House
Legislative
Analysis
Section

House Office Building, 9 South
Lansing, Michigan 48909
Phone: 517/373-6466

OPTOMETRISTS: EXPAND SCOPE OF PRACTICE

House Bill 5552 (Substitute H-6)
First Analysis (5-8-02)

Sponsor: Rep. Sue Tabor
Committee: Health Policy

THE APPARENT PROBLEM:

Optometrists are probably best known as eye doctors who examine their patients' eyes to determine whether they need glasses or contact lenses. Optometrists are licensed health professionals but they are not physicians, and the Public Health Code restricts the practice of optometry to specific types of procedures, leaving other procedures to be performed by comprehensive ophthalmologists and specialists. At its most fundamental and general level, the health code attempts to ensure the health, safety, and welfare of the state's residents, and optometrists and ophthalmologists share that goal as well as a strong commitment to working with one another to achieve it. When it comes to the details of eye care, however, optometrists and ophthalmologists often disagree about which procedures can be safely entrusted to optometrists and which procedures should be reserved for ophthalmologists and other physicians.

Currently, the health code allows a licensed optometrist who has received special certification to use diagnostic drugs to examine the eye in order to determine whether an ocular problem exists and to use therapeutic drugs to correct, remedy or relieve an ocular problem. The code defines "diagnostic" and "therapeutic pharmaceutical agent[s]," which effectively restricts the drugs that an optometrist may use. Specifically, "diagnostic pharmaceutical agent" refers to two specific topical drugs: Proparacaine HCL 0.5 percent and Tropicamide, in strength not greater than 1 percent. Proparacaine is a topical anesthetic used to diagnose glaucoma. Tropicamide is a "mydriatic," meaning that it dilates the pupils and so makes the inside of the eye more visible, and a "cycloplegic", meaning that it temporarily paralyzes the ciliary muscle, making it impossible to focus the eye. The code's definition of "therapeutic pharmaceutical agent" includes topical drugs and prescription drugs administered for certain purposes, but the code does not include oral drugs, and it expressly excludes controlled substances.

The code also states that when an optometrist suspects that a patient has glaucoma, he or she must consult an ophthalmologist so that the two professionals can mutually agree on the diagnosis and an initial treatment plan. If the initial treatment is ineffective, the optometrist must consult with an ophthalmologist regarding any further diagnosis and treatment.

Many optometrists believe that these restrictions are based upon misconceptions about optometrists' education and training. More importantly, they argue, such restrictions inhibit patients' access to, and raise the cost of, health care. According to committee testimony from representatives of the Michigan Optometric Association, 38 states currently allow optometrists to use at least some oral therapeutic drugs and no other state restricts optometrists' ability to administer diagnostic agents to the extent that Michigan does. Legislation has been introduced that would expand optometrists' ability to administer both diagnostic and therapeutic drugs and would allow an optometrist to make an initial diagnosis of glaucoma and begin treating the patient without first consulting with an ophthalmologist or other physician.

THE CONTENT OF THE BILL:

House Bill 5552 would amend part 174 of the Public Health Code (MCL 333.17401 and 333.17432), which regulates the practice of optometry, to allow an optometrist to diagnose glaucoma and to begin treatment. The code currently specifies that when an optometrist suspects that a patient has glaucoma, he or she must consult an ophthalmologist for a co-management consultation in order to mutually agree on the diagnosis and an initial treatment plan. If the initial treatment does not meet or exceed the goals, the optometrist must consult with an ophthalmologist regarding further diagnosis and treatment. Under the bill, the optometrist could make the initial diagnosis and begin treatment but would have to consult an

appropriate physician for further diagnosis and further possible treatment if the condition did not demonstrate adequate clinical progress as a result of the (initial) treatment. (House Bill 5552 is no longer tie-barred to House Bills 5548-5551, which would require coverage under insurance policies and contracts that include optometric services to cover and reimburse for services that fall within the code's definition of "practice of optometry," as it has been amended since 1992. Those bills remain under consideration by the House Health Policy Committee.)

The bill would also revise the definitions for "diagnostic pharmaceutical agent", "therapeutic pharmaceutical agent", "drug", and "prescription drug", as those terms relate to the practice of optometry. The practice of optometry includes "the use of therapeutic pharmaceutical agents to correct, remedy, or relieve" certain defects or abnormal conditions and "the employment of . . . diagnostic pharmaceutical agents", as such practices are regulated under article 174. Thus, changes in these definitions effectively change optometrists' scope of practice. The bill would amend the definitions as follows:

Diagnostic pharmaceutical agent. Currently, "diagnostic pharmaceutical agent" is defined as two specific drugs: Proparacaine HCL 0.5 percent and Tropicamide in strength not greater than 1 percent. The bill would define "diagnostic pharmaceutical agent" instead as any topically administered "prescription drug" or other topically administered "drug" used for the purpose of investigating, analyzing, and diagnosing a defect or abnormal condition of the human eye or ocular "adnexa." ("Ocular adnexa", or "appendages of the eye", include the eyelid, tear drainage system, and the orbital wall and contents.)

Therapeutic pharmaceutical agent. Currently, "therapeutic pharmaceutical agent" is defined as either a topically administered antiglaucoma drug or a topically administered drug or prescription drug used for the purposed of correcting, remedying, or relieving defects or abnormal conditions (or effects of such defects or abnormal conditions) of the anterior segment of the human eye. The bill would define "therapeutic pharmaceutical agent" as a topically *or orally* administered antiglaucoma drug or a topically *or orally* administered drug or prescription drug for the purpose of *investigating, analyzing, diagnosing*, correcting, remedying, or relieving those defects or abnormal conditions (or effects thereof) of the anterior segment of the human eye *or adnexa*.

Drug and prescription drug. The bill would also change the definitions of "drug" and "prescription drug", which are used in the definitions of diagnostic and therapeutic pharmaceutical agents. Currently, each definition refers to the general definition provided in Article 15 of the Public Health Code, except that "drug" and "prescription drug", as used with respect to the practice of optometry, do not include controlled substances. The bill would specify only that "drug" and "prescription drug", as used with respect to the practice of optometry, do not include a Schedule 2 controlled substance or an oral cortical steroid. The terms would, however, include schedule 3, 4, and 5 controlled substances as well as dihydrocodeinone combination drugs.

BACKGROUND INFORMATION:

For useful recent background on many of the changes proposed by House Bill 5552, see the House Legislative Analysis Section's second analysis of House Bill 4331 of 1993, enrolled as Public Act 384 of 1994, dated 1-3-95, and first analysis of Senate Bill 139 of 1997, enrolled as Public Act 151 of 1997, dated 10-22-97. Also, see the Attorney General's Opinion #6846, dated 5-8-95, which addressed Public Act 384 and was addressed in turn by Public Act 151.

FISCAL IMPLICATIONS:

According to the House Fiscal Agency, the bill could expand the level of treatment provided by optometrists relative to ophthalmologists and other physicians. This could reduce health care costs, which could, in turn, reduce state costs related to Medicaid payments, though by an indeterminate and likely negligible amount. According to recent Department of Community Health data, total annual Medicaid payments for services provided by optometrists fell just below $2 million. (5-8-02)

ARGUMENTS:

For:

Current law prevents optometrists from fully using their solid education and clinical training to provide high-quality health care to their patients. Optometrists are required to have completed at least 90 credits towards a bachelor's degree and four years of optometry school. The bill would essentially do three things. First, it would expand optometrists' authority to administer topical diagnostic drugs. Second, it would expand optometrists' ability to administer therapeutic drugs. Third, it would allow an optometrist to diagnose and begin treatment of a

patient with glaucoma. There are good reasons for making each of these changes independently. Taken together, these changes would improve patients' access to treatment and help the state contain health care costs.

To begin with, optometrists who wish to administer diagnostic and therapeutic drugs must receive special certification, which involves satisfying specific education and training requirements beyond that required for licensure. Applicants for certification to administer diagnostic drugs must, among other things, successfully complete "60 classroom hours of study in general and clinical pharmacology as it relates to the practice of optometry, with particular emphasis on the use of diagnostic pharmaceutical agents for examination purposes." Currently, however, Michigan only allows an optometrist who has completed those requirements as well as additional certification requirements to administer two specific diagnostic drugs—Proparacaine HCL and Tropicamide. Authority to administer these two drugs was granted to optometrists back in 1984, and even then optometrists regarded the limitation on their use of diagnostic drugs as severely restrictive. The code fails to acknowledge that other pharmaceuticals are widely used for the same purposes both by ophthalmologists in this state and by optometrists in other states. Michigan is the most restrictive state when it comes to optometrists' authority to administer topical diagnostic drugs, and there is no real evidence suggesting that wider authority to administer such drugs been a problem for other states. Further, the code does not contain any similar limit on the types of therapeutic topical agents that an optometrist may administer, and it is unclear why the code should restrict optometrists' authority to use diagnostic agents to a greater extent—let alone to a significantly greater extent—than it restricts optometrists' ability to use therapeutic agents. In essence, the bill represents a clarification of the spirit of the law, which is to allow optometrists to diagnose and treat primary level eye diseases topical agents.

Before administering therapeutic drugs, a licensed optometrist must first meet the specialty certification requirements for administering diagnostic drugs and then complete additional requirements, including either seven semester hours (or ten quarter hours) of credit or 100 classroom hours in "courses relating to the didactic and clinical use of therapeutic pharmaceutical agents". Currently, however, optometrists in this state may not administer any oral drugs, despite both their training and the positive experience of the 38 states that currently allow optometrists to do so. Although this authority would clearly expand optometrists' scope of practice, it would not expand it beyond that of similarly trained health care professionals, such as dentists who may administer a variety of oral medications, including controlled substances.

Allowing optometrists to diagnose and begin treatment of a patient with glaucoma also makes sense. Under current law, an optometrist who is certified to administer Proparacaine HCL 0.5 percent, which optometrists use specifically to determine whether a patient has glaucoma, may administer the drug but may only *diagnose* the patient as having glaucoma in co-consultation with an ophthalmologist or other physician. Often the co-consultation is nothing more than a phone call in which the ophthalmologist "rubber stamps" the optometrist's "determination"—i.e., diagnosis. Some ophthalmologists, however, require the patient to make an appointment before agreeing with an optometrist's diagnosis. This can be particularly burdensome for a patient who has a long-standing relationship with her optometrist but no similar relationship with an ophthalmologist. Such a patient must make an initial appointment with the ophthalmologist and pay a premium for an initial appointment, which is usually significantly more expensive than subsequent appointments, and then return to her preferred health care provider for subsequent treatment. Optometrists know that the eye often manifests diseases throughout the body, and thus they subscribe wholeheartedly to the view that the eye is "the body's most important cubic inch". Their education and training equip optometrists with the ability to determine whether or not a patient has glaucoma, and if initial treatment does not work, an optometrist would still have to refer the patient on to a comprehensive ophthalmologist or a specialist. At the same time, nothing in the bill suggests that optometrists cannot or should not continue to consult and generally work closely alongside ophthalmologists and other physicians. In fact, any optometrist who felt uncertain about his or her capacity to diagnose glaucoma would be wise to err on the side of caution.

Each of the bill's proposed changes makes sense independently, and together, they would enhance optometrists' role in the health care system in a way that that reflects their expertise. In turn, this would improve the quality of health care available to their patients, since patients would get diagnosed and could get the care they needed sooner rather than later. Optometrists perform roughly two-thirds of all eye exams, and are many people's primary eye care providers given their typically long business hours,

which generally include Saturdays. Delays in treatment often result in increased costs, as do unnecessary referrals to other health care professionals. In the end, ophthalmologists and other physicians should welcome an increased role for optometrists as this would allow ophthalmologists to focus on those services that they are especially well qualified to provide.

Response:

Optometrists' education and training in the use of *diagnostic* drugs is sufficient to merit expanding the types of topical drugs that optometrists should be allowed to administer. Still, the bill would expand this authority too far. Also, the bill would not clearly prohibit an optometrist from using topical diagnostics to determine whether a secondary, more systemic condition, such as stroke, cancer, or aneurysm, exists. Some compromise on language that addresses these concerns may be possible.

Against:

Protecting patient health, safety, and welfare demands that the primary care provider be well qualified to determine whether a given problem is local or is simply a manifestation of a more systemic condition. When expanding the scope of practice of non-physician health care professionals will clearly result in improved quality, access, and affordability of care, physicians and others support such expansion. However, expanding the scope of the practice of optometry as the bill proposes will not lead to such benefits. Whether or not it is the most important cubic inch, the eye is clearly a very important cubic inch of the human body, and the very threat of blindness should give everyone reason to pause before relaxing current restrictions on optometrists.

Optometrists are not physicians, and the education, training, and clinical experience they receive clearly falls short of the expertise required to responsibly prescribe oral medications for treating patients and to be entrusted with the ability to independently diagnose and treat glaucoma. Supporters of the bill argue that most optometrists have a bachelor's degree and complete four years of additional training. Whether or not most optometrists have a bachelor's degree, they are only required to have completed 90 credit hours towards a bachelor's degree, and four years of optometry school is hardly equivalent to four years of medical school when one considers the demanding medical school curriculum and the level of discourse in medical school courses taught largely by practicing physicians. Medical students also spend far more time in clinical training, have a significantly higher number of patient encounters, including surgical encounters, and work more hours per week and number of weeks per year than optometry students. Usually when health care professionals attempt to broaden their scope of practice, they propose or at least agree to increased education and training requirements to reflect the additional responsibility that they want to acquire. In this case, however, optometrists suggest that they currently have all the expertise they need to take on the proposed added responsibilities. At the very least, it would be appropriate to add continuing education requirements to ensure that optometrists kept up with changes in diagnosis and treatment strategies that ophthalmologists must currently meet.

More specifically, allowing optometrists to use oral medications would increase the risk of inappropriate use of drugs as well as the risk of harmful drug interactions, both of which tend to increase health care costs. Equally important, ophthalmologists have embraced some new treatment strategies that do not require the use of oral drugs, and it is important that optometrists not overprescribe. As grave as these risks may be, expanding optometrists' ability to diagnose and treat glaucoma may pose the most serious threat to patients' ocular and general health. Glaucoma can be very difficult to diagnose, even with medical training, and treatment can also be very complex. According to the Michigan Ophthalmological Society, glaucoma is the second most common cause of blindness in the U.S. and the single most important cause of blindness in African Americans, largely because it is not caught in time. At the same time, between five and ten million Americans do not have glaucoma but do have elevated eye pressure—a symptom that is often caused by glaucoma. Underdiagnosis of glaucoma increases the risk to the patient, and there are simply too many diseases that manifest themselves as eye problems that optometrists do not have the background to recognize. Overdiagnosis leads to unnecessary treatment and thus increases the costs of care, and the heavy emotional toll on a misdiagnosed patient should be counted as a significant, if not financial, burden.

Although many of the potential dangers of increasing the scope of practice of optometry are hypothetical, proponents of the bill have failed to make the case that the legislation will enhance the quality of and access to care or reduce the costs of care. The state's residents do not appear to be clamoring for the ability of optometrists to increase the services they provide. A Rand Manpower study has suggested that there should be one ophthalmologist per 20,000 residents,

and according to the Michigan Ophthalmological Society there is one ophthalmologist per 18,500 Michiganians. There is no strong evidence suggesting that expanding the scope of practice in these ways would improve patient ocular care or general health care, and the evidence on whether the bill would ultimately lead to cost savings is mixed at best. Given the potential risks of expanding optometrists' scope of practice, and absent strong reasons to think that the bill will provide patients with strong benefits, it is safer and thus wiser to leave the code's current restrictions on optometrists.

POSITIONS:

The Michigan Optometric Association supports the bill. (5-7-02)

The Michigan Ophthalmological Society opposes the bill. (5-7-02)

The Michigan State Medical Society opposes the bill. (5-7-02)

The Michigan Osteopathic Association opposes the bill. (5-7-02)

The Economic Alliance for Michigan opposes the bill. (5-8-02)

Analyst: J. Caver

■This analysis was prepared by nonpartisan House staff for use by House members in their deliberations, and does not constitute an official statement of legislative intent.