

ALASKA LEGISLATURE COMMITTEE FILES 2001-2002 8672

10210 HOUSE HEALTH EDUCATION & SOCIAL SERVICES

55

**HB**

**2009**



Health, Education, and Social Services Committee  
Alaska State Legislature  
House of Representatives

**Sponsor Statement**

**HB 209**

**An act directing the Department of Health and Social Services to establish a foster care transition program.**

Presently there are around 200 youth 16 or older in DFYS Custody as of March 2001. These young adults are soon to leave the foster care system and may not be adequately equipped and not prepared to transition into independent living.

Under the Foster Care Independence Act of 1999, the State of Alaska shall receive no less than \$5,000,000 per year to carry out programs designed to help children make the transition from foster care to self-sufficiency.

HB 209 will require the department to establish and implement a foster care transition program.



# FISCAL NOTE

**STATE OF ALASKA**  
**2001 LEGISLATIVE SESSION**

Fiscal Note Number: \_\_\_\_\_  
 Bill Version: HB 209  
 (H) Publish Date: \_\_\_\_\_

Revision Date/Time (Note if correction): \_\_\_\_\_ Dept. Affected: Health & Social Services  
 Title: Foster care transistion program BRU: Health & Social Services  
 Component: \_\_\_\_\_  
 Sponsor: Rep. Dyson  
 Requester: House HSS Component Number: \_\_\_\_\_

**Expenditures/Revenues** (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
<b>TOTAL OPERATING</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>

<b>CAPITAL EXPENDITURES</b>						
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<b>CHANGE IN REVENUES</b> ( )						
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**FUND SOURCE** (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type)						
<b>TOTAL</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>

Estimate of any current year (FY2001) cost: 0.0

**POSITIONS**

Full-time						
Part-time						
Temporary						

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

Prepared by: Randall C. Lorenz, House HSS Committee Aide

Phone 465-3759

REPRESENTATIVE FRED DYSON  
 Chairman

Date 4/19/01

AMENDMENT

OFFERED IN THE HOUSE

BY REPRESENTATIVE DYSON

TO: HB 209

- 1 Page 1, line 5, following "(42)":
- 2       Insert "grants and"

Amendment 1

AMENDMENT

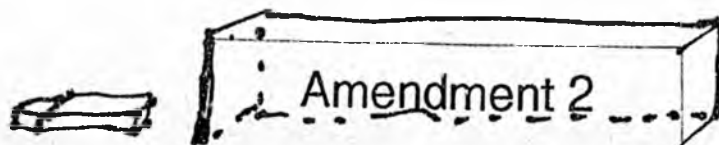
OFFERED IN THE HOUSE

BY REPRESENTATIVE DYSON

TO: HB 209

- 1 Page 1, line 12:
- 2 Delete "20, or 21"
- 3 Insert "or 20"

L



# FISCAL NOTE

**STATE OF ALASKA**  
**2001 LEGISLATIVE SESSION**

Fiscal Note Number: \_\_\_\_\_  
 Bill Version: HB 209  
 (H) Publish Date: \_\_\_\_\_

Revision Date/Time (Note if correction): \_\_\_\_\_ Dept. Affected: Health & Social Services  
 Title: Directing the Dept. of HSS to establish a Foster BRU: Health & Social Services  
           Care Transition Program Component: \_\_\_\_\_  
 Sponsor: House HSS  
 Requester: House HSS Component Number: \_\_\_\_\_

**Expenditures/Revenues** (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
<b>TOTAL OPERATING</b>	*	*	*	*	*	*

<b>CAPITAL EXPENDITURES</b>						
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<b>CHANGE IN REVENUES ( )</b>						
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**FUND SOURCE** (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type)						
<b>TOTAL</b>	*	*	*	*	*	*

Estimate of any current year (FY2001) cost: 0.0

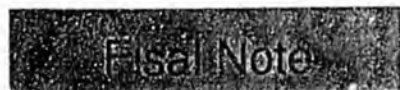
**POSITIONS**

Full-time						
Part-time						
Temporary						

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

Prepared by: Randall C. Lorenz, HHSS Committee Aide Phone 465-3759

REPRESENTATIVE FRED DYSON Date 4/19/01  
 Chairman



YOUTH AGE 16 OR OLDER IN DFYS CUSTODY AS OF MARCH 2, 2001

Total Number	175
Number over 18 years old	36

Region	Age	
	16 years or older	18 years or older
Anchorage	59	14
Northern Region	58	12
Aniak	2	0
Barrow	8	2
Bethel	13	1
Delta	4	1
Fairbanks	20	4
Ft. Yukon	2	1
Galena	1	0
Kotzebue	1	1
Nome	3	1
St. Mary's	4	1
South Central Region	29	6
Cordova	1	0
Dillingham	2	0
Kenai	6	1
King Salmon	1	0
Kodiak	2	1
Mat-Su	11	3
Seward	2	0
Unalaska	2	0
Valdez	2	1
Southeast Region	29	4
Craig	1	1
Juneau	20	3
Ketchikan	2	0
Petersburg	2	0
Sitka	4	0
TOTAL	175	36

Permanency Plan Goal	Number
Adoption	12
Guardianship	25
Independent Living	6
Permanent Relative Placement	6
Permanent Foster Care	32
Return to Home	94

## Youth age 16 or older in DFYS Custody as of March 2, 2001

The following tables are the result of a direct telephone survey to social workers who have youth age 16 or older on their caseloads who are currently in the foster care system. A total number of 182 youth were identified by PROBER. Of this population, 15 were identified as being under DJJ authority and were eliminated from the sample, leaving a total of 167 youth age 16 or older who were in DFYS foster care.

From this population, we received a total of 126 responses, for a 75% response rate. While the responses are not a stratified sample, it is safe to assume that simple percentages from the response population may be extrapolated to the total population. These tables also identify the number of youth in the response population that were age 18 or older as of March 1, 2001.

Youth's Permanency Goal	Number of responses	Percent of responses	Extrapolated number in total population
Adoption	10	7.9%	13
Long Term Residential	5	4.0%	7
Runaway	3	2.4%	4
Dismissed	2	1.6%	3
Guardianship	8	6.3%	11
Independent Living	71	56.3%	94
Relative Placement	3	2.4%	4
Return Home	17	13.5%	23
Unknown	7	5.6%	9
TOTAL	126	100.0%	167

Disability	Number of responses	Percent of responses	Extrapolated number in total population
physical	2	1.6%	3
learning	14	11.1%	19
emotional	27	21.4%	36
FAS/FAE	7	5.6%	9
substance abuse	7	5.6%	9
other	3	2.4%	4
none	66	52.4%	87
TOTAL	126	100.0%	167

Would remain in custody past high-school?	Number of responses	Percent of responses	Extrapolated number in total population
yes	42	33.3%	56
no	48	38.1%	64
maybe	7	5.6%	9
unk/na	29	23.0%	38
total	126	100.0%	167





**HB**

**215**

# ALASKA STATE LEGISLATURE

Representative Lisa Murkowski Chair  
Representative Andrew Halero Vice-Chair  
Representative Pete Kott  
Representative Kevin Meyer  
Representative Norman Rokeberg  
Representative Harry Crawford  
Representative Joe Hayes



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Juneau, AK 99801-1182  
Telephone: (907) 465-4954  
Fax: (907) 465-2293  
Representative\_Lisa\_Murkowski@legis.state.ak.us

## HOUSE LABOR AND COMMERCE COMMITTEE

### Sponsor Statement

#### HB 215

#### Optometrists and Pharmaceuticals

Optometry is a primary health care profession that examines, diagnoses, and treats conditions of the human eye and visual systems using methods and procedures in accordance with professional training and competency.

Similar to other limited licensed health care professions such as optometrists, dentists, podiatrists, and nurse practitioners, the methods and procedures used by optometrists are determined in regulation by their respective state boards. Over the years, as technology and training has advanced, optometry has had to return to the legislature to update statutes to practice at the highest standard of care.

In 1988, Alaska was the last state to enact statutes allowing optometrists to use diagnostic drugs. In 1992, Alaska was the 32<sup>nd</sup> state to authorize prescriptive privilege of topical therapeutic drugs to treat eye diseases. There have been no complaints to the Alaska board concerning drug prescriptions by optometrists since that privilege was granted. Currently, all 50 states authorize optometrists to prescribe drugs, with 34 states allowing for oral or systemic drugs, while 16 states, including Alaska, further restricted to topical drugs only.

In 2000, SB 73 allowed for qualified optometrists to prescribe and use medications related to the eye and for emergency anaphylaxis. SB 78 was passed by the legislature, but vetoed by the governor, citing possible inadequate board oversight of training and testing, and concern regarding eye injections to the eye.

HB 215 addresses the governor's concerns by providing for board authority to ensure competency. It will change the scope of board-endorsed optometrists to prescribe the additional medications beyond topical for treatment related only to the eye and prohibits injections into the globe of the eye. It further allows the board to require additional education for endorsement and to apply limitations to a licensee's endorsement.

HB 215 allows optometrists to practice at the currently accepted standard of care, and provide improved access to quality, cost-effective eye care throughout Alaska.

Staff Contact: Amy Erickson 465-4954  
Last Updated April 5, 2001





The Medical Board  
recently voted to send  
a letter to the  
Optometry Board inviting  
them to talk at  
a future Medical Board  
meeting

- Catherine Reardon  
Director of Occupational Licensing

**Testimony for HB 215  
Linda Casser, OD, FAAO  
April 24, 2001**

Chair Dyson and Members of the House Health Education and Social Services Committee:

My name is Dr. Linda Casser. I am an optometric physician and the Associate Dean for Academic Programs at the Pacific University College of Optometry in Forest Grove, Oregon. I am pleased to have this opportunity to testify in support of House Bill 215 by briefly providing specific information on the extensive training and education received by optometric physicians. My testimony today is based upon the following perspectives:

- In my current position as Associate Dean, I am responsible for the curriculum at the College, including content and development.
- I have nearly 25 years of experience in faculty and administrative positions in four different schools and colleges of optometry.
- I have served as an instructor in numerous classroom courses, clinical courses, and continuing education courses.

My testimony will briefly summarize several important areas:

- Classroom Education
- Training and Education in Pharmacology
- Clinical Education
- National Standardized Testing/Assessment
- Program Accreditation
- Continuing Education

### ***Classroom Education:***

The Doctor of Optometry degree program at Pacific University is comprised of 4,315 contact hours (180 semester credits: please see the "2000-2001 Curriculum"). This course of study is a four-year graduate level program. Enrollment in the program follows completion of an undergraduate degree that encompasses the prerequisites, or a minimum of 90 semester hours of prerequisite courses in Biological Sciences, General Physics, Chemistry, Mathematics, Statistics, General Psychology, and English. This prerequisite course of study is not only a rigorous and comprehensive one but is comparable to that completed by pre-medical and pre-dental students.

Pre-optometry students are also required to successfully pass the Optometry Admission Testing (OAT) examination, which is comparable to the MCAT examination required of medical students. The Admissions process is competitive and thorough: approximately 20% of the candidates who apply are actually admitted to a given entering class.

Those students who are admitted to the program experience a curriculum that is broad in scope and diverse in content, reflecting contemporary practice of the optometric physician. The process of curriculum development is a very dynamic and ongoing one to ensure that state-of-the-art optometric practice is reflected in our curriculum and to help set the future direction of our profession.

Students in the Doctor of Optometry program are thoroughly educated in the basic sciences in preparation for clinical diagnosis, treatment, and management of the eye and its associated structures, including the use of therapeutic medications. The breadth and depth of the basic science background is designed so that diseases and disorders of the eye are understood and treated in their proper context---as affecting an organ system contained within the body as a whole. Unique to the optometry curriculum are courses on optics, examination techniques, visual perception, the care of special populations, specialty optometric care, patient communication, legal and professional aspects, ethics, and public health, to name just a few.

### ***Training and Education in Pharmacology:***

In the 2000-2001 Curriculum, 255 classroom hours are assigned to the specific area of pharmacology, including the use of topical, oral, and injectable medications in the treatment of the eye and associated structures. This cited figure does not include the additional 165 classroom hours of courses pertaining to the diagnosis, treatment, and management of ocular disease, as well as the extensive patient care clinical experience in which these pharmacological concepts are actively applied.

Studies indicate that optometry students as a whole receive the same number of course hours in pharmacology as do medical and dental students. Students in the Doctor of Optometry degree program receive added specialty training in ocular pharmacology.

A brief comparison of the education and training of dentistry and optometry:

	<b>Dentistry</b> <i>(Review of materials from OHSU)</i>	<b>Optometry</b> <i>(Pacific University College of Optometry)</i>
Prerequisites:	3 years (90 semester hrs)	3 years (90 semester hours)
Admissions Examination:	Dental Admissions Test	Optometry Admissions Test
Graduate studies:	4 years	4 years
Degree:	DMD (Doctor of Dental Medicine)	OD (Doctor of Optometry)
National Examination:	Yes	Yes
Accreditation:	Yes	Yes
Pharmacology:	260 contact hours	255 contact hours

***Clinical Education:***

The College has excellent clinical facilities located on campus as well as an outstanding network of community-based clinical centers in the Portland metropolitan area. Many of these facilities provide care to the under-served. Our students begin their clinical activity in the first year of the professional program; this patient care experience increases in complexity and intensity throughout the program. The fourth year is spent in full-time patient care activity, and two of the three semesters are spent in off-campus clinical preceptorships in a variety of health care settings. In total, our students spend at least 2,000 patient contact-hours in a variety of optometric clinical settings examining diverse patient populations.

***National Standardized Testing/Assessment:***

Graduates of the four-year Doctor of Optometry professional degree program are required to pass a series of rigorous standardized national examinations administered by the National Board of Examiners in Optometry. The major areas of testing include:

Part I Basic Science

*Human Biology*

*Ocular/Visual Biology*

*Theoretical, Ophthalmic, and Physiological Optics*

*Psychology*

Part II Clinical Science

*Systemic Conditions*

*Ocular Disease/Trauma*

*Refractive/Oculomotor/Sensory Integrative Conditions*

*Perceptual Conditions*

*Public Health*

*Legal and Ethical Issues*

Part III Patient Care, including the Treatment and Management of Ocular Disease

*Clinical Skills Examination (practical examination)*

*Patient Assessment and Management Examination*

***Program Accreditation:***

The curriculum at the Pacific University College of Optometry is very representative of programs at our sister institutions. All of the 19 schools and colleges of optometry in North America are accredited by the Council on Optometric Education (COE). The Council, and the standards against which the programs are assessed, are recognized by the United States Department of Education (USDE). The activities and policies of the Council on Optometric Education are regularly reviewed by the USDE to ensure that valid and reliable accreditation processes are conducted.

An extensive accreditation review of each program by COE generally occurs once every seven years following an exhaustive self-study review. In addition, each program is required to submit an annual report to the profession's accrediting body.

*Continuing Education:*

Optometric physicians are required to meet significant continuing education (CE) requirements for relicensure. Depending upon the course offered, a lecture format, hands-on workshop, web-based interactive format, or video format may be conducted. Course offerings are submitted to state boards of optometry to qualify for credit in meeting requirements for license renewal.

In summary, graduates of the Doctor of Optometry professional degree program complete an intensive curriculum that includes rigorous classroom studies, as well as an intensive and extensive clinical experience. This thoroughly prepares optometric physicians to provide safe and effective eye and vision care services for the patients they serve.

Thank you for your kind attention. I will be glad to answer any questions that members of the Committee may have.

## **CASE IN POINT: ELEMENTS REPRESENTATIVE OF CURRICULAR CHANGE**

The Pacific University College of Optometry has a long and rich history of a strong curriculum of which our faculty, students, and alumni deserve to be very proud. Curricular changes at the College are active, ongoing, and forward-looking: they serve to appropriately broaden the scope and diversity of the curriculum while retaining its traditional strengths and emphases.

Two aspects in the training and education of the optometric physician illustrate this dynamic evolution of the curriculum very clearly: general/ocular pharmacology and the use of injections in the management of ocular disease. Our students have continually received a comprehensive education in the diagnosis, treatment, and management of conditions and disorders of the eye and associated structures, the visual system, and related systemic diseases; as the scope of the profession has changed, so, too, has the curriculum. Curricular changes over the course of a decade illustrate this:

### **Case in Point: Education in Pharmacology**

- In the 1988-89 Curriculum, 84 classroom hours were assigned to the specific area of pharmacology, including Diagnostic Pharmaceuticals, Therapeutic Pharmaceuticals, and Systemic Disease and Management.
- Ten years later, in the 2000-2001 Curriculum, 255 classroom hours are assigned to the specific area of pharmacology, including the use of oral medications in the treatment of the eye and associated structures. This cited figure does not include the additional 165 classroom hours of courses pertaining to the diagnosis, treatment and management of ocular disease, as well as the extensive patient care clinical experience in which these pharmacologic issues are actively applied.

### **Case in Point: Education in Injections**

- In the 1988-89 Curriculum, no classroom hours were assigned to covering the topic of the use of injections in the assessment and management of ocular disease
- Ten years later, in the 2000-2001 Curriculum, the use of injections in the assessment and management of ocular disease is included in the curriculum, including hands-on training. One of our fourth year students, who completed a preceptorship in Pennsylvania, forwarded this correspondence to a faculty member:

*"Way back in 1996 when I took the disease lab, I was one of those who got so queasy even when pretending to do a stick that my ears begin to buzz. I have to admit that I still get that way when someone sticks me. But last semester I was able to do these injections and am glad to have had the early exposure to the procedure. My preceptor feels that new optometrists need to be very flexible and well trained to survive in the managed care environment, and is pleased that Pacific has an injections lab. He was just as pleased that I was well versed in vision therapy techniques."*

PACIFIC UNIVERSITY COLLEGE OF OPTOMETRY

Doctor Of Optometry Degree  
2000-2001 Curriculum: Class of 2004

FIRST PROFESSIONAL YEAR

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

SECOND PROFESSIONAL YEAR

OPT #	Fall Semester:	Credits	OPT #	Spring Semester:	Credits
601	Ophthalmic Optics	3.0	617	Optometric Case Analysis	4.0
602	Sensory-Motor Interactions in Vision with Lab	4.0	618	Theory and Practice of Spherical Rigid and Soft Contact Lenses with Lab	3.0
616	Theory and Methods of Refraction	3.0	621	Clinical Experience IV	0.5
620	Clinical Experience III	0.5	633	Diagnosis and Treatment of Posterior Segment Diseases	3.0
631	Diagnosis and Treatment of Anterior Segment Diseases	2.0	634	Detection, Assessment and Treatment of Posterior Segment Diseases	1.0
632	Detection, Assessment and Treatment of Anterior Segment Diseases	1.0	638	Etiology, Diagnosis and Management of Systemic Diseases with Lab; Pharmacology of Systemic Medications III	2.0
637	Etiology, Diagnosis and Management of Systemic Diseases; Pharmacology of Systemic Medications II	2.0	648	Clinical Procedures: Phorometry and Ocular Health with Lab	4.0
646	Clinical Procedures: Refractive Error Measurement with Lab	2.0	682	Visual Information Processing and Perception with Seminar	4.0
647	Ophthalmic Dispensing Procedures with Lab	2.0			
661	Physiological, Psychological and Cognitive Changes During the Lifespan	2.0			
<b>Total Semester Credits</b>		<b>21.5</b>	<b>Total Semester Credits</b>		<b>21.5</b>
					<b>Total Second Year Credits</b>
					<b>43.0</b>

THIRD PROFESSIONAL YEAR

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

\* = Students are required to complete at least 4 credit hours of electives during third year.

FOURTH PROFESSIONAL YEAR

OPT #	Summer/Fall/Spring:	Credits	OPT #	Summer/Fall/Spring:	Credits
	<u>Preceptorships:</u>			<u>Internal Clinic Rotation:</u>	
815	Primary Patient Care: Preceptorship Rotation #1	15.0	817	Primary Patient Care: Internal Clinic Rotation	7.0
816	Primary Patient Care: Preceptorship Rotation #2	15.0	818	Vision Therapy Patient Care	3.0
892	Optometric Thesis: Completion (Fall Semester Only)	1.0	819	Low Vision Patient Care	1.0
			820	Contact Lens Patient Care	1.0
			821	Clinical Rounds	1.0
			822	Pediatric Patient Care	1.0
			832	Ocular Disease and Special Testing Patient Care	1.0
<b>Preceptorship Rotation #1 = 15 Credit Hours</b>			<b>Preceptorship Rotation #2 = 15 Credit Hours</b>		
					<b>Total Fourth Year Credits</b>
					<b>48.0</b>

**TRAINING AND EDUCATION IN PHARMACOLOGY**  
**PACIFIC UNIVERSITY COLLEGE OF OPTOMETRY**

In the 2000-2001 Curriculum, 255 classroom hours are assigned to the specific area of pharmacology, including the use of topical, oral, and injectable medications in the treatment of the eye and associated structures. An additional 165 classroom hours of courses pertain to the diagnosis, treatment and management of ocular disease. These pharmacologic concepts are applied in an intensive and extensive patient care clinical experience, including primary and specialty care (a portion of which is represented below). Studies indicate that optometry students as a whole receive the same number of course hours in pharmacology as do medical and dental students. Students in the Doctor of Optometry professional degree program then receive added specialty training in ocular pharmacology.

Opt 536 Pharmacological Principles and Autonomic Agents  
*3 credit hours; 45 contact hours*

Opt 533 Microbiology, Genetics and Immunology; Pharmacology of Anti-infective Drugs;  
Diseases of the Lid and Lacrimal System  
*3 credit hours; 45 contact hours*

Opt 534 Laboratory Procedures for Assessment of Ocular Disease  
*1 credit hour; 30 contact hours*

Opt 537 Etiology, Diagnosis and Management of Systemic Diseases;  
Pharmacology of Systemic Medications I  
*4 credit hours; 60 contact hours*

Opt 637 Etiology, Diagnosis and Management of Systemic Diseases;  
Pharmacology of Systemic Medications II  
*2 credit hours; 30 contact hours*

Opt 638 Etiology, Diagnosis and Management of Systemic Diseases with Laboratory;  
Pharmacology of Systemic Medications III  
*2 credit hours; 45 contact hours*

Opt 631 Diagnosis and Treatment of Anterior Segment Diseases  
*2 credit hours; 30 contact hours*

Opt 632 Detection, Assessment and Treatment of Anterior Segment Diseases  
*1 credit hour; 30 contact hours*

Opt 633 Diagnosis and Treatment of Posterior Segment Diseases  
*3 credit hours; 45 contact hours*

Opt 634 Detection, Assessment and Treatment of Posterior Segment Disease  
*1 credit hour; 30 contact hours*

Opt 735 Applied Ocular Therapeutics  
*1 credit hour; 30 contact hours*

Opt 832 Ocular Disease and Special Testing Patient Care (This is a specialty care clinic dedicated to ocular disease assessment, treatment, and management. This patient care activity is in addition to primary care settings in which these conditions are also treated and managed.)  
*1 credit hour; 60 contact hours*

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# Optometry Educational Program for the Diagnosis, Treatment and Management of Ocular Disease

Linda Casser, O.D., and Sally Hegeman, Ph.D.  
Indiana University School of Optometry

During the recent passage of Senate Bill 281,<sup>1</sup> which clarifies the authority of doctors of optometry to prescribe legend drugs, we had an opportunity to share with legislators and other interested parties background information documenting the professional educational program of optometry students here in Indiana. It is a pleasure to have an opportunity in this article to present a brief summary of this material for Indiana pharmacists.

Doctors of Optometry are trained and educated to diagnose diseases of the eye and its associated structures, and are fully qualified to prescribe legend drugs. This brief synopsis of the various facets of the professional optometric program highlights the following four areas:

- The Admissions Process
- The Pre-Clinic Educational Program
- Patient Care Activity/Clinical Education
- State and National Standardized Testing

## The Admissions Process

Students accepted into the four-year optometry program have successfully completed a rigorous undergraduate course of study that actually exceeds that of pre-medical and pre-dental students in the areas of biology, mathematics, physics, and statistics.<sup>1</sup>

Entering optometry students must complete a broad range of science-oriented prerequisite courses. The mean GPA for undergraduate work for students in the doctor of optometry class of 1994 (entered in Fall, 1990) is 3.35.<sup>2</sup> Mean GPA for the Class of 1994 dental students, as reported by the IU Health Professions and Prelaw Information Center is 3.10; that of medical students is 3.50.<sup>1</sup>

Pre-optometry students are also required to successfully perform on the Optometry Admission Testing (OAT) examination which assesses aptitude in Biology, General Chemistry, Organic Chemistry, Reading Comprehension, Quantitative Reasoning, and Physics. The OAT examination is comparable to the MCAT examination required of medical students.<sup>4</sup>

## Pre-Clinical Educational Program

Optometry students are thoroughly educated in the Basic Sciences in preparation for clinical diagnosis, treatment and management of the eye and its associated structures, including the use of legend drugs. The Basic Science optometry curriculum is designed so that diseases and disorders of the eye are understood and treated in their proper context . . . as affecting an organ contained within the body as a whole. The Pharmacology training is comparable to that of the medical student both in depth and breadth of subjects covered. For example, studies show that optometry students as a whole receive the same number of course hours in pharmacology training as do medical and dental students.<sup>1,6</sup> Optometry students then receive added specialty training in ocular pharmacology (Fig. 1). At Indiana University, optometry students receive 5 credit hours of systemic pharmacology plus 5 credit hours of ocular pharmacology and therapeutics; medical and dental students each receive 6 credit hours (1 credit hour = 15 contact hours).

The 1991-93 IU School of Optometry Bulletin describes the established Basic Science courses that pertain to the training of optometry students for the diagnosis, treatment and management of eye diseases and associated disorders.<sup>1</sup> A study of this listing reveals that optometry students complete 3 Basic Science tracks:

- Basic Science pertaining to the body as a whole (eg, Gross Anatomy, Medical Microbiology, Physical Diagnosis)
- Basic Science pertaining to the eye (eg, Ocular Anatomy, Ocular Microbiology, Neurophysiology of Vision)

## Pharmacology Preparation of Optometrists

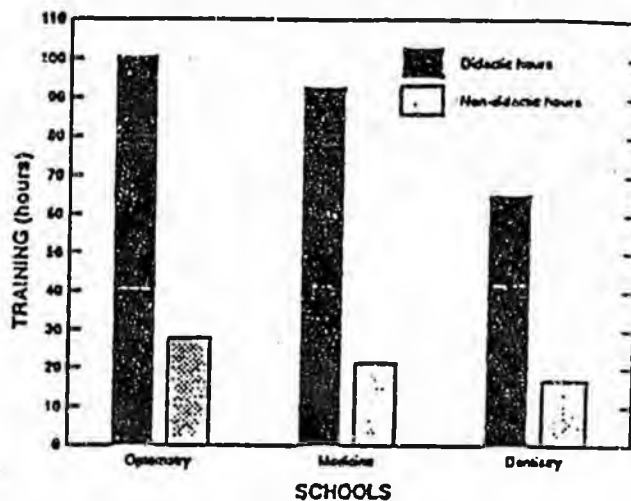


Figure 1 Didactic and non-didactic pharmacology training hours for schools of optometry, medicine, and dentistry.

- Basic Science pertaining to optics (eg, Physiological Optics, Geometrical Optics)

Added to the didactic courses listed in this section are those on optics, examination techniques, legal and professional aspects, and public health, to name just a few.

## Patient Care Activity/Clinical Education

The first two years of the 4-year graduate optometry curriculum are spent in intensive didactic and laboratory course work. In the summer before the third professional year, optometry interns begin their clinical patient care activities, which include the diagnosis, treatment and management of diseases of the eye and associated structures utilizing legend drugs in conjunction with licensed faculty members. Over a two year period, in excess of 2000 patient contact hours are spent in a variety of clinical settings examining patients, and diagnosing and treating eye diseases in each of the major clinical experiences:

- The Bloomington Patient Care Program
- The Indianapolis Patient Care Program
- The External Clinical Rotations

## The Bloomington Patient Care Program

The Campus Clinic in the School of Optometry in Bloomington houses the following service units: Primary Care, Pediatrics, Contact Lens, and Ocular Disease. Each student is assigned to patient care activity in each of these service units.

Optometry interns participate in 24-hour emergency call along with the faculty members. They also care for patients needing acute eye care at the IU Student Health Center in Bloomington. Patients are referred to this urgent eye care clinic by the Health Center Physicians. Optometry interns examine general medical patients alongside Health Center physicians. Interns participate in first day status post-operative cataract surgery patients at a local ophthalmologist's office.

## Indianapolis Patient Care Program

Optometry interns are assigned to one of two IU School of Optometry external clinics located in Indianapolis: the Walker Eye Clinic (located in the Walker Theatre Building)

of the Illinois Street Eye Clinic (near Methodist Hospital). The inner city location of these two facilities attracts a patient population that has a high incidence of ocular disease requiring treatment with legend drugs. The Course Syllabus and the Patient Examination Protocols manual document intern activity in diagnosis, treatment and management of eye diseases, including the use of legend drugs. Interns also participate in cataract patient pre- and post-operative care, as well as acute eye care, at a local eye referral center.

#### External Clinical Rotations

In addition to the Bloomington and Indianapolis clinic educational program, optometry interns are assigned to a minimum of two External Clinical Rotations. Most of these clinic sites are located out-of-state and include VA Hospitals, Public Health Service Hospitals, military bases, community co-management centers, and ophthalmic secondary/tertiary care centers. Optometry interns work with optometrists and ophthalmologists at these External Clinics. The External Clinic sites provide clinical experiences that concentrate in the area of ocular disease diagnosis and treatment. Surveys recently completed by each of the External Clinic sites indicate that:

- 100% of these External Clinics report "routine" use of Therapeutic Pharmaceutical Agents (TPA's)
- Directors of the External Clinics report that, on average, 58% of the patients seen by the optometry interns involve the diagnosis and treatment of ocular disease

#### State and National Standardized Testing and Examination

Graduates of the four-year optometry professional program are required to pass a series of standardized national board examinations, administered by the National Board of Examiners in Optometry (NBE). The major areas of testing include:

- Basic Science
- Clinical Science
- Treatment and Management of Ocular Disease (TMOD)

The 1991 NBE Candidate's Guide describes the content outline of the questions comprising the Basic Science component of the examination, designed to test and measure "a candidate's fundamental knowledge base of the scientific principles upon which optometric practice is built." The Clinical Science component of the NBE Examination tests and measures "a candidate's application of the fundamental knowledge base to the prevention, diagnosis, management, and treatment of clinical conditions within the scope of optometric practice."

Also included in the NBE examination is the examination in the Treatment and Management of Ocular Disease (TMOD). The TMOD Examination is designed as an entry-level examination since "therapeutic drug use is part of the practice repertoire of graduating optometry students".

Before the new graduate is granted a license to practice optometry in Indiana, he/she must also pass an examination conducted by the Indiana Optometry Board. New graduates must demonstrate clinical skills in general health evaluation and management, as well as ocular health evaluation, diagnosis, and management.

#### Conclusion

Some 70 percent of Doctors of Optometry practicing in Indiana are graduates of IU School of Optometry, one of only 16 in the country. Optometrists prescribe proper medications based on their clinical findings, assessing patient history aspects such as medication allergies, as well as the presence of any systemic illnesses. Once treatment is begun, optometrists then manage their patients through appropriate follow-up care.

The use of legend drugs for treatment and management of diseases of the eye and its associated structures is an integral part of the optometry curriculum, and comprises a substantial portion of the patient care activity provided in each of the School of Optometry Clinics. Senate Bill 281 provides an opportunity to clarify what Indiana optometrists have been doing for decades, so that, without obstacle, they can continue caring for the needs of their patients, and training IU students to be the best eye care providers possible.

*Dr. Casser is Associate Professor of Optometry, Department of Clinical Sciences, and Director, Indianapolis Clinic*

*Dr. Hegeman is Associate Professor of Optometry, Department of Visual Sciences, and Adjunct Associate Professor of Pharmacology, Medical Sciences Program*

#### References

1. Wilson GT. Indiana optometrists granted legend drug prescribing authority. *Indiana Pharmacist* 1991; 12:8-9 (No. 7).
2. "Preoptometry Requirements," "Preparing for Medical School: A Guide for Freshmen and Sophomores," and "Pre dental Requirements: A Guide for Freshmen and Sophomores," Health Professions and Prelaw Information Center, Indiana University, Bloomington, IN.
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5. Waigandt M, Waigandt A. An analysis of pharmacology training in schools of optometry, medicine and dentistry. *Journal of Optometric Education* 1985; 10:20-25.
6. Hegeman S. Comparison of pharmacology courses for optometry and medical students, Indiana University, Bloomington. *Journal of Optometric Education* 1983; 8:22-23.
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**STATE OF INDIANA**  
EXECUTIVE DEPARTMENT  
INDIANAPOLIS

**PROCLAMATION**  
To All To Whom These Presents May Come, Greeting

WHEREAS, the improved use of prescription medicine is often called America's second drug problem and

WHEREAS, nearly 5.0 billion prescriptions are dispensed each year at an estimated cost of nearly \$20 billion and

WHEREAS, up to half of available prescriptions are used inappropriately, contributing to potential illness, avoidable side effects, unnecessary hospitalizations and even deaths and

WHEREAS, certain non-legend controlled substances have a high potential for abuse and diversion, and some 200 million prescriptions are written annually for Schedule II controlled substances and some 400 million for the nation's most commonly abused and

WHEREAS, approximately 7% of patients do not use medicines when their medicines are issued and up to 20% of patients receive no information from their health care professionals about the medicines prescribed for them and

WHEREAS, certain non-legend controlled substances, particularly Schedule II controlled substances and Schedule III controlled substances are subject to a national effort to promote safe and effective use of certain of all of them

AND WHEREAS, I, ERIC SHEL, Governor of the State of Indiana, do hereby proclaim January 1, 1991 as

**NATIONAL PRESCRIPTION DAY**

In the State of Indiana and I call upon all citizens to join in observing this important occasion.

IN WITNESS WHEREOF, I have hereunto set my hand and caused the official seal thereof to be affixed on this 20th day of the State of Indiana at the Capital in Indianapolis on this 19th day of September, 1990.

*Eric S. Shel*  
GOVERNOR OF INDIANA

*James H. Ziegler*  
COMMISSIONER OF HEALTH

# FISCAL NOTE

**STATE OF ALASKA**  
**2001 LEGISLATIVE SESSION**

Fiscal Note Number: \_\_\_\_\_  
 Bill Version: HB 215  
 () Publish Date: \_\_\_\_\_

Revision Date/Time (Note if correction): \_\_\_\_\_ Dept. Affected: Community & Econ Dev.  
 Title: An Act relating to the use of pharmaceutical BRU: Occupational Licensing  
agents in the practice of optometry.... Component: Occupational Licensing  
 Sponsor: House Labor and Commerce  
 Requester: House HESS Component Number: 2360

**Expenditures/Revenues** (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
<b>TOTAL OPERATING</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>

<b>CAPITAL EXPENDITURES</b>						
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<b>CHANGE IN REVENUES ( )</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>
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**FUND SOURCE** (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
1156 Receipt Supported Services						
<b>TOTAL</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>

Estimate of any current year (FY2001) cost: 0.0

Check this box (X) if funding for this bill is included in the Governor's FY 2002 budget proposal:

**POSITIONS**

Full-time						
Part-time						
Temporary						

**ANALYSIS:** (Attach a separate page if necessary)  
 New funds are not required to implement this bill.

Prepared by: Jennifer Strickler, Administrative Manager Phone (907) 465-2144  
 Division: Occupational Licensing Date/Time 4/23/2001 3:30 p.m.  
 Approved by: \_\_\_\_\_ Date \_\_\_\_\_  
 Agency: Dept. of Community and Economic Development

For distribution information, call the Governor's Legislative Office

Re: HB 215, HEARING  
TODAY

American Academy of Ophthalmology  
1101 Vermont Avenue NW  
Washington, D.C. 20005-3570

Tel. 202-737-6662

Fax 202-842-5854  
[bpalmer@aaodc.org](mailto:bpalmer@aaodc.org)

April 24, 2001

The Honorable Fred Dyson  
Chair, Health, Education and Social Services Committee  
Alaska State House of Representatives

Re: H.B. 215

Dear Representative Dyson and Committee Members:

Thank you for the opportunity to comment on H.B. 215. I very much appreciate the Committee taking the time from its busy schedule to begin this review process. Although this bill is short, the policy ramifications of this proposal on the Alaska health policy care system, specifically in regards to eye health care, is complex. Due to the time constraints that you are now facing, you may find it necessary to complete a review of H.B. 215 during the interim.

H.B. 215 gives optometrist a "blank check" to prescribe oral and injectable drugs with little supervision and pharmaceutical training. I believe H.B. 215 if enacted would increase potential health risks to Alaska citizens. Last year legislation with this "blank check" scope of practice provisions were rejected in other states including, Florida, Georgia, Hawaii, Maryland, Mississippi, New York, Pennsylvania, South Dakota, Vermont, and Washington State. This year, state legislatures again in Georgia, Mississippi, and Washington State, and also Iowa, have already rejected optometric drug expansion proposals. I think you would agree, State Legislators across the United States are seriously questioning the wisdom of enacting additional legislation that would further expand optometric drug prescribing authority.

The question that you must address is: Why is this bill before you? The citizens of Alaska are not calling for enactment of this type of broad drug prescribing authority, only the optometry profession. To our knowledge, there have been no claims of delay in getting an appointment with an ophthalmologist where symptoms of disease are present. If there are such problems, Alaska ophthalmologists want to know and would gladly work with you to remedy any such delay. This can be easily accomplished without a change in the law. For example, ophthalmologists from the Alaska State Society are examining rural eye health care delivery, the objective being to further improve the quality of rural eye care services at less cost to Alaska citizens.

H.B. 215 contains far-reaching health policy implications that may not be in the best interest of the citizens of Alaska. H.B. 215 *does not* improve access to health care. It *does not* open new clinics. It *does not* make new services available to the citizens of Alaska. Finally, this bill would not lower health care costs for Alaskans.

For these reasons, I ask you to vote against H.B. 215.

Sincerely,

*Bob Palmer*

Bob Palmer  
Director  
State Governmental Affairs  
American Academy of Ophthalmology



Alaska State House of Representatives  
Health, Education and Social Services Committee  
April 24, 2001  
Page two

Physicians have long criticized the attempts to short cut the acquisition of authority for medical practice on the part of optometrists. Indeed, there is an entire population of former optometrists who have returned to medical school to obtain the experience and authority necessary to allow them the fuller form of medical practice. My partner and I did our residency with such a gentleman, Colonel James Besson of the United States Army Medical Corp. It was his unchanged opinion freely and frequently expressed that the experience and training he underwent in optometric school was a pale shadow of even the very basic experience that we started in the first year of our residency training and had no comparison to the subsequent specialized training of our advanced years and had no counterpart in our broader training as interns in our first post-graduate year.

Please do not degrade standards of education and experience that have served the public in the United States so well for this past century. Advocacy for this alteration is misguided and inappropriate and does not create any improvements for our residents in either access or expertise. Thank you for your attention.

Sincerely,

Gordon R. Preecs, M.D.

GRP:mjo

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**EDITOR'S PAGE**

**Encore! Encore!**

**Rich Kirkner**  
Editor-in-Chief



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

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

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

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

- **Eye exams for infants.** Operation Bright Sight is onto something here (see "Pilot Program Takes Eye Care to the Cradle.") Cradle-to-grave eye care has to start somewhere. The cradle seems like a logical place.
- **Eye exams for school children.** Kentucky has the right idea passing a law that mandates these. Besides, hasn't anyone yet figured out that our children who see well can learn well?
- **Eye exams for licensed drivers.** The eyes can change a lot between license renewals. Imagine how much they change between the 16th and 65th birthdays. The DMV can't.
- **Promote medical comanagement.** Surgical fees are in a free-fall, so organized ophthalmology is squabbling over your role in managing these patients. To them, it's about money, not sound medical practice. Every patient deserves to have his or her family doctor quarterback care, whether it's brain surgery, foot surgery or eye surgery.
- ★ • **Continue to expand the scope of practice.** Optometry now has an excellent track record in disease management. Time to move to the next

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

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

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

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

*Rich Kirkner*

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## Q&A on Optometric Scope of Practice Expansion

**Q: What is the expansion of optometric scope of practice?**

**A:** The expansion of optometric scope of practice in Alaska is an attempt to repeal the safeguards in existing law to authorize optometrists to treat more diseases with systemic drugs and with little or no oversight by medical doctors. It's like writing a blank check! Legislation with these blank check scope of practice provisions were rejected last year in other states including South Dakota, Florida, Georgia, Hawaii, Maryland, Mississippi, New York, Pennsylvania, Vermont, and Washington.

**Q: Don't we already have Eye M.D.s (ophthalmologists) in ALASKA trained to treat complex eye diseases?**

**A:** YES. An Eye M.D. has completed 4 years of medical school and has received a medical degree; PLUS an Eye M.D. has completed a 1 year, 60 hour per week hospital residency (an internship) in the 5<sup>th</sup> year of study; PLUS an Eye M.D. has returned to medical school for a 3 more years of study for closely supervised, advanced medical training by leaders in the field of medical eye care. This advanced training includes a 2<sup>nd</sup> residency program. Ophthalmologists have as much training as a cardiologist, neurologist, or oncologist.

However, optometrists do not undergo the thorough grounding in medicine and disease that Eye M.D.s complete. Only about 10 percent of the patients that optometry students see in their clinical training suffer from serious eye disease. In addition, only 10 percent of optometrists opt to do what is called an "optometric residency." And most of these "optometric residencies" do not even focus on the treatment of eye disease. Moreover, optometrists do not return to school for advanced medical training and do not undergo the 2<sup>nd</sup> residency which Eye M.D.s must complete in their medical discipline.

**Q: Why won't the expansion of optometric scope of practice reduce the costs of medical eye care in ALASKA?**

**A:** The fee schedule that Medicare and Medicaid uses is the same for optometrists and Eye M.D.s. Moreover, participating Medicare providers are not allowed by law to charge private patients a lower fee than Medicare patients. The expansion of optometric scope of practice would create two tiers in the quality of medical eye care but at the same reimbursement level. Indeed, many patients would seek a second opinion from an Eye M.D., requiring duplicate testing and incurring additional costs.

**Q: What is so dangerous about the treatment of serious eye diseases by optometrists?**

**A:** One cannot treat serious eye disease separate from understanding the whole body. Eye complaints have led medical doctors to accurately diagnose AIDS, multiple sclerosis, diabetes, arthritis, kidney ailments, high blood pressure, heart disease, hardening of the arteries, thyroid disease, brain tumors, and some types of cancer. Moreover, systemic drugs themselves can have very powerful effects on the body. Extended use of steroids, for example, can lead to permanent damage of the joints and other parts of the body. Steroid use must be managed properly to avoid serious withdrawal effects. Further, if taken by individuals who have certain chronic diseases, such as diabetes, steroids can cause an increase in glucose (sugar) levels sufficient to cause the patient to suffer a diabetic coma. The overprescribing of antibiotics has already contributed to the significant problem of resistant microorganisms, resulting in infectious disease that is more difficult to treat. This occurs even with fully trained medical doctors, and extending prescriptive privileges to inadequately trained allied health personnel will only aggravate this problem. Controlled substances can be habit-forming and subject to abuse. Moreover, even Eye M.D.s in clinical practice rarely have to prescribe narcotic pain medications and then mostly in the post-operative period. Indeed, many Eye M.D.s never prescribe any narcotics over an entire year. Finally, since seniors often have serious eye medical conditions as well as chronic illnesses and less tolerance to drug side effects, careful evaluation and close coordination by an Eye M.D. with other medical treatments is essential.

## **Alaska Optometric Association**

*Alaska Optometric Assn.  
1689 C Street, Suite 222  
Anchorage, AK 99501-5126*

*Phone: 907.770.3777  
Toll Free (Alaska): 877.693.2562*

### **Why Should Optometrists be Authorized to Prescribe Meds to Treat Eye Disease?**

In Alaska, the practice of optometry has been severely restricted by public policy that reflects a bygone day of ancient history. It was only recently that the Alaska Legislature authorized an optometrist to remove a foreign body (a piece of metal) embedded in the cornea of the eye. Today, in Alaska, an optometrist still may not write more than an eyedrop prescription to treat his patient's eye infection, nor prescribe a pain medication. In many locations, a doctor of optometry must refer the patient to a PA or a nurse practitioner (who is authorized) to write a prescription!

This restriction on optometry is out of step with the level of clinical training and education that today's doctor of optometry receives. What's more, it is inconsistent with what other comparably trained medical professionals (such as the dentist or the podiatrist) are authorized to practice.

Last year, with SB78, the Alaska State Legislature tried to correct that. After examining the quality of education and clinical training, the Legislature agreed that Alaskan optometrists were qualified to use advanced training to write expanded prescriptions. Stipulating that only after appropriate education and examination, Board-endorsed optometrists would be authorized to write full prescriptions for therapeutic pharmaceutical agents. Unfortunately, the Outside national Academy of Ophthalmology didn't agree with the Alaska State Legislature. After the Legislature adjourned, they staged an eleventh hour campaign to misrepresent optometric education and mislead the Alaska State Medical Board and the Governor, which resulted in the veto of SB78. (see the story behind the Governor's veto.)

This year, it's up to members of the 22<sup>nd</sup> Alaska Legislature to re-examine the credentials of optometry all over again. It is a fact that an optometrist's level of clinical and pharmacology training is comparable to that of a dentist, podiatrist, and a general medical practitioner. It is also a fact that they are restricted because of the turf opposition by the medical profession to any expansion of the scope of practice by any profession other than an MD. These battles have waged for over 30 years in all 50 States against optometrists (OD), advanced nurse practitioners, etc.

The Academy of Ophthalmology argues that an ophthalmologist is more qualified to treat diseases of the eye. This is partially true, as they are trained in tertiary care and surgery of the eye as a specialist, just as a heart surgeon is specialized. But the optometrist is specialty trained for primary and secondary care and limited surgery, including the prescribing of pharmaceuticals for treating the eye. The question is not "who is more qualified?" But rather, "Should qualified optometrists be allowed to practice at the highest level of their training with the current standard of care?" After carefully examining the facts, we are confident that you can trust the Board endorsed Alaska doctor of optometry to provide competent primary and secondary eye care for their patients, and refer to the ophthalmologists when needed for advanced specialty care, no different than family doctors that refer to specialists.

Over forty years ago, leaders in optometry discussed the future of their profession. They concluded that in order for their profession to grow and adequately serve their patients, they must expand beyond the old "detect and refer" model and change to the medical model of "diagnose and treat". Changes were implemented in the colleges of optometry and the old curriculum was expanded to a full 4-year professional program using the current medical model of training, starting about 1965. The scope of optometric education and clinical practice changed from what was an old traditional "eyeglasses" mode, to one of a primary eye care professional, diagnosing and treating eye diseases using medications and limited surgery such as foreign body removal and laser treatment as allowed by each individual state law. In every state, the older practitioners were required to update their training to use any new privileges, there was never any "grandfathering" allowed. Those older doctors that chose not to receive additional training are of course restricted from prescribing medications. In Alaska, only about 4 older optometrists are left in this restricted category.

It cannot be emphasized enough, that this came about only because of a revolution in the optometrist's training. Specifically, enhanced clinical training and education, including the study of eye conditions, clinical medicine as it relates to eye disease processes, and pharmacology. While an optometrist is trained to expertly serve as a primary eye care provider, the level, quality, and hours of professional education is equivalent to that of other health care professional programs, including medicine, dentistry, and podiatry. A 4-year undergraduate degree, followed by a 4-year professional degree (MD, DDS, DPM, OD), and often an additional residency program in an advanced clinical setting.

One of the least known facts about optometry today is how much clinical training the optometrist actually undergoes. Before graduation, optometric students have experienced approximately 3,000 hours of clinical and laboratory training, comparable to the number of hours in medical and dental training and far greater, in eye care specifically, than that of the family MD or any other type of

doctor or nurse practitioner currently authorized to treat the eye, with the exception of the specialty ophthalmologist. And Alaska's 90+ optometrists are located in over 18 towns and travel to many villages, while the ophthalmologists are located mostly in Anchorage (18), with a few in Fairbanks (4), Juneau (2), and the Kenai Peninsula (2).

The average optometry student will examine approximately 1,000 patients over the course of his or her clinical training. By comparison, the student of general medicine will see a few patients with eye problems, but in much smaller numbers than the optometrist due to the time spent on other organ systems. The Legislature offers full authority to MD's to perform anything they wish, trusting that they will not practice above their highest level of training and refer to specialists to do so. The same applies to dentists and nurse practitioners in Alaska, with their scope of practice determined by their State Board and the Alaska Legislature TRUSTING them to practice only as qualified. Why then are OD's so untrustworthy, with MORE EDUCATION, in applying the same standards of the other health professions ??? (Simple answer: Economic turf competition with the ophthalmologists.)

Since the training expansion starting 40 years ago, optometry's scope of practice has been carefully examined and expanded in the United States and around the world. Optometrists today diagnose, manage and treat their patients' eye conditions and eye diseases. This includes evaluating the eye with dilated exams, prescribing corrective lenses, removing embedded foreign objects from the eye, and all 50 states now authorized qualified optometrists to write prescriptions for therapeutic pharmaceutical agents (TPAs), with 37 states plus Wash. DC including oral drug authority. But not Alaska.

Optometrists are now recognized as "physicians" under Federal Medicare Law, and as primary eye care providers by health care consumers, primary care physicians, and benefit plan administrators. They serve as integral health care providers in numerous HMO, PPO, and other managed care plans, serving effectively as both vision and medical eye care practitioners. Today, we respectfully ask the Alaska Legislature to revise the outdated statutes so that doctors of optometry can practice their learned profession at the level that they are trained. This will provide much better access to quality eye care for Alaskans, especially in our rural areas.

*For more on the Scope of Practice issue see:*

**[Trustoptometry.com](http://Trustoptometry.com)**

**Subject: FW: Falconer Sr, OD Letter**  
**Date:** Wed, 4 Apr 2001 09:27:30 -0700  
**From:** "Linda Sylvester" <lindasyvester@gci.net>  
**To:** "Amy Erickson" <Amy\_Erickson@legis.state.ak.us>

-----Original Message-----

**From:** Jeff Gonnason, O.D. [mailto:jeff@alaska.com]  
**Sent:** Tuesday, April 03, 2001 8:52 PM  
**To:** Linda Sylvester  
**Subject:** Falconer Sr, OD Letter

To whom it may concern,

As an optometrist in Anchorage, Alaska, practicing here for 36 years I have seen changes in medications make treatment of eye disease much more effective.

Without the use of oral medications I am unable to treat many eye diseases to the extent that my training would allow. Many chronic diseases and acute diseases of the lid and eye require oral medications for treatment or supplemental treatment. Often I send these patients to their general practitioner telling the MD what to prescribe, as they don't know the proper diagnosis and treatment of many eye diseases. This incurs extra expense for the patient and the State of Alaska (Medicaid), and delays treatment.

Since optometrists have the training and the patients expect us to solve their problems it is time for Alaska to allow us to use these additional medications. Alaska is one of the few states in the U.S. to not allow qualified optometrists the use of these medications.

James C Falconer Sr, OD  
1345 W 9th  
Anchorage, Alaska 99501

**Subject:** FW: Dr. Shank Letter

**Date:** Wed, 4 Apr 2001 09:27:31 -0700

**From:** "Linda Sylvester" <lindasyvester@gci.net>

**To:** "Amy Erickson" <Amy\_Erickson@legis.state.ak.us>

-----Original Message-----

**From:** Jeff Gonnason, O.D. [mailto:jeff@alaska.com]

**Sent:** Tuesday, April 03, 2001 4:59 PM

**To:** Linda Sylvester

**Cc:** John Shank

**Subject:** Dr. Shank Letter

April 3, 2001

Dear Alaska Legislator,

My practice is in Kodiak, AK. I see most of the eye infections and problems in town and am the referral center for our physicians (MD's). Often patients need to be treated with systemic medication, in addition to topical ophthalmic medications. It is a waste of my time, the patient, and the physician for me to have to call or send the patient back to their practitioner or the ER for the routine medications I am fully qualified to prescribe. I am often requested to follow up on the MD's patients. This costs our patients and their insurance, whether state or private, more money and wasted time

I urge you to pass HB 215 / SB 173

Thank your for your support.

John T. Shank, O.D., F.A.A.O.

**Subject:** FW: Kosterman OD Letter

**Date:** Wed, 4 Apr 2001 09:27:30 -0700

**From:** "Linda Sylvester" <lindasyvester@gci.net>

**To:** "Amy Erickson" <Amy\_Erickson@legis.state.ak.us>

-----Original Message-----

**From:** Jeff Gonnason, O.D. [mailto:jeff@alaska.com]

**Sent:** Tuesday, April 03, 2001 8:28 PM

**To:** Linda Sylvester

**Subject:** Kosterman OD Letter

I work in an ophthalmologist's office. On many occasions, I have had occasion to prescribe oral medicines for patients, only to have to locate one of the MD's in the office to sign the prescription. Normally, this is just a waste of time, but frequently, I am the only doctor in the office. There have been occasions when a patient was experiencing a pressure spike (a dangerous increase in pressure inside the eyeball, which can cause acute glaucoma and blindness). After taking a careful health history and determining the proper course of medication, I have had to try to contact one of the MD's to "OK" the prescription. Meanwhile, the patient is waiting while nerve fibers are being killed off by the dozen. It has taken up to two hours to make contact, and finally begin the medication. On other occasions, I have been the only doctor on duty when patients returned for post-surgical follow-ups in severe pain. I have been unable to prescribe the strong pain relievers they need, offering the weak substitute of temporary topical anesthetic, which is not always in the patient's best interest, since it delays the healing process.

I don't intend to treat the patients' diabetes, colds, flu, high blood pressure, or whatever other systemic diseases they may have. But I am well-trained to begin an appropriate course of oral medications when that is the best indication for the eye problem I am treating. In most cases, I am able to complete the therapy without oversight. If at any time I feel the patient's sight is threatened, and I am not confident that I know the right treatment for the condition, I have no reservations about referring that patient to a higher-level specialist. But there is no need to refer if I understand the disease, the treatment and its contraindications, and there is a good prognosis.

Daniel J. Kosterman, O.D

**HB**

**219**

# Alaska State Legislature

REPRESENTATIVE  
HUGH "BUD" FATE

Mailing Address:

119 N. Cushman, Suite 101

Fairbanks, Alaska 99701

(907) 452-4448

Fax: (907) 456-3346



While in session  
State Capitol  
Juneau, Alaska  
99801-1182  
(907) 465-4976  
Fax: (907) 465-3883

House District 33

## House Of Representatives

### HB 219

**“An Act relating to mental health treatment facilities; repealing the termination date of the mental health treatment assistance program; and providing for an effective date.”**

HB 219 would repeal the sunset clause on a bill that passed in 1999 that created the Designated Evaluation Program. This program provides treatment through local hospitals for people who are in mental crisis. These individuals are working poor people who have no insurance or Medicaid coverage, who cannot afford hospitalization and who meet certain eligibility requirements.

If the sunset clause is not repealed, the following will be lost:

- Description of application, application review and appeal procedures
- Authorization of the department to establish eligible services and reimbursement rates
- Description of procedures for payment for the services provided
- Clarification of language and definitions to accurately reflect statutory intent
- Clarification of the responsibilities of the Department
- Language that establishes who is eligible for assistance for inpatient services:
  - Individuals who meet criteria for commitment under current statutes (i.e. danger of harming self or others or gravely disables as a result of mental illness, and is likely to improve with treatment)
  - Individuals whose household income is below 185% of federal poverty guidelines for Alaska and who have no other third party payer

HB 219 would remove the sunset clause and extend the program indefinitely. Without this change, individuals in need of treatment would have to be transported to Alaska Psychiatric Institute or held in correctional facilities.

Without this bill, all of this is due to sunset July 1, 2001, sending the program back to it's original vague and problematic state.

---

Sponsor Statement

# Alaska State Legislature

REPRESENTATIVE  
**HUGH "BUD" FATE**

Mailing Address:  
119 N. Cushman, Suite 101  
Fairbanks, Alaska 99701  
(907) 452-4448  
Fax: (907) 456-3346



While in session  
State Capitol  
Juneau, Alaska  
99801-1182  
(907) 465-4976  
Fax: (907) 465-3883

House District 33

## House Of Representatives

### House Bill 219

#### Sectional Analysis

**“An Act relating to mental health treatment facilities; repealing the termination date of the mental health treatment assistance program; and providing for an effective date.”**

This bill repeals the sunset clause for the Designated Evaluation and Treatment program (DET).

Section 1. of the bill repeals the sunset provisions Sections 2, 4, 6, and 9 of ch. 87 SLA 1999. Those current sections that would be removed cover:

- the clarification of liability for expenses of placement in a treatment facility, (Section 2.)
- the clarification of the definition of “designated treatment facility”, (Section 4.)
- clearly defines the eligibility and procedures of the DET program. (Section 6.):
  - Applicability
  - Eligibility for assistance
  - Application for assistance
  - Decision on eligibility
  - Eligible services rates
  - Payment
  - Appeal
  - Regulations
  - Definitions
- Established an effective date of sunset as July 1, 2001 (Section 9.)

Section 2 of this bill causes the repeal to take effect immediately.

---

If the sunset occurs, then it reinstates the vague language that led to confusion and inconsistencies in managing the program. These problems led to a lawsuit which prompted the statutory change.

RECEIVED  
MAR 28 2001

**ACMHSA**

**Alaska Community Mental Health  
Services Association  
3050 Fifth Avenue  
Ketchikan, Alaska 99901**

March 28, 2001

**VIA FACSIMILE: (907) 465-3883**

Representative Bud Fate  
Capitol Room 416  
Juneau, Alaska 99811

Re: HB 219

Dear Representative Fate,

The Alaska Community Mental Health Services Association (ACMHSA) supports your legislation HB 219 which repeals the sunset for the DET program.

ACMHSA is a statewide association representing all of the non-profit mental health providers in the state. We support this legislation and commend your leadership with this important mental health issue.

Sincerely,



Ron Adler  
President

Ron Adler, Chair  
Brenda Knapp, Treasurer

Pete Braveman, Vice Chair  
At-Large: Bill Hogan, Doug Veit

Diana Strzok, Secretary

Phone: (907) 225-4135

FAX: (907) 247-4135

e-mail: rona@city.ketchikan.ak.us.

Support Letter

# FISCAL NOTE

**STATE OF ALASKA**  
**2001 LEGISLATIVE SESSION**

Fiscal Note Number: \_\_\_\_\_  
 Bill Version: HB 219  
 ( ) Publish Date: \_\_\_\_\_

Revision Date/Time (Note if correction): \_\_\_\_\_ Dept. Affected: Health & Social Services  
 Title: Sunset of Designated Evaluation and BRU: Community Mental Health Grants  
Treatment Program Component: Designated Eval & Treatment  
 Sponsor: Rep. Fate  
 Requester: House (HES) Component Number: 1014

**Expenditures/Revenues** (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims	2,652.1	2,652.1	2,652.1	2,652.1	2,652.1	2,652.1
Miscellaneous						
<b>TOTAL OPERATING</b>	<b>2,652.1</b>	<b>2,652.1</b>	<b>2,652.1</b>	<b>2,652.1</b>	<b>2,652.1</b>	<b>2,652.1</b>

<b>CAPITAL EXPENDITURES</b>						
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<b>CHANGE IN REVENUES ( )</b>						
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**FUND SOURCE** (Thousands of Dollars)

1002 Federal Receipts	582.1					
1003 GF Match						
1004 GF						
1037 I/A Receipts	723.7	723.7	723.7	723.7	723.7	723.7
1037 GF/Mental Health	1,146.3	1,728.4	1,728.4	1,728.4	1,728.4	1,728.4
1092 MHTAAR	200.0	200.0	200.0	200.0	200.0	200.0
<b>TOTAL</b>	<b>2,652.1</b>	<b>2,652.1</b>	<b>2,652.1</b>	<b>2,652.1</b>	<b>2,652.1</b>	<b>2,652.1</b>

Estimate of any current year (FY2001) cost: 0.0

Check this box (X) if funding for this bill is included in the Governor's FY 2002 budget proposal:

**POSITIONS**

Full-time						
Part-time						
Temporary						

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

**ALL FUNDING FOR DET IS INCLUDED IN THE GOVERNOR'S BUDGET.** This bill allows for the continuation of Designated Evaluation and Treatment services covered in the FY02 Governor's Request. These statutes (sunset date July 1, 2001) establish consistent methods for the Department to pay for voluntary or involuntary inpatient psychiatric services for individuals who pose a danger to themselves or others because of mental illness, or who are gravely impaired by mental health systems, and who have no third party payor and cannot afford the high cost of hospitalization. The provision of these services in local communities fits with the objectives of serving consumers close to home. Federal laws have reduced the % of the \$10 million in Disproportionate Share Hospital funds that have been available to API on an annual basis since the 1980s. This "frees up" the balance of the DSH funds for other special needs populations served by qualifying hospitals. The DET assistance program is a logical, eligible recipient of these funds..

Prepared by: Sarah Brinkley, Admin Manager Phone 465-3167  
 Division: DMHDD Date/Time: 1/0/00 12:00 AM  
 Approved by: Elmer A. Lindstrom, Special Assistant Date: 3/29/01 3:47 PM  
 Agency: Department of Health & Social Services

For distribution information, call the Governor's Legislative Office

## ANALYSIS: (continued)

Of the total \$2,652.1 DET budget for FY02, \$2,392.1 was in the FY02 Governor's Request and \$723.7 was added through the FY02 Governor's Amended Request.

## Breakdown of FY02 DET projections:

Grants - \$260.0

Fee for Service - \$2,392.1

Fairbanks \$1,262.1

Juneau \$ 641.6

Mat-Su \$ 237.1

Ketchikan \$ 99.9

Anchorage \$ 60.3

YKHC \$ 55.2

other \$ 35.9

\*Note: The DET component's FY02 budget contains, in addition to the above \$2,652.1 authority for projected needs, another \$142.8 in excess federal authority on the books for potential unanticipated future federal awards.





# Alaska State Legislature

*Session:*  
State Capitol  
Juneau, AK 99801  
Phone: (907) 465-2327  
Fax: (907) 465-5241



*Interim:*  
119 N. Cushman  
Fairbanks, AK 99701  
Phone: (907) 456-8161

**Senator Pete Kelly**  
District P

## SB154

**“An Act relating to mental health treatment facilities; repealing the termination date of the mental health treatment assistance program; and providing for an effective date.”**

SB154 would repeal the sunset clause on a bill that passed in 1999 that created the Designated Evaluation Program. This program provides treatment through local hospitals for people who are in mental crisis. These individuals are working poor people who have no insurance or Medicaid coverage, who cannot afford hospitalization and who meet certain eligibility requirements.

If the sunset clause is not repealed, the following will be lost:

- Description of application, application review and appeal procedures
- Authorization of the department to establish eligible services and reimbursement rates
- Description of procedures for payment for the services provided
- Clarification of language and definitions to accurately reflect statutory intent
- Clarification of the responsibilities of the Department
- Language that establishes who is eligible for assistance for inpatient services:
  - Individuals who meet criteria for commitment under current statutes (i.e. danger of harming self or others or gravely disables as a result of mental illness, and is likely to improve with treatment)
  - Individuals whose household income is below 185% of federal poverty guidelines for Alaska and who have no other third party payer

SB 154 would remove the sunset clause and extend the program indefinitely. Without this change, individuals in need of treatment would have to be transported to Alaska Psychiatric Institute or held in correctional facilities.

Without this bill, all of this is due to sunset July 1, 2001, sending the program back to it's original vague and problematic state.

# Alaska State Legislature

*Session:*  
State Capitol  
Juneau, AK 99801  
Phone: (907) 465-2327  
Fax: (907) 465-5241



*Interim:*  
119 N. Cushman  
Fairbanks, AK 99701  
Phone: (907) 456-8161

**Senator Pete Kelly**  
District P

## Senate Bill 154

### Sectional Analysis

**“An Act relating to mental health treatment facilities; repealing the termination date of the mental health treatment assistance program; and providing for an effective date.”**

This bill repeals the sunset clause for the Designated Evaluation and Treatment program (DET).

**Section 1.** of the bill repeals the sunset provisions Sections 2, 4, 6, and 9 of ch. 87 SLA 1999. Those current sections that would be removed cover:

- the clarification of liability for expenses of placement in a treatment facility, (Section 2.)
- the clarification of the definition of “designated treatment facility”, (Section 4.)
- clearly defines the eligibility and procedures of the DET program. (Section 6.):
  - Applicability
  - Eligibility for assistance
  - Application for assistance
  - Decision on eligibility
  - Eligible services rates
  - Payment
  - Appeal
  - Regulations
  - Definitions
- Established an effective date of sunset as July 1, 2001 (Section 9.)

**Section 2** of this bill causes the repeal to take effect immediately.

If the sunset occurs, then it reinstates the vague language that led to confusion and inconsistencies in managing the program. These problems led to a lawsuit which prompted the statutory change.

# FISCAL NOTE

STATE OF ALASKA  
2001 LEGISLATIVE SESSION

Fiscal Note Number: \_\_\_\_\_  
B.II Version: SB 154  
( ) Publish Date: \_\_\_\_\_

Revision Date/Time (Note if correction): \_\_\_\_\_ Dept. Affected: Health & Social Services  
Title: Sunset of Designated Evaluation and BRU: Community Mental Health Grants  
Treatment Program Component: Designated Eval & Treatment  
Sponsor: Sen. Kelly  
Requester: Senate (HES) Component Number: 1014

## Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
Personal Services						
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Contractual						
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<b>TOTAL OPERATING</b>	<b>2,652.1</b>	<b>2,652.1</b>	<b>2,652.1</b>	<b>2,652.1</b>	<b>2,652.1</b>	<b>2,652.1</b>

CAPITAL EXPENDITURES						
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CHANGE IN REVENUES ( )						
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1003 GF Match						
1004 GF						
1007 I/A Receipts	723.7	723.7	723.7	723.7	723.7	723.7
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1092 MHTAAR	200.0	200.0	200.0	200.0	200.0	200.0
<b>TOTAL</b>	<b>2,652.1</b>	<b>2,652.1</b>	<b>2,652.1</b>	<b>2,652.1</b>	<b>2,652.1</b>	<b>2,652.1</b>

Estimate of any current year (FY2001) cost: 0.0

Check this box (X) if funding for this bill is included in the Governor's FY 2002 budget proposal:

### POSITIONS

Full-time						
Part-time						
Temporary						

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

**ALL FUNDING FOR DET IS INCLUDED IN THE GOVERNOR'S BUDGET.** This bill allows for the continuation of Designated Evaluation and Treatment services covered in the FY02 Governor's Request. These statutes (sunset date July 1, 2001) establish consistent methods for the Department to pay for voluntary or involuntary inpatient psychiatric services for individuals who pose a danger to themselves or others because of mental illness, or who are gravely impaired by mental health systems, and who have no third party payor and cannot afford the high cost of hospitalization. The provision of these services in local communities fits with the objectives of serving consumers close to home. Federal laws have reduced the % of the \$10 million in Disproportionate Share Hospital funds that have been available to API on an annual basis since the 1980s. This "frees up" the balance of the DSH funds for other special needs populations served by qualifying hospitals. The DET assistance program is a logical, eligible recipient of these funds..

Prepared by: Sarah Brinkley, Admin Manager Phone 465-3167  
Division: DMHDD Date/Time: 1/0/00 12:00 AM  
Approved by: Elmer A. Lindstrom, Special Assistant Date: 3/22/01 10:12 AM  
Agency: Department of Health & Social Services

For distribution information, call the Governor's Legislative Office

## ANALYSIS: (continued)

Of the total \$2,652.1 DET budget for FY02, \$2,392.1 was in the FY02 Governor's Request and \$723.7 was added through the FY02 Governor's Amended Request.

## Breakdown of FY02 DET projections:

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other \$ 35.9

\*Note: The DET component's FY02 budget contains, in addition to the above \$2,652.1 authority for projected needs, another \$142.8 in excess federal authority on the books for potential unanticipated future federal awards.



INTERIOR  
NEIGHBORHOOD  
HEALTH  
CLINIC

1949 Gillam Way, Suite D  
Fairbanks, Alaska 99701  
Phone: (907) 455-4567  
Fax: (907) 455-7675  
TTY: (907) 455-4507

March 25, 2001

Senator Pete Kelly  
119 North Cushman Suite 201  
Fairbanks, Alaska 99701

*Pete*  
Dear Senator Kelly:

One in 5 adults has a diagnosable mental disorder and one in four families will have a member with mental illness. Meeting the mental health needs of our communities remains one of the greatest challenges for healthcare providers. Many individuals needing treatment are unable to work because of their illness and will not seek needed inpatient treatment for fear of large medical bills, although they may be at risk of endangering themselves or others.

We urge you to support SB-154 introduced by Senator Kelly. The bill repeals the sunset clause of the mental health treatment assistance program. This program was established two years ago as part of the reform of the state mental health program. It provides for the local hospitalization of mentally ill individuals who would otherwise be committed to API. In many instances, this includes traveling from Fairbanks to Anchorage through the judicial system. This option can be frightening and detrimental to someone already suffering from mental illness. With the expansion of the mental health unit at Fairbanks Memorial Hospital from 9-20 beds, the need to transport patients' through the judicial system to API has drastically been reduced.

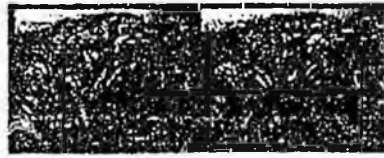
The Designated Evaluation and Treatment Program (DET) promotes access to hospital care for mentally ill individuals as close to home as possible. Involvement of family members and local community providers in hospital care and discharge planning results in shorter length of stays, more realistic follow-up care and local family support.

The 1998 statute clearly defines the boundaries of the program while encouraging local hospitals to take a greater role in providing care for the civilly committed patients. The success of the efforts over the last two years would be lost if the program is sunsetted and Alaska returns to its former way of doing business. By passing SB-154 before June 2001, access to local mental health care in Fairbanks and Alaska will continue the strengthening of local programs that began with the inception of the original bill.

Please contact me if I may provide further information.

Sincerely,

Cheryl Kilgore  
Executive Director

**NAMI of Fairbanks****P.O. BOX 72543 FAIRBANKS, AK 99707 PH: 907-456-4704****FAX: 907-456-3593 e-mail: fami@mosquitonet.com**

March 26, 2001

Senator Pete Kelly  
State Capitol, Room 518  
Juneau, AK 99801-1182

Dear Senator Kelly:

I strongly support the passage of SB-154 by the legislature this session.

The Designated Evaluation and Treatment Program (DET) encourages local treatment of the mentally ill by community hospitals. Prior to the state mental health reforms of 1998 mentally ill individuals were sent to API. The 1998 statute provides guidelines for extent of treatment to be given, as well as urging hospitals to offer expanded services for the mentally ill of their community. The sunset clause for the DET will go into effect at the end of June 2001.

As advocates of the mentally ill in the Fairbanks Community we supported the increased size and scope of Fairbanks Memorial Hospital's psychiatric unit in order to facilitate care of Fairbanks' mentally ill individuals. Family support of a mentally ill patient is important to their recovery and decreases the patient's length of stay. By allowing patients to remain in the care of their community provider, the patient will receive the optimum continuum of care during and following hospitalization.

The mental health assistance program is responsible for two years of progress in psychiatric treatment. However, these two years of effort and progress will count for little if the sunset clause is allowed to go into effect. Please join us in supporting the passage of SB-154.

I enjoyed meeting you this last week and am pleased at your sincere regards of mental health issues. Keep up the good work, and I feel I have a friend in Juneau. Thank-You.

Sincerely,

Jackie Pananen

President

NAMI of Fairbanks, Alaska, Inc

# STATE OF ALASKA

## DEPT. OF HEALTH AND SOCIAL SERVICES

DIVISION OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES  
CENTRAL OFFICE

TONY KNOWLES, GOVERNOR

P.O. BOX 110620  
JUNEAU, ALASKA 99811-0620  
PHONE: (907) 465-3370  
FAX: (907) 465-2668  
TDD: (907) 465-2225  
TOLL FREE: 1-800-465-4828

March 16, 2001

The Honorable Pete Kelly  
State Capital  
Juneau, Alaska 99801


Dear Senator Kelly:

Thank you for your continuing support of the Designated Evaluation and Treatment (DET) program. The DET program is a critical component in the continuum of mental health services in Alaska, particularly for indigent persons with mental illnesses who are being civilly committed, or meet the criteria for civil commitment. Through this program, many poor people with mental illness who do not qualify for Medicaid are able to receive services in community hospitals across the state, closer to their families and local support systems. Without the DET program, it would be necessary to transport many consumers in crisis to Alaska Psychiatric Institute (API) to receive evaluation and treatment services.

Consumers have advocated aggressively for receiving community-based services in the least restrictive environments. The Division is responding by creating local and regional systems of care for persons experiencing mental illnesses. We would like to limit the use of API to those psychiatric crises that exceed the ability of local communities to address. The DET program provides a stable, predictable reimbursement structure for community hospitals to proactively address these crises for persons who lack other means to pay for services. This in turn allows many communities in Alaska to develop a more comprehensive and coordinated approach to addressing local mental health emergencies.

Without new legislation to extend its existence, the current clarifying statutory language of the DET program will expire as of July 1, 2001, plunging the program back into vagueness and confusion. We strongly encourage the passage of this legislation, and again thank you for your support.

Sincerely,



Walter Majoros  
Director

**Subject: Kelly Bill Extends Program for Mentally Ill**

**Date:** Wed, 21 Mar 2001 11:37:37 -0900

**From:** Laura Achee <Laura\_Achee@legis.state.ak.us>

**Organization:** Alaska State Legislature

ALASKA SENATE  
Senator Pete Kelly  
District P

**For Immediate Release: March 21, 2000**

**Contact: Sen. Pete Kelly, 465-2327**

## **Kelly Bill Extends Program for Mentally Ill**

(JUNEAU) – Sen. Pete Kelly introduced legislation today to extend a program that provides treatment for mentally ill Alaskans.

The Designated Evaluation and Treatment Program was created in the Spring of 1999 to provide treatment through local hospitals for people who are in mental crisis and have nowhere else to go. These individuals are working poor people who have no insurance or Medicaid coverage, who cannot afford hospitalization and who meet certain eligibility requirements.

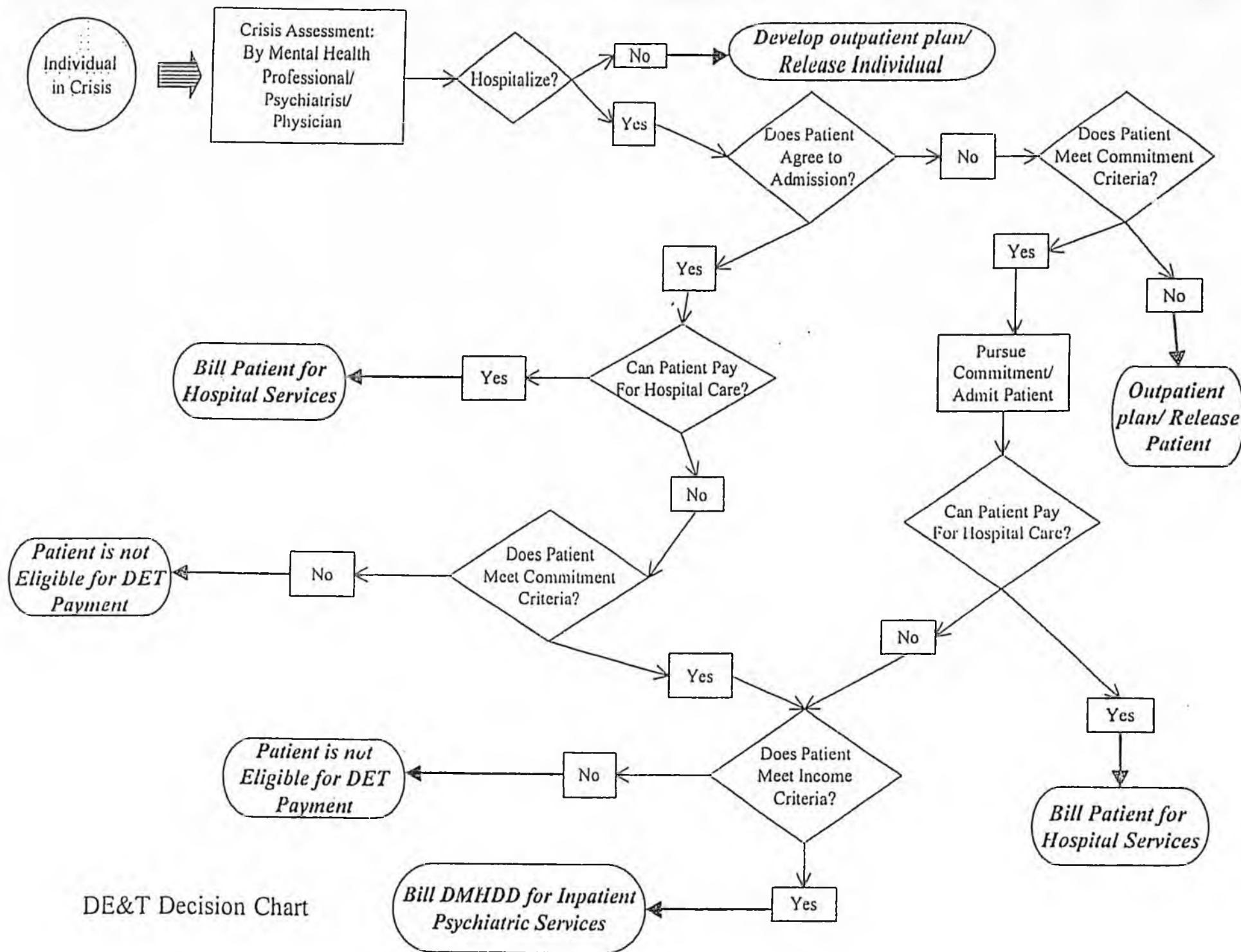
The Division of Mental Health and Developmental Disabilities has designated eight local community hospitals as evaluation facilities providing 72-hour psychiatric evaluations, and two as treatment facilities providing up to 30 days of treatment. The division pays for care provided by the hospitals on a payor of last resort basis. Up to 250 receive hospital services reimbursed through this program each year.

"This assistance has been available since 1978, but the eligibility criteria were vague and open to individual interpretation," said Sen. Pete Kelly (R-Fairbanks). "That's why I sponsored Senate Bill 97 two years ago, to clarify the criteria and create the program as it exists today. But the bill includes a sunset clause that will end the program on July 1, 2001 and return it to the state it was in before."

Senate Bill 154, also sponsored by Kelly, would remove the sunset clause and extend the program indefinitely. Without this change, individuals in need of treatment would have to be transported to Alaska Psychiatric Institute or held in correctional facilities.

"It is important that those who are in acute mental crisis receive help as quickly as possible, without having to spend time in a jail or leave the support of their home community to go to Anchorage," said Kelly. "This program has proven to be beneficial for the people who need it most. It would be a tragedy for these patients and their families if the program were to end."

# # #



DE&T Decision Chart



# ALASKA PSYCHIATRIC INSTITUTE

## ADMINISTRATION

2900 PROVIDENCE DRIVE

ANCHORAGE, ALASKA 99508-4677

PHONE # 9907) 269-7106 FAX # (907) 269-7251

### FAX COVER SHEET

SEND TO FAX # \_\_\_\_\_

DATE: 3/10 TIME: 4:15 COVER + 3 PAGES

TO: Sen Peter Kelly PHONE #: \_\_\_\_\_

FROM: Randall Burns PHONE #: \_\_\_\_\_

Here is the DET letter. Call if you want changes, have questions!

Randall Burns

THE INFORMATION ATTACHED TO THIS COVER SHEET MAY CONTAIN CONFIDENTIAL INFORMATION WHICH CAN BE ACCESSED ONLY IN ACCORDANCE WITH AS 39.25.080 IF THIS MATERIAL IS MISTAKENLY RECEIVED BY AN UNAUTHORIZED INDIVIDUAL, PLEASE DISPOSE OF IT IMMEDIATELY.

# STATE OF ALASKA

## DEPT. OF HEALTH AND SOCIAL SERVICES

DIVISION OF MENTAL HEALTH AND  
DEVELOPMENTAL DISABILITIES

TONY KNOWLES, GOVERNOR

ALASKA PSYCHIATRIC INSTITUTE  
2900 PROVIDENCE DRIVE  
ANCHORAGE, ALASKA 99508-4677  
PHONE: (907) 269-7100  
FAX: (907) 269-7251

March 16, 2001

The Honorable Pete Kelly  
Alaska State Senate  
State Capitol - Room 518  
Juneau, AK 99801-1182

Dear Senator Kelly:

I am writing to express the support of the management of Alaska Psychiatric Institute (API) for continuation of the legislation authorizing payments to designated evaluation and treatment (DET) hospitals across the State of Alaska who provide inpatient psychiatric services to Alaskans who meet statutory criteria for inpatient treatment.

As you know, API is the State's only public hospital. Our mission is to provide an appropriate array of quality, inpatient psychiatric services for the treatment of Alaskans with psychiatric disorders who meet admission criteria. API's patients come from all around the State.

One of our major and ongoing concerns is the admission pressure on the facility. Between FY95 and FY00, API's admissions have increased 56%, while our bed capacity has actually decreased to our present capacity of 74 beds. The attached graph demonstrates the impact on treatment capacity (higher admissions, shorter lengths of stay). Because our bed capacity is limited and the admissions frequent, we are required to discharge patients quickly, leading to criticism from some community mental health service providers that the hospital stays of the persons admitted to API are too short and that patients are discharged before they are ready to return to their communities.

However, API treatment staff truly have no choice but to discharge the majority of our patients relatively quickly because otherwise our beds would quickly fill up with patients with longer hospital stays and our patient census would not only quickly reach our supposed maximum capacity of 74 but soon seriously exceed the beds available (we have been as high as 88 in the last year or so).

Therefore, the reason API fully supports DET legislation is that it encourages local community hospitals to admit and treat persons experiencing a mental health crisis in their community of residence rather than transporting these individuals to API.

Page Two - Senator Pete Kelly - March 16, 2001

When we look at the annual increase in the number of API admits, we consider ourselves fortunate indeed that the DET statute has actually reduced referrals to API from the communities of Juneau and Fairbanks, and more recently from Kodiak and Nome.

Without the willingness of these hospitals to provide DET services, many of the persons admitted in the last few years to Bartlett Memorial Hospital in Juneau or Fairbanks Memorial Hospital, for example, would have been transported from their community (often in handcuffs!) and admitted to API instead, only further substantially increasing admission pressure on API.

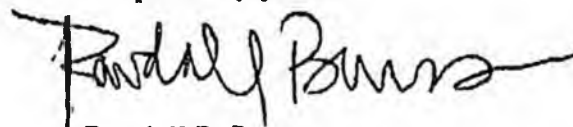
However, as a result of the provisions of the DET legislation, admissions from Juneau remain very low and, with the recent opening of the Fairbanks Memorial Hospital's expanded psychiatric unit, the admissions from Fairbanks to API have dropped substantially. This has been a real success story.

My concern would be, should the statutory authority to reimburse DET hospitals be allowed to sunset, that local hospitals would soon cease providing this service and the persons experiencing a mental health emergency requiring hospital-level care who now are able to be treated in their home community, near family and friends, would be transported to API for admission and treatment, neither a therapeutic or cost-effective solution.

I understand that you are supportive of continuing this important service to Alaskans with mental illnesses, and I provide this letter to you to demonstrate to you the present value of funded DET services to API. If these local services were not present, API would itself soon need additional budget funds to staff and operate the hospital to its increasing capacity.

If I can be of further assistance to you, or if you have any additional questions, please do not hesitate to contact me. And thank you for this opportunity to comment on the value of the DET legislation to API.

Respectfully yours,



Randall P. Burns  
Chief Executive Officer

cc: Anne Henry, DMHDD

THE  
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POOR  
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COPIES

**SEVEN (FISCAL) YEAR DATA COMPARISON**  
**Alaska Psychiatric Institute**

	<u>FY94</u> <u>(114 Beds)</u>	<u>FY95*</u> <u>(79 Beds)</u>	<u>FY96</u> <u>(79 Beds)</u>	<u>FY97</u> <u>(79 Beds)</u>	<u>FY98</u> <u>(79 Beds)</u>	<u>FY99</u> <u>(79 Beds)</u>	<u>FY00**</u> <u>(74 Beds)</u>	<u>Increase</u> <u>from FY95</u> <u>to FY00</u>
Admissions	1,052	946	1,164	1,258	1,352	1,350	1,480	56%
Discharges	1,043	984	1,161	1,266	1,333	1,361	1,487	51%
Inpatient Days	35,144	23,208	23,382	25,403	25,421	26,205	23,260	0%
Highest Daily Census	112	72	71	91	84	88	80	
Lowest Daily Census	82	56	56	51	51	55	49	
Average Daily Census	96	54	64	70	70	72	64	
ALOS ***	21 (28)	15 (35)	13 (18)	13 (21)	13 (18)	13 (21)	10 (22)	

\* Following a substantive budget cut, API down-sized from 114 beds to 79 beds in late 1994.

\*\* As a part of the API 2000/Community Mental Health Project, following the placement of a number of long-term patients in a residential program operated through ASSETS in Anchorage, effective January 1, 2000, API reduced its bed capacity on its longer term patient unit (Kotmai) by five beds, thus reducing API's total bed capacity to 74.

\*\*\* "ALOS" means the *average length of stay* for a patient at API; the top number provided in this row *does not include* any patient at API whose stay exceeded six months. Patients with lengths of stay in excess of six months are generally treated on API's Kotmai Unit, where their complex treatment or placement needs, or their legal status, frequently require stays in excess of six months and often many years; it also will include any patient on API's Taku Unit whose treatment needs may require stays that extend beyond six months. The bottom number in parentheses in this row reflects a LOS that includes all patients, regardless of their length of stay at the hospital.

# ACMHSA

**Alaska Community Mental Health  
Services Association  
3050 Fifth Avenue  
Ketchikan, Alaska 99901**

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March 26, 2001

Senator Pete Kelly  
Capitol Room 518  
Juneau, Alaska 99811

Re: SB 154

Dear Senator Kelly,

The Alaska Community Mental Health Services Association (ACMHSA) supports your legislation SB 154 which repeals the sunset for the DET program.

ACMHSA is a statewide association representing all of the non-profit mental health providers in the state. We support this legislation and commend your leadership with this important mental health issue.

Sincerely,



Ron Adler  
President

---

Ron Adler, Chair  
Brenda Knapp, Treasurer

Pete Braveman, Vice Chair  
At-Large: Bill Hogan, Doug Veit

Diana Strzok, Secretary

---

Phone: (907) 225-4135

FAX: (907) 247-4135

e-mail: [rona@city.ketchikan.ak.us](mailto:rona@city.ketchikan.ak.us)

Amendment  
Rep Stevens

Page 2, following line 12:

Insert a new subsection to read:

“(d) It is the intent of the legislature that the Department of Education and Early Development, through its existing federally required monitoring program of district special education programs, review the potential for an individualized education program team’s inappropriate lowering of individualized education program goals and objectives for the purpose of providing a diploma to a student who has not achieved the state performance standards to the maximum extent practicable and take appropriate corrective action.”

Page 3, lines 10-19:

Delete all material and insert:

(1) a student who is a child with a disability and who does not achieve a passing score on the examination required under (a) of this section is eligible to receive a diploma if the student successfully completes an alternative assessment program required by the student’s individualized education program or required in the education plan developed for the student under 19 U.S.C. 794; an alternative assessment program must, to the maximum extent possible, conform to state performance standards established for the competency examination required under (a) of this section;”

Page 4, following line 7:

Insert new subsections to read:

“(f) A student shall receive an endorsement on the student’s diploma and transcript identifying the areas of the examination successfully passed.

(g) The department shall by regulation establish uniform standards for an alternative assessment program required under (c)(1) of this section. The alternative assessment program under (c)(1) of this section may not be changed after February 1 of the student’s junior year of study.”

Page 7, lines 16-18

Delete





# Alaska State Legislature

*Session:*  
State Capitol  
Juneau, AK 99801  
Phone: (907) 465-2327  
Fax: (907) 465-5241



*Interim:*  
119 N. Cushman  
Fairbanks, AK 99701  
Phone: (907) 456-8161

Senator Pete Kelly  
District P

## SB154

“An Act relating to mental health treatment facilities; repealing the termination date of the mental health treatment assistance program; and providing for an effective date.”

SB154 would repeal the sunset clause on a bill that passed in 1999 that created the Designated Evaluation Program. This program provides treatment through local hospitals for people who are in mental crisis. These individuals are working poor people who have no insurance or Medicaid coverage, who cannot afford hospitalization and who meet certain eligibility requirements.

If the sunset clause is not repealed, the following will be lost:

- Description of application, application review and appeal procedures
- Authorization of the department to establish eligible services and reimbursement rates
- Description of procedures for payment for the services provided
- Clarification of language and definitions to accurately reflect statutory intent
- Clarification of the responsibilities of the Department
- Language that establishes who is eligible for assistance for inpatient services:
  - Individuals who meet criteria for commitment under current statutes (i.e. danger of harming self or others or gravely disables as a result of mental illness, and is likely to improve with treatment)
  - Individuals whose household income is below 185% of federal poverty guidelines for Alaska and who have no other third party payer

SB 154 would remove the sunset clause and extend the program indefinitely. Without this change, individuals in need of treatment would have to be transported to Alaska Psychiatric Institute or held in correctional facilities.

Without this bill, all of this is due to sunset July 1, 2001, sending the program back to it's original vague and problematic state.

# Alaska State Legislature

*Session:*  
State Capitol  
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*Interim:*  
119 N. Cushman  
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Phone: (907) 456-8161

Senator Pete Kelly  
District P

## Senate Bill 154 Sectional Analysis

“An Act relating to mental health treatment facilities; repealing the termination date of the mental health treatment assistance program; and providing for an effective date.”

This bill repeals the sunset clause for the Designated Evaluation and Treatment program (DET).

**Section 1.** of the bill repeals the sunset provisions Sections 2, 4, 6, and 9 of ch. 87 SLA 1999. Those current sections that would be removed cover:

- the clarification of liability for expenses of placement in a treatment facility, (Section 2.)
- the clarification of the definition of “designated treatment facility”, (Section 4.)
- clearly defines the eligibility and procedures of the DET program. (Section 6.):
  - Applicability
  - Eligibility for assistance
  - Application for assistance
  - Decision on eligibility
  - Eligible services rates
  - Payment
  - Appeal
  - Regulations
  - Definitions
- Established an effective date of sunset as July 1, 2001 (Section 9.)

**Section 2** of this bill causes the repeal to take effect immediately.

If the sunset occurs, then it reinstates the vague language that led to confusion and inconsistencies in managing the program. These problems led to a lawsuit which prompted the statutory change.

**HB**

**239**

# Alaska House of Representatives

Richard Foster  
P.O. Box 1630  
Nome, AK 99762  
907-443-5036  
Fax 907-2162



During Session  
State Capitol Rm. 410  
Juneau, AK 99801-1182  
907-465-3789  
Fax 907-465-3242

## Majority Whip

### HB 239

#### An Act establishing a pilot program for a regional learning center

#### Sponsor's Statement

The Twenty-first Alaska Legislature through the Legislative Budget and Audit Committee (LB&A) hearings found indications of broad support for regional learning centers. Several communities have expressed interest in creating regional boarding programs focused on the special interests of their region.

The LB&A meeting in Nome helped create a renewed interest in the possibility of a regional boarding school that would teach vocational skills and other job related and living skills that are not available in the high schools of small isolated communities.

The Bering Strait School District and the Nome City School District have been exploring the feasibility of a cooperative program that would utilize the existing Nome Beltz School complex to develop and operate a pilot regional learning program.

The Bering Strait School Board and the Nome Common Council have both taken actions to support the creation of a pilot program and to seek federal funding to help cover program planning and initial operation costs.

A conceptional overview of the program is contained in the March 20, 2001 from, Dr. John Davis, Superintendent of the Bering Strait School District.

### Fiscal Analysis of HB 239

1) Provides for 2 full time house parents.	\$120,000
2) 1 Program Coordinator	75,000
3) Transportation for students 20 student X 40 units X \$300	60,000
4) Food	<u>56,000</u>
20students X 40 units X 7 days X \$10	\$311,000



Health, Education, and Social Services Committee  
Alaska State Legislature  
House of Representatives

We the undersigned agree to waive HB 239; An Act relating vocational education pilot program from House Health, Education, and Social Services Committee.

Date: April 25, 2001

Representative Fred Dyson, Chair

Handwritten signature of Fred Dyson in cursive, written over a horizontal line.

Representative Peggy Wilson, Vice Chair

Handwritten signature of Peggy Wilson in cursive, written over a horizontal line.

Representative Sharon Cissna

Handwritten signature of Sharon Cissna in cursive, written over a horizontal line.

Representative John Coghill

Handwritten signature of John Coghill in cursive, written over a horizontal line.

Representative Reggie Joule

Handwritten signature of Reggie Joule in cursive, written over a horizontal line.

Representative Vic Kohring

A horizontal line with a faint, illegible signature written over it.

Representative Gary Stevens

Handwritten signature of Gary Stevens in cursive, written over a horizontal line.