The Contact Lens Rule and the Evolving Contact Lens Marketplace

Panel V: Prescription Release and Consumer Choice

DANIEL GILMAN: We are going to have another break. But we don't have one slated right now. And I think that as the afternoon wears on, there will probably be unanimity across prescribers, sellers, regulators that prompt release from the room is welcome. So I've been asked, this is really not part of our law enforcement mission, but this is as a courtesy. I've been asked to read, if you have an outstanding debt to the cafeteria, please pay your balance. He will be there until 4:15 P.M., which is to say the end of panel five, which is to say the end of this panel that's taking place right now. On to things we're supposed to know more about or find out more about.

My name is Dan Gilman. I work in the FTC's office of Policy Planning. I'm going to be co-moderating this panel with my colleague, Beth Delaney from our Bureau of Consumer Protection. Some of you may remember Beth from 60 seconds ago if you have any working short-term memory whatsoever. We are going to give, I think, increasingly short shrifts to the many qualifications and accomplishments of our participants today.

So the panelists, now I'm just going to introduce people by their names and affiliations. We do have bios, as I think you know, available that say more about who our participants are and what they've done. And I commend those to you. A couple of bits of housekeeping just to revisit something that we've been going on about. If you have a question, there will be people who collect question cards, filter some of them up here, staff will read every single question that's written out. Staff will not read them necessarily out loud here during the panel. We have a lot of ground to cover, but staff will read them. If you have questions, I urge you to do that. And of course, the comment period remains open. So if you have more considered thoughts about the proceedings today or anything that we've published, please consider the public comment period.

A little thing for our panelists. I hope that we're not going to have formal presentations kicking off, except for one from Beth. We're not going to have formal presentations kicking off this discussion. If the panelists could, when you have something you'd like to say, just turn your comment card this way. And then I might see it. Beth, more perceptively than myself, might see it. And we'll at least keep track and try to call on everybody.

So and then I said, well, I suppose I should say, anything I say here today, any question I might ask is my own. It does not necessarily reflect the views or curiosity of the Federal Trade Commission, any of its individual commissioners, or the Office of Policy Planning here at the FTC. I'm going to turn this over to Beth who has a few framing, very brief framing remarks about the flip side of the verification request, which is--

BETH DELANEY: Oh, we need to introduce the panel?

DAN GILMAN: Yeah, I'm going to introduce it, which is Prescription Release and Consumer Choice, after Beth, the panelists will be Dr. Edward Chaum, Plough Foundation professor at the

University of Tennessee Health Science Center. Dr. David Cockrell who's past president of the AOA and a diplomate of the American Board of Optometry. Dr. Zachary McCarty, chair of the Quality Improvement and Registry Committee of the AOA. Joseph Neville. Joe is executive director of the National Association of Optometrists and Opticians and Linda Sherry who is the Director of National Priorities at the organization Consumer Action. So let me turn it over to Beth. And then we'll get the discussion started.

BETH DELANEY: Right. So I'm just going to get a little bit of an overview. As you all know, prescribers must give a copy of the contact lens prescription to the patient when the contact lens fitting is complete. We call this automatic prescription release. You don't have to ask for it, it's supposed to be just turned over to you. The patient getting a copy of the prescription is one of the key underpinnings of the Rule. It's the mechanism that's going to make comparison shopping possible.

So in our rulemaking review, the Commission examined the available evidence about prescription release and it determined that it would be beneficial to increase compliance with automatic prescription release. To do so, the Commission has proposed requiring prescribers to obtain a signed acknowledgment from their patients at the time the prescription is provided to the patient. The Commission believes that this proposal would serve several important objectives.

It's going to remind prescribers to release the prescription. It will inform patients of their rights. It will reduce misunderstandings. And probably most importantly, it'll improve the Commission's ability to make sure that the prescriptions have been released. It's going to provide a recordkeeping mechanism. The proposed form reads, my eye care professional provided me with a copy of my contact lens prescription at the completion of my contact lens fitting. I understand I am free to purchase contact lenses from the seller of my choice.

So on this panel, some of the topics we plan on covering are prescription release, the signed acknowledgment proposal, the pros and cons of the proposal, and possible alternatives to the signed acknowledgment form that could help ensure that prescriptions are automatically released to patients.

DAN GILMAN: OK, great. So this is a statutory requirement. We're supposed to implement the statutory requirement. And maybe just go down the row, but let's start with Linda. You're from the consumer organization, can you talk a little bit about the importance to consumers of receiving a copy of the contact lens prescription and what you've found there.

LINDA SHERRY: Sure. Well, I do agree with Beth that the Contact Lens Rule is the underpinning, I mean, excuse me, getting the copy of your prescription is the underpinning of the Contact Lens Rule, which, of course, requires optometrists to provide their patients with a copy of the prescription without having to ask. And that's a very important part of it. But our polling, we did a poll in January of 2017, showed that about a third of contact lens wearers weren't getting their prescriptions. And many didn't even know, even a much higher percentage, didn't even know they had a right to get it automatically.

Having that prescription means that they have the option to use it to purchase their contact lenses from their retailer of choice. I mean, there's still, most consumers, seem to still be buying from the prescriber. And that could be that they're not getting the copy. I don't know. But they do trust these providers and these prescribers. And if they want to remain there, that's still their choice. But if they want to go to one of the new places that are available to buy and save some money, because we do believe that consumers usually save money by shopping around for contact lenses.

We also believe that this helps consumers wear fresh, clean lenses and not try to overwear their prescription.

DAN GILMAN: Maybe I could just go to Dr. Cockrell. I mean, you are a very established member of the profession, a past president of the association, and I guess you've suggested that it's routine practice in your office to release the prescription. I don't know if that's typical or not, but maybe just in terms of your experience of best practices, how do you implement this requirement? What are the procedures that you have in your practice in place to see that this is done, that this works smoothly, efficiently both in terms of the initial release and then maybe follow-up requests? What do you do to make this work?

DAVID COCKRELL: At the conclusion of the contact lens fitting in our office, across the board from all of our docs, at the time the fitting is completed, we have electronic medical records, so we literally press a button in our system to print that prescription. And that button's pressed in front of the patient. And literally we say, they're going to bring that in for me to sign. Because we don't have a printer in every examination room.

So but we tell them, we're done. We're printing a copy of your contact lens prescription. You'll have that, and we'll sign, and away they go. Now, what do we do to make sure that we did it, because every single day we have a patient call asking for a copy of their contact lens prescription. And it's always someone we've given it before. And it's probably as Ms. Sommer said, they've misplaced it or they've lost it or they've given it to someone and didn't get it back. It's all for the right reasons.

But we look to see, A, is it current when they call to ask about the prescription, is it still a current prescription? And when did we do it? And did we give it to them already? I want to know how many times I've given it. Because as I mentioned a few minutes ago, in one day, I had three requests and three different online retailers asking for a copy of the prescription as the third-party agent. So we went we want to track those numbers. So we keep track of it inside of our EMR, by the patient.

DAN GILMAN: Now, do you have any, I mean, obviously your best experience is with your own practice. But you have any sense of other practices and other models where they might have more difficulty? Of course, not every practice has an EMR. Not every practice that has an EMR, has the same one. What's the utility of the EMR integration or of electronic prescribing, what's missing in practices where compliance is more of a burden?

DAVID COCKRELL: We created a space inside of our EMR. Our EMR doesn't come with a tab to record it. So inside of where we have the contact lens prescription in the note box. We record who gave it by name and initials who handed it to the patient. So that's our record. We can go back and look it up. But to my knowledge, there are no EMRs where that we have the opportunity to click a button and know that we record and audited.

For the friends of mine that I have that are not EMR, in those particular cases, almost 100% of them have a copy of the prescription when they write it. It's a duplicate prescription that's kept in the chart. So, again, there's no audit trail other than you have to go look up the chart to see when did they get the prescription, did we give it to them? But that's the way we did it prior. And we've had EMRs for a long, long time. But that's how we did it prior to that.

DAN GILMAN: Do you know in AOA, obviously, via CMS there was a big incentive program for health care providers, physicians, hospitals, other provider entities to adopt EMR. It's not 100%, very widespread. Do you know within AOA, either for the population of optometrists versus the population of ophthalmologists and other prescribers what the adoption rate is for EMRs?

DAVID COCKRELL: I'll let Zach answer that, because he's the one--

ZACHARY MCCARTY: Certainly I can speak to that and be happy to say, I've looked at the CMS data. And the best that we can ascertain from that data is, who is meaningfully using their EHRs. And for optometrists, it looks to me about 1/4 of the optometrists have an EHR and have attested to the meaningful use program. So it is not widely adopted across the United States. And there's many reasons for that.

The CMS has tried to put in place a program to, as you said, push the adoption of EHRs. Unfortunately, when they put this program into place, they made some errors. And they basically looked extensively at primary care and avoided looking at the specialties and the specifics that are nuanced with other medical specialties, particularly in eye care. And because we have those issues, there's a lot of doctors out there that have just walked away.

They said, we cannot continue using these EHRs because they are inefficient. They do not meet our needs for eye care and what we do on a day in and day out basis. As a local personal example, we try to work with the standards that ONC, the Office of the National Coordinator, has put forth for electronically communicating just patient data. And this panel is talking about electronic exchange of information.

We tried to talk to some of our other referring doctors. Our practice is referral only. We take care of our colleagues' patients that have medical problems. I don't dispense. We do not sell. We treat the problems that are caused by contact lenses. As so we're trying to exchange this medical information between our colleagues. With one of our other providers in our community, we spent over a year and a half working between our EHR vendor and the EHR vendor of our colleague and still cannot get the systems to talk across a defined standard by the ONC.

It is a very, very sorry state of interoperability in health care today. CMS recognizes this. We are nowhere near what we need to be in order to be able to communicate electronically.

DAN GILMAN: Can I just ask a related question? Dr. McCarty I know that, as you said, you get a lot of referrals for medical care for eye problems. And we've seen that adoption for electronic prescribing of medicines has been much more widespread. Do you know, just without getting into complications, what would be adapted? Maybe later in the conversation we can get there.

But do you have some sense of what the adoption rate is? I mean, I gather for pharmacies it's nearly 100% for electronic prescribing systems. For optometrists and/or ophthalmologist separately, collectively, do you know how many are using electronic prescribing for medicines, not necessarily for contact lenses.

ZACHARY MCCARTY: Absolutely. I'd love to speak about that. So as far as to prescribing medications electronically, the CMS data shows that's happening quite frequently for those that use EHR systems. But a big difference. If we're talking about a pharmacy, and that is what some of the retailers are trying to compare themselves to, to pharmacies, we have adequate two-way communication. If I send a prescription to a pharmacy, or they send one to me and they say, this patient wants a refill and is expired. When I click and say, decline, I get a notice back from the pharmacy saying, this prescription will not be filled.

There's a comments box. It's very legible. And we're able to put in a comment. There's often times, again, we're dealing with patients if we're talking medications, they may need one month's supply. And we can put in the notes, one month supply and needs to be seen again. So we can determine, is their medical problem changed before we prescribe more medication. They make that in-person visit to ensure that eye health has not changed. And there's that great two-way communication with the verification with pharmacies.

BETH DELANEY: OK, let's turn to the actual proposal itself. And I want to start with Joe. Maybe you could give us a little bit of background on who you represent and what your members feel about the signed acknowledgment form.

JOSEPH NEVILLE: Sure. The NAOO is composed of the majority, the vast majority, of the large optical firms in the United States. Many are also in Canada. And collectively, the members have over 9,000 locations throughout the United States. So we have a lot of retail locations. And because of that, we also have quite a few business relationships, typically landlord tenant, with the prescribers. And so we have a nice mix of both sides of this conversation, if you will.

Not wanting to sound like an ungrateful guest, my members' response to the idea was, oh no, not another form, not another signature that the consumer is going to have to put on some kind of a piece of paper. And how and where are we going to keep it? The sense was that patients and really doctors have got a lot of paperwork to deal with, and this is some more paperwork. And the way the rule was proposed was that it would be a separate form. So we are adding a piece of paper.

And so our natural thoughts went to, maybe the better approach is to inform patients of their rights. Let's make sure there's more information about their rights. So that if there is a problem with the release, the patients are more engaged.

BETH DELANEY: OK. Well, we'll shift to proposals.

JOSEPH NEVILLE: Yes.

BETH DELANEY: Before we do that, let me ask Dr. Cockrell, as an independent optometrist with your own practice, if you could give us a little feedback on the signed acknowledgement proposal.

DAVID COCKRELL: I think it creates a very significant burden. I looked at the numbers before I came. In 2017 we prescribed for over 6,800 individual contact lens patients. And when I think about the process of asking 6,800 people to sign a piece of paper, and in then the length of time it will take to explain to those patients, here's why you're having to sign it, because it's a ruling from the FTC that you have to do this. And then in my mind, it creates that little bit of patient doubt, which interferes with doctor patient relationship.

Then at that point in time, because our EMR doesn't have a place where a patient can sign. So we will have to literally have them sign a piece of paper and then take the time to scan that document in. It's unfortunately more than a minute. It really is. That conversation is two to three minutes for the staff and then absolutely I'm going to, I guarantee you, somebody will say, well the patient wants to talk to you about this form before they sign it. Because we have that occur right now.

So I just look at the economic dollar cost in terms of spending time explaining it. And then the one or two minutes scanning it into the appropriate spot in the electronic medical records. Because I darn sure don't want to keep 6,000 pieces of paper, 18,000 over a course of three years, and have to keep up with them.

BETH DELANEY: Could you elaborate on the creation of the patient doubt. Because that was in a lot of the comments, a sense of distrust. And we're wondering what does that mean?

DAVID COCKRELL: Well, just imagine, you're an attorney. And you've been my patient for the last 25 years wearing contact lenses. And whether you purchase it from me or not, I've given you a prescription. And next year, you come in, and I say, by the way Beth, you'll need to sign this piece of paper today acknowledging that I gave you that. Would that not give you pause to wonder, now why is he doing that? He's never done it before.

And you have a legal mind and legal training. Think about those folks who don't have. They're all going to wonder, what just happened to that doc? Why is he having to do that? Who made him do it? Now, I'm going to blame it, quite frankly, on FTC. The FTC is making me do this. Well, why are they making you do that? Oh, I don't know. Or they think there's a problem that we really can't confirm. That's literally going to be the conversation across the United States.

And maybe I shouldn't speak for all my colleagues. But that will be the conversation certainly coming out of our office. Because that's reality. But that still creates a little bit of doubt. Isn't it going to make you wonder just a little bit? He didn't have to do that before. I didn't have to sign up before. And now I have to sign it. Gosh, we get questioned on every single piece of paper we have to sign, whether it's the HIPAA forms, the office policy forms. You'd just be surprised.

BETH DELANEY: Yeah. Well, let me ask Linda about this. Because this is a consumer issue. So with HIPAA, you do kind of a confusing form, and you don't really understand that your medical records go to a pharmacy in order to get a prescription filled. So Linda, what do you think would, you know, you've heard the language of the form. And what do you think the consumer takeaway would be with having to sign another form? Would that raise a lot of questions? Would they--

LINDA SHERRY: Well, offhand, I don't think it would. I think that unless for some reason the doctors decide to try to shoehorn something in there like you have to go to arbitration to settle all your disputes or something like that. If it's simple statement, and it's there for their protection, I think that a reasonable consumer could understand that. Unlike other medical professionals in industries, optometrists are allowed to sell these very products that they prescribe. And many are also retailers of the contact lenses. So this is a conflict.

And maybe consumers don't realize it. But it is protecting them from that if they know that they have the right given to them by the Contact Lens Rule to go and shop around. I feel that our polling has showed that, despite this right to get this copy of this prescription, sadly, many consumers are finding it difficult to get a copy. So if there was a better record of this, I believe, why would this not be a win-win for both sides?

Even if it took a minute more or two minutes more, it would establish trust. And it would establish the fact that the eye doctor could prove it was given and that the consumer could acknowledge receipt of it. So it seems to kind of solve two problems at once, at least to us. You mentioned a carbon copy that you had years ago. Well, couldn't this just be a carbon copy with the sign off? Could you, I know HIPAA was raised with email, but could you email or text it?

You said you're using electronic medical record.

BETH DELANEY: I think, yeah, we're going to definitely have a whole segment on proposals. But I see Dr.--

LINDA SHERRY: Could these things be made more consumer friendly, these receipts? But--

BETH DELANEY: If you want to fax it, definitely.

LINDA SHERRY: The fact the consumer has the receipt is very important.

BETH DELANEY: So Dr. Chaum, you want to--

EDWARD CHAUM: Yeah, I think what you're seeing here is actually really important. This is in front of you is the evolution and the growth of medicine as we move from the paper era to electronic health record era and this transformation is not going to be easy. It's going to be long, it's going to be painful but it has been initiated. T he HITECH Act mandates that all of us who submit electronic billing using electronic records are mandated, by law, to implement meaningful use applications in the care of our patients.

And I think this is really an incredible opportunity for us to see where we can take that mandate and apply it and use it to address some very painful issues in the course in managing our practices. The reality is, and most people don't realize this, the reality is that the patient owns his or her health information. The medical record, the prescription in my record, belongs to the patient. I'm the steward of that information. I'm responsible for managing it. But it belongs to the patient.

And there are now applications that are being developed that have been implemented across many platforms that allow the patient to utilize a portal to go in and acquire his or her information on their own. Those portals are associated with electronic audits. They can be associated with the, not only the transfer of an electronic record that gives the patient a prescription. If it's out of date, then it's out of date, and they can't use it for a vendor.

But it can be associated with the transfer of other information, health information, educational information, reminders to come and get an eye examination if that's what the doctor wants. That electronic format and the interaction of that patient with his or her own information is where this discussion needs to go.

BETH DELANEY: OK. I'm going to--

DAN GILMAN: I actually just wanted to ask a follow-up question of Dr. Cockrell. I think you raised an important point. A lot of practitioners are under burden of accretion of regulatory requirements. And so, even if it's a simple form, it's another one. There's a process. There's an amount of time. And I don't think we want to make light of that. I think we want to get a handle on what the burden is, whether we go forward with this proposal, a modified proposal, a different one.

I do want to push a little bit on this sort of one, two, three minutes. Because we have some substantial experience with forms. And, for instance, with the HIPAA form. I mean HIPAA was enacted some time ago. The first and then second Privacy Rule under HIPAA were promulgated. And people routinely signed various forms and medical practices. And I don't know whether the literature on the time spent is encouraging or discouraging. Maybe it depends on the way you look at it.

But, I mean, it seems like a lot of people don't read the forms at all. They sign the forms. They're used to forms. And we've all sat, and even practitioners have sat in physician's offices. I don't see that many lengthy conversations. I don't recall a lot of articles about, or even ad hoc complaints about, oh, this HIPAA requirement, have you been sharing my personal health information with every Tom, Dick and Harry who asked you for it? And I can't see you anymore.

I mean, you might have a one-minute conversation, a two-minute conversation, a two-hour conversation with a patient. But are you really expecting conversations of multiple minutes with each patient? You named the number of patients you see. With no other forms have I seen any literature suggesting that this happens.

DAVID COCKRELL: When-- you evidently weren't sitting in the offices when the HIPAA forms first came into compliance and we had to start using them or maybe not in rural Oklahoma. Because the reality is, every form that comes along that we've got to sign and do, it is a discussion. And I didn't say it's a 10-minute discussion. It's a one-minute discussion maybe for the front desk to say, here's why you've got to sign this as we give them their prescription. Then if it winds up with me, it's going to be another minute or two, because I'm leaving the exam room. Now I'm out of it.

So not only is it the regulatory burden that I believe is truly unnecessary, there's an economic cost. As you know, the AOA submitted our survey to you from Avalon.

DAN GILMAN: We saw it, yeah.

DAVID COCKRELL: We can agree or disagree on the dollars. But the reality is there is a cost to paying the staff to do those things. When they're not doing some other job, they're doing that job. So there is a real cost. And is it really necessary? I don't actually have, Dr. Chaum, any patients that don't know that the records are their medical records, that they can't request their medical records any time they want.

We get those requests on a routine basis, if not daily. So I think we have an educated population that knows the records are theirs. Certainly when we give them the prescription now, they call back to ask for another copy, they know it's theirs. So I just look at this as one more job that we don't need to do that I'm going to pay someone to do that provides no real benefit to the patient.

BETH DELANEY: And so do you think that it will reduce the verifications?

DAVID COCKRELL: I think absolutely. If every single patient had the prescription in their hand every single time they had it, it will reduce them. The reality is, I can tell you from our experience, we get calls every day for another copy of prescription. So I don't know if they lose them, if they turn them in. I don't know what happens. Those folks, we get verification. We've got, obviously, a large contact lens practice, so we get verification calls, or robocalls, or faxes every day in our office. And I know how many of those we give out. So it's not going to eliminate it. It's really not.

LINDA SHERRY: Well, I think--

DAN GILMAN: I'm going to go back, I'm sorry, Dr. McCarty had his tent card.

ZACHARY MCCARTY: I'm going to go back to what you just said about most patients aren't reading these anyway. What good is something as an enforcement tool if they're not even reading it in the first place?

BETH DELANEY: Well, they'd get the copy of it.

LINDA SHERRY: They're getting the copy.

DAN GILMAN: It documents-- well--

ZACHARY MCCARTY: They're not reading it in the first place. So--

LINDA SHERRY: Now, I think you should think of ways, in your associations, which are very vital apparently, how to create something that is going to give the consumer the choice to pull down their own prescription anytime they want so they don't even have to go through you. They'll be able to print it out. And if--

ZACHARY MCCARTY: I'd love to respond to that.

LINDA SHERRY: And if it's expired, you could also give them some health information. We do this for your protection. You need to get another eye exam. You can come to me, or you can go to somebody else. It's a wonderful, teachable moment.

DAN GILMAN: It might be. I'd like to give Dr. Cockrell a chance to answer. But there's a question from the audience simply asked, if a signed acknowledgment did, in fact, cause consumers to ask about the new requirement, isn't it likely that that's a growing pain that would go away, diminish over time?

DAVID COCKRELL: Possibly, yeah. Because they're going to get them year after year. So at some point they would stop asking, absolutely. But there's also a flat line of about 40 million contact lens patients, which means over the last several years, which means we've gotten new patients every single year coming in as patients stop wearing them. Otherwise that number would have grown exponentially. So there is always going to be a constant education process.

And just to briefly address your question, as Dr. McCarty talked about the portals. We have a portal right now where we give every single patient a piece of paper. And our staff takes the time to go over to say, please use our portal. Why do we do that? Because we're incentivized by the CMS, if we get enough people to do it, we're going to get a bonus. Do you know what our percentage is?

LINDA SHERRY: It’s low, I'm sure.

DAVID COCKRELL: It's less than 1%, less than 1. So the fact that we can have all the portals we want, they're not going to look at them.

BETH DELANEY: Well, we'll talk about--

DAVID COCKRELL: Maybe in 10 years, they will. I don't know.

BETH DELANEY: We'll talk about portals in a second. But I do want, before we move over to alternatives to signed acknowledgment and start fleshing that out, and we're going to have Joe do that. I did want to ask Dr. Cockrell about, in the comments, we did have a lot of prescribers that are concerned about patients having to come back in to the office if they finalize a contact lens fitting over the phone. So maybe your patient that's been coming for a few years, and you decided to switch to a new brand with your prescriber. So you say to me, wear them for a week and see if you like them. I call you in a week and you say, OK, sure, go ahead. So does that happen in your practice?

DAVID COCKRELL: Never.

BETH DELANEY: Never, OK.

DAVID COCKRELL: And the reason for it, the reason--I really want to take an opportunity to address that. The reason it will never happen in my practice is, the end of the day, if I say take this lens and wear it, you decide if it fits you or not. It feels pretty good and something goes south, who loses the lawsuit? I can tell you right now, if that actually was brought to the state board, and someone was sued, I'd blame the doc who did it. They didn't provide good care.

They need to get the patient back in, look at the lens, and make sure it actually fits on their eye. Because despite what we heard this morning, every single contact lens is different. I don't care if it's Johnson & Johnson's brand line, every one of those is or CooperVision's or Bausch & Lomb's, they're all different. There is no such thing as generic. Because all those parameters that Dr. Eydelman talked about, every one of them constitutes-- and I'm telling you after doing this for 36 years--

BETH DELANEY: OK, so--

DAVID COCKRELL: It doesn't work.

BETH DELANEY: So as past, president of the AOA, what percentage of prescribers do you think have that follow up, that second visit is in person? Because this is a concern people have. They feel that the patient would have to come in and sign the acknowledgment form. I mean, we'll think about a work around. I mean we could have an email signed acknowledgment where you save the email receipt. And that's good enough if they don't come back in. But is this going to be a real issue? Or--

DAVID COCKRELL: I would really be surprised if it's less than 80% to 90%. And it should be 100%. I can't imagine anybody, accepting the liability of telling a patient to go wear something and not looking at it after the fact. We can certainly get the numbers from our contact lens section. But I can't imagine it. But the onus is on us to say, that thing fits.

BETH DELANEY: So are we ready to move to-- did you have a follow up, Dan?

DAN GILMAN: Well, I wanted to ask about, I mean, Beth is going to ask, and I think it's important to ask about alternatives, possible alternatives. But I'd like to think about alternatives

with a small “a” first. So not something radically different, but there's a federal statute that demands prescription release upon completion of the fitting, upon the patients request, upon request from an authorized third party.

We, a law enforcement agency, are charged with implementing and enforcing this requirement. So one idea to document the actual release is this signed acknowledgment form. It's a pretty brief form. And I think the initial proposals didn't say it had to be papers, it said paper, electronic, you can scan what you want. But let's think about alternatives with a small “a” and just put a little proposal.

We had one proposal. Now we're going to slightly modify a proposal. We're going to ask, is it better or is it worse? What's a little better way of doing this as opposed to doing something else entirely? More reliable from the practitioner's standpoint? More economical from a practitioner's standpoint but not something completely different. A more efficient way of doing this.

DAVID COCKRELL: Is that question for me?

DAN GILMAN: You, and then anybody else who wants to chime in. My technical suggestions about the cards have obviously, I'm not an engineer. This is terrible. Nobody's taking me up on this proposal. But sure, why don't we start with you. And then anybody who wants to do this thing can chime in.

DAVID COCKRELL: Well, as you know our recommendation is for appropriate signage. There are many different government agencies that require us to post signage for people. And I'll let Dr. McCarty address that, maybe it's specific. But I truly believe that appropriate signage at the front desk where the patient signs in, at the front desk where the patient exits the office, if that signage is there and clear and legible,

I believe that's enough. I really do. I think that's appropriate. It educates them. I can't imagine that there's really a third of the people who don't realize they can get their records or their prescription, so I believe that will work. And we've also seen it in California demonstrated where the survey we did was above 90% of the people believe that it's sufficient. That's a pretty big state.

ZACHARY MCCARTY: Thank you, Dr. Cockrell. And I'll take and say, looking at your sister agencies, we deal with the Office of Civil Rights. They deal with some pretty hefty issues, discrimination. It's a much bigger issue than I think this little piddly thing we're talking about contact lens release. They feel that it is sufficient for section 1557 to post a sign in our medical practices saying, we do not discriminate. When such an issue can be done with a poster, why can't we do it with a poster with contact lens release?

BETH DELANEY: Linda?

LINDA SHERRY: Despite, that's a good point. Thank you. I think that signs don't really work. I think they can be hidden. In California there is such a requirement that you post a sign about your rights to get a copy of your prescription. And having learned of that, we took a look around

just in San Francisco and in San Jose. And we did not see a lot of compliance. Now maybe it was sitting behind a potted plant somewhere. I don't know.

But there was not a lot of compliance. And with something like that, you do have to have the ability for law enforcement, in this case the FTC, or the state enforcement people, to go out and say, hey, you're not showing that sign. And that seems like pie in the sky. I think that the money is better off put towards educating consumers as to what they can gain, say for instance, if they used your portal.

So in addition to having them sign this thing, why don't you give him a couple of minutes of education about the fact of, look, you have a cell phone. You use it every day. You have it in your pocket. You live with it. Try pulling down this app. Try using this portal. You will have access to everything you need. You will be able to tell us in the portal, hopefully, that you want to use 1-800 Contacts or that you want to use, I don't know what, Simple Lens or whatever you want to use. But you'll be able to have your preferences in here. And it will be easy.

And I understand that I have at least six of these medical record things now. So they do get confusing, and you forget the passwords. But I still think that we have to present them in a way that is beneficial to the consumer and the consumer understands that these are helpful things that will save them time and money in the future.

BETH DELANEY: I want to go to Joe. Because I know, yeah, I know you turned your card.

JOSEPH NEVILLE: Our starting point was signage. And we talked about the California example. Because our members that are out there try to comply. What the percentages are, I can't tell you. We had the AG look. And we passed the test. So we were happy. But we thought that signage, and we couch it in terms of a prominent place, so it's like Dr. Cockrell mentioned, someplace where the patient is going to be getting that prescription finalized and paying for the services and perhaps the product. Make sure there's a way.

But our other approach, and maybe this is a little “a”, Dan, I'm not sure, is on the theory that the FTC needs an enforcement mechanism, instead of a separate piece of paper or a separate electronic thing, incorporate the notice and the acknowledgment into documents that already exist. Perhaps that could be on the script itself at the bottom. I looked at the script for my doctor. There's a lot of room on that piece of paper. He had a little counter sign.

But allow the doctor the option to figure out, how can I demonstrate that I'm complying with this rule? Is it email transmission, fax transmission, some mechanism that exists for all the different ways that prescriptions can be transmitted.

BETH DELANEY: So what we would do is we would make something a little bit broader saying to prescribers, you need to have some sort of recordkeeping mechanism. And then it wouldn't be a one size fits all. We'd let the prescriber kind of figure it out. And maybe we would offer some guidance on different ways to comply with the requirement?

JOSEPH NEVILLE: That's exactly what we're thinking. But we also think you have to couple that with enforcement and make sure that the community knows that enforcement is happening.

BETH DELANEY: So before we move off of signs, did anybody else want to add anything with signs? OK, so we did-- when we got the sign as an alternative, we did reach out to the California State Board of Optometry. And there's really nothing there in terms of enforcement of the signs, or even them looking for the signs. They didn't have independent inspection authority until this year. So basically, they would only go into an optometrist or a retailer to get documents or they had some other reason to be there.

If they noticed the sign wasn't there, they wouldn't dock them for it if they put the sign up then. So there's really no evidence either way. I just talked to the executive director yesterday. There's no evidence either way that it's working or it's not working. So we did get a lot of comments that say it's working great in California. But we went to the source and there is really no evidence. And there is a perception that putting a sign up isn't actually evidence of the prescription was given out. It's just evidence that a sign was posted.

JOSEPH NEVILLE: Well, to us, it's a part of the education process.

BETH DELANEY: Right, is it education?

JOSEPH NEVILLE: And that to us is important as a starting place.

BETH DELANEY: It's a starting place. Great. Dr. Cockrell?

DAVID COCKRELL: Yeah, I also, after we had that earlier conversation, I called the state board in California as well and introduced myself as a state board member of Oklahoma and asked them how the process was going. And they did say what you said. But then I said, OK, what do you do-- what will you do if that's brought to your attention? Because as a state board, their job is to not look after the professional or the practicing OD, their job is to look after the public. They're there to act as that enforcement measure on the state on behalf of the patients.

And so in my mind, if you have that requirement of signage, now that's a federal government requirement that the signage has got to be up. If a patient has any complaint and it goes to the state board, the state board will act, every single one of them, will act judiciously and work in favor of the patient to enforce that process and whatever things they do.

And I don't know what enforcement process the FTC has in mind, whether that's a fine, whether that's something else. But I know that when the state board calls, every doc's worried about the jeopardy of their license.

BETH DELANEY: Right. I guess from our standpoint, I mean, if a sign is not posted, a patient wouldn't know where to complain. They wouldn't know that a sign needed to be posted. So it would involve the FTC visiting spots to make sure the sign was up. And we did do a little bit of a, let's send out some investigators in California. And they visited 15 locations, and no signs were found. And they did ask the receptionist about them. And no receptionist knew about a sign

requirement. So I don't know if that was just the luck of the draw. But that was kind of a sad result --

DAVID COCKRELL: It could be. But you may remember my comment that one of the problems I said when we first discussed this idea of signing a piece of paper was that the average job tenure in the average optometric office was 16 months. And that the average office at 3.4 staff. And that within a two to three-year period of time, all those staff have gone. And they're all small businesses. So the institutional memory is gone. The reality that that piece of paper is getting given out to be signed is not great either.

DAN GILMAN: Oh, I'm sorry. I mean, maybe that's true. But the office, that's not the turnover for offices, right?

DAVID COCKRELL: That is the turnover for offices.

DAN GILMAN: So I'm-- no, no, that the whole office disappears within 16 months?

DAVID COCKRELL: If you've go three staff--

DAN GILMAN: You go out, your practice--

DAVID COCKRELL: If you've got--

DAN GILMAN: Rises, and falls in 16 months?

DAVID COCKRELL: If you've got three staff, and they average 16 months, if they're not all hired at the same time, no, it's not 16 months.

DAN GILMAN: No, I get it. But let's say Dr. Smith and et all has an optometry office. That's not the average life of an optometry office. The office as an institution knows, I mean, boy that sounds like a nightmare having to re-educate everybody about every single--

DAVID COCKRELL: It is a nightmare.

DAN GILMAN: Wait a minute, every three months.

DAVID COCKRELL: It is.

DAN GILMAN: You persist, right? So if there's a sign on month one, and one receptionist leaves, you wouldn't expect the sign to disappear, would you? The office is responsible for that. I mean, this is not--

BETH DELANEY: Well, I--

DAN GILMAN: A random sample. This is not a big “n”. But I'm thinking, if we sent people to 15 offices--

BETH DELANEY: No, I think-- I think-- were you talking-- you were talking-- he's talking about signed acknowledgment.

DAN GILMAN: A signed acknowledgment, but a sign, if we didn't find a sign in 15 out of 15 offices, then that that's not because the receptionist left. That's because the office doesn't have a sign, right?

DAVID COCKRELL: Well, yeah, clearly there's not a sign there. Maybe there was and maybe there wasn't. We don't know whether there was or wasn't, whether it did get thrown away, whether it never got put out. What we do know is, if the regulation went out and they're not complying, it's a pretty simple process to send that complaint into the state board. Every single state board has a DAG. Every single one of them is required by law to respond to a written complaint. That means they're going after the doc. That simply.

BETH DELANEY: Well, so what you're--

LINDA SHERRY: If they don't know it, they're not going to--

BETH DELANEY: With your staff turnover example, I mean, I wonder if that sheds a little bit of light on why some patients aren't getting a copy of their prescription. I mean--

DAVID COCKRELL: Possibly.

BETH DELANEY: You hand over the prescription yourself. But if staff turnover is preventing prescriptions from being released the way they should be, I mean, that is the law. And that has to be fixed. So at the same time that offices are fixing that problem, the signed acknowledgment would be a piece of that. I mean, it would almost be a better reminder for staff to turn over the prescription than just-- it would be an affirmative act that might help remind them to do it.

DAVID COCKRELL: You are correct. I really wish I could describe what it's like running a small business with three to four staff working for you and the fact that everything doesn't happen every single time. But the FTC has now said, we're going to enforce. You've got to have that piece of paper signed as well. Not just that you got to give out the prescription, but you've now got to be able to produce that piece of paper three years out. I realize it sounds simple to you all. But--

BETH DELANEY: Well, no, we're--

DAVID COCKRELL: They're not.

BETH DELANEY: We're holding a workshop because of these issues.

DAVID COCKRELL: Right.

BETH DELANEY: It doesn't--

LINDA SHERRY: They're not just simple.

BETH DELANEY: We're not dismissing them. And we're not-- we really want to hear. And we want more comments in the next month. I don't want our grilling of you by Dan to make you think that we're not taking you seriously. We really, no, no, this is a great conversation.

DAVID COCKRELL: Yeah, I think he makes good points

BETH DELANEY: It's making it much more interesting than if everyone just had a canned presentation. So we are listening, though. And that's why we're all here today.

EDWARD CHAUM: I think this gets to the issue of trying to migrate this into an electronic format where there is an audit trail, where there's electronic memory, where there is meaningful use demonstrated that brings value to the practices. I think it clearly needs to move in that direction. And it seems like there are practices in which that will be a shorter term migration and practices in which that will be a longer term migration.

But ultimately, providing that information electronically, providing patients access to their information electronically so that they don't have to-- so they can do it independently with valid prescriptions that are overseen by the practice, takes away a lot of the pain that's being discussed here.

ZACHARY MCCARTY: I think that since Dr. Chaum brought that up, it's good to interject and say, I think there was a misstatement earlier that HITECH demands that the practice put in EHRs. It is not a demand. Is not a requirement of providers. Some providers will see penalties for not having an EHR. But it is not required to practice medicine nor optometry or ophthalmology in this country under that law. We are in a very, very under-utilized fashion at this time.

Our practice, I'll just go ahead and use our practice for an example. Last year we saw over 26,000 patients at our practice. Of that, we have a portal, and we've had for four years now, so this is not new. These patients have seen it. They know, we've been advocating, go use the portal. We have made every attempt to be meaningful users. We have tested meaningful use since the inception back in 2011 with our EHR.

We've offered it to over 84% of our patients. 8% of those 26,000 choose to engage in some fashion with our patient portal. Of that, 1% actually message us through the portal. For those asking for a medical record request through the patient portal, and mind you, 26,000 patients across Nashville, Chattanooga, and Knoxville, we're not in the boonies. We're not in rural America. These are metropolitan areas. We have had approximately seven patients ask for their medical records through the portal.

We've had two that have asked for their medical prescription through the portal. And of course, we don't provide, we don't do contact lens prescribe in our office or glasses prescription. So we don't have that release within our portal. But many portals don't have that. Because again, the portals are written to the high tech standard, as Dr. Chaum alluded to.

And the ONC set those standards. And they ignored eye care. So it's not there. You can't audit the record and say, was it released? Because most these portals aren't built for that. And you're talking about hundreds of different disparate EHRs that are not prepared for this. And if you think moving Congress or government is easy, try making an EHR vendor improve their system to help the provider.

BETH DELANEY: Linda, did you have a question?

LINDA SHERRY: Well, I mean we heard about LensFerry today. So the potential to do these kinds of things is there. I would like to know, though, as far as, I know there's a little pick up on portals. But how does the little pick up on portals compare to the verification request you're getting from the online vendors? Is it commensurate or are the people who are not signing up for the portal, say if they're 2%, are you also getting like 2% of people coming in from online vendors asking for verification? So is it commensurate at all? They'll use an online vendor but they won't use your portal type of thing? I'm just trying to understand their behavior.

DAVID COCKRELL: Yes. The simple answer to that last question is yes. They will use their online vendor to purchase lenses. And then when we go through verification where they don't use our portal.

LINDA SHERRY: So if all the online vendors put their heads together and built a verification system, would you guys use it? I mean, would it be, could it be used by everyone? Or do you think it just would-- nobody would agree or it would be anticompetitive idea?

ZACHARY MCCARTY: I think the numbers kind of speak for themselves right now.

DAVID COCKRELL: Yeah, I would--

DAN GILMAN: So what would make it--

LINDA SHERRY: Why day they like to go online but not use the portal? This is-- I mean, do you ever survey your customers to find out why they feel this way?

BETH DELANEY: I think Dr. Chaum knows something about that, right?

EDWARD CHAUM: Well--

BETH DELANEY: Portal adoption--

EDWARD CHAUM: Again, just looking at the literature about portal adoption, Dr. McCarty is correct. Adoptions have been very low across the board for most portals in various aspects of clinical medicine. Even Kaiser, which has a great integrated health care system has relatively low portal use at this point in time. I think what you're going to see is, as patients now are beginning to have experience interacting with their banks and they're making airline reservations and doing all these things on the phone that the availability of applications to interact with patient portals is going to, like with LensFerry, is going to open that up.

You're seeing that a tremendous amount of growth in the contact lens market is in the 18 to 30-year-old group. That's where the greatest growth is. And so these are millennials who are going to take advantage and drive this adoption. There are a number, there are four or five different features to portals that have been identified as having a negative impact on adoption.

The first one is health literacy. There are many people who aren't comfortable accessing information online. And for those patients, it may be a difficult challenge. It may be an insurmountable challenge to get them to interact with their portal. But as the younger population of patients grows and this becomes part of all of our daily lives, doing those types of interactions, I think, are going to become more part of the norm.

The other things that limit adoption of portals are the provider interactions as well. And I think you've good example of providers that do a good job of trying to interact with their patients and are seeing the frustration at getting those patients to adopt. But many electronic portals that where the physicians are not interacting, that clearly has an impact on whether or not the patients adopt and use the portals.

The other two features of portals that have an impact on utilization are usability. How easy is it to function? How many buttons do you have to push to get where you want to go to get the information that you want? And utility, what are the features in that portal that provide value to the patient? And so the development of new types of portals like Blue Button, which is a VA based system that's widely adopted in the VA system and in the Department of Defense.

It's a one button access for patients to access all of their information. So it's easily usable. It has high utility. It provides patients access to a variety of information. These types of applications have already been developed, have already been implemented in many electronic health record systems. And you're seeing innovation like in LensFerry, new apps that are going to come along that are going to hopefully drive adoption in the future.

DAN GILMAN: Can I follow up with both Dr. Chaum and Dr. McCarty? So, I think we want to both track the promise of some developing utilities but also be aware of some difficulties including usability difficulties people may have, whether they're patients or practitioners. What, and going back to small “a” steps, what are things that might be done to facilitate? And this could this could be electronic recording and transmission as an option.

We heard, and indeed it need not be electronic, we heard about integration of the prescription with the acknowledgment. We've been relatively unprescriptive about the form of the prescription, maybe less than in the medical realm. But there are statutory requirements for a contact lens prescription. And there are requirements in the Rule.

I would say in terms of little “a”, what do you think is the promise of maybe, we have these two panels in a row of providing either requirements or guidance that would be a little more prescriptive about the details of the prescription as one issue about integrating the prescription itself with the acknowledgement of the prescription, about doing this on paper, electronically, either. Or what can we do to facilitate this?

And part of what I'm thinking about is between the two panels exploring ways for there to be a little more of an economic trade-off so it's not just another requirement. But maybe there's another requirement or some substantial guidance that has a pay-off. The transmission of the information, canonical information, inspectable information is easier, cheaper, and more reliable. So there's less of a bother with these calls.

Maybe not the 1-800 calls but whatever the source, the calls that your practice doesn't like, the incomplete calls, the hard to understand calls. What are some things we can do to either integrate these functions or facilitate the development of these things?

ZACHARY MCCARTY: I think that's a very, very big challenge. I mean, when you get up in the ivory tower, it sounds great. You're up there robo-signing on prescriptions and say, oh, this will be wonderful. It will be easy to implement and adopt this into technology. And the reality is vendors have to be on board. And right now the EHR vendors are overwhelmed with trying to make changes just to keep up with the change in requirements of the CMS, of the MIPS program, the formal meaningful use program, the advancing confirmation.

So much of their resources is devoted to already the regulatory notion of what's happening at the moment. And so unless you can bring the vendors on board to make those changes, even trying to change and add things to prescriptions takes vendor changes. And again, it wouldn't be just one, two, three, four, five EHRs, but there are literally hundreds of EHRs. Some are eye care specific. Some are not eye care specific. But they're all use by eye care providers. Those would all have to make those changes.

And even to transmit that information, again, the standard does not exist. So unless the FTC suddenly has the ability to define those standards and put in some type of enforcement vendors to comply, I think we're looking at a fantasy world at this point. Yes, it would be nice. Yes, it would be beneficial. But are we there yet? No. And will we be there in five, 10 years? That's a crystal ball that's very tough to look into and see.

EDWARD CHAUM: I would disagree a little bit. I think Dr. McCarty is absolutely correct that there isn't going to be a lot of buy-in from the EHR vendors from a practical and market perspective. Optometry and ophthalmology are very small markets. And they really don't care about us. They just don't. But I think within the existing structure of electronic health records, there are relatively simple work-arounds that we already use that can address some of these issues.

So, for example, there is no formal function in our EHR where I can click a button and it will populate a field with the patient's prescription. But I can take that patient’s prescription as an image and download it into that patient portal with a click of a button. And I can take an educational material with a click of a button and put that there. And then send that and the patient will get an email that says we have information for you in your electronic portal. Please log on. And that information is waiting for you.

And so there are, I think, simple work-arounds that will allow us to provide that information. Maybe there's still some pain associated with it. But it's electronic. It creates an audit trail. It

creates a permanent record of compliance on both ends. It allows a touch to the patient, which is, I think, has been an issue here today. We all want good, strong relationships with our patients. And it wasn't my intention to imply that that shouldn't be part of our practice. It's part of all of our practices.

So these are touch points that allow us to reengage our patient, do what we need to do, what we're mandated to do as covered entities and yet still try and bring some functionality and move this process into the future. Because the reality is, in five years, all of our patients are going to have all their health information on their phones or some chip. I mean, we all know this. And so the question is, how do we help to migrate it more effectively maybe with little "a" steps to start.

Get patients engaged in our practice. Send them an email. You have a-- I have a dentist appointment next week. I got an email from my dentist saying, you have an appointment. Please contact us. I got a text message saying please confirm. So little baby steps that get patients engaged in interacting with you in your practice as we move forward in this new era of electronic records. I think we'll ultimately gain traction and make it easier for patients and for ourselves.

ZACHARY MCCARTY: I wish audit logs, and I should have brought one with me to show you what these EHRs produce. But when you speak about audit logs, Dr. Chaum or Dan, if you ever looked at one--

The voluminous data that comes out of those in trying to track back and the amount of staff time reading through those to say, OK, where does it say in here that I printed my prescription? Yes, audit logs exist in EHRs. Is it intelligible or an easy to find format? Most definitely not.

BETH DELANEY: Well, let's--

ZACHARY MCCARTY: The ones that we've looked to.

BETH DELANEY: Let's take it back a step in like the way Joe had framed it, in terms of, it's not a one size fits all. So maybe some people could start moving towards audit logs and portals. But what are some of the other-- I want to talk about some of the other alternatives to signed acknowledgment as well. So let's just explore a little bit more the carbon copy duplicate angle. Is that doable?

I mean that's not a signed acknowledgment. There's not going to be a disclosure. So it doesn't have the consumer ed angle. But if you had two copies of the prescription, and you had the patient sign one of them, and you put that back in the patient folder, would that work? Would that-- is that one of the options that we could do?

DAVID COCKRELL: Is that for me or?

BETH DELANEY: Joe or Dr. Cockrell.

DAVID COCKRELL: Joe, you want to go first?

JOSEPH NEVILLE: Well, that's an idea that we have. And in consulting with a few of our members, they didn't reject that idea. They thought that with the kind of prescription forms that they know that their doctors use, that's something that could be incorporated into the script. There are a few states that have prescribed what the prescription form must look like. So forget New Jersey, for example. And I think there's one or two others.

But the sense was, that would be an easy way to do it. And it quite honestly would be maybe your one sentence. I acknowledge receipt of my prescription. And then I sign it. So it's kind of both. Whether that's practical or not from the practitioner's point of view, that's the question that we're exploring.

DAVID COCKRELL: I'm trying to think how that actually accomplishes your goal if you put that on the actual contact lens prescription itself. I mean, the doc's already signed it, right? They're signing it to give it to them. If that's part of the prescription, so be it. But in my particular case, remember, well, I guess I'm pressing the button, then I'm signing it later anyway on electronic medical records. So I'm not going have a duplicate of it. But I've already got my audit trail if it's producible, if it needs to be produced.

You know, I don't see that in and of itself is a problem. I'm going to go back to what Dr. McCarty said. There's only 25% of the ODs that are actually using electronic medical records at this point in time. So it's going to have to be some format obviously other than electronic audit trail that you use. I don't agree with Ms. Sherry that 30% of the population has no idea they have a right to their record, to their contact lens prescription, I think, is what you said, or a third is what you said. And that could well--

LINDA SHERRY: Through a poll.

DAVID COCKRELL: Right. And--

LINDA SHERRY: Yeah.

DAVID COCKRELL: Right. I could-- unfortunately, I could do the same one and get 90% that do depending on the population I use.

LINDA SHERRY: Well, ours was commensurate with the FTC findings as well.

DAVID COCKRELL: I understand.

LINDA SHERRY: And they were done separately.

DAVID COCKRELL: I understand. But my point is that-- well, I've made my point. I don't need to reiterate it.

LINDA SHERRY: You know, I hear from all of you the frustration. I really hear the frustration. It must be quite frustrating to deal with, number one, these terrible patients that stockpile boxes of lenses and lie about having been your patient. Oh my word, they just sound awful. But I think

that if everyone puts their head together and works together to solve this particular problem, that will allow more competition in the marketplace, more people to use the online vendors if they want.

It's a 12-- maybe it's a $12 differential in the price or something of a box? But that means a lot to a lot of families. And the fact that you have some flexibility on price yourselves shows me that this is something that can help all consumers in the end if we get it right. I don't see why the two sides are so completely far apart at this point.

ZACHARY MCCARTY: You know, I think it just goes back to what is the heart of the matter? Are we looking for a solution for a problem that doesn't exist? Dr. Cockrell already expressly said with the owned data that we had to request through the Freedom of Information Act, there are less than 0.0003% of complaints?

BETH DELANEY: OK, well we would disagree that--

ZACHARY MCCARTY: 41 million.

BETH DELANEY: We would disagree that--

LINDA SHERRY: Oh, people don't complain about things.

BETH DELANEY: OK, we would disagree that complaints are an indication of prescription release. But this morning, we did have questions where people in the audience were saying that their state has a 100% prescription release rate or other things that are higher. This data has not been provided to us. So please submit that in the comment process. And we will take a look at it.

And you can actually email it to me directly. And this comment also says the national data is very different as well. It's a 100% release in our state. Doesn't say what state it is. We'd like more information about that. Dr. Cockrell? Or, Linda, I'd interrupted you, Linda. So you can finish and then Dr. Cockrell.

LINDA SHERRY: Sure. Is this our wrap up or-- because I mean I had a question.

BETH DELANEY: No it's not the wrap-up, no.

LINDA SHERRY: For the eye doctors if they use--

BETH DELANEY: No, let's--

LINDA SHERRY: Yeah, if they, in fact, use the excellent education materials that are available out there in their offices. Do you have these there on the tables and all that and explaining to folks what's going on?

DAVID COCKRELL: We put them in their hand. You know, I think one of the things, and some of the frustration you hear from the doctors in this room is, the reality of that is as Dr.

Steinemann said and all of us has said is, contact lenses, as great a products as they are, are not without harm. And we wind up dealing with the harm. And when I look at a number like the paucity of complaints that were turned into the FTC, and perhaps people don't complain.

But they certainly do in my office. And I guarantee I've had more complaints in my last five years than was turned in on contact prescription released to the FTC. So I have to look at those as real numbers. If someone went to the effort to write those out, they're real. That's where Dr. McCarty says, is it a solution in search of a problem?

None of us want to keep a patient from having their contact lens prescription. None of us do. The reality is, it's federal law. If there's someone out there who's silly enough to not comply with that, that's their problem. And they're going to be held to a standard. But the reality is that I don't think that, even by signing that form and increasing another regulatory burden on another small business is going to be helpful.

BETH DELANEY: Let's move more towards-- let's talk more about alternatives. Because we still have a few that I'd like to get through.

LINDA SHERRY: Beth, could they just take a picture of it? Would that be appropriate by law to send to the-- I mean, if the patient themselves took a picture of the prescription at the office, was encouraged to do so on their phone, if they had a phone. Would that be enough to have something they could send to 1-800?

BETH DELANEY: Yes, that is enough. But you have to be given the prescription in order to do that.

LINDA SHERRY: Right. But you know--

BETH DELANEY: Let's talk about another way of, like, a lot of commenters have complained about, if I have to do this form with every patient and I have to save every single one of them. Let's talk about a hybrid solution and get your feedback. What if what if the signed acknowledgment form came along with a patient bill of rights but you only have to do it for every new patient. Like if you've a recurring patient, you just execute this once?

Do people think that something like that would work? So the first time I visit Dr. Cockrell, his receptionist gives me the patient bill of rights and says, you know, gives me the signed acknowledgment form. I have a right to my pre-- I've been given my prescription. I get the education that I have a right to it. Would that be OK?

DAVID COCKRELL: I guess I have several comments on that one. I've never heard the term patient bill rights until we had our conference call last week. So it was a surprise to me to hear that was being considered by the FTC. Then when I went back and did some research, I realized that 1-800 actually submitted that idea. So I'm still surprised to see it discussed.

I'm also surprised to see that, for some reason, the FTC would think that the optometrists and ophthalmologists of this world need a patient bill of rights. And the dermatologist, who also

supply products and the dentist who also supply products and the orthopedics who also supply products--

BETH DELANEY: OK, so let's just say consumer education about the fact that you get a copy of your prescription. We'll take away tho--

DAVID COCKRELL: I'm all for consumer education.

BETH DELANEY: OK.

DAVID COCKRELL: But not the other issue. Because, again, it implicitly--

BETH DELANEY: Sure, OK.

DAVID COCKRELL: --implies we've done something wrong.

BETH DELANEY: So we'll reframe the proposal, which is, you alert the patient that they have a right to their prescription and you have only new patients execute it. Would that be a hybrid solution? Joe, do you want to weigh in on that?

JOSEPH NEVILLE: Well, it's a solution for educating the patient. And we think that makes a lot of sense on the front end. If your goal is to have a means for the prescriber to demonstrate that they've actually handed over the prescription--

BETH DELANEY: Well, it'd be to-- right, so at least with the first instance, they would collect a signed acknowledgment.

JOSEPH NEVILLE: If it--

BETH DELANEY: And they would give patient education that would kind of help further down the road. So it would still be the signed acknowledgment. But it would be accompanied by patient education that then wouldn't require to be re-executed every year.

JOSEPH NEVILLE: Yeah, we think that that makes sense as long as it can be part of an existing form. In other words, it's not another piece of paper. So it could be-- I've seen too many intake forms that are top to bottom 10 point type, and they're full. So I'm not sure about the practical side of that. But if it could be incorporated into something that already exists and in that way the patient is seeing it and needing to sign it, we think that makes sense.

BETH DELANEY: Now should we have a safe harbor for prescribers that do not sell contact lenses? And how would we do that? Is that a way that would decrease the burden?

JOSEPH NEVILLE: For the NAOO members where most of the affiliated ODs do not sell the product, yes, it would relinquish the burden.

BETH DELANEY: They don't get any sort of profit from the sale of contact lenses?

JOSEPH NEVILLE: Well, the way we look at it is that if the doctor is employed by the optical establishment, so even though they may not physically sell the contact lenses, that store they work for does, they wouldn't be part of that exemption. If there was some sort of a bonus arrangement, I don't think they should be part of the exemption either. But if there's no bonus arrangement involved in the separate optical sale of contact lenses, then we think that exception makes sense.

DAVID COCKRELL: I don't. You're either required to give a prescription or you're not.

BETH DELANEY: No, no, you're required to give the prescription. It would just be you'd be exempted from having to execute the signed acknowledgment form. Because you don't sell contact lenses, so you're--

DAVID COCKRELL: So implicitly the rest of us are thieves?

DAN GILMAN: No, no. I think it's a fair question whether it's better or worse, I think.

ZACHARY MCCARTY: Yeah, you could--

DAN GILMAN: So one response is, this is worse because it introduces uncertainty and difference in the practice. Another is, this is better because practitioners who have no interest whatsoever in lenses are-- we just want your feedback.

DAVID COCKRELL: Then I would ask this question.

DAN GILMAN: Mm-hm.

DAVID COCKRELL: How in the world could you look at every commercial contract and know whether that doc who isn't physically selling them is incentivized in any other way, whether it's a decrease in the rent space, whether it's advantage in something else? I think if you're going to apply this, you're going to have apply it across the board. I'm not intimating any illegal behavior. But there's many different ways to incentivize providers, right?

There are many different ways the contracts are written that I've seen come through our state board where a doc is incentivized for action X and had something to do with item Y over here that was not tied together on a bill.

DAN GILMAN: I don't know how complex the job is in the space. But certainly there are many different types of contractual arrangements.

DAVID COCKRELL: So I don't see how you can separate that out and exclude anyone.

LINDA SHERRY: It does sound that it would be simpler to have one law for everyone.

BETH DELANEY: So let's, I think we're right about at the end of our time, so let's do our wrap-up and have everybody kind of give us a thought for the takeaway. And we'll start with Dr. Cockrell at the end.

DAVID COCKRELL: My request would be that whatever action the FTC takes, that they would keep uppermost in their mind that patient health care is also part of your charge. It's not just commerce and not take an action that might in anyway jeopardize the patient's health care as you also take an action that is going to increase the burden on a small business. That's my comment.

BETH DELANEY: OK. Linda?

LINDA SHERRY: Well, for us getting the sign-off on the prescription copy and keeping it for X years is not, as required anyway for medical records in many places, it's just really not a crazy burden. It would seem to be, as I said before, a win-win. One side has something to prove. And the consumer can't really come back to you and say, you didn't give me a copy of my prescription. The online prescription renewal for contacts, and for that matter glasses, saves consumers and taxpayers money.

It saves time and increases convenience, increases access for rural and medically underserved communities, and it promotes eye health. So I think we do need to be able to give people the ability to easily renew their prescription online and also to get a copy of it online from some sort of portal or from the doctor's office themselves.

I've learned a lot of things today. And I appreciate the other side, the views of the side that don't want this update to be promoted the way it is at this point in time. But it does seem that it would be most protective for consumers to be able to have something to hang their hat on that they got their copy of their prescription.

BETH DELANEY: Joe?

JOSEPH NEVILLE: Well, because automatic release is the law, and enforcement should be a part of that, we think, give the doctors option to demonstrate compliance. And that's really our key takeaway.

BETH DELANEY: Great. Zach?

ZACHARY MCCARTY: I'd have to speak and say, that as you looked at the other government agencies, they've been mandated to start looking how to decrease regulation and not increase regulation such as what this proposed rule will do. Just yesterday, CMS recognized that health care providers are leaving the profession having increased burnout because of this over-regulation.

BETH DELANEY: But not optometrists--

ZACHARY MCCARTY: Of the profession--

BETH DELANEY: From this morning, it's a growing field.

ZACHARY MCCARTY: Of the profession and because they're being regulated, they realize Blue Button does not work. And they released, they're going to do a new Blue Button to try to get people to do their electronic health records. They say that we need to work to reduce that administrative burden so doctors can get back to doing what we do best, which is caring for our patients. It's called #patientsoverpaperwork.

BETH DELANEY: And Dr. Chaum.

EDWARD CHAUM: So, I think what we're seeing here is growing pains. Clearly medicine is changing. It's changing in front of us. It's changing under our feet. And figuring out the best way through to meet the needs of the consumers and also the needs of our own practices and our livelihoods and our frame of mind, if you will, are issues that we need to come to terms with. And we need to find a common ground to meet all of those obligations.

And I think as we grow into an electronic health record era, and that becomes part of our daily medical practice, that a lot of these growing pain issues are going to be issues of the past.

BETH DELANEY: Great. And I'd like to just remind everybody about the comment period. There's another month. Please send us your suggestions, some feedback on what our panelists have been talking about. We really want this to be an ongoing dialogue. And I want to end with, please pay your lunch bill.

DAN GILMAN: I used cash.