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LOGGING IN KACHEMAK BAY STATE PARK: PUBLIC VALUES AT RISK

Executive Summary

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INTRODUCTION

Study of values at risk:
The purpose of this study is to review some of the economic and intrinsic values of the Kachemak Bay State Park area, to educate the reader about what is at stake if the Seldovia Native Association and Timber Trading Company inholdings are not purchased for inclusion in Kachemak Bay State Park. The study was designed to document these values statistically through the use of surveys and research of information from agency and documentary sources. The survey methods employed were the development and distribution of questionnaires.

Study author and funding:
The primary author of the study is Anne Wieland, retired Anchorage School District science teacher and long time resident of Anchorage and Homer. Wieland, a member of the Kachemak Bay Citizens Coalition, works in Homer in the summer as a marine biology counselor and as a sea kayak guide. Assistance with the study was provided by numerous Homer and Anchorage residents. The study was funded by donations from a few individuals. Several specialists served as volunteer editors.

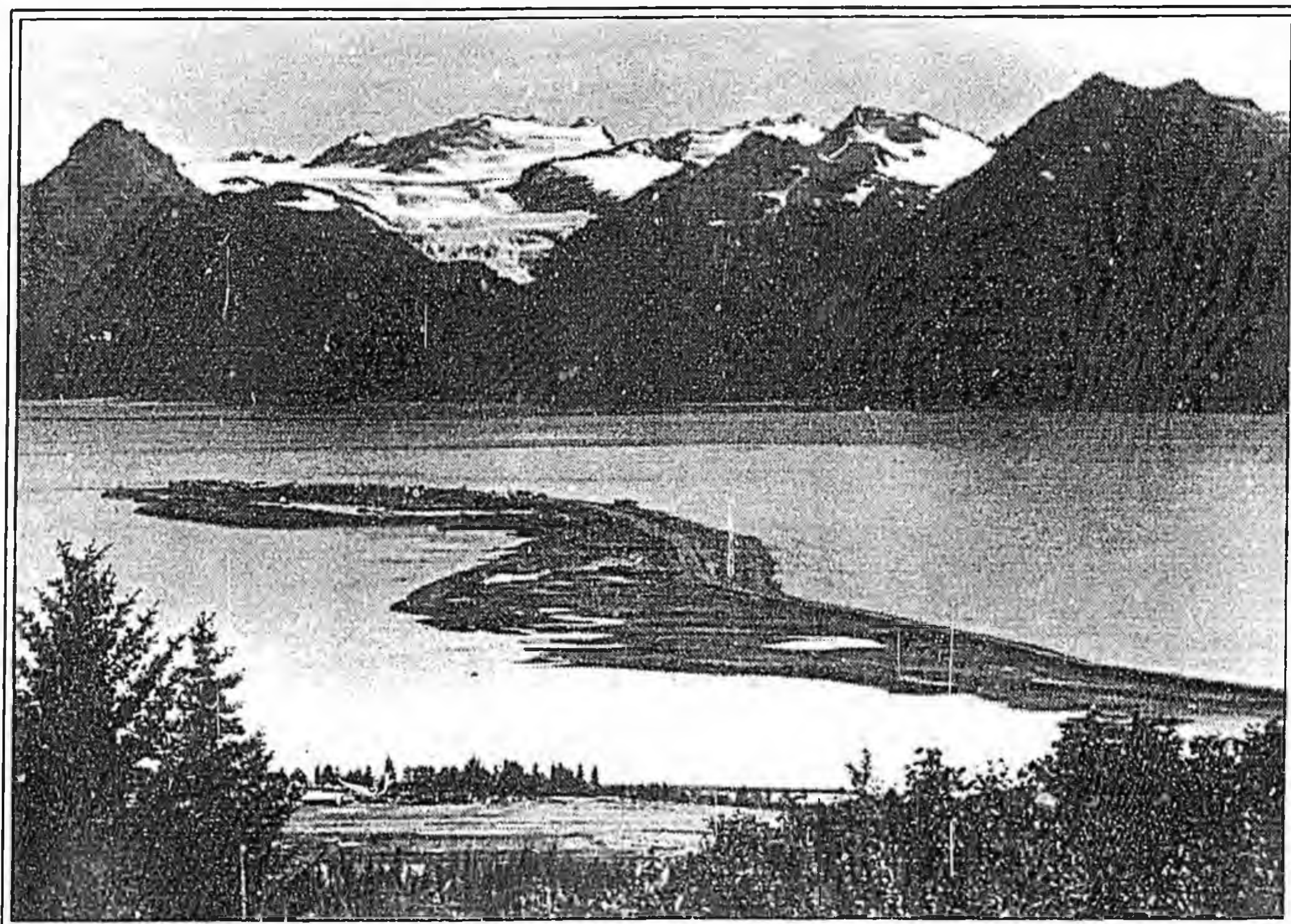
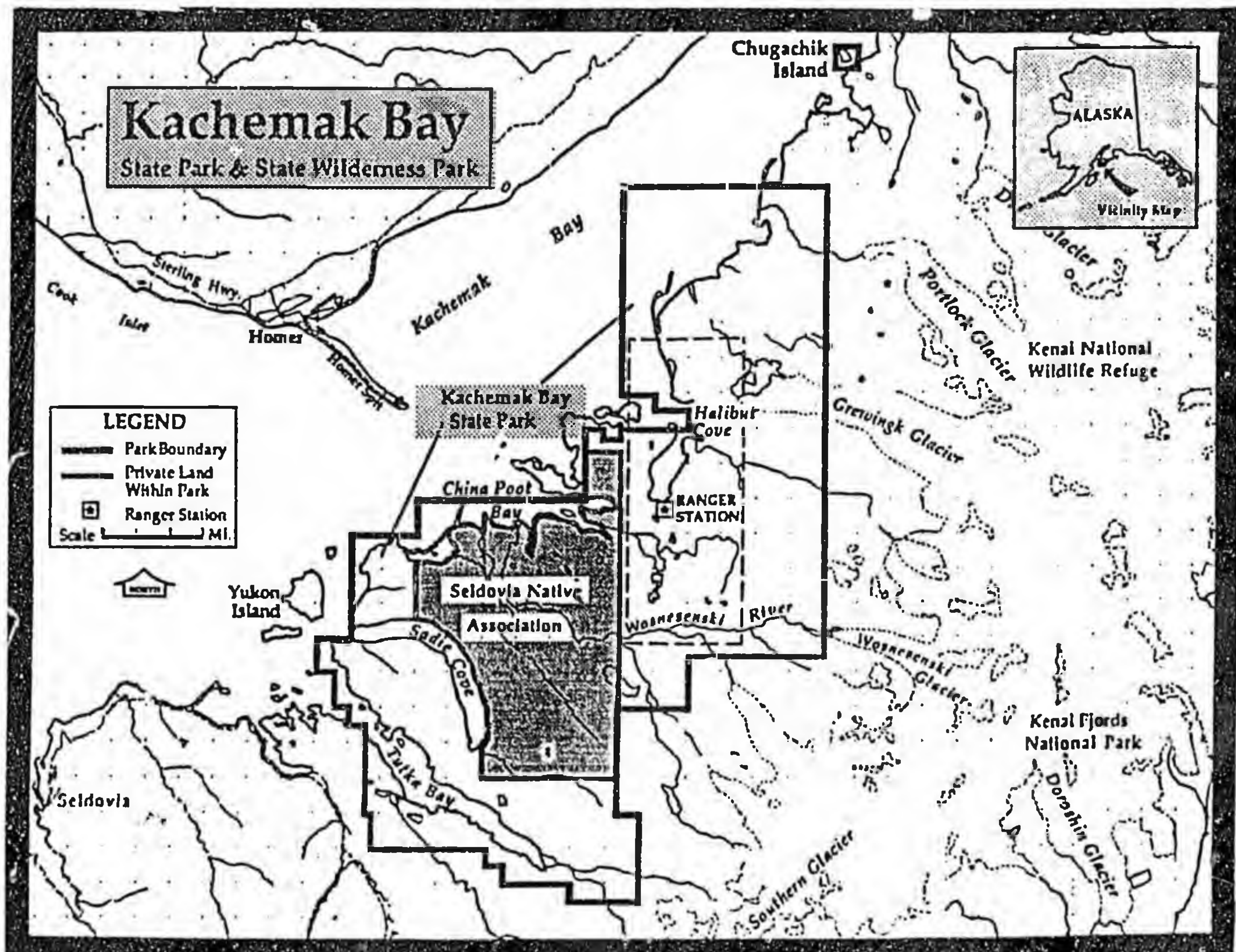


Photo by: Hal Spence Photography

BACKGROUND:
The Alaska Native Claims Settlement Act entitled Seldovia Native Association (SNA) to select 69,000 acres in the Seldovia area. SNA's preferred selections, Jakolof Bay lands, were protested by the state, so in 1974, SNA selected nearly 30,000 acres in and adjacent to Kachemak Bay State Park. In 1979, SNA signed a Memorandum of Understanding with the Kenai Peninsula Borough, Cook Inlet Region, Inc. and the state Department of Natural Resources (DNR) agreeing to exchange SNA's inholdings for state land of equal value. Some small exchanges subsequently occurred.

In 1987, when the complete exchange still had not been consummated, SNA signed a 12 year timber harvest contract with Timber Trading Company (TTC) on land within and adjacent to the park. Kachemak Bay Citizens Coalition (KBCC) formed to serve as facilitator to encourage DNR, SNA, and TTC to enter into exchanges. In the 1990 legislative session these proposed land and timber exchanges were transformed into a $20 million buy-back which failed by a 20-20 vote in the House.

TTC submitted logging permit applications in January, 1991 and has reiterated its intention to harvest if the buy-back fails in the 1991 legislative session.



REVISED 1/22/91

KACHEMAK BAY TIMBER HARVEST AREA

HOMER SMALL
BOAT HARBOR

LEGEND

■ = Commercial
Timber
Stand

KACHEMAK BAY

Neptune Bay

PASSAGE

ELDRED

SADIE

COVE

TUTKA

BAY

China
Poot
Lake

MAP OF
KACHEMAK BAY
TIMBER HARVEST AREA

KACHEMAK BAY, ALASKA

JAKOLOF BAY TIMBER HARVEST AREA

LEGEND

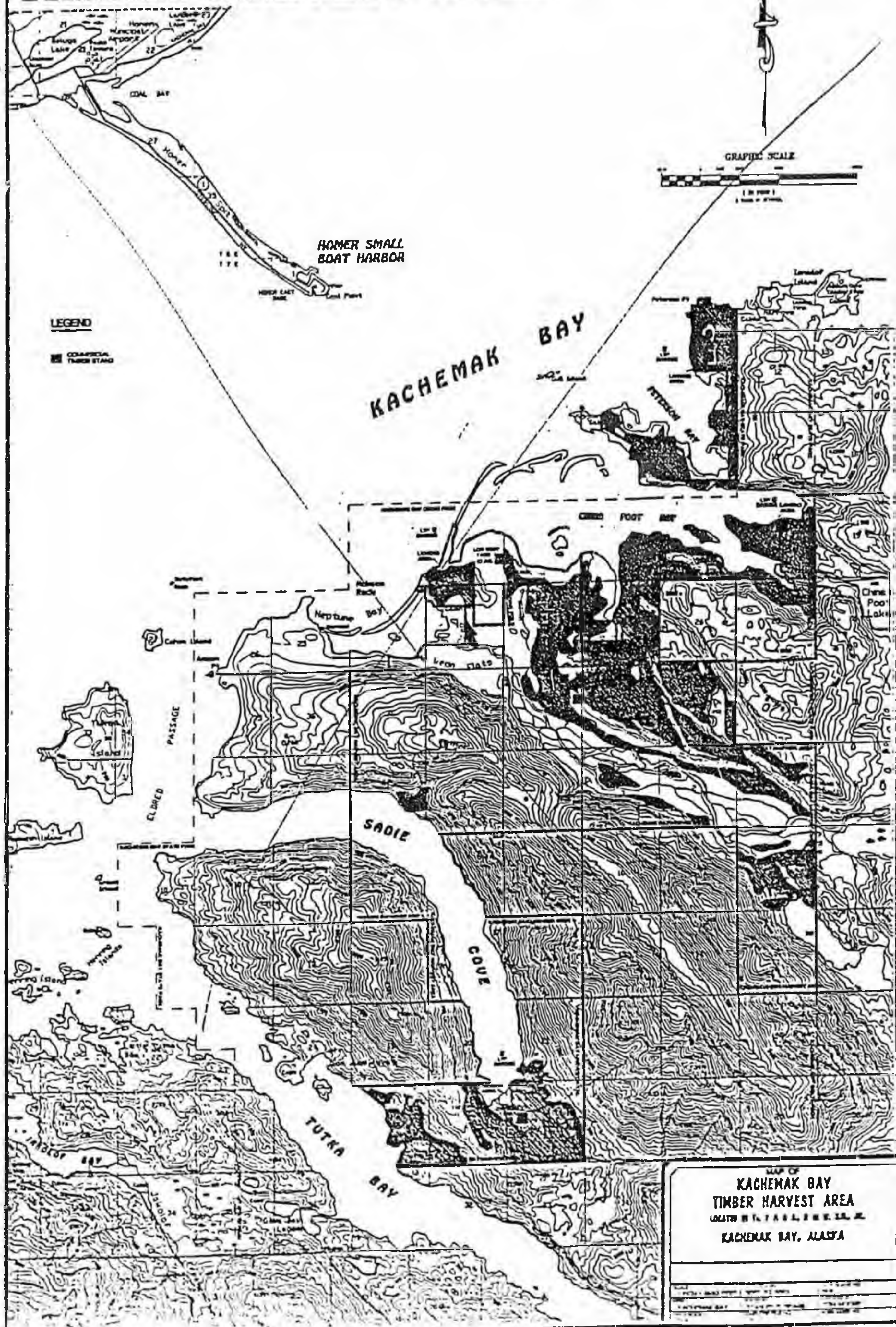
PRELIMINARY REPORT: JAKOLOF TIMBER CRUISE
KERR AND ASSOCIATES
NOVEMBER 1988

MAP OF
JAKOLOF BAY
TIMBER HARVEST AREA

KACHEMAK BAY, ALASKA
TIMBER TRADING COMPANY

MOORE AND ASSOCIATES

SCALE: 1 INCH = 2640 FEET	DATE DRAWN: SEPT 20, 1990	DATE SURVEYED: N/A
GRID: KACHEMAK BAY	DRAWN BY: STANLEY E. SEARS	CHECKED BY: TOM MOORE
FIELD BOOK: N/A	COMPUTER FILE NO. JAKOI	WORK ORDER NO.


KACHEMAK BAY
TIMBER HARVEST AREA
HOMER SMALL
BOAT HARBOR
LEGEND
KACHEMAK BAY
GRAPHIC SCALE
SADIE
COVE
TUTKA
BAY
ELDRED
PASSAGE
Neptune Bay
Peterson Bay
Coal Bay
Homer Spit
MAP OF
KACHEMAK BAY
TIMBER HARVEST AREA
KACHEMAK BAY, ALASKA

IMPACT OF PURCHASE OF INHOLDINGS ON PARK MANAGEMENT:
Purchase of inholdings within and adjacent to Kachemak Bay State Park will have several major positive impacts on this popular park. Significant recreational and scenic values as well as habitat will be acquired and preserved. The integrity of the park will be maintained instead of perpetuating the "doughnut hole" situation that currently exists with the heart of the park in private ownership. Opportunities to develop new trails, trailheads, ranger stations, campsites and access points will exist.

Acquisition will improve boundary definition. Many people are unfamiliar with the location of current park boundaries, particular in non-contiguous portions of the park away from the Halibut Cove Lagoon ranger station.

Kachemak Bay has been designated as a State Critical Habitat Area by the Alaska Legislature and is managed by the Alaska Department of Fish and Game and the Department of Natural Resources. Acquisition of private inholdings will protect park lands and waters adjacent to private inholdings from the disruption to the ecosystem that would occur as a consequence of logging.

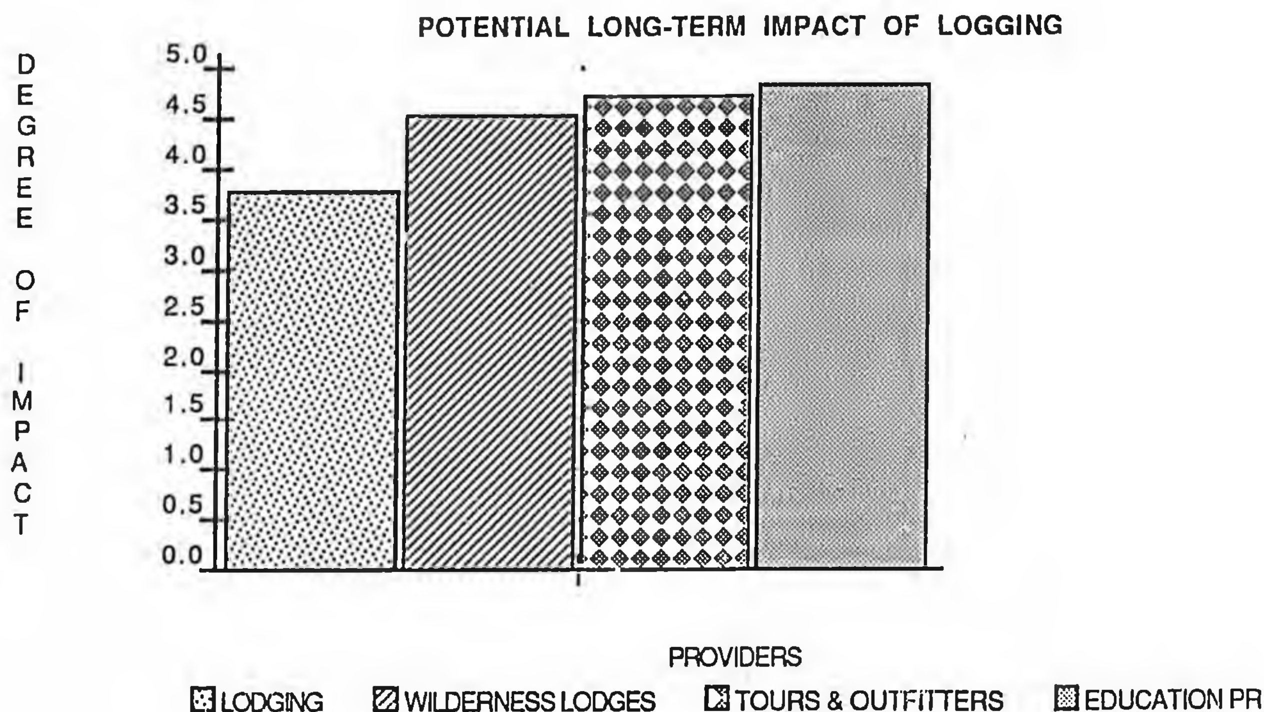
Impact of adjacent logging:
Impact of adjacent logging on Kachemak Bay State Park would be negative. Management would be reactive, not proactive, because of multiple impacts on trails and access points, visitor use, boundary problems such as definition and trespass, and new law enforcement needs. Low flying helicopters may create noise pollution for park users. Additionally, there would be negative impacts on anadromous streams and wildlife habitat. The possibilities exist for increased topsoil erosion as a result of cutting on slopes, fire through carelessness, as well as enhanced conditions for spruce bark beetles such as windthrow in areas adjacent to clearcuts.

ECONOMIC VALUES AT RISK IF THE BUY-BACK FAILS AND LOGGING OCCURS:
Tourism and fisheries are the mainstays of the Homer economy. This report documents the impacts to these and other industries if logging is allowed to occur. Homer is a very popular tourist destination, having been visited by about 76,000 out-of state or foreign residents six years ago (Alaska Division of Tourism 1985 estimates), by at least an equal number of Alaskans, and by a high percentage of Anchorage residents (The McDowell Group of Juneau study).

Impacts on tourism:
Seventy-four tourism-related area businesses were surveyed for this study, representing only a fraction of the Kachemak Bay focused tourism-related businesses. Surveyed were providers of lodging, education programs, tours and outfitters, and wilderness lodges. There were forty responses (54%). Others **not** surveyed because of study funding constraints include restaurants and other businesses on Homer Spit, liquor stores, boat storage yards, souvenir, general merchandise and tackle shops, and the owners of the cruiseships Sagafjord, S.S.Universe, Lindblad Explorer, etc. which make several calls per season to Homer.

Opinions about potential impact of logging:
The providers of goods and services were asked to predict the short and long term impact on their businesses if clearcut logging were to occur on SNA's land in and adjacent to Kachemak Bay State Park. The following chart summarizes the respondents' predictions of the long term impact.

The scale is 1 = strongly positive impact to 5 = strongly negative impact.



The twenty-one responding providers of goods and services most connected with the south side of Kachemak Bay (wilderness lodges, tours & outfitters, and education programs) were almost unanimously negative in their perception of the possible impact of logging on their businesses. For several, logging would necessitate relocation, if that were even economically feasible, with extreme disruption to the owners or operators.

The opinions of lodging providers, most of whom are based in Homer and Anchor Point, were divided about the potential impact of logging. The majority (68%) thought logging would have slightly or strongly negative impact on their businesses and gave a wide variety of reasons for their positions.

Over 200 jobs provided by surveyed businesses:

The following table shows the estimated over 200 seasonal and permanent jobs provided by the 74 surveyed businesses in 1990 in the Homer area and elsewhere.

PROVIDERS OF GOODS AND SERVICES - NUMBERS OF JOBS

	LODGING	WILDERNESS LODGES	TOURS & OUTFITTERS	EDUCATION PROGRAMS
NUMBER OF SEASONAL JOBS:	Not Given	26 (3 lodges)	20	24.5
TOTAL REPORTED JOBS = 70.5				
EXTRAPOLATED SEASONAL JOBS:	Over 100 est.	32	45	30
TOTAL ESTIMATED JOBS = OVER 200 (SOME ARE YEAR-ROUND)				

The 21 responding wilderness lodges, tours and outfitters, and education programs provided 70.5 seasonal jobs. If all 34 businesses had responded, this figure may be extrapolated to over 100 jobs.

The lodging providers served an estimated 1/2 million people in the peak season, and employ between 75-150 people. Adding their estimated figures to the ones reported by the other three categories yields over 200 jobs in just the four categories of goods and services surveyed.

Gross incomes of surveyed businesses:

The following table shows the gross incomes of the 74 tourism-related businesses that were surveyed.

PROVIDERS OF GOODS AND SERVICES - GROSS INCOME

	LODGING	WILDERNESS LODGES (3 only)	TOURS & OUTFITTERS (7 only)	EDUCATION PROGRAMS
GROSS INCOME	Not Given	$500,000.00	$455,000.00	$123,000.00
EXTRAPOLATED INCOME	$7 million est.	$650,000.00	$1,026,000.00	$150,000.00
TOTAL ESTIMATED INCOME = OVER $8.8 MILLION				

The total income reported by the responding tours, wilderness lodges, and education programs for 1989 or 1990 was $1,078,000. If all had responded, this figure may have reached $1,826,000. Add to that the estimated yearly $7 million gross income of lodging providers, and the total rises to over $8.8 million.

In summary, the responses reflect a workforce of 200 jobs. Obviously, there is great concern by these employers that many jobs will be sacrificed if logging occurs. The responses also represent an industry which serves an estimated half million people and provides an income estimated at over $8.8 million.

Interdependence of tourist industry:
The great majority of the persons served by the forty responding tourism-related businesses were from the south 49 states, southcentral Alaska, or elsewhere in Alaska. Only about 8% were from Homer. Therefore it can be expected that if logging occurs, not only these businesses but many other tourism-related businesses in the Homer area may be adversely affected. Some of these businesses are owned or operated by interests outside of Homer and even outside Alaska. Responding businesses reported their clients frequently incurred other expenses while visiting Homer. Wilderness lodges reported making major purchases in Anchorage as well as in Homer and elsewhere in Alaska.

Survey of non-Homer people on the Homer Small Boat Harbor waiting list:
One hundred non-Homer people on the Homer Small Boat Harbor moorage waiting list were surveyed. The majority of 49 respondents, many of whom currently transport their boats to and from Homer, would reduce the number of trips to Kachemak Bay if logging occurred. They included strongly worded negative comments about the consequences of logging on their boating habits, including the willingness to transport their boats and build elsewhere.

The demand for recreational use of Kachemak Bay comes from around the state and elsewhere. Of the 414 people currently on the waiting list, 35% are from Homer. Anchorage area residents, (28%), Matanuska-Susitna Valley residents, (4%), and Fairbanks area residents (3%) total an equal number. Soldotna and Kenai area residents comprise 9% and 8% respectively. Residents of other Alaskan towns and south 49 states comprise the remaining 13%. Of the over 700 boats currently moored in Homer Small Boat Harbor just under half, 48.9%, belong to Homer residents. Anchorage residents own 21.9%, second behind Homer.

IMPACTS ON COMMERCIAL AND SPORT FISHING:
Fishing is a major contributer to the Homer economy. Both commercial finfish and shellfish fisheries provide many jobs and bring millions of dollars into the local and the Kenai Peninsula economies annually. Sport fishing is given as the number one reason why clients of area lodging providers come to Homer, and the ADF&G sport fish summary statistics support this conclusion.

Finfish fisheries:
Species fished include halibut, all five salmon species, dolly varden, and rainbow trout in lakes. Salmon fisheries at risk include commercial seining, commercial and personal use setnetting, sport and dipnet fishing in areas slated for clearcut logging. In 1989, 64 southern district seiners and 23 setnetters fished. Yearly delivery of salmon averages $1.9 million (ex-vessel value.) Commercial fishermen interviewed for this study say logging may damage ADF&G salmon enhancement projects and have a variety of negative impacts on salmon streams. They also comment that logging debris may escape into the water, as happened twice at nearby Koyuktolik Bay in 1990, creating entanglement problems.

To a lesser degree, commercial and charter halibut fisheries within Kachemak Bay are at risk. The halibut charter industry, a major contributor to the Homer economy, yielded $9 million in 1985. Seventy-five percent of interviewed charter owners thought that logging may have a slightly negative impact on their business, primarily through loss of tourists no longer attracted by disfigured scenery, and by potential entanglement and safety hazards.

Shellfish fisheries:
Shellfish fisheries such as commercial and sport Dungeness and Tanner crab, clam, and mussel fisheries are also at risk from pot entanglement with debris and from accidental bark loss in water which damages habitat.

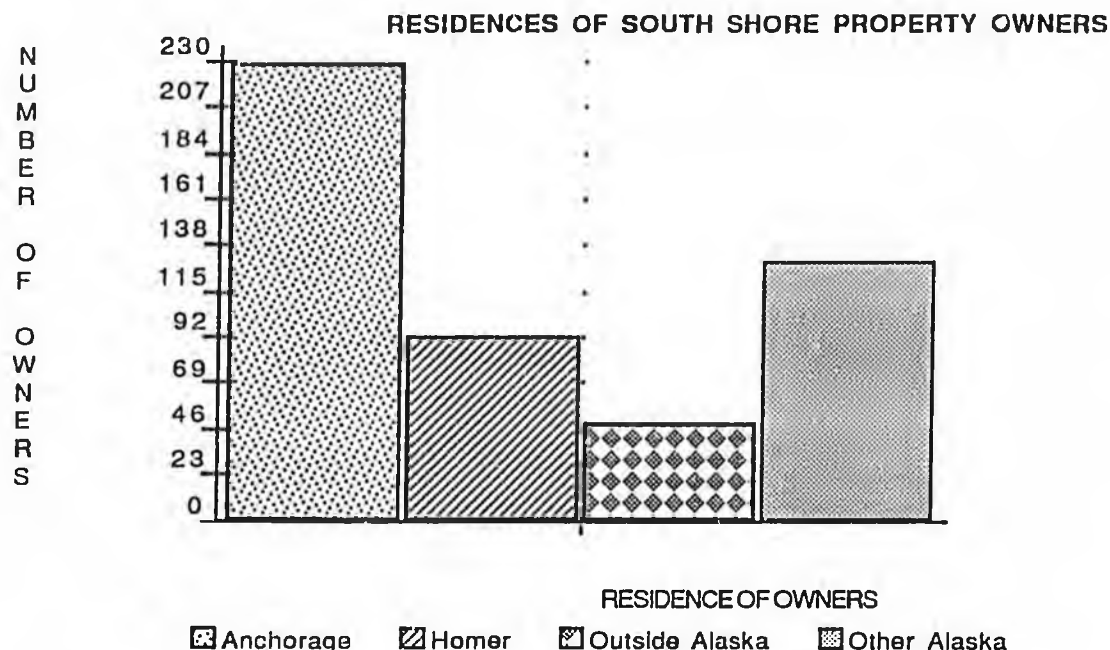
BOATING SAFETY CONCERNS:
Partially submerged floating logging debris is a safety issue mentioned by both commercial and sport fishermen. Recreation boats particularly are vulnerable because they are less likely to be equipped with radar. Since it takes the waters of Kachemak Bay an average of 27 days to exchange, loose logs and debris could present a long term hazard, increasingly so as logs become waterlogged and float lower in the water. Although the plans of Timber Trading Company are to prevent logs getting loose in the water, two such incidents occurred in nearby Koyuktolik Bay in 1990.

SURVEY OF HOMER RESIDENTS:
Eighty percent of 60 Homer adults contacted in a random telephone survey in October oppose logging, citing a variety of economic, esthetic, and environmental reasons. Only 8% favor logging.

SURVEY OF IMPACTS ON REAL ESTATE VALUES:
Sixty percent of responding real estate professionals predict a 10% decline in real estate values in Homer ($27 million assessed value loss) if clearcutting occurs, and other factors remain constant. One consequence would be loss of tax revenues.

Many out-of-town people retire in Homer or have a second home here because of the high scenic and recreational values and proximity to major population centers. These owners as well as long-time Homer residents would be affected, according to realtors.

A significant decline in south shore Kachemak Bay property values near clearcuts is also predicted, but with an increase in values farther away, because of the unique nature of the south shore. The largest number of the 495 south shore land owners, 46.1%, are from Anchorage and would be the most affected.



INTRINSIC VALUES AT RISK IF THE BUY-BACK FAILS AND LOGGING OCCURS:

Scenic values:

The proposed clearcut would be visible from Homer, Homer Spit, and elsewhere in the bay and park areas. As determined by the survey of Homer residents, the lost scenic values would be greatly missed by 82%, most of whom oppose logging. Based on other southern Kenai Peninsula tree regrowth rates, evidence of this logging may be visible for close to 50 years.

Recreational values:

Most Homer residents (85%) visit the south side of Kachemak Bay for a variety of recreational uses ranging from fishing, hiking, sightseeing, berry picking, hunting, trapping, skiing, flying, to even rockhounding. A large number (72%) say that logging would diminish their enjoyment of these lands. Fourteen percent say that they would stop using the lands altogether.

Cultural values:

There is a rich cultural heritage consisting of over 100 prehistoric and historic sites in Kachemak Bay documented by the Alaska Heritage Resources Survey, some dating to as early as 6000 years ago. Undoubtedly, based on the large number of new finds of the October 1990 survey, many more exist. Those on or adjacent to logging areas would be at risk.

Wildlife, vegetative, and soil quality values:

Long term negative consequences to several game species and furbearers including moose, mountain goat, bear, and land otters, would occur due to loss of habitat or presence of humans. The proposed logging camps may attract nuisance bears, necessitating their elimination.

Disturbance of seals and threatened Steller sea lions on haul-outs and pupping areas by low-flying helicopters transporting logs may occur, especially in China Poot and Peterson Bays. These marine mammals have already experienced recent drastic population declines in the Gulf of Alaska, and even in Kachemak Bay.

A possible loss of 9000 birds per year to logged areas has been predicted by an ornithologist, with particular negative impact to bald eagles and murrelets, both species that experienced losses in Kachemak Bay due to the Exxon Valdez oil spill. Murrelets are experiencing population declines in the southern portion of their range due to the exploitation of Pacific northwest old growth forests where they nest.

Topsoil in logged areas would be lost because of erosion and strong winds, causing flooding, siltation, sedimentation, loss of soil productivity. This may be especially critical in the Wosnesenski River valley, scheduled for extensive logging.

Areas of botanical interest may experience negative impact.

FOUR QUESTIONS ADDRESSED BY THIS STUDY:

Question 1. *Will moose benefit from a clearcut?*

Answer: No. There are few moose in the park area currently. Since Timber Trading Company plans to utilize clearcut harvesting, a method that would not be beneficial to moose and other wildlife species, much depends on how much and what kind of brush regrows after the cut. Because of past regrowth patterns, it is unlikely that much high quality moose browse will be established. Instead, the same species of brush that existed before a cut is most likely to regrow, with possible expansion of alder and/or grass cover. Additionally, moose would lose cover provided by the forest and would therefore have to negotiate greater snow depths in the winter, especially on the many north-facing slopes.

To quote a memorandum by Lance Trasky, Regional Supervisor, Habitat Division of Alaska Department of Fish and Game Re: Timber Harvesting Impacts on Moose Habitat - Kachemak Bay, dated November 19, 1990, "Increased browse production from the removal of the coniferous overstory by logging could lead to a short-term increase in local moose numbers, but we believe that the limiting factors discussed above will likely minimize that increase over the long term. Any increase in moose numbers after logging will depend on the quantity and quality of available understory browse plants. We believe that the low availability of palatable high quality browse during winter will continue to limit moose population growth over the long term."

Question 2. *Do spruce bark beetles infest Kachemak Bay State Park ?*

Answer: Spruce bark beetles prefer other species of spruce over Sitka spruce, and a warmer dryer climate found in the central Kenai Peninsula, rather than a cooler moist one found in Kachemak Bay State Park. The beetles also prefer uniform stands of old trees to broken stocks of mixed age trees. The following table demonstrates the conditions that affect success of spruce bark beetle populations.

TYPE OF SPRUCE	CLIMATE	STOCKING OF TREES	CONDITIONS FOR BEETLES
White	warmer, dryer	mature, uninterrupted	more favorable
Lutz	to	to	to
Sitka	cooler, moister	mixed age, broken stands	less favorable

In each case, the conditions on the south side of Kachemak Bay do not favor spruce bark beetle expansion unless there is a major disruption such as logging with subsequent blowdowns left on the ground, or significant climatic change. Spruce bark beetle populations there are being monitored by the Forest Service as well as state agencies.

To quote a memorandum by Roger Burnside of the Resource Management Section of the DNR, Re: Spruce Bark Beetle (Dendroctonus rufipennis Kirby) Occurrence on Seldovia Native Association (SNA) Land/Timber Trading Co. (TTC) Timber in Kachemak Bay State Park (KBSP), dated December 19, 1990, "Potential for increased spruce bark beetle activity on SNA land within the Kachemak Bay State Park (and subsequent threat of a major infestation developing) appears to be low at this time."

"Based on past detection surveys, spruce bark beetle impact on southside Kachemak Bay within Kachemak Bay State Park historically is low. Low spruce bark beetle impact is predicted, for the next 2-3 years, based on past survey data for this area. Major site disturbance such as unseasonable climatic trends could alter this prediction. Ongoing sampling will document beetle activity in live timber."

Question 3. *What is SNA's attitude regarding the sale of their land?*
Answer: SNA has continued to attempt to trade or sell their land for the last 16 years since they were denied their initial request for lands in Jakolof Bay and accepted land selections within Kachemak Bay State Park instead. SNA has stated that it is a land company but is willing to sell this land to the state to finalize this long process. Purchase of their inholdings would allow the SNA the opportunity to implement some long range plans and projects. These would include the retirement of debt on their fish plant, and the construction of a new office building to enable meetings to be held there.

Question 4. *Is the buy-back only a Homer issue?*
Answer: No. Kachemak Bay State Park is visited by people from the south 49 states, foreign countries, as well as Alaskans. The goods and services provided by 74 area tourist-related businesses that were surveyed primarily serve visitors. Only 8% of the clients were from Homer. Some of the owners or operators of these businesses live in other parts of the state. For example, the University of Alaska, Fairbanks uses two facilities on the south side of Kachemak Bay; one for Marine Science studies, and another for in-field teacher training.

Just 18% of south side property owners are from Homer; 46% are from Anchorage. Only one third of the people on the waiting list for moorage in Homer Small Boat Harbor are Homer residents; an equal number are from Anchorage, Fairbanks, and MatSu valley combined. Petitions supporting the park buy-back have been signed by Alaskans from 57 towns, with an approximately equal number from Homer and Anchorage. Residents from 45 states and 11 countries also signed these petitions.

Logging within Kachemak Bay State Park would establish a precedent of logging within state parks, which might then continue in other state parks.

SHORT TERM GAINS AND LONG TERM LOSSES:
In summary, the Kachemak Bay area including Homer and other nearby communities is gifted with many unique intrinsic and economic values; an intact wilderness ecosvstem, a State Critical Habitat Area, an archaeologically rich heritage, two outstanding state parks, beautiful scenery, and a healthy intact economy whose main pillars are fishing and tourism.

Its economies are interwoven with other areas of Alaska, particularly the Kenai Peninsula and Anchorage. If well managed, the Homer and Kachemak Bay area will continue to have very productive fisheries and be an important tourist destination as the gateway to outstanding roadless recreation areas. It is an area of much vested and esthetic interest from all over southcentral Alaska, from rest of the Alaska, and from the south 49 states and foreign countries.

This study documents that logging is not especially welcome in the Kachemak Bay area. It is seen as a threat to the co-existing economies of fishing and tourism as well as to the intrinsic and recreational values of the park and surroundings. The fifty or so jobs that logging may provide in the short term (nine years remain in the timber harvest contract) may well cause a long term loss of many more jobs, and damage the wilderness ecosystem.

The buy-back of oil leases in Kachemak Bay as previously done by the state proved to be a very significant positive occurrence in the development of the area. The buy-back of these land and timber inholdings promises to promote the continued well-being of the area's existing industries and scenic and recreation values. It is hoped that consideration of these many values at risk will be given prior to a decision regarding the fate of the Seldovia Native Association and Timber Trading Company inholdings within and adjacent to Kachemak Bay State Park.

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Homer News 12-15-88

Land trust may solve trade woes

by Joel Gay
Managing Editor

The complicated three-way Kachemak Bay State Park land trade has just gotten an additional player, but one that may add a measure of stability to the negotiations.

A group of local residents is forming a Kachemak Bay land trust that would, with the help of national organizations and local donors, purchase land or timber rights or make long-term leases outside the park's boundaries.

Janice Schofield, who stumbled onto the

See "Land," Back Page

... Land trust idea seen as trade aid

Cont. from Page 1

land trust idea through her work with the Kachemak Bay Citizens Coalition, said she will meet next week with the three main trading partners and hopes to make them an offer they can't refuse.

The land trade was complicated enough when it included just the state and Seldovia Native Association. The state has agreed to give Seldovia state assets worth no more and no less than the association's 23,000 acres within Kachemak Bay State Park. The state thinks it's possible, and last Friday Seldovia's board of directors approved continued negotiations.

The deal starts getting tangled when Koncor Forest Products comes in. They have purchased the right to cut 125 million board-feet of lumber out of Seldovia's holdings in China Poot Bay and other nearby lands.

So not only does the state have to trade Seldovia for the raw land, it must trade Koncor for the timber rights.

What makes the trade difficult, according to all sides, is that not all of Koncor's timber is within the park boundaries. The state does not want to trade for trees outside the park, while Koncor has said their timber holdings are worth less if the good trees in China Poot Bay are removed from their original purchase package.

Seldovia's board last Friday said their number one concern is that the state and Koncor work out their differences.

Enter Ms. Schofield and the land trust. If a private, non-profit group could purchase those timber holdings outside the park, it would free everyone up for the important work — trading the park lands.

"Koncor sees it as a wonderful possibility," Ms. Schofield said. "They're excited about participating in it."

She said the land trust's articles of incorporation are already being drafted, and she has talked to several national organizations about ways to fund such a deal.

Although she would not divulge details, Ms. Schofield said a key element is the idea of "bridge funding" — in which a national organization might loan the local trust enough money to purchase the timber rights and expect to be paid off within a few years.

The larger organizations might also help the Kachemak Bay group find grants and fund-raisers, she said.

Selling its lands to a non-profit such as the land trust could also give Seldovia and Koncor excellent tax benefits, she said.

However, the Seldovia trade would not be the land trust's sole function, Ms. Schofield said. "This is only the first of any number of projects," she said. It could acquire greenbelt areas around Homer and address other land issues that have high environmental value but no agency or entity to protect them.

> *The land trust is "the brightest ray of sunshine I've seen in this whole trade deal."*
>
> *Fred Elvsaa[s]*

Charlie Nash, general manager of Ko[n]cor's Timber Trading Co., said he is o[p]timistic about the formation of a land tru[st] and its participation in the trade process.

"We think it's a good idea. We don't kno[w] much about it, but to the extent it might pr[o]vide another vehicle to compensate us f[or] our timber and move the trade along, w[e] think it's worthwhile exercise at this poin[t]. We'll help them all we can."

Mr. Elvsaas called the idea "the brighte[st] ray of sunshine I've seen in this whole tra[de] deal."

There are numerous details yet to b[e] worked out, he said, and so he will withho[ld] his full approval until then. But the bas[ic] idea is good, he said.

"The concept sounds real good me. I thin[k] it may alleviate some of the problems th[e] state has with trading for land outside th[e] park."

America's Best! WILDERNESS LODGE

Kachemak Bay Wilderness Lodge

China Poot Bay
via Homer, Alaska 99603

Michael and Diane McBride, Proprietors

$1,750 per day (5-day min.); $1,950 at Brown Bear Camp (5-day min., air fare incl.)

At Kachemak Bay Wilderness Lodge, 225 miles from Anchorage, seals herd on the sand bar out front, Ollie the sea otter frolics on the beach, and eagles nest within walking distance. You can ride the incoming tides past wildflower cliff gardens, streams, and waterfalls. Or you can trace the line of ancient *barabaras* (sod houses) to reconstruct the past lives of ancient man. Most exciting of all is a bush flight into the northern camp to look for and photograph the magnificent brown bear, with an incomparable ice-blue glacier as your scenic backdrop.

Owners Mike and Diane McBride operate one of the few Alaskan lodges where guests join a year-round resident family. They have kept the camp small and usually accommodate only eight people at a time. The McBrides will meet you on a Thursday or a Sunday at the Homer Small Boat Landing. There they will show you something of the commercial fishing industry of the area, then head for the lodge in an open dory. On a clear day, you can see the mountains of Cape Douglas in the distance. Seals, porpoises, and whales help guide your way, and passing Gull Island, you'll see a rare nesting ground teeming with thousands of sea birds.

When you reach China Poot Bay, the area will be bustling with red-face cormorants, puffins, and guillemots playing in the waves. One of the hiking trails on the shore leads to the sea caves, which archaeologists think were used as the site of ancient burials.

The McBrides schedule their visitors according to the rhythms of nature—the salmon run, the extremely low tides, summer activity at the bird rookery, the concentrations of brown bears at the salmon streams.

The log lodge is dominated by a massive stone fireplace and is decorated with material the McBrides have salvaged and restored. (The kitchen cabinets came from an old halibut schooner.) Stone ledges in the living room walls lead to sleeping lofts.

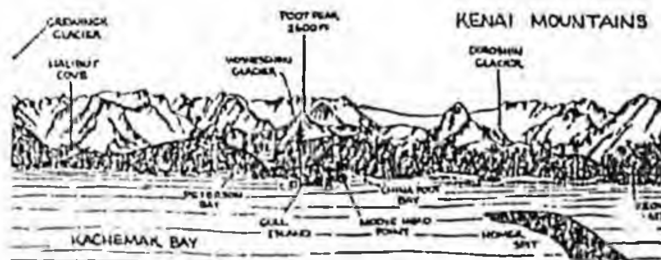
Meals always include home-baked bread and are served family-style in the dining room, where you can watch the ever-changing tidal pools from huge picture windows. Occasionally, a black bear will mosey by the window to check out the diners.

There are two guest rooms in the lodge, and private accommodations in three nearby cabins. They are considered deluxe by bush standards, containing electricity, wood stoves, and outside privies. There is also a community bathroom in the lodge with a tub and shower, and a large sod-roofed Finnish sauna.

The McBrides recommend visits of at least three days to become familiar with the territory. A typical day might include a trip to Grewingk Glacier, where you can sit and listen to the groaning of the ice and watch terns nest on the shoreline. You can also kayak, fish for salmon, trout, and halibut, hike through the dense forests, study the marine life—the possibilities are endless.

By special arrangement you can visit the Brown Bear Camp, 100 miles north of Kachemak Bay. This area has the largest concentration of brown bears in the world, and it's not unusual to see twenty bears at one time. The McBrides consider man to be the intruder in these parts. They feel he must be an unobtrusive visitor, and they will not allow you to take photographs unless you can guarantee that you will not interfere with the life patterns of the animals. The rustic tent cabins lie at the base of a great peninsular land bridge stretching toward Siberia. Archaeologists think this area may have been a link in man's earliest migrations.

The China Poot Bay area has had no permanent residents (except for a few scattered settlers) since the Athabaskans and the Eskimos, who flourished there centuries ago. Temperatures are rarely below freezing, and the proximity of the Japanese current makes the winter extremely warm. Mike fell in love with the area when he was stationed there with the Air Force. In 1969 he and Diane sailed across the Bay from Homer to settle their new home.



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* DELIVER TO: LIOCROG                                      *
*                                                          *
*                                                          *
* ORIGINAL                                                 *
* SENT:            03/27/91  TIME: 16:11                   *
* FROM:            LTCCMAT                                 *
* SUBJECT:         106PLII SLAB TMBR, GAME 3/27            *
* PRINT DATE:      03/27/91  TIME: 16:11                   *
*                                                          *
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SUBJECT LINE TO READ: TC NO,; PL/FS;SHORT SUBJECT;DATE

T/C NO: 91-03-106
DATE: 3/27/91
SPONSOR: S L&C
SUBJECT: KACHEMAK TIMBER, ALCOHOL, GAMING
SITE: MAT-SU LIO — "update"
MODERATOR: MARY

PARTICIPANT LIST NUMBER 2

****

TO TESTIFY RE SB 148 KACHEMAK BAY:

1 LARRY VICTORS POB 521057 BIG LAKE 99652 892-6245

left

2 DAVID VIDMAR, VACE 701 E PARKS WASILLA 99687 376-8223
3 RICHARD DEBUSMAN 830 LANARK WASILLA 99687 376-5538
4 KAREN HOLSEN H233 BX 3177-K WASILLA 99687 376-6231

****

TESTIFY RE SB 4 AND SB 6 - GAMING:
1 ROGER CUNNINGHAM POB 874731 WASILLA 99687 373-1500
2 376.0253

****

OBSERVING:
1 TOM LESTER POB 872896 WASILLA 99687 376-7787
2

****

TO TESTIFY: 5
UNABLE:
OBSERVING:
TOTAL: 6

START TIME: 3:30 END TIME

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*                                                              *
* DELIVER TO: LIOCROG                                          *
*                                                              *
*                                                              *
* ORIGINAL                                                     *
* SENT:          03/27/91   TIME: 16:21                        *
* FROM:          LTCCHOM                                       *
* SUBJECT:       91-03-106;PL#3;S.L&C;3-27-91                  *
* PRINT DATE:    03/27/91   TIME: 16:21                        *
*                                                              *
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SUBJECT LINE TO READ: TC NO.,PL/FS;SHORT SUBJECT,DATE

T/C NO: 91-03-106
DATE: 3-27-91
SPONSOR: S LABOR AND COMMERCE
SUBJECT: SB 148 AND OTHERS
MODERATOR: CHARLENE AND ELLEN
SITE: HOMER

PARTICIPANT LIST #3

"update"

****

TESTIFIED

to testify

NAME/REPRESENTING	ADDRESS	PHONE	BILL NO.
1. JANICE SCHOFIELD, KHLT			SB148
2. ROBERTA HIGHLAND,KBCC,BOX 15312,FRTZ.CR		235-8558	SB148
3. R. W. TYLER, BOX 1281, HOMER		235-5171	SB148
4. JONI (JOHNNY) WHITMORE,106 W.BUNNELL,HOM			SB148
5. CHRISTA COLLIER,CACS,BOX 2225, HOMER		235-6667	SB148
6. DAN DELMISSIER,144 W. PIONEER, HOMER		235-8620	SB148
7.			
8.			
9.			
10.			

****

OBSERVED

NAME/REPRESENTING	ADDRESS	PHONE	BILL NO.
1. KURT MARQUARDT,106 W. BUNNELL, HOMER		235-7558	SB-148
2.			
3.			
4.			

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*                                                               *
* DELIVER TO: LIOCROG                                           *
*                                                               *
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* ORIGINAL                                                      *
* SENT:          03/27/91   TIME: 16:32                         *
* FROM:          LTCCMAT                                        *
* SUBJECT:       3106,PL,SB148,3/27/91                          *
* PRINT DATE:    03/27/91   TIME: 16:32                         *
*                                                               *
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SUBJECT LINE TO READ: TC NO,; PL/FS;SHORT SUBJECT;DATE

update #2

T/C NO:	91-03-106
DATE:	3/27/91
SPONSOR:	S L&C
SUBJECT:	KACHEMAK TIMBER, ALCOHOL, GAMING
SITE:	MAT-SU LIO
MODERATOR:	MARY

PARTICIPANT LIST NUMBER 2

****

TO TESTIFY RE SB 148 KACHEMAK BAY:

1 LARRY VICTORS	POB 521057	BIG LAKE 99652	892-6245
2 RICHARD DEBUSMAN	830 LAMARK	WASILLA 99687	376-5538
3 KAREN HOLSEN	H233 BX 3177-K	WASILLA 99687	376-6231
4 NURM LAWLER	POBOX 520231	BIG LAKE 99652	892-8071

****

OBSERVING:

1
2

****

TO TESTIFY: 4
UNABLE:
OBSERVING:
TOTAL: 4

START TIME: 3:30 END TIME

SB

157

FISCAL NOTE

STATE OF ALASKA
1991 LEGISLATIVE SESSION

No. 1

Bill Version: SB 157

Revision Date: ______ Department Affected. (S) Publish Date: 5/3/91

Title: An Act relating to optometrists. BRU: Occupational Licensing

Component: Administration

Sponsor: Senator Adams

Requestor: Senate HESS

COMPONENT SERIAL NO. 0 3 3 6

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY 92	FY 93	FY 94	FY 95	FY 96	FY 97
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0	0	0	0	0	0
CAPITAL						
REVENUE	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER						
TOTAL	0	0	0	0	0	0

POSITIONS:

FULL-TIME	0	0	0	0	0	0
PART-TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

Estimate of current year impact: None

ANALYSIS: (Attach a separate page if necessary.)
The bill amends the optometry statutes to authorize the use of pharmaceutical agents in the practice of optometry. New funds are not required to implement this bill.

Prepared By: Jennifer Strickler, Administrative Officer Phone: 465-2144
Division: Occupational Licensing Date: March 11, 1991
Approved by Commissioner: Glenn A. Olds
Agency: Department of Commerce & Economic Development Date: 3-11-91

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

Rev 10/90

Alaska State Legislature

Al Adams
District L

WHILE IN SESSION
P.O. Box V
State Capitol
Juneau, Alaska 99811
(907) 465-3707

OUT OF SESSION
P.O. Box 333
Kotzebue, Alaska 99752
(907) 442-3245

3111 C Street
Anchorage, Alaska 99503
(907) 561-7622

Official Business

TO: Senator Drue Pearce, Chair
Senator Labor and Commerce Committee

FROM: Senator Al Adams APA

RE: Senate Bill 157

DATE: May 7, 1991

I would like to request a hearing on the aforementioned legislation in the Senator Labor and Commerce Committee. I understand you have already received back-up information from the Senate HESS Committee.

If you have questions or concerns, please feel free to contact Martha Stewart in my office.

ALASKA'S DOCTORS OF OPTOMETRY

Fact sheet for SB 157

A: Access:

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

B: Better Care:

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

C: Cost Containment:

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

D: Doctors of Optometry:

Optometrists have been prescribing drugs for their patients across the nation for the past 15 years, with 26 states currently allowing therapeutic drug treatment of eye diseases. No laws have been repealed, and 13 more states have bills pending. There have been no problems nationally, and the malpractice insurance premiums for optometry are the same in states with and without therapeutic drug laws.

E: Education:

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

F: Fairness:

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

G: Government:

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

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

7-LS0881\A.1
Luckhaupt
03/13/92

A M E N D M E N T

OFFERED IN THE SENATE

TO: SB 157

Page 1, following line 2:

Insert a new bill section to read:

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

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

Page 1, line 3:

Delete "**Section 1**"

Insert "**Sec. 2**"

Renumber the following bill sections accordingly.

Page 1, line 4, following "may":

Insert "prescribe and"

Page 1, line 13, following "authorizing the":

Insert "prescription and"

Page 2, line 1:

Delete "or administer"

Insert "prescribe, or use"

7-LS0881\A.2
Luckhaupt
03/13/92

AMENDMENT

OFFERED IN THE SENATE

TO: SB 157

Page 1, line 7:

Delete "(A)"

Delete "or"

Insert "and"

Page 1, lines 8 - 12:

Delete all material.

SB 157: "An Act relating to optometrists."

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

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

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

The department does not oppose SB 157.

Glenn A. Olds, Commissioner

Date: 3-13-92

FRANK H. MURKOWSKI
ALASKA

COMMITTEES:

VETERANS' AFFAIRS (RANKING MEMBER)
ENERGY AND NATURAL RESOURCES
FOREIGN RELATIONS
SELECT COMMITTEE ON INTELLIGENCE
SELECT COMMITTEE ON INDIAN AFFAIRS

United States Senate

WASHINGTON, DC 20510
(202) 224-6665

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Anchorage, AK 99513
(907) 271-3735

101 12th Avenue, Box 7
Fairbanks, AK 99701
(907) 456-0233

P.O. Box 1647
Juneau, AK 99802
(907) 586-7400

120 Trading Bay Road, Suite 350
Kenai, AK 99611
(907) 283-5808

109 Main Street
Ketchikan, AK 99901
(907) 225-6880

April 9, 1990

Dr. Jeffrey A. Gonnason, O.D.
Medical Park Eye Care
2211 E. Northern Lights - Suite 202
Anchorage, Alaska 99508

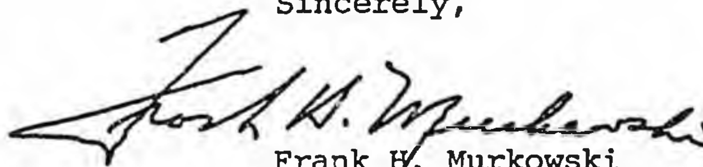
Dear Jeff:

It was a pleasure to visit with you during your recent visit to Washington. I appreciate your taking time to stop by my office.

Lisa Moore has provided me with the written information which you left. I concur with you that optometrists should not be discriminated against in federal and state legislation. I wish you luck with the Alaska legislature on the prescription drug issue. Please let me know the outcome.

If I can be of any assistance to you, please let me know.

Sincerely,



Frank H. Murkowski
United States Senator

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

T E S T I M O N Y

SB 157

MAY 13, 1991

SENATE L & C COMMITTEE

ALASKA STATE LEGISLATURE

Member
American Optometric Association

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

Telephone: (907) 276-2080

May 10, 1991

I am representing the Alaska Optometric Association, which is affiliated with the American Optometric Association. My term recently expired as a member and president of the State Board of Examiners in Optometry. I am a life-long Alaska Native from Southeast, and currently practice in Anchorage.

Optometrists in Alaska practice under a restricted license, so that any time we have an increase in training, scope or a new procedure, we must return to the Legislature to update our practice act, unlike our other medical and non-medical colleagues. In 1988, Alaska was the 49th state to allow optometrists to receive a license endorsement to use certain drugs on the eyes of their patients, after meeting strict Board requirements and examinations. This bill would amend the law, allowing the use of therapeutic medication by Board qualified optometrists, using their professional judgement and expertise to treat common eye disorders that do not require the services of a surgical sub-specialist. I will present a brief summary of the facts that demonstrate the public need for this legislation.

A: Access:

Alaskans in communities like Sitka, Kodiak, Homer, Ketchikan and others do not have access to eye care. Most Alaskan communities have no ophthalmologists, who are surgical specialists in secondary and tertiary care, but the local optometrist is the most highly trained, specialized, and instrument-equipped provider of primary medical eye care available. There are over 60 doctors of optometry scattered throughout Alaska.

B: Better Care:

The optometrist is often the first contact for a patient suffering from an eye disorder. Needed treatment can be started immediately, which is an important aspect in treating many eye diseases. Under current state law, the optometrists in most Alaskan communities must refer their patients needing eye medication to a nurse practitioner, health aide, or general medical doctor with far less training in eye treatment than the optometrist. The family doctor of optometry is a valued and trusted friend to many people in the community, who would prefer to have a choice for primary eye treatment.

Member
American Optometric Association

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

C: Cost Containment:

Optometrists' fees are generally lower than those of ophthalmologists and hospitals. The cost of a 2nd visit to another doctor or clinic for medication would be eliminated; travel time and expense would be eliminated, as well as extra time away from work. These are experienced cost savings from other states. Increased competition with freedom of choice among health providers also holds down costs. Anchorage has the state's lowest fees for routine eye exams for both M.D.'s and O.D.'s because of competition, and the optometrist's fees are lower.

D: Doctors of Optometry:

Optometrists have been prescribing therapeutic medication for their patients across the nation for the past 15 years, with 26 states currently allowing therapeutic drug treatment of eye diseases. No laws have ever been repealed, and 13 more states have therapeutic bills pending. There have been no problems nationally, and all the predictions of public harm have proven false. The malpractice insurance premiums for optometry are the same in states with and without therapeutic drug laws. The courts hold optometrists to the same standard of care as medical doctors.

E: Education:

Optometry training is on a par with medicine, dentistry and podiatry. An undergraduate college degree, plus a 4 year doctorate program and often a residency in a hospital-based setting. Of all the other health professions with a similar education, optometrists are the only ones not allowed to prescribe medications in Alaska. The letter from Les Walls, M.D., a medical school professor and now an optometry school dean, best explains optometry education. Older optometrists who did not originally receive advanced therapeutic training would not be grandfathered. They would be required to return to school for additional training and pass the same rigid State Board standards and exams to be endorsed to use therapeutics.

Member
American Optometric Association

JEFFREY A. GONNASON, O.D.
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Medical Park Eye Care
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Anchorage, AK 99508
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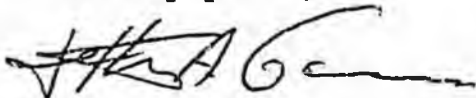
F: Federal Government:

Approximately 5 agencies of the Federal Government have studied optometry and found competentcy in therapeutic treatment and surgical co-management. Military and Indian Health optometrists have used therapeutic drugs for many years. Optometrists are considered "physicians" under federal Medicare law, being allowed to provide any eye treatment services the state law allows. The national American Public Health Association recently passed a resolution supporting optometry's use of therapeutics in all 50 states.

This legislation is in the best interest of the public health. All these facts are backed by volumes of documentation, research, and experience on a national basis. I can provide more detailed information on any question you may have. Thank you for this opportunity.

Sincerely yours,



Jeffrey A. Gonnason, O.D.

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

Telephone: (907) 276-2080

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

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

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

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

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

Telephone: (907) 276-2080

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

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

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

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

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

JEFFREY A. GONNASON, O.D.
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Medical Park Eye Care
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Anchorage, AK 99508

Telephone: (907) 276-2080

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

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

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

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

Member
American Optometric Association

Tanana Valley Clinic

Family Medical Care

Since 1959

OBSTETRICS & GYNECOLOGY
Richard S. [illegible], M.D.
[illegible], M.D.
Richard C. Hess, M.D.
[illegible], M.D.
[illegible], M.D.
[illegible], PA-C
[illegible], CNP

SURGERY
[illegible], M.D.

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

PEDIATRICS
Marvin E. Bergeson, M.D.
J. Timothy Foote, M.D.
Richard C. Ream, M.D.
Nancy J. Schultz, M.D.
Mark H. Stauffer, M.D.

FAMILY PRACTICE
Hunter Judkins, M.D.
Donald E. Thenian, M.D.
Jean M. W. Tsigonis, M.D.
Charles Steiner, M.D.
Corinne Leistikow, M.D.
David Lewis, PA-C
Donna Rogers, PA-C

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

PATIENT EDUCATION
Sharon Stephenson, R.N.

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

April 18, 1991

Alaska State Legislature
Juneau
Alaska 99811

To the Legislators:

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

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

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

Sincerely,

Marvin E. Bergeson, M.D.
Pediatrics

MEB:sr

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

Fairbanks Clinic

Quality Care Since 1932

April 23, 1991

Alaska State Legislature
PO Box V
Juneau, Alaska 99811

Dear Sirs:

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

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

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

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

Sincerely,

Enlow R. Walker, M.D.
Family Practice

ERW/hlb

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

April 4, 1991

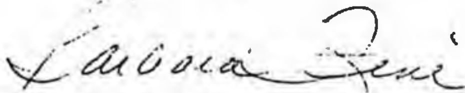
To the Legislature.

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

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

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

Thank you.



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

April 8, 1991

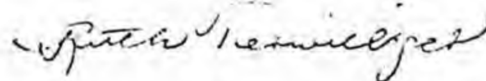
Alaska Legislature
Juneau, AK

Dear Legislators,

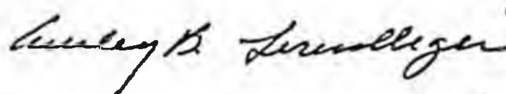
We are writing this letter to inform you that we support the bill in legislation that will allow Optometrists to prescribe medications for the treatment of eye disease.

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

Regards,



Ruth Terwilliger

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

April 5, 1991

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

Dear Legislator:

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

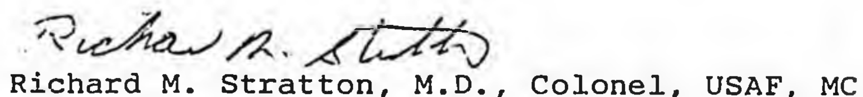
This action is long overdue and has already been approved in 26 other states.

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

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

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

Sincerely,



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

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

May 2, 1991

Dear Legislator:

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

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

I appreciate your support.

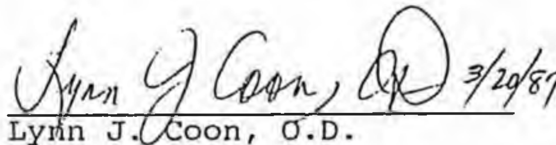
Sincerely,

Paul D Raymond MD

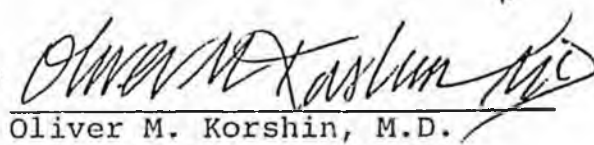
Paul D. Raymond, M.D.

PDR:nmc
cc: Boyd Walker

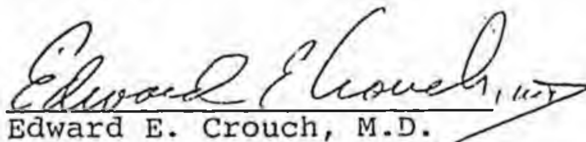
We, the undersigned authorized representatives of the Legislative Committee of the Alaska Optometric Association and the Legislative Affairs Committee of the Alaska Association of Ophthalmology, assign the support of our respective organizations to the attached negotiated bill that amends the current Alaska optometry statute. By our signatures below and on the attached bill we attest that support. We will, if called upon, testify before the Alaska State Legislature in favor of the bill as written. This agreement expires at the end of the 1987 session of the 15th Alaska Legislature.



Lynn J. Coon, O.D.



Oliver M. Korshin, M.D.



Edward E. Crouch, M.D.

FEB 24 1992

MEDICAL CLINIC

"Numquam occidens stella"

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

Peggy Midgett Jones
Patient Coordinator

Jean Kemmerer
Office Manager

Susan Walsh R.N.
Nursing Services

February 18, 1992

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

Dear Senator Pearce:

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

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

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

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

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

Senator Drue Pearce
Alaska State Legislature
State Capitol
February 18, 1992
Page 2

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

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

Sincerely,

Thomas L. Conley, M.D.

TLC:ts

ANPA
Alaska Nurse Practitioner Association

February 24, 1992

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

Dear Legislator:

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

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

We hope you will join us in support of SB 157

Sincerely,

Wendy Thon, ANP
Alaska Nurse Practitioner Association
Secretary

American Public Health Association

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

March 10, 1992

Dear Alaska Legislator:

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

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

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

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

Very truly yours,

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

Enclosure

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

PROFESSIONAL NEWSLETTER *February 1992*

Things you should know

A TPA For New Jersey

■ New Jersey Governer Jim Florio has made his the first industrial state to allow O.D.s to use therapeutics. In January, Florio signed a bill allowing O.D.s to use all topical therapeutics. The bill excludes orals, injectables and controlled substances. In other news, *Ohio and Michigan lawmakers were slotted to vote on TPAs in late January and early February.

Not Enough Dilation

■ Although 75 percent of adults at high risk for

* Ohio's law was signed by their Governor about 2 wks ago — as you can see, these changes are inevitable.

Once — this law is probably more important for Alaska - because of its size - than for any of the other states.

By increasing access to eye care, this will help keep a "lid" on increasing health care costs.

Also, it is bothersome that folks we went to school with are able to practice differently (better) because they live in Washington, Iowa, etc. —

Thanks for your understanding —

Bill [signature]

Employee Benefits Division
Medicare Claim Administration
P. O. Box 1998
Portland, Oregon 97207-1998
Telephone No. (503) 222-6831

Form Approved
OMB No. 0938-0222

Medicare

10/14/87 F00 511 SS05

JEFFREY A GONNASCN OD
2211 E.-NORTHERN LGHT
ANCHORAGE, AK 99504

CORRESPONDENCE NC. 807264800C300G

WE RECEIVED YOUR LETTER ABOUT A RECENT MEDICARE NEWSLETTER ARTICLE PERTAINING TO OPTOMETRISTS .

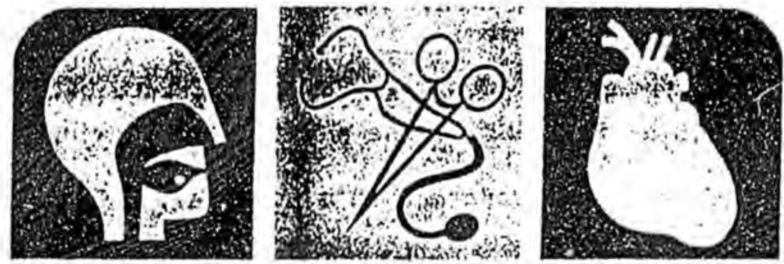
THE NEWSLETTER ARTICLE WAS IN ERROR REGARDING THERAPEUTIC TREATMENT OF EYE DISEASES OR DISORCERS BY OPTOMETRISTS.

EFFECTIVE 4/1/87, A DOCTOR OF OPTOMETRY IS CONSICERED A PHYSICIAN WITH RESPECT TO ALL SERVICES THAT THE OPTCMETRIST IS AUTHORIZED TC PERFORM UNDER STATE LAW. IF STATE LAW AUTHORIZES THERAPEUTIC TREATMENT BY AN OPTOMETRIST, MEDICARE CAN CONSIDER THE CHARGE FOR PAYMENT.

SINCERELY,

SRisner
MEDICARE CLAIMS ADMINISTRATION
AETNA LIFE INSURANCE COMPANY

3-3-87



Medicare News

Volume 13, Issue 2 February, 1987

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SERVICES RELATED TO NONCOVERED SERVICES

All providers are reminded that routine services "related to" noncovered services (e.g. cosmetic surgery, noncovered organ transplants), including services related to the followup care, are not covered services under Medicare.

In addition, services provided primarily for the purpose of administering a noncovered injection, are excluded from Medicare payment. For example, if the primary treatment is noncovered dimethyl sulfoxide (DMSO) or ethylenediamine-tetra-acetic acid (EDTA chelation therapy), the associated office visits and lab tests will also be excluded from payment.

COVERAGE FOR OPTOMETRIST EXPANDED

Coverage has been expanded on services performed by optometrists on or after 4/1/87. Medicare will then allow payment for vision care services of optometrist when:

1) the optometrist is legally authorized by the state to perform the service, and

2) the service is already covered by Medicare when performed by a physician

Previously Medicare allowed payment to optometrist for services related to the treatment of Aphakic patients only.

TREATMENT STATES

Twenty five, one half, of the fifty states of our great Union allow Optometry to utilize therapeutic medications as part of their health care delivery system. The U.S. Military, Public Health Service, Indian Health Service, and Veterans Administration also permit qualified optometrists to use therapeutic medications as a broad base eye care delivery system.

■ States that authorize optometrists to use both DPAs and TPAs.

□ States that authorize optometrists to use only DPAs.

Bringing lifetimes of experience and leadership to serve all generations.

NEW JERSEY STATE LEGISLATIVE COMMITTEE

CHAIRMAN
Mr. DeWitt Reinecke
17 Primrose Trail
Morristown, NJ 07960
(201) 766-2406

VICE CHAIRMAN
Mr. David Brown
16 Woodbridge Avenue
Metuchen, NJ 08840
(201) 549-0001

SECRETARY
Mrs. Carol Kenny
352 E. Virginia Ave.
Manasquan, NJ 08736
(201) 223 8342

December 6, 1990

Dr. Larry C. Wallis
Legislative Chairman
New Jersey Optometrist Association
88 Lakedale Drive
Trenton, NJ 08648

Dear Dr. Wallis:

The members of the New Jersey State Legislative Committee (NJSLC) of the American Association of Retired Persons (AARP) have reviewed the provisions of Assembly Bill A-743. The bill would allow optometrists to prescribe and utilize eye medications, limited to eye drops or ointments. The NJSLC also conferred with your association and the Academy of Ophthalmology and Otolaryngology before making a decision.

I am happy to report that the committee strongly supports Bill A-743. Its passage would be in the best interests of our members and would benefit all New Jersyians. The facts weigh heavily in favor of expanding the responsibility of optometrists to include the use of therapeutic pharmaceuticals. Some of these compelling facts are:

a) It will be less costly, especially for seniors and the disabled, to be treated by an Optometrist for Optometrists are more readily accessible than Ophthalmologists.

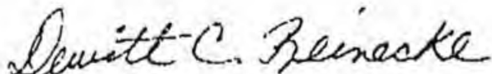
b) Optometrists receive excellent training including training in Pharmacology.

c) The need for a second visit to an Ophthalmologist for treatment would be eliminated.

d) Optometrists have been using therapeutic eye drops and ointments in 24 states and the District of Columbia without any significant or prevailing problems.

In the interests of good eye health and easier access to such, AARP supports A-743.

Sincerely,



DeWitt C. Reinecke
Chairman, New Jersey State Legislative Committee

DCR/rg

cc: Honorable Joseph I. Roberts, Jr.
655 Creek Road
Bellmawr, NJ 08031

V2532

MINN.

OPTOMETRIC THERAPUETIC DRUG LEGISLATION

COMMON QUESTIONS AND ANSWERS

WHAT IS THE PURPOSE OF THIS LEGISLATION ?
This legislation would give qualified optometrists the right to prescribe topical medication and four specific types of oral medication to treat common eye health problems of the front part of the eye.

WOULD ALL OPTOMETRISTS AUTOMATICALLY BE ALLOWED TO USE THESE DRUGS?
Only those optometrists that have demonstrated adequate education and have shown competency by passing national board exams in treatment and management of ocular disease would be allowed these privileges.

HOW WILL THE OLDER OPTOMETRIST BE HANDLED AFTER PASSAGE OF THIS LEGISLATION?
Again, only those optometrist completing all mandated requirements for certification will be allowed to use drugs to treat eye disease. No one, however, will be forced to become certified. If an older optometrist does not wish to become certified to use therapeutic drugs, he/she will simply continue to practice in the way that current law allows them. There will be no grandfathering!

WHAT IS THE RATIONALE FOR ALLOWING OPTOMETRISTS TO TREAT EYE DISEASE?
Optometrists have been responsible for accurately diagnosing eye disease for years. Since the most difficult part of treating an eye disease is accurately diagnosing the condition,treatment by optometrists is a logical extension of their scope of practice.

WHAT IS THE EDUCATION OF AN OPTOMETRIST TODAY?
The average student entering optometry school today has a bachelor of science degree and the same required courses as a student entering medical or dental school. The actual optometry program is an additional four years of intensive training specifically on the eye. General and ocular pharmacology are stressed along with in depth training in differential diagnosis of eye disease and treatment and management of those diseases At least two years of this training are spent examining patients in a variety of clinic and hospital settings.

WHAT ARE THE BENEFITS TO THE CITIZENS OF MINNESOTA?
By allowing optometrists this expanded scope of practice, citizens of the state will be given:
1. Better access to eye care
2. More efficient delivery of eye care

3. Cost containment in eye care expenses

HOW MANY OTHER STATES OFFER OPTOMETRISTS THESE THERAPEUTIC DRUG PRIVELEDGES?
At this time, 25 states have passed legislation allowing optometrists the use of therapeutic drugs. Some states have had these laws in effect for thirteen years. Minnesota is one of the last states in the Midwest to enact this expansion of optometric practice.

WHAT HAS THE EXPERIENCE BEEN IN STATES WHERE OPTOMETRISTS PRESCIBE THERAPEUTIC DRUGS?
After many years and millions of patient encounters the optometric use of therapeutic drugs has had an overwhelming positive history. The patients in these states are enjoying the increased access and more efficient delivery of primary eyecare while at the same time reducing expenses. No adverse affects have been experienced.

WHAT ADVERSE EFFECTS COULD HAPPEN WITH THE USE OF THESE THERAPEUTIC DRUGS AND HOW WILL THE OPTOMETRIST DEAL WITH THEM?
The therapeutic drugs we are speaking of have a very,very low incidence of adverse effects. The most common reactions being nothing more than a simple rash. The diagnostic drugs that optometrists were given the priveledge to use in 1982 actually have a higher potential for adverse effects and in the 7 years they have been used, no significant adversed reactions have been reported. In the rare event , however, that there would be a serious adverse response to a drug, the optometrist is trained in emergency medical procedures such as CPR and would get the patient to an emergency medical facility just as any other health care provider would do in a similar situation.

WHAT WILL HAPPEN TO MALPRACTICE RATES FOR OPTOMETRISTS WHEN THEY START PRESCIBING MEDICATION?
Optometry has enjoyed such a good malpractice history that it has seen only a 20% increase in malpractice rates over the past five years while the medical profession has seen an increase of 500% during that same period. In fact, this year optometric malpractice rates in all states, including those where optometrists prescribe therapeutic drugs, are actually decreasing by almost 40%.

HOW ARE OPTOMETRISTS AND OPHTHALMOLOGISTS DISTRIBUTED GEOGRAPHICALLY IN MINNESOTA?
Optometrists are well distributed throughout Minnesota with offices in 99% of all counties while ophthalmologists are primarily located in the metropolitan areas and have full time offices in only 25% of the counties.

In fact outside the Twin cities and Rochester there are only 55 ophthalmologists in 28 towns to serve over 2,000,000 residents. In that same outstate area there are 292 optometrists in 118 communities.

WHY MUST OPTOMETRISTS GO TO THE LEGISLATURE IN ORDER TO GIVE PATIENTS FULL BENEFIT OF THEIR TRAINING?

Unfortunately optometry has no choice. Medicine has a practice act that allows them the ability to treat patients to the full extent that their training prepares them. As their training advances their patient's care advances. Optometry's practice act,however, requires a legislative change in our practice act every time we want to pass improved education and technology to our patients. Stop and think about how many coronary by-passes would have been done today if MDs were required to legislate first.

WHO OPPOSES THIS LEGISLATION ?

Organized ophthalmology formally opposes this legislation in Minnesota. In our neighbor state to the south,however,the Iowa academy of ophthalmology actually endorsed the same optometric legislation in 1984.

WHAT DOES THE OPPOSITION SAY?

The Minnesota academy of ophthalmology claims that optometrists are inadequately trained to treat eye disease with medication. They further believe that harm will come to residents of Minnesota if optometrists are allowed this therapeutic privilege.

WHO SHOULD YOU BELIEVE?

The dispute between ophthalmology and optometry is not new....

In the 1960's ophthalmology opposed optometric testing for glaucoma. They claimed optometry was inadequately trained and that harm would come to the citizens of Minnesota if optometry was allowed this privilege. Optometry won the fight and has prudently and safely tested for glaucoma to the benefit of Minnesota citizens since. Ophthalmology's claims proved unjustified

In the 1970's ophthalmology opposed optometric use of drugs for diagnostic purposes. They claimed optometry was inadequately trained and that harm or even death would occur to the citizens of Minnesota if optometry was allowed this privilege. Optometry again won the fight and has prudently and safely utilized diagnostic drugs to the benefit of Minnesota citizens since.

In the 1980's ophthalmology is opposing optometric use of drugs for therapeutic purposes. They are using the very same arguments they have used unsuccessfully for years. Their claims have proved false in every preceding case. Who do you think you should believe this time?

RECEIVED APR 2 5 1989

COMMONWEALTH OF KENTUCKY

BOARD OF OPTOMETRIC EXAMINERS

1000 W. MAIN STREET

GEORGETOWN, KENTUCKY 40324

863-5816
AREA CODE 502

April 24, 1989

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

Dear Sen. Ney:

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

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

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

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

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

Sincerely yours,

John C Schertzinger

J. C. Schertzinger, O.D.
President

cc: Darlene Eakin
Earl K. Green

JCS/at

WEST VIRGINIA BOARD OF OPTOMETRY

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

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

October 16, 1986

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

Dear Mr. Lex:

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

(1) Law became effective March, 1976.

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

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

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

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

Sincerely,

Dale E. Palmer

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

DEP:jj

BOARD OF EXAMINERS IN OPTOMETRY
STATE OF OKLAHOMA

OFFICE OF THE SECRETARY-TREASURER
P.O. BOX 719
BRISTOW, OKLAHOMA 74010

Dr. Floyd White, President
110½ N. Broadway
Hugo, Oklahoma 74743

Dr. Jesse Johnson, Jr., Vice-President
3801 N.W. Expressway
Oklahoma City, Oklahoma 73112

Dr. George E. Foster, Secretary-Treasurer
P.O. Box 719
Bristow, Oklahoma 74010

November 5, 1987

Senator Steven Rees
5716 Jordan Canal Road
Kearns, Utah 84118

Dear Senator Rees,

In response to your questions regarding doctors of Optometry prescribing pharmaceuticals for treatment of eye disease, we are pleased to answer the following questions.

U. Have public complaints regarding Optometrists increased as a result of law authorizing Optometrists to administer and prescribe therapeutic drugs?

Ans. The Central Office of the Oklahoma Optometric Association, with a WATS line open to all Oklahomans with any complaints, has not received a single call relating to this question. Also, the Board of Examniners has not received a single call from the public regarding administering and prescribing therapeutic drugs.

V. Have Optometrists experienced significant increases in malpractice insurance rates since being granted the right to use therapeutic drugs?

Ans. Carriers report, almost uniformly, that malpractice rates for Optometrists are so low that they cannot administer a program without some subsidy from related insurers. To subsist under these conditions they typically add premise liability and unrelated hazards. We can state without equivocation that the only creditable malpractice suit pursued in this state was against an Optometrist who failed to get certified with diagnostic and therapeutic privileges, was sued successfully, whereas such a suit would not have been successful if he had been certified.

W. Does the public seem to be more confused about different kinds of eye care practitioners since Optometrists were granted therapeutic drug use authority?

Ans. There is inherently a blur in the public perception of the eye care field. The administration of therapeutic drugs would be to those who are perceptive, a natural evolution and consequence of progressive education. To those who do not follow the field closely, they have assumed that Optometrists render the service.

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X. What are the major problems and advantages which have resulted from enactment of the therapeutic use law?

Ans. In a rural state, a principal advantage is the proximity and availability of the distribution system of Optometrists. They are available. The therapeuric law has dovetailed most beautifully with new Medicare provisions recognizing the legal scope of optometric practice. If there is a problem, it is the need for expanded public awareness. We should cite as an advantage the forced cooperation between Ophthalmologists and Optometrists to a degree that never existed before in the public interest.

Yours truly,

George Foster, O.D., Sec. Treas.
Board of Examiners in Optometry

GF/eh

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Thank you for allowing me to testify before your Board.

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

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

I. Introduction

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

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

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

II.

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

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

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

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

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

III.

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

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

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

IV.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

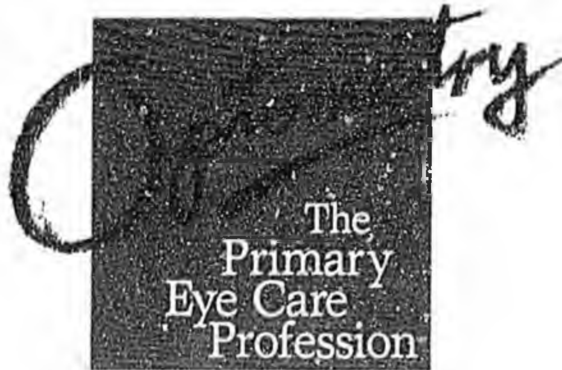
All therapeutic education is primary care oriented. Training is directed toward the diagnosis of patients' problems as the highest priority, treatment of non-surgical ocular conditions, and follow-up care to completion with adjustments in treatment or referrals when indicated.

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

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

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

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



OPTOMETRY: THE PROFESSION

Optometry is an independent primary health care profession.

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

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

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

American Optometric Association

EDUCATION OF THE DOCTOR OF OPTOMETRY

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

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

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

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

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

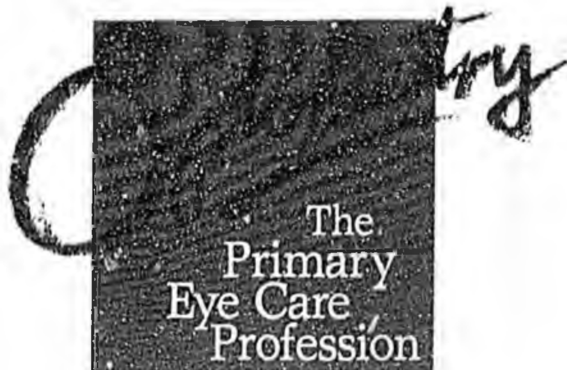
"From earliest times, the training of physicians has been based in large measure on apprenticeship, and vestiges of this orientation are clearly visible today in the clinics and the wards of teaching hospitals." "The residents, training to be specialists, usually serve as surrogate faculty for both interns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

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

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

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

American Optometric Association



WHAT SERVICES DO DOCTORS OF OPTOMETRY PROVIDE?

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

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

Codes for Optometry

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

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

American Optometric Association

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

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

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

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

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

LOW VISION TREATMENT	
Microscopic System	92354
Telescopic System	92355

OPHTHALMIC LENS TREATMENT GLASS __ RESIN __		CPT
Monofocal Lens	RE-LE	92340
Bifocal Lens	RE-LE	92341
Multifocal	RE-LE	92342
Monofocal Aphakia	RE-LE	92352
Bifocal Aphakia	RE-LE	92353

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

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

DIAGNOSIS ICD-9

Abnormal Pupil	379.40	Diab., Per History	250._	Mod. Profound	369.10	Pinguecula	372.51
Accom. Disorder	367.50	Diab. Retinopathy	362.00	Mod/Severe, OD OS	369.20	Presbyopia	370.40
Amblyopia	368.00	Diplopia	368.20	Unequal, both	369.30	Pterygium	372.40
Aniseikonia	367.32	Drusen	362.57	Iritis, Iridocyclitis	364.0	Ptosis	374.3
Anisometropia	367.31	Dry Eyes	375.15	Keratitis	370.90	Retinal Detachment	361 9
Aphakia OD OS	379.31	Ectropion	374.10	Kerat. Sicca	370.33	Retinal Tear	361.0
Asthenopia	368.13	Entropion	374.00	Keratoconus	371.6	Ret. Degen./Periphrl	362.60
Astigmatism	367.20	Epiphora	375.20	Krukenberg's Spindle	371.13	Strabismus	378.9
Blepharitis	373.00	Esophoria	378.41	Lacrimal Disorder	375.	Sudden Vision Loss	368.11
Blepharospasm	333.81	Esotropia	378.00	Macular Degeneration	362.5	Subj. Hemorrhage	372.72
Blindness, legal	369.40	Exophoria	378.42	Migraine	346.8	Suppression	368.31
Cataract OD OS	366.90	Exotropia	378.10	Myopia	367.10	Transient Vision Loss	368.12
Chalazion	373.20	Glaucoma	365.90	Nystagmus	379.50	Trichiasis	374.05
Color Vision Def	373.20	Glaucoma Suspect	365.00	Ocular Hypertension	365.04	Uveitis	364.3
Conj. Foreign Body	930.10	Headache, Per History	784.00	Ocular Migraine	368.15	Vascular Lesions	362.17
Conj. Hemorrahage	372.72	Hordeodum	373.11	Opaque Post Capsule	366.53	Viral Warts	078.1
Converg. Excess	378.84	Hyperphoria	378.43	Optic Atrophy	377.1	Visual Distortion	368.14
Corneal Abrasion	918.10	Hyperopia	367.0	Optic Nerve Drusen	377.21	Visual Field Defect	368.4
Corneal Edema	371.24	Hypertensive Retinop.	362.11	Paresis	378.55	Vitreous Floaters	379.24
Cornea Foreign Body	930.00	Hypertropia	378.31	Photophobia	368.13	Xanthelasma	374.51
Corneal Ulcer	370.00	Prof. Impair/OD OS	369.00	Photopsia	368.15	Normal State	V65.5

American Optometric Association

DOCTORS OF OPTOMETRY AS PRIMARY EYE CARE PROVIDERS

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

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

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

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

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

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

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

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

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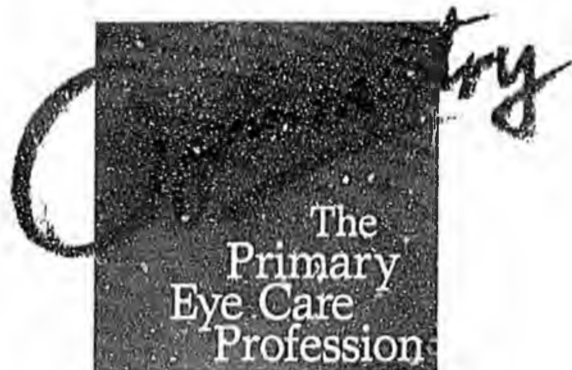
Headache is possibly the most common symptom that confronts doctors. Very often the family physician will refer a patient with headaches to a doctor of optometry to determine if the headaches are ocular in origin before other costly neurological evaluations are done. Doctors of optometry and family physicians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

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



WHAT ABOUT QUALITY ASSURANCE?

Success in eyecare programs necessitates the assurance of quality eyecare.

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

1. Credentials Committee -- Evaluates all candidates for network participation to assure the best qualified optometrists are involved.
2. Quality Assurance Committee -- Establishes and reviews standards of care to assure quality of services delivered.
3. Utilization Review Committee -- Establishes and monitors utilization norms for the delivery of eye care.

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

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