Report of Final Findings and Recommendations

By The

Technical Committee for the Review of the Application for a Change in Scope of Practice by the Nebraska Optometric Association

To The

Director of Health and the Nebraska Legislature

December 20, 1985

The members appointed by Gregg F. Wright, M.D., M.Ed., Director of Health, to serve on the Vision Care Credentialing Review Technical Committee are as follows:

Julie Brown-Arfmann, D.D.S. - Chair, Member of Board of Health (Gering)

Charles E. Baasch, F.N.A.O. - optician, private practice (Grand Island)

Carol Barr - consumer member (York)

David Brown, Ph.D. - Chairman, Department of Oral Biology and Director of Research, UNMC Dental School (Lincoln)

John T. Ramsell, M.D. - ophthalmologist, private practice (Omaha)

Edmund Schneider, O.D. - optometrist, private practice (Lincoln)

Bernard Wilson, R.Ph. - pharmacist, private practice (Omaha)

Summary of the Committee's Recommendations

The committee rejected the proposal as submitted by the Nebraska Optometric Association for review by a vote of 3 in favor and 4 against. Instead, the committee recommended by a vote of 4 to 2 with one abstention the adoption, with amendments, of the original version of LB 131 which proposed that optometrists be certified to use only topical drugs for treatment of minor eye disease. Recommended changes included:

1. An amendment with wording that specifically excludes the treatment of glaucoma from LB 131.
2. Stipulations for implementation of LB 131 (See pp. 13, 14).

The committee discussed but did not adopt amendments that would have created a list of practices and topical agents that optometrists would have been prohibited from using. The vote was 2 in favor, 4 against and one abstention.

Introduction

The Nebraska Credentialing Review Program, established by the Nebraska Regulation of Health Professions Act (LB 407), is a review process advisory to the Legislature which is designed to assess the necessity of state regulation of health professions in order to protect the public health, safety, and welfare.

The law directs those health occupations seeking credentialing or a change in scope of practice to submit an application for review to the Director of Health. At that time, an appropriate technical committee is formed to review the application and make recommendations after a public hearing is held. The recommendations are to be made on whether the health occupation should be credentialed according to the three criteria contained within Section 21 of LB 407; and if credentialing is necessary, at what level. The relevant materials and recommendations adopted by the technical committee are then sent to the Board of Health (after 1985) and the Director of Health for their review and recommendations. All recommendations are then forwarded to the Legislature.

In order to accommodate the health occupations that submitted credentialing legislation in the 1985 session, priority has been given to them so that they may complete the review process before the 1986 legislative session. This accommodation has resulted in a shortened review process in which the technical committee recommendations are sent directly to the Director of Health, bypassing the Board of Health for 1985.

Summary of the Proposal

The Nebraska Optometric Association seeks an expanded scope of practice for optometrists in the State of Nebraska. According to the proposal, the expanded scope of practice would come from the use of pharmaceutical agents in the treatment of the human eye, adnexa, and vision system. The pharmaceutical agents used for therapeutic purposes would include topical and oral antimicrobal agents, topical and oral antihistamines, topical and oral antiglaucoma agents, topical anti-inflammatory agents, and oral analgesic agents. In addition, the proposal provides for the removal of superficial foreign bodies from the human eye and adnexa by appropriately credentialed optometrists. Nothing in the proposal permits optometrists to engage in surgery. Existing law in the State of Nebraska allows optometrists to use pharmaceutical agents for diagnostic purposes only.

Under the proposal, an optometrist may be licensed to use pharmaceutical agents for diagnostic purposes, therapeutic purposes, or both. An optometrist could not engage in the use of pharmaceutical agents for therapeutic purposes until he/she submits to the Board of Examiners in Optometry evidence of satisfactory completion of all educational requirements established by the State Department of Health and has been certified by the State Department of Health as qualified to use pharmaceutical agents for therapeutic purposes. The proposal does not affect those optometrists who are previously licensed to use pharmaceutical agents for diagnostic purposes.

Overview of Committee Proceedings

The Vision Care Credentialing Review Technical Committee first convened on August 1, 1985, in Lincoln at the State Office Building. An orientation session given by the staff focused specifically on the role, duties, and responsibilities of the committee under the credentialing review process. Other areas touched upon were the charge to the committee, the three criteria for credentialing contained within Section 21 of LB 407, and potential problems that the committee might confront while proceeding through the review.

The second meeting of the committee was held on August 22, 1985, in Lincoln at the State Office Building. After study of the proposal and relevant material compiled by the staff and submitted by interested parties between the meetings, the committee formulated a set of questions and issues it felt needed to be addressed at the public hearing. Contained within these questions and issues were specific requests for information that the committee felt was needed before any decisions could be made.

The committee reconvened on September 20, 1985, in Lincoln at the State Office Building for the public hearing. Proponents, opponents, and neutral parties were given the opportunity to express their views on the proposal and the questions and issues raised by the committee at their second meeting. Seven people spoke in favor of the proposal and seven spoke in opposition to it. Interested parties were given ten days to submit final comments to the committee.

The committee met for the fourth time on October 10, 1985, in Lincoln at the State Office Building. After studying all of the relevant information concerning the proposal, the committee then formulated its recommendations. The three criteria found in Section 21 of LB 407 formed

the basis for the discussion. The following "standards" have been developed in order to better adapt the criteria to the needs of a scope of practice proposal.

Standard 1

Current practice can clearly harm or endanger the health, safety, or welfare of the public, and the potential for the harm is easily recognizable and not remote or dependent upon tenuous argument.

Information Provided by the Applicant Group

The proponents state that adequate care for primary eye disease is not available in many towns and communities of Nebraska due to restrictions placed upon Doctors of Optometry by current statutes. The treatment of eye disease is exclusively being done either by ophthalmologists or by general practice physicians. This situation creates a hardship for the public in the form of loss of time from work and the cost of office visits to a secondary or tertiary provider. There are fewer ophthalmologists than optometrists, and most of the former reside in either Lincoln or Omaha. According to the data provided by the proponents, 49 of the 67 ophthalmologists reside in either Lincoln or Omaha. However, only 60 of Nebraska's 214 optometrists are located in either of these two metropolitan areas. (Appendix 28 of the Application.)

The current situation also has implications for the cost of primary eye care services. The current monopoly on primary eye care by the medical profession artificially limits the number of primary eye care providers available to the people of Nebraska, which in turn drives up the cost of eye care. The proponents cite evidence that the fees charged by

optometrists are significantly lower than are those charged by ophthalmologists. (Appendix 18 of the Application.)

Proponents presented evidence which indicated that HMOs could reduce costs if optometrists rather than ophthalmologists were used to provide primary eye care. (Appendix 33 of the Application.)

The proponents also cited evidence from North Carolina, a state which has passed legislation similar to LB 131, that suggests that the passage of the proposal would not have a significant impact on the cost of malpractice insurance. (The testimony of John D. Robinson, O.D. at the public hearing of the Vision Care Technical Committee.)

The proponents state that the availability of general practitioners does not necessarily alleviate these problems, since many general practitioners are not as well equipped to treat eye diseases as are optometrists. They present evidence which shows that there has been decreased emphasis on training programs relevant to eye disease in medical schools in recent years. (The AUPO Symposium) In summary the proponents feel that the existence of a monopoly in eye care delivery by the medical profession causes inconvenience and economic harm. (pp. 22 to 25 of the Application.)

Information from Other Sources

The opponents of this proposal state that the availability of medical doctors qualified to treat most diseases of the eye far exceeds that of optometrists in Nebraska. There are 63 ophthalmologists in Nebraska, as well as 547 general practitioners, 199 practitioners of internal medicine, and 102 pediatricians, all of which are qualified to treat diseases of the eye. According to Health Department data from the Board of Optometric Examiners, as of August, 1985, 151 of 214 Nebraska optometrists are

certified to use diagnostic eye drops. The opponents believe that these figures demonstrate that the citizens of Nebraska are well served by the current eye care delivery system. (Appendix 1 of the NMA Response to the Application.)

The opponents state that there is no evidence to support the contention that this proposal would lower the cost of treatment of eye disease, and offer as evidence an overview of eye care costs in states that have passed proposals similar to this one. Data from Iowa was presented to refute the proponents' statement that the average fee per service is 45 percent higher when performed by ophthalmologists than by optometrists. Opponents presented evidence to suggest that costs of routine vision examination services are higher when provided by optometrists who also dispense glasses than when provided by ophthalmologists plus opticians. Data from West Virginia suggests that 97 percent of Medicaid patient services by optometrists involve routine functions, rather than treatment of eye diseases. This, according to opponents, indicates that there are not likely to be substantial cost savings from expanding optometrists' scope of practice as proposed. (pp. 12 & 13 of the NMA Response to the Application of the Optometrists.)

Information from North Carolina suggests that there is in fact little difference between the fees of optometric eye care and that provided by an ophthalmologist. However, North Carolina data does suggest that the cost of malpractice insurance for optometrists increases substantially when their scope of practice is expanded to include the treatment of eye diseases. In North Carolina malpractice insurance rates have doubled since 1980, which cannot all be accounted for by inflation. Some of it is due to the greater risk that optometrists have taken on as a result of the

expansion of their scope of practice. (pp. 109 & 110 of the Transcript of the Public Hearing of the Vision Care Technical Committee.)

The opponents of the proposal also state that the training of medical students is such that any general practitioner has more qualifications to treat eye disease than do most optometrists.

Standard 2

The change in scope of practice proposed can clearly harm or endanger the health, safety, or welfare of the public, and the potential for the harm is easily recognizable and not remote or dependent upon tenuous argument.

Information Provided by the Opponents

The opponents of the proposal argue that there is great potential for harm in the proposed change in the scope of practice of optometry. They state that optometric education and clinical experience are too narrow to qualify optometrists to treat eye diseases of any kind. Optometrists, they say, lack sufficient training in general medicine to fully appreciate the potential impact of topical (or oral) eye drugs on the human body as a whole. It is not enough to be knowledgeable about the human eye. A practitioner who treats eye disease must be aware of the possible negative impacts of eye drugs not only on the eye itself, but on the entire body as well. (pp. 72-77 of the Transcript of the Public Hearing of the Vision Care Technical Committee).

The opponents of the proposal state that the education of optometrists is focused too narrowly upon the eye itself to enable them to engage in the treatment of diseases, something which requires a knowledge of wholistic medicine. There is, in the view of the opponents, a vast body of knowledge

and experience that an ophthalmologist has and an optometrist does not, and which may be crucial to treating eye disease. Even ophthalmologists who have had an internship and three or four years in specialized treatment of eye disease have difficulties with the treatment of eye disease. Optometrists with much less wholistic medical training than medical students will certainly have far greater problems in the diagnosis and treatment of such diseases. (pp. 94-98 of the Transcript of the Public hearing of the Vision Care Technical Committee).

The opponents state that even the training at the best schools of optometry is not sufficient to serve as a basis for the treatment of eye disease. Uniform standards and minimum requirements for training on a national basis for optometrists are nonexistent. Each school sets its own standards, with only general guidelines provided by the Council on Optometric Education of the American Optometric Association. However, at even the best schools, the number of hours of clinical training is inadequate, and does not begin to compare with the hours of clinical experience at medical schools. In addition, most of the patient visits to optometric centers are unrelated to the diagnosis and treatment of disease, whereas the opposite is the case in schools where ophthalmologists are trained. (pp. 98-101 of the Transcript of the Public hearing of the Vision Care Technical Committee).

In summary, the opponents of the proposal believe that there is potential harm to the public inherent in the proposal to extend the scope of practice of optometrists to include the treatment of eye diseases.

Information Provided by the Proponents

The advocates of the proposed change in scope of practice state that the best schools of optometry are prepared to provide their students with

the necessary medical and clinical training to enable them to treat minor eye diseases competently. Optometric educational programs are structured very similarly to any other health care profession's programs. Optometry students receive the same basic science education as that of a dentist or a podiatrist. In addition, optometry students receive more ocular pharmacology than any other health professional at the undergraduate level because they treat and diagnose eye disease. Furthermore, optometry schools teach courses that put eye disease into a broad medical context. Their students are taught to be aware of the ocular implications of systemic diseases, even though they are not being taught to treat systemic diseases themselves. (pp. 16-20 of the Transcript of the Public Hearing of the Vision Care Technical Committee).

The proponents also stress the merits of their clinical training programs. Clinical training in optometry begins during the first year, although at that time it may be limited to observation. By the time the student is in his third or fourth year, the clinical training becomes the most important component of education. The entire fourth year is often entirely clinical training. This clinical training is described by the proponents as being more extensive than that of any other primary health care provider. As in medicine, an externship program is an integral part of the clinical training at many schools and colleges of optometry. Optometry students rotate through such settings as private ophthalmological offices, ophthalmological clinics, HMOs, and hospitals, gaining access to a wide variety of clinical experiences. (pp. 20 and 21 of the Transcript of the Public Hearing of the Vision Care Technical Committee).

The proponents make comparisons between their educational programs on the one hand, and those of dentists, podiatrists, and general medicine, on

the other. In their view, optometric training equals or exceeds that of dentists and podiatrists in all areas, especially in the area of pharmacology and ocular pharmacology. They go on to say that most medical students receive little exposure to ophthalmology. A significant number of physicians graduate without ever having been formally taught how to examine an eye or to manage common ocular problems. (pp. 23 and 24 of the Transcript of the Public hearing of the Vision Care Technical Committee).

In summary, the proponents state that their proposed change in scope of practice will not harm the public. They state that the education of optometrists is as good or better than that of comparable professions that already use drugs to treat minor ailments. In some cases, the optometrist's training better prepares him to treat eye diseases than does that of the general medical practitioner.

Committee Findings and Recommendations

The committee decided to reject the proposal of the Optometric Association by a vote of 4 to 3.

The committee decided to recommend adoption of the current language of LB 131, with proposed amendments by a vote of 4 to 2 with one abstention. This bill differs from the proposal in that it includes only the use of topical drugs, not oral drugs, by optometrists.

The committee recommended that treatment of glaucoma by optometrists not be permitted in LB 131.

The committee also recommended the following stipulations for implementation of LB 131 by the Department of Health and the Board of Examiners in Optometry by a vote of 4 to 0.

1. With regards to optometrists currently practicing in the state, before they may individually use pharmaceutical agents for therapeutic purposes, each of the following educational requirements must be met:
   A. They must have taken and passed the 100+ hour Pennsylvania College of Optometry course or its approved equivalent;
   B. They must have taken and passed the 34+ hour Southern California College of Optometry course or its approved equivalent; and
   C. They must take and pass all of the following additional educational requirements which are to be provided by approved optometry colleges or other approved institutions with approved clinical facilities. (Private offices of ophthalmologists are not intended to be considered as approved institutions or facilities.)
      1. 40 additional didactic hours on the use of pharmaceutical agents for therapeutic purposes.
      2. 20 hours of clinical grand rounds provided at approved institutions.
      3. 40 hours of clinical preceptorship training at approved institutions.
2. In regards to optometrists graduating after LB 131 becomes effective:
   A. They shall be allowed to use pharmaceutical agents for therapeutic purposes only if they meet all of the following criteria:
      1. They have passed all sections of the state board examination and the national board examination, both of which shall include a section on therapeutic use of pharmaceutical agents.

2. They have passed all other requirements of the state board.
3. They have graduated from an optometry college the dean of which has declared, in writing, that its graduates are qualified to use pharmaceutical agents for therapeutic purposes as described in LB 131.

B. If a new graduate of an optometry college does not meet the criteria listed in part A immediately above, he/she shall be required to take and pass the additional educational requirements described in Section 1, C, 1-3 above, before using pharmaceutical agents for therapeutic purposes.

The proposal was rejected primarily because a majority of committee members perceived that use of oral drugs by optometrists represented potential harm to the public health and welfare.

The committee discussed but did not adopt amendments that would have created a list of practices and topical agents that optometrists would have been prohibited from using. The vote was 2 in favor, 4 against, and one abstention.