



**Evan H. Black, MD, FACS**  
**Michigan Society of Eye Physicians and Surgeons**  
**Leadership Development Program XIII, Class of 2011**  
**Project Abstract**

***Title of Project:*** Michigan Society of Eye Surgeons (MiSEPS) Ambassador Program

**Purpose:** Develop a grassroots network for legislative advocacy.

**Methods:** 1) Identify MiSEPS members who both have strong interpersonal skills and who will be a positive MiSEPS ambassador with policy makers. 2) Match identified members with their Representative and Senator. 3) Identify duties of each MiSEPS ambassador, including attending an in-district fundraiser once a year, meeting informally with their legislators once a year, and participating in MiSEPS legislative advocacy day. 4) Develop collateral materials for use by MiSEPS ambassadors. 5) Engage young ophthalmologist section (YOS) members, residents, and fellows as “Junior Ambassadors.”

**Results:** As MiSEPS members are being paired with their respective legislators, new and important relationships are being forged. At a legislative effort on March 22, 2011, the first groups of Ambassador members visited their state legislators in Lansing, MI and were well received. We focused on scope of practice issues, medical marijuana’s lack of efficacy for treatment of glaucoma and school vision screening funding. This ongoing project is continuing to gain momentum and we expect continued results as the number of legislative relationships increases.

**Conclusions:** Enlisting grassroots defensive support is the most effective means of fighting any potential unsafe scope of practice expansions by optometrists, protecting citizens from misinformation regarding marijuana and glaucoma treatment and continuing to protect the children of our state with funding for vision screening. When legislators have a positive relationship with the ophthalmologists who are both their constituents and supporters, they will be receptive to our concerns and will utilize our training and experience to help guide their decisions regarding eye related issues in state government.



**James S. Brown III, MD, FACS**  
**Mississippi Eye, Ear, Nose and Throat Association**  
**Leadership Development Program XIII, Class of 2011**  
**Project Abstract**

***Title of Project:*** *Website Development for the Newly Formed Mississippi Academy of Eye Physicians and Surgeons*

**Purpose:** To develop an informative website as the primary source for eye care information for patients in Mississippi and as an interactive tool for members of the newly formed Mississippi Academy of Eye Physicians and Surgeons.

**Methods:** We examined websites throughout the country to find what other societies had done well. A target audience was established so that the website design could be tailored to meet the needs of our audience. MAEPS members, legislators, and the general public served as our target audience. A face page was created to be both attractive and informative to the public. Frequently Asked Questions relating to what ophthalmologists do were included as well as links to other information that the public would find useful. Additionally we sought to provide additional benefits to members. Benefits included a “members only” section that keeps members informed of legislative updates and strategies to promote our profession, online dues payment, and a listing to “Find an Eye MD”.

**Results:** The website is still under development but the result will be a more user-friendly informative way to interact with members and the public.

**Conclusion:** With the newly formed Mississippi Academy of Eye Physicians and Surgeons a new way to interact with its audience was also needed. The website will bring additional information and benefits to the public and ophthalmology members.



**James W. Culclasure, MD**  
**South Carolina Society of Ophthalmology**  
**Leadership Development Program XIII, Class of 2011**  
**Project Abstract**

**Title of Project:** *Facilitating the Transition to Electronic Health Records (EHR): A Workshop for South Carolina's Ophthalmology Practices*

**Background:** In 2009, the American Recovery and Reinvestment Act was signed into law, providing multiple incentives to those who transition to an electronic health records system. Although incentives are now provided, it is likely that EHR will be mandated in the future and penalties will be incurred for those who do not make the transition.

**Purpose:** In light of this legislation and the incentives on the table, the South Carolina Society of Ophthalmology hopes to help South Carolina's ophthalmologists and practice administrators learn about the sometimes complex EHR by facilitating discussion about the meaningful use of EHR, by exposing members to the process and various choices presented by EHR, and by providing a venue to learn more about the system and ask questions to professionals and those already utilizing EHR.

**Methods:** A one-day workshop will be provided in Columbia, SC, a central location within approximately two hours of any practice. This workshop will include educational sessions to explain EHR (pros and cons, costs, products, and other relevant information for practitioners and administrators). Vendors in the EHR industry also will be invited to display their products and make short presentations about what their products can offer. In addition, the hope is that vendors will be willing to host a roundtable lunch for attendees, where practices currently utilizing EHR can openly talk about their experiences transitioning from a traditional to an EHR system.

**Results/Conclusion:** TBD. Event will be held in Spring of 2012.



**Andrew P. Doan, MD, PhD**  
**California Academy of Eye Physicians and Surgeons**  
**Leadership Development Program XIII, Class of 2011**  
**Project Abstract**

**Title of Project:** *Improving the California Academy of Eye Physicians & Surgeons Website*

**Purpose:** To survey the members of the California Academy of Eye Physicians & Surgeons (CAEPS) and determine desirable, useful, and functional website elements to better serve CAEPS members.

**Methods:** A ten-question survey was generated based on a standard Likert scale on SurveyMonkey.com. Seven hundred emails were sent to CAEPS members asking them to determine the importance of having the following elements for the CAEPS website: 1) mission & vision of CAEPS; 2) online searchable, public directory of CAEPS members; 3) patient information; 4) archive of CAEPS newsletters; 5) information about current legislative issues; 6) pay dues & registrations online; 7) information about CAEPS membership benefits; 8) information about using social media to effectively educate and market to patients; 9) information on how to use vetted, web-based services that seek to increase patient referrals and/or protect online reputations; and, 10) provide features that would be helpful for you and/or your practice.

**Results:** Of the 700 emails sent, we received a response from 42 individuals. In response to the statement “it is important to have information on the mission & vision of CAEPS on the website”, 83.3% of the respondents agreed, 16.7% of the respondents neither agreed nor disagreed, and none disagreed. When presented with the statement “it is important to have an online searchable, public directory of CAEPS members, e.g. Doctor Finder, on the CAEPS website”, 73.1% of the respondents agreed, 22% of the respondents neither agreed nor disagreed and 4.9% of the respondents disagreed. When asked to rate the statement “it is important to have information for patients on the CAEPS website”, 69.1% of the respondents agreed, 23.8% neither agreed nor disagreed, and 7.1% disagreed. In regards to having “an archive of CAEPS newsletters on the website”, 61.9% of the respondents agreed, 28.6% neither agreed nor disagreed, and 9.5% disagreed. In regards to having “information about current legislative issues (governmental & regulatory) on the CAEPS website”, 92.8% of the respondents agreed, 2.4% neither agreed nor disagreed, and 4.8% disagreed. When presented with the statement “it is important to pay for dues and registrations on the CAEPS website”, 83% of the respondents agreed, 14.6% neither agreed nor disagreed and 2.4% disagreed. The statement “it is important to provide information on membership benefits on the CAEPS website” elicited 87.8% of the respondents who agreed, 9.8% who neither agreed nor disagreed, and 2.4% who disagreed. When presented with the statement “it is important to provide information on the CAEPS website on how to use social media to effectively educate and market to your patients” 38.1% of the respondents agreed, 38.1% neither agreed nor disagreed, and 23.8% disagreed. When asked to rate the importance of providing “information on the website on how to use vetted, web-based services that seek to increase patient referrals and/or protect online reputations” 40.5% of the respondents agreed, 45.2% neither disagreed nor agreed, and 14.3% disagreed.

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*Project: Improving the California Academy of Eye Physicians & Surgeons Website*

**Conclusions:** The response rate to the survey was low at 6%, and the survey results may not accurately represent the majority views of the CAEPS membership. Interestingly, CAEPS members agreed that the website should communicate current legislative issues, allow payment of dues online, state the organization's mission & vision, outline membership benefits, and offer an online directory for patients. Less important to implement on the website are patient education and make available an archive of CAEPS newsletters. Least important, but with nearly 40% of the respondents agreeing, CAEPS members would like more information on how to utilize social media, how to increase patient referrals through the Internet, and how to protect their online reputation. Although the response rate of the survey was low, the survey provides helpful guidelines to focus web development efforts that will improve the overall experience for CAEPS members. Other state societies may implement a similar survey to assist in their website development and implementation of new features.



**Arash Eshghabadi, MD**  
**Middle East Africa Council of Ophthalmology**  
**Leadership Development Program XIII, Class of 2011**  
**Project Abstract**

**Title of Project:** *Creating an updated educational web site with content in English and Persian, to improve the knowledge of young ophthalmologists in Persian-speaking countries*

**Purpose:** The objective of this project is to set up an updated educational website to improve the knowledge of ophthalmologists, especially the young ones, in Persian-speaking regions. Through creating this website in two languages, English and Persian, the ophthalmologists in the region will be able to arm themselves with the updated knowledge of ophthalmology easily and cost-effectively in their own mother tongue. In addition, the website will be configured to allow the ophthalmologist to send files of difficult cases to the more expert doctors in a variety of fields to get necessary advice, and to share their experiences of difficult cases with their colleagues.

**Methods:** General support for the project was provided by the Iranian Society of Ophthalmology; however, additional financial support was also needed. The initial steps in this project involved negotiation to secure credible and interested investors, and we eventually succeeded in reaching an agreement for support with the Noor Ophthalmology Research Center, Tehran Iran. Following that, the organizational chart of administrative roles for the site was prepared, which included the technical and scientific staff. In the technical chart, positions were identified for technical, updating, financial, translation, PR management and scientific affairs. A scientific editor was identified for a subdivision that will include the heads of subspecialty sections that will each be in charge of providing scientific content pertaining to their own fields, responding to questions, and giving advice on relevant cases. Also, in designing the website, some sections will be developed to train other related professions, such as optometry and ophthalmic nursing. Another section will contain the most important news of ophthalmology in the world, in the region and regarding the Congress of Ophthalmology. Simultaneous review of the important conferences in our research centers will be enabled. Moreover there will be direct relationships between leaders of the organization and the members.

**Results:** At the beginning of the project, to save on the expenditures suggested by the investor; we started with an existing but not dynamic site, and planned to gradually incorporate new software. At present, we have attempted to make ophthalmology articles from Iran available for use by all users of the website.

**Conclusion:** At present the site is in its trial version and the necessary investments have been made. The initial designing of the site is done, necessary objectives have been determined, and the technical manager is designing the software for the website. Also, we are negotiating to get the cooperation of some experts for different subspecialty branches so that with the complete launch of the site we will be able to assist the young ophthalmologists and move ahead toward the ultimate purpose which is to equip ophthalmologists with the most current ophthalmic knowledge so that they might help more patients.



**Dean P. Hainsworth, MD**  
**Missouri Society of Eye Physicians and Surgeons**  
**Leadership Development Program XIII, Class of 2011**  
**Project Abstract**

***Title of Project:** Access to Care: Distribution of Ophthalmology and Optometry Offices in Missouri*

**Purpose:** Missouri Speaker of the House is an optometrist with a goal of expanding optometric scope of practice, specifically injectables and lasers. Missouri optometric legislative initiatives in 2011 consisted of attempts to extend a mandate of comprehensive kindergarten exams. This initiative was defeated. We expect additional broader efforts in 2012. In Kentucky and elsewhere, optometric scope expansion arguments have been based on perceived lack of “access to care”. A map of Kentucky showing optometry and ophthalmology offices was used effectively in legislative hearings to show large areas of the state with optometric offices, but without proximity to ophthalmic care. Many ophthalmologists see patients in satellite offices in addition to their main office. A map that included ophthalmic satellite offices would likely negate any “access to care” argument for optometric scope expansion.

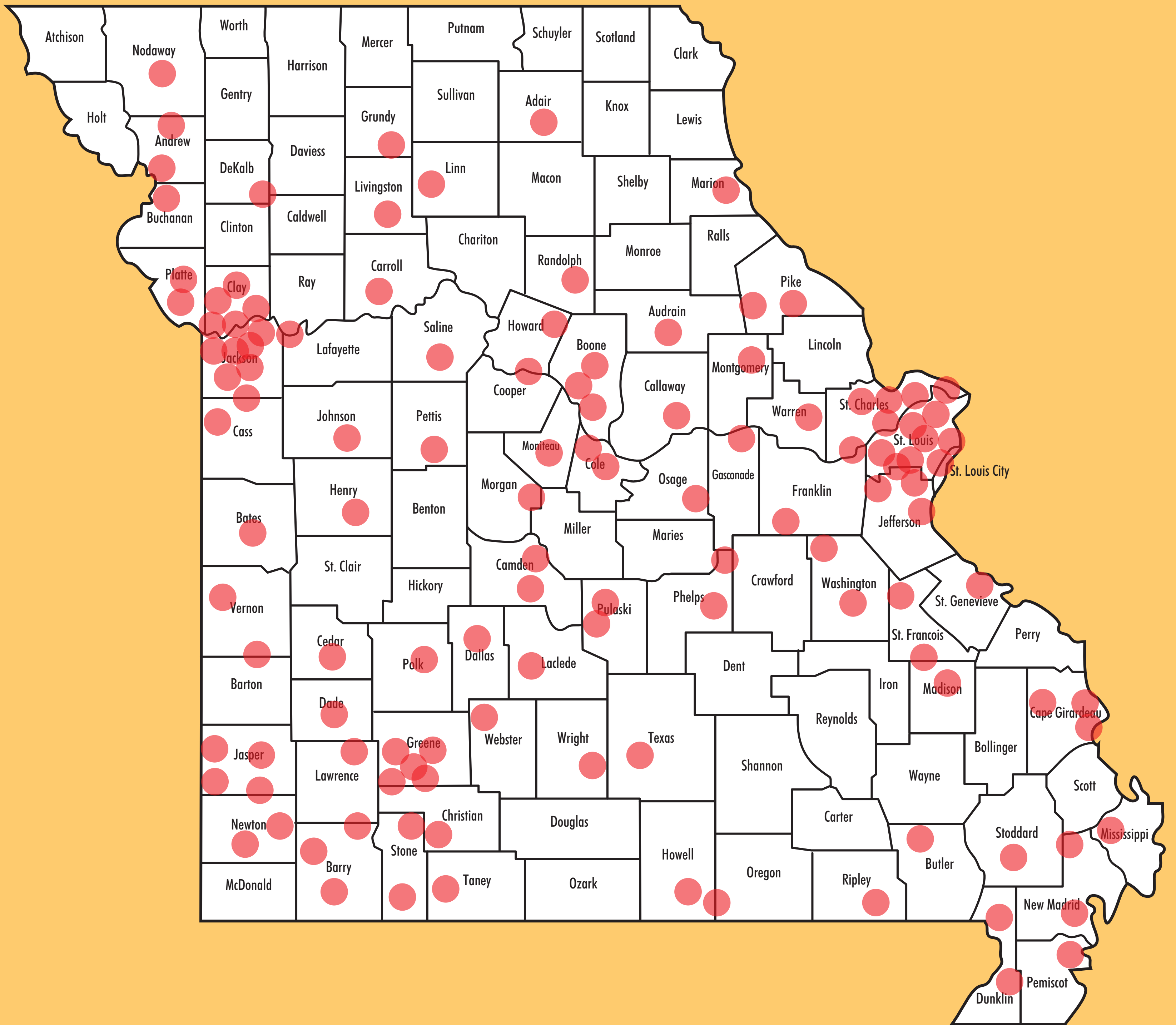
**Methods:** I contacted all Missouri Ophthalmologists to determine locations of satellite offices. I obtained the offices of Missouri Optometrists from the MOA website. I plotted out 4 maps of the State of Missouri: 1) Ophthalmology Main Offices, 2) Ophthalmology Main Offices and Satellite Offices, 3) Optometry Offices, and 4) Ophthalmology Main and Satellite Offices combined with Optometry Offices. Note that the map symbols do not represent individual practices, but rather their distribution across the state, i.e. a city may have 10 ophthalmologists but only one “dot” on the map to keep the map from becoming too cluttered. However, there is no city or county that is not represented if there is at least one ophthalmology or optometry office there.

**Results:** Optometry offices in Missouri are evenly distributed when compared to Ophthalmology main offices plus satellite offices. No part of the state has an optometry office located more than 30 miles from an ophthalmology office. The vast majority of the state’s residents live equally accessible to an optometry or ophthalmology office. Increased “access to care” is not an effective argument for expansion of optometric scope of practice.

**Conclusion:** These distribution maps will be useful in future Missouri optometric scope of practice legislation. These maps are printed on large poster boards, suitable for presentation at legislative hearings, etc. They will be kept in the MoSEPS office to be used as needed, even on short legislative notice. Since they were created electronically, they can be easily updated every few years to serve as effective deterrent to future “access to care” arguments for optometric scope of practice increases. Copies of these maps are included with this abstract.

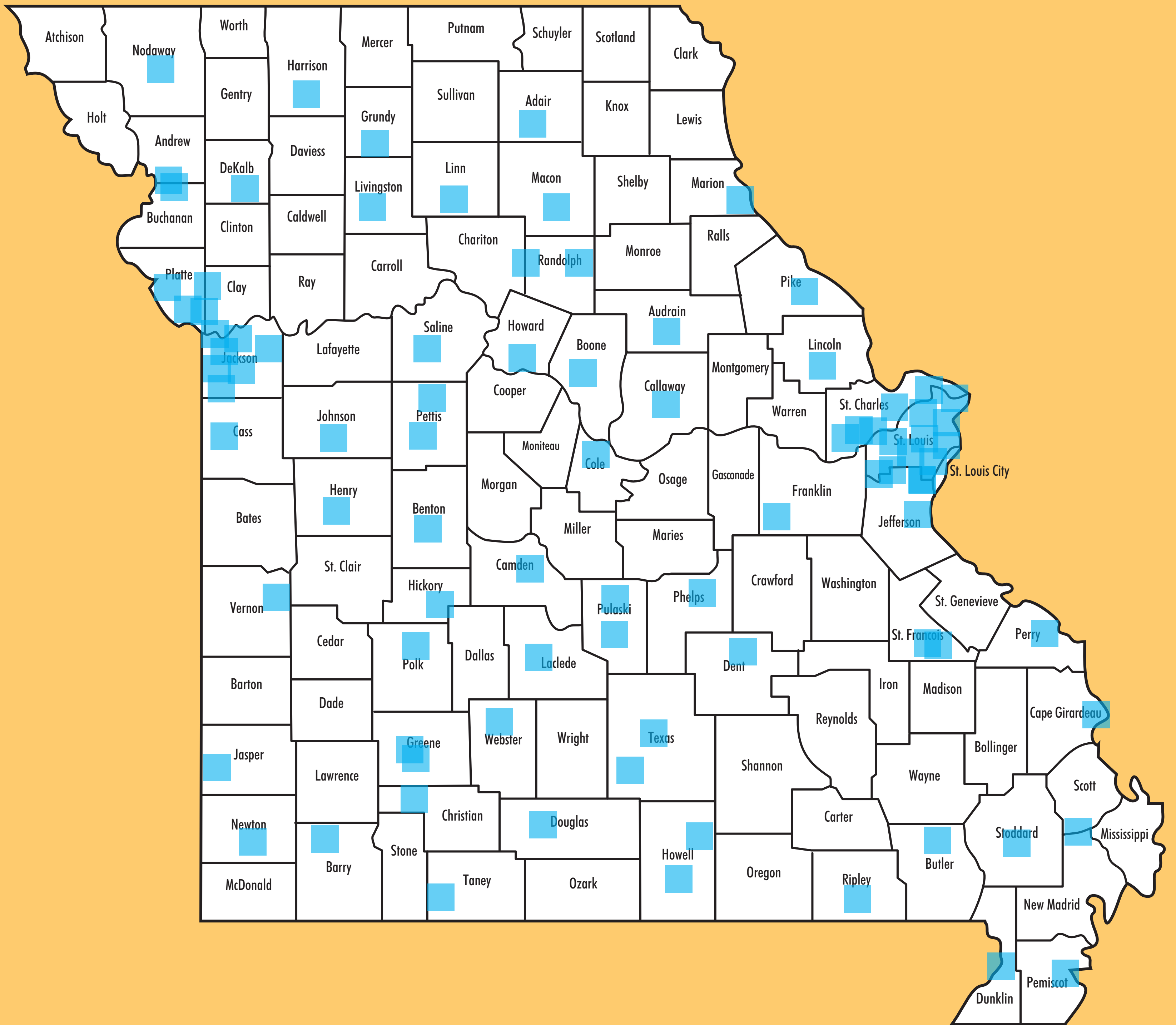


# Distribution of Missouri Optometrists

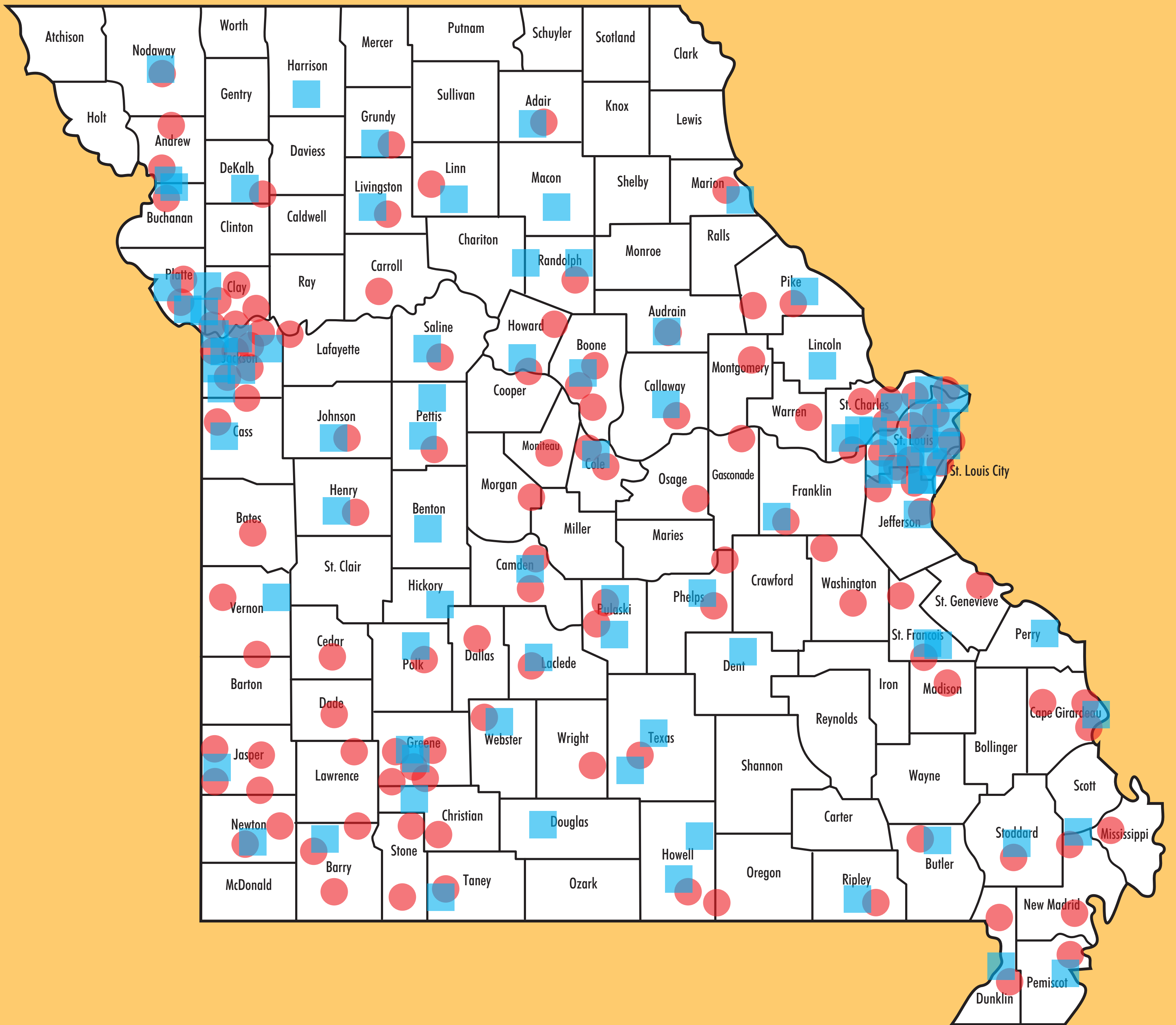




# Distribution of Missouri Ophthalmologists Main and Satellite Offices

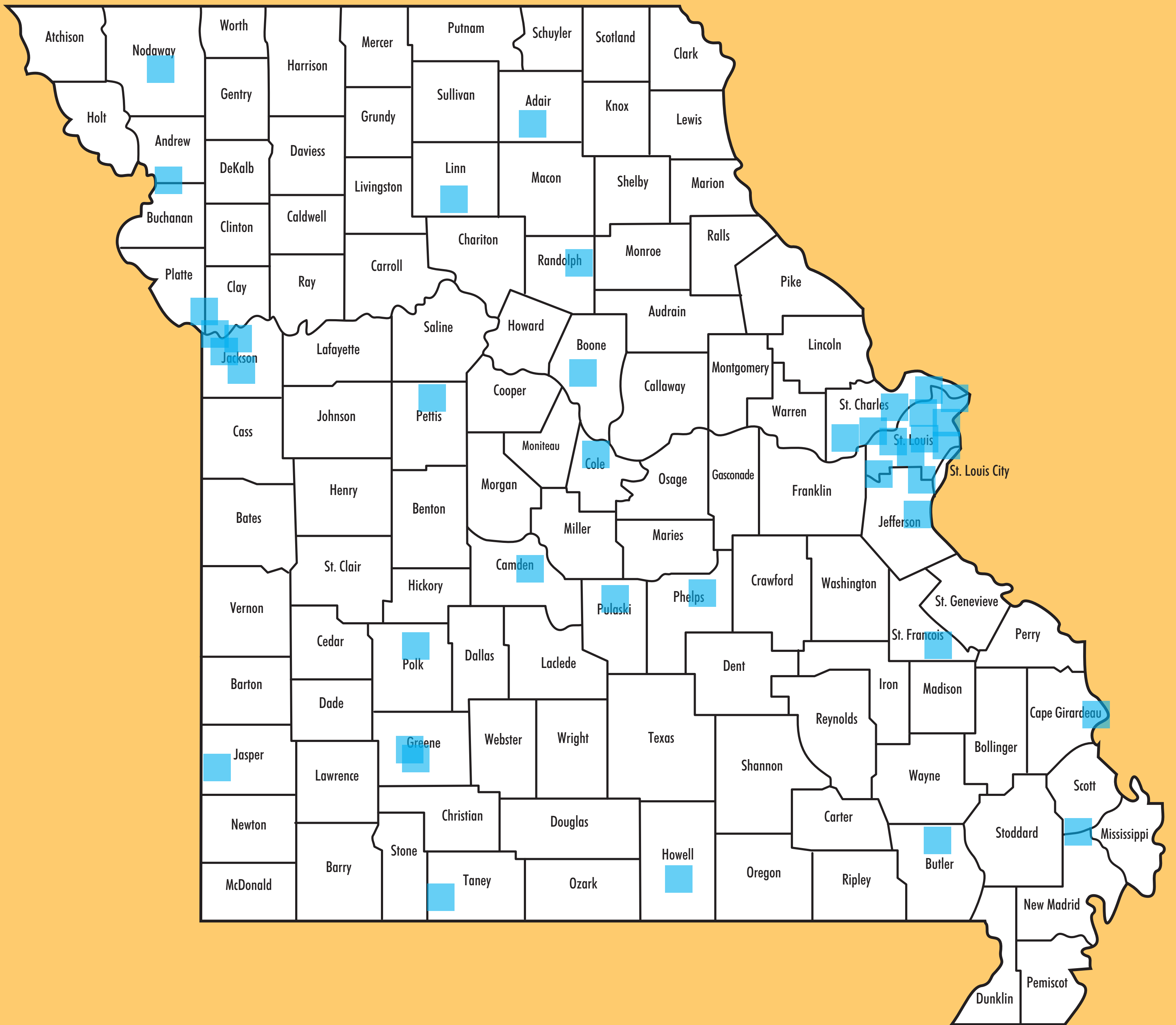


# Distribution of Missouri Ophthalmologists and Optometrists Main and Satellite Offices



- **Optometrists**
- **Ophthalmologists**

# Distribution of Missouri Ophthalmologists Main Offices





**Isaac J. Hearne, MD**  
**Nevada Academy of Ophthalmology**  
**Leadership Development Program XIII, Class of 2011**  
**Project Abstract**

***Title of Project:** Level II Trauma Center Standard of Care*

**Purpose:** To understand the current after-hours ophthalmic surgery standard of care among western states Level II trauma centers for appropriate comparisons with local centers. This was prompted by a local Level II trauma center whose administration insists their ophthalmic standards meet national and local standards of care for after-hours eye surgery.

**Methods:** A standard form letter with three questions was sent to 30 different Level II trauma center eye surgeons. These questions were; 1) Do you feel that your center provides adequate after-hours surgical eye equipment? 2) Are you satisfied with staffing provided by the center for after-hours eye surgery? 3) Do you feel the performance of after-hours eye surgery is safe? This survey was followed up by a phone survey for those areas which did not provide an initial response. At the request of some surgeons the form was faxed directly to them and then returned. These responses were then compiled and compared with the responses from surgeons at our local center obtained previously.

**Results:** 20 eye surgeons responded either by letter, fax or phone from 20 different Level II trauma centers. 100% of respondents felt that their centers had adequate equipment for after-hours surgery. 16/20 or 80% were satisfied with staffing and 100% felt their facilities were safe for the performance of after-hours eye surgery. For the local Level II trauma center the responses to these questions were 14%, 29% and 36% respectively.

**Conclusions:** These results are highly suggestive that the local Level II trauma center is far below standards for after-hours eye surgery. Patient care is the highest concern of practitioners. This concern should be reflected by the centers privileged to provide patient care. This center and its administration should take steps to meet and if possible match national and community standards of care.



**Gary S. Hirshfield MD**  
**New York State Ophthalmological Society**  
**Leadership Development Program XIII, Class of 2011**  
**Project Abstract**

**Title of Project:** *New York State Leadership Development and Young Ophthalmologist Engagement*

**Purpose:** To establish a program at the New York State level mirroring the AAO LDP program for the purpose of engaging young ophthalmologists in state society leadership and advocacy as well as empowering and establishing a young ophthalmologist sub-committee of the Board. There is an increasing lack of engagement among young physicians in every specialty. More and more decisions about how we practice are determined by government at every level and other outside market and insurance influences. Unless the next generation become proactively involved physicians will have a decreasing say in matters of vital importance to us and our patients. Furthermore, young physicians who would like to get involved are not often invited in and have no easy way to become involved in organized medicine. This program is an attempt to make some headway in these issues for New York State and our society.

**Methods:** 1) A schedule of meetings was established to coincide with three NYSOS Board meetings, New York State Lobby Day and Mid-Year Forum 2) Industry support of \$10,000 was requested and multiple grant proposals were submitted to several companies for the purpose of subsidizing speakers, meeting and travel expenses. 3) A communication was sent to all NYSOS members regarding a request for candidates. 4) A subcommittee of the Board will review by-laws and the possibility of establishing a YO subcommittee of the Board with some voting rights on the Board and a charter and mission.

**Results:** 1) \$10,000 total support was granted, 5K from Alcon and 5K from Allergan. The Allergan sponsor was Jim Trunick who is well known to the AAO LDP team. 2) So far we have received one definite candidate and we are vetting others. 3) The goal is to have 4 or 5 candidates which is as much as the budget is allowed. 4) The by-laws review committee will meet in August and I have drafted language to empower a YO subcommittee of our Board.

**Conclusions:** This project is just getting started and we have lined up all the necessary components. At our meeting in Orlando at the AAO I will be able to report on the success of the recruiting process and our initial meeting in September.





**Michael R. Hodges, MD**  
**Indiana Academy of Ophthalmology**  
**Leadership Development Program XIII, Class of 2011**  
**Project Abstract**

**Title of Project:** *American Academy of Ophthalmology Young Ophthalmologists, Indiana Academy of Ophthalmology Chapter*

**Purpose:** To develop a state chapter of Young Ophthalmologists in the Indiana Academy of Ophthalmology that will promote and encourage participation of residents in training, physicians in fellowships and ophthalmologists in their first five years of practice in the AAO Young Ophthalmologists Program. This will consist of educating the Young Ophthalmologists of Indiana in the value of developing professional networks with peers within the state of Indiana so they can assist one another in promoting advocacy and educational growth while trying to deal with the new stresses associated with the quickly evolving environment of healthcare reform in America. By establishing relationships with peers at the state level, an enhanced experience will be obtained by becoming active at the YO Program.

**Methods:** 1) The Indiana Academy of Ophthalmology has decided to announce the establishment of the Indiana Chapter of the Young Ophthalmologist at its annual meeting on September 16<sup>th</sup>, 2011. 2) The announcement of the co-chairmen who will be the first to lead this IAO YO Chapter will be announced at the annual IAO meeting. 3) A brochure explaining the details of the program will be mailed to all qualifying members and potential members of the IAO prior to the IAO annual meeting. 4) The Co-chairmen of the IAO YO Chapter will be at the annual meeting to answer questions from individuals interested in becoming members of the new IAO YO Chapter.

**Results:** The results of this project are not yet available due to the fact our annual meeting has not yet taken place. The meeting will be on September 16<sup>th</sup>, 2011. Results can be updated prior to the AAO annual meeting.

**Conclusion:** The success of this project is unable to be determined at this time and may not be truly evident for several years. I believe that the AAO YO Program has already been shown to be incredibly successful and this project is simply trying to encourage a stronger participation of Indiana YO dealing with issues specific to Indiana. I have no reason to doubt it will ultimately be a great success in developing future leaders in the IAO, as well as the AAO.



**Paul C. Kang, MD**  
**Washington DC Metropolitan Ophthalmological Society**  
**Leadership Development Program XIII, Class of 2011**  
**Project Abstract**

**Title of Project:** *Local Ophthalmologists Affecting National Politics. Is it Possible?*

**Background:** The national political community in Washington DC is largely transient, with new leadership and administrations serving their terms and making way for others. However, the community of ophthalmologists who serve these individuals, their families, and associates is established and well-rooted. Thus, if organized and informed, Washington DC ophthalmologists may be able to use their unique position to promote the interests of our profession on the national scale.

**Purpose:** To identify and initiate organization of Washington DC area ophthalmologists who are ready to serve as liaisons between the American Academy of Ophthalmology and the national political landscape.

**Methods:** This initiative was described to the membership of the Washington DC Metropolitan Ophthalmological Society. It was also shared with the Young Ophthalmologists Club in Washington DC. Further discussion regarding this project took place with the chairmen of the academic medical centers in Washington DC. Their personal involvement along with that of their residents and fellows was requested. Inclusive in the description of the initiative was encouragement of all to attend the AAO Mid-Year Forum as a first step towards becoming organizing and informed.

**Results:** The foundation for this coalition has been identified. The Mid-Year Forum was attended by five WDCMOS members, and others, while they could not attend the meeting, voiced their interest to be involved in the future. The chairmen of the ophthalmology departments at Georgetown University and Howard University were in attendance along with many of their residents and fellows. They expressed their long-term commitment to this effort and interest in becoming leaders of the group. The WDCMOS recently formed an executive committee that has been active in successfully leading the society in local political efforts. Aligning with this group in the future would also increase area ophthalmologists' involvement and awareness.

**Conclusion:** There is a strong core of local Washington DC ophthalmologists who are interested in becoming active in the national political scene. However, knowing that much of health care politics is local, the question remains whether a group like this can be effective. Nevertheless, the AAO may want to explore ways of using this group to in their efforts especially through their Washington DC office.





**Susan M. MacDonald, MD**  
**Women in Ophthalmology**  
**Leadership Development Program XIII, Class of 2011**  
**Project Abstract**

***Title of Project:*** *WIO Goes Global*

**Purpose:** To expand Women in Ophthalmology to include an international membership.

The mission of WIO is to enhance and improve the professional environment for women ophthalmologists and women ophthalmology professionals. This organization unites MDs, researchers and other eye care professionals and promotes leadership, education and service.

The primary focus of WIO has been female ophthalmologists and professionals of the United States. WIO has made the decision to expand our membership to the international community.

**Methods:** In order to expand our membership to an international audience several factors were identified. These included: 1. Addressing economic, social and geographic barriers. 2. Establishing a presence at international meetings. 3. Developing needs assessments. 4. Identifying country's female leaders and members interested in developing local network. 5. Continuing development of our website to connect members and other like-minded communities.

We realize that this is a long term project that will WIO infrastructure and individual country networks development. We have chosen a multistep approach to grow into this vision.

**Results:** 1. To see whether there was an international interest in WIO, we launched a WIO Facebook page. Within 6 months we have over 750 members of which 210 are international members from 18 different of countries including Egypt, Italy, Mexico, Turkey, India, Indonesia, United Kingdom, Saudi Arabia, Romania, Canada, Argentina, Russia, Germany, Australia, Croatia, Pakistan, Iraq, and Bangladesh. We have held informal gatherings in several countries and have been received with positive enthusiasm. 2. An International membership committee was created identifying current WIO members with an international ophthalmology interest and international relationships. 3. A sliding scale membership fee was established based on the world bank economic classification scale. This will remove the economic barrier of membership. 4. A WIO power point presentation has been created to provide members traveling internationally with a standardized education tool to promote and recruit members. 5. All board members traveling internationally have been asked to hold WIO gatherings in country of visit. These meetings are made with the goal of developing interest in WIO, recruiting members and identifying interested country leaders.

**Susan M. MacDonald, MD**

*Project: WIO Goes Global*

6. Website development has been targeted to promote teaching, exchange of ideas and to post job, research and educational opportunities. We have plans to create a member map to allow quick identification of members throughout the world and a protected site where members only can exchange information. 7. Identification and Cultivation of female leaders in different countries. A grassroots word of mouth has identified several women all over the globe. We are contacting these women, via email, person to person, phone, skype and other communication means to ask for their participation in developing a network of female leaders and help identify the needs of female ophthalmologists in their country. 8. In order to accomplish these goals we realize the necessity of funding. We have a subcommittee identified to focus on grant and donation development. 9. WIO continues to promote women in the field of ophthalmology by increasing our presence at international meetings. At several future international meetings there will be dual support for specific sessions and networking opportunities to enhance the experience for women in ophthalmology worldwide.

The most recent meeting was the European Society of Ophthalmology Meeting in Geneva, Switzerland in June 2011. We will have our annual meeting at AAO and there is a WIO symposium scheduled to be held at the World ophthalmology Congress Abu Dhabi February 2012.

A copy of the program is attached.

**Conclusions:** WIO has begun the first steps to a long journey to grow into an international organization. The response from our first six months has been overwhelmingly positive. We are confident that the interest and enthusiasm for the expansion exists.

We have approached this project with a hybrid model of a grass roots model and known networks and organizations. We feel this will allow individuals the ability to self identify and join, while also utilizing our known networks to ask for assistance.

We will continue to develop our web site to allow the exchange of information concerns and opportunities. WIO is actively planning several formal symposium and informal gatherings to allow the development of a network that will support and promote women.

Finally we will continue to approach the needs assessments with an open mind and to listen. We realize we do not know what other women's needs may be and our cultural differences will require a level of sensitivity to fully learn from each other.

Our goal is to create a network to support, promote and remove barriers for all women in ophthalmology.



**SSS**

## Women In Ophthalmology

### Invited Topics

- **Status of Women Ophthalmologists in Tunisia**, Amel Ouertani
- **Status of Women Ophthalmologists in Lybia**, Suad El Fitouri
- **Potential Obstacles in Women's Career**, Manal Bouhaimed
- **Inequality of Training**, Ciku Mathenge
- **Developing Equity in Training**, Lama Al-Aswad
- **Engaging the Next Generation of Ophthalmologists**, Salim Sarwat
- **Balancing Personal Life and Profession**, Ebtisam Al Alawi
- **Leadership Development: Philosophy and Practice**, Manal Taryam
- **Profession Advocacy- Principles, Resources, and Methods**, Ruth Williams
- **Creating your Brand**, Bonnie Henderson
- **Developing Women's Network**, Susan MacDonald

This session will be followed by a Panel Discussion.



**Brenda Pagán-Durán, MD**  
**New Jersey Academy of Ophthalmology**  
**Leadership Development Program XIII, Class of 2011**  
**Project Abstract**

***Title of Project:** Development of a Facebook Page for the New Jersey Academy of Ophthalmology as an Interactive Tool*

**Purpose:** To develop an effective interactive tool to increase awareness of ophthalmology and the importance of high quality eye care in our community, and to promote participation of members in educational events and involvement in ophthalmology advocacy.

**Methods:** A Facebook page for the New Jersey Academy of Ophthalmology (NJAO) was developed in an attempt to use this Internet tool as a popular means of communication to convey four crucial objectives: 1) relay our state organization's mission of endorsing the importance of the ophthalmology profession by educating both its members and the public enabling ophthalmologists to provide the highest quality of service to the community; 2) identify and support ophthalmologists as the exclusive medical members of the eye care team; 3) provide a source of accurate ophthalmology and eye care information; and 4) demonstrate NJAO's active involvement in supporting both ophthalmologists and offering guidance to the public.

**Results:** The NJAO Facebook page was created during the summer of 2011 and so far appears to be an effective way for our organization to communicate with ophthalmologists in our community. It has led ophthalmologists to navigate our website and to register for our annual meeting. We have therefore designed a means to promote our mission and have been able to post information for our annual meeting. We are also currently collecting photos to include in the webpage. Along the way, we were able to provide not only a link to the NJAO website ([www.njao.org](http://www.njao.org)), but also to the excellent source of information at the AAO developed website ([www.geteyesmart.org](http://www.geteyesmart.org)).

**Conclusion:** Although it is not certain yet how effective the Facebook page will continue to be, we have succeeded in taking advantage of a popular social media engine to reach out to ophthalmologists in our community and the general public and to disseminate important messages about high quality eye care as well as ophthalmology advocacy. We hope to continue engaging people, providing appropriate information and guidance, and communicating our organization's objectives.



**Rachel C.J. Reinhardt, MD**  
**Washington Academy of Eye Physicians and Surgeons**  
**Leadership Development Program XIII, Class of 2011**  
**Project Abstract**

***Title of Project:*** *A White Paper on the Future of Physician Assistants in Ophthalmology*

**Purpose:** The predicted future shortage of ophthalmologists is a concern. In an era of optometry attempting to expand its scope of care, patient care and safety issues arise. Physician assistants – who are licensed to practice medicine with physician supervision - offer a solution for the ophthalmologist. This white paper investigates the viability of incorporating physician assistants into ophthalmology in the United States with a special focus on Washington State.

**Methods:** Research was conducted through PubMed and the internet in general. Examples of sources include the American Academy of Physician Assistants (AAPA), Accreditation Review Commission on Education for the Physician Assistant, the National Commission of Certification of Physician Assistants, state statutes and regulations on physician assistants, insurance regulations, such as Medicare, and review of AMA policies and positions. In addition I had personal meetings with the Washington State Department of Health as well as program directors from the University of Washington MEDEX PA program. I also had conversations with representatives from the AAPA and Washington Association of Physician Assistants. I conducted a brief survey of members of the Washington Academy of Eye Physicians and Surgeons.

**Results:** Current trends: Physician assistants (PAs) were first introduced into primary care in the 1960s, but now over 72,000 PAs are integrated into almost every medical and surgical specialty. Approximately a quarter of PAs practice in surgical specialties. Their duties extend into all aspects of patient care, similar to that of a physician. Education and licensing: PA programs average 27 months in duration and most award a master's level degree. These programs are based on the medical school model and unlike optometry, are 100% medically and surgically oriented. PAs are educated in the same manner that medical students are educated and are trained to think and act like physicians. All states require PAs to graduate from an accredited PA program and to pass a national certifying exam. Scope of practice: In the vast majority of states the PA's scope of practice is defined by the supervising physician's scope of practice. More than a third of states have some restrictions that potentially could restrict PAs in ophthalmology, but most of these are minor. Physicians delegate those duties for which the PA is trained, keeping in mind that PAs may expand their skill set over time. Supervision: Physician assistants are licensed to practice medicine with physician supervision. Most states do not require the physician to be on-site. Billing and reimbursement: Insurance companies reimburse for PA services the same way they would for any physician service. The difference is Medicare will reimburse at a slightly reduced rate during certain visit types, but will reimburse at 100% physician rate if the "incident to" billing requirement is met.

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Project: *A White Paper on Physician Assistants in Ophthalmology: What We Need To Know To Make It Work*

**Conclusions:** Unlike technicians and optometrists, PAs are licensed to practice medicine with physician supervision. Unlike technicians, PAs can bill for any service the physician can do. Unlike optometrists, PAs have a purely medical and surgical education. The physician-physician assistant relationship is the foundation on which the PA field has been built and PAs are dedicated to the concept of physician-led care. Because optometrists are independent providers, the potential expansion of their scope has patient safety concerns, not only because of the non-medical and non-surgical foundation of training, but also because they would not be under the supervision of a physician. With a medical and surgical education serving as the foundation, PAs practice delegated, supervised medicine. PAs can handle the routine cases in order to free-up the ophthalmologist to care for the more complex medical and surgical patients for which their extensive training provides. The physician-physician assistant team would be a benefit to the future of ophthalmology.

# **The Future of Physician Assistants in Ophthalmology**

**A White Paper by Rachel Reinhardt, MD**

**AAO Leadership Development Program XIII, Class of 2011**

## ***Introduction***

The predicted future shortage of ophthalmologists is a concern. As Baby Boomers age the demand for specialized eye care services will grow, but the number of ophthalmologists may not keep pace with that demand. Expanding medical schools and residency programs in ophthalmology may help, but it is unlikely to be enough. It will also be important to consider ways to delegate care without compromising safety, so the ophthalmologist can concentrate on higher level medical and surgical care. Technicians have been and will continue to be a valuable resource for the ophthalmologist and it is possible that the ophthalmologist-technician model will need to increase in the future as the Baby Boomers age. In addition, the ophthalmologist-optometrist model is also beneficial in some cases. Optometrists employed by ophthalmologists can be an effective way to delegate routine eye care so the ophthalmologist can concentrate on more complex medical and surgical patient care. Optometry will continue to play a valuable role in the care of our aging population, but patient safety is paramount. Optometry has recently used the argument of the future shortage of ophthalmologists to attempt to expand its scope of practice to include surgery. Optometry has been successful in several states already, such as Oklahoma and Kentucky. However, a major concern is that optometrists are not physicians and have not been through a rigorous medical and surgical training that ophthalmologists receive. Arguably, it is more important that ophthalmologists were trained as general physicians first and specialists second. This makes ophthalmologists uniquely proficient in putting eye disease in context within the greater human body, and most importantly, allows the ophthalmologist to react to unplanned or unwanted systemic reactions that can frequently occur when patients receive medical or surgical eye care. The field of optometry is not based on a medical or surgical education. This expansion of scope via legislation rather than education poses a serious public health and safety threat.

Does another option exist to help provide care to our aging population? Is there another way to delegate certain services, not just to technicians and optometrists, thereby making more efficient use of the ophthalmologists' specialized training? Unlike optometry, is there a field of medically trained professionals who have been educated on the medical school model? Yes. Physician assistants have the potential to expand ophthalmology services to more patients and could be valuable members of the ophthalmology team. Physician assistants would not be replacing the role of technician



or optometrist, but simply would be an added player to help expand services to our aging population.

Physician assistants were first introduced to the medical field in the 1960s. During that era there were a number of military corpsmen who were being re-introduced into civilian society who had developed medical and surgical skills during wartime. Eugene Stead was the chairman of the Department of Medicine at Duke University at that time and recognized the skill set these individuals brought to the field of medicine. He was inspired to start the first physician assistant program at Duke University with the belief that these men could serve as mid-level health care providers in primary care. That program was the first physician assistant program in the United States and the University of Washington followed within a few years. Today over 80,000 physician assistants practice medicine in the United States across most medical and surgical specialties, not just primary care. Even though physician understanding and acceptance of physician assistants have been rapidly expanding, physician assistants have not yet been widely accepted in the field of ophthalmology. Less than 0.1% are currently employed in ophthalmology.<sup>1</sup>

By reviewing the physician assistant education, current trends of employment, scope of practice, supervision, billing and reimbursement, and other issues, this white paper will introduce the concept and hopefully open up a discussion about the idea of incorporating physician assistants into the field of ophthalmology.

### ***Physician Assistant Education:***

Physician assistant (PA) education is based on the curriculum of medical schools and similar to medical students, PA students must first have completed at least two years of undergraduate prerequisites in basic and behavioral sciences.<sup>2</sup> The Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) is the independent agency in charge of accrediting PA programs. There are 156 accredited physician assistant programs in the United States. A complete list of those programs is available on the ARC-PA website at [http://www.arc-pa.org/acc\\_programs/](http://www.arc-pa.org/acc_programs/). There are also six postgraduate clinical residency programs, including surgery (examples include Duke University and Johns Hopkins), Internal Medicine (Mayo Clinic), as well as programs in orthopedics and oncology,<sup>3</sup> but postgraduate programs are not the norm at this time. The ARC-PA establishes the standards for the PA education. These standards are determined by a collaborative effort from the American Academy of Family Physicians, the American Academy of Pediatrics, the American Academy of Physician Assistants, the American College of Physicians, the American College of Surgeons, the American Medical Association and the Physician Assistant Education

Association.<sup>4</sup> Out of the 18 current ARC-PA Commissioners serving in 2011, 9 are MDs and 6 are PAs.<sup>5</sup> The University of Washington MEDEX program is the only Washington State PA program. It is one of the earliest programs in the country and has been accredited since 1971. Oregon has two accredited PA programs including the Oregon Health Sciences University and Pacific University.<sup>6</sup>

The average PA program lasts 26 months and is based on the medical school model. The ARC-PA Accreditation Standards for Physician Assistant Education (Standards), 4<sup>th</sup> Edition outlines the curriculum requirements in Part B.<sup>7</sup> The Standards are based on the medical school model, but in half the typical time. Like medical school, the first half of the education is based on classroom courses and the second half on clinical rotations. The introduction of Section B of the Standards states “The professional curriculum for PA education includes applied medical, behavioral and social sciences; patient assessment and clinical medicine; supervised clinical practice; and health policy and professional practice issues.”<sup>7</sup>(pg12) To reinforce the fact that PAs are trained to practice medicine, section B1.03 states “The curriculum *must* be of *sufficient* breadth and depth to prepare the student for the clinical practice of medicine.”<sup>7</sup>(pg13) The following course content is required: anatomy, physiology, pathophysiology, pharmacology and pharmacotherapeutics and the genetic and molecular mechanisms of health and disease.<sup>7</sup> The curriculum must also include clinical medicine of all organ systems and patient evaluation, diagnosis and management.<sup>7</sup>

Section B2.05 of the Standards states, “Instruction in patient assessment and management includes caring for patients of all ages from initial presentation through ongoing follow-up. It includes instruction in interviewing and eliciting a medical history; performing complete and focused physical examinations; generating differential diagnoses; and ordering and interpreting diagnostic studies. Patient management instruction addresses acute and longitudinal management. Instruction related to treatment plans is patient centered and inclusive, addressing medical issues, patient education and referral.”<sup>7</sup> (pgs 14-15) Instruction includes preventive, emergent, acute, chronic, rehabilitative, palliative and end-of-life care that must include prenatal, infant, children, adolescent, adult and elderly populations. There must be instruction of technical skills and procedures. The curriculum must also include the behavioral and social sciences. This includes instruction in recognizing, treating and counseling patients with, for example, substance abuse.<sup>7</sup> Programs must also teach students how to search and interpret the medical literature and apply it to individual patients. Topics of proper patient documentation, coding, billing and reimbursement must be included.<sup>7</sup>

The second half of the PA education, like medical school, involves supervised clinical education. The following specialties must be covered during these clinical rotations:

Family Medicine, Internal Medicine, General Surgery, Pediatrics, OB/Gyn and Behavioral and Mental Health Care.<sup>7</sup> These rotations include patient care in the outpatient setting, emergency room, inpatient care and operating room care. These rotations are required to cover medical care for all age groups across the life span as well as surgical care, including pre-operative, intra-operative and post-operative care. Rotations are supervised by either board certified physicians, PAs who are teamed with board certified physicians, and in some cases by other licensed health care providers who are “experienced in their area of instruction.”<sup>7(pg17)</sup> However, in general the ARC-PA will only approve a non-physician preceptor in special cases.<sup>7</sup>

The University of Washington MEDEX program is an accredited program and enrolls 54 students in the Seattle program and approximately 110 total in the WWAMI (Washington, Wyoming, Alaska, Montana and Idaho) area. The MEDEX program lasts 27 months. Like most PA programs across the country, the Seattle MEDEX program awards a Master’s level education, specifically at the Seattle and Spokane sites. The Yakima and Alaska sites award a BA level degree. Most PA programs award a Master’s level degree, and according to conversations with Linda Vorvick, MD (September 2011) from the MEDEX program, in the next few years all programs will require a Master’s level education. Dr. Vorvick is one of the Medical Directors for the MEDEX Program and the Seattle Site Didactic Coordinator and Lecturer. Conversations with Dr. Vorvick revealed that students in the UW MEDEX program typically have an average of five years of medical experience prior to entering the program. The student population is split evenly between male and female students. The average student is in his or her thirties. First year courses include anatomy and physiology, basic science, pathophysiology, clinical skills, technical skills, behavioral medicine, adult medicine, maternal and child health, emergency medicine, pharmacology and professional role development. The UW MEDEX program places emphasis on the physical exam course and by the time of graduation, students have mastered the art of the physical exam.

Lisa Roberts, MHP, PA-C is the Director of Urban Clinical Education at the MEDEX program and is in charge of overseeing the clinical rotations in the second year. According to conversations with Lisa Roberts (June 2011) the required clerkships include Internal Medicine (4 weeks), Surgery (4 weeks), Emergency Medicine (4 weeks), Family Medicine, which includes Pediatrics and OB/Gyn (4 weeks), Behavioral Medicine (4 weeks) and an elective (2 weeks). These are similar to the required, core clinical clerkships that medical students complete, both in content and length. According to conversations with Linda Vorvick and Lisa Roberts, in recent years about half of the graduates from the MEDEX program enter primary care and about half enter specialties. The curriculum is designed to expose the PA student to a broad medical

education and therefore there is no specific ophthalmology course. Students are exposed to ocular anatomy during the anatomy course and are exposed to ocular disease in context with didactics on systemic disease. Some PA students learn to use the slit lamp on their ER rotations, but this is not standard.

The MEDEX program requires a *minimum* of 4,000 hours of direct patient care. Dr. Vorvick feels that by completion of the program students are more on par with a graduating intern physician rather than a graduating medical student. This is because the emphasis of the program is to graduate a medical professional who is ready to treat patients on “day one” after graduation.

In summary, the physician assistant education is based on the medical school model and most programs are located at medical schools and teaching hospitals where PA students often share courses and clerkships with medical students and residents. Their education is a broad-based medical education that serves as a foundation for all medical and surgical fields. PA “education” will continue through every year post-graduation as they gain more training and experience from the individual physicians with whom they work. In addition, Washington State requires PAs to complete 100 hours of continuing medical education every 24 months.<sup>8</sup>

### ***Physician Assistant Licensing and Certification:***

All 50 states require physician assistants to first graduate from an accredited PA program prior to obtaining a license to practice medicine. PA licenses are issued at the state level. In addition, all 50 states require PAs to pass the Physician Assistant National Certifying Exam (PANCE) which is administered by the National Commission of Certification of Physician Assistants (NCCPA).<sup>9</sup> The NCCPA was founded in 1975 under the leadership of the AMA and National Board of Medical Examiners (NBME). The National Commission for Certifying Agencies has accredited the NCCPA.<sup>10</sup> The PANCE is a computer-based, multiple choice exam that tests basic medical and surgical knowledge.<sup>11</sup> When PAs pass the PANCE, they are considered certified and carry the title PA-C. In order for a PA to maintain certification, they must log 100 hours of CME every two years and pass the recertification exam every 5<sup>th</sup> or 6<sup>th</sup> year in a six year cycle.<sup>10</sup> For those PAs who lose their certification (i.e. do not log 100 hours of CME in a two year cycle) they must retake the PANCE, even if it is before six years, in order to be recertified.<sup>12</sup> There are over 70,000 certified PAs (PA-C) practicing across most medical and surgical specialties today.<sup>13</sup> Therefore the vast majority of PAs are PA-Cs. There is some variability state-to-state as to when PAs must pass the PANCE. Some states require passage for initial licensure while others do not require it for initial licensure, but require it for different scenarios, such as prior to reinstating a lapsed

license. Although all states require PAs to pass the PANCE, about half of the states, including Washington State, do not require PAs to maintain their certification. All states require “licensure” of PAs, but technically PAs are licensed in 45 states, “certified” in 3 states and “registered” in 2 states. The AAPA recommends using the term “license” to apply to state credentialing and “certified” to apply to NCCPA certification.<sup>14</sup> In Washington State, certified physician assistants (PA-C) do not require co-signatures on patient notes and orders and can practice at remote sites. All charts of non-certified physician assistants (PA) require the MD or DO cosignature within two working days and non-certified PAs cannot work at remote sites. In most states, including Washington, PA-Cs and PAs are licensed to prescribe, order, administer and dispense legend drugs and schedule II-V controlled substances.<sup>15</sup> In Washington State regulations for PAs who work for osteopathic physicians vary slightly.

In addition to licensing and certification, most states must also first approve a practice plan submitted by the physician and PA prior to commencing practice.<sup>16</sup> In Washington State the Medical Quality Assurance Commission must approve the practice plan, called the Physician Assistant Practice Arrangement Plan,<sup>16</sup> which is a document that contains information about the PA or PA-C, supervising physician, alternate supervising physician(s), physician group, information about the PA duties and plan for supervision. All states have this requirement, but technically this is not required for state licensure. State licensure is the first step and then once employed by a physician, the practice plan is required prior to practicing medicine.

For more information on the NCCPA and PANCE exam, please visit the NCCPA website at <http://www.nccpa.net/About.aspx>. For more information on state-to-state requirements for licensure, please visit the AAPA website at <http://www.aapa.org/>.

### ***Current Trends in Physician Assistant Practice:***

Physician Assistants already practice in many medical and surgical fields. AAPA’s 2009 National Physician Assistant Census Report<sup>1</sup> states 65% of PAs are female and 35% are male. 93% are in clinical practice. Mean years in clinical practice is 10.1, mean years at current position is 9.4 and mean years in current specialty is 7.1. This suggests that PAs in general tend to stay long periods of time in one specialty or one group setting and may suggest job satisfaction. 35% work in group physician practices, 38% in hospital settings, 9% in solo physician practices, 8% in rural or community health centers and 10% other settings. 36% are employed in primary care, 22% in surgical subspecialties, 11% in internal medicine specialties, 10% in emergency medicine, 3% in general surgery and 16% other. Only 0.1% of respondents listed ophthalmology as their specialty. Of the surgical specialties, the most common fields include orthopedics,

cardiothoracic, general surgery, neurosurgery, urology and ENT. As part of their primary clinical duties, 65% perform minor surgical procedures, 41% manage care of inpatients and 26% first assist in surgery.

The Census Report<sup>1</sup> states the average salary overall was \$93,486, for primary care was \$85,461, for surgical subspecialties was \$99,968 and for emergency medicine was \$102,018. PAs are found in all 50 states, but New York, California, Pennsylvania and Texas have the highest percentage of the PAs working in their states. Washington State ranks 8th, with 3% of the respondents employed in Washington State. New York is the highest at 7.9%. In general PAs have a much lower unemployment rate than the country as a whole with 1.3% of respondents being unemployed, seeking a PA position. 93.6% of respondents work in a metropolitan area or adjacent to a metropolitan area.

At the time of this paper, data about PAs practicing ophthalmology in Washington State have not been available. The Washington Academy of Physician Assistants (WAPA) and the American Academy of Physician Assistants (AAPA) are not aware of any PAs working in ophthalmology in Washington State. Conversations with Betty Elliott, Licensing Manager at the Medical Quality Assurance Commission at the Washington State Department of Health (July 2011), suggested that data would not be easy to access. A survey of Washington Academy of Eye Physician and Surgeons conducted by the author generated no responses of ophthalmologists currently employing a PA. There are anecdotal reports of PAs employed by ophthalmologists in other parts of the country.

In summary, physician assistants are employed in all 50 states and span most medical and surgical fields. Roughly a quarter of all PAs work in surgical fields with an average salary of \$99,968.

### ***Scope of Practice:***

The most important foundation of physician assistant practice is the concept of a physician-directed medical team. This concept of physician supervision is a fundamental concept that is taught in PA schools and is part of the definition of a PA. In an AAPA issue brief on PA scope of practice, the concept of a PA being defined by the physician-led medical team "...is unique; no other health profession sees itself as entirely complementary to the care provided by physicians."<sup>2</sup>(pg4) State law, PA education and experience and the physician's scope of practice are the main factors that define a PA's scope of practice.

Every state has statutes and regulations that define all aspects of PA practice, including scope, supervision, prescribing and dispensing, qualifications, liability, etc. It is important to understand that statutes and regulations on all these issues, including scope of practice, vary from state-to-state. Prior to hiring a PA, ophthalmologists must review their state laws. Having said that, most states define a PA's scope of practice in broad terms, usually defined by the physician's scope of practice. In fact only about four states actually list the various duties that PAs can perform, but even the states that provide these lists also state that the PA duties are not limited to these duties.

As mentioned earlier, a written delegatory document is almost always required. The delegatory written agreement that most states require - in Washington State it is called the Physician Assistant Practice Arrangement Plan - is designed to outline in broad terms what duties the physician has delegated to the PA. These practice plans do not require specific line-item duties however. In Washington State for instance, the physician must describe the general duties of the PA for which the PA is trained.<sup>17</sup> But it is the determination of the physician as to what the PA is trained to do. This obviously changes with the amount of time a PA spends in one specialty as well as overall experience. In general, scope of practice is defined by the physician's scope of practice, assuming the state approves the practice plan. This includes medical and surgical duties. With some limitations that vary state-to-state, a PA can do what a physician can do, since like physicians, PAs are licensed to practice medicine. According to the AAPA's 2009 census report, as part of their primary clinical duties, 65% of PAs perform minor surgical procedures, 41% manage care of inpatients and 26% first assist in surgery.<sup>1</sup> In most states, including Washington, PAs are licensed to prescribe, order, administer and dispense legend drugs and schedule II-V controlled substances.<sup>15</sup>

Ultimately state law will dictate what a PA can and cannot do, but again, since physician assistants are licensed to practice medicine with physician supervision, much of what a PA does depends on the delegatory autonomy the physician assigns to the PA. States, as well as the AMA, leave the details of this delegated autonomy up to the physician. As discussed later in this paper the AMA House of Delegates adopted guidelines for the physician/physician assistant practice.<sup>18</sup> Regarding scope of practice, the AMA states:

- Health care services delivered by physicians and physician assistants must be within the scope of each practitioner's authorized practice, as defined by state law
- The role of the physician assistant in the delivery of care should be defined through mutually agreed upon guidelines that are developed by the physician and the physician assistant based on the physician's delegatory style



The physician is responsible for determining what the PA is qualified to do based on training and experience. Aside from graduating from an accredited PA program that teach PAs to think and act like doctors, PAs have on-going education through individual training by the physician as well as CME. Therefore, the PA's clinical scope of practice and autonomy will expand as their experience expands. PAs will learn new skills through the physician's tutelage. The physician and PA should be encouraged to review and revise the practice plan regularly as skills and duties evolve over time. The practice plan should be updated with the state as the duties of the PA expand. Many states require a patient log to document proficiency in new skills. In general, the PA is expected to act autonomously, with physician direction and supervision, on those cases that are appropriate for the level of training and experience of the PA. More routine cases tend to be assigned to the PA and more complex cases may require more frequent consultation with the supervising physician. In an AAPA issue brief the author summarizes this concept, "More routine care, initial evaluation of specialty patients, follow up, patient education and care coordination can be delegated to the PA. Complex patient problems, high acuity care, and management of difficult-to-treat conditions involve a greater proportion of physician time and expertise"<sup>19</sup>(pg3)

Hospitals, ASCs, nursing homes, etc. may have variability in their credentialing process, but they are bound by state law. In general, PAs are credentialed the same way as physicians. Like physicians, but unlike nurses and Allied Health Personnel, they are considered part of the medical staff and the by-laws that apply to physicians apply to PAs as well. The physician must sign the request for privileges and the PA can only practice medicine with supervision, just as in all other medical settings.<sup>20</sup>

In summary, in Washington State, as in most states, physician assistants can perform any medical service that is within the skill set and experience of the PA, within the physician's scope of practice, and with supervision. Details may vary somewhat depending on the clinical setting, whether it be office, hospital, nursing home, etc. The skill set and experience of the PA are determined by the physician and are based on education and practical experience. In Washington State, like most states, a practice plan is required and first must be approved by the governing board (the Medical Quality Assurance Commission in Washington State), although a comprehensive "list" of the PA's day-to-day activities is not required. Essentially PAs do what doctors do: take histories, perform physical exams, generate differential diagnoses, order and interpret labs and special testing, arrange consultations when needed, commit to a diagnosis, initiate treatment and manage follow up care. PAs think and act like doctors and all states support this concept.

### ***Limitations on Scope of Practice:***

In the field of ophthalmology there are very important issues that must be considered before hiring a PA. Most states do not have an exhaustive list of restrictions on PA care. However, there are a few and out of all medical specialties, these restrictions probably have the greatest effect on ophthalmology. Washington State defines a PA's scope of practice as the physician's scope of practice. But, there are several notable exceptions listed in Washington State law. PAs in Washington State cannot legally perform a refraction, prescribe contact lenses or use any optical device in connection with ocular exercises. However PAs are not prohibited from checking vision.<sup>21</sup> They also are prohibited from using lasers on the eye.<sup>22</sup> It is worth including the actual language of the RCW 18.71A.060,<sup>21</sup> which lists the limitations on PA practice:

- (1) The measurements of the powers or range of human vision, or the determination of the accommodation and refractive state of the human eye or the scope of its functions in general, or the fitting or adaptation of lenses or frames for the aid thereof.
- (2) The prescribing or directing the use of, or using, any optical device in connection with ocular exercises, visual training, vision training, or orthoptics.
- (3) The prescribing of contact lenses for, or the fitting or adaptation of contact lenses to, the human eye.
- (4) Nothing in this section shall preclude the performance of routine visual screening.
- (5) The practice of dentistry or dental hygiene as defined in chapters 18.32 and 18.29 RCW respectively. The exemptions set forth in RCW 18.32.030 (1) and (8), shall not apply to a physician assistant.
- (6) The practice of chiropractic as defined in chapter 18.25 RCW including the adjustment or manipulation of the articulations of the spine.
- (7) The practice of podiatric medicine and surgery as defined in chapter 18.22 RCW.

A review of all 50 states' statutes and regulations<sup>23</sup> reveals that 22 states have some degree of potential restriction of PA practice that could limit their scope in ophthalmology. These limitations almost always make reference to the field of optometry and not ophthalmology specifically. 12 of those 22 states, including Washington State, have what could be considered as a mild limitation of scope, generally restricting PAs from refractions or prescribing glasses or contact lenses.<sup>23</sup> For example, in West Virginia the statute language specifically states that a PA "may

not dispense a prescription for a refraction” (W.VA. Code.Ann.Section 30-3-16) but does not have any other restrictions.<sup>24</sup> For only 8 states (California, Idaho, Illinois, Kansas, Massachusetts, Montana, Nevada and South Dakota) the statute language could be interpreted as very restrictive.<sup>23</sup> An example of that language, and arguably the most severe of the examples, is included in the Kansas statutes, “Physician assistants may not perform any act or procedure performed in practice of optometry” (Kan.Stat.Ann.Sec 65-28a08).<sup>25</sup> Interpreting this statute is beyond the scope of this paper, but certainly it would be important in these 8 states in particular, to seek expertise in state law prior to hiring a PA in ophthalmology. It is difficult to know if the governing body in these states considers “practice of optometry” to preclude practice of ophthalmology, since there is considerable overlap. Since optometrists do not perform surgeries in most states, it is conceivable that this statute could be interpreted that PAs can assist in surgery. The majority of states have no specific language that would restrict a PA from doing the day-to-day duties in an ophthalmology practice. Again, the importance of seeking professional advice on interpreting these statutes cannot be underestimated. For more information on the specifics of state statutes and regulations, please visit the AAPA website.

In summary, some states have restrictions of PAs in ophthalmology, but most are considered minor. Arguably this should not be a major hindrance of incorporating PAs into ophthalmology. One of the reasons is that the role of PAs would not be to replace or duplicate the optometrist’s role. This would not be making the most out of PA’s training. Quite the opposite. PAs would simply be one more valuable team member that brings a separate skill set to the ophthalmology team. PAs have medical and surgical training similar to the physician. PAs are trained to think and act like doctors. They can serve as a physician extender in a way that the supervising physician decides they can be the most useful. Furthermore, because of the medical and surgical background, unlike optometrists, the physician can delegate medical tasks to the PA in order to boost efficiency of the overall physician-led team. Even though some states, including Washington State, prohibit PAs from doing refractions (and in some states simply prohibiting the final refraction that results in a glasses prescription), PAs can still check vision during an exam. And, it is likely that the type of ophthalmology practice that would tend to hire a PA would be a medium to large practice, one that probably has ophthalmic technicians who typically perform the refractions. PAs can be utilized in many other areas besides refractions, contact lens fittings and vision therapy. In fact, based on their medical and surgical training, their skills are better served in different areas that optometry may not be qualified to practice. An ophthalmologist–led team that includes ophthalmic technicians, optometrists and physician assistants has the potential to be a very effective model for patient care.

In the future if PAs play a role in ophthalmology it may be worth considering proactive legislation to change the specific limitations on refractions. No other medical field, with the exception of anesthesia, has restrictions on PA scope of practice like ophthalmology. When states list the specific limitations on PA scope of practice the majority tend to restrict refractions and similar duties. However, since refractions are within the scope of practice of the ophthalmologist, these restrictions contradict the statutes that define the PA scope of practice by the ophthalmologist's scope of practice. Refractions are one of the few functions in an ophthalmology practice that is often delegated to any and all members of the team. In fact, ophthalmic technicians, medical students, nurses and residents can all be trained on-the-job to perform refractions. In many practices refractions are often performed by a technician. A PA is certainly capable of learning how to do a refraction, just as the ophthalmic technicians learned. It would be difficult to argue to the contrary. Since PAs practice "dependent medicine", optometrists should not fear that PAs will practice independent optometry. But, if the PA could either confirm or check a post-op cataract refraction, this could be tremendously useful for a busy ophthalmology practice.

It is possible that the specific limitations that certain states list were designed to prohibit PAs from practicing non-physician areas of healthcare, including dentistry, podiatry, chiropractic care and optometry. Again, PAs by definition practice dependent medicine with an MD or DO, but not the above listed non-physician providers. Unfortunately by specifying the obvious - that PAs cannot practice non-medical care (in other words cannot be supervised by a non-physician such as a dentist, podiatrist or optometrist) - certain states have likely inadvertently limited PAs in the field of ophthalmology. Out of the vast array of medical specialties, there is no doubt that ophthalmology has been unfairly targeted.

In conclusion, the majority of states have no specific language in their statutes that suggest limitation of PA scope of practice for general duties in the field of ophthalmology. For those states that do list restrictions, the majority of those states tend to have mild restrictions, generally related to prescribing glasses, contact lenses and vision therapy that is unlikely to interfere with the contribution PAs can make to an ophthalmology practice. The broader language in restricting PA scope within eye care in a handful of states certainly is a potential challenge in incorporating PAs into an ophthalmology practice. This is where it will become important for ophthalmologists to educate their legislatures that the intention is not to turn a PA into an optometrist, but to not unfairly limit scope of PAs in the field of ophthalmology, unlike nearly all other medical fields.

## **Supervision:**

Physician Assistants are licensed to practice medicine with physician supervision. “The PA profession embraces this concept and considers supervision to be so essential to PA practice that supervision is included in the definition of a PA.”<sup>19(pg1)</sup> Before a PA can practice medicine the physician and PA must complete a practice plan and submit it to the state. The details required on the practice plan will vary state-to state, but in general practice plans will require documentation of the supervising physician, alternate physician(s), practice sites, general duties to be performed by the PA and plans for supervision. The application must be approved before the PA can practice medicine. In Washington State the practice plan must be submitted and approved by the Medical Quality Assurance Commission.

The term supervision has many different levels to consider. Physician supervision is one of the foundations of the PA field, but the specific rules can vary state-to-state. In addition, hospitals and even insurance plans may have slightly variable requirements for PA supervision. Even though all PAs are supervised, in most states, including Washington State, “supervision” does not mean that physicians must review 100% of the PA’s work and does not mean the physician must be present on-site 100% of the time.<sup>26</sup> The physician must be available, but the definition of being available may range from being in the suite of offices, being available by phone, or having a designated alternate available.

All PAs must have a supervising or sponsoring physician on file with the state, according to the practice plan. This is the physician who has primary authority over the PA. States will have variable limits on how many PAs can be assigned to one supervising physician and Washington State limits 3 PAs per supervising physician.<sup>27</sup> In addition, there must also be a designated alternate supervising physician for those times when the primary physician is not available. Many states allow the alternative physician to be a group of physicians. According to conversations with Betty Elliott at the Washington State Department of Health (July 2011), this scenario is permitted in Washington State. For instance, if the primary physician is on vacation, the alternate supervising physicians can be any or all of the other physicians in the practice, as long as this was documented on the practice plan with the state.

Washington State defines a supervising physician as “the physician who is responsible for closely supervising, consulting, and reviewing the work of a physician assistant.”<sup>28</sup> But rather than provide a strict definition of supervision, Washington State makes it the responsibility of the supervising physician and physician assistant “to ensure that adequate supervision and review of the work of the physician assistant are provided.”<sup>29</sup> Even though PAs require supervision to practice medicine, Washington State does not necessarily require the supervising physician to be personally present on-site at the

time of service.<sup>26</sup> It is important to remember, however, that Medicare and some private payers do require the supervising physician to be on-site only if “incident to” billing is desired. This topic will be covered in the Billing and Reimbursement section. In Washington State, certified physician assistants (PA-C) do not require co-signatures on patient notes and orders and can practice at remote sites. All charts of non-certified physician assistants (PA) require the MD or DO co-signature within two working days and non-certified PAs cannot work at remote sites.<sup>15</sup>

Washington State allows PAs to consult with other physicians assuming the supervising physician has a written statement on file as to what physicians and what scenarios these physicians may be consulted.<sup>30</sup>

PAs can be used at remote sites, but Washington State has certain requirements before a PA can be approved at a remote site. A remote site is defined as a setting that is not the primary place of practice or where the physician spends less than 25% of his practice time. PAs can practice at a remote site if the physician spends at least 10% of the PA’s practice time at the remote site, there is “adequate provision for timely communication”<sup>31</sup> between the PA and supervising or alternate physician, and the names of the supervising or sponsoring physician must be “prominently displayed at the entrance”<sup>32</sup> of the remote site clinic area.

The American Medical Association has suggested guidelines for PA supervision. In 1995 the AMA House of Delegates issued H-160.947 Physician Assistants and Nurse Practitioners,<sup>18</sup> which states:

- (1) The physician is responsible for managing the health care of patients in all settings.
- (2) Health care services delivered by physicians and physician assistants must be within the scope of each practitioner's authorized practice, as defined by state law.
- (3) The physician is ultimately responsible for coordinating and managing the care of patients and, with the appropriate input of the physician assistant, ensuring the quality of health care provided to patients.
- (4) The physician is responsible for the supervision of the physician assistant in all settings.
- (5) The role of the physician assistant in the delivery of care should be defined through mutually agreed upon guidelines that are developed by the physician and the physician assistant and based on the physician's delegatory style.

(6) The physician must be available for consultation with the physician assistant at all times, either in person or through telecommunication systems or other means.

(7) The extent of the involvement by the physician assistant in the assessment and implementation of treatment will depend on the complexity and acuity of the patient's condition and the training, experience, and preparation of the physician assistant, as adjudged by the physician.

(8) Patients should be made clearly aware at all times whether they are being cared for by a physician or a physician assistant.

(9) The physician and physician assistant together should review all delegated patient services on a regular basis, as well as the mutually agreed upon guidelines for practice.

(10) The physician is responsible for clarifying and familiarizing the physician assistant with his/her supervising methods and style of delegating patient care. (BOT Rep. 6, A-95; Reaffirmed: Res 240 and Reaffirmation A-00; Reaffirmed: Res. 213, A-02; Modified: CLRPD Rep. 1, A-03).

Legal aspects of supervision are important considerations, but non-legal issues of supervision need to be considered as well. Randy Danielsen, et al in their recent publication *The Preceptor's Handbook for Supervising Physician Assistants* discusses common sense supervision and states that "supervision is ultimately a function of shared expectations and trust."<sup>33(pg139)</sup> The authors offer three tiers of clinical supervision, including prospective, concurrent and retrospective. Prospective supervision includes submitting a practice plan that is tailored to the physician and the PA's level of experience. New graduates may require stricter and more detailed plans whereas more experienced PAs may require less rigid guidelines. The authors suggest examples of concurrent supervision which generally deal with the day-to-day patient care, such as reviewing the schedule at the start of the day, being available for questions and having both structured and unstructured meetings. Again, supervising physicians need not be physically present 100% of the time and this varies by state. Finally they recommend retrospective supervision which involves reviewing the PAs work. This can be structured in many different ways, but will likely involve a chart review that can take place at a predetermined interval. This can vary depending on the PA's level of experience and on the physician's preferences. For newer PAs, chart reviews may be extensive, but for more experienced PAs chart review may be limited to complex cases or procedures.<sup>33</sup>

In summary, effective physician supervision of physician assistants requires knowledge of state law and regulations, a well-defined practice plan, regular consultation with the

physician when needed, intermittent review of the PA's work as predetermined by the physician and PA, but most of all, mutual respect and support and commitment to the physician-physician assistant team concept

### ***Billing and Reimbursement:***

What else can a physician assistant do, that a technician cannot, aside from practicing medicine with physician supervision? Bill for services. Medicare, Medicaid and private carriers reimburse for services rendered by PAs. The Balanced Budget Act of 1997 expanded PA coverage to include medical and surgical services in all practice settings, such as medical offices, emergency rooms, hospitals and nursing homes for example.<sup>34</sup> PAs can bill for any service for which the physician can bill. Medicare will reimburse for PA services at either 85% or 100% of the physician's fee, depending on the specifics of the patient encounter and level of supervision. Medicare reimburses at 85% when PAs evaluate new patients or return patients with new problems. In these scenarios the PA would bill the full amount, but under their personal NPI number. The PA's NPI number would then alert Medicare to reimburse with the 15% discount.<sup>35</sup> The advantage is the physician need not be on-site while the PAs are evaluating these patients.

Medicare will reimburse for PA services at 100% the physician fee during certain situations. This is called "incident to" billing. The difference is that physicians must see the new patients or return patients with new problems; the PA sees follow-up patients with established problems and can be reimbursed at 100% for those return visits. Also, services are billed under the supervising physician's NPI number and the supervising physician or designated alternate must be on-site. On site is defined as the same suite of offices, but does not mean the same exam room and it does not mean the physician must also see the patient during the same encounter. The physician can be seeing other patients concurrently. Details are listed in the Medicare Carriers Manual, Part 3: Claims Process.<sup>36</sup> Remember however, Medicare allows a PA to see *any Medicare patient and will be reimbursed*. But, if the "incident to" criteria are not met, then the PA simply bills under his or her NPI and the reimbursement is 85%. For instance, PAs are allowed to evaluate new Medicare patients as well as return Medicare patients with new problems, even when the supervising physician is not on-site, but with a 15% discount in reimbursement.<sup>36</sup>

There is another scenario in which Medicare will allow 100% reimbursement. This is called "shared visit" billing, usually in a hospital. As long as the physician has any amount of face-to-face time, even if the PA is responsible for most of the care, the combined efforts of both the physician and PA can be reimbursed at 100%. An example would be if the PA rounded and cared for all of the in-patients on the service,



but the surgeon had at least some face-to-face time during the same day, then the reimbursement is 100%. It is not enough for the physician to simply sign the chart.<sup>36</sup>

PAs may also first assist during surgery and Medicare will reimburse at 85% of the physician first assist fee (the physician surgical assist fee is 16% of the surgeon's fee, which makes the PA reimbursement  $85\% \times 16\% = 13.6\%$  of the surgeon's fee). Some restrictions apply, which are the same restrictions for physicians and physician assistants; not all surgeries allow an assistant, and in teaching hospitals that have qualified residents available, PAs (and physicians) cannot bill as a surgical assistant.<sup>37</sup>

Reimbursement for private carriers can differ from Medicare's rules. Although most plans cover PA medical services,<sup>38</sup> there is often variability in the policies surrounding PA services and billing. Therefore it is important to carefully review each carrier's rules, your individual contract, as well as the individual plans within the carrier. Since some plans are not familiar with the PA role, it will often be the role of the physician to educate the carrier. The AAPA has collected data on PA reimbursement for various private payers in all 50 states.<sup>39</sup> For Washington State, Aetna, Regence, Premera and Uniform Medical Plan are summarized. On average, these private payers reimburse for PA services at a higher rate than Medicare (Aetna 85%, Premera 100%, Regence 95% and Uniform Medical 90%).<sup>40</sup> In fact, under most plans, unlike Medicare, the PA can see the patients on the initial visit (i.e. new patient encounter) and not receive a reduced reimbursement.<sup>40</sup> But, it is important to remember that ophthalmology practices will need to check their individual contracts with each private payer.

In summary, PAs can bill for any service for which the physician can bill. This reinforces the concept that physician assistants are *licensed to practice medicine with physician supervision*. PA services are sometimes reimbursed at 85% and sometimes 100%, depending on the specifics of the patient encounter and depending on the carrier. Keep in mind that although billing for services is certainly a benefit to the practice, and sets the care of PAs apart from ophthalmic techs, billing for services is not the only financial benefit of PAs. Even services that are not separately billable, such as post-op exams or pre-op history and physicals, by having the PA handle those visits (and these are visits that cannot be done by technicians), the physician is freed up to see other patients.

### ***Special Considerations of Physician Assistant Ophthalmic Education and Scope of Practice:***

The topic of incorporating PAs into the field of ophthalmology will likely trigger debate about particular issues. What would PAs do? How would we standardize ophthalmic education? Would we *need* to standardize ophthalmic education? According to state law, what an individual PA can do is up to the individual ophthalmologist. The entire PA

field is based on this premise. PAs receive a broad-based medical education based on the medical school model, but they graduate as generalists. It is up to the supervising physician to build on that education and teach the skills that both the physician and physician assistant deem appropriate. Remember, PAs are not just working in primary care as generalists, they are working in specialized fields across the United States including most medical and surgical specialties. PAs did not receive specific education in those fields either. The point of PA school is *not* to graduate a specialist. That is up to the physician. This is one of the appeals of the PA field; PAs can change specialties throughout their career if desired. There are a handful of PA post-graduate residency programs in the United States, but these programs are not standard at this time. According to conversations with Dr. Linda Vorvick, MD at the UW MEDEX Program (September 2011), there is some discussion among PA programs across the country that post-graduate specialty programs and certification may be in the future. This is a debated topic however, since at this time, the point of PA programs is not to produce a specialist. Nonetheless, if post-graduate residencies become the norm, then it may be worth considering creating a program in ophthalmology.

In the meantime, what could ophthalmologists do in order to help promote the ophthalmic education of employed PAs? Aside from the personal instruction from the physician, it would make sense to make available CME courses specifically in ophthalmology. It may be worth considering opening up meetings, traditionally exclusive to ophthalmologists, to PAs currently hired by an ophthalmologist. In general PAs attend the same CME courses that physicians attend and currently the annual AAO meeting is open to PAs. There generally is no distinction between physicians and physician assistants when it comes to CME courses, but certainly there could be some courses offered that are more appropriate for the level of care that a PA would perform. This could be done at the state and national level and would not necessarily require creating an entirely new PA curriculum. PAs are trained to think and act like doctors, and therefore are encouraged to enroll in CME with doctors. Ultimately it may also be beneficial to expose PAs to the field of ophthalmology while they are still in school. This is not to say that PA students will become experts in ophthalmology, but it may spark interest in the field. Most PA programs allow an elective clinical rotation in the second year, so another idea is to create a PA rotation in ophthalmology. Most PA programs are associated with medical schools and hospitals, so it could be modeled on the medical school rotation, and in some cases medical students and PAs could share rotations.

PAs are trained as generalists, but have already been trained on-the-job in most specialties. PAs can be trained by the sponsoring physician to perform those duties that the ophthalmologist wishes to delegate. Examples include basic anterior segment diseases such as foreign bodies, conjunctivitis, preseptal cellulitis, in addition to

performing pre-operative history and physical exams, assisting on surgeries, rounding on in-patients in a busy hospital setting and endless other scenarios. Again, the scope of practice of a PA is defined by the scope of practice of the physician, but under supervision. Any training a PA receives on the job is based on a solid medical and surgical foundation, similar to the medical school model. PAs also have a thorough training on all organ systems and, like physicians, understand the systemic implications of any medication they prescribe or procedure they perform. This is another distinction between PAs and optometrists. PAs are already diagnosing and treating basic ophthalmic diseases across the US in emergency rooms and urgent care centers. Many PAs in these settings have been trained on and regularly use the slit lamp to diagnose and manage anterior segment disease, much like our non-ophthalmology ER physician colleagues. ER physicians and physician assistants already regularly diagnose and treat superficial foreign bodies, conjunctivitis, flash burns, chemical injuries and preseptal cellulitis, to name a few examples. The important point is that PAs have the medical foundation on which can be layered a specific set of ophthalmologic skills that the supervising physician wishes for them to know. Assuming these skill sets are outlined in the “practice plan” required by the state and if the supervising physician and physician assistant are both comfortable with this delegated set of skills, then the PA is within his scope of practice to perform these duties.

### ***Conclusions:***

Physician assistants are physician “extenders” that have been trained to think and act like doctors and are licensed to practice medicine with physician supervision. PAs already have a presence in most primary care and specialty fields, including surgical fields. They have been an asset to the practice of medicine for over 40 years and studies have concluded that PAs are well received by patients.<sup>41,42</sup> If PAs enter the field of ophthalmology, it will not be to replace or duplicate the ophthalmologist, optometrist or technician, but rather to carve out a unique role in a future where ophthalmologists will be in demand. Their medical and surgical background is the foundation on which to build ophthalmology-specific skills that can be used in all aspects of patient care. PAs bring a unique education, separate from optometrists, nurses and ophthalmic technicians, in that PAs have an understanding of the human body and its systems as a whole. This gives them the ability, like physicians, to have a complete understanding of potential associations of systemic disease, understand the potential effects of topical and systemic medications, and in general, understand that everything we “do” to a patient has a potential ramification on the patient as a whole.

Patient safety has always been and will always be a priority for the ophthalmologist. In this age of attempted expansion of optometry scope of care, including attempts and

some successes, to expand optometric care to include surgery, PAs offer hope to patients and ophthalmologists. Unlike technicians and optometrists, PAs are licensed to practice medicine with physician supervision. Unlike technicians, PAs can bill for any service the physician can do. Unlike optometrists, PAs have a purely medical and surgical education. The physician-physician assistant relationship is the foundation on which the PA field has been built and PAs are dedicated to the concept of physician-led care. Because optometrists are independent providers, the potential expansion of their scope has patient safety concerns, not only because of the non-medical and non-surgical foundation of training, but also because they would not be under the supervision of a physician. With a medical and surgical education serving as the foundation, PAs practice delegated, supervised medicine. PAs can handle the routine cases in order to free-up the ophthalmologist to care for the more complex medical and surgical patients for which their extensive training provides. The physician-physician assistant team would be a benefit to the future of ophthalmology.

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*Most data from the AAPA website was accessed between February and August, 2011. Just prior to submission of this white paper, the AAPA underwent a major restructuring of its website. Some content on the website has become restricted to AAPA members. I am grateful to the AAPA for granting me access to specific website content in order to complete my paper.*

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Addendum to The Future of Physician Assistants in Ophthalmology  
Rachel Reinhardt, MD  
September 19, 2011

After the submission of this white paper, reconsideration was given to the interpretation of Washington State legislation RCW 18.71A.060 and the limitations on PA scope of practice. It is possible that it could be interpreted more restrictively, that PAs are not able to examine the eye in any capacity, except to check vision. However, PAs today are evaluating patients with eye diseases in emergency rooms in Washington State. This fact argues that the language could be interpreted less restrictively, by limiting PA scope of practice only in the context of refractions, contact lens fittings and vision therapy. This illustrates the importance, in all states, of having legal counsel review your practice plan prior to submission.





**Cynthia A. Self, MD**  
**Maine Society of Eye Physicians and Surgeons**  
**Leadership Development Program XIII, Class of 2011**  
**Project Abstract**

***Title of Project:*** *Initiation of a Program for Continuous Development of Liaison Between MSEPS Members and their State Legislators*

**Purpose:** To strengthen the liaison between MSEPS and the Maine State Legislature with the goal of improved patient and profession advocacy. To build the importance of advocacy as a member responsibility, a concept that was started with the development of the MSEPS Advocacy Fund.

**Method:** A database was prepared documenting the name of the legislators for each MSEPS member's home and work districts. A one-on-one contact will be made with each member to try to obtain buy-in for the project. Each member will be asked to meet with each of his or her legislators once a year. Members will be provided with talking points, legislative tracking sheets, and a strength-of-relationship form to complete. Members will be encouraged to sign-up for e-mails from their legislator, attend and contribute to fundraisers, attend the "Doctor of the Day" program, and gradually improve the strength-of-relationship with their legislators.

**Results:** The Member / Legislator database has been prepared. At the last MSEPS meeting, the program was discussed and good feedback was obtained. At the next MSEPS meeting, members will be given contact information for their legislators as well as supporting documents.

**Conclusion:** As the project moves forward, legislators on key committees will be identified for action. As new ophthalmologists join MSEPS, they will be oriented to the program and encouraged to start early. Over time, objective data can be tracked regarding number of contacts, dollars contributed, and improved strength-of-relationship. This will likely significantly help the society's state advocacy efforts.



**Prem S. Subramanian, MD, PhD**  
**North American Neuro-Ophthalmology Society**  
**Leadership Development Program XIII, Class of 2011**  
**Project Abstract**

**Title of Project:** *Determining the Effect of Multiple Fellowship Training on Neuro-Ophthalmic Practice Patterns*

**Purpose:** To investigate factors that influence the practices of ophthalmology-trained neuro-ophthalmologists, with specific attention to fellowship training history and its effect upon the amount of time each physician commits to the practice of clinical neuro-ophthalmology. The hypothesis driving this study is that dual fellowship-trained physicians are less likely to have neuro-ophthalmology comprise at least 50% of their practice effort.

**Methods:** A written, computerized survey was designed to capture information from practicing neuro-ophthalmologists in North America; all respondents had completed a clinical fellowship in neuro-ophthalmology. This survey gathered data about years in practice, additional fellowship training, amount of time allocated to clinical vs research activities, and the patient mix (neuro vs. non-neuro) seen by each physician. When physicians chose to expand their practice voluntarily beyond sub-specialty patients, they were encouraged to provide reasons for doing so.

**Results:** The survey was distributed to subscribers to NANOSNET in the form of a Survey Monkey link. There were 101 respondents; 60 were ophthalmologists (5 had residency training in neurology as well) and were included in this analysis. One-third (20) of physicians had completed an additional fellowship (13 pediatrics, 6 oculoplastics, 1 headache). Over 75% (31) of those with no other fellowship were in academic practice, as were 77% (10/13) in pediatrics, in contrast to 50% (3) of oculoplastics trained physicians. Fifty-one percent (10/19) of peds or oculoplastics-trained MDs had dedicated neuro clinic time, compared to 87.5% of neuro-ophthalmologists. Among single fellowship trained neuro-ophthalmologists, 76.2% of non-surgeons spend >80% of clinic time seeing patients with neuro-ophthalmologic disorders. Only 36.8% (7) of similarly trained individuals who perform any type of surgery reported that >80% of their time was for neuro-ophthalmology alone. Likewise, 40% of dual-fellowship trained MDs who reported having dedicated clinic time for neuro patients committed >80% of clinic time to these patients. The underlying reasons for the reported differences include personal satisfaction and financial concerns.

**Conclusions:** One-third of surveyed neuro-ophthalmologists had completed a fellowship other than neuro-ophthalmology, and while this training resulted in less effort being given to the clinical care of neuro patients, a similar reduction in dedicated effort to neuro-ophthalmologic patients was observed among all surgeons regardless of second-fellowship status. Thus, second fellowship training does not appear to have a greater detrimental effect on the amount of time spent by physicians in the care of neuro-ophthalmologic patients when compared to those physicians who perform general or other ophthalmic surgery without additional fellowships.



**Mark F. Torres, MD**  
**Society of Military Ophthalmologists**  
**Leadership Development Program XIII, Class of 2011**  
**Project Abstract**

**Title of Project:** *Fostering International Relationships in Ophthalmology through Humanitarian Military Medical Missions with the AAO*

**Purpose:** Utilize the global outreach resources and capabilities of the American Academy of Ophthalmology to augment diplomacy between US Military Humanitarian Ophthalmology Medical Missions and the Ophthalmology leadership infrastructure of the host nation, and by doing so in advance of mission implementation, improve diplomatic relations, foster professional relationships between Ophthalmologists from different nations, and improve productivity and outcomes of humanitarian Ophthalmology medical missions.

**Methods:** Utilizing the American Academy of Ophthalmology's global communication and outreach capabilities and resources, officials in the US Department of Defense Ophthalmology community will identify and communicate, in advance, with those Ophthalmology leadership individuals of the host nation regarding the timing, location, nature, and scope of planned humanitarian Ophthalmology medical missions conducted by US military personnel visiting the host nation.

**Results:** The American Academy of Ophthalmology provided Ophthalmology leadership identification of host nation individuals, and facilitated communication with such individuals, in advance of US Department of Defense Military Ophthalmology Humanitarian Medical Missions in the following nations between summer 2010 and fall 2011 – Honduras (two separate missions), Dominican Republic (two separate missions), El Salvador (two separate missions), Malawi, Africa, and Tanzania, Africa.

**Conclusion:** The American Academy of Ophthalmology's unique global presence, and identification and communication resources and capabilities, were invaluable in positively impacting the success of US Military Humanitarian Ophthalmology Medical Missions in a wide variety of foreign host nations. By utilizing such resources in advance of mission implementation, communication between US and host nation Ophthalmologists was greatly facilitated. Such advance communication improved diplomatic relations between nations, fostered professional Ophthalmology relationships, and allowed mission planners to take into account such factors as demographics, economics, politics, and host nation resources which otherwise would not have been recognized or identified prior to mission implementation. This allowed for improved mission productivity and outcomes, and greatly influenced the diplomatic success of such missions.