HB

113

SFIN

FILE

SENATE FINANCE COMMITTEE REPORT

REPORTED OUT
MAY 1 4 2007
SENATE FINANCE COMMITTEE

DATE: 5/10/07

FURTHER:

DATE TURNED IN TO OFFICE: 14 May 2007

Finance Committee considered CS FOR HOUSE BILL NO. 113(HES)

HB 113 OPTOMETRISTS' USE OF PHARMACEUTICALS

"An Act relating to the prescription and use of pharmaceutical agents, including controlled substances, by optometrists."

and recommends:

[ ] be **replaced** with [ ] **SCS** or [ ] **CS** _____ (_____)

[✓] adopt **previous** [✓] **SCS** or [ ] **CS** CS HB 113 (L&C)

[ ] attached amendment(s)

[ ] adopt _____ Letter of Intent

[ ] further referral to _____ Committee

SENATE BILL:
[ ] Same Title
[ ] New Title

HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[✓] New Title w/ SCR #TECH

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#
Commerce	3/16/07			✓	#1

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
	Elton	✓			
	Thomas			✓	
	Dyson	✓			
	Huggins	✓			
	Olson				✓
CO-CHAIR:	Hoffman	✓			
CO-CHAIR:	Stedman			✓	

FISCAL NOTE

STATE OF ALASKA
2007 LEGISLATIVE SESSION

Fiscal Note Number: 1
Bill Version: CSHB 113(HES)
(H) Publish Date: 4/2/07

Revision Date/Time (Note if correction):
Dept. Affected: Commerce
Title: Optometrists Use of Pharmaceuticals
RDU: Corp, Bus & Prof Licensing (117)
Component: Corp, Bus & Prof Licensing
Sponsor: Samuels et al
Requester: House HES
Component No.: 2360

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
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 (Specify Type--Do not abbreviate)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2007) cost: 0 0
Mark this box (X) if funding for this bill is included in the Governor's FY 2008 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

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

This legislation amends various provisions of AS 08.72 Optometrists and Use of Pharmaceutical Agents, including adding specifications for controlled substances. This is not expected to result in the need for additional funds to implement the provisions.

Prepared by: Chris Wyatt, Administrative Manager
Phone: (907) 465-2572
Division: Corporations, Business, and Professional Licensing
Date/Time: 3/16/07 2 09 PM
Approved by: Emil Notti, Commissioner
Date: 3/16/2007
Agency: Commerce, Community, and Economic Development

(Revised 9/18/2006 OMB)

COMMITTEE COPY

Representative Ralph Samuels

Sponsor Statement
House Bill 113

"An Act relating to the prescription and use of pharmaceutical agents, including controlled substances, by optometrists."

House Bill 113 would allow optometrists to prescribe systemic (oral) medications to treat a patient's eyes or for an allergic shock reaction. Currently Alaskan optometrists are limited to prescribing only topical medications, while optometrists in 45 states, the District of Columbia and Guam are able to prescribe systemic (oral) medications.

The course of study that optometrists undergo is comparable or exceeds that required of their peers in the health care professions who are already granted the ability to prescribe medications. Optometry programs include several semesters of pharmacology, in addition to studies in human anatomy, physiology and biochemistry. Optometrists, like dentists and podiatrists, attend four years of graduate school after receiving their undergraduate degree. Yet of these professions, only optometrists are limited to prescribing topical agents.

Regulations are already in place to ensure that only qualified optometrists may prescribe systemic medications. Optometrists must pass an exam, such as the "Treatment and Management of Ocular Disease" from the National Board of Examiners in Optometry, and must show that they have completed the necessary continuing education in pharmacology each year in order to prescribe any medications authorized under statute.

Increasing optometrists' prescribing authority will be of benefit to Alaskan patients, preventing those who require oral or injectible prescriptions from having to visit a general practitioner in addition to their regular optometrist. This will save patients time and money, and allow optometrists greater participation in their patients' care.

Alaska Optometric Association

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Toll free: 877-693-2562
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May 1, 2007

We are pleased to have the opportunity to provide you with this information packet describing the profession of optometry. We hope you find the materials enclosed as an easy reference to an optometric physician's scope of practice and the education that is involved.

Included in this packet are details and facts about the following topics:

Statement for optometric practice under this legislation.

Current and proposed therapeutic pharmaceuticals legislation for optometric physicians.

Scope of practice for optometric physicians.

Education required to be an optometric physician includes at least 4,315 contact hours of graduate studies. (A four-year doctorate program.)

Thank you for your interest in becoming familiar with optometry as a profession and the benefits it will continue to provide through education and legislation to the health care of Alaskans.

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Statement for Optometric Practice Under this Legislation

As optometric physicians, our intent for expanding our statutes to include oral pharmaceuticals is to provide better and more complete eye care to Alaskans.

Currently, we are limited in the treatment of eye diseases we see on a routine basis. Diseases such as acute allergic reactions, ocular Herpes and ocular Herpes Zoster, chronic lid diseases, and infectious conjunctivitis and lid diseases, would benefit from the help of oral medications.

106 optometric physicians 85 different locations currently serve the Alaskan population spanning from Barrow to Juneau.

Optometric physicians are often the only eye care physicians available in rural areas throughout Alaska. **Our specialty is in primary and preventative eye care. We are educated and trained in the use of oral therapeutics.** This legislation is not adding to the profession but enabling optometric physicians to practice at the level they are trained and needed.

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Scope of Optometry Practice

The practice of optometry includes:

(The following is a sample of what is included in the scope of optometry and does not list every disease or disorder that is treated in the practice of the profession.)

A **complete analysis** of the following components of the eye and visual system:

The health of the ocular tissue including the eyelids, lashes and the surrounding tissues, conjunctiva, cornea, anterior chamber, iris, lens, vitreous, retina and optic nerve.

The ocular vascular systems including the eyelids and surrounding tissues, cornea, conjunctiva, optic nerve and retina.

The intraocular pressures and blood pressure.

Pupil responses, extraocular muscles and eye lid muscle responses.

The ability for the eye to see with and without correction.

Diagnosis, treatment and management of ocular diseases:

Conjunctivitis including viral, bacterial and allergic corneal inflammation, ulcers, degeneration and dystrophy, keratoconus, abrasions, foreign body removals, uveitis, glaucoma, macular degeneration, retinitis pigmentosa, macular edema, retinitis, vitreal disorders, cataracts, retinal melanomas and masses, and other ocular tissues including eye lids.

Pre and post surgical care for variety of ocular surgeries.

Diagnosis of ocular disease and related systemic diseases*:

Hypertensive retinopathy and hypertension, arteriosclerotic plaques and arteriosclerosis, vascular incidences including central retinal and branch vein occlusions, central retinal artery occlusions, ischemic optic neuropathy and diabetic retinopathy and diabetes.

Neurological evalu[illegible] involving the visual system related systemic conditions:

Optic neuritis and multiple sclerosis, pseudo-tumor cerebri secondary to increased intracranial pressure, retrobular optic neuritis, brain tumors involving the visual pathway, pupillary response defects which can be secondary to a lesion or mass along the neuropathway.

**An optometric physician manages the ocular manifestations of the disease and the patient is referred to the appropriate physician to treat the systemic portion of the disease.*

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Doctorate Degree Education and Training for Optometric Physicians

There are between **200 to 300 classroom hours** assigned to the specific area of pharmacology and **two years of clinical applications** of systemic and ocular agents in the treatment of ocular disease.

General pharmacology 1 & 2 cover **systemic pharmacology** of agents in each drug class, pharmacokinetics, and the quantitative and qualitative aspects of pharmacodynamics and the drug and patient relationship variables. This includes the topics of autonomic nervous system agents, cardiovascular drugs, renal pharmacology, gastrointestinal drugs, respiratory pharmacology, anti-inflammatory agents, chemotherapeutic agents, neuropharmacologic agents, anesthetics, hormones and hormone antagonists, pain pharmacology, toxicology and the toxicology of poisons.

Ocular pharmacology and ocular pharmacological therapies includes ocular and systemic pharmacological agents related to the treatment and management of ocular disease the pharmacokinecties and pharmacodynamic. This includes the **use of topical, oral and injectable medications in the treatment of eye and the associated structures.**

Related required classes and labs:

Human anatomy	Neuroanatomy	Histology
Human physiology	Neurophysiology	Embryology
Human pathology	Neurobiology	Biochemistry
Ocular anatomy	Ocular physiology	Ocular pathology
Ocular disease	Ocular emergencies	Immunology
Clinical medicine	Clinical emergencies	Patient Care

Clinical Education

There are **at least 2,000 patient contact hours** in a variety of optometric clinical settings examining diverse patient populations. This includes clinical, hospital and emergency experience.

Please see the attached examples of the course work required by optometry schools.

PACIFIC UNIVERSITY COLLEGE OF OPTOMETRY

Doctor of Optometry Degree
2005 - 2006 Curriculum

FIRST PROFESSIONAL YEAR: 2005-2006

OPT #	Fall Semester:	Credits	OPT #	Spring Semester:	Credits
501	Geometric Optics with Lab	4.0	502	Physical Optics with Lab	3.0
516	Clinical Experience I	0.5	503	Visual Optics and Ocular Motility with Lab	4.0
531	Ocular Anatomy, Physiology and Biochemistry with Lab	4.5	517	Clinical Experience II	0.5
535	Functional Neuroanatomy and Neurobiology	3.0	532	Anatomy of the Visual System with Lab	3.0
536	Pharmacological Principles and Autonomic Agents	3.0	533	Microbiology, Genetics and Immunology; Pharmacology of Anti-Infective Drugs; Diseases of the Lid and Lacrimal System	3.0
546	Clinical Procedures: Non-refractive Diagnostic Tests with Lab	3.0 4.0			
562	Behavioral Optometric Science with Lab		534	Laboratory Procedures for Assessment of Ocular Disease	1.0
			537	Etiology, Diagnosis and Management of Systemic Diseases; Pharmacology of Systemic Medications I	4.0
			547	Clinical Procedures: Binocular Testing and Optics with Lab	2.0
	Total Semester Credits	22.0		Total Semester Credits	20.5
				Total First Year Credits	42.5

SECOND PROFESSIONAL YEAR: 2005 - 2006

OPT #	Fall Semester:	Credits	OPT #	Spring Semester:	Credits
601	Ophthalmic Optics	3.0	617	Optometric Case Analysis	4.0
602	Sensory-Motor Interactions in Vision with Lab	4.0	618	Theory and Practice of Spherical Rigid and Soft Contact Lenses with Lab	3.0
616	Theory and Methods of Refraction	3.0			
620	Clinical Experience III	0.5	621	Clinical Experience IV	0.5
631	Diagnosis and Treatment of Anterior Segment Diseases	2.0	633	Diagnosis and Treatment of Posterior Segment Diseases	3.0
632	Detection, Assessment and Treatment of Anterior Segment Diseases	1.0	634	Detection, Assessment and Treatment of Posterior Segment Diseases	1.0
637	Etiology, Diagnosis and Management of Systemic Diseases; Pharmacology of Systemic Medications II	2.0	638	Etiology, Diagnosis and Management of Systemic Diseases with Lab; Pharmacology of Systemic Medications III	2.0
646	Clinical Procedures: Refractive Error Measurement with Lab	2.0	648	Clinical Procedures: Phorometry and Ocular Health with Lab	4.0
647	Ophthalmic Dispensing Procedures with Lab	2.0	662	Visual Information Processing and Perception with Seminar	4.0
661	Physiological, Psychological and Cognitive Changes During the Lifespan	2.0			
	Total Semester Credits	21.5		Total Semester Credits	21.5
				Total Second Year Credits	43.0

THIRD PROFESSIONAL YEAR: 2005 - 2006

OPT#	Summer Semester	Credits	OPT#	Fall Semester:	Credits	OPT#	Spring Semester	Credits
715	Patient Care: First Session	1.0	718	Advanced Optometric Case Analysis with Lab	4.0	723	Patient Care: Third Session	2.0
716	Theory and Practice of Specialty Contact Lenses with Lab	4.0	720	Vision Therapy for Binocular and Oculomotor Dysfunction with Lab	4.0	725	Assessment and Mgt of Strabismus and Amblyopia with Lab	4.0
721	Clinical Experience V	0.5	722	Patient Care: Second Session	2.0	727	Evaluation and Mgt of Patients with Perceptual Problems with Lab	3.0
726	Normal and Abnormal Visual Perception	2.0	724	Pediatric and Developmental Optometry	2.0			
761	Public Health Optometry	2.0				735	Applied Ocular Therapeutics	1.0
763	Environmental, Occupational and Recreational Vision	2.0	728	Assessment and Mgt of the Partially Sighted Patient	2.0	762	Communication in Optometric Practice with Lab	2.0
791	Optometric Thesis Orientation and Planning	1.0	733	Assessment and Mgt of Ocular Disease Patients	2.0	764	Optometric Economics and Practice	4.0
	Electives*			Electives*			Electives*	
	Total Semester Credits	12.5		Total Semester Credits	16.0		Total Semester Credits	16.0
	*=Students are required to complete at least 4 credit hours of electives during third year						Total Third Year Credits (Including Electives)	48.5

FOURTH PROFESSIONAL YEAR: 2005 - 2006

OPT #	Fall Semester	Credits	OPT #	Spring Semester	Credits
	Preceptorships			Internal Clinic Rotation	
			817	Patient Care XI: Internal Clinic Rotation	5.0
814	Patient Care VIII: Preceptorship Session 1	11.0	818	Vision Therapy Patient Care	2.0
815	Patient Care IX: Preceptorship Session 2	11.0	819	Low Vision Patient Care	1.0
816	Patient Care X: Preceptorship Session 3	11.0	820	Contact Lens Patient Care	1.0
892	Optometric Thesis: Completion	1.0	821	Clinical Rounds	1.0
			822	Pediatric Patient Care	1.0
			832	Ocular Disease and Special Testing Patient Care	1.0
				Total Fourth Year Credits	46.0

ILLINOIS COLLEGE OF OPTOMETRY

Doctor of Optometry Degree
2005 - 2006 Curriculum

FIRST PROFESSIONAL YEAR: 2005 - 2006

OPT #	Fall Quarter 1.1	Credits	OPT #	Winter Quarter 1.2	Credits	OPT #	Spring Quarter 1.3	Credits
114	Human Anatomy	5.0	106	Histology and Embryology	4.0	111	Neuroanatomy and Neurophysiology	4.0
116.1	Human Physiology and Pathology I	4.0	107	Applied Ocular Anatomy	6.0			
120.1	Geometric and Theoretical Optics I	4.0	116.2	Physiology and Pathology II	2.0	116.3	Physiology and Pathology III	4.0
140.1	Sensory Aspects of Vision I	4.0	120.2	Geometric and Theoretical Optics II	4.0	140.2	Sensory Aspects of Vision II	5.0
150.1	Biochemistry I	4.0				162.3	Optometry 1.2	3.0
162.1	Introduction to Optometric Procedures	1.0	150.2	Biochemistry II	4.0	170	Physiological Optics I	3.0
			162.2	Optometry 1.1	3.0	194	Health Promotions	1.0
	Total Quarter Credits	22.0		Total Quarter Credits	22.0		Total Quarter Credits	20
							Total First Year Credits	64.0

SECOND PROFESSIONAL YEAR: 2005 - 2006

OPT #	Fall Quarter 2.1	Credit	OPT #	Winter Quarter 2.2	Credit	OPT #	Spring Quarter 2.3	Credit
212	Ocular Physiology	4.0	245	Color Vision and Developmental Neurobiology	4.5	222	Theoretical and Physical Optic Immunology	2.0
244	Binocular Vision and Ocular Motility	5.0	246	Visual Perception	2.0	256	Ocular Pharmacology and Therapeutics	4.0
254.1	General Pharmacology I	4.0	248	Perspectives on Behavioral Disorders	1.5	261	Physical Diagnosis	2.0
262.1	Optometry 2.1	4.0				263.2	Ocular Disease II	3.0
270.1	Ophthalmic Optics I	4.0	254.2	General and Ocular Pharmacology	4.0	262.3	Optometry Seminar	3.5
			262.2	Optometry 2.2	3.5		Introduction to Binocular Vision	1.0
			263.1	Ocular Disease I	2.0	262.4	Disorders	
			270.2	Ophthalmic Optics III	3.0	266	Microbiology	1.0
	Total Quarter Credits	21.0		Total Quarter Credits	20.5		Total Quarter Credits	16.5
							Total Second Year Credits	58.0

THIRD PROFESSIONAL YEAR: 2005 - 2005

OPT #	Summer 3.1 & Fall 3.2 Quarters	Credit	OPT #	Winter 3.3 & Spring 3.4 Quarters	Credit
363.1	Ocular Disease III	4.0	360.2	Clinical Medicine II	2.0
365.1	Contact Lenses I	6.0	363.3	General & Ocular Emergencies	1.0
380.1	Patient Care	6.0	367	Low Vision Rehabilitation	3.0
390	Evidenced Based Health Care	1.0	376.1	Strabismus and Amblyopia I	4.0
360.1	Clinical Medicine	2.0	380.3	Patient Care	6.0
363.2	Ocular Disease IV	3.0	364	Neuro-Ophthalmic Disorders	4.0
365.2	Contact Lenses II	3.0	376.2	Strabismus and Amblyopia II	3.0
375	Binocular Vision Disorders	3.5	379	Infant & Child Development and Management	3.0
380.2	Patient Care	6.0	380.4	Patient Care	6.0
390	Evidenced Based Health Care	1.0	391	The Business of Optometry	2.0
	Total Semester Credits	35.5		Total Semester Credits	34.0
				Total Third Year Credits	69.5

FOURTH PROFESSIONAL YEAR: 2005 - 2006

OPT #	Summer 4.1, Fall 4.2, Winter 4.3, & Spring 4.4 Quarters	Credit
403	Independent Study	3.0
480	Patient Care	16.0
	Or	
485	Patient Care Externship	20.0
	Total Fourth Year Credits	19/23

[Note: This language is intended to be the foundation of other messaging and communication related to optometry. This document is not intended for public distribution.]

FAQ's

Why do optometrists need oral prescriptive authority?
ODs provide primary eye care and need oral pharmaceuticals to provide better and more comprehensive care. In many rural areas throughout Alaska, ODs are the only eye care physicians available.

Are optometrists trained to prescribe oral medic: 'ion? What about the OD who went to school 30 years ago?
ODs are educated and trained in general and ocular pharmacology as well as the side effects and interactions of pharmaceuticals. Optometrists receive at least 200 classroom hours of pharmacology as well as at least 2,000 patient contact hours examining patients and prescribing topical and oral medications when necessary. In addition, all optometrists must participate in ongoing continuing education courses to stay current on the latest standards of care.

What is the worst case scenario...does this place the public at risk?
With the utilization of peer review mechanisms and Board of Optometry oversight, there are adequate safeguards in place for the general public

Will Optometrists benefit financially from this legislation?
No. This legislation does not benefit optometrists financially. However, it does allow the citizens of Alaska to benefit through better overall eye care while saving time and money.

[illegible]s Alaska really need Optometrists to have this authority?
This elevation of scope is particularly appropriate in rural states. It will be of great benefit to the citizens of Alaska because of the broad geographical distribution of our optometrists. In addition, in larger communities it will allow greater freedom in choice of an eye care professional.

[Note: This language is intended to be the foundation of other messaging and communication related to optometry. This document is not intended for public distribution.]

Important Facts

-This legislation will be beneficial in lowering health care costs for the citizens of Alaska.

-As a state that is behind the times, it is very difficult to attract new ODs to the state. A new graduate would prefer to practice optometry in a state that follows current standards of care.

-Optometrists are an integral part of the health care team and work closely with other physicians.

-Optometrists must pass a rigorous national exam administered by the National Board of Examiners in Optometry (NBEO). The 3-part exam includes academic science, clinical science and patient care.

-45 states in the nation allow ODs to prescribe orals with no reported problems over 35 years.

-Expansion of scope of practice is natural. All professions advance as the science of their profession advances, all to the benefit of the patient.

-Primary Care providers, such as optometrists, pediatricians, dentists, and family care MD's offer care for the majority of conditions, but refer to specialists for more complex Secondary Care or sub-specialists for most complex Tertiary Care. The entire medical community teams with specialists such as ophthalmologists, cardiologists, ENT's, neurosurgeons, etc. Primary care is cost-effective, while specialty care is more expensive.

> For example, when a child has an ear infection you take them to see their pediatrician who prescribes an oral medication to treat the infection. If the ear infection continues to come back or does not go away with the medication, the pediatrician then refers the child to the ENT for more intense treatment and possibly surgery. This example shows the best use of the medical system. It would not be necessary or efficient to take a child to the ENT for every minor ear infection.

-Granting oral prescriptive authority to optometrists does not take away the purpose of an ophthalmologist. They are specialists and surgeons and are overqualified for many of the routine treatments that require oral medications. What optometrists are asking for are the tools necessary to provide efficient, effective care to Alaskans.

PRIMARY EYE CARE (Optometrist)	SECONDARY EYE CARE (Ophthalmologist)	TERTIARY EYE CARE (Specialty Ophthalmologist)
Conjunctivitis (Pink Eye)	Eyelid surgery	Reconstructive oculoplastic surgery
Eyelid infection (stye)	Eyelid tumor	Intraocular tumor
Corneal abrasion	Corneal laceration	Corneal transplant
Therapeutic treatment of glaucoma	Laser surgery for glaucoma	Filtering surgery for glaucoma
Foreign body removal- Anterior eye surface	Foreign body removal– Interior of eye	Foreign body removal with complications
Cataract care, pre-op & post-op	Cataract surgery	Severe complications of cataract surgery
Refractive surgery care, pre-op & post-op	Refractive surgery	Severe complications of refractive surgery

1. First Diagnostic Drug Authority, 1971 – Rhode Island (pg 1)
2. First Oral Drug Authority, 1977 – North Carolina (pg 1)
3. Laws establishing or expanding prescriptive authority for ODs have been enacted **164** times in the 50 states, D.C., Guam & Puerto Rico (pg 2)
4. Laws repealing or diminishing prescriptive authority for ODs have **never** been enacted. (pg 2)
5. 45 States, D.C. & Guam have oral prescriptive authority. (pg 3)
6. 19 states have no restrictions on oral drugs. (pg 3)
7. 29 states have injectable drug authority. (pg 13)
8. 18 states are limited to anaphylaxis only. (pg 13)
9. 36 states did not require additional CE for increased scope of practice. (pg 5)
10. The Alaska Medical Board surveyed Medical Boards throughout the nation in 2001. There were no reported problems. (pg 14)

April 26, 2007

Representative Ralph Samuels
Alaska State Legislature
Juneau, AK 99801

Dear Representative Samuels:

Please support House Bill 113 that expands prescribing privileges for Alaska optometrists. These doctors are extremely qualified and should not have unnecessary restrictions placed on their licenses.

Several years ago, my eye was injured with a piece of sharp metal and I went to a medical doctor in Anchorage. I was examined and received eye drops but suffered with a painful eye for 3 days, then returned for another visit with the MD and still it was not improving.

I then went to an Anchorage optometrist who examined me with a special microscope and in 30 seconds discovered that my cornea had been punctured. He immediately contacted a local eye surgeon to come in and stitch up the hole in my eye. The optometrist followed my progress for many months, and has provided my eye care for many years since that injury.

Regular medical doctors do not have the special instruments or special training for treating the eye that optometrists have. Optometrists are qualified doctors the same as dentists, with virtually identical training. Most other states recognize and respect the services of optometrists, and do not have such restrictions as Alaska.

I also was required to go to an ophthalmologist for an insurance exam, where I received hasty, expensive, and less caring treatment compared to what I experience with my optometrist. I am thankful for the surgeon that stitched up my cornea, but it was the expertise and fast action of the optometrist that saved my eye.

Sincerely,

Andrea Gribbin
Prudential Jack White Real Estate
3801 Centerpoint Drive, STE 200
Anchorage, AK 99503

OF OPHTHALMOLOGY
The Eye M.D. Association

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1101 Vermont Avenue NW
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Via Facsimile
April 24, 2007

Alaska State Legislature
State Senate
State Capitol
Juneau, AK 99801

Dear Senator Green:

I am writing to ask you to oppose CSHB 113, a bill that would give optometrists the authority to prescribe oral and injectable drugs. Although the bill language has changed since introduction, the current language does not improve the quality of eye healthcare available to Alaska citizens. Indeed, enactment of this legislation would result in a decline of both the short and long-term quality of eye care available to Alaska citizens.

The CSHB 113 "blank check" authorization of oral medications (antivirals, antifungals, antihistamines, antimetabolites, steroids, antibiotics, and oral anti-glaucoma drugs) will result in increased potential patient risks. In addition to the oral systemic drugs authorized in CSHB 113, this legislation also would allow Alaska optometrists to inject Botox into the eyelids and surrounding tissues, inject steroids into chalazions, inject anesthetics into the lid, and prescribe a broad array of narcotics and analgesics. Such a wide expanded prescription and injection authority is not in the best interest of patient care.

Optometry did not seek the approval of or even consult with the Alaska State Medical Board, any medical schools, or any ophthalmology residency program regarding the education and clinical training necessary to competently prescribe and administer the drugs authorized in CSHB 113. Optometry school is not a substitute for four years of medical school, a hospital residency, and three years of ophthalmology residency training.

It should be pointed out that optometry education is not comparable to even podiatry or dentistry education. To be licensed in Alaska, podiatrists must complete a one-year podiatric surgical residency program. To be licensed as a dental specialist in Alaska, these students must complete a two-year postgraduate program. Although there is no residency requirement for dental school graduates, 41 percent of dental school graduates immediately enter a post-graduate training program. In contrast, only about 10 percent of optometrists complete a residency program nationally. Furthermore, a residency program is not required as a part of any optometry school program or a requirement to be licensed in Alaska.

The supporters of the bill state that optometrists are authorized to prescribe oral drugs in 45 states. However, most of these states have significant limitations and patient safeguards on oral drug prescribing authority. Frankly, we wish there were additional limitations. Even so, given that our paramount concern is patient safety, we are alarmed that Alaskan optometrists are refusing to present and discuss these limitations with you. Unwisely, what optometrists want in Alaska is a "blank check" to prescribe any oral drug for any eye disease without any significant, additional educational requirement. It is important to remember that one cannot treat serious eye disease separately from having an understanding of the entire body. Medical schools uniquely provide this knowledge base. Optometrists lack this critical, fundamental knowledge and experience.

This legislation is not of front of you because of public concern and an outcry regarding a lack of quality eye care. This is a piece of rather unfortunate, special interest legislation promoted by Alaska's optometry lobby. As an ophthalmologist, it is important for me to ensure that the citizens of your state receive appropriate medical eye care. Limiting optometrists to the tasks for which they are competent is in the best interest of patients. Therefore, I ask you again to oppose CSHB 113.

Sincerely,

CP Wilkinson

C P. Wilkinson, MD
President

Attachment (1) Cc: Alaska State Senate

AMERICAN ACADEMY OF OPHTHALMOLOGY
The Eye M.D. Association

American Academy of Ophthalmology
State Governmental Affairs
April 18, 2007

Review of Alaska State Board of Examiners in Optometry Letter dated April 10, 2007.

The Alaska State Board of Examiners in Optometry claims that this bill would allow optometrists to prescribe limited systemic drugs. In fact, compared to the optometric practice acts in 49 out of 50 states, this bill is not limited.

The Alaska State Board of Examiners in Optometry claims that similar legislation has been enacted in 45 states. In fact, similar legislation has not been enacted in 45 states. Virtually, every state has stricter limitations on the use of systemic medications.

The Alaska State Board of Examiners in Optometry claims that there are many new drug treatments every year. This is not a reason to expand the scope of practice of optometry. In fact, there are not many new drug treatments that are introduced every year in the specialty of ophthalmology. The standard of care in the treatment of eye disease evolves over time.

The Alaska State Board of Examiners in Optometry claims that optometrists are fully educated and competent to prescribe any drug for the treatment of the eye regardless of the route of administration. Fully competent suggests an equivalence with ophthalmology. Unlike ophthalmologists, optometrists do not go to medical school, complete a hospital residency, and complete a three year residency in ophthalmology. Optometric education does not include substantial clinical training in the prescribing of systemic medications.

The Alaska State Board of Examiners in Optometry cites a 2001 survey of optometric boards in other states that have enacted similar legislation, suggesting there have been no problems. In 2001, there were no states that had similar legislation. In fact today, there is only one state with a comparable statute.

The Alaska State Board of Examiners in Optometry claims that there are adequate safeguards in place to protect the public. Given that no one on the board prescribes these medications in the state of Alaska and that the board did not consult with the medical board on any education and training requirements that might be needed, a claim about protecting the public cannot be made with authority or confidence by the state optometry board.

The Alaska State Board of Examiners in Optometry states that this bill would improve access to quality eye care and reduce costs. In fact, this bill would only create two tiers in access to quality eye care. Given the fact that many patients with serious eye disease requiring systemic drugs will obtain a second opinion and that delayed, appropriate treatment by an ophthalmologist may result in additional costs to the patient and lost work time for the patient, this bill would not reduce costs. Moreover, federal law requires ophthalmologists and optometrists to be reimbursed at the same rate for the services they provide to Medicare patients, regardless of any differential in education and training. Private payors generally follow the same fee schedule and use similar reimbursement practices.

STATE OF ALASKA
DEPARTMENT OF
COMMERCE
COMMUNITY AND
ECONOMIC DEVELOPMENT

Division of Corporations, Business and Professional Licensing

Sarah Palin, Governor
Emil Notti, Commissioner
Rick Urion, Director

ALASKA STATE MEDICAL BOARD

RESOLUTION OF THE
ALASKA STATE MEDICAL BOARD

Title: An Act Relating to the Prescription and Use of Pharmaceutical Agents, Including Controlled Substances, by Optometrists

WHEREAS, the Alaska State Legislature is considering CSHB 113, a bill that would give optometrists licensed in the State of Alaska the authority to prescribe oral and injectable medications; and

WHEREAS, a degree from a college of optometry school is not a substitute for four years of medical school, a hospital residency, and three years of ophthalmology residency training; and

WHEREAS, optometrists do not have the clinical experience to safely administer injections and prescribe oral medications; and

WHEREAS, CSHB 113 may result in increased potential patient risks; and

WHEREAS, CSHB 113 would not improve the quality of eye healthcare available to the citizens of Alaska.

NOW THEREFORE BE IT RESOLVED, the Alaska State Medical Board opposed CSHB 113 because the board believes that this legislation would endanger patients.

David Head MD

David M. Head, MD, Chair.
Alaska State Medical Board

12 April 2007

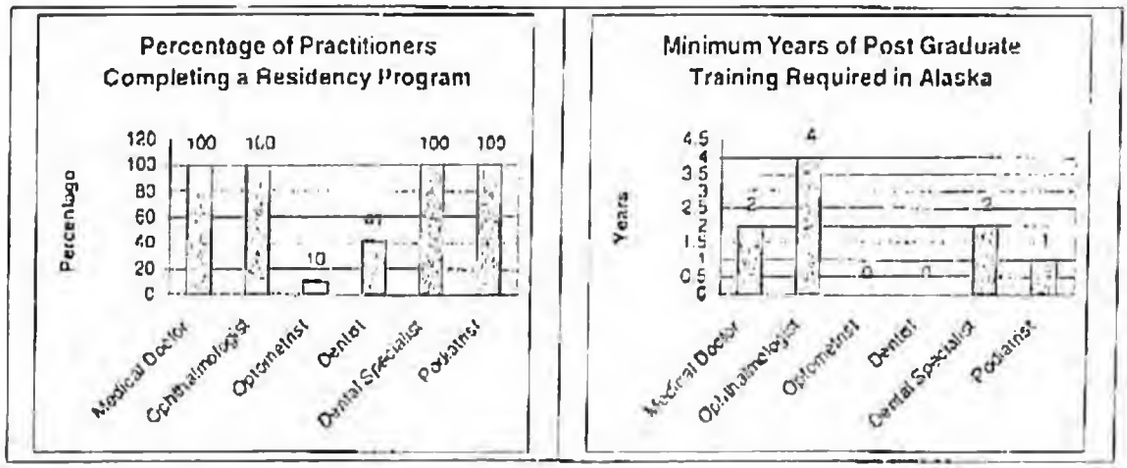
550 West Seventh Avenue - Suite 1500, Anchorage, AK 99501-3567
Telephone: (907) 269-8163 Fax: (907) 269-8196 Website: www.commerce.state.ak.us/occ/pmed.htm

Post Graduate Training Comparison Between Optometrists and Selected Professions

Ophthalmologists are medical doctors who specialize in the treatment of eye disease after three to four years of training after medical school and hospital residency. In arguing for expanded scope of practice to treat eye disease, optometrists, on the other hand, compare their education and training to podiatrists and dentists. However among the many significant differences between optometrists and these other professions is post-graduate training.

Since we are discussing eyes - not feet or teeth, the more reasonable comparison is between the education and training of an ophthalmologist and that of an optometrist. The question at hand is whether optometrists, without seeking the approval of or consulting with the state medical board, any medical schools, or any ophthalmology residency program, have devised a unique method to learn to prescribe systemic medications with just enough fragments and bits of knowledge to not harm patients in this state. The answer is that they have not. Optometry school is not a substitute for four years of medical school, a hospital residency, and three years of ophthalmology residency training.

It should be pointed out that optometry education is not comparable to even podiatry or dentistry education. To be licensed in this state, podiatrists must complete a one-year podiatric surgical residency program. To be licensed as a dental specialist, these specialists must complete a two-year postgraduate program. Although there is no residency requirement for dental school graduates, 41 percent of dental school graduates immediately enter a post-graduate training program. In contrast, only about 10 percent of optometrists complete a residency program nationally. Furthermore, the completion of a residency is not required as a part of any optometry school program and is not a requirement to be licensed in this state.



Medical Doctors

All medical doctors must complete at least a one year residency program upon graduation from medical school. In Alaska, the requirement is two years if the medical doctor graduated after 1995. http://www.labor.state.ak.us/research/dlo/plw_surg.htm

Ophthalmologists (EYE MDs)

In addition to the same one year residency program that all medical doctors must complete, to become an ophthalmologist the medical doctor must also complete an additional three to four year residency training program that specializes in medical and surgical treatment of the eye. http://www.acgme.org/acWebsite/downloads/RRC_progReq/240pr106.pdf

Optometrists
Nationally, approximately 10 percent of all optometrists complete a one year residency program. Moreover, optometric *residencies are not required in Alaska or elsewhere by law or by professional standard.* http://www.opted.org/teampublish/uploads/SpringStudentInterest.pdf

Dentists
Nationally, approximately 41 percent of dental school graduates immediately enter into post-graduate training program. About 27 percent of all dentists enter a general dentistry residency program and an additional 14 percent enter a dental specialty program. www.adea.org/DEPR/Assocreptjune01.pdf

Dental Specialists
Completion of a two year post graduate program is a prerequisite to be licensed as a dental specialist in Alaska. http://www.labor.state.ak.us/research/dlo/dentist.htm

Podiatrists
Alaska requires podiatrists to complete a one-year podiatric surgical residency program. Today, virtually all podiatry school graduates in the US complete a podiatric residency. It is now a licensing requirement in 41 states. http://www.labor.state.ak.us/research/dlo/podiatr.htm

AMERICAN ACADEMY OF OPHTHALMOLOGY
The Eye M.D. Association

Suite 700
1101 Vermont Avenue NW
Washington, DC 20005-3570

Tel 202.737.6662
Fax 202.737.7061
http://www.aao.org

TANANA CHIEFS CONFERENCE
Health Services
Eye Clinic
122 First Ave, Suite 600
Fairbanks, AK 99701
(907) 452-8251 Fax: 459-3853
Toll Free in Alaska 1-800-478-7822

April 4, 2007

Dear Legislator,

I am writing in support of HB 113 which would allow qualified optometrists to prescribe oral medications for the treatment of eye disorders. I am an optometrist working in an Indian Health Service affiliated clinic. Much of my practice involves travel to the bush where direct access to a physician is very limited and travel to the city for care is expensive. Rural patients who need oral medications as part of their eye care are greatly inconvenienced since these medications must be prescribed by a physician (or a health aide under a physician's supervision). My optometric colleague, a U.S. Public Health Service officer, already has credentials through that agency to prescribe oral medications but is unable to do so in Alaska because our pharmacy cannot accept his prescriptions. 45 of the smaller states have passed legislation the same as or similar to this bill and all recent optometry school graduates are trained in the use of oral medications for the eye. Obviously, Alaska is well behind the times regarding ocular health care. Your vote in favor of HB 113 will benefit my patients and bring Alaska's optometric practice statutes in parity with the rest of the United States.

Sincerely,

TANANA CHIEFS CONFERENCE

James R. Taylor, OD
Eye Clinic

Southcentral Foundation

April 9, 2007

Representative Kurt Olson
State Capitol, Rm 408
Alaska State Legislature
Juneau, AK 99801-1182

RE: Support HB 113 - "An Act relating to Optometry"

Dear Representative Olson:

I am writing to urge support of HB 113, which would add additional prescriptive authority for licensed optometrists with a board endorsement, who obtain the additional educational requirements approved by the Alaska Board of Examiners in Optometry. Alaska optometrists already treat eye disease by prescribing medications, but this bill increases their scope by authorizing additional systemic medications with certain restrictions and requiring additional education.

Southcentral Foundation is a non-profit health care organization of Cook Inlet Region, Inc., which provides a wide range of health care and related services to Alaska Natives and American Indians in Anchorage, the Mat-Su Valley, and surrounding rural villages. When Southcentral Foundation was established in 1982, it consisted of 12 staff providing limited services in three program areas: optometry, dental, and social services. Today, after 25 years, optometry remains one of our core health care services, although we now have over 900 employees and provide health-related services to over 32,000 Alaska Natives through about 65 different programs.

We seek optimum health care for our Alaska Native clients, and view optometry with the respect that is due a profession of its caliber. Please vote "YES" on the passage of HB 113 to ensure quality optometry that is both cost-effective and accountable. This bill has been modified to comply with issues raised in earlier years, and now contains several added restrictions and requirements placed upon the license endorsements of qualified Alaska doctors of optometry.

Sincerely,
SOUTHCENTRAL FOUNDATION

Katherine Gottlieb, MBA
President/CEO

4501 Diplomacy Drive • Anchorage, Alaska 99508
(907) 729-4955 • Fax (907) 729-5000 • www.scf.cc

ALASKA PUBLIC HEALTH ASSOCIATION

Committed To Advancing Alaska's Public Health Since 1978

ALPHA

The Alaska Public Health Association supports HB 113. Currently 45 states, Washington, DC and Guam allow optometrists to prescribe systemic drugs with no reported problems in over 30 years. The American Public Health Association in 1991 recommended that legislatures amend licensing statutes to allow optometrists to use those therapeutic pharmaceuticals that have been determined by the State Board of Examiners in Optometry as being within the scope of competency pharmaceutically licensed optometrists. The State of Alaska has 106 practicing optometrists in 84 communities. We believe that by expanding the scope of practice of optometrists HB 113 will increase access to care in those communities that are not served by an ophthalmolo_ 'st.

John Riley
Board President
April 10, 2007

P.O. Box 9-1825 Anchorage, AK 99509 907/332-1030 *e-mail:* publichealth@alaska.net www.alaskapublichealth.org

Alaska Primary Care Association

"...uncompromising in the pursuit of access to primary care for all Alaskans."

The Honorable Ralph Samuels
Alaska House of Representatives
State Capitol, Room 204
Juneau, Alaska 99801-1182

Re: Support for HB 113 Optometrists' Use of Pharmaceuticals

April 17, 2007

Dear Representative Samuels,

The Alaska Primary Care Association (APCA) wishes to express its support for your legislation, HB 113, which would expand the scope of practice for optometrists by allowing them to administer systemic eye medications in addition to the topical medications they can currently administer under the law. The APCA considers the education and training of the relevant health care providers prior to lending its support to increased scopes of practice changes; in the case of the optometrists, the APCA has concluded that these providers have received the proper training for the administration of these medications.

By expanding the scope of practice for optometrists, HB 113 will increase access to health care for Alaskans while reducing health care costs. Because the APCA's main mission is to increase access to primary care in Alaska, the APCA has an interest in the success of HB 113. Primary care encompasses basic medical care, which includes the treatment of routine eye conditions, in addition to behavioral health and dental services.

The Alaska Primary Care Association represents 24 Community Health Centers (CHCs) with 115 clinic delivery sites as well as other safety net providers throughout the state. Alaska's CHCs treat over 80,000 patients annually. The expansion of health providers' scopes of practice, when educationally appropriate, is an important step the Alaska State Legislature can take to assist in the promotion of health care access, the reduction in health care costs, and the improvement of health outcomes for its residents. The APCA offers its full support for HB 113 and joins you in asking the Senate to move this legislation through the committee process and secure its passage.

Respectfully,

Regan Mattingly
State Affairs Coordinator

Shelley S. Hughes
Government Affairs Director

Marilyn Kasmar
Executive Director

Alaska Primary Care Association
903 W Northern Lights Blvd, Suite 200
Anchorage, AK 99503

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MARSH

Marsh Affinity Group Services
a service of Seabury & Smith, Inc.
1440 Renaissance Drive
Park Ridge, IL 60068-1400
847-803-3100
800-323-2106

January 26, 2007

Ms. Sherry L. Cooper, Manager
State Government Relations
American Optometric Association
243 N. Lindbergh Blvd., Floor 1
St. Louis, MO 63141

Dear Ms. Cooper:

On behalf of our client, the American Optometric Association (AOA), we ask that you please consider the following information regarding professional liability coverage available to licensed Optometrists practicing in all 50 States and the District of Columbia.

Marsh Affinity Group Services, a service of Seabury & Smith, Inc., has an uninterrupted 10+ year relationship with the AOA as their sponsored professional liability partner. Because of our long-term partnership with AOA, we believe Marsh currently represents the largest portfolio of Optometrist professional liability insurance in the country. We are very fortunate to have over 7,500 Optometrists depend on Marsh for this important liability coverage.

Our primary carrier for professional liability coverage is Chicago Insurance Company, a member of the Interstate National Corporation, one of the Fireman's Fund Insurance Companies. Chicago Insurance Company does not currently charge different rates based on the procedures performed or not performed by each Optometrist. In other words, the scope of optometric related professional services does not increase or decrease the rate charged for each insured. Prescription authority granted to Optometrists in other states does not in any way impact the premium paid by individuals in those states.

Unfortunately, a small percentage of our insured Optometrists have experienced professional liability claims that they in turn have reported to Chicago Insurance Company. When allegations of professional malpractice have necessitated a defense, the carrier has responded by conducting a professional investigation of care and outcome. Chicago Insurance Company confirmed on January 25, 2007 that their very credible claim portfolio shows that prescription authority is not a significant cause of loss for Optometrists. As such, they also confirmed that they have no plans to change their underwriting guidelines or rates regarding prescriptive authority.

Marsh is not presently concerned with the overall financial health or performance of the AOA professional liability program, although we must acknowledge that we have not conducted an actuarial review of the adequacy of Optometrist rates. We rate the likelihood of Chicago Insurance Company remaining a professional liability market for Optometrists as "Excellent".

We appreciate your willingness to consider the above information. If any questions or concerns arise as a result of this letter, please contact us at your earliest convenience.

Sincerely,

Mark

Mark A. Brostowitz, Senior Vice President
Allied Healthcare Professional Liability
Mark.brostowitz@marshpm.com
847-493-4418

D.L. THANEPOHN, OD.
P.N. REBER, O.D.
S.A. LENTFER, O.D.
J.C. FALCONER JR., O.D.
L.M. NOUN, O.D.

Alaska
EYE CARE CENTERS

DOWNTOWN ANCHORAGE
(907) 272-2557

WASILLA
(907) 376-5266

1345 W. 9th Ave.
Anchorage, Alaska 99501
(907) 272-2557
FAX (907) 274-4932

March 19, 2007

Representative Peggy Wilson
Chair, House HESS Committee

Representative Wilson,

I am writing to express my support for the committee substitute for House Bill 113. This bill will allow me to prescribed drugs other than those topically applied (drops and ointments) to my patients.

As an optometrist in Alaska, I am a health care provider who is not being utilized to his fullest capabilities. Optometrists have degrees from four year graduate institutions which include extensive education and training in the treatment of ocular disease and pharmacology. While the topical drugs which I can now prescribe are sufficient for treating many types of eye disease, there are many others in which alternative routes of drug administration are far superior or even essential. Some eye conditions that come into my office are accompanied by severe pain, and some are medical emergencies. It is inefficient and unnecessary to require them to see another doctor to get the prescription. And in Alaska, with many rural communities where the only eye doctor is an optometrist, this legislation is especially needed.

Forty-five states have already seen the wisdom in allowing optometrists prescribe oral drugs, and we still have one of the lowest malpractice rates in the health care industry. That gives you a measure of how much of a risk we are to our patients.

The people of Alaska expect their local eye doctor to be able to prescribe the treatment they need. Please let us do our jobs better.

Sincerely,

James C. Falconer, Jr. OD
President-Elect, Alaska Optometric Association

CATARACT AND LASER INSTITUTE

March 20, 2007

Honorable Representative Peggy Wilson
Chair, House HESS Committee

Representative Wilson:

I am writing to support your committee substitute for House Bill 113.

This is legislation that is long overdue for the state of Alaska. Similar legislation has been adopted in 45 other U.S. states which has allowed Optometrists to provide more comprehensive care to their patients.

As you know Alaska is largely a rural state, consequently Alaskans don't have the same access to care that patients have in the lower-48. Optometrists outnumber ophthalmologists in Alaska and we better serve rural Alaska than does ophthalmology. This legislation would give Alaskans better access to more comprehensive eye care, and would eliminate the need for a patient to see another provider for a medication the Optometrist has already determined they need.

You may hear arguments against this legislation stating that Optometry does not have the training or the experience needed to prescribe systemic medications. These arguments simply do not hold water. An Optometric education consists of four years of post-graduate, doctoral-level training concentrating on the eye, visual system, and systemic diseases affecting vision. If we were not adequately trained and experienced 45 other states would not have already adopted this legislation.

Corporate Office
[illegible]

This legislation would be good for Alaskans giving them better access to quality eye care.

Thank you for you time and attention to this important issue.

Sincerely,

Paul M. Barney, O.D.
Center Director
Pacific Cataract & Laser Institute
Anchorage, Alaska

April 9, 2007

House of Representatives
Alaska State Capitol
Juneau, Alaska 99801-1182

Dear Legislator,

I have had experience with the treatment of eye diseases by an optometrist. He was very knowledgeable and thorough during his examinations and I have every confidence in an optometrist ability to treat eye diseases. So with that said, I support HB113.

Sincerely,

Ted M. Rohloff
Finance Director
Denali Family Services
1675 C St. Suite 117
Anchorage, Alaska 99501
(907) 222-2307

cc: Alaska Optometric Association

March 28, 2007
The Honorable Peggy Wilson
Chair, Health, Education & Social Services
Alaska State Capitol
Juneau, Alaska 99801-1182

Madame Chair,

I am writing to ask your committee's support on HB 113. This bill, if passed, would bring the scope of practice of Alaska's optometrists to a level commensurate with their training and closer to the scope allowed in 45other states. HB 113 would allow optometrists to add systemic medications for treatment of diseases of the eye and related structures. Since 1987 optometrists in Alaska have been able to use topical medication for treatment. Optometric practice expansion to include treatment with systemic medications is a contentious issue with strong views for and against. When you blow away the smoke and look at it on face value this bill IS important to the eye health of Alaskans now and especially in the future.

I am an optometrist who has practiced in Alaska for 21 years. I feel blessed to have been able to be the eye expert in a wide variety of practice situations. In the 21 years I have practiced in Alaska I was the primary vision care provider in Barrow for 3 years and after that Ketchikan for the past 18 years. I have done itinerant clinics in Kotzebue, Nome, King Salmon, Dutch Harbor, Pt. Hope, Pt. Lay, Wainwright, Atquasuk, Nuiqsut, Kaktovik, Anaktuvuk Pass, Metlakatla, and Craig, Alaska. Ketchikan serves as the hub of Southeast Alaska so I have patients from Hyder, Myers Chuck, Thorne Bay, Coffman Cove, Hydaburg, Klawock, Port Protection, Port Alexander, and Kasaan. I have referred patients to and co-managed with many ophthalmologists in the state. Because I am in Ketchikan I have also worked with ophthalmologists in the Seattle area. I have seen and co-managed many hundreds of patients with the M.D.s/physicians assistants/nurse practitioners/health aides at the clinics based in the communities above.

In primary eye care it's about proper diagnosis and instituting the proper initial treatment in a timely fashion.
In 1987 optometrists in Alaska with a proper license endorsement began using topical medications only for treatment of eye and related disease. This expansion of practice allowed M.D.s/physicians assistant's/nurse practitioners/health aides (collectively Primary Health Care Providers = PHCP's) to place the responsibility of diagnosing and treating eyes in the optometrist's hands. It gave these medical professionals and the patients they serve an additional eye expert besides the ophthalmologist to refer to for diagnosis and treatment of primary eye disease. This provider, the optometrist, is local and usually available. PCHPs are more than happy to refer their patients to the local eye expert because accurate eye disease diagnosis is dependent on having and being able to properly use specialty equipment (i.e. slit lamp, ophthalmoscopes, tonometers) to gain clinical knowledge about the affected organ (eye and related structures). Proper treatment is based on accurate diagnosis and timely institution of therapy. PHCPs do not have access to or are unfamiliar with the operation of eye diagnostic instruments. Optometrists and ophthalmologists have access to eye diagnostic equipment and have the necessary expertise to use these devices to make accurate eye diagnoses. If the initial diagnosis is not accurate the patient is put through needless worry; un-necessary travel; un-necessary medical testing; improper use of the wrong medicines; increased disability; increased time off work; and in some cases permanent vision loss. Optometrists are accurate diagnosticians of eye disease. Our track record with topical medications and practice liability rates prove it.

Look at the facts and not the rhetoric. Optometrists already manage the eye conditions affected by HB 113…indirectly.
PHCPs have developed a trust in optometry to manage primary eye problems, make the proper diagnosis, choose the appropriate initial treatment, and make the proper referral to a sub-specialist When a patient is referred to an optometrist does the PHCP single out those patients who need topical medication only? NO!!! The PHCP sees the patient and says "your eye is red/or vision is decreased/or you have sudden vision loss/or something is in your eye and hurts/or it itches/or there is mucous coming out/or your cornea is cloudy/or your eyelids are swollen". GO SEE THE EYE DOCTOR. When the patient comes in the optometrist uses their specialty tools and medical expertise to diagnose the problem. If topical medication is most appropriate then a prescription is written for this medication. If an oral or systemic medication is needed the optometrist must take time and contact the referring provider and tell them what medication is recommended. The PHCP then will see the patient again for an office visit to simply write an RX. If the O.D./PHCP relationship is good they may write the prescription for the patient based on the information given them by the doctor of optometry. The doctor of optometry is then typically asked by the provider to follow the patient. Does the initial referring provider see the patient again? No, not unless there are other conditions needing their attention. Who monitors the side effects of the medication in most cases? The doctor of optometry does!!! Doctors of optometry are already one of the primary decision makers in treating primary eye disease. The only thing we can't do is RX systemic medications that we recommend for acute treatment or prescribe refills in the case of chronic treatment. The current method of needing an M.D. to write the RX for these medications is cumbersome and increases the amount of time necessary to begin time sensitive treatment.

HB 113 is not new ground. HB 113 is about trust in the clinical decision making skills of doctors of optometry and acknowledging the additional responsibility associated with prescribing systemic medications. There are only a handful of eye problems that need treatment with systemic medications and these conditions fall into two general categories…ACUTE and CHRONIC conditions of the eye and related structures. Who sees the patient in these instances? The optometrist sees the **acute** patient due to their availability and primary care focus. In rural Alaska the optometrist again is the one who follows the **chronic** patient after they return home from seeing the medical sub-specialist. We live close to or where the patient lives. Optometrists in rural Alaska and in larger urban clinics already do the diagnosing and treating of the majority of primary eye disease…directly with topical medications and indirectly through other PCHPs by recommending systemic medications. Optometrists already manage the case. Ophthalmology doesn't get involved unless the patient is not responding and needs more intensive treatment. We are already seeing the patient for follow-up and are the first one they call if they are having problems.

No there isn't public outcry about rampant eye mistreatment by PHCPs. Why? Because most of the time the eye heals itself or the patient feels they must live with the discomfort and effects on vision they have because of treatment from inaccurate diagnosis. The patient deserves to have the best and most up-to-date care possible. Optometrists and Ophthalmologists have much greater access to information on advances in eye treatment than PHCPs. Proper diagnosis and treatment of eye conditions greatly improves the patient's quality of life.

Passing HB 113 is the right thing to do for Alaskan's today and tomorrow. Look ahead to the future of eye care and the additional contributions prescribing optometrists bring to the table. Increasing the pool of doctoral level educated professionals that are involved in treatment and committed to research makes the probability of finding future cures for common eye problems bright.

Do the proper thing for your constituents…our patients…acknowledge the ability of the optometrist or family eye doctor…finish placing the responsibility for treatment of primary eye disease in the hands of the most available and best trained primary health care provider for the eyes…the doctor of optometry…give us direct access to the additional tools necessary to effectively and efficiently continue to treat primary eye disease. Pass HB 113!!!

Regards,

Erik D. Christianson, O.D.
Ketchikan Eye Care Center
351 Carlanna Lake Rd
Ketchikan, AK 99901
907 225-2020

March 28, 2007

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

Dear Representative Wilson;

I am writing in support of your committee substitute for House Bill 113.

About ten years ago, I began experiencing vision distortions and color loss. After several unfruitful visits with local ophthalmologists, who kept telling me to "come back in six weeks", I turned to Roy Box, my optometrist. After careful evaluation, he told me that I was presenting symptoms of MS, and he immediately researched and then referred me to an excellent MS neural ophthalmologist in Seattle. This doctor confirmed Dr. Box's diagnosis and immediately started treatment, which probably saved what vision I had left. I will be ever grateful to Dr. Box for his knowledge and quick and appropriate referral, and have received equally competent and informed care from his successor. As a result of my optometrists' professional knowledge and cooperative collaboration with the MD's in Seattle, I believe I have had most excellent care, care which allowed me to continue teaching for several years.

I believe that Alaskans need options in choosing competent and conscientious health care professionals. For many Alaskans living in isolated communities, their optometrist is their primary eye care professional. Alaska should follow the examples set by almost all other states and give their optometrists the tools to best serve their patients.

Sincerely, Jacklynne Lorensen

PO Box 210108
Auke Bay, Alaska

March 19, 2007

Steve Dobson, OD
1000 E Dimond Blvd
Anchorage, AK 99515

Honorable Representative Peggy Wilson
Chair, House HESS Committee

Representative Wilson:

I am writing to support your committee substitute for House Bill 113.

HB113 would significantly ***improve access*** and ***decrease cost*** for the thousands of Alaskans in our state who each year seek quality ***optometric medical eye care.*** HB113 when enacted will allow patients to receive prescriptive treatment in-office or go straight to a pharmacy with a prescription written by the primary eye care doctor, instead of having to schedule another doctor's visit simply to get the prescription or the medicine the optometrist has already determined they need. Optometrists do not gain additional income by expanding their prescriptive authority, as the patient is charged for the office visit not which drug is prescribed.

Currently, optometrists in Alaska including myself, prescribe ***antibiotics, anti-virals, anti -inflammatory, allergy, and steroid medications along with medications to treat glaucoma (beta- blockers, alpha- agonists, carbonic anhydrase inhibitors, prostaglandins***) on a routine basis when treating our patients for diseases of the eye and adnexa. Unfortunately, for those optometric patients residing in Alaska these medications are limited to topical (not so for the patients who seek optometric medical eye care throughout most of the United States).

Today, 45 other states allow optometrists to prescribe oral medications for their patients. Levels of authority vary slightly from state to state based on the authority granted by each state legislature. Even if HB113 were enacted, many states would still have more expansive scopes of practice. In fact, optometrists in one state currently perform laser surgeries.

Since 1970 all optometry schools have elevated their education level to a four year post-graduate, doctorate-level professional program along with extensive core curriculum course work in pharmacology, physiology and pathology using the same medical model as taught in dental and medical schools. As a result, optometrists have been safely prescribing systemic drugs in other states since 1977. ***Alaska is unfortunately behind the curve in eye care access and delivery.***

When posed with the question whether Ophthalmologists have more education and training than the Optometrists the answer would be yes. The Optometric curriculum is

comprised of four years of post-graduate, doctorate-level study emphasizing the eye, vision and associated systemic disease with an optional one-year residency. This education is the same medical model as medicine, dentistry, and podiatry. Ophthalmology is a three-year residency beyond medical school. This additional three year residency prepares the Ophthalmologist to be an eye surgeon and tertiary-level specialist. This model is the same for other medical specialties such as cardiology, ENT's (ear, nose, and throat), nephrology, orthopedics etc. Patients routinely schedule appointments with their primary care provider and are referred to a specialist when necessary. This model ***increases access*** to care and helps to ***control costs***. Optometrists refer patients frequently to Ophthalmologists for more advanced eye care or surgery the same as family doctors refer their patients for specialty consultations. General practitioners including Optometrists live and serve in many rural communities through out our state. Other specialists including Ophthalmologists reside mostly in the more metropolitan communities.

HB113 will provide Alaskans with ***additional access*** to high quality medical eye care and help ***control costs*** associated with ***unnecessary referrals*** (lost wages due to time away from work, additional office visit fees). An important fact to realize is similar legislation has passed in 45 other states throughout the last 30 years with ***none*** ever repealed and no reported problems. In fact, the Alaska Medical Board surveyed medical boards throughout the nation to find out if there were any problems in states where similar legislation had passed. Not one medical board reported any problems. In addition, medical malpractice insurance premiums for optometrists did not rise in states where systemic medication (versus topical only) prescriptive authority legislation was approved

Sincerely,

Steven S Dobson O.D.
Past Chairman, Board of Examiners in Optometry

March 20, 2007

David Karpik, OD
1001 Noble St, Ste 410
Fairbanks, AK 99701

Honorable Representative Peggy Wilson
Chair, House HESS Committee
Juneau, AK 99801

Representative Wilson:

I am writing to support your committee substitute for House Bill 113.

First of all, I am passionate about both Alaska and her people. I am a recent graduate of The Ohio State University College of Optometry. Following receiving my degree, I completed post-graduate specialty training: a residency in contact lens and family practice optometry through Pacific University. I now have the good fortune to be serving patients in Fairbanks.

It was quite a shock to come to a state in which so much of my training went underutilized due to restrictive legislation. My didactic and clinical training in pharmacology met or exceeded the quantity and caliber of my colleagues in Dentistry and Medicine at Ohio State. This is not to claim a superior education is provided at Ohio State; in fact a comparison between Illinois College of Optometry, Pacific University College of Optometry, Harvard College of Dental Medicine, and The Ohio State College of Medicine shows equivalency in pharmacology hours of education. This is by design. Optometry is a doctoral level program. The current legislation would make sense 2 generations ago, but does not today.

Additionally, competence with oral pharmaceuticals is confirmed through rigorous testing by the National Board of Examiners in Optometry (NBEO). This board certification consists of approximately 36 hours of testing, with 1 out of the 4 sections of board certification dedicated to treatment of ocular disease with systemic and topical pharmaceuticals. Passing all sections of NBEO examination is required to gain licensure in Alaska.

It is the patient who will gain the most from expansion of prescriptive privilege already in place in the lower 48 that matches the past 30 years of level of training received in an optometric education. No longer will delayed treatment for simple and well understood eye problems cause harm. No longer will public health dollars be wasted for duplicate office

visits to prescribe the medication that the optometrist has deemed necessary.

Sincerely,

David Karpik, O.D.

Dr. Bill Faulkner, Optometrist
400 L Street, Suite 104 Anchorage, Alaska 99501
(907) 276- 1984
Fax (907) 276- 1981

Honorable Representative Peggy Wilson
Chair, House HESS Committee

Representative Wilson:

I am writing to support your committee substitute for House Bill 113.

This is a very simple issue. Optometrists in Alaska would like to join their colleagues in 45 other states in being able to provide a higher level of care to our patients.

With regard to eye care, Optometry takes care of most of the problems most of the people have, most of the time. The circumstances that would require our use of systemic agents might not occur for a week, or we might have three patients in one day that would benefit from this service. We just never know from day to day.

I have recently activated my Oregon Optometric license. It is interesting to note that in the State of Oregon, by the 2009 licensing cycle, it will be an absolute requirement for all licensed Optometrists to have their systemic medication certification. If it is not obtained, then you cannot practice in that State. This is how "mainstream" this certification has become in our profession.

When Optometrists have tried to enhance our level of care in the past, organized Ophthalmology has demonstrated a history of mistruths, half truths and distortions in their opposing testimony. This surely must be based on ego, not logic. Please do not be fooled by their self serving claims.

Alaskan Optometrists simply want to join with the rest of the profession in the United States in being better able to care for our patients.

Thank you for your time and attention to this matter.

William D. Faulkner, O.D.
Cc: Alaskan Optometric Association

Alaska State Medical Association

Rep. Anna Fairclough

From: katy rice [katyrice4@yahoo.com]

Sent: Saturday, March 24, 2007 3:41 PM

To: Rep. Peggy Wilson; Rep. Bob Roses; Rep. Anna Fairclough; Rep. Mark Neuman; Rep. Paul Seaton; Rep. Sharon Cissna; Rep. Berta Gardner

Subject: *****SPAM***** House Bill 113

Dear Representatives,

I am an optometrist currently practicing in Fairbanks, AK. I moved here last summer after completing an ocular disease residency at a Veterans Administration Hospital in Huntington, West Virginia and continue to hold licensure in the states of Ohio and Alaska.

After listening to the audio from Wed. March 21, 2007 regarding House Bill 113, Optometrists' Use of Pharmaceuticals, I wanted to give my opinion in hopes that this would be considered before a final decision is made. One significant part of any profession is to understand one's boundaries and limitations and know when it is necessary to refer a patient to a different doctor. However, it is not necessary for me to refer a patient to someone else in order to treat certain eye conditions that I have been educated, trained, and tested on. Opposition to HB 113 states that optometrists do not have the same education or training as an ophthalmologist. This is true. We do not have the same training for if we did, we would be asking for privileges to do surgery. Optometrists and ophthalmologists are not the same in training, or clinical applications, however that does not mean that optometrists should be limited by what they are allowed to do because the state already has ophthalmologists. If the state wanted to limit eye care availability because "there are already enough doctors" then they would put a cap on the number of ophthalmologists or optometrist owed to practice in this state and this is obviously a ridiculous situation. We are simply asking e right to practice to the level of our training. I am confidant that once the members of the com e understand the training and testing of doctors of optometry, support of HB 113 will come with significantly less difficulty.

Base on the audio of the HESS committee hearing on March 21, I would like to provide additional information on some issues that were brought up. First, it should be known that the pre-requisites for getting into optometry, dental, medical, osteopathy, pharmacy, veterinary, and podiatry school are essentially the same. All of the medical professions schools are four year programs, and yes this means optometry as well. All optometrists graduate with a Doctor of Optometry degree. The amount of pharmacology, anatomy, and pathology are essentially the same between optometry, medicine, osteopathy, and dentistry. (I do not have the exact number of semester hours to give you but know Representative Kawasaki can pass this information on to you.) Also, before anyone is considered for optometric licensure in a state, one must have already graduated from an optometry school and pass all of the National Board of Examiners in Optometry tests. These are a series of approximately 36 hours of testing taken over two years. You can access the content information on the website: http://www.optometry.org/index.cfm. This can be compared to the medical boards that Doctors of Osteopathy and Medical Doctors and must pass.

Representative Samuels emphasized that because we live in a "rural" state where medical help can be hours or days away, it is even more important for optometrists to have prescriptive authority. I would like to add that it doesn't matter if there are two ophthalmologists right across the street from me, or two days away from me. My proximity to an ophthalmologist does not change, negate, or validate my level of training. While I understand that the proximity will influence my decisions and care it should not

dictate the care I provide. A dentist does not have to call an M.D. or D.O. in order to inject a shot of Novocain, why should I have to call an M.D. or D.O. in order to practice within the training of my profession?

I understand that the committee has concerns regarding this bill. I urge you to look at the other 45 states who already grant prescriptive authority as an example that this is nothing new or out of the ordinary, but is a commonly accepted way of practicing. Yes, our bill will be different than any other state, but that is because optometry is state legislated, unlike medicine or osteopathy. Also, please look at the malpractice insurance across the country for optometrists as an indicator of the level of safety with which optometrists utilize their prescriptive authority. Private insurers are in it to make money and have very sophisticated ways of placing statistical evidence on their clients. If optometrists were taking advantage of their prescriptive rights and placing patients in harms way this would be evident and optometry would not have the lowest malpractice insurance rates of all doctorate level health care professions.

Two concerns that were brought up during the meeting were whether optometrists are trying to get their foot in the door to do laser surgery and if writing for oral medications would make optometrists more money. These questions seem irrelevant to the issue at hand. What is relevant is that we have the training to prescribe, and that we have a proven track record of safely doing so in all states that have had this authority granted. To satisfy curiosity, I don't want to do laser surgery, just as not all ophthalmologists want to do laser surgery. And no, allowing optometrists to prescribe oral medications to treat eye conditions will not provide a larger income. An office visit is charged when a patient is seen regardless of any medication being prescribed or any referrals written. These concerns do not relate to optometrists' education or training with regard to writing prescriptions, nor should they prevent optometrists' from treating eye conditions that are well within the scope of practice and level of training. Full prescriptive authority is within the level of training.

Thank you for all of your time and consideration to House Bill 113. If you have any questions or concerns you would like to discuss further, please feel free to contact me.

Sincerely,
Kathleen Rice, O.D.
2142 Standard Ave
Fairbanks, AK 99701
614-214-5289

Honorable Representative Kurt Olson
Fax 907-465-3835

Representative Olson:

I am writing to support your committee substitute for House Bill 113.

First of all, I am passionate about both Alaska and her people. I am a recent graduate of The Ohio State University College of Optometry. Following receiving my degree, I completed post-graduate specialty training: a residency in contact lens and family practice optometry through Pacific University. I now have the good fortune to be serving patients in Fairbanks.

It was quite a shock to practice in a state in which so much of my training went underutilized due to restrictive legislation. My didactic and clinical training in pharmacology met or exceeded the quantity and caliber of my colleagues in dentistry and medicine at Ohio State. This is not to claim a superior education is provided at Ohio State; in fact a comparison between Illinois College of Optometry, Pacific University College of Optometry, Harvard College of Dental Medicine, and The Ohio State College of Medicine shows equivalency in pharmacology hours of education. This is by design. Optometry is a doctoral level program. The current legislation would make sense several generations ago, but does not today.

Additionally, competence with oral pharmaceuticals is confirmed through rigorous testing by the National Board of Examiners in Optometry (NBEO). This board certification consists of approximately 36 hours of testing, with 1 out of the 4 sections of board certification dedicated to treatment of ocular disease with systemic and topical pharmaceuticals. Passing all sections of NBEO examination is required to gain licensure in Alaska.

It is the patient who will gain the most from expansion of prescriptive privilege already in place in 45 other states that corresponds with the level of training received in an optometric education during the past 30 years. Optometrists have a proven track record of safe, high quality care in these other states. No longer will delayed treatment for simple and well understood eye problems cause harm, and no longer, and no longer will public health dollars be wasted for duplicate office visits to prescribe the medication that the optometrist has deemed necessary.

Sincerely,

David Karpik, O.D.
2142 Standard Ave.
Fairbanks, AK 99701

Alaska Optometric Association

Alaska's Authority on Primary Eye & Vision Care

1689 C Street, Ste 222
Anchorage, AK 99501
907.770.3777
Fax: 907.272.7532
akoa@alaska.com
www.akoa.org

March 19, 2007

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

Dear Representative Wilson;

On behalf of the frontline eye care providers serving patients in communities across our state, the Alaska Optometric Association would like to voice our support of your committee substitute for House Bill 113.

Optometrists across the United States have been safely diagnosing and treating eye conditions with topical and systemic medications since 1977 with no problems, and with topical medications in Alaska since 1992, with zero complaints to the Board. HB 113 simply elevates Alaska optometry scope of practice to include systemic medications.

Optometrists are fully educated and trained on all types of prescriptive medicines for the whole body plus the eye, including contraindications and side effects. They pass comprehensive National Board Examinations covering these topics. This education and training fully prepares them to diagnose and treat eye conditions appropriately or refer patients to a more specialized provider when necessary.

The purpose of this bill is to allow patients to receive prescriptive treatment from their primary eye-care provider, instead of having to schedule another doctor's visit simply to get the prescription for the medicine the optometrist has already determined they need. Optometrists gain no additional income by expanding their drug authority, it simply benefits the patients by providing better access to eye care throughout Alaska.

Alaska is far behind the curve in eye care access and delivery. HB 113 elevates optometry's scope of practice in line with the 45 other states throughout the nation that have been successfully prescribing systemic medications for the past 30 years with no reported problems. In addition, it lowers health care costs for Alaskans and provides better incentives to bring the best qualified doctors of optometry to Alaska.

Please review the enclosed "Frequently Asked Questions" for more details.

Sincerely,

Tracy Oman

Tracy Oman
Executive Director

Enclosure

Alaska Optometric Association

Alaska's Authority on Primary Eye & Vision Care

1689 C Street, Ste 222
Anchorage, AK 99501
907.770.3777
Fax: 907.272.7532
akoa@alaska.com
www.akoa.org

January 12, 2007

The Honorable Ralph Samuels
House of Representatives
Alaska State Capitol
Juneau, Alaska 99801-1182

Dear Representative Samuels;

This letter is in response to the letter sent to you by Carl Rosen, MD regarding his analysis of HB 113, Optometric Scope of Practice Legislation. Although I am sure Dr. Rosen's letter was well intended, his analysis does not reflect the education, training, and experience of optometrists over the past 30 years.

Optometrists across the United States have been safely diagnosing and treating eye conditions with topical and systemic medications since 1977 with no problems, and with topical medications in Alaska since 1992, with zero complaints to the Board. HB 113 simply elevates Alaska optometry scope of practice to include systemic medications.

Optometrists are fully educated and trained on all types of prescriptive medicines for the whole body plus the eye, including contraindications and side effects. They pass comprehensive National Board Examinations covering these topics. This education and training fully prepares them to diagnose and treat eye conditions appropriately or refer patients to a more specialized provider when necessary.

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Please review the enclosed "Frequently Asked Questions" for more details.

Sincerely,

Tracy

Tracy Oman
Executive Director

Enclosure

AMERICAN ACADEMY OF OPHTHALMOLOGY
The Eye M.D. Association

Via Facsimile
May 11, 2007

Suite 700
1101 Vermont Avenue NW
Washington, DC 20005-3570

Tel. 202.737.6662
Fax 202.737.7061
http://www.aao.org

Honorable Senator Bert Stedman, Co- Chair
State Senate Finance Committee
Alaska State Legislature
State Capitol
Juneau, AK 99801

Dear Senator Stedman:

I am writing to ask you to oppose SCS CSHB 113 (L&C), a bill that would give optometrists the authority to prescribe oral and injectable drugs. Although the bill language has changed since introduction, the current language does not improve the quality of eye healthcare available to Alaska citizens. Indeed, enactment of this legislation would result in a decline of both the short and long-term quality of eye care available to Alaska citizens.

The SCS CSHB 113 (L&C) "blank check" authorization of oral medications (antivirals, antifungals, antihistamines, antimetabolites, steroids, antibiotics, and oral anti-glaucoma drugs) will result in increased potential patient risks. In addition to the oral systemic drugs authorized in SCS CSHB 113 (L&C), this legislation also would allow Alaska optometrists to inject steroids, anesthetics, diagnostic dyes and other therapeutic substances, and prescribe a broad array of narcotics and analgesics. Such a wide expanded prescription and injection authority is not in the best interest of patient care.

Optometry did not seek the approval of or even consult with the Alaska State Medical Board, any medical schools, or any ophthalmology residency program regarding the education and clinical training necessary to competently prescribe and administer the drugs authorized in SCS CSHB 113 (L&C). Optometry school is not a substitute for four years of medical school, a hospital residency, and three years of ophthalmology residency training.

It should be pointed out that optometry education is not comparable to even podiatry or dentistry education. To be licensed in Alaska, podiatrists must complete a one-year podiatric surgical residency program. To be licensed as a dental specialist in Alaska, these students must complete a two-year postgraduate program. Although there is no residency requirement for dental school graduates, 41 percent of dental school graduates immediately enter a post-graduate training program. In contrast, only about 10 percent of optometrists complete a residency program nationally. Furthermore, a residency program is not required as a part of any optometry school program or a requirement to be licensed in Alaska.

The supporters of the bill state that optometrists are authorized to prescribe oral drugs in 45 states. However, most of these states have significant limitations and patient safeguards on oral drug prescribing authority. Frankly, we wish there were additional limitations. Even so, given that our paramount concern is patient safety, we are alarmed that Alaskan optometrists are refusing to present and discuss these limitations with you. Unwisely, what optometrists want in Alaska is a "blank check" to prescribe any oral drug for any eye disease without any significant, additional educational requirement. It is important to remember that one cannot treat serious eye disease separately from having an understanding of the entire body. Medical schools uniquely provide this knowledge base. Optometrists lack this critical, fundamental knowledge and experience.

This legislation is not of front of you because of public concern and an outcry regarding a lack of quality eye care. This is a piece of rather unfortunate, special interest legislation promoted by Alaska's optometry lobby. As an ophthalmologist, it is important for me to ensure that the citizens of your state receive appropriate medical eye care. Limiting optometrists to the tasks for which they are competent is in the best interest of patients. Therefore, I ask you again to oppose SCS CSHB 113 (L&C).

Sincerely,

CP Wilkinson

C P Wilkinson, MD
President

Attachment (1)
Cc: Alaska State Senate

Central Council
Tlingit and Haida
Indian Tribes of Alaska

CENTRAL COUNCIL
tlingit and haida indian tribes of alaska
ANDREW P. HOPE BUILDING
320 West Willoughby Avenue • Suite 300
Juneau, Alaska 99801-9983

CENTRAL COUNCIL OF TLINGIT AND HAIDA INDIAN TRIBES OF ALASKA
Seventy-Second Annual General Assembly
April 18-21, 2007

Resolution GA/ 07-16

Title: **An Act Relating to the Prescription and Use of Pharmaceutical Agents, Including Controlled Substances, by Optometrists**

By: Tlingit and Haida's of the City & Borough of Juneau

WHEREAS, Central Council of Tlingit and Haida Indian Tribes of Alaska (Central Council) is a federally recognized tribe of more than 26,000 tribal citizens; and

WHEREAS, the Alaska State Legislature has been considering proposed changes to law that would enable optometrists to use oral and injectable drugs; and

WHEREAS, there exists a difference in the education and training between optometrists and ophthalmologists, with the more comprehensive training of ophthalmologists who are considered medical doctors. Optometrists complete four years education at optometry school without any requirement in Alaska for residency training, ophthalmologists, must complete four year of medical school, a hospital residency, and an additional three to four year residency training program that specializes in medical and surgical treatment of the eye; and

WHEREAS, over the last six years optometrists and ophthalmologists have been engaged in a professional dispute in the legislature with the optometrists promoting the expansion of their scope of practice and the ophthalmologists supporting and protecting public health by advocating comprehensive eye and total health care of Alaskans; and

WHEREAS, very little citizen input to protect the safety and health of Alaskan citizens has been presented to law makers; and

WHEREAS, eye care is related to total body health and the risk of the loss of eyesight is major if eye care is not undertaken by qualified medical doctors. The loss of eyesight cannot be replaced and the diminishment of eyesight can be only prevented with the assistance of medical doctors addressing comprehensive health of patience; and

WHEREAS, legislative authorization of eye care by unqualified persons with the expanded authority to undertake the prescription of drugs and other procedures is not in the best interest of Alaskan citizens.

NOW THEREFORE BE IT RESOLVED, that the Seventy-Second General Assembly of Central Council of Tlingit and Haida Indian Tribes of Alaska convened in Wrangell, Alaska on April 18-21, 2007, hereby opposes CS for HB 113, An Act Relating to the Prescription and Use of Pharmaceutical Agents, Including Controlled Substances, by Optometrists; and

BE IT FURTHER RESOLVED, it is believed that CSHB 113 provides authorization of oral medications (antivirals, antifungals, antihistamines, antimetabolites, steroids, antibiotics, and oral anti-glaucoma drugs) - that will result in increased potential patient risks. In addition to the oral systemic drugs authorized in CSHB 113, this legislation also would allow Alaska optometrists to inject Botox into the eyelids and surrounding tissues, inject steroids into chalazions, inject anesthetics into the lid, and prescribe a broad array of narcotics and analgesics. Such a wide expanded prescription and injection authority is not in the best interest of patient care for Alaskans; and

BE IT FURTHER RESOLVED, that it is believed that Alaskans should receive specialized medical care from the most qualified medical doctors available on the most comprehensive basis possible for the human body, including eyes; and

BE IT FINALLY RESOLVED, that the Alaska State Legislature emphasize patient safety for all Alaskan citizens in the provision of all health care and that the Legislature, on behalf of its citizens, protect citizen and consumer interests over economic competition between professional service groups, including optometrists and ophthalmologists.

ADOPTED this 21st day of April 2007, by the Seventy-Second General Assembly of Central Council of Tlingit and Haida Indian Tribes of Alaska.

CERTIFY

President William E. Martin

ATTEST

Tribal Secretary Dana Leask Ruaro

4/18/07

OPPOSITION TO CSHB113

Attachments enclosed.

Sincerely,

Carl Rosen, M.D.
American Academy of Ophthalmology/Alaska Chapter
Anchorage, Alaska
907-276-1617

Central Council
Tlingit and Haida
Indian Tribes of Alaska

CENTRAL COUNCIL
tlingit and haida indian tribes of alaska
ANDREW P. HOPE BUILDING
320 West Willoughby Avenue • Suite 300
Juneau, Alaska 99801-9983

CENTRAL COUNCIL OF TLINGIT AND HAIDA INDIAN TRIBES OF ALASKA
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WHEREAS, the Alaska State Legislature has been considering proposed changes to law that would enable optometrists to use oral and injectable drugs; and

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BE IT FURTHER RESOLVED, that it is believed that Alaskans should receive specialized medical care from the most qualified medical doctors available on the most comprehensive basis possible for the human body, including eyes; and

BE IT FINALLY RESOLVED, that the Alaska State Legislature emphasize patient safety for all Alaskan citizens in the provision of all health care and that the Legislature, on behalf of its citizens, protect citizen and consumer interests over economic competition between professional service groups, including optometrists and ophthalmologists.

ADOPTED this 21st day of April 2007, by the Seventy-Second General Assembly of Central Council of Tlingit and Haida Indian Tribes of Alaska.

CERTIFY

President William E. Martin

ATTEST

Tribal Secretary Dana Leask Ruaro

Dear Senator Ellis, Chair Labor and Commerce Committee,

My name is David Chamberlain. I am an Ophthalmologist or Eye MD and have worked in Alaska for over 12 years, 9 years at my current position at Alaska Native Medical Center. On 5/2/2007 HES committee members heard testimony regarding HB 113 that was factually incorrect and misleading. I am writing to clear up some misunderstandings that were evident.

It was stated that Ophthalmologists do not provide services to Klawock or Craig. In fact, I myself or one of my Eye MD partners have indeed held an eye clinic in Klawock once or twice a year for the last 10 years and, although, we don't hold a clinic in Craig we do serve many patients from Craig. Craig patients drive a few minutes to Klawock. The 3 Eye MDs at Alaska Native Medical Center, work closely with 19 IHS Optometrists, forming a cohesive team with clearly defined roles offering comprehensive service within Alaska. Eye MDs from my department hold 1-4 annual clinics in each of the following villages: Barrow, Kotzebue, Nome, Bethel, Dillingham, Kodiak, Sitka, Ketchikan, and Klawock. The Optometrists on our team in Nome, Kotzebue, Bethel, Sitka, Dillingham, Fairbanks, Juneau, and Anchorage each provide eye care in their respective locations and the surrounding smaller villages. Pamela Steffes, OD for example, is based in Sitka and holds clinics in Klawock, Angoon, and Yakutat, among other places. Under the current system, when eye patients are sick enough to require oral or injectable medicine, Ophthalmology gets a call from the Optometrist or sometimes from a Village Health Aid, or a Physician, or Nurse Practitioner. In Alaska, there are at least 2 Eye MDs on-call 24/7 365 days per year for just such emergencies (I know of no comparable on-call system for Optometry). HB 113 does not increase access to Optometry and may instead decrease access to Eye MDs. HB 113, if allowed to pass, would both reduce the training level required to inject and prescribe medicines and force a redefinition of our relative roles. So, exactly what level of training is required to responsibly inject and prescribe medicine for eye conditions and who should make such determinations? To answer these questions, one must have knowledge of the particular disease including its differential diagnosis, natural course, risks and benefits of treatment. Sounds like a job for an MD doesn't it? MDs are uniquely qualified to make such assessments, and Eye MDs even more so if your talking about eye disease. Lets face it; the human organism and Alaska Statutes are both highly complex. We need to respect that complexity by getting the most highly qualified advice when it comes to making medical decisions and when it comes to making laws. I prescribe a lot of drugs and inject both into the globes and around it. Each drug I use caries risks and benefits. One of my patients died from a non-allergic reaction to a totally appropriately prescribed oral medicine. She had developed clear signs and symptoms of a life-threatening drug reaction that unfortunately went unrecognized by her internist. I frequently inject medicines next to the globe with thorough awareness of the risk of inadvertent intraocular injection which can result in severe vision loss. The risk of inadvertent intraocular injection has been reported to be much higher when non-Ophthalmologists perform such injections. HB 113 does prohibit injection into the "ocular globe of the eye" (sic) but allows for any other injections including those near the globe. It is surprisingly difficult to fully control the needle tip location once it is not visible after it is embedded into tissue. It is an unwritten informal but essential part of my job to assess the level of eye knowledge of the providers who call me from all over Alaska. I get calls from providers at all levels of skill. It is frequently the case that the diagnoses are wrong, and the proposed treatments are wrong. I have noticed this to be true especially for Optometrists just out of training. They know enough to be scary, and they don't know that they don't know. HB 113 in the hands of a fearless knowledge-shy aggressive Optometrist I fear will eventually result in disaster. None of the Optometrists I work with closely fit that description, but I do wonder about the knowledge and motives of those pushing this bill. Where and who is the specific patient they would like to help? Dr. Mike Bennett for example, in testimony 5/2/07 HES, indicated the primary reason for increased injection authority was for "antibiotics ... injection into the eyelid is what you would be looking at". It is well known that antibiotics can kill infections, and well known that antibiotics can be injected. It may seem intuitive that therefore antibiotics could be injected into an infected eyelid, as Dr. Bennett seems to suggest. This is exactly the type of seemingly innocent even intuitive but erroneous action an unqualified practitioner is likely to take never even knowing the harm they may cause. Why not inject antibiotics into the eyelid? I am not sure myself, it is not something I have ever seen done, but I am aware of some potential problems with it. Medicines ll have approved routes of administration and dosages that have been tested and confirmed through clinical trials, animal studies etc. Intramuscular injections, for example, are only to be injected well within the body of a relatively large muscle. I know of no

antibiotics that are approved for local injection into eyelids. I know of no disease requiring such an injection. This is just one example of the naivety of those who support this bill.
Some HES committee members may have the impression that it costs more for an individual to see an Ophthalmologist than an Optometrist. To my knowledge, insurance companies including Medicare and Medicaid pay by the service given or by the condition not by the level of education or training or license of the provider.
The Alaska State Legislature has a duty to responsibly regulate narcotic usage. The Controlled Substances Advisory Committee is to be composed of a panel that includes MDs. Has this committee been consulted regarding HB 113 and its controlled substance impact? Has the state medical board been consulted? The State of Alaska has wisely exhibited a great deal of concern regarding the level of training required before a person can inject medicine or prescribe codeine or opium. For example, Alaska requires (as of Jan 1, 1995), MD's to undergo an additional 2 years of medical education after medical school graduation to qualify for the Md license (http://www.acgme.org/acWebsite/downloads/RRC_progReq/240pr106.pdf). This is the license that allows MDs to prescribe the medicines, which would be available to Optometrists with only a seven-hour postgraduate course (if HB 113 passes). We do need Optometrists in rural and urban areas in Alaska but they and their patients need MD involvement when patients get so sick that they need surgery, or non-topical medicines. HB 113 does nothing good for the public interest.

David Chamberlain, MD (sole author, not authorized to speak for anyone)
2401 Brittany Cir.
Anchorage, AK 99504
May 10, 2007

CC: Alaska, Labor and Commerce Committee Members

Alaska Senate Finance

May 3, 2007

Eric W. Coulter, M.D.
Medical Director
Alaska Lasik Center
3601 C St., Suite 1134
Anchorage, AK 99503
eric@alaskalasikcenter.com
907-317-1455

Senate HESS Chairman and Members
Alaska State Legislature
Chair, Health, Education and Social Services Committee

Dear Senators,

At some point you will be considering HB 113, a piece of legislation introduced to expand the scope of practice for non-medically licensed practitioners of optometry. **You are likely to hear many arguments for and against this bill from two sides of the fence; the optometrists' side and everyone else in the state who is a medically licensed professional.** The Alaska State Medical Board is against this, the Alaska State Medical Association is against this, the Alaska Ophthalmology Society is against this and the American Academy of Ophthalmology is against this as well as every ophthalmologist in the State of Alaska.

Current law allows optometrists to utilize topical medications, antibiotics, steroids, glaucoma medications and to treat and follow all ocular conditions without requiring medical licenses. There is not a cry for help from communities in Alaska for lack of available eye care and 40 ophthalmologists serve throughout the State to maintain a high standard of care. **To argue that a lack of care in Alaska warrants expanded pharmacologic privileges or that their current level of pharmacologic privilege compromises patient care is simply erroneous and misleading.** I would ask that you look for any evidence supporting the statement that rural areas are subject to increased risk of blindness due to lack of care or appropriate availability. This is not "just a little bit more" to "help out" as Representative Samuels has stated; this is a paradigm shift in medical practice and standards. **Essentially, optometrists would like to legislate medical competency, which is not only impossible, but dangerous to the public.**

Optometrists are not medical doctors or surgeons and are not trained as such. They are not allowed surgical privileges at any facility in Alaska or the United States. Attempts at this in Oklahoma were met with overwhelming opposition and laws briefly allowing optometrists such privileges throughout the VA hospital system came to a crashing halt just a few years ago. No hospital in Alaska or the United States recognizes their training as sufficient to practice medicine at their facilities and no insurance companies insure them for such. No optometrist in Alaska or the United States is allowed to help in the emergency rooms or to take call for the community. They are not medical doctors, they do not have medical licenses and they are not allowed to perform procedures around the eye any more than a chiropractor is allowed to perform back surgery. **They are well trained for what they do, but dispensing and injecting pharmaceuticals on a level with the medical doctors and in this country is not one of them.** That is the nature of this bill.

To vote for this bill is to go against the very body (the Alaska State Medical Board) you rely on to make appropriate medical decisions for the citizens of Alaska. You and they are tasked with maintaining the highest level of medical standards and responsibility for our State. This bill would allow paramedical individuals to write prescriptions and perform injections for drugs they do not have cause or need for including Botox™, retro bulbar anesthetics (injections behind the eye and near the brain) and dermatologic plastic injections. They would be allowed to police themselves, make determinations about required training, and determine injection

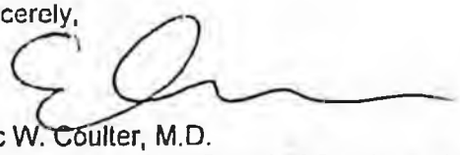
proficiency without a single one of them possessing a medical license. Does this sound "better for the State" to you?

We need to draw the line that paraprofessionals can not cross, placing our States population at risk for their own gain. **This bill is much broader and more loosely written than all but 5 other states in the union according to the American Academy of Ophthalmology research department.** If this passes, other groups will follow in the name of 'patient access' and the next bill on the table will be for medical procedures etc. There is an agenda here, but it is not for the well managed, competent care of our people. The optometric lobbyists have pushed for this for years without success. There are reasons these individuals are not medically licensed which will be presented to you ad nauseum. There is a reason Tony Knowles vetoed this bill in the past.

Please respect the historic validity of our medical system and do not rewrite what constitutes competent medical care in our communities. If their interest is truly for improved patient care, then let them come forward through these existing pathways of required training and education. To date, none of them have approached the Alaska State Medical Board, the Alaska State Medical Association, the American Academy of Ophthalmology, the Alaska Ophthalmology Society or any hospital administration etc. to approach this in a unified way. This does not represent an effort at community improvement but reveals its special interest and effective reduction of medical standards. Do not succumb to this modicum.

I am glad you are in the position you hold to ensure the best for our State and our populace. Thank you for you attention.

Sincerely,



Eric W. Coulter, M.D.
Diplomat, American Board of Ophthalmology
Fellow, American Academy of Ophthalmology
Active Staff member, Providence Alaska Medical Center, Alaska Regional Hospital

cc: Senate Finance
Alaska State Senate

April 18, 2007

Dear Members of the House of Representatives,

As the American Academy of Ophthalmology/Alaska Chapter President I am writing this letter of opposition to eshb113 for four reasons.

Firstly, our patients and the citizens of Alaska place their trust in their doctors and in their elected officials to act in their best interest. To enact this far reaching bill would not be in the best interests of Alaskans. Medical school graduates have proven themselves and Ophthalmologists represent the best the American Medical System has to offer with regards to diagnosing and treating diseases of the visual system. To equate optometric training as equal to medical school and ophthalmology residency training would be like suggesting there is no difference between Major and Minor League Baseball. As a fellowship trained board certified ophthalmologist I have performed over 24,000 hours of supervised clinical training, with my final fellowship year as a one on one apprenticeship. At best an optometrist may perform 2000 clinical hours.

Secondly, this bill is massive in expanding optometric scope of practice. As a busy surgeon I have no use for pain medicines typically for more than 2-3 days, and I use a handful of oral antibiotics when needed and consult infectious disease specialists if atypical presentations arise. There is simply no need for an optometrist either in an urban or remote setting to have the ability to use the drugs listed in eshb113. In virtually all states where these privileges are given an Ophthalmologist must be consulted or supervise the optometrist.

Thirdly, injecting drugs around the eye can lead to hemorrhage given the vascular nature of the eyelids and orbital area and to direct injury to the eyeball. A seven hour course deemed satisfactory by the optometric board is very concerning, especially since residents are required to have three years of experience doing this procedure, and to patients who won't know or understand the training differences. In fact, when optometrists talk about injections they really are concerned with chalazions or styes that they want to inject with steroids. You should know that styes are treated first with warm compresses and time which cure well over 80%. Rarely have I injected a steroid into a chalazion and I am Alaska's only eyelid specialist.

Fourthly, there is simply no public outcry for this bill. The only advocates are the optometrists. With the implementation of telemedicine and digital technology we are getting better and better at diagnosing and treating patients using digital images and computer networks. This applies to the entire State of Alaska. In fact, Robert Arnold, MD a pediatric ophthalmologist has screened over 21,000 children looking for amblyopia or lazy eyes using this technology and continues to do so. David Chamberlain at Alaska Native Medical Center travels throughout the State to see patients as do most of the ophthalmologists who live in Alaska. For the past two years I have been working with Dr. Fred Pearce at the University of Alaska Anchorage on a first responder trauma

system whereby information gathered by EMT's is sent to physicians in the Emergency Room allowing for faster patient diagnoses and treatment. There are approximately 40 Ophthalmologists who are licensed to practice and currently do treat Alaskans and they visit approximately 35 communities. With telemedicine this number keeps growing and within the next 3 to 5 years I predict we will have the State wired and telemedicine centric for not only Ophthalmology consults but other medical specialties as well.

I urge you to vote against cshb113, it is simply not a good bill as written.

Sincerely,

Carl Rosen

Carl Rosen, MD
President

American Academy of Ophthalmology/Alaska Chapter
542 West Second Ave.
Anchorage, Alaska 99501
907-276-1617
Director of Orbital and Oculoplastic Surgery and Neuro-Ophthalmology
Ophthalmic Associates
Anchorage, Alaska

cc: Alaska State Senate

AMERICAN ACADEMY OF OPHTHALMOLOGY
The Eye M.D. Association

202-737-6662

American Academy of Ophthalmology
State Governmental Affairs
April 18, 2007

Review of Alaska State Board of Examiners in Optometry Letter dated April 10, 2007.

The Alaska State Board of Examiners in Optometry claims that this bill would allow optometrists to prescribe limited systemic drugs. In fact, compared to the optometric practice acts in 49 out of 50 states, this bill is not limited.

The Alaska State Board of Examiners in Optometry claims that similar legislation has been enacted in 45 states. In fact, similar legislation has not been enacted in 45 states. Virtually, every state has stricter limitations on the use of systemic medications.

The Alaska State Board of Examiners in Optometry claims that there are many new drug treatments every year. This is not a reason to expand the scope of practice of optometry. In fact, there are not many new drug treatments that are introduced every year in the specialty of ophthalmology. The standard of care in the treatment of eye disease evolves over time.

The Alaska State Board of Examiners in Optometry claims that optometrists are fully educated and competent to prescribe any drug for the treatment of the eye regardless of the route of administration. Fully competent suggests an equivalence with ophthalmology. Unlike ophthalmologists, optometrists do not go to medical school, complete a hospital residency, and complete a three year residency in ophthalmology. Optometric education does not include substantial clinical training in the prescribing of systemic medications.

The Alaska State Board of Examiners in Optometry cites a 2001 survey of optometric boards in other states that have enacted similar legislation, suggesting there have been no problems. In 2001, there were no states that had similar legislation. In fact today, there is only one state with a comparable statute.

The Alaska State Board of Examiners in Optometry claims that there are adequate safeguards in place to protect the public. Given that no one on the board prescribes these medications in the state of Alaska and that the board did not consult with the medical board on any education and training requirements that might be needed, a claim about protecting the public cannot be made with authority or confidence by the state optometry board.

The Alaska State Board of Examiners in Optometry states that this bill would improve access to quality eye care and reduce costs. In fact, this bill would only create two tiers in access to quality eye care. Given the fact that many patients with serious eye disease requiring systemic drugs will obtain a second opinion and that delayed, appropriate treatment by an ophthalmologist may result in additional costs to the patient and lost work time for the patient, this bill would not reduce costs. Moreover, federal law requires ophthalmologists and optometrists to be reimbursed at the same rate for the services they provide to Medicare patients, regardless of any differential in education and training. Private payors generally follow the same fee schedule and use similar reimbursement practices.

AMERICAN ACADEMY OF OPHTHALMOLOGY
The Eye M.D. Association

April 18, 2007

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Tel. 202.737.6662
Fax 202.737.7061
http://www.aao.org

Alaska State Legislature
House of Representatives
State Capitol
Juneau, AK 99801

Dear Representative:

I am writing to ask you to oppose CSHB 113, a bill that would give optometrists the authority to prescribe oral and injectable drugs. Although the bill language has changed since introduction, the current language does not improve the quality of eye healthcare available to Alaska citizens. Indeed, enactment of this legislation would result in a decline of both the short and long-term quality of eye care available to Alaska citizens.

The CSHB 113 "blank check" authorization of oral medications (antivirals, antifungals, antihistamines, antimetabolites, steroids, antibiotics, and oral anti-glaucoma drugs) will result in increased potential patient risks. In addition to the oral systemic drugs authorized in CSHB 113, this legislation also would allow Alaska optometrists to inject Botox into the eyelids and surrounding tissues, inject steroids into chalazions, inject anesthetics into the lid, and prescribe a broad array of narcotics and analgesics. Such a wide expanded prescription and injection authority is not in the best interest of patient care.

Optometry did not seek the approval of or even consult with the Alaska State Medical Board, any medical schools, or any ophthalmology residency program regarding the education and clinical training necessary to competently prescribe and administer the drugs authorized in CSHB 113. Optometry school is not a substitute for four years of medical school, a hospital residency, and three years of ophthalmology residency training.

It should be pointed out that optometry education is not comparable to even podiatry or dentistry education. To be licensed in Alaska, podiatrists must complete a one-year podiatric surgical residency program. To be licensed as a dental specialist in Alaska, these students must complete a two-year postgraduate program. Although there is no residency requirement for dental school graduates, 41 percent of dental school graduates immediately enter a post-graduate training program. In contrast, only about 10 percent of optometrists complete a residency program nationally. Furthermore, a residency program is not required as a part of any optometry school program or a requirement to be licensed in Alaska.

The supporters of the bill state that optometrists are authorized to prescribe oral drugs in 45 states. However, most of these states have significant limitations and patient safeguards on oral drug prescribing authority. Frankly, we wish there were additional limitations. Even so, given that our paramount concern is patient safety, we are alarmed that Alaskan optometrists are refusing to present and discuss these limitations with you. Unwisely, what optometrists want in Alaska is a "blank check" to prescribe any oral drug for any eye disease without any significant, additional educational requirement. It is important to remember that one cannot treat serious eye disease separately from having an understanding of the entire body. Medical schools uniquely provide this knowledge base. Optometrists lack this critical, fundamental knowledge and experience.

This legislation is not in front of you because of public concern and an outcry regarding a lack of quality eye care. This is a piece of rather unfortunate, special interest legislation promoted by Alaska's optometry lobby. As an ophthalmologist, it is important for me to ensure that the citizens of your state receive appropriate medical eye care. Limiting optometrists to the tasks for which they are competent is in the best interest of patients. Therefore, I ask you again to oppose CSHB 113.

Sincerely,

CP Wilkinson

C.P. Wilkinson, MD
President

Cc: Alaska House of Representatives

STATE OF ALASKA
DEPARTMENT OF
COMMERCE
COMMUNITY AND
ECONOMIC DEVELOPMENT

Division of Corporations, Business and Professional Licensing

Sarah Palin, Governor
Emil Notti, Commissioner
Rick Urion, Director

ALASKA STATE MEDICAL BOARD

RESOLUTION OF THE ALASKA STATE MEDICAL BOARD

Title: An Act Relating to the Prescription and Use of Pharmaceutical Agents, Including Controlled Substances, by Optometrists

WHEREAS, the Alaska State Legislature is considering CSHB 113, a bill that would give optometrists licensed in the State of Alaska the authority to prescribe oral and injectable medications; and

WHEREAS, a degree from a college of optometry school is not a substitute for four years of medical school, a hospital residency, and three years of ophthalmology residency training; and

WHEREAS, optometrists do not have the clinical experience to safely administer injections and prescribe oral medications; and

WHEREAS, CSHB 113 may result in increased potential patient risks; and

WHEREAS, CSHB 113 would not improve the quality of eye healthcare available to the citizens of Alaska.

NOW THEREFORE BE IT RESOLVED, the Alaska State Medical Board opposed CSHB 113 because the board believes that this legislation would endanger patients.

David Head MD

David M. Head, MD, Chair
Alaska State Medical Board

12 April 2007

550 West Seventh Avenue - Suite 1500, Anchorage, AK 99501-3567
Telephone: (907) 269-8163 Fax: (907) 269-8196 Website: www.commerce.state.ak.us/occ/pmed.htm

Alaska Native Brotherhood Camp 2

Resolution No: 001-07

Resolution in Opposition to CSHB113

Whereas the Alaska Native Brotherhood Camp 2 (A.N.B. Camp 2) of Juneau is a Native membership organization; and.

Whereas the A.N.B. Camp 2 represents and advocates for Tribal members in the Greater City and Borough of Juneau, Alaska; and,

Whereas, the A. N.B. Camp 2 is an institution that protects and promotes the best interest in health, education and welfare, and other social concerns of its membership; and,

Whereas the A. N. B. Camp 2 has members from rural Alaska and the urban communities of Alaska; and,

Whereas, the A. N. B. Camp 2 has advocated that people of Alaska continue to receive quality health care, including eye health; and,

Whereas, A.N.B. Camp 2 has opposed legislation in the past similar to CSHB 113, now being considered in the Legislature.

Now, Therefore be it resolved, by the A.N.B. Camp2 finds that CSHB 113 is contrary to the core of health services that its citizens would receive under the proposed legislation; and,

Be it further resolved that A.N.B. Camp 2 opposes the passage of CSHB 113.

President: _____ Date: 4-12-07

Andrew Ebona, President

Secretary: _____ Date: 4/12/07

Sueann Williams

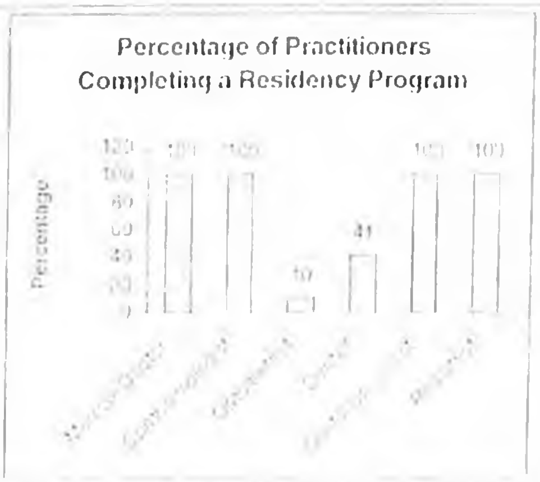
320 W. Willoughby Suite 100* Juneau, Alaska 99801* 907-586-2044* Fax: 586-3301
Email: anbjnu2@ak.net

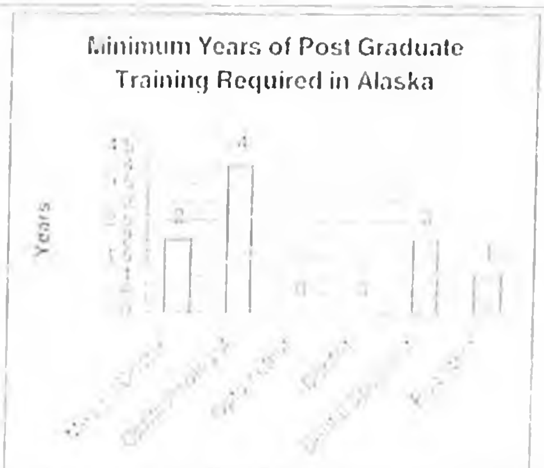
Post Graduate Training Comparison Between Optometrists and Selected Professions

Ophthalmologists are medical doctors who specialize in the treatment of eye disease after three to four years of training after medical school and hospital residency. In arguing for expanded scope of practice to treat eye disease, optometrists, on the other hand, compare their education and training to podiatrists and dentists. However amongst the many significant differences between optometrists and these other professions is post-graduate training.

Since we are discussing eyes - not feet or teeth, the more reasonable comparison is between the education and training of an ophthalmologist and that of an optometrist. The question at hand is whether optometrists, without seeking the approval of or consulting with the state medical board, any medical schools, or any ophthalmology residency program, have devised a unique method to learn to prescribe systemic medications with just enough fragments and bits of knowledge to not harm patients in this state. The answer is that they have not. Optometry school is not a substitute for four years of medical school, a hospital residency, and three years of ophthalmology residency training.

It should be pointed out that optometry education is not comparable to even podiatry or dentistry education. To be licensed in this state, podiatrists must complete a one-year podiatric surgical residency program. To be licensed as a dental specialist, these specialists must complete a two year postgraduate program. Although there is no residency requirement for dental school graduates, 41 percent of dental school graduates immediately enter a post-graduate training program. In contrast, only about 10 percent of optometrists complete a residency program nationally. Furthermore, the completion of a residency is not required as a part of any optometry school program and is not a requirement to be licensed in this state.





Medical Doctors

[illegible]

Ophthalmologists (EYE MDs)

[illegible]

Optometrists
Nationally, **approximately 10 percent** of all optometrists complete a one year residency program. **Moreover, optometric *residencies are not required in Alaska or elsewhere by law or by professional standard.*** http://www.opted.org/teampublish/uploads/SpringStudentInterest.pdf

Dentists
Nationally, approximately 41 percent of dental school graduates immediately enter into post-graduate training program. About 27 percent of all dentists enter a general dentistry residency program and an additional 14 percent enter a dental specialty program. www.adea.org/DEPR/Assocreptune01.pdf

Dental Specialists
Completion of a two year post graduate program is a prerequisite to be licensed as a dental specialist in Alaska. http://www.labor.state.ak.us/research/dlo/dentist.htm

Podiatrists
Alaska requires podiatrists to complete a one-year podiatric surgical residency program. Today, virtually all podiatry school graduates in the US complete a podiatric residency. It is now a licensing requirement in 41 states. http://www.labor.state.ak.us/research/dlo/podiatrt.htm

AMERICAN ACADEMY OF OPHTHALMOLOGY
The Eye M.D. Association

Comparison of Training and Accreditation in Optometry with Medicine and Ophthalmology

The following chart is based on requirements and minimum standards, or averages if no standards are stated.

	Ophthalmologist	Optometrist
Degree	M.D.	O.D.
Medical School/ Optometry School Accreditation	Liaison Committee on Medical Education (LCME). The LCME has determined minimum curriculum and patient contact standards.	Council on Education (COE). The COE has no minimum curriculum or patient contact standards
Pre-training Admission requirements	4 year college degree Premedical program	3 years of undergraduate courses and pre-optometry program (most complete a 4 year degree program[1]
Didactic curriculum	First two years of medical school. 2,000 hours in class, at least 1,250 hours of basic and clinical sciences, according to minimum accreditation standards.	No accreditation standard minimums. Typical didactic program is one year of basic and clinical sciences and two years of vision sciences.
Student clinical training	Second two years (3,200 hours). Clinical rotations in hospitals / health care settings completing 2,000 hours in basic medical specialty services plus 1,200 hours in elective rotations, according to minimum accreditation standards	No accreditation standard minimums or required service rotations. Typical service is an average of 2,000 hours in the 4th year, split between school-based clinic and what ever externship rotations can be arranged.

[1] Three of the 17 optometry schools in the U.S. require an undergraduate degree before admission

	Ophthalmologist	Optometrist
Degree	M.D.	O.D.
Postgraduate Accreditation	Accreditation Council for Graduate Medical Education (ACGME), Ophthalmology RRC	Council on Education
Postgraduate clinical training: First Residency (PGY-1)	**Required:** hospital residency, including on-call service. 50 week, 80 hour a week limit (60 hours week average = 3,000 patient contact hours)	**Optional**: one year postgraduate training (less than 10% of OD graduates ever pursue postgraduate training)
Postgraduate clinical training: Second Residency (PGY-2) *Completion of PGY-1 required*	**Required** :36 month ophthalmology service to include 360 hours didactic education in basic and clinical sciences and 50 hours in pathology. Minimum patient requirements: 3,000 outpatient visits with 1,000 closely supervised (including 1,500 refractions), 150 consultations involving disease, documented surgical experience, and 288 hours of clinical conferences	No option
Specialty Board Certification	Optional (but achieved by almost all recent graduates) American Board of Ophthalmology, accredited by the Association of Medical Specialty Boards	No option
Subspecialty Fellowship Training	Optional (but achieved by approximately one-half of all recent graduates). one to two year position. No accreditation, but programs follow guidelines of subspecialty associations	No option

md_gd.doc

AMERICAN ACADEMY OF OPHTHALMOLOGY
The Eye M.D. Association

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April 3, 2007

Chair Kurt Olson
House Labor & Commerce Committee
State Capitol
Juneau, AK 99801 **Re: CSHB 113**

Dear Representative Olson:

In the interest of patients, optometrists should communicate with medical doctors over circumstances requiring systemic medications. In the event of an ocular manifestation of a potentially systemic disease, the Alaskan optometrist should confer with local ophthalmologists. In the extremely unlikely event of an anaphylactic reaction in the optometrist's office, emergency services or local family medical doctors should be called.

Since 1989, I have practiced with some fine optometrists as collegial partners with subspecialty ophthalmologists. Their experience has been gleaned by decades of optometric practice adjacent to ophthalmic practice. There are optometrists, when covering cases that might benefit from systemic medications, easily contact ophthalmologists in or out of our practice, or directly with other medical physicians. They also clearly recognize that their individual familiarity with medical conditions has been mainly influenced by the years of adjacent practice with ophthalmologists rather than from their training in optometry school. I recommend we keep things as they are in Alaska and oppose HB 113, if the system is not broken, why meddle, especially when it comes to patient care.

The following information is written to clear up some misinformation expressed by several optometrists that occurred in House HESS, regarding the extent to which Alaskan ophthalmologists interact with rural patients.

After graduating from UAF in 1980, I trained at Yale Medical School and did an Internship and ophthalmology residency at the Mayo Clinic in Rochester, Minnesota. After completing an additional year of subspecialty training in pediatric ophthalmology in Indiana, I returned to Alaska to start a practice with Ophthalmic Associates. I have since conducted ongoing subspecialty clinics in Cordova, Homer, Kodiak, Wasilla, Bethel, Galena and the Koyukon region as well as a surgical practice in Anchorage covering both private hospitals, ANMC and Elmendorf. I have mentored a dozen premedical students one of the first of which is now Dr. Griff Steiner. At the request of Alaskan optometrists, I have offered education to many of them and to optometrist interns. Over arrange of experiences and skills, it is best for Alaskan eye patients, young and old, to have collegial communication between optometrists, local physicians and with general and subspecialty ophthalmologists who continuously cover the urgent and emergent cases.
The most common cause of vision impairment in children is Amblyopia; this disease can potentially be eliminated through early consistent screening and persistent,

Alaska Blind Child Discovery (ABCD)
542 West Second Avenue, Anchorage, Alaska 99501-2212
(800)270-1617 • (907)276-1617 • fax 278-1705 • abcd-vision.org

accurate treatment. As a result, I have devoted over a decade and over $300,000 to a cooperative, charitable vision screening program called the Alaska Blind Child Discovery (ABCD; w ww.abcd-vision.org). As you may know, the single most expensive component of the Alaska Medicaid travel budget has been for follow-up exams and glasses for children who are referred by non-specific wall-chart acuity screening. ABCD instead offers much more valid, and cost-effective objective screening to over 21,000 children through out the state, Ketchikan to Adak, from Kodiak to Barrow. No insurance or Medicaid yet pays for this new enhanced vision screening. The ABCD program carefully interprets objective screening results and recommends that referred children get a carefully defined Confirmatory Exam from the "nearest convenient eye doctor." ABCD then coordinates follow up over thc years referred children are treated. ABCD has demonstrated a significant reduction in Alaskan amblyopia vision impairment cost-effectively.

This is one example of the extent to which ophthalmologists in Alaska are offering rural eye care. Please review our experiences offering this state-of-the-art pediatric vision screening free of charge to Alaskans at the State Fair(1), in the Koyukon region(2, 3), and state-wide(4-7).

Sincerely Yours,

Robert W. Arnold

Robert W. Arnold, M.D.

Cc: House Labor & Commerce Committee

1. Arnold RW. Highly specific photoscreening at the Alaska State Fair: Valid Alaska Blind Child Discovery photoscreening and interpretation. Alaska Med 2003;45(2):34-40.
2. Lang DM, Arnold AW, Leman RE, Arnold RW. Validated portable pediatric vision screening in the Alaska Bush: A VIPS-like study in the Koyukon. Alaska Med 2007;49(1):2-13.
3. Arnold RW, Arnold AW, Stark L, Arnold KK, Leman RE, Armitage MD. Amblyopia detection by camera (ADBC): Gateway to portable, inexpensive, vision screening. Alaska Med 2004;46(3):63-72.
4. Arnold RW, Armitage MD, Gionet EG, et al. The cost and yield of photoscreening: Impact of photoscreening on overall pediatric ophthalmic costs. JPOS 2005;42(2):103-11.
5. Arnold RW, Donahue SP. The yield and challenges of charitable state-wide photoscreening. Binocul Vis Strabismus Q 2006;21(2):93-100.
6. Arnold RW, Gionet E, Jastrzebski A, Kovtoun T, Armitage M, Coon L. The Alaska Blind Child Discovery project: Rationale, Methods and Results of 4000 screenings. Alaska Med 2000;42:58-72.
7. Leman R, Clausen MM, Bates J, Stark L, Arnold KK, Arnold RW. A comparison of patched HOTV visual acuity and photoscreening. J Sch Nurs 2006;22(4):237-43.

Alaska Blind Child Discovery (ABCD)
542 West Second Avenue, Anchorage, Alaska 99501-2242
(800)270-1617 • (907)276-1617 • fax 278-1705 • abcd-vision.org

March 14, 2007

Representative/Chairman Peggy Wilson
House Health, Education and Social Services Committee
Capitol Building, Room #204
Juneau, Alaska 99801

Dear Representative Wilson:

A bill, House Bill 113, though well intentioned, may have devastating effects to uniformed patients.

Ocular diseases are very serious, often resulting in partial or complete loss of vision. In treatment, strong and potentially dangerous drugs are administered when necessary, and only under the most extreme circumstances. Ophthalmologists are well trained to recognize when systemic drugs are necessary and are qualified in the administration of these medications in coordination with other medications.

Optometrists have not been provided with this expertise. Their education and training is approximately one half of that of an Ophthalmologists and are traditionally qualified to center their concerns to defects in vision and the issuance of corrective lenses. Extending to them the right to work on the same level of Ophthalmologists would defy logic or responsibility.

Professional standards are crucial to the medical field; especially to the human eye, as any faulty determination can lead to loss of the patient's vision. For these reasons, and for the interests of all Alaskans, I respectfully request your "NO" vote on HB 113.

Thank you for your consideration

Joseph Bustamante
P.O. Box 201836
Anchorage, AK 99520

cc: House HESS Committee members

April 16, 2007

Honorable Representative John Coghill
State House of Representatives
Alaska State Legislature
State Capitol, Rm 214
Juneau, AK 99801-1182

Re: Opposition to CS HB 113, An Act Relating to the Prescription and Use of Pharmaceutical Agents, Including Controlled Substances, by Optometrists

Dear Representative Coghill:

The Alaska State Legislature has been considering proposed changes to law that would enable optometrists to use oral and injectable drugs.

There exists a difference in the education and training between optometrists and ophthalmologists, with the more comprehensive training of ophthalmologists who are considered medical doctors. Optometrists complete four years education at optometry school without any requirement in Alaska for residency training, ophthalmologists, must complete four year of medical school, a hospital residency, and an additional three to four year residency training program that specializes in medical and surgical treatment of the eye.

Over the last six years optometrists and ophthalmologists have been engaged in a professional dispute in the legislature with the optometrists promoting the expansion of their scope of practice and the ophthalmologists supporting and protecting public health by advocating comprehensive eye and total health care of Alaskans. Very little citizen input to protect the safety and health of Alaskan citizens has been presented to law makers.

Eye care is related to total body health and the risk of the loss of eyesight is great if eye care is not undertaken by qualified medical doctors. The loss of eyesight cannot be replaced and the diminishment of eyesight can be only prevented with

the assistance of medical doctors addressing comprehensive health of patience. Legislative authorization of eye care by unqualified persons with the expanded authority to undertake the prescription of drugs and other procedures is not in the best interest of Alaskan citizens.

It is believed that CS HB 113 provides authorization of oral medications (antivirals, antifungals, antihistamines, antimetabolites, steroids, antibiotics, and oral anti-glaucoma drugs) - that will result in increased potential patient risks. In addition to the oral systemic drugs authorized in CS HB 113, this legislation also would allow Alaska optometrists to inject Botox into the eyelids and surrounding tissues, inject steroids into chalazions, inject anesthetics into the lid, and prescribe a broad array of narcotics and analgesics. Such a wide expanded prescription and injection authority is not in the best interest of patient care for Alaskans. I believe that Alaskans should receive specialized medical care from the most qualified medical doctors available on the most comprehensive basis possible for the human body, including eyes.

I urge you to advocate, in your capacity as an Alaska State Legislator, to emphasize patient safety for all Alaskan citizens in the provision of all health care and that the Legislature, on behalf of its citizens, protect citizen and consumer interests over economic competition between professional service groups, including optometrists and ophthalmologists.

As you know, I am legally blind. I have had nine (9) surgeries on my eyes and have remaining only a little bit of clouded vision in my left eye. All of this blindness was brought on by me through diabetes and a kidney transplant. My experience is that a persons eyes is a part of his total health well being and must be treated in concert with all other vital functions of the body. Only qualified medical doctors are able to keep medications, treatment of other vital organs and a prescribed health regime in balance.

I urge you to oppose CH HB 113 as a measure of protecting the health and safety for all Alaskans and I urge you to continue the Legislatures effort to fund and train more qualified medical doctors so that comprehensive and quality health care is available to all Alaskans.

Thanking you for this consideration.

Sincerely,

Robert W. Loescher

10645 Misty Lane
Juneau AK, 99801
Ph: 907-723-8516

Chair Peggy Wilson
HESS Committee
State Capitol
Juneau, AK 99801

March 26, 2007

RE: HB113

Dear Representative Wilson:

Expanding the scope of practice for optometrists through the legislature, especially as delineated in the current bill, would be a horrible mistake. We ophthalmologists have repeatedly delineated the vast educational differences, so I will not repeat them here. Mistakes made by other states do not constitute a safe precedent. It is very frustrating and dangerous that these bills keep coming before you. **At the end of the day it has to somehow make sense to you to pass a bill allowing optometrists to perform injections of the eyes of Alaskans, including your own eyes and the eyes of your children.** These are injections that ophthalmologists do hundreds of times in training under the supervision of other MDs - optometrists have never done them. Never. The injection itself requires skill and just as importantly the experience to know when to use them. Optometrists have none of this experience. Zero. Passage of this bill will be equivalent to allowing chiropractors to inject the spine because they swear up and down they have read as much as orthopedists or neurosurgeons. Even if they had read as much, which is manifestly false, this does not remotely qualify them to perform these injections.

Also relevant is that these injections are rarely necessary. What is the positive outcome of such a bill? Is the optometric agenda actually improved patient care? If a patient in a rural area has such a severe condition that it requires an eye injection, it is already beyond the scope of optometrists and the patient must see an ophthalmologist. Other milder conditions that might benefit from an injection, such as chronic sties, are rarely injected. I am a subspecialist in this area and I never inject them, using more conservative measures the vast majority of the time, with surgery only if these measures fail.

It is also well documented in other states that these absurd requests for increased procedural scope of practice (that can hardly enhance patient care) are actually designed as legislative stepping stones to later argue for surgical privileges.

As MDs, our most important oath is "First do no harm". Please help us help Alaskans by rejecting this bill. Please contact me at any time if you have any questions.

Sincerely,

Griff C. Steinert MD (4th generation Alaskan and Stanford graduate)
Ophthalmologist subspecializing in Cornea/External disease.
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cc: HESS Committee Members

March 18, 2007

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

Dear Representative Wilson:

I am an Alaskan ophthalmologist and I strongly urge you to oppose HB 113. This bill would allow optometrists to prescribe oral medications to patients. This bill is touted as a convenience for patients, claiming that optometrists have the training and experience to prescribe narcotics, steroids, and all other classes of potentially lethal medicine to patients with eye conditions.

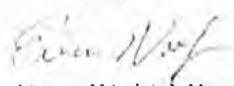
I believe that optometrists are often helpful in screening patients for eye disease and systemic problems. **But it would be very dangerous to allow the unsupervised "practice of medicine" by anyone who has no medical training.** Please understand that I have completed 11 years of intensive medical training since college, as compared to 4 years of optometry school. I became "board certified" by the Academy of Ophthalmology after two more years of work/study. I complete over 25 hours of accredited "continuing education" every year to maintain my medical license under the jurisdiction of the Alaska Medical Board.

As far as patient convenience, I have never turned down a patient or optometrist request for a same-day exam, usually with less than one hour waiting time. For routine exams, my "next available" appointment is only 2 weeks or so away. I work very hard to protect patients and to see them within a reasonable time period.

Perhaps like you, I grow weary of the annual "turf battles" that occur in state legislatures across the country. If optometrists want to be medical doctors (physicians) or even surgeons, there are plenty of openings in medical schools for qualified applicants.

Please reject this dangerous bill, this year and in the future.

Sincerely,



Evan Wolf, MD, PhD

Valley Eye Associates, PC
935 E Westpoint Drive
Wasilla, AK 99654

CC: Legislative members of the House HESS Committee

UNIVERSITY EYE SPECIALISTS

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Myron Yanoff, MD
Comprehensive Ophthalmology
Cataract Surgery

Leo Santamarina, M.D.
Retina-Vitreous
Medical and Surgical

Elliot B. Werner, M.D.
Glaucoma
Cataract Surgery

March 12, 2004

Harry Grossman, M.D.
100 Brick Road
Suite 115
Marlton, NJ 08053

Dear Harry:

It has been brought to my attention that Sheryl Lentfer, O.D., a 1998 graduate of The Pennsylvania College of Optometry testified before a committee of the Alaska State Legislature. According to Committee Minutes 23 Legislature, "*She explained that at the school she attended the first year ophthalmology residents were under (fourth year optometry students) in emergency care.*" This is found on page 26 of the document as posted on the web site of the Alaska State Legislature.

This is not a true statement. Since 1988 until the present time I have been a member of the clinical staff of The Eye Institute of the Pennsylvania College of Optometry (TEI). I have the title of Glaucoma Consultant and have served as Co-chief of The Glaucoma Service at TEI. During that time I have been actively involved in patient care and educational activities at The Pennsylvania College of Optometry. During that time I have also served on the faculty of the Department of Ophthalmology at Hahnemann University Hospital and currently serve as the Residency Program Director. At no time and under no circumstance would any ophthalmology resident be "under" optometry students in any capacity. Ophthalmology residents at Hahnemann at all times report to and are supervised by the faculty of the Department of Ophthalmology and the officers of the hospital and medical school. Students at The Pennsylvania College of Optometry neither supervise any activity of our ophthalmology residents nor do they have any role in formal or informal teaching of our residents. I hope this clarifies this matter.

Very truly yours

Elliot B. Werner, M.D.

Feb 3, 2004 Health Education & Social Services Committee Hearing on HB 306:

SHERYL LENTFER, O.D., testified in support of HB 306 and answered questions from the committee. She told the members that access to the curriculums of the schools is readily available. She urged the members to take a look at [the curriculums] because she believes that will clarify the education issue. She questioned why, if education is a big issue, PAs and nurse practitioners are prescribing and not prescribing with a doctor right behind them at every moment. They are able to do this pretty much on their own, she commented. Dr. Lentfer asked the members to deal with the education issue factually by comparing [the curriculums] of the optometry schools and medical schools. Dr. Lentfer stated that education should not even be an issue in this debate. She urged the committee to compare the education qualifications with those for dentists or podiatrists.

DR. LENTFER told the members that she would like to talk about who currently treats the public with oral pres iptions and the educational relationship to these professionals. She said medical doctors, osteopathic doctors, podiatrists, dentists, nurse practitioners, and PAs all have prescriptive authority to prescribe pharmaceutical agents in Alaska. Medical doctors, osteopathic doctors, podiatrists, dentists, and optometrists all have a four-year doctor degree.

DR. LENTFER clarified that after a four-year college undergraduate degree, an optometrist receives a four-year doctorate degree. There is no variatio n in that education, she stated. Nurse practitioners have two years of master's work after an undergraduate degree, but to her surprise she found that PAs do not have to have a four-year undergraduate degree to be accepted into the [PA] program.

Number 1916

DR. LENTFER emphasized that PAs and nurse practitioners have been very beneficial to Alaska and that it is not her intention to [undermine their role in ensuring good public health]. She emphasized that her point is only to demonstrate the correlation between their ability to prescribe drugs and their educational background, compared to that of optometrists.

DR. LENTFER pointed out that the pharmacology education for medical doctors, osteopathic doctors, and optometric doctors is

the same. She told the members that optometrists provide 70 percent of the eye care in the U.S. Considering that there are many professionals treating eye conditions today including PAs, nurse practitioners, physicians, and eye surgeons, that is a large percentage. In Alaska [the percentage of eye care that is provided by optometrists] is greater. There are 103 optometrists in 17 different locations, and many travel a lot. There are only 28 eye surgeons in six locations, most of which do surgery. She pointed out that with a population of over 500,000, eye surgeons availability and accessibility have been a big challenge for this state. Dr. Lentfer explained that this [fact] has put more demand on optometrists to practice to their fullest training.

DR. LENTFER spoke to Representative Coghill's comments about training. She told the members that this is not new or additional training, since she was prescribing [oral medications] in 1996 after graduating from medical school. She told the members that while additional training is not required, there will be additional training for those optometrist who have not had prescriptive authority in the last few years. The [Alaska Board of Examiners in Optometry] will require optometrists to probably have over 200 hours of course work, pass a test, and get a therapeutic endorsement on the license. If the optometrist does not pass the test, he/she cannot prescribe [oral medications], she said. An OD [doctor of optometry] would have to have graduated [from medical school] in the last two years in order to be qualified to prescribe. When therapeutic eye drops were approved by the legislature, optometrists were not automatically allowed to prescribe because the [Alaska Board of Examiners in Optometry] required that optometrists prove that they were qualified.

DR. LENTFER pointed out that the language in this legislation is for the treatment of eye-related conditions, as the language on line 9 and 10 is very specific where it says "ocular disease or conditions, ocular adnexal disease or conditions, or emergency anaphylaxis." She added that [this language] makes it clear that optometrist are not interested in prescribing a broad spectrums of pharmaceuticals like PAs or nurse practitioners. The only interest in prescribing is for the treatment of conditions and diseases for which optometrists are trained and practicing.

DR. LENTFER explained that it is difficult physically, as well as financially for patients to be sent from an optometrist's

office to another practitioner's office to receive treatment that the optometrist has prescribed. In some instances this requires the patient to travel some distance, she said. Dr. Lentfer told the members of an individual who needed an oral prescription for a drug that would relieve a condition she had diagnosed, but could not find a practitioner to prescribe the medication. In this case the medication is most effective when administered within the first 48 hours.

Number 1719

DR. LENTFER told the members that after the then Governor Knowles vetoed the legislation that passed the Alaska House of Representatives and the Alaska State Senate, the Alaska Board of Examiners in Optometry went to the State Medical Board and did everything Governor Knowles requested. She stated that there was no cohesiveness. The "so-called turf war" is not a good reason to make a judgment on this bill. The only reason to support this bill is to provide better health care for Alaskans.

Number 1680

CHAIR WILSON explained that she worked in the clinic Tok where she worked with a PA or a nurse practitioner who were under the umbrella of a [physician]. She asked if optometrist would want work under [the umbrella] of a physician in the prescribing of drugs.

DR. LENTFER responded that optometrists have already completed a four-year doctorate degree program. She said the same comparison could be made in asking a dentist to work under a medical doctor.

CHAIR WILSON clarified that she is not talking about dentists; she is talking about PAs and advanced nurse practitioners.

DR. LENTFER responded that going under an umbrella of another physician does not make sense. Whose umbrella would optometrists be under? She said that optometrists are established entities with a regulating board that has an excellent history. If the committee had doubts about optometrists' education, training, and ability to prescribe [oral] medications, she urged them to research the educational background. Optometrists are not [in the same educational category] as PAs or nurse practitioners. The educational background is the same as for dentists and medical doctors in

pharmacological education. Dr. Lentfer asked why optometrists' educational qualifications are in question, when those for dentists and medical doctors are not.

Number 1587

CHAIR WILSON responded that the [educational qualification] is in question because optometrist have not had the other specialized training. Professionals who have not had that training [such as PAs and nurse practitioners have had to] work under other professionals.

DR. LENTFER told the members that she took human anatomy, neuroanatomy, physiology, pathology, ocular biology, and ocular physiology at the same time. She explained that, depending on which medical school a medical student goes to, in the third or fourth year there is a series of rotations. During this time the medical student is trying to decide what kind of doctor he/she chooses to be. For those [students] that know they want to be an eye doctor, in the third year of medical school they begin to see patients. **She explained that at the school she attended, the first-year ophthalmology residents were under [fourth-year optometry students] in emergency care.** Dr. Lentfer emphasized that optometry students not only learn about the whole body, but also specialize in eye care, while other medical students are learning about the whole body and not specializing. The fourth year of medical school consists entirely of clinical hours. There are as many as 2,000 patient hours before finishing the fourth year of medical school, which is very good for any health care profession.

EDITOR'S PAGE

Encore! Encore!

Rich Kirkner
Editor-in-Chief

About 30 years ago, a handful of optometric visionaries hammered out an agenda for the profession. At the top of that agenda: gain diagnostic agents, then therapeutics.

Today, you can say mission accomplished. Because of that, our special report, "The State of Optometry," finds that state is solid.

It begs the question: What's next now that the DPA-TPA curtain has dropped?

The vanguards of optometry will have to sort that out, but here's a wish list they can work with:

- **Eye exams for infants.** Operation Bright Sight is onto something here (see "Pilot Program Takes Eye Care to the Cradle.) Cradle-to-grave eye care has to start somewhere. The cradle seems like a logical place.

- **Eye exams for school children.** Kentucky has the right idea passing a law that mandates these. Besides, hasn't anyone yet figured out that our children who see well can learn well?

- **Eye exams for licensed drivers.** The eyes can change a lot between license renewals. Imagine how much they change between the 16th and 65th birthdays. The DMV can't.

- **Promote medical comanagement.** Surgical fees are in a free-fall, so organized ophthalmology is squabbling over your role in managing these patients. To them, it's about money, not sound medical practice. Every patient deserves to have his or her family doctor quarterback care, whether it's brain surgery, foot surgery or eye surgery.

- **Continue to expand the scope of practice.** Optometry now has an excellent track record in disease management. Time to move to the next

level: universal privileges for glaucoma meds, orals and injectibles. Then go for laser privileges for all O.D.s. Today Oklahoma, tomorrow America!

- **Raise awareness of computer-related eye problems.** Most people who use a computer have some kind of eye-related symptom-and that's a lot of people, about 75 million on the job and almost as many at home. A good pair of glasses and some expert consultation can fix just about all those aches and pains.

Indeed, this is a public health agenda. Some items are legislative efforts—something the profession can proudly say it is quite skilled at. All would require big-time public awareness campaigns.

The group of visionaries who laid out optometry's DPA and TPA movements 30 years ago scored a rousing success. Now, that the profession finds itself in a pretty good state, it's time for an encore.

Richard Kirkham

top

Return to November Highlights

April 27, 2000

Governor Tony Knowles
State of Alaska
Juneau AK 99811

In response to your request for an opinion, the State Medical Board, at its April 27, 2000, meeting unanimously voted to oppose the enactment of Senate Bill 78.

Although this legislation may have been passed by the House and Senate in an effort to improve patient access to care, the board believes that the potential for harm to Alaskans from optometrists prescribing and administering non-topical medications greatly exceeds the benefits. Optometrists do not have the clinical experience to safely administer eye injections, intravenous and intramuscular injections, and oral medications, including some narcotics. Reading about the effect and side effects of medications or attending seminars, does not prepare an optometrist for complications related to patients' other medical problems and chronic medications. The board's charge is to protect Alaskan patients; we believe that this legislation would endanger patients.

Sarah A. Isto, MD, Chair
Alaska State Medical Board

Tony Knowles, Governor

Alaska Department of Community and Economic Development

Division of Occupational Licensing
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March 18, 2002

Barbara Gabier, Program Coordinator
Division of Occupational Licensing

MAIL BALLOT ON CSHB 215

Ms. Gabier, following is a compilation of the results of a mail ballot survey distributed to the medical board soliciting their opinions on CSHB 215. All eight board members have now responded to the mail ballot.

	QUESTION	VOTE
1	What should the position of the state Medical Board be regarding CSHB 215?	7 Opposed 1 Supports
2	Do you believe CSHB 215 creates increased risk to patients?	6 Yes 2 No
3	Do you believe CSHB 215 would increase access to needed health care?	2 Yes 6 No
4	Do you believe the bill should be amended to reduce the maximum length or prescriptions for systemic analgesic agent from seven days to 72 hours?	5 Yes 2 No 1 Not applicable*
5	If you oppose CSHB 215, would reduction of the length of the prescription remove your opposition to the legislation?	1 Yes 6 No (1 did not vote**)
6	Do you believe the training requirements in CSHB 215 are adequate?	3 Yes 5 No

ISSUE FOR CONSIDERATION: CSHB 215 Optometrists Prescribing Authority

Following this page is the complete text of CSHB 215 that makes changes to optometrists prescribing authority. You are being asked to provide your recommendations on this bill. Please vote and return your ballot to me as soon as possible. Please fax your completed ballots to me at 907/269-8196. Thank you for your continuing efforts in this matter.

AMERICAN ACADEMY OF OPHTHALMOLOGY
The Eye M.D. Association

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Washington, DC 20005-3570

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Prohibitions and Restrictions on the Practice of Optometry Checklist

I. Oversight Of Optometrists Prescribing Therapeutic Drugs

Index	Provision	State	No.
Formulary	Prohibits expansion of formulary, unless reviewed by interprofessional committee.	FL	1
	Requires interprofessional committee to set formulary	IN	1
	Requires interprofessional committee to meet every 3 months to discuss issues related to glaucoma certification	NH	1
	Requires optometric board to consult with pharmacy board on rules specifying oral dosages of drugs or dangerous drugs	OH	1
	Requires interprofessional committee to identify additional classes of drugs that may be used by ODs and must approved by Medical Board	TX	1
	Requires interprofessional committee to decide which drugs require co-management	IN	1
	Medical Board to give advice on the use of pharmaceutical agents for topical use in the practice of optometry	OR	1
	Requires interprofessional committeee to decide which systemic drugs will be in the OD formulary.	OR	1
	Prohibits legend and nonlegend drugs unless approved by the Secretary of Health in consultation with the Physician General for the treatment of eye, eyelids, lacrimal system, and the conjunctiva	PA	1
	Prohibit oral not specified in statute or not approved by interprofessional committee and approved by Medical Board	TX	1
	Prohibits oral drugs unless interprofessional committee approves specific drugs or classes of drugs (Formularies to be published in stages (to 12/06))	VT	
	Requires Pharmacy Board to be consulted and to approve specific guidelines for the prescription and administration of drugs by optometrists	WA	1
Treatment	Requires interprofessional committee to set parameters for treatment as technology advances and must be approved by Medical Board	TX	1
	Encourages ODs to notify patient's physician of the use of legend drugs	IN	1
Review of ODs	Requires state optometric association and state ophthalmological association to make	MD	1

	recommendations to health secretary regarding regulations on standards of quality for TPA-certified ODs and a quality assurance study of co-managed glaucoma patients.		
	Requires interprofessional committee to examine education and training for out-of-state optometrists.	CA	1
	Requires interprofessional committee to set continuing education requirements	IN	1
	Requires interprofessional committee to review application of pre-acquired clinical training for therapeutic optometrists.	NY	1
	Requires interprofessional committee to set clinical training and education requirements for use of oral, parenteral, or glaucoma and must be approved by Medical Board	TX	1
	Requires interprofessional committee to review the use of orals on persons under six	KS	1
Collaboration ,Consultation , and Referral generally	Where an OD must consult with Eye MD, the OD shall maintain a written record in the patient's file of the info provided to the Eye MD, the Eye MD's response and any other relevant info. The info must be provided to the Eye MD on request.	CA	1
	All collaborations, consultations, and referrals made by an OD shall be made to an Eye MD located geographically appropriate to the patient.	CA	1
	Except as otherwise specified in law, if a patient's condition worsens after 72 hours of diagnosis, the OD must consult with Eye MD	CA	1
	Except as otherwise specified in law, if a patient's condition has not resolved after 10 days of diagnosis, the OD must refer to Eye MD.	CA	1

II. Optometric Malpractice Provisions Related to Prescribing Therapeutics

Index	Provision	State	No.
Standard of Care	ODs to be held to same standard of care as Eye MD or medical practitioner	CA;CO;CT;DE;FL;GA;IA;MD;ME;MD;MN;MO;MS;ND;NE;NJ;NY;OR;SC;TN;TX;WY	23
	ODs to be held to same standard of care as Eye MD or medical practitioner in treatment of glaucoma	NE;KS	2
Liability Insurance	Requires ODs treating glaucoma to obtain professional liability insurance acceptable to optometric board	KS	1
	Requires OD to have professional liability insurance in the amount of	PA	1

	1,000,000/occurrence and 3,000,000/annual aggregate if treating glaucoma.		
	Requires ODs prescribing orals to obtain professional liability insurance acceptable to optometric board	WV	1
	Requires ODs to hold $1 million in malpractice insurance	GA;SC	2
Testimony	Admits the testimony of Eye M.D.s practicing in the state.	DE	1

III. Prohibitions on the Treatment of Specific Diseases or Symptoms Using Therapeutics by Optometrists, excluding Glaucoma

Index	Provision	State	No.
Retina	Prohibits Infectious Diseases of the Retina	CT	1
Ocular Inflammation, See also Anti-inflammatories)	Prohibits treatment of ocular inflammation in patients under 18 years of age,	CA	1
	Prohibits treatment of ocular inflammation other than traumatic iritis, peripheral corneal inflammatory keratitis, episcleritis, and unilateral nonrecurrent nongranulomatous idiopathic iritis	CA	1
	Prohibits treatment of peripheral corneal inflammatory keratitis if recurring within one year of the initial occurrence, unless OD consults with Eye MD	CA	1
	Prohibits treatment of episcleritis if recurring within one year of the initial occurrence, unless OD consults with Eye MD	CA	1
	Prohibits treatment of unilateral nongranulomatous idiopathic iritis if recurring within one year of the initial occurrence, and must refer to Eye MD	CA	1
	Prohibits treatment of nontraumatic anterior uveitis if patient is under 12, unless under consultation with MD	CO	1
	Prohibits treatment of anterior uveitis, if unresolved after 14 days of treatment, unless under consultation with MD	CO	1
	Prohibits Iritis if patient does not improve substantially within 72 hours after which condition requires referral to Eye M.D.	CT	1
	Prohibits treatment of anterior uveitis, unless OD consults with Eye M.D.	RI	1
Ocular infections	Prohibits treatment of person with AIDS for ocular infections	CA	1

(See Also Antibiotics, topical and oral)			
	Prohibits treatment of ocular infections of the lacrimal gland, the lacrimal drainage, system and the sclera.	CA	1
Systemic Disease	Prohibits Ocular Cancer	CT	1
	Prohibits Diagnosis and Treatment of Systemic Disease	CT;PA	2
	Requires referral to physician if treatment of systemic disease requires further diagnosis and possible treatment beyond the scope of practice	IA	1
	Prohibits use of a pharmaceutical agent for the specific treatment of a systemic disease, unless the agent is used specifically for an ocular disease.	ME	1
	Prohibits use of drugs, unless the treatment is required for diseases and conditions of the human eye	WA	1
Symptoms	Prohibits treatment of Ocular Tumors	CA	1
	Requires consultation and/or referral to physician if adverse drug reaction occurs	FL	1
	Requires referral to physician upon sudden onset of spots or "floaters"	FL	1
Response to Treatment	Requires OD to communicate with patient to determine response of topical ocular agent as soon as practicable after 72 hours from the time the agent was administered or prescribed. If patient has not responded, OD must consult with Eye M.D.	MD	1
	Requires referral if patient does not respond to treatment	ND;MS	2
	Requires consultation with MD, if OD is to treat person for more than 6 weeks. Treatment initiation need not include prescription of therapeutics.	PA	1
Condition Outside Scope	Requires referral to physician for medical diagnosis and treatment of abnormal conditions.	DC	1
	Requires referral if condition is outside scope	AZ;HW;MA;MO;MS;WA;WI	7
	Requires referral of therapeutic optometrists if condition is outside scope to Eye M.D., patient's physician, a physician if required under a managed care contract, or a hospital emergency room if necessary.	MD	1
	Requires OD to advise patient to seek evaluation by MD for diagnosis and	MN	1

	treatment and not to treat if condition is outside scope		
	Requires referral if additional evaluation or treatment is required.	SC	1
	Unprofessional conduct includes performing treatments or providing services which a licensee is not qualified to perform or which are beyond the scope of the licensee's education, training, capabilities, experience, or scope.		
Delegation	Prohibits delegation of the application or prescription of drugs.	CT	1

IV. Prohibitions on the Treatment of Glaucoma and the Use of Topical and Oral Antiglaucoma Drugs

Topicals and Orals	Prohibits All Antiglaucoma Drugs	MA;PR	2
Topicals	Requires OD to refer patient to an Eye M.D. if requested by the patient, if treatment goals are not achieved with the use of two topical medications. A combination medication that contains two agents shall be considered two medications.	CA	1
	Prohibits ODs from using more than two concurrent topical medications	CA	1
	Prohibits treatment with beta blockers, unless physical first completed by physician w/i last year.	GA	1
	Prohibits treatment with beta blockers, unless OD consults with physician with patient's consent.	RI	1
	Prohibits treatment with beta blockers unless OD consults with or refers to physician.	SC	1
	Prohibits treatment with beta blockers, unless physical first completed by physician w/i six months.	TX	1
	Prohibits treatment with beta blockers, unless persons with heart disease first examined by physician.	GA;TX	2
	Requires referral to an ophthalmologist if glaucoma patient does not respond to up to 3 topical agents within a reasonable time.	VT	1
	Prohibits treatment with more than 3 topical agents at any given time.	VT	1
Orals	Prohibits use of all Oral Antiglaucoma drugs	AK;CA;FL;GA;IL;LA;MA;MD;ME;ND;NE;NY;PA;PR;RI	16
	Prohibits Oral Antiglaucoma Drugs, except in case of emergency	CT;DC	2
	Prohibits Oral Antiglaucoma Drugs, except in case of emergency and OD must	NH	1

	immediately patient to ophthalmologist.		
	Prohibits Oral Anti-glaucoma drugs, without consultation with Eye M.D.	KS	1
	Prohibits Oral Anti-glaucoma drugs administered for more than 48 hours	WY	1
	Prohibits Oral Anti-glaucoma drugs, except oral carbonic anhydrase inhibitors	WV	1
	Prohibits Oral osmotic agents	AK;CA;FL;GA;IL;LA;MA;ME;MD;ND;NE;NH;NM;NJ;NY;PA;PR;RI	18
	Prohibits Oral Carbonic Anhydrase Inhibitor	AK;AZ;CA;FL;GA;IL;LA;MA;MD;ME;ND;NE;NH;NJ;NY;OR;PA;PR;RI	18
	Prohibits Oral Carbonic Anhydrase Inhibitors for more than 7 days	MN	1
	Prohibits Oral Carbonic Anhydrase Inhibitor except in case of emergency and requires immediate referral to Eye M.D.	TX	1
	Prohibits an oral medications, unless the OD consults with an Eye M.D. as soon as clinically prudent and require that patient to be seen by the consulting ophthalmologist. Only hyperosmostics and oral carbonic anhydrase inhibitors approved by formulary committee.	VT	1
Open Angle	Prohibits treatment of all glaucomas except for open-angle glaucoma	CA;MD;ND;NH	4
	Prohibits treatment of all glaucomas, except for open angle, exfoliation, and pigmentary glaucomas	PA	1
Angle Closure/ Narrow Angle	Requires OD to refer patient to an Eye M.D. if requested by the patient, if indications of narrow angle glaucoma develop.	CA	1
	Prohibits treatment of angle closure glaucoma	CT;FL;GA;NH;PA;TX	6
	Requires referral within 30 days to Eye M.D. if patient develops angle closure glaucoma	NH	1
	Prohibits oral agent for treatment of closed angle glaucoma attack	AZ	1
	Prohibits treatment of angle closure, except for initiation of immediate or emergency treatment.	DC;NV;RI;SC;VA;VT	5
Malignant Glaucoma	Prohibits treatment of malignant glaucoma and requires referral to Eye M.D.	PA;NV;TX;VT	4
Neovascular Glaucoma	Prohibits treatment of neovascular glaucoma and requires referral to Eye M.D.	PA;NV;TX;VT	4
Diabetes	Prohibits treatment of glaucoma patient who has diabetes, unless OD consults in writing with the physician treating the patient's diabetes in developing the glaucoma treatment plan. The physician shall provide written confirmation of these notifications.	CA	1
	Prohibits treatment of glaucoma patient who	CA	1

	has diabetes, unless OD notifies the physician treating the patient's diabetes in writing of any changes in the patient's glaucoma. The physician shall provide written confirmation of these notifications.		
	Prohibits treatment of glaucoma caused by diabetic complication if consulting Eye M.D. or physician determine that a referral is required.	NV;TX	2
Age Limitations	Prohibits treatment of infantile or congenital glaucoma	FL;NE;RI;VA	4
	Requires referral to Eye M.D. or other physician if faced with pediatric glaucoma	CT	1
	Prohibits treatment of glaucoma in persons under 18 years.	CA; NH	2
	Prohibits treatment of glaucoma in persons under 16 years.	NV;TX;VT	3
Secondary	Requires OD to refer patient to an Eye M.D. if requested by the patient, if indications of secondary glaucoma develop.	CA	1
	Requires referral to Eye M.D. or other physician in case of secondary glaucoma	CT	1
	Requires referral within 30 days to Eye M.D. physician in case of secondary glaucoma.	NH	1
Co-management Period	Prohibits independent glaucoma treatment, unless OD co-manages 50 glaucoma patients for a period of 2 years for each patient. Afterwards, OD must be certified by board to treat open angle glaucoma. The original patients may treated independently after OD has received certified by the board, with written consent of the patient.	CA	1
	Prohibits independent glaucoma treatment, unless OD co-manages 20 cases over a 2 year period; recent grads may be exempted.	KS	1
	Prohibits independent glaucoma treatment, unless OD provides evidence of 20 glaucoma referrals to MDs and 30 glaucoma consultations with MD. New graduates may be exempted.	MI	1
	Prohibits glaucoma treatment, unless OD comanages 25 glaucoma patients, including up to 5 established patients, during a period of not less than 18 months for each patient. New graduates; DVA, DOD, and NHS ODs credintialed to treat glaucoma for 12 months; ODs from another state credentialed to treat glaucoma treatment for 12 moths; ODs who have completed a 12 month OD residency program may be exempted.	NH	1
	For the purposes of comanagement, a Joint	NH	1

	pharmaceutical formulary and credentialing committee of 3 ODs and 3 Eye MDs must meet quarterly to review glaucoma reporting forms and develop prescription drug protocols; develop a reporting form and patient consent form; determine which combination medication shall be considered one medication for glaucoma treatment; and determine which optometrists have successfully completed the comanagement training regimen. A glaucoma credentialing reporting form must be submitted to the committee upon 18 months of treatment for each patient during the comanagement period..		
	Prohibits glaucoma treatment unless OD consults on 15 patients with Eye M.D. for at least 1 year.	NV	1
	Prohibits independent glaucoma and ocular hypertension treatment, unless OD co-manages 75 cases or co-manages for three years; recent grads may be exempted.	NY	1
	Prohibits independent glaucoma treatment, unless OD co-manages 20 cases for at least a 1 year period or until the patients have stabilized whichever is longer; new grads may be exempted.	RI	1
Initial Consultation	Prohibits treatment until OD makes a provisional diagnosis of glaucoma and the OD and the patient identifies a collaborating Eye MD during co-management period.	CA	1
	Prohibits treatment until OD makes a provisional diagnosis of glaucoma during comanagement period.	NH	1
	Prohibits treatment until OD makes a provisional diagnosis of glaucoma during 2 year post-comanagement period.	NH	1
	Prohibits treatment until OD transmits relevant documentation from the provisional examination along with the treatment plan to the collaborating Eye MD during co-management period.	CA	1
	Prohibits treatment until OD transmits relevant information from the provisional examination and history of the patient along with the treatment plan to the collaborating Eye MD during co-management period.	CA	1
	Prohibits glaucoma treatment w/o prior consultation with physician.	DC;OR	2
	Prohibits glaucoma treatment unless OD consults with Eye M.D. w/i 72 hours of	ND	1

	initiating treatment.		
	Prohibits glaucoma treatment, w/o written consultation with MD when diagnosis made; during co-management period.	NY	1
Confirmation of Diagnosis	Prohibits treatment unless Eye MD confirms the diagnosis during co-management period. Eye MD shall refute or confirm the diagnosis w/I 30 days by performing a physical examination of the patient.	CA	1
	Prohibits glaucoma treatment, unless Eye M.D. confirms diagnosis during co-management period.	KS;ME;NH;NV;RI;NY	6
	Prohibits glaucoma treatment, without confirmation of diagnosis by Eye M.D.	MD;TX	2
	Prohibits glaucoma treatment, unless Eye M.D. confirms diagnosis w/I 30 days of initial diagnosis for a period of 24 months after the end of the comanagement period.	NH	1
Treatment Plan	Prohibits treatment, unless OD develops treatment plan which considers target intraocular pressures, optic nerve appearance, visual field testing, and an initial proposal for therapy.	CA	1
	Prohibits treatment unless Eye MD approves the treatment plan in writing during co-management period.	CA	1
	Prohibits glaucoma treatment, unless consultation with Eye M.D. to develop written treatment plan during co-management period.	KS;ME;NY;RI	4
	Prohibits glaucoma treatment, unless OD jointly and promptly develops written treatment plan with Eye M.D. and can only be changed by joint agreement of OD and Eye M.D.	MD	1
	Prohibits glaucoma treatment unless OD and Eye M.D. develop treatment plan in accordance with the currently accepted standard of care.	ND	1
	Prohibits treatment unless ophthalmologist reviews proposed OD treatment plan during comanagement period.	NH	1
	Prohibits glaucoma treatment unless Eye MD, OD and patient mutually agree to and document a treatment plan during comanagement period.	NH	1
	Prohibits glaucoma treatment, unless Eye M.D. reviews treatment for a period of 24 months after the end of the comanagement period.	NH	1

	Prohibits glaucoma treatment, unless consultation with Eye M.D. w/i 30 days of diagnosis to develop treatment plan.	TX	1
Target Pressure	Requires referral to Eye M.D. or other physician if interocular pressure exceeds 35	CT	1
	Requires referral to Eye M.D. if target pressure is not met in 60 days.	SC	1
	Requires consultation with Eye M.D. if target pressure in treatment plan is not reached.	MD	1
	Requires referral to Eye M.D. if not progress achieved in realizing the selected pressure range considered unlikely to cause further optic nerve damage or result in further visual field loss.	ND	1
	Requires optometrist to consult with the co-managing ophthalmologist if target pressure is not reached within 90 days and the patient is experiencing optic nerve damage and visual field loss or the patient develops angle-closure or other secondary glaucoma.		
	Requires consultation and/or referral to Eye M.D. if patent does not respond to target pressure which is 80% of initial intraocular pressure.	TX	1
Review of Patient's Progress	Requires OD to notify Eye MD in writing if there is any change in medication used to treat the patient during co-management period	CA	1
	Requires OD to annually provide a written report to Eye MD about the achievement of goals contained in the treatment plan during co-management period. The Eye MD shall acknowledge receipt of the report in writing w/i 10 days.	CA	1
	Permits the Eye MD to periodically examine the patient at his or her discretion during co-management period.	CA	1
	Prohibits glaucoma treatment w/o periodic review of the patient's progress by Eye M.D.	TX	1
	Prohibits glaucoma treatment, unless Eye M.D. examines the patient once a year	MD	1
	Requires referral to Eye M.D. or other physician if no substantial improvement in condition.	CT	1
	Requires consultation with Eye M.D. if there is worsening in a patient's visual field or optic nerve head.	MD	1
	Requires consultation within 30 days with Eye M.D. if there is worsening in a patient's visual field or optic nerve head upon maximum tolerated therapy.	NH	1

	Requires consultation with Eye M.D. if patient does not have expected response to treatment.	MD;ND	2
	Requires tests or photos to be provided to Eye M.D. for his or her review	MD	1
Notice to Patient	Requires OD, during co-management period, to provide the following information to the patient in writing: nature of the working suspected diagnosis, consultation evaluation by Eye MD, treatment plan goals, expected follow-up care, and a description of the referral requirements. The document shall be dated by both the OD and Eye MD and maintained in their files.	CA	1
	Requires OD to inform patient of seriousness of glaucoma.	FL	1
	Require patient to agree to treatment plan with the Eye MD and the OD during the comanagement period.	NH	1
	Requires OD to inform patient that disease will be confirmed and co-managed by Eye M.D. and must post notice in office; recent grads may be exempted	NY	1
	Requires OD to inform patient that disease will be confirmed and co-managed by Eye M.D.	TX	1
	Requires ODs to describe OD and ophthalmology education and state that they will refer to an ophthalmologist when collaboration is not enough and must be signed by patient.	VT	1
Education	Prohibits glaucoma treatment, unless OD completes 24 hour course in treatment and co-management of open angle glaucoma; new grads may be exempted.	CA	1
	Prohibits orals unless OD completes 44 hours of continuing education in glaucoma and use of oral drugs	IA	1
	Prohibits glaucoma treatment, unless OD completes 24 hour course in treatment and co-management of open angle glaucoma	KS	1
	Prohibits glaucoma treatment, unless OD completes 24 hour course in treatment of ; glaucoma; new grads may be exempted. Six hours of continuing education in glaucoma annually to be sunsetted after 10 years.	MO	1
	Prohibits glaucoma treatment unless OD completes additional education requirements determined by the board; new grads exempted, but may be waived for those graduating after 2002.	NE	1

	Prohibits glaucoma treatment unless OD completes 40 hours of classroom education approved by interdisciplinary committee, but may be waived for those graduating after 2002..	NH	1
	Prohibits glaucoma treatment unless OD passes exam based on classroom glaucoma education approved by interdisciplinary committee.	NH	1
	Prohibits glaucoma treatment unless OD completes a minimum of 10 hours in glaucoma specific education of continuing education. 7 & hours must be by participation in formal courses and 3 hours may be by independent study	NH	1
	Prohibits glaucoma treatment, unless OD completes 100 hours of clinical training; recent grads and ODs independently treating for five years in another state exempted.	NY	1
	Prohibits glaucoma treatment, unless OD complete 18 hours of continuing education in glaucoma.	PA	1
	Prohibits glaucoma treatment, unless OD completes 4 hours of continuing education upon license renewel.	PA	1
	Prohibits glaucoma treatment, unless OD completes 24 hour course in use of therapeutics, including 14 hours on glaucoma.	RI	1
Oversight	Corroborating proof of completion of co-management requirement shall be supplied by Eye MD, before OD can be certified to treat open angle glaucoma independently by OD board.	CA	1
	Requires interprofessional committee to review evidence of glaucoma consultations	ME	1
	Requires interprofessional committee to set clinical training and education requirements for treatment of glaucoma and must be approved by Medical Board	TX	1

Prohibitions on the Use of Controlled Substances[1]

Index	Provision	State	No.
General Provisions	Prohibits General Anesthesia	CT, OR	2
	Prohibits oral sedative-hypnotics	WY	1
	Prohibits Conscious sedation	OR	1
	Prohibits Deep Sedation	OR	1
Schedule I	Prohibits all Schedule I Controlled	AK;AL;AR;AZ;CA;CO;CT;DE;FL;GA;HW	40

	Substance	;IL;IN;KY;LA;MA;MD;MI;ME;MN;MS;ND;NE;NH;NJ;NM;NV;NY;OK;PA;PR;RI;SC;TX;UT;VA;UT;WA;WV;WY	
	Prohibits Schedule I oral analgesics	MO	1
	Prohibits Schedule I controlled substances unless oral analgesic	DC;IA;KS;	3
	Prohibits Schedule I controlled substances that are not oral analgesics codeine, propoxyphene, hydrocodone, and dihydrocodeine, alone or in combination with nonscheduled or nonregulated drugs	MT	1
Schedule II	Prohibits all Schedule II Controlled Substances	AK;AL;AR;AZ;CA;CO;DE;FL;GA;HW;IN;KY;LA;MA;MD;ME;MI;MN;MS;ND;NE;NH;NJ;NV;NM;NY;OK;PA;PR;RI;SC;TX;UT;VA;VT;WA;WV;WY	38
	Prohibits Schedule II Oral Analgesics	MO	1
	Prohibits Schedule II controlled substances unless oral analgesic	DC;IA;KS;	3
	Prohibits Schedule II Controlled Substances, unless limited to 72 hour supply.	CT	1
	Prohibits Schedule II controlled substances unless non-narcotic oral analgesic	IL	1
	Prohibits Schedule II controlled substances that are not oral analgesics codeine, propoxyphene, hydrocodone, and dihydrocodeine, alone or in combination with nonscheduled or nonregulated drugs	MT	1
Schedule III	Prohibits Schedule III Controlled Substances	AK;DE;FL;HW;IN;MA;MD;MN;MS;ND;NY;PR;RI;	12
	Prohibits Schedule III pharmaceutical agents that are not narcotic analgesics or that do not contain Dihydrocodeinone, ("Hydrocodone") for more than 96 hours.	AL	1
	Prohibits Schedule III controlled substances, unless oral analgesic	AZ;DC;IA;KS;NE;NM;SD	7
	Prohibits Schedule III Controlled Substances except those used for ocular pain and inflammation.	CO	1
	Prohibits Schedule III Controlled Substances, unless limited to 72 hour supply.	CT;KY;UT	3
	Prohibits Schedule III controlled Substances except oral analgesics; narcotic oral analgesic limited to 72 hours.	WV	1
	Prohibits Schedule III narcotic Controlled Substances	DE;	1
	Prohibits Schedule III controlled substances, unless oral analgesics but requires consultation with physician after 72 hours	GA	1
	Prohibits Schedule III controlled substances, unless non-narcotic analgesic	IL	1
	Prohibits Schedule III Controlled substances	LA	1

	for more than 48 hours and one additional 48 hour prescription is warranted by a follow-up		
	Prohibits Schedule III oral analgesics, unless OD consults w/ or refers to Eye M.D. after 48 hours	MO	1
	Prohibits Schedule III controlled substances except acetaminophen with thirty milligrams of codeine	ND	1
	Prohibits Schedule III controlled substances, unless oral analgesic but excludes treatment of lacrimal drainage system, lacrimal gland, or structures posterior to the iris. Specific analgesics must be approved by interprofessional committee.	NH	1
	Prohibits Schedule III controlled substances except Tylenol with codeine	VT	1
	Prohibits Schedule III controlled substances, except analgesics with hydrocodone with compounds or codeine with compounds if OD limits dose to 3 days with referral to Eye MD is pain persists.	CA	1
	Prohibits Schedule III controlled substances that are not oral analgesics codeine, propoxyphene, hydrocodone, and dihydrocodeine, alone or in combination with nonscheduled or nonregulated drugs	MT	1
	Prohibits Schedule III controlled substances, except analgesics with hydrocodone with compounds, codeine with compounds or propoxyphene with compounds if OD limits dose to 72 hours with no refill	NV	1
	Prohibits Schedule III analgesics for more than 7 days without consultation from a physician	OR	1
	Prohibits Schedule III analgesics for more than 7 days for a single trauma, episode, or incident without consultation from a physician	WA	1
	Prohibits Schedule III controlled substances, except for seven day supply of oral analgesic	SC	1
	Prohibits Schedule III controlled substances, except for one three day supply of an analgesic	MI, TX	2
	Prohibits Schedule III Controlled Substances, except oral analgesics	VA	1
Schedule IV	Prohibits Schedule IV Controlled Substances	AK, AZ, DE, FL, HW, IN, MA, MD, NY, PR, RI,	11
	Prohibits Schedule IV Controlled Substances that are not narcotic analgesics	AI	1
	Prohibits Schedule IV Controlled Substances except those used for ocular pain an	CO	1

	inflammation.		
	Prohibits Schedule IV Controlled Substances, unless limited to 72 hour supply.	CT;KY	2
	Prohibits Schedule IV Controlled Substances except oral analgesics; narcotic oral analgesic limited to 72 hours.	WV	1
	Prohibits Schedule IV narcotic Controlled Substances	DE;	1
	Prohibits Schedule IV controlled substances for more than 48 hours and one additional 48 hour prescription is warranted by a follow-up	LA	1
	Prohibits Schedule IV controlled substances, unless oral analgesics but requires consultation with physician after 72 hours	GA	1
	Prohibits Schedule IV oral analgesics, unless OD consults w/ or refers to Eye M.D. after 48 hours	MO	1
	Prohibits Schedule IV controlled substances, except for oral analgesic.	DC;IA;KS;MS;NM;NE;	6
	Prohibits Schedule IV controlled substances, unless non-narcotic analgesic	IL	1
	Prohibits Schedule IV controlled substances that are not oral analgesics codeine, propoxyphene, hydrocodone, and dihydrocodeine, alone or in combination with nonscheduled or nonregulated drugs	MI	1
	Prohibits Schedule IV controlled substances, unless oral analgesic but excludes treatment of lacrimal drainage system, lacrimal gland, or structures posterior to the iris. Specific analgesics must be approved by interprofessional committee	NH	1
	Prohibits Schedule IV controlled substances, except analgesics with hydrocodone with compounds or codeine with compounds if OD limits dose to 3 days with referral to Eye MD is pain persists.	CA	1
	Prohibits Schedule IV controlled substances, except analgesics with hydrocodone with compounds, codeine with compounds or propoxyphene with compounds if OD limits dose to 72 hours with no refill	NV	1
	Prohibits Schedule IV controlled substances, except for seven day supply of oral analgesic	SC	1
	Prohibits Schedule IV controlled substances, except for one three-day supply of an analgesic	ME;UT	2
	Prohibits Schedule IV Controlled Substances, except oral analgesics	VA	1
	Prohibits Schedule IV analgesics for more	WA	1

	than 7 days for a single trauma, episode, or incident without consultation from a physician.		
Schedule V	Prohibits Schedule V Controlled Substances	AK;AZ;DE;FL;GA;HW;IL;IN;MA;MD; NE;NH;NY;PR;RI;	15
	Prohibits Schedule V Controlled Substances that are not narcotic analgesics.	AL	1
	Prohibits Schedule V Controlled Substances except those used for ocular pain an inflammation.	CO	1
	Prohibits Schedule V Controlled Substances, unless limited to 72 hour supply.	CT;KY	2
	Prohibits Schedule V Controlled substances for more than 48 hours and one additional 48 hour prescription is warranted by a follow-up	LA	1
	Prohibits Schedule V oral analgesics, unless OD consults w/ or refers to Eye M.D. after 48 hours	MO	1
	Prohibits Schedule V controlled substances that are not oral analgesics codeine, propoxyphene, hydrocodone, and dihydrocodeine, alone or in combination with nonscheduled or nonregulated drugs	MT	1
	Prohibits Schedule V Controlled substances except oral analgesics; narcotic oral ...nalgesic limited to 72 hours.	WV	1
	Prohibits Schedule V controlled substances, except for oral analgesic.	DC;IA;KS;MS;NM;	5
	Prohibits Schedule V controlled substances, except analgesics with hydrocodone with compounds or codeine with compounds if OD limits dose to 3 days with referral to Eye MD is pain persists.	CA	1
	Prohibits Schedule V controlled substances, except analgesics with hyd ocodone with compounds, codeine with compounds or propoxyphene with compounds if OD limits dose to 72 hours with no refill.	NV	1
	Prohibits Schedule V controlled substances, except for seven day supply of oral analgesic.	SC	1
	Prohibits Schedule V controlled substances, except for one three day supply of an analgesic.	MI;UT	2
	Prohibits Schedule V Controlled Substances, except oral analgesics.	VA	1
	Prohibits Schedule V analgesics for more than 7 days for a single trauma, episode, or incident without consultation from a physician.	WA	1

1. Generally, there are no topical controlled substances. Topical cocaine is an exception .hat is uncommonly used by ophthalmologists and usually in connection with surgery involving the nose.

I. Prohibitions and Limitations on the Use of Topical and Oral Steroids, Immunosuppressives, Antimetabolites, and Anti-Inflammatories (See also Ocular Inflammations)

Topical and Oral Steroids	Prohibits Topical and Oral Steroids	PA;PR	2
Topical Steroids	Prohibits topical steroids for the treatment of ocular allergies, unless OD consults with Eye MD if patient's condition worsens 72 hours after diagnosis.	CA	1
	Prohibits topical steroids for the treatment of ocular allergies, unless OD consults with Eye M.D. if the inflammation is still present three weeks after diagnosis.	CA	1
	Prohibits topical steroids for the treatment of ocular allergies for more than six weeks after diagnosis after which OD must refer to Eye MD	CA	1
	Prohibits topical steroids for the treatment of ocular allergies for more than six weeks after diagnosis after which OD must refer to Eye MD	CA	1
	Prohibits topical steroids for the treatment of ocular allergies if condition recurs after six months after which OD must refer to Eye MD	CA	1
	Prohibits topical steroids for the treatment of unilateral nonrecurrent nongranulomatous idiopathic iritis or episcleritics, unless OD consults with an Eye MD if the patient's condition worsens 72 hours after the diagnosis.	CA	1
	Prohibits topical steroids for the treatment of unilateral nonrecurrent nongranulomatous idiopathic iritis or episcleritis, unless OD consults with an Eye MD if the patient's condition has not resolved within three weeks of diagnosis	CA	1
	Prohibits topical steroids for the treatment of unilateral nonrecurrent nongranulomatous idiopathic iritis or episcleritis if the patient is still receiving medication for the condition six weeks after diagnosis, after which a referral	CA	1
	Under no circumstances can OD treat	CA	1

	peripheral corneal inflammatory keratitis if it is Moorens or Terriens diseases.		
	Prohibits topical steroids for the treatment of peripheral corneal inflammatory keratitis, unless OD consults with an Eye MD if the condition worsens 48 hours after diagnosis.	CA	1
	Prohibits topical steroids for the treatment of peripheral corneal inflammatory keratitis if patient is still receiving medication two weeks after diagnosis, after which OD must refer patient to Eye MD.	CA	1
	Prohibits topical steroids for the treatment of traumatic iritis if condition worsens 72 hours after diagnosis, unless OD consults with Eye MD	CA	1
	Prohibits topical steroids for the treatment of traumatic iritis if patient condition has not resolved one week after diagnosis, after which OD must refer patient to Eye MD.	CA	1
	Prohibits Topical Steroids, if OD does not consult physician after 5 days; this requirement must be posted in OD's office.	NY	1
	Prohibits topical steroids, unless a collaborative practice protocol is established by the optometry board in consultation with and subject to the approval of the State Board of Physicians	MD	1
	Prohibits Topical Steroids, unless OD consults with Eye M.D. after 14 days and refers after 21 days	RI	1
	Prohibits Topical Steroids, unless OD consults with Eye M.D. during first 10 days and refers after 21 days	SC	1
	Prohibits Topical Steroids, unless OD refers to Eye M.D if patient has not improved in 10 days and must consult with ophthalmologist before prescribing.	NH	1
Oral Steroids	Prohibits Oral Steroids	AK;AZ;CA;DC;DE;FL;GA;IL;IN;LA;MA; ME;MD;MI;MN;MS;ND;NE;NH;NM;NV; NY;PR;RI;PA;SC; TX;WA;WV	29
	Prohibits oral steroids, unless consultation with Eye M.D.	KS	1
	Prohibits oral steroids, if used for more than 14 days.	IA	1
	Prohibits oral steriods for more than 7 days without consultation from a physician.	OR	1
	Prohibits oral steroids, if used for more than 6 days.	WV	1
	Prohibits oral steroids beyond 14 days if patient's primary care physician is not notified	VT	1

	Prohibits oral steriods without consultation with a physician.	SD	1
Immunosup-pressives	Prohibits Oral Immunosuppressives	AK;AZ;FL;GA;IL;LA;MA;MD;MS;NE;NM;NY;PR;RI;VT;WA;WY	17
Anti-Metabolites	Prohibits Antimetabolites	AK;AZ;CA;DC;FL;GA;IL;LA;KS;MA;MD;ME;MS;ND;NE;NH;NM;NV;NY;PR;RI;SC;VT;WA;WY	25
	Prohibits Oral Methothexrate	IA	1
	Prohibits Imuran	IA	1
	Prohibts antineoplastics	OR	1
Nonsteroidal Anti-inflammatory	Prohibits nonprescription nonsteriodal anti-inflammatory agents, if dose exceeds maximum dose for prescription counterpart.	AZ	1
	Prohibits prescription nonsteriodal anti-inflammatory agents	AZ	1
	Prohibits prescription nonsteriodal anti-inflammatory agents for more than 3 days, after which if not resolved must refer to Eye MD	CA	1
	Prohibits prescription nonsteriodal anti-inflammatory agents, unless approved by interprofessional committee (10 have been approved)	NH	1
	Prohibits more than one seven-day supply of oral nonsteriodal anti-inflammatories	ME;TX	2
	Prohibits oral nonsteriodal anti-inflammatory agents	AK;CO;FL;DE;GA;IL;LA;MA;MD;NY;PR;RI	12

VII. Additional Prohibitions on the Use of Topical Therapeutic Pharmaceutical Agents

Index	Provision	State	No.
Topicals Generally	Prohibits all topical drugs	PR	1
	Prohibits topicals on Children less than 1 YR	CA;MD	2
	Prohibits the dispensing of more than 72 hour supply of topical drug	MD	1
Miotics	Prohibits Miotics for treatment purposes other than emergency relief of eyeball pressure buildup.	SC	1
Anti-Biotics (See Also Ocular Infections)	Prohibits specifically formulated or fortified ocular antibiotics	MD	1
	Prohibits use of topical antibiotics, sulfonomides which are topically administered, excluding treatment of lacrimal drainage system, lacrimal gland, or structures posterior to the iris, approved by interprofessional committee	NH	1
Antivirals	Prohibits use of topical antivirals for more than 3 weeks	CA	1

	Prohibits topical antivirals unless an optometrist informs the patient that if the condition does not improve in 5 days, a physician will be notified. Also requires optometrist to post office sign.	NY	1
	Prohibits Topical Steroids, unless OD refers to Eye M.D if patient has not improved in 10 days.	NH	1
	Prohibits topical antivirals unless an optometrist consults with an Eye M.D. after more than 14 days of treatment.	OR	1
Antifungals	Prohibits antifungals	CA;MD	2
Anti-parasitics	Prohibits antiparasitics	MD	1
Referral	Requires OD to communicate with patient to determine response of topical ocular agent as soon as practicable after 72 hours from the time the agent was administered or prescribed. If patient has not responded, OD must consult with Eye M.D.	MD	1
Adverse reactions	ODs and MDs must report adverse topical drug reactions with a report on adverse drug reactions filed with the legislature annually. Requires emergency plan for management and referral for adverse drug reactions	MN	1
	Pharmacy board must file complaints on administration of topicals to OD Board	MN	1
Education	Prohibits topicals, unless OD completes 60 classroom hours in ocular and clinical pharmacology, therapeutics, and anterior segment disease and 60 hours of clinical training	CO	1
	Prohibits topicals, unless OD completes 6 month internship, 24 hours continuing education every 2 years (12 in pharmacology).	DE	1
	Prohibits topicals, unless OD completes 110 hour transcript quality course work and clinical training in general and ocular pharmacology and one year in supervised diagnosis of eye disease or disorders.	IL	1
	Prohibits topicals, unless OD competes 20 hours of continuing education biennially	IA	1
	Prohibits topicals, unless OD completes 1 year of clinical training in diagnosis of eye disease	IL	1
	Prohibits topicals, unless OD completes 90 hours didactic and 30 supervised clinical education in therapeutics.	MA	1
	Prohibits topical, unless OD completes 60 hours in general and ocular pharmacology; 100 hours in treatment of eye condition with	MN	1

	topical drugs, 2 year of supervised clinical experience in diagnosis of eye disease or disorder or 1 year experience and 10 year actual clinical experience as licensed OD.		
	Prohibits topicals, unless OD completes 100 classroom course, including 60 hours clinical training in eye disease management.	NE	1
	Prohibits topicals, unless OD completes 100 classroom-clinical course hours in ocular and general pharmacology	NM	1
	Prohibits topicals unless 300 hours of clinical training in ocular disease other than glaucoma and ocular hypertension. Recent grads exempted.	NY	1
	Prohibits topicals, unless OD completes 72 hours of clinical therapeutic training in the direct therapeutic management of ocular disease in an internship with Eye M.D. The ratio of Eye M.D. to optometrists in the clinical training shall not exceed 1:4. The training shall include 50 eyelid, 50 conjunctiva, and 50 cornea disease cases. Prohibits glaucoma and anterior uveitis, unless OD completes 24 more hours of classroom study for amplified privileges to treat glaucoma and anterior uveitis	RI	1
	Prohibits topicals, unless OD completes 150 hours of classroom education and 40 hours of clinical training, and 5 hours of continuing education annually in ocular pharmaceuticals	SD	1
	Prohibits topicals, unless OD completes 75 hours of didactic and clinical instruction in general and ocular pharmacology.	WA	1

VIII. Additional Prohibitions on the Use of Oral Therapeutic Drugs

Index	Provision	State	No.
Orals Generally	Prohibits All Orals	AK;FL;MA;NY;PR;RI;	6
	Prohibits All oral drugs except tetracyline	MD	1
	Prohibits All oral drugs, except specified oral analgesics	GA;	1
	Prohibits All oral drugs, except over the counter agents and nonnarcotic analgesics	IL	1
	Prohibits orals drugs, unless OD communicate with the patient's primary care provider, or with a physician skilled in eye disease, when it is medically appropriate, as determined by the OD	VT	1
Age Limitations	Prohibits oral drugs to persons less than six years of age	KS	1
	Prohibits oral drugs to persons less than one	CA;MD	2

	year of age.		
	Prohibits oral drugs to persons less than twelve years of age.	SD	1
Oversight	Prohibits orals not specified in statute or not approved by interprofessional committee and approved by medical board	TX	1
	Requires consultation with a treating Eye M.D. for 90 days following surgery if an oral drug is used by the optometrist.	WA	1
Antibiotics (See also Ocular Infections)	Prohibits Oral Antibiotics	AK;FL;GA;IL;MA;NY; PR;RI	8
	Prohibits Oral Antibiotics to Persons under 6	AZ	1
	Prohibits use of antibiotics except tetracycleine and derivatives cephalosporins, penicillin and derivatives, and erithromycin, azithromycin, and clarithromycin, but limited to 72 hours for other than blepharitis and 10 days for blepharitis. If no improvement is shown in condition the OD must consult with PCP for referral to specialist is required	AZ	1
	If after the normal treatment period the condition is not resolved, the optometrist shall request that the primary care or family physician refer the patient to a specialist.	AZ	1
	Prohibits use of oral antibiotics except tetracyclines, dicloxacillin, amoxicillin, amoxicillin with clavulanate, erythromycin, clarythromycin, cephalexin, cephadroxil, cefaclor, trimethoprim with sulfamethoxazole, ciprofloxacin, azithromycin. Azithromycin shall be limited to the treatment of eyelid infections and chlamydial disease manifesting in the eyes	CA	1
	Prohibits Central Corneal Ulcer when the condition has not improved w/i 24 hour of diagnosis, unless OD consults with Eye MD	CA	1
	Prohibits Central Corneal Ulcer when condition has not improved w/i 48 hours of diagnosis, after which OD shall refer patient to Eye MD.	CA	1
	Prohibits Central Corneal Ulcer if patient is still receiving antibiotics 10 days after diagnosis after which OD shall refer patient to Eye MD.	CA	1
	Prohibits treatment of corneal peripheral inflammatory keratitis if recurring within one year of initial occurrence, unless OD consults with Eye M.D.	CA	1
	Prohibits treatment of preseptal cellulitis if	CA	1

	the condition has not improved after 72 hours, after which OD must refer to Eye MD		
	Prohibits treatment of dacryocystitis if the condition has not improved after 72 hours, after which OD must refer to Eye MD	CA	1
	Prohibits treatment of preseptal cellulitis if the patient is still receiving oral antibiotics after 10 days, after which OD must refer to Eye MD	CA	1
	Prohibits treatment of dacryocystitis if the patient is still receiving oral antibiotics after 10 days, after which OD must refer to Eye MD	CA	1
	Prohibits Blepharitis if the condition has not improved w/I six weeks after which OD must consult with Eye MD.	CA	1
	Prohibits use of prescription oral drugs except for tetracycline and its derivatives for treatment of meibomitis and seborrheic blepharitis.	MD	1
	Prohibits more than one 10-days supply of oral antibiotics	ME	1
	Prohibits use of oral antibiotics, sulfonomides which are orally administered, excluding treatment of lacrimal drainage system, lacrimal gland, or structures posterior to the iris, approved by interprofessional committee	NH	1
	Prohibits more than one 10-day supply of oral antibiotics	TX	1
Antivirals	Prohibits Antivirals	AK;AZ;DC;DE;FL;GA;IL;LA;MA;MD;NV;NY;PR;RI;WV	13
	Prohibits oral Acyclovir for treatment of conditions other than herpes simplex viral keratitis, herpes simplex viral conjunctivitis, periocular herpes simplex viral dermatitis, varicella zoster viral keratitis, varicella zoster viral conjunctivitis, periocular varicella zoster viral dermatitis.	CA	1
	Prohibits oral acyclovir for the treatment of herpes simplex keratitis or varicella zoster viral keratitis if condition has not improved 7 days after diagnosis, after which OD must refer patient to Eye MD	CA	1
	Prohibits oral acyclovir for the treament of herpes simplex keratitis or varicella zoster viral keratitis if condition has not resolved 3 weeks after diagnosis, after OD must refer patient to Eye MD	CA	1
	Prohibits oral acyclovir for the treatment of herpes simplex viral conjunctivitis, herpes	CA	1

	simplex viral dermatitis, varicella zoster viral conjunctivitis, varicella zoster viral dermatitis, if condition has worsened after 7 days after diagnosis, OD must consult with Eye MD.		
	Prohibits oral acyclovir for the treatment of herpes simplex viral conjunctivitis, herpes simplex viral dermatitis, varicella zoster viral conjunctivitism, varicella zoster viral dermatitis, if condition has not after 3 weeks of diagnosis, after which OD must refer to Eye MD.	CA	1
	Prohibits more than one 10 day supply of oral antivirals	MN	1
	Prohibits more than one 10 day supply of oral antivirals with referral to a physician.	ME	1
	Prohibits acyclovir, valacyclovir, or famciclovir, unless the OD consults a physician.	OH	1
	Prohibits anti-virals, except for acyclovir, valacyclovir, or famcielovir.	NH;VT, PA	3
Antifungals	Prohibits Antifungals	AK;AZ;CA;CO;DC;DE;FL;GA;IL;KS;LA; MA;MD;MS;NH;NM;NV;NY; PR;RI;VT;WV;WY	22
Antiparasitics	Prohibits Antiparasitics	AK;CA;DE;FL;GA;HW;IL;MA;MD; MN;NY;PR;RI;VT	14
Anti-histamines	Prohibits Antihistamines	AK;FL;GA;HW;IL;MA;MD;NY;PR;RI;	10
	Prohibits antihistamines, except for 7 day supply of cetirizine, loratadine, fexofenadine, but requires OD to get referral from MD.	AZ	1
	Prohibits oral antihistamines after two weeks, after which OD must refer to Eye MD.	CA	1
	Prohibits more than one 72-hour supply of oral antihistamines	ME;TX	2
	Prohibits oral decongestants	AK;CA;FL;GA;HW;IL;MA;MD;NY;PR;RI; SD;	12
	Prohibits oral mast-cell stabilizers	AK;CA;FL;GA;HW;IL;MA;MD;NY;PR;RI; SD; WV	13
Education	Prohibits any orals, unless OD completes education requirements specified by the board.	AZ;WV	2
	Prohibits orals unless OD completes 44 hours of continuing education in glaucoma and use of oral drugs	LA	1
	Prohibits orals, unless OD completes 15 hour course in the use of orals, recent grads exempted.	KS	1
	For persons without a therapeutic license, prohibits advance therapeutics unless OD completes 100 hour course is ocular	ME	1

	therapeutics, including at least 25 hours of supervised clinical training and another 25 hours devoted primarily to pharmacology and glaucoma. For person with a therapeutic license, prohibits advance therapeutics unless OD completes 25 hours course devoted primarily to pharmacology and glaucoma and 3 didactic hours on antiglaucoma agents.		
	Prohibits orals, unless OD completes 10 hours of TPA in orals every two years	NJ	1
	Prohibits orals, unless OD completes 20 course in clinical pharmacology, including systemic pharmacology.	NM	1
	Requires interprofessional committee to set clinical training and education requirements for use of oral and must be approved by Medical Board	TX	1
	Requires completion of instructional clinical review course before orals	TX	1
	Prohibits oral drugs unless OD completes 16 hours of didactic and 8 hours of supervised clinical education that is certified by an institution of higher learning.	WA	1

IX. Specific Limitations on the Ordering of Tests

Index	Provision	State	No.
X-Rays	Prohibits X-Rays	AK;CT	2
Cultures	Prohibits ordering of tests, except for a conjunctival culture.	MD	1
CLIA	Prohibits ordering or performing of tests, if tests are not CLIA-waived clinical tests	AZ	1
	Authorizes commissioner of health to regulate laboratory practice of ODs to ensure that they are in full compliance w/CLIA.	TN	1
Costs	Requires ODs to disclose laboratory costs	LA	1
Topicals	Prohibits ordering of tests not related to the use of topical pharmaceutical agents	HW	1

X. Specific Limitations on Superficial Foreign Body Removal

Index	Provision	State	No.
Depth	Prohibits superficial foreign body removal below the Bowman's Layer.	CT;HW;TX;WI	4
	Prohibits superficial foreign body removal below anterior stroma	CA	1
	Prohibits perforating superficial corneal foreign body removal	CA	1
	Prohibits superficial foreign body if foreign body has penetrated the globe	FL	1
	Prohibits superficial foreign body removal	UT	1

	deeper than the anterior one-half of cornea		
	Prohibits foreign body removal from within the tissue of the eye	NY	1
	Prohibits superficial foreign body removal below the conjunctiva	WI	1
Visual Axis	Prohibits the use of sharp instruments if superficial foreign body is w/I central 3mm of cornea	CA	1
	Prohibits superficial foreign body removal w/i 2.5mm of visual axis.	MD	1
	Prohibits superficial foreign body removal w/i 3mm of visual axis, if body has penetrated deeper than the corneal epithileum	NH	1
Instruments	Prohibits superficial foreign body removal unless removed with cotton-tipped applicator or blunt spatula.	MD	1
	Prohibits superficial foreign body removal requiring surgical repair upon removal.	CA	1
Referral	Requires OD to refer to Eye M.D. to remove foreign bodies that are not superficial ocular or ocular adnexal foreign bodies.	SC	1

XI. Prohibitions on the Use of Injections

Index	Provision	State	No.
Types of Injections	Prohibits all Injectable Drugs	AK;CO;DE;FL;GA;HW;IL;KS;MA;MI;MS;MO;NE;NM;NV;NY;OH;PA;PR;RI;SC;WV;WY	24
	Prohibits Intravenous Drugs	AZ;CT;MA;ME;MN;NH;SC	7
	Prohibits Injections into the Eyeball	AL	1
	Prohibits use of needles	TX	1
	Prohibits Botox Injections	OR;VT	2
	Prohibits Intramuscular injections	MA;MN;ME	2
	Prohibits Intraocular injections	OR;VT	2
	Prohibits Subdermal injection	MA;ME	2
	Prohibits Retrobulbar injections	OR;MA;ME;VT	4
	Prohibits Subcutaneous injections	MA;VT	1
	Prohibits Subtenon injections	OR;VT	2
	Prohibits Ketamine (IM) for an infant's examination under anesthesia	VT	1
	Prohibits all injections except for flourescein angioigraphy, injection of chalazia, and injection of periocular muscles. Prohibits Injection of the periocular muscles for cosmesis; Prohibits injections into the extraocular muscles.	NC	
	Prohibits Infusions	WA	1
Specific Conditions	Prohibits the removal of benign skin lesions involving subcutaneous injections	VT	1

	Prohibits the management of skin and conjunctival neoplasms	VT	1
Anaphylactic Shock	Prohibits Subcutaneous injections, except for an injection to counter anaphylactic shock	ME	1
	Prohibits injectable drugs, except for epinephrine auto-injectors to counter anaphylactic shock and must maintain supportive equipment and supplies, including oxygen equipment, airway maintenance equipment or other necessary equipment.	AZ	1
	Prohibits injectable drugs, except for a automatic injectors	CA	1
	Prohibits injectable drugs, except for a automatic injectors and epi-pens followed by immediate referral to the nearest emergency facility	MS	1
	Prohibits injectable drugs, except for a automatic epinephrine injectors	LA	1
	Prohibits Injectable Drugs except for an injection to counter anaphylactic shock	AR;CT;DC;IA;KY;MN;NH;NJ	8
	Prohibits Injectable Drugs except for an epinephrine injection to counter anaphylactic shock	MD;VA;WA	3
	Prohibits Injectable Drugs except for an injection to counter anaphylactic shock and then must refer immediately to physician.	TX	1
	Prohibits Injectable Drugs except for an injection to counter anaphylactic shock, unless board approves individual ODs.	TN	1
	Prohibits Injectable drugs except for injections appropriate for the emergency stabilization of a patient.	VT	1
Diagnostic Agents	Prohibits Invasive diagnostic agents	HW	1
	Prohibits Indocyanine green angiography	VT	1
Education	Requires interprofessional committee to set clinical training and education requirements for use of parenteral drugs and must be approved by Medical Board	TX	1
	Prohibits injections for anaphylaxis unless OD gets an extra 4 hours of didactic and clinical education.	WA	1

XII. Prohibitions on Surgery

Index	Provision	State	No.
Surgery Generally	Prohibits Surgery	AK;AZ;CA;CO;CT;DC;DE;FL;GA;HW;IA;ID;IN;KS;KY;LA;MD;MN;MI;MO;MS;MT;NC;NE;NH;NJ;NM;NV;NY;OH;PA;PR;RI;SD;TX;UT;VA;VT;WA;WV;WI;WY	42

9:53:05 AM
5/12/07

May 11, 2007

Senator Bert Stedman
Co-Chair, Senate Finance
State Capital, Rm 516
Juneau AK 99801-1182

Re: Opposition to CS HB 113, An Act Relating to the Prescription and Use of Pharmaceutical Agents, Including Controlled Substances, by Optometrists

Dear Senator Stedman,

As you know, I am legally blind. I have had nine (9) surgeries on my eyes and have remaining only a little bit of clouded vision in my left eye. All of this blindness was brought on by me through diabetes and a kidney transplant. My experience is that a persons eyes is a part of his total health well being and must be treated in concert with all other vital functions of the body. Only qualified medical doctors are able to keep medications, treatment of other vital organs and a prescribed health regime in balance.

The Alaska State Legislature has been considering proposed changes to law that would enable optometrists to use oral and injectable drugs.

There exists a difference in the education and training between optometrists and ophthalmologists, with the more comprehensive training of ophthalmologists who are considered medical doctors. Optometrists complete four years education at optometry school without any requirement in Alaska for residency training, ophthalmologists, must complete four year of medical school, a hospital residency, and an additional three to four year residency training program that specializes in medical and surgical treatment of the eye.

Over the last six years optometrists and ophthalmologists have been engaged in a professional dispute in the legislature with the optometrists promoting the expansion of their scope of practice and the ophthalmologists supporting and

protecting public health by advocating comprehensive eye and total health care of Alaskans. Very little citizen input to protect the safety and health of Alaskan citizens has been presented to law makers.

Eye care is related to total body health and the risk of the loss of eyesight is great if eye care is not undertaken by qualified medical doctors. The loss of eyesight cannot be replaced and the diminishment of eyesight can be only prevented with the assistance of medical doctors addressing comprehensive health of patience. Legislative authorization of eye care by unqualified persons with the expanded authority to undertake the prescription of drugs and other procedures is not in the best interest of Alaskan citizens.

It is believed that CS HB 113 provides authorization of oral medications (antivirals, antifungals, antihistamines, antimetabolites, steroids, antibiotics, and oral anti-glaucoma drugs) - that will result in increased potential patient risks. In addition to the oral systemic drugs authorized in CS HB 113, this legislation also would allow Alaska optometrists to inject Botox into the eyelids and surrounding tissues, inject steroids into chalazions, inject anesthetics into the lid, and prescribe a broad array of narcotics and analgesics. Such a wide expanded prescription and injection authority is not in the best interest of patient care for Alaskans.
I believe that Alaskans should receive specialized medical care from the most qualified medical doctors available on the most comprehensive basis possible for the human body, including eyes.

I urge you to advocate, in your capacity as an Alaska State Legislator, to emphasize patient safety for all Alaskan citizens in the provision of all health care and that the Legislature, on behalf of its citizens, protect citizen and consumer interests over economic competition between professional service groups, including optometrists and ophthalmologists.

I urge you to oppose CH HB 113 as a measure of protecting the health and safety for all Alaskans and I urge you to continue the Legislatures effort to fund and train more qualified medical doctors so that comprehensive and quality health care is available to all Alaskans.

Thanking you for this consideration.

Sincerely,

Robert W. Loescher

10645 Misty Lane
Juneau AK, 99801
907-723-8516

May 12, 2007

Senator Bert Stedman
Co-Chair, Senate Finance
State Capital, Rm 516
Juneau AK 99801-1182

Re: Fiscal Note Impact Questions for CSHB 113, An Act Relating to the Prescription and Use of Pharmaceutical Agents, Including Controlled Substances, by Optometrists

Dear Senator Stedman,

I have been following this legislation this year. I have questioned in the previous committee hearing why there is no fiscal note. I believe that there are fiscal note questions that should be asked. I have not been able to get any legislator to ask the questions about fiscal impacts to the Alaska State Departments, various boards, and the University of Alaska.

I have prepared a number of questions (hereby attached) that I request you ask at the Senate Finance Committee hearing. Please ask these questions.

I will attend the hearing and provide testimony if public testimony will be permitted by the committee. However, I am blind and it may be difficult for me to read or reflect each of the questions that I have laid out in the attachment to this letter. If you could help me in this regard I would appreciate it.

This bill has been moving quite rapidly through the House and Senate. I hope that these questions can be asked by the Senate Finance Committee or a sub-committee of finance. I hope and request that the legislation is not waived through the committee without asking these questions and getting answers from the appropriate departments and boards that are affected by this bill. I believe that consumer interests need to be protected and that the highest standards of medical care be available and maintained by the most qualified medical practitioners within the

State of Alaska. I know that you share this same goal and I hope that you will seek the answers to the questions that I have put forth.

Thanking you for this consideration.

Sincerely,

Robert W. Loescher

10645 Misty Lane
Juneau AK, 99801
907-721-8516

Cc: Governor Sarah Palin
Commissioner Emil Notti

CS HB 113, AN ACT RELATING TO THE PRESCRIPTION AND USE OF PHARMACEUTICAL AGENTS, INCLUDING CONTROLLED SUBSTANCES, BY OPTOMETRISTS
BEFORE
SENATE FINANCE
MAY 12, 2007

FISCAL NOTE QUESTIONS: IMPACTS TO THE ALASKA BOARD OF EXAMINERS IN OPTOMETRY; ALASKA STATE MEDICAL BOARD; DEPARTMENT OF LABOR; DEPARTMENT OF COMMERCE, COMMUNITY, AND ECONOMIC DEVELOPMENT; UNIVERSITY OF ALASKA

Under current law, optometrists usually treat patients with simple eye diseases using topical drugs, whose effect on the body is generally more localized. If a patient presents him or herself with a complex eye disease, optometrists refer the patient to an ophthalmologist or other physician. However, because this bill would authorize optometrists to prescribe systemic drugs – oral drugs and injections, this bill could result in a wholesale shift in responsibilities in treating these very sick patients from physicians to optometrists.

WILL THE ALASKA BOARD OF EXAMINERS IN OPTOMETRY NEED TO HIRE AND TRAIN ADDITIONAL STAFF TO INVESTIGATE COMPLAINTS RESULTING FROM THE ADDITIONAL PATIENT LOAD AND THE MORE COMPLEX CONDITIONS THAT OPTOMETRISTS WILL BE TREATING?

WILL AN AGGREGATE SHIFT IN PATIENT POPULATION TO OPTOMETRISTS, HAVE A FISCAL IMPACT ON THE ALASKA STATE MEDICAL BOARD DUE TO A POSSIBLE CHANGE IN THE NUMBER AND TYPE OF INVESTIGATIONS PURSUED BY THE STATE MEDICAL BOARD?

SINCE MEMBERS OF THE OPTOMETRY BOARD DO NOT CURRENTLY TREAT THESE CONDITIONS WILL THE STATE OF ALASKA (I.E. DEPARTMENT OF LABOR, DEPARTMENT OF COMMERCE AND COMMUNITY ECONOMIC DEVEOPMENT, OR

UNIVERSITY OF ALASKA) BE REQUIRED TO PROVIDE MEMBERS WITH ADDITIONAL TRAINING IN ORDER TO APPROPRIATELY INVESTIGATE THESE MORE COMPLEX MEDICAL CASES?

SINCE SOME OF THESE COMPLEX CASES MAY ALSO INVOLVE PHYSICIANS LICENSED BY THE ALASKA STATE MEDICAL BOARD OR SYSTEMIC DISEASES NOT DIRECTLY RELATED TO EYE DISEASE BEING TREATED, WILL THE STATE MEDICAL BOARD BE REQUIRED TO HIRE ADDITIONAL STAFF TO ASSIST IN INVESTIGATIONS?

CS HB 113, AN ACT RELATING TO THE PRESCRIPTION AND USE OF PHARMACEUTICAL AGENTS, INCLUDING CONTROLLED SUBSTANCES, BY OPTOMETRISTS
BEFORE
SENATE FINANCE
MAY 12, 2007

FISCAL NOTE QUESTIONS: IMPACTS TO THE ALASKA STATE MEDICAL BOARD; DEPARTMENT OF COMMERCE, COMMUNITY, AND ECONOMIC DEVELOPMENT; ALASKA BOARD OF PHARMACY

Physicians have plenary licenses, but optometrists do not. If this bill is enacted optometrists would not be able to prescribe all systemic drugs and controlled and cannot treat diseases unrelated to the eye. However, only a few of these limitations, such as Botox and Schedule I and II Controlled Substances are specified in the bill. This presents the Alaska Board of Examiners in Optometry with the difficult problem of determining whether licensees are conforming to limitations in the law.

IN ADDITION TO ANALYZING INDIVIDUAL COMPLAINTS FROM PATIENTS AND SURVEYS OF LICENSEES, WILL THE OPTOMETRY BOARD AND/OR THE STATE MEDICAL BOARD BE REQUIRED TO PURCHASE PHARMACEUTICAL INDUSTRY DATA AND TO HIRE STAFF TO ASSIST IN STATISTICAL ANALYSIS TO MAKE AN ACCURATE ASSESSMENT OF PRESCRIBING PATTERNS TO PROPERLY PROTECT THE PUBLIC?

WILL THE ALASKA BOARD OF PHARMACY BE REQUIRED TO INVESTIGATE, TRAIN, AND TEST LICENSEES TO ENSURE THAT PHARMACISTS ARE NOT FILLING PHARMACEUTICAL ORDERS FOR DISEASES THAT ARE NOT RELATED TO THE EYE AND OUTSIDE THE SCOPE OF PRACTICE OF OPTOMETRY?

CS HB 113, AN ACT RELATING TO THE PRESCRIPTION AND USE OF PHARMACEUTICAL AGENTS, INCLUDING CONTROLLED SUBSTANCES, BY OPTOMETRISTS
BEFORE
SENATE FINANCE
MAY 12, 2007

FISCAL NOTE QUESTIONS: IMPACTS TO THE ALASKA BOARD OF EXAMINERS IN OPTOMETRY; DEPARTMENT OF COMMERCE, COMMUNITY, AND ECONOMIC DEVELOPMENT

This bill would authorize optometrists to prescribe controlled substances.

SINCE THESE SUBSTANCES HAVE BEEN KNOWN TO BE SUBJECT TO ABUSE BY THOSE WHO PRESCRIBE THEM, WHAT WILL BE THE COST TO THE ALASKA BOARD OF EXAMINERS IN OPTOMETRY OF ESTABLISHING AND ADMINISTERING AN IMPAIRED LICENSEE PROGRAM FOR THOSE PRESCRIBING CONTROLLED SUBSTANCES?

CS HB 113, AN ACT RELATING TO THE PRESCRIPTION AND USE OF PHARMACEUTICAL AGENTS, INCLUDING CONTROLLED SUBSTANCES, BY OPTOMETRISTS
BEFORE
SENATE FINANCE
MAY 12, 2007

FISCAL NOTE QUESTIONS: IMPACTS TO THE DEPARTMENT OF HEALTH, EDUCATION AND SOCIAL SERVICES; DEPARTMENT OF REVENUE; DEPARTMENT OF COMMERCE, COMMUNITY, AND ECONOMIC DEVELOPMENT

This bill would increase the number of providers eligible for reimbursement from the State Medicaid System who treat systemic eye disease by several hundred percent. Alaskans who would be impacted are largely children and senior citizens.

WHAT WILL BE THE FISCAL IMPACT OF THE INCREASE IN THE PROVIDER POPULATION FROM PRIVATE MEDICAL CARE VISITS AND THE IMPACT ON THE STATE MEDICAID BUDGET, SINCE PRESUMABLY MORE OFFICE VISITS WILL BE MADE, MORE TESTS WILL BE ORDERED, MORE PATHOLOGY WILL BE TREATED, AND MORE MEDICATIONS WILL PRESCRIBED?

CS HB 113, AN ACT RELATING TO THE PRESCRIPTION AND USE OF PHARMACEUTICAL AGENTS, INCLUDING CONTROLLED SUBSTANCES, BY OPTOMETRISTS
BEFORE
SENATE FINANCE
MAY 12, 2007

FISCAL NOTE QUESTIONS: IMPACTS TO THE ALASKA BOARD OF EXAMINERS IN OPTOMETRY; ALASKA STATE MEDICAL BOARD; DEPARTMENT OF LABOR; DEPARTMENT OF COMMERCE, COMMUNITY, AND ECONOMIC DEVELOPMENT; UNIVERSITY OF ALASKA

12 AAC 48.021 and 12 AAC 48.025 authorize the board to issue a license endorsement to prescribe topical diagnostic agents and topical pharmaceutical agents and to charge specified fees under 12 AAC 02.300. Therefore, all the endorsements issued up to now have been for optometrists to prescribe either diagnostic drugs or all topical drugs. In addition to the requirements to prescribe topical drugs under existing law, to prescribe all the systemic drugs and controlled substances in CSHB 113, optometrists are required to take a nontopical therapeutic pharmaceutical agent course of at least 23 hours approved by the board or an examination approved by the board on the treatment and management of ocular disease; AND an optometry and nontopical therapeutic pharmaceutical agent injection course of at least seven hours approved by the board or equivalent training acceptable to the board. Optometrists with a topical drug endorsement may have already complied with the first requirement under existing board regulations IF the test they are referring to in the bill is the same test referenced in 12 AAC 48.025 (3)(B) known as the TMOD test. In any case, optometrists would also have to submit proof that they complied with the injection requirement to obtain an endorsement to prescribe all the drugs in this bill. All new optometrists and all existing optometrists wanting to prescribe all the drugs in this bill would have to submit an application for an endorsement. According to Section 6 of the bill, optometrists with topical endorsement would not be able to renew their endorsements. Therefore, if optometrists want to prescribe any drug after the endorsement expires, they would have to obtain endorsement to prescribe all drugs. To pay for the administrative impact of issuing the drug endorsement to new optometrists that want the endorsement, existing optometrists that have no endorsement

but want an all drug endorsement, existing optometrists that only have a diagnostic endorsement, and existing optometrists that already have a topical endorsement, the optometry board has the authority to levy fees.

WHAT WILL BE THE ADDITIONAL OR ADMINISTRATIVE COSTS TO THE ALASKA STATE BOARD OF EXAMINERS IN OPTOMETRY ASSOCIATED WITH ESTABLISHING AND MANAGING THIS SYSTEM OF ENDORSEMENTS FOR OPTOMETRISTS THAT WOULD BE PRESCRIBING SYSTEMIC DRUGS?

WILL THE FEES LEVIED BE TIER BASED ON THE FACT THAT THE APPLICANTS MAY HAVE DIFFERENT LEVELS OF DRUG ENDORSEMENT AND SO ADMINISTRATIVE COSTS MAY VARY IN RELATION TO THE LICENSEE'S ENDORSEMENT STATUS? WILL A TIERED SYSTEM BE PRACTICAL, EQUITABLE, AND COVER COSTS?

CS HB 113, AN ACT RELATING TO THE PRESCRIPTION AND USE OF PHARMACEUTICAL AGENTS, INCLUDING CONTROLLED SUBSTANCES, BY OPTOMETRISTS
BEFORE
SENATE FINANCE
MAY 12, 2007

FISCAL NOTE QUESTIONS: IMPACTS TO THE ALASKA BOARD OF EXAMINERS IN OPTOMETRY; ALASKA STATE MEDICAL BOARD; DEPARTMENT OF LABOR; DEPARTMENT OF COMMERCE, COMMUNITY, AND ECONOMIC DEVELOPMENT; UNIVERSITY OF ALASKA

This bill requires an optometrist to file a federal drug enforcement registration number that is valid for controlled substances with the Alaska Department of Commerce, Community, and Economic Development. This also implies that the department would have to coordinate with the Alaska State Medical Board and the Alaska Board of Examiners in Optometry to ensure compliance with this paragraph.

WOULD THE BILL HAVE AN ADMINISTRATIVE COST IMPACT ON THE ALASA DEPARTMENT OF COMMERCE, COMMUNITY, AND ECONOMIC DEVELOPMENT SINCE THE BILL APPEARS TO INCREASE ITS DUTIES AND MAY IMPACT AGENCY SPENDING OR STAFFING REQUIREMENTS?

WOULD THIS BILL INCREASE THE DUTIES OF THE ALASK STATE MEDICAL BOARD AND THE ALASKA BOARD OF EXAMINERS IN OPTOMETRY IF OPTOMETRISTS ARE NOT IN COMPLIANCE WITH THIS PROVISION?

STATE OF ALASKA
DEPARTMENT OF
COMMERCE
COMMUNITY AND
ECONOMIC DEVELOPMENT

Sarah Palin, Governor
Emil Notti, Commissioner
Rick Urion, Director

Division of Corporations, Business and Professional Licensing

May 14, 2007

The Honorable Lyman Hoffman, Co-Chair
The Honorable Bert Stedman, Co-Chair
Finance Committee
State Senate
Alaska State Capitol
Juneau, AK 99801

Dear Senators Hoffman and Stedman:

Re: CSHB 113

Alaska State Board of Examiners in Optometry
Official Position Statement

House Bill 113, if enacted, would authorize qualified optometrists with a current license endorsement to prescribe additional classes of pharmaceutical agents including limited systemic drugs. The Board voted unanimously via mail ballot dated April 9, 2007 to fully support HB 113.

The Board's support of HB 113 is based upon the following points:

- Optometrists have been safely prescribing systemic drugs in other states since 1977. Similar legislation has been enacted in 45 other states throughout the last 30 years with no reported problems. With advancing research and technology, there are many new drug treatments introduced every year, and Alaska licensees with a therapeutic endorsement need to be able to prescribe the most advanced treatments.

- The Alaska Board of Optometry has received zero complaints involving drug prescriptions since the 1992 Alaska legislation was enacted authorizing therapeutic prescribing by optometrists. HB 113 expands this authority to include limited systemic medications for those licensees with a therapeutic endorsement.

- HB 113 restricts optometrists to treating ONLY the eye and surrounding tissues. Doctors of optometry complete comprehensive training on all types of prescriptive medicines for the whole body plus the eye, including contraindications and side effects. Optometrists are fully educated and competent to use any drug for treating the eye regardless of its route of administration.

- In 2001 the Alaska State Medical Board surveyed medical boards throughout the nation to find out if there were any problems in states where similar legislation had been enacted. Not one medical board reported any problems with optometrists prescribing.

- Optometrists take national board exams administered by the National Board of Examiners in Optometry (NBEC). HB 113 requires licensed optometrists to take additional continuing education courses to stay current in their knowledge and training. With Board of Optometry oversight, there are adequate safeguards in place to protect the public.

- HB 113 greatly improves access to quality eye care, as Alaska optometrists have excellent geographic distribution in many rural areas and often service remote areas. It will be beneficial in lowering health care costs by reducing unnecessary second referrals and reducing travel costs and lost work time for the patient.

Sincerely,

Jill Geering Matheson, OD

Jill Geering Matheson, OD, Chair
Board of Examiners in Optometry

cc: Senator Elton
Senator Olson
Senator Thomas
Senator Dyson

From the desk of Bob Loescher, 10645 Misty Ln, Juneau, Alaska 99801 – 907-723-8516

May 14, 2007

Re: HB 113

Dear Alaska Legislature,

Below is information I gathered yesterday in reviewing more information from the state web site.

Thank you for your consideration.

Bob

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On September 27, 2005, a Legislative Audit Report submitted by the Division of Corporations, Business, and Professional Licensing to the Members of the Legislative Budget and Audit Committee recommended that the Optometry Board should review its fee schedule to decrease licensing fees in order to eliminate the Board's current and projected surplus. Given that CS HB 113 would impose new duties on the board pertaining to administrative costs related to endorsement, investigations, and training of Board members, it is unclear whether the Legislative Audit report's recommendation to decrease fees would remain valid and if they did, to what extent and for how long it would remain valid.

http://www.legaudit.state.ak.us/pages/audits/2005/pdf/20042rpt.pdf
<http://www.legaudit.state.ak.us/pages/audits/2005/pdf/20042rpt.pdf>

During the summer of 2006, the Division apparently completed a review of optometry licensing fees. At its May 12th 2006 Board meeting, the optometry board went into executive session to review and discuss the division's proposal for license fees amendments. The outcome of the discussion is not stated in the public record. Furthermore, at that same meeting, the Board also agreed to recommend to the Division that fees for the endorsement to prescribe pharmaceuticals be absorbed into the license fee and that all licensees would be charged the same fee, regardless of endorsement status.

http://www.dced.state.ak.us/occ/pub/OPT_5_05_meeting_minutes.pdf
<http://www.dced.state.ak.us/occ/pub/OPT_5_05_meeting_minutes.pdf>

Because the Optometry Board has not posted minutes of its December 1st 2006 meeting or its May 11th 2007 meeting* on its website, there is no readily accessible public record of whether both of these proposed changes in the fee structure were discussed further and what was the quality of the analysis and how the proposals would be affected by CS HB 113, if it were to be enacted. In sum, there are a number of unanswered questions pertaining to the appropriate funding level and fee structure of the Board in relation to the new duties imposed by CSHB 113

*May 11th meeting was postponed on May 7th according to the Board's web site!!!!!!!!!!!!!!!!!!!!

SENATE COMMITTEE REPORT

DATE: 5/7/07

FURTHER: (Finance)

DATE TURNED IN TO OFFICE: 5/10/07

Labor and Commerce Committee considered CS FOR HOUSE BILL NO. 113(HES)

HB 113 OPTOMETRISTS' USE OF PHARMACEUTICALS

"An Act relating to the prescription and use of pharmaceutical agents, including controlled substances, by optometrists."

and recommends:

[X] be replaced with [✓] SCS or [ ] CS CSHB 113 (L+C)

[ ] adopt previous [ ] SCS or [ ] CS _____ (_____)

[ ] attached amendment(s)

[ ] adopt _____ _____Letter of Intent

[ ] further referral to _____Committee

SENATE BILL:
[ ] Same Title
[ ] New Title

HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[✓] New Title w/ SCR #TECH

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#
~~HES~~ COMMERCE	4/2/07			✓	1

[ ] APPROPRIATION - no fiscal note

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
C Bunde	Bunde			✓	
B Davis	DAVIS				✓
CHAIR: Gary Ellis	ELLIS			✓	

SENATE COMMITTEE REPORT

DATE: 4/23/07

FURTHER: Labor and Commerce
Finance

DATE TURNED IN TO OFFICE: 5/7/07

Health, Education and Social Services Committee considered CS FOR HOUSE BILL NO. 113(HES)

HB 113 OPTOMETRISTS' USE OF PHARMACEUTICALS

"An Act relating to the prescription and use of pharmaceutical agents, including controlled substances, by optometrists."

and recommends:

[✓] be **replaced** with [✓] **SCS** or [ ] **CS** CS HB 113 (HES)

[ ] adopt **previous** [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt _____ Letter of Intent

[ ] further referral to _____ Committee

SENATE BILL:
[ ] Same Title
[ ] New Title

HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[✓] New Title w/ SCR #TECH

NEW FISCAL NOTE(S):

Department	Date	Fiscal	indet.	Zero	FN#

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#
CED	3/16			✓	1

[ ] APPROPRIATION - no fiscal note

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
	E/h	✓			
	Cowdery			—	
VICE-CHAIR:	Thomas			✓	