House
Legislative
Analysis
Section

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OPTOMETRISTS: EXPAND SCOPE OF PRACTICE

House Bill 5552 as passed by the House
Second Analysis (7-10-02)

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 corrective lenses, such as glasses or contact lenses. Optometrists are licensed health professionals, but they are not physicians, and the state's 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 a patient's eye in order to determine whether a problem exists and to use therapeutic drugs to correct, remedy or relieve an ocular problem. The code defines "diagnostic" and "therapeutic pharmaceutical agent[s]," and the definitions effectively restrict the drugs that a licensed and specially certified optometrist ("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, making 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 an optometrist may diagnose non-acute glaucoma and devise an initial treatment plan for the condition only in consultation with an ophthalmologist. If the initial treatment is ineffective, the optometrist must continue to consult with an ophthalmologist regarding any further diagnosis and treatment. (An optometrist may make a diagnosis of acute glaucoma without first consulting a physician, but the optometrist must consult a physician for 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 and begin treatment of (non-acute) glaucoma 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 a licensed and specially certified optometrist to diagnose glaucoma and to begin treatment without consulting an ophthalmologist. 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. (As is the

case under current law, if an optometrist diagnosed a patient a having acute glaucoma, he or she would still have to consult a physician for further diagnosis and treatment, as soon as possible. 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 would effectively change optometrists' scope of practice. (Only those licensed optometrists who have met special certification requirements may administer diagnostic drugs or administer and prescribe therapeutic drugs. Education requirements for certification are described below in "Background Information".) 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 purpose 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 expand the definition of "therapeutic pharmaceutical agent" to include all of the following:

- a topically *or orally* administered antiglaucoma drug;

- a topically administered prescription drug or other topically administered drug for the purpose of *investigating, analyzing, diagnosing*, correcting, remedying, or relieving a defect or abnormal condition (or the effects thereof) of the anterior segment of the human eye; and

- an orally administered prescription drug or other orally administered drug used for the purpose of investigating, analyzing, diagnosing, correcting, remedying, or relieving a defect or abnormal condition (or the effects thereof) of the anterior segment of the human eye *and adnexa*, subject to continuing education requirements described below.

Education requirements. The code allows the Board of Optometry to require--and the board currently does require (R 338.256)—a licensed optometrist seeking renewal of a license to attend an education program consisting of at least 24 hours in optometry-related subjects during the two years prior to the application for renewal. An applicant for license renewal who holds certification to administer diagnostic pharmaceutical agents or certification to administer and prescribe therapeutic agents must complete an additional 12 hours of board-approved continuing education. The bill would allow the board to require that the education program for license renewal consist of at least 40 hours addressing optometry-related subjects (In which case, optometrists certified to administer diagnostic drugs or to administer and prescribe therapeutic drugs would have to complete at least 52 hours of continuing education.) Regardless of whether the board increased the continuing education requirement, the bill would specify that an optometrist could not orally administer a prescription drug or other drug for the purpose of investigating, analyzing, diagnosing, correcting, remedying, or relieving a defect or abnormal condition (or effects thereof) of the anterior segment of the human eye and adnexa, unless he or she had completed 50 percent of the required hours in pharmacological management of ocular conditions.

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:

Legislative history. Public Act 384 of 1994 amended the Public Health Code to allow properly certified optometrists to prescribe and administer topical therapeutic drugs for the treatment of conditions such as pink eye, certain corneal abrasions, and other common eye disorders that affect the front part of the eye. Public Act 384 further required an optometrist to refer a patient to an ophthalmologist or other appropriate physician whenever the optometrist treated a patient for a condition or disease that could be related to a nonlocalized or systemic condition or disease or did not respond adequately to treatment. Reportedly, some optometrists believed that Public Act 384 authorized them to treat certain forms of glaucoma. In response to a legislative inquiry, the attorney general issued Opinion No. 6846 in May of 1995. In his opinion, the attorney general concluded that the language in Public Act 384 restricted optometrists to using topical therapeutic pharmaceuticals that treated the anterior, or front part, of the eye, and that "since anti-glaucoma topically administered drugs relieve defects that extend beyond the anterior segment of the eye . . . the Public Health Code [did] not authorize optometrists to treat glaucoma.

Public Act 151 of 1997 amended the code to allow an optometrist to use topically administered anti-glaucoma drugs. The act also required an optometrist who suspected that a patient had glaucoma to consult with an ophthalmologist to mutually agree upon a diagnosis and treatment plan, or with a physician, in the case of acute glaucoma.

For more background, see the House Legislative Analysis Section's second analysis of House Bill 4331 of 1993, enacted as Public Act 384 of 1994, dated 1-3-95, and the first analysis of Senate Bill 139 of 1997, enacted as Public Act 151 of 1997, dated 10-22-97. Also, see the attorney general's opinion #6846, dated 5-8-95.

Educational requirements for certification to administer/prescribe diagnostic/therapeutic drugs. The code specifies education requirements for optometrists who wish to receive certification to administer diagnostic pharmaceutical agents and certification to administer and prescribe therapeutic pharmaceutical agents. To become certified to administer diagnostic drugs, an optometrist must (among other requirements) complete 60 classroom hours of study in general and clinical pharmacology as it relates to the practice of optometry, and at least 30 of those hours must be in ocular pharmacology. An optometrist who wishes to administer and prescribe therapeutic drugs must complete certain requirements in addition to those required for the administration of diagnostic drugs. These additional requirements include at least ten quarter hours or seven semester hours of credit, or 100 classroom hours of study in, "courses relating to the didactic and clinical use of therapeutic pharmaceutical agents".

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. (7-9-02)

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, and taken together such 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 with 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 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 often make an initial appointment with the ophthalmologist and pay a premium for that appointment and then return to her optometrist—i.e., 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 and their commitment to developing further expertise. Optometrists perform roughly two-thirds of all eye exams and serve as the primary eye care providers for many people, given their typically long business hours, which generally include Saturdays. Delays in treatment, which may occur when an optometrist has to consult with an ophthalmologist, often exacerbate conditions and increase costs, as do unnecessary referrals to other health care professionals. In recognition of the added responsibilities proposed by the bill, optometrists would take on additional education requirements, affirming their commitment to providing quality eye care. 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:

Physicians generally support expanding the scope of practice of non-physician health care professionals when doing so will clearly result in improved quality, access, and affordability of care. But whether or not it is the most important cubic inch of the human body, the eye is clearly a very important cubic inch, and the very threat of blindness or the possibility of a systemic condition going undetected should give everyone reason to pause before relaxing current restrictions on optometrists' scope of practice. Moreover, it is unclear whether there really are any significant access and affordability issues with respect to ophthalmologists.

Optometrists are not physicians, and the education, training, and clinical experience they receive clearly fall short of providing the expertise required to responsibly prescribe oral medications for treating patients. Optometrists should not be entrusted with the ability to independently diagnose and treat glaucoma. Supporters of the bill claim that most optometrists have a bachelor's degree and complete four years of additional training and argue that this gives them sufficient background to take on the added responsibilities that the bill proposes. 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, especially 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 more weeks per year than optometry students. In addition to their medical school training, ophthalmologists typically go through internships and residencies before practicing on their own. Although the bill could lead to an increase in the number of hours of continuing education than an optometrist must complete for license renewal, and would lead to some stricter continuing education requirements for optometrist administering orally administered drugs, these increases would do little to offset the difference in education and training between ophthalmologists and optometrists.

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 some ophthalmologists and other physicians worry that optometrists might 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. 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. 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.

There is no strong evidence suggesting that expanding the scope of practice in these ways would improve patient ocular care or general health care. 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. Thus, Michiganians appear to have a sufficient number of providers to choose from. 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 any strong reason to think that the bill will provide patients with significant benefits, it is safer and thus wiser to leave the code's current restrictions on optometrists.

POSITIONS:

The Michigan Optometric Association supports the bill. (7-9-02)

The Michigan Ophthalmological Society opposes the bill. (7-9-02)

The Michigan State Medical Society opposes the bill. (7-9-02)

The Michigan Osteopathic Association opposes the bill. (7-10-02)

The Economic Alliance for Michigan opposes the bill. (7-9-02)

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■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.