



IS CHILDREN'S EYE CARE NEGOTIABLE?



Understand the potential outcomes were a proposed bill for vision screening to be enacted.

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Part one of this series explained the proposed Early Detection of Vision Impairments in Children (EDVI) Act and analyzed its inclusion of unsubstantiated “vision screening” as a preventive health measure for children.¹ Supporters of the proposed legislation have accepted this action as a federally funded approach to improve early primary eye care intervention and treatment for children.

This article examines the policy and the professional and health implications of potential outcomes of the EDVI Act, including effects on

eye care delivery, children’s health and health equity, the optometric profession, the value of evidence-based health and eye care policy, and related unintended consequences. A crucial call to action for all optometrists is to obtain clarity, exercise accountability, and demand detailed answers to important questions raised by the lack of data in the stated aims of the proposed legislation. Colleagues who have signed on to this approach from positions that affect the profession’s future in the US primary health care arena remain accountable to every doctor of

optometry and the care they provide across the nation for patients.

WHO IS DEFINING CHILDREN'S EYE CARE? (AND OTHER UNANSWERED QUESTIONS)

Recall that the proposed EDVI Act states the following: “HRSA at the US DHHS [Department of Health & Human Services] will award grants and cooperative agreements for states and local communities to:

- Implement approaches, such as vision screenings, for the early detection of vision concerns in children, referrals for eye exams,

- and follow-up mechanisms;
- Identify barriers in access to eye care and strategies to improve eye health outcomes;
- Raise awareness about the importance of early interventions and screenings;
- Establish a coordinated public health system for vision health and eye care diagnosis and treatment; and
- Develop state-based data collection, quality monitoring, and performance improvement systems.

Resources will also be made available through the Centers for Disease Control and Prevention to provide technical assistance and guidance to states and communities to implement children's vision screening and early intervention programs."²

From the perspective of improving children's health and delivering evidence-based care, there are critically important questions to ask; namely: Who is setting the acceptable standard for eye and vision care for children? The EDVI Act aims to provide financial support to states and local communities to "increase screenings and early interventions." Aside from eye exams,

what are these "early interventions," and how are they supported by evidence and objectively assessed?

From a health economic perspective, who receives the monies for "screenings" and "interventions"? Many interested parties are involved, including both health care and non-health care entities. How are funding decisions to be made, what will become priorities, and who will determine what they are? Will optometrists' tax dollars go toward funding for non-evidence-based vision screenings?

The EDVI Act includes the term "screening" three times, whereas "primary eye care" is never discussed, and "referral for eye exams" is stated only once. "Screening implementation" is mentioned multiple times with no accompanying nationally recognized definition, context, or specificity. Recall gaps in US vision screening research and other related shortcomings were highlighted in a National Academies of Sciences, Engineering, and Medicine report a decade ago.³ The United States Preventive Services Task Force has no national recommendations for vision screening for anyone of any age other than for amblyopia in children 3 to 5 years of age.⁴ The Act's

press release also states that "more than one in every four children in America [...] has a vision problem requiring treatment,"⁵ contradicting current "screening" approaches. Although there is no vision screening in existence that can detect the full range of vision problems presenting in infants and children, more than 270 different conditions and diseases can be identified through a comprehensive primary eye examination.⁶ The question remains: Why is vision screening so difficult to quit when the nationally recognized lack of evidence remains well-documented?^{5,7}

A LOWER COMMON DENOMINATOR

Increasing use of available children's eye care resources is a complicated, multifactorial issue combining a range of professionals. Established best practices for quality eye care are mixed with various historical agendas and a range of knowledge and perceptions, and longstanding difficulties have persisted over decades. Other health care professionals, parents, caretakers, and the public still do not fully recognize or accept the value of early, ongoing primary optometric eye care for infants and children. New optometric training programs are emerging, and more optometrists enter the health care workforce each year. Optometric eye care for infants and children (as well as adults) remains available but underutilized in the United States.

The EDVI Act states that "grants and cooperative agreements" will be awarded to "implement approaches (such as vision screenings) for the early detection of vision concerns in children [and] referrals for eye exams." In general, referral for eye examination is still generally not a requirement in most communities. Is unsubstantiated vision screening to be the children's community gatekeeper for accessing optometric eye care?

AT A GLANCE

- Although no vision screening can detect the full range of vision problems presenting in infants and children, more than 270 different conditions and diseases can be identified through a comprehensive primary eye examination.
- Optometry remains underrepresented at or absent from the tables where important health care-related decisions are negotiated.
- A call to action for optometrists is to obtain clarity, exercise accountability, and demand detailed answers for unknowns in the proposed Early Detection of Vision Impairments in Children Act.

Funding and advocacy for children's primary eye care continues through the Affordable Care Act, the Department of Health and Human Services, Essential Health Benefits, and Centers for Medicare & Medicaid Services, to name a few. Other state and community actions (ie, legislation requiring eye exams prior to school enrollment, school-based health care delivery, inclusion of eye care within the Center for Health Care Strategies, etc) have increased eye examination and optometric care for children. The American Optometric Association (AOA) Evidence-Based Clinical Practice Guideline for children makes clear that optometric eye care is essential to children's health.^{9,10} The EDVI Act does not reflect what is known about primary eye care in 2024; it aims to "raise awareness of early interventions and screenings" but does not state the same for increasing awareness of available primary optometric eye care.

"SATISFICING" THE ISSUE AND THE PROFESSION

As vision screening has yet to be defined, researched, and adopted as a safe preventive health measure, the EDVI Act represents an attempt at "satisficing" the issue of eye care for the sake of finding common ground. *Satisficing* is a decision-making administrative strategy combining

the words satisfy and suffice.¹¹ Decision makers can satisfice either by finding optimum solutions for a simplified world or satisfactory solutions for a realistic world. In other words, they choose to satisfy the issue with a decision they believe suffices them and their constituents, often due to intractability and a lack of knowledge or information.¹²

This approach to increasing evidence-based primary eye care begs the question: How much is the optometric profession willing to compromise for our youngest and most vulnerable patients in return for another attempt at bringing an industry together, using barriers to primary eye care as a rationale for vision screening?^{13,14} Should optometrists accept that something other than frontline eye examination for children is adequate, let alone beneficial, in identifying time-sensitive, correctable vision issues?

CONSEQUENCES OF A LACK OF OD REPRESENTATION

A multitude of unknown potential outcomes can arise from health legislation. It is not uncommon for optometry to be underrepresented at or absent from the tables where important health care-related decisions are negotiated. For example, no ODs serve on the United States Preventive Services Task Force. There are, however,

a number of MDs, some PhDs, and one RN. Likewise, neither the Health Resources and Services Administration nor the Maternal and Child Health Bureau have optometrists as key staff. Both the Department of Health and Human Services leadership and the Association of Clinicians for the Underserved include MDs but no ODs. The Centers for Disease Control and Prevention leadership does not list an OD, nor does the leadership of the National Eye Institute. Nineteen members of Congress are physicians; not including one senator OD.

Moreover, neither the American Academy of Optometry nor the AOA were represented or quoted in the EDVI Act press release. Both the American Academy of Optometry and AOA board members have stated support for the Act. Press release quotes are included from two other organizations—the American Academy of Ophthalmology and Prevent Blindness—both of which historically have worked closely to advocate for unsubstantiated vision screening (the National Center for Children's Vision is administered by Prevent Blindness).

Unwelcome outcomes of the EDVI Act failing to involve ODs may include but are not limited to:

- Reductions in optometric eye examination uptake for children if they are determined to be healthy through nonsubstantiated precursor screening and/or unspecified interventions and approaches included in the EDVI Act
- Prioritization and/or funding for only certain diagnosis and treatment situations
- Limitation of funding for states and communities to only non-physician, nonclinical interventions/screenings due to existing mandated coverage of examination and treatment for children by insurers under the Department

“OTHER HEALTH CARE PROFESSIONALS, PARENTS, CARETAKERS, AND THE PUBLIC STILL DO NOT FULLY RECOGNIZE OR ACCEPT THE VALUE OF EARLY, ONGOING PRIMARY OPTOMETRIC EYE CARE FOR INFANTS AND CHILDREN.”

“FROM THE PERSPECTIVE OF IMPROVING CHILDREN’S HEALTH AND DELIVERING EVIDENCE-BASED CARE, THERE ARE CRITICALLY IMPORTANT QUESTIONS TO ASK; NAMELY: WHO IS SETTING THE ACCEPTABLE STANDARD FOR EYE AND VISION CARE FOR CHILDREN?”

of Health and Human Services Essential Health Benefits

- Increased health disparities and health inequities, especially among at-risk children if unspecified interventions and unsubstantiated vision screening processes remain variable, are based on geography or health literacy, are targeted to certain groups, etc
- Reductions and/or deficits in care delivery standards due to variation in professional practices/guidelines, selective funding, etc
- Increased barriers to accessing optometric care due to “cooperative agreements” that exclude optometrists (ie, those that target board-certified physicians, hospital/health care system networks, or other settings where optometry is underrepresented).

We can only blame ourselves and our leadership if, due to a failure of imagination, our profession lacks advanced preparation and planning for a range of potential unintended consequences of the EDVI Act.

EFFECTS ON OPTOMETRY IN THE HEALTH CARE ARENA

In the EDVI Act’s press release, a sponsor states that it “will empower

states and communities [...] to improve systems of care for our youngest citizens and their families.” In brief, a health care system is a collection of resources that provide health care services to a population.¹³ Doctors of optometry are classified as physicians (not practitioners) under the CMS. Primary optometric eye care and its delivery system is well-established, well-rooted, and readily available in the United States, and referral to primary eye care is not a requirement or guarantee for access. Who determines what the aforementioned “systems of care” are and whether they are targeted and acceptable for improvement for children—will nonphysicians be the new gateway to prescription glasses for children and to meeting state/school requirements for “eye testing” or “vision screening” policies?

Technology continues to accelerate direct access to many aspects of primary eye care, including refraction, glasses and contact lenses, and remote consultation. Will online procedures and other screening approaches (ie, autorefractometry) be encouraged through the EDVI Act? What will substitute for in-person primary eye care, if it is to be deemed unnecessary or too difficult by the yet-to-be-defined “system”?

CALL TO ACTION

Support for the EDVI Act appears well-intentioned but misguided. We must not compromise on best practices. The proposed EDVI Act gives our profession the opportunity to recognize and articulate evidence gaps regarding vision screening versus primary eye care and address them. ■

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