



2023 Council Advisory Recommendations September Status Report

Includes the original Council Advisory Recommendation, Academy background statement and the latest status report.

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Ensuring the Financial Health of State Societies

Council Advisory Recommendation 23-01

Problem Statement:

All politics is local is more than just a phrase. Advocacy activity at the state level is critical to the crucial ongoing legislative battles across the country. These local connections are equally important for effective activity at the federal level. Unfortunately, the ability to conduct this important activity is rapidly waning as state societies become less robust due to flat and often declining memberships. Once strong, successful state societies are experiencing troubling membership trends. The failure to reverse this trend now WILL result in a significantly reduced ability to advocate for our profession and patients.

Summary of Facts and Background Information:

In 2004 when the AAO Council began to address state society membership concerns, a survey based on 2003 data indicated the average state ophthalmology society's percentage of membership was 52.86%. This average declined to 39.54% in 2021. Private equity and hospital acquisitions among other structural and economic factors are negatively impacting this existential trend.

Declining membership and the resultant lack of revenue hinders each society's ability to engage the services of qualified executives, effective lobbying firms, and professional public relations groups. While in the past membership in both the Academy and the state society was absolute and unquestioned, that is no longer the case. Members are now looking for perceived benefits or value added to them personally, professionally, or to their practice. A desire for membership in the "club" is no longer an adequate motivation for many to continue their state society involvement. Generational changes regarding the value of joining local organizations further exacerbates the problem. In the past, state societies were able to offset loss of membership dues with revenue from educational activities. However, the prevalence of competing online educational offerings has limited the ability of state societies from shoring up their finances with these alternative sources of income.

Declining and inadequate state society membership levels have been the subject of numerous past AAO Council discussions and the Academy has offered several solutions and resources. Unfortunately, it is no longer adequate to host a seminar, send an email from the AAO President, publish an article in EyeNet or send a state's dues notice along with that of the AAO in a combined dues mailing. Despite these efforts, many state societies continue to experience a worrisome decline in membership. It is imperative that the Academy provide more substantial support to the state societies to ensure their continued viability.

Possible Solutions:

The Academy should move to collect mandatory state dues in a single invoice combined with Academy dues. The Academy would then send membership data and funds to the states on a monthly basis. This method is used successfully by several other medical associations including the American Society of Anesthesiologists, the American Psychiatric Association, and the American College of Emergency Physicians.

This solution would capture those ophthalmologists who are Academy members but do not support the activities of their state society. Paying one invoice is an easier solution for practices as well. It is not uncommon for members to pay their Academy dues believing

they have also paid their state dues when in fact they have not. A substantial increase in state society membership and dues collection would potentially require less of a commitment per member as this obligation is shared by a greater number of beneficiaries. The current trend of a declining number of members bearing a greater and greater burden is not sustainable and threatens the very existence of our state societies.

Organized ophthalmology must take immediate action. State societies are increasingly critical in advocating with state and federal legislators as well as regulators for both our members and their patients. The need for strong state societies is more important than ever, and it is in the long-term interest of the AAO to ensure that the states continue in their critical mission.

Submitted by:

Stephen R. Klapper, MD

On Behalf of: Indiana Academy of Ophthalmology

Date Board Approved This CAR: 1/20/2023



Academy Background Statement Council Advisory Recommendation

23-01: Ensuring the Financial Health of State Societies

Assigned to and reply from: Aaron M. Miller, MD, MBA – Secretary for Member Services

Presenting: Aaron M. Miller, MD, MBA – Secretary for Member Services

Analysis:

Strong and vibrant state ophthalmic societies are integral partners of the Academy for advocacy, member engagement, policy development and advancement of ophthalmology. The Academy recognizes the ability to advocate for the profession and patients is hindered without a robust grassroots network on the state level. Several initiatives were established to elevate the visibility of and highlight the value of membership in state ophthalmic societies following the approval of CAR 15-03.

The Academy's Ophthalmic Society Relations team provides membership and prospects reports to state societies to assist with member recruitment. This includes bimonthly reports of individuals that have moved in or out of the specific state, and up to two annual complimentary mailing lists of ophthalmologist members for targeted outreach.

The Academy currently collaborates with state societies in the AAO/State Society combined dues mailing program. Twenty-one societies participated in the 2023 dues cycle; participation from state societies varies from 21 to 26 per cycle since the inception of the program. Many state societies also list optional contributions to Political Action Committee (PAC) in their dues invoice. For each participating society, the Academy creates a customized state society membership invoice with the society logo, solicitation statement and tax deductibility information. State societies are also highlighted in the Academy's online dues portal where Academy members are encouraged to learn more about and join their state society.

As background, the Academy established separate checking accounts for each entity to ensure compliance with federal reporting requirements for collection of Academy membership dues, OPHTHPAC contributions, Surgical Scope Fund contributions and donations to the American Academy of Ophthalmology Foundation. Internal Revenue Code Section 527 stipulates special reporting requirements for PACs, including that PAC funds must be held in a separate checking account, and all contributions of \$200 or more must be reported to the Federal Election Commission (FEC).

A single invoice combined billing is estimated to cost \$362,093.82¹ in new annual expenses to the Academy to cover two new FTE staff needed to review, reconcile and disburse payments to state societies; modification or purchase of a new integrated dues system for payment processing; legal fees to develop new joint billing agreements; and increased credit card and bank fees with expanded scope of dues collection. New infrastructure and process must also be considered to ensure:

¹ Based on economic analysis conducted in 2018 to cost \$300,000 and adjusted to 2023 costs with the U.S. Bureau of Labor Statistics CPI inflation calendar.



- Compliance with federal and state tax laws as well as FEC regulations. The Academy, as the initial recipient of the payment, must guarantee all partnering state societies are compliant with federal and state reporting requirements. State societies may be required to provide a copy of their filed Form 990s annually.
- Comprehensive accounts receivable (A/R) function. The majority of payments to the Academy go directly to a Wells Fargo Lockbox and automatically clear receivables to the specified accounts. Inclusion of all dues and voluntary contributions on a single invoice routed to a single account requires complete manual processing, reconciliation of payments and disbursement of funds to state societies by Academy staff.
- Exclusion of state PAC solicitations. 11 CFR 114.1(e)(2) in the Code of Federal Regulations states that prospective members have not yet satisfied conditions for membership in the association and are thus not within the restricted class for PAC solicitations. Some Academy members do not currently hold membership in their state societies and therefore cannot be solicited to contribute to their respective state PACs in the dues mailing.

The Academy agrees with the CAR that robust state societies positively strengthens federal advocacy, and organized ophthalmology's impact and relevance in the communities we serve. The Academy regularly considers opportunities through which we can support state society membership development efforts. Past initiatives included a one-day Membership Development Meeting attended by ophthalmologist leaders and staff of 44 state ophthalmology societies, and a grant program to support innovation in state society membership.

We will continue to evaluate interest from state societies to participate in the combined dues mailing program. We will also continue to explore opportunities to increase members' awareness of state societies and their impact on the profession, including:

- Partner with individual state societies to develop joint email campaigns on an annual basis that highlight state advocacy wins and emphasize the value of state society membership. State societies can leverage the Academy's membership list and email marketing platform to engage with a wider audience. Emails will be sent through the Academy's email management system to all Academy members that work or reside in the state.
- With the impending Academy website upgrade, include a state society section/news feed in the member dashboard for greater visibility of state society achievements as well as direct links to join or renew state society membership. Individual members can view information specific to their state without conducting a website search for news and announcements.



Status Report for Council Advisory Recommendation 23_01

Title: Ensuring the Financial Health of State Societies

Report From: Aaron M. Miller, MD, MBA – Secretary for Member Services

Analysis:

The CAR asks the Academy to implement a mandatory joint state and national membership for U.S. members to ensure the viability of state societies. Strong state ophthalmic societies are integral partners of the Academy for advocacy, member engagement, policy development and advancement of the profession.

Rating: 2 = Cannot implement right now because...

Report:

The Academy recognizes the importance of ensuring a sustainable financial foundation for state societies' operations and growth. Strong state societies positively strengthen federal advocacy, and organized ophthalmology's impact and relevance in the communities we serve.

The Academy's Secretariat for State Affairs, State Governmental Affairs team, and Ophthalmic Society Global Relations (OSGR) team are dedicated to support state societies. OSGR regularly provides membership and prospects reports for recruitment and retention, collaborates with societies to promote society efforts and events in Academy publications, and recognizes state society members at the Academy's annual meeting. The Secretariat and OSGR provide state society executive directors opportunities to share membership development best practices via the twice-yearly State Society Executive Directors' Forum, hosted by State Affairs, and the Academy continues to support state society membership by offering all state societies to participate in the AAO/state society combined dues mailing program.

While the Academy understands the merits of exploring mandatory joint dues as a potential solution, the costs associated are significant. A single invoice combined billing is estimated to cost \$362,093.82 in new annual expenses to the Academy in addition to restructuring of the current system from both the Academy and state society levels to ensure compliance with FEC regulations and federal and state tax laws. We believe it's vital to consider a holistic approach that strengthens the membership value proposition and fosters a more engaged and vibrant membership base. As CAR author and Indiana councilor Dr. Stephen Klapper shared, "Members are now looking for perceived benefits or value added to them personally, professionally, or to their practice."

We look forward to collaborating closely with state societies to implement a range of strategies to achieve this goal.

- **Enhanced Member Value and Diverse Programming:** Collaborate on exclusive programs to deliver tangible value to members, including:
 - Foster networking events that connect state members with influential individuals in their region, allowing them to build meaningful connections and derive more value from their state membership

Rating: 0 = Recommend no action because... 1 = Currently being addressed by the following AAO activities... 2 = Good idea but cannot implement right now because... 3 = Implemented or will be implemented by...

- Provision of complementary ethics education through the Academy's Ethics Program to help members fulfill CME requirements for relicensure/risk management
- Joint providership of Continuing Medical Education (CME)
- Co-sponsorship of coding education with a proposal to restructure revenue share to alleviate financial burdens on state societies to fund events
- State societies can help identify local trends and preferences, which can inform the development of targeted programs and initiatives.
- **Landscape Analysis and Targeted Engagement:** The Academy has piloted with the Tennessee Academy of Ophthalmology to assess its current membership composition and identify areas where TNAO have lower penetration by benchmarking against Academy membership. The landscape analysis of Academy members based in Tennessee includes breakdowns by various demographic fields including age, gender, practice type and clinical focus. The membership analysis is available by state to share with societies.
- **Communication and Promotion:** Together, we can amplify our advocacy efforts at both the state and national levels. By showcasing the impact of our collective work on important issues, we can inspire members to remain committed on the state and national levels.
 - The Academy plans to partner with individual state societies to develop joint email campaigns on an annual basis that highlight state advocacy wins and emphasize the value of state society membership. State societies can leverage the Academy's membership list and email marketing platform to engage with a wider audience. Emails will be sent through the Academy's email management system to all Academy members that work or reside in the state.
 - With the impending Academy website upgrade, create a state society section/news feed in the member dashboard for greater visibility of state society achievements as well as direct links to join or renew state society membership. Individual members can view information specific to their state without conducting a website search for news and announcements.

We value the input of state societies and working towards scheduling meetings between state society executives (Alabama, Connecticut, Florida, Illinois, Indiana, Kansas, Missouri, New Jersey, New York, Ohio, Oklahoma, Pennsylvania) and the secretaries of State Affairs and Member Services (Drs. John Peters and Aaron Miller respectively). We believe that by working together and sharing insights and best practices, we can build a stronger, more resilient membership base that will support the long-term success of our state and national societies.

Pediatric Ophthalmology Subspecialty Workforce Shortage

Council Advisory Recommendation 23-02

Problem Statement:

In the past decade the decline in fellowship-trained pediatric ophthalmologists in this country has become exponentially worse. The Academy needs to expand its role working with subspecialty societies, State Societies, the Association of University Professors of Ophthalmology (AUPO), medical schools as well as other large organizations for example, the American Academy of Pediatrics (AAP) and the American College of Surgeons (ACS) in addition to increasing its advocacy efforts with governmental bodies to ensure that fellowship training in pediatric ophthalmology and adult strabismus continues.

Summary of Facts and Background Information:

In 2009 Council Advisory Recommendation (CAR) 09-02 was submitted by Anthony Arnold, MD on behalf of the North American Neuro-Ophthalmology Society (NANOS) seeking assistance from the American Academy of Ophthalmology (AAO) to address the under-supply of fellowship trained neuro-ophthalmologists as well as subspecialists in ophthalmic pathology and uveitis. In a detailed set of facts and background information this shortage was well documented and possible root-causes were addressed. The AAO was asked to review reimbursement strategies, collaborate with federal and state policy makers to help direct reimbursement changes, develop strategies for continued training and engage the American Academy of Neurology (AAN) to name a few.¹

In the past 5 years, the match-rate for pediatric ophthalmology has averaged around 70%. Of 43 fellowship-matched positions filled in December 2021, 18 (41%) were filled by foreign medical graduates (Increased from 33% in 2018) while the number of US graduates was 25, decreased from 34 in 2018. Nineteen positions were left unfilled.²

The single largest factor in creating a reimbursement disparity for pediatric ophthalmology relates to Medicaid reimbursement. According to the Kaiser Family Foundation, 39% of children in the United States were covered by Medicaid in 2021; in some states that rate is over 58% and over 60% in Puerto Rico.³ Medicaid reimburses on average 72% of Medicare level.⁴ Additional financial issues arise from relative value units (RVU) that are geared toward the practice of adult ophthalmology and do not take into consideration the difference in time required to perform services on children nor the locations of said service. (For example, in an operating room, under general anesthesia versus office or ASC.) Additional revenue from office procedures (that generate additional RVUs per visit) are limited in this young population of patients as well.

In its response to CAR 09-02 the AAO states, "The Association of University Professors of Ophthalmology (AUPO) is well aware of the recruitment shortfall in pathology, neuro-ophthalmology, uveitis and pediatric ophthalmology and strabismus, and this topic was the subject of the AUPO president's keynote address at its recent annual meeting. He discussed the link between recruitment and reimbursement and the need for academic departments to think creatively about compensation issues." Furthermore, it states, "No new action is anticipated at this time. Monitoring of healthcare reform will include attention to support for smaller subspecialties to allow participation in all aspects of future programs. We intend to work as appropriate with American Academy of Pediatrics, AUPO, AAMC and other

organizations to promote programs that will benefit ocular pathology, neuro-ophthalmology, uveitis and pediatric ophthalmology and strabismus training and faculty development.”⁵

It has been almost 14 years since this response was recorded and we respectfully request that this issue be revisited since there has been a continued decline in fellowship-trained sub-specialists in pediatric ophthalmology and “watchful waiting” has had limited effect.

References:

1. CAR 09-02
2. 2022 AAPOS Fellowship Directors Committee Report
3. <https://www.kff.org/other/state-indicator/children-0-18/?currentTimeframe=0&sortModel=%7B%22collId%22:%22Location%22,%22sort%22:%22asc%22%7D>.
4. <https://www.kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index>
5. Status Report for Council Advisory Recommendation: June 2009

Possible Solutions:

- A. Work with AAPOS and other sub-specialty societies to create and advocate for a separate taxonomy code recognized by CMS indicating a subspecialty shortage area which could be contracted at higher reimbursement rates.
- B. Alternatively work with AAPOS and other societies to create and advocate for a modifier indicating an extended length of time (and reimbursement) to be applied to pediatric patients.
- C. Work with AAPOS, AAP, ACS to advocate on a federal level to raise Medicaid reimbursement rates to equal Medicare rate for pediatric patients.
- D. Create a liaison within the AAO’s Secretariat for State Affairs, Health Care Policy Committee or create a separate committee (Medicaid Relations) to regionally work with states and state societies to increase Medicaid reimbursement to providers in under-served subspecialties.
- E. Create a detailed study of the ophthalmology workforce to obtain subspecialty and DEI data (see separate AAPOS CAR on this subject).
- F. Work with AAPOS and help to engage AAP to create a medical pediatric ophthalmology fellowship track for pediatric-trained residents who may have an interest in ophthalmology.
- G. Work with AAPOS and AUPO to formulate specific, measured, achievable, realistic and timely (SMART) goals to further recruitment into pediatric ophthalmology.
- H. Advocate for state and federal programs that better-target loan forgiveness for sub-specialists who opt for an underserved subspecialty.

Submitted by:

Stacey J Kruger, MD

On Behalf of: American Association for Pediatric Ophthalmology and Strabismus

Date Board Approved This CAR: 11/9/2022

Additional Submitters: Scott Larson, MD; American Association for Pediatric Ophthalmology and Strabismus

Co-Sponsors:

Alabama Academy of Ophthalmology
Alaska Society of Eye Physicians and Surgeons
Arizona Ophthalmological Society
Arkansas Ophthalmological Society
California Academy of Eye Physicians & Surgeons
Colorado Society of Eye Physicians and Surgeons
Connecticut Society of Eye Physicians
Florida Society of Ophthalmology
Georgia Society of Ophthalmology
Hawaii Ophthalmological Society
Idaho Society of Ophthalmology
Illinois Society of Eye Physicians & Surgeons
Indiana Academy of Ophthalmology
Iowa Academy of Ophthalmology
Kansas Society of Eye Physicians and Surgeons
Kentucky Academy of Eye Physicians and Surgeons
Louisiana Academy of Eye Physicians and Surgeons
Maine Society of Eye Physicians and Surgeons
Maryland Society of Eye Physicians and Surgeons
Massachusetts Society of Eye Physicians and Surgeons
Michigan Society of Eye Physicians and Surgeons
Minnesota Academy of Ophthalmology
Mississippi Academy of Eye Physicians and Surgeons
Missouri Society of Eye Physicians and Surgeons
Montana Academy of Ophthalmology
Nebraska Academy of Eye Physicians and Surgeons
New Hampshire Society of Eye Physicians and Surgeons
New Mexico Academy of Ophthalmology
New York State Ophthalmological Society
North Carolina Society of Eye Physicians and Surgeons
North Dakota Society of Eye Physicians and Surgeons
Ohio Ophthalmological Society
Oklahoma Academy of Ophthalmology
Oregon Academy of Ophthalmology
Pennsylvania Academy of Ophthalmology
Puerto Rico Society of Ophthalmology
Rhode Island Society of Eye Physicians and Surgeons
South Carolina Society of Ophthalmology
South Dakota Academy of Ophthalmology
Tennessee Academy of Ophthalmology
Texas Ophthalmological Association

Utah Ophthalmology Society
Delaware Academy of Ophthalmology
Vermont Ophthalmological Society
Washington Academy of Eye Physicians and Surgeons
Washington DC Metropolitan Ophthalmological Society
West Virginia Academy of Eye Physicians and Surgeons
Wisconsin Academy of Ophthalmology
Wyoming Ophthalmological Society
American Academy of Pediatrics, Section on Ophthalmology
American Association of Ophthalmic Oncologists and Pathologists
American College of Surgeons, Advisory Council for Ophthalmic Surgery
American Glaucoma Society
American Ophthalmological Society
American Osteopathic College of Ophthalmology
American Society of Cataract & Refractive Surgery
American Society of Ophthalmic Plastic & Reconstructive Surgery
American Society of Ophthalmic Trauma
American Society of Retina Specialists
American Uveitis Society
Association for Research in Vision and Ophthalmology
Association of University Professors of Ophthalmology
Association of Veterans Affairs Ophthalmologists
Canadian Ophthalmological Society
Cornea Society
Eye and Contact Lens Association
Eye Bank Association of America
Intl Joint Commission on Allied Health Personnel in Ophthalmology
Macula Society
National Medical Association, Ophthalmology Section
North American Neuro-Ophthalmology Society
Ocular Microbiology and Immunology Group
Outpatient Ophthalmic Surgery Society
Pan American Association of Ophthalmology
Retina Society
Society of Military Ophthalmologists
Virginia Society of Eye Physicians and Surgeons
Women in Ophthalmology



AMERICAN ACADEMY
OF OPHTHALMOLOGY®

Academy Background Statement
Council Advisory Recommendation

23-02 Pediatric Ophthalmology Workforce Shortage

Assigned to: Federal Affairs

Reply From: David B. Glasser, MD - Secretary for Federal Affairs; Michael X. Repka, MD, MBA - Medical Director for Governmental Affairs; George A. Williams, MD - Senior Secretary for Advocacy

Presenting: Michael X. Repka, MD, MBA - Medical Director for Governmental Affairs

Analysis: The Academy agrees that addressing pediatric ophthalmology workforce challenges is a pressing issue and requires renewed efforts. We believe success will take not only increased Academy focus, but also a strong collaboration with subspecialty organizations, state societies, and other stakeholders from the ophthalmic community. We believe the broad support for this Council Advisory Recommendation (CAR) is demonstrative of the willingness to work together to address these challenges.

As was outlined by the CAR authors, the causes of shortages impacting pediatric ophthalmology are multifactorial. They include limitations on residents pursuing pediatric ophthalmology fellowships, as well as economic factors disincentivizing pursuit of the subspecialty. In addition, because their patient population is increasingly covered through Medicaid, low reimbursement rates are amplifying the economic challenges and undermining the financial stability needed to run a strong practice. The Academy is aware of the need to address pediatric ophthalmology reimbursement challenges at the state and federal level. Unfortunately, these challenges are faced by their colleagues within our specialty as well. Addressing these issues has been and will remain a top Academy priority.

The Academy is willing to pursue all the potential solutions outlined in the CAR. We do believe that it is important to understand that change will take time, and that success will depend not just on the efforts of the Academy, but of a strong coalition of organizations.

Options

The CAR offers a number of potential solutions and we agree that many are worth pursuing or exploring.

- 1) **Work with AAPOS and other sub-specialty societies to advocate for the pediatric ophthalmology subspecialty taxonomy code (207WX0110X) to be recognized by CMS as indicating a subspecialty shortage which could be contracted at higher reimbursement rates.**
 - a. The Academy believes this is worthy of discussion with AAPOS and other subspecialties, but this should be targeted as a long-term goal. We note that the specialty has a separate taxonomy developed in the last decade. There will be a conflict with law and policy to pay all doctors the same for equal work.
- 2) **Work with AAPOS and other societies to create and advocate for a claims modifier indicating an extended length of time (and reimbursement) to be applied to children up to 18 years of age.**
 - a. The Academy also believes this is worthy of discussion with AAPOS and other sub-specialty societies.
 - b. Given the challenge and resources needed to advance recommendations 1 & 2, the Academy would suggest the development of a pediatric ophthalmology support coalition that could work in collaboration, as well as pool resources, to pursue these initiatives.
- 3) **Work with AAPOS, AAP, ACS to advocate on a federal level to have states raise Medicaid reimbursement rates to equal Medicare rate for pediatric patients.**
 - a. The Academy is supportive of such a policy and can monitor potential opportunities to advocate for this change, specifically via federal legislation. Currently, the political climate makes this very difficult to achieve given interest in reducing federal spending and control state spending at the local legislature level. but we can explore with AAPOS, AAP, and ACS.
- 4) **Create a liaison within the AAO's Secretariat for State Affairs, Health Care Policy Committee or create a separate committee (Medicaid Relations) to regionally work with states and state societies to increase Medicare reimbursement to providers in under-served subspecialties.**
 - a. The Academy is supportive of increasing Medicare reimbursement to providers in under-served subspecialties and will discuss the best mechanism to achieve it, either by creation of a liaison or a broader coalition across AAO and other specialty/subspecialty organizations.
- E. **Create a detailed study of the ophthalmology workforce to obtain subspecialty and DEI data**
 - a. See separate AAPOS CAR on this subject

F. Work with AAPOS and help to engage AUPO, ABO and AAP to create a medical pediatric ophthalmology fellowship track for pediatric-trained residents who may have an interest in ophthalmology.

a. This can be pursued, but it is not likely to be a rapid solution.

G. Work with AAPOS and AUPO to formulate specific, measured, achievable, realistic and timely (SMART) goals to further recruitment into pediatric ophthalmology.

a. For these suggested solutions, we suggest the development of an Academy led coalition across pediatric and ophthalmology organizations to ensure efforts to boost recruitment and new fellowship opportunities are collaborative.

H. Advocate for state and federal programs that better-target loan forgiveness for subspecialists who opt to serve in an underserved subspecialty.

a. The Academy has made this a top priority for the Governmental Affairs Division for 2023, specifically legislation that seeks to defer interest from accruing on student loans during residency and increased funding to the Pediatric Subspecialty Loan Repayment Program.

Statement to the Senate Health, Education, Labor, and Pensions Committee

The Academy recently issued a formal statement to the US Senate Health, Education, Labor, and Pensions Committee for their February 2023 hearing on US healthcare workforce challenges. We shared our belief that there are options available to policymakers to grow the ophthalmology subspecialty workforce, including addressing educational debt via student loan relief, improving Medicaid reimbursement, reducing administrative burdens and elimination of other barriers that increase physician burnout. The Academy Federal Affairs team will continue to identify opportunities to engage with Congress on these important issues.



Status Report for Council Advisory Recommendation 23_02

Title: Pediatric Ophthalmology Subspecialty Workforce Shortage

Report From: Michael X. Repka, MD, MBA – Medical Director for Governmental Affairs

Analysis:

This Council Advisory Recommendation urges the Academy to address the complex causes of workforce shortages impacting pediatric ophthalmology. As highlighted in the Academy's initial response, we agree that success will take not only increased Academy focus, but also a strong collaboration with subspecialty organizations, state societies, and other stakeholders from the ophthalmic and medical community.

Rating:

1 = Currently being addressed by the following AAO activities...

Report:

The Academy understands that low Medicaid reimbursement, medical student loan debt, and workforce shortages are inextricably linked and that positive change will take time and involvement of many stakeholders. For that reason, many of the Academy's efforts described below are also included in Council Advisory Recommendation 23_05, Access to Pediatric Eyecare: Medicaid Disparity. We believe that our ongoing engagement with the American Association for Pediatric Ophthalmology and Strabismus (AAPOS) and the American Academy of Pediatrics (AAP) will enable additional opportunities in the future.

- *February 2023 Senate Committee Hearing Statement: In collaboration with subspecialty societies, including AAPOS, the Academy submitted a statement to the Senate Health, Education, Labor & Pensions Committee ahead of their hearing focused on healthcare workforce shortages. The Academy highlighted issues facing pediatric ophthalmologists and provided recommendations, including increasing funding for the Pediatric Specialty Loan Repayment Program.*
- *March 2023 Coding Resources: The Academy's Health Policy and Coding & Reimbursement Departments are collaborating with AAPOS leaders to develop coding resources to assist pediatric ophthalmologists in billing the most appropriate level evaluation & management code. We anticipate that these resources will be finalized shortly. In the interim, the Coding & Reimbursement Department staff taught these concepts during a special session during the 2023 AAPOS Annual Meeting in March 2023.*
- *April 2023 EyeNet: Cover article on shortages facing pediatric ophthalmology, neuro-ophthalmology, and uveitis.*
- *April 2023 Congressional Advocacy Day: Talking points developed for pediatric ophthalmologists to present to their legislators.*
- *June 2023 the PREEMIE Reauthorization Act: Joined AAPOS in supporting legislation to reauthorize and expand research, education and intervention activities related to preterm birth.*
- *June 2023 the Ensuring Lasting Smiles Act: Partnered with AAPOS to develop joint recommendations for modifications to the ELSA will ensure that ocular and eyelid congenital anomalies are covered by the legislation that will be reintroduced in the 118th Congress.*

Rating: 0 = Recommend no action because... 1 = Currently being addressed by the following AAO activities... 2 = Good idea but cannot implement right now because... 3 = Implemented or will be implemented by...

- June 2023 Pediatric Specialty Loan Repayment Program: Academy Governmental Affairs staff confirmed that pediatric ophthalmologists are eligible for loan relief through the Health Resource and Services Administration Pediatric Specialty Loan Repayment Program. Developed a joint communication to educate pediatric ophthalmologists on this opportunity. We continue to partner with AAPOS and other physician and provider organizations to increase congressional funding for the PSLRP in order to expand opportunities for pediatric ophthalmologists to receive loan repayment assistance.
- June 2023 Medicaid Proposed Rules: Partnered with AAPOS to develop joint comments on two proposed rules that would force transparency of Medicaid payment rates and make the disparity between Medicaid and Medicare reimbursement more visible to the public. We think these rules could be instrumental to AAPOS' efforts to improve Medicaid payments for pediatric ophthalmology services.
- July 2023 Coding Resource for Billing Modifier -63: The Academy's Coding & Reimbursement Department will be publishing a resource to assist members billing modifier -63, which can be billed with some procedures to indicate the additional work associated with treating infants weighing up to 4 kg. Some payors may provide increased reimbursement with the modifier appended. The resource will also include retinopathy of prematurity (ROP) coding guidance.
- August 2023 Meeting with AAP: Staff from the Academy's Governmental Affairs Division had a meeting with key staff from AAP Pediatrics in August 2023 to discuss alignment on Medicaid reimbursement and workforce shortage issues.
- August 2023 Meeting with Polsinelli Law Firm: Staff from the Academy's Governmental Affairs Division met with the Polsinelli team handling the AAPOS account in August 2023 to better understand the projects they are undertaking for AAPOS and how the Academy may support those efforts. We will be engaging in regular check-in meetings with the Polsinelli team.
- Ongoing: The Academy continuously engages with manufacturers and the Food & Drug Administration to understand, communicate and address drug and device shortages impacting pediatric ophthalmologists, including recent shortages of erythromycin ointment and SilSoft contact lenses.

The Academy's Governmental Affairs staff will continue to look for additional opportunities to partner with AAPOS leaders and other stakeholders to address the issues raised in this CAR.

Study of the Ophthalmologist Workforce

Council Advisory Recommendation 23-03

Problem Statement:

An accurate understanding of the current and ongoing state of our physician workforce, including subspecialty practice patterns, gender identity and race characteristics, is critical to identifying deficits that shape policy recommendations and guide the physician marketplace. The AAO with the cooperation of the organizations that make up the council are in a unique position to create a comprehensive population-based study of the state of the ophthalmology workforce.

Summary of Facts and Background Information:

For years the AAO board, council and many members have been concerned about the state of the ophthalmology workforce. Addressing shortages in subspecialties was the subject of a 2009 CAR "Shortage of Selected Ophthalmic Subspecialists" CAR 09-02. Shortages and concerns about diversity was the subject of a more recent CAR "Improving Diversity Within the Ophthalmic Workforce" CAR 22-02. Unfortunately, past workforce projections have been based on flawed data as was keenly pointed out by David Parke in an editorial in Eye Net in June 2016 and then expanded again in a more recent editorial in 2020. (Current Perspective. "The Ophthalmology Workforce" David W. Parke II, MD. EyeNet February 2020, p 16.) We will continue to struggle to develop effective strategies to correct our workforce shortages if we do not have accurate information about the problems.

The AAO membership data combined with data from subspecialty and state societies, where possible, overlaid on the most recent US census data would give us the most comprehensive and accurate look at the ophthalmology workforce ever compiled. Understanding our workforce areas of vulnerability and strength would then allow us to more effectively influence policies that impact physician reimbursement as well as legislation on scope of practice. There would be better information for students and ophthalmologists in training about future career choices. Federal and state programs for loan repayment could be better targeted. Diversity in the workforce could be better addressed as we understand the current state of diversity and can measure future outcomes.

The AAO member data is based on members providing their own information. This represents a challenge and an opportunity. Many data points that would need to be accurately studied could be incomplete or may require additional permission by members to share. (i.e., data on gender and racial identity). An important part of this effort will be for each council member organization to help motivate their members to update their member profiles to ensure accuracy.

Possible Solutions:

- A. Develop a comprehensive workforce database that includes subspecialty and diversity information for each state and county in the USA.
 - a. Develop a plan to encourage members to update their AAO member profile to include data points with subspecialty practice focus, gender, gender identity and racial identity.

- i. Current member subspecialty information questions may need to be expanded to allow for members to more accurately account for the amount of time they spend doing subspecialty work.
 - b. Develop data sharing agreements between AAO and council member societies to ensure complete and accurate data where possible.
 - c. Include representatives from member organizations to develop a workforce data working group to help guide the AAO's efforts in choosing the appropriate data points to collect and analyze as well as coordinate communication efforts to member groups.
 - i. This could be synergistic with other planned workforce studies (based on response to CAR 22-03)
 - d. Overlay AAO membership data onto US census data for each state and county to compare workforce distribution to population data.
 - i. Identify areas of significant disparity in each member category of interest.
 - ii. Develop a plan to review these data to coincide with future US censuses.
 - iii. identify trends over time and measure the effects of successful initiatives.
 - e. Develop a plan and platform for sharing data and analysis to the council and AAO members.
- B. Incorporate workforce data into policy statements and advocacy efforts to help rectify workforce shortages.

Submitted by:

Scott A Larson, MD

On Behalf Of: American Association for Pediatric Ophthalmology and Strabismus

Date Board Approved This CAR: 11/9/2022

Additional Submitters:

Stacey Kruger, MD; American Association for Pediatric Ophthalmology and Strabismus

Co-Sponsors:

American Academy of Pediatrics, Section on Ophthalmology
 American Glaucoma Society
 American Ophthalmological Society
 American Osteopathic College of Ophthalmology
 American Society of Ophthalmic Plastic & Reconstructive Surgery
 Arizona Ophthalmological Society
 Arkansas Ophthalmological Society
 Florida Society of Ophthalmology
 Hawaii Ophthalmological Society
 Idaho Society of Ophthalmology
 Illinois Society of Eye Physicians & Surgeons
 Intl Joint Commission on Allied Health Personnel in Ophthalmology
 Montana Academy of Ophthalmology

North Dakota Society of Eye Physicians and Surgeons
Oregon Academy of Ophthalmology
Pennsylvania Academy of Ophthalmology
Puerto Rico Society of Ophthalmology
South Dakota Academy of Ophthalmology
Tennessee Academy of Ophthalmology
Wyoming Ophthalmological Society
North American Neuro-Ophthalmology Society



Academy Background Statement **Council Advisory Recommendation**

23-03: Study of the Ophthalmologist Workforce

Assigned to and reply from: Aaron M. Miller, MD, MBA – Secretary for Member Services

Presenting: Aaron M. Miller, MD, MBA – Secretary for Member Services

Analysis:

Conducting accurate physician workforce projections has vexed medicine over the years. The multitude of variable factors that impact the predicted future physician workforce needed make this a daunting task. As outlined in Dr. Parke’s EyeNet workforce article of 2020, some of these key variables include:

- Ophthalmologists rate of retirement
- Changes in models of practice that impact productivity, for example private equity, consolidation of practices, etc.
- Use of telehealth
- State expansion of scope of practice
- New technologies in patient care

That said, there is value in ascertaining exactly where we stand with the ophthalmology workforce now and to project future growth in the number of ophthalmologists, in conjunction with figures from the U.S. census and future population growth, particularly among those over 65 years of age. The number of optometrists and their role would also need to be included in this analysis. While this would not be a true workforce study, it would give us data on the growth of the eyecare workforce and the U.S. population.

Through the 2020 Academy task force on Member Diversity & Inclusion, chaired by Terri Young, MD, MBA, recommendations were accepted by the Board of Trustees to gather greater demographic information about members. Efforts have been underway with minimal results to date, unfortunately.

We continue our campaigns to gather this information, including the Member Demographics counter that are being staffed during the Mid-Year Forum and Council meeting this year. As far as sharing member data with Council member societies, privacy issues arise for which we would need legal counsel guidance. We welcome the assistance of state and subspecialty societies to urge their members to enter demographic information into their Academy profiles.

We would welcome involvement of Council member organization representatives in any future workforce projects approved by the Board of Trustees.



Status Report for Council Advisory Recommendation 23_03

Title: Study of the Ophthalmologist Workforce

Report From: Aaron M. Miller, MD, MBA – Secretary for Member Services

Analysis:

The CAR submitted by the American Association for Pediatric Ophthalmology and Strabismus and co-sponsored by 21 state and subspecialty societies asks the Academy to establish a comprehensive ophthalmology workforce database, including personal demographic data, and benchmark the data against U.S. census data to identify geographic disparities and workforce shortages.

Rating: 1 = Currently being addressed by the following AAO activities...

Report:

The Academy is committed to understand its membership composition and the needs of its membership. However, possession of comprehensive data is a critical element to conduct a study of the ophthalmology workforce. A significant percentage of Academy members have not provided their personal and/or practice demographic data. Only 3% of U.S. practicing ophthalmologist members shared their race and ethnicity information despite 18 months of continual outreach, from 50% to 53%.

In 2022, the Academy implemented the recommendations of the Task Force on Member Diversity & Inclusion, chaired by Terri Young, MD, MBA to gather greater demographic information about members. Gender identity, race and ethnicity (primary and secondary), sexual orientation, pronouns and language proficiency were added to clinical focus/subspecialty (primary and secondary), practice type (primary and secondary) and birth year in the secure, encrypted online member profile section. Member participation has been lackluster across segments from members in training to mid-career ophthalmologists to those nearing retirement.

The Academy will continue efforts to gather these information, including:

- Targeted email outreach to core member segments with lower participation in sharing personal demographic data, such as the member-in-training category (e.g., residents).
- Promotional campaign during AAO 2023 to incentivize members to update their profiles. First 500 members that complete their profile will receive an AAO-branded water bottle. A social media strategy will also be used to give this campaign greater visibility.
- Make it easy for members to share their demographic data with the Academy through 1) data collection kiosks at Mid-Year Forum and Council meetings; 2) opportunity to provide information when completing registration for the annual meeting; 3) on-demand access in My Profile section of aao.org.
- Inclusion of demographic data questions in future member surveys, including a practice environment survey scheduled to go out to the U.S. membership in 2024.

Many members may have concerns about privacy, potential misuse of data, or the intrusion of personal information into their professional lives. The Academy has developed a new campaign focusing on building member trust and engagement to include a comprehensive

Rating: 0 = Recommend no action because... 1 = Currently being addressed by the following AAO activities... 2 = Good idea but cannot implement right now because... 3 = Implemented or will be implemented by...

communication strategy and a clear explanation of the benefits and purposes of data collection to persuade members to share their personal demographic data. Demographic data will not be displayed publicly unless members choose to have it displayed. The Academy has also implemented robust data security measures, including encryption, access controls and regular audits to safeguard members' information.

Developing a comprehensive workforce database based on member demographic data is a valuable endeavor, but it must be undertaken with meticulous planning, consideration of privacy concerns, and active engagement with our membership. The Academy will explore opportunities for collaboration with state and subspecialty/specialized interest societies to increase member participation in the demographic data collection.

Ensuring Virtual Options for National Meetings

Council Advisory Recommendation 23-04

Problem Statement:

This CAR written by Emily Schehlein, MD and Olivia Killeen, MD is jointly sponsored by Women In Ophthalmology (approved 1/23/23) and the Michigan Society of Eye Physicians and Surgeons (approved 1/25/23).

In-person national ophthalmology meetings typically require air travel, car/bus, or alternative transportation for hundreds or thousands of attendees in addition to the use of paper and plastic goods, making these conferences a major contributor to climate change. Recently, ophthalmic conferences have begun to eliminate virtual options that were introduced during the pandemic, leading to the exclusion of those who are unable to attend in-person, such as pregnant individuals, breastfeeding mothers, people who cannot leave home due to childcare or eldercare responsibilities, disabled individuals, and ophthalmologists who are on-call for patient emergencies during the conference.

Summary of Facts and Background Information:

The COVID-19 pandemic forced alternative modes of learning and communication in the field of ophthalmology. In 2020 and 2021, ophthalmic educational conferences introduced virtual attendance options. The 2020 American Academy of Ophthalmology (AAO) meeting was held exclusively online. The 2021 and 2022 AAO meetings were hybrid, offering both virtual and in-person options. The 2021 ARVO meeting was held virtually, and the 2022 ARVO meeting was a hybrid meeting. The 2023 ARVO meeting will be held in person only, with no virtual option. As time goes on, it is likely that more and more ophthalmology conferences will shift back to in-person attendance only. We recommend a virtual option for all ophthalmic conferences for two reasons: to reduce the carbon footprint of ophthalmology and to prevent the exclusion of individuals who cannot attend for family, health, disability, or scheduling reasons.

In 2015, the University of California, Santa Barbara found that air travel of faculty to conferences was 30% of their total greenhouse gas emissions yearly, equivalent to over 24,000 metric tons or over 50 million pounds of CO₂.¹ In 2018, the AAO Chicago total meeting attendance was over 24,000 individuals, including physicians, other healthcare providers, spouses/guests, and exhibitors. A roundtrip flight from New York to Chicago produces approximately 0.474 tons of CO₂. If only 75% of the attendees traveled by plane for this short distance, the carbon footprint of air travel would be over 8,000 metric tons of CO₂ or over 18 million pounds. However, because over 4,000 international physicians flew much farther to attend the 2018 meeting and others traveled with alternative modes of transportation, the carbon footprint of conference travel was likely far higher. In recent years, many people have taken advantage of virtual attendance options for the AAO Annual Meeting. The 2022 Chicago meeting attendance was 15,198 in-person and 2,993 registered virtually.²

The membership of the Academy wants the AAO to be a leader in the field of sustainability. In a survey of over 1300 cataract surgeons and nurses in 2020, 87% wanted their medical societies to advocate for reducing the carbon footprint of eye surgery.³ In 2020, the AAO joined the Medical Society Consortium on Climate & Health to help mitigate medicine's contributions to climate change.⁴ The AAO can promote sustainability by continuing to offer virtual options for the annual meeting and encouraging other ophthalmic organizations to do

the same. Virtual conference attendance options will allow Academy members to make environmentally conscious decisions while still learning and interacting with their fellow members.

Virtual conference attendance options also benefit industry partners. At large conferences such as the AAO Annual Meeting, industry sponsors print and disseminate vast amounts of educational materials and use numerous plastic and paper single-use items such as badges and food service products. Virtual options decrease single-use items, the costs associated with producing these items, and the waste associated with these items. Virtual options also expand the reach of industry promotional materials, making them more broadly available to attendees who would not have attended an in-person-only conference. Industry partners may be more inclined to support a meeting with virtual options given opportunities for increased exposure of their promotional materials.

The elimination of virtual conference attendance options would exclude attendees who cannot travel to the conference. Ophthalmologists must balance travel to conferences with family responsibilities, and this burden is often greater for women. According to the National Academies of Sciences, Engineering, and Medicine, providing virtual options for conference attendance during the pandemic often increased women's access to conferences "by removing travel-related barriers that can affect women more than men, given their caregiving responsibilities."⁵ Women in science have reported that virtual options make conferences more accessible because they reduce financial and caregiving barriers.⁶ Virtual conference options promote attendance by all members of the ophthalmic community, including disabled individuals, those currently experiencing health challenges, and ophthalmologists who are on-call for patient emergencies during the conference.

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1. Yang HT, Auston D, Fisher M, et al. UC Santa Barbara Climate Action Plan. Available at: https://sustainability.ucsb.edu/sites/default/files/Draft_2016-CAP_2_1_2017.pdf [Accessed January 4, 2023].
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3. Chang DF, Thiel CL, Ophthalmic Instrument Cleaning and Sterilization Task Force. Survey of cataract surgeons' and nurses' attitudes toward operating room waste. *J Cataract Refract Surg* 2020;46:933–940.
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5. The Impact of COVID-19 on the Careers of Women in Academic Sciences, Engineering, and Medicine |The National Academies Press. Available at: <https://nap.nationalacademies.org/catalog/26061/the-impact-of-covid-19-on-the-careers-of-women-in-academic-sciences-engineering-and-medicine> [Accessed December 28, 2022].
6. Skiles M, Yang E, Reshef O, et al. Conference Demographics and Footprint Changed by Virtual Platforms. *Nat Sustain* 2022;5:149–156.

Possible Solutions:

- A. Ensure virtual options for AAO Annual Meetings indefinitely and encourage other ophthalmology organizations to offer virtual options as much as possible.

Submitted by:

Tom Byrd, MD

On Behalf of: Michigan Society of Eye Physicians and Surgeons

Date Board Approved This CAR: 1/25/2023

Co-Sponsors:

American Glaucoma Society

Maryland Society of Eye Physicians and Surgeons

Minnesota Academy of Ophthalmology

North Carolina Society of Eye Physicians and Surgeons



Academy Background Statement **Council Advisory Recommendation**

23-04: Ensuring Virtual Options for National Meetings

Assigned to and reply from: Bennie H. Jeng, MD - Secretary for Annual Meeting

Presenting: Bennie H. Jeng, MD - Secretary for Annual Meeting

Analysis:

The Academy agrees that having a virtual option for meetings can be beneficial to those who are not able to attend, and in fact, the Academy was one of the first national medical societies to offer a virtual component. Starting in 2013, the Academy livestreamed 10 hours of highlights from Subspecialty Day and the annual meeting. The hours increased to 25 in 2019 with over 1,700 attendees.

As to be expected, the virtual meeting attendance for the 2020 annual meeting was very high at 9,284, but last year in 2022, it had dropped to 35% of that figure (to 3,205), and the Academy's experience is not unique: virtual attendance overall is declining. This may be due "zoom fatigue," but whatever the reasons are, we are seeing that now that people can attend meetings in person again, their preference appears to be in-person.

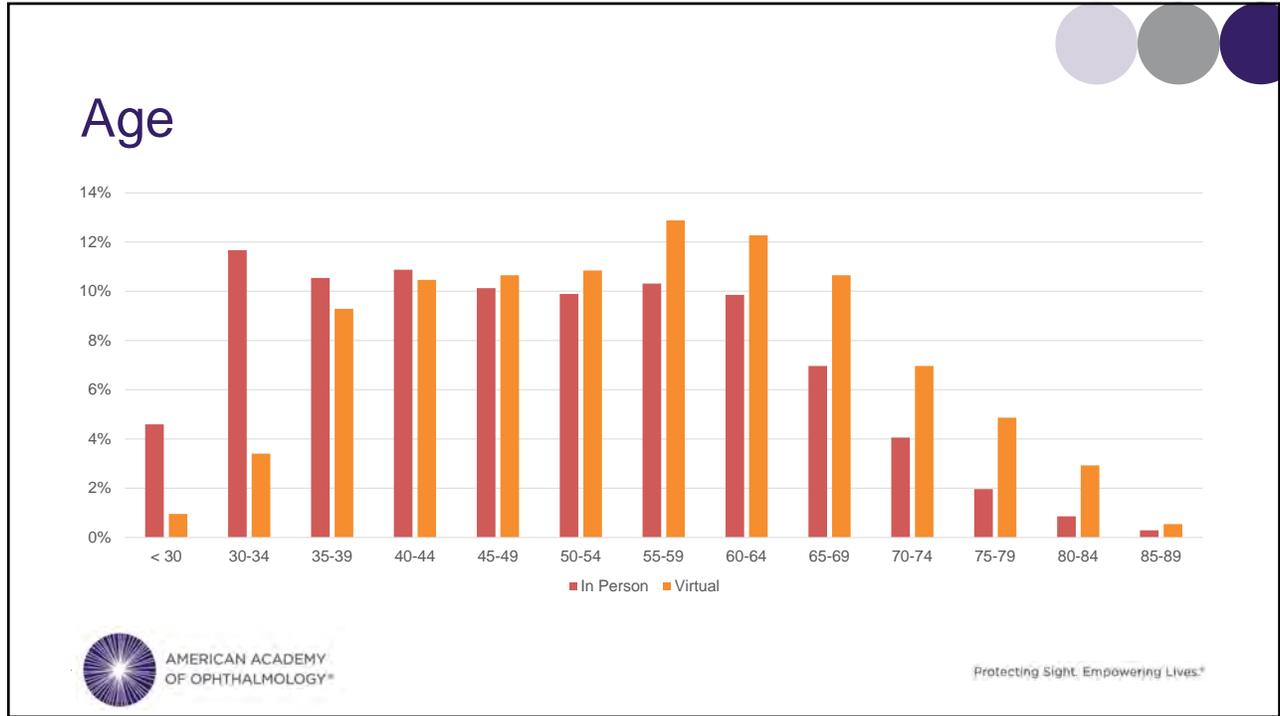
Some aspects of an in-person meeting are hard to replicate online. For example, no one has been able to recreate the in-person exhibit hall that is beneficial to both attendees and the exhibitors. Most of the large ophthalmic companies do not want to participate in an online exhibition, even if it's included in the in-person exhibit fee. The companies are not getting the return on investment virtually that they do in-person.

While other meetings may have different statistics, for the Academy, the virtual meeting audience does not seem to be reaching younger attendees, more women, or even more international as shown on the attached graphs, so it is not necessarily expanding the overall audience.

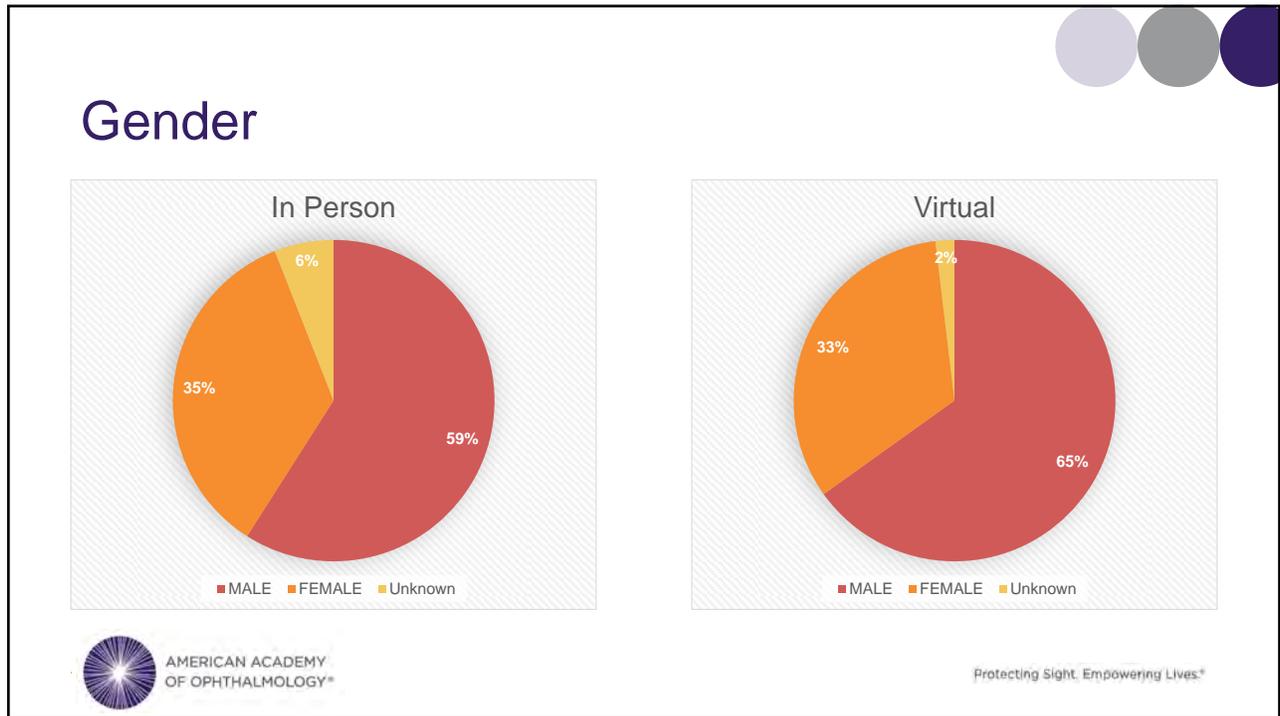
Virtual meetings are also expensive to host both in terms of actual costs and staff resources needed to prepare the platform, invite the speakers, upload the content, and monitor the livestream. While the Academy has been able to incorporate these additional tasks, not all societies have the resources available to do so.

The Academy also recognizes the impact that a large global meeting can have on the environment. Certainly, a virtual option does help to mitigate some of the carbon emissions, but it doesn't eliminate it – one estimate is that one hour of livestreaming produces 150 to 1,000 grams of carbon dioxide. Separate from the virtual meeting option, the Academy is working on a plan to continue to reduce the carbon footprint of the annual meeting and all meetings it hosts.

The Academy is committed to continuing the virtual meeting option as long as virtual attendance warrants the effort to produce it. And while we can encourage other societies to consider virtual options, each society has different resources, as well as different audiences. Each society will need to make a decision that fits with their mission and goals.

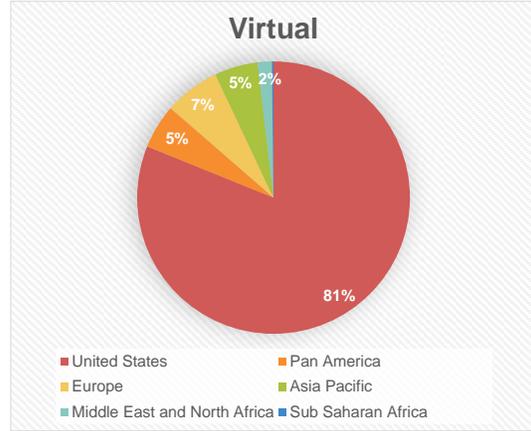
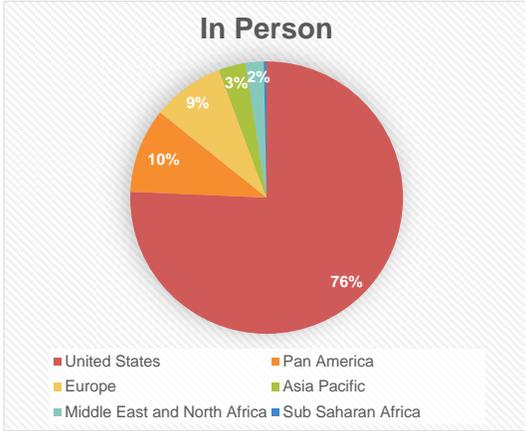


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Status Report for Council Advisory Recommendation 23_04

Title: Ensuring Virtual Options for National Meetings

Report From: Bennie H. Jeng, MD – Secretary for Annual Meeting

Analysis:

This CAR addresses the continuing availability of virtual options for the Academy's annual meeting to encourage participation from those who cannot attend in person and to reduce the meeting's carbon footprint.

Rating:

0 = Recommend no action because:

Report:

As the Academy has had a virtual component to the annual meeting since 2013, and as attendance at these virtual sessions has continued to be popular, the Academy remains committed to providing all or a portion of the meeting virtually for the foreseeable future.

However, how much content is available and in what format (livestreaming or on demand) is evaluated each year in conjunction with the number of attendees accessing the virtual meeting and the associated virtual meeting cost.

Rating: 0 = Recommend no action because... 1 = Currently being addressed by the following AAO activities... 2 = Good idea but cannot implement right now because... 3 = Implemented or will be implemented by...

Access to Pediatric Eyecare: Medicaid Disparity

Council Advisory Recommendation 23-05

Problem Statement:

There is a dire access to pediatric eye care crisis in PA and throughout the US that can be analyzed on the basis of supply and demand. Since the early to mid-2000s, the field of pediatric ophthalmology has faced a serious decline with fewer ophthalmology residents pursuing fellowship positions and an increase in positions filled by international medical graduates who ultimately return to their country of origin.¹ When surveying senior ophthalmology residents for the reasons they chose not to pursue pediatric ophthalmology, economic factors along with large amounts of educational debt contributed to their decision.² Over half of the country's children are covered under Medicaid, but providers are not evenly distributed by state to meet population demand.¹ Among all states, PA has one of the most serious access to eye care issues for children driven largely by low Medicaid reimbursements. As of 2022, PA has only 39 pediatric ophthalmologists.³ serving a population of more than 1.5 million children enrolled in Medicaid/CHIP.⁴ PA has the lowest Medicaid reimbursement for new patient and follow-up visits in the country, which is not only affecting access to care, but is also deterring newly trained pediatric ophthalmologists from seeking employment in the PA area. The current levels of reimbursement have fallen below the costs of providing care for most practices. This has forced many pediatric ophthalmologists to stop seeing Medicaid patients, which forces young children traveling to academic centers that continue to take Medicaid.

Summary of Facts and Background Information:

Pediatric ophthalmology has experienced a significant economic downturn marked by increasing levels of disillusionment as demonstrated by 37.8% of pediatric ophthalmologists who would not recommend residents pursue pediatric ophthalmology fellowship.⁵ Nearly 40% of pediatric ophthalmologists have experienced a decrease in income between 10% and 25%, and 11.1% have stopped performing surgeries to maintain their office practice.⁵ In the setting of these economic hardships, approximately 30% of pediatric ophthalmologists have limited their Medicaid patients, which exacerbates the provider supply shortage.⁵

The workforce distribution of pediatric ophthalmologists as it relates to geographical location reveals that many states are severely underserved. Therefore, states with high percentage Medicaid coverage and low number of providers may face the worst access to care issues. In Pennsylvania, reimbursements are comparatively lower than neighboring states such as Delaware for which new patient (99203) and follow up (99213) visits are nearly double that of PA (\$54.25, and \$35.00 compared to \$108.03 and \$73.03 for Delaware). Even historically lower reimbursing southern states such as Mississippi have new patient rates of \$78.84 and follow up of \$63.34. Medicare reimbursement in PA also overshadows that of Medicaid (\$118.77 for new patient visit and \$95.42 for follow up).

Each state's Medicaid reimbursement rates are determined by the state with combined federal and state sources of funding. This precludes fixing these disparities at the federal level alone under the current structure. This also causes Medicaid to become a political tool in the heated dispute of state's rights over federal mandates. In this climate it is unlikely federal laws can be enacted to correct these concerns in the near future.

To maintain practice viability, many pediatric ophthalmologists are no longer seeing Medicaid patients⁶ and or are resorting to income generating practices outside pediatric ophthalmology⁷ including laser in situ keratomileusis, facial treatments, and plastic surgeries.⁸ Many of these Medicaid patients are forced to seek out academic centers where there is a high acceptance rate for Medicaid patients to receive necessary eye care. These academic centers are being inundated by the overabundance of Medicaid patients. For example, major academic centers in PA such as Wills Eye Hospital, St. Christophers Hospital, University of Pittsburgh, and Children's Hospital of Philadelphia (CHOP) have Medicaid percentages of 50%, 82%, 50%, and 40%, respectively. Because of the overabundance of Medicaid patients, many travel long distances or face long wait times for new patient, follow ups, and surgeries. This is indicated by wait times of 4-6 months for new patient and follow up at CHOP, 6 months for new patient and 3 months for follow-up at Penn State Hershey, and 4 months for new patient and follow up at St. Christopher's. The time and costs of seeking care further from their communities increases barriers to care for our most vulnerable populations exacerbating disparity of care. Worried parents may wait months on end without answer for their child's eye condition, and these extended wait times also contribute to the access to eye care issue.

References:

1. Lee KE, Sussberg JA, Nelson LB, Thuma T. The Economic Downturn of Pediatric Ophthalmology and Its Impact on Access to Eye Care. *J Pediatr Ophthalmol Strabismus*. Published online November 28, 2022:1-7. doi:10.3928/01913913-20221108-01
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8. Bernstein BK, Nelson LB. Workforce Issues in Pediatric Ophthalmology. *J Pediatr Ophthalmol Strabismus*. 2020;57(1):9-11. doi:10.3928/01913913-20191101-01

Possible Solutions:

- A. AAO should assess the Medicaid landscape to identify states with Medicaid Reimbursement in the lowest quartile.

B. AAO should raise awareness of the public as well as federal and state legislators as to the disparities among states in Medicaid compensation and how this affects the pediatric ophthalmology workforce, and how it is adversely impacting children.

C. AAO should work with the state societies from the lowest reimbursed states such as PAO to understand the state specific economic and legislative dynamics with the goal of enacting correcting legislation in a timely manner.

D. AAO should work to involve pediatric specialty societies and state medical societies to partner in these efforts to increase Medicaid reimbursements for pediatric care.

E. The AAO should advocate for increased Medicaid compensation raising compensation to Medicare rates nationally.

F. AAO should advocate for an add on code for billing pediatric care that reflects the extra time and complexity involved in working with children.

G. AAO should increase education for Pediatric Ophthalmologists on how to maximize reimbursement supporting higher level office visits (E&M 4 and 5 level) for a larger proportion of their patient visits.

Submitted by:

Sharon L Taylor, MD

On Behalf Of: Pennsylvania Academy of Ophthalmology

Date Board Approved This CAR: 1/25/2023

Additional Submitters:

David Silbert, MD; Pennsylvania Academy of Ophthalmology



Academy Background Statement **Council Advisory Recommendation**

23-05: Access to Pediatric Eyecare: Medical Disparity

Assigned to and reply from: Michael X. Repka, MD, MBA - Medical Director for Governmental Affairs;
George A. Williams, MD - Senior Secretary for Advocacy; John D. Peters, MD - Secretary for State Affairs

Reply From: Michael X. Repka, MD, MBA - Medical Director for Governmental Affairs; George A.
Williams, MD - Senior Secretary for Advocacy; John D. Peters, MD - Secretary for State Affairs

Presenting: Michael X. Repka, MD, MBA - Medical Director for Governmental Affairs

Analysis:

Recognizing the mechanics of Medicaid funding is important as we analyze opportunities to address the current challenges. Medicaid is a joint federal and state program designed to provide healthcare coverage to low-income persons and families. While the majority of funding for state Medicaid programs comes from the federal government¹, the program is designed to give states the power to determine specific eligibility requirements, services offered, and payment rates, which leads to substantial variability from state to state. Examples of variability in state Medicaid program evaluation and management (E/M) payment rates noted in the CAR demonstrate this flexibility.

Unfortunately, the Centers for Medicare and Medicaid Services do not have authority to dictate Medicaid payment rates. Historically, any boosts to Medicaid payment from the federal level have come from legislation. For example, under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended), states were required to pay Medicare rates for certain primary care services in 2013 and 2014 when they were furnished by physicians with a primary specialty designation of family, general internal, or pediatric medicine.² With the divided party control of the U.S. Congress, the pathway for the enactment of new federal legislation boosting Medicaid rates for pediatric physicians in the 118th Congress is challenging.

Since funding for Medicaid in state budgets is both a major source of revenue and expenditure, states are typically cautious when making changes to eligibility requirements, covered services, and payment rates. As highlighted in several of the possible solutions outlined in the CAR, this makes any improvements to state Medicaid reimbursement a state-by-state battle, which would require substantial investment in strategy and resources.

The CAR highlights the negative downstream effect of poor Medicaid reimbursement rates leading to the demonstrated pediatric ophthalmologist supply shortage.

Further exacerbating access to care barriers for pediatric patients, is the looming Medicaid disenrollment crisis. The Families First Coronavirus Response Act (P.L. 116–127) requires states to provide continuous Medicaid enrollment in exchange for enhanced federal matching funds during the pandemic. With the continuous enrollment provision ending on March 31, 2023, states are preparing to



resume eligibility redetermination processes and clearing Medicaid enrollment rolls of those who no longer qualify for coverage. Unfortunately, many advocates are predicting that as many as 5 million children will lose Medicaid or CHIP coverage during this process due to administrative or paperwork issues, despite still being eligible for coverage.^{3,4}

Options

The magnitude of this issue is further evidenced by multiple CARs submitted for 2023 that highlight the need to address the shortage of pediatric ophthalmologists. As such some of the below options may overlap with other CAR responses.

As noted in the CAR and the above analysis, actionable solutions at a federal level will be difficult to find given the structure of Medicaid funding and the current political climate. For these reasons, the Academy has already begun looking to other ways to address access to pediatric eyecare:

- 1) Staff in the Academy's Governmental Affairs office have consulted with Dr. Sylvia Yoo and AAPOS leaders on a project she is undertaking to assess the Medicaid landscape and identify states with low Medicaid reimbursement for office visit codes. Dr. Yoo is associate professor at Tufts and is a 2023 AAO Leadership Development Program participant for the American Academy of Pediatrics (AAP).
- 2) The Academy's Health Policy and Coding & Reimbursement Departments are collaborating closely with AAPOS leaders to develop E/M visit coding resources to assist pediatric ophthalmologists in billing the most appropriate level. Coding & Reimbursement Department staff will also teach these concepts during a special session during the 2023 AAPOS Annual Meeting.
- 3) The Academy's Coding & Reimbursement Department published a resource in the near future to assist members billing modifier -63, which can be billed with *some* procedures to indicate the additional work associated with treating infants weighing up to 4 kg. Some payors may provide increased reimbursement with the modifier appended. The resource will also include retinopathy of prematurity (ROP) coding guidance.
- 4) AAO Governmental Affairs staff shared analysis of new federal guidance that could allow pediatric ophthalmologists to bill state Medicaid plans for interprofessional consultations with AAPOS leadership in January 2023. The Academy will continue to share this kind of analysis as opportunities arise.
- 5) AAO Governmental Affairs staff shared analysis of the Access to Prescription Digital Therapeutics Act of 2022 (S.3791). The Academy will continue to share this kind of analysis as future opportunities arise.
- 6) The Academy has sent a letter of support to the sponsors of the recently reintroduced "Resident Education Deferred Interest (REDI) Act" (HR 1202) that, if passed, will allow borrowers to qualify for interest-free deferment on their student loans while serving in a medical or dental internship or residency program.
- 7) The Academy's Health Policy Committee is exploring a strategy for a medical myopia diagnosis ICD code. While this could allow myopia treatments to be billed to medical insurance rather than vision, convincing payors to cover as medical benefit will be a challenge and some may still decide to process under vision benefits.



Poor Medicaid reimbursement affects all of pediatrics health care; therefore, any advocacy efforts, particularly those around creating add-on codes or modifiers, would require the support of the AAP to have a chance of success. Some ways the Academy may continue collaborating with other stakeholders include:

- 1) The Academy initially shared several ideas developed in concert with AAPOS with AAP last year, but the staff point person left before a meeting was scheduled and held. Academy staff will identify a new staff contact at AAP and reinitiating conversations on ways to improve Medicaid reimbursement across pediatrics.
- 2) The Academy may also consider making connections to other stakeholder groups, such as the Medicaid Health Plans of America, which represents Medicaid managed care organizations.

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Status Report for Council Advisory Recommendation 23_05

Title: Access to Pediatric Eyecare: Medicaid Disparity

Report From: Michael X. Repka, MD, MBA – Medical Director for Governmental Affairs

Analysis:

This Council Advisory Recommendation submitted by the Pennsylvania Academy of Ophthalmology offered several possible solutions to help the Academy address the negative impact of low Medicaid reimbursement on pediatric ophthalmology workforce shortages and patient access. As the CAR highlights, actionable solutions at a federal level will be difficult to find given the constraints of Medicaid funding and the current political climate. For these reasons, the Academy continues to explore creative opportunities to address access to pediatric eyecare.

Rating:

1 = Currently being addressed by the following AAO activities...

Report:

Due to the connection between inadequate Medicaid reimbursement and its potential impact on filling pediatric ophthalmology fellowship positions many of the Academy's efforts described below are also included in Council Advisory Recommendation 23_02, Pediatric Ophthalmology Subspecialty Workforce Shortage. Many of these initiatives reflect the list of possible solutions proffered by the CAR, such as developing an E&M coding resource and partnering with pediatric specialty societies.

We believe that our ongoing engagement with the American Association for Pediatric Ophthalmology and Strabismus (AAPOS) and developing our relationship with the American Academy of Pediatrics (AAP) DC Office will enable additional opportunities.

- *March 2023 Coding Resources: The Academy's Health Policy and Coding & Reimbursement Departments are collaborating with AAPOS leaders to develop coding resources to assist pediatric ophthalmologists in billing the most appropriate level evaluation & management code where those have more favorable reimbursement profiles than the eye codes. We anticipate that these resources will be finalized shortly. In the interim, the Coding & Reimbursement Department staff taught these concepts during a special session during the 2023 AAPOS Annual Meeting in March 2023.*
- *April 2023 Congressional Advocacy Day: Talking points developed for pediatric ophthalmologists to present to their legislators.*
- *June 2023 Medicaid Proposed Rules: Partnered with AAPOS to develop joint comments on two proposed rules that would force transparency of Medicaid payment rates and make the disparity between Medicaid and Medicare reimbursement more visible to the public. We think these rules could be instrumental to AAPOS' efforts to improve Medicaid payments for pediatric ophthalmology services.*
- *July 2023 Coding Resource for Billing Modifier -63: The Academy's Coding & Reimbursement Department will be publishing a resource to assist members billing modifier -63, which can be billed with some procedures to indicate the additional work*

Rating: 0 = Recommend no action because... 1 = Currently being addressed by the following AAO activities... 2 = Good idea but cannot implement right now because... 3 = Implemented or will be implemented by...

associated with treating infants weighing up to 4 kg. Some payors may provide increased reimbursement with the modifier appended. The resource will also include retinopathy of prematurity (ROP) coding guidance.

- *August 2023 Meeting with AAP: Staff from the Academy's Governmental Affairs Division met with key staff from AAP in August 2023 to discuss alignment on Medicaid reimbursement and workforce shortage issues.*
- *August 2023 Meeting with Polsinelli Law Firm: Staff from the Academy's Governmental Affairs Division met with the Polsinelli team handling the AAPOS account in August 2023 to better understand the projects they are undertaking for AAPOS and how the Academy may support those efforts. We will be engaging in regular check-in meetings with the Polsinelli team.*

The Academy's Governmental Affairs staff will continue to seek additional opportunities to partner with AAPOS leaders to address the issues raised in this CAR.

Ethical Obligation of After-hours Care

Council Advisory Recommendations 23-06

Problem Statement

Ophthalmologists have an ethical obligation to provide care for patients. An important part of our obligation is ensuring access to after-hours care – whether at night, on the weekend or a holiday. Many ophthalmologists decline to offer after-hours care, and instead have voicemail or web-page messages that redirect patients to seek care at community clinics or a hospital emergency room. This behavior shifts the access burden during weekends and holidays, usually to a very limited number of facilities that are qualified to provide the necessary care.

Summary of Facts and Background Information:

Although it is an ophthalmologist's ethical obligation to provide care for their patients, there is very little in the AAO Code of Ethics that addresses access for care beyond business hours. Examples include:

- 1 – An Ophthalmologist's Responsibility. It is the responsibility of an ophthalmologist to always act in the best interest of the patient.
- 2 – Providing Ophthalmological Services: Ophthalmological services must be provided with compassion, respect for human dignity, honesty and integrity.
- 3 – Postoperative Care. The provision of postoperative eye care until the patient has recovered is integral to patient management. The operating ophthalmologist should provide those aspects of postoperative eye care within the unique competence of the ophthalmologist. Alternatively, the ophthalmologic surgeon is required to make arrangements before surgery that transfers patient care to another ophthalmologist, with patient approval of the alternative ophthalmologist. The operating ophthalmologist may also make arrangements for the provision of special circumstances, such as emergencies or when no ophthalmologist is available, so long as the patient's welfare and rights are of primary consideration. Fees should adhere to standard postoperative care rules and regulations.

Direction from the AAO regarding the responsibilities of member ophthalmologists to arrange for after-hours care of their established patients would be beneficial.

Possible Solutions:

- A. Add a clause to the Principles of Ethics and the Rules of Ethics within the AAO Code of Ethics to clarify that an ophthalmologist's responsibility to their patients extends beyond business hours.
- B. Publish an Advisory Opinion of the Code of Ethics on the topic of after-hours responsibilities.
- C. Publish an "Ask the Ethicist" piece on the topic of after-hours responsibilities.
- D. Develop a white paper on the topic of after-hours responsibilities.

Submitted by:

Sasha Strul, MD

On Behalf OF: Minnesota Academy of Ophthalmology

Date Board Approved This CAR: 1/6/2023

Co-Sponsors:

Arkansas Ophthalmological Society
Nebraska Academy of Eye Physicians and Surgeons
South Carolina Society of Ophthalmology
Texas Ophthalmological Association
Wisconsin Academy of Ophthalmology



Academy Background Statement

Council Advisory Recommendation

23-06: Ethical Obligation of After-hours Care

Assigned to: Carla J. Siegfried, MD – Chair, Ethics Committee

Reply From: The AAO Ethics Committee

Presenting: Russ N. Van Gelder, MD, PhD – Member, Ethics Committee

Analysis: The Minnesota Academy of Ophthalmology submitted Council Advisory Recommendation (23_06) concerning ophthalmologists' ethical obligation for after-hours care of their patients and notes that *"Although it is an ophthalmologist's ethical obligation to provide care for their patients, there is very little in the AAO Code of Ethics that addresses access for care beyond business hours... Direction from the AAO regarding the responsibilities of member ophthalmologists to arrange for after-hours care of their established patients would be beneficial."*

The problem statement from the CAR expresses four possible solutions regarding this issue for the Ethics Committee to undertake. We will address each in turn.

1. Add a clause to the Principles of Ethics and the Rules of Ethics within the AAO Code of Ethics to clarify that an ophthalmologist's responsibility to their patients extends beyond business hours.
2. Publish an Advisory Opinion of the Code of Ethics on the topic of after-hours responsibilities.
3. Publish an "Ask the Ethicist" piece on the topic of after-hours responsibilities.
4. Develop a white paper on the topic of after-hours responsibilities.

Regarding recommendation #1: Many Principles of Ethics already touch on points surrounding this issue, such as:

- Principle 2, An Ophthalmologist's Responsibility, states "It is the responsibility of an ophthalmologist to always act in the best interest of the patient.
- Principle 9, Community Responsibility, states "The honored ideals of the medical profession imply that the responsibility of the ophthalmologist extends not only to the individual but also to society as a whole. Activities that have the purpose of improving the health and well-being of the patient and/or the community in a cost-effective way deserve the interest, support, and participation of the ophthalmologist."
- Principle 10, Healthcare Inequities, states "Ophthalmologists should be aware of disparities in ophthalmic care within the communities they serve in the United States and internationally. Ophthalmologists should assist patients in need to secure access to appropriate ophthalmic care."

As noted in the Code, the Principles of Ethics are non-enforceable, aspirational guidelines, and realistically do not act as a catalyst for behavioral change.

Regarding the Rules of the Code of Ethics,

- Rule 7, Delegation of Services, addresses this topic by noting that “if aspects of eyecare for which the ophthalmologist is responsible are delegated to an auxiliary, the auxiliary must be qualified and adequately supervised. An ophthalmologist may make different arrangements for the delegation of eye care in special circumstances, so long as the patient's welfare and rights are the primary considerations.”
- Rule 8, Postoperative Care, partially addresses this topic by noting that the operating ophthalmologist is responsible for the postoperative care of the patient “until the patient has recovered.” The primary goal of Rule 8 is to ensure that the patient is adequately served throughout the vulnerable period following surgery.

Regarding recommendation #2: The ethics Advisory Opinions are designed to augment and interpret the Rules of the Code. The Advisory Opinions, Postoperative Care and Delegated Services, interpret Rules 7 and 8 as noted above.

Regarding recommendation #3: The Ethics Committee published two *Ask the Ethicist* columns on this topic, one in 2010 and the other in 2011 (see links below).

- <https://www.aao.org/ethics-detail/ask-ethicist--responsibilities-of-oncall-ophthalmop>
- <https://www.aao.org/ethics-detail/ask-ethicist--hospital-privileges-call-coverage>

Regarding recommendation #4: A white paper can be written about this topic; however, very much like a Principle, it may not act as a catalyst for behavioral change. White papers are not silver bullets; but may serve in concert with the Code of Ethics.

The AAO Code of Ethics, as written, provides both aspirational model standards (Principles of Ethics) and enforceable standards of professional conduct (Rules of Ethics) regarding the ethical responsibility of the ophthalmologist to always act in the best interests of the patient. The Ethics Committee believes the issue of after-hours care of established patients is appropriately addressed in the Principles and Rules of the Code of Ethics.

Ophthalmologists should provide after-hours care or arrange for their established patients to be cared for by others as the need arises. To do otherwise is not in the patient’s best interests nor in the interest of preserving a meaningful physician-patient relationship.

Existing AAO Resources:

[Who’s on Call? Emergency Care Crisis Looms - American Academy of Ophthalmology \(aao.org\)](#) (EyeNet article, 2019)

[On-Call Compensation for Ophthalmologists - 2014 - American Academy of Ophthalmology \(aao.org\)](#) (Hoskins Center, 2014)

[Junior residents safely provide on-call triage for symptoms of retinal tears or detachments - American Academy of Ophthalmology \(aao.org\)](#) (Article Review, 2021)



Status Report for Council Advisory Recommendation 23_06

Title: Ethical Obligation of After-Hours Care

Report From: Carla J. Siegfried, MD – Chair, Ethics Committee, and Russell N. Van Gelder, MD, PhD – Member, Ethics Committee

Analysis:

This CAR, submitted by the Minnesota Academy of Ophthalmology, asks the Ethics Committee to provide additional direction on ophthalmologists' obligation to provide after-hours care for their established patients rather than shifting this obligation to other ophthalmologists and the limited facilities qualified to provide this necessary care.

Rating: 3 = Implemented by publication of an *Ask the Ethicist* titled, Crisis in On-Call Coverage in the November 2023 issue of *EyeNet* (provided below.)

Report:

One of the Ethics Committee's primary goals is member education - to define those behaviors and practices that the members of the Academy consider to be "ethical" and in the best interests of patients.

Following receipt of CAR 23_06, the Ethics Committee began drafting the to-be-published *Ask the Ethicist* to specifically address ophthalmologists' responsibilities for after-hours care of their established patients. Additionally, the committee addressed the burdensome effect on the community and hospital emergency rooms of this shifting of after-hours care to others, as well as the responsibility of local hospitals to provide resources for on-call arrangements, including tangible support of minimum standards in terms of equipment and technical staff.

As noted in the Ethics Committee's spring 2023 Background Statement in response to this CAR, the Ethics Committee already addresses ophthalmologists' responsibilities to act in the best interests of their patients, not just in the after-hours moments but throughout the physician-patient relationship. Ethical care is good care, and the patient will always benefit.

1. The Principles of Ethics and the Rules of Ethics
 - [Principle 2, An Ophthalmologist's Responsibility](#)
 - [Principle 9, Community Responsibility](#)
 - [Principle 10, Healthcare Inequities](#)
 - [Rule 7, Delegation of Services](#)
 - [Rule 8, Postoperative Care](#)
2. Advisory Opinion of the Code of Ethics
 - [Postoperative Care](#)
 - [Delegated Services](#)
3. Publish an "Ask the Ethicist" piece on the topic of after-hours responsibilities.
 - [Responsibilities of the On-Call Ophthalmologist](#)
 - [Hospital Privileges and Call Coverage](#)
4. Redmond Ethics Center - [Fundamental Ethical Issues in Delegation and Comanagement](#)

Rating: 0 = Recommend no action because... 1 = Currently being addressed by the following AAO activities... 2 = Good idea but cannot implement right now because... 3 = Implemented or will be implemented by...

Ask the Ethicist

Crisis in On-Call Coverage

Question: Our regional hospital is the busiest Level 1 trauma center in the state. In order for it to maintain Level 1 status, it needs ophthalmology coverage, so we have negotiated generous payments in exchange for those services. Even with the pay-for-call situation, there are few of us providing coverage, but we do it anyway, at least partially because of our ethical obligation to our patients and the community.

I know some colleagues refuse to take call or provide ER coverage because of the time commitment and red tape involved, but that freedom from responsibility ignores community needs, penalizes under and un-insured patients, and unjustifiably overburdens those of us who feel morally obligated to care for all patients regardless of their ability to pay or the time of night when they need care.

Additionally, because of ophthalmologists who will not accept Medicaid patients, approximately 20% of the local population is without any ophthalmic care. These underserved patients end up in the ER seeking care. Can on-call/ER coverage be mandated?

Answer: Not surprisingly, this is a question several ophthalmologists ask. An enforceable mandate could only come from an entity that contracts for those physicians' services, such as a local hospital or healthcare system. It is not per se unethical if one wishes to avoid on-call or emergency coverage and is willing to relinquish hospital privileges. However, withdrawal may diminish the local health care system's ability to provide emergent eye care with particular impact on vulnerable populations. For the individual provider, there may be implications for recredentialing from certain third-party payers and potentially adverse effects on practice volume, professional reputation, and collegiality with nearby colleagues.

Hospitals have a certain level of responsibility in this situation. If hospitals have the resources to support considerable payments for on-call arrangements, then they likely have the resources to tangibly support minimum standards in terms of equipment and technical staff, to hire Ophthalmic Hospitalists (hospital-based ophthalmologists) or locum tenens to fill the on-call/ER coverage gaps, and to develop creative and sustainable models for after-hours care.

It is an ethical precept that a physician's fiduciary duty is to hold patients' interests above those of the physician. Ideally, physicians' responsibilities would extend beyond care provided during business hours in medical offices or hospitals to any patients who are in medical need in times of emergency.

Ophthalmologists should certainly provide after-hours care for their established patients, or arrangements for such by others. To routinely direct their own patients to an emergency room for after-hours care is likely not in the patient's best interest nor in the interest of preserving a meaningful physician-patient relationship.

While there are no specific ethical guidelines for those who choose not to provide on-call or after-hours care for their patients, the potential for important consequences should be considered when making this decision.

Distribution of Emergency Eye Care

Council Advisory Recommendation 23-07

Problem Statement:

Over the last 25 years, many ophthalmologists have switched from performing surgery in full-service hospitals to ambulatory surgery centers (ASCs). One unforeseen result of this change is that emergency eye patient care is often directed to a small number of hospitals, resulting in fewer ophthalmologists managing a greater number of emergency cases.

Summary of Facts and Background Information:

Many ophthalmology patients require emergent surgery. Causes may be spontaneous (e.g. retinal detachment) or traumatic (e.g. ruptured globe, scleral laceration). Through the end of the 20th Century, most ophthalmologists performed routine surgery in full-service hospitals. Consequently:

- Ophthalmologists maintained surgical privileges in at least one hospital.
- Hospitals supported up-to-date surgical equipment and staffing.
- Most hospitals were capable of managing nearly all ophthalmic cases.

However, beginning early in the 21st Century, routine eye surgery has shifted from hospitals to ASCs for patient and surgeon convenience as well as shared ASC ownership with secondary financial benefits. Most ASCs do not provide after-hours or emergency care, and many ophthalmologists are no longer required to have surgical privileges at hospitals. In addition, at many local and regional hospitals, the operating rooms, equipment, and staffing no longer have sufficient patient volume to provide appropriate emergency eye care. As a result, many community emergency eye cases are referred to larger, metropolitan and/or academic hospitals where a smaller number of ophthalmologists are responsible for providing the majority of emergency care. While beneficial for ophthalmic surgeons in training, staff surgeons and OR staff at these locations face burnout. Funding is typically inadequate to support care related to complex ophthalmic cases, thereby creating both a staffing and financial burden for metropolitan and academic centers that is becoming unsustainable.

Possible Solutions:

A. Create a task force on emergency ophthalmology care and produce a white paper that addresses:

1. Current triage patterns for emergency eye care.
2. Relevant shortages and disparities in emergency eye care.
3. The effects of providing disproportionate emergency care and provider burnout.
4. Triage and funding suggestions/recommendations for emergency ophthalmologic patient care in the context of national health care funding and delivery.

Submitted by:

Sasha Strul, MD

On Behalf Of: Minnesota Academy of Ophthalmology

Date Board Approved This CAR: 1/13/2023

Co-Sponsors:

American Association for Pediatric Ophthalmology and Adult Strabismus

Arkansas Ophthalmological Society

Florida Society of Ophthalmology

Nebraska Academy of Eye Physicians and Surgeons

New Mexico Academy of Ophthalmology

New York State Ophthalmological Society

South Carolina Society of Ophthalmology

Texas Ophthalmological Association

Wisconsin Academy of Ophthalmology



Academy Background Statement **Council Advisory Recommendation**

23-07: Distribution of Emergency Eye Care

Assigned to: Governmental Affairs, Clinical Education and Ophthalmic Practice

Reply From: George A. Williams, Senior Secretary for Advocacy; Ravi D. Goel, MD, Senior Secretary for Ophthalmic Practice; and Christopher J. Rapuano, MD, Senior Secretary for Clinical Education

Presenting: George A. Williams, MD – Senior Secretary for Advocacy

Analysis:

Fewer physicians across specialties, including ophthalmology, are willing to provide on-call coverage at hospital emergency departments. The Academy Board of Trustees has recognized this important issue, and the Academy has provided significant resources and invested substantial effort to support ophthalmic trauma care and education to equip more ophthalmologists to provide emergency eye care services.

In 2019, the Academy Board of Trustees also established a workgroup, chaired by then AAO President-Elect Robert Wiggins, MD, to address the trend for decreasing hospital emergency call coverage by ophthalmologists. This Council Advisory Recommendation highlights many of the same issues identified by the Board's workgroup, including the evolution of ophthalmology as a profession. The workgroup also found that the extent of access issues is not well quantified and problems with access vary by community. After careful examination of the issue, the workgroup made several recommendations including:

1. Improving education of ophthalmologists on management of emergency eye care;
2. Providing examples of ways to improve the system of emergency care and relieve the call burden;
3. Providing members with materials to help with contract negotiation for ER care; and
4. Supporting military-civilian partnerships in the provision of trauma care.

A December 2019 *EyeNet* article that outlines the workgroup's findings in more detail is available [here](#). This article also includes a link to a [compensation survey](#) to give practitioners data regarding fair market value for call compensation when discussing this issue with their hospitals.

A detailed historical background and an overview of the Academy's other efforts accompanies this response. A few important highlights of the Academy's activities include the following:

- In 2018, the Academy's Education Division and Ophthalmic Society Relations (OSR) initiated efforts to relaunch the American Society of Ophthalmic Trauma (ASOT). After substantial work by this group and others at the Academy and ASOT, this finally occurred in 2020. ASOT's [home page](#) highlights Academy online education courses including [Imaging Acute Ocular Trauma](#) and [Repair of the Open Globe](#). With the approval of Academy CEO, Stephen D McLeod, MD, the



ASOT recently established a special Board position for a designated Academy liaison to maintain close relationships between the two organizations.

- In 2019, the Academy established a dedicated [Ocular Trauma](#) section within the Academy's EyeWiki. Since its launch, this section has experienced robust growth and more than 60 articles related to trauma are currently available.
- Access to the [Wills Eye Manual](#) has been made available to Academy members at no cost, and specifically this chapter: Chapter 3: Trauma is online and available on the ONE Network and on the AAO Education App.
- [Focal Points](#), which became a free member benefit in January 2021, includes relevant titles on corneal burns and melts, eyelid lacerations, enucleation/exenteration, and open-globe injuries.
- In addition, the Academy and ASOT developed a [trauma webinar session](#) which was released on January 27, 2022. Topics covered in the webinar include the treatment of pain caused by corneal abrasions and point-of-care ultrasound in the diagnosis of ocular emergencies.
- Ocular trauma symposia sponsored by ASOT were held at both AAO 2021 and AAO 2022 and another symposia and two courses are planned for AAO 2023.
- Since 2009, the Academy has worked with the Blinded Veterans Association (BVA) and the National Alliance for Eye and Vision Research (NAEVR) to advocate for funding for the DOD Vision Research Program (VRP). This program funds extramural research into deployment-related vision trauma. Initially, the program was funded at \$4 million but the Academy and our vision research partners have been able to increase funding for the program to \$20 million. For Fiscal Year 2024, the Academy will encourage Congress to increase funding for the VRP during our 2023 Congressional Advocacy Day.

The Academy applauds the respective sponsors of this CAR and ASOT's efforts to reach out to non-ophthalmic societies such as the American College of Emergency Physicians and the American College of Surgeons to improve ophthalmic trauma care across the casualty care continuum. Moving forward, the Academy encourages the sponsors to collaborate with ASOT to develop a strategic document with prioritized objectives and associated tactics to support the design, development, and implementation of these initiatives. The Academy is also willing to participate in these discussions and in an ASOT-led task force focused on improving ophthalmic trauma care.

The Academy will also continue working with ASOT and other ophthalmic organizations such as the American Board of Ophthalmology (ABO) and the Association of University Professors of Ophthalmology (AUPO) on the development of additional ophthalmic trauma educational materials, practice management tips, and curriculum requirements.



Academy Backgrounder on Efforts to Support Ophthalmic Trauma Care and Education including Emergency Room Coverage

March 6, 2023

The Academy has provided significant resources and invested substantial effort to support ophthalmic emergency and trauma care and education. Below is a historical background and an overview of its current efforts; specifically, the following are examples of Academy ophthalmic emergency and trauma-related activities and initiatives:

Education

- For nearly two decades and in collaboration with the American Academy of Pediatrics and the American College of Emergency Physicians, the Academy published *The Physician's Guide to Eye Care* as the seminal resource for non-ophthalmic medical professionals to rapidly identify serious ophthalmic conditions that require further treatment and referral. Likewise, articles related to gunshot wounds from *EyeNet Magazine* are in its [January 2013](#) and [February 2013](#) issues, and the Academy's Digital Media Committee developed multiple *Clinical Skills* and *Expert Management* DVDs to include a dedicated DVD product, *Repair of the Open Globe*. With the move to streaming video, the Academy repurposed and published as a dedicated multimedia [Repair of the Open Globe](#) course on the ONE Network in November 2019.
- In November 2018, Dr. Robert Mazzoli contacted the Academy regarding opportunities to manage ophthalmic trauma issues, and as a result the Academy's Education Division Staff along with Dr. Christopher Rapuano held a number of teleconference discussions with Drs. Jim Auran, Grant Justin, Fasika Woreta, and others to find approaches to support this subject. For example, the Academy's Education Division suggested and helped facilitate through the Academy's Ophthalmic Society Relations (OSR) group that they relaunch ASOT. After substantial work by this group and others at the AAO and ASOT, this finally occurred in 2020. A visit to the ASOT [home page](#) highlights Academy online education courses including [Imaging Acute Ocular Trauma](#) and [Repair of the Open Globe](#).
- In 2019 the Academy established a dedicated [Ocular Trauma](#) section within the Academy's EyeWiki. Dr. Anna Murchison is the Section Lead Editor along with Drs. Jim Auran, Brett Davies, Grant Justin, Zeba Syed, and Fasika Woreta as committee members. Since its launch, this section has experienced robust growth as there are over 60 articles related to trauma here.
- Access to the [Wills Eye Manual](#) at no cost has been made available to Academy members, and specifically this chapter: Chapter 3: Trauma is online and available on the ONE Network and on the [AAO Education App](#).
- The Academy has provided ocular trauma content in the [Oculofacial Plastic Surgery Education Center](#) of the ONE Network such as [Orbital Roof Fractures](#).
- On the Academy's ONE Network, news/literature reviews ([example](#)), a number of surgical videos ([example](#)) and interviews ([example](#)) on open-globe injuries and repair are available. Additional resources include an [Ocular Trauma Case](#), a [disease review of visual rehabilitation of children with eye trauma](#), [a video on the management of severe ocular trauma](#), and 6 [online chapters](#) on pediatric trauma.
- [Focal Points](#), which became a free member benefit in January 2021 includes relevant titles on corneal burns and melts, eyelid lacerations, enucleation/exenteration, and open-globe injuries.
- In 2019, the Academy BOT established a workgroup to address the trend for decreasing hospital emergency call coverage by ophthalmologists for hospitals chaired by the AAO President-Elect Bob Wiggins. A related article in the December 2019 *EyeNet* is available [here](#). This article included a link



to a [compensation survey](#) to give practitioners data regarding fair market value for call compensation when discussing this issue with their hospitals.

- An online [ocular trauma case](#) was developed show medical student how to evaluate a patient who presents with ocular trauma, and when to refer a patient with ocular trauma to an ophthalmologist.
- On a related matter there may be an opportunity for the Academy's Codequest team to work with ASOT to improve trauma coding education and improve reimbursement for ophthalmic trauma procedures.
- An article was published in the [March 2021](#) issue of *EyeNet* "Ocular Trauma and Guns: The Need for Data."
- In the spirit of the Academy's shared goal to support ophthalmic trauma care and education and in consultation with Academy Education leadership, the Academy's Education Division extended an invitation to ASOT to provide a peer review of *BCSC Section 7: Oculofacial Plastic and Orbital Surgery*. The Academy received the ASOT review from Lora R. Dagi Glass, M.D., which was delivered to the *BCSC Section 7* committee. The committee held its revision meeting on January 2022. It appreciated receiving the comments and incorporated a number of revisions to the text (scheduled to be published in June 2023).
- In addition the Academy worked with ASOT to develop a trauma webinar session for the 1st quarter of 2022. The [AAO/ASOT Ocular Trauma Journal Club](#) with Dr. Fasika Woreta, James Auran, Christopher Rapuano, Charles Bogie, Zeba Syed, Grant Justin, Marcus Colyer & Jayanth Sridhar was released on January 27, 2022 with the first section of the webinar conducted by Drs. Auran and Rapuano who had a discussion with Drs. Bogie and Syed about the article Short-Term Topical Tetracaine Is Highly Efficacious for the Treatment of Pain Caused by Corneal Abrasions: A Double-Blind, Randomized Clinical Trial. In the second section, Drs. Colyer and Justin moderated a discussion with Drs. Lema and Sridhar about point-of-care ultrasound in the diagnosis of ocular emergencies.
- Performing a literature review of Academy ocular trauma-related content for the past three years resulted in the following findings:
 - **CME Content (ONE Network)**
 - [Management of Corneal Lacerations and Anterior Segment Trauma](#) (Learning Plan)
This collection of content reviews preoperative, intraoperative, and postoperative concerns when managing corneal lacerations and traumatic injuries to the anterior segment.
 - [Intimate Partner Violence \(IPV\)](#) (Course)
This online course on intimate partner violence (IPV) looks at this important, yet underappreciated, etiology of ocular and orbital trauma.
 - [Restricted Ocular Motility and Corneal Ulcer](#) (Case)
A 54-year-old with no significant past medical history presents to the emergency room with concerns of acute progressive left-eye vision changes, pain, redness, tearing, and white, purulent drainage.
 - [Imaging Acute Ophthalmic Trauma](#) (Course)
This online course on imaging acute ocular trauma describes modalities for specific trauma indications and identifies critical, not-to-miss findings.
 - [Repair of the Open Globe](#) (Course)



This course is designed to help ophthalmologists recognize an open globe and predict surgical outcomes.

- **EyeWiki**

A [complete section dedicated to trauma](#) was started in 2020, with the following seeing most work; there are 72 total articles currently up to date.

[Anesthesia for Ruptured Globe Repair](#)

For the repair of open globe injuries, the goal of anesthesia is to provide paralysis and insensitivity; however, anesthetic management is multifaceted and can be challenging.

[Choroidal Rupture](#)

A choroidal rupture is a break in the choroid, Bruch membrane, and the retinal pigment epithelium usually a result of open or closed globe trauma.

[Ocular Penetrating and Perforating Injuries](#)

Ocular penetrating and perforating injuries (commonly referred to as open globe injuries) can result in severe vision loss or loss of the eye.

[Zone of Injury](#)

Zones of Injury are used to classify open- and closed-globe Injuries.

[Intraocular Foreign Bodies \(IOFB\)](#)

Intraocular foreign body (IOFB) injuries vary in presentation, outcome, and prognosis depending upon various factors.

[Eyelid Laceration](#)

Eyelid lacerations refer to partial- or full-thickness defects in the eyelid and constitute a significant subset of facial trauma.

[Ruptured Globe](#)

This article details high yield clinical information regarding ruptured globes and their treatment.

- **EyeNet**

[A Nail Gun, a Ruptured Globe—and a Surprise](#)

His ruptured globe was repaired, but the eye became increasingly inflamed. What's your diagnosis?

[Open Globe Injury: Assessment and Preoperative Management](#)

Advice for assessment and preoperative management of open-globe injury.

[Changing Trends in Emergency Ocular Trauma](#)

In an effort to understand the effect of the COVID-19 pandemic on ocular trauma, Halawa et al. compared the quantity and type of eye injuries that presented to emergency departments (EDs) in 2020 with those during 2011-2019.



[Ocular Trauma and Guns: The Need for Data](#)

This article discusses ocular trauma related to gun violence and the need for concrete data on outcomes.

[Eye Injuries and Fireworks: Prevalence and Trends](#)

Studies of the trends and national prevalence of firework-related ocular injuries are scarce.

[Sinking Into His Sockets](#)

Over five years, the 15-year-old boy had experienced increasing foreign body sensation, blurry vision, and diplopia, as well as constant tearing.

[Eye Injuries in the Iraq and Afghanistan Conflicts](#)

In an effort to inform future military surgical training requirements and medical planning, Breeze et al. compared incidences, ocular injury types, and treatment performed on U.S. and U.K. military service members and host nation civilians within the Iraq and Afghanistan conflicts.

[Facial Trauma Caused by Electric Scooter Accidents](#)

As electric scooters have become popular, injuries associated with their use have risen concurrently. However, little is known about ophthalmic trauma related to scooter use.

[Prompt Open Globe Repair Is Crucial](#)

Open globe injury from an intraocular foreign body (IOFB) can severely affect vision and lead to endophthalmitis.

- **News**

[Study unveils characteristics of firework-related ocular injuries](#)

This study characterized firework-related injuries in the United States to determine specific actionable associations that could guide public policies.

[Several retinoblastoma clinical findings are correlated with high-risk pathologic features](#)

Knowing which clinical features indicate high risk for metastases could help determine treatment approach: globe preservation or enucleation.

[Nonlethal crowd control measures can cause serious ocular injuries](#)

Crowd control measures used to disperse protesters cause a unique set of serious ocular injuries, and in some cases even lead to blindness.

[Sympathetic ophthalmia following open globe injury is relatively rare](#)

A meta-analysis estimated the overall incidence of sympathetic ophthalmia (SO) and the rate of SO development after open globe injury.

[Most orbital roof fractures can be managed conservatively](#)

Researchers characterized orbital roof fractures in adults who presented at a single level 1 tertiary care center between 2015 and 2018.



[Ophthalmic injuries at historic Port of Beirut blast show the need for ocular trauma protocols](#)

Investigation of ocular and orbital injuries in survivors of the Port of Beirut explosion, the largest in a population center in recent history, revealed types of secondary blast injuries and the need for trauma preparedness.

- **Resident Lectures and Videos**

[Oculoplastics 101: Trauma](#)

This video discusses orbital fractures and periorbital soft tissue trauma (includes material from 2009 MOC Exam Review Course).

[Neuro-Ophthalmology and Oculofacial Plastic and Orbital Surgery](#)

Dr. Maria E. Aaron discusses neuro-ophthalmology and oculoplastics topics for the comprehensive ophthalmologist.

[Posterior Segment Trauma and Ocular Melanoma](#)

Dr. Justin Gottlieb discusses posterior segment trauma, including blunt trauma, open-globe injury, intraocular foreign bodies, endophthalmitis and ocular melanoma.

[Oculoplastics Exam: Lids, Orbit, Infectious and Inflammatory Disorders, and Trauma](#)

Dr. Louise Mawn discusses the oculoplastics exam, which covers lids, orbit, infectious and inflammatory disorders, and trauma.

- **Presentations and Clinical Videos**

The International Symposium on Wartime Ophthalmic Trauma

[ASOPRS/ESOPRS: Symposium on Wartime Ophthalmic Trauma Part 1](#)

[ASOPRS/ESOPRS: Symposium on Wartime Ophthalmic Trauma Part 2](#)

[ASOPRS/ESOPRS: Symposium on Wartime Ophthalmic Trauma Part 3](#)

[ASOPRS/ESOPRS: Symposium on Wartime Ophthalmic Trauma Part 4](#)

[AAO/ASOT Ocular Trauma Journal Club](#)

This webinar discusses the use of short-term topical tetracaine for the treatment of pain caused by corneal abrasions and point-of-care ultrasound in the diagnosis of ocular emergencies.

[Ophthalmic Trauma: Responsibilities of the On-Call Ophthalmologist](#)

In this AAO 2021 presentation, panelists highlight the emerging role of the ophthalmic hospitalist in providing emergency care.

[Blunt Trauma with Lensectomy, Iridodialysis Repair, and ILM Peeling](#)

Drs. Tahsin Khundkar and Sandra Montezuma describe the repairs made to a pediatric patient with a bungee cord injury.

[Dense Brunescant Cataract and a History of Head Trauma](#)

In this presentation from Cataract Spotlight 2022, Dr. Naveen Rao reviews the case of a 70-year-old man with a history of significant head trauma.



[Evisceration by Equatorial Sclerotomy Technique](#)

In this video, we demonstrate evisceration in a 39-year-old male with a painful blind eye following trauma.

[Intraocular Foreign Body in a Pediatric Patient](#)

Drs. Mohammed Al Falah, Marko Popovic, and Rajeev Muni present a case of a 9-year-old girl with a self-sealing corneal wound and an intraocular foreign body (IOFB) caused by a penetrating ocular trauma.

[Penetrating Fishhook Injury](#)

Dr. Shawn Kavoussi presents two surgeries for a traumatic penetrating fishhook injury: initial removal and open globe repair, followed by surgery for a traumatic cataract and hyphema, and pars plana vitrectomy.

Meetings

- Ocular trauma reviewers have been added to Annual Meeting Program Committee subcommittees that review and recommend courses, papers/posters, and videos for the scientific program.
- To assist ASOT's goal to improve trauma education, the Annual Meeting Program Committee offered a new Trauma Poster Theater session and these were successfully executed during the AAO 2021 Annual Meeting. Namely, a poster session (Session PT09: Trauma), two On-Demand sessions (819V: Open Globe Trauma: Surgical Management for the On-Call Ophthalmologist and LEC134V: Ophthalmic Trauma: Military Lessons on Management), and a symposium (SYM22: Ophthalmic Trauma: Responsibilities of the Ophthalmologist) were held. Likewise, the topic, Trauma, was added as a searchable keyword that delivers 22 results (e.g., posters, videos, on-demand only sessions, et al.).
- Ocular trauma sessions were held at both AAO 2021 and AAO 2022 to include relevant sessions and symposia.
 - At AAO 2021, the Annual Meeting Program Committee offered trauma poster theater sessions (PT09: Trauma), on-demand sessions (819V: Open Globe Trauma: Surgical Management for the On-Call Ophthalmologist and LEC134V: Ophthalmic Trauma: Military Lessons on Management), and a symposium (SYM22: Ophthalmic Trauma: Responsibilities of the Ophthalmologist). Likewise, the topic, Trauma, was added as a searchable keyword that delivers 22 results (e.g., posters, videos, on-demand only sessions, et al.).
 - Examples at AAO 2022 include Session 806V: Open Globe Trauma: Surgical Management for the On-Call Ophthalmologist and Symposium SYM51: Controversies in Ophthalmic Emergencies: An Evidence-Based Debate.
 - More are expected for AAO 2023.

Government Affairs

- Each year at the Academy's annual meeting, the Academy's Government Affairs team hosts a VA-DoD special meeting and related symposia that has at times focused on ocular trauma to include the evolution of combat eye care since World War I, the visual impacts of traumatic brain injuries, the challenges and successes in the continuum of care for eye injured service members and veterans, and a session on the use of simulation for surgical training.



- From an advocacy perspective, the Academy has focused on military-related ocular trauma for more than a decade and advocated for legislation that established the joint DoD-VA Vision Center of Excellence (VCE). The VCE was established in 2009 to address the full scope of vision care including prevention, diagnosis, mitigation, treatment, research and rehabilitation of military eye injuries and diseases including visual dysfunctions related to traumatic brain injury (TBI). The 2008 National Defense Authorization Act also required the implementation of the Vision Registry that longitudinally collects eye injury and vision dysfunction data from the Department of Defense (DoD) and the Department of Veterans Affairs (VA) medical records at <https://vce.health.mil/>.
- The Academy worked with the Blinded Veterans Association (BVA) to secure funding for the VCE offices that are located at the Walter Reed National Military Medical Center in Bethesda, MD. Since 2009, the Academy has worked with BVA and the National Alliance for Eye and Vision Research (NAEVR) to advocate for funding for the DOD Vision Research Program (VRP). This program funds extramural research into deployment-related vision trauma. Initially, the program was funded at \$4 million but the Academy has been able to increase funding for the program to \$20 million. For Fiscal Year 2024, the Academy will encourage Congress to provide increased funding for the VRP.

The Academy is supportive in ASOT's efforts to liaise with the ABO, ACGME, and AUPO regarding various facets of ophthalmic trauma surgery such as content and curriculum requirements and is willing to participate in these discussions and participate in an ASOT-led task force. Likewise, the Academy welcomes ASOT's enthusiasm to reach out to non-ophthalmic societies to include the American College of Emergency Physicians or National Association of Emergency Medical Technicians to build upon past efforts such as the aforementioned Academy resource *The Physician's Guide to Eye Care*.

Moving forward, the Academy encourages ASOT 1) to develop a strategic document with prioritized objectives and associated tactics to support the design, development, and implementation of these initiatives and 2) to communicate with the Academy's Ophthalmic Society Relations group as progress in this initiative is made.



Status Report for Council Advisory Recommendation 23_07

Title: Distribution of Emergency Eye Care

Report From: George A. Williams, MD – Senior Secretary for Advocacy

Analysis:

Fewer physicians across specialties, including ophthalmology, are willing to provide on-call coverage at hospital emergency departments. This CAR requests that the Academy take actions to address the distribution of emergency eye care and develop recommendations to ensure that ophthalmology patients requiring emergent surgery have timely access to the care they need.

Rating: 1 = Currently being addressed by the following AAO activities...

Report:

The Academy Board of Trustees has recognized this important issue, and the Academy has provided significant resources and invested substantial effort to support ophthalmic trauma care and education to equip more ophthalmologists to provide emergency eye care services. The Academy's response to the CAR outlined a wide range of activities that have been undertaken to address emergency eye care services.

During the Council's regional meetings on Friday, April 21, 2023, the meeting chairs led a discussion with Councilors on the status of emergency eye care in their states and problems with access to and delivery of emergency eye care. [Key points from these discussions](#) were summarized in the Council Meeting report and were reviewed by Academy staff.

Since the Mid-Year Forum meeting, the Academy has continued its efforts to support activities in this area. Dr. Kristen Hawthorne contacted the Academy to collaborate on improving ophthalmic trauma care across the US by improving interdepartmental relationships within hospitals and to ensure that consulting ophthalmologists receive appropriate patient care triage information at the time of consultation. In response, multiple meetings were held in April, May, and June between the Senior Secretary for Clinical Education (Christopher Rapuano, MD), the Secretary for State Affairs (John Peters, MD), and Academy staff with a group of ophthalmologists from Austin, Texas, led by Dr. Hawthorne, MD.

As part of these conversations, the Academy was able to share its current trauma resources and connect Dr. Hawthorne and her colleagues with the American Society of Ophthalmic Trauma (ASOT) to advance the discussion and to complement ASOT's ongoing efforts to create a hierarchical triage schema that should help not just the trauma and emergency room physicians but also the ophthalmology community as well.

It is expected that the ASOT will hold a meeting to discuss this and related issues in early fall, and the Academy looks forward to providing support as appropriate.

In addition, Academy and *EyeNet* staff are exploring opportunities to include ocular trauma related content in *EyeNet*. This content could be tagged so that it is readily found in an online curated trauma section on the ONE Network.

We will continue to look for additional opportunities to address this concern.

Rating: 0 = Recommend no action because... 1 = Currently being addressed by the following AAO activities... 2 = Good idea but cannot implement right now because... 3 = Implemented or will be implemented by...

Environmental Consciousness in Academy Meetings

Council Advisory Recommendation 23-08

Problem Statement:

Academy arranged meetings represent a large potential environmental impact due to the size of such meetings. It has come to our attention during these meetings that there are opportunities for changes in behavior that can lessen this impact.

Summary of Facts and Background Information:

There are many meetings supported by the Academy each year. The largest of these are the Annual Meeting and Mid-Year Forum. However, there are several smaller ones, such as committee meetings, LDP, Board meetings, etc. Each meeting takes significant planning in order to achieve success. Included in this planning are: 1) Decisions on location; 2) Agendas; 3) Meal planning; 4) Transportation; 5) Entertainment; 6) Dissemination of information; 7) Financing/Support; 8) Infrastructure and many other smaller items that work to bring the plans together. Each of these steps carries a true cost in waste and emissions that can add up very quickly.

In person conferences, per Meet Green, a sustainable conference agency/planner, yield approximately 400 pounds of CO₂ per person per day. More heavily scrutinized events, such as the Paris Climate Talks, yielded approximately 300,000 tons of CO₂ emissions. In fact, a recent paper from Cornell University, published in Nature Communications in December of 2021, highlighted that the global convention/meeting industry has an annual carbon footprint "on par with" the annual carbon footprint of the entire US economy. This is an incredibly large impact. However, in the absence of regulatory guidance/enforcement (This group does not advocate for such), it is up to each individual group to find ways to reduce their CO₂ emissions.

As such, the American Academy of Ophthalmology makes a measurable contribution to this problem. The Annual meeting last year in Chicago saw a total attendance (health professionals, guests and exhibitors) of 15,198, almost 15% of whom were international. This shares an incomplete overlap with subspecialty attendance of about 7,300 (The writer only came to subspecialty but knows others that attended both). Thus, the likely total number of people coming to the event was over 15,198 reported at the general meeting. The annual meeting, pre-Covid, routinely saw between 22,000 and 25,000 attendees, and subspecialty attendance of between 7,500 and 8,500. If we consider the estimated impact of 400 pounds of CO₂ per person per day, this equates to a conservative (assuming on average that attendants are only present for 4 of the 6 days encompassing the meeting days and travel days) estimate of over 12,000 tons of CO₂. In addition, the same data estimates the creation of approximately 127 tons of solid waste that will end up in landfills (1.89 kg waste per person per day). This was in Chicago last year alone. This will clearly rise as we continue to increase our attendance to historical norms.

Finally, the above is the Annual Meeting alone. The costs of the other meetings are lower due to smaller meeting sizes, but they carry impact as well. The likely cost of Mid-Year Forum, for example, is estimated at 241 tons of CO₂ and 2,500 pounds of solid waste.

Possible Solutions:

The various contributions to waste and emissions during these meetings are numerous and identifiable.

The EPA, and various private groups such as Meet Green, have several publications to provide guidance and resources to address all aspects of environmental impact from large meetings. Any attempt to describe all of them here is too cumbersome, and beyond the scope of this CAR.

Instead, we ask the Academy to set up a task force, or a standing subcommittee on the meetings committee, to address the various environmental impacts of Academy meetings. We also ask that any such committee or subcommittee directly reports to the trustees with their recommendations to minimize potential interference with their work. They will be able to take the time to research each recommendation and find the best ways to address and implement them in a manner best suited to the Academy memberships' needs and desires.

Submitted by:

Matthew F Appenzeller MD

On Behalf of: Nebraska Academy of Eye Physicians and Surgeons

Date Board Approved This CAR: 1/17/2023

Co-Sponsors:

American Association for Pediatric Ophthalmology and Strabismus 1/18/2023

American Ophthalmological Society 1/25/2023

American Osteopathic College of Ophthalmology 1/28/2023

Cornea Society 1/24/2023

Int'l Joint Commission on Allied Health Personnel in Ophthalmology 1/20/2023

Minnesota Academy of Ophthalmology 1/27/2023

Montana Academy of Ophthalmology 1/22/2023

North Dakota Society of Eye Physicians and Surgeons 1/19/2023

Ohio Ophthalmological Society 1/21/2023

Pennsylvania Academy of Ophthalmology 1/18/2023

South Dakota Academy of Ophthalmology 1/31/2023

Wisconsin Academy of Ophthalmology 1/30/2023



Academy Background Statement **Council Advisory Recommendation**

23-08: Environmental Consciousness in Academy Meetings

Assigned to and reply from: Bennie H. Jeng, MD - Secretary for Annual Meeting

Presenting: Bennie H. Jeng, MD - Secretary for Annual Meeting

Analysis:

The Academy recognizes the impact that the annual meeting, and other meetings, have on the climate and has already been working to reduce the carbon emissions. The Annual Meeting Secretariat is working on a plan for the Board to address the issue. The plan will be presented to the Academy Board in September 2023 for consideration.

The Academy has already made several changes to the annual meeting to reduce its carbon footprint. These include eliminating the meeting bag which was produced in and transported from China; eliminating the plastic badge holder; and transitioning to electronic meeting materials such as the mobile meeting guide, online course handouts and subspecialty day syllabus. The reduction in materials has reduced the number of trucks needed to ship to the meeting location and the amount of waste going to landfill at the end of the meeting.

The meeting vendors and convention centers have also been reducing their carbon emissions, as well. For example, single use signs are now printed on recyclable cardboard instead of Poly Form. Aisle carpet is now made from partially recycled content. McCormick Place in Chicago recently replaced exhibit hall lighting with LED bulbs reducing their carbon footprint by 12%. Ernest N. Morial convention center in New Orleans now has an extensive recycling program that diverts over 250,000 pounds of materials from landfill. These are just a few examples of how the entire meeting industry is working to reduce carbon emissions throughout the entire meeting cycle and will continue to do so. The Academy will also continue to do its part.

The Academy is happy to share the plan with the Council once it's reviewed by the Board.



Status Report for Council Advisory Recommendation 23_08

Title: Environmental Consciousness in Academy Meetings

Report From: Bennie H. Jeng, MD – Secretary for Annual Meeting

Analysis:

This CAR expressed concern about the environmental impact of the Academy's meetings, particularly the annual meeting due to its size.

Rating:

1 = Currently being addressed by the following AAO activities

Report:

The Academy is aware of the environmental impact of the annual meeting and other meetings. There have been great strides already in reducing the carbon footprint of the meeting through reduction in single use plastic, printed materials, and freight going to the meeting. One of the biggest changes was the elimination of the registration bags which were made in China and shipped to the meeting site.

In addition, the Academy is also doing the following:

- Creating a sustainability plan for all Academy meetings with actionable items to reduce environmental impact. Initial draft will go to the Academy Board in September 2023.
- Calculating the current carbon footprint of the 2023 annual meeting as a benchmark for the future.
- Developing sustainable knowledge and resources within the Academy. Academy meetings staff are encouraged to take the [Sustainable Event Professional Certificate](#) program.
- Working with meeting vendors to identify areas that can reduce carbon emissions.

The Academy is committed to ensuring that its meetings are held in an environmentally conscious manner going forward.

Rating: 0 = Recommend no action because... 1 = Currently being addressed by the following AAO activities... 2 = Good idea but cannot implement right now because... 3 = Implemented or will be implemented by...

New Approach Needed for Protecting Medicare Patient Access

Council Advisory Recommendation 23-09

Problem Statement:

The ability to provide care to patients is based in economic feasibility. Due to lack of Congressional action, the economic feasibility to provide care to Medicare patients has steadily declined, and may very well be on the verge of infeasible.

Summary of Facts and Background Information:

There is an old adage that what is economically feasible will happen and what is economically infeasible will not happen. This feasibility is calculated based upon costs vs potential gains. In medicine, the large cost centers are facility management, supplies and human compensation. Each of these have increased annually, and, more recently, have accelerated.

The most recent data shows that healthcare support staff wages have increased 15% in 2022. Supplies have increased 4-6% depending on specialty in 2022. At the same time, we have seen an effective freezing of reimbursement from Medicare Part B, which represents the largest payer in Ophthalmology, for the past 20 years. Until 12/30/2022, this has resulted in an inflation adjusted decline of over 20% in reimbursement/purchasing power, while costs continue to rise. In our attempt to address this, the organized medical community, often with the AAO taking an outsized role, has taken the position of lobbying and attempting to reason with our Congressional representation.

Unfortunately, this situation has worsened in 2023 due to a decision by Congress to cut reimbursement by 2% across the board, and a reduction of 1.5% in 2024. If this is combined with accelerated inflation of 6.5% in 2022, this equates to a cumulative reduction in reimbursement approaching 25% since 2000. This truly represents a very large threat to the economic feasibility of providing care to ophthalmology patients sooner rather than later. Thus, it is reasonable to assume that this represents an existential threat to our patients. In addition, it is a threat that is no longer in the long-range future. It is now a threat that is likely in the very near term.

The AAO has been lobbying every year against this for almost 30 years, per some of our older peers. In the writer's personal experience, these conversations have grown more and more acrimonious over time. In the early 2000's, most conversations have been political, but amicable. Members of Congress have stated that they understand, or that it is the elephant in the room, or they need to do what they can to protect patients. Since that time, the writer has been told: 1) "The doctors need to be ready for pain," Health LA for a Senator; 2) "There is no political will to fix the system," Senator; 3) "Nobody gives a damn about how much doctors get paid," House Representative.

These comments are of grave concern, especially those comments that point to a need for greater political will. Historically, political will in congress is derived from crisis. However, the advent of crisis in healthcare will lead to significant harm to the citizens prior to any correction to the crisis. In addition, any such correction will be more expensive to the taxpayer, and more difficult to implement, then if any correction was implemented prior to any crisis.

Therefore, it is up to the membership of the various medical organizations to become more active in this political space. If a greater voice is applied in number and action by physicians, then it will become clearer that a crisis is pending, and we may be able to avert disaster.

Currently, a small minority of physicians actively participate in trying to avert crisis. As a proxy, we see that less than 15% of the AAO membership gives to OphthPAC. In addition, we see thousands of American ophthalmologists attend the annual meeting. However, only a few hundred attend Mid-Year Forum. This has been the result of many years of work trying to convince the membership to become more involved.

It is clear that the current strategy, one that has been employed for decades, is failing our patients. It is time to reassess our options and strategies.

Possible Solutions:

Every group of concerned citizens has the right to lobby their government for redress of grievance. We have done this in the usual manner of discussion and reasoned conversation. This appears to be no longer adequate. As noted above, the system has been slowly eroded, thus putting patient access at risk, and that risk is more immediate than ever. Per the AMA, the margin on Medicare patients for many specialties is about 2%, thus the current cut will remove any such margin.

We ask that the Board use the resources available to the AAO to re-assess our strategy. We must look at our lobbying efforts and ask if more can be done. We suggest the following as points of discussion only:

- A) Continue current lobbying efforts such as the Mid-Year Forum and full-time staff.
- B) Increase these efforts with more frequent visitation from members. We have made use of the "I am an Advocate," however, many of us who have asked for assistance in meeting with our legislators have had our requests unanswered.
- C) Consider more direct, and aggressive, tactics such as staged protest, marching.
- D) Consider a day, or days, of closing our doors to patients (except EMTALA events). We know that if the trajectory is not changed, then this is the final result, especially in more rural communities. This would be a symbolic moment of protest to draw attention to the issue, similar to protests in the early 2000's taken in Las Vegas regarding Tort reform.
- E) Coordinate any of the above to happen with other specialty societies and the AMA.

We ask that the AAO legal counsel be involved to discuss more aggressive strategies. We, as a state society do not advocate for any one in particular. We simply wish to convince the Board that a new strategy is likely needed to engage the membership in greater number and action. However, we recognize that other societies have taken such steps to affect change on behalf of their patients and nothing is gained without risk.

This is not an exhaustive list of options. We only ask that the current strategy be augmented and/or changed.

Submitted by:

Matthew F Appenzeller, MD

On Behalf of: Nebraska Academy of Eye Physicians and Surgeons

Date Board Approved This CAR: 1/17/2023

Co-Sponsors:

American Association for Pediatric Ophthalmology and Strabismus 1/23/2023

Connecticut Society of Eye Physicians 1/26/2023

Montana Academy of Ophthalmology 1/22/2023

New York State Ophthalmological Society 2/1/2023

South Dakota Academy of Ophthalmology 1/31/2023

Texas Ophthalmological Association 1/27/2023

Wisconsin Academy of Ophthalmology 1/30/2023

Wyoming Ophthalmological Society 1/19/2023



Academy Background Statement **Council Advisory Recommendation**

23-09: New Approach Needed for Protecting Medicare Patient Access

Assigned to and reply from: David B. Glasser, MD - Secretary for Federal Affairs; Michael X. Repka, MD, MBA - Medical Director for Governmental Affairs; George A. Williams, MD - Senior Secretary for Advocacy

Presenting: Michael X. Repka, MD, MBA - Medical Director for Governmental Affairs

Analysis:

In 2015, the bipartisan Medicare Access and CHIP Reauthorization Act (MACRA) was signed into law by President Barack Obama. It repealed and replaced the sustainable growth rate (SGR) formula with the Quality Payment Program (QPP), which planned to shift Medicare's approach to physician payment to paying providers based on quality, value, and outcomes rather than the number of services provided. The QPP offers two tracks to participation, the Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs).

Unfortunately, MACRA has not delivered upon its stated promise. Logistical challenges, misaligned incentives, and lack of opportunities for specialists and even primary care to meaningfully participate have slowed the transition to APMs. The CY 2023 Medicare Physician Fee Schedule Proposed Rule projects only 144,700 – 186,000 clinicians will be Qualified Participants in Advanced Payment Models this year.¹ There remains no clear path for creating an APM for ophthalmology, and the incentive for qualified participants is shrinking from 5% in Performance Year 2022 to 3.5% in Performance Year 2023. For Performance Year 2024 and beyond, payment rates for services furnished by APM qualified participants will be updated annually by the 0.75% APM conversion factor.²

As noted in the CAR, the Academy has been a leader in lobbying efforts to avert the year-over-year Medicare physician fee schedule cuts resulting from MACRA. As a founding member of the Surgical Care Coalition (SCC), the Academy has invested in advocacy campaigns to avert drastic Medicare payment reductions. Since 2020, the Academy has invested \$300,000 each year (\$900,000 total through the end of 2022) in the SCC, which has averted over \$1 billion in payment cuts for ophthalmologists.

For 2023, Medicare payments for most physicians would have taken an 8.5% hit, but Congress mitigated most of the cut in year-end legislation. As highlighted in the CAR, the *Consolidated Appropriations Act, 2023* (P.L. 117-328)³ eased the overall cut for 2023 to 2%. The legislation also delayed an additional payment cut of 4%, which had been triggered by the passage of COVID-19 relief legislation in 2021, from going into effect for at least two years. For 2024, the legislation proactively provided a small 1.25% boost. However, the magnitude of anticipated reductions in the 2024 Medicare Physician Fee Schedule rulemaking are unknown, making it impossible to determine the ultimate impact of the proactive boost at this time.

While we cannot predict the cuts for 2024, it is clear significant reform is required to break the cycle of year-end pleading to avert cuts. The ongoing erosion of Medicare physician payment relative to inflation is not sustainable and has reached a critical stage that will adversely affect access to care. The Medicare physician fee schedule needs additional funding now. The Academy is already actively engaging Congress and collaborating within the House of Medicine to start the conversation.

In October 2022, the Academy answered a Request for Information from a group of House members lead by Representatives Ami Bera, M.D. (CA-07) and Larry Bucshon, M.D. (IN-08) on MACRA reform.⁴ The Academy's letter raised alarm for the growing financial instability of the Medicare physician payment system and provided specific recommendations for Congress to include in a long-term solution. Briefly, the Academy asked that Congress work quickly to bring an inflationary update back into the conversion factor formula, fix the outdated budget neutrality rule trigger, and overhaul the Quality Payment Program to reward specialists for high-quality care.

Additionally, the Academy has partnered with the American Medical Association and over 100 state medical and national specialty societies to develop a set of principles to guide advocacy efforts on Medicare physician payment reform. Based on the concepts of simplicity, relevance, alignment, and predictability, the *Characteristics of a Rational Medicare Physician Payment System* lays the foundation for future discussions with policymakers about what physicians need in the next iteration of Medicare payment reform.⁵ Academy staff in the Governmental Affairs Department continue to actively participate in AMA workgroups that are developing specific legislative asks for each principle.

Medicare payment reform will be one of the key issues for the Academy's Congressional Advocacy Day on April 20, 2023.

Options

The Academy agrees with the CAR that active engagement from the physician community, including Academy members, is critical to addressing this issue going forward.

- 1) The Academy will continue current lobbying efforts such as Mid-Year Forum to engage our members in advocacy efforts and give them an opportunity to meet directly with member of Congress. AAO staff and leadership will continue those meetings throughout the year
- 2) The Academy will look for more ways to increase the number of opportunities members have to interact with their Congressional representatives, including but not limited to:
 - a. Supporting and coordination of in-district virtual or in-person meetings with state society leaders when feasible.
- 3) The Academy agrees that it is very important to emphasize that Medicare reimbursement cuts present a substantial risk for practices to close. New political activities should be considered that illustrate the harm presented by the cuts and what practice closure would mean to patients, especially in rural areas. Any such actions should be based on First Amendment freedoms and taken consistently with applicable law.
- 4) The Academy agrees that it is important and appropriate to partner with other specialty societies and the AMA to achieve our shared public policy goals.

In considering more aggressive strategies we agree that AAO legal counsel will be involved to ensure compliance with applicable law.

References

1. Medicare and Medicaid Programs; CY 2023 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies, 87 Fed. Reg. 46408 (July 29, 2022) (to be codified at 42 CFR Parts 405, 410, 411, 414, 415, 423, 424, 425, and 455) <https://www.federalregister.gov/d/2022-14562>
2. Centers for Medicare & Medicaid Services. (n.d.). *Advanced Alternative Payment Models (APMs)*. APM Overview. Retrieved March 7, 2023 from <https://qpp.cms.gov/apms/advanced-apms>
3. For the statutory language of P.L. 117-328, see <https://www.congress.gov/bill/117th-congress/house-bill/2617/text>.
4. American Academy of Ophthalmology. (2022, November 3). *Academy Responds to Call for Medicare Physician Payment Reform Ideas*. Eye on Advocacy. <https://www.aao.org/eye-on-advocacy-article/response-call-medicare-physician-payment-reform>
5. American Medical Association. (2022, May 25). *Characteristics of a Rational Medicare Payment System*. <https://www.ama-assn.org/system/files/characteristics-rational-medicare-payment-principles-signatories.pdf>



Status Report for Council Advisory Recommendation 23_09

Title: New Approach Needed for Protecting Medicare Patient Access

Report From: Michael X. Repka, MD, MBA – Medical Director for Governmental Affairs

Analysis:

This Council Advisory Recommendation encourages the Academy consider additional strategies to address the downward trend in Medicare physician payments, which threatens the feasibility of delivering ophthalmic care to patients. The Academy is taking a multi-pronged approach to Medicare patient access. We continue to work tirelessly to mitigate impending cuts for the coming year, while also engaging with the physician community to address long-term Medicare payment reform.

Rating:

1 = Currently being addressed by the following AAO activities...

Report:

- We believe that ongoing initiatives and continuing to identify opportunities to engage and partner with various organizations is sufficient at this time, including:
- The Academy has partnered with the Surgical Coalition to push the Centers for Medicare & Medicaid Services (CMS) and Congress to delay implementation of the G2211 visit complexity add-on code, which will cause a 2 percent cut to the 2024 Medicare physician fee schedule conversion factor.
- The Surgical Coalition sent a letter to the CMS Administrator on July 26, 2023.
- A letter to Congressional leaders will be sent in September, once legislators return from August recess.
- The Academy will be submitting formal comments to the 2024 Medicare Physician Fee Schedule proposed rule by September 11, 2023. In these comments, the Academy will urge CMS to use their authority to maintain stability in the physician payment system by not implementing the G2211 add-on code or making it not subject to budget neutrality. The Academy will also urge the agency to maintain the threshold to avoid negative payment adjustments for the 2024 Medicare Incentive-based Payment System performance year at 75 points.
- Staff for the Academy's Governmental Affairs department continue to actively participate in the American Medical Association-lead workgroups to refine the [*Characteristics of a Rational Medicare Physician Payment System*](#) to specific Congressional asks. These efforts have resulted in the introduction of legislation (H.R. 2474) that would provide an annual update equal to the Medicare Economic Index (MEI) to the Medicare Physician Payment System. The Academy has endorsed H.R. 2474.
- The Academy supported and coordinated 11 in-district meetings during 2023 August recess. These meetings provided members the opportunity to advocate for Medicare payment reform with state leaders.

Rating: 0 = Recommend no action because... 1 = Currently being addressed by the following AAO activities... 2 = Good idea but cannot implement right now because... 3 = Implemented or will be implemented by...

- Medicare payment reform will continue to be one of the top issues for the Academy's 2024 Congressional advocacy agenda.

Public Perception of Ophthalmology - Are we 'Eye Doctors' or Ophthalmologists?

Council Advisory Recommendation 23-10

Problem Statement:

Advocacy serves to improve eye health for our patients in a myriad of ways, whether through access to care by removing barriers to sight-saving procedures or by making eye medication refills available on a timely basis. State societies across the US are committed to advocacy and spend a considerable portion of their time and resources on behalf of patients. Over the past 5-7 years, an increasing portion of time and resources have been allocated to scope issues in an effort to protect patients from receiving a lower standard of care from non-physician providers gaining state licensure for ophthalmic procedures by legislative fiat rather than by years of advanced medical and surgical residency training.

Summary of Facts and Background Information:

Despite the considerable efforts of many state societies, more and more states have granted enhanced medical intervention and surgical privileges to optometrists. These battles take place in each state legislature and consume untold thousands of state society dollars annually. For many state societies, scope battles consume so much time and resources that their ability to advocate on non-scope issues is greatly diminished.

Because state society advocacy efforts benefit all ophthalmologists' patients in a state, many ophthalmologists do not feel the need to join their state societies, further limiting resources available for advocacy.

The American Academy of Ophthalmology (AAO) facilitates advocacy via its OphthPAC and Surgical Scope Fund programs. Because all ophthalmologists benefit from these programs directly or indirectly, participation in these programs is generally low, expecting that there are enough participants necessary to fund the effort.

Ophthalmologists who take time to talk with and establish relationships with their state legislators find that they face the same challenges year after year, legislative session after legislative session:

1. A poor understanding on the part of legislators as to the difference between ophthalmologists and optometrists – and sometimes even the differentiation of opticians
2. Lack of adequate financing
3. Numerous scope battles impacting other medical specialties

Organized optometry has made a concerted effort to obfuscate the distinction between ophthalmologists and optometrists by always using 'Dr.' in front of their names without a credential and always referring to themselves (and ophthalmologists) as 'Eye Doctors'. There have been limited efforts made on both the national and state levels to address this. They even manufactured the seemingly equivalent monikers of "OD" and "OMD" to suggest more commonality in the training of non-medically trained eye care providers and ophthalmologists.

The AAO started their publicity program 'EyeMDs' about twenty years ago which provided some benefit and was adopted by some state societies. This effort appears to have waned in recent years and may not have been well adopted by osteopathic ophthalmologists.

At the state level, the Texas Ophthalmological Association (TOA) and Texas Medical Association (TMA) successfully supported a bill in the Texas legislature that requires all healthcare providers to wear identification tags clearly stating their credentials in an inpatient setting.

Ophthalmology-derived state resources for patient safety-directed advocacy are limited. As practices expenses continue to rise, and as more and more ophthalmologists become employees of hospital systems and large networks, many see organizational dues as expenses that are easy to eliminate. Some state societies have addressed this by providing other membership benefits, such as help with coding and insurance issues. Other state societies have established their own PACs, such as TOA's EyePAC, to support legislative candidates. But these efforts are a drop-in-the-bucket compared to fundraising by optometry. Optometric fundraising (including a thorough training in legislative advocacy on behalf of the profession) starts in optometry school, and the average optometrist in practice contributes many times more to advocacy than the average ophthalmologist, compounded by the numerical advantage of optometrists relative to ophthalmologists. As an illustration, the Texas Optometric Association raises more funds annually than the entire Texas Medical Association!

Scope battles are no longer limited to eye care. In Texas, the nurse practitioners no longer want to be supervised by a physician, physical therapists are seeking to provide services without a physician prescription, physician assistants want to change their name to "physician associates" and no longer be supervised by a physician, psychologists are seeking to prescribe medications, etc., etc. But optometry's efforts antedated all the others with an aspirational reach far beyond that of primary care physicians.

There are benefits and drawbacks to having multiple scope battles affecting multiple specialties. When optometry was the only one, ophthalmology as a small specialty did not get much attention from the house of medicine. Now that other specialties have recognized what is happening in terms of scope, the house of medicine has supported ophthalmology's efforts, recognizing this issue as the 'tip of the iceberg.' On the other hand, now that so many fields have become impacted by aggressive scope battles of their own, fewer resources may be available to assist ophthalmology.

Possible Solutions:

1. The AAO should retain a public relations/public affairs firm to develop branding for ophthalmology that sets it apart from other eye care providers, making it easy for legislators and the public to understand. This public relations effort can be used by individual ophthalmologists with their patients and will make it easier for state societies to defend against dangerous scope bills. This effort will also make it desirable for ophthalmologists to want to be 'part of the club' and may benefit state society membership. This education program must be permanent in its design and saturation, so that the difference in providers rises to the level of conventional wisdom.

2. The AAO should craft model legislation that can be used at the state and federal levels requiring disclosure of credentials if 'Dr.' is used in front of a name. This will be supported by other specialties considering that nurse practitioners are now obtaining DPN or PhD degrees and calling themselves 'Dr.' to their patients.

Submitted by:

Robert D. Gross, MD

On Behalf of: Texas Ophthalmological Association

Date Board Approved This CAR: 11/15/2022

Additional Submitters:

Sidney K Gicheru, MD; Sanjiv R Kumar, MD; Texas Ophthalmological Association

Co-Sponsors:

American Association for Pediatric Ophthalmology and Strabismus

Arkansas Ophthalmological Society

California Academy of Eye Physicians and Surgeons

Florida Society of Ophthalmology

Illinois Society of Eye Physicians and Surgeons

Indiana Academy of Ophthalmology

Iowa Academy of Ophthalmology

Kansas Society of Eye Physicians and Surgeons

Louisiana academy of Eye Physicians and Surgeons

Maryland Society of Eye Physicians and Surgeons

Michigan Society of Eye Physicians and Surgeons

Minnesota Academy of Ophthalmology

Missouri Society of Eye Physicians & Surgeons

Nebraska Academy of Eye Physicians and Surgeons

New Mexico Academy of Ophthalmology

New York State Ophthalmological Society

Ohio Ophthalmological Society

Pennsylvania Academy of Ophthalmology

South Carolina Society of Ophthalmology

Virginia Society of Eye Physicians and Surgeons



Academy Background Statement Council Advisory Recommendation

23-10 Public Perception of Ophthalmology – Are we ‘Eye Doctors’ or Ophthalmologists?

Assigned to: Communications

Reply from: Dianna Seldomridge, MD, MBA – Secretary for Communications

Presenting: Dianna Seldomridge, MD, MBA – Secretary for Communications

The Academy agrees that organized optometry has obfuscated the distinction between ophthalmologists and optometrists in advertising and testimony.

The suggestions to examine how effectively we are countering this with our public communications and to consider potential actions through the legislative process both have merit.

Identifying ophthalmologists as physicians who specialize in medical and surgical eye care is a critical element of the Academy’s public communications strategy. Use of the poorly defined term “eye doctor” assists those optometrists who attempt to confuse and equate the two professions. The Academy feels strongly that this term should not be used in referring to ophthalmologists.

Every year, we distribute dozens of press releases, patient stories, and patient story videos, as well as some 500 social media posts, all with this consistent message:

Ophthalmologists are the physicians who specialize in medical and surgical eye care. The care that ophthalmologists provide is transformative. We Protect Sight and Empower Lives.

We agree that the confusion created by optometry impacts advocacy efforts and that more states have granted optometrists enhanced medical intervention and surgical privileges. We recognize that the strategies used by optometrists seeking this expansion include claiming differences perceived as advantageous (greater workforce distribution and lower cost for enhanced access), while simultaneously attempting to blur critically important differences (training and experience).

What the Academy is Doing

The CAR suggests that the Academy could retain a public relations firm to develop branding for ophthalmology to help set it apart from other eye care providers and that this material could be made available to individual ophthalmologists and to state societies. It is important to know that the Academy has extensively engaged public relations firms over the last 15 years. This has been extremely helpful in developing a large body of materials and messaging that have been used in educating both legislators and the public on the distinction between ophthalmology and optometry, and the importance of this distinction with regard to patient safety. These efforts have been reflected in millions of dollars spent (through the Surgical Scope Fund) at the state level on advocacy initiatives opposing dangerous legislation that would allow optometrists to perform surgery. This has now been extended to the

Federal level to address threats to quality of eye care in the VA system. Ongoing Surgical Scope funding continues to support our engagement of public relations firms to educate state and federal lawmakers, as well as the public, about the differences between ophthalmologists and optometrists and the relevance of this distinction to safe, high quality eye care. Increased donations to the Surgical Scope Fund will allow us to do more.

The campaign to prevent changes to the VA National Standards that could expand optometric scope of practice serves as an example of this type of public awareness campaign. The board has authorized funding from Academy reserves and the Surgical Scope Fund to fight this battle which includes funding dedicated to hiring grassroots and public relations firms. Advocacy staff and leaders have built relationships with veteran service organizations and reached out to members of the U.S. House and Senate Veterans Affairs Committees.

The major blitz of public activity will happen during the commenting period, including digital advertising, social media posts, op-eds and news stories. To date, we have garnered 68 op-eds and letters to the editor, all of which call out the distinction in education and training between ophthalmologists and optometrists and how important this is for quality of care in our VA system and the health of our veterans.

However, the nature of this campaign points out a fundamental difference between one that is targeted to a specific stakeholder audience in response to a specific threat compared to a broad, sustained “re-branding” directed toward the general public. That general public awareness campaign is sometimes described as a “Got Milk” publicity campaign, which provides valuable lessons.

“Got Milk?” is one of history's most extensive and best-known ad campaigns. The campaign's first year cost \$23 million in 1993 — \$48 million in today's dollars. The campaign inundated Americans with an aggressive national print and broadcast advertising campaign, exposing 80 percent of all U.S. consumers. After five years, 91 percent of adults surveyed in the U.S. were familiar with the campaign, by that measure a success, but at an astronomical cost. Of note, the campaign did not achieve its goal of getting more people to drink milk. After an initial bump, by the campaign's end and a spend of approximately a quarter billion in today's dollars, milk sales were down.

Similarly, in 1998, the Academy launched the EyeMD campaign. The Academy spent \$1.8 million over the three years of the campaign — that's \$3.3 million in today's dollars. The goal was to identify ophthalmologists as medical doctors (MDs) to differentiate ophthalmologists from other eye care providers and to promote the value of ophthalmology and eye health. The campaign successfully engaged a modest number of members and state societies. However, there were no indications that it changed public opinion or had an impact on optometric scope expansion. In other words, similar to the “Got Milk” campaign, it did not move the needle.

The most obvious concern for ophthalmology with a campaign of this scale is the risk of diverting critical resources from ongoing specific state and federal battles over to a general public campaign that would include eyecare stakeholders but reach them inefficiently and at an incredibly high cost. Moreover, even if every legislator in America knew the difference between ophthalmologists and optometrists, it is unlikely that would eliminate or even substantially impact scope battles. For example, there is a clear distinction in training between anesthesiologists and nurse anesthetists that the public generally understands, but that knowledge has not prevented intense scope battles in this space.

Nevertheless, we must face down each scope battle and continue to develop and support strategically targeted campaigns. The CAR identifies an opportunity to share these experiences, resources and practices with individual practitioners and state societies to help in these efforts.

There is a lot of material upon which to draw. The Academy has developed and regularly shares information to promote the profession of ophthalmology. Our EyeSmart website, emails, social media posts and press releases directly or indirectly promote the profession and clearly distinguish between ophthalmologists and optometrists. The site's "What Is an Ophthalmologist?" article, promoted on social media and linked from every EyeSmart article containing the word "ophthalmologist," had more than 200,000 views in the past year. The site has 11 YouTube videos addressing the difference between ophthalmologists and other eye care professionals. We consistently own the share of voice in the media over optometry, where we routinely have more than 70 percent of the market share. Thousands of people engage with this content with hundreds of posts on social media (Exhibits 1 - 3).

We believe there is an opportunity for us to make these resources better known. One option may be to create a toolkit for practitioners and societies that aggregates these resources along with a guide of communications "Best Practices" brought together from our long experience of campaigns and numerous engagements with a range of public relations firms to be made available for individuals and State Societies. The Academy welcomes suggestions to improve these articles and public communications.

State and Federal Legislation

The Academy absolutely agrees that statutory requirements to disclose credentials should be required in every state. And to that end, the Academy has strongly supported efforts to increase transparency in health care at both the federal and state levels.

The CAR calls for the crafting of model legislation that can be used at the state and federal levels to better clarify provider credentials, not just in ophthalmology but across specialties. We are pleased to share that indeed such model legislation exists and is available. The Academy has partnered with the American Medical Association to develop model state truth-in-advertising legislation that state medical and specialty societies can use to pursue action in their state legislatures. Fifteen states have already enacted legislation to ensure patients know their healthcare providers' education, training and licensure. A copy of this model legislation is included in this response (Exhibit 4). We must work together across the house of medicine to pass this legislation in the remaining states

Termed the "Health Care Professional Transparency Act," all healthcare professionals would be required to wear a name tag during all patient encounters, clearly identifying the type of license they hold. Healthcare professionals must also display their education, training and licensure in their office. This model bill would promote "Truth in Advertising" among healthcare professionals by ensuring that any advertisements or professional websites they have do not promote services beyond what they are legally permitted to provide. These advertisements or websites must be free of deceptive or misleading information and must identify the professional license.

The Academy is happy to work with state ophthalmic societies interested in pursuing truth-in-advertising legislation in their states. We encourage them to partner with their state medical association on these advocacy efforts.

The Academy has endorsed the Truth in Healthcare Marketing Act at the Federal level, which would make it illegal to make misleading or deceptive claims about holding a state healthcare license. It also

would require advertisers to disclose the license that allows them to provide the service they are advertising. A bipartisan bill (H.R. 896) has been reintroduced in the 118th Congress by Representatives Larry Bucshon, MD (R-Ind.) and David Scott (D-Ga.). The Academy will continue working with the American Medical Association and other physician organizations to build strong support for H.R. 896.

We thank the authors of this CAR for the opportunity to consider how we promote the profession in communications and legislation, the opportunity to share what the Academy is already doing, and the inspiration to continue to develop these messages, materials and tools.

Exhibits

1. Links to Website Content
2. EyeSmart Article: What is an Ophthalmologist
3. Know Your O's reproducible flyer
4. AMA Model Legislation

Exhibit 1: A Sample of what is currently being done through public and patient education

Summary: Everything we do with EyeSmart (all the content, the social media, the Google ads, the staff resources) — even the content that isn't on point about ophthalmologists — is intended to promote the profession either directly or indirectly. Otherwise, we wouldn't do it.

More specifically, we have a collection of 5 articles and 11 YouTube videos that directly address the difference between ophthalmologists and other eye care professionals:

- [What Is an Ophthalmologist?](#) (215,220 views since Feb. 2022) – we link to this from every EyeSmart article that contains the word “ophthalmologist”; we also promote this article on social media and in a public EyeSmart newsletter 1-3 times per year.
- [Ophthalmology Subspecialists](#) (12,641 views since Feb. 2022)
- [Training and Certification for Ophthalmologists](#) (3,721 views since Feb. 2022)
- [Ophthalmologists: Physicians Protecting Your Vision](#) (457 views since Feb. 2022) – this article has a gallery of 11 YouTube videos on the unique qualifications of ophthalmologists (videos range from 0-138 views since Feb. 2022)

Additional content that emphasizes the unique skills of ophthalmologists – the articles and first video below are promoted 1-2x/year in newsletters and on social media; we have promoted them in the past using Google Ads

- Article: [20 Reasons to See an Ophthalmologist](#) (5,579 views since Feb. 2022)
- Article: [Famous People You Didn't Know Were Ophthalmologists](#) (1,856 views since Feb. 2022)
- Video: [I'm an Ophthalmologist and This Is When You Should Get Your Eyes Checked](#) (2,700 views since Feb. 2022)
- Video: [Unsung Heroes: Paul Steinkuller, MD](#) (326 views since Feb. 2022)
- Video: [Unsung Heroes: Alejandra de Alba Campomanes, MD](#) (279 views since Feb. 2022)
- Video: [Unsung Heroes: Martin Spencer, MD](#) (98 views since Feb. 2022)
- Video: [Unsung Heroes: Chasidy Singleton, MD](#) (100 views since Feb. 2022)
- Video: [Unsung Heroes: Judith Kirby, MD](#) (47 views since Feb. 2022)

Social Media Metrics

Instagram

45K Followers

24 Posts on the difference between ophthalmologists and optometrists

26K Engagements

Facebook

54K Page Likes

118 Posts on the difference between ophthalmologists and optometrists

3.4K Engagements

Twitter

20K Followers

122 Tweets on the difference between ophthalmologists and optometrists

835 Engagements

Exhibit 2: EyeSmart Article – What is an Ophthalmologist?

Nearly every mention of ophthalmology or ophthalmologists in news releases and social media posts is linked to this article.

For Public & Patients Tips & Prevention

About Ophthalmology

What is an Ophthalmologist?

Ophthalmology Subspecialists

Training and Certification for Ophthalmologists

How to Report a Concern About Your Ophthalmologist

Ophthalmologists: Physicians Protecting Your Vision

What Is an Ophthalmologist?

Leer en Español: [¿Qué es un oftalmólogo?](#)



By Jennifer Churchill and Dan T. Gudgel
Reviewed By Kendra Denise DeAngelis, MD
Dec. 08, 2022

When it's time to [get your eyes checked](#), make sure you are seeing the [right eye care professional](#) for your needs. Each member of the eye care team plays an important role in providing eye care, but many people confuse the different providers and their roles in [maintaining your eye health](#). The levels of training and expertise—and what they are allowed to do for you—are the major difference between the types of eye care provider.

Ophthalmologists versus optometrists and other eye care providers

An **ophthalmologist** is a medical or osteopathic doctor who specializes in eye and vision care. Ophthalmologists must complete many more years of training than optometrists and opticians. As a result, ophthalmologists can diagnose and treat a wide range of conditions.

Here's how the role of ophthalmologists compares with other members of the eye care team:

- [Ophthalmologists](#)
- [Optometrists](#)
- [Opticians](#)
- [Ophthalmic technicians](#)
- [Ophthalmic technicians/technologists](#)
- [Ophthalmic registered nurses](#)
- [Ophthalmic photographers](#)

Ophthalmologists are eye doctors with advanced medical and surgical training

An ophthalmologist is a medical or osteopathic doctor who specializes in eye and vision care. Ophthalmologists differ from optometrists and opticians in their levels of training and in what they can diagnose and treat.

Ophthalmologists complete 12 to 14 years of training and education including medical school and are licensed to practice medicine and surgery. This advanced training allows [ophthalmologists to diagnose and treat](#) a wider range of conditions than optometrists and opticians. Typical training includes a four-year college degree followed by at least eight years of additional medical and surgical training.

An ophthalmologist diagnoses and treats all [eye diseases](#), performs eye surgery and prescribes and fits [eyeglasses](#) and [contact lenses](#) to correct vision problems. Many ophthalmologists are also involved in scientific research on the causes and cures for eye diseases and vision disorders. Because they are medical doctors, ophthalmologists can sometimes [recognize other health](#)

Find an Ophthalmologist

Enter ZIP Code

[Advanced Search](#)

Ask an Ophthalmologist

Search questions:

[Browse Answers](#)

Free Newsletter

Get ophthalmologist-reviewed tips and information about eye health and preserving your vision.

Email Address:

[Privacy Policy](#)

Exhibit 3: The Three O's of Eye Care



AMERICAN ACADEMY OF OPHTHALMOLOGY®

When It Comes To Your Eyes, Know Your “O”s!

Caring for your eyes takes a team of trained professionals. Each of these professions starts with the letter “O,” yet they are very different in terms of their training and knowledge.

Know your “O”s so you know who is trained to safely provide your eye care.

Eye Care Provider	Ophthalmologist Has MD or DO after name	Optometrist Has OD after name	Optician
	<ul style="list-style-type: none"> A medical (M.D.) or osteopathic (D.O.) doctor and surgeon specializing in all aspects of eye and vision care. Can do everything from eye exams to complex eye surgery. Understands all of a patient's medical needs, from skin infections to heart disease and cancer. Leads the eye care team (incl. nurses, technicians, medical assistants, optometrists and opticians.) 	<ul style="list-style-type: none"> A healthcare professional who provides primary vision care. Historically known as “refracting opticians.” They test and correct vision as well as diagnose, treat and manage vision changes. 	<ul style="list-style-type: none"> A technician trained to design and fit eyeglass lenses and frames, contact lenses and other vision-correcting devices. Opticians are not allowed to diagnose or treat eye diseases.
How many years of school/training?	12-13 years or more <ul style="list-style-type: none"> 4 years of college 4 years of medical school 4 years of residency training 1-2 years of optional fellowship training 	6 years <ul style="list-style-type: none"> 2 years of college 4 years of optometry school 	Varies by state <ul style="list-style-type: none"> high school diploma/GED Training or certificate program (depending on state)
What care can they provide?	Fully trained and licensed to diagnose and treat all eye conditions with medicine and surgery; medically/surgically trained to handle any possible complications after surgery.	Trained to perform eye exams and vision tests and prescribe and dispense eyeglasses and contact lenses. Also trained to detect certain eye problems and prescribe medications for some eye diseases.	Trained to fulfill lens prescriptions or orders from ophthalmologists or optometrists.
Are they a medical & surgical doctor?	Yes	No	No

For safety's sake, only surgeons should do surgery.

In the United States, each state can set its own regulations saying what optometrists are licensed to do for their patients. Only ophthalmologists—with their full medical and surgical knowledge and training—are qualified to make sure that patients get the right eye care, from the right provider, at the right time.

Protecting Sight. Empowering Lives.®

Exhibit 4: AMA Truth in Advertising Campaign

View the AMA's full document here: <https://www.ama-assn.org/system/files/2020-10/truth-in-advertising-campaign-booklet.pdf>



Status Report for Council Advisory Recommendation 23-10

Title: Public Perception of Ophthalmology – Are we ‘Eye Doctors’ or Ophthalmologists?

Report From: Dianna L. Seldomridge, MD, MBA – Secretary for Communications

Analysis:

The Council Advisory Recommendation submitted by the Texas Ophthalmological Association and co-sponsored by 21 other state societies highlighted the increasing challenge of scope battles and the ongoing problem of the need to educate state legislators regarding the differences between ophthalmologists and optometrists. The CAR suggests two possible solutions. First, the Academy should launch a public relations campaign to help legislators and the public understand the differences between the two professions. Second, model legislation should be developed requiring the disclosure of credentials if “Dr.” is used in front of a name.

Rating: 1 = Currently being addressed by the following AAO activities...

Report:

The Academy agrees that organized optometry has intentionally clouded the distinction between ophthalmologists and optometrists in advertising and testimony. The suggestions to examine how effectively we are countering this with our public communications and to consider potential actions through the legislative process both have merit. The Academy is pursuing them with the following actions:

- Working with the Governmental Affairs Division, the Communications and Marketing Division is developing various materials, including news releases, social media posts, op-eds, letters to the editor, digital advertising, and more, supporting the fight against the VA National Standards. The major blitz of activity will occur during the commenting period and may serve as a launch for ongoing efforts to distinguish the two professions to the public.
- At its June retreat, the Communications Secretariat spent a half day in a strategic session on a public campaign for the profession.
- As a result of that strategic session, a workgroup has been formed to develop a long-term comprehensive plan to evolve our library of materials (the tool kit) and to strategize on a public campaign.
- The Academy contracted with a PR firm to help create guidelines for members to generate best practices and impactful public and legislative communications. While designed specifically for the VA fight, it can be used more broadly.
- Academy Communications staff continue their ongoing work to promote the profession through dozens of news releases, patient stories, and hundreds of social media posts.
- The Academy has partnered with the American Medical Association to develop model state truth-in-advertising legislation that state medical and specialty societies can use to pursue action in their state legislatures. In addition, the Governmental Affairs Division has offered to assist and work with any state that wishes to pursue this legislation. The Academy further encourages state ophthalmology societies to partner with other medical specialty societies within their state to pursue truth-in-advertising legislation.

Rating: 0 = Recommend no action because... 1 = Currently being addressed by the following AAO activities... 2 = Good idea but cannot implement right now because... 3 = Implemented or will be implemented by...

- The Academy has endorsed the Truth in Healthcare Marketing Act (HR 896) at the Federal level, making it illegal to make misleading or deceptive claims about holding a state healthcare license.

The Academy is committed to partnering with state societies and pursuing these solutions. In addition, the Academy welcomes members' input on how it can improve existing materials and communications resources.