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Supporting the Case for Optometric Full Practice Authority

In January 2020, the Vermont Secretary of State and Office of Professional Regulation (OPR) published a Study of Optometric Advanced Procedures. The study was to *"evaluate the safety and public health needs of enlarging the scope of practice of optometrists to include advanced procedures."* The OPR was to *"evaluate, among other considerations, approaches to advanced procedures in jurisdictions outside Vermont, patient need for access to additional practitioners, effects on patient access to care, effects on patient safety, costs to the health care system, and the existing education and training for optometrists, including the degree to which it addresses training in advanced procedures"* and to *"inquire into the specific clinical training for both optometrists and ophthalmologists for specific procedures."*

OPR's assertions in the *Study of Optometric Advanced Procedures* document claim to be based on in-depth factual gathering, but unfortunately the data cited and claims made are misrepresented, incomplete in thoroughness and only stand to support the historical bias put forth by self-interested groups like Ophthalmology.

First, OPR's inaccuracy makes damaging assumptions about the training and education of Doctors of Optometry, based heavily upon anecdotal evidence from limited sources, provided by individuals who have historically and publicly opposed efforts like scope expansion and more importantly, have little to no first-hand knowledge of the educational qualifications afforded optometrists. OPR also did not take into consideration affidavits from optometry schools demonstrating education in these areas or the fact that existing optometric licensees would be required to demonstrate competency.

Despite the disregard for publicly available materials on optometric education and limited outreach by OPR to optometric colleges and universities to obtain this information, all twenty-three colleges and universities recently delivered over 500 pages of information to again, provide evidence to the level of training Doctors of Optometry receive in these accredited institutions.

Secondly, patient and public safety concerns have historically and continually been alleviated by the stellar record optometrists have demonstrated for decades. This record of top-level patient care can be seen by the lack of malpractice claims filed against optometrists, directly attributed to the ophthalmic procedures in question. This long-standing record of outstanding patient care can also be seen in the low rates for malpractice insurance Doctors of Optometry have been enjoying for twenty plus years.

Despite these publicly verifiable records of patient safety, OPR's assessment of patient safety dismisses this information outright and again cites anecdotal evidence to support their ultimate position. According to the Vermont document from OPR *"Despite these anecdotes, the ophthalmologists could not point to any outcomes data showing an increased risks of patient harm due to expanded optometric*

scope of practice." Also, the one liability insurer OPR consulted, Ophthalmic Mutual Insurance Company (OMIC), did not report that rates for states with updated laws were higher or that they had increased claims.

Finally, on access and patient demand, OPR was provided multiple sources to support Optometry's position. A report published just last year by *Avalon Health Economics* showed the overall financial benefit to the health care system when Doctors of Optometry are practicing to the levels taught, ultimately providing competition in the health care marketplace. OPR was also sent the U.S. Health and Human Services (HHS) report, which fully supports the position that Doctors of Optometry should be practicing at the highest levels taught and less than that is an unnecessary barrier in the healthcare marketplace. OPR was also sent a thoughtful and measured response to the *JAMA* study on geographical access in a state, highlighting the flaws in the sources utilized, as well as providing updated licensee data from both the AMA and AOA licensee databases.

Unfortunately, OPR chose to dismiss much of the information from third party sources supporting access in the marketplace and again chose to use anecdotal evidence, which had already been cogently countered, to support their final and flawed assumption.

Despite the litany of information available and directly provided, the OPR chose to rely on flawed data and information, incorrectly recommending against expanding optometric scope of practice to include the proposed advanced procedures. *"OPR cannot conclude that optometrists are properly trained in and can safely perform the proposed advanced procedures".*

The following document responds to the OPR report which was based on inaccuracies, anecdotal testimonies, and misinformation.

The Need for Updating Optometric Scope of Practice

Recently Doctors of Optometry in states across the nation have introduced legislation to change the scope of practice. Some states have adopted this new scope while others are considering it. Why do optometrists feel this is necessary?

GROWTH OF KNOWLEDGE

FACT: All health care professionals are challenged with keeping up with the latest developments in their fields.
"Medical knowledge has been expanding exponentially. Whereas the doubling time was an estimated 50 years back in 1950, it accelerated to 7 years in 1980, 3.5 years in 2010, and a projected 73 days by 2020", according to a *2011 study in Transactions of the American Clinical and Climatological Association.*

Certainly, optometry schools, as well as medical, dental, nursing, and other health care programs, are constantly updating their curriculums to teach students the latest health care information. However, in a short time after finishing their training, the education health care professionals receive in formal education can be outdated. All health providers must be life-long learners to provide their patients with the best possible care. Antiquated "regulatory" obstacles to "accredited" professional education and training serve to disadvantage professions like optometry and promulgate and benefit the "professional" medical monopoly which has existed for so long. They serve to stifle growth and innovation and advantage the political medical establishment by allowing them to control markets and maintain referral networks for their exclusive benefit.

Physicians including ophthalmologists utilize many surgical techniques now that did not exist when they finished their formal training. When SLT was approved in 2001, what did ophthalmologists do – go back to medical school, do another residency? No, at best, they attended CME courses to learn to utilize the new technology, and often they receive this training from the surgical representative who sells the equipment.

This is how all medical professionals learn new skills and keep current.

After four years of doctoral level study of the human body and the eye, Doctors of Optometry have the intelligence, ability and foundational skills upon which to build and learn and utilize the newest medical applications and innovations just as all health care providers do.

For current medical or optometric practitioners learning new technology is based on the foundation of formal education, clinical practice experience and continuing medical education. For example, the lasers optometrists use, are used in conjunction with slit lamps, which is equipment ODs use on every patient every day. This is a basic skill developed from the first semester of optometry school, refined and verifiably perfected by the time the optometric physician begins practice. It is not the same as taking a lay person with no knowledge of the eye or ophthalmic equipment and training them to do the procedure. Optometrists understand the clinical aspects of examining and treating the eye. They do it in everyday practice.

Doctors of Optometry are independent doctoral level practitioners just like dentists, podiatrists, chiropractors, and medical doctors. All of these providers attend four years of professional school after college to study their specialties which may include post-doctoral residencies, etc.

FACT: To update their scope of practice and utilize new technologies after they finish training, medical doctors and dentists are not required to ever go back to the legislature for permission. No matter what new techniques are developed, MDs and dentists are entitled to incorporate those procedures into their practices without having to prove competency or if their licensure boards approve of the technology. Medical licensing boards do not approve or regulate technology or what a medical/osteopathic physician may or may not do with respect to medical practice. A medical license is a "plenary" license, unrestricted and unregulated with respect to technology or method. The Food and Drug Administration (FDA) regulates the approval of medical devices and drugs for sale or use in the US. Individual hospitals, clinics, and groups may regulate what is done in their facilities via credentialing and privileging, but in their own practices physicians essentially regulate themselves.

A critical distinction here between medicine and optometry is that a "medical" license REMOVES ALL OBSTACLES to further education and training in whatever skill, procedure, technique, etc., the medical licensee chooses to undertake at any time in the future.

For example, the newest surgical techniques on the market for glaucoma are Microinvasive Glaucoma Surgery (MIGS). To learn these procedures, MDs attend continuing medical education (CME) courses or are trained by surgery representatives of the manufacturers (not necessarily MDs) with videos and in the operating room. They are not being certified by the medical licensure board, Accreditation Council for Graduate Medical Education (ACGME), or going back to medical school.

Should the Vermont legislature mandate proof of competency before allowing these MDs to implant these new devices utilizing these new surgical procedures? Should they have to prove this will save costs or it is needed by Vermont consumers?

So why does optometry keep coming back to state legislatures to change their scope of practice?

Historically, when the medical licensure laws were first passed, there were no restrictions on what physicians could do. Physicians have always been able to utilize any new treatment modality, new drug treatment, or new surgical technique without changing their practice act. Any MD can treat eyes or use these procedures, not just ophthalmologists.

Dentists also are able to expand their scope of practice without new legislative authority as long as it relates to the mouth, teeth, etc. For example, most recently dentists have incorporated the use of lasers to treat their patients without additional legislative authorization. Upon completion of their training, these providers use CME tools to keep current in their chosen fields.

So why is optometry forced to come back to the legislature time and again to update their scope of practice? Why is a competitive (and often hostile) profession allowed to dictate the terms of optometry's evolution?

When optometrists were first licensed at the turn of the 20th century, the scope of practice was quite narrow because drugs and modalities used today didn't exist to treat eye and vision problems. The way the practice acts were written, the licensure boards didn't have the authority to determine what new things would be within the scope of practice.

FACT: Medical doctors have opposed any scope of practice expansion for optometry in every state for decades. **This includes opposing osteopathy during the first half of the 20th Century.** A specialty within medicine, ophthalmology, has tried to keep a monopoly on all medical care related to eyes. Therefore, whenever, optometry petitioned the legislature for permission to expand practice to reflect education updates, ophthalmology has always opposed their efforts claiming that patients would be harmed.

These battles occurred when contact lenses were first introduced, but optometry prevailed and demonstrated they were highly competent in contact lens prescribing, fitting, etc. Afterward, when diagnostic drugs came on the market to facilitate better examination of the eyes, ophthalmology alleged that patients would go blind or even die if optometrists were allowed to use these drugs. This has not occurred, there has been no documented case in which an optometrist has blinded or killed a patient with these medications anywhere in the country. The same arguments were used to oppose optometrists prescribing drugs for treatment of eye diseases. But again, optometric expansion of scope of practice has proven to safely benefit patients, not harm them. Now ophthalmologists are again trying to keep optometry from being able to provide patients with the newest technologies. Every time optometric education has been updated to reflect new modalities; ophthalmologists have opposed allowing optometrists to use the knowledge they have gained.

The result is that students are restricted from using the education they have received when they return to practice in a state where the optometric practice act has not been updated. Graduates are more likely to go to states where they can use their full training. This particularly hurts those states with provider shortages.

Ophthalmologists make claims of concern for public safety in their efforts to maintain a monopoly on certain practice modalities. To prove their concern is based on controlling the access to this care rather than ensure patient safety, in 2014 in Nebraska, organized medicine and ophthalmology lobbied against optometrist's scope expansion to allow for the prescribing of oral steroids, oral glaucoma, and oral immunosuppressive medications. They did so by claiming optometrists did not have the requisite knowledge of these dangerous medications to keep the public safe. When they were presented with a political compromise which would preserve their monopoly on surgical procedures, they conceded the additional oral medications without the requirement of additional optometric CME. The CME was not necessary to protect the public because optometrists do in fact, have the requisite knowledge, education and training to utilize these medications safely, but it was the contention of organized medicine until it was clear they would lose a political battle.

The same arguments have been used against optometric scope changes for decades. As scope has changed over the years, the proof has been in the successful care Doctors of Optometry have provided their patients. Once the new scope was implemented, all the terrible things predicted by ophthalmology did not occur. If patients had been harmed as ophthalmology alleged would occur, the expanded scope laws would have been quickly repealed.

In December 2018, the U.S. Department of Health and Human Services (HHS) published a report, *Reforming America's Healthcare System Through Choice and Competition.*

This report identified areas where federal and state rules inhibit adequate choice and competition and offered recommendations for improving public policy in these areas.

State licensing and scope-of-practice (SOP) restrictions were examined. HHS concluded, *"when state regulators impose excessive entry barriers and undue restrictions on SOP for particular types of providers, they often are not responding to legitimate consumer protection concerns. There is a risk that healthcare professionals with overlapping skill sets will seek these restrictions; they view SOP restrictions as an easy, state-sanctioned opportunity to insulate themselves from competition*."

By restricting the entry of competitors, licensure can restrict supply, which can increase the income of incumbents.
"For example, advanced practice registered nurses, physician assistants (PAs), pharmacists, optometrists, and other highly trained professionals can safely and effectively provide some of the same healthcare services as physicians." P33

"Recommendations: Broaden Scope of Practice"
"States should consider changes to their scope-of-practice statutes to allow all healthcare providers to practice to the top of their license, utilizing their full skill set."

FACT: All providers currently licensed must learn new technologies to update their skills whether they are ODs or MDs.
Medical knowledge doubles every few months. Unless a healthcare profession is allowed to utilize this knowledge to improve itself for the benefit of its patients, it will quickly become irrelevant.

SAFETY

FACT: To date, no optometric practice expansion has ever been repealed in a state legislature.
The credibility of the profession has given legislators confidence in further expanding optometric practice when requested. Optometrists have never asked for changes they were not capable of safely using.

Optometrists dedicate their lives to saving their patients vision. They are not going to do something they are not trained and able to perform safely.

Optometry has the exact same independent, objective oversight mechanisms to assure the competency of entry-level providers and look to minimize risk to the public, namely state-appointed licensing boards, national criterion-referenced competency examinations run by independent boards which utilize acknowledged best-industry practices in terms of psychometrics and exam development and deployment, and the same medico-legal oversight to which every licensed professional answers.

No state has ever repealed any type of optometric scope expansion. If optometry had the dangerous outcomes predicted by ophthalmology, the expanded scope would have been repealed. If optometric

patients were going blind and even dying when optometrists cared for them as ophthalmologists warned, there would have been an outcry from the public to stop optometrists from harming the public. Certainly, ophthalmologists would have easily convinced legislators to repeal the expansions.

In the Vermont report and other testimonies by ophthalmologists the alleged problems with optometric practice are anecdotal. Undoubtedly, many optometrists could testify to examining patients who have seen ophthalmologists whose medical and surgical care for patients with glaucoma, dry eye, cataracts, macular degeneration, diabetic eye diseases were mismanaged or lead to bad outcomes. Would it mean no ophthalmologists should be allowed to perform those services procedures? Anecdotal testimonies reflect the bias of the one opposing the legislation.

FACT: According to the Vermont report *"Despite these anecdotes, the ophthalmologists could not point to any outcomes data showing an increased risk of patient harm due to expanded optometric scope of practice*." P 18
Even though no harm was found, the Vermont report refused to acknowledge Doctors of Optometry were doing these procedures safely in other states (specifically Oklahoma, Louisiana, and Kentucky).

FACT: A major factor in the positive outcomes of changes in optometric scope of practice is the state boards do not grandfather existing licensees to become certified to practice the new scope without required additional training and proof of competency.
This is a far more stringent oversight than practiced in medicine or dentistry.

When prescriptive authority was gained by the states, existing licensees had to provide proof of pharmacology courses and training equivalent to that of new graduates in order to be certified to treat patients with drugs. A new section was added to the National Board of Examiners in Optometry (NBEO) test that covered all of those areas. Now the NBEO has established another section that tests for use of lasers and advanced procedures (ref: The NBEO Laser & Surgical Procedures Examination which consists of two parts: Ophthalmic Laser Procedures and Office-based Surgical Procedures. With each part further sub-divided into a written and a practical component).

FACT: Neither new licensees or existing licensees are permitted to perform these new procedures without first documenting specified training and competency.
States who passed advanced procedures and those who are now requesting to add certain new procedures to their scope of practice (including Vermont) are requiring their licensees to meet certain educational criteria in order to obtain this new certification.

If a Doctor of Optometry chooses to specialize in an area like contact lenses or children's vision where these modalities are not needed, they do not have to meet the additional standards, but they are not allowed to perform the ophthalmic procedures without additional training.

This is in contrast to medicine where the medical licensure boards never require licensees to have additional courses or testing to provide a new procedure. Hospitals or board certification may require such, but not the state boards or the legislatures.

The Vermont report first argued ODs should not be allowed to perform these procedures because if there was a problem, they are not in a hospital or with other providers. But later they report only two out of 28 Vermont ophthalmologists perform these ophthalmic procedures in a hospital setting.

Anecdotal testimony of biased practitioners is not the standard to judge the safety of these procedures performed by ODS.

MALPRACTICE EXPERIENCE

FACT: The objective means to validate the safety of optometric practice can be measured by the malpractice outcomes and rates.

FACT: Actual liability insurance rates for optometrists practicing in states with expanded scope of practice are no higher than those in other states and a fraction of the rates of any other doctoral level health care professional.
The Vermont report denies low malpractice rates indicate expanding the optometric scope of practice is safe for the public. The Vermont report alleges optometric rates are low because they are nationwide and therefore not reflective of experience in the states with expanded scope.

FACT: Untrue statement. - *"Any malpractice cases from these states would not yet be factored into the premium calculation."*
This is untrue. Doctors of Optometry in Oklahoma have been performing these procedures since 1998, (22 years). Kentucky ODs have been performing these procedures since 2011 (9 years). Any liability insurer would have certainly factored in malpractice claims into their rates by 2020.

Every state experience is reviewed and factored into setting rates for each state.

Lockton is the largest insurer of optometric liability insurance in the country. In a letter dated, January 30, 2020, Oliver Sowards, Assistant Vice President, Lockton Affinity, LLC, writes: *"Thank you for your inquiry regarding Malpractice Insurance rates for Doctors of Optometry. As one of the largest insurers of Doctors of Optometry, we insure thousands of optometrists. The Malpractice Insurance rates currently being charged to Doctors of Optometry* ***reflect the scope of practice in the respective***

***state along with historical frequency and severity experience loss data for optometrists across the country. Malpractice Insurance rates are subject to change based on updates to the scope of practice or material change in the historical loss data for the state in question**."*

For 2020, these are the current Lockton rates for the states who have updated their laws. This is for coverage of $1 million/$3 million limits.

FACT: Malpractice rates for 2020 from Lockton, the largest insurer of optometrists in US, are very low.

- Oklahoma $451 per year
- Kentucky $451 per year
- Louisiana $957* Rates for all health professional are higher due to ease of filing a lawsuit.
- Alaska $451 per year
- Arkansas $451 per year

Insurers are in the business of making money. A liability company would not set low rates if they were losing money on malpractice cases. Optometrists in Oklahoma have 22 years of experience and in Kentucky nine years of experience. Insurers would certainly have increased rates for those two states if they were paying out liability claims.

These are incredibly low liability rates even compared to those of other professionals like attorneys and CPAs.

In the Vermont report, the only information on malpractice claims is from the Ophthalmic Mutual Insurance Company (OMIC), an ophthalmology company. The data provided by OMIC is reflective of only 800 optometrists. That is only 1.6 % of the optometrists in the US. Lockton insurers thousands of optometrists.

FACT: OMIC did not report rates for states with updated laws were higher or they had increased claims.

<u>EXPERIENCE IN STATES WITH PROCEDURES IN QUESTION</u>

FACT: State healthcare licensure boards are notified by the National Practitioner Data Bank (NPDB) when there is a judgement against one of their licensees. This informs the licensure boards so they can follow up with remedial or disciplinary action if necessary.

FACT: The state boards where the ophthalmic procedures are practiced have not received any notifications from the NPDB on judgements against their licensees regarding the ophthalmic procedures in question.
The state boards have not received complaints regarding their doctors use of ophthalmic procedures.

For example, in a letter dated January 9, 2020 from Dr. James Sandefur, Secretary, Louisiana State Board of Optometric Examiners, he stated:

"*In response to your request I can report that Louisiana Act 398 of the 2014 Louisiana legislature expanded the scope of practice of Optometry allowing Doctors of Optometry who qualified, with additional training, to perform advanced ophthalmic surgery procedures, including laser procedures.*

In promulgating the rules to administer the act, the Louisiana State Board of Optometry Examiners (Board) included a provision that all Doctors of Optometry who perform laser procedures were required, as a provision of renewal of their license to practice Optometry, to keep a log of the number of laser procedures performed, and any adverse outcomes noted, and report that to the Board.

Of the 489 Doctors of Optometry practicing in Louisiana, 289 have become certified to perform the procedures to date.

The data from the years 2015-2018 show that Louisiana Doctors of Optometry have performed 11,545 laser procedures with zero negative outcomes reported.

In addition, there have been no complaints to the Board regarding Doctors of Optometry performing these procedures from patients or other doctors, and the Board is not aware of any malpractice suits filed regarding this.

It is clear to the Board that the law has been of great benefit to the citizens of Louisiana, allowing greater access to these procedures, especially in the rural areas of the state."

Further communication from the Louisiana State Board of Optometry Examiners (LSBOE) confirmed the following as it relates malpractice information from the National Practitioner Data Bank (NPDB):

"The LSBOE participates with the National Practitioner Data Bank/Health Care Integrity and Protection Data Bank (NPDB/HIPDB) in sharing data regarding Doctors of Optometry and any disciplinary actions committed or reported.

The LSBOE has received no communications from the NPDB/HIPDB regarding any malpractice suits, licensure suspensions/revocations or other adverse actions regarding Louisiana Doctors of Optometry performing these advanced ophthalmic procedures including laser procedures"

In contrast, the Vermont report did not investigate complaints or malpractice cases filed against ophthalmologists.

EDUCATION

Fact: Medical schools are not the only educational institutions that can educate students to provide quality, safe, and current health care to patients. Dentists, podiatrists, psychologists, nurse practitioners and physician assistants learn their skills outside of medical schools.
Many medical and surgical residencies are run by hospitals, clinics, and physician groups which are independent of and function outside of formal "academia".

FACT: Repeatedly throughout the Vermont report, the OPR mistakenly asserts there is no evidence optometrists are trained in these procedures or managing any complications. This assertion fails to take into consideration the training today's optometry students receive. Many of the "complications" which would be included here are not necessarily unique to laser or surgical care. They are the exact same conditions which manifest with many other diseases and conditions which optometric physicians already treat daily and have for decades.

Just like all other health professional schools, optometry colleges revise their curriculums over time to incorporate the most current knowledge and technologies for their students. Once students finish their training, they want to go practice where they can fully utilize their skills. This has necessitated updates in state practice acts to modernize them to match current education.

Doctors of Optometry are the nation's largest eye care profession, serving patients in nearly 6,500 communities across the country, where in more than 3,500 of these communities, they are the only eye doctors. Of the 14 counties in Vermont, optometrists are the only providers in two counties.

Doctors of Optometry are trained to examine, diagnose, treat and manage disorders that affect the eye or vision.

Optometry school consists of four years of post-graduate, doctoral-level study concentrating on the eye, vision, and associated systemic diseases. In addition to profession-specific courses, optometrists are required to take systemic health courses which focus on a patient's overall medical condition as it relates to the eyes.

Prior to admittance into optometry school, optometrists typically complete four years of undergraduate study, culminating in a bachelor's degree. Required undergraduate coursework for pre-optometry students is extensive and covers a wide variety of advanced health, science, and mathematics courses.

Optometry students concentrate specifically on the structure, function and disorders of the eye for four additional years during their graduate education to earn their doctoral degree.

While concentrating on the eye and visual system, optometrists also study general health in courses such as human anatomy and physiology, immunology, microbiology, systemic pathology, biochemistry and pharmacology.

In addition to their formal, doctoral-level training, all optometrists participate in ongoing CME to stay current on the latest standards of care and to maintain their licenses to practice. Optometry is one of the only doctoral-level health care professions to require CME in every state for license renewal.

Upon completion of optometry school, candidates graduate from their accredited college of optometry and hold the Doctor of Optometry (OD) degree.

Some optometrists participate in residency programs following optometry school. This experience offers Doctors of Optometry who are training in an optometric sub-specialty such as pediatric optometry, family practice, cornea & contact lens, refractive surgery, low vision care, or geriatrics.

In the Vermont report, the ophthalmologists *"were unaware of any standardized, comprehensive curriculum from U.S. Schools of optometry."* This is not surprising since they are private practitioners with no experience in optometric education. Just because they did not know about optometry school curricula, doesn't mean it doesn't exist.

FACT: No new licensees can obtain certification unless their schools have documented to state licensure boards the curriculum covers these procedures.
The Kentucky Board of Optometric Examiners and the Louisiana State Board of Optometric Examiners have notarized affidavits from all 23 optometry schools in the U.S. attesting that their curriculums teach all the didactic courses and clinical courses necessary for their graduates to qualify for a Kentucky or Louisiana license to perform advanced procedures.

FACT: The National Board of Optometric Examiners tests for use of lasers and advanced procedures.
Upon graduation, students must pass the NBEO as part of the requirements to obtain a state license. One of the sections on the NBEO is testing for lasers and advanced procedures. This requires standardization of education across all the schools and demonstrates students are being taught these things; otherwise how could they be expected to pass this part of the national boards? The NBEO Laser & Surgical Procedures Exam consists of both a "written component," testing conceptual knowledge, analysis and application, as well as a "practical component" testing technical ability and procedural skill using professional "patients" and high-fidelity models for simulation. Please note national ophthalmology exams have no "practical" component testing. The NBEO examination, was developed over a period of several years by a group of optometric physicians, ophthalmologists, and educators who themselves have decades of experience with all these procedures.

FACT: Optometry students must receive this complete education because when they enter practice they are held to the same standard of care as ophthalmologists. If an OD misses a diagnosis or fails to refer in a timely manner, they are held liable. Therefore, they must be educated through classes and clinics to recognize eye conditions and evaluate the need for treatment.
One of the arguments used by opponents is ODs do not have the same training on the human body medical students receive. In some programs where the optometry school is part of a university health care center and where other types of doctoral students are educated, the anatomy, physiology, etc. courses are actually taught by the same professors as the medical or dental students, and in some cases, they are all in the same classrooms together for a number of courses. Optometry students receive the full spectrum of basic systemic sciences medical, dental, and podiatry students receive with regards to human anatomy, physiology, neuroanatomy, pathology, immunology, microbiology, and pharmacology. Optometry students complete semester long graduate courses in systemic diseases with additional concentrated emphasis on those conditions with ophthalmic correlates. Emphasis on vision and eye issues occurs in 3rd and 4th year clinical courses.

An excellent example of the rigorous education received by students in optometric institutions of higher learning can be found at Ohio State University (OSU). Students at OSU must complete a 17 week in-clinic course, where the procedures questioned by OPR are performed. The culmination of these 17 weeks alone, account for nearly 1,000 hours of hands on experience clinical experience.

Upon graduation, optometry students have an extensive knowledge and understanding of the human body (both structure and function) as a whole. Optometrists are trained to take detailed health histories of their patients including all medications they take, family histories, etc. They are able to order laboratory tests, and work with primary care and specialists in caring for their patients with systemic diseases. Because of their knowledge of systemic conditions that can manifest in the eye, optometrists are often the first providers to discover systemic conditions like diabetes, hypertension or even brain tumors. They then refer the patient to the appropriate provider for follow up care, as would any ethical medical or dental provider.

Optometrists do know how to evaluate conditions of the eye and judge when a patient may need surgical or specialty care. They refer patients to ophthalmologists and others all the time for further treatment or surgery.

FACT: Doctors of Optometry also know how to take care of postoperative situations. Optometrists have been comanaging cataract and other surgeries under Medicare protocols for decades.
Even in states where the optometry laws are not updated, optometrists are currently able to perform preoperative and postoperative care for patients who have these procedures. Certainly, if an optometrist is competent to do surgical follow-up, and manage the complications which may present, they must have an excellent working knowledge of the eye, the surgical procedure, and related systemic issues.

CONTINUING COMPETENCY

The ophthalmologists who commented for the Vermont report had limited understanding of modern optometry. They allege, "there is no oversight of an optometrist' competence or whether that competence is maintained." This is not true. State optometric licensure boards have required CME for decades. CME was first required for MDs in Vermont in 2011. Only 30 hours over a two-year period is required.

Vermont optometric licensees who hold an endorsement permitting use of therapeutic pharmaceutical agents must complete 40 hours of CME, of which 20 hours shall be in the use of therapeutic pharmaceutical agents, including treating possible complications arising from their use, and the treatment of glaucoma. *"Continuing education" means the direct participation of an optometrist in a structured educational format taught by qualified presenters. Continuing education has significant intellectual and practical content directed at maintaining the professional competence of optometrists. Continuing education as used in this Part does not include practice management courses or programs.*

FACT: In all the states with updated optometric practice acts, CME is required for re-licensure.
In Kentucky for example, ODs who are certified to use lasers must have additional hours of Board approved continuing education specifically relating to the advanced procedures for license renewal.

FACT: Continued competency is also a part of Board Certification.
The American Board of Optometry (ABO) oversees board certification for Optometrists. The ABO is accredited by the National Commission for Certifying Agencies (NCCA) and recognized by CMS. Once a licensee meets all the post graduate requirements to become Board Certified, there is a Maintenance of Certification requirement similar to medicine.

PRIMARY EYE CARE

The Vermont report argues these ophthalmic procedures are not part of Primary Eye Care and therefore should not be performed by optometrists. No law limits optometric scope to just Primary Eye Care.

FACT: There is no universally accepted definition of Primary Eye Care.
The American Academy of Ophthalmology' official definition of surgery published by the AAO Hoskins Center for Quality Eye Care in 2014 states, *"Primary eye care services include: Performing surgery when necessary"*.

In some state laws, primary care is defined only as family practice, nurses and physician assistants.

Is Primary Eye Care anything that can be performed in the office?

Obviously, the definition of primary eye care varies. The issue is not whether these procedures are defined as primary eye care, but whether optometrists have the training to perform them safely. Family Practitioner's (MD or DO), with no particular training or expertise in ophthalmic procedures, are permitted to perform essentially all of the same procedures ophthalmologists are constantly seeking to block optometrists from including in their modern practice acts. Pfenninger & Fowler's *"Procedures for Primary Care,"* 4th ed., which is often referred to as the "Bible" of Family Medicine and listed as one the 100 most-influential texts in medicine in recent years includes numerous chapters on ophthalmic procedures. A Doctor of Optometry is eminently more qualified by virtue of an expanded knowledge-base and practical experience to render these services within their communities.

ACCESS

FACT: Optometrists are the only eye care providers within two Vermont counties, providing access to eye care for 7,997 urban residents and 47,705 rural residents.

FACT: No other health care providers are denied the ability to practice what they have been trained to do because there is another type of provider 30 miles or 60 minutes away who could perform the service. No medical doctor is prevented from providing their patients the benefits of new technologies because there is another medical doctor in their town already using the new technologies on their patients.
Patients should have the right to choose their provider if they are qualified whether they are in an urban or rural area.

Allowing patients to choose to receive services locally could save the Medicaid program transportation money. Many Medicaid recipients lack readily available transportation. A 30-mile trip might be impossible for them to arrange.

Costs savings would also accrue to patients who save time and money in time off work, travel time and costs, and second exams. If a patient chooses to have their local optometrists perform the service, the optometrist should be allowed to do so. The patient can still always choose to go to an ophthalmologist.

The two ophthalmologists who testified in Vermont downplayed the number of potential procedures to be performed by Vermont optometrists based on the number of procedures referred to them by 13 optometrists out of 128 Vermont optometrists. There is no reason to believe the 13 ODs referred exclusively to them and did not refer other surgeries to other ophthalmologists. Again, anecdotal testimony by two ophthalmologists opposing the legislation was widely credited in the Vermont report.

Vermont alleges ODs won't do enough procedures to maintain competency. Are medical doctors prohibited from doing cataract surgeries if they don't meet a numerical threshold? No. No other profession is judged on the number of procedures they perform.

FACT: Optometrists are conservative practitioners. Older practitioners may not choose to become certified, especially if there is someone else in their practice or local area who is certified. Only a fraction of medical physicians choose to provide surgical services to their patients even though ALL of them may legally do so. There are no obstacles for medical physicians to seek out training programs and develop the skills they choose to pursue. Yet optometrists are restricted by outdated laws from employing the full measure of their education and developing their abilities to their fullest.

But for new graduates and those who wish to get the additional training, why should they be denied the ability to provide their patients these services?

FACT: Regarding utilization – there is a limited potential patient population who would be eligible for these ophthalmic procedures. Whether the procedure is performed by an MD or OD the costs would be the same.

FACT: There are many more optometrists than ophthalmologists. Nationally, the number of full time equivalent OMDs DECLINED by 1% from 2000 to 2020. The number of Optometrists INCREASED by 48% in that same time period. During this same time period the population of the U.S, grew by an estimated 55 million. With little to no growth in the numbers of ophthalmologists, optometrists are positioned to meet the needs of these additional citizens.

SUMMARY

In summation, relevant and readily available information on why Doctors of Optometry should be recognized to practice at the highest levels of education exist and are outlined in the above document. The American Optometric Association encourages OPR to quickly amend their public document to accurately reflect the information available and reverse the flawed document and ultimate outcome.