

Approved 3-4-86
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE

The meeting was called to order by SENATOR ROY M. EHRLICH at
Chairperson

10:00 a.m. ~~xxx~~ on February 26, 1986 in room 526-S of the Capitol.

All members were present except:

Committee staff present:

Emalene Correll, Legislative Research
Clarene Wilms, Committee Secretary

Conferees appearing before the committee:

Dr. Terry Hawks, Optometrist, Overland Park, Kansas
Dr. Lesley L. Walls, O.D. Glenpool, Oklahoma - written testimony only
Dr. Thomas Lewis, Dean of Academic Affairs & Acting Director of Institute for
visually Impaired, Pennsylvania College of Optometry
Dr. Thomas Griffith, Optometrist, St. Albans, West Virginia
Dr. Tim Harkins, Optometrist, Kansas City, Kansas
Belated Written Testimony - Trish Hall, SB-588 held on 2-20-86

Others attending: See attached list

Dr. Terry Hawks testified and presented written testimony in support of SB-651. Attachment I Dr. Hawks stated that SB-651 would allow optometrists to treat eye diseases with topical medications, remove foreign materials from the surface of the eye, and update continuing education requirements. It was stated that presently optometrists have more training in diagnosis of ocular disease and more training in ocular pharmacology than the general physicians who are currently treating these routine eye problems; also optometric offices are equipped with diagnostic instrumentation that is not frequently found in general physicians' offices. Dr. Hawks referred to written testimony supporting SB-651 from Dr. Lesley R. Walls. Attachment II Dr. Walls stated the detailed ocular anatomy, ocular physiology, ocular pathology, and ocular pharmacology training in optometry school is far superior to the same ocular topics in any general medical school course in the country. This is not to slight medical education, there simply is not enough medical school curriculum time to devote to the eye because of training in vital organ systems such as the heart, lung, vascular system, etc. He also discussed his personal experience with side effects, stating that he had never had a patient with anything other than a very minor side effect from ocular pharmaceutical agents. He saw a few mild allergic reactions and none of these serious and none had evidence of systemic reactions. None ever required hospitalization and certainly there were no deaths. He saw very few significant side effects and all that occurred were very minor in nature.

Dr. Tom Lewis testified and presented written testimony. Attachment III Dr. Lewis presented the committee with educational background of the optometric students. It was pointed out that on-campus clinical training was supplemented by public, private and community resources which include ophthalmology practices and clinics, V A Hospitals, community teaching hospitals, etc. Dr. Lewis stated that optometrists simply wanted to practice their profession to the limits of their competencies.

Chairman Ehrlich introduced the Kansas Hospital Auxiliary members who were visiting the committee meeting, also Dr. Simpson from Sterling, Doctor for the Day and his Physician's Assistant. Other committee members introduced doctors from their districts who were in the audience.

Dr. Tom Griffith testified and presented written testimony in support of SB-651. Attachment IV Dr. Griffith stated that West Virginia was the first state to pass therapeutic drug legislation which allowed for the treatment of eye diseases. It was stated that West Virginia State Board has had no reports

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

CONTINUATION SHEET

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE,

room ~~526-S~~, Statehouse, at 10:00 a.m./~~pm~~ on February 26, 1986

or complaints filed against any West Virginia Optometrist for improper or illegal use of pharmaceutical agents since the passage of the bill.

Staff questioned lines 102 through 112 and was answered by Dr. Terry Hawks who stated that all new applicatns for license would need to qualify and those up for license renewal who did not qualify would eventually be phased out.

Dr. Tim Harkins testified and presented written testimony supporting SB-651. Attachment V Dr. Harkins stated that he practiced for two years in New Mexico and during this time a law similar to SB-651 was enacted. He further stated that he found the required instruction essentially duplicated the education received in optometry school. It was also stated that he felt Kansas law limited his practice to a level below that of his training and below the limitations of his license in another state. In answer to questioning he stated that the move from New Mexico to Kansas was made because of a career opportunity for his wife.

Belated written testimony on SB-588 was presented to committee members. Attachment VI

Meeting adjourned 10:50 a.m.

SENATE
PUBLIC HEALTH AND WELFARE COMMITTEE

DATE 2-26-86

(PLEASE PRINT)
NAME AND ADDRESS

ORGANIZATION

Larry Kepley - Ulysses

Farmer

Gary Robbins

Ks Opt 933N

Jim Youngally - Topeka
Thomas Edm. MD

KOA

KOA

LARRY LUTTOMANN - Topeka

ICOA

J. DAVID CRUM, DR. AUGUSTA

CHARLES G. BEIER, DR.

Rep Don Reese - Otago

Ken Schactermeyer - Topeka

Ks Pharmacists Assoc

Timothy Harkins, DR

KOA

W.P. Howland - St. Louis

URSON CO.

Carl Schmittberger

Ks Dental Assoc

Richard Hamaker

Physician's Assistant

Tom C Simpson MD - STERLING

OKAPP

Thomas Lewis

Adrienne Prokop

AMERICAN SOCIETY OF Ophthalmic
REGISTERED NURSES - Kansas Chapter

Suzanne Collins

univ of Ophthalmologist

Edward J. Collins M.D.

Ophthalmologist

Harold C. Pitts

TARTA

Larry E. Harris, DR

Rich D. Summers DR

Optometrist

Joe Bee, M.D.

Ks. Society of Ophthalmology

Frank H. Griffith MD

Ks State Ophthalmology Society

Good morning, I am Dr. Terry Hawks, a practicing optometrist from Overland Park. I am a 1974 graduate of the University of Houston College of Optometry and am President of the Kansas Optometric Association which represents some 300 Kansas optometrists.

Senate Bill 651 would allow optometrists to treat eye diseases with topical medications (drops and ointments) applied to the surface of the eye. Neither oral medications nor injections are allowed by this legislation.

Secondly, optometrists could remove foreign material from the surface of the eye.

Additionally, we wish to update our continuing education requirements to a minimum of 20 hours per year. This reflects the current practice of the majority of our members and gives the State Board of Examiners in Optometry the discretion to increase the hours as needed. No "grandfathering" is allowed with this bill, as only those optometrists who complete and pass a 100 hour transcript quality course and who pass the Kansas Board of Examiners in Optometry examination may utilize pharmaceutical agents in treating their patients.

At the present time, primary eye care in Kansas is being delivered by General and Family Practitioners, optometrists and ophthalmologists. Ophthalmologists are specifically trained to provide surgical and advanced medical care of the eye.

Attachment I
2/26/86 S. PH&W

Attachment I

There has been some misunderstanding that we want to replace ophthalmology by acquiring topical treatment and foreign body removal. This is incorrect. We don't want to provide any of the surgical and advanced medical care that ophthalmology provides. We are thankful to have these fine physicians to whom we can refer our patients for complicated eye diseases and surgery, just as we feel blessed that there are family practitioners, internists, neurologists and endocrinologists to refer our patients to for non-ocular care such as diabetes, thyroid problems, hypertension, tumors, viral infections, etc. However, we do want to compete with ophthalmology for provision of primary eye care.

Optometrists are distributed in nearly seventy-five percent of Kansas counties on a full-time basis. Optometrists currently are required by Kansas law to examine for and make specific diagnoses of eye diseases. We have routinely used diagnostic pharmaceutical agents since 1977. These drugs allow us to perform proper clinical procedures to make these diagnoses, such as dilating pupils. We manage patients and, where appropriate, refer to or consult with various branches of medicine for relief of disease, injury, or inflammation of the eye. Optometry is an integral part of the health care system. Over the years, optometry's relationship with ophthalmology has been excellent in providing quality vision care for Kansans. A system of referral for complicated eye problems and surgery established over the years is working effectively.

Ours is an evolving profession. Optometry law in Kansas was first enacted in 1923. Since that time a four year post-graduate course of study with the doctorate level degree has become standard.

In 1940, Kansas became one of the first States to have a continuing education requirement for optometrists. In 1977, we sought and obtained from this Legislature the right to use diagnostic drugs. We again need to re-define optometric practice acts for the benefit of the public and to accurately describe our profession. No profession remains static. Dynamic advances in health care and optometric education have occurred over the last 15 years. New products since the 1977 legislation such as extended wear contact lenses, have both solved and created new problems for our patients. Improvements in diagnostic techniques and instrumentation have also occurred in the nine years. With the widespread use of diagnostic drugs, procedures not envisioned a decade ago are being utilized today.

We would like to care for our patients who come to us with routine eye problems just as the family practitioner provides care for his patients with routine health problems. We use clinical judgment every day by diagnosing and responsibly referring our patients to secondary care practitioners when necessary.

We've always enjoyed good rapport with ophthalmology, and we expect this to continue. Unfortunately, we are unable to meet our patients' expectations of treatment for primary conditions that we could easily provide. The present system requires that these patients suffer unnecessary discomfort as well as time, travel and

monetary loss by seeing a secondary provider for conditions that optometrists are qualified to treat. Many of them must be seen in emergency rooms since no secondary provider is readily available. This, of course, is not an efficient use of our hospitals and is surely an economic waste.

We presently have more training in the diagnosis of ocular disease and more training in ocular pharmacology than the general physicians who are currently treating these routine eye problems. Optometric offices are equipped with diagnostic instrumentation that is not frequently found in general physicians' offices.

We, therefore, offer to the public an improved management of these entry level problems by providing widespread service and availability. The patient who has consulted an optometrist for relief of routine eye problems should be allowed to receive treatment in that office.

Objections by ophthalmology will be heard by this committee. They will contend that optometrists are not well educated, don't have clinical experience, that these drugs are inherently dangerous, and that the public will suffer harm if this bill is made law.

The ophthalmologists misunderstand our current education and training which has changed over the past fifteen years. Just as ophthalmologists have updated their skills in secondary care to do laser surgery and cataract lens implants, so have optometrists

updated their education and skills in primary treatment. The advances in both professions have been accomplished through the continuing education process for established practitioners, the updating of our respective schools' curricula, and the evolution of more sophisticated instrumentation.

Nine years ago, by this same updating process, we were permitted by the legislature to use diagnostic pharmaceutical agents. In that time span, the State Board of Examiners in Optometry has received no complaint of any harm or misuse of these drugs. Through proper use of these diagnostic drugs, there have been no reports of any significant systemic side effects. This is true even though these diagnostic drugs are potentially more harmful than the therapeutic drugs requested by this bill.

This legislature was told in 1977 that the use of diagnostic drugs by optometrists would lead to significant side effects resulting in public harm. This has not happened. Optometric conservatism is a major factor in the care given to our patients. As primary care professionals, optometrists tend to seek consultation, advice, and support from specialists in any field relating to areas involved in diagnosis and patient management. If optometrists have misdiagnosed and failed to properly refer ocular and systemic problems, the state board complaint record and malpractice insurance rates would reflect these deficiencies. This track record of safety in diagnosis is a product of both conservatism and competency.

As you have been made aware, optometry has attempted to resolve this issue prior to today with ophthalmology. They understandably resent any change that broadens optometric services. The issue isn't what is in the Bill, only that there is a Bill.

In summary:

1. Senate Bill 651 asks to perform procedures that are within the education and training of optometrists. The bill ensures additional education and training by requiring 100 hours of lecture and clinical training. I would refer the Committee to Dr. Lesley Walls' comments on optometric education in his letter attached to my testimony. Dr. Walls is the Head of Family Practice, University of Oklahoma Medical School, Tulsa Branch.
2. Optometrists have been using diagnostic drugs safely in Kansas for approximately (9) nine years. Optometric use of therapeutic drugs proposed by this bill does not pose any increased risk (I would again refer you to Dr. Walls' letter). Seven states -- West Virginia, North Carolina, Oklahoma, Iowa, New Mexico, Rhode Island and Kentucky -- now allow procedures similar to those requested by this bill. Similar legislation is pending in Nebraska, Missouri, South Dakota and Florida.
3. Optometry is not trying to replace ophthalmology. What optometry does wish to do is to perform primary care services needed by our patients the same as general physicians do at the

present time. Referral to ophthalmologists of complicated visual problems and to other specialties of medicine for non-ocular care will continue.

4. Optometrists are well distributed geographically throughout the state and can perform these services at less cost to the patient. By cost, I also mean less time away from work and travel time. This legislation is a benefit to the public and more accurately defines the optometric profession.

I thank you for your consideration.

**UPDATING
KANSAS
OPTOMETRY
LAW**

Kansas Optometric Association

Purpose of the bill

The Kansas Optometric Association is supporting legislation to update Kansas Optometry Law. This legislation will permit doctors of optometry to utilize their education to prescribe and use topical pharmaceutical agents for the treatment and management of eye diseases. Also included is a provision to allow removal of foreign bodies from the eye without the use of surgery. This legislation will ensure the availability of quality vision care at a reasonable cost to the residents of Kansas. This binder contains a summary of the legislation being requested as well as documentation supporting our belief that this legislation is in the public interest.

We expect opposition to this legislation from organized medicine in general and ophthalmologists in particular. Although medicine's questions appear to be about the optometric education and the public safety, the real reasons for their opposition are economic. It is optometry's belief that the legislation speaks to and provides safeguards to the public.

If you would like additional information or documentation, we would be happy to provide it.

Five reasons for updating Kansas Optometry Law.

Kansas optometrists are educationally prepared to diagnose and treat their patients.

Allowing optometrists to treat the conditions they now diagnose will save Kansas citizens money.

Kansas optometrists are more accessible and better equipped to provide efficient care.

Kansas optometrists' track record proves their effectiveness in diagnosis and treatment.

Kansas optometrists should be allowed to provide the public the full benefit of their training and experience as vision care professionals.

1. Education

The average optometry graduate has eight years of college and graduate education, the first four being in predominantly pre-medical school courses.

Optometry students receive more hours of training in the diagnosis and treatment of eye disease than do general medical students.

Optometrists' education in pharmacology is comparable to that of medical students in terms of hours with emphasis on ocular pharmacology in optometry school.

2. Economics

Optometrists' fees are generally lower than those of physicians and hospitals. Increased competition in the service of primary eye care will help control those costs.

The cost of a visit to another doctor or hospital will be eliminated.

Extra travel time will be eliminated.

Extra time away from work will be eliminated.

This bill will allow optometrists to treat the same conditions that they have been diagnosing.

3. Efficiency

Optometrists practice full-time in 74 of 105 Kansas counties while ophthalmologists practice full time in only 23.

By virtue of their training and the availability of specialized instruments, optometrists are better equipped than general physicians to diagnose and treat eye disease.

4. Effectiveness

Since 1977, optometrists have been permitted to use drugs for diagnostic purposes. There have been no reports of significant adverse reactions.

Although there has been an increase in all liability insurance premiums, malpractice premiums for Kansas optometrists showed no significant increase following legislation authorizing them to use drugs for diagnostic purposes. In the seven states where optometrists are currently permitted to treat eye disease, there have been no substantiated reports of problems and no significant increase in malpractice premiums due to the legislation.

5. Equity

At the present time, two non-physician health professions (dentistry and podiatry) are permitted by Kansas law to administer and prescribe drugs for the treatment of disease. Optometrists have similar education, without similar privileges.

Optometrists have proven themselves to be competent, conscientious health professionals.

Kansas Optometrists are educationally prepared to diagnose and treat their patients.

Optometric education has expanded beyond the framework of current state law. Like any profession, optometry would like to be allowed to provide those expanded services which are consistent with the current scope and training of its member doctors of optometry.

1. Eighty percent of all students accepted into optometry schools have already completed four-year bachelor degree programs. The optometry program is an additional four-year program which includes studies in optics, pharmacology, disease processes, detection and treatment of eye disease, microbiology, neurology, physics, physiology, anatomy, and public health. Thus, the average educational background of an optometrist is eight years of college-level and advanced graduate study.
2. Clinical experience is received in hospitals and clinics in a variety of urban and rural settings.
3. Optometrists possess an education similar to dentists and physicians, and support the concept that scope of practice be based upon proven education and demonstrated clinical competency. Optometrists are now prepared to deliver treatment programs which require therapeutic pharmaceutical agents.
4. Among the health professions trained in therapeutic pharmacology (medicine, dentistry, podiatry, and optometry), only optometry is restricted to the use of certain diagnostic pharmaceuticals.
5. All schools and colleges of optometry are accredited by the same types of organizations which accredit medical schools.
6. All Kansas optometrists, after graduating from an accredited school or college of optometry, must further demonstrate competency by successfully passing a state board examination prior to being licensed to practice.
7. Since 1940, Kansas law has required that optometrists complete 10 hours per year of continuing education in order to renew their licenses to practice. This bill would double the current requirement to twenty (20) hours per year.
8. The proposed amendments to the statute will not allow "grandfathering" of presently licensed optometrists to use therapeutic pharmaceutical agents. Each optometrist will be required to provide evidence of having received the required 100 hours of transcript-quality training, and demonstrate competence in order to be certified to use therapeutic pharmaceutical agents.
9. *The Gourman Report*, a rating of graduate and professional programs in American universities, gave each of the 13 schools and colleges of optometry its highest rating, with scores ranging from 4.67 to 4.96 on a scale of 5.0. Only 15% of American medical schools received the highest rating, and only 13% scored as high as the optometry schools.
10. Optometric education includes more than 1500 hours of training specifically related to the diagnosis and treatment of eye disease.

Education

11. Optometry students receive an average of 156 hours of classroom training in pharmacology (the use of drugs), about one-half of which is specifically related to drugs used in the diagnosis and treatment of eye disease. Medical students typically receive a comparable number of hours in pharmacology. However, only a small part of that pharmacology is related to the eye.

In recent years the expansion of medical knowledge has led to a decrease in the amount of training physicians receive in the diagnosis and treatment of eye disease. A survey by the Association of University Professors of Ophthalmology showed that the average medical student in the United States receives only 22 hours of lectures and demonstrations on eye conditions during the entire four years of medical school. The editor of the *American Journal of Ophthalmology* has stated, "One can no longer depend upon primary care physicians to have a general awareness of ocular abnormalities." It is our position that optometry can provide this care for our patients.

Robert E. Kalina, M.D., in
American Journal of Ophthalmology
March, 1982

"There is much less ophthalmic instruction in medical schools today than in those of a generation ago. One can no longer depend upon primary care physicians to have a general awareness of ocular abnormalities."

Henry J. L. Van Dyk, M.D., and
George W. Weinstein, M.D., in
"Ophthalmology Training in
Medical Schools"
Journal of Medical Education
February, 1981

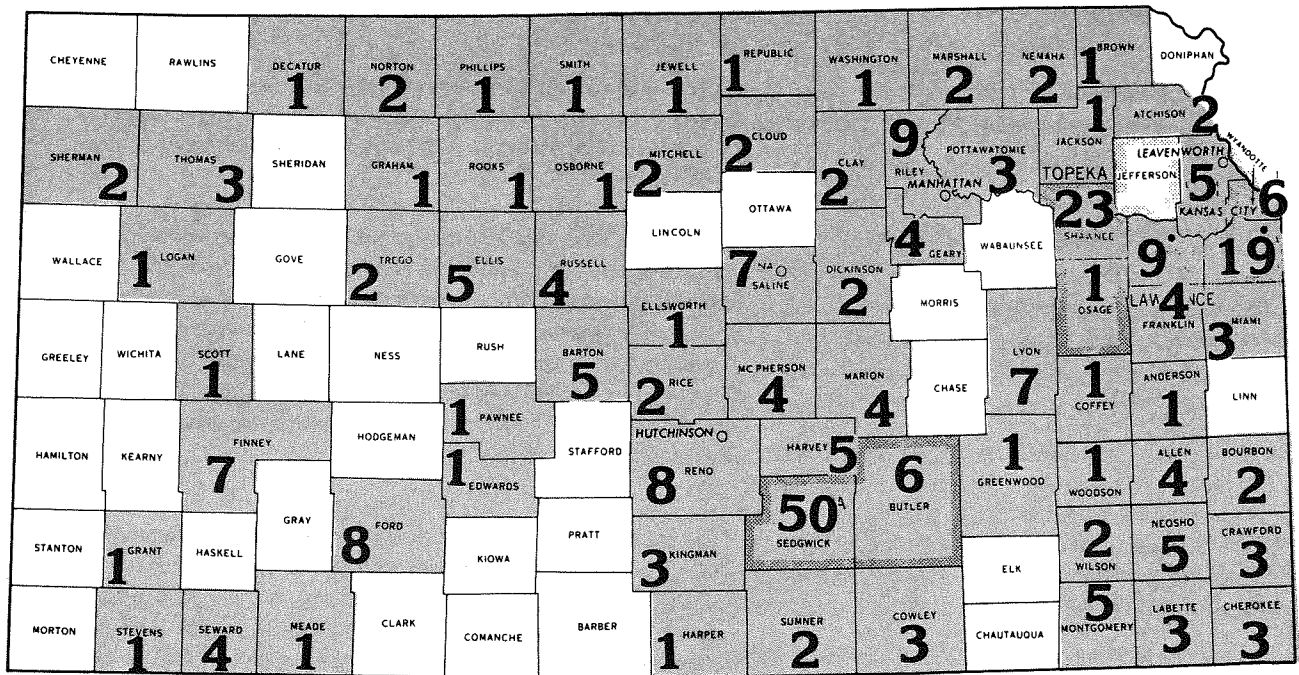
"There was a decline in mean required curriculum hours from 25 in 1974 to 22 in 1979, while the median declined from 18 to 15. Hours actually assigned to the department or division of ophthalmology decreased proportionately from a mean of 22 in 1974 to 20 in 1979. Assigned hours were most frequently for lectures or demonstrations . . . (Instances in which ophthalmology teaching is done in a primary care clinical setting) . . . are rare, often unscheduled, and likely to be the first to suffer from time constraints."

L. A. Winograd, M.D., Editor
"The Ophthalmologist"
March/April 1978

"The students that I now teach are assigned on an elective basis for a total of two weeks in the Junior year to the eye clinic! Aside from a few lectures in the basic science years, this is the extent of their exposure to ophthalmology — and only about 50% of the students elect the eye clinic. The other 50% may never set foot in the eye clinic before graduation!"

**Kansas
Optometrists are
more accessible
and better
equipped to
provide efficient
eye care.**

Optometrists practice full time in 74 of 105 Kansas counties while full time ophthalmologists practice in only 23, primarily in the large urban areas.



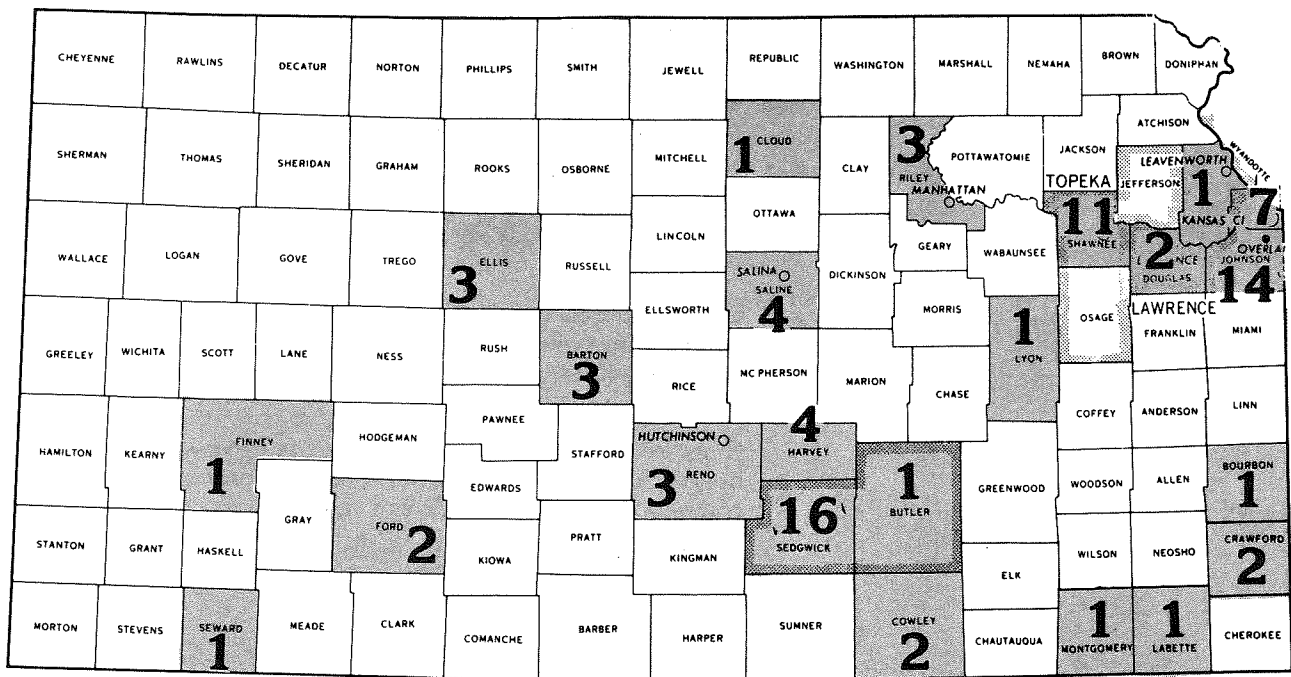
Distribution of
Optometrists
February, 1986

Total 296 Optometrists

Efficiency

By virtue of their extensive training and the availability of specialized instruments, optometrists are better equipped than most non-specialized physicians to diagnose and treat eye disease.

72% of the ophthalmologists are located in only nine counties.



Distribution of
Ophthalmologists
February, 1986

Total: 85 Ophthalmologists

Kansas Optometrists' track record proves their effectiveness in diagnosis and treatment.

Joseph C. Toland, M.D.
Professor of Ophthalmology
Jefferson Medical College
Philadelphia, PA

1. Since 1977 Kansas optometrists have been permitted to use drugs for diagnostic purposes. There has never been a report of a significant adverse reaction.
2. Except for the general increase in all liability insurance costs, malpractice premiums for optometrists have not increased significantly in the last five years.
3. In the seven states where optometrists are currently permitted to treat eye disease there have been no substantiated reports of adverse outcomes and no increase in malpractice premiums attributable to the legislation.

"Optometrists are more capable of diagnosing eye disease than general practitioners . . . Optometrists are more than adequately educated in the basics of pharmacology and the rational use of drugs as professionals."

Why should the scope of Optometric Practice be updated?

1. This change is a tried and proven method of lowering the cost of eye care for the consumer without lowering the quality of care.
2. Health care practitioners, including optometrists, are responsible for providing their patients with the highest level of eye care consistent with their education and training.
3. Current optometric training provides the doctor of optometry with the skills and expertise necessary to update his or her scope of practice to include the use of medications to treat common eye disease.
4. Changes in Kansas statutes have lagged behind the advances and expansions of optometric education and training thereby preventing Kansas optometrists from providing the best possible care to their patients.
5. It has been conclusively demonstrated in other states that the use of pharmaceutical drugs by qualified optometrists to treat common eye diseases is safe and cost-effective.
6. At present, optometrists are legally required to diagnose eye disease. Treatment of the disease that has been diagnosed is a logical extension of this requirement.
7. In many Kansas communities, the doctor of optometry is the only health professional who is specifically trained and licensed to detect and diagnose eye disease and monitor a program of treatment.
8. HMO studies have shown that the utilization of doctors of optometry to the full extent of their training lowered the cost of care by as much as 36%.
9. The far greater accessibility of the doctor of optometry, who serves as the primary provider of eye care services, greatly increases the cost-effectiveness of eye care.

**Kansas
Optometrists
should be allowed
to provide the full
benefit of their
training and
experience.**

At the present time, two non-medical health professions (dentistry and podiatry) are permitted by Kansas state law to administer and prescribe drugs and/or perform surgery. Optometrists are at least as well-trained in their area of specialization as are these professions. Dentists and podiatrists use oral drugs with much greater potential for systemic side effects than the topical medications optometry is requesting. The absence of reports of dire consequences is strong evidence against the argument that "medical education and training is required in order to competently prescribe drugs."

Lesley L. Walls, O.D., M.D.
Post Office Box 78
Glenpool, Oklahoma 74033

February 19, 1986

Honorable Roy Ehrlich, Chairman
Senate Public Health and Welfare Committee
State House
Topeka, Kansas 66612

Dear Senator Ehrlich:

I am writing you in support of Senate Bill 651 which would broaden the scope of practice for optometrists in the State of Kansas. I know this topic is an emotional issue, however, I feel that careful review of other states, etc. will substantiate the fact that with proper education and training it is safe. As well, in the present day of astronomical health care costs I feel it is cost efficient. I also feel that with such a law it can be demonstrated that better and more appropriate referrals to physicians will be made by optometrists.

I write to you with a personal background of graduating from both optometry school and medical school. I am very comfortable presently and have no axe to grind, rather simply wish to express my personal opinion.

Let me now address some specific aspects of optometric and medical education by my own first hand experience.

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

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

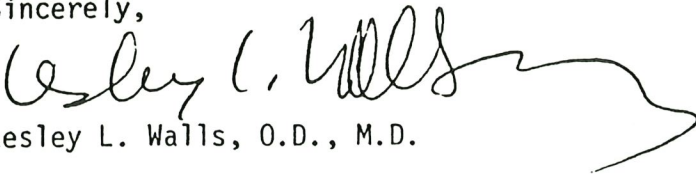
A On the other hand, optometry school is mostly devoted to ocular training. There are courses in general pathology and ocular signs of systemic disease because the optometrist is responsible to detect systemic diseases with ocular manifestations and to make appropriate referrals. The detailed ocular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

B Secondly, I will discuss my personal experience with side effects of ocular pharmacologic therapy. This section will be very brief as I have never had a patient with anything other than a very minor side effect from ocular pharmaceutical agents. I have seen a few mild allergic reactions and none of these serious and none had any evidence of systemic reactions such as elevated blood pressure, rapid heart rate, arrhythmias of the heart, etc. None ever required hospitalization and certainly there were no deaths. I have seen very few significant side effects and all which have occurred were very minor in nature.

In summary I would like to point out that ophthalmologists are vitally needed. The medical profession would be in sad shape without them because of their expertise in the area of ocular trauma, cataract surgery, retinal surgery, serious ocular infections, etc. However, in a rural state the ophthalmologists are primarily in large and medium sized cities with a poor distribution in the rural communities.

I also strongly feel that optometrists are vitally needed. Optometrists are well distributed in rural communities and by definition serve as primary care professionals. In my opinion, the patient, particularly in the rural areas and small town, will be the beneficiary of modern optometric practice. With the use of pharmaceutical agents, disease detection will be facilitated thus making the referral system into medicine more efficient. As well, this will save the patient a lot of inconvenience and time. I feel optometrists should be allowed to practice modern optometry which includes therapy with various pharmaceutical agents. I believe the key to utilizing these medications by any health care professional is proper education and training.

Sincerely,



Lesley L. Walls, O.D., M.D.

LLW/laj

TESTIMONY

SENATE PUBLIC HEALTH & WELFARE COMMITTEE

FEBRUARY 26, 1986

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

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

I am here this morning to discuss some of the basic elements of optometric education as they relate to the legislation being considered by this committee. I believe that I can assure you that optometrists are far better trained than any other primary health care practitioner with the exception of a residency in

Attachment III
2/26/86 S. PH&W

Attachment III

ophthalmology to provide therapeutic eye care to the people of Kansas.

The fundamental philosophy of professional optometric education is equivalent to that of all other health professional programs including medicine, dentistry, osteopathy, and podiatry. The biomedical and the clinical sciences are taught in the classroom, applied in the clinics and refined through internships, externships, and residencies.

Eighty percent of the students entering optometry school have completed four years of college and hold a baccalaureate degree. Pre-requisite requirements for optometry include basic and advanced biology, physics, chemistry, and a variety of social sciences. These requirements are similar to medicine, dentistry, osteopathy, and podiatry. All 15 schools and colleges of optometry are accredited by the same agencies as other health professions, and all receive substantial federal and state grants and subsidies.

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

Endocrinology and Neurology given the ever increasing percentage of diseases that these systems produce which affect the eye.

The previously mentioned basic biomedical science courses are directed toward a greater understanding of systemic diseases. Courses in medical urgencies and emergencies and clinical medicine (taught by physicians) discuss the role of the primary care optometrists, including emergency medical care such as CPR, and the management of patients with systemic diseases. Optometrists learn to recognize systemic disease through proper history and patient interview, direct observation, and various clinical signs and tests.

It is important to note that all the biomedical sciences courses taught in other health professional schools are also included in the curricula of the schools and colleges of optometry, and that the quality of the instructors is similar. (* See Appendix A.)

Two areas which require special comment include pharmacology and the diagnosis and treatment of ocular diseases. On an average, 156 hours of pharmacology are presented at the schools and colleges of optometry. This is equal to or greater than all other health professions that use therapeutic pharmaceutical agents exclusive of residencies. The courses are taught by faculty with credentials similar to those teaching pharmacology to medical, dental, osteopathic, and podiatric students. Within these courses, greater emphasis is placed on ocular pharmacology than those courses presented to other health professionals including general physicians.

Pharmacology courses in optometry schools emphasize the systemic manifestations of ocular drugs, ocular manifestations of systemic drugs, toxicities and adverse reactions. In essence, optometrists receive more training than all other non-ophthalmologic health care practitioners in ocular pharmacology.

Ocular disease diagnosis and treatment is covered more extensively and comprehensively in optometric curricula than in any other health professional program. The courses include a detailed discussion of the history, symptoms, clinical picture, etiology, prognosis and management related to ocular diseases. Students are presented the histopathological basis of all diseases discussed. Special emphasis is placed on the importance and potentially life-threatening implications of certain systemic diseases which may manifest through ocular signs and symptoms.

The management of ocular diseases is approached in a manner which supports the role of the optometrists in dealing with these conditions at the primary care level. This is done by emphasizing early vs. advanced conditions, simple vs. complicated conditions, conditions that respond well to treatment vs. resistant diseases, the need for timely referral and most appropriate referral sources, and conditions requiring advanced medical and/or surgical treatment. The diagnosis and treatment of ocular diseases is taught by highly qualified experts, including board certified ophthalmologists and sub-specialist ophthalmologists.

Clinical training programs at the schools and colleges of optometry begin during the first year of training with maximum patient care exposure during years three and four. A variety of innovative teaching techniques are used to maximize the students' potential exposure to the largest number of eye diseases, their treatment and management. These techniques include closed circuit television and video technology, case conferences, group observations, and grand rounds. All schools and colleges support multi-disciplinary faculties of medical, optometric, ophthalmological, social, psychological, and rehabilitative practitioners and specialists. These disciplines teach optometry students on live clinical patients.

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

At many schools and colleges of optometry, the on-campus clinical training is not the sole source of the students' clinical experiences. As in medicine, an externship program plays a significant role in training. Public, private and community resources with supervised preceptors serve as settings for externs. These would include ophthalmology practices and clinics, health maintenance organizations, military hospitals and clinics, V.A. hospitals, public health hospitals, community teaching hospitals, Indian health services, and multi-disciplinary clinics. Optometric practices in states which currently allow the use of therapeutic

drugs to treat eye diseases also are an ideal location for externships.

Continuing optometric education follows the same tenets just described for the professional optometric curriculum. This includes discussion of ocular diseases or conditions from their basic science understanding through their clinical management. Multi-disciplinary teaching settings are also used in continuing education. The Pennsylvania College of Optometry has been extensively involved in continuing education presenting its Ocular Therapy course in 13 states to over 1,220 optometrists.

In reality, the most effective continuing education to update and maintain clinical competency is the less structured and informal process of self-education. Ophthalmic literature is extensive and available to optometrists through medical and/or optometric journals, audiovisual and video programs, and books and monographs. Optometrists also collaborate with other health professions, including ophthalmologists, on a day-to-day basis with a significant exchange of knowledge and information occurring. One can never underestimate the importance of years of clinical experience which improve the skills and competencies of all health care professionals.

Hopefully, this gives the committee an overview of the current status of optometric education.

Now let us compare the education of optometrists and general

physicians as it relates to the treatment and management of eye disease. In a rural state such as Kansas, a high percentage of anterior segment eye disease is being treated by non-ophthalmological physicians. If you compare the training of optometrists with these non-ophthalmological physicians, you will find some startling results. A recent textbook by Jacob T. Wilensky and John E. Reed, both ophthalmologists at the University of Illinois at Chicago, entitled, Primary Ophthalmology, was written to address the inadequacies of general physicians' training to treat eye diseases. The following are quoted statements from this textbook:

"Most medical students receive little exposure to ophthalmology in medical schools.

"Moreover, residencies and family practices, internal medicine, pediatrics, and emergency medicine commonly fail to correct this deficit.

"A significant number of physicians graduate without ever having been formally taught how to examine an eye or manage common ocular problems.

Unfortunately, the constant comparison made concerning the issue before you is between optometry and ophthalmology. The comparison should be made between optometry, dentistry, podiatry, and general medicine. Optometrists are not attempting to become ophthalmologists. They simply want to practice their profession to

the limits of their competencies.

COMPARISON OF TOTAL COURSE HOURS IN
BIOCHEMISTRY, PATHOLOGY, PHYSIOLOGY AND PHARMACOLOGY
AT SELECTED PENNSYLVANIA HEALTH PROFESSIONAL SCHOOLS

<u>SCHOOL</u>	<u>TOTAL CLASSROOM HOURS (per catalog)</u>	<u>CLINIC & LAB HOURS (approx.*)</u>	<u>TOTAL HOURS</u>	<u>LICENSURE RESTRICTIONS</u>
Pennsylvania College of Optometry	612 hours	1800 hours	2412	Limited to topical diagnostic agents
University of Pennsylvania School of Dentistry	621 hours	1600 hours	2221	None
Thomas Jefferson Medical College	475 hours	>2000 hours	2475	None
Philadelphia College of Podiatric Medicine	430 hours	Unavailable	-	None
Philadelphia College of Osteopathic Medicine	528 hours	>2000 hours	2528	None

* Clinic and laboratory hours are interpreted differently for comparative courses within each catalog.

I am Dr. Thomas Griffith from St. Albans, West Virginia. I graduated from Illinois College of Optometry in 1974. I have been in private practice in St. Albans for 12 years. I am also chairman of the West Virginia Optometric Association Continuing Education Committee. I am a Preceptor for optometry students on clinical externships from both Pennsylvania College of Optometry and Southern College of Optometry.

In 1976, West Virginia was the first state to pass therapeutic drug legislation which allowed the treatment of eye disease. In the last decade, we have been able to serve our patients properly and effectively. Our law is comparable in substance to the legislation pending before you today. Optometrists in West Virginia routinely utilize diagnostic and therapeutic drugs and remove foreign bodies from the surface of the eye. Over the last decade we have served the people of West Virginia and saved considerable time and money over comparable care.

Ophthalmology in West Virginia have made allegations of improper care by optometrists during this last decade. By law, the West Virginia Board of Optometry has been given the authority to certify, monitor, and discipline optometrists in the area of pharmaceutical use. As of Monday, February 25, the West Virginia State Board has had no reports or complaints filed against any West Virginia optometrists for improper or illegal use of pharmaceutical agents since the passage of the bill.

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Attachment IV
S. PH&W

My optometric training and education has prepared me to recognize potential risks of side effects before prescribing or administering pharmaceutical agents. In my ten years of use of these drugs, I have only had rare occasions where there has been any side effect from their use. The effects were recognized and were easily managed by me in my office. My experience is typical of my colleagues who provide this type of optometric care in West Virginia.

There are many reasons we could discuss to show the advisability of passage of this legislation. However, the best of these concern the improvement of care to a great majority of the people of your state. Like West Virginia, many of your people live in the smaller communities without immediate ophthalmological services. Most of these areas already have optometric practitioners. These optometric practices already have in their offices the technology as well as the basic knowledge to provide the type of care requested by this legislation.

My optometric education gave me the basis upon which I obtained quality continuing education and personal clinical experiences to equip me to deliver this level of care to my patients in West Virginia.

As examples of the benefits to the public I have had the

opportunity to care for individuals who could not obtain ophthalmological care due to age or physical impairment.

On Monday an 85-year-old lady recovering from total hip replacement was brought to my office with a red painful eye. This was caused by a marginal corneal ulcer which required immediate care. Due to her physical impairment, she was unable to travel except locally. My ability to provide this lady with proper care was both beneficial to her and cost effective.

There are numerous other examples of individuals such as workers and a mother with children who are able to be served with minimal disruption to their lives.

Ocular diseases such as glaucoma are more properly and effectively managed by frequent follow-up. Care of these patients by their their local optometrist who is more accessible ensures that the patient is more likely to present themselves in the optometrist's office to receive the required care.

Likewise the patients who experience ocular foreign bodies are more likely not to suffer severe ocular damage when they are removed by the local optometrist timely because of easier accessability to the required care. Optometrists can safely and effectively provide this type of care.

I have been actively involved in therapeutic practice in West

Virginia for over ten years; and it works.

Senators, I want to thank you for this opportunity to appear on Senate Bill 651. I am Dr. Tim Harkins, a practicing optometrist from Kansas City, Kansas. I support the proposed changes in the Kansas Optometry Law.

Opponents of Senate Bill 651 argue that optometrists lack the training to properly use topical pharmaceutical agents to treat ocular conditions. As a recent graduate of the Southern California College of Optometry, I assure you that today's optometrists have the education and are well qualified to treat the ocular conditions in the manner described in this bill.

Subsequent to my graduation in 1983, I was licensed by the State of New Mexico and practiced there for two years before joining my present practice in Kansas City, Kansas. While I was in New Mexico, legislation similar to Senate Bill 651 was enacted in that State. To become licensed to use the topical pharmaceutical agents allowed by that legislation, optometrists were required to take a course consisting of 100 hours of classroom and clinical training on diagnosis and treatment of ocular diseases. The proposed requirement for optometrists currently practicing in Kansas is also 100 hours. This course was taught by outstanding ophthalmologists and optometrists, and included instruction by a professor who teaches the same pharmacology course to students of both the Indiana University School of Optometry and the Indiana University School of Medicine. While I found the course to be well-instructed, stimulating, rigorous, and comprehensive, I also found it to be essentially a

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Attachment V
S. PH&W

Attachment V

review of my education in optometry school. My optometric education included, but was not limited to, 150 classroom hours in the diagnosis and treatment of ocular disease as well as 1500 hours of clinical training in Veterans Administration hospitals, military hospitals and other teaching clinics. This clinical training included removal of foreign bodies, treatment of glaucoma, diagnosing and treating the different causes of red eyes, etc. The New Mexico course confirmed my belief in the quality of the education of today's optometrists. Our training enables us to safely and competently provide this type of care to our patients in the State of Kansas.

Under the current restrictions, I find it discouraging that I am required to diagnose, but am prevented from treating ocular conditions that are presented in my office. Instead, I must refer them for a repeat of my tests and diagnosis, so they may receive the same treatment that I could have provided. Not only is this unfair to my patients, but it limits me to practicing optometry at a level below that of my training and at a level below the limitations of my license in another State. I am therefore unable to provide my patients with the highest level of care consistent with my education.

Thank you for your thoughtful consideration of this measure.

DATE: February 20, 1986
TO: Senate Public Health and Welfare Committee
SUBJECT: SUPPORT FOR S.B. 588 -- SRS FUNDING FOR NURSING
CARE SERVICES

Mr. Chairman and Members of the Committee:

My name is Trish Hall, Regional Supervisor for Beverly Enterprises-Kansas. I would like to thank you for taking the time to allow me to address the bill and issue as it relates to urban areas and nursing homes.

Let me start off by confirming my support of the philosophy behind the concept of 24-hour nursing care. We have been diligently trying to meet the criteria for well over a year and at every turn we find roadblocks that reinforce the fact that philosophy and economics don't make for good bed fellows. Please consider:

Real World Considerations:

- 1) The \$6.31 SRS average nursing home wage is not realistic. Urban average is between \$7.00 and \$7.50 at present.
- 2) In order to meet the "competitive" criteria for a waiver we will be forced to deal with the salaries and benefits being offered by hospitals, industry, and home health agencies, and other employers of nurses, including state agencies.
- 3) Additional training costs for new employees and continuing education units for them.
- 4) Salary adjustments.
Cost fallout - Inhouse adjustments to acknowledge tenure for existing employees.

The attached example shows the fallacy of the replacement salary methodology, and because of the SRS funding limitation, the expense incurred by a facility.

Your favorable reporting of S.B. 588 is requested.

Attachment VI
2/26/86 S. PH&W

Attachment VI

FACILITY EXAMPLE OF COSTS

Additional coverage - one shift.

Raw wage -----	\$7.00 hour
+ .27¢ benefit factor -----	1.89
	<u>\$8.89 hour</u>

X 56 hours

X 2 FTE's

Cost	\$51.775.00
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Assuming that we are replacing personnel and not adding additional staff:

-Med Aide average -----	\$4.30 hour
	X 56 hours
	X <u>2 FTE's</u>
	\$25,043.00

Difference: \$26,732.00

State wants to pay:

Wage -----	\$ 6.31
-Med Aide -----	\$ 4.30
X .27 factor -----	\$
	<u>\$13,776.00</u>

\$13,000 to be absorbed by facility.