AMERICAN ACADEMY OF OPHTHALMOLOGY®

2024 Council Advisory Recommendations

Problem: Mandated Pediatric Comprehensive Eye Exams
Council Advisory Recommendation 24-01

Problem Statement:
State-wide mandatory COMPREHENSIVE eye exams for children are currently promoted by many groups, most notably large optometric organizations. At present, vision SCREENING examinations are recommended in a policy statement jointly authored by the American Association for Pediatric Ophthalmology and Strabismus (AAPOS), American Academy of Pediatrics (AAP), American Association of Certified Orthoptists (AACO) and American Academy of Ophthalmology (AAO)1. Vision screening is also supported by the United States Preventative Task Force (USPTF)2. This encroachment by organized optometry into pediatric eye care comprises a significant attempt at scope expansion (or at minimum a way to increase volume/revenue) that adversely affects patients, pediatric ophthalmologists, and our healthcare system.

Summary of Facts and Background Information:
In 2004, data published by Sean P. Donahue, MD demonstrated that a significant proportion of children are prescribed glasses unnecessarily.3 Extrapolation of the data for the US population at the time of the study estimated that a single mandatory eye exam prior to school entry could cost over $200,000,000 for unnecessary spectacles. This does not include the cost of reimbursement to the eye care providers for performing the exam.
CAR 23-024 presented at the AAO Council meeting in the spring of 2023 addressed the workforce shortage of pediatric ophthalmologists in this country. We believe the data presented at that time to be sufficient to the Council today to claim that if every school-age child in the US required an exam to enter school, that pediatric ophthalmologists would simply be inundated performing unnecessary eye exams as well.
Many state societies do not have a pediatric ophthalmologist on their Board of Directors or who are actively engaged. Awareness of submitted comprehensive eye exam bills is surveilled by both AAPOS and the AAO. However, action on them must be taken at the state level and many ophthalmologists are unaware of this issue. Sadly, in one instance in 2007, a comprehensive eye exam bill was allowed to pass unopposed by a state ophthalmology society as it was "traded" away to deflect a surgical scope bill.

Possible Solutions:
A. We propose creating and/or update materials to create a "tool kit" in conjunction with the AAO. This would be distributed to state ophthalmology societies as well as other organizations in order to educate State Ophthalmology Society Board Members about this issue and the importance of supporting vision screening exams versus mandatory comprehensive eye exams for children.

B. We propose creating an educational forum (possibly a webinar or other recurring presentation at the annual meeting and/or Mid-Year Forum) in conjunction with AAO to review this topic with State societies and other stakeholders.

C. We propose that AAO identify and present the states facing these legal challenges and the status of each bill in a similar format to how surgical scope bills are presented online, at Council meetings and at Mid-Year Forum; this information should be shared with State Societies directly as well.

D. We propose creating/updating model vision SCREENING legislation template(s) so that

state societies in conjunction with AAPOS and AAO resources may feel empowered to initiate vision screening legislation where such regulations do not already exist.

Submitted by:
Stacey J Kruger, MD

On behalf of:
American Association for Pediatric Ophthalmology and Strabismus

Date Board Approved this CAR:
11/15/2023

Co-sponsoring Societies:
Alabama Academy of Eye Physicians and Surgeons
Alaska Society of Eye Physicians and Surgeons
American Academy of Pediatrics, Section on Ophthalmology
American Association of Ophthalmic Oncologists and Pathologists
American Board of Ophthalmology
American College of Surgeons, Advisory Council for Ophthalmic
Surgery American Osteopathic College of Ophthalmology
American Society of Cataract & Refractive Surgery
American Society of Ophthalmic Plastic & Reconstructive Surgery
American Society of Ophthalmic Trauma
American Uveitis Society
Arizona Society of Eye Physicians and Surgeons
Association of University Professors of Ophthalmology
California Academy of Eye Physiciansand Surgeons
Canadian Ophthalmological Society
Colorado Society of Eye Physicians and Surgeons
Cornea Society
Florida Society of Ophthalmology
Hawaii Ophthalmological Society
Idaho Society of Ophthalmology
Indiana Academy of Ophthalmology
Intl Joint Commission on Allied Health Personnel in Ophthalmology
Iowa Academy of Ophthalmology
Louisiana Academy of Eye Physicians and Surgeons
Macula Society
Maine Society of Eye Physicians and Surgeons
Maryland Society of Eye Physicians and Surgeons
Massachusetts Society of Eye Physicians and Surgeons
Michigan Society of Eye Physicians and Surgeons
Minnesota Academy of Ophthalmology
Mississippi Academy of Eye Physicians and Surgeons
Missouri Society of Eye Physicians and Surgeons
Montana Academy of Ophthalmology
New Hampshire Society of Eye Physicians and Surgeons
New Jersey Academy of Ophthalmology
New York State Ophthalmological Society
North American Neuro-Ophthalmology Society
North Carolina Society of Eye Physicians and Surgeons
North Dakota Society of Eye Physicians and Surgeons
Ocular Microbiology and Immunology Group

Ohio Ophthalmological Society
Oklahoma Academy of Ophthalmology
Oregon Academy of Ophthalmology
Outpatient Ophthalmic Surgery Society
Pennsylvania Academy of Ophthalmology
Society of Military Ophthalmologists
South Carolina Society of Ophthalmology
South Dakota Academy of Ophthalmology
Tennessee Eye Surgeons
Texas Ophthalmological Association
Utah Ophthalmology Society
Vermont Ophthalmological Society
Virginia Society of Eye Physicians and Surgeons
Washington Academy of Eye Physicians and Surgeons
Washington DC Metropolitan Ophthalmological Society
West Virginia Academy of Eye Physicians and Surgeons
Wisconsin Academy of Ophthalmology
Women in Ophthalmology
Wyoming Ophthalmological Society

AMERICAN ACADEMY OF OPHTHALMOLOGY®

Academy Background Statement
Council Advisory Recommendation

24-01: Problem: Mandated Pediatric Comprehensive Eye Exams

Assigned to: John D. Peters, MD - Secretary for State Affairs

Analysis:
The Academy has worked closely over the years with the American Association for Pediatric Ophthalmology and Strabismus (AAPOS) and the American Academy of Family Physicians (AAFP) to ensure that children have access to periodic vision screenings for the early detection and treatment of eye and vision problems and to oppose optometry-led initiatives to mandate comprehensive exams. The Academy firmly believes that good vision is essential for children's physical and mental health and development. Like immunizations, routine vision screenings are an important part of a child's comprehensive medical care. These screenings detect vision and eye problems at a stage when many problems can be successfully treated. However, as CAR 24-01 points out, organized optometry continues its push for state governments to mandate costly and unnecessary comprehensive eye exams for children. Mandating comprehensive eye exams for children is a poor public health policy because they occur at one point in time and thus can catch a disease late or miss it entirely if performed too early. As an alternative, regular vision screenings serve as the most appropriate method to assess children's vision health. Screenings provide multiple opportunities to identify disease or detect problems in the children who are appropriate candidates for a comprehensive exam. Routine vision screenings in the offices of pediatricians, family physicians, school nurses, and trained screeners are the first step toward making sure every child sees his or her way to adulthood.

In regard to the four possible solutions proposed in CAR 24-01:

A.) The creation of a "tool kit" for state ophthalmology societies and other organizations in order to educate their board members about this issue and the importance of supporting vision screening exams versus mandatory comprehensive eye exams for children.
• The Academy has an existing "tool-kit" developed in partnership with AAPOS to do precisely what the CAR is proposing. This tool-kit was shared with, and presented to all state societies at the time of development and continues to remain available upon request. The Secretariat for State Affairs recognizes that the current version was created over a decade ago and could be refreshed, re-designed, and re-introduced to state societies. The Secretariat would support the creation of a small workgroup comprising of AAPOS and AAO representatives to work on an updated version of this tool-kit.

B.) Developing an educational forum (possibly a webinar or other recurring presentation at the annual meeting and/or Mid-Year Forum) in conjunction with AAO to review this topic with State societies and other stakeholders.
• The Secretariat would support the same type of workgroup referenced in item A to develop a webinar during which the rebooted tool-kit can be reintroduced to AAO state societies and reenergize state advocacy on the issue. A webinar is recommended over a presentation at either the AAO annual meeting or Mid-Year Forum due to the restrictive scheduling of these meetings. A webinar would also provide for greater flexibility for attendance.

C.) Proposing that AAO identifies and presents the states facing these comprehensive eye exam legislation and the status of each bill in a similar format to how surgical scope bills are

presented online, at Council meetings and at Mid-Year Forum; this information should be shared with State Societies directly as well.
• Non-scope legislative issues—including states facing comprehensive exam mandates for children—are routinely addressed by members of the Secretariat when giving state advocacy updates at these various forums. For example, the state advocacy updates given here at Mid-Year include an update on comprehensive exam bills in Mississippi, New Jersey, and West Virginia, and will be again at appropriate venues during Annual Meeting. Additionally, the outcome of these state legislative initiatives are reported in the Academy Washington Report Express newsletter, which is sent on a weekly basis to all AAO members, staff, and state society executive directors. There is also an entire issue page dedicated to children's vision issues on the Academy's Advocacy page (https://www.aao.org/advocacy/vision-screenings). The Secretariat would support revising this issue page so that it provides an update on states facing the most recent comprehensive exam legislation.

D.) Developing a template for model legislation on vision screening.
•The Academy has an existing template for model legislation which was developed in partnership with AAPOS and is readily accessible on our Advocacy page in the section titled Children's Vision Screenings. It is also readily available for state societies upon request. To date, this model legislation has been the basis of laws enacted in over a dozen states (Arkansas, Connecticut, Indiana, Iowa, Maryland, Massachusetts, Minnesota, Nebraska, New Mexico, North Carolina, Oklahoma, Oregon and Wisconsin).

Sharing Member Contact Information Among States and AAO
Council Advisory Recommendation 24-02

Problem Statement:
State societies need to be able to communicate quickly and effectively with new doctors in the state. However, the list of these potential members sent periodically to the states lacks email addresses. As a result, the state society is forced to send a letter through the US Postal Service which may not be effective.

Summary of Facts and Background Information:
Timely communication with members and potential members is a critical function for both the Academy and state societies. This is especially true when the AAO State Affairs office sends states the lists of new doctors in a state. There's no doubt that electronic communication is the most effective method. The potential member lists sent by the Academy to the states omits email addresses, thus reducing the timeliness and effectiveness of contacting these doctors.

It certainly is a reasonable policy for the Academy to protect the email addresses of its members. Many (if not most) state societies also have this concern. However, state societies and the Academy share members. Indeed, the functions and services provided to members by both the AAO and state societies overlap in substantial ways.

Possible Solutions:
• The Academy should include an opt in/opt out form on its membership application and membership dues invoice asking physicians if they allow their email address to be shared with the state society where they practice, and forward that information to state societies on a regular basis.

• Annually, each state society will provide the AAO a current list of email address for its members so that each organization has the most current contact information available for the members they share.

Submitted by:
James Ford McDonnell, MD
Krishna Patel, MD

On behalf of:
Illinois Society of Eye Physicians & Surgeons

Date Board Approved this CAR:
1/30/2024

Co-sponsoring Societies:
Connecticut Society of Eye Physicians
Indiana Academy of Ophthalmology
New York State Ophthalmological Society

AMERICAN ACADEMY OF OPHTHALMOLOGY®

Academy Background Statement
Council Advisory Recommendation

24-02: Sharing Member Contact Information Among States and AAO

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

Analysis:
Collaboration between the Academy and state societies is crucial for effective advocacy on behalf of the profession and patients, and reinforces the collective strength of the profession. The Academy agrees with the CAR authors that sharing member contact information increases the visibility of state societies, enhances member engagement, and amplifies the voice of ophthalmology.

As background, state societies are highlighted in the Academy's annual dues mailing to U.S. members. The dues invoice includes a checkbox for members to indicate interest, "Yes, I would like information on joining my state ophthalmological society." Participation rate to date has been low, with under 20 responses per year.

The Academy's Ophthalmic Society Relations team provides membership and prospects reports to state societies to assist with member recruitment. This includes bimonthly reports of individuals that have moved in or out of the specific state, and up to two annual complimentary mailing lists of Academy members for targeted outreach. Addresses provided in the lists are the same ones that the Academy uses to communicate with members. Email addresses were excluded to comply with the CAN-SPAM Act[1] and privacy laws.

Academy members are experiencing email fatigue and have indicated their desire for fewer emails through member surveys and focus groups. Twelve percent of Academy members opted out of all communications. Notably, 27% of U.S. young ophthalmologist members within five years of training completion have opted out of receiving communications from the Academy.

To facilitate the sharing of member emails, the Academy will adopt the suggestion from CAR authors to capture members' consent to release their email with state societies and implement the following:

- Update the checkbox printed on dues invoices from "Yes, I would like information on joining my state ophthalmological society" to "Yes, share my contact information, including email address, with my state society." The change will take effect with the 2025 dues mailing scheduled for October 2024. The Academy will compile and distribute opt-in emails to state societies on a regular basis.

- Include an opt-in to release member's email address to state societies on the Academy's member application form and membership renewal invoice. The membership application form (paper and pdf format) has been updated to reflect the change. The same opt-ins will be incorporated into the online application and dues payment portals in 2025. The Academy is unable to implement immediate change due to current system limitations and planned migration to a new member database in 2025.

[1] CAN-SPAM Act: A Compliance Guide for Business, Federal Trade Commission; https://www.ftc.gov/business-guidance/resources/can-spam-act-compliance-guide-business

The Academy, as the initial recipient and data processor of member information, is liable to ensure partnering state societies are compliant with the CAN-SPAM Act. The CAN-SPAM Act sets rules for commercial email and requires businesses and organizations, including medical societies, to follow specific guidelines when sending commercial electronic messages. Email communications, such as promoting educational events, publications, or membership benefits, could be considered commercial in nature under the Act. State societies must attest to have an infrastructure in place to allow email recipients to unsubscribe and opt out of future communications.

The Academy will also continue to explore opportunities to increase members' awareness of state societies and their impact on the profession, including:

- Partner with individual state societies to develop joint email campaigns on an annual basis that highlight state advocacy wins and emphasize the value of state society membership. State societies can leverage the Academy's membership list and email marketing platform to engage with a wider audience. Email will be sent through the Academy's email management system to all Academy members that work or reside in the state.

Lastly, the Academy acknowledges and appreciates the CAR suggestion for state societies to share the email addresses of its members with the Academy. We seek to collaborate with state societies to collect members' practice demographic data. State societies can support the initiative by encouraging members at the state level to update their practice demographic information. The data enables the Academy and state societies to have a deeper understanding of the composition of members and practice environment.

Virtual Board Service Training Module

Council Advisory Recommendation 24-03

Problem Statement:
For many, serving in a leadership position with the state eye society might be a physician's first experience with board service. Many state ophthalmological societies are managed by a staff of one who is akin to a "Jack of all trades" juggling membership, marketing, social media, finance, communications and advocacy functions. That staff person may not have the resources, legal and otherwise, to develop a comprehensive orientation and training session for new board members.

Summary of Facts and Background Information:
For many, serving in a leadership position with the state eye society might be a physician's first experience with board service.

Many state ophthalmological societies are managed by a staff of one who is akin to a "Jack of all trades" juggling membership, marketing, social media, finance, communications and advocacy functions. That staff person may not have the resources, legal and otherwise, to develop a comprehensive orientation and training session for new board members.

Possible Solutions:
That the AAO should organize a webinar dedicated to educating new state ophthalmology society board members on their responsibilities. The webinar should cover general overarching topics such as basic governance structures, running an effective meeting, fiduciary duties, strategic planning, and effective communication within a board. Standardizing the information through a webinar training program ensures that all new board members across the country receive the same foundational knowledge of the intricacies of their roles, helping them better contribute to the success of their respective state ophthalmology societies.

Because state organizations elect new leaders at different times, the webinar should be recorded and made available for viewing throughout the year.

The webinar should also be available to existing board members who may need a refresher in governance and oversight.

Submitted by:
Michael A Pisacano, MD
Brad E Kligman, MD
Amy A Mehta, MD
Sawar Zahid, MD

On behalf of:
New York State Ophthalmological Society

Date Board Approved this CAR:
1/26/2024

Co-sponsoring Societies:
Connecticut Society of Eye Physicians
Indiana Academy of Ophthalmology

Maryland Society of Eye Physicians and Surgeons
Missouri Society of Eye Physicians and Surgeons

AMERICAN ACADEMY OF OPHTHALMOLOGY®

Academy Background Statement
Council Advisory Recommendation

24-03: Virtual Board Service Training Module

Assigned to: Lawrence Mendenhall, MBA, JD – COO, CFO, CLRO
Michael Stevens, JD – General Counsel and VP, Legal Affairs

Analysis:
The Academy agrees with the facts and background outlined in the CAR. The Academy understands that many ophthalmologists' first appointment to a state ophthalmology society's governing body may represent the first time they have served in a similar role for any organization. The Academy also recognizes that staffing and other resource limitations may challenge some ophthalmology societies' ability to provide a comprehensive orientation and training session for their new board members.

The Academy is willing to develop and host a webinar or other virtual training for new governing body members of ophthalmology societies represented on the Council that educates them on their roles and responsibilities as board members. Potential topics might include, but not be limited to:

- Board governance basics
- fiduciary duties
- role of the board vs. the role of management
- directors and officers (D&O) insurance
- avoiding inadvertent anti-competitive behavior
- identifying and mitigating conflicts of interest
- running effective meetings
- confidentiality

Because development and presentation of an effective training would take significant time and effort, the Academy would only take action to implement such a training if, following deliberations, the Council consensus identifies the issue of this CAR as a high priority.

If the Council determines that this project should proceed, and recognizing that topics of greatest import may vary from society-to-society, the Academy will seek input from society executive directors to ensure that key concerns are addressed during the training.

The Academy agrees that the training should be in a form that is available for later use to ensure that successive groups of leaders taking office will receive needed training. We propose that participation in the training be opened to members of the governing bodies of all societies with representation on the Academy's Council. As noted in the CAR, we propose that participation in the training be available to both incoming and veteran members of the societies' governing bodies to allow all to expand their understanding of the included topics.

Bold New Vision for Addressing the State Society Membership Crisis
Council Advisory Recommendation 24-04

Problem Statement:
According to data from the 2021 AAO State Organizational Survey, average state membership for practicing eye physicians nationally is a woeful 39.5% (given this data is already two years old, the current percentage is most likely even lower). Many state societies are on the brink of financial crisis. While well-intentioned, joint billing, whereby a state society's dues notice is included in the Academy's dues mailing, has yielded no significant impact on state society member recruitment or retention. Stakeholders must identify ways to keep state organizations solvent so that they can continue to fulfill their mission and serve the needs of constituent eye physicians.

The legislative and membership functions of state eye societies are interconnected and equally important. Without a healthy base of participants, an organization doesn't have the "foot soldiers" to advocate with legislators and lacks the income necessary to hire and maintain a lobbying team and professional staff. It is now essential that the Academy and state societies explore alternate models of integration that emphasize efficiency, economy, and where the whole organization can be greater than the sum of its parts.

The existing membership framework is not sustainable in the long term. While well-intended, ad hoc solutions like recognizing state society members with an asterisk in the Academy Directory, tag lines on emails, or including a state society dues notice with the Academy's invoice, are simply inadequate. Our experience has demonstrated that band aid solutions don't work. If we are to have a bold vision for the future, we must have a bold response to the state society membership crisis.

Summary of Facts and Background Information:
State ophthalmology societies were created and continue to exist today primarily to fill the role of advocating for the profession at the state level with the major focus being scope of practice. Other services and benefits are provided to attract and retain members and create revenue opportunities so that state societies have the resources (professional staff and lobbyists) to achieve desired advocacy outcomes.

Despite the creation of new dues categories and creative payment options, state ophthalmology society membership has been on a steady decline for the past several years. A number of external factors are affecting this decline including: 1) a proliferation of private equity, practice mergers and hospital acquisitions; 2) less disposable income as a result of reimbursement cuts; and 3) physician apathy following a state scope bill loss.

While an exhaustive survey was not undertaken, it is known that many medical specialties embrace unified national-state society membership -- anesthesiology, Ob/Gyn, radiology, psychiatry, emergency medicine, cardiology, internal medicine, addiction medicine and family practice. Membership unification is likewise seen among many allied health professionals such as athletic trainers, dentists, midwives, PTs, PAs, podiatrists and, of course, optometrists. The concept of dual national-state membership is not unique to health care. Planners, engineers, realtors, and special education administrators, for instance, operate under a unified system of association membership. As a matter of fact, a 2016

study by Mariner Management and Whorton Marketing and Research, found that 31% of professional associations have unified membership and the trend is toward that structure.

We need to think about how to do business differently. Financially secure state societies will be less dependent on resources like the Surgical Scope Fund and allow the AAO to more effectively spread these funds across critical battles nationwide.

Possible Solutions:
A. The AAO has implemented a number of initiatives aimed at raising awareness of and support for state societies (e.g., recognizing physicians who are state society members with an asterisk in the Academy Directory, tag lines on emails, special color ribbons, etc.). Unless such projects have a direct, quantifiable, positive impact, they should be reconsidered and the staff and financial resources they consume be redirected to more meaningful and previously untried, alternatives that represent a win-win for organized ophthalmology both on the state and national levels.

B. Establish a Workgroup on Unified Membership to:

- Study the array of dual membership alternative structures (hybrid, chapters, gold standard, etc.)
- Consider a range of financial options to offset AAO costs to administer a new membership model.
- survey national medical specialty societies to ascertain their experience with unified membership including how they manage workload and associated administrative costs.
- issue a detailed report and recommendations to the Council.

C. This Workgroup should consist of appropriate AAO staff from Membership, State Affairs and Finance Departments, and at least five state executive directors selected by the state execs group. Upon completion of its review, the Workgroup should report its findings back to the Council for discussion and further action by that physician-led body.

Submitted by:
Michael A Pisacano, MD
Brad E Kligman, MD
Amy A Mehta, MD
Sawar Zahid, MD

On behalf of:
New York State Ophthalmological Society

Date Board Approved this CAR:
1/26/2024

Co-sponsoring Societies:
Connecticut Society of Eye Physicians
Florida Society of Ophthalmology
Illinois Society of Eye Physicians
Indiana Academy of Ophthalmology

Maryland Society of Eye Physicians and Surgeons
Missouri Society of Eye Physicians and Surgeons
New Jersey Academy of Ophthalmology
New York State Ophthalmological Society
Virginia Society of Eye Physicians and Surgeons

AMERICAN ACADEMY OF OPHTHALMOLOGY®

Academy Background Statement
Council Advisory Recommendation

24-04: Bold New Vision for Addressing the State Membership Crisis

Assigned to: Aaron M. Miller, MD, MBA – Secretary for Member Services;
John D. Peters, MD – Secretary for State Affairs

Analysis:
The Academy acknowledges the importance of a sustainable financial foundation for state societies' operations and growth. Strong state societies positively advance advocacy efforts and enhance organized ophthalmology's impact and relevance in the communities we serve.

To this end, initiatives have been established to elevate the visibility of and highlight the value of membership in state ophthalmic societies following CAR 15-03 and CAR 23-01, including:

- A grant program to support innovation in state society membership
- A combined dues mailing program between the Academy and state societies, with approximately half of the societies participating
- Facilitation of strategic planning session with members of the Secretariat for State Affairs and Ophthalmic Society & Global Relations staff team
- Provision of complimentary ethics education through the Academy's Ethics Program to assist members in fulfilling CME requirements for relicensure
- Co-sponsorship of coding education with a proposal to restructure revenue sharing to alleviate financial burdens on state societies to fund events
- Provision of prospective member analysis and targeted recruitment campaigns
- Meeting with state society executives, including six co-sponsoring societies of this CAR, on October 3, 2023, to discuss membership trends and collaborative opportunities

In addition, the Surgical Scope Fund was initiated in 1999 by the Academy's Secretariat for State Affairs in response to the optometry's national effort to enact optometric surgical scope statutes in states across the country. As a public policy education fund, it has supported activities including the production of radio, TV and print advertisements and the employment of lobbyists and other experts to advocate surgery by surgeons across states. Even though optometry significantly outspends ophthalmology, the Surgical Scope Fund has amassed an approximate 90% win rate for ophthalmology in state surgical scope battles since 2012.

Similar to state societies, the Academy faces challenges with weaker member engagement and membership retention. With a growing segment of employed physicians[1] and rising practice overhead costs, more ophthalmologists are postponing to pay dues or allowing their membership to lapse due to non-payment.

The Academy recognizes the importance of assessing the current membership model and exploring potential alternatives that may better serve the needs of an increasingly diverse ophthalmologist community. It is crucial to ascertain that the proposed shift to unified membership aligns with the interests of all state societies and are reflective of the needs and perspectives of our shared membership base.

[1] 36% of U.S. Academy practicing ophthalmologist members do not have practice ownership based on the 2021 Academy practice environment survey.

We would like to conduct a survey of all state ophthalmological societies to gauge their opinions and preferences about the national and state membership structure. Separately, Academy Members will be asked to share their perspective on unified membership in the Academy's all-member survey scheduled for September 2024. This dual approach seeks to foster a collaborative and inclusive decision-making process, where the voices of all stakeholders are heard and considered.

Lastly, we share the CAR authors' concerns of losing "foot solders to advocate with legislators" and physician apathy following a scope bill loss. The Academy has named increasing member engagement as a top advocacy priorities for 2024.

We believe that current resources may be better directed toward initiatives that offer more immediate and tangible benefits to our shared member base. We propose establishing a workgroup of Academy physician leaders and state society physician leaders to examine the relationship between the Academy and state societies, identify opportunities for mutual support to achieve shared objectives, and provide recommendations to further strengthen the partnership. By working together and sharing insights and best practices, we can build a stronger, more resilient membership base that will support the long-term success of state societies and the Academy.

Employing Optometrists Prudently in Ophthalmological Practices

Council Advisory Recommendation 24-05

Problem Statement:
Over half of the ophthalmological practices in the United States affiliate with optometrists as employees or independent contractors. Optometrists may wish to practice to the limits of licensed scope as defined in their home state legislation. However, this may be inconsistent with the policies of the AAO (one example is incisional or laser procedures) and sound medical practice.

Summary of Facts:

A. Ophthalmologists are physicians (as defined by graduation from a school of medicine) who are licensed to practice medicine and surgery in each of the United States.

B. Optometrists are not physicians. Optometrists and other non-physicians cannot independently engage in acts, tasks or functions falling exclusively within the licensed scope of practice of medicine, whether in an ophthalmological practice or in other settings. The role of optometrists within a medical practice, as with other non-physician clinicians, is to gather data and implement medical judgments made by the ophthalmologist(s) as indicated by the patient's status and the ophthalmologist's delegation and/or supervision.

C. The education of the two professions is vastly different and non-equivalent. (Attachment A1) (25 pages, 81 References, 5 Charts) (Attachment A2)

D. The various roles optometrists undertake in academic, military, and private ophthalmological practices vary widely.

E. Many optometrists erroneously believe that state laws expanding their scope of licensed practice mandate that medical practices must allow or condone such practices. While state legislatures may make political decisions to expand the licensed scope of practice of optometrists, the enactment of such legislation does not mean that optometrists are qualified by education, training and experience to furnish all tasks and functions permitted by such state legislation. This does not mean that patients will safely and effectively receive such care in the absence of appropriate clinical care rendered by an ophthalmologist.

F. Over time, the Council of the American Academy of Ophthalmology has considered 17 Council Advisory Recommendations which relate to Optometry (Attachment B). However, it has never considered a CAR or issued a Policy Statement on the role of the optometrist in a medical practice.

G. Patients and ophthalmologists are exposed to various legal and/or licensing and financial risks in the absence of such a relevant policy addressing the scope of optometric practice.

H. Delegating tasks and functions which exclusively fall within the licensed scope of practice of medicine to persons without medical licensure may not be clinically prudent, even if permitted by applicable law. This potentially puts patients and the supervising physician at significant risk due to the differences in education, training and licensed scope of practice between ophthalmologists and their employed optometrists.

I. Medical practices have a vicarious liability risk exposure for the actions and omissions of optometrists they employ or engage on an independent contractor basis. Failing to set forth a defined scope of practice, based on an optometrist's education, training, and experience may result in a direct liability risk exposure against the medical practice and the ophthalmologist. It may also expose the ophthalmologist to licensing complaints and actions.

J. Ophthalmologists have full authority, right, legal and ethical responsibility to determine the limits of employed optometrists' clinical behavior in their practices.

K. The AAO has a *Policy Statement on Referral of Persons with Possible Eye Diseases or Injury* (Attachment C) which contains guidelines recommended for non-ophthalmologist physicians and other practitioners ("AAO Referral Policy Statement").

L. This AAO Referral Policy Statement has been reviewed and approved multiple times by the AAO Board of Trustees and is subject to periodic revision. It can be used in academic, military, and large and small medical ophthalmological practices. The AAO Referral Policy Statement identifies patient populations which non-ophthalmologist physicians and optometrists should not attempt to manage.

Possible Solutions:

A. We propose that the AAO Referral Policy Statement, which is directed to non-ophthalmologists, should serve as the initial basis of a sound optometric scope of practice policy statement for consideration and adoption by the AAO Board of Trustees, and for use by ophthalmologists and any optometrists practicing with them.

B. We propose that this AAO Referral Policy Statement be reviewed and revised periodically and used as an appropriate basis for a derivative scope of practice policy for employed optometrists. We suggest it can protect patients from the risk of personal injury and ineffective care due to the rendering of eye care services by those without appropriate education, training and experience. We believe it will protect ophthalmologists as well as optometrists from related legal liability and licensing risk exposures.

C. We propose that the AAO encourage member ophthalmologists and their affiliated optometrists (i) to agree to abide by the terms of the AAO Referral Policy Statement, (II) to agree to such other restrictions and limitations as the ophthalmologist shall require. In addition to promoting better quality patient care, this would begin to better align optometrists with clinical standards which have long been imposed on physicians, such as requirements to sign conflict of interest policies and credentialing documents as a condition of hospital medical staff membership and the exercise of clinical privileges.

D. We propose that optometrists affiliated with ophthalmology practices should participate in AAO educational offerings which address the expectations of ophthalmologists for optometrists as clinical practitioners in ophthalmology practices.

E. Further, we propose that:
    a. Ophthalmological practices be encouraged to include in their terms of affiliation with an optometrist a requirement for the optometrist to annually confirm in writing compliance with the AAO Referral Policy Statement.

b. Ophthalmological practices should be encouraged to furnish financial support for optometrists to attend AAO educational offerings designed specifically to address the contents of the AAO Referral Policy Statement.
c. Base salary levels, practice benefits, and ophthalmologist funded financial support for AAO educational offerings be based on annual optometric signature.

Attached PDF:

A.1 AAO A Review of Optometric Education: An Analysis of the Current Status, and A Comparison of Differences Between Ophthalmology and Optometry (Cover Only)

A.2 Legislative Questions (AAO Planning and Research Unit)

B. Optometry Related CARs (Considered by Council – not all referred to BOT)

C. AAO Referral of Persons with Possible Eye Disease or injury

Submitted by:
Thomas Aaberg MD
Thomas Byrd MD

On behalf of:
Michigan Society of Eye Physicians and Surgeons

Date Board Approved this CAR:
8/3/2023

Co-sponsoring Societies:
American Association for Pediatric Ophthalmology and Strabismus
American Association of Ophthalmic Oncologists and Pathologists
American Osteopathic College of Ophthalmology
American Uveitis Society
Colorado Society of Eye Physicians and Surgeons
Florida Society of Ophthalmology
Idaho Society of Ophthalmology
Hawaii Opthalmological Society
Intl Joint Commission on Allied Health Personnel in Ophthalmology Iowa Academy of Ophthalmology
Kentucky Academy of Eye Physicians and Surgeons
Maryland Society of Eye Physicians and Surgeons
Missouri Society of Eye Physicians and Surgeons
Montana Academy of Ophthalmology
Nebraska Academy of Eye Physicians and Surgeons
Ocular Microbiology and Immunology Group
Retina Society
Vermont Ophthalmological Society
Washington DC Metropolitan Ophthalmological Society
West Virginia Academy of Eye Physicians and Surgeons Wisconsin Academy of Ophthalmology
Women in Ophthalmology
Wyoming Ophthalmological Society

Attachment A1

American Academy of Ophthalmology®

A Review of Optometric Education:

An Analysis of the Current Status, and A Comparison of Differences Between Ophthalmology and Optometry

LEGISLATIVE QUESTIONS

Question: How do years of formal education compare between optometrists, primary care physicians, (PCP) and ophthalmologists?

OD	7 years	(one year clinical/experiential)
MD-PCP	11-12 years	(5-6 years clinical/experiential)
MD-Oph	12 years	(6 years clinical/experiential)

Degree:	Undergraduate:	Professional school:	Post-graduate:
OD	3 years	4 year degree	none
MD-PCP	4 year degree	4 year degree	1 year MD internship 2-3 years PCP residency
MD-Oph	4 year degree	4 year degree	1 year MD internship 3 years Oph residency

Question: Does optometric education exceed the education of primary care physicians (PCP) in diagnosis and pharmaceutical treatment of eye disease?

Answer: No.

Primary care physicians learn much beyond the classroom curriculum of the first two years of medical school concerning eye care. Academic knowledge developed clinically far exceeds didactic classroom training in the development of a physician.

While ocular-specific classroom hours during the first two years of medical school training may not compare to the one-half year of ocular medical content in some optometry schools, the third and forth year clinical rotations, the MD internship clinical training, and primary care residency training offer considerable academic advancement in ocular conditions, learned clinically. In primary care residencies, that includes caring for patients presenting with ocular conditions and ocular manifestations of systemic disease and treatment.

While clinical learning and experience is not as easy to document or quantify as classroom clock hours, it is the true foundation for all competent medical practice, especially for pharmaceutical therapy. Physicians learn to administer pharmaceuticals through years of supervised clinical experience with sick patients.

The clinical training of optometry students is further limited by the fact that they are not licensed practitioners while in training. Medical residents are licensed practitioners, and can legally prescribe and treat illness while under the supervision of graduate medical faculty.

Question: How many clinical contact hours involving sick patients do optometry students complete before graduation?

Answer: 100-200 hours (5%-10% of total hours)

An average of 2,000 total supervised hours of student contact with vision care patients is estimated. Most of these hours involve learning visual assessment and eye wear prescribing in optometry school vision clinics.

No evidence has been presented to refute the reported finding that no more than 5-10% of patients cared for by optometry students present with signs or symptoms of any serious disease, thus offering little opportunity for optometry students to learn clinically and develop diagnostic or therapeutic skills.

Question: How many clinical contact hours involving sick patients are required to graduate and be licensed to practice optometry?

Answer: Zero

Accreditation standards in optometry set no minimum level of sick patient contact. Without minimum standards, the optometric system of education cannot assure that every student has had significant supervised exposure to sick patients. Neither graduation nor licensure under these conditions can assure the public that each student has had supervised experience with diagnosis, making therapeutic decisions, and managing the care of sick patients.

Question: How does that compare to medicine?

Answer: 12,000-15,000 hours

Accreditation standards for medical schools and residency programs require medical students to spend 3,200 clinical training hours over the third and forth years in medical rotations, virtually all involving sick patients. The post-graduate MD internship averages another 3,000 hours, including emergency experience. Post-graduate residencies involve 3,000 hours per year of care for sick patients.

Question: How many years of post-graduate education are required to practice optometry?

Answer: Zero.

Optometrists go into practice immediately after graduation and licensure. A few one-year post-graduate "optometric residencies" are available, but over 90% of graduates do not take them. In medicine, all physicians complete a one-year post graduate MD internship where clinical learning is stressed, followed by 2-4 years of residency training in the fields of choice. All primary care physicians complete residencies. In optometry, graduation and licensing marks the end of formal training, while in medicine, it marks the beginning of 2-4 years of post-graduate training in primary care and specialty care.

Question: Do optometry schools follow a uniform curriculum, based on minimum standards?

Answer: No.

There is great variation in offerings between schools, despite accreditation. Concerning medical-related content, the bottom school provides only one-half the didactic credit hours compared to the top school. The same is true for clinic-based training hours. No minimum contacts with sick patients have been required.

Question: How much academic time does an average optometry student spend in the classroom studying medical-related subjects and eye disease?

Answer: just one academic year

On average, a 4 year optomtetry school requires 245 quarter credits to graduate. Of that, 38.2 quarter credits relate to medical topics and 30.3 quarter credits relate to ocular medical topics. (average quarter = 20 credits).

- All medical knowledge is learned in 1.9 quarters
- All ocular medical knowledge is learned in 1.5 quarters.
- All optometric knowledge and practice management is learned in 5.2 quarters.
- Clinical/experiential training is completed in 3.5 quarters (*only 5%-10% involving sick patients*)

Question: How intensively do optometrists use TPA in practice?

Answer: Less than one prescription per week.

Wisconsin studied this issue in 1992, where 409 TPA-certified optometrists reported 17,600 therapeutic administrations, or 43 per year. Given a fair estimate of 2,900 ambulatory encounters per year per optometrist, that suggests that 98.5% of an optometrists annual effort is unrelated to therapeutic practice.

Hospitals often require physicians to perform a minimum number of procedures annually to maintain hospital privileges and assure a basic level of skill. How can optometrists develop or maintain therapeutic skills on such a low volume of TPA practice?

How important is it to allow or advance a scope of practice to a profession that shows reluctance to use it? The public may be deciding with its feet who best serves their eye health care needs.

Attachment B

A Review of AAO CARs which relate to optometry

99-7 Legislative Strategy to Deal with Optometric Surgery Bills
00-6 Legislative Strategy to Deal with Optometric Surgery Bills (Wisconsin)
00-7 Shortage of Ancillary Staff for Ophthalmology Practices (New Jersey)
00-16 Ophthalmology Training Programs for Ophthalmologists? (Ohio)
01-11 Support for and Implementation of a National Strategy for Combatting Optometric Scope of Practice Expansion Efforts (New York)
02-05 The Problem of "Co-Education" and the Awarding of CME Credits to Optometry (Pennsylvania) *
04-02 Medically Sound Vision Care Benefit Plans (Michigan) *
04-03 Optometric Attendance at Academy Sponsored Educational Functions (Michigan)
07-01 Optometry Participation at the AAO Annual Meeting (Michigan)
09-09 Development of the Eye Care Team (Texas)
11-09 Educating Optometrists at the annual AAO Meeting (Ohio) *
13-04 Separating Ophthalmologists and Optometrists on www.medicare.gov (Pennsylvania) *.
14-04 Broadening the Scope of Surgery by Surgeons (Puerto Rico)
15-01 Ophthalmology Associated Optometrists (Pennsylvania)
15-05 Ophthalmologists and Our Ophthalmic Associates (Michigan)
17-08 The American Academy of Ophthalmic Associates (Michigan)
18-05 The Gatekeeper Role of Ophthalmology (Indiana)

- Of these 17 CARs those starred (*) are of particular significance to this Michigan CAR.
- All of these CARs are available from AAO.

pch/md.aao22. 4/4/2022 12:04 PMaaocar2023.

Attachment D
C

APR 2014

Referral of Persons with Possible Eye Diseases or Injury - 2014

AAO Hoskins Center for Quality Eye Care
Comprehensive Ophthalmology

Compendium Type: III

Policy

The American Academy of Ophthalmology supports prompt, appropriate referral of individuals to an ophthalmologist when certain signs are observed and/or certain symptoms of possible eye disease or injury are reported.

Background

Many eye diseases, systemic diseases, and injuries that affect the eyes may begin with subtle signs and minimal or barely detectable symptoms. Most of these diseases and injuries require prompt, appropriate medical treatment to minimize the risks of impaired vision or even blindness. Ophthalmologists are medical specialists who are qualified by education, training, and clinical experience to provide total eye care, which includes a vision examination (refraction), a medical eye examination, and necessary medical and surgical care and treatment.

Guidelines

A person who exhibits any of the following signs, symptoms, or diseases should be referred promptly to an ophthalmologist for definitive diagnosis and necessary medical treatment:

A. Failure to achieve normal visual acuity in either eye, unless the case of the impairment has been medically confirmed by prior examination and visual acuity is stabilized. (Different levels of visual acuity screening for different ages of preschool children have been established to accommodate the maturity of the child.)
B. Significant eye injury, eye pain, or periocular trauma.
C. Symptoms of flashes of light; recent onset of floaters, halos, transient dimming, or distortion of vision; obscured vision; loss of vision or pain in the eye, lids, or orbits; double vision; or excessive tearing in the eye.
D. Transient or sustained loss of any part of the visual field, or clinical suspicion or documentation of such field loss.
E. Abnormalities or opacities in the normally transparent media of the eye, or abnormalities of the ocular fundus or the optic nerve head.
F. Tumor or swelling of the eyelids or orbit, or protrusion of one or both eyes.
G. Inflammation of the lids, conjunctiva, or globe, with or without discharge.
H. Strabismus or crossed eyes that do not straighten with glasses.
I. Intraocular pressure at an abnormal level or family history of glaucoma, especially in patients of African or Hispanic origin.

A C

J. Diabetes mellitus without a recent retinal examination.
K. Eye and orbital abnormalities associated with thyroid disease (Grave's disease).
L. Other history, symptoms, or signs that indicate the need for an ophthalmologist to perform an eye examination or treatment.

The following groups of individuals should also be referred promptly to an ophthalmologist:

- HIV-positive patients with ocular symptoms and all patients with AIDS.
- Newborn babies at risk by prematurity, systemic disease, family history of conditions that cause or are associated with eye or vision problems, or serious ocular symptoms or signs.

Approvals

American Academy of Ophthalmology,
Board of Directors, 1986

Revised and Approved by:

American Academy of Ophthalmology,
Board of Directors, June 1992

Reaffirmed by:

American Academy of Ophthalmology,
Board of Trustees, September 1995

American Academy of Ophthalmology,
Board of Trustees, February 2000

Revised and Approved by:

American Academy of Ophthalmology,
Board of Trustees, February 2005

American Academy of Ophthalmology,
Board of Trustees, April 2009

Reaffirmed by:

American Academy of Ophthalmology,
Board of Trustees, April 2014

P.O. Box 7424 / San Francisco, CA 94120 / 415.561.8500

AMERICAN ACADEMY OF OPHTHALMOLOGY®

Academy Background Statement
Council Advisory Recommendation

24-05: Employing Optometrists Prudently in Ophthalmological Practices

Assigned to: John D. Peters, MD - Secretary for State Affairs

Analysis:
The recommendations of CAR 24-05 are based largely on the Academy Clinical Statement "Referral of Persons with Possible Eye Diseases or Injuries – 2014."[1] The clinical statement recommends that persons with specified signs, symptoms and diseases of the eye be referred promptly to an ophthalmologist. The clinical statement also recommends that persons with specified systemic conditions be promptly referred to an ophthalmologist. These include persons with:

- Diabetes mellitus without a recent retinal examination;
- All Patients with AIDS; and
- Newborn babies at risk by prematurity or systemic disease.

CAR 24-05 states that this clinical statement should serve as the initial basis of a sound optometric scope of practice policy statement for consideration and adoption by the Board and for use by ophthalmologists and optometrists practicing with them. It further states that ophthalmological practices should be encouraged to include in their terms of affiliation with an optometrist a requirement for the optometrist to annually confirm in writing compliance with the Academy's Referral Policy Statement.

This clinical statement is not directed exclusively to optometrists. Referrals to an ophthalmologist are one aspect of an optometrist's appropriate scope of practice. Aspects of the clinical statement's content may in some instances be more applicable to family physicians, pediatricians, and other medical specialists. Like other Academy resources, ophthalmologists have access to this clinical statement to use as a guideline in their practices where appropriate.

CAR 24-05 also calls on optometrists affiliated with ophthalmology practices to participate in Academy educational offerings which address the expectations of ophthalmologists for optometrists as clinical practitioners in ophthalmology practices. The resolutions also states that ophthalmological practices should be encouraged to furnish financial support for optometrists to attend Academy educational offerings designed specifically to address the contents of the Academy Referral Policy Statement.

The issue of educating optometrists at Academy-sponsored meetings has been discussed before the Council several times.[2] Discussions have historically centered around whether optometrists could misrepresent these educational opportunities in a legislative advocacy context related to scope of practice.

The question of optometrist education has also been extensively discussed at the Board level, culminating in the development of the AAO2AAO program in which several select optometrists present at each Annual Meeting on limited eye care topics. Currently, there are no other educational opportunities including optometrists at Academy-sponsored events.

Options:

- Review and, if necessary, update the Academy Clinical Statement "Referral of Persons with Possible Eye Diseases or Injuries – 2014."
- Consider use of Academy communications channels to make members more aware of the Academy Clinical Statement on "Referral of Persons with Possible Eye Diseases or Injuries – 2014."
- Investigate vehicles for sharing the Academy's Clinical Statement on "Referral of Persons with Possible Eye Diseases or Injuries – 2014" with members of the American Medical Association.

References

1. Referral of Persons with Possible Eye Diseases or Injury – 2014
https://www.aao.org/education/clinical-statement/guidelines-appropriate-referral-of-persons-with-po

2. 04-03 Optometric Attendance at Academy Sponsored Educational Functions
https://secure.aao.org/aao/council-advisory-recommendations?_gl=1*1wr966p*_ga*MjAxMjYxNzc2NS4xNzA0NzU1NDE2*_ga_3PN52QWGQQ*MTcxMDczOTMyMS41MS4xLjE3MTA3Mzk5NTguNS4wLjA.

04-09 Optometric Presenters at AAO-Sponsored Meetings
https://secure.aao.org/aao/council-advisory-recommendations?_gl=1*1wr966p*_ga*MjAxMjYxNzc2NS4xNzA0NzU1NDE2*_ga_3PN52QWGQQ*MTcxMDczOTMyMS41MS4xLjE3MTA3Mzk5NTguNS4wLjA.
07-01 Optometry Participation in the AAO Annual Meeting
https://secure.aao.org/aao/council-advisory-recommendations?_gl=1*1wr966p*_ga*MjAxMjYxNzc2NS4xNzA0NzU1NDE2*_ga_3PN52QWGQQ*MTcxMDczOTMyMS41MS4xLjE3MTA3Mzk5NTguNS4wLjA.

11-09 Educating Optometrists at the AAO Annual Meeting
https://secure.aao.org/aao/council-advisory-recommendations?_gl=1*1wr966p*_ga*MjAxMjYxNzc2NS4xNzA0NzU1NDE2*_ga_3PN52QWGQQ*MTcxMDczOTMyMS41MS4xLjE3MTA3Mzk5NTguNS4wLjA.

15-01 Ophthalmology Associated Optometrists
https://secure.aao.org/aao/council-advisory-recommendations?_gl=1*1wr966p*_ga*MjAxMjYxNzc2NS4xNzA0NzU1NDE2*_ga_3PN52QWGQQ*MTcxMDczOTMyMS41MS4xLjE3MTA3Mzk5NTguNS4wLjA.

15-05 Ophthalmologists and Our Ophthalmic Associates
https://secure.aao.org/aao/council-advisory-recommendations?_gl=1*1wr966p*_ga*MjAxMjYxNzc2NS4xNzA0NzU1NDE2*_ga_3PN52QWGQQ*MTcxMDczOTMyMS41MS4xLjE3MTA3Mzk5NTguNS4wLjA.