

Yara P. Catoira-Boyle, MD
Indiana Academy of Ophthalmology
Leadership Development Program XVII, Class of 2015
Project Abstract

Title of Project: *The use of social media and in-person events to educate legislators and the public about the difference between optometrists' and ophthalmologists' training*

Purpose: To increase awareness of the training required to become a physician and an ophthalmologist amongst two groups: group 1 was the state legislature health committee; group 2 was the public at large.

Methods: 1) Letters were sent to legislators (senators and representatives) in the Health Committee of the state legislature. The letter outlined the training required to become an ophthalmologist and offered the opportunity to spend time at an Eye MD's office in their district. 2) Emails and phone calls were made to local ophthalmologists in the respective districts to facilitate contact between Eye MD and the local legislator. 3) A local start-up digital media company was contacted regarding the possibility of a pro-bono general public campaign related to medical care as it relates to eye diseases.

Results: In progress

Conclusions: TBA

Atif B. D. Collins, MD
National Medical Association, Ophthalmology Section
Leadership Development Program XVII, Class of 2015
Project Abstract

Title of Project: *Improving the pipeline: determining barriers to a successful match for the minority Ophthalmologist in the new Millennium.*

Purpose: Recent data has shown a decline in the number of minority and African Americans in medical school¹. The number of minority ophthalmologists is small and even smaller for African Americans². The face of America is rapidly changing and in 2020 minority children (<18 years old) will become the majority of children (50.2%); the total population of the US will be majority minority in 2044 (50.3%)³. The current national population of African Americans is 12% but less than 4% of trainees in Ophthalmology². In order to prepare our physician workforce for the next 50 years we need to rapidly increase the diversity of our ophthalmologists. Our study will focus on variables that may determine success of the practicing minority Ophthalmologist.

Methods: A computerized survey consisting of 24 multiple-choice questions was written and distributed via Survey Monkey to members of the National Medical Association (NMA), Ophthalmology Subsection. This is a historically African American run medical organization that focuses on promoting diversity and ending health disparities in ophthalmic disease and care. This survey was reviewed and approved by the President of the NMA and the executive committee.

Results: 200 members of the National Medical Associations Ophthalmology subsection were sent the link for the survey. Results pending

Conclusions: TBA

References:

1. Smith et al, Diversity of United States medical students by region compared to US Census data. *Advances in Medical Education and Practice* 2015;6 367-372
2. AAMC Physician Specialty Data 2008
3. US Census data; Projections of the Size and Composition of the US population 2014-2060: March 2015

Ophthalmologist NMA Diversity

1. Did you attend an allopathic or osteopathic medical school?

- Allopathic
- Osteopathic

2. Did you graduate from a foreign, domestic or Caribbean medical school?

- Foreign
- Domestic
- Caribbean

3. How many years have you been practicing Ophthalmology?

- 0-4
- 5-10
- 10-15
- 15-20
- 20-25
- 25-30
- 30-35
- 35-40
- 40+

4. Was your medical school based in a city or rural area?

- City
- Rural

5. Did you have a department of Ophthalmology affiliated with your medical school?

- Yes
- No

6. Did your medical school have an Ophthalmology interest group?

- Yes
- No

7. Did your medical school have basic science or clinical exposure to Ophthalmology in the first two years?

- Yes
- No

8. Did you have an Ophthalmology residency training program at your home or affiliated institution?

- Yes
- No

9. Did you have an Ophthalmology residency training program at your home or affiliated institution that offered an elective rotation?

- Yes
- No

10. What is your ethnic background?

- Black/African American
- Hispanic/Non White
- Caucasian
- Asian

11. What is your nationality?

- United States
- Canada
- Latin America
- Europe
- Asia

12. What languages do you speak?

- English
- Spanish
- Chinese
- French
- Other

13. What is the highest level of education of your parents?

- Grade school
- Highschool
- College
- Masters
- Doctorate
- Law Degree

14. Do/did you have a physician in your family?

- Yes
- No

15. Do/did you have an Optometrist in your family?

- Yes
- No

16. Do/did you have an Ophthalmic technician or Optician in your family?

- Yes
- No

17. Did you have mentors of your same ethnic background in the medical school?

- Yes
- No

18. Did you have mentors of a different ethnic background in the medical school?

- Yes
- No

19. Did you have mentors of your same ethnic background in the community?

- Yes
- No

20. Did you have mentors of different ethnic background in the community?

- Yes
- No

21. What year in medical school did you decide on Ophthalmology?

- First
- Second
- Third
- Fourth

22. Did you complete training in another medical speciality?

- Yes
- No

23. Did you complete an Ophthalmology fellowship?

- Yes
- No

24. Did you complete a pre-residency fellowship?

Yes

No

Done

Geoffrey G. Cooper, MD, FACS
Virginia Society of Eye Physicians and Surgeons
Leadership Development Program XVII, Class of 2015
Project Abstract

Title of Project: *It's just lunch: a program to link Virginia Ophthalmologists with their Legislators*

Purpose: To involve Virginia Ophthalmologists in the political process on an ongoing basis by developing formal and informal links with their legislators. This will allow Ophthalmologists to be involved in the political process continually, and not be responding only in times of crisis.

Methods: A program design was discussed with our VSEPS lobbyist, and with the AAO regional chairman. The program design consisted of a survey to be distributed to all Virginia Ophthalmologist to determine who already had linkage to legislators, as well as to determine which legislators were their representatives. The Virginia legislature is in sessions for 45 to 60 days each year, and the legislators are very busy during these times. This program was designed to make contact with legislators when they are not meeting in Richmond. The second phase involved calling legislators to determine times of availability to meet for breakfast or lunch with an Ophthalmologist for a get acquainted meeting. The availability times were then given to the Ophthalmologist with the message that your legislator would like to meet with you to get to know you. The Ophthalmologist was given a script and encouraged to talk about training, practice and surgery. As follow up, where allowed by the Ophthalmologist's hospital or surgery center, the legislator was invited to visit to watch surgery. The overall message we want to convey is that Ophthalmologists are extensively trained and that the surgery we perform is complex. The Ophthalmologist was encouraged to have ongoing contact with his or her legislator, to attend community and fund raising events, and become a familiar face who could be called upon as an expert on Health Care and Eye Care matters.

Results: We have conducted the survey, and are processing data, waiting until the Fall for the next phase. I have met with my State Senator. We have not yet linked other Ophthalmologists with their representatives, but plan to do so in the late Fall after the November elections (Virginia is one of the few States to hold elections in odd numbered years, so all representatives and senators to the Virginia House of Delegates are now campaigning for the November, 2015 elections). I hosted a fund raising, and community awareness event for my State Senator (newly elected to our senatorial district to complete a partial term 1 year ago), and have introduced her at several community meetings. Our precinct provided her margin of victory during her primary, and has been among her most loyal supporters. Interestingly, she has a background in health care as a nurse and nurse manager, and is well respected by both parties, and provides the swing vote in a closely divided senate with her ability to work across the aisle. I plan on hosting further events for her during her general election campaign. I feel that I have gotten to know her on a personal level and that she will take my call and listen to our position when the need arises.

Conclusions: Creating a mechanism for Ophthalmologists to become involved in the political process on a one on one, non-threatening basis enhances our ability to have our voices heard. VSEPS as an organization has an effective lobbyist, and a core of committed physicians. We seek to expand our contact with legislators. It is important that we reach out and involve as many ophthalmologists as possible in the political process. Quite simply, if we wait for a time of crisis in order to be represented then it is too late. We must stay constantly involved in the political process at a grass roots level in order to have our positions considered.

Scott M. Guess, MD
Montana Academy of Ophthalmology
Leadership Development Program XVII, Class of 2015
Project Abstract

Title of Project: *Montana Academy of Ophthalmology (MAO) Annual Winter Meeting*

Purpose: To evaluate ways to improve the MAO Winter Meeting for attendees and the organization. Specifically to increase attendance, add value of the meeting to the attendees and increase revenue to the society.

Methods: An 11-question survey was administered via SurveyMonkey (Palo Alto, CA) to members of the MAO with permission from the state society. A total of 40 individuals were contacted representing 100% of the MAO membership. Survey responses were merged to create a data set. Also, profit and loss from the 2014 and 2015 annual meeting were analyzed to determine revenue source and areas of expense.

Results: Survey response rate was 42.5%. Of those that responded 64.7% attended the 2015 meeting. Reason to attend the meeting from most important to least important were, 1) Meeting with colleagues, 2) Clinical Education, 3) Skiing, 4) Supporting the state society and 5) Advocacy at the state level. Overall 54.6 % of respondents that attended the meeting rated the meeting as Excellent and 27.3% rated the meeting as Very Good. A majority of the respondents that attended the meeting thought that it was About Right in regard to duration. Those that did not attend the meeting listed a Conflict With Other Plans as the underlying reason in 83.4% of responses. An additional reason for not attending was being on call. 83.4 % of the non-attendees plan to attend next year. 72.7% of those that did attend would be interested in having CodeQuest (AAO) at next year's meeting. Profit was down in 2015 compared to 2014 due to increase in facility cost. 75% of revenue came from corporate sponsorship with only 25% from registration fees.

Conclusion: The MAO Winter Meeting is a valuable resource to members of the organization. Members that attend the meeting value the ability to network with colleagues and receive clinical education as the top two reasons to attend. Taking time off to enjoy Montana's beautiful winter on skis comes in third. Adding CodeQuest in the future may add additional value while drawing more members to the meeting. A majority of the respondents that did not attend the meeting plan to do so next year. Facility cost was the primary expense to the organization. Having the meeting during the off season at a ski resort would lower facility cost. This would likely result in a decline in membership participation given that the 3rd ranked priority at the meeting is skiing. A majority of the revenue came from corporate sponsorship and more specifically companies that supply pharmacologic agents to treat retina disease. In the past these companies have required lectures on retina topics to continue their sponsorship. Retina grand rounds will be created to satisfy this requirement.

James G. Howard, MD
Utah Ophthalmology Society
Leadership Development Program XVII, Class of 2015
Project Abstract

Title of Project: *Encouraging and Facilitating Advocacy Efforts in the Utah Ophthalmology Society*

Purpose: Legislative advocacy efforts are often stifled by a lack of knowledge regarding how to begin as well as by a variety of other existing barriers. The purpose of this project is to provide members of the Utah Ophthalmology Society with opportunities to engage in advocacy efforts and to facilitate advocacy efforts within our state society.

Methods: In an effort to accomplish the aforementioned goals, we have done three things. First, we have provided each of our members with the names and contact information for their state representative and senator. Second, we have invited our state legislators to spend a day with our ophthalmologists in the operating room. Third, we will have our legislative affairs committee monitor relevant legislation as it is introduced and moves through the state legislature and will have them send out email blasts regarding such legislation.

Results: The result of matching ophthalmologists with their state representatives is difficult to quantify, but we believe that it will help to familiarize our members with their representatives and make it easier to contact them when needed. We have sent invitations to our members' representatives and invited them to join our members in the operating room to observe eye surgery. This portion of the project is mid-process – data regarding the success of this program will be forthcoming. In the coming legislative session our legislative committee will be monitoring ophthalmology and healthcare-related legislation. The committee, in conjunction with the councilor and UOS leadership, will develop informational email content with a recommended course of action that can be sent to our membership as email blasts.

Conclusion: We are confident that removing barriers and facilitating advocacy efforts will improve advocacy efforts within our state society. With advocacy efforts, there can be an “energy of activation” that needs to be overcome as we try to get our state society members engaged in advocacy efforts. Anything that we can do to lower the energy of activation will benefit and improve our advocacy efforts. We anticipate that accomplishing these three objectives – providing legislative contact information, inviting legislators to the OR, and sending out email blasts – will yield positive results.

Nada S. Jabbur, MD
Lebanese Ophthalmological Society
Leadership Development Program XVII, Class of 2015
Project Abstract

Title of Project: *Increasing awareness of importance of visual screening in young children in Lebanon*

Purpose: To investigate the consistency of visual screenings first in schools in Greater Beirut and then implement ways to increase awareness and importance of visual screenings in children of amblyogenic age and in underprivileged areas in Lebanon.

Methods: First, a telephone survey was designed to capture information from schools in Greater Beirut at start of school year regarding availability and consistency of visual screenings and personnel involved in it and interest in developing a quick screening when it was not available.

Second, ophthalmologists reached out to pediatricians and family practitioners to teach basic vision screening in children of amblyogenic age.

Third, underprivileged children of lower socioeconomic status were visited in orphanages and/or refugee camps to complete visual screenings.

Results: Less than one third of schools in the Greater Beirut area do regular visual screenings in children. This is estimated to be even less in the rest of Lebanon.

Children in camps do not get visual screenings.

Most pediatricians do not have enough personnel in their offices to do visual screenings and depend on schools to do so.

A number of eye-related professionals are interested in teaching personnel to do screenings.

Conclusions: There is a definite need in increasing awareness of visual screenings in Lebanon at all socioeconomic levels. Developing teams of volunteers among eyecare professionals is essential. The latter will identify and teach key personnel in schools, orphanages, and family practitioner as well as pediatrician offices. Interested donors will be identified to help financially with providing first the tools for eye exams as well as providing the glasses when needed.

Public media in the form of short TV ads, posters and pamphlets can also improve awareness.

Janice C. Law, MD
Tennessee Academy of Ophthalmology
Leadership Development Program XVII, Class of 2015
Project Abstract

Title of Project: *Mentoring and Advocacy for Young Ophthalmologists in Tennessee Academy of Ophthalmology (TNAO)*

Purpose: To increase participation and engagement of Tennessee young ophthalmologists-in-training in their state ophthalmic society; to nurture a relationship between ophthalmologists-in-training and Leadership Development Program graduates or board members from TNAO; to improve the online presence of the TNAO organization and marketing the importance of Eye MDs being the leader of the eye care team.

Methods: A retreat is scheduled for October 2015 to unite both training programs in Tennessee: University of Tennessee Hamilton Eye Institute and Vanderbilt Eye Institute. The retreat will have an (1) introduction by a TNAO board member on the history of the organization and its mission, (2) two key note speakers on marketing and shaping your online professional presence, and a (3) small-group brainstorming session to craft solutions for improving the current TNAO online presence. Ideas that come from the brainstorming session will be reviewed by the TNAO board and LDP graduates/board members will be assigned to mentor the groups during the completion of their projects throughout the year.

A paper evaluation and online survey will be distributed post event to further understand how each participant experienced the retreat and brainstorming session. The results of the projects will be reviewed and evaluated in spring of 2016 before the academic year ends. A survey will be distributed to the TNAO organization to survey their experience in engaging young ophthalmologists in marketing and online presence improvement projects.

Expected Results: Members-in-training and TNAO board members will be educated on how to enhance their own online presence as well as the ophthalmic society's online presence with respect to marketing to the community the importance of Eye MDs being the leader of the eye care team. Members-in-training will build relationships with the members of Tennessee Academy of Ophthalmology and have first-hand experience with working together towards crafting solutions and designing improvements for the state society.

Results of improvement projects for TNAO's online presence will be available Spring of 2016. We expect to see an increase in website traffic from the public as well as from members and non-member community ophthalmologists. We expect to see more educational information and outreach from the TNAO to the community establishing that Eye MDs are the leaders of the eye care team.

We also expect that members-in-training will see the tangible impact they can make in their state society organization as it relates to advocacy.

Janice C. Law, MD

Mentoring and Advocacy for Young Ophthalmologists in Tennessee Academy of Ophthalmology (TNAO)

Expected Conclusions: Young ophthalmologists-in-training can play an important role in state societies. They offer a fresh energy, technology skillsets, and a unique perspective as it pertains to online professional presence, information acquisition, and outreach to communities. The Tennessee Academy of Ophthalmology does not have a young ophthalmologists section and does not have direct relationships with the members-in-training in Tennessee. Conversely, most members-in-training do not realize that there are TNAO leaders within their own community.

Young ophthalmologists-in-training need to be shown at an early stage in training the importance of state society membership and how the state society advocates for physician practices and patient safety. This project affords the trainees and practicing ophthalmologists an opportunity to work together, bridge local relationships, and rejuvenate the online presence of their organization. The organization benefits from the collaboration between groups and the young ophthalmologists will have first-hand experience they can take to other state societies in their future practices.

Rachel A. Lieberman, MD
Society of Military Ophthalmologists
Leadership Development Program XVII, Class of 2015
Project Abstract

Title of Project: *Observership for International Military Ophthalmology Residents*

Purpose: To familiarize international military ophthalmology residents with clinical practice in a U.S. military hospital setting. Medical observerships provide a unique opportunity to solidify international relationships between nations, as well as to promote international standards and advance medical knowledge by investigating regional differences. During this observership, international military residents will be able to study professional communication and interaction between physicians and patients, as well as all members of the health care delivery team and hospital administration. They will also gain exposure to U.S. cultural practices, academic medicine, and electronic medical record systems.

Methods: Nations with military ophthalmology residencies were identified by contacting international LDP participants, as well as word of mouth among military ophthalmologists on overseas assignments. A discussion was led between the program directors of the four U.S. military ophthalmology residency programs (Walter Reed National Military Medical Center, San Antonio Military Medical Center, Madigan Army Medical Center in Tacoma, Washington, and Naval Medical Center San Diego) to structure the one-month observership and create guidelines. Various departments which coordinate international military training were contacted for the Army, Air Force, and Navy. Federal rules and restrictions guiding international military training were reviewed with all concerned. Funding and security agreements were also addressed.

Results: Military and civilian ophthalmologists from many nations repeatedly expressed strong support for the observership. Afghanistan, Argentina, Colombia, Hungary, Iraq, Mexico, Peru, and Turkey were identified as having ophthalmology residents in military hospitals or training programs who will serve as active duty ophthalmologists upon graduation. Due to a history of successful training partnerships with Hungary and Mexico, these two nations were selected to initiate the observership program. A review of U.S. military policy showed that both the Army and Navy have guidelines formulated for this type of observership. After careful discussion with the U.S. residency program directors and international training managers, the Army hospitals of San Antonio Military Medical Center and Madigan Army Medical Center were chosen to begin. As required by U.S. federal regulations, funding for the observership (to include transport, lodging, and the cost of training at the hospital) will be provided by the sending nation. Multiple other regulations apply, including the fact that observers must pass an English-language comprehension test and significant background checks to be eligible for the training. The authorization process for the observership is currently underway. Approval is required on many levels, starting with the U.S. Embassies in Hungary and Mexico and extending to the U.S. State Department and Surgeon General's office.

Conclusions: Doctors around the world strongly value an observership program for international military ophthalmology residents. The observerships will educate visiting trainees in American ophthalmic practices, while also fostering cooperation and partnership between nations. Additional steps are required to send the initial observers from Hungary and Mexico, expand the observership to other sites in the U.S., and involve residents from more countries. Other specialties may also use this program as an example to start a military observership of their own.

Faruk H. Orge, MD
American Association for Pediatric Ophthalmology and Strabismus
Leadership Development Program XVII, Class of 2015
Project Abstract

Title of Project: *Pediatric Ophthalmology Worldwide Education Resource (POWER) Center.*

Purpose: To form a comprehensive educational and interactive website for pediatric ophthalmology and strabismus. This website is formed with the AAO ONE Network infrastructure and will have an open access to allow anyone and everyone to reach the content.

Methods: A generous donation from the Knight Templar Eye Foundation of \$1 Million to the AAO Foundation secured for this project will allow acquisition, formation and maintenance of the site. More than 20 sections have been formed and multiple world renown experts are assigned as editors for each section. Under every section multiple chapters are formed by the editors and their teams. The content level is kept at the level of US pediatric ophthalmology fellowship training. More than 110 editors have volunteered to contribute more than 55 chapters, books, lectures, videos for this project Also under this project, novel concepts like “ROP Training Module” and “Strabismus Examination and Testing Simulator” was formed. This content is housed under the AAO ONE Network umbrella. This site was also endorsed and supported by national and international organizations such as AAPOS, IPOSC, ORBIS, etc.

Results/Conclusion: This site immediately will not only expand the educational content accessible for pediatric ophthalmologists and strabismologists but also will be utilized as a tool by educators to be able to teach their students and ophthalmologists they are mentoring worldwide. There has been no other reliable, comprehensive resource available in this scale. The design of the site will allow expansion of the content constantly, forming an ever expanding dynamic digital library.

Heather A. D. Potter, MD
American Association of Ophthalmic Oncologists and Pathologists
Leadership Development Program XVII, Class of 2015
Project Abstract

Title of Project: *Increasing awareness of new AAO website-based Forum for Discussion of Ophthalmic Pathology and Oncology*

Purpose: The American Association of Ophthalmic Oncology and Pathology is unique in several distinct ways.

- 1) There are not a lot of us. Colleagues in our field tend to be geographically dispersed.
- 2) Many times institutions or universities only have one or two ophthalmic oncologists or pathologists on staff limiting alternative insights.
- 3) Our cases are complex and can be approached in many different ways, and our specialty is constantly changing with newer imaging and testing modalities, new genetic research, and new therapies and means of delivering therapies.

As a result of these three points, we have an issue with rapid knowledge sharing and rapid feedback especially when it comes to complex cases.

At this point, the only available forums for discussion of interesting cases are at regional and national meetings and at these, the patient has usually already received treatment or a diagnosis has been rendered. This might change case management in the future, but did nothing to help the discussed patient.

The current process for pre-diagnosis or pre-treatment dialogue from other members of the community of ophthalmic oncologists and pathologists is slow and cumbersome.

An online forum to discuss interesting cases, changing trends in therapy and other topics pertinent to the field would serve our subspecialty better addressing the problems of slow feedback and slow knowledge transfer.

Methods: A search was done for online forums and showed that, while the AAO forum was under development early in the year, it is now ready for membership and participation. It did import a forum discussion which had previously been in use and this showed that no one had posted anything in 4 years and only 1 previous case had been posted. It appears as though fewer than 10 people had ever participated.

An email was written to the Program Planning Committee of the AAOOP explaining the benefits and current state of the forum. A request was made so that at this year's annual meeting in Las Vegas, we can introduce the attendees to the AAO ophthalmic pathology/oncology forum. I will prepare a presentation showing where to access the site, what can be posted, how to post, and how to sign up for weekly notifications. We will then have several people on site during the poster sessions and lunch to help sign people up. We plan to start an interactive, up-to-date discussion of learners and leaders in our field.

Heather A.D. Potter, MD

Increasing awareness of new AAO website-based Forum for Discussion of Ophthalmic Pathology and Oncology

Results: To be determined.

Conclusion: Ophthalmic pathology and oncology is an ever-changing field containing some of the most complex cases in ophthalmology. A forum for interactive up-to-date discussion will help keep our ideas fresh and will assist in providing several opinions on approaches to clinical challenges. The ultimate goal is to help all members provide the best service possible to their patients.

Lindsay A. Rhodes, MD
Alabama Academy of Ophthalmology
Leadership Development Program XVII, Class of 2015
Project Abstract

Title of Project: *Winter is coming: Preparing the ALAO for a possible scope battle*

Purpose: To strengthen the Alabama Academy of Ophthalmology (ALAO) and prepare for a possible future scope expansion challenge. Recognizing that the ALAO has dwindling membership with low PAC donations, a multifaceted approach will be taken to strengthen the state society.

Methods: Several different mechanisms will be used to address the current ALAO deficiencies. 1) Membership: 120 (47%) of the 257 ophthalmologists licensed in Alabama are current members of ALAO. Each member of the Board of Directors (currently 16 members) will be given a list of 5 non-member ophthalmologists to personally contact to encourage membership. Secondly, a retired ophthalmologist and former President of ALAO will be paid a stipend by ALAO to personally contact those non-members in order to secure their membership. Thirdly, the membership dues will change such that members over age 65 will receive a reduced rate, as opposed to the current age of 60. 2) ALAO Funds: A fundraiser will be organized by ALAO in order to increase donations. An ALAO member and 2007 Van Cliburn International Amateur Pianist Competition winner will perform a private recital at the Lyric Fine Arts Theatre in Birmingham, AL in the summer of 2016, with ticket sales raising money for ALAO.

Expected Results: 1) Membership: An increase of 34 (13%) members will be considered a success. 2) ALAO Funds: The ALAO fundraiser will raise \$10,000.

Conclusion: By increasing membership and funds, the ALAO will become a stronger organization better equipped to face a possible scope expansion challenge.

Michael H. Scott, MD
Iowa Academy of Ophthalmology
Leadership Development Program XVII, Class of 2015
Project Abstract

Title of Project: *Creating a website for ophthalmic job opportunities in the State of Iowa; increasing the perceived value of membership in the Iowa Academy of Ophthalmology*

Purpose: One of the goals of any ophthalmic state society is to have every ophthalmologist in the state be a member in that society. In Iowa, we have not yet met that goal. A survey was performed and when nonparticipating ophthalmologists were asked why they were not members in the state society, they stated they did not see any “value” in it. They stated they were all ready AAO members or a member of their subspecialty organization. The question that naturally followed was how to create a perceived “value” for these outliers. The purpose of this project is to have the Iowa Academy of Ophthalmology (IAO) provide a service that would be perceived as valuable to current nonmembers to entice them to join.

Methods: One potential opportunity to create a perceived value was selected based upon a survey that was sent out across Iowa to ophthalmologists and their business managers. The opportunity selected was to try to help ease the ophthalmologist’s ability to practice in Iowa. Even in a solo practice, an ophthalmologist never works alone. The ophthalmologist needs help through a variety of staff members to provide excellent patient care. The plan was for the IAO to help in several ways. First, the IAO was going to help create ophthalmic technician programs in conjunction with existing community colleges. Secondly, the IAO was to add to their website an employment opportunity/job resume page to facilitate access between ophthalmic employers and job seekers. Thirdly, the IAO would add to their website a “chat”/blog site that ophthalmic practice managers to communicate amongst each other to help to solve practice difficulties and, by having the IAO participate in that discussion, increase the IAO’s value.

Results: The creation of an ophthalmic training program was not found to be cost-effective. The plan was shifted to provide local medical assistant students exposure to ophthalmology and then, if interested, access to IAO website to post their curriculum vitae for employment. The IAO website was altered to include the employment/job resume page. The IAO is currently in the process of work with a web designer to create the “chat”/blog site for ophthalmic managers.

Conclusions: The goal of the IAO is to have 100% membership of every ophthalmologist in Iowa. It is the hope of the IAO that the changes made to the website will be useful and perceived as valuable to the entire community. These website changes will be presented at our joint IAO/University of Iowa meeting in October. We will measure over the next several years if the membership increases. If it does, a survey can be performed to assess the changes impact. It is hope that the “chat”/blog site will be very effective in helping the IAO respond quickly to its members.

Leonard K. Seibold, MD
Colorado Society of Eye Physicians and Surgeons
Leadership Development Program XVII, Class of 2015
Project Abstract

Title of Project: *Improving Young Ophthalmologist participation in advocacy and the Colorado Society of Eye Physicians and Surgeons*

Purpose: To utilize the pursuit of an early glaucoma medication refill bill as a vehicle to educate and invigorate ophthalmology residents and young ophthalmologists (YOs) in Colorado on the legislative process, vital role of advocacy, and importance of membership and participation within the state society.

Methods: Discussions among the CSEPS board of directors and the residency program director revealed the lack of participation in advocacy and the state society among residents and young ophthalmologists in the state. It was also identified that a broadly popular legislative effort could be utilized to demonstrate the value of membership and the importance of advocacy for physicians and their patients. The process would be educational and enlightening to these ophthalmologists and foster a durable involvement in advocacy and state societies throughout their career.

Results: A survey was distributed among CSEPS members to determine the need for legislation addressing the lack of coverage for early refills of topical glaucoma medications. The results confirmed that most physicians have encountered this complaint among their patients on a frequent basis. The process of seeking legislation to remedy this problem became the vehicle for improving YO education and involvement. The AAO state governmental affairs office was solicited for aid in developing the language of this legislation along with other state societies successful in the passage of similar bills. A member of the Colorado state legislature has been identified as a bill sponsor for the 2016 legislative session. A day at the state capital will be planned in accordance with the bills progress through the legislature to provide an opportunity for YOs and residents to meet with state representatives and advocate for this bill. Other CSEPS members will provide mentorship during these meetings. The day at the capital will also include education on the legislative process in general as well as the significance of advocacy through the state society. The University of Colorado residency program director has agreed to the release of resident clinical duties so they may participate in this day at the capital. Furthermore, a YO has been appointed to the CSEPS board of directors. Future YO social mixers will be utilized to encourage participation in this effort.

Conclusion: The pursuit of legislation regarding early glaucoma medication refills can be harnessed to address several needs among CSEPS. This widely popular legislation will provide an easy opportunity for all YOs to rally and demonstrate the ability they have to come to the need of their patients outside the clinic. Their participation in the process through a day at the capital will hopefully foster a vested interest in advocacy and illustrate the need for continued participation in their state society.

David I. Silbert, MD, FAAP
**American Academy of Pediatrics, Section on Ophthalmology/
Pennsylvania Academy of Ophthalmology**
Leadership Development Program XVII, Class of 2015
Project Abstract

Title of Project: *KinderSee: a program in service to low-income at-risk youth in Lancaster County, PA*

Introduction: KinderSee is a public-private partnership between the School District of Lancaster and Conestoga Eye. It provides medical and refractive pediatric ophthalmic care at no out-of-pocket cost to low-income children in the Lancaster City schools. It has been in operation for the past three academic years housed in a school-based health center at George Washington Elementary School in Lancaster City, PA. Original funding for the clinic arose from a federal grant as part of the 2009 stimulus and allowed for the outfitting of one and a half lanes of ophthalmic equipment, and also provided photoscreeners for nurses to screen children in the school district.

KinderSee is entirely self-funded, utilizing the Medicaid or other medical insurance benefits of the students. Over the past three years, KinderSee has examined 491 children, providing over 200 pairs of glasses, and delivered amblyopia treatment to a high proportion of the children fitted with glasses. All examinations are performed in the clinic during the school day. Parents may be present if they wish but their absence does not preclude care being provided to their children. Any surgery required is handled outside the program. KinderSee endeavors to remove obstacles to care for these economically disadvantaged, at-risk children by providing it in the schools obviating the need for transportation or days missed from work by the parents.

Purpose: To identify the barriers to growth and to expand the KinderSee program to the entire School District of Lancaster and to other school systems in Lancaster County.

Methods: At the close of the 2014-15 school year an aural survey was conducted in reference to the KinderSee program in its current form. This survey allowed stakeholders to share their critical insight into the positive and negative aspects of the program. These stakeholders included teachers, school and district-wide administrators, school nurses, parents, and the medical professionals providing care at the KinderSee clinic.

Results: From the survey, it was concluded that the main issues facing the program are transportation, organization, awareness, and funding. With these key barriers identified, a program taskforce was established to further investigate the issues and begin a strategic planning initiative for implementation. This team has begun meeting on a regular basis and will be charged with maintaining focus and rigor for the program's growth.

David I. Silbert, MD, FAAP

KinderSee: a program in service to low-income at-risk youth in Lancaster County, PA

Conestoga Eye next hired a Director of Community Outreach. In her role with Conestoga Eye, she will also serve as the executive director for the KinderSee program. Her background in non-profit operations, fundraising, marketing and communication make her uniquely qualified to spearhead positive change in the program's areas of need. The program will begin the process of approval for 501(c)3 status, making it an independent non-profit entity. This will allow funding to be sought for a part-time social worker, transportation from other schools to the clinic, and awareness to greatly increase the number of children seen.

Conclusion: KinderSee has been an effective and impactful program, providing specialty pediatric ophthalmic care to an economically disadvantaged, at-risk population in the School District of Lancaster. Until now, its reach in the community has been limited to those children at the elementary school where the clinic is based and those children who could walk from other nearby schools in the district. Changes to the program have been made which will enable greater funding for transportation, social work, and awareness. Thus, further expanding the program to all children in the School District of Lancaster. KinderSee hopes to serve as a model for other urban school districts to provide pediatric ophthalmic care to at-risk youth.

Grace Sun, MD
New York State Ophthalmological Society
Leadership Development Program XVII, Class of 2015
Project Abstract

Title of Project: *YO New York!: Engaging Young Ophthalmologists in the New York State Ophthalmological Society*

Purpose: To engage more Young Ophthalmologists (YOs), currently in training or in their first 5 years of practice, as members of the New York State Ophthalmological Society (NYSOS) by building a YO community.

Methods: A NYSOS young ophthalmologist community was formed by:

1. Creating a NYSOS YO subcommittee with the YO subcommittee chair as a permanent voting Board Seat of NYSOS, ensuring that the concerns of New York young ophthalmologists are heard.
2. Organizing an annual NYSOS YO conference focusing on advocacy, practice management, and the profession of ophthalmology.
3. Fostering a link between the New York residency programs and NYSOS by creating a network of resident liaisons from each New York training institution.

Results: The NYSOS Board approved the creation of a YO subcommittee with its own focused mission statement. The newly created YO subcommittee successfully held the first annual *YO! New York* program that attracted over 50 participants from 9 New York residency programs. Residents from 14 of the 17 New York training programs were identified to serve as NYSOS residency liaisons. NYSOS had the highest participation rates in the 2015 State Lobby day by ophthalmologists-in-training in its history.

Conclusions: NYSOS is uniquely poised to raise overall awareness of the value of state society membership given the large number of ophthalmology training programs in New York State. A targeted approach to engage young ophthalmologists during their training by creating a NYSOS YO community may yield both higher exposure to and higher participation in their state societies later on in their careers. While the long-term results will need to be monitored, initial indications of YO participation are promising.

Michael C. Tigani, MD
Ophthalmic Mutual Insurance Company
Leadership Development Program XVII, Class of 2015
Project Abstract

Title of Project: *Claims Reporting Guidelines and Recommendations for Ophthalmologists*

Purpose: Highlight differences in reporting guidelines between National Data Bank and state Board of Medicine. Develop format to educate physicians on this subject.

Method: Coordinated with OMIC staff and OMIC affiliated Virginia defense counsel to review Virginia Board of Medicine reporting guidelines and compare and contrast differences from National Data Bank guidelines. Developed a flow chart on how an attorney would approach a request for money versus a claim versus a lost malpractice case. We analyzed 4 cases from OMIC files that occurred in Virginia and demonstrated how each was different regarding the various reporting guidelines. We then presented an OMIC sponsored lecture at the Virginia State Society meeting on June 20, 2015, entitled “Oh No, Who Needs to Know?” We presented the 4 cases with their outcomes, then reviewed the guideline flow chart for Virginia (developed by OMIC defense counsel) highlighting the nuances and technicalities, and subsequently reviewed the cases with the audience and asked them to answer a multiple choice question as to which agency must be sent a report of the outcome, A) National Data Bank, B) Virginia Board of Medicine, C) Both, D) Neither.

Results: The first 2 cases were straightforward and over 90% of the audience understood the material and answered correctly. The last 2 cases were more complicated and the audience was evenly split among the 4 choices. We emphasized the take home message was that these matters are complicated and physicians should contact their malpractice carrier as early as possible when they receive a written or oral request from a patient for money, a claim for malpractice, or any correspondence regarding patient dissatisfaction. We surveyed the attending physicians through the Virginia state society online survey mechanism and had a favorable review; however, the society’s survey was onerous and lengthy with low numbers participating in the review process.

Conclusion: The subject matter and format were well received and viewed as very important by a majority of physicians. The printed handout of the guidelines for both Virginia Board of Medicine and National Data Bank, and the flowchart of decision making, generated favorable responses from the attendees. For future reference, the flow chart and handout material provided at the Virginia lecture will be posted on the OMIC website. <http://www.omic.com/partners/virginia/> When OMIC presents this course in another state, we plan on including our own survey to be completed at the same time in order to improve the sample size and speed of surveying the physicians, and to better assess our effectiveness and observe criticism and advice on how to improve our delivery of this material. We believe this topic can become a regularly scheduled subject for state society meetings and an OMIC website resource.



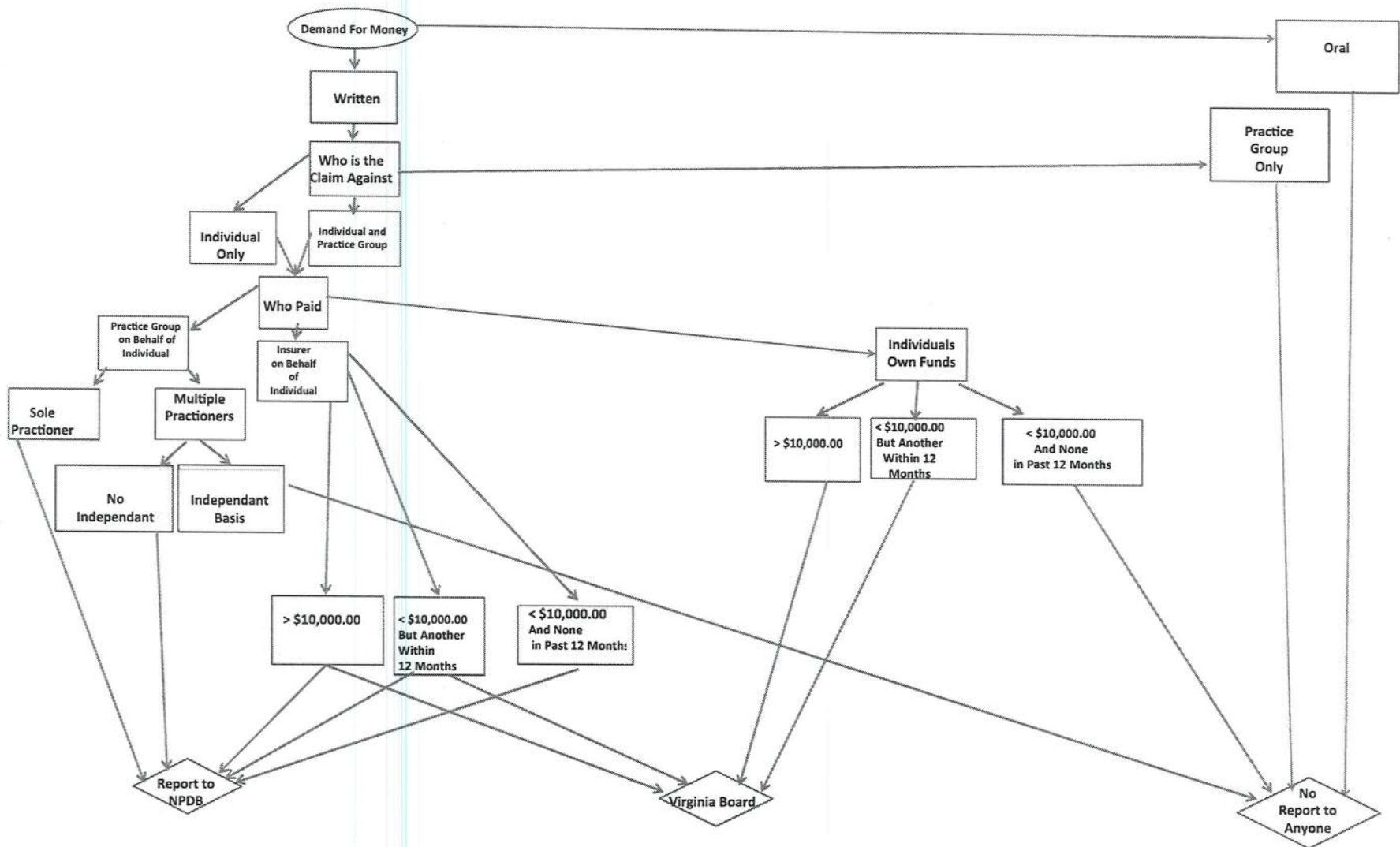
OMIC

**“Oh no!
Who needs to
know?”**

MICHAEL TIGANI, MD
KENNETH T. ROEBER, JD
MICHELLE PINEDA, MBA

VSEPS, 2015

OPHTHALMIC MUTUAL
INSURANCE COMPANY
(A Risk Retention Group)



This handout contains the Virginia state laws that govern physician reporting of malpractice payments and also excerpts from the National Practitioner Data Bank Guidebook on reporting malpractice payments.

VIRGINIA STATE LAW REGARDING REPORTING

1. Definitions
2. Further reporting requirements; civil penalty; disciplinary action.
3. Certain data required
4. Competency assessments of certain practitioners
5. Elements of a Competency Assessment
6. Reporting of medical malpractice judgments and settlements
7. Noncompliance or falsification of profile

1. Definitions.

As used in this chapter, unless the context requires a different meaning:

...

"Medical malpractice judgment" means any final order of any court entering judgment against a licensee of the Board that arises out of any tort action or breach of contract action for personal injuries or wrongful death, based on health care or professional services rendered, or that should have been rendered, by a health care provider, to a patient.

"Medical malpractice settlement" means any written agreement and release entered into by or on behalf of a licensee of the Board in response to a written claim for money damages that arises out of any personal injuries or wrongful death, based on health care or professional services rendered, or that should have been rendered, by a health care provider, to a patient.

Va. Code Ann. § 54.1-2900.

<http://law.lis.virginia.gov/vacode/title54.1/chapter29/section54.1-2900/>

2. Further reporting requirements; civil penalty; disciplinary action.

A. The following matters shall be reported within 30 days of their occurrence to the Board:

1. Any disciplinary action taken against a person licensed under this chapter in another state or in a federal health institution or voluntary surrender of a license in another state while under investigation;
2. Any malpractice judgment against a person licensed under this chapter;
3. Any settlement of a malpractice claim against a person licensed under this chapter; and

4. Any evidence that indicates a reasonable probability that a person licensed under this chapter is or may be professionally incompetent; has engaged in intentional or negligent conduct that causes or is likely to cause injury to a patient or patients; has engaged in unprofessional conduct; or may be mentally or physically unable to engage safely in the practice of his profession.

The reporting requirements set forth in this section shall be met if these matters are reported to the National Practitioner Data Bank under the Health Care Quality Improvement Act, 42 U.S.C. § 11101 et seq., and notice that such a report has been submitted is provided to the Board.

B. The following persons and entities are subject to the reporting requirements set forth in this section:

1. Any person licensed under this chapter who is the subject of a disciplinary action, settlement, judgment or evidence for which reporting is required pursuant to this section;

2. Any other person licensed under this chapter, except as provided in the protocol agreement entered into by the Medical Society of Virginia and the Board for the Operation of the Impaired Physicians Program;

3. The presidents of all professional societies in the Commonwealth, and their component societies whose members are regulated by the Board, except as provided for in the protocol agreement entered into by the Medical Society of Virginia and the Board for the Operation of the Impaired Physicians Program;

4. All health care institutions licensed by the Commonwealth;

5. The malpractice insurance carrier of any person who is the subject of a judgment or settlement; and

6. Any health maintenance organization licensed by the Commonwealth.

C. No person or entity shall be obligated to report any matter to the Board if the person or entity has actual notice that the matter has already been reported to the Board.

D. Any report required by this section shall be in writing directed to the Board, shall give the name and address of the person who is the subject of the report and shall describe the circumstances surrounding the facts required to be reported. Under no circumstances shall compliance with this section be construed to waive or limit the privilege provided in § 8.01-581.17..

E. Any person making a report required by this section, providing information pursuant to an investigation or testifying in a judicial or administrative proceeding as a result of such report shall be immune from any civil liability or criminal prosecution resulting therefrom unless such person acted in bad faith or with malicious intent.

F. The clerk of any circuit court or any district court in the Commonwealth shall report to the Board the conviction of any person known by such clerk to be licensed under this chapter of any (i) misdemeanor involving a controlled substance, marijuana or substance abuse or involving an act of moral turpitude or (ii) felony.

G. Any person who fails to make a report to the Board as required by this section shall be subject to a civil penalty not to exceed \$5,000. The Director shall report the assessment of such civil penalty to the Commissioner of the Department of Health or the Commissioner of Insurance at the State Corporation Commission. Any person assessed a civil penalty pursuant to this section shall not receive a license, registration or certification or renewal of such unless such penalty has been paid.

H. Disciplinary action against any person licensed, registered or certified under this chapter shall be based upon the underlying conduct of the person and not upon the report of a settlement or judgment submitted under this section.

Va. Code Ann. § 54.1-2909.

<http://law.lis.virginia.gov/vacode/title54.1/chapter29/section54.1-2909/>

3. Certain Data Required

The Board of Medicine shall require all doctors of medicine, osteopathy and podiatry to report and shall make available the following information:

A.

...

12. Other information related to the competency of doctors of medicine, osteopathy, and podiatry, as specified in the regulations of the Board.

C. The Board shall promulgate regulations to implement the provisions of this section, including, but not limited to, the release, upon request from a consumer, of such information relating to a specific doctor. The Board's regulations shall provide for reports to include all medical malpractice judgments and medical malpractice settlements of more than \$10,000 within the most recent 10-year period in categories indicating the level of significance of each award or settlement; however, the specific numeric values of reported paid claims shall not be released in any individually identifiable manner under any circumstances. Notwithstanding this subsection, a licensee shall report a medical malpractice judgment or medical malpractice settlement of less than \$10,000 if any other medical malpractice judgment or medical malpractice settlement has been paid by or for the licensee within the preceding 12 months.

Va. Code Ann. § 54.1-2910.1.

<http://law.lis.virginia.gov/vacode/title54.1/chapter29/section54.1-2910.1/>

4. Competency assessments of certain practitioners

The Board shall require an assessment of the competency of any person holding an active license under this chapter on whose behalf three separate medical malpractice judgments or medical malpractice settlements of more than \$75,000 each are paid within the most recent 10-year period. The assessment shall be accomplished in 18 months or less by a program acceptable to the Board. The licensee shall bear all costs of the assessment. The results of the assessment shall be reviewed by the Board and the Board shall determine a plan of corrective action or appropriate resolution pursuant to the assessment. The assessment, related documents and the processes shall be governed by the confidentiality provisions of § 54.1-2400.2 and shall not be admissible into evidence in any medical malpractice action involving the licensee. The Board shall annually post the number of competency assessments undertaken on its website.

Va. Code Ann. § 54.1-2912.3.

<http://law.lis.virginia.gov/vacode/title54.1/chapter29/section54.1-2912.3/>

5. Elements of a Competency Assessment:

1. Review of the facts regarding the paid claim cases:
2. Describe this doctor's fund of knowledge, medical judgment or decisionmaking and in the case of procedural specialties, skills.
3. Doctor's strengths:
4. Doctor's weaknesses:
5. Is there a need for remediation?
6. Is this doctor safe to practice?

Competency Assessment Guidance Document - link

<https://www.dhp.virginia.gov/Medicine/guidelines/85-6%20Competency%20Assessment%20Guidance%20Document%202011.pdf>

2009 REPORT OF THE VIRGINIA BOARD OF MEDICINE

In the last twelve months, twelve physicians were identified as being subject to a three-paid claims competency assessment pursuant to 54.1-2912.3. Eight physicians submitted reports to the Board in a timely fashion; none of the eight required action beyond obtaining the assessment.

6. Reporting of medical malpractice judgments and settlements.

A. In compliance with requirements of § 54.1-2910.1 of the Code of Virginia, a doctor of medicine, osteopathic medicine, or podiatry licensed by the board shall report all medical malpractice judgments and settlements of \$10,000 or more in the most recent 10-year period within 30 days of the initial payment. A doctor shall report a medical malpractice judgment or settlement of less than \$10,000 if any other medical malpractice judgment or settlement has been paid by or for the licensee within the preceding 12 months. Each report of a settlement or judgment shall indicate:

1. The year the judgment or settlement was paid.
2. The specialty in which the doctor was practicing at the time the incident occurred that resulted in the judgment or settlement.
3. The total amount of the judgment or settlement in United States dollars.
4. The city, state, and country in which the judgment or settlement occurred.

B. The board shall not release individually identifiable numeric values of reported judgments or settlements but shall use the information provided to determine the relative frequency of judgments or settlements described in terms of the number of doctors in each specialty and the percentage with malpractice judgments and settlements within the most recent 10-year period. The statistical methodology used will include any specialty with more than 10 judgments or settlements. For each specialty with more than 10 judgments or settlements, the top 16% of the judgments or settlements will be displayed as above average payments, the next 68% of the judgments or settlements will be displayed as average payments, and the last 16% of the judgments or settlements will be displayed as below average payments.

C. For purposes of reporting required under this section, medical malpractice judgment and medical malpractice settlement shall have the meanings ascribed in § 54.1-2900 of the Code of Virginia. A medical malpractice judgment or settlement shall include:

1. A lump sum payment or the first payment of multiple payments;
2. A payment made from personal funds;
3. A payment on behalf of a doctor of medicine, osteopathic medicine, or podiatry by a corporation or entity comprised solely of that doctor of medicine, osteopathic medicine, or podiatry; or
4. A payment on behalf of a doctor of medicine, osteopathic medicine or podiatry named in the claim where that doctor is dismissed as a condition of, or in consideration of the settlement, judgment or release. If a doctor is dismissed independently of the settlement, judgment or release, then the payment is not reportable.

18VAC85-20-290.

<http://leg1.state.va.us/cgi-bin/legp504.exe?000+reg+18VAC85-20-290>

7. Non-compliance or falsification of profile.

A. The failure to provide the information required by 18 VAC 85-20-280 and by 18 VAC 85-20-290 within 30 days of the request for information by the board or within 30 days of a change in the information on the profile may constitute unprofessional conduct and may subject the licensee to disciplinary action by the board.

B. Intentionally providing false information to the board for the practitioner profile system shall constitute unprofessional conduct and shall subject the licensee to disciplinary action by the board.

18VAC85-20-300.

<http://leg1.state.va.us/cgi-bin/legp504.exe?000+reg+18VAC85-20-300>

NATIONAL PRACTITIONER DATA BANK

Link to NPDB Guidebook - <http://www.npdb.hrsa.gov/resources/aboutGuidebooks.jsp>

1. Reporting Medical Malpractice Payments
2. Reporting of Payments by Individuals
3. Payments for Corporations or Hospitals
4. Practitioner Fee Refunds
5. Loss Adjustment Expenses
6. Dismissal of Defendant from a Lawsuit

1. Reporting Medical Malpractice Payments

Each entity that makes a payment for the benefit of a physician, dentist, or other health care practitioner in settlement of, or in satisfaction in whole or in part of, a claim or judgment against that practitioner must report the payment information to the NPDB. A payment made as a result of a suit or claim solely against an entity (for example, a hospital, clinic, or group practice) and that does not identify an individual practitioner is not reportable under the NPDB's current regulations.

Eligible entities must report when a lump sum payment is made or when the first of multiple payments is made. Medical malpractice payments are limited to exchanges of money and must be the result of a written complaint or claim demanding monetary payment for damages. The written complaint or claim must be based on a practitioner's provision of or failure to provide health care services. A written complaint or claim can include, but is not limited to, the filing of a cause of action based on the law of tort in any State or Federal court or other adjudicative body, such as a claims arbitration board.

NPDB Guidebook, E-8

2. Reporting of Payments by Individuals

Individual subjects are not required to report payments they make for their own benefit to the NPDB. On August 27, 1993, the Circuit Court of Appeals for the District of Columbia held that [445 (DC Cir. 3 F.3D 1993)] the NPDB regulation requiring each "person or entity" that makes a medical malpractice payment was invalid, insofar as it required individuals to report such payments. The NPDB removed reports previously filed on medical malpractice payments made by individuals for their own benefit.

A professional corporation or other business entity comprised of a sole practitioner that makes a payment for the benefit of a named practitioner must report that payment to the NPDB.

However, if a practitioner or other person, rather than a professional corporation or other business entity, makes a medical malpractice payment out of personal funds, the payment is not reportable.

NPDB Guidebook, E-10

3. Payments for Corporations and Hospitals

Medical malpractice payments made solely for the benefit of a corporation such as a clinic, group practice, or hospital are currently not reportable to the NPDB. A payment made for the benefit of a professional corporation or other business entity that is comprised of a sole practitioner is reportable if the payment was made by the entity rather than by the sole practitioner out of personal funds.

NPDB Guidebook, E-10

4. Practitioner Fee Refunds

If a refund of a practitioner's fee is made by an entity (including solo incorporated practitioners), that payment is reportable to the NPDB. A refund made by an individual is not reportable to the NPDB.

For purposes of NPDB reporting, medical malpractice payments are limited to exchanges of money. A refund of a fee is reportable only if it results from a **written** complaint or claim demanding monetary payment for damages. The written complaint or claim must be based on a physician's, dentist's, or other health care practitioner's provision of, or failure to provide, health care services. A written complaint or claim may include, but is not limited to, the filing of a cause of action based on the law of tort in any State or Federal court or other adjudicative body, such as a claims arbitration board.

A waiver of a debt is not considered a payment and should not be reported to the NPDB. For example, if a patient has an adverse reaction to an injection and is willing to accept a waiver of fee as settlement, that waiver is not reportable to the NPDB.

NPDB Guidebook, E-12

5. Loss Adjustment Expenses

Loss adjustment expenses (LAEs) refer to expenses other than those in compensation of injuries, such as attorney's fees, billable hours, copying, expert witness fees, and deposition and transcript costs. If LAEs are not included in the medical malpractice payment amount, they are not required to be reported to the NPDB.

LAEs should be reported to the NPDB **only** if they are included in a medical malpractice payment. Reporting requirements specify that the total amount of a medical malpractice payment and a description and amount of the judgment or settlement and any conditions, including terms of payment should be reported to the NPDB. LAEs should be itemized in the description section of the report form.

NPDB Guidebook, E-12

6. Dismissal of a Defendant from a Lawsuit

A payment made to settle a medical malpractice claim or action is not reportable to the NPDB if the defendant health care practitioner is dismissed from the lawsuit **prior** to the settlement or judgment. However, if the dismissal results **from a condition in the settlement or release**, then the payment is reportable. In the first instance, there is no payment for the benefit of the health care practitioner because the individual has been dismissed from the action **independently** of the settlement or release. In the latter instance, if the practitioner is dismissed from the lawsuit **in consideration** of the payment being made in settlement of the lawsuit, the payment can only be construed as a payment for the benefit of the health care practitioner and must be reported to the NPDB.

NPDB Guidebook, E-12-13

David E. Vollman, MD, MBA
Missouri Society of Eye Physicians and Surgeons
Leadership Development Program XVII, Class of 2015
Project Abstract

Title of Project: *Creating a Digital Map of Areas of Coverage of Ophthalmology Offices in Missouri*

Purpose: A prior LDP project completed by Dean Hainsworth, MD from the Missouri Society of Eye Physicians and Surgeons created several printed maps that could be used by ophthalmologists in legislative hearings to demonstrate coverage areas to help defeat an “access to care” arguments when dealing with optometric scope expansion legislation. MoSEPS now desired this to be re-created in an electronic format to be posted on the society’s website as well as more easily distributed to legislators’ offices/staffs. In discussions with other state societies who have produced similar electronic maps, they contracted out the project to a consultant. Another purpose was to try and determine a low cost and low time investment process to create/update these maps for all state ophthalmic societies.

Methods: Working with our state society Executive Director, I used an updated Excel spreadsheet listing all the ophthalmic practices and satellite offices in Missouri. I also had a listing of all the optometric offices derived from the Missouri Optometric Association website. After discussions with representatives from MOSEPS as well as other state societies, it seemed the best map would be one that demonstrates a radius of coverage by an office rather than mapping each individual office location. This has two benefits: 1) when all optometric locations are mapped it makes it more difficult to determine where the ophthalmology offices are located and 2) access to care arguments should focus on reasonable travel times by patients to reach a provider. For this reason, a radius of 50 miles around an office (~1 hour of travel time) was chosen. Of note, the travel time is approximate since these radii of coverage do not follow roads of travel. Next, I experimented with different free software options including Google Maps. Most free sites only allow you create point locations for an address. The only free site I could find that allowed a determination of a radius of coverage was www.mapdevelopers.com. With some file reworking, the map created on this website can be converted to a JPEG file for posting online or electronic distribution. I am still in the process of creating a “how-to” video for possible posting on AAO.org as a resource for other state societies.

Results: The electronic map created supports that the increased “access to care” is not an effective argument for expansion of optometric scope of practice in Missouri. The entire state is covered by ophthalmology practices when a radius of coverage of 50 miles is used. This map will be posted on the MOSEPS website as well as distributed to legislative offices as needed to help with scope arguments.

David E. Vollman, MD, MBA

Creating a Digital Map of Areas of Coverage of Ophthalmology Offices in Missouri

Conclusion: This electronic coverage map will be useful in future Missouri optometric scope of practice legislation. The JPEG file will be shared with MOSEPS Executive Director so that can be easily accessed. Since the map is electronically created, it can be easily updated every few years to serve as effective deterrent to future “access to care” arguments for optometric scope of practice increases. A copy of the created map is shown below.



Pamela E. Williams, MD
Louisiana Academy of Eye Physicians and Surgeons
Leadership Development Program XVII, Class of 2015
Project Abstract

Title of Project: Louisiana Academy of Eye Physicians and Surgeons: A Reformation

Purpose: The Louisiana Ophthalmology Association (LOA) recently shut down operations and has reformed as the Louisiana Association of Eye Physicians and Surgeons (LAEPS). This project will focus on reestablishing the state society under its new brand with new staffing. The idea is to offer Louisiana Ophthalmologists a new state society that will offer benefits to the members including legislative and educational benefits that may not have been perceived with the LOA.

Methods: Conference calls were set up to explain to the LOA board members why the organization needed to be reorganized and restructured. Additional discussion among leaders within the state society helped to decide priorities and the focus of the new organization. Some suggestions from other state society leaders and AAO state affairs members have been incorporated into the new organization and others are also being considered as we move forward in the new organization.

Results: A new and improved website has been launched. We hired a new lobbyist and navigated the last political session with relative success. New officers have been elected and a board of directors is currently being selected. Membership has increased from 75 members in 2014 to 81 members, or 34% of practicing ophthalmologists in the state. While increasing only slightly, we have identified areas of the state with low membership penetration and plan to target these areas with new membership committee members and a membership chair from an underrepresented area.

We are targeting young ophthalmologists with a membership discount for those new to practice, and committee positions to increase involvement. Several upcoming CME events for residents and practicing physicians are planned and sponsored by the LAEPS.

Conclusions: Events of the past 2 years have brought increasing awareness in Louisiana of the need for a strong state society. After being forced to close down the LOA, the Louisiana Academy of Eye Physicians and Surgeons has been formed with a more balanced approach to our mission. We realize that a solely legislative organization will have limited success. The LAEPS will offer social and educational membership benefits along with our legislative mission to build a stronger state society in the future.