



## 2023 Council Advisory Recommendations

<b>23-01</b>	<b>Ensuring the Financial Health of State Societies</b> Indiana Academy of Ophthalmology	page 2
<b>23-02</b>	<b>Pediatric Ophthalmology Subspecialty Workforce Shortage</b> American Association for Pediatric Ophthalmology and Strabismus	page 4
<b>23-03</b>	<b>Study of the Ophthalmologist Workforce</b> American Association for Pediatric Ophthalmology and Strabismus	page 8
<b>23-04</b>	<b>Ensuring Virtual Options for National Meetings</b> Michigan Society of Eye Physicians and Surgeons	page 11
<b>23-05</b>	<b>Access to Pediatric Eyecare: Medicaid Disparity</b> Pennsylvania Academy of Ophthalmology	page 14
<b>23-06</b>	<b>Ethical Obligation of After-Hours Care</b> Minnesota Academy of Ophthalmology	page 17
<b>23-07</b>	<b>Distribution of Emergency Eye Care</b> Minnesota Academy of Ophthalmology	page 19
<b>23-08</b>	<b>Environmental Consciousness in Academy Meetings</b> Nebraska Academy of Eye Physicians and Surgeons	page 21
<b>23-09</b>	<b>New Approach Needed for Protecting Medicare Patient Access</b> Nebraska Academy of Eye Physicians and Surgeons	page 23
<b>23-10</b>	<b>Public Perception of Ophthalmology - Are we 'Eye Doctors' or Ophthalmologists?</b> Texas Ophthalmological Association	page 26

## **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

## **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.<sup>1</sup>

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.<sup>2</sup>

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.<sup>3</sup> Medicaid reimburses on average 72% of Medicare level.<sup>4</sup> 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.”<sup>5</sup>

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%22colId%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

## **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

## **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 CO<sub>2</sub>.<sup>1</sup> 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 CO<sub>2</sub>. 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 CO<sub>2</sub> 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.<sup>2</sup>

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.<sup>3</sup> In 2020, the AAO joined the Medical Society Consortium on Climate & Health to help mitigate medicine's contributions to climate change.<sup>4</sup> 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."<sup>5</sup> Women in science have reported that virtual options make conferences more accessible because they reduce financial and caregiving barriers.<sup>6</sup> 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.

#### References:

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](https://sustainability.ucsb.edu/sites/default/files/Draft_2016-CAP_2_1_2017.pdf) [Accessed January 4, 2023].
2. Meeting Attendance - American Academy of Ophthalmology. Available at: <https://www.aao.org/annual-meeting/meeting-attendance> [Accessed January 4, 2023].
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.
4. Survey: Most Ophthalmologists Support Efforts to Reduce Medicine's Big Carbon Footprint. American Academy of Ophthalmology 2020. Available at: <https://www.aao.org/newsroom/news-releases/detail/ophthalmologists-support-reducing-carbon-footprint> [Accessed January 4, 2023].
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

## **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.<sup>1</sup> 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.<sup>2</sup> Over half of the country's children are covered under Medicaid, but providers are not evenly distributed by state to meet population demand.<sup>1</sup> 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.<sup>3</sup> serving a population of more than 1.5 million children enrolled in Medicaid/CHIP.<sup>4</sup> 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.<sup>5</sup> 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.<sup>5</sup> In the setting of these economic hardships, approximately 30% of pediatric ophthalmologists have limited their Medicaid patients, which exacerbates the provider supply shortage.<sup>5</sup>

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 patients<sup>6</sup> and or are resorting to income generating practices outside pediatric ophthalmology<sup>7</sup> including laser in situ keratomileusis, facial treatments, and plastic surgeries.<sup>8</sup> 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
2. Lee KE, Sussberg JA, Nelson LB, Thuma T. In the Setting of Heightened Economic and Workforce Issues, What are the Third Year (PGY-4) Ophthalmology Residents’ Perspectives of Pediatric Ophthalmology? *J Pediatr Ophthalmol Strabismus*. In press.
3. State Health Care Snapshots: Pennsylvania. Kaiser Family Foundation. Accessed January 21, 2023. <https://www.kff.org/statedata/election-state-fact-sheets/pennsylvania/>
4. Medicaid State Fact Sheets. Kaiser Family Foundation. Published October 3, 2022. Accessed January 19, 2023. <https://www.kff.org/interactive/medicaid-state-fact-sheets/>
5. Lee KE, Sussberg JA, Nelson LB, Thuma T. The Economic Factors Impacting the Viability of Pediatric Ophthalmology. *J Pediatr Ophthalmol Strabismus*. 2022;59(6):362-368. doi:10.3928/01913913-20220817-01
6. Thuma TBT, Sussberg JA, Nelson LB, Schnall BM. Economic Impact of the COVID-19 Pandemic Post-Mitigation on Pediatric Ophthalmologists. *J Pediatr Ophthalmol Strabismus*. 2022;59(5):291-295. doi:10.3928/01913913-20220623-01
7. Lee KE, Sussberg JA, Nelson LB, Thuma T. Is There a Path for an Economic Turnaround in Pediatric Ophthalmology? [published online ahead of print, 2022 Nov 28]. *J Pediatr Ophthalmol Strabismus*. 2022;1-8. doi:10.3928/01913913-20221025-03
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



## **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

## **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

## **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 CO<sub>2</sub> per person per day. More heavily scrutinized events, such as the Paris Climate Talks, yielded approximately 300,000 tons of CO<sub>2</sub> 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 CO<sub>2</sub> 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 CO<sub>2</sub> 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 CO<sub>2</sub>. 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 CO<sub>2</sub> 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

## **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

## **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