Information Summary and Recommendations

Optometry Scope of Practice Sunrise Review

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THE SUNRISE REVIEW PROCESS

A sunrise review is an evaluation of a proposal to change the laws regulating health professions in Washington. The legislature's intent, as stated in Chapter 18.120 RCW, is to permit all qualified people to provide health services unless there is an overwhelming need for the state to protect the interests of the public by restricting entry into the profession. Changes to the scope of practice should benefit the public.

The purpose of the Sunrise Act, RCW 18.120.010, is to "establish guidelines for the regulation of health professions not licensed or regulated prior to July 24, 1983, and those licensed or regulated health professions which seek to substantially increase their scope of practice." Section two goes on to say a health care profession should be regulated by the state only when:

- Unregulated 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;
- The public needs and can reasonably be expected to benefit from an assurance of initial and continuing professional ability; and
- The public cannot be effectively protected by other means in a more cost-beneficial manner.

There are no corresponding criteria for the evaluation of a proposal to substantially increase a profession's scope of practice. The Department of Health has adapted these stated criteria to proposed scope of practice expansions. Although they may not exactly match the circumstances of a scope expansion, the department presumes the legislature intended this use by including scope expansions in the same statute as regulation of new professions.

If the legislature identifies a need and finds it necessary to regulate a health profession not previously regulated, it should select the least restrictive alternative method of regulation, consistent with the public interest. Five types of regulation may be considered as set forth in RCW 18.120.010(3):

1. *Stricter civil actions and criminal prosecutions.* To be used when existing common law, statutory civil actions and criminal prohibitions are not sufficient to eradicate existing harm.
2. *Inspection requirements.* A process enabling an appropriate state agency to enforce violations by injunctive relief in court, including, but not limited to, regulation of the business activity providing the service rather than the employees of the business, when a service being performed for people involves a hazard to the public health, safety or welfare.
3. *Registration.* A process by which the state maintains an official roster of names and addresses of the practitioners in a given profession. The roster contains the location, nature and operation of the health care activity practices and, if required, a description of the service provided. A registered person is subject to the Uniform Disciplinary Act, Chapter 18.130 RCW.
4. *Certification.* A voluntary process by which the state grants recognition to a person who has met certain qualifications. Non-certified people may perform the

same tasks, but may not use "certified" in the title. A certified person is subject to the Uniform Disciplinary Act, Chapter 18.130 RCW.

5. *Licensure.* A method of regulation by which the state grants permission to engage in a health care profession only to people who meet predetermined qualifications. Licensure protects the scope of practice and the title. A licensed person is subject to the Uniform Disciplinary Act, Chapter 18.130 RCW

EXECUTIVE SUMMARY

Proposal

The state association, the Optometric Physicians of Washington (OPW) (applicants), applied for sunrise review of Draft House Bill H-0931.2 that would significantly expand the scope of optometric practice. Proposed changes to current law include expanding the definition of the practice of optometry, allowing optometrists[1] to perform "office-based medical procedures," to administer injectable medications and to prescribe oral corticosteroids. In addition, the proposal would reduce the number of training hours to administer epinephrine from four hours to two hours.

The applicant's report cites several justifications for the proposed expanded scope of practice. In summary:

- To increase access to affordable and quality eye care to potentially underserved populations.
- To coincide with the level of education and training optometrists already receive.
- To clarify outdated and unclear provisions of RCW 18.53.010, which defines the scope of optometric practice.
- To provide patients with treatment options.
- To provide a brighter line regarding scope of practice, thus reducing denials made by insurance companies to patients' claims
- To reduce consumer costs by allowing optometrists to perform more services rather than patients having to consult ophthalmologists.

Recommendations

The scope of practice for optometry was last updated by the legislature in 2003. At that time, optometrists were allowed to use an expanded list of medications subject to a strict educational plan in the legislation. However, certain drugs and procedures were specifically excluded. Several of those exclusions are now included in this proposal. The department does not believe the applicants have provided sufficient justification to change the 2003 legislation.

The department's mission is to protect and improve the health of the citizens of Washington State. In addition, the department must consider the criteria set out in chapter 18.120 RCW when reviewing a sunrise proposal. Based on those two considerations, the department makes the following recommendations regarding the proposal:

The department supports the following changes:

- RCW 18.53.010(1)(b) explicitly stating that optometrists may dispense eyewear including cosmetic lenses.
- RCW 18.53.010(2)(d) reducing the hours of didactic and supervised clinical instruction for the injection of epinephrine to treat anaphylactic shock from four hours to two hours.
- RCW 18.53.010(3) allowing optometrists to provide free drug samples to patients.

The department does not support the following changes:

- RCW 18.53.010(1) expanding the definition of the practice of optometry.
- RCW 18.53.010(1)(e) allowing office-based medical procedures.
- RCW 18.53.010(2)(e) allowing optometrists to use injectable drugs.
- RCW 18.53.010(4) allowing optometrists to prescribe oral corticosteroids.

[1] The applicants prefer the title "optometric physicians." For purposes of this report, the more traditional title "optometrist" is used. No disrespect is intended.

Please refer to the "Detailed Recommendations" section of this report for a full the discussion of the department's position.

SUMMARY OF INFORMATION

Background and Proposal for Sunrise Review

The scope of practice overlaps for different licensed eye care professionals. This has historically created confusion for the public regarding the differences between ophthalmologists, optometrists and opticians. Ongoing changes to the scopes of practice for these professions have further blurred the lines between them.

While reviewing proposed changes within these professions, balance must be maintained between public safety, need for increased services and access to affordable care in a highly competitive industry.

In April 2009, the House Health Care and Wellness Committee referred Draft House Bill H-0931.2 to the department for sunrise review. According to the applicants, changing the definition of the practice of optometry and setting the criteria for office-based medical procedures, do not expand, but rather clarify the scope of practice by creating a bright-line test to determine which medical procedures are within an optometrist's scope of practice. They characterize the changes as providing clear direction regarding procedures and rectifying misinterpretation by the public or regulatory bodies without changing the prohibition against ophthalmic surgery in the current statute.

In addition, the applicants state these changes would clarify the statutory authority for some existing areas of care that are ambiguous to insurance companies. They assert that insurers sometimes deny payment for covered services the insurers think are outside the scope of practice of optometry.

The department interprets the draft bill as containing several proposals that would individually and collectively expand the current scope of the practice of optometry.[2] Significant changes include:

- Expanding the definition of the practice of optometry.
- Allowing "office-based medical procedures."
- Allowing the use of injectable medications.
- Allowing the prescription of oral corticosteroids.

The applicants also believe the proposed changes to the optometrist scope of practice are necessary to promote accessible and affordable health care to the public. The applicants emphasize that the number of Washington optometrists (about 1,000) compared to the number of Washington ophthalmologists (about 670) results in optometric services being more readily available to the public, particularly those living in rural and less populated areas. The applicants argue that an expansion of practice is necessary to keep that accessibility meaningful to the public.

[2] Prior to the public hearing, the applicants announced they would not pursue the proposed provision regarding low vision rehabilitation services contained in the draft bill. Consequently, that provision will not be addressed in this review.

In response, opponents to the proposal submitted a chart showing that of the about 1,000 optometrists in Washington; only 10 are located outside a 30-mile service area buffer for an ophthalmologist (see appendix H). They allege that optometrists are not significantly more geographically accessible than ophthalmologists.

Public Participation and Hearing

The department received the sunrise application from the applicants in July, 2009 (see appendix A) and follow-up information in early August (see appendix C). Staff members shared the application with interested parties and began accepting comments on the proposal July 13, 2009. Twelve optometrists, three physicians, and two others submitted comments in support of the proposal. Many agreed this bill would improve access and efficiency for eye care, and that optometrists are fully trained to perform these additional tasks. In addition, the North Carolina Optometry Board wrote in favor of the proposal, stating it has 30 years of experience with a similar scope of practice with no serious incidents. A few colleges of optometry wrote that their programs provide adequate training to cover the proposed scope of practice.

The department received comments in opposition to the proposal from 31 physicians and physician associations, and three others, stating optometry training is inadequate to prepare them to perform the additional procedures, especially because optometrists lack the intensive clinical training ophthalmologists receive. Many wrote that this is not a clarification of optometrists' scope of practice, but a large expansion into ophthalmic surgery and high-risk procedures. (See Appendix E for summary of written comments.)

Opticians and some other professional associations expressed serious concerns about the low-vision rehabilitation section. Subsequently, the applicants withdrew this section of the proposal. The opticians have also questioned whether other parts of the proposal, such as dispensing plano (no corrective power) and cosmetic contact lenses, affect the optician scope of practice.

A public hearing was held on August 10, 2009, in Tumwater, Washington. Members of the public were invited to give testimony. (See Appendix D for hearing summary). Thirty-eight people attended. Eighteen signed in and/or testified in favor of the proposal. A majority of those in favor were optometrists. Eighteen signed in and/or testified in opposition to the proposal for similar reasons as those who provided written comments. A majority of those in opposition were physicians, with a few other health professionals and associations included. Two people signed in without indicating a position on the proposal.

Following the public hearing, there was a 10-day comment period and another period for rebuttals following release of the draft report.

Current Regulation and Practice

Chapter 18.53 RCW governs the practice of optometry. The proposed bill affects RCW 18.53.010 Definition – Scope of Practice. The current definition is:

> (1) The practice of optometry is defined as the examination of the human eye, the examination and ascertaining any defects of the human vision system and the analysis of the process of vision. The practice of optometry may include, but not necessarily

be limited to, the following:

(a) The employment of any objective or subjective means or method, including the use of drugs, for diagnostic and therapeutic purposes by those licensed under this chapter and who meet the requirements of subsections (2) and (3) of this section, and the use of any diagnostic instruments or devices for the examination or analysis of the human vision system, the measurement of the powers or range of human vision, or the determination of the refractive powers of the human eye or its functions in general; and

(b) The prescription and fitting of lenses, prisms, therapeutic or refractive contact lenses and the adaption or adjustment of frames and lenses used in connection therewith; and

(c) The prescription and provision of visual therapy, therapeutic aids, and other optical devices; and

(d) The ascertainment of the perceptive, neural, muscular, or pathological condition of the visual system; and

(e) The adaptation of prosthetic eyes.

Section two of the statute sets parameters for the use of drugs in an optometric practice. An optometrist can currently use or prescribe topical or oral drugs for diagnostic or therapeutic purposes. Epinephrine may be injected for the treatment of anaphylactic shock. Section seven specifically prohibits the administration of any other injection or infusion by an optometrist.

Section four prohibits an optometrist from using, prescribing, dispensing, or administering oral corticosteroids.

Section eight states:
Nothing in this chapter may be construed to authorize optometrists to perform ophthalmic surgery. Ophthalmic surgery is defined as any invasive procedure in which human tissue is cut, ablated, or otherwise penetrated by incision, injection, laser, ultrasound, or other means, in order to: Treat human eye diseases; alter or correct refractive error; or alter or enhance cosmetic appearance. Nothing in this chapter limits an optometrist's ability to use diagnostic instruments utilizing laser or ultrasound technology. Ophthalmic surgery, as defined in this subsection, does not include removal of superficial ocular foreign bodies, epilation of misaligned eyelashes, placement of punctal or lacrimal plugs, diagnostic dilation and irrigation of the lacrimal system, orthokeratology, prescription and fitting of contact lenses with the purpose of altering refractive error, or other similar procedures within the scope of practice of optometry.

Prior Changes to the Scope of Practice

In 1994, the legislature passed the Consumer Access to Vision Care Act, recognizing the potential for confusion in the vision care industry caused by overlapping scopes of practice among providers. In addition, the legislature recognized that the risk of losing a balance between public safety and access to affordable care is high in this industry due to competitive pressures. This Act clarified necessary prescription content and ensures prescriptions are released to the patient (Chapter 18.195 RCW).

The 2003 legislature expanded optometrists' prescriptive authority for topical drugs, and added limited use of oral Schedule III and V controlled substances and oral legend drugs as

approved by the Board of Pharmacy. The 2003 legislation specifically excluded oral corticosteroids, as well as injections or infusions. It also added the current definition of ophthalmic surgery and the prohibition against optometrist performing such surgeries.

In 2004, the Federal Trade Commission passed Title 16, Part 315 to implement the Fairness to Contact Lens Consumers Act, codified at 15 U.S.C. 7601–7610. Title 16 addresses the release, verification, and sale of contact lens prescriptions.

On November 9, 2005, the Federal Food, Drug, and Cosmetic Act established that all contact lenses, including cosmetic or plano lenses, are regulated as medical devices and require a prescription.[3]

REVIEW OF PROPOSAL USING SUNRISE CRITERIA

The Sunrise Act RCW 18.120.010(2) suggests that the scope of a profession's practice should be expanded only when:

> (a) Unregulated 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;
>
> (b) The public needs and can reasonably be expected to benefit from an assurance of initial and continuing professional ability; and
>
> (c) The public cannot be effectively protected by other means in a more cost-beneficial manner.

First criterion: Unregulated practice can harm or endanger health or safety.

This criterion does not apply to the proposal.

Optometry is currently a thoroughly regulated profession. The proposal expands the practice into areas now primarily reserved for physicians, another highly regulated profession. The public's health is not at risk of harm or danger from unregulated practice.

Second Criterion: Public needs and will benefit from assurance of professional ability

The proposed legislation does not satisfy this criterion.

There is no challenge to the professionalism of optometrists or to the quality of care they provide their patients. Currently, there are adequate laws and rules in place to assure the public of optometrists' initial and continued professional ability. The proposed legislation does not contain similar assurances.

Under the current law, the procedures within an optometrist's scope of practice are succinctly stated in RCW 18.53.010(8). They are not allowed to perform ophthalmic surgery. A number of procedures are listed and defined as not being ophthalmic surgery. This list provides clarity regarding what is or is not within the scope of practice.

Under the proposal, all optometrists would be allowed to perform "office based medical procedures" if those procedures:

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[3] http://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/HomeHealthandConsumer/ConsumerProducts/ContactLenses/ucm062319.htm

- Are taught in accredited schools or colleges of optometry;
- Involve the eye or visual system, structures adjacent to the eye, or the proper functioning of the eye or visual system;
- Can be performed without penetration of the globe and without closure by suture;
- Can be performed without pharmaceutical agents or with only those pharmaceutical agents authorized for use by persons licensed under this chapter;
- Can be performed without conscious sedation, deep sedation, intravenous sedation, or general anesthesia;
- Are not lasik, photorefractive keratectomy, other laser refractive surgery, or cataract extraction; and
- Do not involve injection of medication beneath the posterior tenons capsule.

In essence, this is an all-inclusive list with only limited exceptions. An optometrist could conceivably do a limitless number of procedures as long as none of the narrow prohibitions were breached. This is in direct opposition to the current law which prohibits all ophthalmic surgeries except for a limited and well-defined list of allowed procedures.

The department does not believe this brief list of limiting events or conditions is sufficient to adequately or accurately inform practitioners, consumers or third party payors regarding the scope of practice for optometrists. The public would largely be on its own to determine whether an optometrist was acting within the proper scope. This would actually add to the confusion the public already experiences regarding the difference between an optometrist and an ophthalmologist and would create uncertainty where there is currently clarity.

Third criterion: Public protection can not be met by other means

The proposed legislation does not satisfy this criterion.

Public protection is already in place with the current scope of optometry practice. Additionally, the practices embodied in the proposed expansion are already authorized to be provided by other practitioners. The public is not being denied regulated services if the proposal is not granted.

DETAILED RECOMMENDATIONS TO LEGISLATURE

The department supports the following changes:

RCW 18.53.010(1)(b) allowing optometrists to dispense eyewear including cosmetic lenses.

Rationale: Quality assurance is of the utmost concern when it comes to eyewear. Sale of such devices without proper instruction, particularly for cosmetic lenses, can result in misuse that may lead to damage or infection of the eye. Allowing optometrists to dispense glasses and contact lenses (both corrective and cosmetic) promotes public health and safety.

RCW 18.53.010(2)(d) reducing the hours of didactic and supervised clinical instruction for the injection of epinephrine to treat anaphylactic shock from four hours to two hours.

Rationale: This educational requirement was established in 2003 when optometrists were first granted the authority to administer epinephrine by injection. Experience has shown that two hours are sufficient. In addition, this is consistent with the standard for other states.

RCW 18.53.010(3) allowing optometrists to provide free drug samples to patients.

Rationale: Allowing optometrists to provide patients with access to necessary medication while also alleviating or eliminating the cost of the medication provides a direct benefit to the patient. However, the department suggests a modification to the bill language to clarify that the samples provided may only be for drugs and conditions within the current authorization for optometry.

In addition, this section clarifies that an optometrist is not prohibited from dispensing or selling "ophthalmic devices such as contact lenses, which are classified by the federal food and drug administration as a drug." The term "ophthalmic devices" is not defined within the proposal or the existing statute. "Ophthalmic goods" is defined in the Consumer Access to Vision Care law as "eyeglasses or a component or components of eyeglasses, and contact lenses." The department suggests the applicants either use "ophthalmic goods" or provide a definition of "ophthalmic devices."

The department does not support the following changes:

RCW 18.53.010(1) expanding the definition of the practice of optometry.

Rationale: The proposed legislation expands the definition of optometry from the examination of the eye to the "examination, diagnosis, treatment, and management of disease or conditions of the human eye and adjacent structures." The additional language essentially allows optometrists to practice medicine as defined by RCW 18.71.011 ("...diagnose, cure, advise or prescribe for any human disease ...").

The department has the utmost respect for the rigorous academic and clinical training required to become a licensed optometrist. However, an optometrist's training is not functionally equivalent to an ophthalmologist's training. After earning a bachelor's degree, an ophthalmologist must complete medical school, an internship, and a residency. An ophthalmic physician is academically and clinically trained in all the body's systems and the full range of treatment options, including extensive training in pharmacology. (See appendix G for description of training programs.)

Note: Please see the next section for a discussion of the department's concerns regarding the vagueness of the term "adjacent structures."

RCW 18.53.010(1)(e) allowing office-based medical procedures.

RCW 18.53.010(8) currently prohibits optometrists from performing ophthalmic surgery. The proposed legislation keeps the words "nothing in this chapter may be construed to authorize optometrists to perform ophthalmic surgeries" but essentially removes the prohibition with very few restrictions. The current definition of ophthalmic surgery, with an enumerated list of approved procedures, should be retained.

Rationale:

- To qualify as an approved procedure, it must be taught in accredited optometry schools. There are 19 optometry schools in the United States. There are no optometry schools in Washington. Optometry schools, particularly those schools not subject to any regulatory authority by Washington State, should not dictate the scope of practice via their curricula. In addition, there is no guarantee that a particular procedure is taught in all schools of optometry across the United States. When optometrists were granted enhanced prescriptive authority in 2003, a specific statutory scheme was enacted to guarantee all practitioners had the necessary training and education to safely carry out this new scope of practice. The current proposal contains no such safeguards.
- The office-based procedure must be performed on the visual system or structures adjacent to the eye. The term "adjacent" is not defined in the proposed legislation. The applicants have stated the term was intended to be a plain language formulation of the term adnexa, which is defined as the appendages of the eye including the eyelids and lacrimal apparatus (the system that produces and drains tears). This clarification is not contained in the proposed bill. The Merriam-Webster On-Line Dictionary defines adjacent as "nearby" or "not distant." Common interpretation of the word "adjacent" could reasonably allow procedures to be performed on the area of the face from the eyebrow to the cheekbone and the nose bridge to the temple that have nothing whatsoever to do with the eye and its workings.
- Optometrists would not be allowed to perform lasik, photorefractive keratectomy, other laser refractive surgery, or cataract extraction. However, a variety of other laser surgeries would be authorized, such as repair of retinal tears and treatment of tear duct issues. It could be argued that even ocuplastic laser surgeries on eyelids would be permitted. While recognizing the value of the technological innovations available in healthcare professions, this leap from a complete prohibition on laser surgery approval of high volume procedures and puts the public at risk.
- An optometrist's training is not the functional equivalent of an ophthalmologist's training. Optometrists are not required to complete any post-graduate residency training. (See appendix G for description of training programs.)
- Based on the comments we received, there was confusion about what procedures could be performed under the criteria in the proposal. Rather than clarifying existing authority or creating the bright-line test asserted by the applicants, this section seems to add confusion.

- The limitation regarding whether the procedure can be performed "without closure by suture" also drew numerous comments. Many people thought this phrase lacked meaning because there are several alternatives to sutures such as butterfly strips, and adhesives such as glue and staples.
- The department also has concerns regarding the limiting phrase "can be performed without conscious sedation, deep sedation, intravenous sedation, or general anesthesia." In 2007, the legislature recognized the significant danger to the public when any type of sedation or anesthesia is administered. It passed HB 1414 (2007), which required licensure for ambulatory surgical facilities. It also authorized the Medical Quality Assurance Commission, Board of Osteopathic Medicine and Board of Podiatric Medicine to adopt rules governing the administration of sedation and anesthesia in providers' offices, including necessary training and equipment. The proposal contains no such assurances that optometrists will be adequately trained and equipped to provide sedation.

The department does believe the existing list of allowed procedures could be expanded in a way that both promotes patient safety and provides clear boundaries for all parties. For example, comments were provided regarding an optometrist who was disciplined by the Board of Optometry for draining a fluid-filled cyst with a needle, which involved penetrating human tissue in violation of RCW 18.53.010(8). Most optometrists believe this is clearly within their education and experience to perform. Adding this (and other similar procedures) to the allowed list in the existing law would be an alternative way to expand the scope of practice while still maintaining well-defined expectations for providers, patients and third-party payors.

The applicants believe adding to the existing list of specifically identified approved office procedures would result in a continuous cycle of returning to the legislature to approve more procedures. The department acknowledges that is possible but believes it is outweighed by the public protection afforded when each proposed expansion into the surgical field is given careful consideration.

The applicants and other supporters urge the department to rely on the individual optometrist's good judgment to determine what procedures he or she is able to perform with reasonable skill and safety. They make comparisons to physicians, who are able to practice the entire scope of medicine but choose to stay within one specialty and/or not perform services for which they lack skill. The department recognizes that this is true for physicians. However, all other regulated health professionals, including the dentists and podiatrists cited by supporters, have a legislatively mandated scope of practice. Allowing each practitioner to attempt any procedure he or she feels able to perform is not in the best interests of public safety.

In their rebuttal, the applicants state that the '[d]epartment's recommendation not to support this portion of the bill relies primarily on specific terms in the language that can be revised at this stage of the process." They are correct. The sunrise law requires the department to evaluate the specific bill language that accompanied the legislature's request for review. Department staff members remain willing to work with the applicants to craft alternative language.

Note: The applicants state that the proposed office-based procedures are similar to the procedures allowed in the bordering states of Oregon and Idaho, as well as similar scopes in Alaska, New Mexico, and Louisiana. However, the laws in these states are more specific as to what procedures are authorized.[4] The proposed legislation is too vague to do a proper comparison. In addition, the other states' laws all use the terms "adnexa" or "appendage," or specify "eye and/or eyelid," rather than using the undefined term "adjacent structures."

RCW 18.53.010(2)(e) allowing optometrists to use injectable drugs

Rationale: The prohibition against the administration of drugs by injection (with the exception of epinephrine for the treatment of anaphylactic shock) was specifically included in the 2003 scope of practice legislation.

Currently, five states allow optometrists to inject medications other than epinephrine for the treatment of anaphylaxis. Representatives from some of these states provided statements during the review process indicating no significant issues since adding injections to their scope of practice. Although this is a small percentage of states, it is notable that two of these border Washington – Oregon and Idaho. Testimony was presented at the hearing that this difference between neighboring states can cause confusion and inconvenience for practitioners and patients.

Unlike the 2003 bill allowing the expanded use of topical and oral drugs, the proposal does not require specific education or experience requirements for the administration of injections similar to what was specified in the 2003 bill. Instead, it requires the Board of Optometry to "adopt such rules to designate education or training requirements…The board may differentiate requirements based on the type of medication and the type of injection."

The applicant proposes what amounts to a tiered sorting of optometrists based on the type of medication to be injected or the type of injection and leaves it to the Board of Optometry to determine the education and training requirements for each tier. There is no system of certification, accreditation, or endorsement required. This puts patients in the difficult position of having to determine on their own whether an optometrist is qualified to be administering various drugs by various means.

Note: The department supported a 1996 sunrise proposal to add prescriptive authority for injectable medications. That proposal included an additional 20 hours of didactic and clinical instruction in addition to the 135 hours that was added to qualify for prescriptive authority for topical and oral medications, as discussed above.[5]

RCW 18.53.010(4) allowing optometrists to prescribe oral corticosteroids.

Rationale: About half of all states allow optometrists to use oral corticosteroids. Washington currently has a specific prohibition against their use by optometrists. This prohibition was included in the same law that authorized the use of other drugs in 2003. Clearly, the intent of the legislature was not to allow use of this class of drug. There is no

[4] For example, New Mexico's law includes a specific exclusion for surgery or injections, only allowing a specific list of procedures, such as "removal of nonperforating foreign bodies from the cornea, conjunctiva and eyelid."

[5] http://www.doh.wa.gov/hsqa/sunrise/Pre1999Reports/OptomRxAuth.pdf

evidence of a change in the law or the practice of optometry that indicates this provision should be altered at this time.

Corticosteroids play a significant role in the treatment of diseases of and injury to the eye. While helpful in treating inflammation, corticosteroids can produce various medical complications an optometrist may not be trained to anticipate or monitor. For example, certain childhood diseases such as chicken pox may be made more serious by the use of corticosteroids. Children using these drugs may also experience growth disruption. Corticosteroids interact negatively with some other drugs and are generally contraindicated for patients with certain diseases such as diabetes and osteoporosis. Corticosteroids are important for the treatment of eye ailments, but their potential to harm a patient's other bodily systems, about which optometrists are not fully educated, is too great to justify lifting the current prohibition.

REBUTTALS TO DRAFT RECOMMENDATIONS

We shared a draft report with interested parties and received rebuttal comments from the applicants, 13 optometrists, two patients, and the Opticians Association of Washington. Appendix I contains a more detailed summary of rebuttals. Following are the main issues raised and the department's response to each.

Issue: The applicants requested the department correct a statement in the report to clarify that their intent was to increase and clarify the scope of practice, and that injectable medications and oral corticosteroids were expressly intended to increase their scope of practice.

> **Department response:** Under Background and Proposal for Sunrise Review, page five, the department clarified the intent.

Issue: The applicants and others wrote that the department misstated the intent of the sunrise statute and applied the criteria incorrectly. In addition, they stated the department was inconsistent with how we applied the criteria in past reviews, and that they think the burden is not on the applicant to establish the public cannot be protected by any other means than the scope increase being sought.

> **Department Response:** Under the Sunrise Review Process, page one, the department explained how we applied the criteria in this report. Under Review of Proposal Using Sunrise Criteria, page eight, we revised the first criterion to show it does not apply to the proposal.

Issue: The applicants and others stated the department should recommend in favor of injectable drugs and corticosteroids because they think the report did not show easily recognizable harm, and that it acknowledged that the differences in authority with bordering states confuse the public. Some wrote that optometrists have the same level of education and training as dentists and podiatrists, and more than registered nurses, who can all perform injections. Some added that the concern optometrists do not receive the same training as ophthalmologists is irrelevant because the expansion being sought is supported by optometry education and training.

> **Department Response:** Under Detailed Recommendations to Legislature, page 14, the department further explained the rationale for not supporting this section of the proposal.

Issue: The applicant and others disagreed with the recommendation on office-based medical procedures, stating the rationale in the report relies on specific issues that can be revised later in the process. Some disagreed that the new criteria could allow a limitless number of procedures, and stated there are only a limited number of ocular procedures that actually meet all the criteria. In addition, they stated the criterion that the procedure must be taught in optometry school is just a baseline check to make sure it is accepted as safe and effective, and that all the criteria must be met.

> **Department Response:** Under Detailed Recommendations to Legislature, pages 13-14, the department further explained the rationale for not supporting this section of

the proposal, suggested potential alternative language, and reiterated our willingness to continue to work with the applicants and other stakeholders to revise this language.

Issue: There were concerns that the language regarding dispensing of eyewear, including cosmetic lenses, is not needed because WAC 246-852-005 includes noncorrective and plano contact lenses. In addition, there was a request to remove the section on providing free samples to patients because the term "ophthalmic device" is not defined anywhere and it is unclear what optometrists are seeking with this part of the proposal.

Department Response: The department did not change the recommendation regarding dispensing of eyewear and cosmetic lenses because it adds clarity to explicitly state it in statute.

Under Detailed Recommendations to Legislature, page 11, the department added a suggestion to either use the term "ophthalmic goods," because it is defined in the Consumer Access to Vision Care law, or to define the term "ophthalmic device."

Additional Issue: In addition, the department recognized we had not addressed the proposal to reduce the hours of training for injection of epinephrine from four hours to two hours.

Department Response: The department added this to the report, supporting the change.

Appendices

Appendix A: Proposal from Applicant

Application for Washington Statement Department of Health Sunrise Review and Approval of Draft House Bill H-0931.2

Amending the Scope of Practice of Optometry in RCW 18.53.010

Submitted by

Optometric Physicians of Washington

July 1, 2009

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OPW currently has 713 members. Approximately 1014 optometric physicians are currently practicing in Washington. OPW is affiliated with the national organization, the American Optometric Association.

The Optometric Physicians of Washington ("OPW") respectfully submits this petition to the Washington State Department of Health ("the Department"). OPW urges the Department to recommend adoption by the legislature of Draft House Bill H-0931.2 for the 2009-2010 Biennium ("the Bill").

I. SUMMARY

This Bill would update RCW 18.53.010 to modernize and clarify the definition of the practice of optometry in Washington State. The Bill would improve access to care for the citizens of the State, and clarify the scope of care that optometric physicians are allowed to provide to patients, by (1) creating a bright-line test for determining which medical procedures are within the scope of practice of optometry, (2) removing the prohibition against the use of oral corticosteroids and medications delivered by injection, and instead relying on the collaboration between the Boards of Optometry and Pharmacy to identify appropriate medications for use by optometrists, and (3) clarifying the statutory authority for several existing areas of optometric care, including plano (cosmetic) contact lenses, medicated contact lenses, low vision rehabilitation and provision of drug samples by optometrists.

Health care in general and eye care, in particular, have changed dramatically in the last several years. The overall costs of health care have soared, and the availability of insurance that permits the patient to choose providers has shrunk. As a result, access to high quality, affordable eye care has become increasingly difficult for the public to obtain, particularly in the rural communities of Washington State. In this environment, access to care, cost of care and quality of care are of paramount importance, and failure of any aspect

of the health care system to deliver high quality, accessible, and affordable care is harmful to the public.

Because of their greater number and broader distribution through the state, optometric physicians are ***more accessible*** to patients than are ophthalmologists; this translates into more efficient delivery of care. In particular, optometric physicians are more accessible to elderly and low income patients, and to patients living in rural communities. More efficient care is more cost effective, and more available care is both more cost effective and more efficient. Moreover, optometric physicians are trained with the knowledge and skill necessary to provide all aspects of primary eye health care to patients, including the prescribing of medicated contact lenses, injectable medications, topical medications, and oral medications as well as low vision rehabilitation. Through Board-monitored and approved continuing education, optometric physicians remain current on eye health knowledge and treatment. Therefore, optometric physicians provide affordable, easy access to primary eye care, including the diagnosis and treatment of conditions their patients present with, and the performance of appropriate office-based procedures that fall within the scope of optometry.

However, despite the ability of optometric physicians to provide needed high quality care, several aspects of current RCW 18.53.010 are outdated, unclear, or overly restrictive, causing confusion in insurance coverage decisions and ultimately limiting patient access to care.

Specifically,

- The outdated and overly restrictive language in current RCW 18.53.010 has been interpreted by some out-of-state insurance carriers to deny payment for

covered services when optometric physicians provide treatment for eye conditions.

- Current state law does not conform with recent changes to Federal law regulating and requiring prescriptions for plano or cosmetic contact lenses.
- Current low vision rehabilitation can include services from sources other than an optometric physician or ophthalmologist, meaning the services can be delivered to a patient without the oversight of a regulatory board.
- Current language in RCW 18.53.010 requires subjective evaluation to determine whether an office-based medical procedure falls within the scope of practice of optometry.
- Current training requirements for optometric physicians' use of epinephrine are inconsistent with epinephrine training requirements in other states and for other practitioners in Washington.
- Current restrictions on the use of injectable medications by optometrists are overly restrictive and deprive patients of needed treatment and pain management care options.
- Current law does not clearly define the authority of optometric physicians to dispense drug samples at no cost.
- Current law does not make clear that optometric physicians may dispense or use ophthalmic devices, such as medicated contact lenses, when those devices are classified by the FDA as a drug.
- Current law does not include oral steroids within the classes of drugs eligible for consideration by approval by the Board of Optometry in consultation with and approval by the Board of Pharmacy.

The Bill will correct these problems to provide increased clarity in the law and to improve patient access to care and treatment with no compromise in the quality of care.

II. WHAT THE BILL WILL ACCOMPLISH

A. Changes to the Optometry Statute.

The Bill amends RCW 18.53.010 in the following respects:

1. Adds "diagnosis, treatment, and management of disease" to the primary definition of the practice of optometry in RCW 18.53.010(1).
2. Defines the dispensing and use of plano or cosmetic contact lenses as the practice of optometry in RCW 18.53.010(1)(b).
3. Defines low vision rehabilitation services as the practice of optometry in RCW 18.53.010(1)(c).
4. Defines the criteria in RCW 18.53.010(1)(e) for office-based medical procedures that are within the scope of practice of optometry.
5. Changes the number of training hours required in RCW 18.53.010(2)(b) for administering epinephrine to two hours, consistent with training requirements in other states.
6. Authorizes the use of injectable medications in the practice of optometry when the medications and training are approved by the optometry board and the Board of Pharmacy, consistent with the very successful cooperation between those boards that has already taken place in accordance with RCW 18.53.101(4)(a).
7. Clarifies that RCW 18.53.010(3) does not prohibit the dispensing of drug samples to a patient to initiate a course of treatment.

8. Clarifies that RCW 18.53.010(3) does not prohibit the sale of ophthalmic devices, such as contact lenses, that are classified by the federal food and drug administration as a drug.
9. Adds oral corticosteroids to the classes of drugs eligible for consideration for approval by the Board of Optometry in consultation with and approval by the Board of Pharmacy.

These amendments will primarily clarify ambiguities in the scope of practice, some of which are currently being interpreted in certain insurance coverage situations to deny coverage to consumers for treatment that is clearly within the scope of practice contemplated by RCW 18.53. In addition, the amendments will align Washington law with Federal law, and make epinephrine training requirements consistent with the requirements of other practitioners in Washington and with other states. The amendments will allow the Board, in consultation with and approval by the Board of Pharmacy, to consider the beneficial applications of injectable medications.

B. Administrative Implementation and Enforcement of the Bill.

If the Bill becomes law, the Board of Optometry will not be subject to any obligations substantively different from those currently imposed on the Board. Although one of the amendment's criteria for authorized office-based procedures is that the procedure be taught in accredited schools or colleges of optometry, under the current statute the Board must already approve schools of optometry. Accreditation by the Counsel on Optometric Education is necessary but not necessarily sufficient for Board approval. RCW 18.53.060; WAC 246-851-040. The Board currently establishes minimum continuing education requirements and determines which courses offered to practicing optometric physicians

qualify for continuing education credits. WAC 246-851-090 through 240. It would be well within these functions for the Board to approve the appropriate training to allow optometric physicians to deliver medication by injection and authorize a two hour training course for the use of epinephrine.

Moreover, the increased clarity in the definition of the scope of practice would lend certainty and efficiency to the Board's rule making and disciplinary functions. In addition, the definition of low vision rehabilitation services and plano or cosmetic lenses as the practice of optometry will aid in enforcement against unlicensed practice that is carried out by hairdressers, flea markets, opticians, physical therapists, or occupational therapists.

Finally, under the current statutes authorizing therapeutic and diagnostic drug use by optometric physicians, the Board has developed a formulary of medications with ophthalmic application and has established education requirements for certification to use these medications. RCW 18.53.010(3) and (4); WAC 246-851-400-420. Clearly authorizing the Board to consider oral corticosteroids and other injectable medications is entirely consistent with the Board's existing authority and practice. Any additional regulatory issues that may arise can and should be appropriately addressed within the administrative process rather than within the legislature.

Optometric physicians are the entry point into the health care system for most patients with eye care problems, and provide a majority of primary eye care in Washington. Single visit treatment by an optometric physician, in lieu of having a patient referred to another practitioner for an additional visit and treatment, will reduce costs.

III. WILL THE BILL REDUCE OR ELIMINATE A RISK OF HARM TO THE PUBLIC?

The Bill unquestionably reduces the significant risk of harm and expense that accompanies the unclear, outdated, and overly restrictive aspects of current law. In addition to creating inconsistencies in insurance coverage, the current definition of the scope of practice of optometry allows for ambiguity and confusion among patients, ophthalmologists, and optometric physicians themselves. Although difficult to quantify, harm to the public certainly accompanies the combination of confusion about practice parameters and unnecessary restrictions in the scope of practice. Because of the greater availability of optometric physicians in Washington, when the law unnecessarily restricts the scope of practice, fewer patients obtain needed high quality treatment at a lower cost. Whenever an optometric physician can treat a patient without sending them to an ophthalmologist or primary care physician, the treatment will be available faster and with less risk of complication or deterioration caused by a delay in treatment. Whenever an optometric physician can prescribe and administer medications to a patient in need of immediate care, the risk of complication or deterioration that could result during the delay while the patient goes to another provider can be eliminated. These are real benefits to the public.

OPW anticipates that some insurers may oppose the Bill based on their plans to create a "medical home" for their patients. However, the concept of medical home should not be used to limit patient access to care or to require patients to incur the additional costs of seeking care that is more expensive and in some cases more difficult to access. The Bill establishes clear parameters of the scope of practice that encompass the current training and practice standards of optometry. This will result in the more efficient delivery of eye health services because referrals for certain medications or treatment which the current

system requires or contributes to will be reduced or eliminated. Clearly, a more efficient health care delivery system is less expensive for the public seeking care as well as for the public paying taxes.

IV. WILL THE BILL BENEFIT THE PUBLIC?

OPW is confident that the Bill will result in significant benefit to the public in terms of access to care, quality of care, clarification of insurance coverage and consistency with federal law and with other states' laws. The specific analysis of the benefit of each proposed amendment encompassed in the Bill is addressed separately as follows.

A. The addition of "diagnosis, treatment, and management of disease" to the primary definition of the practice of optometry in 18.53.010(1).

This amendment benefits the public by clarifying the primary definition of optometry to reflect the intent of the scope statute and the accepted practice of optometric physicians. RCW 18.53 when taken as a whole clearly defines treatment and management of eye disease as within the scope of practice of optometry. For example, optometric physicians regularly work with diabetic patients; in fact, the initial diagnosis of diabetes is often made by an optometric physician. However, despite the statutory authority of optometric physicians to treat and manage eye disease, some carriers have challenged claims for services that patients have received, basing those challenges on the argument that the opening statement in RCW 18.53.010 only authorizes diagnosis of eye health issues and not their treatment. This language will protect insured patients from attempts to exploit a semantic loophole and deny payment for covered services.

B. **Defining dispensing and use of plano or cosmetic contact lenses as the practice of optometry.**

Defining plano or cosmetic lenses as the practice of optometry brings state law into conformity with Federal law. Federal law was amended in November 2005 to clarify that plano or cosmetic lenses are regulated as a medical device – and thus require a prescription. Moreover Federal law encourages states to enact legislation making it clear in state statute that plano or cosmetic lenses require a prescription.

Clear state law requiring prescriptions for these lenses can be an effective tool for local enforcement agencies to stop illegal sales and protect the public. The use of contact lenses for cosmetic or entertainment purposes carries the same risks to the user as prescription lenses. Sale of such devices without proper instruction from an eye care provider can result in misuse which may lead to damage or infection of the eye. The Bill is an important amendment to current law that will protect the public from the risk of this type of harm.

C. **Defining low vision rehabilitation services as the practice of optometry.**

The Bill brings low vision rehabilitation services within the practice of optometry in order to protect the public and ensure that eye doctors (optometric physicians or ophthalmologists) are involved in the care of low vision patients. Only doctors licensed to examine and treat conditions of the eye and vision system posses the education, training, and proper instrumentation to properly and thoroughly assess the eye health, vision, and vision function of patients. RCW 18.53; RCW 18.71.

It is important to the protection of the public that eye doctors be involved in the examination of low vision patients. If patients receive low vision services from other sources such as occupational therapists, low vision rehabilitation instructors, and others, an eye

doctor should be involved to make sure the services are appropriate. That involvement could take place through making a referral, writing of a prescription or protocol, or periodic monitoring of the patient's progress. This is particularly important because low vision rehabilitation services, like other types of therapy, can utilize non-traditional procedures.

Current practice carries a risk that unregulated therapy may result in poor practice or fraud on the public utilizing these services. Including low vision rehabilitation within the definition of optometry gives consumers a regulatory board, the Board of Optometry, to oversee therapy practices. This helps ensure that the public will be protected.

D. Defining the criteria for office-based medical procedures that are within the scope of practice of optometry.

The current statute requires a subjective evaluation to determine which procedures are exceptions to the prohibition against ophthalmic surgery. Because the term is defined so broadly, it could be read to include actions that are self-administered by a patient. The Bill benefits the public, the Board, ophthalmologists, and optometric physicians alike by defining clear and understandable parameters for the practice of optometry. To accomplish this, the Bill defines authorized office-based medical procedures with an objective checklist of criteria. The Bill retains the current prohibition on ophthalmic surgery with exceptions, but instead of being unduly vague the exceptions are the office-based medical procedures specifically defined in the Bill.

One obvious benefit of having well-defined parameters for scope of practice is the increased efficiency for the Board in its rule-making, licensure, and disciplinary functions. However, an even more direct benefit to the public is the ability of a criteria-based definition to encompass new procedures or modalities that meet the criteria, instead of requiring the Legislature to revisit the scope issue every time there is any development in optometry. This

allows the public to benefit more readily from advancements in optometry, even as the public continues to be protected from experimental or untested treatments that do not meet the statute's defined criteria.

The benefit to the public becomes even more clear when the number of optometric physicians state-wide is considered. There are approximately 1014 optometric physicians practicing in Washington; at least one can be found in 144 of the state's cities, including cities in more rural areas of the state.[1] This compares favorably to ophthalmologists, who number only 670 in Washington and are found in only 44 cities and primarily in metropolitan areas in the western part of Washington.[2] Therefore, it is much easier and less expensive for a majority of the public to see an optometric physician, particularly in those areas where there are few or no ophthalmologists. Consequently, a greater number of patients seeking eye care will benefit from optometry's advancements more readily, and at less expense, than would otherwise be the case.

E. Change in training requirement for use of epinephrine by injection from 4 hours to 2 hours.

The Bill aligns epinephrine training requirements for Washington optometric physicians with training requirements for other states and practitioners. Training for use of epinephrine by persons other than optometrists, or by optometrists in other states, is consistently less than the four hours currently prescribed in Washington law.

Two hours of training is sufficient to ensure that doctors of optometry are prepared to use epinephrine if a patient were to suffer anaphylactic shock. Moreover, training

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[1] See Appendix A.

[2] *Id.*

requirements consistent with those of other states will allow optometric physicians to qualify for licensing in Washington without a Washington-specific epinephrine training requirement.

F. Authorizing injectable medication for use when the medication is approved and approved training requirements are met.

The Bill would allow the public to benefit from the appropriate and authorized use of injectable medications by optometric physicians under conditions approved by the Boards of Optometry and Pharmacy. There are many beneficial applications that could be considered by the Board of Optometry and the Board of Pharmacy, and consideration of the possible benefits of use of medications to patients of optometric physicians should not be prevented simply due to the method of delivery. Moreover, optometric training programs already include the application of injectable medication for superficial ocular and lid conditions.

Injectable glaucoma medications are on the approval horizon. Optometric physicians in our state need to be able to administer these treatments, or Washington's glaucoma patients living in areas in which no ophthalmologist is readily accessible will suffer restricted access to these medications. There are several examples of other applications of injectable medication that would benefit patients as well. For example, treatment of a chalazion, a swelling of the upper lid, due to a plugged gland, responds very well to steroid injection into the lesion. In addition, Verruca (skin tag or plantar wart) removal has already been determined to be within the scope of practice of optometry, but this procedure would be easier for patients to tolerate if a local anesthetic could be employed. Similarly, biopsies of suspicious lid lesions, evermore common as our population ages, are also better tolerated under local anesthesia.

An established process exists through the boards of optometry and pharmacy for approval of the use of medications. Consideration of the possible benefits of use of medications for optometric patients should not be prevented simply due to the method of delivery, as long as proper training and demonstration of competency of practitioners is required.

G. **Clarifying that the existing topical drug list and regulations for use of topical drugs do not prohibit dispensing of drug samples at no cost.**

The current statute is silent as to the ability of optometric physicians to dispense drug samples at no cost, and that silence should be rectified. It is a long standing practice for healthcare providers to give free samples of medications to certain patients to determine, in a cost-effective manner, whether a particular medication will effectively treat a condition before the patient has the prescription filled. There are several benefits of this practice.

Dispensing free samples from the provider's office can decrease or eliminate any time lag in commencing urgently needed treatment while a patient gets a prescription filled. In addition, dispensing samples from a provider's office increases the likelihood that a patient will promptly initiate a needed course of treatment. Both of these benefits are particularly important when a patient is seen late at night, on weekends, or in rural areas. Finally, certain patients who have no insurance coverage for necessary prescription medications will benefit if they can receive samples of these medications from their doctors. The Bill clarifies the authority of optometric physicians to dispense these samples to their patients at no cost.

H. **Clarifies that the existing topical drug list does not prohibit the dispensing or use of ophthalmic devices such as medicated contact lenses, classified by the FDA as a drug.**

The Bill would clarify the law by making it clear that the existing topical drug list does not prohibit optometric physicians from dispensing or using ophthalmic devices, such as medicated contact lenses, when they are classified by the FDA as a drug. If the FDA classifies this combination product as a drug rather than a device, it will become a drug for regulatory purposes even though it is prescribed like, looks like, must be fit like, and is worn like a contact lens. In general, pharmacies are not equipped to fit contact lenses; therefore the Bill will ensure that the public will be able to obtain these products from their eye doctor. In addition, utilization of ophthalmic devices classified by the FDA as a drug would benefit patients by allowing for an additional option for delivery of topical medication by their primary eye care practitioner.

The Bill is consistent with the current scope of practice of optometry. More specifically, the utilization of ophthalmic devices, such as contact lenses, and the utilization of topical medication are each independently included in the definition of the practice of optometry. A product that fits under both definitions, as will be the case with medicated contact lenses, should therefore also fall within the current definition of the practice of optometry. The Bill makes clear that they do, thus protecting the public from any limitation on access to these types of devices.

I. **Adding oral corticosteroids to classes of drugs eligible for consideration for approval by Board of Optometry in consultation with and approval by the Board of Pharmacy.**

The Bill corrects outdated, arbitrary restrictions on classes of drugs eligible for consideration by approval by the Board of Optometry in consultation with and approval by the Board of Pharmacy. Other independent, doctoral-level provider groups in Washington

that hold prescriptive authority–medical physicians, podiatrists, and dentists–are not arbitrarily limited by state law as to which oral drugs they may appropriately prescribe for their patients.

All drugs have known side-effects and contraindications to use in certain patients, yet their use by appropriately trained medical professionals benefits patients enormously. The Bill does not automatically allow the prescription of oral corticosteroids, but simply adds this class of drugs to those eligible for consideration with approval of the Board through the accepted procedure of consultation with and approval by the Board of Pharmacy. Consequently, the Bill brings RCW 18.53.010 in line with the statutory authority granted other similarly situated provider professions.

V. CONCLUSION

OPW respectfully urges the Department to recommend passage of Draft House Bill H-0931.2. The Bill will increase clarity in the scope of practice for optometry, and allow the citizens of Washington increased access to eye health care that is more readily available, less expensive, and yet equally high in quality.

OPHTHALMOLOGISTS
OPTOMETRIC PHYSICIANS

OPTOMETRIC PHYSICIANS

Aberdeen
Anacortes
Arlington
Auburn
Bainbridge
Ballard
Battle Ground
Belfair
Bellevue
Bellingham
Blaine
Bonney Lake
Bothell
Bremerton
Brewster
Burien
Burlington
Camas
Cascade Park
Cathlamet
Centralia
Chehalis
Chelan
Cheney
Chewelah
Clarkston
Cle Elum
Clinton
Colfax
Colville
Davenport
Dayton
Deer Park
Des Moines
East Wenatchee
East Sound
Edmonds
Ellensburg
Elma
Enumclaw
Ephrata
Everett
Federal Way
Ferndale
Forks
Fort Lewis
Friday Harbor
Gig Harbor
Goldendale
Grand Coulee
Grandview
Greenwood
Hazel Dell
Hoquiam
Issaquah
Kelso
Kennewick
Kent
Kettle Falls
Kingston
Krikland
Lacey
Lake City
Lake Stevens
Lakewood
Leavenworth
Liberty Lake
Long Beach
Longview
Lynden
Lynnwood
Magnolia
Marysville
Mill Creek
Milton
Monroe
Montesano
Morton
Moses Lake
Mount Vernon
Mountlake Terrace
Mulilteo
Newcastle
Newport
North Bend
Oak Harbor
Ocean Shores
Olympia
Omak
Othello
Parkland
Pasco
Port Angeles
Port Hadlock
Port Orchard
Port Townsend
Poulsbo
Prosser
Pullman
Puyallup
Queen Anne
Quincy
Raymond
Redmond
Renton
Republic
Richland
Sammamish
Seattle
Salmon Creek
Shoreline
Sedro Woolley
Selah
Sequim
Shelton
Silverdale
Snohomish
Spanaway
Spokane
Spokane Valley
Stanwood
Sunnyside
Tacoma
Tonasket
Toppenish
Tumwater
Tukwila
Twisp
University Place
Vancouver
Vashon
Veradale
Walla Walla
Wapato
Wellpinit
Wenatchee
Westport
White Salmon
Winlock
Winslow
Woodinville
Wooland
Yakima
Yelm

OPHTHALMOLOGISTS

Aberdeen
Anacortes
Auburn
Bainbridge
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Bellevue
Bellingham
Bothell
Bremerton
Chehalis
Clarkston
Colville
Coupeville
Edmonds
Ellensburg
Everett
Federal Way
Freeland
Gig Harbor
Issaquah
Kennewick
Kent
Krikland
Lacey
Lakewood
Longview
Lynnwood
Mercer Island
Moses Lake
Mount Vernon
Oak Harbor
Olympia
Omak
Port Angeles
Port Orchard
Port Townsend
Poulsbo
Pullman
Redmond
Renton
Richland
Seattle
Sedro Woolley
Sequim
Shelton
Silverdale
Snoqualmie
Spokane
Sunnyside
Tacoma
Touchet
University Place
Vancouver
Wenatchee
Yakima

Appendix B: Request from Legislature and Bill Draft

STATE REPRESENTATIVE
34th DISTRICT
EILEEN CODY, R.N.

State of
Washington
House of
Representatives

HEALTH & WELLNESS
CHAIR
HEALTH & HUMAN SERVICES
APPROPRIATIONS
WAYS & MEANS

April 30, 2009

Mary C. Selecky, Secretary
Washington State Department of Health
P.O. Box 47890
Olympia, Washington 98504-7890

Dear Secretary Selecky,

I am requesting that the Department of Health consider a Sunrise Review application for a proposal that would change the scope of practice for optometrists. The proposal makes a variety of changes to the statute that defines the scope of practice for optometrists (RCW 18.53.010), including:

- altering the definition of "the practice of optometry;"
- allowing the dispensing of plano or cosmetic contact lenses;
- allowing the performance of, and providing standards for, "office based medical procedures;"
- changing educational standards for the administration of epinephrine by injection; and
- requiring the Board of Optometry to adopt rules to designate education or training requirements for optometrists utilizing approved medication delivered by injection.

A copy of the proposal (H-0931.2/09) is attached and my office can provide you with an electronic copy. The House Health Care and Wellness Committee would be interested in an assessment of whether the proposal meets the sunrise criteria for expanding the scope of practice for a regulated health profession in Washington.

I appreciate your consideration of this application and I look forward to receiving your report. Please contact my office if you have any questions.

Sincerely,

Eileen Cody

EILEEN CODY, Chair
House Health Care and Wellness Committee

Cc: Karen Jensen, Washington State Department of Health
Brad Tower, Optometric Physicians of Washington
Jim Morishima, Office of Program Research

AN ACT Relating to the practice of optometry; and amending RCW 18.53.010.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

Sec. 1. RCW 18.53.010 and 2006 c 232 s 1 are each amended to read as follows:

(1) The practice of optometry is defined as the examination ((~~of~~)), diagnosis, treatment, and management of disease or conditions of the human eye and adjacent structures, the examination and ascertaining any defects of the human vision system, and the analysis of the process of vision. The practice of optometry may include, but not necessarily be limited to, the following:

(a) The employment of any objective or subjective means or method, including the use of drugs, for diagnostic and therapeutic purposes by those licensed under this chapter and who meet the requirements of subsections (2) and (3) of this section, and the use of any diagnostic instruments or devices for the examination or analysis of the human vision system, the measurement of the powers or range of human vision, or the determination of the refractive powers of the human eye or its functions in general; and

(b) The prescription ((~~and~~)), fitting, and dispensing of lenses, prisms, therapeutic or refractive contact lenses, including plano or cosmetic contact lenses, and the adaption or adjustment of frames and lenses used in connection therewith; and

(c) The prescription ((~~and~~)) or provision of visual therapy, low vision rehabilitation services, therapeutic aids, and other optical devices; and

(d) The ascertainment of the perceptive, neural, muscular, or pathological condition of the visual system; and

(e) Office-based medical procedures that:

(i) Are taught in accredited schools or colleges of optometry;

(ii) Involve the eye or visual system, structures adjacent to the eye, or the proper functioning of the eye or visual system;

(iii) Can be performed without penetration of the globe and without closure by suture;

(iv) Can be performed without pharmaceutical agents or with only those pharmaceutical agents authorized for use by persons licensed under this chapter;

(v) Can be performed without conscious sedation, deep sedation, intravenous sedation, or general anesthesia;

(vi) Are not lasik, photorefractive keratectomy, other laser refractive surgery, or cataract extraction; and

(vii) Does not involve injection of medication beneath the posterior tenons capsule; and

(f) The adaptation of prosthetic eyes.

(2)(a) Those persons using topical drugs for diagnostic purposes in the practice of optometry shall have a minimum of sixty hours of didactic and clinical instruction in general and ocular pharmacology as applied to optometry, as established by the board, and certification from an institution of higher learning, accredited by those agencies recognized by the United States office of education or the council on postsecondary accreditation to qualify for certification by the optometry board of Washington to use drugs for diagnostic purposes.

(b) Those persons using or prescribing topical drugs for therapeutic purposes in the practice of optometry must be certified under (a) of this subsection, and must have an additional minimum of seventy-five hours of didactic and clinical instruction as established by the board, and certification from an institution of higher learning,

accredited by those agencies recognized by the United States office of education or the council on postsecondary accreditation to qualify for certification by the optometry board of Washington to use drugs for therapeutic purposes.

(c) Those persons using or prescribing drugs administered orally for diagnostic or therapeutic purposes in the practice of optometry shall be certified under (b) of this subsection, and shall have an additional minimum of sixteen hours of didactic and eight hours of supervised clinical instruction as established by the board, and certification from an institution of higher learning, accredited by those agencies recognized by the United States office of education or the council on postsecondary accreditation to qualify for certification by the optometry board of Washington to administer, dispense, or prescribe oral drugs for diagnostic or therapeutic purposes.

(d) Those persons administering epinephrine by injection for treatment of anaphylactic shock in the practice of optometry must be certified under (b) of this subsection and must have an additional minimum of ((~~four~~)) two hours of didactic and supervised clinical instruction, as established by the board, and certification from an institution of higher learning, accredited by those agencies recognized by the United States office of education or the council on postsecondary accreditation to qualify for certification by the optometry board to administer epinephrine by injection.

(e) The board shall adopt rules to designate education or training requirements for optometrists utilizing approved medication delivered by injection in the practice of optometry. The board may differentiate requirements based on the type of medication or the type of injection.

(f) Such course or courses shall be the fiscal responsibility of the participating and attending optometrist.

((~~(f)~~)) (g)(i) All persons receiving their initial license under this chapter on or after January 1, 2007, must be certified under (a), (b), (c), and (d) of this subsection.

(ii) All persons licensed under this chapter on or after January 1, 2009, must be certified under (a) and (b) of this subsection.

(iii) All persons licensed under this chapter on or after January 1, 2011, must be certified under (a), (b), (c), and (d) of this subsection.

(3) The board shall establish a list of topical drugs for diagnostic and treatment purposes limited to the practice of optometry, and no person licensed pursuant to this chapter shall prescribe, dispense, purchase, possess, or administer drugs except as authorized and to the extent permitted by the board. This does not prohibit the dispensing of drug samples at no cost to a patient to initiate a course of treatment or the dispensing and sale of ophthalmic devices, such as contact lenses, that are classified by the federal food and drug administration as a drug.

(4) The board must establish a list of oral and injectable Schedule III through V controlled substances and any oral legend drugs, with the approval of and after consultation with the board of pharmacy. No person licensed under this chapter may use, prescribe, dispense, purchase, possess, or administer these drugs except as authorized and to the extent permitted by the board. ((~~No optometrist may use, prescribe, dispense, or administer oral corticosteroids.~~))

(a) The board, with the approval of and in consultation with the board of pharmacy, must establish, by rule, specific guidelines for the prescription and administration of drugs by optometrists, so that licensed optometrists and persons filling their prescriptions have a clear understanding of which drugs and which dosages or forms are included in the authority granted by this section.

(b) An optometrist may not:

(i) Prescribe, dispense, or administer a controlled substance for more than seven days in treating a particular patient for a single trauma, episode, or condition or for pain associated with or related to the trauma, episode, or condition; or

(ii) Prescribe an oral drug within ninety days following ophthalmic surgery unless the optometrist consults with the treating ophthalmologist.

(c) If treatment exceeding the limitation in (b)(i) of this subsection is indicated, the patient must be referred to a physician licensed under chapter 18.71 RCW.

(d) The prescription or administration of drugs as authorized in this section is specifically limited to those drugs appropriate to treatment of diseases or conditions of the human eye and the adnexa that are within the scope of practice of optometry. The prescription

or administration of drugs for any other purpose is not authorized by this section.

(5) The board shall develop a means of identification and verification of optometrists certified to use therapeutic drugs for the purpose of issuing prescriptions as authorized by this section.

(6) Nothing in this chapter may be construed to authorize the use, prescription, dispensing, purchase, possession, or administration of any Schedule I or II controlled substance. The provisions of this subsection must be strictly construed.

(7) ((~~With the exception of the administration of epinephrine by injection for the treatment of anaphylactic shock, no injections or infusions may be administered by an optometrist.~~

~~(8)~~)) Nothing in this chapter may be construed to authorize optometrists to perform ophthalmic ((~~surgery. Ophthalmic surgery is defined as any invasive procedure in which human tissue is cut, ablated, or otherwise penetrated by incision, injection, laser, ultrasound, or other means, in order to: Treat human eye diseases; alter or correct refractive error; or alter or enhance cosmetic appearance. Nothing in this chapter limits an optometrist's ability to use diagnostic instruments utilizing laser or ultrasound technology. Ophthalmic surgery, as defined in this subsection, does not include removal of superficial ocular foreign bodies, epilation of misaligned eyelashes, placement of punctal or lacrimal plugs, diagnostic dilation and irrigation of the lacrimal system, orthokeratology, prescription and fitting of contact lenses with the purpose of altering refractive error, or other similar procedures within the scope of practice of optometry~~)) surgeries other than office-based medical procedures, as authorized under subsection (1)(e) of this section.

--- END ---

Appendix C: Follow-Up Questions and Responses from Applicants

Optometric Physicians of Washington
Response to Follow-Up Questions re Sunrise Application

1. Can you provide documentation showing that all optometric physicians are adequately trained in the additional functions proposed?

The only "additional function" that would be authorized by passage of this bill is the administration of ophthalmic medications by injection. All other procedures and practices referred to in the bill are and have been for years considered to be within the practice of optometry. The changes in the law that this bill would effect are necessary, even though they do not expand the scope of optometric practice, because the current law has been interpreted to limit the scope of practice in a way that the legislature never intended.

When the law was changed in 2003 to exclude ophthalmic surgery from the scope of practice of optometry, the legislature specified that certain identified practices, and "other similar procedures within the scope of practice of optometry," were not included in the definition of ophthalmic surgery and thus could be performed by optometric physicians. RCW 18.53.010(8). Unfortunately, this law has proven to be somewhat ambiguous. In at least one case, a procedure that for years was commonly understood to be within the scope of practice of optometry, the lancing of a sty, was found to be banned by the 2003 definition of ophthalmic surgery. That was not the intent of the legislature, and the proposed changes to the law that this bill would accomplish simply confirm that those practices and procedures recognized as within the scope of optometric practice can lawfully be performed by optometric physicians.

As to both the in-office procedures and the injection of ophthalmic medications, there is ample evidence that all optometric physicians are or will be adequately trained to perform these procedures safely and effectively.

First, current law imposes strict requirements on any optometric physician who wishes to practice at the highest level of licensure. Today, according to records of the Department of Health, some 94% of the optometric physicians practicing in Washington have already received all training and passed all examinations necessary for certification at that level. Moreover, in 16 months (January 1, 2011), all optometric physicians licensed in the state must be certified as qualified to practice at that level of licensure. RCW 18.53.010(2)(g)(iii). Thus, there is every reason to believe that when this bill is passed and takes effect, all optometric physicians licensed and practicing in Washington will have met all necessary training requirements.

Second, the bill includes a requirement that the Board of Optometry establish minimum standards for education or training necessary to permit the administration of ophthalmic medications by injection. Such education or training will be required of every person practicing optometry after December 31, 2010. The education currently required includes extensive training in the use of ophthalmic

medications, both topical and oral. This includes knowledge of side effects and other aspects of the use of systemic medication, which as a general rule applies equally to medications administered by injection and to medications administered orally. Thus, the only additional education or training that will be required involves training specific to giving injections.

The training programs to accomplish this are already in place and offered regularly through schools and optometric associations.[1] In Oregon, optometric physicians have been authorized to administer ophthalmic medicines by injection since 2001. Washington's didactic and clinical training for current licensees (AOT, or Advanced Ophthalmic Therapeutics) satisfies the licensing requirement in Oregon and includes training in all forms of injection. (See 2004 AOT course schedule outline attached at Appendix 1; see also Pacific University, College of Optometry lab outline attached at Appendix 2). Indeed, 649 optometric physicians licensed in Oregon have been certified in the AOT Didactic, a 23-hour course which includes training in administering injectable medications, and 534 optometric physicians have been certified through a seven hour injectable course. In Washington, more than 1,000 optometric physicians have been certified as passing the AOT didactic and clinical training. Those that are not recent graduates of a School of Optometry need only the additional injectables course as approved by the Board of Optometry to be fully trained in this area.

2. You state on page 2, "In particular, optometric physicians are more accessible to elderly and low income patients..." Can you elaborate on this statement and do you have any data to support it?

With the initial sunrise application, the Optometric Physicians of Washington ("OPW") provided a map showing that in rural areas, optometric physicians are more accessible geographically to all patients than are ophthalmologists. (See Appendix A to Sunrise Application.) Geographic access is particularly important to elderly and low income patients who are more likely to have difficulty obtaining transportation to distant care.

Even in more populous areas, optometric physicians are more accessible to all members of the population, including elderly and low-income patients. There are more optometric physicians than there are ophthalmologists. Moreover, a significant number of ophthalmologists limit their practices to surgery or other specialty care and do not provide primary eye care services. Thus, the number of ophthalmologists who are readily available to patients, including elderly or low-income patients, is far lower than the number of optometric physicians those patients can see.

In many communities, optometric physicians routinely see patients on-site at nursing homes, assisted living facilities, correctional institutions, mission or tribal outreach centers, or other facilities, saving those patients the rigors of getting to a

[1] The bill anticipates that the Board of Optometry would be able to evaluate the injectables training in the existing programs in order to ensure that it meets necessary training requirements.

doctor's office for eye health care and reaching patients who may not otherwise receive needed screenings or care. OPW is not aware of any statistics on this subject, but anecdotal evidence suggests that there are very few, if any, ophthalmologists who provide such on-site care.

It is also worth noting that OPW represents, and the proposed bill will affect, all modes of optometric practice. This includes what is commonly referred to as "corporate" practices, which are often located in shopping malls and other similar locations. Such commercial locations are more likely to be accessible by public transportation, making these practices easier to reach for low-income patients. These practices tend to be open longer hours to accommodate people's schedules, and tend to be open on Saturdays, and often on Sundays. The extended hours permit many people to receive eye health examinations and care without missing work, which is often of great importance to low-income patients.

3. Can you provide documentation on the costs of care through an optometric physician versus care through an ophthalmologist? Can you also provide this information specific to office-based medical procedures?

Unfortunately, there is no documentation OPW is aware of that confirms the relative costs of care provided by optometric physicians versus the same care provided by ophthalmologists. At one time optometric physicians generally billed less than ophthalmologists for identical services, but that difference has largely if not entirely disappeared. Even if there is some difference in billing levels, the common use of co-pays, conversion factors, maximum allowables and other procedures makes it is almost impossible to ferret out what that difference might be.

However, the savings that individual patients, and the health care system in general, will realize from adoption of this bill are not related to billing rates. Rather, the cost savings will result from the elimination of unnecessary and duplicative visits to other eye care professionals. When an insurer is unwilling to pay for services provided by an optometric physician because of questions as to whether the services are within the scope of practice, the patient must either pay for the services directly or accept a referral. When the patient gets referred to an ophthalmologist, or worse referred to a primary care physician for further referral to an ophthalmologist, for care that is within the scope of optometric practice, the patient is forced to spend more time and more money (co-pays), and in many cases forego more work. These are very real costs that could be avoided if the scope of practice of optometry were clearer and insurance companies were less able to avoid paying for services optometric physicians provide.

It should go without saying that many of these savings translate directly into savings for the health care system, for employers, and for society as a whole. If an employee needs less time off from work, the employer saves. If a patient does not need to see two or three doctors, Medicaid, Medicare or a private insurer saves the cost of those extra office visits. If a patient receives effective treatment more quickly, the likelihood of further complications and attendant costs is reduced.

It is difficult to assign specific dollar amounts to these savings without detailed statistical review by independent statisticians, and OPW is not aware of any such review having been done. However, it appears to be commonly believed that these savings to patients, payors and employers are substantial.

Elimination of unnecessary and duplicative visits will also spare patients the emotional and physical costs associated with postponing treatment, particularly treatment of painful or dangerous conditions. Though very real, those costs are impossible to quantify.

4. What covered services are being denied by out-of-state insurance companies? Is it just out-of-state companies?

In general, routine eye exams are covered by most payors across the country when performed by optometric physicians through in-house plans or subcontracted plans. However, medical eye care services within the scope of practice of optometry are all too often denied by out-of-state payors. In particular, out-of-state plans administered by Blue Cross or Blue Shield frequently deny coverage for medical services performed by optometric physicians. According to OPW's insurance liaison, the most common explanation for these denials of coverage is the claim by the insurer that it is unclear whether Washington optometrists have the authority to provide medical eye care services. Another example is the fact that at one point Zenith administrators refused to pay for any medical services performed by Washington optometric physicians because a consultant had advised the company, incorrectly, that those services were outside the scope of practice of optometry in this State. OPW was able to resolve this issue by educating Zenith on the true scope of practice, and it has been able to resolve similar problems with some other out-of-state insurers. OPW has also had to resolve similar issues regarding insurance coverage denials with March vision and others, and has faced questions about the scope of practice for optometry when being evaluated for inclusion on certain carriers' panels. There are some payors that still question the extent of the authority under Washington law, and until the law is clarified there will always be the potential for additional confusion. One particularly significant example of a need for clarification is shown by the fact that Medicare contractor Noridian Medicare has recently requested clarification on the scope of practice for optometry in Washington.

In Washington, larger payors such as Regence, Premera and Aetna typically cover medical services performed by optometric physicians. However, some of the smaller in-state plans and private plans, such as third-party plans controlled by doctors of medicine, do not provide this coverage.

5. Can you provide documentation of harm from the services provided by unlicensed individuals for low vision rehabilitation and plano or cosmetic lenses?

With regard to plano or cosmetic contact lenses, the bill seeks to clarify in Washington state law what already is required by Federal law – that plano or

cosmetic contact lenses, like prescription contact lenses, require a prescription for dispensing. Adding a specific requirement for a prescription to dispense plano or cosmetic lenses in Washington statute will aid the licensing boards or local officials in enforcing current Federal law. The bill is not intended to, and in our view would not, have any impact on the ability of any licensed professional to dispense contact lenses of any sort if that is within the scope of the license today.

OPW is withdrawing its request for sunrise review of the portions of our proposed bill, H 0931.2/09, dealing with low vision. OPW did not intend the bill to limit the ability of any licensed profession to provide low vision therapy or rehabilitation services. With regard to occupational therapists and other licensed professionals currently providing low vision therapy or rehabilitation, OPW's sole concern was and is making sure that persons in need of low vision therapy first receive appropriate eye examinations, because there are some conditions leading to low vision that cannot be corrected by therapy but instead require treatment through medicine or surgery.

OPW has received comments and questions in response to the bill that indicate it was not properly drafted to accomplish this limited purpose. Accordingly, OPW is withdrawing this portion of the bill in order to reevaluate the proposed language and determine what changes, if any, are necessary to protect consumers without unreasonably impinging on other professions. The members of OPW have great respect for the professionals who provide low vision therapy and rehabilitation, and have every intention of continuing to work productively with them.

6. You state that the number of training hours required for administering epinephrine is being changed to two hours to be consistent with training requirements in other states and with training requirements for other practitioners in Washington. Please provide support documentation for the states where this is true, as well as documentation to support that two hours are adequate to protect the public.

The majority of states that authorize the use of injectables do not require separate education or training for the administration of epinephrine. In fact, exhaustive research by OPW has failed to uncover a single instance in which Washington[2] or any other state specifies the number of hours of training required before any provider can administer epinephrine. Accordingly, OPW believes the requirement of 4 hours of training for the very limited purpose of administering epinephrine is unreasonable.

OPW believes training in epinephrine administration should and will be incorporated into the training requirements that the Board of Optometry will establish for injections in general. As discussed above, the bill would authorize the use of injectable medications as deemed appropriate by the Boards of Optometry and Pharmacy, subject to appropriate education and training as will be established

[2] Excepting the four hour requirement in Washington for Optometric Physicians.

by the Board of Optometry. Based on what we have seen from Oregon (OAR 852-080-0400(4)(b)), Alaska (Alaska Stat. §08.72.175(3)), and other states, it is likely that the Board of Optometry will require at least seven hours of training on injections, in addition to all of the training currently required for the use of therapeutic drugs. It is anticipated that training on the use of epinephrine will be incorporated into this requirement. However, requiring four hours of training on epinephrine administration, whether a separate requirement or part of the overall education, would be excessive. However the requirement is structured, two hours would be more than enough for training on epinephrine administration.

7. What steroids are anticipated? For what use and duration?

The intent of the bill is to authorize the use of corticosteroids for short term use. (Technically, corticosterold includes both glucocorticoids and mineralo-corticoids; however, most doctors who prescribe these drugs refer to them as corticosteroids.) There are some steroids that are appropriate for ophthalmic use and that are administered by injection. This bill would not authorize the use of any injectable sterold that was not first approved for use by the Board of Pharmacy and the Board of Optometry, and any such use would be subject to any limitations deemed appropriate by the two boards.

The use of topical coricosteroids is and almost certainly will continue to be the most common method of applying steroids in ophthalmic applications. Oral coricosteroids can supplement topical therapy in patients who have severe non-infectious inflammatory eye disease. In such cases when maximal topical corticosteroids treatment is inadequate, a short course of treatment with oral administration can be effective in resolving ocular inflammation.

The oral corticosteroid medication anticipated to be used most often is prednisone. The specific ocular diseases for which it is appropriate, and in some cases necessary, include:

Non-infectious uveitis
Diffuse lamellar keratitis (can occur years after LASIK surgery)
Anterior scleritis
Corneal graft rejection

Optometric physicians receive training and education in diagnosing and evaluating these conditions as part of current licensing requirements. The dose and duration of oral corticosteroids for ophthalmic practice depends not only on the disease, but the severity. Most, but not all, of these conditions should respond to a dose and duration of up to 60 mg daily with taper not to exceed 14 days.

Prompt initiation of treatment under the appropriate circumstances is also within the intent of the bill. Oral corticosteroids must be ***immediately*** initiated in circumstances where patients present with signs and symptoms of arteritic anterior ischemic optic neuropathy (AAION), a blinding disease. In these situations, immediately starting the patient on oral prednisone and referral to their primary

care physician or medical specialist for management of the underlying systemic condition (temporal arteritis) is required. Time is of the essence, because of the speed with which the disease can destroys vision. Approximately one-third of patients who have recently gone blind in one eye will be blind in the second eye within *one day*; and an estimated one third will lose vision in the second eye within one week.

For patients with a diagnosis of AAION, positive laboratory blood analysis of ESR and CRP, a working diagnosis of temporal arteritis, and no contraindications for short term oral corticosteroid use, 80-100 mg of prednisone is generally recommended immediate therapy, with prompt referral to their medical doctor or specialist to coordinate care, including required temporal artery biopsy.

8. Do you anticipate that any low vision "patient" would need to receive an eye examination from an optometrist or ophthalmologist prior to receiving low vision services from other sources?

OPW believes such an eye examination would be appropriate in most if not all cases. However, as discussed above OPW is withdrawing its request for enactment of the low vision portions of the bill in order to further examine whether and to what extent any changes in the law are necessary. See the response to Question 5 above.

9. Would a prescription be required that outlines the specific low vision rehabilitation service that is needed?

This question raises another issue that OPW believes requires further consideration before it can be determined what, if anything, would be appropriate. See the response to Question 5 above.

10. Is there a threshold that defines a low vision rehabilitation service patient that distinguishes them from an individual who is purchasing a magnifying glass to assist in fine print or in viewing a stamp collection, etc? What is your definition of low-vision rehabilitation services?

See the response to Questions 5 and 9 above.

11. There are non-profit low vision services through Lions Club or Services for the Blind. How would this affect the services these organizations provide?

See the response to Questions 5 and 9 above.

12. Is there any evidence of poor practice or fraud with these services?

See the response to Questions 5 and 9 above.

FACULTY:
Robert Rosenow, Pharm D., O.D.,
Professor of Pharmacology, Pacific University College of Optometry and Pacific University School of Physician Assistant Studies

Mark Sawamura, O.D.
Assistant Professor, Southern California College of Optometry

Les Walls, O.D., M.D., D.O.S.
President, Southern California College of Optometry

SCHEDULE - SEATTLE
Thursday, March 11
8:00 - 10:00 Principles of Systemic Therapy LES WALLS
10:00 - 12:00 Review of Oral Pharmaceuticals, part 1 ROB ROSENOW

Friday, March 12
8:00 - 10:00 Review of Oral Pharmaceuticals, part 2 ROB ROSENOW
10:00 - 12:00 Other Systemic Medications ROB ROSENOW

Saturday, March 13
8:00 - 9:00 Side Effects, Adverse Reactions ROB ROSENOW
9:00 - 10:00 Essential Systemics Formulary ROB ROSENOW
10:00 - 12:00 Grand Rounds MARK SAWAMURA

1:00 - 3:00 Judicious & Practical Management of Eye Pain LES WALLS
3:00 - 5:00 Grand Rounds/Review MARK SAWAMURA
6:00 - 7:00 *Written Exam*

SCHEDULE - SPOKANE
Thursday, July 15
8:00 - 10:00 Principles of Systemic Therapy LES WALLS
10:00 - 12:00 Review of Oral Pharmaceuticals, part 1 ROB ROSENOW
1:00 - 3:00 Review of Oral Pharmaceuticals, part 2 ROB ROSENOW
3:00 – 5:00 Other Systemic Medications ROB ROSENOW

Friday, July 16
8:00 - 9:00 Side Effects and Adverse Reactions ROB ROSENOW
9:00 – 10:00 Essential Systemics Formulary ROB ROSENOW
10:00 – 12:00 Grand Rounds MARK SAWAMURA
1:00 – 3:00 Judicious and Practical Management of Eye Pain LES WALLS 3:00 – 5:00 Grand rounds MARK SAWAMURA

6:00 – 7:00 *Written Exam*

Injections laboratory and practicum

Steve Graham, MD
Nada Lingel, OD
Jerry Melore, OD
Kathleen Peterson, RN
Dennis Smith, OD

Fluorescein angiography to include intravenous, intramuscular and subcutaneous injections (2 hrs)

A. Intravenous injection
   1. Instrumentation
   2. Patient preparation and instructions
      a. Sterile technique
   3. Demonstration of procedure
      a. IVFA performed on lab instructor
      b. Discussion and analysis
   4. Performance of procedure in small groups
      a. IV line established on partner
      b. Sharps disposal
   5. Evaluation and certification of mastery
      a. Lab instructor certifies successful completion of procedure

Goal: After a discussion and demonstration, each participant will establish an IV line for fluorescein injection on a partner. Each student will be evaluated and certified as competent by an instructor.

B. Intramuscular injection
   1. Instrumentation
   2. Patient preparation and instructions
      a. Sterile technique
   3. Demonstration of procedure including use of Tonopen
   4. Performance of procedure in small groups
      a. Injection of sterile saline given to partner
      b. Sharps disposal
   5. Evaluation and certification of mastery
      a. Lab instructor certifies successful completion of procedure

Goal: After a discussion and demonstration, each participant will give an IM injection of sterile saline to a partner. Each student will be evaluated and certified as competent by an instructor.

C. Sub-cutaneous injection
   1. Instrumentation
   2. Patient preparation and instructions
      a. Sterile technique
   3. Demonstration of procedure
   4. Performance of procedure in small groups
      a. Injection of sterile saline given to partner
      b. Sharps disposal
   5. Evaluation and certification of mastery
      a. Lab instructor certifies successful completion of procedure

Goal: After a discussion and demonstration, each participant will give a sub-Q injection of sterile saline to a partner. Each student will be evaluated and certified as competent by an instructor.

Fluorescein angiography to include local anesthesia, intralesional, and subconjunctival injections (4 hrs)

D. Periocular injections (2 hrs)
   1. Local anesthesia via infusion and nerve block
      a. Instrumentation
      b. Patient preparation and instructions
         i. Sterile technique
      c. Demonstration of procedure
      d. Performance of procedure in small groups
         i. Injection of sterile saline or lidocaine given to partner
         ii. Sharps disposal
      e. Evaluation and certification of mastery
         i. Lab instructor certifies successful completion of procedure

   2. Intralesional injection (1 hr)
      a. Instrumentation
      b. Patient preparation and instructions
         i. Sterile technique
      c. Demonstration of procedure
      d. Performance of procedure in small groups
         i. Injection of sterile saline given to partner
         ii. Sharps disposal
      e. Evaluation and certification of mastery
         i. Lab instructor certifies successful completion of procedure

   3. Subconjunctival injection (1 hr)
      a. Instrumentation
      b. Patient preparation and instructions
         i. Sterile technique
      c. Demonstration of procedure

d. Performance of procedure in small groups
    i. Injection of sterile saline given to partner
    ii. Sharps disposal
e. Evaluation and certification of mastery
    i. Lab instructor certifies successful completion of procedure

Goal: After a discussion and demonstration, each participant will give periocular injections of sterile saline to a partner. Local anesthesia with lidocaine will also be taught. Each student will be evaluated and certified as competent by an instructor.

Advanced Ocular Therapeutics Injection Lab

Pacific University College of Optometry & Oregon Optometric Physicians Association

Lab Date: August 17, 2008

Location: Pacific University, College of Optometry

Video grand rounds in the use of injectibles in eye care – 1 hour _____

Performance and interpretation of fluorescein angiography – 1 hour _____

Clinical performance and procedures; injections in eyecare – 1 hour _____

Peri-ocular injections, performance and practicum – 4 hours

Intravenous _____

Subconjunctival _____

Infiltrative Anesthesia _____

Intramuscular _____

Subcontaneous _____

Nerve block _____

Intralesional _____

Print Name: _____

Signature: _____

License #: _____

Address: _____

City, State, Zip: _____

Appendix D: Public Hearing Summary and Participant List

Optometrist Scope of Practice Sunrise Review
Public Hearing Summary
August 10, 2009

Kristi Weeks opened the hearing. Ms. Weeks is the Director of Policy and Legislation in the Health Systems Quality Assurance Division of the Department of Health. She introduced Sherry Thomas, sunrise coordinator. She then introduced the panel members and other staff:

- Kris Reichl and John Hilger from the Health Systems Quality Assurance Division, panel members.
- Anne Oswald, public panel member.
- Patty Stuart, staff attorney drafting the report.
- Leslie Magby, timekeeper.

Kristi explained how the hearing will work and asked participants to focus on the statutory criteria when presenting or testifying. She included an explanation of the panel and that the draft report should go to the Secretary of Health in October. She also explained there is an additional 10-day comment period beginning today through August 20 at 5:00 PM for stakeholders to comment on anything they feel has not been addressed or to follow up from the hearing. She explained that there will be a five-minute limit on public testimony because of the number of people signed up to testify.

Applicant Presentations

Dr. Curtis Ono

I would like to extend my thanks to the Department of Health sunrise review committee for this opportunity to present information supporting draft house bill H-931.2, and to answer questions for the panel. This proposed legislation will update and modernize RCW 18.53.010, which defines the practice of optometry in Washington State. I am Curtis Ono, President of the Optometric Physicians of Washington. We're also known as the OPW. The OPW is an organization representing the practice and profession of optometry in Washington State. We have 721 members in our association. OPW is a state affiliate of the American Optometric Association, or AOA, which comprises 36,000 members throughout the United States. There are a little over 1,000 actively practicing optometric physicians providing care in the 144 Washington cities or 38 of the 39 counties. Optometric physicians can be found in a wide range of practice settings, including private optometric practice, refractive surgery centers, health maintenance organizations, veteran's administrations, hospital and university based practices, and settings affiliated with retail businesses. We are also in general and specialty practices in collaboration and partnership with ophthalmologists. As stated earlier, we hope this bill will update the current RCW defining optometry with the highest priority placed on increasing accessibility and efficiency of care to patients, and clarifying the scope of care of optometric physicians in Washington. Each section of the bill has precedence in other states' laws pertaining to optometry and also in federal statute. Highlights of the bill include removing ambiguity by adding diagnosis, treatment, and management of disease to the primary definition of optometry; clarifying that optometric physicians can dispense complementary drug samples to patients; and clarifying that optometric physicians are not prohibited from dispensing devices that the Federal Food and Drug Administration, or FDA classifies as a drug. In addition, the bill defines dispensing and use of cosmetic or plano contact lenses, and defines criteria for office-based medical procedures and authorizing use of injectible medications as the practice of optometry. Lastly, the bill would decrease the number of training house for epinephrine administration, and

add oral corticosteroids to the classes of drugs for consideration for approval by the Board of Optometry in consultation with the Board of Pharmacy. OPW is withdrawing the low-vision rehabilitation services section of the bill. It was clear from feedback received from the low-vision rehabilitation community that we did not clearly convey our intent for this portion of the bill. It was not the intention of OPW to limit access to valuable services or products from patients with low-vision challenges. In addition, we did not intend to limit the ability of licensed professionals to provide low-vision therapy or rehabilitation services to patients. OPW will reevaluate our position and determine what changes, if any, we think are necessary without limiting patient access to services or infringing on other professions. The members of OPW have great respect for the professionals who provide low-vision therapy rehabilitation services, and we have a strong history of working alongside these professionals to improve and maximize the quality of life for thousands of Washington State residents with low-vision needs.

I would like to do a brief introduction of our panel representing OPW. First is Dr. Jennifer Smythe, the Dean of the Pacific University College of Optometry in Forest Grove, Oregon. Dean Smythe has served as professor, chief of contact lens services, and associate dean for academic programs at the college. She will review the education program for optometry students and continuing education programs conducted for practicing optometric physicians. Secondly, we have Dr. Brett Bence, a fellow and board member of the American Academy of Optometry. He will talk about oral corticosteroids. Next is Dr. Bob Ford, a board certified ophthalmologist and president and CEO of Pacific Cataract and Laser Institute. He will give an ophthalmologist's perspective on working with optometric physicians in Washington. Last will be Dr. Lori Youngman, an optometric physician who practices at Pacific Cataract and Laser Institute. She will talk about office-based procedures, including medications by injection, and her experience working with other optometric physicians.

Dr. Jennifer Smythe

My name is Dr. Jennifer Smythe. I am a professor of optometry and Dean of the Pacific University College of Optometry. Of the 20 colleges of optometry in the United States, we are in the closest proximity to Washington. We are located in Forest Grove, Oregon. My role here is to serve as a resource and provide evidence attesting to the educational experience and the clinical training optometric physicians receive during their four years of optometry school, as well as the post-doctorate training they receive through continuing education. Each year we graduate 84-89 optometric physicians from Pacific University in Oregon. Many of our alumni choose to remain in the northwest to practice. A significant number practice in Washington. Because our two states border one another, many of our alumni choose to practice in Oregon and Washington, holding an active license in both states. Our program educates optometric physicians to provide all aspects of eye care including the use and prescription of injectible medications, topical medications, and oral medications. Our students graduate with the knowledge, skills and certification to be eligible to obtain the highest level of credentialing in the state of Oregon, which is non-topical therapeutic agents with injections, also known as ATI. Within our four-year post baccalaureate core curriculum, we have at least 561 hours that are specifically dedicated to anatomy and physiology, pharmacology, ocular and systemic disease. Our students are assigned to a minimum of 210 hours of clinical experience, as well as didactic and laboratory experience in examination and treatment procedures for preparation to enter into clinic. In addition to that didactic and laboratory curriculum, all students complete intense primary care clinical experience that begins in the first year. They are assigned to direct patient care in the third year, culminating in an all clinical fourth year. During that all-clinical fourth year, our students rotate through multiple externship sites in renowned medical centers, such as Bascom Palmer Eye Institute, the Mayo Clinic, multiple VA centers, hospitals, as well as independent and private practices. In total our students are assigned to just under 2,000 hours of clinic before they graduate. Throughout that experience, they are utilizing state-of-the-art equipment. Since the 02/03 academic year, we have actually required all students prior to graduation to complete the

injectible medication certification program that is accepted in Oregon. That curriculum includes indications, contraindications, medications, techniques, benefits, risks, and post-injection management. The students learn the procedures on human subjects in a closely supervised environment with a proficiency examination they must pass to graduate through our program. I need to add that since 02/03, and actually we started this program in 2000 on a voluntary basis, there has not been one single reported injury as a result of that educational experience. They demonstrate proficiency with subcutaneous injections in the eyelids, as well as venipuncture and intramuscular injections. They are also trained in the use of the Epi-pen. As I mentioned, we actually established the curriculum in 2000 on a voluntary basis for students who wanted to practice in states where they are allowed to use injectible medications. Beginning in 02/03, it has been required over the last seven years for every student to graduate. You will see from letters from some of my colleagues in other programs that our curriculum is similar to other programs in the country. We've also been actively involved in providing continuing education in the area on systemic pharmaceutical agents and injections for optometric physicians in Washington, Oregon, and Alaska. Since February of 2002, the college has facilitated a 23-hour advanced ocular therapeutics course and a seven-hour injection workshop, which is a laboratory hands-on course. Since that course began in 2002, we now have nearly 700 Oregon practitioners that have completed the course. Also, there have been 145 from Alaska. Since that time, not a single problem regarding patient care and the prescription of oral medications or injections has been reported to the Oregon Board of Optometry regarding any of the optometric physicians who completed the course and received full ATI certification in the state. I should point out that to date 978 practitioners from Washington have completed that same 23-hour course. Some have also completed the seven-hour workshop, and it will continue to be available based on licensure requirements. I want to reiterate what you heard from Dr. Ono that as the population ages, the need for affordable access to eye care will become a paramount issue, affordable health care in general, but specifically eye care. A majority of the practitioners in Washington are graduates of Pacific University, and have received the exact same educational experience as those licensed in the state of Oregon. The proposed changes will allow optometric physicians in Washington to meet the needs of the population to provide safe, full-spectrum care on the same level as Oregon.

Questions from Panel

Kris Reichl: Can you give some specific examples of the types of injectibles that could be used and also talk about how other states compare in relation to injectibles?

Response: That information is coming up with a later panel member.

Dr. Brett Bence

I practice in Mount Vernon and Bellingham. I will address the use of oral corticosteroids in optometry practice. These agents are essential for managing specific ocular conditions with severe inflammation. Most ocular inflammation, particularly of the anterior eye responds well to topical treatment. We've prescribed these drugs in Washington State for about 20 years. However, there are selective ocular diagnoses where maximal topical treatment is inadequate and necessitates enhanced delivery of corticosteroids. This is where oral and injectible administration of these compounds is considered necessary to treat our patients. The primary conditions we use these agents we use include:

- Non-infectious uveitis, inflammation of the ocular uvea which is the colored tunic including the iris.
- Diffuse lamellar keratitis, an abrupt inflammatory response in the central cornea that can occur after lasik surgery or can occur years later after corneal trauma. I've seen patients exactly like this within the last few minutes who have had lasik in 2001. I've probably

seen a dozen cases like this with severe corneal abrasions which subsequently triggers a reactivation of inflammation in the cornea.

- Corneal graft rejection. Even though a privileged tissue which means that physiologically the vantage tissue with no direct blood supply and less tendency for detection of the immune system, so in that way it's privileged. However, rejection can occur. The protocol for treatment is topical and oral corticosteroid administration.
- Anterior scleritis, inflammation of the sclera, the white outer coat, can extend at low doses for several weeks.

The dose and duration of corticosteroids is dependent on the disease entity and its severity. Any health care provider has to measure the risk to benefit ratio with any treatment or medicine decision. The benefit needs to outweigh the risk. For ocular conditions here, most but not all should respond to a dose and duration of oral prednisone, up to 60 mgs daily, with a taper not to exceed 10-14 days. A typical protocol for prednisone for unresponsive non-infectious uveitus, severe DLK, or corneal graft rejection is 60 mgs for two days, then 40 times four days, and then 20 times four days. Systemic corticosteroids for anterior scleritis can be indicated if non-steroidal anti-inflammatory compounds like ibuprofen produce no improvement. Current use of antacid may also be required for potential gastric upset. I give you that information. I work at a center that uses oral steroids and that is pretty much our protocol, and I have seen almost no side effects from very short-term use. Short-term use of oral corticosteroids is relatively safe, but is contraindicated in patients with peptic or gastric ulcer, hypertension, and depression. For ophthalmic practices, our need is for short-term use. Long-term use carries other risks that can be significant. There is one blinding condition that I have to mention here and that is arteritic anterior ischemic optic neuropathy. This is a blinding condition that unfortunately providers do see. It's a systemic condition with ocular morbidity. These patients present often with one blind eye that happened very suddenly. It's an inflammatory condition within the blood vessels. It can be occlusive like a stroke, and has a predilection towards the vessels on the optic nerve. We've all seen these occur. They present with suddenly going painlessly blind and it follows the rule of thirds, which means one-third of patients will go blind in the second eye in one day, one-third in one week and one-third in one month. I say that from many different sources, including ophthalmology. That's one rare condition where we see these patients, and we have to get a patient on oral steroids, and that's the standard of care. Unfortunately these patients come to us too late, undiagnosed by other doctors and physicians. That's diagnosed with blood testing, which we know to do, as well as a temporal biopsy within one week, even on steroids. That's the standard of care. We need a biopsy to confirm the diagnosis. The medical literature confirms our clinical experience, that about half our patients with UVI scleritis have a causal systemic condition. Since optometric physicians are in nearly every county and community in Washington State, we are an excellent resource to manage their optic condition and work with their medical doctor, dermatologist, or internist to uncover potential systemic health problems. So, using medications, we are aware there are systemic ramifications for them. We receive our training in diagnosing and ocular conditions, as was mentioned by Dr. Smythe, and are knowledgeable about their therapy. We receive post-graduate C.E. in pharmacology and ocular disease on an ongoing basis. There are 29 states in the U.S. that allow doctors of optometry to treat patients with oral steroids, but not in Washington. I work in a medical and surgical optometry practice. We see referrals from doctors of optometry, medical doctors, many specialties including ophthalmology, nurse practitioners, and many others. Across the board we witness all groups of providers are equally knowledgeable of their limits, professional experience, and their ability with certain medical and surgical conditions, and they refer when necessary. Optometric doctors refer patients to physicians for second opinions and treatment even when they have authority to provide treatment. This is across the board. Optometrists have good judgment, for example, we get a lot of referrals for glaucoma management. We've had glaucoma in optometry for 20 years in this state. Doctors will refer to someone with more experience. I do not think you will see optometrists running out and prescribing something dangerous.

Question from Kris Reichl: I have a question. The existing law requires 15 hours of didactic and 8 clinical hours in order to be able to prescribe orals, and I see corticosteroids is an addition to that. Do you know what the thought process was behind not expanding the existing hours if you are adding a new type of drug into that category?

Response: Good question. We had a course called oral pathogens in 2003. We've included oral compounds and oral steroids into the didactic curriculum. We need to know this compound group so we had the training at that time.

Question from Patty Stuart: Thank you for your comments. Would you please describe for us what the potential medical complications might be from use of oral corticosteroids, what might be typical in your practice? Could you also describe for us what the training is that addresses the complications, and whether that is original training at optometric school or continuing education.

Response: The curriculum in schools now is quite comprehensive. We have 50 hours C.E. training required every two years, and pharmacology is part of that training. As far as reviewing complications, I mentioned the four short-term risks. This information is from two people I spoke to, one with a pharmacology degree, and the other a pharmacist who discussed the short-term risks to be aware of, and we already knew that. I work with physicians who prescribe these compounds, and these are questions we look for in patient history. As far as long-term complications, obviously we aren't going to be prescribing for long-term, but I can mention a few, diabetes, hypertension, ulcer gastritis, stunted growth in young people, osteoarthritis. But we are getting away from the intent of this legislation. We actually work in concert with their primary care physicians. We prescribe these compounds and patients have contraindications. We will call their primary doctor on the phone to confirm when we have to adjust their diabetes management, or sometimes blood pressure medication. That's where the risk ratio has to be decided, if the risk of blindness is great, that's a decision you have to make with other doctors.

Dr. Robert Ford, owner of Pacific Cataract and Laser

We are a network of ambulatory surgery centers with 16 centers in 6 states. We employ 25 optometrists and 8 ophthalmologists. About 25 years ago, I made a course change in my life. When I came out of my training, my perception was that optometry was the enemy, in a sense. Then I turned a corner and realized we need to work together. I've been enthusiastically doing that for 25 years. I'm very proud of optometrists and have seen a wonderful quality of care. Just two days ago I was talking to the director of the emergency room at the Centralia General Hospital. He was remarking on how good a service he gets for eye consultation. He had recently attended a lecture from somebody from the Department of Health who said he realized emergency rooms have a hard time getting eye consults, and he said that he doesn't. The reason the service is so good there is that optometrists provide the consultations for the emergency room. This director was commenting on the immense quality that he gets when optometrists he employs come into the emergency room and help triage and manage eye problems. My guiding light for the relationship between optometrists and ophthalmologists is what I learned from my dad. He was a family practitioner. He would have liked to have been a surgeon, because he was good with his hands. He passed that on to me and that's why I'm a surgeon. But he wasn't trained to be a surgeon so he couldn't do that. He took good care of his patients and he knew who the good surgeons where. So, if one of his patients needed surgery, he knew who to refer them to. And the surgeons knew that my dad was very good with post-operative care and would get the patients back to my dad very promptly. I saw that as a win, win, win situation. The patients won because they were able to have most of their care from the doctor they knew best, my dad. The surgeons won because they got a referral from my dad that was already worked out. They could trust his judgment on whether the patient needed surgery, and they could get the patient back to the doctor

they knew the patient best promptly. And my dad won because he was able to provide good care efficiently for his patients.

So when I first heard about this expansion, I wondered if optometry was getting into surgery. Do I support that? I went back to my guiding light. Where was the dividing line for my dad? He did minor surgical procedures in his office. He needed to do that or it would have been a great inconvenience for his patients, and absolutely unnecessary for him to refer them to a surgeon for a minor lump or bump. The line is between minor surgery and major surgery. The line is not between no surgery and minor surgery. That's what worked for family doctors and that's what should work for optometry and ophthalmology. Optometrists are the family eye doctors with a majority of the patients. There are a lot more optometrists than ophthalmologists. Ophthalmologists can be very good primary eye care doctors too if they choose to do that. But there are not enough of them to do that. For most patients, their primary care eye doctor is their optometrist who should be able to do minor office procedures.

Dr. Lori Youngman

I practice in Vancouver, Washington and Portland, Oregon. The bill before you is intended to expressly authorize treatment that optometric physicians are trained to perform and do perform in other states. The individuals before me testified to the training and competence of the profession, as well as the effectiveness to deliver independently or in a co-management relationship. This legislation would allow for effective and efficient delivery of care that optometric physicians are trained to provide and are providing in our communities. In Vancouver, we are part of the greater Portland metropolitan area. As an optometric physician practicing in Vancouver and Portland, I strive to provide efficient delivery of care for my patients. This is hampered when a patient is seen in Washington and we aren't allowed to perform the most basic procedures, such as draining a cyst, removing a small growth from the lid, or injecting medication. These are all procedures I'm trained in and licensed to do in Oregon. It makes no sense to patients and their families that by driving eight miles south to Portland, we can accomplish the treatment, but it must be scheduled with another provider, usually on a different day at another clinic. As you can imagine, this adds costs to the patient and insurers. It is certainly not efficient. This bill is not intended as a surgical bill to expand this profession into the operating room, which our colleagues may claim. But instead will provide access to delivery of services in a less costly and more efficient manner. These procedures are described in the bill as follows:

> Office-based medical procedures that are taught in accredited schools or colleges of optometry; involve the eye or visual system, structures adjacent to the eye or proper functioning of the eye or visual system; can be performed without penetration of the globe and without closure by suture; can be performed without pharmaceutical agents, or with only those pharmaceutical agents authorized for use by persons licensed under this chapter; can be performed without conscious sedation, deep sedation, intravenous sedation or general anesthesia; are not lasik, photorefractive, keratectomy, other laser refractive surgery, or cataract extraction; and does not involve injection of medication beneath the posterior tenons capsule.

The intent of the language makes it clear what we would be performing and what we would not. If the answers to these criteria are in the affirmative, then it would be within the scope of practice of optometry. This is no different than how we consider procedures in Oregon that have been part of the practice of optometry for 18 years without cause for concern or complaint. I hope that the track record we have established for the profession speaks for itself as you consider the bill. Regarding the question asked earlier by the panel, states specifically allowing for injections are Pennsylvania, Oklahoma, Alaska, Oregon, and Idaho. Examples of medications would be anesthetics, steroids, and antibiotics.

Question from Kris Reichl: My original question was regarding examples of functions you don't do now that could fit into the new definition. I know you said the intent was to

allow optometrists to do the same thing as before, but it seems like it is actually being broadened. I'm also wondering about adjacent structures and the intent of adding that to the language.

Response: I want to make sure I understand the question. Adding additional procedures than what we currently do, correct? For example, in Oregon we will remove lumps and bumps from the eyelids, growths from the lid for biopsy, drain cysts from the eyelid or conjunctival, which is the white part of the eye. Adjacent structures would be the eyelid area.

Kris Reichl: Only the eyelid? I'm just curious because there is not a clear definition of adjacent structures. To me, it doesn't say connecting structures.

Response: I think we will clarify that in our rebuttal.

Patty Stuart: Dr. Youngman, What laser procedures would be authorized under the proposed definition of office-based procedures?

Response: None by my read.

Public Testimony

Kristi Weeks opened the public testimony period. There was a five-minute time limit set.

Dr. Aaron Weingeist

I am a board certified ophthalmologist practicing in West Seattle and the legislative chairman of the Washington Academy of Eye Physicians and Surgeons. Frankly, we have found the language of this proposal to be confusing. We have attempted to have conversations with the OPW regarding these issues in an attempt to have more openness with legislative issues, and there hasn't been any communication. When this sunrise review came up we attempted to talk to them to try to determine what was meant by the language they were proposing, and they were not willing to meet with us to discuss the legislative intent. We believe the legislative intent is, by our reading, different than what is being presented here. All we really have to go on is the language they have provided. The language they use appears to be restrictive in those seven components of what are supposed to be restrictions on optometric surgery. But at the same time, they removed a broad definition of ophthalmic surgery that both parties agreed on in 2003, in a meeting where the language was drafted jointly. They completely removed any sort of definition of ophthalmic surgery. At that time, we inquired what procedures they felt were important to perform in the practice of optometry and they were unwilling to discuss that with us, and would not tell us what procedures were appropriate for them, only that they did not want to perform ophthalmic surgery and we came up with that definition. I also want to point out that the 2003 legislature carved out corticosteroids as an area they felt had too much danger for optometrists, with more limited clinical experience in severely ill patients, to be able to manage without excess risk to the citizens of the state of Washington. I would like to go back to the seven restrictions they placed on the new procedures in the definition of office-based medical procedures, which we really believe is a definition of surgery. Most procedures we perform in the practice of ophthalmology can be performed in an office-based setting, and the current new language actually does not have a definition to go along with it, so we feel this is the practice of surgery.

The first restriction, taught in accredited schools or colleges of optometry, is actually very broad. In the 20 schools and every state, the scope of practice is different, and while they are starting to have more parity, there are still large gaps in what can be taught and what can be practiced. There is an excellent example in California, in the Berkely school, where the school of optometry said these procedures have been taught for many years. The ophthalmologists pointed out that

they may have been taught it, but there was no patient care experience regarding the surgical procedures. So the first section of restrictions actually broadens and allows the scope of practice to be expanded to the maximum of what is taught in an optometry curriculum.

The second one, involve the eye or visual system, structures adjacent to the eye, or the proper functioning of the eye or visual system; I think you brought up that is very unclear and that adjacent structures is very vague.

Section three, can be performed without penetration of the globe and without closure by suture; penetration of the globe is not defined and may allow partial surface procedures and allows most eyelid procedures, structures on the surface of the eye such as abnormal growths, and partial corneal procedures because they do not enter the eye. All of those things can be interpreted to involve even potentially muscle surgeries or retinal detachments.

Four, Can be performed without pharmaceutical agents or with only those pharmaceutical agents authorized for use by persons licensed by this chapter; once injections are authorized that would mean they could basically use all medications in their treatment. So that is not actually a restriction. We're concerned even though the Board of Pharmacy will be consulted in the process of developing the formulary for optometry. When we included that as a protective measure in 2003, it has turned out that the Board of Pharmacy has in the vast majority of cases, allowed the medication the Board of Optometry has requested to use in their oral formulary. We're not confident that the Board of Optometry will act in a different way when it comes to injectibles. Regarding sutures, many out-patient procedures can now be performed without sutures, including grafting procedures on the surface of the eye.

Number five, performed without conscious sedation, deep sedation, intravenous sedation, or general anesthesia; that's pretty much what the practice of ophthalmology is with the exception of things are done in the hospital that are very significant procedures. The vast majority of ophthalmologists practice in this way.

Number six, are not lasik, photorefractive, keratectomy, other laser refractive surgery, or cataract extraction; I drew up a diagram showing ophthalmic surgery and what optometrists are prohibited from performing based on the definition of ophthalmic surgery in our practice. (Diagram shows a comparison of the large area of restriction currently as compared to a very small area that would be restricted under the bill.) If this proposed language were enacted it would mean a small area that is restricted from the practice of optometry and a very large increase in the procedures optometrists can perform based on this language.

They specifically mention several high-volume procedures that many ophthalmologists perform, but they removed the prohibition of lasers and other instruments that penetrate the eye without damaging the surface. We believe this language can be interpreted to allow repair of retinal tears with laser, Yag laser capsulotomies, secondary membranes after cataract surgery, and glaucoma. The wording of this is very unclear. I've talked with several other ophthalmologists and we're not sure what they mean by "beneath posterior tenons capsule." This language would allow injections behind the eye for anesthesia, around the eye for nerve blocks, which would allow all sorts of other procedures to be performed. In our response to the OPW language, we've included a lengthy list of surgeries which could be allowed based on this language, with removal of ophthalmic surgery. In summary, we have concerns about removing governing authority over the practice of optometry from the legislature and placing it in the hands of the Board of Optometry. We're concerned about the systemic use and injected use of corticosteroids and other agents because we think the training is very different and that quality is of the utmost importance when it comes to medication and surgeries which tend to involve overall systemic health. We believe really that the language could be construed to allow a significant number of ophthalmic surgeries. Despite the testimony here, the language tells a different story.

Question from Kris Reichl: I'm just curious, if the language was modified to include the list of things Dr. Youngman had mentioned, would there be the same concerns?

Response: The intent of the language in 2003, and the ambiguities inherent in that prohibition, are related to their unwillingness at that time to tell us what it is they feel they are qualified to do. So, if there were language that continued to include the definition of ophthalmic surgery and carve outs, I think that would be a starting place for talks. But removing the entire definition of ophthalmic surgery and leaving such large gaps to me is a clear indication of the overall intent of the bill, which is a much larger expansion of the practice of optometry than what they have testified to.

Dr. Michael Brennan

I did sign in as an MD, doctor of medicine. My background is that I graduated from the military academy of West Point, spent 20 years in the army, completed medical school at University of Texas, and a residency in ophthalmology at Brook Harmon Medical Center, and am certified by the American Board of Ophthalmology. I have ten years or so of recent experience in dealing with federal and state governmental affairs for the American Academy of Ophthalmology, and serve this year as their president. I speak for an association. I'm going to focus my remarks on this. This is a surgical bill first of all. Let's just make it clear that this is a surgical bill, so I'm going to focus on three things. Number one is what I call the "gold standard" for surgical specialty certification. Number two is translating that standard into what should concern you as a commission proposing something to the legislature, or endorsing something to the legislature, the public health, safety, and welfare with regard to surgery. Finally I would like to stay proactive and commend the optometry board, comment on their board certification. I would like to say that I have never been an enemy of optometry. They are in my practice. They have been in my military and in my private practice. I enjoy working with them. They know what I do. I know what they do, and in North Carolina we get along very well. I still think this is a surgical bill, so let's talk about the gold standard. This is a specialty board certification that happens after medical college, after the USMA, after an internship, for ophthalmologists, after a rigorous three-year intensive daily patient experience. My colleagues coming up to comment later will discuss this, and you have other testimony in your submitted written documentation that outlines the rigorous training. It's formal. It's supervised. It's patient-centered. You see routine patients. You see complex patients, and you learn to be a surgeon, not just technique or just injection. You learn the blade technique, or the laser technique, and the judgment that goes into that. This is what I call the gold standard. This is in contrast to local optometry board's proposition to develop some rules without proper training. We're talking about weekend and evening courses for experienced optometrists who have seen a lot of patients, no doubt about it. There are many senior optometrists out there caring for patients. They see patients with eye conditions like I do. But let me give you an example of what could happen with this loose proposition by the optometric board. They have separate in this legislative revision this idea that the definition of surgery is gone and they'll be able to perform office-based medical procedures. Notice they didn't say surgical procedures, but we're talking about surgery here. So these office-based medical procedures are surgeries whether they use staples or glue or whatever to close the wounds. The exclusion of those requiring sutures doesn't mean too much to me. I think that you as a commission need to consider this gravely because you're going to consider the gold standard against a relatively loose proposition of weekend and evening courses for an optometrist who's already licensed. I'll go into their future education in a minute and commend the optometry schools. We're talking about patient health, safety and welfare. Let's say you've got a 14 year old child with a lid lesion, or they call them lumps and bumps, and this child presents to the optometrist who went to the weekend course and is now certified to perform office-based medical procedures and can use injections. Here is the optometrist with a tough call, thinking "I think I'm expected to do this because I went to the course." The mother is sitting there with the 14 year old

child, and you should place yourself in the mother's mind of who should do this. Should they travel the 30 minutes to Monroe, Washington where Dr. Markus, our colleague is in the emergency room? Yes, it is 30 minutes to the next ophthalmologist but you can go to a dermatologist, or a plastic surgeon. The general surgeon in the community might be a better choice. The emergency room would be a better choice in my mind for a needle to be placed in the eye of a child. Think about that as you come up with your proposition about this endorsement of what I call surgical approaches.

Finally, I will comment on the optometry board. I think this is long overdue. You have twenty 20 schools that are in different states, different scopes of practice, so the education in the optometry world is widely variant. It is time for them to come to grips with a uniform national definition. The way I see their education is not hospital based, not experiential, with no surgical faculty, how could they come up with a surgical board certification? At the same time, they are necessary. You cannot have an ophthalmologist in every rural community. It does take longer to train us. So think about it this way, if you accept my arguments for the gold standard. Either there's something wrong with me because it takes me too long to learn as an ophthalmologist, or there's something wrong with their system, because they would be getting to the same plane with a different pathway. In conclusion, I am again happy to work with them. I'll be going home this afternoon to my community and there will be optometrists in my office tomorrow and I look forward to taking care of the public health and safety of eyes in North Carolina. I hope that's the way it works out here in Washington.

Dr. Cindy Markus
I am an emergency physician and currently president of the Washington State Medical Association, representing 9,000 physicians. We share the concerns outlined by the previous two speakers, of the ophthalmologists. The proposed legislation contains many amendments to RCW 18.53 that are troubling to members of the medical profession. The most recent changes to 18.53 were crafted in 2003, and at that time optometrists said they did not want to do surgery. Now six years later, we are here with proposed legislation that would be a major increase in the optometrist scope of practice, including surgery and the use of systemic drugs. The legislature has repeatedly indicated that they are not inclined to support optometrists adding surgery to their scope of practice. Surgery should be done by physicians who are specialty trained to perform surgery of the eye. Ophthalmologists complete 12 years of training and education to qualify for eye surgery. They see and operate on hundreds, if not thousands, of real patients under the careful supervision of academic ophthalmologists. Optometrists have nowhere near this level of training and experience, and I think nothing contradicts that statement that we've heard today. The proposed legislation does not define "office-based medical procedures." It appears to go beyond the eye by permitting optometrists to do surgery on areas adjacent to the eye, including functional and cosmetic surgeries on structures such as the eyelids and tear ducts. In answer to your question, we still don't know what adjacent structures means. I know that the intent of the sunrise review process is to be permissive of services unless there is a need to protect the public's health. In this matter, we believe that while the absolute risk numbers may be a small percentage, the potential magnitude of harm is so great that we hope the department will recommend against passage of this legislation. Patients have no way to know the differences in training and experience between optometrists and ophthalmologists. They assume that state licensure means the practitioner is trained and qualified to do what they do. The state must assure that patients undergoing eye surgery are operated on by the most qualified practitioners. In closing, WSMA, Washington State Medical Association, strongly opposes this legislation and its expansion of the optometrists' scope of practice into surgery because of the potential to jeopardize patient safety and quality of patient care. Further, the proposed legislation fails to adequately define criteria for training and evaluation of clinical competence for the additional procedures and treatment for which the optometrists are seeking authorization. Thank you for your time.

Question from Kris Reichl: I would like to ask you the same question I asked earlier. One of the things I understand in the proposal is that the list they put in the legislation, I think it was the '03 legislation but may be wrong, created a limitation that was not intended. I guess my question again is, are there procedures that are now being limited that weren't before, that are actually appropriately for optometrists to be doing?

Response: I cannot answer that question because I don't know enough about the '03 legislation. Maybe someone else here can answer it, but I can't.

Kristi Weeks: If you have an answer to that and have already testified, poke your neighbor and ask them to give it, or you can send it to us in writing.

Michael Mockovak

I practice in Washington in three locations, Seattle, Vancouver, and the Tri-Cities. I employ optometrists in my practice and also have very good relationships with optometrists that refer patients to me. I also have optometrists that I refer back out to for follow up care. I don't really see myself here as a pro or con against optometrists. I have good working relations with them. I see myself here as more of an advocate for what is best for the patients in the state of Washington. Working relationships are really much like marriages. It is very important to remain open, completely honest, and very specific. I've had marital spats where I say, "Oh honey, I didn't really mean that." It is much better to be very specific about what it is we are talking about. I'd like to commend the speaker that spoke pro to the legislation about corticosteroids. He went very specific through a set of conditions. It was very easy for him to list these very specific conditions and talk about the training for each condition, the side-effects of administering the medications, and basically go through and say, "this is why we should be able to do that." I would also like to commend the last speaker who answered the question about laser procedures and said there would be no laser procedures allowed in the defining criteria for office-based procedures. That's the section I would specifically like to address. Rather than clarify, I think this section will create substantial difficulties by speaking largely in the negative, that we can't do A, B, and C. It should really be written in the positive, like the speaker who addressed uveitis said. It would be quite easy to list conditions on one sheet of paper what is included in the office-based procedures. Then it can be discussed, including what the particular training is, what the possible side-effects are, the possible ramifications of not doing it in an optometrist's office, and how this might harm the public. It would be completely easy to do. I think before this bill is voted on, we need much more clarification and much more specificity about exactly what is going to be done. It could be done just as easily as the second speaker listed, and certainly I think that given that it has been stated that no laser procedures would be part of it, I think it would go a long way towards moving this bill through passage to state exactly that. There would be no lasers, no Yag lasers, no glaucoma lasers, no retinal lasers that could potentially blind people. A lot of these retinal lasers are even referred by ophthalmologists to retinal specialists because of the potential for errors here. If you are off by, I think, about $1/1000^{th}$ of a millimeter you can blind somebody. That's the difference between blindness and not. So, adding that level of specificity that lasers would be completely out of the bill would really address a lot of your questions and go a long way toward protecting the safety of Washington and allow the parties to communicate on an open and honest basis, rather than a very muddled fashion. I think the muddling is really unnecessary.

The second point I want to address is one of cost. A lot of the arguments with cost have to do simply with geography, and it's only about 50 miles separating any optometrist from an ophthalmologist. I don't think the issue of geography alone addresses the issue of cost. Furthermore, I know a lot of optometrists refer to me. These people are often referred over 100 miles to come to my office. They drive past several providers that could provide the same service. I know with Dr. Ford, that these patients often go from one city to another in order to

travel to his particular office. The issue of geography itself doesn't address the cost issue, nor does the issue of how much each visit costs. For example, with Medicare, there have been studies that show that even though a patient might pay less per visit to see an optometrist, that glaucoma care is overall cheaper when performed by an ophthalmologist. There are fewer visits. Efficiency of treatment is greater. I think before this bill is voted on, there needs to be a lot more rigorous presentation of how this is going to be cheaper, not just the assertion that there are more of them, or they are more scattered out.

The final point I'll make is that a lot of the optometrists that want these new procedures are in urban areas where a lot of these procedures are already available. A lot of my colleagues in optometry don't want the risk of doing this stuff. They work out of local areas and make a fine living. This isn't really a turf battle. We're going to be fine economically, both optometrists and ophthalmologists, regardless of the outcome of this bill. But a lot of these people who are in this business don't want the hassle or the extra training or the risk. So just stating that geographically and numerically, there are more isn't sufficient to make the cost argument. I think there needs to be much more convincing data on that before it is accepted as carte blanche by the committee. Thank you.

Dr. Rachel Reinhardt

I'm a local ophthalmologist in the Seattle area. I want to talk to you about the rigorous training an ophthalmologist goes through. I feel I am pretty qualified to discuss this both because I'm a comprehensive local ophthalmologist and because I recently graduated from the University of Washington residency program within the last five years. It's pretty fresh in my mind. I am certified by the American Board of Ophthalmology as well. After a four year undergraduate degree, all ophthalmologists attend a four year medical school program. The first two years of that program consist of rigorous classroom didactic that covers everything about human conditions, including human anatomy and physiology, pharmacology, biochemistry, everything. It also includes study in detail of every organ system, not only the anatomy and physiology of those organ systems but the pathology and physiology of thousands of systemic diseases. The final two years of medical school involves rigorous clinical rotations, where we rotate through every medical specialty, whether it's ear-nose-throat, neurology, OB/GYN, internal medicine, or pediatric medicine. It is under the direct supervision of licensed physicians. It's at that time we really develop our clinical judgment, as well as master the medical and surgical management of thousands of systemic diseases. All graduating doctors from medical school have that highly standardized, regulated education. It is not until then that you go on to subspecialties like dermatology, pediatrics, ophthalmology and others. You can't really skip that part in order to become a specialized physician. After medical school, all future ophthalmologists spend one year doing an internship, whether it's medical, surgical, or a combination. They continue to hone their skills in medical and surgical management of disease. That often includes rotations in the ICU, emergency room, often at Harborview, outpatient medicine, inpatient medicine, and so on where you have direct access to patient care. That is followed by three years of ophthalmology specific residency. This is a highly intense residency program, as most are, that gradually increases your responsibility from early on observing to later being a primary surgeon. Overall it is 8,000 hours of medical school and 8,000 hours of ophthalmology and internship, of direct daily patient care, whether it's medical or surgical. By the time I finished my residency not too long ago, I completed hundreds and hundreds of surgeries under the direct supervision of a licensed ophthalmologist, and was certainly involved in hundreds if not thousands more indirectly. There is thousands of hours of direct patient care, nothing but direct patient care, with the exception of roughly 800 hours of didactic. Again this is also very standard and there are federal regulations in order to accredit a program. It's through this training that an ophthalmologist acquires an unparalleled depth of knowledge that allows us to safely and confidently perform medical and surgical procedures on the eye, and not only that but to anticipate the systemic implications of what we do. Again, the eye is not an isolated system or an isolated organ. It is connected to

everything we do, with potential blinding effects, and potential serious systemic effects, including death. I've even had one patient who has died, so it's something that's on our mind on a daily basis. I feel it is not possible to abbreviate our training. I feel that would be unfair and unsafe for patients. Ask yourself this, if we were going to inject your eye with a needle, or somehow alter the tissues of the eye, what level of training would you want? I would like to bring your attention to a white paper done on eye care providers by the National Consumers League in October 2005, and what this shows is that there is continued confusion in the general public about the difference in eye care providers. One-third of respondents incorrectly stated that optometrists have a medical degree, whereas about two-thirds knew that an ophthalmologist has a medical degree. But given the information and given specifics, 92 percent of respondents said they would prefer an ophthalmologist to prescribe medication for their eyes. 93 percent said they would prefer an ophthalmologist to inject medication near the eye. And 95 percent said they would prefer an ophthalmologist to perform surgery on the eye. One other issue with access to care is that the same study pointed out, on average, respondents indicated a 21-minute travel time to visit their routine eye care provider, and respondents seeking non-routine eye care reported an average travel time of 26 minutes. My final point is that on a daily basis, whether I'm doing surgery in clinic or in the OR, or trying to sort out the complex medical case in my exam chair, there is not a day that goes by that I don't realize the harm I could cause. I think that a 23-hour course or 7-hour workshop is not quite the same as 16,000 hours of direct patient care. And I feel that surgery should be done by someone with this training. Thank you.

Diane Charles

I am a licensed dispensing optician and legislative director for the Optician's Association of Washington. I'm also President Elect for the Optician's Association of America. I'm the legislative director for them also. Our concerns on this bill are a little different than the previous speakers'. We thank the optometrists for withdrawing the low-vision rehabilitation piece because we had a lot of concerns about that issue. The two issues left we are concerned about are, on the proposed bill page 2b, they make reference to dispensing, which could be interpreted to be spectacles. That is definitely within the scope of practice for opticians, and we would like that removed or clarified to say it doesn't include spectacles. In 1994, the Consumer Access to Vision Bill was passed into law for "the optometrists and opticians" through a sunrise review hearing like this. In 2005 and 2007, it was revised to be compliant with the federal statute. Right now the very first section of it says any contact lens for which federal law requires a prescription, including non-corrective or plano lenses. So, one of the issues in their proposed bill is already clarified in their statute and ours. Also, in the definition in their application, we were lumped in with flea markets. In the state of Washington, we have a 108-page law with rules and regulations that govern what I do. If plano contact lenses are being dispensed at flea markets or hair dressers, they are not in compliance with the law. We would also like to have that clarified or removed. We don't believe this was the intent of the optometrists of OPW to limit our scope of practice, but unfortunately the way it is written implies the intent is just that. Thank you.

Emily Studebaker

Thank you for accepting comments on behalf of the Washington Ambulatory Surgery Center Association (WASCA) that represent approximately 150 surgery centers, or surgical facilities throughout the state. It also represents the surgeons who perform surgery at those centers. WASCA understands that the sunrise process is designed to gather information about whether expansion of a scope of care would either harm or endanger the health, safety, or welfare of the public. It is for this reason that WASCA felt compelled to address certain aspects of the proposed legislation that that are unsettling.

In particular, and I'll add more detail to this later, WASCA feels this proposal would compromise the safety of care provided to Washington citizens. Preliminarily I would like to address a few comments. The OPW asserts in its application that what it is seeking to do is to clarify its scope of practice. WASCA feels this is misleading and that it is clearly intending to greatly and

aggressively expand its scope of practice. Its basis for doing this is two-fold. One, they assert there is a lack of access to primary eye care. Two, it seems there are claim denials by insurers for services optometrists are providing on the basis that these procedures are outside their scope of practice. I'd like to address those two bases briefly, before I address the expansion to surgical care the legislation proposes. WASCA feels strongly that before expanding the scope of practice for optometry, a lack of access to eye care should be established. Though we have heard today there exists a lack of access, there has been no data provided. What we really have is just an assertion of this as fact. WASCA feels that this lack of access should not only be established, but it should be specifically identified what services Washington citizens lack access to. In particular, if there is going to be an expansion of a scope of practice to include surgical care, it certainly needs to be established that there is a shortage of surgical care available for Washington citizens. No evidence of this has been provided. In addition, this is a linguistic issue; OPW seems to feel optometrists are more accessibility than ophthalmologists, and that their accessibility will translate into more efficient care. I think it's important to note that accessibility does not equate to efficiency because efficiency has to be looked at in the context of quality of care and safety.

Secondly, in terms of general comments, I think it is important to really explore this issue of claim denials. If insurers are denying claims for optometric services on the grounds that the services are beyond optometrists' scope of practice, I think it's important that those services be identified. And that an assessment is done to determine whether these procedures are beyond the scope of practice of optometrists. I noticed the DOH provided some follow up questions to OPW related to the application, and among those questions was for more information on those services where they are experiencing claim denials. Although OPW spent about a page answering that question, there was no specific information provide. So it left the reader wondering still what services are resulting in claim denials. I think that really needs to be worked out because the concern might be that what is currently going on is the unlicensed practice of medicine.

With respect to the scope of services that are being advocated for, the term office-based medical procedures shows up in the legislation. That is not defined and I think it's important to note that it isn't defined elsewhere in the law. But if you turn to Washington's clinical guidelines for off-site surgery, you will note that the office-based medical procedures that are in the legislation constitute office-based surgery. We are talking about surgery, despite being called something else in the legislation. Surgical authority has been reserved historically for medical doctors, and there exists a framework in our law of regulations that provides for oversight of those facilities where surgeries are performed by medical doctors. You have office-based surgery guidelines. You have ambulatory surgery center licensing laws. I think what has not been addressed and is concerning is that the way the legislation is drafted, it looks as though these office-based medical procedures or surgeries being performed by optometrists in their offices might escape those mechanisms for oversight. So you would have very significant risk in individuals performing surgery that they don't have adequate training to perform compounded by the fact that the facility does not have adequate oversight because it escapes through various loopholes from the existing framework that are in the regulations for oversight. In conclusion, WASCA very much opposes the draft legislation and asks that the department not support it. It feels like surgeons should perform surgery.

Dave Fitzgerald

I am the CEO of Proliance Surgeons, which is a private physicians and medical group of 170 physicians and 13 ambulatory surgery centers. We have neither optometrists nor ophthalmologists in our group, so I have no skin in the game. I felt like we needed to comment anyway because we have specific concerns with a few areas of the bill we consider to be extremely vague, and even purposely vague, which is to expand in the future without review what they can do. A few areas of concern are specifically, in-office procedures and injections. The bill

actually attempts to limit surgical procedures to in-office procedures, but by so doing the procedures are not limited, only the location. In-office surgical procedures are not regulated and offices are not licensed in the state of Washington. The performance of these procedures in any unlicensed facility is not safe for the citizens of Washington. Secondly, the definition of which surgical procedures to be performed is way too broad. It includes any procedure taught at any accredited school of optometry. This is not a standard of care and provides way too liberal of a definition of what procedures would be allowed. A school could just add in another course of what we can do, and it would be approved in our law. That's probably not where we want to go for the safety and the risk of our patients. Surgeons also are required to have significant amounts of training. Optometric physicians do not receive this surgical training. A devaluation of a surgeon's training does not improve the safety of patients, it only increases risk. Fourth, optometric physicians have been historically trained for topical applications for the eye. Injections and the medications completely change how optometric physicians treat the eye. While they are now teaching this, the continuing education and the short training is not sufficient to change the law and allow all optometric physicians to systemically treat the eye. Thank you.

Geoff Charlton

I'll go on record as saying I am not a doctor and I don't play one on TV. I am here to offer a perspective much like Dr. Reinhart and Dr. Mockovak, and that is from the patient's perspective. I'm the CEO of Clarus Eye Center in Lacey, Washington and we are a large group practice comprised of both optometrists and ophthalmologists, so I feel like I'll kind of straddle the fence. I have also worked in recent years as a consultant to various eye care providers, both optometric and ophthalmic, so I think I have a really good understanding of what they face on a daily basis and how they interact with their patients. In both roles, I have had the unique opportunity to witness excellent care, and I think that is what this review process is all about, ensuring that is maintained. In my consulting practice, when I work with clients I really try to stress the idea of differentiating themselves. I think that with all the debate around health care, that can be kind of confusing for patients while selecting eye care providers. Certainly previous surveys have shown that there is still a lot of misunderstanding in the public about which services are offered by which group. I think for the OPW to suggest an expansion of duties does little to clarify that issue and will just continue to add to the confusion. In our own practice, I'm impressed with the day to day happenings and the collegiality between our providers. Part of that is really a function of each of them knowing their respective roles and responsibilities, again with the end result of improving quality of care and efficiency of care to our patients. I guess in my mind as both a health care consumer and as one who is intimately involved in the practice management side of the game, I'm a little uncertain that the proposed changes will really in some way benefit me in either role. Thank you.

Melissa Johnson

I'm here on behalf of the Physical Therapy Association of Washington. Our concerns were specifically on 1b, the low-vision rehabilitation section. We initially had some concerns because it wasn't defined and we felt it would infringe on the practice of physical therapists who do low-vision rehabilitation, dealing with neurology, pediatric neurology, balance, and other parts of their practice. So we were concerned this would restrict what physical therapists could do. We appreciate OPW saying they will remove that section and if that section is removed, our concerns with the legislation will also be removed. Thank you.

Kristi Weeks: Asked Dr. Ono to come up to respond to one question from the panel.

Question from Anne Oswald: In your application, appendix 1, is a map and a list of the numbers and locations of ophthalmologists and optometrists in the state of Washington. On the copy I had it wasn't clear what the source of this information was, what the date is, and also I was interested in knowing what the trends from the prior ten years of data are.

Response: I'm not sure I can answer that because we had our legislative team gather that information together. This has been something we have been interested in keeping current because of the questions that come up about accessibility of eye care in the state of Washington, not only with legislative concerns, but other collaborative projects we do along with other organizations. I believe this is a source from the Department of Health, the licensing division. We get some of our information from DSHS about providers on the network who are ophthalmologists verses optometric physicians as well. I can't talk to you about the age. I believe we updated it very recently. I don't have any information on trends, but we would be happy to supply that with the information that comes to you within the ten-day period.

Question from Kris Reichl: This may sound like a funny question coming from someone who works at the Department of Health. I'm just curious that the current endorsements in the law that are being phased in, but are not totally effective yet, won't be effective fully until 2011. I guess my question is why bring injectibles and expand the oral drugs that can be prescribed when those endorsements have not been fully phased in yet? Also have you done any research into disciplinary action taken based on those endorsements in the process of being phased in?

Response: First of all, that actually speaks to the continuation between eye care providers. It also speaks to the confusion of the public to the different levels of licensure within the optometric field. Before the level licensure law passed, which will be required of all providers licensed in Washington by 2011, there was confusion about what an OD can do. They may have been diagnostically certified. They may have been therapeutically certified. And then they may have been oral and injectible certified. That was confusing to the public, so we felt it was important to eliminate that ambiguity by having all practitioners practicing as optometrists or optometric physicians at the highest level of licensure. As far as safety studies, I think we have a strong track record. The closest thing we have to the expansion of our scope is in Oregon, and as Dr. Smythe indicated, there have been little or no complaints about the expanded scope in Oregon. I don't have the information on other states in my head but I'm sure we can supply that information in the next ten days.

Applicant Rebuttal – Dr. Ono began the rebuttal

I will begin the rebuttal. It really speaks to collaboration with ophthalmology. I think, as you have heard in testimony, that we in Washington have a history of close collaboration with ophthalmology. I'm a little surprised to hear that we did not want to meet with them or talk to them about this particular legislative issue. I think I have an especially close relationship with the current president of the Washington Association of Eye Surgeons and that is Charles Birnbach who is a retinal specialist in Seattle. He practices very close to where I practice. I work with him professionally with our patients, and I met with him at the end of June, or in June, to talk about better ways to collaborate between our two organizations. As recently as July 28, I talked to Dr. Burnbach via the phone about this legislation or about this bill. He expressed to me that his association's greatest concerns were the perception of it being a surgery bill, as well as the oral steroid or prednisone use as part of the bill. We talked about part of the issues on that. We also talked about the fact that the state of Oregon has similar legislation having to do with office procedures. He acted surprised by that. Because of the time constraints of getting everybody together, his team as well as our team, it was impractical for us to physically meet. We are planning a meeting after this sunrise hearing with the ophthalmology group.

John Guadnola

I am the legal counsel for the association, the Optometric Physicians of Washington. It probably seems unusual to have a lawyer come up and speak at this proceeding, but there are a couple of points we need to emphasize. I've represented the association since 1992. I've been through a number of these proceedings and a lot of legislative hearings. To be honest, the one common theme you hear all the time is that only doctors of medicine can be trusted to have good judgment when it comes to patient care. That is the common theme. One of the speakers said to imagine this is optometry and you've had the training, and you think that you might not be comfortable with a procedure, but you've had the training so you think you should do it. Nobody has ever suggested this would ever be a problem with a doctor of medicine. Nobody has ever come up with any concrete evidence that this is a problem with doctors of optometry. The difference is that the optometric physicians are a profession whose scope of practice is defined by legislation. The medical profession is not. The medical profession knows very well when they can do something and when they can't. At the last one of these hearings I pointed out that I have a friend whose husband at the time was an 80 year old general practice doctor. His license authorized brain surgery. No one spent two seconds worrying that he would do brain surgery. He knew what he could do and when to refer. One of the speakers commented this morning that even ophthalmologists refer to specialists when it is needed. The real question isn't whether it's appropriate to allow this scope of practice clarification, expansion, however you characterize it. The question is, can you assume optometric physicians will be responsible and there is absolutely no reason to think they won't. We will provide you with written answers to some of these questions, and elaboration on some of this information. Off the top of my head, my recollection is that North Carolina has had some of these medications for several years without complaints. I can't be sure whether that's injections. There's no real basis to worry about quality of care. There is a suggestion from several people that the legislative process in 2003 was somehow definitive and that we shouldn't be changing it now. The legislative process in 2003, which I was a part of, was just that, a legislative process. There was a compromise on the definition. We didn't like the end result and the ophthalmologists didn't like the end result, but that's where we ended up. The idea was to come up with a list that was illustrative but not exhaustive. The idea was to not limit the practice of optometry through this definition. Unfortunately at least in one case, it has been limited, with the issue of lancing a sty. That's the only one I know about. It had been considered within the scope for years and has now been determined by someone not to be within the scope because of that definition. As far as the education, how we do it, people are going to get the education they need. They are going to have the sense to know whether they have the education appropriate for providing a particular service. But the mere fact that some of this education is going to come in night and weekend courses as some have said, certainly doesn't disqualify it. Let me remind you that the excimer laser, which ophthalmologists use routinely wasn't even in existence before, I think, 1996. So any ophthalmologist that graduated before 1996 had to learn how to operate the excimer laser in night and weekend courses. That's the way people stay on top of their profession, when things evolve. Again you have to rely on them to exercise some good judgment. We will submit written comments and responses to the questions you had.

Question from Patty Stuart: I have two definitional questions. The first one regards adjacent structures. That term was not defined in the proposed legislation. What was OPW's intent regarding that term and why wasn't a definition supplied?

Response: I'm not sure I can answer that entirely. I know that at one point we had legislation that had the eye and adnexa. I didn't know what that meant. My understanding in our discussions and only thing I have heard of are the eyelid issues and tear duct issues. That's the only adjacent structure I'm familiar with. We can certainly clarify. I hope we can. We will try.

Question from Patty Stuart: The other definitional question I had was brought up by the representative of the optician's association. With the addition of the dispensing language, is there the intent that optometrists would dispense spectacles and if not, why was that not included?

Response: I'm not sure I know enough about the nuances of dispensing. I know I have gone to ophthalmologists and optometrists and have picked up glasses and that's where I went back and had them fitted to make sure they worked. I've done the same thing with opticians. I've gotten a prescription from an optometrist and taken it to an optician. As I understand dispensing, it's the process of getting the prescription, checking the lenses, checking them on the eye, the contact lenses or spectacles, and making sure they fit. It's making sure they do what they're supposed to do. Both professions are licensed to do that. I know there's no intent to exclude that profession. I don't see how you can interpret a law that says that it's in the scope of practice of A to dispense, and it's not in the scope of B to dispense when it's in the law governing them. I don't think that's an issue, but I will look at that again from a legal view.

Closing Remarks

Kristi Weeks gave next steps:

- Beginning today through August 20 at 5:00 PM, there is an additional comment period for the proponent and public to address anything you haven't addressed, or to respond to questions at the hearing.
- We will share the draft report with participants in mid-September.
- You will have an opportunity to comment on the draft recommendations.
- We will then incorporate these comments into the report if appropriate and submit the report to the Secretary of the Department of Health for approval in mid-October.
- Then, it goes to the Office of Financial Management for their approval, and then to the legislature.
- Once it is released to the legislature, we will post it on the web site to be available to the public.
- At that point, it is in the hands of the legislature to act on. The report is only recommendations.

Follow up question from audience member: Will you ask follow up questions of any other participants during this process?

Response from Kristi Weeks: Yes, if questions arise during the drafting of the report, we will ask them. Rather than leaving holes in the report, we will reach out to get answers from the appropriate people.

Hearing closed at 11:00.

Hearing Participant List

Name	Signed in Representing	Position on Proposal
Aaron Weingeist, MD	WAEPS	Con
Michael W. Brennan, MD	American Academy of Ophthalmology	Con
Cindy Markus	WSMA	Con
Jennifer Smythe	OPW	Pro
Chris Barry	OPW	Pro
Michael Mochovak	WAEPS	Con
Rachel Reinhardt	WAEPS	Con
J.A. Balzer	OPW	Pro
Diane Charles	OAW	Con
Ron Swenger	OAW	Con
Emily Studebaker	WASCA	Con
Lori Youngman	OPW	Pro
Curtis Ono	OPW	Pro
Donna Hatch	OAW	Con
Glenn Charles	OAW	Con
Susie Tracy	WAEPS	Con
Dave Fitzgerald	Proliance Surgeon	Con
John Guadnola	Gordon Thomas Honeywell	Pro
Andrea McNeely	Gordon Thomas Honeywell	Pro
Ken White	OPW	Pro
Elody Samuelson	Northwest Eye Clinic	Con
Mark Maraman	OPW	Pro
Geoff Charlton	Clarus Eye Center	Con
Carl Nelson	WSMA	Con
David Hays	OPW	Pro
Mark Gjurasic	WA OT Association	Con
Brad Tower	OPW	Pro
Holly Chisa	OPW	Pro
Melissa Johnson	PT Association of WA	Con
Cliff Webstter	WA Academy of Eye Physicians & Surgeons	Con
Sanford Berry, OD	OPW	Pro
John Merslich, OD	(no information provided)	Pro
Brett Bence, OD	Optometry	Pro
Joe Pfeifer, OD	Optometry	Pro
Cindy Murrill, OD, MPH	Optometry	Pro
Robert Ford, MD	Optometry	Pro
Clif Finch	(No information provided)	Not indicated
Wayne Carlson	MQAC	Not indicated

Appendix E: Summary of Written Comments

Comments in Support of Proposal

We received comments from optometrists, ophthalmologists and other MDs, as well as other health care professionals in support of this proposal. Many have stated they believe this will improve efficiency and effectiveness of optometry practice by using medical providers to their fullest extent of training and ability. They wrote that this proposal brings the law into alignment with the education, training, and responsibilities of today's optometric physicians, and allows for an expansion of practice consistent with the natural evolution of skill sets. Here is a summary of the comments we received in support of this proposal.

Some commented that the definitions in the optometry scope of practice laws are outdated and ambiguous. They stated the law fails to recognize that the "diagnosis, treatment and management of disease" is fundamental to the practice of optometry. In addition, they stated the laws are out of touch with the education and training optometrists have been receiving for a long time.

Some stated the eye care profession will soon be flooded by aging baby boomers, which will be difficult for ophthalmologists to handle alone. They stated citizens are being left behind without access to care, and feel part of the solution is to increase the professionals who can provide care. Optometrists tend to be more geographically distributed, and may be accessed in local communities and rural areas. Optometric practices have an opportunity to be more available to the public than ophthalmic practices which are often located in more densely populated areas. They also stated that minor surgical authority should be spread out among larger numbers of practitioners so that the specially trained cataract, retinal, oculoplastic surgeons can focus on their specialties.

Ophthalmologists and others wrote attesting to the ability of optometrists to effectively diagnose, treat, and manage varying degrees of ocular diseases and vision problems. They told about working directly with optometrists to observe the high quality of their services. Some ophthalmologists and general practice doctors wrote to state they refer ocular disease cases to optometrists unless surgical in nature. When surgical, they refer to specialists. One stated she would not hesitate to have any of the optometrists she has worked with do injections or write for oral corticosteroids because they have consistently done an excellent job responding to her patients' concerns.

Some wrote that the extra challenge with this proposal is that optometry is heavily regulated, more so than medical specialties like ophthalmology. In ophthalmology, new techniques and methods are integrated into practice fairly freely, whereas in optometry, new techniques and methods typically require permission. They stated this is why optometry repeatedly returns to the legislature to evolve.

Some wrote there is a great track record in other states, stating there have been few, if any problems with increases to optometrists' scope of practice. The North Carolina State Board of Examiners in Optometry wrote about 30 years of experience with some of these issues. They stated they have the largest population of optometrists in the nation who have been actively engaged in the use and prescribing of pharmaceutical agents for over 32 years. They stated there has been no credible evidence nor cases documented to them where the use or prescribing of pharmaceutical agents or the diagnosis, treatment or management of diseases of the eye or adnexa has resulted in "death or irreversible harm to a patient."

Some optometrists stated their opponents always predict public health crises will occur when they request changes to their scope of practice. They stated that the predictions of crises were unfounded and did not occur, for example, when they added use of dilating eye drops (diagnostic agents) to help with eye exams. The prediction that malpractice insurance would go up with each change did not come true, indicating optometrists are a very safe group of providers.

Addition of Diagnosis, Treatment, and Management of Disease to Definition
Many wrote in support of this addition in order to truly reflect the updated model of their profession. They stated optometric physicians are vision care specialists, and learning how to diagnose, treat and manage eye diseases is heavily emphasized in their training. Some stated this is not a change in scope, but a restatement of language from other parts of various RCWs. In addition, they indicated the federal government is in support of training optometric physicians to be medical eye care providers with intensive training provided at the Veteran's Affairs hospital system, who they stated provide the majority of internship and residency opportunities to optometry students. The majority of the Veterans Affairs hospitals and clinics rely on optometric physicians to be the primary eye care providers for our veterans.

Injectable Medications
A few optometry schools wrote attesting that the use of injectable medications has been taught in optometry schools in the U.S. for many years. Many wrote that the proposal clarifies office-based medical procedures and updates pharmaceuticals optometric physicians are authorized to use. Some stated there is no reason the scope of practice of optometry, like other doctoral level providers who have prescriptive authority, should be limited by state law.

The North Carolina Board wrote that in 2006 they credentialed the first of about 150 licensees to perform peri-ocular and chalaxion injections, which have been performed without incidents reported to the board. They estimated that patients encountering optometrists performing procedures or using or prescribing pharmaceutical agents now exceeds 34 million encounters without serious incident. They also wrote that there have been fewer than 15 cases of malpractice brought against optometrists in the 32 years they have been prescribing pharmaceutical agents, none of which have gone to trial, and none have involved performing a specific procedure or the use or prescribing of pharmaceutical agents.

Oral Corticosteroids
A primary care physician wrote to state that he welcomes the change to allow optometrists limited prescriptive privileges for oral steroids to patients in dire need, such as those with temporal arteritis or recalcitrant and severe uveitis. He feels optometrists would be aware of the risks involved, and that further delay would incur unnecessary risk to the patient.

Office-Based Medical Procedures
Some colleges wrote that optometrists receive sufficient clinical experience to perform the procedures the proposal would allow.

Adding Plano or Cosmetic Contact Lenses
Some wrote that defining the dispensing and use of plano or cosmetic lenses will benefit patients and the board. Corneal abrasions are sometimes treated with bandage contact lenses. Optometrists fit and prescribe tinted contact lenses, so addition of this language does not change or expand the scope of practice; it just clarifies the types of contact lenses in use. They stated that clarification of this issue will help patients obtain care and insurance coverage, and assist the board in review processes.

Dispensing and Sale of Ophthalmic Devices, Such as Contact Lenses
Some wrote that patients may have difficulty getting this type of treatment from providers without this type of language. This clarifies the issue and protects access to care for patients.

Dispensing of Drug Samples
We received statements that there is no current law restricting dispensing of drug samples by medical physicians, so there should not be restrictions for optometric physicians to dispense drug samples. They stated they are family eye care providers, often the first person patients think of when they have eye problems. Optometric physicians can often see patients the same day for urgent conditions. If someone develops an eye infection, every second counts and antibiotics may need to be started right away to save a patient's eye sight. It could be hours or days after leaving a doctor's office before someone can get a prescription filled if they have to get them through a pharmacy. They stated that using drug samples in an optometrist's office would ensure prompt treatment of critical conditions.

We also received comments stating pharmacists' objections that this would remove oversight of drug interaction or potential over-use or overdose of medications are misguided and baseless. They stated that since medical treatment by optometric physicians is mostly eye drop based, over-use and overdose is extremely rare. It is extremely rare for eye drops to be overdosed on because nobody likes putting things in our eyes. In addition, driving around with a "sick" and painful eye could result in public danger due to poor vision. In addition, they stated patients are often out of the work force when they have eye problems; which translates to a decrease in family income.

Education

The Dean of Pacific University of Oregon, College of Optometry wrote that the proposed changes are more consistent with the current level of education and training in the schools of optometry. She described the curriculum at the College of Optometry of Pacific University.

She stated each year, 85-89 new optometric physicians graduate from Pacific University College of Optometry in Forest Grove, Oregon. Many alumni remain in the Pacific Northwest, including Washington State, to practice. She stated their program educates optometric physicians to provide all aspects of primary eye health care, including prescribing medicated contact lenses, injectable and topical medications, and low-vision rehabilitation. Her graduates are eligible for the highest level of credentialing in Oregon: Non-topical Therapeutic Agents with Injections (ATI). The four-year core curriculum includes didactic, hands-on laboratory and internal clinic hours specifically devoted to: 126 hours on Systemic disease; 238 hours on Ocular disease; 56 hours on Pharmacology; 10 hours on Injections; 126 hours on Contact lenses; 28 hours on Low vision rehabilitation; 44 hours on Ocular disease specialty clinic; 44 hours on Contact lens specialty clinic; 44 hours on Low vision rehabilitation specialty clinic.
These hours are in addition to the intense primary care clinical experience that occurs in the third year and all-clinical fourth year. Furthermore, all students rotate through three 11-week externships, one of which is an ocular disease specialty site such as a veteran's hospital.

All students are now required to complete the certification curriculum for injections as accepted by the Oregon Board of Optometry for licensure. In addition, Pacific University has been providing continuing education in systemic pharmaceutical agents and injections. Since February of 2002, the college has facilitated a 23-hour Advanced Ocular Therapeutics course with a 7-hour Injections Workshop in Oregon, and over 370 doctors have completed the course. No problems have been reported involving patient care.

The Dean of Salus University, Pennsylvania College of Optometry wrote that graduates of their program are thoroughly trained and educated to diagnose, treat, and manage diseases of the eye and associated structures. The Doctor of Optometry degree program at the Pennsylvania College of Optometry (PCO) is comprised of 4,811 contact hours (162 credits). It is a four-year graduate level program requiring an undergraduate degree that includes requirements comparable to those completed by pre-medical and pre-dental students for admission.

She wrote that the curriculum is broad in scope and diverse in content. The curriculum includes basic sciences in preparation for clinical diagnosis, treatment, and management of the eye and its associated structures, including oral and injectable therapeutic medications. The basic science background is designed to help students understand diseases and disorders of the eye in their proper context of affecting an organ system contained within the body as a whole. Optometry students as a whole receive the same number of pharmacology course hours as medical and dental students. Students in the Doctor of Optometry professional degree program then receive added specialty training in ocular pharmacology.

She further stated the 2008-2009 Curriculum included a total of 530.5 classroom and laboratory hours pertaining to integrated training and education in anatomy, organ systems, physiology, and pharmacology. This included the use of topical, oral, and injectable medications in the treatment of the eye and associated structures and related systemic conditions applied in an intensive and extensive patient care

clinical experience. There were 1260 contact hours in clinical settings that emphasize the diagnosis, treatment, and management of ocular disease.

The president of the Illinois College of Optometry described their program. Graduating Doctors of Optometry must have an established knowledge of the basic and clinical sciences. The foundation must be broad and include the biological, medical, vision and optical sciences, and a basic understanding of the health care delivery system. The Doctor of Optometry must recognize the dynamic nature of knowledge, and possess the commitment and skills needed to responsibly assess and apply new information and treatment strategies throughout his/her career. In addition, they must possess appropriate cognitive and motor skills to prevent, diagnose, treat and manage clinical conditions which are within the scope of their professional responsibilities.

Comments in Opposition to Proposal

We heard from many ophthalmologists, MDs, opticians, other health care providers, and representatives of the pharmaceutical and vision care industry with concerns and objections to this proposal. Many stated optometrists do not have adequate training to perform the additional procedures proposed. They wrote this proposal would result in a dramatic and unwarranted increase in the scope of practice, allowing optometrists to perform procedures that are beyond their core training. These procedures are currently performed by physicians with medical school and an extensive medical residency. This expansion increases the potential for patient harm. In addition, they wrote that this expansion would actually increase confusion and misinformation of patients on the true qualifications and training of members of each profession, especially when optometrists refer to themselves as "eye doctors." Many members of the public wrongly believe that an optometrist is a medical doctor because he or she is called doctor.

The former President of the Oregon Academy of Ophthalmology wrote that he believes there are significant concerns with this proposal, offering some insight into what has happened in Oregon. He asked that we consider the Oregon experience before granting drug-prescribing and invasive procedure privileges to optometrists in Washington State.

He stated that in 2007, Oregon passed a law that rescinded some of the medical-prescribing privileges that had been granted in 2005 legislation. The 2005 legislation had given a broad increase in scope of practice to optometrists. The 2007 changes placed restrictions on optometrists' management of glaucoma, reducing the number of medications an optometrist can use without consulting an ophthalmologist. He stated, "This law was supported in a bipartisan manner and signed into law by the governor because it was clearly directed at patient welfare and quality of care." He wrote that a survey of Oregon ophthalmologists showed "virtually no optometrists have complied with this law." Regarding the proposal for office-based medical procedures, he stated that in Oregon laws, procedures optometrists are allowed to perform are explicitly stated, and that optometrists are prohibited from performing surgery.

Some stated this proposal would place Washington in a position as either the most liberal or second most liberal state in the nation in terms of scope of practice. Other states have considered similar proposals and have rejected them as outside of optometrists' training and expertise. Oklahoma is the only state that allows optometrist to perform surgery on the eye and surrounding structures without medical school.

Addition of Injectable Dugs and Corticosteroids

There were many objections and concerns regarding the addition of injectable drugs and corticosteroids. Many stated optometrists do not have the clinical experience to add these to their scope of practice. The concerns are summarized below.

They stated oral corticosteroids pose considerable, well documented risks when administered inappropriately. When oral prescriptive authority was granted in 2003, the legislature explicitly exempted oral corticosteroids. There are many common dangers with these medications, including gastrointestinal bleeding, suppression of adrenal function leading to metabolic collapse, psychosis, stunted growth in children, hypertension, heart failure, or even the possibility of death. In addition, the number of situations

where an optometrist would need to prescribe these medications is negligible, making this addition to their scope unnecessary.

Many wrote that this proposal eliminates current patient safeguards by placing the approving authority with the Board of Optometry and Board of Pharmacy. This could open the authority of optometrists to prescribe a wide range of diagnostic drugs to be administered by any route, including schedule III and V injectable controlled substances. This may include intravitreal injections of steroids, cancer drugs, antibiotics, antifungals, and others that cannot be performed by optometrists anywhere else in the country. Many of these pharmaceuticals have the potential for serious impacts on patients, not only on the specific disease being treated, but also on multiple organ systems that may be compromised by other diseases such as cancer, heart, or liver disease. In addition, these drugs have very different systemic effects on children. Optometrists are not trained to manage these potential complications, which require access to care 24 hours per day, every day. The knowledge required for this is gained through four years of medical school and four years of specific training in eye surgery and eye disease. Also, most optometrists don't take hospital-based calls, nor do they have hospital privileges to provide this care.

Some gave specific examples of what they interpret would be allowed by the criteria in the proposal. One example given was tensilon, a drug administered intravenously in children and adults to diagnose myasthenia gravis, which causes drooping eyelids and double vision. They stated this injection requires proper monitoring and equipment, and that it is critical to have a doctor with knowledge and experience with bradycardia and asystole, both life-threatening side effects of tensilon. Another example given was botulinum, a toxin used to treat eye muscle problems. Orbital hemorrhage is a possible complication of this injection. Immediate treatment is necessary to prevent blindness. They stated that no optometrist has the experience to treat this.

Some wrote that intravenous or injectable medications are rarely used to treat non-surgical disorders. They wrote that the only logical reason for seeking prescriptive authority for injectables is to set the stage for local anesthetic injections and intravenous medications for optometric surgery in the future, not supported by expansion of optometric surgical education. Some also wrote suspecting the addition of injectables is targeting drugs used for the treatment of macular degeneration, which are administered by direct injection into the eye. They stated these injections require meticulous attention to sterile technique to avoid bacterial endophthalmitis, an infection that risks painful loss of vision and the eye. Many ophthalmologists, who have at least four more years of training than optometrists, don't feel comfortable with or qualified to perform intraocular or periocular injections, making the possibility of optometrists performing this dangerous.

In addition, many wrote that there is no information regarding what medications would be considered, how decisions would be made, and how training would be determined, evaluated, and enforced other than the Board adopting rules. They felt this whole section is dangerously over-broad and vague in determination of which medications might be considered, and in the criteria for clinical competency. At the very least, some stated the Medical Quality Assurance Commission should be involved in this list.

Training

Many stated that the knowledge acquired during medical school and residency training prepares physicians to safely perform surgery, anticipate and address unexpected complications during and following surgery, and effectively manage a patient's care. Below is a summary of the different points made comparing optometry and ophthalmology training.

Some wrote that ophthalmology is a surgical specialty. Washington State ophthalmologists are medical doctors or osteopathic doctors who have completed medical or osteopathic medical school (four or more years), a one year of accredited medical and/or surgical internship, and at least three years of ophthalmology residency training. Subpecialists, such as retina specialists, cornea specialists, and oculoplastic specialists acquire one or two years additional subspecialty training. Ophthalmologists are certified by the American Board of Ophthalmology.

Residency training provides an opportunity for the medical resident to safely and progressively increase his or her level of responsibility in the care of patients. Surgical residents progress from observing surgical procedures to assisting the lead surgeon on performing the surgery, to performing the surgery under the close supervision of the licensed surgeon. Ophthalmologists accumulate over 3,000 patient contact hours in their first year of residency, and in their second year complete 3,000 outpatient visits, 150 consultations involving eye disease, and 288 hours of clinical conferences. Ophthalmologists develop sound medical judgment by observing, treating and overseeing patients with serious eye disease.

We received comments that the University of Washington residents spend approximately 8,000 carefully tracked hours in hands-on, supervised training over the three years of residency. This is in addition to over 800 hours of lecture and didactic teaching. Residents are formally evaluated by the faculty every three months. They must demonstrate competency in seven areas, including objective knowledge, surgical competency, and professionalism, based on examinations and direct observation of patient care, in order to be advanced each year and graduated.

In addition, we received comments that residents undergo extensive training in medical ophthalmology. This includes the recognition of important systemic diseases based on examination of the eyes, and hands-on instruction in the use of powerful injected and systemic medications. For example, all residents spend six months working in an ocular inflammation clinic as part of their training. In this clinic, they participate in the care of several hundred patients receiving systemic or intravenous corticosteroid medications, and learn to recognize and treat the potentially health- and life-threatening complications of these medications including severe diabetic reactions, gastric ulceration, psychosis with suicidal ideation, and others. They learn that use of many strong systemic medications requires very careful patient selection, and regular laboratory monitoring of blood counts and metabolic responses. They learn the art of dosage titration of corticosteroid medications and the severe side effects induced by too-rapid cessation of these medications following chronic use (i.e. Addisonian crisis).

We heard that there are four ophthalmology residents per year at the University of Washington who rotate through multiple hospital settings, including Harborview, UW Medical Center, and the Veterans Administration Hospital and Medical Center over three years following medical, surgical, or transitional internship. In contrast, 80-90 students graduate optometry school at Pacific University in Forest Grove, Oregon, the nearest optometry school. That is over 20 times the number of future practitioners competing for exposure to pathology to build up the expertise to address ocular problems. This is assuming the level of pathology was the same, which it is not due to setting and level of licensure.

One commenter referred to a recent American Medical Association (AMA) study of the curricula of several optometry schools throughout the United States, which revealed minimal to no instruction devoted to surgical treatment of eye diseases or conditions. They found that students of optometry are not exposed to standard surgical procedure training, aseptic surgical training, or medical response to adverse surgical events in their education. Optometrists are not required to take any post-graduate advanced training. In addition, they pointed out that the AMA's study showed striking differences in pharmacological exposure. They found the average range of didactic credit hours in pharmacy sciences an optometry student receives is 7.5-15 hours. Optometry students begin clinical training in their third and fourth years and typically receive approximately 2,000 hours, split between school-based clinic and whatever externship rotations can be arranged.

Many stated that the training in optometry school is gained through sitting through lectures, reading books, watching videos, observing physicians or medical students, or practicing on rubber arms or cadaveric material. They wrote that ophthalmology training has been rigorously developed and defined, and constitutes the minimum necessary training for an individual to perform any type of surgery on the eye, or administer drugs with significant risk to the patient's health. To reduce the training requirements or oversight to allow non-surgeons to perform injections and surgery on the eye is to trivialize this intensive training and invite catastrophe.

Office-Based Medical Procedures
Many have stated this actually grants surgical authority to optometrists. They have many concerns to this happening. They state optometrists do not have the clinical experience to safely perform surgery and manage dangerous complications. We have summarized the comments below.

One commented that granting surgical authority is in direct contradiction to the previous legislature and current law. The legislation that passed in 2003 was drafted with compromising language that was negotiated between the ophthalmology and optometric lobbies at the time. OPW stated at that time that surgery was not their goal. Commenters stated that optometrists refused to compile a list of procedures they wanted authorization to perform so it could be included in the statute, which resulted in the agreement to specifically define ophthalmic surgery and specifically prohibit surgery by optometrists. The current sunrise proposal eliminates the agreed upon definition of ophthalmic surgery and allows optometrists to perform procedures that can only be considered to be surgery. Many wrote that this is a critical and important alteration, potentially opening the door for optometrists to perform a wide range of procedures currently outside their scope.

We heard that surgery includes learning who needs to have a procedure done and who does not. It involves patient selection and education of the patient, as well as dealing with complications. Writers explained that the eye is a uniquely delicate organ; even the most minor error in surgery can lead to irreversible blindness. For example, misplacement of a laser burn in treating diabetic eye disease by just 100 micrometers (1/25,000th of an inch) can lead to permanent blindness. Optometrists' education and training cannot duplicate the surgical skills or clinical judgment of ophthalmologist physicians honed through the medical education continuum. Optometrists generally do not see patients with serious eye disease or gain optometric residency. Without exposure to ill patients, optometrists lack direct clinical experience to understand physiologic interactions of medications and treatment.

We received the following explanation of surgery from commenters. Training programs define surgery as any procedure that physically alters the structure of the eye. In addition to surgery using microsurgical scalpels (such as cataract surgery), this includes use of lasers to alter ocular structure. In many procedures, lasers are used as a type of knife to break tissue apart; the fact that they are not metal instruments does not alter the fundamental surgical nature of the procedure. Many surgical procedures performed by ophthalmologists are carried out in the office rather than the operating room. The fact that these procedures are not performed in an operating room does not mean they are not fundamentally surgical. Performing procedures in the office does not lessen the amount of training required to competently perform such procedures, and in fact increases the burden on the ophthalmologist, who may not have the trained support team or as sophisticated instrumentation in the office as he or she does in the operating room. The risk of a surgical procedure may be unrelated to its complexity. Injection of drugs into or around the eye is a surgical procedure which requires only a few minutes to complete in the office; but lack of attention to strict aseptic surgical technique, inappropriate patient selection, or inattention to anatomical landmarks measured in millimeters can result in irreversible blinding complication if the procedure is not performed correctly.

Many wrote that by the time an ophthalmologist is board certified, he or she has directly participated in the medical and surgical care of many thousands of patients in outpatient and hospital-based settings. He or she has been the primary surgeon on hundreds of eye surgeries. Surgery is learned by highly educated and trained graduates of medical school who have broad skills and knowledge, being carefully mentored by experienced surgeons and educators. This training teaches not only the technique of surgery, but the judgment to perform it safely and effectively. Ophthalmic surgery is best performed by surgeons. The current definition of optometrists should be upheld with the prohibition of surgery. If an optometrist wants to perform ophthalmic surgery, he or she should go to medical school and residency.

Regarding some of the criteria specifically, people wrote the following:

- The criterion, "can be performed without pharmaceutical agents or with only those pharmaceutical agents authorized for use by persons licensed under this chapter," means that procedures can be performed using any drug the Board of Optometry and Board of Pharmacy

allow. They have allowed almost every topical and oral agent not prohibited by specific RCW inclusion so far, so there is no reason to think they would use critical judgment in approving future medications.

- The criterion, "are taught in accredited schools or colleges of optometry," allows the most extreme optometric scope of practice in Washington State. The procedure must only be taught at one optometric school in the nation, which is currently Oklahoma, to be included in the scope. The federal government recognized this potential in 2004. It passed the VETS Act (Veterans Eye Treatment Safety Act) prohibiting optometrists from performing eye surgery on veterans, where before, they could practice to the limit of their state licensure at any Veterans Administration facility, no matter where it was located.
- Many surgical wounds are closed without sutures, and are done with topical or injected anesthesia, not with conscious or deep sedation, intravenous lines, or general anesthesia. The term "adjacent structures" is much too vague.

We received many examples of what health care providers interpret could be included under the proposal. Many of these procedures carry major risks, including disfigurement, severe scarring, misdiagnosis of cancerous lesions, infections, lost eye muscles, and blindness. These include retinal cryopexy (freezing treatment), YAG laser for secondary cataract, pterygium excision with biologic glue, glaucoma laser procedures (such as laser trabeculoplasty or laser peripheral), retinal laser procedures (such as photodynamic therapy, or macular degeneration), laser cosmetic lid and facial procedures, eyelid and ocular surface tumor removal (with biologic adhesive), complex surgeries on the tear duct system, including surgeries on infants & newborns, starting intravenous lines or central catheters used in critical care & advance surgery, injections into sensitive tissues around the eye, topical, peribulbar blocks (passing a needle blindly into the tissue around the eye) or retrobulbar blocks (passing a 1.5 inch needle into the muscle cone near the optic nerve) to deposit anesthetic agents, use of injectable botulinum toxin, intraocular injections, removal of potentially cancerous eyelid and facial lesions, laser facial resurfacing of the eyelids and undefined adjacent tissues, delicate corneal and possibly retinal surgeries that don't require entering the eye, and certain adult eye muscle surgeries.

We received some examples of pediatric eye surgeries that may meet the criteria, including removal of ocular and periocular growths, eye muscle surgery to adjust eye alignment, repair of eyelid ptosis, and tear duct surgery on infants and newborns. They stated children with complicated eye conditions traditionally are cared for by pediatric ophthalmologists who obtain fellowship training beyond ophthalmology residency. They also often have other complications, including diabetes, juvenile rheumatoid arthritis, lung disease from prematurity, and genetic syndromes. Caring for them takes additional knowledge of other medications, anatomy, physiology, and complicated systemic disease, which optometry training does not include.

Some wrote of the legal framework that provides oversight of facilities where medical doctors perform surgical procedures. They stated this framework includes clinical guidelines for office-based surgery and licensure requirements for ambulatory surgical facilities. Optometrists would not be included in this framework or have this oversight under this proposal.

Definition of Optometry

Some wrote that the proposed change to RCW 18.53.010(1) significantly increases the scope of practice, bringing the definition close to the practice of medicine. Adding "diagnosis, treatment, and management of disease" and adding the term "adjacent structures", which when read broadly includes all medical and surgical treatments of the eye and surrounding structures.

Ophthalmic Medical Devices

Some write this term is not defined in the proposal and is unclear. It is not defined here or in other laws. Does it include drug implants, lens or prosthetic implants, scleral buckle materials, nasolacrimal drainage devices, materials to repair bone problems? Also, it is not appropriate to request legislative authority to use devices which are not legal so they can prescribe them in the future if they become available. The proposal uses the example of drug-soaked contact lenses, which are not FDA-approved.

Patient Access to Care
Many stated that there has been no public outcry or data supporting the claims in the proposal that there is a lack of access to eye care. Commenters provided maps they stated show ophthalmologists and optometrists have a broad overlap of practices, with very few counties served by only optometrists. It shows that an ophthalmologist is located in a county adjacent to each of these locations. Maps provided by the National Center for Analysis of Healthcare Data show only ten out of 1,022 optometrists beyond the 30-mile service area for each ophthalmologist. No optometrist practices more than 50 miles from an ophthalmologist in Washington.

In addition, some referred to a 2005 survey by the National Consumers League that showed 85. percent of respondents would prefer their eye care provider have a medical degree when it comes to surgeries, with 91.6 percent stating the same for injections/prescribing of medications, and 86.1 percent for emergency care for severe pain or vision loss. 90.5 stated only skilled, licensed medical doctors should perform eye surgery.

Cost of Care
Some asked where the data is for OPW's assertion that insurance carriers deny payment for covered services because of current statutory language. They stated it was unclear what services are not being covered, and wondered if the services are actually within optometry's scope of practice. Some stated that Medicare pays the same for services regardless of whether an optometrist or ophthalmologist provides them, and anecdotal information indicates optometrists may prescribe more drugs more often than MDs. Some added that they have seen data to support optometrists are more likely to perform in-office testing, such as visual field tests, compared to ophthalmologists within the same population. They wrote this creates the concern that excess surgery may be performed. The more practitioners authorized to perform surgeries, the more surgeries that will be performed, which would increase costs. In addition, they wrote of economic studies showing the most cost-effective care includes initial evaluation by the physician best equipped by training and experience to treat them.

Rule-Making Authority of the Board of Optometry and the Board of Pharmacy
Some wrote that the proposal grants too much authority and removes most of the decision-making and checks and balances from the legislature. The Board of Optometry would determine which injections optometrists could deliver, and how much education or training would be required. They wrote that the Board of Optometry has already allowed procedures that should be considered outside the current scope of practice of optometrists. One person wrote that since 1988, the Joint Administrative Rules Review Committee has ruled four times that Board of Optometry decisions were out of scope. The board and optometrists chose to disregard those rulings, one concerning surgery. The Board determined optometrists could provide all pre-operative and post-operative care for eye surgeries. The legislature formally limited portions of that authority in statute in 2003.

One wrote that when authority to prescribe oral medications was granted to optometrists in 2003, inclusion of the Board of Pharmacy as a "back up" for determination of drugs considered safer or relatively safe for optometrists to prescribe was negotiated. They wrote that the assumption pharmacists would provide a safety net because of their greater familiarity of medications did not prove valid because the Board of Pharmacy has "rubber stamped" almost everything requested including virtually all oral medications. In addition, some wrote that it is inappropriate for optometrists to look to their own board to make the decisions required for this proposal. They do not have the background or perspective to consider the risks involved.

Dispensing of Samples
Some stated that this proposal would add to the current problems encountered with overuse and abuse of samples by doctors and their staff. Most patients see more than one provider, leading to multiple medications for patients with no oversight. Samples should not be allowed to be distributed by optometrists, and ophthalmologists should remain at the forefront of eye care for protection of vulnerable citizens. Ophthalmic drugs are already expensive without allowing drug manufacturing representatives to

perpetuate the cycle of influence they have over prescribing patterns. There does not seem to be any benefit of allowing this.

In addition, some wondered about the purpose and intent of this part of the proposal in specifying that free contact trial lenses shall be dispensed by optometrists. They wondered if they intend that only optometrists should be allowed to trial fit contact lens patients. Opticians wondered how this would impact their current practice

Some wrote that this authority is too broadly written in the proposal. It needs to be more specific in what types of samples may be dispensed, which should be limited to topical drugs within the practice of optometry that are approved by the FDA for treatment of eye disease.

Dispensing of Plano and Cosmetic Contact Lenses
Opticians wondered what the intent is of adding plano and cosmetic contact lenses because a recently added federal law already specifically prohibits their distribution without prescription. They asked whether this would mean only optometrists could fill those prescriptions, and worry this bill would restrict licensed dispensing opticians from completing this process for consumers. They asked whether this bill restricts consumer access to services, such as contact lens fitting services. They state that the Federal Trade Commission (FTC) passed Title 16, part 315, Contact Lens Rule in 2004 to address the public's need for improved consumer access to contact lens prescriptions and products, and that the FTC definition specifically includes them as authorized.

Low-Vision Rehabilitation Services

The applicants have removed this section from the sunrise review, so we are not including comments on it or considering it. They received many objections to this portion of the bill from the following: Community Services for the Blind and Partially Sighted, VisionServe Alliance, Physical Therapy Association of Washington, Washington Occupational Therapy Association, Opticians Association of Washington, Eschenbach Optik of America, California Academy of Eye Physicians and Surgeons, Washington Academy of Eye Physicians and Surgeons, as well as one private citizen, Steffi Coleman. We want to note that the Opticians Association of Washington asked to go on record stating that, although verbally, they were told by OPW that this portion was being withdrawn, Dr. Curtis Ono's indicated they will be reevaluating this issue.
The implication of his statement implies it may be reinserted into the bill with modifications. he OAW strongly opposes anything defined or otherwise that would limit the ability for a licensed dispensing optician to dispense low vision aid devices as it is clarified in their scope of practice.

Follow Up Comments from Hearing

We received a few comments with follow up information in response to testimony at the hearing. We have briefly summarized these comments.

A few wrote to comment that the applicant group did not deny their intent was to practice surgery. Opponents continue to assert this draft bill is almost entirely about surgery, and is a giant leap in optometrists' scope of practice. There was still dissatisfaction relayed about the applicant group's assertion that this bill is not an expansion of their scope of practice, but clarification with injections of ophthalmic injections being the only additional function the proposal authorizes. Some stated if the OPW does not intend to expand its scope in this way, the draft legislation needs to be drastically rewritten. They feel the wording in the legislation does not match the Sunrise Application or follow up answers to the Department of Health.

Commenters still felt the OPW was being vague in its responses at the hearing, and that they are still unwilling to list specific procedures they are seeking. They feel this lack of specificity leaves a lot of room for interpretation, which is counter to one of OPWs expressed goals of clarifying their scope of practice by creating a bright-line test for these types of procedures.

New concerns brought up after the hearing included questioning the 23 hour course that includes injectables OPW mentioned at the hearing. They stated ophthalmologists receive hundreds of hours of training specifically about injectables, and are trained on living patients. Further OPW testimony indicated these weekend courses are sufficient training, comparing them to the short LASIK courses given for EyeMDs. Opponents stated this comparison is inaccurate because ophthalmologists have already been trained to be proficient at complex intraocular surgery. Injections in or around the eye can blind a patient and an intravenous injection can kill one, so these procedures require a great deal more education and practice than an optometrist receives. There are general ophthalmologists who choose not to do injections such as Avastin or Lucentis because of the risk, not because they lack a license to perform them, but because they have the judgment to recognize when patients would be better managed by a specialist.

They asserted that optometry stretched the envelope with the injection of epinephrine for anaphylaxis. When the legislature adopted the 2003 prohibition on ophthalmic surgery, the term "injection" was used because epinephrine is administered in subcutaneous or intramuscular injection to treat anaphylaxis. They stated that the Board of Optometry later determined epinephrine could be administered by IV "injection" for this treatment, and approved it for optometrists even though there is inherent risk of heart attack, stroke.

One commenter questioned optometrist Brett Bence's examples he used during his testimony, such as non-infectious uveitis, diffuse lamellar keratitis, etc., stating oral corticosteroids are not the first line of treatment for the diseases he listed. They are instead typically treated with topical steroids non-steroidal anti-inflammatory drugs (NSAIDs), and sometimes the addition of oral non-steroidals, and uncommonly, oral corticosteroids. In addition, they stated these procedures require optometrists to communicate with a surgeon before initiating medications.
Anterior scleritis can be a sign of a more significant systemic disease, and therefore should be referred to a rheumatologist for consideration of corticosteroid or steroid-sparing treatment.

They asserted that most patients will not require medical or surgical management of eye disease, which is one obvious reason optometrists outnumber ophthalmologists. They disputed the assertion there is inadequate geographic coverage by ophthalmologists to cover all of the state, citing the WAEPS web site, which currently shows 268 ophthalmologists, located in every larger metropolitan area like Seattle, Tacoma, Olympia, Vancouver, and Spokane, but also in the Bellingham, Edmonds, Arlington, Wenatchee, Ellensburg, Anacortes, Coupeville, Walla Walla, Aberdeen, Port Angeles, Yakima, Poulsbo, Longview, Moses Lake, Kennewick, Gig Harbor, and Mt. Vernon.

They added that the number of optometrists who use the most advanced scope privileges granted may be relatively small. Many optometrists they know are content to practice more traditional optometry and are not interested in, nor aware of the expanded scope their association is proposing. In addition, optometric prescribing data from other states demonstrates that ODs in cities and urban areas are most likely to prescribe oral medications for eye disease. They stated this leads to the conclusion that the claim the increased scope will give rural patients greater access to treatment is likely unfounded.

Some objected to the OPW lawyer's statement during the hearing that optometrists should be given the benefit of doubt to use reasonable judgment on what they can and cannot do. They stated his example of an 80 year old MD doing brain surgery, who was licensed to do it but wouldn't because of good judgment, is not a good example. They stated that is a hospital-based procedure, and the hospital credentialing processes would allow only properly trained individuals to perform any type of surgery or injection. Optometrist would be performing these procedures in their office, which is outside of credentialing processes and peer-review processes that would monitor their ability to exercise good judgment.

We received the one follow up comment in support of the proposal. Optometrists with the appropriate education on oral steroids, including application and precautions, should be able to prescribe them for a maximum 10-14 day course. Delay in initiating this treatment for severe ocular conditions can be

harmful to the patient. Risk of serious side effects is more likely after two weeks of treatment. They cited the following reference:

> ChrousosGP. Adrenocorticosteroids and adrenocortical antagonists. In: Katzung BG, ed. Basic and Clinical Pharmacology, 9th ed. New York: McGraw-Hill, 2004: 641-660.

In addition, Dr. Brett Bence provided follow up to his testimony at the hearing, when he was asked to list some of the side effects of corticosteroids. His answer was that most side effects are for long term use, more than two weeks, and that most eye uses are for less than 2 weeks. He listed the short term contraindications in his testimony. When asked about long term side effects, he meant to state "osteoporosis" was a key concern, but mistakenly stated "osteoarthritis." He was thinking one term but said another. Uses for ophthalmic disease are for short periods, averting the concern for severe side effects like osteoporosis, stunted growth and others associated with chronic prednisone use.

Written Comments Provided by:

Support

- Linda Casser, OD, FAAO, Dean, Salus University, Pennsylvania College of Optometry
- Willie Shields, MD, Retina and Macula Specialists
- Jennifer Smythe, OD, OS, FAAO, Dean, Professor of Optometry, Pacific University Oregon
- Joan Ploem Miller, OD, Baseline Vision Clinic
- North Carolina State Board of Optometry
- Robert Ford, MD, Pres., CEO & Cindy Murrill, OD, OD Dir., Pacific Cataract & Laser Institute
- Kevin L. Alexander, OD, PhD, FAAO, President, Southern California College of Optometry
- Dr. Rebecca Saunders, Board Certified Family Physician
- Alan Homestead
- Louise Achey, R.Ph., Pharm.D., BCPS
- Chris Barry, Optometric Physicians of Washington
- Lori Youngman, OD, Optometric Physicians of Washington
- Ed Kosnoski, OD, Optometric Physicians of Washington
- Mark Maraman, OD, Optometric Physicians of Washington
- Mira Sweicicki, OD, Optometric Physicians of Washington
- James DeVleming, OD, Optometric Physicians of Washington
- Brett Bence, OD

Opposed

- Michael Brennan, MD, President & Cynthia A. Bradford, Senior Secretary for Advocacy of the American Academy of Ophthalmology
- Mark J. Mannis, MD, University Faculty Trustee and Craig H. Kliger, MD, Executive Vice President of the California Academy of Eye Physicians and Surgeons
- Brian Paul Roth MD
- Charles Sung, M.D.
- Thomas Hicks, President, Opticians Association of America
- David F. Williams, MD, MBA, President, American Society of Retina Specialists
- C. Gail Summers, M.D., President, AAOS
- David Fitzgerald, CEO, Proliance Surgeons
- Erik Skoog, MD
- Jack G Muckleroy, COMT, FCLSA, Ophthalmology Assoc of San Antonio
- Thomas R. Russell, Executive Director, American College of Surgeons
- Richard J. Eggleston, M.D.
- Keith Dahlhauser MD, FACS, Cascade Eye and Skin, P.C.
- Michael E. Deitz, M.D.
- Alan Crandall, MD, President, ASCRS, American Society of Cataract and Refractive Surgery
- Russell N. Van Gelder, MD, PhD
- Frederick S. Kaiser, M.D.
- Steven H. Swedberg, M.D.

- Washington Academy of Eye Physicians and Surgeons
- Robert W. Nash, OD, MD, Vitreoretinal Surgery
- Cynthia A. Markus, MD. President, Washington State Medical Association
- Beth Harvey MD, President, Washington Chapter of the American Academy of Pediatrics
- Paul Emmans, III, DO, President, Washington Osteopathic Medical Association
- David Rose, R.Ph., Pharmacy Director, HealthPoint
- Catherine I. Hanson, JD, Vice Pres., Private Sector Advocacy & Advocacy Resource Ctr., AMA
- Roy J. Park, MD
- Linda E. Day, MD
- Paul Kremer, MD
- Gary Scholes, MD, CEO, Clarus Eye Center
- Michael L. Gilbert, MD
- Harry Geggel, MD, Section Head, Ophthalmology, Virginia Mason Medical Center
- Devin Harrison, MD
- Brian R. Mckillop, MD

Concerns with Part of Proposal

- Donna Eggen, LDO
- Diana Charles LDO, HFOAA, Opticians Association of Washington
- Susan Chalcraft, PT, Physical Therapy Association of Washington
- Paul Caletti, Chair, Board of Directors & June Mansfield, President/CEO, Community Services for the Blind and Partially Sighted
- Roxann Mayros, CEO (in collaboration with Community Services for the Blind…)
- Kate Fewel, MSW, LICSW, Community Services for the Blind and Partially Sighted
- Kenneth T. Bradly, President Eschenbach Optik of America
- Robert E. Tibolt, M.D.
- Steffi Coleman, M.A., COMS
- Katherine B. Stewart, MS, OTR/L, Member WA OT Association's Legislative Committee
- Sam Duncan, Ritzville Drug Company

In addition, Department of Social and Health Services, Health and Recovery Services Administration and the Health Care Authority wrote with concerns and questions about the proposal.

Appendix F: Applicant Follow-Up After Hearing

Optometric Physicians of Washington
Written Comments re August 10, 2009, Sunrise Hearing on Draft House Bill H-0931.2

I. Introduction

To provide the greatest possible and most cost-effective access to health care for Washington's citizens, Washington law makes clear that the regulation of health professions should be set at the least restrictive level necessary to protect the public interest. RCW 18.120.010(1). In short, health professionals should not be limited in their practices unless there are legitimate public safety reasons for doing so. Regulation – if it is to be instituted – is to be targeted only at demonstrable harm to public welfare that is "easily recognizable and not remote or dependent upon tenuous argument." RCW 18.120.010(2)(a). OPW respectfully submits that through the sunrise process it has shown there will be clear benefit to the public in passing Draft House Bill H-0931.2 ("the Bill"), and that the critics of the bill have produced no credible evidence of harm. Therefore, in keeping with the purpose and intent of the sunrise review process, the Department should recommend that the Bill be passed.

As OPW made clear in its written materials and hearing testimony, the Bill's primary effect is to (1) clarify what is and has long been authorized as within the scope of practice for optometry, and (2) allow for the appropriate use of corticosteroids and injectable medication in order to provide more immediate and accessible treatment to Washington's eye care patients. Claims that the Bill seeks to expand the scope of practice to allow optometric physicians to perform ophthalmic surgery are designed to be inflammatory and are simply untrue. The Bill is intended to make clear that optometry includes those procedures, and only those procedures, that involve diagnosis, treatment, and management of superficial conditions of the eye and its adjacent structures,[1] i.e., the eyelid and lachrymal system, *as specified in the Bill*–procedures that are already within the training and licensure requirements for Washington's optometric physicians. In essence, the intent of the Bill is to accomplish three primary goals: (1) to clarify the types of office-based procedures that are within the scope of optometry; (2) to authorize the administration of board approved medications by injection; and (3) to authorize the use of corticosteroids.[2]

[1] The term "adjacent structures" as used in the Bill is intended to be a plain language formulation of the medical term adnexa, which is defined as the "appendages or accessory structures of an organ, as the appendages of the eye *(a. oculi)*, including the eyelids and lacrimal apparatus." Mosby's Medical Dictionary, 8th Edition, copyright 2009.

[2] As OPW has previously stated, it is withdrawing the section of the Bill addressing low vision services. In addition, based on the comments made through the sunrise process, OPW is likely to propose additional language stating explicitly that the sections of the Bill related to the dispensing of plano or cosmetic contact lenses are not intended to and should not be construed to limit the scope of practice of any other licensed health care provider.

II. Office-Based Procedures

The Bill makes clear that lasik, photorefractive keratectomy, laser surgery,[3] and cataract extraction are all expressly outside of the scope of optometry, as is any procedure involving penetration of the globe, closure with suture, or injection beyond the posterior tenons capsule. The procedures authorized by the Bill are not only procedures that are already within Washington optometry's scope and training, but are similar to the procedures allowed in the bordering states of Oregon and Idaho (see Oregon and Idaho statutes, attached at Appendix A, B), as well as in states in other regions. (See, e.g., Alaska statute, attached at Appendix C; New Mexico statute attached at Appendix D; Louisiana statute, attached at Appendix E.). In these states, optometric physicians regularly perform the kind of in-office procedures specified by the Bill, without harm to and in fact to the benefit of the public.

In light of this, it is apparent that opposition by the Washington Academy of Eye Physicians and Surgeons ("WAEPS"), as well as some others, is grounded in a self serving effort to preserve professional "turf," distorting both the language and intent of the Bill in an attempt to generate a fear of harm to the public where no actual threat of harm exists. Unfortunately, despite extensive efforts to work with the WAEPS that included multiple conversations with WAEPS president Dr. Charles Birnbach, WAEPS continues to rely on inaccurate claims that amount to little more than scare tactics.

Perhaps the clearest example of this is found on page 4 of the written submission from WAEPS, where the author stridently proclaims that adoption of the Bill would permit optometric physicians "to perform ophthalmic and facial surgeries." This is patently untrue, and is simply an attempt to frighten the sunrise review panel. Another egregious example of the kind of scare tactic employed by WAEPS and other opponents of the Bill is found on page 16 of the WAEPS submission. There, the author suggests that cataract surgery patients might have a choice between having the surgery performed by an ophthalmologist or having it performed by an optometric physician. This is deliberately misleading, since cataract surgery is expressly excluded from the office-based procedures optometric physicians can perform.

The WAEPS submission contains a laundry list of all the "ophthalmic surgery" procedures the Academy claims optometric physicians will be doing if the Bill is passed. See pages 7-10 of the WAEPS submission. Dr. Chris Barry and a number of other highly-respect optometric physicians are expected to submit a letter to the review panel which goes through this laundry list item by item and demonstrates that WAEPS' claims are false, or at best misleading. As outlined in detail in that

[3] The Bill would continue to allow optometric physicians to use lasers in diagnostic functions as is allowed by current law but expressly excludes any use of lasers for office-based procedures as defined in the Bill.

letter, the Bill is intended to make clear that the practice of optometry includes minor office procedures such as insertion of punctual plugs and drainage of the lachrymal system, the removal of skin lesions, and incision and drainage of eyelid cysts. Lack of clarity in Washington's current law has led to confusion about the scope of optometric practice in the State and, in at least one case, to a ruling that a previously allowed procedure was no longer authorized. The Board of Optometry recently concluded that lancing of a hordeolum, a process by which a superficial but painful sty near the eye is quickly drained without suture or anesthetic, is outside the scope of practice for optometric physicians because of the 2003 statutory language defining surgery. This is a glaring example of the ambiguity in the current law, because the Board has now prohibited optometric physicians from performing a procedure that they have done safely for years, and that, as is illustrated by the testimony and documentation provided by Dean Smythe and others, is well within the scope of optometry's training and experience.

It is particularly disappointing that WAEPS and others continue to characterize the Bill as a blanket attempt to authorize surgery when the both the language and the intent of the bill make clear this is not the case.[4] The chart introduced with the hearing testimony of Dr. Aaron Weingeist is particularly misleading. The chart appears to depict a current prohibition on all forms of optometric "surgery" that would be largely eroded if the Bill were passed, leaving only a small carve-out of prohibited practices. This is inaccurate. The explicit limiting factors on office-based procedures contained within the Bill would allow only the types of minor procedures that were clearly within the scope of optometry before the 2003 amendment of the optometry law. That amendment introduced a prohibition on ophthalmic surgery, defined as any procedure in which "human tissue is cut, ablated, or otherwise penetrated by incision, injection, laser, ultrasound, or other means..."[5] At the same time, the amendment excluded from the definition of ophthalmic surgery certain identified procedures and other similar procedures within the scope of practice of optometry. It was the intention of the legislature, and of all the persons who participated in the negotiations leading up to the final language adopted by the legislature, that the 2003 amendment would preserve the scope of practice of optometry. Unfortunately, the language of the amendment has been read to accomplish the exact opposite, and diminish optometry's scope of practice. This change created ambiguity in the law, which the Bill will remedy.

Clarity in the law is also critical in ensuring insurance coverage for the services that optometry provides. For example, when optometric physicians submit E&M codes

[4]The claimed fears raised by the Bill's opposition are further put into perspective by the fact that state law already recognizes and to a large extent relies on other non-M.D. health care providers who are authorized to perform injections and other invasive procedures. For example, RCW 18.35, as recently amended by HB 1414, authorizes health care assistants to "administer skin tests and subcutaneous, intradermal, intramuscular, and intravenous injections; (2) perform minor invasive procedures to withdraw blood; (3) administer vaccines in accordance with RCW 18.135.120; and (4) administer certain drugs, in accordance with section 3 of this act."

[5] This definition is so broad as currently written that it encompasses tattooing, ear piercing, manicures and pedicures, and acupuncture, as well as others.

that reflect medical decision making, some payors have routinely denied coverage. Although OPW has not formally tracked statistics for these denials, based on the anecdotal evidence of its insurance liaison, OPW is aware of dozens of occasions since 2003, on which these denials of coverage have occurred.

Significantly, neither WAEPS nor any other group in opposition to the Bill has provided any statistical evidence that calls into question the quality of care provided by optometry in Washington, Oregon, Idaho, or any other state. To the contrary, in hearing testimony, both proponents of and opponents to the Bill were uniform in their recognition of the high quality of skill within optometry's ranks. The concerns raised regarding training are similarly unfounded. Optometric Physicians receive just under 2,000 hours of clinical training in eye systems. By way of comparison, medical doctors who are not ophthalmologists are authorized to perform everything within the scope of the Bill but are increasingly receiving less and less training specific to the eye and eye conditions. (See articles from Ophthalmology Times and American Academy of Ophthalmology, attached at Appendices F, G.)

III. Injections and Corticosteroids

The Bill seeks to revise the scope of practice for optometry to allow for the prescription of corticosteroids and administration of injectable medications. Evidence from other states that already include this authority within the scope of practice of optometry makes clear that this request parallels the current training of optometric physicians and is a safe and reasonable way to increase health care access. For example, in Oregon, where the practice of optometry has included the administration of injectable medication since 2001, optometrists have safely administered injections without incident. (See letter from Oregon Board of Optometry, attached at Appendix H.) Similarly, in Idaho optometric physicians safely administer medication by injection. (See Appendix I.)[6] The training necessary for an optometric physician in these states to be certified to give injections is described in the Oregon and Idaho statutes attached at Appendix J and B.

Washington's optometric physicians are currently authorized to prescribe oral and topical medications that have been approved by the boards of pharmacy and optometry. The Bill follows this current practice and adds only an additional form of delivery to the existing scope of practice, mandating that only those injectable medications that have also received board approval would be authorized for use. OPW anticipates that the medications optometric physicians would be most likely to administer by injection are local anesthetics (e.g. Xylocaine / lidocaine for superficial eyelid lesion removal), corticosteroids (e.g. triamcinolone acetomide / Kenalog as periocular depot injection for severe non-infectious uveitis not responsive to maximal topical treatment; or intralesional injection for eyelid chalazion), and antiobiotics (e.g. IM treatment with a cephalosporin such as

[6] In addition, optometric physicians in 30 other states safely administer medication by injections.

ceftriaxone for pre-septal cellulitis, gonoccocal conjunctivitis, or for immediate antibiotic prophylaxis for penetrating eye injuries prior to referral to a specialist).

Similarly, corticosteroids are already approved for use in 29 states nationwide. It is anticipated that prescription of corticosteroids for ophthalmic purposes would be for short term use. Within this parameter, the benefit can be provided to patients of primary care optometry who need immediate treatment within the relatively safe parameter of short term prescription. As was addressed in the testimony of Dr. Bret Bence, training associated with the use of corticosteroids, precautions regarding prescribing contraindications, and potential complications has been incorporated into the training requirements for Washington's optometric physicians since 2003.

IV. Conclusion

Ultimately, in reviewing the submissions and testimony in support of and opposing the Bill, it becomes clear that optometry provides high quality care. Optometric physicians are well trained to continue to perform the office-based procedures addressed in the Bill, to administer medication by injection and to prescribe corticosteroids for short term use. Moreover, when lack of clarity in the law means that patients who see their optometric physician as their primary eye care provider are not able to receive immediate and appropriate routine treatment or insurance coverage for treatment from that provider, everybody loses.

Optometric physicians are without question the most prevalent eye care providers within the state. Five hundred and one (501) optometric physicians are listed on the Washington Department of Social and Health Services panel, as opposed to one hundred and twenty-two (122) ophthalmologists and 66 opticians. Despite opposition claims to the contrary, the greater numbers of optometric physicians that exist within the state necessarily means they provide patients with greater access to care both in terms of geographic access and immediacy. The claim that a patient can schedule an appointment and drive up to fifty miles to an ophthalmologist to receive routine eye care as quickly and easily as he or she can get to a local mall to see an optometric physician on a Saturday ignores the economic and employment realities of a significant number of Washington's eye care patients.

Opposition to the Bill ultimately boils down to questioning the judgment of optometric physicians. Critics express grave concern that individual doctors will perform procedures that are within their scope of practice while knowing that they are not trained or competent to do them. There is absolutely no basis in fact for assuming that optometric physicians do not have the same good judgment, and the same professionalism, as medical doctors and other health care providers. To the contrary, Washington's optometric physicians have demonstrated a high level of skill and safety and a track record of responsible professional judgment. Patients in

Washington routinely rely on the judgment of M.D.s, midwives,[7] occupational therapists, and other providers to make a referral or seek a consultation when the circumstances call for it. No one assumes that these providers are going to perform procedures they are licensed to perform when they are not competent to do so, and no one should assume that optometric physicians will do so either. It would be a loss to Washington's eye care patients if the Bill were not recommended because of the unfounded attack on the judgment of optometric physicians who interact safely and effectively with patients and other providers every day to the benefit of all.

[7] RCW 18.50.010 codifies patients' reliance on the judgment of midwives as follows, "[i]t shall be the duty of a midwife to consult with a physician whenever there are significant deviations from normal in either the mother or the infant."

Appendices to OPW Follow Up After Hearing

For brevity purposes, we removed multiple pages referencing state laws, appendices A-E, and J, of OPWs follow up document and have listed the statutory references below.

Appendix A
Oregon Revised Statutes – Title 52. Occupations and Professions
Chapter 683. Optometrists; Opticians
ORS 683.010 to 683.310
ORS 683.200. Optometrists; treatments

Appendix B
Idaho Code – Title 54. Professions, Vocations, and Business
Chapter 15. Optometrists
54-1501. Practice of optometry defined

Appendix C
Alaska Statutes Annotated – Title 8. Business and Professions
Chapter 72. Optometrists
Article 4. General provisions
08.72.300. Definitions
08.72.273. Removal of foreign bodies

Appendix D
New Mexico Statutes Annotated
Chapter 61. Professional and Occupational Licenses
Article 2. Optometry
61-2-2. Definitions

Appendix E
Louisiana Statutes
Title 3. Professions and Occupations
Chapter 12. Optometry
1041. Legislative declaration; statement of purposes; definitions

Appendices F-I follow this page as submitted

Appendix J
Oregon Revised Statutes – Title 52. Occupations and Professions
Chapter 683. Optometrists; Opticians
ORS 683.040

Ophthalmology Times, Vol. 30, No. 6, March 15, 2005

Ophthalmology?!—Who needs to learn that?

Medical schools need to emphasize ophthalmology in their curricula

Mar 15, 2005
By: Peter J. McDonnell, MD
Ophthalmology Times

In the first issue of *Ophthalmology Times* after assuming the mantle of chief medical editor, I wrote a piece praising this publication as an effective instrument for providing important, clinically relevant information in ophthalmology. I wish the same could be said for America's medical schools.

Let me explain. Each year, the Association of University Professors of Ophthalmology (www.aupo.org/) convenes in some lovely setting. The attendees are largely department chairpersons and residency program directors from about 125 departments across the United States. The idea is to have a forum where academic leaders can learn from each other about how best to teach their residents and fellows, survive the changes in the healthcare system, strengthen their research programs, etc. For a new chairperson, it represents an opportunity to seek out advice from the most successful chairpersons and to learn some of the things about the position that were taught in medical school.

At this most recent meeting, I learned there is something else they don't teach you in medical school, and it's called ophthalmology. A speaker at the podium asked for a show of hands of those departments where the medical curriculum had a required rotation in ophthalmology. About one-fifth of the hands went up, including my own. No required rotation in ophthalmology and about 80% went up.

In this space that *Ophthalmology Times* allocates to me each issue, I recently (Feb. 1, 2005) opined about what seems to be a decline in many departments of ophthalmology because of the large number of departments without a permanent full-time leader. It seemed to me that many medical schools were de-emphasizing our specialty, and that some deans were focusing increasingly on their "flagship" departments (surgery, medicine, pediatrics) and being forced to ignore the usually small, outpatient-focused ophthalmology departments (I hasten to add that such practice is not the case at my institution).

But why should a dean worry about strengthening a department that does not even have a serious place at the table when it comes to educating his/her medical students? For all I know, perhaps at some schools the ophthalmology faculty are relieved that they do not have to teach every student some of the basics about eye diseases and clinical care in our field. By extension, why should a brilliant medical student consider a career in our field if he or she has no exposure to it, and observes that house officers on the medical and surgical wards are getting by just fine without doing basic examination of the eye, including direct ophthalmoscopy, on every patient?

As an academic ophthalmologist, this trend disturbs me greatly, and I hope we can do something about it. I would like the AUPO and perhaps the American Academy of Ophthalmology to help educate all medical school deans about this issue. Perhaps those of you with influence in your local medical school can also help its leaders to realize what a minority of deans—including mine at Johns Hopkins University School of Medicine—understand, namely that educating our future physicians about the eye is important, and that a medical school that aspires to be great should have a department of ophthalmology that is excellent.

And I would like to offer a medical school dean who doesn't think it is important to educate U.S. medical students about the eye the chance to tell us why in some future issue of *Ophthalmology Times*.

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Impact of a 1-Day Ophthalmology Experience on Medical Students

David A. Quillen, MD, William A. Cantore, MD

Objective: To improve the ophthalmic knowledge and eye examination skills of third-year medical students through the development and implementation of a 1-day ophthalmology experience.

Design: Noncomparative interventional case series.

Participants: One hundred twenty-one third-year medical students at the Penn State College of Medicine completed the 1-day ophthalmology experience.

Methods: A 1-day ophthalmology curriculum, based on the Association of University Professors in Ophthalmology Policy Statement on Medical Student Education, was developed and implemented. The 1-day program consisted of a morning conference series and an afternoon case-based learning and eye examination skills session.

Main Outcome Measures: The students completed a questionnaire to assess the impact of the experience on their ophthalmology knowledge and skills. In addition, the students completed a pretest and posttest to measure the impact of the 1-day ophthalmology experience on their ophthalmic knowledge.

Results: The 1-day ophthalmology experience was effective in improving the ophthalmic knowledge and eye examination skills of medical students based on the results of questionnaires, multiple choice examinations, and skills assessment. There was a statistically significant increase in test score percentage after the 1-day ophthalmology experience: the mean score on the pretest was 55%, compared with a mean score of 80% on the posttest.

Conclusion: The ophthalmology-in-a-day experience is an effective way to improve the ophthalmic knowledge and eye examination skills of medical students. *Ophthalmology 2006;113:2307–2309 © 2006 by the American Academy of Ophthalmology.*

The number of medical schools requiring a formal ophthalmology rotation has declined significantly during the first part of the 21st century—down from 68% in 2000 to 30% in 2004.[1] As a result of limited ophthalmology education in medical schools and primary care residency programs, medical students and primary care physicians are inadequately trained to deal with even the most basic ophthalmic problems.[2,3] They have an insufficient understanding of ocular anatomy, common causes of vision loss, and the relationship between the eye and systemic disease. This decline is not limited to ophthalmic knowledge: Lippa et al recently described a "worrisome erosion" in medical students' eye examination skills.[4]

There is a clear need to improve ophthalmology education for medical students and primary care physicians.[5,6] To reverse the current trend of ophthalmology's declining role in medical education, ophthalmology departments must design innovative and time-efficient educational programs. These programs must be taught by ophthalmologists and must be included in the required curriculum of the school to insure mastery of ophthalmic fundamentals by future physicians.[1] We developed a 1-day ophthalmology experience to improve the ophthalmic knowledge and eye examination skills of third-year medical students at the Penn State College of Medicine.

Materials and Methods

The 1-day ophthalmology experience is the first part of a comprehensive redesign of ophthalmology education at the Penn State College of Medicine. Before this required experience, first-year medical students had a 1-hour lecture on eye anatomy and limited instruction on eye examination skills as part of their physical diagnosis course.

"Ophthalmology-in-a-day" was part of a week-long island rotation developed to improve the clinical skills training of medical students entering their third year of medical school at the Penn State College of Medicine. The island rotation included 1-day sessions in laboratory medicine, the musculoskeletal system, ophthalmology, neurology, and patient–physician communication. The objectives of the 1-day ophthalmology experience were to improve the ophthalmic knowledge and eye examination skills of our students and highlight the importance of ophthalmology in the system of medical education and health care delivery.

The Association of University Professors in Ophthalmology (AUPO) Policy Statement on Medical Student Education served as the basis of our curriculum.[1] According to the AUPO Policy Statement, all students should be able to measure and record visual

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acuity (VA), evaluate a red eye, evaluate a traumatized eye, detect strabismus and abnormal eye movements, detect abnormal pupillary responses, perform direct ophthalmoscopy to detect abnormalities of the optic nerve and fundus, and initiate management and/or referral of detected or suspected abnormalities of the eye and visual system.

The day was divided into 2 sessions. The morning session consisted of 4 conferences conducted by 2 faculty members on ocular anatomy with clinical correlations, common causes of vision loss, trauma and ophthalmic emergencies, and the eye in systemic disease. The conferences were interactive, with ample opportunities for medical student participation. The afternoon session concentrated on eye examination skills: VA, pupils, ocular motility, visual field testing, anterior segment penlight examination, and direct ophthalmoscopy. *Eye Care Skills,* a video presentation highlighting the basic eye examination skills published by the American Academy of Ophthalmology (https://secure3.aao.org/timssnet/products/aao_store_frontpage.cfm; product no.: 0252401), was shown to the entire class. The students were then divided into 14 small groups of 8 to 10 students. A faculty member or ophthalmology resident facilitated each small group session using a standardized approach based on case presentations, skill demonstration, and practice. Approximately 20 minutes were devoted to each skill (5 minutes to discuss the case and 15 minutes to demonstrate and practice the eye examination skill). Six case presentations were developed to stimulate discussion of topics introduced in the morning session and highlight the importance of each examination skill. The Penn State Department of Ophthalmology provided each student with a Rosenbaum-style near card and a penlight equipped with a blue filter. Each student was required to bring a direct ophthalmoscope to the afternoon skills session. For the direct ophthalmoscopy component of the session, one eye of each student was dilated with 1 drop of 1% tropicamide.

The students completed a questionnaire to assess the impact of the experience on their ophthalmology knowledge and skills. In addition, they completed a pretest and postsession examination to measure the impact of the 1-day ophthalmology experience on their ophthalmic knowledge. The pretest and posttest examinations were administered on day 1 and day 5 of the island rotation, respectively (the ophthalmology experience occurred on the second day of the 5-day rotation). Finally, the facilitators were required to observe the students and sign off on each student's ability to perform all 6 eye examination skills competently.

Results

One hundred twenty-one medical students participated in the 1-day ophthalmology experience, which was the top-rated session for the entire 1-week island rotation. Nearly all of the medical students agreed or strongly agreed that the 1-day experience improved their ophthalmic knowledge and eye examination skills. In agreement or disagreement with the statement "the lectures improved my knowledge of the subject areas," the mean score was 4.33, with a standard deviation (SD) of 0.79 (scale: 5, strongly agree; 4, agree; 3, no opinion; 2, disagree; 1, strongly disagree). For the statement "the small group allowed me to practice and improve my skills," the mean score was 4.40, with an SD of 0.79.

The students completed prerotation and postrotation examinations to assess the impact of the 1-day experience on ophthalmic knowledge. A 17-question multiple choice examination was administered to the students at the beginning and end of the island rotation. The questions were taken from the same pretest and posttest examinations administered to third- and fourth-year medical students completing a 1-month ophthalmology elective in the Penn State Department of Ophthalmology. Using a paired t test, there was a statistically significant increase in test score percentage after the 1-day ophthalmology experience: the mean score on the pretest was 55%, compared with the mean score of 80% on the posttest (mean increase of 24%; 95% confidence interval, 22%–26%; $P<0.0001$). This improvement is consistent with the 10-year prerotation and postrotation examination performance of third- and fourth-year medical students completing the 1-month ophthalmology elective in the Penn State Department of Ophthalmology (65% and 85% on the pretest and posttest, respectively).

Discussion

We successfully implemented a 1-day ophthalmology experience for third-year medical students. Ophthalmology was the highest rated session of the entire 1-week island rotation. The 1-day ophthalmology experience was effective in improving the ophthalmic knowledge and eye examination skills of medical students based on the results of questionnaires, multiple choice examinations, and skills assessments. In addition to improving the knowledge and skills of our students, the department successfully reengaged with the institution's medical education community. The Clinical Skills Island Course Director, Vice Dean for Medical Education, and Associate Dean for Clinical Education highlighted the ophthalmology experience as a best practice for the entire island rotation program. The course directors were asked to share the department's approach to the island rotation with the course directors of 4 other departments. Three third-year students met informally with the department chair to express their interest in a career in ophthalmology after their 1-day experience.

Several important factors contributed to the success of the 1-day ophthalmology program: departmental and institutional commitment, development of a targeted curriculum, and standardized teaching and evaluation methods.

Departmental and Institutional Commitment

The department and the institution were committed to improving ophthalmology education at the Penn State College of Medicine. An internal survey of graduating medical students identified ophthalmology (among other areas, including neurology and the musculoskeletal system) as a weakness in their medical school experience. Armed with this report, the Office of Medical Education committed to include an ophthalmology experience in the first island rotation on clinical skills. From the departmental perspective, we advocated that a formal ophthalmology experience—taught by ophthalmologists—provided the best opportunity to train our students. We viewed the island rotation as an ideal opportunity to integrate ophthalmology into medical school training without adding a significant administrative or economic burden to our department. Although there was initial skepticism about the potential impact of a single-day program, the course directors were confident that the learning objectives outlined in the AUPO Policy Statement on Medical Student Education could be achieved. With the exception of the emergency service, the ophthalmology clinic was closed for half a day to enable all faculty and residents to facilitate the small group sessions. Although