HB

151

[redacted] IOUSE COMMITTEE REPOI [redacted]

(7)

Date Referred to Committee: February 14, 2005 **FURTHER REFERRALS: Labor and Commerce**

Date of Committee Action: March 17, 2005

The HEALTH, EDUCATION AND SOCIAL SERVICES Committee considered: **HB 151**

HOUSE BILL NO. 151 **RESPONSIBILITY FOR CARE AFTER EYE SURGERY**

"An Act relating to provider responsibility for ocular postoperative care; and providing for an effective date."

Recommends it be replaced with [ ] HCS *or* [ ] CS *for* _____(_____)
For Senate Bills with new title: [ ] Technical Title [ ] New Title: HCR_____ **[ ] Same Title [ ] New Title**

[ ] attach amendments
[ ] add new referral to _____Committee
[ ] Letter of Intent_____Committee

List of Abbrev for Depts.:
ADM
CED
COR
CRT
EED
DEC
DFG
GOV
HSS
LEG
LAW
LWF
MVA
DNR
DPS
REV
DOT
UA

NEW **FISCAL NOTES** *Assigned by Chief Clerk's Office				
List by Dept(s):	*FN#	Fiscal	Indet.	Zero

PREVIOUS **FISCAL NOTES**				
List by Dept(s):	FN#	Fiscal	Indet.	Zero

Signing with recommendations	Printed Last Name	DP	DNP	NR	AM
	Cissna		✓		
	Gardner		✗		
	Anderson	✗			
	McGuire	✓			
	Seaton		✓		
	Kohring		✓		
Chair:	Wilson		✗		
Chair:					

ALASKA STATE HOUSE OF REPRESENTATIVES

Labor & Commerce Committee, Chair
Administrative Regulation Review, Chair
Judiciary Committee, Vice-Chair
Health, Education and Social Services

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Representative Tom Anderson

Email: Representative_Tom_Anderson@legis.state.ak.us

MEMORANDUM

Date: February 14, 2005

To: Representative Peggy Wilson, Chair
House Health, Education and Social Services Committee

From: Representative Tom Anderson

Re: HB 151

I respectfully request scheduling of HB 151 for consideration by the House HESS Committee.

Enclosed are:

1. The most recent version of the bill
2. Current Sponsor Statement
3. Sectional Analysis
4. Letters of support and other appropriate backup documentation

Thank you for your consideration of this request. Please contact Jon Bittner at 465-5031 in my office if you have any questions or concerns.

Alaska State Legislature
House of Representatives

Official Business

State Capitol
Juneau, AK 99801-1182

SPONSOR STATEMENT FOR HB 151
BY: Representative Tom Anderson

TITLE: "An Act relating to provider responsibility for ocular postoperative care; and providing for an effective date."

The majority of eye surgery preformed in the Untied States today is technologically advanced and is safer and more effective than ever before. The most common major eye surgery performed in the United States is cataract surgery; with more than 1.5 million cases a year. Cataract surgery has evolved to such an advanced state that many cases take less than 15 minutes to perform. The speed with which modern cataract surgery can be preformed has tended to trivialize the seriousness of this surgery in the publics' mind, causing patents to infer that it is risk free. No surgery is risk free, including short cases such as uncomplicated cataract surgery. However, complications do occur and can be serious. Permanent loss of vision and patient death are some of the more serious potential complications. It is important for postoperative care to be managed by an ophthalmologist familiar with the surgery and the potential complications.

Unfortunately, the reduction of surgical time for cataract surgery has led to the appearance of so-called "cataract mills" where patients are referred in large numbers by an optometrist and, in return for a "co-management fee", the referring optometrist is then allowed to manage the patient postoperatively. The operating surgeon, in this setting, often meets the patient just minutes prior to surgery and takes no responsibility after surgery. In some cases this surgeon may travel from cataract mill to cataract mill and is unavailable for any postoperative consultation or advice. The patient's follow-up care is therefore abandoned, by pre-arrangement, to the referring Optometrist who is not qualified by training or experience to handle any serious complications resulting from cataract surgery.

Another serious situation may arise as a result of the "cataract mill". Should the patient require hospitalization, the surgeon is unlikely to have local hospital privileges. The patient is then dumped on another ophthalmologist unfamiliar with the patient but now responsible for rendering critical care.

Co management of eye surgery as currently practiced in Alaska is a recipe for sub-optimal patient care. House Bill 151 addresses the issue of postoperative care for eye surgery in Alaska, taking into account the unusual and sometimes-difficult medical and surgical challenges our state often poses in terms of isolation, limited medical resources and transportation difficulties.

I urge your support for this legislation.

Alaska State Legislature

House of Representatives

Official Business

State Capitol
Juneau, AK 99801-1182

Sectional Analysis for HB 151

BY: Representative Tom Anderson

Section 1. Adds a new section to AS 08.64

Places limits on how and when a surgeon who performs eye surgery in this state may delegate responsibility to someone else for post-operative care of the patient

Section 2-3. Amends AS 08.64.370

Requires compliance with Sec. 1 of the bill by certain people who are exempt from licensing as physicians.

Section 4. Amends AS 08.64.380

Adds definition of "knowingly" which is a term used in secs. 1 and 3 of the bill.

Section 5 and 7 Amends the uncodified law of the State of Alaska and adds an effective date

These sections allow the State Medical Board to begin the regulations process before the rest of the bill takes effect.

Section 6. Amends the uncodified law of the State of Alaska

Applies the amendments made by the bill to eye surgery occurring on or after the effective date of secs. 1-4 of the bill

FISCAL NOTE

STATE OF ALASKA
2005 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: HB 151
() Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: Commerce
Title: Responsibility for Eye Care After Surgery
RDU: Occupational Licensing (117)
Component: Occupational Licensing
Sponsor: House Labor & Commerce
Requester: House HES
Component No.: 2360

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other 1156 - Receipt Supported Services						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2005) cost: 0.0
Mark this box (X) if funding for this bill is included in the Governor's FY 2006 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

HB 151 amends statutes of the State Medical Board to address provider responsibility for ocular postoperative care. New funds are not required to implement provisions of this bill.

Prepared by: Jennifer Strickler, Administrative Manager
Phone (907) 465-2144
Division: Occupational Licensing
Date/Time 2/28/05 12:21 PM
Approved by: Edgar Blatchford, Commissioner
Date 2/28/2005
Agency: Commerce, Community, and Economic Development

PHONE ♦ 907/463-5486 FAX ♦ 907/463-3275

Kito, Inc.
525 W 10th STREET
JUNEAU, ALASKA 99801

Fax

To:	Rep. Peggy Wilson	**From:**	Marit Carlson-Van Dort
Fax:	465-3175	**Pages:**	5
Phone:	465-3824	**Date:**	2/28/05
Re:	HB 151	**CC:**	

☐ **Urgent** ☒ **For Review** ☐ **Please Comment** ☐ **Please Reply** ☐ **Please Recycle**

Rep. Wilson & Staff-

Please review this study that relates to HB 151. The study indicates that comanaged postoperative care is indeed effective without compromising patient health or welfare. We will be providing testimony against HB 151 for reasons related in this study. Please do not hesitate to contact our office with any questions or concerns.

Thank-you,

Marit Carlson-Van Dort

PRIMARY CARE OPTOMETRY NEWS 2/1/2005

Study: Comanagement results in 'excellent' patient outcomes

The study also validates previous studies that indicated cataract surgery results in improved visual functioning.

Evan B. Dreyer, MD; David Zurakowski, PhD; James P. Mondzelewski, MD

Cataract surgery has been shown to have a substantial impact on quality of life for individuals with visual compromise secondary to cataract. Techniques for cataract extraction have been revolutionized in the past decades, shortening recovery time and increasing both the surgeon's and the patient's expectations for visual outcome.

Multiple studies in the past decade have also shown that simple measurements of Snellen or related forms of acuity do not suffice to evaluate outcomes of cataract surgery. This deficit led to the development of several quality of life measurements, with later versions evaluating the impact that visual compromise or its rehabilitation had on quality of life. The VF-14, developed in 1993-1994, has been the most widely reported, but two recent enhancements, the VFQ-25 and VFQ-39, have also been proposed.

In an effort to explore the utility of these instruments, as well as to assess the impact of cataract surgery on visual quality in a suburban practice, we asked 100 consecutive patients scheduled to undergo cataract surgery in a suburban Pittsburgh cataract practice to fill out the VFQ-39. We also assessed the impact of comanagement on patients' perception of outcome.

The practice of comanagement — where a portion of the postoperative care is delegated to members of the optometric community — has come under fire recently from several directions. Revicki and colleagues have evaluated this issue before and found little cause for concern (Revicki DA, Poe ML. Quality of care in cataract surgery cases experiencing post-operative complications with co-managed care. *J Am Optom Assoc.* 1995;66:268-273. Revicki DA, Brown RE, Adler MA. Patient outcomes with co-managed post-operative care after cataract surgery. *J Clin Epidemiol.* 1993;46:5-15.). However, it is clear that if one accepts that the good of the patient is the pre-eminent concern in all such decisions, it would be prudent to re-evaluate the effect of postoperative management of the cataract patient on outcomes.

Study methods

A cohort of 100 consecutive patients were enrolled in this study. Patients were included only if they had voluntarily requested comanagement arrangements with an optometrist and excluded if they were unable to comprehend the directions or unwilling to complete the study. All patients were provided with copies of the VFQ-39 during one of the preoperative visits and asked to complete the questionnaire in the office.

Dr. Mondzelewski performed small-incision phacoemulsification cataract surgery with implantation of a monofocal foldable acrylic lens on all patients. Most cases were performed under topical anesthesia. Dr. Mondzelewski saw the patients 1 day postop in his office, and the patients were again evaluated at 1 week postop. Once deemed stable, these patients were then referred, as per the patient's request, to an outside optometrist for the duration of the postoperative period. Under no circumstances was any inducement supplied to the patient either to remain under the care of the operating surgeon or to return to the referring optometrist.

Patients were mailed copies of the same survey 8 weeks after the date of surgery and were asked to return the survey via mail. In an effort to allow comparison with earlier published studies, we included patients only if they were phakic in both eyes at the time of entry into the study. Data, therefore, allow for evaluation of the impact of first-eye surgery on quality of life.

Scoring the test results

Visual function scores were compared between Mangione's cataract population and preoperative results of our surveyed study group using the two-sample student's *t*-test. Similarly, results of Mangione's normal reference population were compared to postoperative visual functioning of the surveyed study group using student's *t*-tests. Preop and postop data were evaluated by paired *t*-tests, because all continuous variables followed a normal distribution as evaluated using the Kolmogorov-Smirnov test (Armitage P, Berry G, Matthews JNS. *Statistical Methods in Medical Research*. 4th ed. Oxford, England: Blackwell Science. 2002:359-373.).

Comparing patient groups

Seventy-one (71%) of the initially enrolled patients returned the second survey, and only these patients are included in the statistical analysis.

Results were compared with those reported by Mangione for both cataract patients and controls (Mangione CM, Lee PP, Pitts J, et al. Psychometric properties of the National Eye Institute Visual Function Questionnaire (NEI-VFQ). NEI-VFQ Field Test Investigators. *Arch Ophthalmol*. 1998;116:1496-1504.).

Subscales	Mangione (n=93)	Our Preop (n=71)	p Value
General health	55 ± 25	56 ± 23	0.79
General vision	60 ± 17	57 ± 15	0.24
Near vision	73 ± 21	69 ± 20	0.22
Distance vision	73 ± 22	73 ± 22	0.99
Driving	63 ± 30	67 ± 22	0.35
Peripheral vision	37 ± 21	32 ± 23	0.15
Color vision	90 ± 20	95 ± 13	0.07
Ocular pain	36 ± 19	35 ± 19	0.74
Vision-specific role difficulties	76 ± 22	75 ± 25	0.79
Dependency	38 ± 20	36 ± 24	0.56
Social functioning	37 ± 19	50 ± 17	0.30
Mental health	77 ± 22	72 ± 26	0.18

Note: Data are presented as mean ± SD. P values are based on student's t-tests.

We made the first comparison (see table above) between Mangione's cataract population and the preoperative surveys in this study. For each of the 12 subscales in this table (VFQ-25), the sample sizes of 93 and 71 in the cataract reference group published by Mangione and colleagues and the preoperative group provided 80% power (ß=0.2) to detect significant differences of an effect size magnitude of 0.5 for each subscale between the groups based on two-tailed Bonferroni corrected student's *t*-test. The sample sizes provide 90% power to detect slightly larger differences (i.e., effect sizes of 0.65) between the two groups. These power calculations were performed with the nQuery Advisor software program (version 5.0, Statistical Solutions, Boston).

An effect size in power analysis is defined as the mean difference divided by the estimated average standard deviation of the two groups. Effect sizes of 0.5 and 0.65 are considered small, and given that no significant differences were detected (all $p>0.05$) with respect to any of the subscales in the first table, one can safely conclude that the groups are essentially comparable. Therefore, the cataract patients included in this study are similar to the Mangione cataract group (Mangione CM, Lee PP, Pitts J, et al. Psychometric properties of the National Eye Institute Visual Function Questionnaire (NEI-VFQ). NEI-VFQ Field Test Investigators. *Arch Ophthalmol*. 1998;116:1496-1504.).

Subscales	Preoperative (n=71)	Postoperative (n=71)	p Value
General health	56 ± 23	58 ± 21	0.43
General vision	57 ± 15	81 ± 16	<0.001
Near vision	69 ± 20	87 ± 20	<0.001
Distance vision	73 ± 22	90 ± 17	<0.001
Driving	67 ± 22	85 ± 17	<0.001
Peripheral vision	32 ± 23	93 ± 18	<0.001
Color vision	95 ± 13	97 ± 8	0.24
Ocular pain	85 ± 19	92 ± 11	<0.001
Vision specific role difficulties	75 ± 25	90 ± 20	<0.001
Dependency	86 ± 24	93 ± 18	<0.01
Social functioning	90 ± 17	97 ± 12	<0.001
Mental health	72 ± 26	88 ± 19	<0.001

Note: Data are presented as mean ± SD. P values are based on paired t-tests

Subscales	Preoperative (n=71)	Postoperative (n=71)	p Value
General health	65 ± 22	69 ± 19	0.32
General vision	58 ± 16	81 ± 17	<0.001
Near vision	73 ± 19	89 ± 17	<0.001
Distance vision	77 ± 20	92 ± 16	<0.001
Driving	67 ± 22	85 ± 17	<0.001
Peripheral vision	32 ± 23	93 ± 18	<0.001
Color vision	95 ± 13	97 ± 8	0.24
Ocular pain	85 ± 19	92 ± 12	<0.001
Vision-specific role difficulties	78 ± 24	90 ± 18	<0.001
Dependency	85 ± 23	93 ± 18	<0.01
Social functioning	90 ± 16	97 ± 12	<0.001
Mental health	73 ± 26	88 ± 18	<0.001

Note: Data are presented as mean ± SD. P values are based on paired t-tests

The two tables above indicate the effect of cataract surgery on quality of life using the VFQ-25 and VFQ-39. Both instruments revealed a significant improvement in every subscale except color vision and general health.

The table below compares Mangione's normal population with the postoperative visual functioning of our study group (Mangione CM, Lee PP, Pitts J, et al. Psychometric properties of the National Eye Institute Visual Function Questionnaire (NEI-VFQ). NEI-VFQ Field Test Investigators. *Arch Ophthalmol.* 1998;116:1496-1504.).

Subscales	Mangione Reference (n=122)	Postoperative (n=71)	p Value
General health	69 ± 24	58 ± 2[illegible]	<0.01
General vision	83 ± 15	81 ± 16	0.38
Near vision	92 ± 13	87 ± 20	<0.05
Distance vision	93 ± 11	90 ± 17	0.14
Driving	87 ± 18	85 ± 17	0.45
Peripheral vision	97 ± 10	93 ± 18	<0.05
Color vision	98 ± 8	97 ± 8	0.24
Ocular pain	90 ± 15	92 ± 1[illegible]	0.33
Vision-specific role difficulties	93 ± 13	90 ± 20	0.21
Dependency	99 ± 5	93 ± 18	<0.001
Social functioning	99 ± 3	97 ± 12	0.08
Mental health	92 ± 12	88 ± 19	0.07

Note: Data are presented as mean ± SD. P values are based on student's t-tests.

We did find differences with respect to certain subscales listed in the table comparing Mangione and colleagues' reference group (n=122) with our postoperative group (n=71). Cataract surgery appears to have restored normal visual functioning in all categories except general health, near vision, peripheral vision and dependency. Power was excellent to detect even small mean differences, as shown in the table (general health, near vision, peripheral vision, dependency). Again, we are refering to small differences of an effect size magnitude of 0.5.

For example, for general health, the mean difference between the two groups was 11 points, and the common or pooled standard deviation was (24+21)/2 or approximately 22 points. Hence, the effect size is 11/22=0.5. Clearly, with sample sizes of 122 and 71, there was sufficient power for detecting "small," but clinically meaningful differences.

Previous results validated

Our study appears to validate, in part, Mangione's VFQ-25 and VFQ-39 inasmuch as cataract surgery resulted in detectable measurable improvement in visual functioning, a finding noted in multiple prior studies. The population studied here was not different from Mangione's cataract population. Most interestingly, cataract surgery restored normal visual functioning in all except two vision-based categories (near vision and peripheral vision). It must be noted that this comparison was between an age group that has undergone cataract surgery with a younger, otherwise healthy population This may account for these differences as well as the failure to improve general health and dependency.

A secondary outcome of this study was the impact of comanagement on the outcome of surgical intervention for cataract surgery. It was not possible in this study to compare a non-comanaged group with the study population. This will be undertaken in future work. However, given that the intervention performed here restored normal visual functioning in nearly all categories, it is difficult to imagine that greater improvement will be seen in patients who are not comanaged. Therefore, it is a reasonable conclusion that comanagement does not lessen the quality of the outcome after cataract surgery, and in fact seems to result in excellent patient outcomes.

For Your Information:

- Evan B. Dreyer, MD, and James P. Mondzelewski, MD, are staff members at Glaucoma and Cataract Consultants in Pittsburgh and can be reached at Glaucoma-Cataract Consultants, 1050 Bower Hill Rd., Suite 104, Pittsburgh, PA 15243; (412) 572-6121; fax: (412) 571-1327; e-mail: dreyer@fastmail.fm.
- David Zurakowski, PhD, is from the departments of orthopaedic surgery and biostatistics, Children's Hospital, Harvard Medical School, Boston.

ALASKA OPTOMETRIC ASSOCIATION

FACSIMILE TRANSMITTAL SHEET

TO: Representative Wilson

FROM: Alaska Optometric Association

COMPANY:

DATE: 2/28/05

FAX: 907-465-3175

PAGES: 7

PHONE:

RE: HB 151 – Co-Management Study

COMMENTS:

CONFIDENTIALITY NOTICE-

QUALITY OF CARE IN CATARACT SURGERY CASES EXPERIENCING POST-OPERATIVE COMPLICATIONS WITH CO-MANAGED CARE

DENNIS A. REVICKI, PH.D.
MARY L. POE, B.S.

ABSTRACT

Background: The quality of co-managed services and the ability of community optometrists to diagnose complications following cataract surgery were investigated in a previous study of 2,458 cases. Questions were raised about the quality of co-managed care in 50 of the cases; this study evaluates the care received by these patients.

Methods: Medical records for 44 cases (6 cases could not be located) were reviewed to determine whether community optometrists diagnosed post-surgical complications and whether cases were effectively managed. All reviews were performed by two optometrists and an ophthalmologist. Six cases were excluded because of no complication or attribution to underlying disease.

Results: In 34 of the 38 remaining cases (89.5%), co-management was successful in diagnosing complications and in managing the patient to maximize vision function. 99.8% (2,454 of 2,458) of co-managed cases contained evidence that the optometrists provided high quality post-operative care and were able to diagnose complications. Using physician evaluations as the standard, the sensitivity of detection of complications by optometrists was 95.9% and the specificity was 99.5%.

Conclusions: Co-managing optometrists provide quality care and can diagnose post-operative complications.

KEY WORDS: Quality of care, co-managed care, cataract surgery, post-operative complications, optometrists

Revicki DA, Poe ML. Quality of care in cataract surgery cases experiencing post-operative complications with co-managed care. J Am Optom Assoc 1995; 66(5): 268-73

Cataract surgery is one of the most frequent outpatient procedures performed in the United States. It has been estimated that 1,350,000 cataract surgeries were performed on persons covered by Medicare in 1991 and that $3.5 billion was expended by Medicare for cataract surgery related services in that year.[1] Given the large number of cataract surgeries performed annually, the quality of care received by patients undergoing these procedures is an important health care issue. In 1993, the Agency for Health Care Policy and Research published clinical practice guidelines for cataract surgery.[2]

An important development in cataract surgery has been the use of co-managed services during the post-operative period. Co-management allows optometrists and ophthalmologists to coordinate the delivery of services to patients following cataract surgery. In the usual case, a patient is referred by the optometrist to the ophthalmologist when the need for cataract surgery is indicated. The opinthalmologist evaluates the patient and performs the surgery, and the patient is thereafter followed by the ophthalmologist and optometrist. The co-management of post-surgical care is allowed in all states. This expansion of services provided by optometrists has been viewed by some as controversial. Questions have been raised concerning the quality of care delivered by optometrists, with special emphasis on the ability of optometrists to detect and diagnose post-operative problems.[3,4]

Revicki et al.[5] examined 2,458 cases involving co-managed care after cataract surgery. The vision outcomes in these cases and the rates of post-operative complication were comparable to those in the published medical literature. In 87% of these cases vision outcomes of 20/40 or better were obtained; for cases with no evidence of pre-existing ocular conditions or chronic medical problems, 92% had successful vision outcomes. For the study, successful outcomes were defined as a visual acuity of 20/40 or better. Post-operative complications occurred in 7% of cases. The rate of complications ranged from 0.04% (for endophthalmitis/hypopyon) to 2.0% (for bullous keratopathy/significant corneal edema), with most rates under 1%.[5] A recent comprehensive review of outpatient cataract surgery found that the rate of different complications occurring after cataract surgery ranged from 0.1% to 2.4%.[6]

The study by Revicki et al.[5] noted that the overall accuracy of the assessment of post-operative complications by optometrists was 95.8% (using ophthalmologist examinations as the standard). Community optometrists — practitioners not working directly for the surgical centers — detected complications in 72 of

122 cases in which the complications occurred after the patient was released by the surgeon for follow-up care. For the remaining 50 cases with complications, however, there was uncertainty about the quality of care, given the data collected, and whether the community optometrists detected the complications. This issue is important since failure to identify and effectively manage post-operative complications may result in patient pain and discomfort, vision loss, and blindness.

This study was designed to examine the medical records of the 50 cataract surgery cases in which there was some uncertainty about the quality of co-managed care. The records of co-managing ophthalmologists and optometrists were obtained and reviewed to determine whether the optometrists detected post-operative complications, the pattern and use of co-managed services, the vision outcomes, and whether these cases were effectively managed after surgery.

Methods

DATA SOURCE

This study is an extension of a larger retrospective study of the outcomes of co-managed services in cataract surgery in five ambulatory eye centers in the United States.[5] In the previous study, data were collected on consecutive cataract surgery procedures with intraocular lens (IOL) implant during the seven month period between January 1 and July 31, 1988. Cataract surgery cases were identified from surgical logs, while data on vision outcomes, post-operative complications, and post-operative services were collected from medical records. Co-managed care was defined as at least one post-operative care visit to a community optometrist within 90 days following cataract surgery.

In the current study, we identified the 50 cases in which post-operative complications occurred and there was uncertainty about the process of co-managed care. These cases represented 2% of the total co-managed cases in the previous study. The ambulatory eye care centers were contacted and, for each case, we requested the complete pre-operative evaluation records and all notes and records describing post-operative medical services provided by the ambulatory eye care center. In addition, we contacted the community optometrists and requested copies of all records on post-operative services delivered for the 120 days after cataract surgery. In 6 cases full sets of records could not be obtained. This study is based on the 44 (88%) cases in which optometrist and center records could be located.

DATA COLLECTION PROCEDURES

Data on demographic characteristics, pre-existing ocular and medical conditions, and the surgical procedure used for cataract extraction were obtained from the original study data files. Forms were developed to collect data on all post-operative services, post-operative complications, and visual acuity outcome measurements for the 120 days after the surgery. A trained research nurse abstracted information from eye care center and community optometrist records using this standardized data collection form.

DEMOGRAPHIC & MEDICAL CHARACTERISTICS

Age (in years) and gender of patients was recorded. Data were collected on the presence of pre-existing ocular conditions (i.e., glaucoma, diabetic retinopathy, macular degeneration, corneal guttata/Fuch's dystrophy) that could be related to visual acuity outcome.[7] Data were also gathered on the presence of several chronic medical conditions (i.e., cardiovascular disease, diabetes mellitus, renal disease, pulmonary disease) as indicators of general health status. Co-morbidity, when combined with age, preoperative visual acuity, and frequency of reading, has been demonstrated to predict surgical success in cataract patients.[7,8]

CATARACT SURGERY PROCEDURE

Information was collected on the method of lens extraction used, the eye operated on, and the date of surgery.

POST-OPERATIVE MANAGEMENT

The date, eye care provider and main actions for each visit within 120 days of surgery were collected for each eye included in the study. The provider of services was either the practitioner at the ambulatory eye care center or the community optometrist. Actions taken by practitioners included referral to the center, telephone consultation with the center ophthalmologist, further diagnostic evaluations, and scheduling of a follow-up visit.

VISUAL ACUITY MEASUREMENTS

Pre- and post-operative visual acuity measurements were recorded for all cases. For the majority of these patients, potential acuity meter and super pinhole test results were recorded. The corrected visual acuity for each post-operative visit during the 120 days following cataract surgery was abstracted from the records. Successful vision improvement was defined as a visual acuity of 20/40 or better.[2,6]

POST-OPERATIVE COMPLICATIONS

There are a number of complications which may follow cataract surgery; some are temporary and do not result in

impaired vision, some cause discomfort with little long-term vision effects, while others are serious and may result in decreased vision.[24] Complications, notably corneal edema and hemorrhage in the anterior chamber, frequently occur immediately following surgery but resolve spontaneously. Persistence of these conditions, however, may indicate a serious problem. The medical records were examined to identify the onset of complications which may result in poor visual acuity outcomes. The complications included were:

- endophthalmitis/hypopyon
- chronic uveitis
- bullous keratopathy/significant corneal edema
- secondary glaucoma
- wound rupture (e.g., iris prolapse)
- pupillary block
- detached retina
- cystoid macular edema
- lens dislocation.

Data on posterior capsule opacification or secondary capsulotomy were also collected. For this study, if a complication occurred at any time within 120 days of surgery, it was recorded as present. Complications were recorded as present if there was clear evidence of the complication in provider notes or in test results contained in the medical record.

QUALITY OF CARE REVIEWS

An ophthalmologist and two optometrists who were not part of the original study but who were experienced in conducting quality of care reviews of community optometrists and of ambulatory eye care center medical records were recruited to evaluate each case. The reviewers were asked to evaluate whether the community optometrist recorded signs and symptoms of the post-operative complication; how accurately the optometrist assessed the complication; and the overall quality of post-operative care delivered to the patient. The overall quality of care was scored on a five-point scale ranging from outstanding (1) to poor (5).

After the three practitioners completed their independent reviews, a telephone conference call was scheduled to reach consensus on all ratings. During this meeting the discussion continued until consensus was reached. However, consensus was not required for the overall rating of the quality of co-managed care.

DATA ANALYSIS

Descriptive statistics (e.g., means, standard deviations, frequency distributions) were calculated for all study variables. Comparisons were made between the cases under study and the complete study with respect to vision outcomes and service utilization. We examined the pattern and content of visits to center providers and community optometrists. Best visual acuity outcomes within 120 days of cataract surgery were determined, with 20/40 acuity or better being used to define success. Sensitivity and specificity of the detection of post-operative complications by community optometrists were calculated, using the 1,322 cases from the complete study in which there were ophthalmologist evaluations following management by an optometrist. Physician evaluations were used as the standard for the sensitivity and specificity calculations.[8]

Results

Ambulatory eye care center and community optometrist records were located for 44 of the 50 cases (88%). The 6 cases that could not be located did not differ from the 44 that were located in terms of demographic and medical characteristics.

Descriptive information on the 44 cases is summarized on Table 1. The average age of each patient was 74.9 years (SD = 8.1); 61% of patients were women. Cataract surgery was performed on both eyes in 11% of cases during the 7 month study; 89% of the cataract surgeries involved phacoemulsification while the remaining 11% were extracapsular procedures. In 82% of the cases there was a pre-existing ocular or chronic medical condition. Compared to the total group of co-managed cases, these patients were slightly older and more likely to have one or more pre-existing ocular conditions (Table 1).

POST-OPERATIVE COMPLICATIONS

The reviewers identified 2 cases in which no post-operative complication occurred, 2 cases in which the complication occurred but was due to a pre-existing medical condition, and 2 cases in which the complication occurred outside of the 120 day evaluation period. Signs and symptoms of macular degeneration in one case and of diabetic retinopathy in another case were thought to be secondary to pre-existing medical conditions and thus did not constitute post-operative complications. In one case, conjunctivitis was diagnosed 5 months after the surgery, while in another symptoms of uveitis were noted 6 months after the surgery; both complications occurred well after the 120 day evaluation period. Thus 6 cases were excluded from further evaluation in the study.

The post-operative complications observed in the 38 remaining cases included cystoid macular edema (39.5%), chronic uveitis or iritis (15.8%), and bullous keratopathy or significant corneal edema (10.5%). Increased intraocular pressure was observed in 7 cases (18.4%). Lens dislocation occurred in one case and wound ruptures occurred in 6

cases (15.8%). Posterior capsule opacification occurred in 34.2% of these cases.

CO-MANAGED POST-OPERATIVE CARE

Review of the surgical center and community optometrist records indicated that 34 of the 38 cases (89.5%) were successfully managed (Table 2). Center providers diagnosed 41.1% of the complications and community optometrists diagnosed 57.9%. In 12 of these cases (31.6%), the center providers noted a post-operative complication before returning the patient to the optometrist's case. The community optometrist diagnosed or noted a problem in 19 of the 26 remaining cases. In 3 of these 26 cases, the medical records contained evidence of either telephone consultation, referral to the ambulatory eye care center, or both, for management of complications.

Thus, there were 4 cases out of the total of 2,458 (0.16%) in which the evidence suggested that the community optometrist may not have detected a complication which was later diagnosed by a center provider. In 2 cases, the post-operative complications (secondary glaucoma and cystoid macular edema) were diagnosed a month after the last visit to the optometrist. In the 2 other cases bilateral uveitis (which was considered to constitute 2 cases) was diagnosed by center providers in a bilateral pseudophakic patient one week after a follow-up visit to a community optometrist. There is some indication, however, based on telephone conversations, that the patient was sent to the surgical center for care after the community optometrist suspected a complication.

The post-operative problems diagnosed by center providers after a one month interval were most likely not present when the optometrist last evaluated the patient. If this is a reasonable assumption, then in only 0.08% (2 of 2,458) cases is there any question about the accurate detection of post-operative complications by community optometrists following cataract surgery. Therefore, in 29 of the 38 cases the community optometrists noted the signs and symptoms of the post-operative complication.

QUALITY OF CARE REVIEW

The reviewers determined that in 92% of the cases the quality of care was judged as average or better; in 68% of cases the care was rated as good or outstanding.

SENSITIVITY AND SPECIFICITY OF DIAGNOSES

There were 1,316 cases in which an ophthalmologist examined the eye after management by a community optometrist. Using ophthalmologist examinations as the standard, the sensitivity of the diagnosis of complications by community optometrists was 95.9%; the specificity was 99.5%. The positive predictive value was 94.0% and the negative predictive value was 99.7%. The overall accuracy of the assessment of post-operative complications by optometrists was 99.2%.

Table 1. DEMOGRAPHIC AND MEDICAL CHARACTERISTICS OF TARGET AND TOTAL CO-MANAGED CASES

	Target Cases	Co-Managed Cases
Patients		
Number	44	2,034
Mean age (standard deviation)	74.9 (8.1)	72.9 (10.4)
Women (%)	61.4	62.5
Eyes		
Number	44	2,408
Pre-Existing Ocular Conditions (%)		
Glaucoma	9.1%	5.4%
Diabetic retinopathy	0.0%	2.6%
Macular degeneration	18.2%	13.1%
Corneal guttata	9.1%	6.1%
Pre-Existing Medical Conditions (%)		
Diabetes mellitus	11.4%	16.6%
Cardiovascular disease	63.6%	55.9%
Renal disease	2.3%	3.5%
Pulmonary disease	9.1%	9.6%

POST-OPERATIVE SERVICE USE

The average number of post-operative visits was 5.88 (SD = 2.13; range, 3 to 14 visits) for these 38 cases compared to an average of 4.73 (SD = 1.64) visits for cases without complications and 6.23 (SD = 2.05) visits for all cases with complications. Eighty-two percent of the 38 cases had five or more post-operative visits. There was an average of 2.88 (SD = 2.11) center visits and 3.00 (SD = 1.41) optometrist visits for these 38 cases. Optometrists provided all medical care as indicated for all patients. Scheduled follow-up appointments were noted for 86.8% of the visits.

VISION OUTCOMES

Eighty-four percent of the 38 cases had a

final visual acuity of 20/40 or better within 120 days of cataract surgery. This vision outcome compares with 87% for cases not experiencing post-operative complications and 71% for those patients with post-operative complications from the previous study.[5]

Discussion

This study evaluated the quality of co-managed care in 44 cases derived from a large retrospective study of 2,458 post-surgical cases. In these 44 cases there was some uncertainty about the quality of care provided by optometrists. After careful review it was determined that 6 of the 44 cases did not contain evidence of valid post-operative complications. The findings of this study indicate that for 95% of the remaining 38 cases, co-management was successful in detecting complications and in properly managing the patients so as to maximize vision function. Eighty-four percent of the cases had successful vision outcomes.

There were only 4 cases in which there was some uncertainty about whether the community optometrist correctly detected or suspected a post-operative complication. In 2 of these cases, the complication was diagnosed by center providers one month after the patient's last visit to the optometrist. It is possible that at the time of the optometrist's evaluation, no signs or symptoms of the complication were present. For the remaining 2 cases (involving one patient), there was some evidence that the patient was sent to the eye care center for further diagnostic evaluation and treatment of suspected uveitis, but the records of the optometrist did not clearly document this action. Based on these data and data from the larger study,[5] 99.8% (2,454 of 2,458) of cases evaluated contained evidence that the providers involved in co-management provided quality post-operative care.

The overall accuracy of the diagnosis of post-cataract surgery complications by optometrists was 99.2%, with a specificity of 99.5% and a sensitivity of 95.9%. These data suggest that community optometrists can and do diagnose complications with satisfactory accuracy when they occur in patients following cataract surgery.

When a complication was identified or suspected, follow-up visits were scheduled or the patient was referred to the eye care center for diagnostic evaluation and treatment. There was also evidence that co-managing optometrists made telephone contact with the center ophthalmologist to discuss the condition of the patients' eyes. There was also documentation in many of the eye care center records, including copies of letters, concerning the information supplied by the center providers to the community optometrists about the condition of patients and scheduled follow-up evaluations.

There were some caveats which should be taken into account when interpreting the results of this study. First, we could locate both eye center and community optometrist records for only 44 of 50 cases (88%). This percentage is comparable to the percentages reported in other studies using hospital or medical records.[10] Although the remaining 6 cases might contain information which documents poor quality co-managed care, there are no differences between the demographic characteristics of these 6 cases and the 44 cases that were used for the study. Even if all the missing cases contained evidence of poor quality co-managed care (a highly unlikely circumstance), 99.6% of the total number of cases (2,448 of 2,458) would still suggest that quality care was rendered.

Second, the data for this study came from a retrospective review of community optometrist and ambulatory eye care center records. Problems associated with retrospective data collection from medical records (e.g., missing or incomplete data, unstandardized measurements) are shared by this research. The records used for this study were not collected for research purposes and therefore may incompletely describe the actual delivery of post-operative services.

In summary, the findings suggest

Table 2. SUMMARY OF CLASSIFICATION OF CO-MANAGED CATARACT SURGERY CASES FROM TARGET SAMPLE AND TOTAL SAMPLE

	Target Sample n	(%)	Total Sample n	(%)
Number of Cases	50	(100%)	2,458	(100%)
Status of Cases				
No complications	6	(12.0%)	2,294	(93.3%)
Complications	38	(76.0%)	164	(6.7%)
Unknown status	6	(12.0%)	6	(0.25)
Total cases	50	(100.0%)	2,458	(100.0%)
Cases with complications	38	(100.0%)	164	(100.0%)
Physician diagnosed before co-management	12	(31.6%)	60	(36.6%)
Optometrist diagnosed or suspected	22	(57.9%)	94	(57.3%)
Not diagnosed by optometrist	4	(10.5%)	4	(2.4%)
Total cases	38	(100.0%)	164	(100.0%)

that community optometrists participating in the co-managed post-operative follow-up of cataract surgery cases delivered high quality services. They were able to detect post-operative complications in 99% of cases. More importantly, successful vision outcomes were achieved in 84% of cases in which there were post-operative complications, a result which is comparable to other studies of vision outcomes in cataract surgery.[2,5,6,11]

Prospective studies with random assignment and systematic and blinded outcome assessment are needed to document whether co-managed care produces vision outcomes and complication rates comparable to those attained by ophthalmologist managed post-cataract surgical care. The findings of this study suggest, however, that optometrists participating in co-management can detect complications and deliver quality post-operative care to cataract surgery patients.

Acknowledgments

This study was made possible by a grant from the American Optometric Association.

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Submitted 11/94; Accepted 3/95

From the Battelle Centers for Public Health Research and Evaluation, Arlington, VA and the Department of Health Policy and Administration, University of North Carolina, Chapel Hill, NC.

From: John Demske [mailto:johndemske@hotmail.com]
Sent: Sunday, February 27, 2005 11:20 AM
To: Rep. Peggy Wilson
Cc: Rep. Kurt Olson; Rep. Mike Chenault
Subject: HB 151

Hello Representatives Wilson, Chenault and Olson,

I'm writing regarding HB 151, which is presently in the House HESS committee.

If this bill was in the court system, it would be thrown out as a frivolous lawsuit.

It is nothing more than a vendetta against Bob Ford, an excellent surgeon who resides in the state of Washington and does cataract sugery in Alaska. And the well-heeled Alaska surgeons who introduced this bill saw their piece of the pie get a little smaller. His fees are also lower than any of the eye surgeons in Alaska.

Just this morning while reading journals, I read an article written by two private ophthalmologists from Pittsburgh and a Ph.D. researcher from Harvard Medical School. Their conclusion: **"Therefore, it is a reasonable conclusion that comanagement does not lessen the quality of the outcome after cataract surgery, and in fact seems to result in excellent patient outcomes."**

And yes, I refer patients to Dr. Ford routinely. I asked my mother to travel to Alaska from Wisconsin so he could do her cataract surgery. There are patients who would rather travel from Homer, Kenai & Soldotna to Anchorage to see Dr. Ford than see one of the Peninsula surgeons.

It's my humble opinion that this bill is nothing more than an attempt by a bunch of surgeons to increase their piece of the pie.

Respectfully,

John A. Demske, O. D.

Soldotna Optometry Clinic
155 Smith Way, Suite 202
Soldotna, Alaska
99669

CC: Representative Mike Chenault, Representative Kurt Olson

Alaska Society of Eye Physicians & Surgeons
6100 Kalmia Drive
Anchorage, Alaska 99507
907-563-8526

2/27/05

State House of Representatives
House Health Education & Social Services Committee:

Dear Representative Wilson

I am writing this letter to express the support of the Alaska Society of Eye Physicians & Surgeons for HB 151. The American Academy of Ophthalmology, the national association of ophthalmologists, also endorses HB 151. HB 151 would establish necessary guidelines in Alaskan state law for provider responsibility for ocular post-operative care. The bill is intended to close a loophole in the existing law that allows for potential abuses of co-management arrangements between providers due to incentives not related to the care of the patient.

The scope of this bill is thoughtfully limited to ocular post-operative care. Ocular care is one of the rare areas in medicine where non-physicians inappropriately perform post-operative care. Specifically, this bill would prevent itinerant surgeons from allowing non-medical personnel to provide inappropriate post-operative care after eye surgery.

It makes common sense. The operating surgeon, a medical doctor or doctor of osteopathy, should examine patients for infections, other diseases, and complications that might occur in the post-operative period following surgery in order to prevent potential loss of vision. However, irresponsible delegation of post-operative care to an optometrist, who can neither accurately diagnose nor treat complication and emergencies, is a gamble that no patient should have to face.

This legislation would have no fiscal impact to consumers or to health care costs. In fact, patients would receive better and safer treatment at no additional costs.

BRIEFING: HB 151

HB 151 would establish necessary guidelines in Alaskan state law for provider responsibility for ocular post-operative care. The bill is intended to close a loophole in the existing law that allows for potential abuses of co-management arrangements between providers due to incentives not related to the care of the patient.

- HB 151 takes into account the unique challenges of performing eye surgery in Alaska.
- HB 151 does not prohibit legitimate co-management of surgical patients and would have no effect on responsible surgical practices in Alaska.

- HB 151 is consistent with the principles of the Joint Position Paper of the American Academy of Ophthalmology and the American Society of Cataract and Refractive Surgeons on Ophthalmic Post-operative care.
- ***HB 151 provides that unless a surgeon enters into a written co-management agreement with the patient, the bill requires a surgeon to be physically available to the patient for post-operative care in the community in which the operation was performed for 120 hours after surgery.***
- HB 151 PERMITS CO-MANAGEMENT IF:
    - The distance that patient would have to travel to the regular office of the operating surgeon would result in an unreasonable hardship for the patient, as determined by the patient;
    - The surgeon will not be available for post-operative care as a result of the surgeon's personal travel, illness, travel to an area of the state for occasional practice of medicine, or travel to an area of a state designated as a physician shortage area; or
    - Other justifiable circumstances exist, as determined by the Alaska State Medical Board.
- ***HB 151 PROTECTS BOTH PATIENTS AND THE OPERATING SURGEON*** by prohibiting co-management arrangements:
    - In which a fee is paid to the person to whom the care is delegated that does not reflect the fair market value of the services performed by that person;
    - That are entered into as a matter of routine and not on a case-by-case basis;
    - That are not clinically appropriate for the patient;
    - That is made with the intent to induce surgical referrals;
    - That is based on economic considerations affecting the surgeon.
- HB 151 CONTAINS ***EXTRA FLEXIBILITY*** for both the patient and the operating surgeon by allowing the surgeon to delegate post-operative care of a patient without a written co-management agreement because of unanticipated circumstances that were reasonable foreseeable before the surgery was performed.

Please feel fee to call me at anytime at 907-563-8526 if you have any additional questions.

Cordially,

Carl Rosen

Carl Rosen, M.D.
President
Alaska Society of Eye Physicians & Surgeons
6100 Kalmia Drive
Anchorage, Alaska 99507
907-563-8526

cc: All members of the House HESS Committee

PHONE CALL

For _____ Date 2-28 Time _____ A.M. P.M.

M Gary Kjorne (Cook Inlet Electric) Anchorage

Phone _____ Fax _____

Remarks Please Vote No HB 151

Signed B.

SPR02301

- ☐ Telephoned
- ☐ Returned Your Call
- ☐ Please Call
- ☐ Will Call Again
- ☐ Came to See You
- ☐ Wants to See You

Sparco

PHONE CALL

For Rep Wilson Date 3/1 Time 8:35 A.M. P.M.

M Denise Thompson Of _____

Phone 272-2557 345-2231 Fax _____

Remarks disapproval of HB 151

Signed

SPR02301

- ☐ Telephoned
- ☐ Returned Your Call
- ☐ Please Call
- ☐ Will Call Again
- ☐ Came to See You
- ☐ Wants to See You

Sparco

PHONE CALL

For Rep Wilson Date 3/3 Time 2:50 A.M. P.M.

M Ladd Nolan & Pattie Tang

Phone _____ Fax _____

Remarks opposed to HB 151

Signed

SPR02301

- ☒ Telephoned
- ☐ Returned Your Call
- ☐ Please Call
- ☐ Will Call Again
- ☐ Came to See You
- ☐ Wants to See You

Sparco

From: Aharon Sternberg [aharonsternberg@yahoo.com]

Sent: Tuesday, March 08, 2005 10:27 AM

To: Rep. Peggy Wilson; Rep. Tom Anderson; Representative_Paul_Seeaton@legis.state.ak.us; Representative_Lesil_McGuire-@legis.state.ak.us; Rep. Sharon Cissna; Rep. Vic Kohring; Rep. Berta Gardner

Dear Members of the Hess Commitee -

Last year I finished serving 8 years on the Alaska Board of Examiners in Optometry. I would like to comment on HB 151 which is up for hearing today.

I'm sure you have heard enough about the merit of the Bill, the reasons to table it, pass it etc. In my opinion, regardless of the merits of the Bill - if there are any, THIS KIND OF BILL/REGULATIONS SHOULD BE A PART OF THE MEDICAL BOARD AND ITS REGULATIONS rather than being part of a state statues. It seems that this bill is a SPECIAL PRIVATE BILL introduced to limit a competition in only one are of medicine. Why not do the same to the Neurosurgeons, Urologists or any other specialty?
I'm personally not aware of any problems with the status quo and I don't see any problem that has to be fixed.

I'm glad that this Bill is scheduled with the L&C com. so anti trust and anti consumer aspects of this Bill can be discussed.

Thank you for your considerations, Aharon Sternberg, O.D.,F.A.A.O.

p.s. I have been practicing in Alaska since 1976 and have always been a part of Ophthalmic Associates which includes my self and 5 Ophthalmologists.

From: tim mclaughlin [tbmclaughlin@yahoo.com]
Sent: Tuesday, March 08, 2005 9:18 AM
To: Rep. Peggy Wilson; Rep. Tom Anderson; Rep. Vic Kohring; Rep. Lesil McGuire; Rep. Sharon Cissna; Rep. Berta Gardner
Subject: HB151

Dear Representative Lynn,

As a lifelong Alaskan and an Optometric Physician currently practicing in Alaska, as I have for the past 30 years, I ask for your support to strongly OPPOSE HB151. This is an example of the worst type of legislation narrowly focused to promote the self interest of a small group at the disservice to a large population of Alaskans who have been well cared for and have enjoyed their options to experience this choice for their ocular care. Throughout the history of Alaska and its rural population, surgeons have practiced successfully in similar settings in all branches of health care without complications or having to restrict services of the surgeon to satisfy the anti-competitive wishes of a small self interest group. Please review this legislation and see it as not an advancement to benefit the Alaskan but as a poor attempt to limit competition for services that have successfully treated thousands of patients without complication.

Thanking you in advance for your opposition on this most important subject.

Tim McLaughlin O.D.

ALASKA OPTOMETRIC ASSOCIATION

FACSIMILE TRANSMITTAL SHEET

TO: Representative Wilson

FROM: Alaska Optometric Association

COMPANY:

DATE: 3/7/05

FAX: 907-465-3175

PAGES: 2

PHONE:

RE: **American Optometric Association Co-Management Fact Sheet**

COMMENTS:

CONFIDENTIALITY NOTICE-

Legislation Seeking to Restrict or Prohibit Co-Management of Surgical Patients by Ophthalmologists and Optometrists

- The Office of the Inspector General (OIG) of the United States has established guidelines for appropriate co-management of surgical patients under the Medicare program by optometrists and ophthalmologists. The OIG has no plans at this time to reevaluate these guidelines.
- The American Optometric Association (AOA) has adopted a formal policy on co-management strictly following the Federal guidelines.
- Because there are already sufficient Federal guidelines regarding what constitutes aporopriate co-management of ophthalmic surgical patients, there is no need to address this issue further in state law. Efforts to go beyond the Federal guidelines are anti-consumer in nature and are aimed at driving up healthcare costs.
- Co-management of surgical patients by optometrists and ophthalmologists is permitted in every state.
- In general, legislation proposing to restrict or further define parameters for the comanagement of ophthalmic surgical patients is not supported by the rank and file member of the state ophthalmologic societies. Optometrists and ophthalmologists have historically had good professional working relationships.
- In Nevada the optometric association enacted legislation in 2001 establishing similar parameters for ophthalmic co-management of surgical patients as are provided for by the OIG, in fact making the legislation unnecessary, but the Association elected to pass such a law anyway. If the OIG were ever to revise any of the guidelines, the Nevada legislature would most likely have to go back and change the law to bring it into compliance with Federal policy – a poor use of the legislatures' time and energy – when in fact the Federal policy alone suffices in this area.
- The vast majority of primary eye care examinations are provided annually by optometrists. It follows that the main source of referrals to ophthalmologists for surgical services is from optometrists. And, in fact, it could easily be viewed that ophthalmologists are actually the ones co-managing the optometrist's patients, and not the other way around.
- In today's healthcare delivery system primary healthcare professionals such as internists, family practice doctors, general dentists, and optometrists often refer their long-time patients to many different types of specialists for care when warranted and based on the needs of each patient. At the appropriate time in the course of such care, the patients are sent back to the primary care provider for continued care. This is often the most efficient and cost-effective care for the patient, as well as the best clinical option.

Last Revised January 15, 2004

SGRC/G:ScopeOfPractice/ComanagementLegislationFactSheet

Alaska State Medical Association

4107 Laurel Street • Anchorage, Alaska 99508 • (907) 562-0304 • (907) 561-2063 (fax)

March 4, 2005

House Health Education and Social Services Committee Members
Alaska State Legislature
State Capitol
Juneau, AK 99801

Re: HB 151 – Ocular Postoperative Care

Dear House Health Education and Social Services Committee Members: Chair Peggy Wilson:

The Alaska State Medical Association (ASMA) represents physicians from across the State and is primarily concerned with the health of all Alaskans.

ASMA is writing in support of HB 151. Appropriate postoperative care following ocular surgery by an "EYE MD", an ophthalmologist, is imperative for good patient care.

Today's technology makes many surgical procedures, including ocular surgeries, appear to be routine. Most often, such surgeries have a high rate of success. So high, the public loses sight of the seriousness of the surgery and the complications that might occur.

HB 151 provides for appropriate ocular postoperative care by the appropriate professional. ASMA supports HB 151 and urges you to do so as well.

Sincerely,

Paul Worrell, M.D.

By: Paul Worrell, MD President
For: The Alaska State Medical Association

Members HESS Committee
House of Representatives
State of Alaska

28 February 2005

Dear Sirs:

I are writing in support of HB151. I have been a practicing eye surgeon in the state of Alaska for over eight years. I am also one of two retinal surgeons practicing in Alaska. As a retinal specialist I treat disorders of the retina and vitreous, such as retinal detachment, vitreous hemorrhage, severe eye trauma, infections, and complications from eye surgery.

Many of our patients come from outlying areas, making appropriate follow-up of post-surgical patients a difficult task. In general, we keep patients in Anchorage until stable, before allowing them to return to their home. Many times patients will be required to stay for 1 to 2 weeks before they are stable enough to return to home. Serious complications requiring further surgery can arise in this critical post-operative period. The average time for a sight-threatening infection to occur after uncomplicated cataract surgery is 5 days post-operatively. Endophthalmitis, or infection of the inside of the eye occurring after eye surgery, is an absolute emergency requiring surgical vitreous biopsy and injection of antibiotics into the eye. It is the responsibility of the surgeon to manage the patient in this critical post-operative period. If for some reason the surgeon is not available, he or she must refer the patient to another surgeon who can manage a post-operative emergency.

In Ophthalmology, patients from outlying areas may be left in the hands of an Optometrist, an eye care provider who is not a surgeon, for some of their post-operative care. This arrangement is called "co-management" of the patients care. I occasionally rely upon many of my Optometric colleagues to help manage patients from outlying areas. I do not release the patient to be followed by the Optometrist until they are out of the critical post-operative period where complications can still occur. Myself, or my partner are always available thereafter, 24 hours per day 7 days per week, should the patient develop further problems. HB 151 simply defines the critical post-operative period during which a surgeon must be available to provide care for his or her patient. In Alaska it is sometimes necessary for patients from outlying areas to receive care in a co-management type of arrangement, such as exists between Ophthalmologists and Optometrists. It is imperative the management of the patient be done in an ethical manner and not endanger the patient in any way.

Sincerely,

Scott A. Limstrom

Scott A. Limstrom, MD
3500 LaTouche, Suite 250
Anchorage, Alaska 99508
(907)561-1530

American Academy of Ophthalmology

1101 Vermont Ave. NW, Suite 700, Washington DC 20005 (202) 737-6662

Comanagement of Surgical Patients

Introduction

Comanagement occurs when a surgical patient receives surgical care from one physician and postoperative care from another healthcare provider. This type of arrangement most commonly occurs with cataract and refractive surgery.

Why Is It In The News?

The American Academy of Ophthalmology and the American Society of Refractive & Cataract Surgery have issued voluntary guidelines for physicians considering comanaging patients.

Legislation to limit comanagment was introduced in Florida and Missouri in 2001.

Facts & Statistics

American Medical Association and American College of Surgeons guidelines disapprove of comanagement arrangements that exist if economic considerations drive the arrangement.1,2

The Office of the Inspector General of the Dept. of Health and Human Services has expressed concern about comanagement based on economic considerations rather than clinical appropriateness and has refused to provide safe harbor protections (from anti-kickback regulations) for such arrangements, preferring to review cases on an individual basis.

In 2000, the American Academy of Ophthalmology and the American Society of Cataract & Refractive Surgery issued voluntary guidelines for surgeons engaging in comanagement arrangements. Key provisions of the guidelines state:

a.. The surgeon has primary responsibility for preoperative assessment and postoperative care for patients, regardless of the type of surgery.

b.. Comanagement of patients is ethical and appropriate in some circumstances, such as:

The surgeon is unavailable to provide postoperative care (due to travel, illness, leave, itinerant surgery in a rural area or surgery performed in a designated physician shortage area.)

The patient cannot travel to the surgeon's office because of distance or the development of another illness.

a.. When comanagement is practiced for economic reasons (specifically as an inducement for surgical referrals) or is the result of coercion by the referring practitioner, it is unethical, and in many jurisdictions, illegal.

b.. The surgeon, prior to surgery, must inform the patient if there are any prearranged postoperative management plans, and the patient must voluntarily consent to this in writing. This consent process, which should be documented in the medical record, should include the reason for the transfer of care, the qualifications of the health care provider who will render the postoperative care and any special risks that may result from this arrangement.

If an unanticipated transfer of postoperative care is required, the patient should be informed and this information documented in the medical record.

a.. The surgeon should inform the patient of the financial implications resulting from the comanagement arrangement, particularly with regard to the patient's payment obligations and the postoperative provider's reimbursement.

b.. The transfer of care must not occur unless it is clinically appropriate and in the patient's best interest.

c.. The surgeon should confirm that the comanager is legally entitled and professionally trained to provide the particular services.

d.. The comanagement must not be done as a matter of routine policy on all patients.

e.. The surgeon should follow the patient until postoperatively stable, and there is no fixed time when the patient is sent back to the referring provider.

f.. The patient should be reassured that he/she has access to the surgeon, if necessary, during the postoperative period at no additional cost. (If a Medicare/Medicaid patient returns to the surgeon, both the surgeon and postoperative care provider must file a corrected claim.)

g.. Any fees must reflect an appropriate fair market value for the services performed.

Conclusions

Quality medical care can only be achieved when the welfare of the patient is placed above all other considerations. Patients' interests must never be compromised as a result of comanagement.

References

1.. American Medical Association. Ethical Opinion 8.043: Ethical Implications of Surgical Co-Management. Chicago: American Medical Association; 2000.

2.. American College of Surgeons. [ST-25] Statement on Principles Underlying Perioperative Responsibility. Bulletin of the American College of Surgeons 1996; 81 (9):39.

AMERICAN ACADEMY OF OPHTHALMOLOGY
The Eye M.D. Association

March 15, 2005

The Honorable Peggy Wilson
Chair, Health, Education, and Social Services Committee
Alaska State Capitol
Juneau, Alaska 99801-1182

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Dear Chair Wilson:

I would like to compliment the House Health, Education and Social Services Committee for the time the Committee members have taken to review HB 151. HB 151 addresses a particular problem unique to surgical eye care. As you are aware, co-management is the sharing of postoperative responsibilities between the operating surgeon and another health care provider. In theory, this arrangement is to be entered into only in cases when it is in the best interests of the patient, for example, when it is too far for the patient to safely travel. If this were the only kind of co-management around, we would not require corrective legislation. In practice, there is abuse, and there are times when this behavior is unethical.

In the interest of patient safety, the enactment of HB 151 will eliminate the pressure between surgeons and allied health professionals to enter into such agreements that are not in the best interest of patient quality of care. This bill would eliminate the unethical behavior by carefully regulating when post-operative co-management is appropriate and is in the patient's best interest.

The Committee had specifically asked for information as to the possible complications that can occur in the immediate post-operative period. Below, I have listed several of the most common complications that can occur:

COMMON SURGICAL COMPLICATIONS IN THE IMMEDIATE POST-OPERATIVE PERIOD (48 hours) AFTER EYE SURGERY

Hyphema (bleeding within the eye)
Flat chamber (anterior part of the eye collapses)
Iris incarceration (Iris stuck in the wound)
Choroidals (blood between the retina and sclers, causes flat anterior chamber.)
Wound Infection
Elevated Eye Pressure

The enactment of HB 151 will ensure that patients have access to a surgeon within the 48 hour window in which the above complications from eye surgery could occur.

HB 151 does not ban co-management of patients, but it ensures that such arrangements are truly in the best interests of patients. It recognizes unique challenges of delivering health care services to the citizens of Alaska. In addition, the bill permits flexibility in cases of emergencies and unexpected circumstances. HB 151 is a patient-friendly bill, and I urge the committee's support of this important patient care legislation.

Sincerely,

Susan Day

Susan H. Day
President

Katie Shows

From: Rep. Paul Seaton
Sent: Thursday, March 10, 2005 3:05 PM
To: Katie Shows
Subject: FW: HB 151

Ian Laing
Rep. Paul Seaton
Legislative Staff
(907) 465-2689

-----Original Message-----
From: homereye@xyz.net [mailto:homereye@xyz.net]
Sent: Thursday, March 10, 2005 1:38 PM
To: Rep. Paul Seaton
Subject: HB 151

Subject: HB 151

Dear Representative Seaton:

I would like to bring to your attention the following points regarding HB 151 and the hearing on Tuesday.

1. The proponents of this bill (ophthalmologists) made this sound as if the bill was to control the actions of surgeons. Obviously, no group asks the government to control their actions---especially surgeons. The thrust of this bill is to limit optometry, NOT ophthalmology. Certainly, they would like to limit one ophthalmologist so throwing in the 120 hour limitation will hurt him, but everyone else in the state is really unaffected by that in that they can say their partner or friend is covering for them. All of the conditions placed upon comanagement and the required paperwork are simply there to discourage optometric involvement. If this bill were really to control surgeons, it would contain only one sentence: "All eye surgeons will remain available to their patients for a period of 120 hours after surgery, either in person or by delegation of that responsibility to another qualified eye surgeon".

2. I may not have made myself clear on this item. I hear the ophthalmologists saying that optometrists are receiving payment just for the act of referring a patient. That is NOT the case. Yes, optometrists are paid for the services they render (as are the ophthalmologists if they do the post operative care) and that is payment is determined by insurance carriers and Medicare. It is not a kickback for making the referral.

3. The medical board has the power to control the actions of all physicians, whether they choose to do it is up to them. If they choose not to perform their duty as a regulatory body for medicine, why should the legislature do it for them? If this were really a quality of care or safety issue, one would expect the medical board would be obligated to act.

4. The ophthalmologists try very hard to make everyone think that because they are M.D.s (medical doctors) that they are the only providers of "medical care". Obviously, Rep. Wilson does not even realize that optometrists do have a Dr. in front of their name after eight years of training, but none of the ophthalmologists was addressed as Mr. There are numerous doctors that have both M.D. and O.D. degrees, who certainly understand the training of both disciplines. Would the testimony of one of these individuals be of benefit in disclosing to the HESS committee just how ophthalmology is trying to mislead you?

5. Neither of the two ophthalmologists who testified are cataract surgeons. The case described by Dr. Rosen in his testimony was not even a postoperative complication. The

patient had LASIK surgery almost three weeks before the incident, and he was struck in the eye while chipping ice. Dr. Rosen also failed to disclose that the surgeon who lives in Seattle cancelled his patients and flew to Anchorage just to treat this patient (without charge to the patient). Certainly, he is not the ruthless surgeon that the Anchorage ophthalmologists make him out to be. Furthermore, I have not yet been able to identify a single case where a postoperative patient has gone to any Anchorage emergency room for care for a postoperative complication. There is a lot of smoke and mirrors hiding the real motivation of this proposed legislation.

6. You may be aware of this, however, it is worth noting that all health care providers EXCEPT medical doctors are considered limited license practitioners. That is to say that the scope of practice is limited by laws and regulations placed upon them by the legislative body. In the case of optometry, we are presently limited to the use of drugs that are administered through a topical delivery system as opposed to a systemic medication. Most other states allow the use of systemic drugs that are rational to the treatment of eye disease IF the practitioner has the training and has passed the national board examination pertaining to the use of same. You probably have seen the present HB relating to this issue. The point of all this being that medical doctors do not need to ask the legislature for anything. They have unlimited privilege to perform any medical procedure or prescribe any drug, whether that procedure or drug even existed when they underwent training. Therefore, fo!
r a piece of legislation to further limit the license of an optometrist without any evidence of a publi safety issue (or any other valid reason) serves only to reduce competition in favor of the ophthalmologist.

7. Are all of these hearings skewed toward the proponents of a bill? I was told that I had 3 minutes to present my views and then Dr. Coulter was given unlimited time to testify and respond to questions.

I would like to discuss this bill with you prior to the next committee meeting if that would be possible.

Sincerely,
Boyd L. Walker, O.D.

Southern California College of Optometry

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March 11, 2005

To: Members of the Alaska State Legislature, HESS Committee

Re: OPPOSITION to HB 151 "An Act relating to provider responsibility for ocular postoperative care; and providing for an effective date"

Members of the HESS Committee:

First of all, thank you for the opportunity to write a letter explaining why I am opposed to HB 151. I understand the proposed legislation would preclude the outstanding optometrists in your great State from participating in post-surgical care to their own patients that they refer for needed ocular surgical procedures. It is indeed a pleasure to offer you my opinion on the appropriate role of the optometrist in the post-surgical care of their patients.

As a licensed practitioner of both optometry and medicine, I write in opposition to HB 151 as I believe with all my heart that Alaska's optometrists are well-trained and qualified to provide post-surgical care. Indeed, such care is very parallel to other areas of medicine such as a Family Physician rendering care to their own patients after an appendectomy or gall bladder operation, or other types of surgeries.

I personally practiced family medicine in Hartville, Ohio, after having completed a Family practice Residency in Akron, Ohio. The only professional eye care in our community at that time was provided by an optometrist. He and I exchanged patients freely and comfortably for primary care and the co-management in rendering high quality eye care.

Let me offer some specific observations of my own regarding optometric and medical education.

Medical school traditionally prepares the student in general medical and surgical background for 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 to 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 California in which I now reside, most primary care physicians (general practitioners, family practice, internists, and pediatricians) admit that they had from one to three weeks of medical school devoted to ophthalmological care. This includes both didactic course work and clinical experience. I do not need to remind you that these physicians may legally treat eye diseases on an unrestricted basis. But without appropriate education and training and the proper instrumentation, how can the public health be served?

On the other hand, optometry school is mostly devoted to ocular training. There are courses in general pathology and ocular signs of systemic disease because the optometrist is responsible to detect systemic diseases with ocular manifestations and to make appropriate referrals. Included with the systemic disease education is the specific education and training in the use of systemic medications and medication interactions, especially in regard to medications utilized in the management of ocular conditions. 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.

A Doctor of Optometry or Optometric Physician is a physician with a four year doctorate degree just as for dentistry, podiatry and medicine. During the course of study to become a doctor of optometry, there is detailed training in ocular diseases including the management of pre-operative and post-operative care for patients undergoing all forms of ocular surgery. For the optometrists in practice, continuing education courses and practical, hands-on clinical training with patients is the mechanism utilized for assuring that patients receive the highest quality of care possible. In fact, there is testing by the National Board of Examiners in Optometry that tests for these needed skills and graduates must pass these rigorous tests before becoming licensed to care for patients.

This is not to slight medical education; there is simply 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. Additionally, the prerequisites for optometry school meet or exceed the requirements for medical school admission and the Optometry Admission Test parallels that of the Medical College Admission Test. With all the prerequisites and the primary care doctoral program in optometry school, the graduate is trained to make professional judgments and is quick to consult with other health care providers when a patient requires needed services outside the scope of practice. Optometrists now routinely work with medical specialists and subspecialists in the interest of the highest quality patient care.

The clinical education of an optometrist does not have to parallel the education and training of an ophthalmologist anymore than the education and training of a family physician needs to parallel that of a surgeon. Likewise, in my opinion, hospital inpatient

experience is not needed for treating primary open angle glaucoma by the primary care optometrists as patients requiring such extensive treatment will be referred for that level of specialty care. Just as family physicians can safely utilize medications that are also utilized by surgeons, so can optometrists utilize medications that are utilized by ophthalmologists. The education and training for an optometrist includes the safe, effective use of all pharmaceutical agents for ocular diseases in the clinical setting which includes subsequent follow-up. Optometrists are also more than qualified to use an Alger brush, a basic instrument that does not itself remove foreign bodies from the eye, but cleans off particles and residue after a foreign body has been removed.

I would like to point out that ophthalmologists are vitally needed. Patients would be in sad shape without their advanced expertise in the areas of severe ocular trauma, cataract surgery, retinal surgery, complicated ocular infections, etc. These are all vital secondary and tertiary care conditions which optometrists do not propose to treat. I do regret that the opposition resorts to "scare tactics" in this legislative issue. In my opinion, risk to the public is not an issue and the safe use of these therapeutic pharmaceutical agents by optometrists has been well documented in other states.

I also feel strongly that optometrists are vitally needed. There is no question but that the Alaska of Examiners in Optometry will protect the people of Alaska by insuring adequate education, continuing education and training for any optometrist allowed to utilize these oral and topical medications. It is unfair to patients and a waste of resources to prevent optometrists from providing care at the highest level of their education and training. Constraints on the profession contribute to an increase in health care costs. When primary care is provided by specialists it is well known that the delivery of health care adds expense to the system.

In summary, in my professional opinion, the implication that Doctors of Optometry provide "lesser care" and are "not qualified" to co-manage post-surgical cases related to the eye is simply not true! In fact, the National Institute of Health has released two studies by Medical Doctors that proved that Doctors of Optometry provide "EXCELLENT" co-managed care for ocular surgeries. Further, co-management between Ophthalmologist and Optometrists is recognized and well-defined federally through Medicare and this is acknowledged by the American Academy of Ophthalmology in the Clinical Practice Guidelines entitled "Cataract in the Adult Eye" under the "Postoperative Guidelines". Lastly, the American Medical Association recognizes co-management with allied healthcare professionals in the AMA Policy Statement #E303 "Allied health Professionals". Therefore, with all this in mind, I feel strongly that the record will prove that co-management for ocular surgeries has been and should continue to be a successful and integral part of patient care in Alaska.

Sincerely,

Lesley L. Walls, O.D., M.D., D.O.S.
President

Dennis A. Swarner, O.D.
Robert D. O'Connell, O.D.
Doctors of Optometry
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Telephone: (907) 283-7575

MAR 2 1 2005

March 14, 2005

Dear Representative Peggy Wilson:

HB 151 is Pathetic.

HB 151 is a blatant attempt to stifle health care in Alaska orchestrated by the State Ophthalmologists, nothing more, nothing less.

HB 151 is aimed at one (1) provider, Pacific Cataract & Laser Institute, and one profession – Optometry.

Pacific Cataract & Laser Institute (PCLI) is a world class eye institute that provides world class eye care, happily in downtown Anchorage. Oh, and one other thing, eye care at a very competitive price.

I have practiced on the Kenai Peninsula for 28 years. I have provided post-operative care for every eye surgeon, including Dr. Rosen, president of the Alaska Society of Eye Physicians and Surgeons, herewith known as the ASPS – not to be confused with the snakes.

Dr. Rosen and his fellow ASPS would like Pacific Cataract & Laser Institute as well as Optometry to go away. Dr. Rosen and his club want dear old Grandma Bea to drive from her home in Nikiski to Anchorage for her 10 minute post-op check.

Grandma Bea is going to have to get up early because its snowing and her tires are worn and drive to Anchorage. She wants to get there early because she knows her eyes will be dilated and she wants to get home before dark. You know it's snowing and she'll have to drive slow and the moose on the road. Who can afford to stay in Anchorage, it's expensive and she's trying to save money for her grandchildren's Christmas gifts. Oh, how she wishes she could be checked in Kenai like when the first eye was done. Dr. Rosen says this is impossible, she can only be checked by an Ophthalmologist. Optometrists are too stupid.

So What! Who cares about an old woman and her bald tires? Not the ASPS, they don't want to split the surgical fee with anyone else. Well, maybe if they have to, but only if it's another ASPS member. Most Ophthalmologists live in Anchorage, kind of like a fraternity.

The surgeons of Pacific Cataract & Laser Institute provide an excellent service to this state. Optometry has served this state for over 100 years and has done an outstanding job. The argument that Optometrists are incapable of detecting post surgical problems is inane.

Voting <u>for</u> HB 151 will do the following:

1) Raise the income of the ASPS.
2) Raise the cost of surgery for Alaskans
3) Limit the choice of surgeons for Alaskans
4) Decrease surgery quality in Alaska
5) Increase waiting time for eye surgery in Alaska
6) Greatly increase peripheral costs to Alaskans for eye surgery

The authors crafting of HB 151 is an attempt, by fiat, to <u>suppress</u> competition in the health care market. It would be comical if it were not for the human cost of this bill.

Why would anyone, other than the ASPS, be for this bill?

Ethically, <u>no one</u> should support HB 151.

Thank you,

Robert D. O'Connell, O.D.

Member
American Optometric Association

Alaska Native Brotherhood Camp 2

March 17, 2005

Honorable Representative Peggy Wilson
Chair, Health Education & Social Services Committee
Alaska State Legislature
State Capitol
Juneau, AK 99801

Dear Representative Wilson,

You have an excellent opportunity this year to pass legislation that would significantly enhance patient safety when it comes to Alaskans seeking cataract and other types of ocular surgery. Once more by passing House Bill 151 you will increase the safety threshold without necessarily increasing the costs of delivering that service.

It seems that few itinerant surgeons feel that unlike any other form of surgery, it is okay to entrust immediate post-operative care of a patient to an optometrist that is not schooled or trained in post-surgical care. They lack the foundation to identify infections, diseases and other medical complications that could arise following a surgical procedure.

This practice of entrusting post-operative care to non-medically trained optometrists is not endorsed by any society, association or academy of professions that practice eye surgery and Alaska should pass HB 151 to end that practice here. If an eye surgeon is too busy to provide his or her own post-operative care, then they must be required to arrange for an equal level of care for that patient through a co-management agreement with another eye surgeon, for that all important 48-hour period of time. Please pass HB 151.

Sincerely,
Alaska Native Brotherhood Camp 2

Bob

Robert W. Loescher, Chair
Legislative Affairs Committee

Cc: Representative Seaton
Representative Kohring
Representative Anderson
Representative McGuire
Representative Cissna
Representative Gardner

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ATTN: Rep Peggy Wilson FAX 465-3175

Alaska State House of Representatives
HESS Committee Members
Juneau, Alaska 99801

Dear Members:

Thank you for considering HB 151. I follow the Alaska legislature thru media coverage and a daily monitoring of the Alaska Legislature thru it's website and that is where I noticed HB 151. I did some further research by entering the American Academy of Ophthalmology website.

Despite position papers from groups such as the American Academy of Ophthalmology and the American Society of Cataract and Refractive Surgeons that call for ocular surgeons to provide either hands on post-operative care or to enter into a co-management care agreements with a similarly qualified medical doctor for post-operative care, some doctors offering this service have chosen to ignore these guidelines and entrust post-operative follow-up to non-medical personnel.

As these procedures continue to increase in volume the risks to the patient will continue to increase as well, unless something is done to quell the complacency of a few when it comes to post-operative follow-up. HB 151 sets into law that which is already in practice by most people in this profession, but it protects our patients from those few that continue to put profit above proscribed procedure. I urge you to pass HB 151.

Sincerely,

Gwen Norton
P.O. Box 141796
Anchorage, Alaska 99514

Cc: Wilson, Seaton, Cissna, Kohring, Gardner, McGuire, Anderson