SB
157

STATE OF ALASKA

FISCAL NOTE

BILL NO. [illegible]57

1992 LEGISLATIVE SESSION

Revision Date. 03/12/92

Department Affected: Commerce & Economic Development

Title: An Act relating to optometrists.

BRU: Occupational Licensing

Component: Administration

Sponsor: Senator Adams

Requestor: Senate Labor & Commerce

COMPONENT SERIAL NO. | 0 | 3 | 5 | 6 |

Expenditures/Revenues: (Thousands of Dollars)

| OPERATING | FY 93 | FY 94 | FY 95 | FY 96 | FY 97 | FY 98 |
|---|---|---|---|---|---|---|
| PERSONAL SERVICES | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| TRAVEL | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| CONTRACTUAL | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| SUPPLIES | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| EQUIPMENT | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| LAND & STRUCTURES | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| GRANTS, CLAIMS | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| MISCELLANEOUS | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| TOTAL OPERATING | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| CAPITAL | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| REVENUE | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |

FUNDING: (Thousands of Dollars)

| | FY 93 | FY 94 | FY 95 | FY 96 | FY 97 | FY 98 |
|---|---|---|---|---|---|---|
| GENERAL FUND | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| FEDERAL FUNDS | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| OTHER | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| TOTAL | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |

POSITIONS:

| | FY 93 | FY 94 | FY 95 | FY 96 | FY 97 | FY 98 |
|---|---|---|---|---|---|---|
| FULL-TIME | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| PART-TIME | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| TEMPORARY | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |

Estimate of current year impact: None

ANALYSIS: (Attach a separate page if necessary)

The bill amends the optometry statutes to authorize the use of pharmaceutical agents in the practice of optometry. New funds are not required to implement this bill.

Prepared By: Jennifer Strickler

Phone: 465-2144

Division: Occupational Licensing

Date: 03/12/92

Approved by Commissioner: Glenn A. Olds [signature] Asst Comm

Agency: Commerce & Economic Development

Date: 3.13.92

Distribution (by preparer): Legislative Finance, Legislative Sponsor, Requestor, OMB, & Impacted Agency(ies).

Rev 10/90

# Alaska State Legislature

Senator Al Adams

WHILE IN SESSION
State Capitol
Juneau, Alaska 99801-1182
(907) 465-3707
Fax 465-4867

OUT OF SESSION
P.O. Box [illegible]
Kotzebue, Alaska [illegible]
(907) 442-3245

Official Business

TO: Senator Rick Halford, Chair, and
Members of the Senate Judiciary Committee

FROM: Senator Al Adams APA

RE" Senate Bill 157, "An act relating to optometrists"

DATE: April 3, 1992

Thank you for scheduling the aforementioned legislation. Accompanying this memorandum is background information for committee review.

Senate Bill 157 expands the authorized pharmaceutical agents available for use in the practice of optometry. It accomplishes this by repealing and rewriting AS 08.72.272.

The Senate Labor and Commerce Committee substitute, which I support, adds a new Section 1 to clarify that the Board of Optometrists may issue a license to optometrists to both prescribe and use the pharmaceutical agents described in AS 08.72.272. This was done to eliminate uncertainty in the use of pharmaceutical agents in the office setting in addition to prescribing use by clients at home. The substitute bill also deletes a prior version's subsection which authorized the use of oral pharmaceutical agents.

Insofar as this bill is under Judiciary Committee scrutiny, I cannot find any constitutional or legal issues at hand and would appreciate favorable consideration.

# CS FOR SENATE BILL NO. 157 (L&C)

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - SECOND SESSION

BY THE SENATE LABOR AND COMMERCE COMMITTEE

Offered: 3/18/92
Referred: Judiciary

Sponsor(s): SENATOR ADAMS

## A BILL

## FOR AN ACT ENTITLED

1 "An Act relating to optometrists."

2 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

3 * Section 1. AS 08.72.175(a) is amended to read:

4 (a) The board may issue a license endorsement authorizing a licensee to **prescribe and**
5 use the pharmaceutical agents described in AS 08.72.272, if the licensee or applicant for a license
6 passes the written and practical portions of an examination on ocular pharmacology, approved
7 by the board, that tests the licensee's or the applicant's knowledge of the characteristics,
8 pharmacological effects, indications, contraindications, and emergency care associated with the
9 **prescription and** use of pharmaceutical agents. The endorsement expires at the same time as
10 the license to which it attaches. The endorsement may be renewed upon satisfactory completion
11 of continuing education requirements established by the board by regulation.

12 * Sec. 2. AS 08.72.272 is repealed and reenacted to read:

13 Sec. 08.72.272. USE OF PHARMACEUTICAL AGENTS. (a) A licensee may prescribe
14 and use a pharmaceutical agent in the practice of optometry if

NEW

DELETED PRIOR SUB-SECT B PERTAINING TO ORAL MEDICATIONS

1 (1) the pharmaceutical agent is a drug topically applied to the human eye and its
2 appendages; and
3 (2) the person holds a license endorsement issued by the board authorizing the
4 prescription and use of pharmaceutical agents.
5 (b) A licensee may not purchase, possess, prescribe, or use a pharmaceutical agent unless
6 the licensee has obtained a license endorsement under AS 08.72.175.
7 * **Sec. 3.** AS 08.72 is amended by adding a new section to read:
8 Sec. 08.72.273. REMOVAL OF FOREIGN BODIES. A licensee may remove superficial
9 foreign bodies from the eye and its appendages. This section is not intended to permit a licensee
10 to perform invasive surgery.

Department of Commerce & Economic Development / POSITION PAPER

SB 157: "An Act relating to optometrists."

This bill authorizes the use of therapeutic pharmaceutical agents in the practice of optometry after a license endorsement has been earned by providing proof of competency in the use of those drugs.

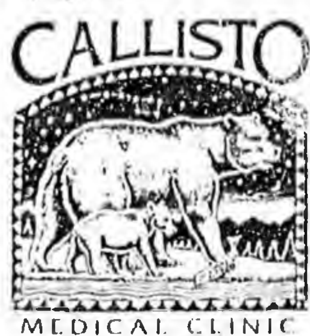
It further authorizes optometrists to remove superficial foreign bodies from the eye and its appendages. The bill states it is not intended to allow "invasive surgery."

The Board of Pharmacy has expressed objections to the prescriptive rights for oral medications, citing the list as being vague.

The department does not oppose SB 157.

Glenn A. Olds, Commissioner

Date: 3-13-92



MEDICAL CLINIC
"Numquam occidens stella"

Thomas L. Conley M.D., FAAP
Physician Services

★

Peggy Midgett Jones
Patient Coordinator

Jean Kemmerer
Office Manager

Susan Walsh R.N.
Nursing Services

February 18, 1992

Senator Drue Pearce
Alaska State Legislature
State Capitol
Juneau, Alaska 99801-1182

Dear Senator Pearce:

I am writing in general support of SB157 which would permit appropriately trained optometrists to use and prescribe ophthalmologic medications. I do think it needs some reworking in a number of areas.

As a member and for five years chairman of the Alaska State Medical Licensing Board I was involved in hammering out the compromise between optometrists and ophthalmologists that permitted use of certain topical agents under the provisions of AS 08.72.175 and AS 08.72.272. It was obvious at the time that eventually optometrists would be back asking for expansion of this authority to use all topical medications and authority to remove foreign bodies from the eye for indeed their training qualifies them to make these judgments and to perform these tasks.

Opposition from ophthalmology in 1988 to Sections 175 and 272 was spirited and can be expected to be spirited in regard to the request for the expansion of authority proposed in SB 157. It was couched in terms of protection of the public health and such surely will be the countering argument in 1992. However such arguments are clearly a smoke screen, optometrists are indeed adequately trained in these areas and the battle is rather one over turf and resultant compensation. In such a contest the state should stand neutral - as long as in this case both groups are trained adequately in the area - and let the market decide the outcome.

I would recommend however some reworking of the bill. It would seem appropriate to delete reference to oral medications for such moves outside the competence of optometry with the exception that oral anti-glaucoma medications might be administered with telephonic consultation and quickly referral. As to topical medications the authority should extend to prescription in addition to administration. This might require some changes in the pharmacy and medicine sections of Chapter 08, a task which legislative research should be able to handle.

CALLISTO MEDICAL CLINIC • A Pediatric and General Medical Clinic
P.O. Box 8220 • Third Floor Ketchikan General Hospital • Ketchikan, AK 99901
(907) 225-4463 FAX (907) 247-0679

Finally, believing as I do that licensing boards should pay their own way, I would tack a $50.00 endorsement fee onto the licensing fee of any optometrist who seeks this authority to help defray the administrative and testing costs of the endorsement.

To put the whole thing in prospective it should be pointed out that physicians assistants, who have much less formal training than optometrists, are routinely prescribing much more potent and dangerous drugs (including topical ophthalmologic drugs) than are proposed here. Medicine accepts their practice. It is therefore logically inconsistent for it to oppose the use of topical medications and the removal of ocular foreign bodies by optometrists. It will be argued that physician assistants are under supervision and so they are in theory. However the required once a quarter in-person supervision hardly makes for close scrutiny. I am not by any means attacking the physician assistant system, which I support, and which has extended medical care to many Alaskans who would otherwise lack it. It has indeed worked fairly well. In similar manner it can be expected that well trained optometrists will, granted the authority asked here, extend competent eye care to many Alaskans who would otherwise not receive such.

Sincerely,

Thomas L. Conley, M.D.

TLC:ts

JEFFREY A. GONNASON, O.D.
Doctor of Optometry
Medical Park Eye Care
2211 E. Northern Lights - Suite 202
Anchorage, AK 99508

Telephone: (907) 276-2080

My name is Jeffrey A. Gonnason, O.D., a doctor of optometry. I am a life-long Alaskan, president of the Alaska Optometric Association, and past president of the Alaska State Board of Examiners in Optometry. I have been in private practice in Alaska for over 15 years. On behalf of the Alaska Optometric Association representing over 60 of Alaska's Doctors of Optometry, I wish to thank the committee for hearing this issue in the public interest. Documents of support are available from Alaska and across the nation relating the 16 years of experience by other states that allow optometrists the use of therapeutic medications.

The purpose of this legislation is to update the Alaska optometry statutes with regard to the use of pharmaceutical agents. Currently, only diagnostic drugs are used for examining the eye. Passage of this legislation would allow qualified Alaska optometrists to treat the conditions they currently diagnose in a manner consistent with their education and training. Alaska statutes currently require optometrists to "keep informed of and use current professional theories and practices" (AS 08.72.240). In the 30 states where optometrists routinely use drugs to treat eye disease, problems have virtually been non-existent over a 16 year track record. Alaska's O.D.'s do not have this earned and justified privilege.

Optometry as a profession has grown progressively more sophisticated and capable. Most doctors of optometry complete 8 to 9 years of college: 4 years undergraduate and 4 years of graduate training in optometry school, as well as a residency program. Admission requirements and tests are similar to those for medical and dental schools. The biomedical sciences presented in other health professional programs are taught in optometry school with the same quality of instruction. Course work in diagnosis and treatment of eye disease and ocular pharmacology is much more extensive than that presented in medical school. Clinical training occurs in various clinics, HMO's, Public Health, Indian Health, and VA Hospitals. Optometry schools are accredited by the same national agencies that accredit medical schools.

Alaska state education funds would be better spent if these doctors could practice their healing arts in their own native state. It is difficult to get new graduates to come to Alaska because they cannot currently utilize the full extent of their training.

JEFFREY A. GONNASON, O.D.
Doctor of Optometry
Medical Park Eye Care
2211 E. Northern Lights - Suite 202
Anchorage, AK 99508
———
Telephone: (907) 276-2080

Optometrists possess an education similar to dentists, podiatrists, and medical doctors. None of these other practitioners, including general medicine, have the extensive training and education specific to eye disease and ocular pharmacology. Yet of these practitioners, only optometry is limited in its use of pharmaceutical agents. We have far more extensive education, as well as training in the use of highly specialized eye instrumentation, than the general medical doctors, nurses, and health aides that are currently allowed to treat eye disease in Alaska.

Last year the American Public Health Association, which represents over 52,000 health professionals, passed a resolution entitled "Access to Treatment for Eye Care". This resolution recommends that legislators update their state optometry practice acts to allow optometrists to use therapeutic pharmaceuticals.

This bill will not allow "grandfathering" of present practitioners. Current statutes already require each Alaska optometrist to pass additional examinations determined by the State Board to receive a license endorsement for pharmaceutical agents. Current regulations for a license already require passing "TREATMENT AND MANAGEMENT OF OCULAR DISEASE", a nationally recognized and standardized examination offered by the International Association of Boards of Examiners in Optometry (IAB), of which Alaska is a member. I can assure you that the Board would exercise the utmost caution in stringent requirements for pharmaceutical endorsement.

The malpractice insurance rate paid by optometrists are the same in states that do allow as those that do not yet allow treatment of eye disease. This is an unbiased reflection of quality, cost-effective care. Malpractice rates have actually been reduced recently. My rate went from $356 last year down to $250 this year. This is positive proof of the public safety of optometry, with 16 years of therapeutic experience and one of the lowest litigation rates of the health professions. The courts hold optometrists to the same standards of care applicable to medical doctors and dentists.

Optometrists are classified as physicians under federal Medicare Law, with respect to all services authorized by state law. Medicare patients are denied access to therapeutic eye care from optometrists in Alaska. U.S. Public Health, Indian Health, and military optometrists in Alaska have used medications for many years. If they enter private practice as many have done, they are then restricted by outdated Alaska statutes.

JEFFREY A. GONNASON, O.D.
Doctor of Optometry
Medical Park Eye Care
2211 E. Northern Lights - Suite 202
Anchorage, AK 99508
---
Telephone: (907) 276-2080

The only reason for this legislation is to provide much better access to quality, affordable, and cost-effective eye care for Alaskans. This is especially true in our smaller towns and villages. In Alaska, optometrists outnumber ophthalmologists 3 to 1 and are widely distributed throughout the state, while the ophthalmologists are only in the Juneau, Fairbanks, and Anchorage areas (including Soldotna). Time and expense would be saved by the public and the state health payers by reducing unnecessary travel, lost work time, not having to pay more than one doctor, or not having to pay the higher fees of a surgical eye specialist for a common primary care condition. According to the Journal of the American Medical Association, April 1985, "The cost of primary care increases when it is provided by specialists, without necessarily improving its quality...". These cost savings have been well documented. Increased competition and freedom of choice among providers is a cost containment reality.

The optometrist is often the first contact for a patient suffering from an eye disorder. In most cases, needed treatment can begin immediately, an important aspect in the treatment of many eye diseases. Early diagnosis and treatment allows the optometrist to eliminate patient suffering, and can prevent serious complications.

Optometrists are reasonable, educated, caring professionals with a clean track record nationally. We are state licensed with strict standards. We are regulated by the State Board, by legal liability concerns, by community opinion, and by medicine and the legislature looking carefully over our shoulders. Unlike our other medical and non-medical colleagues with unrestricted license for new educational developments, we practice under a limited license and must return to the legislature for statute changes as optometric education and eye care technology advances. The State Board of Optometry should be allowed to determine the scope of practice by regulation, as is done by other health professions in Alaska to keep current with health care advances.

We are fortunate to have a legislature that will respond to the health care needs of all Alaskans. By lending your approval to expansion of primary eye care services by optometrists, you will be supporting the basic goal of improved quality of life for all Alaskans. Our support is from a broad base: State health administrators, educators, Native organizations, community and regional health groups, insurance providers, medical doctors, dentists, nurses, pharmacists, and mostly by our patients all over the state who choose to trust us with their eye care.

# ANPA
Alaska Nurse Practitioner Association

February 24, 1992

Subject: SB 157 Qualified optometrists to prescribe limited therapeutic pharmacologic agents for treatment of primary eye diseases.

Dear Legislator:

It is the position of the Alaska Nurse Practitioner Association to support the efforts of the Alaska Optometric Association to obtain limited therapeutic pharmacologic prescriptive authority. The ability to diagnosis and treat common eye problems will be evident in the decreased cost for long term problems related to untreated eye problems.

Often, the optometrist is the only eye specialist travelling to the bush areas. Without the ability to treat the common eye problems seen in the bush, patients would have to pay travel costs to a regional center instead of being treated in the village. The expediency of treatment lowers the costs to both the patients and the state. Untreated eye conditions can develop into more costly long term conditions requiring travel to a larger medical center and specialized treatment.

We hope you will join us in support of SB 157

Sincerely,

Wendy Thon, ANP
Alaska Nurse Practitioner Association
Secretary

March 10, 1992

American Public Health Association

1015 Fifteenth Street, NW
Washington, DC 20005
202/789-5600

Dear Alaska Legislator:

At its 118th Annual Meeting, the American Public Health Association (APHA), which represents a combined national affiliate membership of over 52,000 public health professionals and community health leaders, adopted a resolution entitled "Access to Treatment for Eye Care by Optometrists". A copy is enclosed for you information.

This resolution acknowledges that the expansion of clinical privileges of optometrists has increased the availability, accessibility, and cost effectiveness of eye care to the American public. The resolution recommends that States update their optometric practice acts to allow for optometric use of those diagnostic and therapeutic pharmaceuticals which have been determined by the State Board of Examiners in Optometry as being within the scope of competency of pharmaceutically certified optometrists. We further recommend that dispensing of such pharmaceuticals be regulated by state pharmacy laws.

Currently, 30 states allow optometrists to use therapeutic drugs for the benefit of their patients. APHA urges your support for legislation which encompasses the principles endorsed in the APHA resolution, and would result in better access to comprehensive eye care of the American citizens.

Thank you for considering the American Public Health Association's view.

Very truly yours,

William H. McBeath, M.D., M.P.H.
Executive Director

Enclosure

MAR 03 '92 11:45 P.02

SITKA VISION CLINIC
A PROFESSIONAL CORP.
700 KATLIAN ST., SUITE C
SITKA, AK 99835
(907) 747-6644

WAYNE T. HAGERMAN, O.D.
DOCTOR OF OPTOMETRY

February 29, 1992

Senator Dick Eliason
State Capitol
Juneau, AK 99801-1182

RE: SB 157

Dear Senator Eliason,

I am writing to ask your support of SB 157. This bill will allow Doctors of Optometry, who are properly certified to provide therapeutic medication for common ocular diseases. This bill will provide greater access to eyecare in our State and especially in Southeast. Currently, there are only two specialty eyecare providers for all of Southeast, with approval of this bill, there will be possibly nine providers.

I would appreciate your thoughtful consideration of this bill, as it is a milestone in the level of eyecare of this state, and in particular Southeast.

Best regards,

Wayne T. Hagerman, O.D.

WTH:cnm

NORTH PACIFIC MEDICAL CENTER
104 CENTER AVE. SUITE 100
KODIAK, AK 99615

TELEPHONE (907) 486-4183

KEVIN CREELMAN, M.D.
GENERAL PRACTICE

LOREN HALTER, D.O. (D.A.B.F.P.)
RICHARD HOLYOKE, PA-C


March 6, 1992

TO: Members of the Alaska Legislature

FROM: Loren D. Halter, D.O.

RE: Senate Bill #157, Use of Pharmaceutical Agents by Optometrists

Dear Legislators:

I am writing this letter to support Senate Bill 157 especially for optometrists in general.

I am a family practitioner and have benc in Kodiak for the last 14 years. Dr. John Shank, O.D. has been the optometrist in my office for the past ten years. On numerous occasions I refer patients to Dr. Shank for evaluation and treatment. Also, I use Dr. Shank for hospital consultations on patients with eye problems.

Why optometrists have not had this use of pharmaceutical agents for eye treatments is beyond my wildest imagination. The optometrists are partners in the health care system and should now be included in this system instead of being on the outside looking in.

Therefore, I highly support this Senate Bill 157 and believe we should not withhold the medical treatment and the use of drugs from the optometrists any longer. As a profession, they have proven their worth beyond a shadow of a doubt and it is high time we get into the 21st century and let them do their thing as they have been doing for the past several years.

Therefore, please add my support to the passage of Bill 157 as I think the optometrists in Kodiak and the state of Alaska do an excellent job. Now is the time to take our blinders off and let the optometrists have all the tools to treat their patients in a much better manner.

If you have any further questions please do not hesitate to call or write to the above address.

Sincerely,

Loren D. Halter DO

Loren D. Halter, D.O. (D.A.B.F.P.)
North Pacific Medical Center

LDH:ro

Kachemak Bay Medical Clinic
Professional Corporation
PAUL D. RAYMOND M.D.
4285 Hohe St., Suite 2
Homer, Alaska 99603
(907) 235-4050

May 2, 1991

Dear Legislator:

I am writing this letter in support of Senate Bill 157, which involves the use of pharmaceutical agents by optometrists. As a family practitioner in a rural area of Alaska, without the presence of ophthamologists we depend greatly on qualified optometrists for evaluation and treatment of superficial and anterior chamber eye disease. This would include administrating topical steroids, antibiotics and antiglaucoma agents to the human eye. Obviously, this would be inherent on the licensee having been endorased under AS 08.72.175.

The ability of appropriately trained optometrists to diagnose and treat anterior chamber and superficial eye disease would prove beneficial not only for rural physicians but also would serve in the patients' best interests concerning long term cost containment. In my experience the optometrists in the geographical area in which I practice appropriately refer ophthamologic patients to board certified ophthamologists when indicated.

I appreciate your support.

Sincerely,

Paul D Raymond MD

Paul D. Raymond, M. D.

PDR:nmc
cc: Boyd Walker

April 5, 1991

Alaska State Legislature
P.O. Box V
Juneau, AK 99811

Dear Legislator:

I am writing in support of Senate Bill 157 (Optometry Pharmaceuticals). I am glad to hear Alaska is currently addressing the issue of optometrists being allowed to prescribe a variety of therapeutic agents.

This action is long overdue and has already been approved in 26 other states.

I am a Colonel in the Air Force, a board certified Family Physician and Chief of the Emergency Room, Family Practice, and Primary Care Department at Elmendorf Air Force Base Regional Hospital. I have thus had frequent professional exposure to optometrists and thus feel I can speak quite objectively.

I feel optometrists are fully qualified to expand their prescribing service to their patients.

I would hope an objective review of this issue be undertaken and passage of the bill be the outcome.

Sincerely,

Richard M. Stratton

Richard M. Stratton, M.D., Colonel, USAF, MC

420 Banbury Drive
Anchorage, AK 99504

CATARACT AND LASER INSTITUTE

*TO:* *Members of the Alaska Legislature*

*FROM:* *Robert O. Ford, MD*

*DATE:* *May 21, 1991*


Founders
Robert Ford, MD
Helgi Heidar, MD

Medical
Ronald Sugiyama, MD
Oli Traustason, MD
Paul Barney, OD
Cynthia Murrill, OD, MPH
Donald Peterson, OD
David Stanfield, OD
Michael Van Brocklin, OD

Administrative
Wayne Carlson, PA
Executive Director of Corporate Development

Rose Fischer
Director of Practice Enhancement

Greg Korneluk
Chief Executive Officer

Shirley Puckett
Chief Operating Officer

Verna Stallsworth
Executive Vice President

Lola Swope
Director of Finances


*Over the last ten years of working as an ophthalmologist closely with the optometric profession to provide eye care to the people of Washington, I have made some observations that I would like to share with you.*

*Relations between ophthalmology and optometry in general are unfortunately frequently dominated by competition and turf issues. Once I was able to get past that in my own thinking about eight years ago, I began to see things in a different light.*

*Individual and professional advancement is part of the American way. Optometry as a profession has grown progressively more sophisticated and capable. Unfortunately each step of the way, their efforts at self-improvement have been resisted by organized ophthalmology. The most frequent argument used has been that patients will suffer when practitioners practice beyond their training. It is true that patients will suffer if any practitioner overextends himself whether he be MD, OD, attorney, politician or anything else. The real issue of public safety lies with the morality, honesty, and faithfulness of each person using their own judgement to manage only things for which they are qualified, and to get consultation or make referrals when necessary.*

*My experience with optometry is that they are as a whole, above average in their commitment to providing quality care to their patients and requesting assistance or making referrals whenever a particular case is beyond their knowledge or training.*

*As I have observed the changes in Washington, first with an extension of optometry's freedom to use diagnostic drugs and then later with their freedom to use therapeutic drugs, I have not seen patients harmed. In fact the availability of eye care has improved, and I can recommend this course of action to the state of Alaska.*

*Sincerely,*

*Robert O. Ford, MD*
*/de*


2517 N.E. Kresky
Chehalis, WA 98532
206 748-8632
1 800 888-9903

2302 Union Ave
Suite B-16
Tacoma, WA 98405
206 756-9440
1 800 888-9905

8203 W. Quinault Ave.
Suite 200
Kennewick, WA 99336
509 736-0826
1 800 888 9904

"Prompt, Thorough, Conc[illegible]"

F. LELAND JONES, M.D.
KENNETH S. LAUFER, M.D.
R. MATISON WHITE JR., M.D.
RICHARD R. TAYLOR JR., M.D.

CHARLES AARONS, M.D.
MARK NEWMAN, M.D.
ILONA JEAN HODSON, M.D.
ROBERT K. THORNQUIST, M.D.

Diplomates American Board of Family Practice

2211 EAST NORTHERN LIGHTS BLVD., ANCHORAGE, ALASKA 99508 • (907) 279-8486 • FAX (907) 278-7255

February 12, 1992

Donald Lehmann, M.D.
Alaska State Medical Association
Legislative Committee Chair
700 Katlian Street, Suite E
Sitka, AK 99835

Dear Dr. Lehmann:

As a family practitioner, I have become familiar with the capability of Alaska licensed optometrists.

I support the updating of the Alaska optometry law to allow qualified optometrists to use therapeutic pharmaceutical agents limited to eye treatment. The expansion of clinical privileges of optometrists has been shown to increase the availability, accessibility, and cost effectiveness of eye care to the public.

In 1990 the American Public Health Association passed a resolution supporting this legislation, and 30 states currently allow optometrists to use therapeutic drugs for the benefit of their patients.

I would request that the Alaska State Medical Association Legislative Committee support this legislation.

Sincerely,

F. Leland Jones, M.D.

F. LELAND JONES, M.D.
KENNETH S. LAUFER, M.D.
R. MATISON WHITE JR., M.D.
RICHARD R. TAYLOR JR., M.D.
CHARLES AARONS, M.D.
MARK NEWMAN, M.D.
ILONA JEAN HODSON, M.D.
ROBERT K. THORNQUIST, M.D.
Diplomates American Board of Family Practice

2211 EAST NORTHERN LIGHTS BLVD., ANCHORAGE, ALASKA 99508 • (907) 279-8486 • FAX (907) 278-7255

February 12, 1992

Donald Lehmann, M.D.
Alaska State Medical Association
Legislative Committee Chair
700 Katlian Street, Suite E
Sitka, AK 99835

Dear Dr. Lehmann:

As a family practitioner, I have become familiar with the capability of Alaska licensed optometrists.

I support the updating of the Alaska optometry law to allow qualified optometrists to use therapeutic pharmaceutical agents limited to eye treatment. The expansion of clinical privileges of optometrists has been shown to increase the availability, accessibility, and cost effectiveness of eye care to the public.

In 1990 the American Public Health Association passed a resolution supporting this legislation, and 30 states currently allow optometrists to use therapeutic drugs for the benefit of their patients.

I would request that the Alaska State Medical Association Legislative Committee support this legislation.

Sincerely,

R. Taylor

Richard R. Taylor, M.D.

April 23, 1991

Alaska State Legislature
PO Box V
Juneau, Alaska 99811

Dear Sirs:

I am writing this letter in support of Senate Bill 157 concerning optometry prescribing privileges.

I was on active duty as a medical officer in the United States Air Force from 1981-1988. During the last five years of that time I was assigned to the USAF clinic at Eielson Air Force Base. Part of my duties there was to serve as direct supervisor for the optometrists. During that period of supervision, the Air Force changed its prescribing rules and began to allow optometrists with appropriate training to prescribe certain classes of medication. In order to obtain these prescribing privileges, the optometrist had to show documented proof of ocular therapeutics training during his original professional schooling or evidence of adequate education in ocular therapeutic since graduation from optometry school. With documentation of the appropriate training, these optometrists were then permitted to prescribe medications in classes similar to those mentioned in Senate Bill 157.

I have had the opportunity to work with several optometrists who have been credentialed under these rules and have found that they have been able to provide increased service to their patients. I have not seen any significant problems associated with optometrist-prescribing practices.

I feel that it would be a benefit to the residents of Alaska to permit optometrists to prescribe those medications noted in Senate Bill 157. I believe that appropriately trained optometrists are capable of effectively and safely treating relatively minor eye problems with medications, as specified in Senate Bill 157, and therefore am in favor of passage of this bill.

Sincerely,

Enlow R. Walker, M.D.
Family Practice

ERW/hlb

1867 Airport Way • Fairbanks, Alaska 99701
(907) 452-1761

M. Marcell Jackson, M.D.
A PROFESSIONAL CORPORATION

February 7, 1992

Donald Lehmann, M.D.
Alaska State Medical Association
Legislative Committee Chair
700 Katlian Street, Suite E
Sitka, AK 99835

Dear Dr. Lehmann:

As a family practice physician, I have become familiar with the scope of training and capability of Alaska licensed optometrists.

I support the updating of the Alaska optometry law to allow qualified optometrists to use therapeutic pharmaceutical agents limited to eye treatment.

Nationally, the American Public Health Association has passed a resolution supporting this legislation, and 29 states currently allow optometrists to use therapeutic drugs for the benefit of their patients.

I would request that the Alaska State Medical Association Legislative Committee support this legislation.

Sincerely,

M. Marcell Jackson, M.D.

2211 EAST NORTHERN LIGHTS BOULEVARD SUITE 207 ANCHORAGE, ALASKA 99508-4184
TELEPHONE 279-2531

# Tanana Valley Clinic

Family Medical Care

*Since 1959*


OBSTETRICS & GYNECOLOGY
Richard S. Andersen, M.D.
[illegible], M.D.
Richard C. Hess, M.D.
[illegible], M.D.
[illegible], M.D.
[illegible], P.A.C.
[illegible]

SURGERY
[illegible], M.D.

INTERNAL MEDICINE
Michael J. [illegible], M.D.
Jonathan R. Stoll, M.D.

PEDIATRICS
Marvin E. Bergeson, M.D.
J. Timothy Foote, M.D.
Richard C. [illegible], M.D.
Nancy J. Schultz, M.D.
[illegible] Stauffer, M.D.

FAMILY PRACTICE
Hunter Adkins, M.D.
Donald E. Thieman, M.D.
Jean M. W. Tsigonis, M.D.
Charles Steiner, M.D.
Connie [illegible], M.D.
David Lewis, P.A.C.
Dennis Rogers, P.A.C.

PHYSICAL THERAPIST
Cole Carson, L.P.T.
Beverly Conover, L.P.T.

PATIENT EDUCATION
Sharon Stephenson, R.N.

ADMINISTRATION
Ron Davis, Administrator
Sandra J. Farmer, Controller/Asst. Admin.


April 18, 1991

Alaska State Legislature
Juneau
Alaska 99811

To the Legislators:

I am writing to you requesting support for the proposed Senate Bill 157 allowing optometrists in the State of Alaska to practice at a level consistent with their training which would include limited use of therapeutic drugs, i.e. anti-infectives and anti-inflammatory drugs. I worked for many years in the military which utilized optometrists and allowed them to use the drugs as both diagnostic and therapeutic agents. I found that the optometrists I worked with were very confident and judicious in the use of these therapeutic agents.

There are only four ophthalmologists in Fairbanks and none in the remainder of the Interior; however, there are many optometrists. Allowing optometrists to treat diseases of the eye within their spectrum of expertise would allow many more Alaskans to be adequately taken care of. Optometrists are trained for four years after completing a Bachelor of Arts degree, and in most cases this training includes 150 hours of Pharmacology. Currently all fifty states allow optometrists to use drugs in a diagnostic area, and 25 of the states also allow them to use drugs therapeutically.

Alaska, with its vast land area and remoteness of villages and cities, would certainly benefit by allowing optometrists to use their clinical expertise with the use of diagnostic and therapeutic drugs.

Sincerely,

Marvin E. Bergeson, M.D.
Pediatrics

MEB:sr


1001 Noble Street • Fairbanks, Alaska 99701
(907) 452-1611 • FAX (907) 456-8770

LAURANCE A. MARSHBURN, M.D.
ANESTHESIOLOGY
P.O. BOX 277
HOMER, ALASKA 99603

TELEPHONE (907) 235-7078

February 11, 1992

Don Lehmann, M. D.
Chairman, Legislative Committee
Alaska State Medical Society
700 Katlian Drive, Suite E
Sitka, AK 99835

Dear Dr. Lehmann:

I wish to go on record as supporting Senate Bill No. 157 relating to the change allowing the use of certain types of pharmaceuticals by properly trained and licensed optometrists as well as allowing the removal of superficial foreign bodies.

My background includes a thirteen year period of general practice, most of this in rural Alaska. I feel that frequently optometrists are truly the most knowledgeable person to diagnose and treat eye disease in most rural communities. Outside of the urban areas, there are simply not enough ophthalmologists to care for the need. Optometrists, as a group and with proper training, should be viewed as a medical resource which can more effectively meet the needs of the population of rural Alaska.

Again, I would support the proposals of Senate Bill No. 157 and would urge that the ASMA Legislative Committee consider it favorably.

Very truly yours,

L. A. Marshburn, M. D.

Box 809
Homer, Alaska 99603
April 23, 1990

Senator Paul Fischer
Alaska State Legislature
Juneau, AK

Dear Senator Fischer,

I am writing to ask you to please do your best to get senate bill SCSHB222 - scheduled for debate and vote. I support Board certified optometrists prescribing anti-infectives and anti-inflammatories, topically. Thanks for your support

Sincerely

Hal Smith M.D.

Hal Smith M.D.

April 4, 1991

To the Legislature.

This is a letter of support for the bill in Legislation which will permit Optometrists to prescribe and dispense medication.

The clinic where I work is located in Metlakatla and the nearest Opnthalmologist is in Juneau. Patients that have an acute eye problem and need to be evaluated by an "eye specialist" are referred to the Optometrist, Dr. E. Christiansen, in Ketchikan for evaluation and a treatment plan. After Dr. Christiansen evaluates the patient, he calls the referring physician to tell them his findings and recommendations. On occasion, Dr. Christiansen has recommended that the patient be seen by an Ophthalmologist for care we send the patient to Juneau. But, not all patients have needed to be referred to the Ophthalmologist. It has saved the clinic unnecessary travel expenses for those patients Dr. Christiansen can treat.

For the above reasons, I support the bill which will permit the Optometrist to prescribe and dispense medications.

Thank you.

Barbara Fine, RN
P. O. Box 652
Metlakatla, Alaska 99926

April 8, 1991

Alaska Legislature
Juneau, AK

Dear Legislators,

We are writing this letter to inform you that we support the bill in legislation that will allow Optometrists to prescribe medications for the treatment of eye disease.

I was previously a patient of Ed Craig, O.D. who practiced in our community for many years. In fact it was he who first detected my glaucoma in 1985 and referred me to an ophthalmologist in Seattle for treatment. My health is not as good as it once was and I find it impossible to travel to Seattle for my follow-up visits. Dr. Eric Christiansen has taken over Dr. Craig's practice and has been following the status of my the glaucoma for a year. I feel comfortable with his care and follow-up. I had a bad experience with the ophthalmologists that travel to our city periodically and do not wish to see them for care. It frustrates my husband and I when we cannot get a prescription for eye drops renewed or changed during a follow-up visit at Dr. Christiansen's office. The doctor must call the ophthalmologist in Seattle and have him call my prescription to a pharmacy in Ketchikan. Dr. Christiansen has told us the ophthalmologist in Seattle is uncomfortable with this arrangement due to my inablility to travel to Seattle for follow-up. Optometrist's are available any time because they live here. If their education trains them to understand the prescription of medications for treatment of eye disease then they should be allowed to prescribe it. It would save Alaskan'[illegible] [illegible]ith eye problems time, money, and frustration. I [illegible] [illegible]lso improve our ability to obtain treatment im[illegible]ly if we need it. Please consider passing this impo[illegible]a[illegible] legislation. Thank you.

Regards,

Ruth Terwilliger

Ruth A. and Wesley B. Terwilliger
Marine View, Apt. 509
Ketchikan, AK 99901

## ALASKA'S DOCTORS OF OPTOMETRY

Fact sheet for SB 157
HB 336

A: Access:

Alaskans in communities like Sitka, Kodiak, Homer, Ketchikan and others do not have access to eye care. Most Alaskan communities have no medical specialists, and the local optometrist is the most highly trained, specialized, and instrument-equipped professional in town, with over 60 of us scattered throughout the state.

B: Better Care:

The optometrist is often the first contact for a patient suffering from an eye disorder. Needed treatment can be started immediately, which is an important aspect in treating many eye diseases.

C: Cost Containment:

Optometrists' fees are generally lower than those of medical specialists and hospitals; the cost of a 2nd visit to another doctor or clinic would be eliminated; travel time and expense would be eliminated as well as extra time away from work. These are documented cost savings from other states. Increased competition with freedom of choice among health providers also holds down costs.

D: Doctors of Optometry:

Optometrists have been prescribing drugs for their patients across the nation for the past 16 years, with 30 states currently allowing therapeutic drug treatment of eye diseases. No laws have been repealed, and 13 more states have bills pending. There have been no problems nationally, and the malpractice insurance premiums for optometry are the same in states with and without therapeutic drug laws.

E: Education:

Optometry training is on a par with medicine, dentistry and podiatry. An undergraduate college degree plus a 4 year doctorate program and often a residency in a hospital-based setting. The letter from Dr. Les Walls, a medical school professor and now an optometry school dean, best explains our education. Older optometrists who did not originally receive advanced therapeutic training would not be grandfathered. They would be required to return to school for additional training and pass rigid State Board standards and exams to be endorsed to use therapeutics.

F: Fairness:

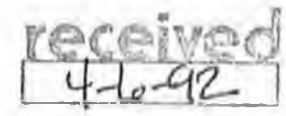
Under the current state law, the optometrists in most communities must refer their patients needing eye medication to a nurse practitioner, health aide, or general medical doctor with far less training than optometrists have.

G: Government:

Approximately 5 agencies of the Federal Government have studied optometry and found us competent in therapeutic treatment and surgical co-management. Military and Indian Health optometrists have used therapeutic drugs for many years. Optometrists are considered "physicians" under federal Medicare law, being allowed to provide any services the state law allows. The national American Public Health Association recently passed a resolution supporting optometry therapeutics in all states.

This legislation is in the best interest of the public health.

Senator Rick Halford
State of Alaska
P.O. Box V
Juneau, AK 99811




April 2, 1992

Dear Senator Halford:

I urge you to support SB 157, the optometry bill allowing Board-qualified optometrists to prescribe eye medication.

Benefits include:

1. Patient Savings - no unnecessary refunds.

2. Patient Convenience -
   There are more optometrists and they have longer office hours.
   Patients don't have to make a second trip to a referral physician.

Examples from my personal experience:

A patient of mine came in on a Saturday with a red, sore eye. I diagnosed a corneal ulcer that needed to be medicated. The ophthalmologist was in the shower when I called, and I didn't hear back for 20 minutes. The patient then had to go to the ophthalmologist's office for examination and prescription.

The patient had to wait to see me, wait to hear from the ophthalmologist, DRIVE ACROSS TOWN to his office and PAY AGAIN for the same diagnosis. Hardly convenient or cost effective.

A patient came in with a piece of metal embedded superficially in his cornea. I called the ophthalmologist office "on call" and got his answering machine. I was to send my patient to the emergency room and they would call him if necessary. The patient had to be driven to the emergency room where he waited two hours to have the foreign body removed by the emergency room physician who is not an eye specialist. This foreign body removal could easily have been done in our office immediately and without the high cost of an ER visit.

Opthalmologists are busy people. Having optometry diagnose and medicate the simple problems would certainly free up their schedules for more difficult and higher revenue producing surgery patients.

Aproximately 30 states already have this legislation, including Washington state. It's working well. It could work well here too.

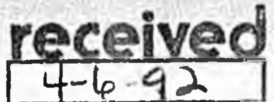
Please support the optometry bill. if you have any further questions, I'd be happy to talk with you on this issue.

Sincerely,

Denise L. Thanepohn, O.D.
130 Beaufort Circle
Anchorage, AK 99515

DLT/vma

*TOM S. POE*
17536 Rachel Circle
Eagle River, Alaska 99577
(907) 694-3393




April 2, 1992

Senator Rick Halford
Box V
Junaeu, Ak. 99811

Greetings, Rick,

I am writing in request for your support of SB 157. I feel as an Alaskan consumers we could all benefit from board-qualified optometrists having the ability to prescribe eye medication. This is an approved practice in thirty other states, and I would appreciate a response to how you will vote on this issue.

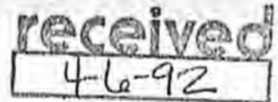
I hope to hear from you soon.

Best wishes,

Tom Poe
17526 Rachel Circle
Eagle River, Ak. 99577

cc: Jeff Keene, Alaskan Optometric Associaton board

"Respect the individual in Society and the spirit in the individual."




Oliver M. Korshin, M.D.
DISEASES AND SURGERY OF THE EYE

Humana Medical Plaza, Suite 310
1200 Airport Heights Drive
Anchorage, Alaska 99508

907-276-8838

March 27, 1992

Senator Rick Halford
Alaska State Legislature
Juneau, Alaska 99801-1182

Dear Senator Halford:

I am writing in opposition to SB157, which would extend to optometrists the power to prescribe therapeutic eye preparations. It is my contention that past and current training in optometry does not qualify optometrists to safely prescribe such medications. Enclosed is a self-explanatory letter to Dr. Thomas Conley, which details the basis of my contention.

The Alaska Legislature has received a number of letters, some from physicians, supporting this bill. I would like to counter the arguments presented in some of those letters.

Several are from physicians who are serving, or have served in the military, and who praise optometrists' prescribing abilities. As a former Indian Health Service ophthalmologist, I was responsible for creating and filling many optometry positions in Alaska Bush locations in the 1980's. The optometrists in these positions did indeed prescribe therapeutic preparations, under standing orders, and did so competently. But they were in continual phone contact with the HIS ophthalmologists in Anchorage, who also visited the optometrists regularly, and saw (and discussed) their problem patients with them. The military provides the same kind of supervision and opportunity for dialogue. But that experience cannot be successfully transposed to the private sector because the supervisory link does not exist.

Another letter contends that optometrists can safely treat "relatively minor eye conditions;" yet another, that they can treat "anterior chamber and superficial eye disease." Yet the SB157 does not define the diseases which optometrists would be able to treat. Surely, if optometrists can safely treat only "minor" or "superficial" eye disease, then, at the very least, the bill's language should be amended to restrict therapeutic agents to topical antibiotics used in the treatment of conjunctivitis, as there are precious few other "minor" eye diseases for which prescription medications are ever used.

Two letters refer to the American Public Health Association's (APHA) 1990 resolution supporting any state legislation allowing optometrists' use of therapeutic preparations. The APHA's membership has only a minority of practicing clinicians; the majority of its membership is not familiar with the clinical issues involved and is certainly not familiar with the quality of formal optometric training. In addition, the APHA was aggressively lobbied by the American Optometric Association (AOA) on this issue; the AOA is also actively engaged in lobbying the military and public health service for expanded roles for optometrists. Both these letters give the appearance of form letters drafted by the AOA and given to sympathetic family practitioners to send.

One notable letter is from a Washington-based ophthalmologist. It should be pointed out that a number of ophthalmologists around the country take cataract referrals from optometrists; 20% of the surgical fee is then paid to the optometrist for "follow-up care." This practice violates an explicit policy of the American Academy of Ophthalmology, which states that the surgeon who performs the cataract surgery is responsible for the postoperative care. I understated that some optometrists in Southeast refer cataract patients to ophthalmologists in the Seattle area for cataract care under this arrangement. Consequently, a letter from a Washington ophthalmologist supporting the SB157 should be viewed as having a potential economic motivation.

Please defeat this legislation. Alaska optometrists have introduced it on an almost annual basis. The legislature has agreed in the past that optometrists are not qualified to use such medications. Nothing has occurred in the past 12 months to make them so now.

Sincereley,

Oliver Korshin, M.D.

COMMENTS OF THOMAS L. LEWIS, OD, Ph.D. BEFORE THE VIRGINIA STATE BOARD OF MEDICINE'S AD HOC COMMITTEE ON OPTOMETRY, DECEMBER 20, 1988 PUBLIC HEARING, REGARDING CERTIFICATION OF OPTOMETRISTS TO PRESCRIBE AND ADMINISTER OCULAR RELATED THERAPEUTIC PHARMACEUTICAL AGENTS.

My name is Dr. Thomas Lewis. I am Dean of Academic Affairs at the Pennsylvania College of Optometry. I earned a Doctor of Optometry Degree from the Pennsylvania College of Optometry and a Ph.D. in Anatomy from the Daniel Baugh Institute of Anatomy, School of Medicine, Thomas Jefferson University. I completed a post-doctoral fellowship in the Department of Ophthalmology, School of Medicine, Washington University, St. Louis, Missouri.

Since 1975 I have been a member of the faculty at the Pennsylvania College of Optometry and have held various teaching, clinical and administrative positions. I have extensive teaching experience both at the undergraduate and continuing education levels. In addition to my role as Dean, I hold the rank of Associate Professor.

I thank you for the opportunity to be am here this morning to discuss some of the basic elements of optometric education as they relate to the diagnosis and treatment of ocular diseases.

The fundamental philosophy of professional optometric education is equivalent to that of all other health professional programs including medicine, dentistry,

osteopathy, and podiatry. The biomedical and clinical sciences are taught in the classroom, applied in the clinics and refined through internships, externships, and residencies.

As with other health professions, the vast majority of students entering optometry school have completed four years of college and hold a baccalaureate degree. Pre-requisite requirements for optometry are similar to other health care professional programs.

The basic biomedical courses taught in the schools and colleges of optometry are extensive. They include: Gross Anatomy, Histology, Human Physiology, General Biochemistry, General & Systemic Pathology, Microbiology, and Neurosciences. The intent of these courses is to give the student an in-depth understanding of the structure and function of normal body systems, in addition to basic histopathological concepts of general pathologies. The curricula focus on important aspects of such basic sciences as Endocrinology and Neurology given the increasing number of diseases which affect the eye arising from these systems.

Biomedical science courses also develop for students a greater understanding of systemic diseases. Courses in medical urgencies and emergencies and clinical medicine (taught by physicians) discuss the role of the primary care optometrist, including emergency medical care such as CPR, in the management of patients with systemic diseases.

Optometrists learn to recognize systemic disease through proper history and patient interview, direct observation, and various clinical signs and tests.

It is important to note that all the biomedical sciences taught in other health professional schools are also included in optometric curricula, and that the quality of the instructors is similar. In fact, many schools of optometry use the same faculty that teach in medical and dental schools.

Two areas which require special comment include pharmacology and the diagnosis and treatment of ocular diseases. On an average, 156 hours of pharmacology are presented at the schools and colleges of optometry. This is equal to or greater than the didactic education of other health professions that use therapeutic pharmaceutical agents. The courses are taught by highly qualified faculty, including pharmacologists. Within these courses, greater emphasis is placed on ocular pharmacology than in pharmacology courses presented to other health professionals. Pharmacology courses in optometry schools emphasize the systemic manifestations of ocular drugs, ocular manifestations of systemic drugs, drug toxicities and adverse reactions.

Ocular disease diagnosis and treatment is covered extensively and comprehensively in optometric curricula. The courses include a detailed discussion of the histopathological laboratory appearance, history, symptoms, clinical picture, etiology, prognosis and management of

ocular diseases. Special emphasis is placed on the importance and potentially life-threatening implications of certain systemic diseases which may manifest through ocular signs and symptoms.

The management of ocular disease is approached in a manner which supports the role of the optometrist in dealing with these conditions at the primary care level. This is done by emphasizing early diagnosis, by differentiating simple ocular conditions from those requiring advanced medical and/or surgical treatment, by differentiating those conditions which respond well to treatment vs. those that are resistant, and by stressing the need for timely and appropriate referrals. The diagnosis and treatment of ocular diseases is taught by highly qualified experts in optometry as well as board certified ophthalmologists and sub-special ophthalmologists.

Clinical training programs at the schools and colleges of optometry begin during the first year of the curriculum with maximum patient care exposure during years three and four. All schools and colleges support multi-disciplinary faculties of medical, optometric, ophthalmological, social, psychological, and rehabilitative practitioners and specialists.

At the Pennsylvania College of Optometry a student is scheduled for approximately 2,000 hours of clinical training and examine about 1,200 patients by graduation. Approximately 20% of the clinical encounters involve interaction with

physicians. Optometry students use therapeutic drugs with direct supervision on a daily basis. They apply the knowledge they have learned in the classroom on real patients in the clinic.

All therapeutic education is primary care oriented. Training is directed toward the diagnosis of patients' problems as the highest priority, treatment of non-surgical ocular conditions, and follow-up care to completion with adjustments in treatment or referrals when indicated.

At many schools and colleges of optometry, the on-campus clinical training is not the sole source of the students' clinical experiences. As in medicine, an externship program plays a significant role in training. Fourth year optometry students are required to complete externships in private practice, as well as institutional settings. Students gain exposure to and direct experience with diagnostic and therapeutic drugs, treatment of ocular diseases as well as observation of ocular medical and surgical techniques. Public, private and community resources with supervised preceptors serve as settings for externs. These would include ophthalmology practices and clinics, health maintenance organizations, military hospitals and clinics, V.A. hospitals, public health hospitals, community teaching hospitals, Indian health services, and multi-disciplinary clinics. Optometric practices in states which currently allow the use of therapeutic drugs to treat eye diseases are an ideal location for externships. At the completion of

their clinical training, optometry students have developed the appropriate competencies to accurately diagnose, treat and manage ocular disease.

Hopefully, this gives the committee an overview of the current status of optometric education. Thank you for allowing me to testify this morning.

Thomas L. Lewis O.D., Ph.D
Dean of Academic Affairs
Pennsylvania College of Optometry
1200 West Godfrey Avenue
Philadelphia, PA 19141
215/276-6220

COMMENTS OF JOHN BALDINGER, MD, BEFORE THE VIRGINIA STATE BOARD OF MEDICINE'S AD HOC COMMITTEE ON OPTOMETRY, DECEMBER 20, 1988 PUBLIC HEARING, REGARDING CERTIFICATION OF OPTOMETRISTS TO PRESCRIBE AND ADMINISTER OCULAR RELATED THERAPEUTIC PHARMACEUTICAL AGENTS.

My name is Dr. John Baldinger. I am board certified ophthalmologist and have been in private practice in Fairfax, VA for the past two years. A substantial percentage of the patients I see and have seen in my practice of ophthalmology are referred directly by optometrists from the Northern Virginia Area. Approximately one half of my patients are referred for anterior segment consultation with the other half referred for posterior segment diagnosis and treatment.

I have also participated as a preceptor in the Virginia Optometric Therapeutic Course over the past 3 months. This 25 hour post graduate educational experience has allowed optometrists to observe and actively participate in the care of patients with anterior segment diseases involving therapeutic intervention. I have also been able to assess on an individual basis the knowledge of those individuals as they have rotated through my office.

As a result of these rather unique and close working experiences, I feel I can objectively comment on the abilities of optometrists in the Commonwealth to use therapeutic drugs in the treatment of ocular diseases.

The optometrists I have interacted with have proven themselves to be well versed in the diagnosis and management of diseases of the anterior segment.

In my opinion optometrists have sufficient training in pathology and pharmacology to safely prescribe FDA approved topical and oral medication for the treatment of eye disease. Although oral agents are not used to a large degree in ophthalmic medical practice, the practicing optometrist should have the ability to prescribe oral agents for medical intervention purposes. For example, optometrists should be able to prescribe oral antibiotics for the treatment of seborrheic blepharitis or preseptal cellulitis associated with a hordeolum, if topical treatment has proven to be ineffectual. Similarly oral analgesics may be needed for pain control in severe corneal abrasions when patient's do not respond to over the counter analgesics.

I can honestly say that in my two years in practice in Virginia, I have yet to see a patient referred to me that was held on to, too long by the optometrist or was misdiagnosed with harm done to the patients ocular well being.

The Virginia Optometric Association has provided a logical and rational credentialing process that will allow optometrists to deliver an excellence in delivery of therapeutic eye care. Organized optometry has shown in states where similar legislation has been passed and enacted, that ophthalmic related medicines can be delivered in a responsible and cost effective manner. I would wholeheartedly recommend to the Board of Medicine this expanded scope of optometric care.

COMMENTS OF JOSEPH C. TOLAND, O.D., M.D., BEFORE THE VIRGINIA STATE BOARD OF MEDICINE'S AD HOC COMMITTEE ON OPTOMETRY, DECEMBER 20, 1988 PUBLIC HEARING, REGARDING CERTIFICATION OF OPTOMETRISTS TO PRESCRIBE AND ADMINISTER OCULAR RELATED THERAPEUTIC PHARMACEUTICAL AGENTS.

My name is Joseph C. Toland. I graduated from the Pennsylvania College of Optometry with a Doctor of Optometry degree in 1954. Following five years of practice as an optometrists, including military service in the United States Air Force, I entered Hahnemann Medical School and graduated with the M.D. degree in 1963. I then undertook a three year residency in ophthalmology at Thomas Jefferson Medical School which was completed in 1967. I was Board Certified as an ophthalmologist in 1969.

I am currently an instructor in ophthalmology at the Thomas Jefferson Medical School and Professor of Pathology and Director of Ophthalmological Services at the Pennsylvania College of Optometry. In this capacity, I have intimate knowledge of the education of ophthalmology residents and optometry students.

I am here this morning to compare optometric and ophthalmologic education as it is related to the examination, diagnosis, treatment and management of ocular diseases of the primary care patient. With my background as an optometrist, I do not think there is anyone better qualified than myself to evaluate this question from the perspective of both an

optometrist and an ophthalmologist. I have taught ophthalmology residents and optometry students to use therapeutic agents in conjunction with these clinical skills.

The education of both professions in basic biomedical sciences, in the clinical sciences, and eventually patient care in hospitals, clinics and private practitioner's offices parallel one another.

During their education and training, both the optometrist and ophthalmologist are given a global view of ocular disorders, which are divided into the following sections:

1. Anterior segment disorders i.e. lids, conjunctiva, cornea, anterior chamber, iris and lens.
2. Posterior segment disorders i.e. choroid, retina, optic nerve.
3. Medical disorders
4. Glaucoma
5. Neuro-eye disorders
6. Surgery

Some optometrists and ophthalmologists may wish to develop an expertise in sub-speciality and may elect to take additional training.

The training of both disciplines is quite similar and intense with the "hands-on" clinical care of patients. Here

is where the optometric intern and ophthalmological residents learn to examine, diagnose, treat and manage ocular disorders.

It is almost a "one-on-one relationship" between the intern/resident and clinical instructor. In all cases, the intern/resident does the initial evaluation and work-up and then he presents that patient to the instructor. The case must be present in an organized fashion and the intern/resident must be able to justify and defend his diagnosis, treatment and management.

It is here that the intern/resident's basic knowledge of pharmacology and pathophysiology is tried and tested. He must be able to support his diagnosis with his clinical findings. He must justify his use or non-use of pharmacological agents with his knowledge of the disease processes.

In our clinics we have a saying, "Our sailors go to sea". The interns/residents not only have the book knowledge of the disease processes, but also have the experience in treating them. This is required to be a good clinician. At the end of clinic sessions, the important teaching cases are reviewed and discussed by all the staff to enhance the learning experience.

Primary care patients, whether seen in an optometric or ophthalmological institution, present with approximately the same percentage of healthy or unhealthy eyes. These

patients, depending on the circumstances, are either treated at the primary level or referred to another level of care.

Secondary and tertiary care patients with ocular problems are generally referred to an ophthalmological institution. It is here where patients with more advanced medical and surgical problems are evaluated and treated. Much of the ophthalmology resident's training is involved with caring for these patients.

In summary, I wish to state that ophthalmological training programs concentrate on advanced medical and surgical cases. Clinical optometric programs provide equal teaching experience in eye disorders and diseases at the primary level. Optometrists are more than adequately educated and trained to diagnose, manage and treat ocular conditions with therapeutic agents.

Thank you for allowing me to testify before your Board.

Joseph C. Toland, O.D., M.D.
Professor of Pathology and
Director of Ophthalmological Services
Pennsylvania College of Optometry
1200 West Godfrey Avenue
Philadelphia, PA 19141

The Evening Sun

A12 Baltimore, Thursday, June 2, 1988

# Double vision

Governor Schaefer justified his veto last week of the "eye drops" bill by saying the measure would have "lowered the standard of medical care here." In fact, the governor's action ensures that Maryland, alone in the nation, will retain a double standard of eye care — one for those who have access to an ophthalmologist, and another for those who cannot afford the higher fees or live in rural areas of the state not served by an ophthalmologist.

The "eye drops" battle has been a legislative fixture for so long that it can almost be seen as an duel between lobbyists. But the political fight shouldn't obscure the real issue here, which is rank protectionism for one branch of the medical profession. Maryland's law governing the practice of optometry was adopted in 1914, and since then not one word has been changed. Meanwhile, every other state in the nation has allowed optometrists to use eye drops ("pharmaceutical agents") in order to check patients for disease. This is not a radical idea; optometrists everywhere else in the country routinely use this important diagnostic tool. Maryland optometrists are trained in the use of diagnostic eye drops and are authorized to use them in the state's Veterans Administration Hospitals or in public health facilities, but not in their private offices.

One result of Maryland's backward law is that the number of new applicants taking the state's optometry exam has dropped by half in the last five years. In other words, affordable eye care will become harder to procure — a sign that does not bode well for vision in this state.

Last week, Gov. William Donald Schaefer vetoed a bill that would finally allow optometrists in Maryland to use eyedrops for diagnostic purposes. For years the bill has been a turf battle in Annapolis between optometrists and ophthalmologists.

Schaefer's veto makes Maryland the only state left which still denies optometrists the right to use eyedrops to dilate patients' pupils. Can you imagine that?

Schaefer said he was swayed by medical authorities and his own ophthalmologist who requested he veto the bill. He said he didn't believe that optometrists' training requirements adequately compare to the training required of ophthalmologists.

Sen. Arthur Dorman, D-21st-Beltsville, an optometrist, didn't buy Schaefer's reasons for the veto. Dorman would like to know the real reason for the veto.

Dorman knows the real reason. He just doesn't want to say. So I'll say it for him.

The real reason is Bruce Bereano, Annapolis' number one money-making lobbyist. Bereano represents the ophthalmologists, and in 1986 he raised tens of thousands of dollars for Schaefer's gubernatorial campaign.

Two months ago, I ran into Bereano after breakfast at the Maryland Inn. Winking, he spoke about getting a veto of the eyedrop bill if it passes. Do you see a quid pro quo?

I learned a long time ago that the sleaze factor in politics comes in bipartisan doses. The Republicans have their Ed Meese, and in Maryland the Democrats have Schaefer and Bereano.

---

*Frank Pesci of New Carrollton, who writes regularly for this page, is a former member of the Maryland House of Delegates.*

A8 THE PRINCE GEORGE'S JOURNAL FRIDAY, JUNE 3, 1988

# Opinion

## Schaefer's eye-drop veto

Gov. William Donald Schaefer was in a quandary last week. He had to decide whether to sign or veto a bill allowing optometrists to administer eye drops to dilate patients' pupils, a procedure that helps the optometrists detect eye disease.

On the side of signing the bill were the governor's own health secretary, optometrists, consumers, the General Assembly, which passed the bill earlier this year, and the fact that every other state in the union allows optometrists to administer eye drops.

On the side of vetoing the bill were ophthalmologists, who stand to lose customers and money if the bill becomes law, and Bruce Bereano, the ophthalmologists' high-powered lobbyist, who also raised tens of thousands of dollars for Schaefer's gubernatorial campaign.

No contest, if you're this governor. Schaefer vetoed the bill.

# DICTIONARY OF VISUAL SCIENCE

## SECOND EDITION

A modern comprehensive dictionary covering the terminology of the visual sciences, including the fields of ocular anatomy, ocular physiology, ocular pathology, ocular embryology, neuro-ophthalmology, ocular histology, ocular genetics, comparative anatomy of the eye, ocular prosthetics physiological optics, psychological optics, ophthalmic optics, geometrical optics, ocular refraction, orthoptics, visual training, dispensing, aniseikonia, perimetry, contact lenses, subnormal vision aids, occupational vision, and motorists' vision, and also including the phases of remedial reading, statistics, illumination, and physical optics that relate closely to vision.

*Illustrated*

EDITED BY

MAX SCHAPERO, B.S., O.D. DAVID CLINE, B.S.

HENRY WILLIAM HOFSTETTER, B.S., M.S., Ph.D.

CHILTON BOOK COMPANY

Radnor, Pennsylvania

nclose or bind a group
, or as a means of at-
for muscles at their
nsertion.
1 orbitale.
ris, a. Tenon's capsule.
neal (ap'o-plek"se).
of blood into the cor-

nal. Copious hemor-
the retina.
'ilb). A unit of lumi-
l to 1/10 millilambert.
otlambert.
ah-ra'tus, -rat'us). 1.
group of organs, or
gans, which collec-
m a common function.
tion of instruments,
implements used for
k, as an experiment
ion.
e a. Those parts of
an, other than the
e and the receptor
are essential for the
of the organ. In the
ld include all struc-
han the optic nerve
and cones of the

a. The structures
hich are related to
n; the ciliary ap-
the crystalline lens.
ciliary muscle and
structures other
talline lens which
accommodation;
y.
tear-forming and
system, com-
mal and accessory
, eyelid margins,
ac, lacrimal lake,
, canaliculi or lac-
mmon canaliculus
ier, lacrimal sac,
uct, and Hasner's
erior meatus of the

intraocular and
musculature of



the eye considered collectively. See under *muscle* for the specific muscles involved.

*nervous a.* The sensory and the motor nerves of the eye and the orbit considered collectively. See under *nerve* for the specific nerves involved.

*refractive a.* Cornea, aqueous humor, crystalline lens, and vitreous humor considered collectively; the surfaces and the media traversed by light entering the eye and involved in the production of the retinal image.

*visual a.* The two eyes, their extrinsic muscles and other contents of the orbits, the nerves, the pathways, and the visual cortex, considered collectively. Syn., *visuum.*

apparent height; magnification; magnitude; movement; position; pupil; size; strabismus. See under the nouns.

apparition (ap"ah-rish'un). 1. A supernatural visual manifestation. 2. A visual hallucination.

appearance. 1. The distinctive characteristics or features of an object or an individual as noted by visual observation. 2. The originating of an experience, particularly visual. 3. An incorrect visual or other impression.

appendages of the eye (ăpen'dĭh-jez). The accessory structures or adnexa of the eye, including the lacrimal apparatus, the conjunctiva, the cilia, the supercilia, the eyelids, and sometimes the extraocular muscles.

apperception (ap"er-sep'shun). The action of past experience upon received sensory stimuli, resulting in individual differences of interpretation of the same sensory stimuli.

applanatio corneae (ap"lah-na'she-o kor'ne-e). A flattened cornea due to degenerative changes.

applanation (ap"lah-na'shun). An abnormal flattening of a convex surface, especially of the cornea or the crystalline lens.

apraxia (a-prak'se-ah, ă-prak'-). The inability to accomplish an intended or purposeful movement, the nature of which is

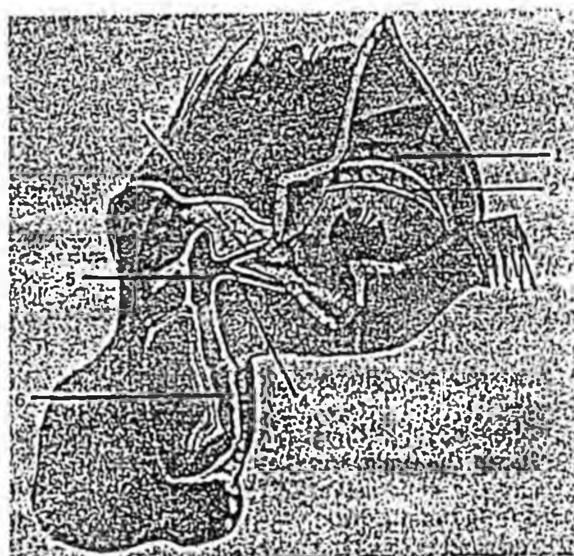



Fig. 3. The lacrimal apparatus. (1) Superior lobe and (2) inferior lobe of lacrimal gland. (3) Superior and (4) inferior canaliculus. (5) Lacrimal sac. (6) Nasolacrimal duct. (From *Text-book of Ophthalmology*, Vol. I, Duke-Elder, Henry Kimpton, 1942)

# YOU WILL HEAR

You have heard or will hear a number of reasons why the use of therapeutic drugs by optometrists is dangerous. Let me consider some of these.

YOU WILL HEAR that optometrists are not properly trained to use pharmaceuticals for therapy. This is simply not true. The course of study in this area is the same as that of medicine and more extensive than that of dentistry. Not only are the hours of pharmacology the same for medicine and optometry, but it should be noted that the medical student must study all organs equally, whereas, the optometry student can specialize in the eye once general pharmacology is completed. The drug interactions and systemic effects of the drugs administered for ocular conditions are studied in great detail. Students see numerous patients with pathology which requires pharmaceutical therapy. These students are supervised by ophthalmologists. So when other ophthalmologists say our students do not receive appropriate clinical instruction they are providing misinformation, by reacting emotionally not rationally.

YOU WILL HEAR that a profession which is non-medical should not be allowed to use drugs. Yet dentistry and podiatry are non-medical and use therapeutic drugs, and surgery in the course of their professional practice and no harm has come to the public. The real issue here is not whether optometrists are medical or non-medical; the fact is that optometrists are well trained health-care professionals.

YOU WILL HEAR that these therapeutic pharmaceutical agents can have systemic effects, effects on other parts of the body, and that there could be interactions with other drugs a patient may be taking. These are true statements and optometrists along with physicians, dentists, podiatrists and pharmacists study these areas and responsibly incorporate it into their practice. The information necessary for responsible use of these agents is in the public domain and accessible to all health professionals, not just to physicians. It was the result of scientific investigations and is not exclusively "medical".

YOU WILL HEAR that there will be public safety problems if optometrists are allowed to use these agents. Very unlikely situations and cases will be put forth, coupled with the assumption of absolutely no professional judgment on the part of the optometrist. These "strawmen" prove nothing. Yet, two states, West Virginia and North Carolina, have had this law for over 10 years and there have been no substantiated problems as a result. The reason I use the word substantiated is that there have been claims of problems but none that have been corroborated, and some have been found to be fraudulent. Twelve states have this law and the safety of the public is just fine. Better access, better quality care and cost containment have been the result.

In conclusion, optometry schools are educating and training optometry students well in the areas of diagnosis of eye pathology and in the responsible use of pharmacological agents. These students will graduate with the appropriate professional judgment to provide high quality eye care to their patients.

STATE OF FLORIDA
DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES

April 23, 1990

Carmin A. Guida
Executive Director
Massachusetts Society of Optometry
101 Tremont Street
Boston, Massachusetts 02108

Dear Dr. Guida:

In response to your inquiry concerning Florida's experience with optometrists having the ability to dispense non-controlled substance drugs to Medicaid recipients, I would have to state my feeling that overall it has been quite successful from several points of view.

- Ability of recipients to access medical care.

Unfortunately in Florida, provider participation among ophthalmologists is low. Many of the ophthalmologists who do participate in the Medicaid program are in the larger metropolitan areas. This leaves vast areas of the state where the only eye care services available are provided by optometrists. By giving optometrists the ability to prescribe certain drugs, we greatly improved the recipient's access to medical care.

- Decrease in transportation costs.

Florida Medicaid does pay for a recipient's transportation costs to obtain medical services. If a recipient was unable to receive the necessary treatment from an optometrist, the state would pay to transport a recipient to an area where there was an ophthalmologist who agreed to accept the recipient. However, there could be time delays waiting for a recipient to get an appointment, thereby limiting the timeliness of the needed medical care.

- Duplicative office visits eliminated.

In our experience, prior to optometrists being able to dispense certain drugs, it was possible to pay for one office visit to the optometrist and then a second visit either to an ophthalmologist or a general physician to obtain the required medication. This caused not only delays where the medical problem would at times go without

1317 WINEWOOD BOULEVARD • TALLAHASSEE, FLORIDA 32399-0700
BOB MARTINEZ, GOVERNOR
GREGORY L. COLER, SECRETARY

In summary, I want to point out that in Florida we have a large, politically active elderly population. It was in the best interests of both the health care system as a whole, and the population in need of quality medical eye care to have a law permitting optometrists to fully participate in the treatment of the individuals under their care.

In response to your request concerning costs, I regret that I am unable to give you data that shows the number of prescriptions by various provider groups. When the law in our state was under consideration, we anticipated an increase in prescriptions. Opponents argued it would remain the same, as different providers would be prescribing the drugs. My feeling, which is not based on any concrete data, is that yes, prescriptions have increased for eye care related services, BUT our recipients under Medicaid are receiving services which they may not have otherwise received. This new access to medical care is the immeasurable success I believe to be the major result of this legislation which was based in our state.

For your comparison, Florida Medicaid currently has approximately 650,000 active Medicaid recipients on our files. While my experience has been in the public health area, the law has of course, has an effect on all of our citizens in the State of Florida.

For further information, I would like to refer you to our Florida Optometric Association, 401 Office Plaza Drive, Tallahassee, Florida 32301. Their office should be able to tell you specific data and/or information about the impact on the non-Medicaid population of our state.

I hope this information has been of some use to you. Please feel free to contact me at (904) 488-9347 if you have further questions.

Sincerely,

Wendy Johnston

Wendy Johnston
Program Administrator
Policy Development Unit

WLJ:ps

COMMENTS OF LESLEY L. WALLS, O.D., M.D. BEFORE THE VIRGINIA STATE BOARD OF MEDICINE'S AD HOC COMMITTEE ON OPTOMETRY, DECEMBER 20, 1988 PUBLIC HEARING, REGARDING CERTIFICATION OF OPTOMETRISTS TO PRESCRIBE AND ADMINISTER OCULAR RELATED THERAPEUTIC PHARMACEUTICAL AGENTS.

## I. Introduction

My name is Dr. Lesley L. Walls and I am from Oklahoma where my job is Dean of the College of Optometry in Tahlequah, Oklahoma.

I am privileged to be a graduate of both optometry school (University of California at Berkeley-1968) and Medical School (University of California at Davis-1972).

My career has been in both Academic Medicine (Northeastern Ohio Universities College of Medicine, 1975-1977; University of Oklahoma Tulsa Medical College, 1977-78 and 1981-88 and Oral Roberts University College of Medicine, 1978-79) and Optometry (Northeastern State University, 1979-81 and February 1988 - present). I served as Department Chairman for Family Practice Tulsa Medical College from 1981-1988. I am very familiar with the curricular requirements of medical and optometric programs.

## II.

Let me offer some specific observations on my own experience with optometric and medical education.

Medical school traditionally prepares the student in general medical and surgical background for the post-graduate training programs. Detailed anatomy and physiology of organs such as the eye is not emphasized during medical school. As well, during surgical rotation in medical school it is uncommon to be exposed to ocular surgery. Because heart disease, cancer, and stroke are the biggest killers of the U.S. population, medical school clinical training is heavily devoted to general internal medicine, general surgery, obstetrics-gynecology and pediatrics. There are usually fourth-year electives in 4-12 week blocks where a student may increase his/her exposure to subspecialty medical and surgical areas such as: ophthalmology, ear/nose and throat, urology, pulmonary medicine, cardiology, etc. In my experience a small minority of students choose ophthalmology as a clinical rotation.

By a small personal survey in the area of Oklahoma in which I reside, most primary care physicians (general practitioners, family practice, internists, and pediatricians) state they had from one to three weeks of medical school devoted to ophthalmological care. This includes both didactic coursework and clinical experience. I do not need to remind you that these physicians treat eye diseases on an unrestricted basis.

In optometry schools there are courses in general pathology and ocular signs of systemic disease since

the optometrist is responsible to detect systemic diseases with ocular manifestations and to make appropriate referrals. The detailed ocular anatomy, ocular physiology, ocular pathology, and ocular pharmacology training in optometry school is far superior to the same ocular topics in any general medical school course in the country. This is not to slight medical education, there simply is not enough medical school curriculum time to devote to the eye because of training in vital organ systems such as the heart, lung, vascular system, etc.

III.

The possession of and use of sophisticated equipment such as binocular indirect ophthalmoscopes, slit lamps, goldman tonometers, goniolenses, Fundus photography, etc. are far superior in a modern optometric practice than in any primary care physicians office such as family practice, internists and pediatricians. Coupled with training and experience in the utilization of this type sophisticated equipment makes the optometrist better prepared to evaluate, diagnose and treat most ocular conditions when compared to the other listed primary health providers. This is not to demean or to cast these fine primary care providers in a bad light, rather, it is simply a fact that we must accept.

Because of the above there is no question that a well trained and well equipped optometrist can more than measure up to medical standards of care for primary physicians in the

area of diagnoses and management of various ocular diseases/disorders.

IV.

I will now briefly discuss my personal experience with side effects of ocular pharmacologic therapy. This section will be very brief as I have never had a patient with anything other than a very minor side effect from ocular pharmaceutical agents. I feel that the optometric curriculum in conjunction with current basic life support certification is adequate preparation to handle an emergency should it occur.

In summary I would like to point out that ophthalmologists are vitally needed. The medical profession would be in sad shape without them because of their expertise in the area of ocular trauma, cataract surgery, retinal surgery, and other ocular problems requiring advanced medical management. However, in a state such as Virginia the ophthalmologists are primarily in larger cities with a poor distribution in the rural communities.

I also strongly feel that optometrists are vitally needed. Optometrists are well distributed in rural communities and by definition serve as primary care health professionals. In my opinion, the patient, particularly in a state like Virginia, will be the beneficiary of modern optometric practice. With the use of pharmaceutical agents, for diagnostic and therapeutic purposes, serious disease detection will be facilitated thus making the referral system

into medicine more efficient. As well, this will save the patient a lot of inconvenience and time. I feel the Virginia State Board of Medicine should allow the people of the state of Virginia to benefit from modern optometry which includes the use of diagnostic and therapeutic pharmaceutical agents. I believe the key to utilizing these medications by any health care professional is proper education and training.

Lesley L. Walls, O.D., M.D.
Dean, College of Optometry
Northeastern State University
Tahlequah, OK 74464
918/456-5511

RECEIVED APR 2 5 1989

COMMONWEALTH OF KENTUCKY

BOARD OF OPTOMETRIC EXAMINERS

1000 W. MAIN STREET

GEORGETOWN, KENTUCKY 40324

863-5810
AREA CODE 502

April 24, 1989

Sen. Robert Ney
State House
Columbus, Ohio 43266-0604

Dear Sen. Ney:

I am happy to give you the following progress report since the passage of SB 104 which went into effect in Kentucky on July 15, 1986.

There has been no increase in complaints from the general public since the passage of this Bill, and there has not been any complaints dealing with the use of therapeutic drugs. Insurance rates for our optometrists have actually decrased. One of the main advantages of this legislation is that, due to the large amount of rural areas in Kentucky, the public has been saved countless numbers of miles and dollars.

When this Bill went into effect the board required each TPA certified O.D. to keep a drug log setting out specific information on each patient prescribed for. The following information was turned in to our office in December, 1987.

Number of Rx's written - 37,817
Number of patients prescribed for - 36,493
Number of conditions treated collectively - 2,158
Number of different conditions treated - 62
Miles saved - 843,368
Dollars saved - $1,115,086.00

I have enclosed a copy of SB 104 for your information. Please contact us if we can be of any help.

Sincerely yours,

J. C. Schertzinger, O.D.
President

cc: Darlene Eakin
Earl K. Green

JCS/at

# WEST VIRGINIA BOARD OF OPTOMETRY

DALE E. PALMER, O.D.
SECRETARY-TREASURER

WEST VIRGINIA BOARD OF OPTOMETRY
POST OFFICE BOX 67
NUTTER FORT, WEST VIRGINIA 26301
(304) 624 5317

October 16, 1986

Dan J. Lex
P.O. Box 2186
Cheyenne, Wyoming 82003

Dear Mr. Lex:

This letter is in response to your inquiry of October 8, 1986, regarding the therapeutic drug experience. For the sake of brevity, I will answer each question by number:

(1) Law became effective March, 1976.

(2) Therapeutic alone would probably be in the neighborhood of 250,000 to 400,000. Combined with diagnostics, the number would be 1,300,000 based on 100 doctors using diagnostics on 1,200 patients per year. Therapeutic figure is conservative estimate of four cases per week, per doctor times 10 years. Actual numbers could double this.

(3) No cases of misuse of therapeutic drugs have been reported to our board, and no cases have come to court involving misuse of therapeutic drugs.

(4) Based on an average of $20.00 office visit for therapeutic patient verses average of $40.00 for ophthalmology, a savings of $5,000,000 to $8,000,000, and I would consider this conservative.

(5) The cost of malpractice insurance has not been adversely affected by therapeutic drug use at all.

Sincerely,

Dale E. Palmer, O.D.
Secretary-Treasurer

DEP:jj

VISION CLINIC, P.C.
*Family Practice of Optometry*

2028 BEAVER AVENUE
DES MOINES, IOWA 50310
515 274-4141

JAMES W. HARTZELL, O.D., F.A.A.O.
DONALD B. HENRY, O.D.

February 17, 1990

The Honorable Joseph Roberts
655 Creek Road
Bellmaur, NJ 08031

Dear Assemblyman Roberts:

I received a letter today from your constituent, Dr. Larry Wallis of the New Jersey Optometric Association. As you know, the New Jersey Optometric Association is currently supporting legislative efforts to expand the scope of the practice of Optometry in the State of New Jersey. Dr. Wallis asked if I would relate to you the current status and history of the use of ocular therapeutics in the State of Iowa.

Iowa currently has the broadest therapeutic pharmaceutical law in the United States. Our law was passed in 1985 and was expanded again in 1987 to include the use of oral and topical antibiotics, controlled substances, and oral and topical agents for the treatment of glaucoma by Iowa optometrists. I can report to you that to date, our experience with optometrists using therapeutic pharmaceutical agents has been good. No abuses or complaints have been reported and no malpractice claims have been filed. We have had to take no disciplinary action against any Iowa optometrists for misusing pharmaceutical agents, therapeutic or otherwise.

Thank you for taking time to read this letter supporting optometric therapeutic legislation in the State of New Jersey.

Sincerely,

James W. Hartzell, O.D.

James W. Hartzell, O.D., Chairperson
Iowa State Board of Optometry Examiners

JWH:shm

cc: Dr. Larry Wallis
88 Lakedale Drive
Trenton, New Jersey 08648

SOUTH DAKOTA
Department of Social Services
OFFICE OF PROGRAM MANAGEMENT
MEDICAL SERVICES
Richard F. Kneip Building
700 Governors Drive
Pierre, South Dakota 57501 2291
(605) 773-3495

December 21, 1988

Representative Timothy Ford
Speaker of the House
House of Representatives
State Capitol Building
Jackson, Mississippi 39201

Dear Representative Ford:

The State of South Dakota passed a law effective July 1, 1986 that allowed qualified optometrists to provide certain therapeutic services that had, in the past, only been provided by physicians.

Subsequent experience under the Medicaid program has not shown any increase in utilization rates as a result of this statute nor have we seen any increase in the average cost of services attributable to these services being provided by optometrists. We would say that the impact of the change in law governing the practice of optometry in South Dakota has been very small, if any.

Please contact our office if you have any questions or wish additional information.

Sincerely,

Ervin Schumacher
Administrator

ES:AF:bk

cc: Dr. Glenn Robeson

THE COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF CONSUMER AFFAIRS AND BUSINESS REGULATION
DIVISION OF INSURANCE
200 FRIEND STREET, BOSTON 02114
(617) 727-7189

TIMOTHY H. GAILEY
COMMISSIONER OF INSURANCE

March 26, 1990

Senator John P. Houston
Representative Paul Kollios
Chairpersons, Committee on Human Services
and Elderly Affairs
State House, Room 22
Boston, MA 02133

Dear Senator Houston and Representative Kollios:

I am writing to support S. 612, "An Act Relative to Cost Effectiveness and Accessibility of Certain Human Services". The bill would expand the scope of practice of optometrists, consistent with regulations to be promulgated by the Board of Registration in Optometry.

An expansion of the permissible scope of optometric practice, subject to appropriate regulatory approval, could make a contribution to containing the rising cost of health care and health insurance premiums. The average cost of a visit to an optometrist is significantly less expensive than a visit to an opthamologist. Currently, there is a significant incidence of double visits for the treatment of certain eye diseases because many patients who initially visit optometrists must be referred to opthamologists for the administration of medication. In addition, many patients who now are forced to seek care in hospital emergency rooms in order to see an opthamologist could be treated much less expensively by community-based optometrists.

I urge the Committee to give S. 612 a favorable report.

Sincerely,
Timothy H. Gailey
Timothy H. Gailey
Commissioner of Insurance

0021N

# The Impact Of The Use By Kansas Optometrists Of Therapeutic Pharmaceutical Agents

By Stacy Fitch, O.D.

ABSTRACT: From July 15, 1987 through December 31, 1988, the Kansas Optometric Association collected information from Kansas optometrists regarding the number of diagnostic cases seen, their respective therapies, and the number of miles saved. This paper attempts to show the impact of the Kansas therapeutics law on optometrists and their patients.

## INTRODUCTION

April 17, 1987 was just a typical day for most of us. But, for Kansas optometrists, it was a milestone. On that day, Kansas became the 17th state to pass a therapeutic law, which has greatly expanded the practice of optometry in Kansas.

The Kansas Optometric Association (KOA) conducted a study for the first year and a half after implementation of this law which asked KOA members to voluntarily keep track of all diagnoses made, therapies, the number of therapeutic encounters, the miles saved, and the referrals made to other doctors. This information was returned to the Kansas Optometric Association.

The Kansas therapeutics law for optometry includes the administering and dispensing of topical pharmaceutical drugs, as well as, the removal of superficial foreign bodies from the cornea and conjunctiva. Any anti-inflammatory agents administered are limited to a 14-day supply and may only be used topically.

## RESULTS

Forty-three offices representing 47 optometrists responded to the study. This represents 23% of the 203 optometrists initially certified at SBEO to use therapeutics. Therefore, the results of this study will significantly understate the actual impact. Overall, the total mileage saved by the patients treated by optometrists during the 1½ year period is over 128,000 miles. This represents a major savings of time and out-of-pocket travel expenses for patients.

In Table 1, 23 major diagnoses are listed, with the number of cases of each per month, dating from July 1987 through December 1988. The cases that were referred to another doctor are not included in the table. Two cases of scleritis treated by rural optometrists are not included in the table. A case of scleral melt secondary to cataract surgery is not listed in the table, but is included in the study. This case was co-managed by an optometrist and a surgeon. This case alone saved the patient 1600 miles, encompassing all trips made to the optometrist.

The percentage of cases seen by optometrists practicing in cities versus those practicing in rural areas is considered in Table 2.

Table 3 shows the percentage of cases per month.

## DISCUSSION

In Table 2, the greatest percentage of cases were seen by rural optometrists. It would seem that patients are turning to optometrists for their primary eye care in rural areas because of greater convenience. However, it is difficult to draw concrete conclusions in this regard because the majority of optometrists responding to this study are optometrists practicing in rural areas. It may be reasonable to assume that urban optometrists didn't respond because the miles saved would not be great. However, a higher urban OD's response would have reflected significant cost savings over emergency room visits.

In Table 3, the greatest percentage of cases seen per month occurs approximately one year after the implementation of the therapeutics law. There could be several reasons for this. The patients may be more aware of what optometrists can treat now than when the law first passed. Optometrists may also be more confident in treating more sophisticated ocular maladies. Also, as found in the study, optometrists are receiving more referrals from hospitals and general physicians.

## CONCLUSION

Prior to April 17, 1987, none of the cases in this study would have been handled by optometrists because the Kansas optometry laws did not allow it.

The mileage saved by the patients became very important in rural areas, which have an optometrist available, but not an ophthalmologist. Since Kansas is largely a rural state, patients are benefiting from the revised optometry laws in time saved, money saved, elimination of unnecessary referrals, as well as improved health care.

## ACKNOWLEDGEMENTS

Thanks to Michael P. Malone, O.D. for his assistance in the study and for the use of his optometric office to compile the information, the KOA for supplying the material to write this paper, and the many optometrists who participated in this study.

## REFERENCE

Kansas Optometry Laws, 65-1501, 65-1501a.

# APHA recognizes contributions to public health, vision care

ATLANTA— The Vision Care Section (VCS) of the American Public Health Association (APHA) recognized the contributions of a public health leader and a public policy center at the association's 119th annual meeting.

Recognized for his important contributions to public health in general and vision care in particular, was Harris Nussenblatt, O.D., Dr.P.H., of Houston, TX, winner of the section's 1991 Distinguished Achievement Award. Dr. Nussenblatt is a founding member of the Vision Care Section and served as chair from 1982-84. He also served as section councilor, program chair and editor of the section's newsletter for many years. He was also cited for his committee work for the American Optometric Association (AOA) and the Association of Schools and Colleges of Optometry (ASCO) by Les Caplan, O.D., M.P.H., awards chair.

"In summary, Dr. Harris Nussenblatt's record is one of academic excellence with significant contributions to public health and eye care issues. His work has always been attune to changes in health care delivery while being both a leader and team player — all of which has improved the health and well-being of the public," said Dr. Caplan.

Harris Nussenblatt, O.D., Dr. P.H.

The section's Outstanding Paper Award went to Mordachai Soroka, Ph.D., of the Center for Vision Care Policy, State College of Optometry, State University of New York. The award paper, titled "Comparison of Examination Fees and Availability of Routine Vision Care by Optometrists and Ophthalmologists," was recently published in *Public Health Reports*. Dr. Soroka's national survey determined that ophthalmologists' fees are $19 more than optometrists' fees for routine eye examination. In addition, he reported that the waiting time for routine examinations with ophthalmologists was 15 days longer than for optometrists, which added a barrier for access to services.

The VCS sponsored numerous papers presented during the conference. The papers highlighted a patchwork quilt of subjects and their effect upon public health. Panel presentations addressed model diabetes control programs, screening underserved populations, and eye care in underdeveloped countries.

Papers were presented by ODs as well as physicians, nurses, government representatives and scientific researchers, according to Debbie Hettler, O.D., M.P.H., Chicago, IL, program chair for the VCS.

"The meeting offered a great opportunity to interact with health professionals from around the world and enhance the role of optometry in the total health care system," said Ian Berger, Ph.D., VCS Action Board representative, Houston, TX.

## SCCO program covers AIDS and vision problems

FULLERTON, CA— "Eye/Vision Problems Associated With AIDS," was the topic of a recent, special edition of the Southern California College of Optometry's (SCCO) Vision and You cable television program. The program featured SCCO faculty members John Nishimoto, O.D., and Russell Jew, O.D., discussing the devastating effect of AIDS on the eyes. In some cases, eye signs of AIDS are the first to be noticed as the retina is almost always affected by the malady. AIDS can have serious consequences on the patient's vision, the doctors noted.

Dr. Nishimoto and Dr. Jew emphasized that all HIV-positive patients should have an eye examination every three months. Sometimes, the first sign of full-blown AIDS is seen in the eye and treatment to prevent the AIDS virus from multiplying rapidly must be started in order to save at least some vision.

The AIDS virus has been noted in the tear layer of the eye, so optometrists should

## Frescura, luminary of European optometry, dies at 85

Romeo Frescura, a founding member of the European Optometry Society (SOE), has died at the age of 85 in Imperia, Italy. The second of four generations in the optical field, Frescura was a consultant to the Italian government for eye care and served as president of the optometric trade union there. Active in optometric education in Italy, France and Germany, he served as president of the SOE for nearly 20 years. He is survived by his son, Ugo Frescura, president of the SOE since 1985.

## Deaths

ST. LOUIS-- The American Optometric Association derives its great strength and spirit from its people, and mourns all those it loses. The following are those members whose passing has been reported to the *AOA News* as of Dec. 1, 1991.

NORTHWEST
EYE CENTER

State of the Art Technology
and Old Fashioned Care

February 8, 1989

State Senator Gary Nelson
106-A Inst. Building
Olympia, WA 98504

Dear Senator Nelson:

We are three ophthalmologists practicing in Seattle. We are writing in support of Senate Bill 5193, and feel that Doctors of Optometry should be allowed to use topical therapeutic drugs. We have had the opportunity and pleasure of sharing in the care of many patients with optometrists in your legislative district: Doctors Michael Medin and David Ross. These doctors provide excellent care. They have shown good judgment in their patient care decisions. We feel they will continue timely and proper care with therapeutic drug use. In the past two years we have participated in educational courses with these doctors. We have encountered a high level of interest and enthusiasm in these endeavors.

It is our hope that passage of this therapeutic bill will result in a greater unity between optometrists and ophthalmologists and ultimately our patients will be the beneficiaries.

If you have any questions or concerns, we would be happy to discuss them with you.

Yours very truly,

J. Stephen Brown, Jr., M.D.

Michael W. Field, M.D.

William E. Hancock, M.D.

J. Stephen Brown, Jr., M.D. Michael W. Field, M.D. William E. Hancock, M.D. Brett G. Bence, O.D.
1560 North 115th Street, Suite 102 Seattle, Washington 98133 206-365-7332 1-800-826-4631

# Valley Eye and Laser Center

March 13, 1989

House of Representatives
Legislative Building, Room #
Olympia, Wa. 98504

Dear Representative

I am writing to express my strong support for Senate Bill #5193. I have been practicing medicine as an ophthalmolgist, specializing in eye disease and surgery for the past ten years.

I have reviewed the proposed change in Legislation carefully, and find it is a reasonable approach for expanding the scope of optometric practice. My experience with optometrists has shown me that they are very competent, careful, and ethical practitioners.

Please support this bill and move the issue out of the political arena, so all ophthalmologists and optometrists can get back to our main concern, the care of eyes.

Sincerely,

Paul N. Joos, M.D.

4011 Talbot Rd. S. #210, Renton, WA 98055 (206) 255-4250, 1-800-325-6498

NEVADA STATE LEGISLATIVE COMMITTEE


CHAIRMAN
Mr. Gail Bishop
2700 West 7th Street
Reno, NV 89503
(702) 747-1814

VICE CHAIRMAN
Mr. George M. Lambert
155 East Cedar Street
Fernley, NV 89408
(702) 575-4876

SECRETARY
Mr. Orland F. Outland
2675 Valmar Place
Reno, NV 89503
(702) 747-3163


April 24, 1989

Senator Randolph J. Townsend
Nevada State Legislature
Capitol Complex
Carson City, NV 89710

re: S.B. 296

Dear Senator Townsend,

Under present circumstances, optometric patients sometimes must be referred from an optometrist to another provider just for the administration of ocular medication, resulting in an added expense for the patient for the added office visit.

The added office visit also results in an added expense attributable to the co-insurance payment for the separate visit.

People living on fixed, limited income could benefit by the passage of this bill by not being forced to undergo two office visits when one would suffice. Each visit entails a provider cost, but it also often entails extreme inconvenience for the elderly in arranging transportation for that added visit.

Very truly yours,

Gail Bishop
Chairman

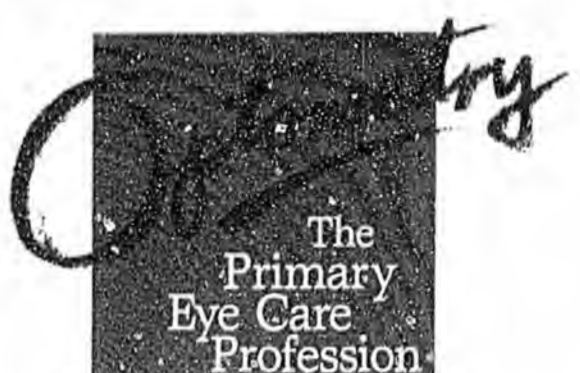
OPTOMETRY:
THE PROFESSION

Optometry is an independent primary health care profession.

It encompasses the prevention and remediation of disorders of the eye/vision system through the examination, diagnosis, treatment and/or management of visual efficiency and eye health. The recognition and diagnosis of related systemic manifestations are designed to preserve and enhance the quality of life and environment.

Doctors of Optometry are primary health care providers who diagnose, manage and treat conditions and diseases of the human eye and visual system as regulated by state law.

These health care professionals are specifically educated, clinically trained and state licensed to examine the eyes for the presence or absence of vision problems, eye diseases or ocular manifestations of systemic diseases such as diabetes, hypertension, hyperthyroidism, etc. The primary vision care needs of consumers have shaped the scope of optometric practice as it is today.




# EDUCATION OF THE DOCTOR OF OPTOMETRY

To establish perspective, there is value in comparing the general characteristics of the education of selected health professionals: optometry, medicine, podiatry, nursing and pharmacy.

Perhaps the most current review is reported by Robert F. Rushmer, M.D.[1] noted author and Director, Center for Advanced Studies in Biomedical Sciences, School of Medicine, University of Washington. He observed that each has state board requirements; all but pharmacy have national boards. All these educational institutions require accreditation at regular intervals. The admission requirements for medicine are less specific or demanding than in some other categories.

Each of these educational processes involves some years of basic sciences, preclinical education and clinical experience. Rushmer concludes, "In general, the basic educational experience of these five professions are remarkably similar and cannot account for consistent under utilization of 'non-medical' health professionals."

Addressing the concern for the provision of primary care, Dr. Rushmer makes the observation that the numbers of general practitioners and family physicians are grossly inadequate to afford the luxury of initial contact with physicians as the standard procedure; this is compounded in remote areas and central cities.

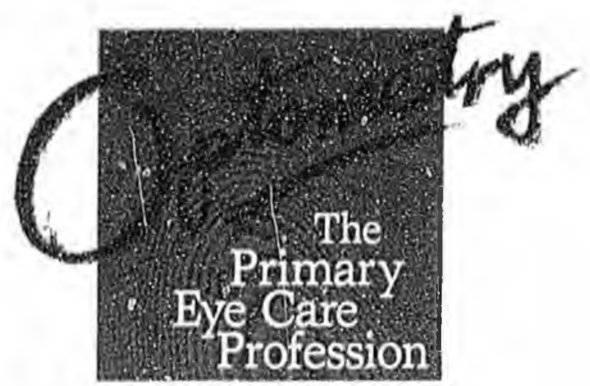
He points to the need for utilization of other health professions. Dr. Rushmer states, "Pharmacists undoubtedly have a sounder education in the details of dosage and distinctions among pharmaceutical agents than do physicians. Similarly, optometrists have a more extensive exposure to the basic principles of physiological optics than do physicians."

"From earliest times, the training of physicians has been based in large measure on apprenticeship, and vestiges of this orientation are clearly visible today in the clinics and the wards of teaching hospitals." "The residents, training to be specialists, usually serve as surrogate faculty for both interns and medical students." In contrast the training of optometrists can be described as a combined didactic, laboratory and clinical curriculum, the design of which has many parallels to dentistry.

By being exempt from the provisions of the statutes governing the practice of optometry, physicians in general are legally entitled to test eyes and prescribe glasses. Ophthalmologists complete a three year apprenticeship-style residency program concerning diseases of the eye; ophthalmology being a subspecialty of surgery. Beyond that of general medicine no licensing is required to practice ophthalmology.

In comparing the specialties Dr. Rushmer states, "...the upgraded curricula of optometry schools generally provide more extensive basic knowledge, training and experience in correcting refractive errors that most ophthalmologists receive. Training and clinic experience in detection of eye pathology now renders recent graduates of optometry school capable of filling an extremely important role in this specialized area of health care. The persistent opposition of the medical profession has retarded but only partially impeded optometrists from providing ever expanding service in the care of the eye."

1. Rushmer, R.F.: National Priorities for Health: New York, Wiley, 1980.



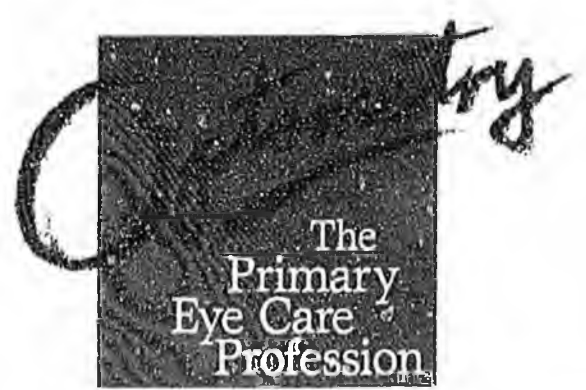

WHAT SERVICES DO DOCTORS OF OPTOMETRY PROVIDE?

The scope of practice for the profession of optometry has progressed beyond the point of simply examining the eyes to prescribe glasses or contact lenses. Optometry is now the main provider of primary eye/vision care services in America.

The most frequent services provided by a Doctor of Optometry are included on the form on the reverse side of this page.

For a more complete listing, refer to AOA's Codes for Optometry published by the American Optometric Association. This digest contains the applicable procedural codes from AMA's Current Procedural Terminology, Fourth Edition (CPT-4); diagnosis codes from the International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9-CM); and materials codes from HCFA's Common Procedure Coding System (HCPCS).

The publication is available through the AOA Order Department, 243 North Lindbergh Boulevard, St. Louis, Missouri 63141.




| EXAMINATION | CPT NEW | ESTAB |
|---|---|---|
| Brief | 90000 | 90040 |
| Limited | 90010 | 90050 |
| Intermediate | 92002 | 92012 |
| Comprehensive | 92004 | 92014 |
| Refraction | Y__ | N__ |

| HOSPITAL SERVICES | INIT | SUBSQ |
|---|---|---|
| Brief | 90200 | 90240 |
| Limited | | 90250 |
| Intermediate | 90215 | 90270 |
| Extended Intermediate | | 90260 |
| Comprehensive | 90220 | 90280 |

| CONSULTATIONS | INIT | SUBSQ |
|---|---|---|
| Brief | | 90640 |
| Limited | 90600 | 90641 |
| Intermediate | 90605 | 90642 |
| Extensive | 90610 | |
| Comprehensive | 90620 | |
| Complex | 90630 | 90643 |
| Afterhours | 9905_ | |
| Emergency Care | 9906_ | |
| Special Rpts | 99080 | |

| SPECIAL PROCEDURES | CPT |
|---|---|
| Gonioscopy | 92020 |
| Visual Fields/Threshold | 92083 |
| Visual Fields/Screening | 92082 |
| Extended Ophthalmoscopy | 92225 |
| Photog/Fundus R-L | 92250 |
| Photog/External R-L | 92285 |
| Endothelial Microscopy | 92286 |
| A-Scan | 76519 |
| Ophthalmodynamometry | 92260 |
| Color Vision Exam | 92283 |
| Provocative Test | 92140 |
| Serial Tonometry | 92100 |
| Lacrimal Probe/Irrigation | 68800 |
| Epilation | 67825 |
| Medication/Supplies | 99070 |

| VISION THERAPY SERVICES | |
|---|---|
| DIAGNOSTIC SERVICE | |
| Sensorimotor Exam | 92060 |
| Developmental Exam | 90775 |
| TREATMENT SERVICE | |
| Vision Therapy Trmt | 92065 |

| LOW VISION TREATMENT | |
|---|---|
| Microscopic System | 92354 |
| Telescopic System | 92355 |

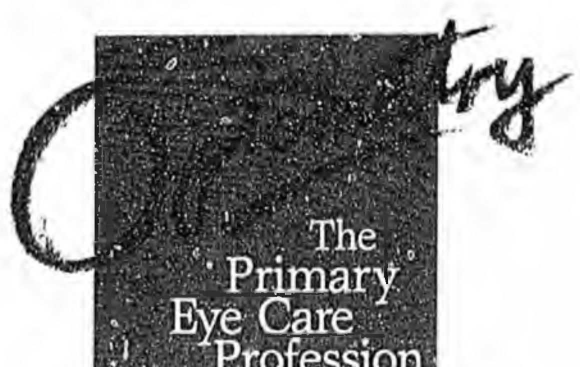
| OPHTHALMIC LENS TREATMENT<br>GLASS _ RESIN _ | | CPT |
|---|---|---|
| Monofocal Lens | RE-LE | 92340 |
| Bifocal Lens | RE-LE | 92341 |
| Multifocal | RE-LE | 92342 |
| Monofocal Aphakia | RE-LE | 92352 |
| Bifocal Aphakia | RE-LE | 92353 |

| CONTACT LENS TREATMENT | | CPT |
|---|---|---|
| Treatment of Disease/CL | RE-LE | 92070 |
| CL Therapy/excpt Aphakia | RE-LE | 92310 |
| Corneal L/Aphakia/1 eye | RE-LE | 92311 |
| Corneal L/Aphakia/2 eyes | RE-LE | 92312 |

| OPTICAL SERVICE | HCPCS | |
|---|---|---|
| Frames | V__ | V__ |
| Lenses | V__ | V__ |
| Coating | V__ | V__ |
| Tint | V__ | V__ |
| Oversize | V__ | V__ |
| Balance Lens | V__ | V__ |
| Prism | V__ | V__ |
| Scratch Resist. Coat. | V__ | V__ |
| UV Coating | V__ | V__ |
| Safety | V__ | V__ |
| Soft CL | V__ | V__ |
| Gas Perm. CL | V__ | V__ |
| Toric CL | V__ | V__ |
| Extended Wear CL | V__ | V__ |
| Repair | V__ | V__ |

DIAGNOSIS ICD-9

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Abnormal Pupil | 379.40 | Diab., Per History | 250._ | Mod. Profound | 369.10 | Pinguecula | 372.51 |
| Accom. Disorder | 367.50 | Diab. Retinopathy | 362.00 | Mod/Severe, OD OS | 369.20 | Presbyopia | 370.40 |
| Amblyopia | 368.00 | Diplopia | 368.20 | Unequal, both | 369.30 | Pterygium | 372.40 |
| Aniseikonia | 367.32 | Drusen | 362.57 | Iritis, Iridocyclitis | 364.0 | Ptosis | 374.3 |
| Anisometropia | 367.31 | Dry Eyes | 375.15 | Keratitis | 370.90 | Retinal Detachment | 361.9 |
| Aphakia OD OS | 379.31 | Ectropion | 374.10 | Kerat. Sicca | 370.33 | Retinal Tear | 361.0 |
| Asthenopia | 368.13 | Entropion | 374.00 | Keratoconus | 371.6 | Ret. Degen./Periphrl | 362.60 |
| Astigmatism | 367.20 | Epiphora | 375.20 | Krukenberg's Spindle | 371.13 | Strabismus | 378.9 |
| Blepharitis | 373.00 | Esophoria | 378.41 | Lacrimal Disorder | 375. | Sudden Vision Loss | 368.11 |
| Blepharospasm | 333.81 | Esotropia | 378.00 | Macular Degeneration | 362.5 | Subj. Hemorrhage | 372.72 |
| Blindness, legal | 369.40 | Exophoria | 378.42 | Migraine | 346.8 | Suppression | 368.31 |
| Cataract OD OS | 366.90 | Exotropia | 378.10 | Myopia | 367.10 | Transient Vision Loss | 368.12 |
| Chalazion | 373.20 | Glaucoma | 365.90 | Nystagmus | 379.50 | Trichiasis | 374.05 |
| Color Vision Def | 373.20 | Glaucoma Suspect | 365.00 | Ocular Hypertension | 365.04 | Uveitis | 364.3 |
| Conj. Foreign Body | 930.10 | Headache, Per History | 784.00 | Ocular Migraine | 368.15 | Vascular Lesions | 362.17 |
| Conj. Hemorrahage | 372.72 | Hordeodum | 373.11 | Opaque Post Capsule | 366.53 | Viral Warts | 078.1 |
| Converg. Excess | 378.84 | Hyperphoria | 378.43 | Optic Atrophy | 377.1 | Visual Distortion | 368.14 |
| Corneal Abrasion | 918.10 | Hyperopia | 367.0 | Optic Nerve Drusen | 377.21 | Visual Field Defect | 368.4 |
| Corneal Edema | 371.24 | Hypertensive Retinop. | 362.11 | Paresis | 378.55 | Vitreous Floaters | 379.24 |
| Cornea Foreign Body | 930.00 | Hypertropia | 378.31 | Photophobia | 368.13 | Xanthelasma | 374.51 |
| Corneal Ulcer | 370.00 | Prof. Impair/OD OS | 369.00 | Photopsia | 368.15 | Normal State | V65.5 |




# DOCTORS OF OPTOMETRY AS PRIMARY EYE CARE PROVIDERS

Often third party entities do not realize the scope of practice of the profession of optometry. The following illustrations will help the third party entity to better understand the scope of practice of a doctor of optometry.

When a patient is seen for a routine examination because of blurred vision, one of the diagnoses that a doctor of optometry may make is that of cataract. The doctor of optometry will follow that patient until such time that cataract surgery becomes necessary. The patient will then be sent for a consultation with an eye surgeon to have the cataract removed. After the surgery, the doctor of optometry will, in most cases, provide the post-operative care.

When a patient is seen with the symptom of blurred vision, another diagnosis considered is macular degeneration. In a few cases, laser treatment will slow the degenerative process and if laser treatment is indicated, the doctor of optometry will refer to a retinal specialist for laser treatment. After the treatment, the doctor of optometry will again assume the management role for the patient.

If a patient's intraocular pressure is higher than "normal" (ocular hypertension) and yet the patient does not have glaucoma, then that patient will periodically be re-evaluated by the doctor of optometry looking for changes indicative of beginning glaucoma.

When a patient has diabetes, the doctor of optometry periodically evaluates the retina to determine if and how the diabetes is affecting the eye. If laser treatment becomes necessary, the doctor of optometry will set a consultation with a retinal specialist to have the retina treated with laser. After the laser treatment, the doctor of optometry will again manage the care of the patient.

A choroidal nevus is a large pigment spot within the retina. These are generally benign but need to be evaluated periodically to insure they do not turn into malignant melanomas. Doctors of optometry routinely manage these patients.

When a family physician is concerned about a possible pituitary tumor, he/she will often refer to a doctor of optometry for visual fields testing to determine if a visual field defect is present. If there is no field defect, he/she may simply follow the patient.

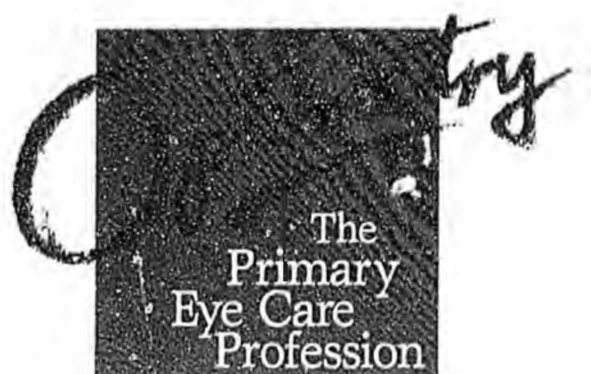
However, if a field defect is present, then the patient would be sent in for a CT-scan and other possible neurological evaluations.

(OVER)

American Optometric Association

Headache is possibly the most common symptom that confronts doctors. Very often the family physician will refer a patient with headaches to a doctor of optometry to determine if the headaches are ocular in origin before other costly neurological evaluations are done. Doctors of optometry and family physicians often work together to manage patients because it is often more effective as well as more cost effective than using other specialists.

Corneal dystrophies cause a clouding of the cornea of the eye. The doctor of optometry follows a dystrophy and, in certain cases, a corneal transplant may be necessary. If a corneal transplant is required, the patient is sent for a consultation with a corneal specialist for surgery. After surgery, patients are again evaluated and followed by the doctor of optometry.




# WHAT ABOUT QUALITY ASSURANCE?

Success in eyecare programs necessitates the assurance of quality eyecare.

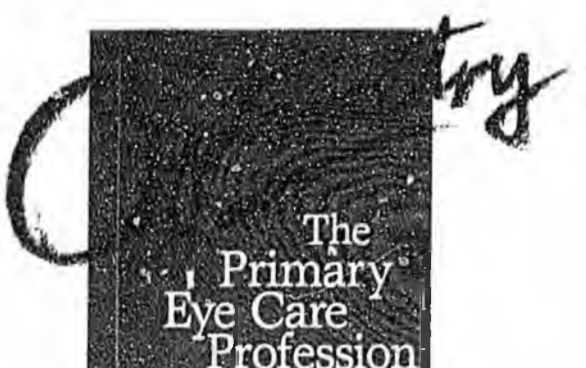
The typical framework of an optometric quality assurance program consists of the following three components:

1. Credentials Committee -- Evaluates all candidates for network participation to assure the best qualified optometrists are involved.

2. Quality Assurance Committee -- Establishes and reviews standards of care to assure quality of services delivered.

3. Utilization Review Committee -- Establishes and monitors utilization norms for the delivery of eye care.

More information about an optometric quality assurance program can be found in **QUALITY ASSURANCE: Framework of a Quality of Care Review Program.** The publication is available from the Vision Care Benefit Plans Center, American Optometric Association, 1505 Prince Street, Suite 300, Alexandria, VA 22314.



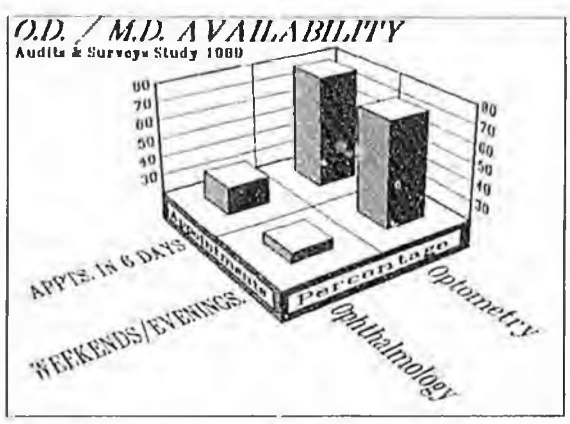

# REPORT ON COST AND AVAILABILITY OF ROUTINE EYECARE

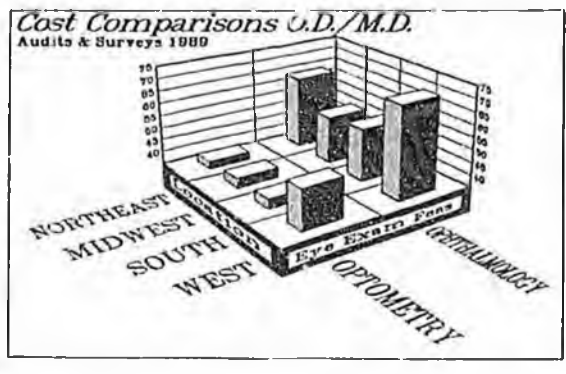
In June 1989, Audits and Surveys, a New York City firm, released its study on a comparison of optometric and ophthalmological care with respect to:

- Appointment availability
- Cost of routine care

## Availability for Primary Care

A potential patient must wait three weeks for an appointment with an ophthalmologist. The same potential patient will wait approximately one week for an appointment with an optometrist. Doctors of optometry are much more likely to be available on weekends than ophthalmologists for primary care. 75% of the optometrists and only 25% of the ophthalmologists offer weekend appointments. This is an important fact for the Monday through Friday worker.



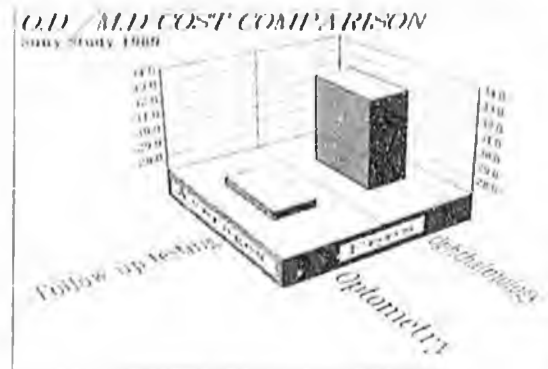




## Cost of Routine Eyecare

The study, utilizing over 1,000 telephone interviews in all regions of the United States, found that optometry is more cost effective than ophthalmology for routine eyecare. Over the entire nation, optometry charged an average of $20.00 less for a primary care eye examination.

## Summary

In summary, optometry is more available and more cost effective for routine eyecare. Optometry is competent to render comprehensive and follow-up care. Optometry is the primary eyecare profession that serves as the entry point into eyecare.




- According to a 1989 study conducted by the Center for Vision Care Policy, the comparison of follow-up testing indicated that charges for services such as gonioscopy, visual fields, extended ophthalmoscopy and photography were significantly lower when services were provided by doctors of optometry. These services are common procedures used in the diagnosis of eye disease.

- Data from the July 1985 issue of REVIEW OF OPTOMETRY shows that the average fee for an optometric examination in 1985 was $36. Comparing the 1985 extrapolated $50 estimated median fee for an ophthalmological exam (data from the February 21, 1983 issue of MEDICAL ECONOMICS) with the $36 estimated average for an optometric exam, one finds that the former is now some 39% higher than the latter.

- Data from the February 21, 1983 issue of MEDICAL ECONOMICS shows that the median fee for an ophthalmological eye examination was $41 in 1982 compared to $31 in 1978 -- an average increase of 7.2% a year. Linear extrapolation would suggest a median fee for an ophthalmological eye exam of $36 in 1980 and $50 in 1985.

- Data from the April 1982 issue of OPTOMETRIC MANAGEMENT shows that the median fee for an optometric examination was $30 in 1980. Comparing the 1980 interpolated $36 estimated median fee for an ophthalmological exam with the $30 estimated median fee for an optometric exam, one can determine that the former is 20% higher than the latter.

- According to an actuarial report prepared in 1982 by the Health Care Finance Administration (HCFA), "Services performed by optometrists cost about 10% less than those done by ophthalmologists".

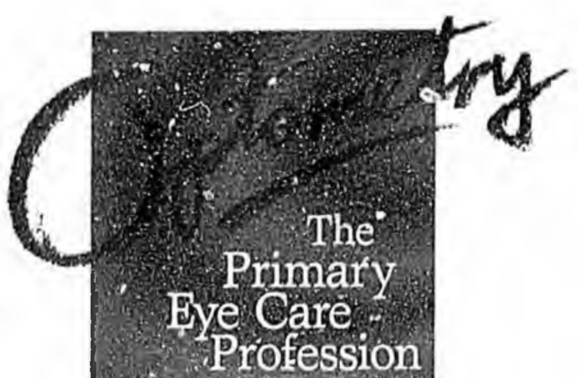
- InterStudy, a noted HMO consulting firm, concludes that the most cost effective group HMO models are those where optometrists perform <u>all</u> routine eye examinations and also manage certain eye diseases and conditions.

- Capitol Health Care, an independent practice association (IPA) in Salem, Oregon, found that eye examinations by optometrists were 7% to 9% less than the charges by ophthalmologists.

- In a 1979 study done by Blue Cross/Blue Shield of Michigan, it was found that for eye examinations with tonometry, the average charge by par optometrists was $26.81 compared to $38.00 for a par ophthalmologist, and $39.92 for a non-par ophthalmologist.

- Table 1, <u>Civilian Consumer Spending for Vision Care and Sight Correction Services in 1975</u> which appears in the report, THE IMPACT OF NATIONAL HEALTH INSURANCE ON THE USE AND SPENDING FOR SIGHT CORRECTION SERVICES, published by Gordon R. Trapnell Consulting Actuaries in 1976, indicates that in 1975 the cost of a diagnostic examination performed in the office of an ophthalmologist was more than 20% higher than the cost of a diagnostic examination performed in the office of an optometrist.

The above studies indicate that Doctors of Optometry are indeed cost effective in providing eye/vision care services.




# Where Are the Optometrists in the U.S.?

**KEY**

**ACCEPTABLE RATIO**
(More than 13 practicing O.D.s per 100,000 population)

**ABOVE AVERAGE RATIO**
(11-13 practicing O.D.s per 100,000 population)

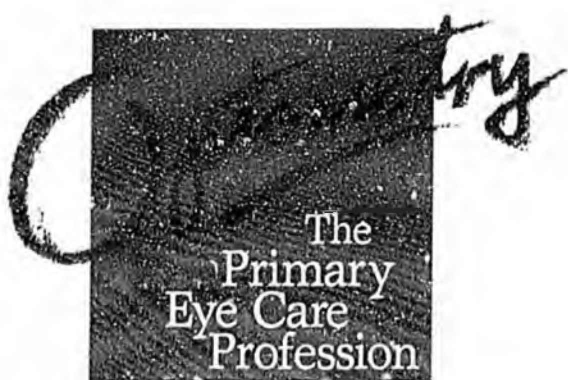
**AVERAGE RATIO**
(9-11 practicing O.D.s per 100,000 population)

**BELOW AVERAGE RATIO**
(7-9 practicing O.D.s per 100,000 population)

**CRITICAL RATIO**
(less than 7 practicing O.D.s per 100,000 population)

WASHINGTON
MONTANA
NORTH DAKOTA
MINNESOTA
MAINE
OREGON
IDAHO
SOUTH DAKOTA
WISCONSIN
NEW HAMPSHIRE
VERMONT
MASSACHUSETTS
WYOMING
MICHIGAN
NEW YORK
RHODE ISLAND
CONNECTICUT
CALIFORNIA
NEVADA
UTAH
IOWA
NEBRASKA
ILLINOIS
PENNSYLVANIA
NEW JERSEY
INDIANA
OHIO
COLORADO
DELAWARE
DISTRICT OF COLUMBIA
MARYLAND
MISSOURI
WEST VIRGINIA
KANSAS
KENTUCKY
VIRGINIA
ARIZONA
NEW MEXICO
OKLAHOMA
TENNESSEE
NORTH CAROLINA
TEXAS
ARKANSAS
SOUTH CAROLINA
ALABAMA
GEORGIA
LOUISIANA
MISSISSIPPI
FLORIDA
ALASKA
HAWAII

American Optometric Association




# State Pharmaceutical Legislation

DIAGNOSTIC USE

DIAGNOSTIC AND THERAPEUTIC USE



AS OF JULY 1, 1991

American Optometric Association

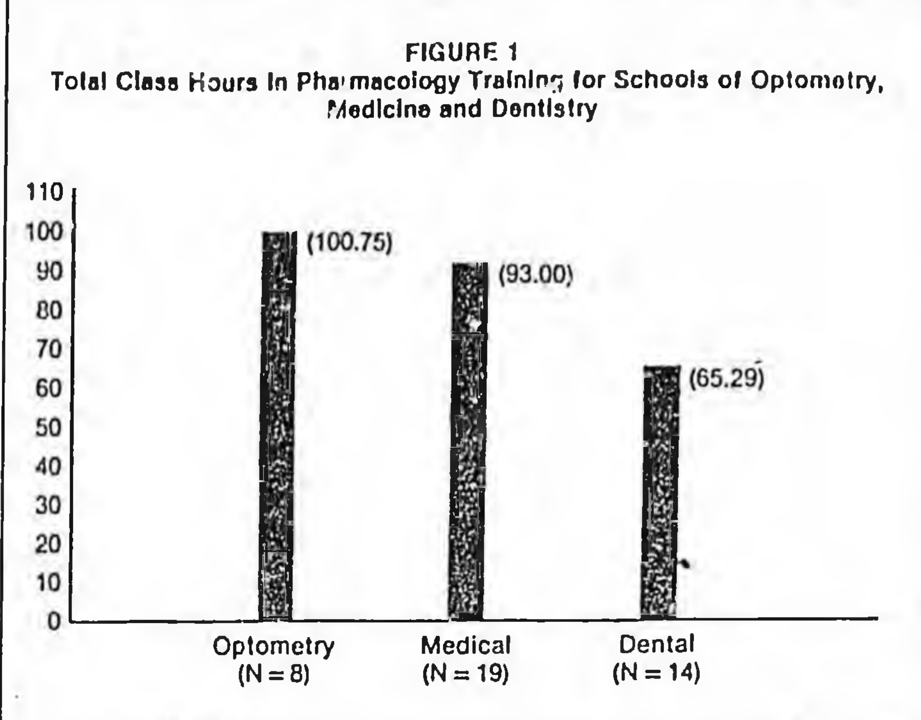



FIGURE 1
Total Class Hours In Pharmacology Training for Schools of Optometry, Medicine and Dentistry

## Basic Principles in Pharmacology

The range of hours in category 1 of the instrument is 15. Four schools spend only three hours and two spend 18 hours on this category. The overall mean for the entire sample is 8.71 hours. An F-ratio of 5.48 shows that there are significant differences among the three school types in hours spent in this study category.

Schools of optometry are not significantly different than either schools of medicine (t=2.51, df=16.2, p=.02) or schools of dentistry (t=0.04, df=14.3, p=.97). Medical schools do, however, spend more hours on this category than schools of dentistry (t=3.01, df=30.8, p=.005).

## Drug Effects on the Nervous System

The second category for comparison within the pharmacology study instrument involves class hours spent studying drug effects on the nervous system. The range of hours was found to be 23 with two schools spending only five hours and one school spending 28 hours on this category.

The mean is 13.24 overall and an F-ratio of 8.61 showed that there are significant differences among the three school types on this category of the instrument. Comparatively, optometrists and dentists do not differ on this category (t=0.99, df=13.1, p=.922), whereas medical schools devote more hours than either optometry (t=2.97, df=14.8, p=.009) or dental schools (t=3.83, df=30.9, p=.001).

## Psychopharmacology

The range for hours spent teaching psychopharmacology is 10. The grand mean for this category is 4.75 with the three school types averaging between four and six class hours. According to the calculations, there are no significant differences (F=1.74, p=.189/n.s.) among optometry schools ($\overline{X}$=4.37, SD=3.25), schools of medicine ($\overline{X}$=5.47, SD=2.24) and schools of dentistry ($\overline{X}$=4.00, SD=1.80).

## Central Nervous System Depressants and Stimulants

The fourth category within the questionnaire involves classroom hours spent on the CNS depressants and stimulants. No significant differences are present among schools of optometry, medicine and dentistry for hours spent in this content area (F=1.02, p=.368/n.s.). The three school types average between seven and ten class hours on the CNS depressants and stimulants.

## Anesthetics

The hourly range on the instrument category identified as anesthetics is 10. The overall mean for the entire sample is 4.63. Although schools of optometry and medicine are not significantly different in this category (t=1.56, df=21.0, p=.133), an F-ratio of 6.91 indicates that significant differences do exist among the three groups. The comparisons between schools on hours spent teaching anesthetics show that schools of optometry require significantly less hours than schools of dentistry (t=3.80, df=18.9, p=.001).

## Cardiovascular Agents

Category six within the pharmacology study questionnaire deals with cardiovascular agents. An F-ratio of 14.31 shows that significant differences exist among the school types on this category. According to the analysis, optometry schools and schools of dentistry do not differ on this category (t=1.24, df=19.8, p=.229). The mean hours for schools of medicine ($\overline{X}$=12.26) fall above the grand mean of 9.49 and indicate that medical schools spend more time on cardiovascular agents than dental schools and schools of optometry (Med vs Den, t=3.74, df=23.8, p=.001; Med vs Opt, t=6.41, df=20.., p=.000).

## Ocular Pharmacology

The seventh category within the instrument asks for classroom hours spent on ocular pharmacology. The overall mean hours spent by the sample schools is 7.12. According to the data, schools of optometry average ($\overline{X}$= 34.00) more than the grand mean whereas medical and dental schools spend less time than the overall average ($\overline{X}$=0.63 and 0.57 respectively). All three groups had relatively large standard deviations that indicate extensive variability.

The results of the analysis of variance (ANOVA) show that there are statistically significant differences among the groups on this category of the pharmacology study questionnaire. The comparative analyses show that optometry schools spend more hours than schools of medicine (t=8.97, df=7.0, p=.000) and schools of dentistry (t=8.94, df=7.0, p=.000) teaching ocular pharmacology to their students.

## COMPARISON OF EDUCATION OF GENERAL PRACTITIONER & OPTOMETRIST

| GENERAL PRACTITIONER* | | OPTOMETRIST** | |
|---|---|---|---|
| Undergraduate School | | Undergraduate School | |
| **Medical School (4 Years)** | | **Optometry School (4 Years)** | |
| Systemic Disease | 9 hrs.*** | Systemic Disease | 6.5 hrs.*** |
| Pathophysiology (Does NOT include ocular disease) | 9 | Pathophysiology (Includes ocular disease) | 12.0 |
| TOTAL | 18 | TOTAL | 18.5 |
| Pharmacology | 8 | Pharmacology | 9.5 |
| Human Anatomy & Physiology | 29 | Human Anatomy & Physiology | 17.0 |
| Neurophysiology | 6 | Neurophysiology | 4.5 |
| TOTAL | 35 | TOTAL | 21.5 |
| Clinical experience in ocular conditions and disease | 4 | Clinical experience in ocular conditions and disease | 47 |

General Practitioners have a 1-year internship after medical school, but the internship is in a hospital and the General Practitioner would not be likely to see routine ocular problems.

* Hours reported in CU Health Sciences School of Medicine Schedule of Courses 1987-88.

** Hours reported in The Southern California College of Optometry 1987-89 catalog.

*** Hours reported in quarter hours, not classroom hours.

Continuously
Serving Optometrists
Since 1973

November 7, 1991

TO WHOM IT MAY CONCERN:

RE: OPTOMETRIC PROTECTOR PLAN

This letter is in response to your inquiry relative to professional liability rates and therapeutic drug usage.

The Optometric Protector Plan which is endorsed by the American Optometric Association currently insures over 7,000 O. D.'s nationwide. Our professional liability experience reflects both therapeutic and non-therapeutic states and the information provided is based on this information.

Poe & Associates, in the past has reviewed on a comprehensive basis the underwriting results for three major carriers for a period of seven years, and found that there is no significant actuarial coordination between therapeutic drug usage and liability insurance rates based on the current underwriting results.

Our current carrier of record, Great American Insurance Companies, does not charge a premium differential or surcharge for therapeutic drug usage in any of the states in which they are currently providing coverage. Because claims and premiums are so closely related to incidents of harm and injury to patients, we do not have evidence at this time that there is a correlation between the use of therapeutic drugs by Optometrists and malpractice claims.

Please contact me if I can be of any further help.

Sincerely,

Kathy Szuszczewicz

Kathy Szuszczewicz
Program Coordinator

KS/sv

National Administrator
Poe & Associates, Inc.

P.O. Box 1348
Tampa, Florida 33601-1348
(813) 222-4100
Fax (813) 221-4109

1015 Fifteenth Street, NW
Washington, DC 20005
202/789-5600

January 10, 1991

Hal V. Marsell
Chairman, Utah State Optometry Board
Utah State Legislature
190 South Fort Lane, #1
Layton, UT 84041

Dear Chairman Marsell:

I am very pleased to write in support of the legislation soon to be introduced which would update your state's laws concerning optometric care.

As you may know, at its 118th Annual Meeting, the American Public Health Association (APHA), which represents a combined national and affiliate membership of over 52,000 public health professionals and community health leaders, adopted a resolution entitled "Access to Treatment for Eye Care by Optometrists." A copy is enclosed for your immediate reference.

This resolution acknowledges that the expansion of clinical privileges of optometrists has increased the availability, accessibility, and cost effectiveness of eye care to the American public. The resolution recommends that States update their optometric practice acts to allow for optometric use of those diagnostic and therapeutic pharmaceuticals which have been determined by the State Board of Examiners in Optometry as being within the scope of competency of pharmaceutically certified optometrists. We further recommend that dispensing of such pharmaceuticals be regulated by state pharmacy laws.

Currently, ~~25~~ 30 states allow optometrists to use therapeutic drugs for the benefit of their patients. APHA urges your support for legislation which encompasses the principles endorsed in the APHA resolution, and would result in better access to comprehensive eye care of the American citizens.

I am confident that the citizens of Utah will be well served and will benefit greatly if comparable legislation is adopted by your state. As an MD. a Dean of a School of Public Health, and President-elect of APHA, I strongly endorse its passage.

Sincerely,

Joyce C. Lashof, MD
President-elect, APHA and
Dean, School of Public Health
University of California at Berkeley

JCL:mam/APHA

enclosure

Jeff Gonnason - Settlement

FROM: Rick Urion

# DOCTOR TO DOCTOR

## Building Better Referral Relationships with Opthalmologists

by Barbara J. Munson

Bolstered by a new-found confidence that comes with their increasing scope of care, optometrists are seeking referral relationships with ophthalmologists in which everyone's a winner.

In years past, good referral relationships with ophthalmologists consisted of one question: "Do they return the patients I refer?" In more recent years optometrists have also developed good comanagement relationships with MDs to whom they refer.

But, according to prominent optometric leaders Irvin M. Borish, O.D., and Irving Bennett, O.D., there are two other important considerations in developing good referral relationships with ophthalmology.

The first is asking ophthalmologists for referrals of *their* patients. Dr. Bennett describes how he went about getting cross-referrals from ophthalmologists 30 years ago:

"I went through my records and counted 42 cataract surgeries I had referred to one ophthalmologist—a significant number for one year—and invited him to lunch at my country club (so I would pick up the tab).

"'By the way,' I told him, 'we sent you 42 patients last year; aren't you happy with us?'

"'Oh yeah, you're great,' he replied. 'What's wrong? I sent back your patients.'

"'They were my patients to begin with,' I said. 'You know, since you don't do contact lenses, what do you tell your patients?'

"'I just tell them we don't do contact lenses,' he said.

"'Well, I'm just as expert a contact lens fitter as you are a surgeon. Maybe I should tell mine I don't do cataract surgeries.'

"He got the idea, and from then on the relationship blossomed."

The second consideration in establishing referral relationships is the necessity of referring to doctors who don't offer competing services. As Dr. Borish points out:

"If the ophthalmologist to whom you refer offers refractive and contact lens services either personally or by others in his or her office, there's a great possibility you will eventually lose the patient and perhaps other members of the family. This can happen even if the MD assiduously attempts to return the patient to you.

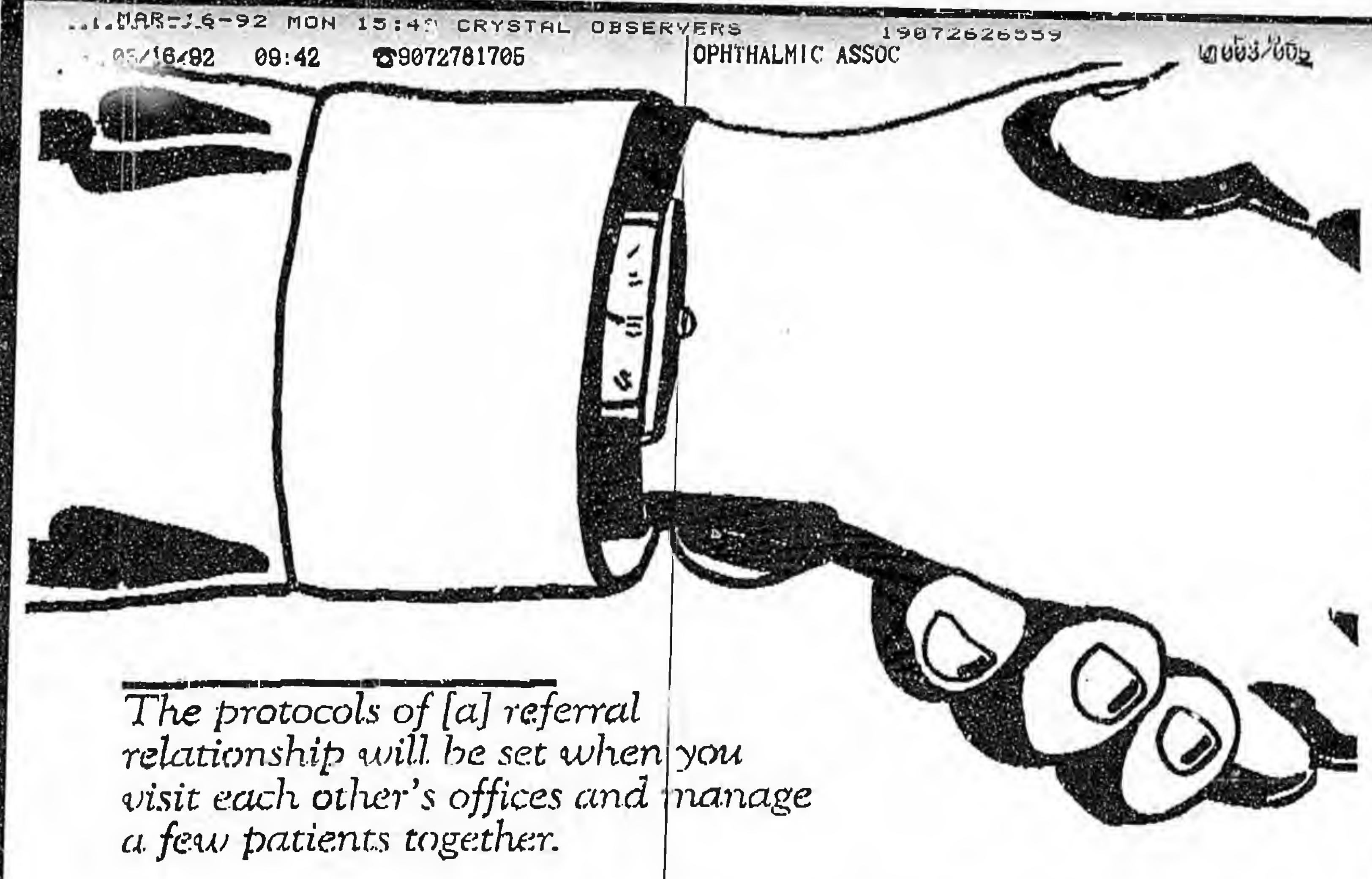
"As an example, I once was referred a difficult contact lens case by another OD. When I completed my work, I returned the patient to the referring OD. But a few weeks later, the patient's mother tried to bypass the other OD and make an appointment with me.

"ODs must lick the habit of referring to ophthalmologists who do refractions and contact lenses, thinking they have a good relationship when they get a turkey from the MD on Christmas."

"With the advent of TPAs and primary care in optometry," says James C. Leadingham, O.D., president-elect of the American Optometric Association, "optometrists no longer have to refer to general ophthalmologists who offer competing services. I find I am referring directly to tertiary specialists—retinal, cataract, corneal, etc.—who of course do not offer competing services that can cause loss of patients."

### CHANGING ATTITUDES IN BOTH PROFESSIONS

Ophthalmologists' attitudes are changing along with optometrists', says Randall N. Reichle, O.D., of Houston, Texas. Dr. Reichle is vice president of managed care at Omega Health Systems, Inc., a comanagement company. "Even in testimony for therapeutic legislation, they (ophthalmologists) are



*The protocols of [a] referral relationship will be set when you visit each other's offices and manage a few patients together.*

admitting optometrists are better educated now than ever . . . a new breed," he says.

Establishing a good two-way referral relationship also depends on maintaining a confident attitude and expecting positive results, optometrists are saying. Dr. Leadingham says, "The process is just not that complicated. Those new to a community [should] simply ask their colleagues who they work well with."

In Ashland, Kentucky, where Dr. Leadingham practices, there are 10 ophthalmologists. "Four absolutely refuse to comanage care," he says. "The ones I work with are 20 miles away and are very happy to work with me.

"If I am treating a patient, I've got to be in a comanagement situation; I need to get reports back. It's very difficult to make decisions without the communication," he says.

The initial communication may develop over lunch (Dr. Leadingham recommends dinner, when you are not as likely to be interrupted) or during a visit to the other's office. "Talk about your prescribing and treatment philosophics and discuss how you want your patients managed—after all, they are your patients," he adds. "Tell them specifically what information you will send them and what you'd like them to send back."

Also, suggest they visit your office. Ask specifically about their preferences types of visual fields, glaucoma pressures, etc. Establish that your therapies will mesh.

"What you'll actually establish is a common interest." The protocols of the referral relationship will be set when you visit each other's offices and manage a few patients together. "You'll initially spend a lot of time on the phone, then later more will be done through letters," Dr. Leadingham adds.

James F. Morrison, O.D., of Colby, Kansas, says he can't understand why optometrists expect ophthalmologists to refer patients to them when ODs are notorious for never writing letters. "The ophthalmologists have heard (in school) that the OD is undertrained and never writes reports. They're amazed to find out otherwise," he says.

The experience of Dr. Morrison and partner Larry Washburn, O.D., typifies successful referral relationships in rural TPA states. Ophthalmologists travel to Colby on regular schedules from outlying towns. Competition from them is nonexistent—those ophthalmologists are too busy doing surgery and using the new YAG lasers, they say.

Homespun respect and caring have helped to establish these relationships, Dr. Morrison says. "It's like anything else; just get to know them.

"Meet regularly and talk shop," he adds. "Most importantly, show how deeply you care and ask how you can help." Then follow up with reports.

"Most MDs want to do high end . . . if they are comfortably freed to do that, they will feed you [patients] like crazy." With that in mind, Dr. Morrison has added equipment to his practice the surgeons are comfortable with. "Make life simpler for them" is the motto, which includes providing ultrasounds, visual fields, and monitoring medications.

The picture is a little different in Anchorage, Alaska, where optometrists have yet to achieve TPAs. ophthalmologists provide similar services, and competition is still.

From: Rick Urion Ak State Medical Ass'n

says Jeffrey A. Gonnason, O.D. He refers many of his patients to the Pacific Cataract and Laser Institute in Washington state, where he knows they will receive good care and be returned to him

"Things are pretty informal here," Dr. Gonnason says. When he refers a patient to an ophthalmologist locally, he's often told, "Sure, we have a doc here, but hurry . . . he's going fishing at 3:00."

## REPORTS COUNT

More typically, optometrists elsewhere are finding that reports, formal or informal, are helping to shore up weak relationships with MDs. "If you don't have a referral center," adds John M. Roberts, O.D., of Denver, Colorado, "it's important to set up a referral relationship that is a two-way street—ophthalmologists understand that."

No time to write a report? No excuse, says Frank D. Puzio, O.D., of Dennis, Massachusetts, who has computerized the whole process. A letter to an ophthalmologist can be generated in two minutes; a letter to a school nurse or teacher takes 15 seconds using his Optometric Patient Information System (OPIS™).

Dr. Puzio's software provides clinical findings from his examinations, including symptoms, medications, family history, spectacle prescriptions, additional testing, and diagnosis. Also included is a notation that the patient has been instructed to return to his office for routine optometric care at the conclusion of the MD's treatment plan.

He uses other modules to send reports to health care professionals on everything from ocular manifestations to vision therapy to office policies. "For every patient, the goal is to send one letter out into the community," Dr. Puzio says. "No doubt, it's been the number one practice builder in my experience."

## INSTITUTIONALIZED REFERRAL SYSTEMS

Referral or comanagement centers grew out of a need to guarantee getting patients back, says Dr. Reichle, who is center director of the Houston Omega center. "Fifteen years ago, an ophthalmologist would gladly accept referrals, then tell the patient that his optometrist is not a real doctor," he says. "And I'd be telling my patients that I'm referring them to a specialist—inferring that they are going to someone higher.

"Now the ophthalmologist says, 'Dr. Reichle correctly diagnosed your disease and after you see me, I want you to go back to him.'

"And I now tell my patients I want to send them to an associate of mine."

Omega, with 26 centers across the country, is one of a new breed of "amiable" OD-administered referral setups. Omni, with 15 locations, is another. The centers are independent and provide tertiary care; the environment is guaranteed noncompetitive.

Due in large part to the success of these pioneering clinics, ODs elsewhere are jumping on the bandwagon. In Toledo, Ohio, for example, optometrists sat down with local ophthalmologists and expressed their frustration with their referral relationships. From that meeting, the Eye Center of Toledo was born, says center director Kevin L. Alexander, O.D., Ph.D.

All patients referred to the Toledo clinic see Dr. Alexander first and then one of four ophthalmologists on staff. Referring ODs get more involved in their patients' surgeries than elsewhere, Dr. Alexander adds. "Patients love this—their family optometrist, whom they've known for years, is there, giving them more attention."

Optometrists who are members of referral centers are assured that the ophthalmologist on staff is top-notch and that their patients will return, usually with compliments all around, adds Dr. Reichle.

These clinics also serve as excellent training grounds for students and residents, adds Robert Prouty, O.D., center director of the Denver Omni Eye Specialists. Although

the clinics are now independently owned and operated, center directors continue to network with colleagues and lecture often.

Dr. Borish, an outspoken advocate of comanagement centers, envisions a day when all eye care professionals have access to similar arrangements. "Every optometrist's office would be the entry point into eye care." Advertising on television, in the Yellow Pages, and in brochures could then tout "a cooperative arrangement of outstanding optometrists and ophthalmologists," he adds.

"Now, let's suppose we don't do this. With more and more cataract surgeries in fewer ophthalmologists' hands, that leaves the MDs with identical resources saying, 'look, we better form our own referral network before they (the ODs) do,' " Dr. Borish cautions.

"The ophthalmologist has painted himself into a high-tech corner," adds Dr. Leadingham, "and his or her only chance at long-term professional survival is to either adopt a primary care practice or one with a high economic return such as consulting networks with optometrists."

The "love affair" practitioners are having with referral centers may be cooling, however, says Dr. Alexander. Now that MDs have had a chance to observe how well optometric centers are working, he says, they are coming to the realization that all they really have to do is treat (optometrists) as the trained professionals they are.

The irony of the situation, Dr. Alexander adds, is that "ophthalmologists are now paying more attention to referral etiquette being more careful, getting letters back."

## THE FIRST CONSIDERATION

Keeping your patients is of obvious importance to your practice, and is worth the extra effort required to develop relationships with MDs and improve your interprofessional communication. But it is still only of secondary importance. The *first* consideration, as always, must be the patients' welfare.

Fortunately the best specialists almost invariably offer non-competing services, return your patients, and—out of respect for your abilities—leave the primary care to you.

*Barbara J. Munson is a freelance writer in Denver, Colorado. She is the former editor of the* American Optometric Association News.

## ESTABLISHING AND MAINTAINING GOOD REFERRAL RELATIONSHIPS

To initiate referral relationships, start by researching the ophthalmologists within a wide radius of your practice. Look for MDs who do not offer services similar to yours (including those who have ODs on staff). Ask colleagues to whom they refer.

If asked for referrals by an ophthalmologist, require that the relationship be a two-way street; say you expect referrals from them as well (point out your capabilities and specialties). Be sure of the MD's competence and compatibility.

To start a two-way referral system, suggest a lunch or dinner engagement to discuss basics. Initiate a second meeting at the MD's office; have him or her also visit yours.

Be specific about what you expect from the relationship, and work out as many details as you can prior to comanaging patients. Your part is to provide written reports and/or phone calls prior to referrals and as follow-up.

A few more tips:

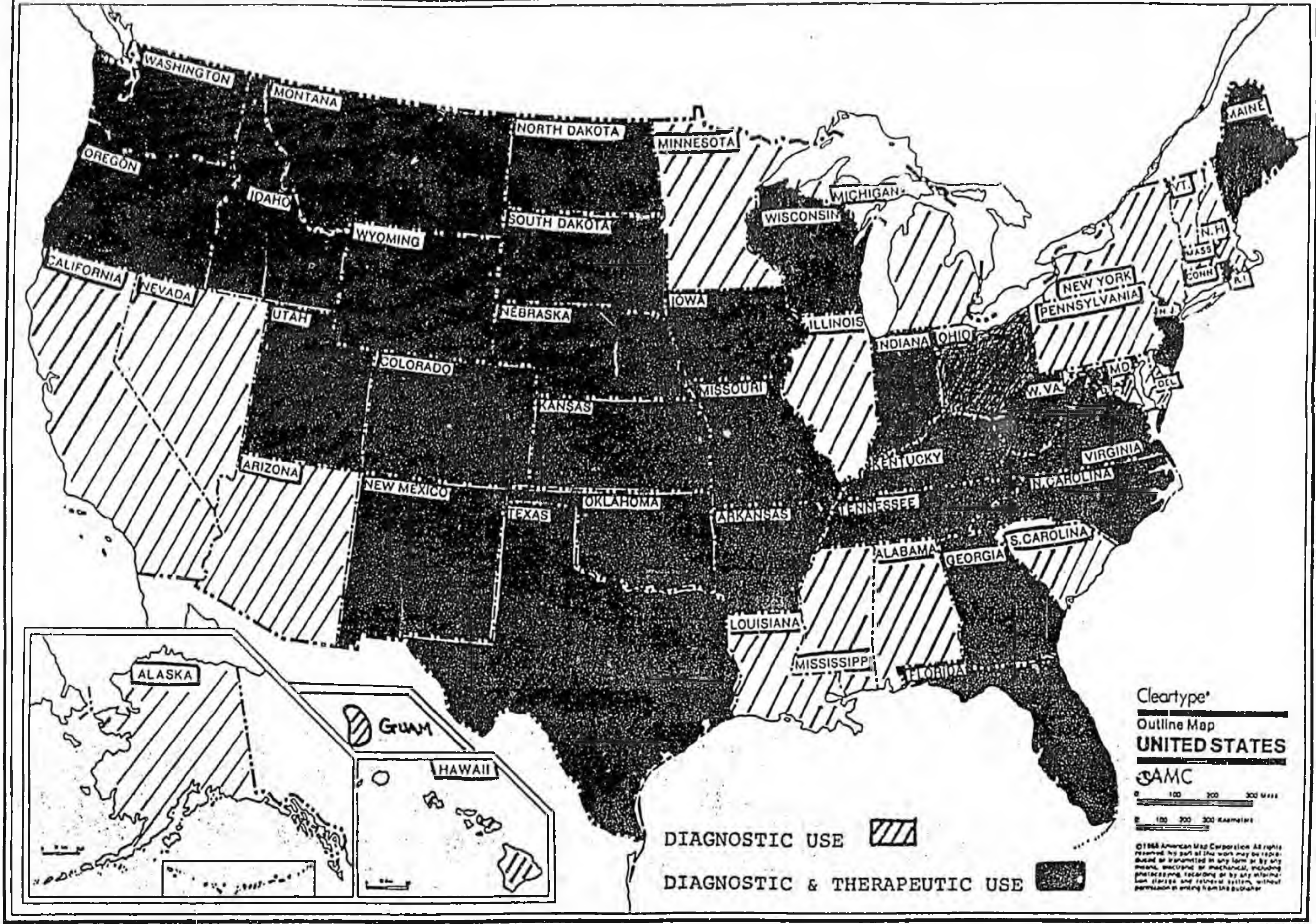
- Remember to thank colleagues for their referrals and compliment them on their good work.
- Keep the MDs abreast of new equipment and new policies in your office.
- Pass along articles and brochures you feel may be of interest to them.
- Introduce your staff to theirs.
- If there is a problem, don't let it persist.
- If a patient fails to return to you, call him or her and ask what the problem is.
- Talk to the MD as well; be candid.

Remember that communication, concern, and professionalism are the three key elements to a good referral relationship.

—*Barbara J. Munson*

STATUS OF PHARMACEUTICAL LEGISLATION

~~January~~ February 16, 1992



| STATE | DIAGNOSTIC USE | THERAPEUTIC USE |
|---|---|---|
| ALABAMA | * | |
| ALASKA | May 25, 1988 | |
| ARIZONA | April 25, 1980 | |
| ARKANSAS | April 2, 1979 | March 3, 1987 |
| CALIFORNIA | July 9, 1976 | |
| COLORADO | June 10, 1983 | April 20, 1988 |
| CONNECTICUT | April 2, 1986 | |
| DELAWARE | July 10, 1975 | |
| D.C. | March 25, 1986 | |
| FLORIDA | July 10, 1986** | July 10, 1986** |
| GEORGIA | February 14, 1980 | February 25, 1988 |
| GUAM | December 28, 1982 | |
| HAWAII | June 12, 1985 | |
| IDAHO | March 23, 1981 | March 31, 1987 |
| ILLINOIS | September 15, 1984 | |
| INDIANA | *** | *** |
| IOWA | June 8, 1979 | May 31, 1985 |
| KANSAS | April 12, 1977 (2:00 p.m.) | April 17, 1987 |
| KENTUCKY | March 29, 1978 | February 7, 1986 |
| LOUISIANA | July 6, 1975 | |
| MAINE | June 24, 1975 | June 25, 1987 |
| MARYLAND | January 13, 1989 | |
| MASSACHUSETTS | December 23, 1985 | |
| MICHIGAN | March 26, 1984 | |
| MINNESOTA | March 8, 1982 | |
| MISSISSIPPI | March 17, 1982 | |
| MISSOURI | July 24, 1981 | June 24, 1986 |
| MONTANA | April 12, 1977 (10:10 a.m.) | April 23, 1987 |
| NEBRASKA | February 13, 1979 | March 26, 1986 |
| NEVADA | May 25, 1979 | |
| NEW HAMPSHIRE | June 6, 1985 | |
| NEW JERSEY | * | January 16, 1992 |
| NEW MEXICO | March 4, 1977 | April 5, 1985 |
| NEW YORK | July 15, 1983 | |
| NORTH CAROLINA | June 3, 1977 | June 3, 1977 |
| NORTH DAKOTA | March 22, 1979 | April 10, 1987 |
| OHIO | March 15, 1984 | February 15, 1992 |
| OKLAHOMA | April 6, 1981 | March 22, 1984 |
| OREGON | May 20, 1975 | August 9, 1991 |
| PENNSYLVANIA | March 1, 1974 | |
| RHODE ISLAND | July 16, 1971 | June 26, 1985 |
| SOUTH CAROLINA | March 21, 1984 | |
| SOUTH DAKOTA | March 15, 1979 | March 15, 1986 |
| TENNESSEE | May 8, 1975 | April 22, 1987 |
| TEXAS | August 5, 1981 | June 15, 1991 |
| UTAH | March 21, 1979 | March 20, 1991 |
| VERMONT | April 23, 1984 | |
| VIRGINIA | February 25, 1983 | April 11, 1988 |
| WASHINGTON | April 23, 1981 | April 18, 1989 |
| WEST VIRGINIA | March 4, 1976 | March 4, 1976 |
| WISCONSIN | April 29, 1978 | August 3, 1989 |
| WYOMING | February 17, 1977 | March 2, 1987 |

*FOOTNOTE KEY:*

** = General legislation, favorable attorney general opinion.*

*** = Previous favorable attorney general opinion. Specific legislation enacted in 1986.*

**** = General legislation, favorable attorney general opinion. Legislation which would have prohibited pharmaceutical utilization defeated. Appeal from dismissal of litigation which would have prohibited pharmaceutical utilization denied by state supreme court, February 27, 1986. Clarification legislation adopted May 13, 1991.*