Minnesota's Optometrists

February 19, 2024

Senator Melissa Wiklund
Chair, Senate Health and Human Services Committee
95 University Ave
Minnesota Senate Bldg., Room 2107
St. Paul, MN 55155

Support for HF1031/SF659 - Optometric scope of practice

Dear Chair Wiklund:

Thank you for recently coordinating two meetings between the Minnesota Optometric Association (MOA) and the Minnesota Academy of Ophthalmology (MAO) to discuss potential consensus around HF1031/SF659, legislation to update the state's optometry scope of practice. Unfortunately, neither meeting produced any positive results. MAO leadership opposed all aspects of the Optometry scope bill and only offered "clone" language used in other states to significantly reverse the current optometry scope of practice.

While MOA is always open to identify better patient access to care, the time has come for the legislature to act on HF1031/SF659.

Based on recent MAO correspondence to legislators and erroneous items raised in our recent meetings with the Academy, I would like to refute and clarify some key claims used to distract and redirect the conversation away from the needs and merits of HF1031/SF659.

Exceptional Training

The scope of practice for Doctors of Optometry should be determined based on the training and clinical decision-making skills of practitioners. Doctors of Optometry undergo comprehensive clinical training in diverse settings, including educational institutions, Veterans Affairs Medical Centers (VAMC), rural and urban clinics under the supervision of optometrists and ophthalmologists; where they actively treat and manage ocular diseases and provide primary eyecare. Optometric education is rigorous in areas of pharmacology, anatomy, physiology and clinical experience in primary care and ocular disease.

The Accreditation Council on Optometric Education (ACOE) is the authoritative body responsible for accrediting all programs that lead to the Doctor of Optometry degree. This organization is recognized by both the U.S. Department of Education (USED) and the Council on Higher Education Accreditation (CHEA) as a trustworthy entity that ensures the quality of education in accredited programs. Important

to note that the USED also recognizes the Liaison Committee on Medical Education (LCME) which accredits medical education programs leading to the MD degree. Both the ACOE and the LCME must meet the same rigorous requirements as outlined by the USED.

Clinical experience for optometry students commences in their first year of training. All Doctors of Optometry must successfully pass three parts of the NBEO (National Board of Examiners in Optometry) exams and a clinical exam before entering into practice. It is important to note that the Academy's statement regarding 2000 clinical hours is inaccurate. Optometry students dedicate nearly 10,000 hours of training and treat thousands of patients before earning a degree. Regarding injections, we have affidavits from all optometry schools confirming that the teaching and evaluation of injection techniques are integral components of their training programs.

Workforce Study

MAO's utilization of geographic data for ophthalmologist coverage is questionable. Their reliance on zip code locations for ophthalmologists and extrapolation of national data at a local level may not accurately represent the true accessibility of eye care services. This data incorporates ophthalmologist providers who visit a location only once a month, leading to potential inaccuracies in assessing actual service availability. It does not matter if 95% of Minnesotans live within 30 minutes of drive time to an ophthalmologist if the ophthalmologist is there once a month, or if the patient cannot find a driver, or if the patient cannot take off work on a certain day, or if the patient simply refuses to drive 30 minutes.

The central issue at hand is the prolonged wait times, particularly concerning specialist referrals including oculoplastics. Scheduling delays of 2-3 months are not uncommon, even within the metro area. In addition, some studies referenced in ophthalmology's letter referring to the rates of herpetic eye disease (treated with oral antivirals) includes antiquated data dating as far back as 1979. [1] Their data includes "unpublished data that has not been peer-reviewed from the Rochester Epidemiology Project". [2]

In 2023, the American Academy of Ophthalmology published their own workforce study in the journal *Ophthalmology* titled "Ophthalmology Workforce Projections 2020-2035." This paper indicated that, "The present analysis of Health Resources and Services Administration (HRSA) Health Workforce Simulation Model (HWSM) shows that the ophthalmology physician workforce is inadequate to meet the demand for ophthalmological services, and this inadequacy is expected to increase by the year of 2035."[3] Minnesotans need both ophthalmologists and optometrists to work together to meet the increasing eye care demands over the coming decades.

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[1] Young RX, Hodge DO, Liesegant TJ, Baratz KH. Incidence, recurrent, and outcomes of herpes simplex virus eye disease in Olmsted County, Minnesota 1976-2007: the effect of oral antiviral prophylaxis. Arch Ophthalmol.2010;128(9):1178-83

[2] Unpublished data from the Rochester Epidemiology project in Olmsted County through direct email communication on 18Jan2024 with Professor John Chen, MD, PhD, Mayo Clinic.

[3] Berkowitz ST, Finn AP, Parikh R, Kuriyan AE, Patel S. Ophthalmology workforce projections in the United States, 2020-2035. Ophthalmology.2024;131(2):133-139

While access to care for Minnesotans is a critical part of why HF1031/SF659 needs to become law, it is necessary to acknowledge that optometrists' training and certification is deeply underutilized in the state. Every aspect of HF1031/SF659 has been taught in optometry schools for decades and optometrists are well-equipped to provide the growing healthcare needs in Minnesota; especially where there are geographic gaps in service.

Unnecessary Limits on Oral Medications

The current medication limits on Doctors of Optometry are an unnecessary burden to providing continuity in care. Antiviral medications are frequently required for patients for durations exceeding 10 days, which is limited in optometry's current scope. It is well recognized that low-dose, long-term dosing of antiviral medication can reduce potentially blinding outbreaks or recurrences of herpes simplex infections. Over two decades ago, the Herpetic Eye Disease Study demonstrated the benefit of long-term oral antiviral therapy to reduce the rate of recurrent ocular HSV. [4] The Acyclovir Prevention Trial demonstrated that oral antivirals were safe and well-tolerated when administered continuously for 12 months[5]. Oral antiviral medications exhibit safety and efficacy, even when administered during pregnancy.[6] Doctors of Optometry routinely handle the management of patients with recurrent herpetic disease in their office.

Over the past two decades, optometrists have safely overseen the treatment of these patients and their eye conditions. We are accustomed to making appropriate referrals when needed and addressing complications. The 10-day restriction is unnecessary and should be removed. Optometrists in 47 states prescribe oral antivirals without limits on duration. The World Health Organization (WHO) model list of essential medication includes acyclovir, a medication[7] widely prescribed in eye care for prophylactic treatment of viral eye infections. These medications pose low risk to the majority of patients and can be managed at higher risk in conjunction with their primary care provider.

Oral carbonic anhydrase inhibitors (CAI's), although rarely needed beyond a short course of action, are necessary in a small class of patients who are not candidates nor choose medical management in place of additional glaucoma surgeries. Doctors of Optometry have been prescribing oral CAI's safely for over two decades with the 7-day limit, possessing the education and training to prescribe and manage patients on these medications as allowed in 44 states. Optometrists currently prescribe topical CAI's with no limit on length of prescribing, which is important to acknowledge as adverse reaction rates

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[4]Wilhelmus KR, Beck RW, Moke PS. Acyclovir for the prevention of recurrent herpes simplex virus eye disease. N Engl J Med 1998; 339:300-306

[5] Acyclovir for The Prevention of Recurrent Herpes Simplex Virus Eye Disease. Herpetic Eye Disease Study Group. *N Engl J Med*. 1998 Jul 30. PubMed

[6] KM Stone, R Reiff-Eldridge, AD White, JF Cordero, Z Brown, ER Alexander, EB Andrews. Pregnancy outcomes following systemic prenatal acyclovir exposure: Conclusions from the international acyclovir pregnancy registry, 1984–1999, Clinical and Molecular Teratology.2004;7(4):201-207

[7] Web Annex A. World Health Organization Model List of Essential Medicines – 23rd List, 2023. In: The selection and use of essential medicines 2023: Executive summary of the report of the 24th WHO Expert Committee on the Selection and Use of Essential Medicines, 24 – 28 April 2023. Geneva: World Health Organization; 2023 (WHO/MHP/HPS/EML/2023.02).

occurred at equal rates between topical and oral administration as referenced in a recent 2022 JAMA Ophthalmology article. It notes a similar, small risk for serious events associated with oral CAIs, similar to topical formulas which have been prescribed by Minnesota Optometrists for decades.[8]

Similarly, oral corticosteroids - infrequently needed in eye care - offer significant sight and lifesaving benefits when necessary. Doctors of Optometry efficiently handle the long-term ocular side effects of these medications, coordinating care with patients' primary care physicians and other specialists and having the ability to order necessary lab work. With our skills and clinical expertise, Doctors of Optometry are fully capable of prescribing these medications on a short-term basis; a practice already in place in 44 other states.

Injection Authority

For the past three decades, Doctors of Optometry have been effectively treating infections and diseases in the eye and eyelid with pharmaceutical agents. In certain situations, oral or topical treatments are insufficient, and patients benefit from medication injections. Treatment protocols include careful patient history assessments, physical examinations, and the utilization of laboratory and diagnostic testing - all currently within the scope and expertise of optometrists. Doctors of Optometry maintain a commitment to referring patients to ophthalmologists, dermatologists, and other health care providers when clinically appropriate, as we have for decades. Injection authority for treatment of diseases of the eye and eyelid will not change our commitment to the highest standard of patient safety.

The State Board of Optometry, our licensing and regulatory authority, holds a pivotal responsibility in safeguarding patient safety and ensuring the proficiency of Doctors of Optometry. This entity sets forth standards, guidelines, and ongoing educational mandates to uphold the training and competency of Doctors of Optometry, including oversight of clinicians administering injections and minor surgical procedures within the updated scope. Correspondence from State Boards of Optometry in various states attests to the absence of any uptick in safety-related complaints subsequent to scope expansions. Furthermore, practicing optometrists possess correspondence from the primary malpractice insurer indicating consistent levels of malpractice claims and rates in states where scope updates have been enacted. Notably, no state has rescinded scope expansions for optometric care, underscoring the established track record of Doctors of Optometry in delivering safe and effective eye care.

There has been absolutely no actual data of reduced patient safety from any of the states currently allowing Doctors of Optometry unrestricted oral antiviral prescription authority (47 states), unrestricted oral carbonic anhydrase inhibitor prescription authority (44 states), oral steroid prescription authority (44 states) and injections (24 states).

Valuable collaboration exists between optometrists and our ophthalmologist colleagues in daily clinical practice. This partnership is built on a foundation of trust, enabling surgeons to dedicate more time to

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[8] MM Popovic, MB Schlenker, MD MSCc, D Thiruchelvam. Serious adverse events of oral and topical carbonic anhydrase inhibitors. JAMA Ophthalmol.2022;140(3):235-242

intricate surgical cases while entrusting the crucial responsibility of medical eye care to their optometry counterparts. Passing HF1031/SF659 will improve access to eye care with qualified providers, improve visual outcomes, and uphold imperative patient safety. We ask for your support of HF1031/SF659.

Sincerely,

Lauren Haverly, O.D.
President
Minnesota Optometric Association