

William S. Clifford, MD
Kansas State Ophthalmological Society
1998-1999 Leadership Development Program
Project Abstract

Title of Project: *Membership....Membership....Membership*

Purpose: The strength of any State Society is ultimately built on the numbers of members, and the active participation of leaders who derive their mandate from the membership. Our Kansas State Society's chronic membership anemia (40% of State Eye M.D.s) has historically resulted in poor representation of all Eye M.D.s' interests and less than ideal political influence.

Methods: Creating a stronger State Society involved "top-down" re-evaluation of our organization. We reevaluated our membership policies, compared our dues structure to other States', and developed a strategy to create more value for members. We also actively sought new "key" members in selected cities and practices.

Results: The fortuitous timing of a change of Executive Directors significantly reduced our overhead and enabled us to immediately reduce annual dues by fifty dollars. Paid members were sent refunds (although they were encouraged to contribute the amount to the State OPHTHPAC) and publicity was generated to attract new membership at the lower rate. At the same time, two annual membership benefits were created; a yearly Winter Forum for CME, and an annual Practice Enhancement Meeting with emphasis on billing, fraud, and third party payor initiatives. Response to the events was encouraging. We have also successfully recruited a key Eye M.D. from a large practice in the Wichita area, and filled all State Society leadership positions.

Conclusion: Our State Society represents all Eye M.D.s, not just our membership. As the de facto voice of Eye M.D.s in Kansas, our political power and ability to maintain the quality of eye care depends on the strength of our Society. This project is a work in progress, however, as we gain members we benefit from a more unified presence in Kansas, added political leverage, and the ability to provide more value for our membership.

John W. Collins, MD
Kentucky Academy of Eye Physicians and Surgeons
David E. Korber, MD
Oklahoma Academy of Ophthalmology
1998-1999 Leadership Development Program
Project Abstract

Title of Project: *Participation in AAO Secretariat for State Affairs Residents' Advocacy Program*

Purpose: To participate in the pilot implementation of the AAO Secretariat for State Affairs' *Residents' Advocacy Program* (RAP) The RAP is intended to provide resident ophthalmologists with practical insights as to how political, legislative and regulatory actions impact their profession and their patients. The objective is to develop an integrated, repetitive and standardized curriculum module for residents in the advocacy arena, including state and federal legislative advocacy, public information advocacy, health plan relations and regulatory advocacy.

Methods: The Oklahoma Academy of Ophthalmology (OAO) agreed to serve as a pilot for the implementation of the RAP which was delivered to residents at the Dean McGee Eye Institute on June 21, 1999. David Korber, MD provided a presentation to Oklahoma residents regarding his participation in the AAO Leadership Development Program while joining other RAP presenters, including Oklahoma Representative Fred Morgan, Senator Ben Brown and OAO leader David Parke III, MD, to enlighten residents about the importance of advocacy. Dr. Collins will join Secretariat for State Affairs member Doug Gossman, MD, to ensure annual implementation of this program to residents in Kentucky.

Results: Secretariat for State Affairs member Cynthia Bradford, MD (Oklahoma City, OK) reported that the residents who participated in the RAP session "were very interactive, asked good questions, and learned a great deal about the responsibilities of the state and national associations". To date, six (6) state ophthalmological societies have implemented the RAP in eight (8) training programs. The goal of the Secretariat for State Affairs is to work with state societies and the AUPO to have 100 training programs implement the RAP by June 2000.

Conclusion: Early education regarding practical insights as to how political, legislative and regulatory actions impact the profession and patients is important to ensure future participation in the advocacy process.

Philip M. Fiore, MD
New Jersey Academy of Ophthalmology
1998-1999 Leadership Development Program
Project Abstract

Title of Project: *Developing an Internet Site for the New Jersey Academy of Ophthalmology*

Purpose: To develop a web site for the New Jersey Academy of Ophthalmology dedicated to providing information, both to its members and the general public.

Methods: We started with an initial grant from Pharmacia-Upjohn and have built the site to include a mission statement and membership directory with references to Eye M.D.s. We have links to the American Academy of Ophthalmology's site to include information on various ophthalmic services such as the National Eye Care Project, Glaucoma 2001 (now known as *Celebrate Sight for Life: Know Your Glaucoma Risks*), and Diabetes 2000. We are including information on eye care for the general public and a resources directory of medical, surgical, and pharmaceutical assistance to the medically underserved as well as programs for the blind and visually impaired. We hope to increase public awareness of the New Jersey Academy of Ophthalmology and Eye M.D.s in general. We have also begun to generate revenue by selling ad links to our members and various pharmaceutical and ophthalmic companies.

Results: The web site so far has been a success as a method for disseminating public information, keeping a forum open to our members and generating income for our society. We continue to improve it as the need arises.

Conclusion: An Internet site can be an important and useful asset to a state society in disseminating information to its members, providing content to the public and as a source of revenue.

Terry L. Forrest, MD
North Carolina Society of Eye Physicians and Surgeons
1998-1999 Leadership Development Program
Project Abstract

Title of Project: *Understanding the Demographics of NC Eye M.D.s*

Purpose: To better understand the demographics of North Carolina Eye M.D.

Methods: A database on ophthalmologists in the state of North Carolina is being constructed which will include, among other information:

- The number of state society members versus non-members
- The number of subspecialists
- The number of generalists
- The geographic distribution by zipcode (and in comparison to the distribution of the general population)

Results: Information is currently being collected and a PowerPoint presentation developed and presented to the NCEPS membership at a future state society meeting.

Conclusion: Leaders of the North Carolina Society of Eye Physicians and Surgeons will be better equipped to serve their constituents and be better legislative and regulatory advocates if there exists a better understanding of the demographics of North Carolina Eye M.D.s.

Tamara R. Fountain, MD
Illinois Association of Ophthalmology
1998-1999 Leadership Development Program
Project Abstract

Title of Project: *Missing in Action: Why Illinois Eye M.D.s Don't Join Their State Society*

Purpose: To identify factors contributing to lack of state society membership for Illinois ophthalmologists.

Methods: A roster of non-members was obtained from the IAO office. This list included those physicians who had never been members as well as former members who had let their memberships lapse. The database listed an office address and phone number and in some cases a home number. Only those physicians whose home phone number was listed were included in the study. A single call was attempted to each physician's residence. Those physicians willing to be interviewed were asked to elaborate on why they weren't members of the IAO.

Results: Of 94 calls placed, 20 non-members and 8 former members were home and willing to be interviewed. The most common factor cited was cost (9/20). In order of decreasing frequency were: unfamiliarity with the IAO, or general inertia (8/20); lack of perceived value (7/20); lack of time (3/20); foreign M.D.s in Illinois temporarily (3/20); IAO too Chicago-centric (3/20), loss of faith in all medical societies (2/20); fear of alienating optometrists (2/20); felt IAO was "too political" (1/20); and didn't realize membership had expired and planned to renew (1/20). Of note, of the 28 physicians contacted, 22 were members of the American Academy of Ophthalmology.

Conclusion: Cost and lack of value rated as the most common reasons for not joining IAO. The IAO will continue to work to decrease the cost/benefit ratio by minimizing dues and increasing perceived benefits. People unfamiliar with the state society or those who just hadn't gotten around to sending a check might be good targets for an awareness and marketing campaign. Despite the demands of work and family, lack of time did not appear to be a significant factor among those physicians queried. Perhaps the most interesting finding was the high rate of AAO membership. The future of state societies may well hinge upon a link to membership in our national organization.

Peter A. Gordon, MD
Georgia Society of Ophthalmology
1998-1999 Leadership Development Program
Project Abstract

Title of Project: *Georgia Legislative Battle*

Purpose: To develop a summary PowerPoint presentation of Georgia Senate Bill 16.

Methods: A summary, PowerPoint presentation of Georgia Senate Bill 16, legislation regarding expansion of the scope of practice of optometry to include “the use of all oral (optometry already has the use of topical) pharmaceutical agents rational to the diagnosis, management or treatment of eye and adnex oculi except those listed in Schedule I & II.” The summary included developing a list of key legislators. The bill’s sponsor, Senator Harold Ragan, and key co-sponsors were listed and elaborated on regarding their viewpoints. The Senate Health Committee’s members were listed and delineated as to friends and fiends as well as swing votes.

Strategy included developing a letter writing campaign, personal contact with legislators, a strong coalition with the Medical Association of Georgia, support for the new Governor’s HMO reform plan (despite the fact that we did not support him for governor).

Timothy F. McDevitt, MD
Hawaii Ophthalmological Society
1998-1999 Leadership Development Program
Project Abstract

Title of Project: *Eye M.D. Branding Using Local Newspaper Advertisement*

Purpose: The purpose of this project was to increase public awareness as to the Eye M.D. name and to educate the public on selected eye care issues.

Methods: A bi-weekly ad was placed in a newspaper that was circulated to households on the Island of Oahu in Hawaii. These advertisements featured a short index on topics related to eye care and were sponsored by a member of the Hawaii Ophthalmological Society. Typically, the photograph of the Society member would be contained in the ad and the public would be directed to call the sponsoring ophthalmologist's office for questions related to the topics.

Topics covered thus far include:

1. What is an ophthalmologist?
2. What causes glaucoma?
3. Does laser eye surgery really restore vision?
4. Can diabetes affect my eyes?
5. Why do I have a fleshy spot growing from the corner of my eye?
6. Why do my eyes water so much?
7. What causes a lazy eye?
8. Why do some children's eyes point in different directions?
9. What is a cataract?
10. What are common risks to poor eyesight?

Results: All advertisements had interested readers call the sponsoring Eye M.D.'s office to ask questions. Some topics generated more interest than others. It was difficult to track the response to each office. A potential problem existed when the Eye M.D. was on leave when the ad ran but this was avoided by trying to coordinate schedules.

Conclusion: Bi-monthly advertisements are effective in generating interest in eye care and in promoting the Eye M.D. brand name.

Mark Michels, MD
Florida Society of Ophthalmology
1998-1999 Leadership Development Program
Project Abstract

Title of Project: *Squeaky Wheel May Fall Off Rusting Wagon*

Purpose: The Florida Society of Ophthalmology (FSO) understands it is targeted in Florida and nationally for expanded scope of practice issues by Optometry. Our objective was to raise the consciousness of organized ophthalmology and Florida Eye M.D.s as to the seriousness of the threat and to elicit interest and funds for the legislative battle in Florida and around the country.

Methods: Red ant/squeaky door tactics were used at all levels by state ophthalmology officers, Councillors, personal contacts and presentations including those at the Leadership Development Program and State Affairs meeting to encourage AAO and allied organizations' leadership to establish real funding for state legislative battles everywhere. Frequent communication of real threats and concrete data established legitimacy of claims.

Results: AAO established State Legislative Fund at least partly as a result of FSO efforts. AAO seemed interested in placing more emphasis on states and survival of quality eye care on the state level. ASCRS initiated grass roots political training for Eye M.D.s across the country. Both contributed token funds to Florida's battle. Both encouraged non-FSO members to join FSO fight. All OD bills were defeated in 1999. Membership in FSO is on the rise...slowly. Late in the year, AAO decided most of its advocacy staff should be moved to Washington, D.C.

Conclusion: Stated objectives enjoyed some success. Unfortunately, though awareness has increased, we failed to motivate the volume of dollar flow that is requisite to maintain our position. Regrettably, the AAO seems to have lost some momentum after a strong start and is sending a mixed message on state affairs issues by moving key personnel to Washington, D.C.

Robert E. Neger, MD
California Academy of Ophthalmology
1998-1999 Leadership Development Program
Project Abstract

Title of Project: *What Motivates Ophthalmologists?*

California is facing the prospect of a massive expansion in the optometric scope of practice in 2000. The California Academy of Ophthalmology represents only half the state's ophthalmologists. The CAO must increase membership to become a more potent force in the legislative arena.

Purpose: To evaluate the factors which might motivate more ophthalmologists to advocate.

Methods: The methods included a conference discussion on how to use motivating factors to increase membership. One idea was to send audio-tapes and written mailings of an encounter between a patient and his insurance carrier who wanted to see an ophthalmologist after an optometrist diagnosed glaucoma.

Results: The results of my project are not yet known. Membership seems to increase dramatically when legislation is imminent. I think that we have accomplished making the more conservative members understand that unless they become more involved in advocacy and encourage others to join the battle, ophthalmology will lose control of eye care in California.

Conclusion: I feel that it is imperative that state societies use strong issues to motivate increased membership and participation in state societies. The time when ophthalmologists can sit by and allow others to control our destiny is over. It is only through united committed societies that we can continue to function providing the highest level of eye care to our patients.

Andrew M. Prince, MD
New York State Ophthalmological Society
1998-1999 Leadership Development Program
Project Abstract

Title of Project #1: *PAC Contributions*

Purpose: To increase PAC contributions to the New York State Ophthalmological Society (NYSOS)

Methods: Personalized letters for contributions were sent by each member of the Board of Directors to all NYSOS members in their geographic district. In addition, contribution forms were included in each letter and every issue of the quarterly newsletter. Board members were encouraged to follow up each letter with a personal phone call.

Results: While our contributions tripled from the previous year, we fell short of our \$100,000 goal. However, it should be noted that total PAC dollars collected for 1999 represent the largest NYSOS PAC balance in the Society's 49-year history.

Conclusion: Factors such as reduced physician reimbursement, competition from other organizations for PAC donations, suboptimal membership (57%), and ignorance on the part of MD's with respect to State Societies' ability to influence legislative outcomes are some of the impediments to raising State Society PAC money. A more personalized approach improves results, but other measures are needed.

Andrew M. Prince, MD
New York State Ophthalmological Society
1998-1999 Leadership Development Program
Project Abstract

Title of Project #2: *NYSOS Docs rap about RAP (Residents' Advocacy Program)*

Purpose: To educate ophthalmology residents concerning the importance of Eye M.D. participation in advocating to government, business, and the public.

Methods: Chairmen of all 23 Ophthalmology Residency Programs in New York State were mailed a letter and materials announcing the new Residents' Advocacy Program. (RAP). The letter explained that the program is being piloted in key states during 1999, and based on feedback and evaluation, it was hoped that the initiative will be rolled out nationwide in the year 2000. Our initial efforts were concentrated on the three largest programs in the Metropolitan NY area: NY Eye & Ear Infirmary, SUNY Health Science Center at Brooklyn, and NY University Medical Center. Additionally, NYSOS developed its own residency advocacy slide presentation which has subsequently been distributed to other state societies.

Results: To date, all department chairs and residency directors have been cooperative and appreciative of the effort. Residents were interested in and concerned with the issues discussed. There were ample questions and discussion at the conclusion of the formal presentation. Evaluation forms were overwhelmingly positive with many attendees recommending that the RAP become an annual event.

Conclusion: The future of ophthalmology rests with the next generation of eye physicians and surgeons. Eye M.D.s must be indoctrinated into and feel comfortable with the process of advocating for their profession at the earliest possible time in their careers. So far, the residents seem to accept this role but clearly need the tools, training and leadership to carry out the mission. The Residents' Advocacy Program has provided a valuable vehicle and a starting point to achieve this end.

Elwin G. Schwartz, MD
Connecticut Society of Eye Physicians
1998-1999 Leadership Development Program
Project Abstract

Title of Project: *Improvement of Legislative Liaison between CSEP and the Connecticut State Legislature*

Purpose: To create Legislative inroads during the off session so that when bills of importance came before the Legislature we already had key contacts through individuals and our lobbyists.

Methods:

1. A Legislative fundraiser was held for every member of the Legislative Public Health Committee both in the Senate and the Assembly.
2. Other fundraisers were held for key leadership people and also members were urged to attend and contribute to fundraisers of their local legislator.
3. Members of the Society with personal relationships with Legislators were asked to be in touch with them to ask how they could further help with their campaign or with any issues that may relate to medicine.
4. A stronger relationship was developed between our lobbying firm and our Society.
 - a. The Society received weekly updates on key legislative issues which we had identified as they were introduced.
 - b. Members of the Society were asked to testify on issues not only relevant to ophthalmology but to medicine as a whole to again foster our relationship with members of the legislature.
 - c. Monthly meetings were held with our two lobbyists to review progress to date and plan strategy for the upcoming month.
 - d. A year end wrap-up was provided by our lobbyist (See attached)
5. Regional legislative teams were made up in case legislation was advanced by optometry which required intensive local lobbying.

Results: The Society was very successful in making key inroads within both the Senate and the Assembly. Our Society was instrumental in helping the Legislature pass legislation involving advanced practice nursing, managed care, requirements for driving, and laser pointers.

Elwin G. Schwartz, MD

Project: Improvement of Legislative Liaison between CSEP and the Connecticut State Legislature (cont'd)

We were also successful in stopping any optometric expansion of scope of practice (this year the optometrists tried to obtain hospital privileges by legislative fiat). We were unsuccessful in passing a definition of surgery bill, however, key members of the Public Health Committee told us to bring it back up for consideration next year.

Conclusion: As CSEP enters the new millenium, we are much better positioned to effectively deal with Legislative issues as they concern ophthalmology and medicine as a whole.

Eye

July 16, 1999
Vol. II Number 1

On The Capitol

The Inside Track on Campaign Activities In Connecticut

'99 Session Adjourns

The 1999 legislative session adjourned at midnight on June 9th and was quickly followed by a special session on June 14th to vote on several budget implementation bills.

This year proved very successful for the CSEP, sponsoring another "Day at the Capitol" and taking a much more proactive role, pushing for quite an extensive legislative agenda.

Although the Legislature failed to adopt a definition of surgery, we will continue to work with the CSMS, and the Department of Public Health on the issue. Additional managed care reforms passed this session, improving the timeliness of payments to physicians, protecting patient medical records and, most importantly, improving the prescriptive ability of physicians with chronic disease patients.

The CSEP worked closely with the CSMS this session, and is now represented in discussions over how best to address the Certificate-of-Need process under the Office of Health Care Access.

Look for our monthly update as we continue to provide information on the status of these issues.

It's That Time Again.....

With the 1999 legislative session complete, it is time to prepare for 2000. Part of that process involves raising campaign funds for the upcoming election in November 2000. Already, the House and Senate caucuses have begun to schedule events. This season, the CSEP is targeting key legislators to focus on and will be looking for local physicians to host events.

Remember, this is something that the Optometrists have been doing for a long time and it has proven to be very effective. Sullivan & LeShane has developed a simple step-by-step brochure to assist physicians to host a successful and enjoyable event. For more information, please contact Deb Osborn at 860.567.3787.

Save the Date... The CSEP will host a fundraiser for Speaker of the House Moira Lyons on Tuesday, September 14, 1999 in the Hartford area. Keep an eye out for more details.

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TO: Deb Osborn, Executive Director
Connecticut Society of Eye Physicians

FROM: Paddi LeShane and Lisa Winkler

DATE: July 9, 1999

RE: 1999 Final Legislative Wrap-Up

The 1999 legislative session adjourned at midnight on June 9th, with many bills failing to be considered before the statutorily imposed deadline. The budget, managed care reform, Adriaen's Landing, and the Tobacco Settlement, all were major issues this session. The Constitutional spending cap was a problem for the first time this session, as the state was faced with cutting important programs, despite a large budget surplus.

In the final minutes of the session, the House attempted to quickly move through budget implementation bills necessary to implement different aspects of the state budget. Time ran out as the House of Representatives discussed the Public Health implementing bill. Not having acted on the Office of Policy and Management implementer, or the Public Health bill, the General Assembly needed to convene a Special Session to vote on these essential proposals. On Monday, June 14th, the Legislature convened a Special Session and voted on the proposals. Over the weekend, legislators battled over different projects, and the bills voted on Monday differed from the bills considered in the final moments of the 1999 regular session.

This document will serve as a summary of our activities on behalf of the Connecticut Society of Eye Physicians during the 1999 legislative session.

■ MANAGED CARE REFORM

Many of the issues of interest to the CSEP focused on managed care reforms, and remained unresolved until the final days of the 1999 legislative session. Numerous bills were introduced on a variety of managed care issues this session in an effort to further improve on advances made in the 1997 bill. **HB 7032, AAC Managed Care Accountability** emerged as the vehicle and incorporated many provisions considered and approved by the Public Health and Insurance Committees.

Our efforts augmented those of the CSMS as we met with key legislative leaders, committee chairs and rank and file members on our priorities and reinforced these discussions with as many

"hard facts" as possible. The CSMS initiated a managed care information campaign which included the development of weekly alerts geared toward specific priorities of the CSMS, with each focusing on a key issue. During initial negotiations over key aspects of the bill, Dr. Schwartz focused on the formulary issue and provided information to key legislators. This greatly enhanced the efforts of the CSMS which bombarded legislators with fact sheets on timely payments, managed care liability, confidentiality, medical necessity, formularies, and physician contracting. This initiative proved successful as we met with legislators and discussed our issues.

Provisions improving managed care formularies, timely payments, and medical record confidentiality were all incorporated into the bill. Some aspects of medical necessity were also included. After lengthy negotiations over managed care liability, the provision was dropped from the bill in large part because of the Trial Lawyers opposition. The Connecticut Trial Lawyers' Association supported the ability to sue managed care companies, but preferred using Judge Droney's decision as the legal precedent, rather than establishing a potentially more narrow statutory provision. Rep. Mary Eberle, co-chair of the Public Health Committee, researched the issue concerning Connecticut licensure of managed care medical directors and determined that most were already licensed here. Despite a great effort by the physician community, fairness in contracting, was not incorporated into the bill. A physician profiling system was also created in the bill which reflects most of the recommendations of the CSMS.

There remains to be several outstanding concerns which the physician community has with managed care. Recognizing the problems created under the present system, Commissioner Reider, of the Department of Insurance, has convened a working group comprised of the CSMS, the Connecticut Hospital Association, and managed care companies to discuss concerns with payment, pre-certification issues as well as other areas. The department wants to improve its image and begin to address as many of these problems administratively as possible.

Presented below is a summary of the key provisions of the managed care bill:

1.) **Sections 2-11 - Ombudsman.** The office is in the Insurance Department for administrative purposes only. The roles of the Ombudsman include: Assistance to consumers with plan selection, assistance to consumers in understanding their rights and responsibilities, provide information on types of problems consumer are facing and suggest remedies, assist consumers with filing a complaint or appeal, analyze & monitor laws on health care and recommend changes, facilitate consumers public comments, ensure that consumers have timely access to the services of the Office, review the health insurance record of consumers with their consent, make and disseminate to employers a notice of the Office's services, establish a toll-free calling number the Office, pursue administrative remedies on behalf of consumers, and adopt regulations to carry out the Office's roles. The chief Ombudsman will be appointed by the Governor with the Legislature's approval and there will be three additional staff to start. A six member advisory board will be created to oversee the work of the Office and recommend candidates.

2) **Sections 12-13 - Decision on Care.** MCO's must notify the insured or the insured's provider

of its decision on a request for service no later than 45 days after receipt of the request. If the decision is to deny coverage the reason why must be made know in the notice.

3) **Section 14 - External Appeals.** The Insurance Commissioner must undertake a public education campaign to inform the public of the external appeals process currently in place. The campaign must include mass media, interactive approaches, and involvement in community groups.

4) **Section 14 - Expedited Appeals.** An expedited appeals process has been created for persons diagnosed with a condition that creates a life expectancy of 2 years or less and has been denied otherwise covered treatment based on it being experimental. The basis of such an appeal is the medical efficacy of the treatment.

5) **Sections 15-16 - Experimental Coverage.** Insurance policies must define the extent to which coverage is provided for experimental treatment and cannot deny coverage of treatments that have successfully completed a phase III clinical trial of the federal Food and Drug Administration.

6) **Sections 18-24 - Medical Records Privacy.** Identifiable medical records cannot be sold or disclosed for purposes of marketing without the prior consent of the person, or in the case of a minor their representative. The Insurance Department has cease & desist powers and fines can be levied.

7) **Section 25 - Medical Records Handling.** Insurance institutions must develop and implement written policies, standards and procedures for the management, transfer, and security of medical record information, including: limiting access to only those employees needing to know in order to perform their job; appropriate training of all such employees; disciplinary measures for violation of the policies; identification of job titles of those who have access to records; procedures for authorizing and restricting the collection, use or disclosure of records; methods for handling, disclosing, storing and disposing of records; and periodic evaluation of implementation.

8) **Section 26 - Medical Records Disclosure.** Prohibits the disclosure of individually identifiable medical information with the malicious intent to damage an individual's reputation or character, and has penalties for violation.

9) **Sections 27-28 - Mental Health & Substance Abuse Parity.** Provides for full mental health and substance abuse parity in both individual and group policies. Parity is based on the most recent Diagnostic and Statistical Manual for Mental Disorders (DSM). Exempt from the law are mental retardation, learning disorders, motor skills disorders, communication disorders, caffeine-related disorders, disorders that may be the focus of clinical attention but not defined in the most recent DSM. Specifies that no policy may establish any terms, conditions or benefits that place a greater financial burden on an insured for mental or substance abuse treatment than for a physical health treatment. Also adds mandated third party payment for certain mental health & drug/alcohol providers into individual poll group policies and drug/alcohol counselors into group policies.

10) **Section 30 - Timely Payments.** Cleans up the "Clean Claim" loophole by requiring plans to notify providers of all deficiencies within 30 days and pay the claim within 30 days of receiving all required information. Timely payments must be made to providers within 45 days, eliminating any other contractual payment provisions.

11) **Section 31 – Unfair Practices.** The Insurance Commissioner may examine the affairs of any MCO licensed in Connecticut to determine if the MCO has engaged in any unfair or deceptive practice prohibited by law. The Commissioner may develop regulations for this section.

12) **Sections 33-34 - Physician Profile.** This section creates a physician profiling program within the Department of Public Health. The information in the physician profile will include:

- The physician's name, address medical school, post-graduate education, specialty, board certifications, hospital affiliations, languages spoke in the practice, nursing home affiliations, publications in peer reviewed literature, professional services, activities and awards, and any appointments to medical school faculties and/or responsibility for graduate medical education.
- The profile will also include any disciplinary action taken against the physician by the Department of Public Health or the Medical Examining Board; any hospital disciplinary actions taken within the last 10 years against a physician that resulted in the termination or revocation of the physician's hospital privileges for a medical disciplinary cause or reason; and a description of any criminal conviction of the physician for a felony within the last 10 years.
- The profile must also include all medical malpractice court judgements, arbitration awards, and settlements in which payment was made to a complaining party within the last 10 years. Because of our efforts, the information will be provided in the following context: 1) Disposition of claims will be reported in a minimum of three graduated categories indicating the level of significance of the award of settlement. 2) Information concerning paid medical malpractice claims shall be placed in a context by comparing an individual physician's medical malpractice judgements, awards or settlements to the experience of other physicians licensed in Connecticut who perform procedures and treat patients with a similar degree of risk. 3) All judgement awards and settlement information reported shall be limited to amounts actually paid by or on behalf of the physician. 4) Comparisons of malpractice payment data must also be accompanied by explanatory statements as to risk, years of practice, and the fact that cases are settled for reasons other than liability, among other things.
- Pending malpractice claims and actual amounts paid by or on behalf of a physician in connection with a malpractice judgement, award or settlement shall not be disclosed by DPH.

- The Commissioner of DPH must study whether additional categories of health care providers should be added to the physician profile system and report back to the Legislature by January 1, 2000.

The CSMS will also participate in the development of the profiling system in conjunction with the Department of Public Health and physicians will be given 60 days to review their profiles and any disputed information will not be released for 30 days or until resolved, whichever is earlier.

13) **Section 35 - Internal Appeals.** This section requires MCO's to establish an internal grievance procedure that enrollees must be informed of when a decision is made not to certify an admission, service, or extension of stay. It also requires that appeals may be made orally, electronically, or in writing and that all appeals under this section must be completed within 60 days unless an extension is requested by the enrollee.

14) **Section 36 - Employee Medical Records.** Medical records, if kept by an employer, must be kept separate and not part of the personnel file. Current law leaves this up to the employer's option.

15) **Section 37 - Drug Formulary.** Patient's using a drug on an outpatient basis cannot be denied coverage for any drug that the insurer removes from the covered list, or otherwise ceases to provide coverage for, if the person was covered for and using the drug for treatment of a chronic illness prior to its removal and the person's attending health care provider states in writing that the drug is medically necessary and lists the reasons why it is more medically beneficial than drugs on the covered list. This was a priority of the CSEP and is certainly an improvement over the current system.

16) **Sections 40-42 - Dental Mandate.** Mandates for general anesthesia, nursing and related hospital services Provided in conjunction with in-patient dental services when its deemed necessary by the dentist/oral surgeon and the patient is under the age of four and has a dental condition serious enough to require the treatment be performed in a hospital, or a person with developmental disabilities, in both cases a primary care physician must certify the need. DSS is instructed to abide by this provision to the extent it is allowed under federal law.

17) **Sections 43-44 - Diabetes Education.** Mandates coverage for outpatient self-management training for persons with diabetes.

18) **Sections 46-47 - Prostrate Cancer.** Mandates coverage for laboratory and diagnostic tests, including but not limited to, prostate specific antigen tests, to screen for prostate cancer for men who are symptomatic, whose biological father or brother has been diagnosed with prostate cancer, and for all men 50 or older.

19) **Sections 47-48 - Lyme Disease.** Mandates coverage for Lyme disease treatment including not less than 30 days of intravenous antibiotic therapy, 60 days of oral antibiotic therapy, or both, and provides for further treatment if recommended by a board-certified rheumatologist, infectious disease specialist or neurologist.

20) **Section 50 - Husky Parity.** Applies the mental health and substance abuse parity language to the Husky program.

Public Act: 99-284
Effective Date: Essentially October 1, 1999. Mandates on January 1, 2000 and Confidentiality of Medical Records on July 1, 2000.
Governor: Signed on July 7, 1999.

■ **SCOPE OF PRACTICE**

Several Scope of Practice bills were introduced this session, including legislation aimed at preventing the discrimination of optometrists on the basis of their not maintaining hospital privileges. This section will primarily detail our activities surrounding that issue.

SB 474 AAC Hospital Privileges, sought to prohibit managed care companies from using hospital privileges as the sole criteria for excluding a provider from a network.

CSEP opposed this legislation and a similar bill (HB 6956) in the Insurance Committee. A public hearing was held on March 11th before the Public Health Committee where Stephen Thornquist, M.D. testified in opposition to the legislation citing the importance of hospital privileges to the full continuum of care necessary for many patients.

The Public Health Committee approved the bill on March 30th, with significant reservation by several members of the committee and an indication that the bill would not move much further in the process.

HB 6956 AAC Contracts with Optometrists, prohibited excluding optometrists from managed care plans solely on the basis of hospital privileges and was the House's companion bill to SB 474.

Dr. Thornquist testified before the Insurance Committee in opposition to the bill on March 9th. After discussions with Rep. Jim Amann, the committee's co-chair, he assured us that he would work with us on the bill and that it was an attempt to address actions taken by CIGNA and ConnectiCare. CSEP followed up with CIGNA, who then discussed the issue with Rep. Amann and demonstrated that they do not exclude providers on the basis of hospital privileges.

We continued to oppose the bill in the House and delayed a vote to craft an amendment to prohibit plans from excluding ophthalmologists on the basis that they do not have dispensaries. Although it was originally conveyed that the bill was "merely to keep pressure on the managed care companies and would not move," optometrists were putting pressure on Rep. Amann to vote on the measure. We met with Rep. Amann and Rep. Hamzy and secured their support for our amendment, which was to be called in the House. Because of confusion the day the bill was called, the amendment was not called and the bill

passed the House without the CSEP provision. We immediately approached Senate leadership and encouraged them to place the bill on the foot of the calendar as was done with all managed care related issues. At the same time we convinced Sens. DeLuca, Daily and Harp to introduce our language, securing a commitment that a bill would not move without our change. CSEP grassroots were particularly helpful in this regard. Neither bill moved, although a provision, which included our language, was included in the original draft of the Department of Public Health implementer. The entire section was removed, however, because the Optometrists complained about our provision.

SB 945 An Act Concerning Authorization of Treatment Under Health Care Practitioner's Scope of Practice, although more broadly drafted, this legislation seeks to strengthen the role of allied health professionals in managed care.

The CSEP joined the CSMS in opposing this proposal, which had a public hearing before the Public Health Committee on March 9, 1999. The committee failed to take action on the bill.

■ DEFINITION OF SURGERY

The CSEP, joined by the CSMS and other specialty groups, initiated legislation aimed at codifying the declaratory ruling of the Medical Examining Board and establishing a statutory definition of surgery. After lengthy discussions, all specialties approved the language and several representatives, including Kristen Zarfos, M.D., Lynn Welchel, M.D., Andrew Packer, M.D., Bruce Browner, M.D., Robert McLean, M.D., all testified before the Public Health Committee and were joined by Mag Morelli, Director of Government Relations in supporting the bill.

HB 5469 AAC the Definition of Surgery, sought to establish a definition of surgery against which to apply new technologies and medical advances in the years to come.

Early on, we met with Rep. Mary Eberle, the co-chair of the Public Health Committee on a variety of issues at which time she indicated she would not schedule the bill for a hearing if a great deal of opposition was mounted, especially within the physician community. Despite efforts by the optometrists to oppose the bill, a hearing was scheduled.

On March 30th, Doctor's Day at the Capitol, several physicians representing a variety of specialty groups presented testimony in support of the proposal. Despite efforts to get the podiatrists on board, the attorney for the chiropractors and podiatrists, Bob Hirtle, raised issue as to why the bill was necessary. Several optometrists also testified against the bill indicating it had been a direct attack on their profession.

As indicated earlier, Rep. Eberle refused to schedule the bill for a vote fearing a big battle on the House floor. The issue became somewhat connected to the debate over office-based surgery in general as raised by the CON proposals

submitted by the Connecticut Hospital Association.

Committee members encouraged us to continue working in the off session with the Department of Public Health and others to resolve the issue. Several options are available: 1) Explore the opportunity to request the Medical Examining Board to rule on the definition of surgery; 2) Use the office-based surgery issue at OHCA as a vehicle to define laser surgery as surgery (See Certificate-of-Need); or 3) Next session seek legislative relief.

▪ **LASER POINTERS**

The CSEP identified laser pointers as a proactive issue this session and made Dr. Riordan the point person.

HB 6975 AAC Laser Pointers, prohibits the sale, lease or giving of a laser pointer to anyone under 18 unless it is related to an educational purpose and used under the direct supervision of a parent, legal guardian, teacher, employer or other responsible adult. The bill prohibits shining, focusing or pointing a laser pointer either directly or indirectly at another person in a manner that caused harassment, annoyance or fear of injury. A violation of this provision is considered an infraction.

Patricia Riordan, M.D. submitted testimony on behalf of the CSEP to the Public Safety Committee at a public hearing on March 9, 1999. The bill was unanimously approved by the Public Safety Committee on March 23rd and referred to the Judiciary Committee for approval. The Judiciary Committee approved the bill on April 14th.

Public Act: 99-256
Effective Date: October 1, 1999
Governor: Signed on June 29, 1999

▪ **DELEGATION OF DROPS**

Originally, this issue was a priority of the CSEP last session, but after discussions with the Public Health Department and assurances not to change department policy until a study of delegation was completed, the CSEP opposed the bill this session.

SB 411 AAC the Administration of Pre-Diagnostic Eye Drops, would have allowed ophthalmologists and optometrists to delegate the administration of certain eye drops to personnel within their offices.

William Ehlers, M.D. testified in opposition to the bill before the Public Health Committee on March 9, 1999. In addition, we met with Rep. Mary Eberle and voiced our opposition to the bill. As a result, the Public Health Committee took no action.

We monitored the amendment process and no amendments were filed to allow for delegation by Optometrists.

■ **APRNs**

Faced again with legislation aimed at granting APRNs independent practice, the CSEP supported the CSMS in their negotiations with the CNA in developing a collaborative approach to APRN/Physician practice.

SB 333, An Act Concerning Advanced Practice Registered Nurses, introduced by Sens. Harp and Peters, was originally proposed to allow APRNs independent practice. HB 5681, AA Providing Direct Access to APRNs in Health Insurance Plans, was never raised by the Insurance Committee.

For several weeks the CSMS met with representatives of the Connecticut Nurses Association (CNA), Sen. Peters and Rep. Winkler, in an effort to reach agreement on compromise language on a collaborative relationship between physicians and APRNs. After many exhaustive negotiation sessions, Sen. Peters finally removed nurse anesthetists (CRNAs) from consideration and the CRNAs will continue to be directed by a physician. This was a key priority for physicians. Rep. Winkler was a strong advocate for requiring nurse anesthetists to remain under the direction of a physician.

The central concept of this compromise is that a collaborative relationship will be required between physicians and APRNs. When prescriptive privileges are also determined to be part of the APRNs role, this collaborative relationship must be in writing. This legislation does not affect nurse midwives and nurse anesthetists who will continue to practice under the same statutory relationship that currently exists in state law. The entire compromise relies on the fact that collaboration will be a **mutually agreed upon** relationship between a physician and APRN that will be individually structured to adequately address and provide for quality patient care. This collaborative relationship can allow for direction by the physician and if the APRNs prescribing ability is expanded to include Schedule II and III drugs it must be specified in the individual's written collaborative agreement. Finally, malpractice coverage for APRNs is also required.

The CSMS worked closely with CSEP and the state's family physicians, anesthesiologists, pediatricians, psychiatrists, and internists during these deliberations. Sen. Peters and Rep. Winkler went a long way to ensure an appropriate bill was crafted. Rep. Eberle was also helpful and clarified that the collaborating physicians must have education and experience in the clinical work of the APRN. We also had legislative intent read into the record in both chambers to clarify our understanding of the compromise. Sen. Peters and Rep. Winkler provided that information to their respective chambers.

Public Act: 99-168
Effective Date: October 1, 1999
Governor: Signed on June 23, 1999

■ **CERTIFICATE-OF-NEED**

CHA requested legislation this session designed to extend the CON process into physician offices that perform surgical procedures. The Office of Health Care Access continues to review the issue and has convened a working group to consider a variety of concerns.

SB 1296 AAC Outpatient Surgical Facilities and CONs, the CHA proposal, defined outpatient surgical facility so broadly that it would have included most physician offices and would have extended the CON requirement to all such facilities.

Steven Thornquist, M.D. testified on behalf of the CSEP in opposition to the proposal before the Public Health Committee on March 11, 1999. Citing the barriers to patient care and the added expense the CON process would create, the CSMS called for recognizing and requiring professional standards of accreditation as established by Medicare, the AAAASF, JCAHO and the AAAHC for office surgical facilities.

HB 6990 AA Extending Hospital Taxes to Outpatient Surgical Facilities, was an alternative created by Rep. Eberle, Co-chair of the Public Health Committee, in response to SB 1296 and in an effort to "level the playing field." This bill extended the hospital gross receipts tax to outpatient surgical facilities, as defined in SB 1296.

The CSEP also opposed the bill before the Public Health Committee on March 11, 1999. Again focusing on added costs, the CSEP comments highlighted the advantage of the non-profit hospitals tax-exempt status and also stressed the uncompensated care provided now by physicians.

The committee failed to take action on either proposal, although originally intended to use Medicare certification as a trigger for CON. Instead, the committee will wait for the recommendations of a working group organized by the Office of Health Care Access (OHCA). At our request, Steve Thornquist, M.D. was included on the working group representing the CSEP. The draft declaratory ruling was published in the Connecticut Law Journal soliciting comments from the physician community and the hope is to come to a resolution that is acceptable to all. Public hearings are to be held by OHCA on August 31st and September 1st.

■ VISION SCREENING

Elwin Schwartz, M.D. was identified as the point person on vision screening issues and testified on several proposals before the transportation Committee.

Dr. Schwartz testified on several proposals before the Transportation Committee, supporting the requirement that motor vehicle operators present proof or pass a vision screening within the two preceding years of renewing a license.

SB 1000 AAC Vision Screening, would have required a motor vehicle operator to present proof of passing a vision screening within the two preceding years of renewing a license. Existing statutes require vision screenings with every other renewal, although that provision is set to take effect July 1, 1999.

In the interest of public safety, Dr. Schwartz encouraged the Transportation Committee to support the bill during a public hearing on February 8th. Faced with budget constraints, the committee instead opted to push back implementation of the vision-screening requirement in HB 6796.

HB 6796 AAC Vision Requirements to Safely Operate a Motor Vehicle, proposed by the governor, this bill originally would have required anyone over the age of 62 to have their vision screened when renewing a license.

Dr. Schwartz submitted written comments and on the basis of age-discrimination instead encouraged the committee to report favorably on SB 1000.

On March 22, 1999 the Transportation Committee approved a substitute version of the bill simply pushing back the implementation of the vision screening requirement until July 1, 2001.

On April 23rd, the Appropriations Committee again substituted the original version as proposed by the Governor.

In the confusion of the final days of the session, the House mistakenly approved HB 6796, which included the age provision. This was never the intent of the co-chairs of the Transportation Committee, and an amendment was later added to SB 1405, AAC Safety Inspections of Motor Vehicles and Vision Screening.

Under the bill, the implementation of the vision screening requirement currently in statute is pushed back to July 1, 2001, and the screening must occur in the twelve months preceding the renewal.

Public Act: 99-287
Effective Date: July 1, 1999
Governor: Signed on June 15, 1999

■ **DISCLOSURE OF OWNERSHIP**

This issue focused on informing patients when a financial interest exists between the insurer and practice.

HB 6705 AAC Health Care Ownership, introduced by Rep. Michele, was aimed at keeping health care consumers informed of the ownership of their provider's practice.

A priority of the CSEP, Stephanie Sugin, M.D. testified in support of HB 6705 before the Public Health Committee on March 11, 1999. Because financial arrangements have the potential to affect the care a patient receives, the CSEP encouraged the committee to approve the bill to serve the interests of patients. The committee failed to take action on the legislation.

HB 6993

AA Requiring Disclosure to Patients of any Fee or Other Compensation for Referral of the Patient to the Provider, requires certain health care providers to notify their patients of changes in ownership within their practices, as well as expanding the current disclosures concerning compensation for referrals.

In addition to notifying a patient when a practice is sold or transferred to any other organization or licensed provider, a provider must post in the waiting room a visible notice naming the practice owner, including a contact person, and phone number. When a patient is referred for any services to any entity owned by the same parent organization, the provider must also disclose this information to the patient.

A public hearing was held on March 9, 1999 before the Public Health Committee. Originally the bill did not include the disclosure provision as testified on in HB 6705. On April 13th, the Public Health Committee approved HB 6993 and inserted the disclosure provision. This was to be one of the issues considered for inclusion in the managed care bill. When the final bill was negotiated, the provision was not included.

DPH Budget Implementation Bill

As mentioned earlier, the session adjourned with several of the budget implementation bills not having been acted on in both chambers. One of the proposals, which implemented several aspects of the budget related to health care initiatives died in the final minutes of the regular session. On Monday, June 14th, the General Assembly convened a special session to vote on these important bills. HB 7501, **AAC Expenditures For The Programs And Services Of The Department Of Public Health**, included a health care provision of interest to the CSEP.

- **Test Result Notification**

Requires a provider to notify a patient of any test results that indicate a need for further treatment or diagnosis. This provision was included at the request of Rep. Tonnucci who had had a constituent problem concerning notification of test results, which had indicated the need for further medical care but this need was never conveyed to the patient or his family. This provision will hold Optometrists accountable to notify a patient of the outcome of any test result and indicate what further medical care may be necessary.

Public Act:	99-02 (Special Session)
Effective Dates:	Upon Passage
Governor:	Signed June 29, 1999

- **HUSKY**

We identified and monitored a number of bills related to the HUSKY program and rather than testify on each proposal, Drs. Packer and Ehlers sent a letter to the Human Services Committee siting the problems CSEP has had in obtaining information on participating plans and how to become a participating provider. The HUSKY bills failed to gain approval, although the managed care bill did include a provision.

Section 50 of the managed care bill, **HB 7032**, applies the mental health and substance abuse parity language to the Husky program.

Public Act: 99-284
Effective Date: October 1, 1999
Governor: Signed on July 7, 1999.

SB 1334, AA Improving Oversight of Medicaid Managed Care Plans, requires the Medicaid Managed Care Council to make recommendation to DSS on the need for program quality studies in the areas under its review, including the HUSKY program

Public Act: 99-167
Effective Date: October 1, 1999
Governor: Signed on June 23, 1999

■ **Conclusion**

This was a successful year for eye physicians, with the passage of additional managed care reform and the resolution of the APRN issue. Although legislation to define surgery failed to win approval this session, we will continue to work with the CSMS and formulate an appropriate strategy on how best to address the issue. We will continue to monitor the CON issue and the development of the physician profile in the coming months. In addition, we plan to work closely with the Department of Insurance to better position physicians for additional improvements to the managed care system in the 2000 legislative session. Throughout the off session, we will monitor the activities of the health department and provide updates to the society whenever appropriate, continue to meet with key proponents on priority issues to better position the society in 1999, and assist in holding fundraisers for key legislators.

While it is always a challenge to represent physicians in this ever-changing landscape of managed care and provider competition, we enjoy our relationship with CSEP. We hope that we have earned your trust and patience and look forward to the year 2000.

Gail F. Schwartz, MD
Maryland Society of Eye Physicians and Surgeons
1998-1999 Leadership Development Program
Project Abstract

Title of Project: *Maryland's Model State Society Strategy*

Purpose: The Maryland Society of Eye Physicians and Surgeons (MSEPS) efforts to become a Model State Society.

Methods: Needs were assessed by conferring with Executive Board members and members in various regions of the state. Plans were designed to increase membership, provide services to regions of the state outside the Baltimore-Washington corridor, and implemented the legislative and annual plans, a third party payor report.

Results: New members were recruited by a combination of mail and direct contact. Attention was also focused on involving younger practitioners to become involved in MSEPS. Two AAO co-sponsored CPT Coding Seminars were held: one in Baltimore and one in Frederick. MSEPS joins with state societies of DC and VA for the Mid-Atlantic Regional Meeting, May 12-14, 2000 *Eye M.D.s Seeing into the Millennium*. A legislative plan was put into action in conjunction with the MSEPS lobbyist. Additional MSEPS activities included a wide range of activities including public service and eye safety awareness, enhanced team planning with Med Chi, the state medical society, and sponsorship of educational and CME programming.

Conclusion: Anticipating meeting the membership requirement upon receipt of completed outstanding applications, Maryland will have fulfilled the criteria to become a model state society.



Gary S. Schwartz, MD
Minnesota Academy of Ophthalmology
1998-1999 Leadership Development Program
Project Abstract

Title of Project: *Young Ophthalmologist Section @ MAO*

Purpose: To increase both membership and involvement of ophthalmologists in training and their first five years of practice in the Minnesota Academy of Ophthalmology (MAO). By showing these young members the value of the MAO at an early stage in their careers, it was hoped that they would remain active members, and become future leaders in the Academy.

Methods: A section was created within the MAO to address the needs of ophthalmologists in training and their first five years of practice. This section was named the Young Ophthalmologist Section at the Minnesota Academy of Ophthalmology (YOS@MAO). All MAO members in training or their first 5 years of practice are automatically included in mailings for the Section. A YOS@MAO article is written for each newsletter to let members know of upcoming events. Educational and social events have been organized. All educational events specifically address the needs of those starting out in practice. All social events are aimed towards those with young children.

Results: Young ophthalmologist membership, involvement in committees and membership on the Board of Directors is at an all-time high within the MAO.

Conclusion: The YOS@MAO has been an effective way to get young ophthalmologists to be not only members, but also active within the MAO. It remains to be seen if those who have been active through this inaugural year will remain active and will seek leadership roles as their careers progress.



Gareth A. Tabor, MD, PhD
Georgia Society of Ophthalmology
1998-1999 Leadership Development Program
Project Abstract

Title of Project: *OAO Public Outreach and Education Program*

Purpose: To renew and strengthen the Oregon Academy of Ophthalmology's *Ageing Eye Speakers Bureau*.

Methods: This past year the Oregon Academy of Ophthalmology renewed and strengthened our Ageing Eye Speakers Bureau. First, we contacted senior centers through the state, offering to have Eye M.D.s give aging eye presentations. At the same time, we promoted the effort with our own members, urging them to volunteer to give presentations.

Results: The response -- from the senior centers and from ophthalmologists -- has been terrific! So far this year, our Academy staff has filled over a dozen requests for speakers at senior centers.

Conclusion: The program accomplishes three goals: 1) it provides valuable eye care information to senior citizens; 2) it helps establish Eye M.D.s as the source of that information; and, 3) it introduces ophthalmologists to people in their communities.

We are also looking for opportunities to reach out to children. This year, for the first time, the Oregon Academy of Ophthalmology participated in the Community Health Fair held in northeast Portland, giving eye screenings to dozens of youngsters.