

Erin P. Benjamin, DO
American Osteopathic College of Ophthalmology
Leadership Development Program XIX, Class of 2017
Project Abstract

Title of Project: *Maintaining Osteopathic Ophthalmology Retention Rate in American Osteopathic College of Ophthalmology (AOCO) and Increasing Awareness and Involvement in the AAO*

Purpose: Osteopathic ophthalmology member retention in the AOCOO may likely decrease in upcoming years in part due to the impending loss of many of our osteopathic ophthalmology residency programs as a result of the 2020 ACGME merger and the adoption of a single accreditation system. Currently, there are 14 osteopathic ophthalmology residencies, but only 5 of these programs have applied for ACGME accreditation. As we progress toward a single accreditation system, it is important to understand that the continued growth and success of our profession depends on the members of AOCO to realize the value in the membership and support of both our college and of the Academy.

Methods: Membership starts early, so it is important to reach out to our current residency program directors to encourage osteopathic residents and new graduates to become members of the AOCO and AAO. Residents are encouraged to become resident members from day one of residency and each program must send at least one resident to both annual meetings each year. Secondly, it is also important to highlight AOCO members who are actively involve in the AAO, such as in programs like the Leadership Development Program and Advocacy Ambassador Program. This can be accomplished via newsletters or presentations at the AOCO annual meeting. Lastly, planning a social gathering for osteopathic ophthalmologists at the AAO's annual meeting yearly is a great way to continue networking and enhance camaraderie among our members.

Results: Osteopathic ophthalmology residency program directors meet yearly in January. Before this meeting, the directors will be contacted regarding encouragement of their residents to become members of both societies. As of today, the results are still pending. As an LDP participant, I will be speaking to the AOCO executive committees and board of governors at our mid-year meeting about my experiences. As part of our annual meeting next spring, we will incorporate lectures into the general membership program about LDP/Advocacy Ambassador Programs. Lastly, a date and place for an AOCO membership meet-up has yet to be determined for the 2017 program, but will likely be discussed at our upcoming mid-year meeting. If not 2017, a date and place will be determined for 2018.

Conclusions: Though it will be difficult to measure how these actions will directly affect membership sign-up and retention in both the AOCO and AAO, they will only help in highlighting the importance in involvement. As the number of practicing osteopathic ophthalmologists will likely be decreasing in the near future it is important to develop lasting relationships with each other in the AOCO and to be as involved as possible with the AAO.



Suzanne M. Falkenberry, MD
Wisconsin Academy of Ophthalmology
Leadership Development Program XIX, Class of 2017
Project Abstract

Title of Project: *Wisconsin Academy of Ophthalmology Early Eye Drop Refill Bill in Cooperation with the Wisconsin Optometric Association*

Purpose: We would like Wisconsin to become the next state to approve an early eye drop refill bill – that is allow authorization to fill prescription eye drops at 70% of the expected days of use. This legislation will provide protections for patients who rely on prescription eye drops for preservation of sight. We would like to work in conjunction with the state optometry society to facilitate passage of the bill and also foster a future relationship among the organizations.

Methods: A concept paper explaining the importance of an early eye drop refill bill was written. We reached out to the leadership team of the Wisconsin Optometric Association and then met with their executive director, lobbyist and president to discuss the potential bill and gain their approval. The Wisconsin Medical Society circulated a copy of our concept paper at its annual Doctor Day to gain acceptance and understanding from the general medical community. Our lobbyist then contacted several lawmakers to draft the bill.

Results: 1. The bill draft has been written and legislative sponsors are being recruited. We expect the bill to be introduced before the end of the year, with the goal of having the bill passed and signed by the Governor before the end of the current legislative session.
2. After the successful meeting with the optometrists regarding this bill, we held a formal dinner meeting with two leaders from each group as well as with both executive directors. We learned about our respective organizations and discussed our mutual interests regarding eye care and various legislative agendas both current and future.

Conclusion: Patience is paramount with legislation. We are optimistic that this bill will be passed during this legislative session which will end in February 2018. Our meeting with the optometry group was extremely well received and congenial. We plan to have an annual spring dinner meeting among the executive directors and a few leaders from each organization.



Robert G. Fante, MD, FACS
Ophthalmic Mutual Insurance Company
Leadership Development Program XIX, Class of 2017
Project Abstract

Title of Project: *Malpractice Experience Among Oculofacial Plastic Surgeons: Closed Claims Analysis 2006-2016*

Background: Data are lacking on the types, size, and outcomes of medical malpractice claims brought against physicians who practice the ophthalmic subspecialty of oculofacial plastic surgery.

Methods: We analyzed malpractice data from 2006 through 2016 for all ophthalmologists covered by the largest nationwide professional liability insurer specializing in exclusively ophthalmology (4,868 physicians and 47,332 physician-years of coverage) for claims related to oculofacial plastic surgery. For this subspecialty, we reported the nature of the claims, the types of associated medical care, and the proportion of claims leading to an indemnity payment when stratified by categories of medico-legal issues.

Results: Over this period, we identified 185 closed claims related to oculofacial plastic surgery out of a total 2,456 closed claims. Claims were most commonly related to eyelid surgery or cosmetic treatments, and cosmetic dissatisfaction claims accounted for 41%. Indemnity payments were made for 25% of overall claims, but 2.7% of cosmetic dissatisfaction claims, 13% of recognized complication claims, 30% of diagnostic error claims, 83% of below standard of care claims, and 100% of informed consent claims. When one was made, the median indemnity payments for each category were \$13,820 for cosmetic dissatisfaction, \$40,500 for recognized complications, \$446,000 for diagnostic error, \$107,000 for treatment below the standard of care, and \$160,000 for informed consent claims.

Conclusions: The likelihood of an indemnity payment for a malpractice claim related to oculofacial plastic surgery in this cohort was much lower for claims limited to cosmetic issues than for claims related to medical error, diagnostic error, or failure to obtain proper informed consent. The size of cosmetic indemnity payments was also much lower, although legal and administrative costs were often substantial for all categories of claims.

John M. Franklin, M.D.
Kentucky Academy of Eye Physicians and Surgeons
Leadership Development Program XIX, Class of 2017
Project Abstract

Title of Project: *Access to Laser Eye Surgery After Expanded Optometric Scope in Kentucky*

Purpose: To determine the proximity of each patient undergoing a laser surgical procedure in Kentucky by an optometrist to the nearest ophthalmologist who performed the same procedure. In 2011, Senate Bill 110, titled "Better Access to Quality Eye Care" was passed, allowing increased scope of practice for Kentucky optometrists. A primary argument for the passage of this bill was that access to laser surgical procedures would be significantly improved.

Methods: The addresses of ophthalmologists and optometrists performing YAG capsulotomy, laser trabeculoplasty, and/or laser peripheral iridotomy in Kentucky in the Medicare population were obtained from the 2015 Medicare Provider Utilization and Payment Data from the Centers for Medicare and Medicaid Services. These addresses were assumed to be the location at which the laser procedures were performed. For each procedure performed by an optometrist, the exact distance and driving time to the nearest ophthalmologist who performed the same procedure that year was calculated based on data from Google maps and the OpenStreetMap project.

Results: In Kentucky during 2015, there were 11,218 total procedures of the above descriptions performed in the Medicare population. Of these, 1,403 were performed by optometrists. For each procedure, the patient was an average of 6.69 miles or 8.63 minutes driving time from an ophthalmologist who performed the same procedure that year. A total of 1,019 procedures were performed in the same city and 746 procedures were billed from the exact same address as an ophthalmologist who performed identical procedures.

Conclusion: Among Medicare recipients, the majority of laser eye procedures performed in Kentucky by optometrists are done in very close proximity to an ophthalmologist performing the same surgery. More than half the procedures performed by an optometrist were billed from the same address as an ophthalmologist who also performed the procedures. Based on this data, there has been minimal increase in access to these procedures by increased optometric scope of practice.



Kathleen B. Gordon, MD
North Carolina Society for Eye Physicians and Surgeons
Leadership Development Program XIX, Class of 2017
Project Abstract

Title of Project: *Evaluation of the reporting of choroidal and ciliary body melanomas to the North Carolina Central Cancer Registry*

Purpose: Hospitals in North Carolina are responsible for reporting cases of cancers including ocular tumors to the North Carolina Central Cancer Registry (NCCCR). Recently there has been significant concern about the possibility of an increase in the incidence of uveal melanoma in one region in North Carolina. Data available through the NCCCR did not support this suspected change. A preliminary investigation discovered that there were relevant cases missing from the NCCCR database. The purpose of this study is to determine whether there are gaps in reporting cases of ocular tumors to the NCCCR and if so, to determine the causes.

Methods: This study was performed at the University of North Carolina at Chapel Hill (UNC.) An IRB approved chart review was performed to evaluate the completeness of reporting tumors of the eye and ocular adnexa diagnosed, treated and/or followed at UNC to the NCCCR. ICD9 and ICD10 codes were used to identify cases seen between 2006-2016. The tumor registrars at UNC provided a list of patients diagnosed, treated and/or followed at UNC with a diagnosis of all ocular cancers who were reported to the NCCCR between these same dates. For the purposes of this study we focused on the reporting of choroidal and ciliary body melanoma cases seen at UNC between 2010-2015. The two lists were compared and discrepancies noted.

Results: There was a significant gap in the number of choroidal and ciliary body melanoma patients cared for at UNC and those reported to the NCCCR. Based on ICD 9 and 10 codes, there were 66 patients diagnosed, followed and/or treated with ciliary body or choroidal melanomas at UNC between 2010 and 2015. Of those, only 41 were reported through the UNC Cancer Registry to the NCCCR. The State Registrars reviewed the missing cases and identified 2 of them in their database that may have been reported through another entity. Therefore, 23 of 66 cases were not reported to the NCCCR.

After meeting with the tumor registrars at UNC, there were several barriers to complete reporting identified.

Imaging protocols: For confirmation of disease, registrars look for the results of diagnostic tests such as MRIs and CTs. At UNC where Epic is utilized as the Health Care System's EMR, tumor registrars looked for imaging results under the 'Imaging' tab. If there was nothing reported there, the patients were sometimes excluded because of 'lack of imaging'. On further review, all of the cases excluded for this reason had diagnostic ultrasounds. At our institution, the results of the ultrasound are reported directly in the patient note.

Lack of pathology: The lack of pathology is a significant barrier. Uveal melanomas are often diagnosed based on clinical exam and ancillary testing. Tumor registrars look for confirmatory biopsies. Unless a patient was enucleated, pathology was not available and some patients were excluded for this reason.

Language used by the physician in the patient record: If the patient's record stated that a tumor was referred to UNC because of a 'suspected melanoma' and the diagnosis was confirmed at the UNC, the tumor was considered to have been 'diagnosed' at the practice of the referring physician. Though not consistent with what is stated in the NCCCR reporting manual, these tumors were sometimes but not always excluded. Unless the referring practice (likely outpatient) was linked to a tumor registry, the case would not have been reported to any entity.

Kathleen Gordon, MD

Evaluation of the reporting of choroidal and ciliary body melanomas to the North Carolina Central Cancer Registry

Registrars look for language such as 'no evidence of disease'. Describing a treated melanoma as a 'stable tumor' created confusion and the case might have been excluded for this reason.

One patient was not considered to have uveal melanoma because there was mention of ciliary body involvement.

Though outside of the scope of this study, there were other 'language barriers.' The registrars do not report skin tumors to the NCCCR. However, patients with conjunctival tumors, such as conjunctival squamous cell carcinoma, were excluded because these were believed to be skin tumors.

Residence at time of diagnosis: Some tumors were excluded because the tumors were treated but not diagnosed at UNC but this was not consistent. Some tumors were excluded because they were diagnosed but not treated at UNC but this was not consistent. The North American Association of Central Cancer Registries' National Interstate Data Exchange Agreement allows North Carolina to exchange data on cancer cases diagnosed or treated in surrounding states but this was not utilized with regard to uveal melanoma.

Conclusions: The North Carolina Central Cancer Registry (NCCCR) is responsible for collecting data for all cancer cases diagnosed or treated in North Carolina. The data is used for research to investigate the causes of cancer and to evaluate geographic and behavioral risk. The data is also used by state and county health departments to target resources for health education and screening services. In addition, national organizations (CDC's National Program of Cancer Registries and the North American Association of Central Cancer Registries) pool the data for national estimates of cancer incidence.

According to the North Carolina Central Cancer Registry 2016 Cancer Collection and Reporting Manual: "North Carolina facilities are legislatively mandated to report any case of cancer meeting the North Carolina definition, regardless of affiliation or Class of Case. If your facility participates in the diagnosis, staging, treatment or continuing care for a patient during the first course of treatment, progression of disease or recurrence the case must be reported to NCCCR. Rigorous data quality standards apply to all cases, regardless of class of case or type of reporting source." [From p. 23 *North Carolina Central Cancer Registry 2016 Cancer Collection and Reporting Manual*, <http://www.schs.state.nc.us/schs/CCR/docs/CCARM2016.pdf>]

Nearly one third of cases of ciliary body or choroidal melanomas evaluated at UNC between 2010 and 2015 were not reported to the state cancer registry. It is unlikely that these cases were accounted for in other registries that contribute to the pooled national cancer data. Because UNC is one of the 3 major centers in North Carolina to which uveal melanoma patients are referred, it is likely that uveal melanoma cases are significantly under-reported in our state. Based on the data contained in the NCCCR at this time, it is difficult to know if there are changing patterns in the demographics of uveal melanoma in North Carolina.

Future studies will focus on:

- 1) Increased collaboration between physicians and registrars in order to improve the process of abstracting cases and ensure complete reporting
- 2) The development of a uniform process to be used by the 3 major referral centers for ocular tumors in North Carolina
- 3) Improved data sharing about tumors of the eye and ocular adnexa diagnosed or treated across state lines.



Natasha L. Herz, MD
Washington DC Metropolitan Ophthalmological Society
Leadership Development Program XIX, Class of 2017
Project Abstract

Title of Project: *Improving Community Ophthalmic Care through Urgent Care Eye Exam*

Purpose: Provide training to urgent care providers to improve their ability to assess and diagnose the red eye, enabling more accurate and appropriate referral to ophthalmology and avoiding unnecessary delays in treatment.

Methods: A power point presentation was developed to teach the urgent care provider what signs and symptoms to document, how to perform an eye exam with the equipment available in the typical urgent care setting, and when urgent referral to an ophthalmologist is necessary. Urgent care centers in the immediate 10-mile radius were contacted to offer this education to their providers free of charge.

Results: Increasing demand for access to urgent care with decreased wait times and increased after-hour availability has triggered the development of urgent care centers and minute clinics across the Washington DC Metro area. Unfortunately, the training of urgent care providers to conduct eye examinations is quite variable. Subsequently many patients are misdiagnosed and improperly treated for serious eye conditions including herpes keratitis and dermatitis treated with steroids, unrecognized corneal foreign bodies treated as "pink eye," bacterial keratitis treated as "pink eye," and iritis treated as "pink eye." I found 25 urgent care clinics in my immediate 10-mile radius and contacted them to offer my Eye Exam for Urgent Care course. Three of them chose to have me give this presentation to them and felt they were much better equipped to assess ophthalmic complaints. Since my presentation, I have received multiple calls from these centers and was able to give them much better advice regarding appropriate treatment and follow-up because they had performed a quality urgent eye exam.

Conclusions: The demand for after-hours care has brought a large number of urgent care centers into the Washington DC Metro area. In an effort to maintain a high quality of eye care with this model and continue to keep ophthalmologists as leaders of the eye care team, the Eye Exam for Urgent Care course will continue to be offered to the local urgent care centers. I will encourage the members of the Washington DC Metro Ophthalmology Society to join in this effort as it is beneficial to our community and indirectly to our advocacy efforts.

Catherine J. Hwang, MD FACS
American Society of Ophthalmic Plastic and Reconstructive Surgery (ASOPRS)
Leadership Development Program XIX, Class of 2017
Project Abstract

Title of Project: *ASOPRS Match Timing Survey*

Purpose: The ASOPRS fellowship match has traditionally occurred in April of the 2nd year of ophthalmology residency. The purpose of this project was to gather opinions on the timing of the ASOPRS fellowship match through a computerized survey.

Methods: Computerized surveys on surveymonkey.com were designed separately for ASOPRS members, residency program directors, and residents to gather their thoughts on the timing of the fellowship match. All responses were anonymous and gathered over a 3.5 week period (5/21/17-6/16/17). Reminder emails were sent periodically. The ASOPRS surveys were sent directly to the ASOPRS member list, the residency program director survey was sent thru a resident program director, and the residents through the residency program directors.

The surveys asked respondents customized questions as well as the main question on the timing of the ASOPRS match in 3 ways to verify responses: 1) Do you think the ASOPRS match should be moved later: yes/no (2 option) 2) The ASOPRS match should be: current time, earlier than others, same time as other fellowship matches (3 option) 3) The ASOPRS match should be: which month (multiple option). Demographic information was taken from each survey respondent, including years in practice, year in training, and for ASOPRS members whether they were a fellowship program director or preceptor, fellow in training, or not related to a fellowship training program.

Results: The survey response rates gathered were: ASOPRS 45% (ASOPRS fellowship director response rate 88%), residency program directors 34%, and resident 6%. Approximately 90% of the residency program directors and residents thought the ASOPRS match should be moved later (92% residency program directors thought same time as other fellowships; 76% residents thought same time as others, 17% thought earlier). This response was consistent through the 3 questions.

With ASOPRS members, 1/3 thought the fellowship match timing should stay the same and 2/3 thought the ASOPRS match should be moved later, with approx. 45% at the same time as other fellowship matches and 20% earlier than others. This response did not change with years in practice. However, there was a big difference if the member was an ASOPRS program director (not fellow in training, ASOPRS not assoc with fellows, or ASOPRS preceptor). The ASOPRS program directors had a strong preference to keep the current match date (67% no change).

Conclusions: The ASOPRS fellowship match has traditionally occurred earlier than other ophthalmology fellowship match programs. According to our anonymous survey, 90% of the residency program directors and residents would like to have the ASOPRS fellowship match moved later. The ASOPRS members were split 1/3 to stay the same and 2/3 to move the date later. The main difference in the survey was found in the ASOPRS fellowship directors, whose majority wished to have the ASOPRS match timing at the current date.

****This survey was presented to the ASOPRS Executive Committee and ASOPRS fellowship directors at our Spring meeting in 6/2017. The result was a vote from the ASOPRS fellowship directors to keep the current timing the same but to investigate whether moving the match to a slightly later time may be possible****



Stacey J. Kruger, M.D.
American Academy of Pediatrics, Section on Ophthalmology
Leadership Development Program XIX, Class of 2017
Project Abstract

Title of Project: *Amblyopia Awareness Month and Vision Screening*

Purpose: To create a public and professional awareness campaign regarding the importance of preschool vision screening and its significant role in the early detection of amblyopia. By creating and cataloging materials this program can be recreated by ophthalmologists, pediatricians and other health care providers and/or groups who wish to organize such events.

Methods: As a result of collaboration between a state ophthalmology society and its PR firm, local pediatric groups, local legislators, local University (ies) and existing non-for-profit vision screening groups, a resolution was drafted and presented to the state legislature. Once "Amblyopia Awareness Month" was approved a multi-month project outline was created which culminated in participation by various groups three state-wide vision screening events.

Results: Amblyopia Awareness Month (FL Senate Resolution 844) raised awareness on a state-wide level about the importance of preschool vision screening. Three well publicized, state-wide, vision screening events were held at which over 200 preschool-aged children were screened. Follow up care for patients needing additional evaluation was arranged. Coverage by local media was obtained by holding a press conference with local legislators, developing marketing and other needed materials, as well as from local print and TV journalism coverage at each event.

Conclusions: A resolution declaring a state-wide amblyopia awareness month can be an excellent way to introduce the importance of preschool vision screening to legislators, health care professionals and the public at large. With the proper equipment and coordination amongst state ophthalmology and pediatric societies, as well as non-for-profit groups, existing resources for vision screening can be combined in strategic and cost effective ways to both provide care to needy patients as well as highlight the need for state-mandated preschool vision screening examinations. In addition, these types of proactive vision screening/amblyopia awareness campaigns and corresponding legislative efforts are difficult to oppose from a public relations perspective. In this regard they can help to stall and/or prevent other groups that favor mandated comprehensive eye exams from obtaining a foothold in local communities and amongst politicians who may be uninformed about the differences between vision screenings and comprehensive eye exams.

A Look at the Reality of Spectacles Being Prescribed In “Normal” Preschool Children

Steven J. Lichtenstein, MD, FAAP

In this edition of the journal, an excellent article, “How Often Are Spectacles Prescribed in ‘Normal’ Preschool Children” by Sean Donahue, M.D., Ph.D., is presented. For those of us who attended the AAPOS Annual Meeting in Washington, D.C., the presentation of the paper was a sobering glimpse into the “real world” of everyday “medicine” as being practiced by a vast majority of “eye doctors” today. Having the opportunity to actually read the manuscript carefully was a very disturbing experience. Actually seeing in black and white what many of us pediatric ophthalmologists have suspected was bothersome, at best, and infuriating, at worst. Practicing pediatric ophthalmology in the only state in the country that has enacted legislation mandating comprehensive examinations for children entering into the educational system has been a rude awakening into the “practice” of medicine. Having legislation on the books that dictates the practice of medicine is a very uncomfortable situation. The discomfort escalates when you start to question whether the law is merely a political football that is being used, inappropriately, by a special interest group, strictly for its entrepreneurial effects.

However, are we possibly taking a slanted view? Is the fight against this type of legislation really just a “turf battle,” being waged only because the “other side” supports it? Unfortunately, Dr. Donahue’s paper shows us that our fight is not a turf battle, but instead, a battle for the correct reasons, our patients and our economy.

Let’s admit one thing right from the outset. Among other reasons, all of us went into medicine to make a living, to support ourselves, and to provide for our families. Our practice of medicine is a business and we practice medicine to make money. However, medicine is not a business like any other business in this country. Our “practice of medicine” is also an art, and a calling. When a corporation looks at business strategies, they look at what is going to affect their bottom line. What will their profit margin be, and what will be the effect on their stockholders? If we were to practice medicine by the same standards, none of us would be fighting the continual barrage by organized optometry and the Vision Council of America (VCA), state after state, to pass more mandatory compre-

hensive exam bills. Since 2000, when the Kentucky law was passed, I have seen hundreds of children who needed their “eye forms” filled out before they could enter school. These were mainly routine exams with no pathology—a one-time, usually quick, visit that the parents frequently had to pay cash for, since routine exams are not covered on most insurance policies. So, I have made money from the law in my state. I routinely do not see the kids on Medicaid for the mandated exams. Since I am a specialist, Medicaid patients can only be seen in my office with a medical diagnosis. However, I can see these children for a second opinion and thus have seen numerous Medicaid kids who went to an optometric mill, walked out with glasses, and then refused to wear them. When checked, these children did not have any ocular problems and their glasses were no stronger than your car windshield. What I have seen in my practice mirrors the scientifically acquired results that Dr. Donahue is publishing in this issue of the journal.

Over the past two years, articles have run on the front page of the newspapers in both Louisville (*The Courier-Journal*) and Cincinnati (*The Cincinnati Enquirer*). One article reported that the number one Political Action Committee in the State of Kentucky, which used to be Churchill Downs, was now the Kentucky Optometric Association. The KOA gave \$60,000 to politicians in the state between October 1 and December 31, 2002; Churchill Downs only gave \$41,000.¹ The second article reported that more than 1400 Kentuckians cared for in nursing homes were no longer eligible for Medicaid benefits, and between April and July 2003, the state had “decertified” or denied admission to 198 nursing home residents, all because of a shortfall in Medicaid funding.² Yet, thousands of dollars are being wasted on unnecessary mandatory comprehensive eye examinations, and thousands more are being wasted on useless, unnecessary glasses. If you think this is going to be limited to Kentucky, or Tennessee, or even the mid-West, you are sadly mistaken. The crisis in the healthcare dollar is a national dilemma.

Now read Dr. Donahue’s paper and see how “eye doctors” who benefit financially from mandatory comprehensive eye exams will have our medical system incur a cost of over \$200,000,000 annually, and that is only for the unnecessary spectacles, not taking into consideration the cost of the examinations themselves. If all of those zeros are hard to read, this might put it into better perspective: that is one-fifth of a billion dollars a year! That is money that will be taken away from our seniors in nursing homes.

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That is money that could be used to subsidize drug benefits for our seniors, or money that could be used to subsidize healthcare for the uninsured or under insured children who have been diagnosed with a true ocular problem and need continued treatment, or surgery, but whose parents are unable to continue their needed care because of financial constraints.

The law in Kentucky states that the comprehensive eye exam must be done by either an optometrist or an ophthalmologist, as there are no other medical professionals or allied health personnel that can detect correctable ocular problems. This removes the pediatrician and the family practitioner from taking care of their patients, removing them from what the American Academy of Pediatrics terms their "Medical Home." This takes asymptomatic, unscreened children and forces them into a healthcare delivery system where they can be prescribed a pair of unnecessary glasses, one step stronger than window glass, because they "won't hurt them." This "reason" for prescribing glasses is now even being challenged by some academicians, both in ophthalmology and in optometry,

because of their possible retardation of emmetropization. Maybe they are not as innocuous as some believe.

So, do we sit back and make money because of a law that mandates an increase in the patient traffic in our offices, quickly seeing hundreds of children routinely without pathology, and increasing our profit margins, functioning as any other "business"? Or do we think back about why we chose medicine as a career, and especially the subspecialty of treating children, which we knew would put us financially on the bottom rung of the eye care ladder? I think by reading the results of Dr. Donahue's excellent research into this situation it becomes quite clear. We really have no choice but to fight this battle to protect our children, our seniors, and ourselves, as one-day recipients of the dwindling medical dollar, from abuse of the system in the guise of protection for our children.

References

1. <http://www.courier-journal.com/localnews/2002/01/13/ke011302s137259.htm>.
2. http://www.enquirer.com/editions/2003/08/19/loc_wwwkymed19.html.

Sample Legislation (AAPOS)

Pediatric Screening Model Legislation

Children's Vision Education Act

An act relating to early school vision screenings providing for the adoption of rules; providing an effective date.

Be it enacted by the State of _____:

Section 1. New law. A new section of law to be codified in the (insert state and appropriate code reference) Statutes as Section ____ of Title _____, reads as follows:

(1) (a) Within 30 days of the start of the school year at a public, private, parochial or nonpublic school in this state, including special education and home education programs and cyber and charter schools or upon entry into the school district, the parent or legal guardian of each child entering kindergarten shall present to school health personnel certification that the child within the previous 12 months passed a vision screening performed by a primary care provider, or a vision screening conducted by screeners with specific training in vision screening techniques and protocols approved by the Department of Health, or has completed a comprehensive eye exam conducted by an ophthalmologist or optometrist. The Department shall promulgate regulations to establish vision screening standards based on instrument-based vision screening technologies, visual acuity testing or both, taking into consideration available established national guidelines (such as those of the American Academy of Pediatrics).

(b) Every school year at a public, private, parochial or nonpublic school in this state, including special education and home education programs and cyber and charter schools until the child completes the 5th grade and every two years thereafter (i.e. typically grades 7, 9, and 11) until the child graduates from the 12th grade, every child should have a vision screening performed by school health personnel or screeners, with specific training in vision screening techniques and protocols approved by the Department of Health. The results of the vision screening should be supplied to the parent or legal guardian of each child. Parents or legal guardians may opt out of the required in-school screenings for their children by providing written request but shall be asked to provide notification that comprehensive eye examination has been completed.

(2) (a) For those individuals who fail a required vision screening, a comprehensive eye examination, performed by an ophthalmologist or optometrist, shall also be required. Notification of the parent or legal guardian of the failed screening should be accompanied by notification of requirement for a comprehensive examination, which must be completed within 120 days or before the start of the next school year, whichever comes first. Notification should also include a form, to be completed by the examining ophthalmologist or optometrist, to be used for reporting the results of the examination.

The report shall include, but not be limited to, the following:

- a. Date of report;
- b. Name, address and date of birth of the child;
- c. Name of the child's school;
- e. A summary of significant findings, including best corrected visual acuity, diagnoses, treatment, prognosis, whether or not a return visit is recommended and, if so when;
- f. Recommended educational adjustments for the child, if any, which may include the following: preferential seating in the classroom, eyeglasses for full-time use in school, eyeglasses for part-time use in school, sight-saving eyeglasses or any other recommendations;
- g. Name, address and signature of the examiner.

The report of the examination shall be accompanied by an envelope for return of the form to school health personnel so the completion status and result of the examination can be recorded.

(b) No child shall be excluded from attending school for a parent's or guardian's failure to furnish a report of the child's vision screening, failure to notify that a comprehensive eye examination has been completed if the parent or legal guardian opts out of a required school vision screening, or for failure to have an examination completed upon failure of vision screening. Parents and guardians that fail to present the required report shall be notified in writing of the required vision examination every 3 months until it's completion has been verified.

(c) Enforcement of the provisions of this Act shall be performed by the Secretary of Education. The department shall issue a report annually on the impact and effectiveness of the law, including rate of screening completion and rate of completion of examinations following failed screening.

(3) Any blanket or general policy of insurance which is delivered or issued for delivery within or without the state and which covers residents of the state shall provide coverage for a vision screening for children conducted by a primary care provider as required in Section 1 of this bill. Coverage shall also be provided for confirmatory comprehensive eye examination for children who fail a vision screening.

(4) The Department of Health shall develop within 120 days of the effective date of this Act, an educational fact sheet that provides information about the pre-school vision screening requirements and distribute the factsheet to the offices of primary care providers and private and public preschool programs licensed to operate in the state.

(5) This Act shall become effective on (insert date).

SAMPLE CONSENT FORM



In Partnership with the Lions
of Florida and the Bahamas



Corporate Address

4340 W. Newberry Road – Suite 301
Gainesville, FL 32607

Administrative Address

833 NW 45th Terrace
Gainesville, FL 32605

Consent Form

(Note: Screening is not necessary if your child is currently under the care of an eye doctor.)

Dear Parent/Guardian:

Free vision screening will be offered to your child by your local Lions Club in association with the Florida KidSight Foundation. The screening is performed by use of a photo-screener that takes a picture of your child's eyes and digitally determines if a potential eye problem that causes amblyopia (lazy eye that may lead to blindness) exist. No physical contact is made with you child and eye drops are not used.

1. Information (Please print)

Child's Name: _____ Date of Birth: _____

Gender (Circle): Male or Female Email Address: _____

Full Mailing Address (including city and zip code): _____

Parent/Guardian Authorization

I understand the following regarding the free screening and give permission for my child to be screened:

- a. It is not a full eye examination, thus, not all eye problems can be detected during the screening. If my child requires more care, I will be responsible for making such arrangements.
- b. This form, along with the eye measurement data, will be forwarded to the Florida KidSight Foundation office when the screening instrument gives a "refer" or "inconclusive" result. When a "passed" reading is given, no data or information is forwarded.
- c. If my child's screening results are forwarded to the Florida KidSight Foundation office for verification and follow-up, I will receive a letter outlining actions to be taken along with the results of the screening.
- d. If my child's screening results reveal a vision problem and my child receives a full eye exam by an eye doctor, the examining doctor is authorized to share the results with the Florida KidSight Foundation staff for verification and correlation purposes.
- e. Screening data are maintained in a database for follow-up purposes and to produce aggregate reports of total children screened and referred, as well as to record the number of inconclusive results.
- f. All information given, and results of this free screening, will be kept confidential.
- g. The Lions Club representatives conducting the screening will not be held accountable or liable for any errors of commission, omission or other misdiagnosis as they are volunteers involved in providing humanitarian service to their community.

Print Name: _____ Telephone Number: () _____

Signature: _____ Date: _____

2. Screening Action (To be completed by the Lions Club volunteer)

Passed ____ (Unable to detect a vision problem at this time.)

Referred/Inconclusive ____ (Forwarded to the Florida KidSight Foundation for further evaluation.)

Unable to Screen ____ (Child is crying, shy, wiggly, etc. and cannot obtain a photo)

Telephone Number: 352-215-3504 ---- Fax Number: 352-240-6199
(Corporate and Administrative Offices)



Eagle Eye says:



"It's fun to get your eyes screened!"

PROTECTING THE VISION OF FLORIDA'S FUTURE™

August is Amblyopia Awareness Month...

FREE Vision Screening Preschool Children

Saturday, August 15

10AM-2 PM

Olinda Park

2101 Northwest 51st Street
Miami

*****A special appearance by Eagle Eye himself will be made! *****

The vision screening will be held in conjunction with the

Annual District 3 Fun Day

Sponsored by Miami-Dade County Commissioner Audrey Edmonson

Special Thanks to the supporters of this screening



For Eye Care Foundation, Inc.

Living Horizons- Protecting Vision

www.mdeye.org

@ Eagle Eye FSO

Website: www.swflionsvisionscreening.org

You can schedule screenings for your county by going on this website and entering your county and fill out a screening and equipment request form. The county coordinator will approve the scheduling and avoid conflicts.

Scheduling:

Timeline

Plan 4 weeks for screening -Set-up to follow-up.

3 volunteers are needed.

Pre-Screening

4 weeks prior to screening: Call Child Care Center or send letter

- Children ages 1 through 5, no 6 year old + children
- Screening Time – morning; avg. 20 children/hour
- Quiet room, controllable lighting, table
- Child care staff assist in managing the children
- Organized site
- Schedule screening instrument

1-2 weeks Prior to Screening: Send to Child Care Director

- An informational letter explaining how the child care director can facilitate the smooth running of a screening.
- copy of consent/result form for each child
- place a reminder poster at the center door

24 Hours Prior to Screening:

- Obtain screening instrument; make sure it is charged if necessary
 - Forms
- Take extra Consent/Result forms and a **Vision Cover Sheet Or Computer with data sheet**

Consent form (see attachment)

Please stress the need for children to receive vision screening only every two years.

Discourage vision screening for children currently under treatment.

Announcement Poster in Child Care Center

FREE VISION SCREENING

SCHEDULED FOR:

(DATE)

PLEASE TURN IN YOUR CONSENT FORM **TODAY!!!**



A simple picture is all that is needed to screen for most problems that cause poor vision in young children, such as **amblyopia**, **strabismus**, **cataracts**, **hyperopia**, **astigmatism**, and **anisometropia**.

Using the PlusOptix

The PlusOptix is a simple, non-invasive vision screening solution. If you put the following directions into practice, you should have a very successful Vision Screening program.

Screening Distance:

- The distance from the front of the camera to the patient's eyes is One (1) meter, or 3.3 feet.

Light in the room:

- It is important to setup your PlusOptix is in an area that does not have direct sunlight or is lit by a halogen light source (bulb that put off heat). Any light source that produces heat will interfere with the screening results.
- Fluorescent lighting is ok for screening, but may make the patients pupils small. If the software tell you "pupils too small" or "pupils not found", try dimming the lights to help dilate the pupils to an adequate pupil size (between 4 and 8 mm).

Screening Stance:

- Keep the handheld device at "eye" level with the patient's eyes – not above or below so as to get the most accurate reading.
- You may sit or stand while screening, whichever is more comfortable and allows you to get the best angle and distance.
- It is sometimes best to stand for this allows you to adjust your distance to the patient with ease.

Distractions:

- Try to minimize all external distractions so that the child will watch the handheld device and their eyes will be focused straight ahead.
- Position the patient so that they cannot directly see the laptop screen.

Vision Screening Cover Sheet

A. Vision Screening Site Information

(Results will be mailed to this address.)

1. Date: _____
2. Screening Site: _____
3. Address: _____
4. City & Zip-code: _____
5. Contact Person: _____
6. Phone: (____) _____
7. E-mail: _____

B. Preliminary Screening Results

1. Number of Children: _____
2. Length of Screening (minutes): _____
3. Instrument Serial No. _____

C. Lions Club Information:

1. Lions Club Contact: _____
2. Address: _____
3. City & Zip-Code: _____
4. Club _____
5. Telephone Number: _____
6. E-mail: _____
7. Photographer: _____
8. E-mail: _____
9. District: _____

10. Supervisor in attendance: _____

Please send the Consent/Results form, along with all measurement forms, to:

KidSight Administrative Office

1701 SW 16th Avenue, Building B

Gainesville, FL 32608

Post-Screening

Thank You

Please send a thank you letter to the staff at the screening site.

FOLLOW UP

Complete follow-up from START to FINISH is the backbone of the KidSight of Florida and The Bahamas KidSight Screening Program.

KidSight Office: Follow-up Procedure

Follow-up Referrals (KidSight Administrative Center)

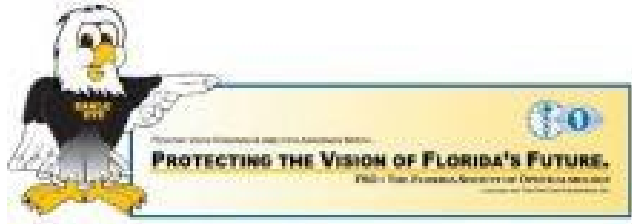
- 1) Organize results and return to preschool
- 2) Return a “referral packet” to the parents of referred children
- 3) Call parents (2-3 wks. after screening)
- 4) Record contact results
- 5) Fax evaluation sheet to eye doctor
- 6) Track appointment information

SAMPLE EVENT PLANNER

- 7) Evaluation packet reviewed by medical director after exam
- 8) Record diagnosis and treatment

Fla. Senators Join Eye Docs, Mascot to Launch Awareness Campaign

June 27, 2015



(MIAMI & PALM BEACH)—Fewer than 20 percent of preschool kids are currently being screened for vision problems despite serious, but treatable, eye disorders found in young children. Recognizing this fact, the Florida Society of Ophthalmology (FSO)—**joined by two Florida senators, Joseph Abruzzo (D-Boynton Beach) and Maria Sachs (D-Delray Beach)** - launched its first-ever pediatric vision screening awareness campaign: August's Amblyopia Awareness Month, as designated by the Florida Senate. The announcement was made Saturday during FSO's annual meeting at **The Breakers in Palm Beach**, where it also introduced **its first-ever mascot, "Eagle Eye"** to help spread the word.

"I was proud to stand alongside my Senate colleagues and support the passage of Senate Resolution 844 declaring this upcoming August as 'Amblyopia Awareness Month,' said **Senator Abruzzo, representing the 25th district in Palm Beach County**. "It is imperative that we work to instate early-childhood vision detection screenings to protect their health as adolescents while improving the overall quality of life for all of Florida's citizens. We need to secure the vision of Florida's future which begins with our children."

Duval and Dade counties will serve as pilot markets for the inaugural campaign, where FSO members and Eagle Eye will visit summer camps, daycares, libraries, science centers and other groups to educate the parents and caregivers of their 3-5-year-olds.

"Amblyopia—commonly referred to as lazy eye—is an eye disorder that can cause permanent vision loss if not identified and treated early," said **Dr. Stacey Kruger, a Miami pediatric specialist and FSO Board member**. "If the disorder is detected in early childhood, especially before the age of five, the chances of successful treatment are significantly increased."

About the Florida Society of Ophthalmology

The Florida Society of Ophthalmology is the state's leading advocate for providing Floridians the highest standard of eye care. The FSO's mission is to promote and protect the medical specialty of ophthalmology through active participation in legislative advocacy and providing continuing medical education and responsible information to its members, physicians and the citizens of Florida. Please visit www.mdeye.org for more information.

By Senator Grimsley

21-00556-15

2015844

Senate Resolution

A resolution recognizing August 2015 as "Amblyopia Awareness Month" in Florida.

WHEREAS, amblyopia is a cause of permanent vision loss if not identified and treated early in life, and

WHEREAS, the detection of amblyopia in early childhood increases the chances of successful treatment, especially if the disorder is detected before a child reaches 5 years of age, and

WHEREAS, many forms of amblyopia are difficult to detect and can be identified only through proper screening techniques, and

WHEREAS, the earlier children are identified as having amblyopia, the sooner treatment can commence, and

WHEREAS, fewer than 20 percent of preschool children are currently being screened for vision problems, despite the fact that such screening is a covered service by many health insurance plans and health maintenance organizations, and

WHEREAS, parents should be encouraged to have their children screened for vision problems prior to admission to preschool, and

WHEREAS, the Florida Society of Ophthalmology and a number of statewide associations, charitable organizations, state agencies, and local public health departments believe that it is of paramount importance to promote statewide preschool vision screening, with the goal of testing all children between 3 and 5 years of age, NOW, THEREFORE,

Be It Resolved by the Senate of the State of Florida:

21-00556-15

2015844

30

31

32

That August 2015 is recognized as "Amblyopia Awareness
Month" in Florida.



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Derek Y. Kunitomo, MD, JD
Arizona Ophthalmological Society
Leadership Development Program XIX, Class of 2017
Project Abstract

Title of Project: *Creating a communication platform between State Societies*

Purpose: To connect leadership of all State Societies through an e-mail based platform; to increase awareness of activities and developments in other State Societies; and to allow State Societies to cross-pollinate each other with programs that have worked for them.

Methods: A group e-mail list serve was created using lists of all current State Society Presidents and their Administrators. Relevant content included recent legislative activity, examples of programs that have worked well for a State Society, and questions to the general group on any matter considered relevant.

Results: Relevant results will include whether State Society leadership finds value in hearing about the goings-on and learning experiences of other State Societies, and whether the platform is used as a source of information and collective knowledge by its members. In progress.

Conclusions: TBA



Mark D. Mayle, MD
West Virginia Academy of Eye Physicians and Surgeons
Leadership Development Program XIX, Class of 2017
Project Abstract

Title of Project: *Redesign of WVAEPS Website*

Purpose: To make the webpage of West Virginia Academy of Eye Physicians and Surgeons (WVAEPS) a better tool for accomplishing the following:

Advocacy
Education
Promotion of WVAEPS and membership
Promotion of AAO

The WVAEPS website was initially developed with minimal functions. It was updated recently, but still not as useful a tool as possible.

Methods: The webpage will be redesigned to have the following general tabs on the homepage:

Protecting sight, Empowering Lives:

- A video link for testimonials from patients of members of WVAEPS
- For public relations
- Entries can be made by patients of WVAEPS members explaining a vision saving or lifesaving intervention by that physician

Finding an ophthalmologist:

- Listing of members of WVAEPS by zip code search function
- Encourages local ophthalmologist to be a member for enhanced exposure

Education:

- Diagrammatic display of education track for MD, Ophthalmologist, Optometrist
- Video link: "How I Became an Ophthalmologist"

Legislators:

- Two portals
 - ♦ One available to everyone explaining political or advocacy concerns generally
 - ♦ One available by special security measures for legislators during scope of practice battles or other selected times with more detailed content

Member Physicians:

- Secure portal for physician members of WVAEPS members for general communications within the WVAEPS (calendars; meetings; events, etc.)

Mark Mayle, MD

Redesign of WVAEPS Website

Goals:

Have a powerful and easily accessible tool when needed for advocacy or other selected times

- Educate public
- Engage/educate and enlist legislators
- Call to action, when needed from public, legislators and/or WVAEPS member physicians

Encourage WV Eye Surgeons to be a member and be involved with advocacy

- Public relations from patient testimonials
- Communication
- Call to action; when needed from members

Results/Conclusion: Still in progress. Plan is to track uptick in hits with its new format



Seyhan B. Özkan, MD
International Council of Ophthalmology
Leadership Development Program XIX, Class of 2017
Project Abstract

Title of Project: *Young Ophthalmologist Training Program for Central Asian Republic countries via Turkish Republics Ophthalmology Society*

Background and current situation: Central Asian Republic (CAR) countries are not well represented in international societies that has a negative influence for the pre- and post-graduate education of ophthalmologists and their interaction with the global ophthalmology. Those countries also have the challenge of national organization of ophthalmologists. Turkish Republics Ophthalmology Society (TROS), an independent international society, was established in 2001 with the support of Turkish Ophthalmological Society (TOS). TROS already has a Young Ophthalmologists (YO) Group but the group has not been active. The six TROS member countries other than Turkey are Azerbaijan, Kazakhstan, Kyrgyzstan, Turkmenistan, Uzbekistan and North Cyprus. Tajikistan and Afghanistan are not member societies.

Purpose: The aim of this project is to facilitate the integration of TROS member countries into global international societies through empowering next generation of ophthalmology leadership. The aim of this project is to start a Young Ophthalmologists Training Program using the platform of TROS and the models of existing, multi-national and national YO programs. Identifying and developing Young Ophthalmologists and then supporting, mentoring them to take that challenge is the core aim of this project.

Methods: Already existing contact relations of TROS is chosen as the platform to develop and initiate such a YO Training Program. At initiation, a preliminary communication was done by TROS Administrative Council and after getting their approval and support, the TROS Meeting in Osh, Kyrgyzstan was chosen for organization of the YO activity. The project holder SBÖ provided the communication with the TROS Administrative Council. The activity is planned by the presence of the project holder SBÖ by the project adviser MB and critically by two YO colleagues in Bishkek and Osh, Kyrgyzstan. The pre-appointed leader of the YO group and the leading names in member countries are identified and informed about the program. The chosen date for the YO activity was 3rd June 2017 just after the closing ceremony of the TROS Meeting. The participation of the YO group was provided by the support of TROS and the YO forum has taken place in a meeting room of a hotel in neighborhood of the meeting venue. An announcement brochure was prepared and distributed in a printed form at the beginning of the meeting. In order to increase the participation, the YO meeting is announced to be as a lunch event and the sponsorship for this activity is provided by ICO.

Results: The announcement procedure ran smoothly as required with connection platform of TROS. Personal communication on an individual basis has also been done to increase the interest of known YO names. In order to increase the motivation and to increase the collaboration the leader of YO group is invited to participate the forum actively. The attendance of the meeting as the YO group was 78. Three presentations were done by the project holder, by the project adviser and by the “young” President of the Azerbaijan national society. Then the forum is done by in small groups by discussing the problems and the major needs of the YO in the region. Those needs were the need of basic ophthalmology education, lack of interest of the seniors to train the young ophthalmologists, lack of organization, and the local barriers to create organizations. The financial limitations and the language problems of the region

Seyhan B. Özkan, MD

Young Ophthalmologist Training Program for Central Asian Republic countries via Turkish Republics Ophthalmology Society

appeared as major barriers to reach to the foreign educational source. The Forum was conducted in Russian with translation by the Host YO's.

Conclusions: Integration of TROS member countries into global international societies will improve those countries' international relations and thus improve in-country ophthalmological education and the quality of ophthalmology practice. The forum provided a useful initiative platform to learn the basic requirements of the ophthalmologists.

The motivation of the YO group is high but this motivation needs support to become an ongoing activity. TROS appears to be the most convenient platform in future to reach to the target population and overcome the language barriers. The YO forum appears to reach the goals of the project as an initiative activity to support the ophthalmology education in the region of CAR.



Russell W. Read, MD, PhD
Alabama Academy of Ophthalmology
Leadership Development Program XIX, Class of 2017
Project Abstract

Title of Project: *Increasing State Society Membership by Engagement of Non-Member State Ophthalmologists in a Socially Engaging, Non-Threatening Environment*

Purpose: Alabama has over 275 board certified ophthalmologists but less half are members of the Alabama Academy of Ophthalmology (ALAO). There are many reasons why an ophthalmologist may not join their state society and those reasons are likely individualized to each non-member ophthalmologist and are not likely to be expressed via formal survey or cold call membership drive contact. Various strategies to enhance state society membership have been proposed and debated at the AAO Council level and the ALAO has conducted multiple membership drives over time, all of these with varying success. The central thesis of this project is the belief that most of these strategies are ineffective since, as with legislators, relationships are the starting point to understanding someone else's position. At present, at least in Alabama, there are few mechanisms through which the state society can engage non-society members in an environment perceived as non-threatening to the non-member (threatening in this context being defined as the non-member's anticipation of being pressured to join or to contribute to the state PAC, OPHTHPAC, SSF, etc.) Creating a non-threatening, socially engaging, and professionally advantageous environment, attractive to the non-society member is the first step to begin collegial discussions regarding reasons for non-participation and effective strategies developed to "bring them into the fold."

Methods: A common thread amongst all ophthalmologists is the need for continuing medical education to maintain licensure as well as the need for regular updates on practice advances in various areas of ophthalmology. In collaboration with the Department of Ophthalmology at the University of Alabama at Birmingham, a series of regional education events has been approved by the ALAO to be held in targeted geographic locales where the largest numbers of non-member ophthalmologists practice.

Results: Data from the American Board of Medical Examiners shows 279 board certified ophthalmologists residing in Alabama while membership data from the ALAO for 2016 lists 110 active members. Analysis of the geographic location of each of these two groups shows a range of eligible ophthalmologists as members of the ALAO from 0% in some small areas of the state to a high of 100% in one mid-size community. Between these extremes the percentage membership ranges from 20% to 68%. The 5 cities with the largest number of ophthalmologists have membership percentages (listed in descending order of population) of 37%, 68%, 38%, 35%, and 53%. To maximize the return on investment of time, these population centers will be the initial targets for the above described educational sessions. The UAB Department of Ophthalmology has multiple subspecialists in most areas of ophthalmology and thus will provide speakers at no cost, while the ALAO will underwrite the cost of food and beverage.

Conclusions: This project is an ongoing work in progress. The ALAO has approved the concept and the leadership is enthusiastic about the possibilities for engagement of the state's non-society members. Success of the project will be determined by increases in membership numbers in those areas where the interactive sessions are to be held.

Michelle K. Rhee, MD
Eye Bank Association of America
Leadership Development Program XIX, Class of 2017
Project Abstract

Title of Project: *Eye Banking and its Critical Role as Partner to Corneal Surgeons*

Purpose: To formalize education of medical students and trainees in ophthalmology on the role of eye banking as a partner to corneal surgeons.

Background: Much of ophthalmology has become isolated from other specialties, largely due to its outpatient and ambulatory surgery practice. With advances in microsurgery, it is no longer an inpatient service where interaction with other specialties commonly occurs. The objectives of this project are: to educate medical students and trainees on organ donation; to increase knowledge of donor tissue selection and preparation; to enhance collaboration between surgeons and eye banks in patient surgery and vision research.

Methods: A regional cornea fellow day course has been established at the Eye-Bank for Sight Restoration in NY with didactic lectures on donor tissue selection and preparation, and endothelial keratoplasty techniques, as well as a DMEK wet lab experience. A formalized curriculum has been developed for medical students and residents in ophthalmology as an observational experience of donor tissue selection and preparation.

Results: In August 2017, 7 fellows were educated at the course and feedback has been positive. The medical student and resident experience is still in its beginning stages.

Conclusion: Eye banking education is most critical for cornea fellows. However, education of a broader audience of physicians supports the advancement of high quality donor tissue, patient care, and vision research. Furthermore, knowledge of eye banking may mitigate tissue wastage and encourage donations.

Rebecca Sands Braverman, MD
Colorado Society of Eye Physicians and Surgeons
Leadership Development Program XIX, Class of 2017
Project Abstract

Title of Project: *Colorado Society of Eye Physicians and Surgeons statewide poll and strategic plan revision.*

Purpose: To remain relevant, professional societies must provide a valuable service. The Colorado Society of Eye Physicians and Surgeons (CSEPS) must periodically determine what service Colorado ophthalmologists value. The purpose of the study was to determine what Colorado ophthalmologists need from CSEPS and to implement changes to address their needs.

Methods: A Kupersmit Research poll was distributed to 244 Colorado ophthalmologists by email. A similar Kupersmit Research poll from 2014 was used for comparison. The poll results were used to update the CSEPS strategic plan.

Results: Sixty-eight respondents completed the survey (28% response rate). Ninety percent of respondents were current members, while 10% were not. Respondents were in a variety of practice types including: group (59%), academic (20%), solo (13%), and miscellaneous (8%). Most ophthalmologists practiced in the Denver metro area (69%), followed by cities outside of Denver (27%), and rural areas (4%). The age range of respondents ages was 30-45 (39%), 46-55 (19%), 56-64 (22%), and 65 or older (16%).

Two-thirds of ophthalmologists rated CSEPS as “excellent” or “very good” for having a positive impact on the practice of medicine in Colorado and for being focused on issues important to Colorado ophthalmologists. Respondents rated the following services offered by CSEPS as very important: advocacy on behalf of ophthalmologists at the state capital (86%), communication and education about issues that affect the practice of medicine in Colorado (68%), OMIC risk management discount (38%), continuing medical education (30%), opportunities to provide charity care (22%), and networking at social mixers (20%). These priorities were like the 2014 poll.

Respondents reported significant concern about multiple issues that affect their daily practice of medicine. Respondents worry “all the time” or “a lot” about the following issues: uncertain future of healthcare reform (64%), hiring good staff and creating a successful work environment (58%), scope of practice issues (52%), insurance claims and payments (43%), financial security of their practice (37%), malpractice suits (32%), prestige (32%), and patient compliance (20%).

The bimonthly CSEPS newsletter distributed to members via email was considered “very” or “somewhat” worth reading by 76% of respondents compared to 58% in 2014. Nearly half of respondents did not feel access to the CSEPS website was worth their time. The opinion towards the website was like poll results in 2014.

The poll results were used to amend the CSEPS strategic plan. Advocacy, communication, and education were made the top priorities of the new strategic plan. The plan was approved by the CSEPS Board of Directors.

Rebecca Sands Braverman, MD

Colorado Society of Eye Physicians and Surgeons statewide poll and strategic plan revision

Conclusion: Most Colorado ophthalmologists who responded to the poll believe CSEPS has a positive impact on the practice of medicine. Ophthalmologists consider advocacy the most important service provided by CSEPS. The new CSEPS strategic plan makes advocacy, communication, and education its top priorities. Opportunities to increase the utility of the CSEPS website exist. Future education activities will focus on healthcare reform and the business of medicine.

Scott K. Schultz, MD
South Carolina Society of Ophthalmology
Leadership Development Program XIX, Class of 2017
Project Abstract

Title of Project: *Understanding the current state of optometric surgical and laser training*

Purpose: Increasingly, state optometric societies are legislating for and becoming successful in achieving the privilege of performing invasive procedures on patients such as lasers, injections, and incisional interventions. I sought to broaden and update our understanding of optometric laser/surgical training by exploring their current curriculums and educational models in an effort to identify gaps in their knowledge and/or supervision/experience during training. In addition, this information will hopefully help us to be better equipped to defend ourselves during scope of practice battles.

Methods: I reviewed the current CME course from the Oklahoma College of Optometry that is being taught nationally to optometrists for “surgical training.” I also investigated the University of Houston and UAB school of optometry training program curriculum regarding surgery/lasers, as well as available online optometric training resources from The Council on Optometry Practitioner Education (COPE), National Board of Examiners in Optometry (NBEO), and The Accreditation Council for Continuing Medical Education (ACCME).

Results: The OK surgical curriculum is taught over a 4-day period consisting of 32 total hours taught by a DO/OD as chair and various other OD’s from the OK College of Optometry. The chair attended a non-accredited DO ophthalmology training program. The average duration spent on each of the 350 slides during the OK surgical course is 1.68min. Following the didactic portion, they are required to perform 1 hour each of: suture, injection, incision, radiofrequency Ellman unit, YAG PI, YAG Cap, gonioscopy, and SLT/ALT lab stations. This is followed by a 1.5 hr exam for final certification. The University of Houston, University of Alabama Birmingham among others are beginning to establish a surgical curriculum in their optometric training programs. Furthermore, The ACCME and COPE are attempting to unify accreditation standards for laser and surgical certification to form a standardized optometric curriculum. The National Board of Examiners in Optometry (NBEO) is in discussions to “embed” the Injections Skills Exam (ISE) into current certification requirements. In addition, there are discussions of a Part III Clinical Skills Exam (CSE) through the National Center of Clinical Testing in Optometry (NCCTO) to add elective advanced skills testing within the Center through the Laser and Surgical Procedures Exam (LSPE).

Conclusions: The OK CME course attempts to teach a sub-specialized surgical curriculum from the ground-up to providers who don’t have the benefit of even the most basic general surgical or OR experience. While the content of the OK CME curriculum is not inappropriate, the training and experience of the instructors is suspect, and more importantly, it fails to adequately provide the “graduate” with an even slightly equivalent education compared to a newly-trained ophthalmologist when you consider the extensive time, experience, judgement, and skill garnered during ophthalmology training and examination. The currently offered optometric surgical CME is inadequate to certify optometrists to perform procedures with the same rigor required of an ophthalmologist. Further investigation of the surgical curriculum being implemented at UH and UAB is necessary to determine their adequacy. However, organized optometry is making significant strides toward a unified and standardized injection, laser, and surgical curriculum and board certification for future optometric graduates who do not have a medical degree.

Adrienne W. Scott, MD
National Medical Association, Ophthalmology Section
Leadership Development Program XIX, Class of 2017
Project Abstract

Title of Project: *Evaluation of Medical Students' Perception of an Ophthalmology Career*

Purpose: Since an increase in underrepresented in medicine (URM) ophthalmologists may improve access to eye healthcare for minority patients, we set out to determine whether URM students' reasons for choosing or not choosing to pursue ophthalmology residency differ from non-URM students' reasons.

Methods: We reviewed the medical and sociological literature to identify reasons for specialty selection, particularly information relating to URM students' reasons for feeling more or less comfortable in a given field. We developed a 7-item questionnaire asking students about their self-identified demographics, choice of specialty, factors influencing their choice of specialty, and reasons for their decisions not to pursue a career in ophthalmology, such as concern about finding a same-gender or same-race role model or mentor. 4th-year medical students from our institution were recruited in person to complete the questionnaire.

Results: Of 114 eligible students, 89 chose to complete the survey (78.1%). 16/89 self-identified as URM per the AAMC definition (18%). Insufficient interest, lack of exposure, and the field being "too specialized" were the main reasons why students, regardless of underrepresented in medicine status, did not pursue ophthalmology. Significantly more URM students than non-URM students were concerned about finding a same-gender or same-race mentor in the field of ophthalmology in their decision not to pursue ophthalmology ($P=0.030$). There was no statistical difference between URM and non-URM students for any other potential reason for not pursuing ophthalmology. URM students were 82% less likely than non-underrepresented in medicine students to indicate "life-work balance" as an influential factor in their specialty decision (OR=0.18; 95% CI: 0.05 to 0.64; $P=0.008$). There was no statistical difference between URM and non-URM students for any other evaluated factor.

Conclusions: URM students and non-URM students indicated insufficient interest and lack of exposure as major barriers to selecting ophthalmology as their career. URM students were significantly more likely than non-URM students to be concerned with finding a same-gender or same-race role model/ mentor in the field. Increasing all medical students' exposure to ophthalmology may help facilitate recruitment of medical students to an ophthalmology residency, and increasing diversity within the ophthalmology workforce may increase recruitment of URM students into ophthalmology.



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Maria Cirone Scott, MD
Outpatient Ophthalmic Surgery Society
Leadership Development Program XIX, Class of 2017
Project Abstract

Title of Project: *A Guide to Implementing Your Charitable Cataract Surgery Program*

Purpose: To assist other practices around the country to implement a successful program. The magnitude and coordination to set up a charitable cataract surgery program can be daunting. This type of program will impact every department in the practice.

Methods: Some of the key factors include: figuring out how to efficiently and effectively implement this type of program that involves one or more surgeons; coordinating cataract consultations in a busy clinic; setting up surgery schedules; securing anesthesiologists and specialists for unforeseen emergencies to donate their time to the program; accessing providers for health and physicals; and covering the cost of all surgery supplies, to name a few.

Results: Essential to success is a well versed, unified team from clinic manager to call center to technicians to schedulers to marketing to surgery center. There may be unforeseen events for the prospective patients including language barriers; possible mental health issues; transportation; and ensuring necessary caretakers

Conclusions: We hope that sharing our experience with this step by step guide will encourage the participation of more surgeons to help serve those who are financially disadvantaged and curtail preventable blindness in the United States

Erin Moore Shriver, MD, FACS
Women in Ophthalmology
Leadership Development Program XIX, Class of 2017
Project Abstract

Title of Project: *Building an International Network of Women in Ophthalmology*

Purpose: To create an international network of women in ophthalmology by building a database of ophthalmologists interested in serving as a key contact for Women in Ophthalmology (WIO) within their local ophthalmology society.

Methods: A database of all national and regional ophthalmology societies including their region, email contact information, and website was compiled. An email address was created for WIO's international efforts, and an email was sent to the contact for each national ophthalmology society. The recipients were asked to identify a women ophthalmologist within their organization who would be interested in serving as a key contact for WIO and to whom the email could be forwarded. The email included information regarding the mission of WIO, online resources available through the organization, details regarding the annual Summer Symposium, and how to form an international chapter. Additionally, the recipients were asked if any training or mission work was needed within their country and in what ways WIO could be of assistance to the women ophthalmologists within their local organization.

Results: A total of 155 organizations were identified and email addresses were available for 154 organizations. The database is currently being compiled as organizations respond to the query.

Conclusions: An international network of women in ophthalmology has the potential to serve as a powerful tool to not only assist female ophthalmologists throughout the world deal with issues related to being women in the field of ophthalmology, but it could serve as a powerful connector. WIO hopes to use this international network to improve ophthalmic education and surgical skill training, collaborate on research, increase gender and regional diversity on speaking panels, empower women to form local organizations, and better serve the needs of women ophthalmologists around the world.



**George O. Waring IV, MD FACS
International Society of Refractive Surgery
Leadership Development Program XIX, Class of 2017
Project Abstract**

Title of Project: *Increasing membership recruitment and retention of young ophthalmologists for the International Society of Refractive Surgery*

Purpose: To increase the percentage of new and existing members out of training of the International Society of Refractive Surgery (ISRS).

Methods: Targeted demographic segments were identified in the American Academy of Ophthalmology (AAO) member database included United States residents, fellows in refractive surgery, cornea or anterior segment, members in the first five years of practice who identified themselves with the aforementioned sub-specialization, and comprehensive ophthalmologists in the first five years of practice. Demographics of current membership and trends were analyzed. Direct outreach and social media campaigns were structured and targeted accordingly emphasizing the value proposition of ISRS. Reduced membership rates were offered, and an updated membership campaign was designed targeted toward young ophthalmologists. The author (GOW) signed direct outreach notifications and invitations to renew or join ISRS membership.

Results: ISRS membership demographics is very different than Academy membership. Internationals account for 50% of ISRS membership compared to roughly 27% of Academy membership. ISRS members tend to be younger on average (2-3 years) compared to Academy members. ISRS has 162 members-in-training currently receiving complimentary membership. Reduced rates were offered for first year in practice member rate of \$160. 302 non-ISRS US young ophthalmologists specializing in refractive, cataract, cornea identified for potential outreach.

The author (GOW) was the signatory for the outreach to 1st and 2nd years in practice members in an internet e-blast. We achieved a 51% unique open rate (75 out of the 149 opened the email), compared to other historic ISRS e-communications which generate a 40% open rate. The campaign is ongoing and data on conversion will be reported.

Conclusions: Targeted demographic database analysis from the AAO, broadening the targeted demographic to include comprehensive ophthalmologists and cataract surgeons, and updating the membership campaign to a more personalized and demographic appropriate campaign may increase conversion from members in training to members for the ISRS.



Jeffrianne S. Young, MD
Iowa Academy of Ophthalmology
Leadership Development Program XIX, Class of 2017
Project Abstract

Title of Project: *More Than Meets the Eye: A Smartphone-Friendly Scope of Practice Video Showing Subconjunctival Injections and Chalazia & Eyelid Lesion Surgeries*

Purpose: To create a very short, smart-phone friendly Scope of Practice Advocacy video that shows actual patients undergoing subconjunctival injections and surgeries of chalazia and other eyelid lesions. The video is designed to be used as a visual aid by lobbyists and ophthalmologists during informal and formal discussions with state legislators to illustrate ophthalmic injections and surgeries that might otherwise be perceived as “simple, minor procedures” and to highlight why only ophthalmologists have the training and expertise to perform these procedures.

Methods: Our lobbyist identified the need to show state legislators actual video content of surgical procedures that are difficult to illustrate to state legislators when discussing scope of practice issues. Videos of the injections and surgical procedures were collected, and a [professional video](#) was created that can be quickly and easily viewed on a smartphone during conversations with legislators. The video has written content but no voiceover material. The pace of the video allows for conversation, but it can also be viewed without additional explanation to demonstrate why ophthalmologists are needed for these injections and procedures. The video purposely does not mention a specific geographic location, so that it can be used by any state facing scope battles for subconjunctival injections and eyelid surgeries.

Results: The video will be used this legislative season in discussions with state legislators regarding scope of practice issues. The video may also be used to educate the public on social media. The impact of the video on state legislators may be difficult to quantify, but it is hoped that the video will educate and persuade state legislators that subconjunctival injections and eyelid procedures require the training and expertise of ophthalmologists.

Conclusion: The impact of the video on state legislators’ votes during scope of practice battles may be difficult to quantify, but it is hoped that the video will educate and persuade state legislators that subconjunctival injections and eyelid surgeries require the training and expertise of ophthalmologists. And perhaps the video can be used across the nation to help increase both state legislators’ and the general public’s awareness about eye injections and eyelid surgeries, and the need to seek eye care by ophthalmologists for seemingly “simple, minor” eye and eyelid procedures.