ APPLICATIONS

Applications Received

2008/2009	
65	BRANCH OFFICE LICENSE (BOL)
145	FICTICIOUS NAME PERMIT (FNP)
206	STATEMENT OF LICENSURE (SOL)
241	OPTOMETRY APPLICATION (OPT)
5	OPTOMETRY APLICATION - THERAPEUTIC PHARMACEUTICAL AGENTS (OPT - TPA)
110	DUPLICATE WALL CERTIFICATE APPLICATION

Licenses Issued

2008/2009	
53	BRANCH OFFICE LICENSE (BOL)
103	FICTICIOUS NAME PERMIT (FNP)
239	OPTOMETRY APPLICATION (OPT)
188	STATEMENT OF LICENSURE (SOL)
2,209	TOTAL LICENSES ISSUED
7,584	TOTAL LICENSEES

Renewed Licenses

2008/2009	
355	BRANCH OFFICE LICENSE (BOL) RENEWAL
2,990	OPTOMETRY LICENSE BIENNIAL (OPT) RENEWAL
257	FICTICIOUS NAME PERMIT (FNP) RENEWAL
1,012	STATEMENT OF LICENSURE (SOL) RENEWAL
11,576	TOTAL RENEWED LICENSES

PUBLIC SERVICES & COMMUNICATION

Outreach/Education

2008/2009	
2	OUTREACH PRESENTATIONS TO BERKELEY AND SOUTHERN CALIFORNIA SCHOOLS OF OPTOMETRY AND STATE FAIR PARTICIPATION

Publication(s)

CALIFORNIA LAWS AND REGULATIONS RELATED TO THE PRACTICE OF OPTOMETRY BOOK, 2006 EDITION (PRINT AND ONLINE)
2009 OPTOMETRY SUMMER NEWSLETTER (PRINT AND ONLINE)
2009 CALIFORNIA LAW EXAM CANDIDATE HANDBOOK AND STUDY GUIDE (ONLINE)
MULTIPLE FACT SHEETS: CONTINUING EDUCATION, CHANGES IN SCHEDULE III PRESCRIPTION REQUIREMENTS, APPEALING THE DENIAL OF AN APPLICATION, ABOUT DEA NUMBERS AND PRESCRIBED CONTROLLED SUBSTANCES, FINGERPRINT INFORMATION, WHAT DO THE LETTERS AFTER AN OPTOMETRIST'S LICENSE MEAN, Q&A: THE CONTACT LENS RULE AND EYEGLASS RULE AND MORE (PRINT AND ONLINE)
FOCUS ON YOUR EYES: A CONSUMER GUIDE TO EYE CARE - BROCHURE (ONLINE)


CALIFORNIA STATE BOARD OF OPTOMETRY >>

California State Board of Optometry

www.optometry.ca.gov

The California State Board of Optometry (Board) regulates the practice of optometry through licensing and enforcement. The Board's mission is to serve the public and optometrists by promoting and enforcing laws and regulations which protect the health and safety of California's consumers and to ensure high-quality care. The Board provides continuing education so that licensees can remain current on emerging trends and industry changes and conducts public outreach to inform consumers about the eye and vision care programs and services available to them.

MAJOR ACCOMPLISHMENTS FOR FISCAL YEAR 2009–10:

- Completed and adopted a 2010–11 Strategic Plan on March 25, 2010. This accomplishment will benefit the Board, staff, licensees and consumers.
- Completed transition to new computer-based examination vendor Psychological Services Inc. (PSI) for the California Laws and Regulations Examination. This meets the Board's examination goals set out in its Strategic Plan and benefits the Board's applicants and employees by streamlining the licensure process. Applicants may now schedule their examination on the date of their choice, Monday–Friday between the hours of 8 a.m. to 5 p.m. In addition, staff processing times have been reduced thanks to PSI's ability to transfer exam scores electronically.
- Created and initiated Customer Satisfaction Surveys specific to general requests, licensing and enforcement in order to assess and improve the level and quality of services provided to licensees, applicants and consumers. This meets the Board's organizational effectiveness goals set out in its Strategic Plan and will benefit licensees, consumers and stakeholders by making staff aware of areas that need improvement.
- Created and published summaries of disciplinary actions on the Board's Web site in order to benefit consumers by keeping them informed on the status of practicing optometrists in the State. This accomplishment meets the Board's education and outreach goals.
- Created and published the 2010 Optometry Business and Professions Codes and California Code of Regulations on the Board's Web site. This accomplishment meets the Board's organizational effectiveness goals and will benefit staff, licensees, and consumers by providing the most up-to-date information.

MAJOR LEGISLATION/REGULATIONS FOR FISCAL YEAR 2009–10:

// Initiated a rulemaking for California Code of Regulations (CCR) section 1571, Glaucoma Certification Requirements pursuant to Senate Bill 1406 (Correa, Chapter 352, Statutes of 2008). This regulation establishes the requirements for optometrists who graduated prior to May 1, 2008 to become glaucoma certified. This regulation is still going through the rulemaking process.

// Initiated a rulemaking to amend CCR section 1520, Infection Control Guidelines. The proposed infection control guidelines are based on minimum standards that are industry-accepted and known to minimize the risk of transmission of infectious diseases or agents. These are not new requirements for optometrists; the Board is explicitly placing these minimum standards into regulation in order to clarify what is expected of optometrists in California. This regulation is still going through the rulemaking process.

// Created and are sponsoring Assembly Bill 2683 (Hernandez) in order to establish requirements for optometrists to practice in health facilities such as skilled nursing and intermediate care facilities. This bill is still going through the legislative process.

PROGRAM SUMMARY

Staffing

12	STAFF POSITIONS APPROVED IN BUDGET
1	EXEMPT EMPLOYEES

Board, Committee, Commission, or Bureau Advisory Group Members

N/A	BUREAU ADVISORY GROUP MEMBERS
6	PROFESSIONAL BOARD MEMBERS
5	PUBLIC BOARD MEMBERS

Strategic Planning and Outreach

03/2010	DATE STRATEGIC PLAN ADOPTED
4	EVENTS AND SPEAKING ENGAGEMENTS

SUMMARY OF LICENSING ACTIVITY

Initial Licenses/Certificates/Permits

TYPE	APPS RECEIVED	ISSUED	RENEWED
BRANCH OFFICE LICENSE	31	66	325
FICTITIOUS NAME PERMIT	127	180	1,032
STATEMENT OF LICENSURE	208	187	285
OPTOMETRY APPLICATION	285	215	3,368
OPTOMETRY APPLICATION - THERAPUTIC PHARMACEUTICAL AGENTS	304	138	N/A
DUPLICATE WALL CERTIFICATE APPLICATION	261	261	N/A

Licensing Population by Type

TYPE	CERTIFICATES/ PERMITS	LICENSES/ REGISTRATIONS	APPROVALS
BRANCH OFFICE LICENSE	N/A	432	N/A
FICTITIOUS NAME PERMIT	1,278	N/A	N/A
STATEMENT OF LICENSURE	1,057	N/A	N/A
OPTOMETRY APPLICATION	N/A	11,782	N/A
OPTOMETRY APPLICATION - THERAPUTIC PHARMACEUTICAL AGENTS	N/A	6,890	N/A
DUPLICATE WALL CERTIFICATE APPLICATION	N/A	6,148	N/A

Renewal and Continuing Education

TYPE	FREQUENCY OF RENEWAL	NUMBER CE HOURS REQUIRED EACH CYCLE
BRANCH OFFICE LICENSE	ANNUAL	NONE
FICTITIOUS NAME PERMIT	ANNUAL	NONE
STATEMENT OF LICENSURE	EVERY 2 YEARS	NONE
OPTOMETRY APPLICATION	EVERY 2 YEARS	50 (TPA); 40 (DPA)
OPTOMETRY APPLICATION - THERAPUTIC PHARMACEUTICAL AGENTS	EVERY 2 YEARS	50
DUPLICATE WALL CERTIFICATE APPLICATION	ONLY IF LOST/STOLEN	NONE

Exam

EXAM TITLE	PASS	FAIL	TOTAL
NATIONAL BOARD OF EXAMINERS IN OPTOMETRY	215	0	215
CA LAWS AND REGULATIONS EXAM	139	29	168
TOTAL	354	29	383

SUMMARY OF ENFORCEMENT ACTIVITY

Consumer Complaints—Intake

173	RECEIVED
27	CLOSED WITHOUT REFERRAL FOR INVESTIGATION
163	REFERRED FOR INVESTIGATION
1	PENDING

Conviction/Arrest Notification Complaints

21	RECEIVED
22	CLOSED/REFERRED FOR INVESTIGATION
0	PENDING

* PLEASE REFER TO PAGE 4 FOR AN EXPLANATION OF THE DEFINITIONS AND CRITERIA FOR DATA REPORTED IN THE ENFORCEMENT SECTION.

SUMMARY OF ENFORCEMENT ACTIVITY

Inspections	
0	INSPECTIONS CONDUCTED
0	INSPECTION CITATIONS ISSUED

Investigations	
185	OPENED
236	CLOSED
60	PENDING

Number of Days to Complete Intake and Investigations	
87	UP TO 90 DAYS
52	91 TO 180 DAYS
53	181 DAYS TO 1 YEAR
39	1 TO 2 YEARS
1	2 TO 3 YEARS
4	OVER 3 YEARS
201	AVERAGE NUMBER OF DAYS TO COMPLETE INTAKE AND INVESTIGATIONS

Citations and Fines	
5	ISSUED
5	ISSUED WITH A FINE
2	WITHDRAWN
0	DISMISSED
269	AVERAGE NUMBER OF DAYS TO ISSUE A CITATION AND FINE

Total Amount of Fines	
$18,250	ASSESSED
$0	REDUCED
$750	COLLECTED

Criminal/Civil Actions	
0	REFERRALS FOR CRIMINAL/CIVIL ACTION
0	CRIMINAL ACTIONS FILED
0	CIVIL ACTIONS FILED

Office of the Attorney General/Disciplinary Actions	
10	CASES OPENED/INITIATED
4	CASES CLOSED
13	CASES PENDING

Number of Days to Complete AG Cases	
0	1 YEAR
1	1 TO 2 YEARS
2	2 TO 3 YEARS
1	3 TO 4 YEARS
0	OVER 4 YEARS
881	AVERAGE NUMBER OF DAYS TO IMPOSE DISCIPLINE

Formal Actions Filed/Withdrawn/Dismissed	
1	STATEMENTS OF ISSUES FILED
6	ACCUSATIONS FILED
1	RESTRAINING/RESTRICTION/SUSPENSION ORDERS GRANTED
0	STATEMENTS OF ISSUES WITHDRAWN/DISMISSED
0	ACCUSATIONS WITHDRAWN/DISMISSED

Administrative Outcomes/Final Orders	
0	LICENSE APPLICATIONS DENIED
0	REVOCATION
0	SURRENDER OF LICENSE
0	PROBATION WITH SUSPENSION
0	SUSPENSION ONLY
4	PROBATION ONLY
0	PUBLIC REPRIMAND
0	OTHER DECISIONS

Petitions to Revoke Probation Filed/Petitions and Accusations to Revoke Probation Filed	
3	TOTAL NUMBER FILED

Subsequent Disciplinary—Administrative Outcomes/ Final Orders	
0	REVOCATION
1	SURRENDER OF LICENSE
1	PROBATION WITH SUSPENSION
0	SUSPENSION ONLY
0	PROBATION ONLY
0	PUBLIC REPRIMAND
0	OTHER DECISIONS

* PLEASE REFER TO PAGE 4 FOR AN EXPLANATION OF THE DEFINITIONS AND CRITERIA FOR DATA REPORTED IN THE ENFORCEMENT SECTION.

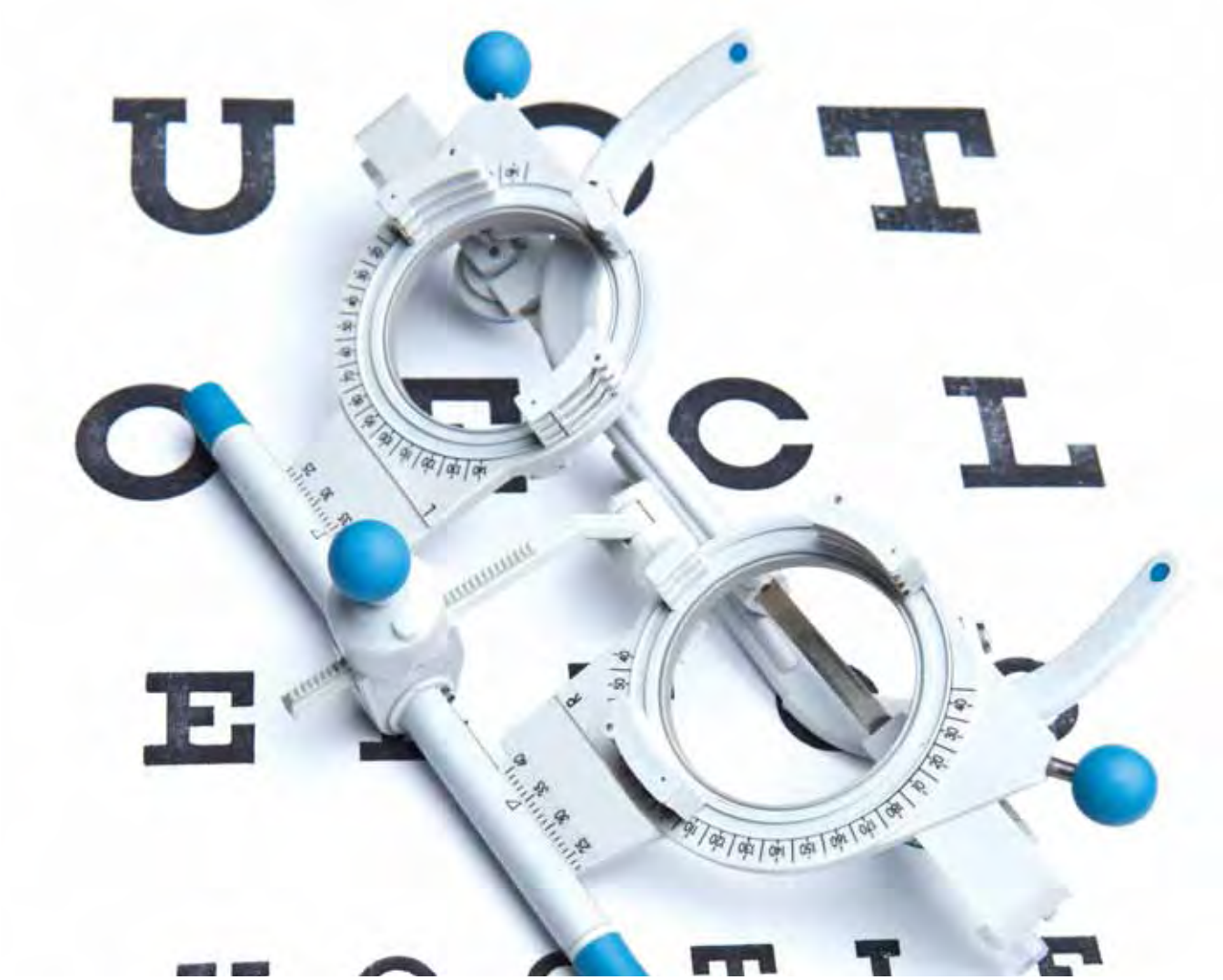
SUMMARY OF ENFORCEMENT ACTIVITY

Petition for Modification or Termination of Probation	
0	GRANTED
0	DENIED
0	TOTAL

Petition for Reinstatement of Revoked License/ Registration/Certification	
1	GRANTED
0	DENIED
1	TOTAL

Cost Recovery to DCA	
$26,516	ORDERED
$31,087	COLLECTED

Consumer Restitution to Consumers/Refunds/Savings	
$0	RESTITUTION ORDERED
$273	AMOUNT REFUNDED
$0	REWORK AT NO CHARGE
$0	ADJUSTMENTS IN MONEY OWED/PRODUCT RETURNED/EXCHANGED
$0	TOTAL SAVINGS ACHIEVED FOR CONSUMERS



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CALIFORNIA STATE BOARD OF OPTOMETRY

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MAJOR ACCOMPLISHMENTS FOR FISCAL YEAR 2010–11

- Conducted outreach about the dangers of purchasing cosmetic contact lenses without a prescription from unlicensed dispensers. Educational letters were sent to unlicensed dispensers to stop the sale of the lenses, a press conference covered by local media was held at a Halloween store to educate the public, and a Halloween flier was created and distributed to California middle school students who are considered to be the target audience for unlicensed dispensers.

  The Board also met with the Northern California Consumer Protection Committee to educate district attorneys regarding this under-reported but prevalent issue. This accomplishment meets the Board's strategic goals related to education, outreach, and enforcement. Consumers benefit greatly because they are being protected from unlicensed activity and licensees are encouraged to report unlicensed dispensers to assist the Board in its enforcement efforts.

- Developed a new logo for the Board as part of the Board's strategic plan. The redesign, completed in November 2010, was done to modernize the Board's look and to rebrand the Board as a leading healthcare profession board that continuously provides consumers and optometrists with effective, collaborative, and proactive services.

- Updated the Board Web site to simplify of navigation for consumers, licensees, and staff. These changes meet the Board's outreach and education goals and benefits consumers, licensees, and Board staff. Improvements include:

  - Added a "What's New" section on the home page with the latest information on the Board's activities.

  - Redesigned icons for the Board's expert witness recruitment, customer satisfaction survey, and mailing list to be more eye-catching and modern.

  - Added a citations and disciplinary actions page to inform the public and increase consumer protection regarding licenses on probation, pending accusations against licenses, surrendered licenses, and other public enforcement actions.

  - Redesigned meetings, forms/ publications, laws/regulations, and other pages for easier navigation.

- Improved the Board's Probation Monitoring Program as part of the Board's strategic plan. Improvements include: the creation of pre-orientation packets, the use of more effective interviewing skills, creation of compliance interviews, implementation of drug testing through Phamatech,

continued

an update of probation terms and conditions including those related to substance use pursuant to SB1441, Ridley-Thomas (Chapter 548, Statutes of 2008) in the Board's Disciplinary Guidelines, and improved techniques on how to respond to violations.

These changes protect consumers by ensuring each probationer is held to every condition. Licensees on probation will also benefit because they will be provided with more, much-needed guidance to complete their probation.

MAJOR LEGISLATION/REGULATIONS FOR FISCAL YEAR 2010–11

- Successfully implemented glaucoma certification requirements through the regulatory process effective January 8, 2011. This action meets the Board's strategic goals related to regulations, and benefits licensees and Board staff by providing a streamlined process for a certification in high demand by California optometrists. Also, consumers will benefit because the implementation of this regulation increases access to care.
- Updated continuing education (CE) requirements though the regulatory process to increase optometric CE opportunities such as the ability to obtain CE units for attending Board meetings and taking a course to receive CPR certification. This action meets the Board's strategic goals related to licensing and regulations by ensuring that California's optometric CE opportunities are current and in line with other states. Licensees and consumers benefit because a variety of CE improves the practice of optometry by keeping optometrists at the top of their profession.
- Updated guidelines for infection control in optometric practice through the regulatory process pertaining to proper hand hygiene, use of personal protective equipment, handling sharp instruments and disinfection requirements. This action meets the Board's strategic goals related to regulations, consumer protection, and outreach by ensuring that optometrists are aware of what is required of them by law. Consumers will benefit greatly from this added clarity regarding infection control.
- Created and sponsored Assembly Bill 2683, Hernandez (Chapter 604, Statues of 2011). The bill became effective January 1, 2011, and establishes requirements for optometrists to practice in health facilities such as skilled nursing homes and intermediate care facilities. The Board conducted outreach to its licensees regarding this new law by writing an informational article in the California Optometric Association's 2010 September/October newsletter. This bill benefits licensees in this type of practice by allowing them to treat patients at multiple locations without having to notify the Board of every single location they visit. This exemption only applies if all the conditions described in the bill are met. The bill benefits consumers by increasing access to care and meets the Board's strategic goals related to legislation.

PROGRAM SUMMARY

Staffing	
14	STAFF POSITIONS APPROVED IN BUDGET
1	EXEMPT EMPLOYEES

Board, Committee, Commission, or Bureau Advisory Group Members	
11	TOTAL NUMBER OF BOARD MEMBERS AS MANDATED
6	PROFESSIONAL BOARD MEMBERS
5	PUBLIC BOARD MEMBERS

Strategic Planning and Outreach	
03/2010	DATE STRATEGIC PLAN ADOPTED
5	EVENTS AND SPEAKING ENGAGEMENTS

SUMMARY OF LICENSING ACTIVITY

Initial Licenses/Certificates/Permits			
TYPE	APPS RECEIVED	ISSUED	RENEWED
BRANCH OFFICE LICENSE	**63**	**46**	**339**
FICTITIOUS NAME PERMIT	**151**	**103**	**1,098**
STATEMENT OF LICENSURE	**243**	**237**	**319**
OPTOMETRY APPLICATION	**274**	**248**	**3,482**
THERAPUTIC PHARMACEUTICAL AGENTS CERTIFICATION	**267**	**267**	**0**
DUPLICATE WALL CERTIFICATE APPLICATION	**253**	**253**	**0**
LACRIMAL IRRIGATION AND DILATION	**276**	**269**	**0**
GLAUCOMA	**293**	**267**	**0**

Licensing Population by Type			
TYPE	CERTIFICATES/ PERMITS	LICENSES/ REGISTRATIONS	APPROVALS
BRANCH OFFICE LICENSE	**N/A**	**46**	**N/A**
FICTITIOUS NAME PERMIT	**103**		**N/A**
STATEMENT OF LICENSURE	**N/A**	**237**	**N/A**
OPTOMETRY APPLICATION	**N/A**	**335**	**N/A**
OPTOMETRY APPLICATION - THERAPUTIC PHARMACEUTICAL AGENTS	**N/A**	**325**	**N/A**
DUPLICATE WALL CERTIFICATE APPLICATION	**N/A**	**253**	**N/A**
LACRIMAL IRRIGATION AND DILATION	**N/A**	**320**	**N/A**
GLAUCOMA	**N/A**	**320**	**N/A**

Renewal and Continuing Education		
TYPE	FREQUENCY OF RENEWAL	NUMBER CE HOURS REQUIRED EACH CYCLE
BRANCH OFFICE LICENSE	**ANNUAL**	**NONE**
FICTITIOUS NAME PERMIT	**ANNUAL**	**NONE**
STATEMENT OF LICENSURE	**EVERY 2 YEARS**	**NONE**
OPTOMETRY APPLICATION	**EVERY 2 YEARS**	**40-50**
OPTOMETRY APPLICATION - THERAPUTIC PHARMACEUTICAL AGENTS	**EVERY 2 YEARS**	**40-50**
DUPLICATE WALL CERTIFICATE APPLICATION	**N/A**	**0**
LACRIMAL IRRIGATION AND DILATION	**EVERY 2 YEARS**	**40-50**
GLAUCOMA	**EVERY 2 YEARS**	**40-50**

Exam			
EXAM TITLE	PASS	FAIL	TOTAL
NATIONAL BOARD OF EXAMINERS IN OPTOMETRY	**456**		**456**
CA LAWS AND REGULATIONS EXAM	**95**	**10**	**105**

* PLEASE REFER TO PAGE 12 FOR AN EXPLANATION OF THE DEFINITIONS AND CRITERIA FOR DATA REPORTED IN THE ENFORCEMENT SECTION.

SUMMARY OF ENFORCEMENT ACTIVITY

Consumer Complaints–Intake	
238	RECEIVED
37	CLOSED WITHOUT REFERRAL FOR INVESTIGATION
202	REFERRED FOR INVESTIGATION
0	PENDING

Conviction/Arrest Notification Complaints	
21	RECEIVED
21	CLOSED/REFERRED FOR INVESTIGATION
0	PENDING

Inspections	
0	INSPECTIONS CONDUCTED
0	INSPECTION CITATIONS ISSUED

Investigations	
223	OPENED
189	CLOSED
96	PENDING

Number of Days to Complete Intake and Investigations	
126	UP TO 90 DAYS
31	91 TO 180 DAYS
20	181 DAYS TO 1 YEAR
12	1 TO 2 YEARS
0	2 TO 3 YEARS
0	OVER 3 YEARS
89	AVERAGE NUMBER OF DAYS TO COMPLETE INTAKE AND INVESTIGATIONS

Citations and Fines	
2	ISSUED
2	ISSUED WITH A FINE
0	WITHDRAWN
2	DISMISSED
390	AVERAGE NUMBER OF DAYS TO ISSUE A CITATION AND FINE

Total Amount of Fines	
$13,000	ASSESSED
$14,250	REDUCED
$2,500	COLLECTED

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SUMMARY OF ENFORCEMENT ACTIVITY

Criminal/Civil Actions	
3	REFERRALS FOR CRIMINAL/CIVIL ACTION
2	CRIMINAL ACTIONS FILED
0	CIVIL ACTIONS FILED

Office of the Attorney General/Disciplinary Actions	
8	CASES OPENED/INITIATED
6	CASES CLOSED
12	CASES PENDING

Number of Days to Complete AG Cases	
0	1 YEAR
3	1 TO 2 YEARS
3	2 TO 3 YEARS
0	3 TO 4 YEARS
0	OVER 4 YEARS
695	AVERAGE NUMBER OF DAYS TO IMPOSE DISCIPLINE

Formal Actions Filed/Withdrawn/Dismissed	
0	STATEMENTS OF ISSUES FILED
8	ACCUSATIONS FILED
0	RESTRAINING/RESTRICTION/SUSPENSION ORDERS GRANTED
0	STATEMENTS OF ISSUES WITHDRAWN/DISMISSED
1	ACCUSATIONS WITHDRAWN/DISMISSED

Administrative Outcomes/Final Orders	
0	LICENSE APPLICATIONS DENIED
4	REVOCATION
1	SURRENDER OF LICENSE
0	PROBATION WITH SUSPENSION
0	SUSPENSION ONLY
4	PROBATION ONLY
0	PUBLIC REPRIMAND
0	OTHER DECISIONS

Petitions to Revoke Probation Filed/Petitions and Accusations to Revoke Probation Filed	
1	TOTAL NUMBER FILED

Subsequent Disciplinary–Administrative Outcomes/ Final Orders	
2	REVOCATION
0	SURRENDER OF LICENSE
0	PROBATION WITH SUSPENSION
0	SUSPENSION ONLY
2	PROBATION ONLY
0	PUBLIC REPRIMAND
0	OTHER DECISIONS

Petition for Modification or Termination of Probation	
0	GRANTED
0	DENIED
0	TOTAL

Petition for Reinstatement of Revoked License/ Registration/Certification	
0	GRANTED
0	DENIED
0	TOTAL

Cost Recovery to DCA	
$6,875	ORDERED
$31,755	COLLECTED

Consumer Restitution to Consumers/Refunds/Savings	
$0	RESTITUTION ORDERED
$0	AMOUNT REFUNDED
$0	REWORK AT NO CHARGE
$0	ADJUSTMENTS IN MONEY OWED/PRODUCT RETURNED/ EXCHANGED
$0	TOTAL SAVINGS ACHIEVED FOR CONSUMERS

* PLEASE REFER TO PAGE 12 FOR AN EXPLANATION OF THE DEFINITIONS AND CRITERIA FOR DATA REPORTED IN THE ENFORCEMENT SECTION.

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MAJOR ACCOMPLISHMENTS FOR FISCAL YEAR 2011–12:

- Created a Board Member Handbook, which includes an updated version of the Board's Administrative Procedures Manual. This benefits the Board's members and consumers because it assists in the creation of an efficient and effective team of professional and public leaders that will carry out the Board's consumer protection mandate. This also meets the Board's strategic plan goals to update and revise its Administrative Procedural Manual and begin the implementation of a new Board member orientation and training program.

- Updated and re-designed "Focus on Your Eyes" consumer brochure, and created two new brochures; "Focus on Consumer Protection" and "Cosmetic Contact Lenses". The brochures outline what to expect during an eye examination, an introduction to the Board and its role as a consumer protection agency, and the dangers of obtaining cosmetic contact lenses without a prescription. In addition to benefiting consumers, this meets one of the Board's goals in its strategic plan to develop and disseminate new publications that inform and engage consumers.

- Established a social media presence with the creation of Facebook and Twitter accounts to highlight pertinent information about optometry. This meets the Board's education and outreach goals and benefits the public and licensees because it is a modern avenue to reach out to them.

- Enhanced outreach program for California optometry students by working with the schools and colleges of optometry to present an overview of the Board's functions to third year students, instead of fourth year students. This meets one of the Board's goals in its strategic plan to continue to provide effective outreach to optometry students. This outreach benefits the students because they learn about the Board sooner, specifically how to avoid enforcement action throughout their career, and how to navigate through the licensure process.

- Completed training of enforcement staff on the implementation of the entire enforcement process, which meets one of the Board's goals in its strategic plan. Staff completed the three-day Advanced Investigative Training by the Council for Licensing, Enforcement and Regulation (CLEAR) and the Department of Consumer Affair's Enforcement Academy. This training benefits consumers because highly competent individuals are ensuring that their interests are protected.

- Updated the Board's Retention Schedule, which had not been updated since 2002. This meets the Board's goal in its strategic plan to improve organizational effectiveness, and will benefit the Board's staff. This will also benefit licensees because files will not get lost and it will be easier for staff to retrieve files from the State Records Center if necessary.

MAJOR LEGISLATION/REGULATIONS FOR FISCAL YEAR 2011–12:

- Senate Bill 1215 (Emmerson) creates a retired license and retired license with a volunteer designation, and defines what constitutes "temporary practice." This legislation was signed by the Governor and will be effective on January 1, 2013. This meets the Board's goal in its strategic plan to establish just laws that reflect current and emerging practices. The bill will benefit licensees who want to receive recognition as "retired" doctors after a lifetime of dedication in their profession. Also, underserved communities will benefit who are in need of experienced professionals to volunteer in free health fairs or other public services.

- The regulatory process is in progress to update the Board's Disciplinary Guidelines, which have not been updated since 1999, and also add the Uniform Standards Related to Substance Abuse (BPC section 315). This meets the Board's goal in its strategic plan to establish fair and just laws that provide for the protection of consumer health and safety. Consumers will benefit because they will be better protected from optometrists who violate the law.

PROGRAM SUMMARY

Staffing

9.4	STAFF POSITIONS APPROVED IN BUDGET
1	EXEMPT EMPLOYEES

Board, Committee, Commission, or Bureau Advisory Group Members

n/a	BUREAU ADVISORY GROUP MEMBERS
6	PROFESSIONAL BOARD MEMBERS
5	PUBLIC BOARD MEMBERS

Strategic Planning and Outreach

2010	DATE STRATEGIC PLAN ADOPTED
2	EVENTS AND SPEAKING ENGAGEMENTS

SUMMARY OF LICENSING ACTIVITY

Initial Licenses/Certificates/Permits

TYPE	APPS RECEIVED	ISSUED	RENEWED
BRANCH OFFICE LICENSE	63	94	423
FICTITIOUS NAME PERMIT	153	147	1305
STATEMENT OF LICENSURE	257	252	473
OPTOMETRY APPLICATION	273	765	3559
OPTOMETRY APPLICATION - THERAPUTIC PHARMACEUTICAL AGENTS	266	266	n/a
DUPLICATE WALL CERTIFICATE APPLICATION	383	383	n/a

Licensing Population by Type

TYPE	CERTIFICATES/ PERMITS	LICENSES/ REGISTRATIONS	APPROVALS
BRANCH OFFICE LICENSE	n/a	94	n/a
FICTITIOUS NAME PERMIT	147		n/a
STATEMENT OF LICENSURE	n/a	252	n/a
OPTOMETRY APPLICATION	n/a	765	n/a
OPTOMETRY APPLICATION - THERAPUTIC PHARMACEUTICAL AGENTS	n/a	760	n/a
DUPLICATE WALL CERTIFICATE APPLICATION	n/a	383	n/a

Renewal and Continuing Education

TYPE	FREQUENCY OF RENEWAL	NUMBER CE HOURS REQUIRED EACH CYCLE
BRANCH OFFICE LICENSE	Annual	None
FICTITIOUS NAME PERMIT	Annual	None
STATEMENT OF LICENSURE	Every 2 years	None
OPTOMETRY APPLICATION	Every 2 years	40-50
OPTOMETRY APPLICATION - THERAPUTIC PHARMACEUTICAL AGENTS	Every 2 years	n/a
DUPLICATE WALL CERTIFICATE APPLICATION	n/a	n/a

Exam

EXAM TITLE	PASS	FAIL	TOTAL
NATIONAL BOARD OF EXAMINERS IN OPTOMETRY		n/a	
CA LAWS AND REGULATIONS EXAM	237	33	270
TOTAL			

SUMMARY OF ENFORCEMENT ACTIVITY

Consumer Complaints—Intake

224	RECEIVED
22	CLOSED WITHOUT REFERRAL FOR INVESTIGATION
201	REFERRED FOR INVESTIGATION
2	PENDING

Conviction/Arrest Notification Complaints

92	RECEIVED
128	CLOSED/REFERRED FOR INVESTIGATION
2	PENDING

SUMMARY OF ENFORCEMENT ACTIVITY

Inspections	
n/a	INSPECTIONS CONDUCTED
n/a	INSPECTION CITATIONS ISSUED

Investigations	
329	OPENED
257	CLOSED
167	PENDING

Number of Days to Complete Intake and Investigations	
97	UP TO 90 DAYS
59	91 TO 180 DAYS
62	181 DAYS TO 1 YEAR
35	1 TO 2 YEARS
4	2 TO 3 YEARS
0	OVER 3 YEARS
191	AVERAGE NUMBER OF DAYS TO COMPLETE INTAKE AND INVESTIGATIONS

Citations and Fines	
2	ISSUED
2	ISSUED WITH A FINE
0	WITHDRAWN
0	DISMISSED
292	AVERAGE NUMBER OF DAYS TO ISSUE A CITATION AND FINE

Total Amount of Fines	
$15501	ASSESSED
0	REDUCED
$5501	COLLECTED

Criminal/Civil Actions	
2	REFERRALS FOR CRIMINAL/CIVIL ACTION
2	CRIMINAL ACTIONS FILED
1	CIVIL ACTIONS FILED

Office of the Attorney General/Disciplinary Actions	
14	CASES OPENED/INITIATED
7	CASES CLOSED
16	CASES PENDING

Number of Days to Complete AG Cases	
0	1 YEAR
3	1 TO 2 YEARS
2	2 TO 3 YEARS
2	3 TO 4 YEARS
0	OVER 4 YEARS
879	AVERAGE NUMBER OF DAYS TO IMPOSE DISCIPLINE

Formal Actions Filed/Withdrawn/Dismissed	
0	STATEMENTS OF ISSUES FILED
5	ACCUSATIONS FILED
0	RESTRAINING/RESTRICTION/SUSPENSION ORDERS GRANTED
0	STATEMENTS OF ISSUES WITHDRAWN/DISMISSED
2	ACCUSATIONS WITHDRAWN/DISMISSED

Administrative Outcomes/Final Orders	
0	LICENSE APPLICATIONS DENIED
1	REVOCATION
1	SURRENDER OF LICENSE
1	PROBATION WITH SUSPENSION
0	SUSPENSION ONLY
4	PROBATION ONLY
0	PUBLIC REPRIMAND
0	OTHER DECISIONS

Petitions to Revoke Probation Filed/Petitions and Accusations to Revoke Probation Filed	
2	TOTAL NUMBER FILED

Subsequent Disciplinary—Administrative Outcomes/ Final Orders	
0	REVOCATION
1	SURRENDER OF LICENSE
0	PROBATION WITH SUSPENSION
0	SUSPENSION ONLY
0	PROBATION ONLY
0	PUBLIC REPRIMAND
0	OTHER DECISIONS

SUMMARY OF ENFORCEMENT ACTIVITY

Petition for Modification or Termination of Probation	
4	GRANTED
0	DENIED
4	TOTAL

Petition for Reinstatement of Revoked License/ Registration/Certification	
0	GRANTED
0	DENIED
0	TOTAL

Cost Recovery to DCA	
40,089.75	ORDERED
14,875.21	COLLECTED

Consumer Restitution to Consumers/Refunds/Savings	
0	RESTITUTION ORDERED
0	AMOUNT REFUNDED
0	REWORK AT NO CHARGE
0	ADJUSTMENTS IN MONEY OWED/PRODUCT RETURNED/EXCHANGED
0	TOTAL SAVINGS ACHIEVED FOR CONSUMERS