InfantSEE®-CDC project making headway

A pilot marketing program is providing InfantSEE® with valuable insight into organizing doctors and raising the public’s awareness of the program. InfantSEE®, an entity of Optometry’s Charity™—The AOA Foundation, provides a one-time, no-cost eye health assessment to infants between 6 and 12 months old.

With nearly 7,500 providers and support from the AOA and Vistakon®, a Division of Johnson & Johnson Vision Care, Inc., the program starts children off to a lifetime of vision care.

The pilot marketing program, made possible by a $430,000 grant from the Centers for Disease Control and Prevention (CDC), includes the launch of “InfantSEE® Weeks” throughout the country.

The pilot marketing program, made possible by a $430,000 grant from the Centers for Disease Control and Prevention (CDC), includes the launch of “InfantSEE® Weeks” throughout the country.

This year, eight locations will host an InfantSEE® Week with concentrated media and public relations efforts designed to raise awareness of the program and encourage parents to make appointments for their infants.

Direct mail pieces, flyer distribution and advance media outreach are part of the efforts leading up to each CDC InfantSEE® Week.

The program is also conducting extensive outreach to community health resources including health departments, pediatrics centers, community centers and other outlets that provide care for infants.

Grassroots efforts include moms and other local advocates, including participating doctors of optometry, to promote and engage fellow community members regarding the InfantSEE® Week.

In preparation for the InfantSEE® Weeks, the program offers orientation sessions and continuing education to volunteer optometrists. The sessions are provided at no cost to the participating provider and are designed to refresh their knowledge on the clinical examination of infants.

The featured weeks do not require any changes on the part of InfantSEE® providers, but instead are concentrated periods of time in

See CDC, page 8

TBI, aviation vision lead Sunday CE

Optometry’s Meeting® Sunday education covers a broad range of topics from aviation vision, to neuro-optometry, to anterior segment challenges.

Essilor and The Vision Care Institute®, LLC, a Johnson & Johnson company, are sponsoring “Aviation Vision,” course #4110, from 8 a.m. to 3 p.m. (Lecturers: T. Brunstetter, O.D., Ph.D.; A. Engle, O.D.; J. Kent, O.D.; V. Nakagawa, O.D.; J. Weaver, O.D.)

This six-hour course is designed to prepare optometrists to meet the basic needs of their pilot patients, whether they are involved in general, commercial, or military aviation.

The course will cover the Federal Aviation Administration medical examination and certification process; aviation vision standards; prescription options for aviation; color vision in aviation; spatial disorientation; night vision in aviation; and refractive surgery in aviation.

“Neuro-Optometric Vision Care”

See Sunday, page 27
THE DESIGN INSIDE.

EyePoint Technology® is a patented component of Shamir’s lens design software - a dedicated ray-tracing program written by Shamir scientists which combines lens surface topography data with highly advanced mathematical algorithms. EyePoint Technology® simulates the human eye in every angle, prescription, and field of vision. These techniques enable Shamir to create the most sophisticated progressive lens surfaces based upon thousands of points of data. It’s this “design inside” that makes Shamir progressive lenses the most advanced in the world.

EyePoint Technology® takes the following into account when calculating the optical performance of thousands of locations covering the lens surface:

- Lens index refraction
- Lens prescription
- Lens center thickness
- Distance from the eye to the back vertex of the lens
- Distance from the lens to the object
- Pantoscopic tilt of the frame
- Pupil distance
- Thickness reduction prism
- Angular position of the object in the eye’s field of vision

Shamir Progressive Lenses - ReCreating Perfect Vision®
shamirlens.com
PRESIDENT’S COLUMN

Optometric Bill of Rights

As I drafted the last President’s Column presenting a Declaration of Optometric Independence, I was about to share the message to nearly 300 industry executives at the Vision Monday Global Leadership Summit prior to Vision Expo East.

It seems fitting today as I depart Washington, D.C., after having met with several members of Congress and senators that I share my version of the Optometric Bill of Rights.

The first five, in this issue, concern the rights of practitioners. With the national discussions of health care reform, it’s critical that optometry is clear with where we believe the profession must be, so we begin with the first five rights of optometrists.

First Amendment – Equitable Reimbursement – optometrists and ophthalmologists shall receive equal reimbursement for the same services regardless of the payer. There is currently discrimination in managed Medicare, some Medicaid and obviously in ERISA plans and even (possibly without common knowledge) traditional commercial insurers. Optometry, through the AOA and state associations, will need due dollars and support in fighting for equal reimbursement for equal services.

Second Amendment – Truth and Transparency – optometrists shall be provided with easy-to-understand full disclosure statements by managed vision or health plans to more easily determine if joining a panel makes financial and professional sense for his/her practice. In particular, as in some managed vision plan carve outs of medical eye care – when there is disparity between reimbursement or scope of services provided between optometry and ophthalmology – the plan will clearly disclose the disparity and the optometrist can then determine if the lower reimbursement or limited scope of services provided is in the patients’ best interest.

Third Amendment – Optometric Co-Management and Intra-Professional Referrals – optometrists in all practice settings shall work closely with their optometric colleagues to ensure all patient needs are met by optometry whenever appropriate.

Provided – The AOA will provide its members with tools and information to ensure that no optometrist ever have to make patient-care decisions based on the economics of reimbursement. Eye examination reimbursement will cover all costs of providing the services and a reasonable profit. The provision of professional services or materials will all cover the costs of the products or services and a reasonable profit.

Fourth Amendment – Fair Reimbursement for Services

Optometrists in all practice settings shall work closely with their optometric colleagues to ensure all patient needs are met by optometry whenever appropriate.

Optometry is a wonderful profession to be a part of. Practitioners have the opportunity to provide medical care for all, including those with disabilities, and a reasonable profit. The AOA will continue to provide its members with tools and information to ensure that no optometrist ever have to make patient-care decisions based on the economics of reimbursement. Eye examination reimbursement will cover all costs of providing the services and a reasonable profit. The provision of professional services or materials will all cover the costs of the products or services and a reasonable profit.

Because our patients are the focus of all we do, the next issue will conclude with my view of patient rights from a presbyopic perspective of optometric care.

Peter H. Kehoe, O.D.
President

PS: Please visit www.PeterAOABlog.com to add your “Amendments” or comment on this or any other topic of importance.

PPS: Watch your e-mail, my blog and snail mail for the latest updates on the board certification discussion – your input is valued!
Carlson files for vice president

Dr. ori M. Carlson, O.D., of Park River, N.D., has filed for the AOA office of vice president.

Dr. Carlson was first elected to the board in June 2004. Currently, Dr. Carlson is the chair of the Finance Committee, Constitution and Bylaws Committee and the Program Planning Committee. She also serves on the Personnel Committee and Building Committee and is the liaison to the Council on Research.

She has served as board liaison to the Advocacy Group Executive Committee, the Federal Legislative Committee, the Federal Relations Committee, the Finance Committee, the Health Information Technology and Telemedicine Project Team, the Professional Relations Committee, the Communications Group Advisory Committee, the Optometry’s Charity, the AOA Foundation Board of Directors and the Commission on Parapodometric Certification.

Dr. Carlson was the first female president of the North Dakota Optometric Association (NDOA). She served on the AOA’s Communications Technology Project Team from 2001-2002 and was chair of the Information & Member Services Group and Membership Development Committee.

Since 1999, she has been a trained consultant for the Accreditation Council on Optometric Education. Dr. Carlson continues to serve on the North Dakota Blue Cross Blue Shield Advisory Committee and is a longstanding member of the North Dakota Legislative Committee.

Her North Dakota colleagues awarded her the Young Optometrist of the Year Award in 1994 and the Optometrist of the Year Award in 2003.

A 1989 graduate of Pacific University College of Optometry and a former resident at the American Lake and Seattle Veterans Administration hospitals, Dr. Carlson and her husband and partner Mark Helgeson, O.D., own practices in Park River and Grafton, N.D. The doctors have two sons, Seth and Ian.

Win prizes, attention in AOA Photo Contest

As a way of building a storehouse of arresting and beautiful photos, the AOA announces its first photo contest. Open to AOA member ODs, American Optometric Student Association (AOSA) student members and Paraoptometric Section members, the contest’s top prize in each category is $500 cash. All participants will have a chance at seeing their photography in AOA publications or online media.

Prizes:

There will be one $500 cash winner in each of four categories: Practice Settings, Special Populations (children, seniors, disabled or diverse), Community, and Events. The first finalist in each category will win an AAXA Pico Projector, a pocket-sized LCD projector valued at $259. The second finalist will win a digital picture frame valued at $125. The third finalist and the Altered Image winner in each category will each receive a “gallery-wrap” 16” x 20” print of their winning photo. In addition, an entrant chosen at random – and his or her guest – will be invited to meet Jeff Foxworthy at Optometry’s Meeting® for a photo session.

Contest dates:

The American Optometric Association’s Photo Contest begins April 1, 2009, and ends May 15, 2009, at 2 p.m. Central Daylight Time (CDT). By submitting an entry, each contestant agrees to the rules of the contest.

Eligibility:

Members of the AOA, the AOA Paraoptometric Section and the AOSA are eligible. For details and to submit photos, visit www.aoa.org/photocontest.xml.

Protect and Advance the profession

Editor:

I have served as the New Jersey Society of Optometric Physicians (NJSOP) legislative chairman for more than 20 years. During that time I have done my best to fulfill the obligation that comes with the title and is shared by those in leadership. Protect and Advance the profession of optometry and in so doing expand our patient base while providing the best eye care we can to our patients.

I believe a short historical review of where we were and where we are going will be helpful.

When our optometric forefathers made the first change from a drugless profession to one utilizing diagnostic pharmaceuticals, it raised our stature in our patients’ eyes and our own. But even then, ophthalmology and medicine fought against our right to simply use diagnostic drugs.

We made a quantum leap in New Jersey in 1992 when we passed our first therapeutics law. We then went through the regulatory process so that we could call ourselves “optometric physicians,” which more accurately defined us and cemented that definition when we passed our oral laws.

But at every turn we were opposed. Remember, we are a legislated profession and have had to fight repeat laws and other legislation meant to limit our professional prerogatives. By the way, within the wording of our practice act was language that held us to the same standard of care as a medical practitioner. We gladly agreed to such wording in order to give our legislative friends the level of comfort necessary to vote for our newfound privileges.

We co-manage without restriction in our state, but behind the scenes another type of battle continues — at the regulatory level where we have to quash attempt after attempt to roll back and limit that privilege. This means meeting with state officials, making and remaking our case to continue the status quo so that co-management prevails. Our adversaries stand ready at the first opportunity at both the state and federal levels to take from us our hard-fought gains and render us second-class practitioners.

Do not be so naive or blase and content to think that it could not happen or won’t happen in some form. Yes, the NJSOP is a strong society politically, but I know too well the thin line that exists between success and failure at our state house and in Congress.

So at every turn, whatever you like it or not, we must continue to prove our worth, make the case for the profession that serves most of our citizens, and Protect and Advance optometry.

It is within this context that we once again find ourselves at a crossroads. We have the opportunity to protect and advance the profession as we choose to let others, in a vacuum left by inaction, dictate what our place will be in the health care marketplace.

I believe board certification will strengthen our hand in meeting a changing health care landscape by creating a uniform process requiring a high level of competency by which, yes, once again, we will prove our worth to those decision makers who make health care policy in Washington.

It will be difficult for them to limit our access as we give them the level of comfort they need to keep us as a main player in providing eye care to the nation. And who knows, it may help to open up access heretofore denied.

So, to reiterate, board certification is another layer of protection against losing our collective patient base and allowing us to advance our profession into the 21st century.

The marginally additional cost or extra hours that may attend this process pale in contrast to its need. I do not believe it to be a hardship severe enough to warrant a no vote. That would be pennywise and pound foolish.

On two critical notes, I would suggest:

- Making the process less complex so as to make compliance less onerous.
- We should also consider making license reciprocity among all states a reality.

See Letters, page 14
Industry leaders take stock of economy

Patient buying behavior is changing as a result of the economic downturn, but in ways that may not have been predicted, according to industry leaders meeting at the Ophthalmic Council™ prior to International Vision Expo East last month.

Several industry leaders said they have observed a clear break in behavior between patients who are covered by managed care plans and those who are paying out of their pockets.

“We’ve seen an increase in utilization of managed care, with usage up almost 30 percent, but private pay down,” said Kerry Bradley, president of Luxottica Retail.

He noted that Luxottica’s Lenscrafters chain, perceived as upscale, has seen a decline in sales — in fact at least 110 stores are closing — but the discount-oriented Pearle Vision, Sears Optical and Target Optical have all seen growth.

Carl Bracy, vice president of marketing at Essilor, said the market most recently “has not been bad, it’s just changed.” He said Essilor noticed a shift at the end of 2008, with patients covered by managed care plans accelerating their visits to the eye care practitioner — perhaps out of fear that they might soon lose their benefits, or jobs.

Patients who are paying for the exams and eyewear themselves, however, seem to be delaying their visits to the eye doctor, Bracy said.

Ranaa Nafalovich, chief executive officer of Shamir Insight, said he was “very concerned personally about people using up their benefits and the coming impact of higher unemployment.”

His take was that people still employed with eyewear benefits are buying now, and artificially inflating the demand.

Wally Lovejoy, senior vice president for eye care development at Luxottica Retail, said, “My biggest concern is that practitioners are incurring self-inflicted harm by selling consumers down.”

Wally Lovejoy, senior vice president for eye care development at Luxottica Retail, describes the vast untapped market for eye care.

“My biggest concern is that practitioners are incurring self-inflicted harm by selling consumers down.”

On the contact lens front, there is some concern among ophthalmic executives that patients are taking measures to cut expenses, such as stretching out the wearing times and re-using solutions, or switching to generic solutions.

The market for LASIK and refractive surgery has slowed down, as many would expect an elective procedure to do in a recession.

However, cataract surgery is “way up,” according to several executives, likely because it is covered by Medicare and baby boomers are starting to turn 65 in large numbers.

One change in the cataract market is that a surprising number of patients are turning to premium IOLs.

Bradley said, “and noted some trading down in frames, but trading up in lenses.”

Howard Purcell, O.D., of Essilor, said that premium anti-reflective coatings seem to have slowing sales growth but value-oriented products are faring better.

One concern, shared by many, is that practitioners are instructing staff to suggest lower-priced options, to their own detriment.

“My biggest concern is that practitioners are incurring self-inflicted harm by selling consumers down,” Bracy said at an Essilor news conference.

He noted that most indicators show that patients are not shying away from higher-end coatings and lens options, if given the choice.

AOA executive director outlines association’s role in helping ODs

With two prominent forums in New York in late March, AOA Executive Director Barry Barresi, O.D., Ph.D., described how the association is taking a more aggressive position regarding third-party plans that sell optometrists’ services short.

At the Vision Monday Global Summit, and at the Ophthalmic Council™, Dr. Barresi described how some plans can best be visualized as handcuffs, barbed wire and scissors cutting dollar bills.

“Are these the icons of the vision plan companies’ entry into the medical benefits administration in eye care?” he asked.

“The AOA is ready to do its part to help bring together all stakeholders — providers, plans, employers, ophthalmic industry — to solve the puzzle of mainstreaming ALL vision and eye care within health insurance and medical plans,” he said.

He questioned whether the reimbursement of optometrists has kept pace with ODs’ rapidly expanding scope of practice. He also described how the AOA’s new Research & Information Center would be seeking data to show how ODs’ practices costs and training justify fairer reimbursements.

AOA Executive Director Barry Barresi, O.D., Ph.D., outlines how the AOA is being structured to reflect the best practices among associations.
Board certification
Changes include ‘board eligible’ status, governance

Following two months of presentations of — and feedback on — a model for board certification in optometry, the Joint Board Certification Project Team (JBCPT) has made several changes and clarifications to the proposed model, as recently as March 23 and 31 via WebEx meetings.

The change that will affect all optometrists intending to become board certified is the creation of a new designation: board eligible.

The designation responds to concerns that new practitioners, or those on the path to certification, would have no way of indicating to the public or third parties their seriousness about the credential.

To be classified as board eligible, a candidate for board certification would submit the eligibility application, application fee, and evidence of the following initial qualifying requirements:

- Graduate of school or college of optometry accredited by the Accreditation Council on Optometric Education (ACOE).
- Possession of an active license to practice therapeutic optometry in a state, District of Columbia, U.S. commonwealth or territory.
- Clearance of a search of the National Practitioner Data Bank (NPDB) and Health Integrity and Protection Data Bank (HIPDB).
- Statement of adherence to the American Board of Optometry Code of Ethics.

Upon confirmation of the requirements, the American Board of Optometry (ABO) would confer that the candidate is board eligible for a period of one year.

Candidates could renew their board eligible status for up to three years total by submitting proof of completion of 50 points progress toward completion of the Post-Graduate Educational Requirements by the end of each year of board eligibility.

The Post-Graduate Educational Requirements of 150 points would remain unchanged.

A board eligible optometrist should pass the Board Certification Examination within 12 months of completing all 150 points and submitting an application for the Board Certification Examination.

In addition to approving the new designation, members of the JBCPT voted to alter the composition and governance of the proposed American Board of Optometry.

- Under the new plan, the American Academy of Optometry (AAO), the Association of Regulatory Boards of Optometry (ARBO) and the Association of Schools and Colleges of Optometry (ASCO) would each have one member on the board.
- The AOA would have two members, reflecting a frequently stated desire of optometrists that practicing ODs have a meaningful voice on the new organization.

A practitioner initially licensed less than five years would represent the American Optometric Student Association.

There would be a member of the public on the board, reflecting the importance of ensuring quality care and education that the board would place on its work.

In earlier drafts of the model, the American Board of Optometry had a representative of the National Board of Examiners in Optometry. At AOA affiliate and regional meetings, there were some concerns voiced that the

See Changes, page 12

Project team takes questions about proposal

In order to shed further light on the proposed model for board certification, AOA News asked members of the Joint Board Certification Project Team (JBCPT) to answer common questions about the process. To submit a question to the team, write: questions@jbcpt.org.

Q: If the AOA House of Delegates vote is “Yes,” is there any further opportunity for input on the final model for Board Certification?

A: The Joint Board Certification Project Team has developed a “model” for a board certification process. While the model has some detail, even more detail will need to be developed before board certification could begin in earnest. If the AOA House of Delegates accepts the model, the process would become the responsibility of the American Board of Optometry. That organization should accept input from the profession as final details are developed prior to implementation of the plan.

Q: If the house vote is “No” at the AOA House of Delegates, will the issue of “BC” die?

A: The issues of competence and board certification have surfaced many times in the past, at least once every decade for the past 40 years. As the U.S. health care system continues to evolve, there will likely be ever-increasing demands on the profession of optometry to have a process to demonstrate ongoing competence in a manner such as board certification and maintenance of certification. The AOA will not support board certification should it be defeated in the AOA House of Delegates.

Q: Is there a game plan to come up with initial funding to get this off the ground? ($2 million has been quoted). Our AOA affiliate members will be asking as they will be fearful of the dues increase or special assessments.

A: Along with other organizations, the AOA could be one of the “funding entities” to finance the startup of the American Board of Optometry. Any funding plan involving the AOA would be in the form of a loan with interest, so it would not affect dues.

Q: Why do the residency and the Academy fellowship points only apply if they have been completed in the last 10 years? An accredited residency is an accredited residency no matter when it was completed. The same can be asked about the AAO. Why is there a limited value on having passed the AAO last year vs. more than 10 years ago?

A: This was discussed and debated extensively by the JBCPT. Our model for board certification and maintenance of certification is based largely on that of the American Board of Family Medicine and other member boards of the American Board of Medical Specialties. Nearly all of their programs have time limits of 10 years, so the JBCPT believes that a similar 10-year summing for residencies and fellowship is a reasonable one. The premise used by other organizations is that the currency of residency or any formal training program becomes stale over time.

Q: I would want to know specifically what happens if the House of Delegates votes “no,” since there are many other agencies involved. Will the other agencies continue to carry the torch?

A: The leadership of all the participating organizations saw the wisdom in working together with all stakeholders in optometry to study this issue. While it is thought that the decision of the AOA House of Delegates is crucial to this decision, it is possible that another group either inside or outside of optometry could move forward with a board certification process.

Q: Does the AOA have an official position regarding adoption of the JBCPT recommendations?

A: The AOA Board of Trustees saw the final product when it was released by the JBCPT in January. The Board will make the formal motion that will begin and allow discussion by the AOA House of Delegates. The motion will likely recommend support of the model as well as recommend that any newly formed entity obtain significant input from the profession before any final process is rolled out.

Q: Was what we heard at the Presidents’ Council the final program or will it be further modified before the House of Delegates in Washington, D.C.?

A: The model released by the JBCPT has been modified by the Project Team and could be further before being voted on by each of the organizations. It will certainly be further refined and developed by the American Board of Optometry if the process moves forward.

Issues that arise through the presentation of the model to the profession should be forwarded to the JBCPT for consideration.
In a new benefit exclusively for AOA members, the AOA provides a daily e-mail summary of health care news. This service is designed to refresh their knowledge on the clinical examination of infants.

The additional promotion increased awareness of the InfantSEE® program and the number of assessments, according to Nancy Kopp, executive director of the North Dakota Optometric Association (NDOA). “We did have a very positive response from Governor John Hoeven and his office staff, as well as an interview with Congressman Earl Pomeroy, who is a great advocate for all children in our state,” said Kopp. “The InfantSEE® Week promotion did open the opportunity to work more closely with pediatricians in Bismarck on vision care for infants.”

In the month following the InfantSEE® Week, the AOA received 51 more local sign-ups. The media exposure was excellent with Congressman Earl Pomeroy, as well as an interview with Governor Chet Culver (D) proclaimed InfantSEE® Week in the state. The project’s efforts to reach out to various industry and non-industry parties in all locations have the potential for extensive and meaningful partnerships.

High-quality prints showcase importance of children’s eye care

To further enhance patient care and education efforts, the AOA has introduced three new “gallery prints” highlighting the importance of comprehensive eye exams for children. These digitally painted, museum-grade canvas gallery prints, focusing on the impact of undiagnosed vision problems in children, educate parents on why every child should be seen by an optometrist. The larger format 20 x 24-inch “gallery-wrapped” prints feature important visual messages that create a branded patient counseling collection.

Prints arrive with hardware, ready to hang with no framing costs and may be purchased individually, or as a collection, depending on the needs of the office.

The cost is $89 per print. Available are:
- CE-1 – Children’s Eye Exam Canvas Print – “She May Never Recover...”
- CE-2 – Children’s Eye Exam Canvas Print – “His Education Costs a Lot...”
- CE-3 – Children’s Eye Exam Canvas Print – “A Child Shouldn’t Have to Fail...”

To order, contact the Order Department at 800-262-2210.

AOA First Look

In a new benefit exclusively for AOA members, the AOA provides a daily e-mail summary of health care and ophthalmic news titled “AOA First Look.” Editors scan the Web and compile digest articles of news most likely to interest optometrists. AOA members and optometry students who already receive association publications should be receiving AOA First Look now. If not, check your spam blocking settings and add FirstLook@AOA.com to your address book. If your network administrator or Internet service provider requests it, you can provide the sending IP address: 65.240.141.95 for whitelisting. To sign up, send an email to addresschange@aoa.org.

I am extremely proud of the InfantSEE® providers in our state, not only for their diligent work during InfantSEE® Week, but for their daily efforts to educate the public regarding the importance of good vision and eye health care for children.
Proactive efforts ensure optometry ‘at the table’ during White House health reform summits

In an effort to reinforce the Obama administration’s commitment to national health care reform, the White House announced in February that the president was making plans to host a summit in Washington, D.C., to identify barriers to quality care and consider a number of reform proposals.

While organized medicine, nurses, health insurers, pharmaceutical companies, labor unions and business groups were quickly selected to attend the March 5 meeting, the AOA’s efforts to gain an invitation were rejected. However, the AOA wasn’t about to take “no” for an answer.

Following up on the original White House forum in the nation’s capital, the White House announced in early March that it would hold a series of health care summits in select locations around the country in an attempt to bring the conversation about health care reform directly to communities and continue the discussion on bringing down health care costs and expanding coverage for all Americans.

The AOA learned that the Regional White House Forums would be held in California, Iowa, Michigan, North Carolina and Vermont during the month of March and into early April. On March 11, the White House made known that the first of the summit events would be held the following day in Dearborn, Mich. After hearing from the AOA, Michigan Optometric Association, O.D., has filed for the AOA of office of president-elect.

Dr. Ellis graduated from the Southern College of Optometry in 1985. He is a member of the Lions Club and is a member of the Marshall County Public Affairs Committee.

Dr. Ellis was very instrumental in his efforts and relationship with Kentucky Gov. Paul Patton and the Kentucky General Assembly to help pass the first school entrance-level eye examination in the United States in 2000. Dr. Ellis is a member and past president of the Benton Lions Club and is a member of the Marshall County Chamber of Commerce. Dr. Ellis graduated from the Southern College of Optometry in 1985. He is in private practice in Benton, Ky.

Stalled DoD-VA vision center lets vets with eye injuries down

A full 13 months after the creation of a much-needed AOA-backed program to ensure a seamless continuum of care for American service members and veterans who have suffered combat eye injuries and vision-related problems associated with Traumatic Brain Injury (TBI), the AOA has joined together with the Blinded Veterans Association (BVA), Rep. John Boozman, O.D. (R-Ark.) and other leading members of Congress to spur progress on a project that is intended to ensure that veterans receive needed eye and vision care without having to deal with the overly bureaucratic process during rehabilitation.

“Our wounded warriors deserve the very best care and optometry is committed to helping Congress, defense and veterans health officials make certain they get it,” said Peter H. Keehe, O.D., president of the AOA. “The AOA worked to help pass Rep. Boozman’s Military Eye Trauma Treatment Act, and we remain confident that the Vision Center of Excellence will ultimately provide the state-of-the-art care that our injured veterans need and deserve.”

The Vision Center of Excellence was created through the National Defense Authorization Act of 2008 (NDAA) and championed in Congress by Rep. Boozman, O.D., the only optometrist in Congress.

The NDAA mandated that “[t]he Secretary of Defense shall establish within the DoD a center of excellence in the prevention, diagnosis, mitigation, treatment, and rehabilitation of military eye injuries…”

However, the Vision Center of Excellence (VCE) is still in the planning phase and minimal execution has occurred, according to the AOA Washington office.

More than a year after the enactment of the NDAA, there is no physical structure identified, no computer hardware, and no support staff.

The Department of Defense (DOD) states that $3 million has been allocated to create this center; however minimal money has been spent to create the VCE.

In addition to the disappoinement of the AOA, the VA and others, on March 17, the House Veterans’ Affairs Oversight and Investigations Subcommittee, led by Chairman Harry Mitchell (D-Ariz.), conducted a hearing to evaluate the progress the DoD and Department of Veterans Affairs (VA) have made on the VCE and how it has affected veterans in need of...
New Medicare address correction rules take effect

Health care practitioners, including optometrists, now must promptly inform Medicare if they move their practices—or else face potentially severe penalties, according to the AOA Washington office.

Under the new rules, health care practitioners must report changes in practice location to their Medicare carrier within 30 days. Physicians will no longer be allowed to establish a new practice Medicare effective billing date when they open or move their practices, or need to enroll or re-enroll in Medicare.

Instead, the Medicare contractor will establish an effective billing date by selecting the date on which the practitioner filed an enrollment application for the new location or the date on which the practitioner first began furnishing services at a new practice location; whichever is later.

Physicians may retroactively bill for services provided at the newly enrolled practice location for up to 30 days prior to their effective billing date.

The new Medicare physician enrollment rules include several other provisions that optometrists should be aware of, according to the AOA Advocacy Group:

- Medicare payment contractors will deny, rather than reject, incomplete enrollment applications submitted by physicians. (However, a practitioner can preserve the effective date of the original application filing by submitting a corrective action plan or appeal with information or documentation that was missing from the incomplete application.)
- Medicare payment contractors may revoke a physician’s billing privileges for failing to comply with Medicare’s ordering and referring documentation, including not maintaining written ordering and referring documentation for seven years from the date of service.
- Electronic funds transfer (EFT) payments for physicians may only be made to a banking institution located in the state in which the practice operates (or the applicable practice office) is located.

These new Medicare enrollment rules are intended to reduce improper billing as well as the waste and inefficiency that can result from simple errors, such as an incorrect address, according to AOA Advocacy Group Director Jon Hymes.

However, even when a doctor does nothing wrong, the mistakes of others could lead to a long and complicated correction.

In fact, the AOA Washington office recently learned, through a state affiliate, of a number of optometrists who unexpectedly stopped receiving Medicare electronic payments.

In each case, the problem turned out to be that a mailman had mistakenly returned the doctor’s paper mail to the Medicare payment contractor undelivered.

The contractors then erroneously assumed that the doctor had moved or stopped practicing, and decided to stop the electronic payments.

“These situations were ultimately resolved, but they serve to illustrate how important it is to keep information current with the CMS and also to investigate any unexpected delay or reduction in Medicare payments,” Hymes said.

“The AOA is working with the CMS and leaders in Congress to address this problem and fix a number of outdated and restrictive Medicare regulations and requirements, but we encourage ODSs, in the meantime, to remain vigilant and continue to report regulatory issues to the AOA Washington office team,” said Hymes.

A Medicare Learning Network Matters article outlining the provisions of the Medicare enrollment rule can be found online at www.cms.hhs.gov/MLN Matters/articles/downloads/MM6310.pdf.

AOA-backed Vision Care for Kids Act approved by U.S. House

On March 31, the U.S. House of Representatives overwhelmingly approved the AOA-backed Vision Care for Kids Act (H.R. 577), which recognizes the link between healthy vision and classroom learning and seeks to provide new federal funding to expand the reach of children’s vision programs enacted at the state level. The measure passed by a wide, bipartisan majority in Congress and would help to ensure that America’s school-age children are ready and able to learn.

Originally introduced by Rep. Gene Green (D-Texas), H.R. 577 aims to establish a federal grant program focusing on treatment and is designed to bolster children’s vision initiatives in the states and encourage children’s vision partnerships with nonprofit entities.

H.R. 577 directs the U.S. Department of Health & Human Services, through the Centers for Disease Control and Prevention, to provide $65 million in grant funding to proven efforts to allow more children, particularly those under 9 years of age who are already known to be at risk for vision problems, to receive comprehensive eye examinations and appropriate care from their local optometrist or other eye doctor. Grants would also go toward supporting public education and awareness efforts designed to promote early detection and treatment of vision.

“The Vision Care for Kids Act creates a much-needed grant program to provide follow-up vision care for children with vision disorders who do not have access to these services. This lack of vision care jeopardizes a child’s development and can unfortunately lead to lifelong vision impairment,” said Rep. Green, a founding member and chair of the Congressional Vision Caucus. “This bill gives states the resources they need to cover vision services to millions of low-income children, and I am glad that it passed the House with such overwhelming support.”

According to the National Parent Teacher Association, 10 million children suffer from vision disorders. Vision disorders are considered one of the most common disabilities in the United States, and they are one of the most prevalent handicapping conditions in childhood. Undetected and untreated vision deficiencies, particularly in children, can take a large toll. Studies have shown that the costs associated with adult vision problems in the U.S. are $51.4 billion.

“The Vision Care for Kids Act is an important assignment for Congress and a timely reminder for America of what needs to be done to help concerned parents and teachers ensure that no child is left behind in the classroom due to an undiagnosed or untreated vision problem,” said Peter Kahoe, O.D., AOA president. “With nearly 25 percent of school-age children suffering from vision problems, the AOA is proud to support visionary leaders in Congress in the effort to provide states with the resources—the federal dollars—they need to help children’s vision and classroom learning a top priority.”

The AOA is also joined in supporting the Vision Care for Kids Act by Prevent Blindness America, Vision Council of America and the American Academy of Ophthalmology.

Sen. Kit Bond (R-Mo.) introduced S. 259, the Senate companion bill to H.R. 577, which has been referred to the Committee on Health, Education, Labor, and Pensions. For S. 259 to be considered as a priority by Congress, a large number of U.S. Senate cosponsors will need to be added to this important bill. Please visit the AOA Online Legislative Action Center, www.aoa.org/DoctorCenter.xml, to immediately contact your senators and members of Congress on this issue.
New Medicare independent auditing program begins

According to the AOA Advocacy Group, the new Medicare independent auditing program begins with the auditing of Part A and Part B claims in April 2009. Auditors are paid a 9 to 12.5 percent commission on the overpayments and underpayments they find.

Under the new program, claims will be reviewed by one of four firms retained directly by the CMS to provide postpayment auditing services on a regional basis as follows:

- **Region C: Connolly Consulting, Inc.** — Alabama, Mississippi, Georgia, South Carolina, Florida, North Carolina, Oklahoma, South Carolina, Texas, New Mexico, Virginia, and West Virginia.

While the new auditing system is likely to focus on the high-dollar Medicare Part A claims filed by hospitals, optometrists and other health care practitioners who provide services under Medicare Part B should be aware that claims will be now potentially subject to additional audits, according to the AOA Advocacy Group.

Practitioners who make recoupment payments can still file appeals for up to 120 days following an overpayment notice. Practitioners can also request extended payment periods (covering both overpayment and interest) up to 120 days following a notice. Providers were often successful when they appealed RAC determinations in the demonstration program.

The RAC program took effect March 1 in Arizona, California, Colorado, Florida, Georgia, Hawaii, Indiana, Maine, Massachusetts, Michigan, Minnesota, Montana, New Hampshire, New Mexico, New York, Nevada, North Dakota, Oklahoma, Rhode Island, South Carolina, South Dakota, Texas, Utah, Vermont and Wyoming.

The program begins on or after August 1 in Alabama, Alaska, Arkansas, Connecticut, Delaware, Georgia, Idaho, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maryland, Mississippi, Missouri, Nebraska, New Jersey, Pennsylvania, Ohio, Oregon, Tennessee, Washington, Virginia, West Virginia, Wisconsin and Washington, D.C. Contact information for the new regional auditors is as follows:

- **Region A: Diversified Collection Services (DCS)**, telephone 866-201-0580,
- **Region B: CGI**, telephone 877-316-7222, e-mail: racb@cgi.com,
- **Region C: Connolly Consulting, Inc.,** telephone 866-360-2507, Web site: www.connollyhealthcare.com/about.aspx,

Additional information on the Medicare Recovery Audit Contractor program can be found on the CMS Web site at www.cms.gov/RAC.

AOA backs bill to aid optometry residents

The AOA is backing a new effort in Congress led by Rep. Vern Ehlers (R-Mich.) aimed at retaining the 20/220 pathway for optometry and other residents to defer their payment of student loans. Rep. Ehlers’ bill, the Medical Economic Deferment or “MEDS” Act (H.R. 1615), seeks to amend the Higher Education Act of 1965 with respect to the meaning of economic hardship under the Federal Family Education Loan (FFEL) or Perkins Loan and related loan insurance programs.

Sen. Richard Burr (R-N.C.) is the sponsor of an identical bill introduced in the U.S. Senate, S. 646. In addition to the AOA, organizations representing medical doctors, dentists and podiatrists are also supporting H.R. 1615 / S. 646.

For optometry graduates in residency training, the bill would allow for deferment of payment on subsidized loans for the length of their residency training without accruing interest. Borrowers under the FFEL and Perkins programs are considered to be suffering economic hardship if they are working full-time, have a federal educational debt burden equal to at least 20 percent of their adjusted gross income, and the difference between their adjusted gross income minus such debt burden is less than 220 percent of the greater of:

1. the annual earnings of a minimum wage earner; or
2. 150 percent of the poverty line applicable to their family size.

This provision, known as the 20/220 pathway, is critically important to optometry residents and other health professional students who, as part of their education, serve a requisite number of years in residency prior to licensure. The 20/220 pathway allows deferment of payment on student loans until residency completion. However, in 2007, the 20/220 pathway was eliminated by The College Cost Reduction and Access Act (Public Law 110-84), and was replaced by an income-based repayment program that requires health professional residents to begin repaying student loans while still in residency training.

Following an immediate outcry from the AOA, the Association of Schools and Colleges of Optometry, the American Optometric Students Association, podiatry, dentistry and organized medicine groups, the U.S. Department of Education took action to keep the 20/220 pathway intact until July 1, 2009, when the income-based repayment program is due to take effect.

The MEDS Act would fully and permanently reinstate the 20/220 rule. For H.R. 1615 / S. 646 to be considered as a priority by Congress, a number of congressional co-sponsors will need to be added to both bills. Concerned ODs and optometry students are urged to visit the AOA Online Legislative Action Center, www.aoa.org/DoctorCenter.xml, to immediately contact their senators and members of Congress on this issue.
**EYE ON WASHINGTON**

Optometrists not subject to DMEPOS deadlines

Unlike suppliers of wheelchairs and home oxygen equipment, optometrists and most other health care practitioners will not be required to post surety bonds or become accredited in upcoming months in order to continue to provide goods or services for Medicare patients, according to the AOA Advocacy Group.

The U.S. Centers for Medicare & Medicaid Services (CMS) has been reminding suppliers to get accredited by Sept. 30, but those announcements do not always make clear that optometrists are exempt.

The Medicare Improvements for Patients and Providers Act (MIPPA) prohibited the CMS from requiring physicians and other health professionals to comply with the accreditation requirement unless the CMS develops quality standards specifically for physicians and other health professionals.

The CMS has announced that, beginning in May, Medicare’s durable medical equipment benefit will apply only to items obtained from equipment suppliers that have posted special surety bonds.

The new requirement is an effort to curb Medicare fraud and abuse in the home health supply industry, according to the agency.

However, health care practitioners are not subject to the surety bond requirement, the AOA Advocacy Group notes.

Congress mandated the surety bond requirement under the Balanced Budget Act of 1997, following reports of widespread Medicare fraud among some suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) — notably providers of wheelchair and oxygen equipment.

Congress added the accreditation requirement broadly in the Medicare Modernization Act of 2003, until relaxing the burden on physicians with MIPPA last summer.

“The DMEPOS surety bond and accreditation requirements were imposed to address numerous reports of improper practices by retailers of large home health supplies such as wheelchairs and oxygen units,” emphasized Jon Hymes, director of the AOA Advocacy Group.

“Health care practitioners are not the problem. Although the CMS technically classifies eyeglasses as durable medical goods, the new requirements do not apply to doctors providing eyewear to their patients,” said Hymes.

“For that reason, while home health goods retailers will be required to post surety bonds by May 3 and be accredited by Sept. 30, optometrists and other physicians will not,” Hymes said.

The CMS originally planned to require health care practitioners to post the surety bonds and to get accredited.

The AOA and other associations successfully convinced the CMS to revise the proposal to more accurately reflect the intent of Congress.

After Congress stepped in to address accreditation, and further meetings with the AOA and other allies, the Medicare agency specifically exempted physicians from the accreditation requirement (see AOA News, Jan. 16).

The DMEPOS surety bond and accreditation requirements have been the subject of several recent CMS bulletins and health care provider trade publication articles.

As a result, the AOA Advocacy Group finds some optometrists may still be concerned about the surety bond requirement and accreditation.

The CMS estimates that these two requirements would cost $2.500 per doctor per practice location if there were no exemptions.

**Changes, from page 7**

NBEO representative, serving on behalf of a test-creating and administering organization, could have conflicts when the board selects testing vendors or evaluates proposals.

Two additional changes were made to the model:

- Members of the American Board of Optometry would serve a maximum of two-three year terms, with staggered initial appointments.
- Also, after the initial board is appointed, subsequent appointments would be selected from three persons nominated by the sponsoring organization for each available position on the board.

Noting the changes to the model, and the ongoing dialogue within the profession, AOA President Pete Kehoe, O.D., sent a letter to state optometric associations and affiliate leaders April 3 asking that they let the dialogue continue rather than casting votes months before Optometry’s Meeting.

“The project team has listened to concerns and has made a number of changes to the proposed board-certification model as a direct result of input from the members,” Dr. Kehoe wrote.

“I know many of you are holding meetings in the next few weeks, and I am asking you to hold off making any final decision on a state position or on instructing your delegates to vote a particular way. What your members would be voting on today may well be different by the time this motion goes to the House,” he noted.

“Please keep your options open so that your delegates can benefit from the additional information and discussions at Optometry’s Meeting. We will continue to send you and your members material relative to this issue on a regular basis to aid in your discussions,” he said.

Dr. Kehoe noted that project team members are continually learning of examples where decision-makers are considering health reform initiatives and terms like “value” and “board certified” are coming to the forefront.

AOA members are encouraged to make constructive comments on the model, and to continue to monitor the AOA News and Web site for updates.
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If legislation passes in a state that forces the issue
(such as appears might be the case in ours)
I would rather have a process our doctors can use rather than be forced to do something developed by our department of health.

Organizations ‘daft’ model
Editor: I am compelled to respond, again, to the misguided notion of “board certification.” I write in regards to the article in the January 2009 issue of AOA News. In this article several members of the project team weakly defend the rationale for imposing a new boarding system upon our profession.

For example, the article is redundant with phrases such as “lack of board certification MAY hinder optometrists, movements on many fronts that would SEEM TO SUGGEST some type of board certification, PQRI and P4P students and new practitioners want a process that facilitates their ambitions of lifelong learning. Lucky for them that they chose a profession that already does that.

I attribute the student misunderstanding of our current process on lack of experience with long existing state, regional and national opportunities to do just that through journals, continuing education requirements for relicensing and professional organizations. Not to mention that anyone who seeks lifelong learning will easily find it without these artificial external constraints.

Is it possible that this is a reflection of poor motivation or poor mentoring of these young doctors?

Then there are the self-serving motivations of those invested in currently existing optometric boarding organizations expounding, “We cannot demonstrate continued competence (beyond entry level) in the same manner as the other health care professions without a board certification process.”

This is an example of putting the fox in charge of protecting the henhouse. It is like asking Ted Kennedy to eliminate the death tax. First, we DO currently have a board certification process. Second, we each are required to obtain continuing education to retain our license. These are very fine and effective programs. Third, it is reminiscent of many formal articles that end with “more research needs to be done to further our understanding…” which should go on to say “because I still need a job and research is how I pay my bills.”

The one nugget of truth their boarding process and maintain their board certification is optimum.

If you have a patient requiring an obscure diagnosis, an ABO-certified ophthalmologist will do. But when your mom needs cataract surgery, you best investigate further.

The answer? Acknowledge and proclaim the virtues of our current education and training programs. We ARE board certified. If you must, create a board RE-certification program. But if you do so, make it clinically relevant, not an academic exercise. Make it inexpensive so as not to line the pockets of the testers. Make it so that after I complete the process I will count the time spent worthy and it will help me take care of my patients. Anything less is window dressing and unworthy of our profession.

Howell M. Findley, O.D. Lexington, KY.

Larger picture
Editor: I am writing to ask for a more honest and factual discussion of the board certification issue in optometry. The time has come for a more balanced dialogue on this pivotal topic. There has been much said regarding the concept of providing our profession with a verifiable mechanism to demonstrate continued competence.

It seems to me that many are too caught up in the lesser important details and are indeed missing the larger picture.

I fear that some of our colleagues truly believe that defeating this measure at the AOA Congress in June will make this issue go away. This issue is not going away, we cannot simply ignore it.

The facts are that optometry is the ONLY independently licensed prescribing doctor level health care profession with no mechanism for proof of continued competence. Much has been said about the mechanisms in place for other professions to demonstrate continued competence, and third-party carriers, state and local governments, and consumer groups have made the assumption, right or wrong, that those mechanisms help ensure a higher level of quality in health care. These assumptions may or may not be valid, but the fact remains that optometry has no such mechanism and cannot compete now with those professions that do.

We need to enact a system of accountability for the public, for our patients, for third-party payers, and for the governmental agencies who are demanding a demonstration of continued competence. Most of us work in a third-party payer system. Accountability measures for quality of care are becoming more commonplace. We have no idea as to what health care reform will bring. While many have stated their feeling that it is inconceivable today that any carrier would deny a physician privileges for lack of a system proving continued competence, it is happening right now in some of the Medicare Medical Home projects.

As the health care delivery system evolves, it certainly could be a more widespread reality in the future. A system such as this is going to take time to develop, time to verify, time to legitimize, and time for doctors to attain. National standards need to be developed. A common language needs to be used in dealing with this evolving system. This is the very thing that

See Letters, page 16
Healthy sight key message at Transitions Championship

With an unprecedented level of attention focused on the importance of good vision, the Transitions Championship for Healthy Sight debuted as an important stop on the Professional Golfers’ Association (PGA) schedule last month.

With the first two rounds televised on the Golf Channel and the final two rounds aired live on NBC, Transitions was able to promote the importance of good vision in sports on many occasions. The proximity to Transitions’ headquarters in Pinellas Park, Fla., allowed the company to reach out to the community with events highlighting healthy sight and vision care.

Copperhead Course at Innisbrook Resort in Palm Harbor is about 20 minutes away from Transitions’ office. A key part of the action at the tournament was the Healthy Sight pavilion, where AOA’s Sports Vision Section hosted hands-on tests of hand-eye coordination, laser-sighted putting and depth perception. On one day, nearly 1,000 schoolchildren came through the exhibit, with local ODs, including AOA President Peter Kehoe, O.D.; Clinical Care Group Director Jeff Weaver, O.D., and Sports Vision Section Chair Graham Erickson, O.D.

Throughout the tournament, volunteers at the AOA exhibit showed how vision can impact their golf game. Other exhibitors included Vision Service Plan, Optos, and Oakley.

Harry Wayne of Wayne Engineering donated the Wayne Saccadic Fixator, a big hit with schoolchildren. Transitions, along with the AOA and VSP, also hosted a Healthy Vision Roundtable for the media. Dr. Kehoe used the opportunity to describe the AOA’s emphasis on children’s vision and prevention of eye disease. Dr. Weaver noted that the eye care community is just beginning to inform patients of the risks not only from ultraviolet but from solar radiation.

Michael Duenas, O.D., AOA associate director of Health Sciences and Policy, added that more than 50 conditions of the eye are related to sun damage and urged the eye care community to spread the news of the importance of prevention.

Among the field of 144 pro golfers at the Transitions Championship were FedExCup leaders Nick Watney, Zach Johnson and 17-year-old Japanese phenom Ryo Ishikawa, making his first PGA cut and finishing 9 over par. The winner, at 8 under par, was Retief Goosen.

Pamela Helbling, O.D., watches a golfer try her skills on the Wayne Saccadic Fixator.

Ryo Ishikawa works the ball out of a bunker in the second day of competition.

AOA President Pete Kehoe, O.D., discusses children’s vision at the Healthy Sight Roundtable.

AOA President Pete Kehoe, O.D., explains the role of eye-hand coordination in sports to a local youngster. More than 800 schoolchildren visited the Healthy Sight Pavilion at the Transitions Championship.

Transitions Optical, Inc., VSP Vision Care and the American Optometric Association sponsored a roundtable event -- Perspectives in Healthy Sight -- during the Transitions Championship at the Innisbrook Resort and Golf Club in Palm Harbor, Fla. Pictured left to right: Sharon Ottey, M.D.; Michael Duenas, O.D.; Smitesh Patel, O.D.; Peter Kehoe, O.D.; Lawrence Lampert, O.D.; Jeffrey Weaver, O.D.; Susan Taylor, M.D.; and Douglas Stewart, Ph.D.
Letters, from page 14

Control our destiny?

Editor: The issue of voluntary continuing competency for the profession of optometry as proposed by the coalition of professional organizations of whom are board certified) to either be board certified in a specialty area or the state department of health would be given the responsibility of coming up with an equivalent competency assurance program. The

In Illinois we have mandatory and tested CE requirements which keep us current in the profession, thank you. Would certification make us practice differently? I think not.

In my home state of Washington our state association’s insurance liaison tells us that private carriers in our state are stepping up quality assurance measuring and one of the items they are increasingly interested in is assurance coordinated through the efforts of the AOA is shaping up to be one of those that could be a potential watershed moment for our profession. Why is that?

In my view it is due to a confluence of events that are shaping up to create a potential storm for our profession. We have a new president who has a friendly legislature to back him…and a mandate partly brought on by the banking crisis and associated recession that have resulted in the unprecedented nationalization of that industry as well as many others.

Health care is clearly in the sights of the new administration and the legislature. The funds released by the passage of the “stimulus” package have given financial impetus to making change with the health care industry. The high unemployment rate is leaving a lot of persons uninsured…which increases motivation to study some form of national health insurance.

Congress appears more ready than ever to spend money on such an enterprise. If they do, they will want a lot of oversight and quality assurance to prove they have been good stewards of our country’s financial resources.

There were changes going on before this…such things as PQRI heralded a “weather change” that has ushered in increased scrutiny of the quality of health care provider services at a national level.

In my home state of Washington our state association’s insurance liaison tells us that private carriers in our state are stepping up quality assurance measuring and one of the items they are increasingly interested in is assurance legislation was tabled in favor of a governor’s study group that has been moving slowly but eventually is expected to give recommendations for legislation that could very well include optometry, dentistry, nurse practitioners, and medicine.

Another item that becomes increasingly important is that of “medical home.” The government has funded several pilot projects in various states involving medical home.

The original concept of medical home in a nutshell was that it was supposed to be a concept whereby a practitioner was selected by a patient to be the primary repository of information about their care and to serve as facilitator of the care involving other providers. It seems to have morphed, particularly in our state, to a gatekeeper system.

The so-called pilot projects do nothing more than reinforce that system rather than study better ways to make medical homes do as they were intended. What does this have to do with continuing competency?

Medical reform being proposed currently has such provisions as decreased reimbursement for providers who do not participate in PQRI and other quality assurance measures…and one such measure, as proposed by Sen. Baucus, related to the CMS Medical Home Model will not allow doctors to participate who

What do we do about this? Wrang our hands and get caught up in a great debate about semantics…or take an active part in determining our own future. No doubt there are those who look at the proposals that have been developed by the coalition of ARBO, COPE, ACOPE, AAO, and others that will find fault and talk about what it won’t do for the profession. I would rather look at what it CAN do…it can enable us to control our own destiny. It is voluntary so those who choose can do it and those who prefer not need not. If legislation passes in a state that forces the issue (such as appears might be the case in ours) I would rather have a process our doctors can use rather than be forced to do something developed by our department of health.

If the perfect storm occurs and medical reform comes about that incorporates the concept of medical home that not only has a gatekeeper system but requires all providers involved to prove continuing competency/board certification, then I would rather we had a program up and running vs. being locked out until something was developed that would be acceptable to the “powers that be” at that time.

In short, I prefer we take an active hand in controlling our own destiny.

Richard Ryan, O.D.
Spokane, Wash.

Phony thing

Editors: The board certification railroad is running again. It is ridiculous to think general practice optometrists should be “board certified.” In Illinois we have mandatory and tested CE requirements which keep us current in the profession, thank you.

Would certification make us practice differently? I think not. The only people who would benefit are special interest groups.

If you want to pass a real certification for specialists who complete residencies, fine. But please not this phony thing which will be voted on in June.

2009 Physician Quality Reporting Initiative

by Rebecca H. Wartman, O.D.

For 2009, the Physician Quality Reporting Initiative (PQRI) has added new eye care measures for reporting. All of the eye care measures used in 2008 have been retained with very little change.

Three new PQRI eye care measures have been added.

Other non-eye care specific PQRI measures that optometrists may choose to use have been altered for 2009.

This article will review the 2009 PQRI measure details. Please refer to the AOA Web site for any updates that might occur and all the tools you may need for the 2009 PQRI reporting period.

The PQRI tools on the AOA Web site include a recorded webinar presentation with PowerPoint on the specifics of the 2009 PQRI measures, a summary sheet for use in the exam room, and other background resources that optometrists will find useful.

The 2009 PQRI guidelines were published in the final form on Dec. 15, 2008. All of the information presented in this article was taken from the final guideline publication.

Background

The PQRI was created as a part of the Tax Relief and Healthcare Act of 2006 that provides the statutory authority for PQRI. The Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) continued the authorization for PQRI in 2008-2009. And finally, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) expanded the bonus payments for 2009-2010.

PQRI reporting is designed to bring attention to the quality of care. The PQRI measures are designed to bring provider attention to evidence-based gaps in care. The measures are developed by professional groups and are endorsed by national consensus groups such as the National Quality Forum (NQF).

When the approved quality measurements are reported frequently enough, the Medicare provider will be rewarded financially. The hope is that PQRI will result in improved patient care.

Eventually, the Centers for Medicare & Medicaid Services (CMS) may move to true “pay for performance.”

PQRI reporting results 2007, 2008 and 2009

For 2007, the overall failure rate was approximately 50 percent and included the following errors in reporting:

1. National Provider Identification (NPI) numbers missing or stripped (12.15 percent)
2. Incorrect diagnosis points for Quality Data Codes (QDC) (13.93 percent)
3. Failure to adhere to measure specifications (18.89 percent) like diagnosis codes, age, sex
4. Split billing - submitting QDC alone (4.97 percent) by provider, clearinghouse, or carrier.

The Eye Care Measures 12-17 were among the highest reported measures with 75 to 80 percent being successfully reported. Measures 18-19 for Diabetic Retinopathy were much less reported with 43 to 55 percent being successfully reported.

The reports of the 2008 PQRI results and bonus payments will be available in the middle of 2009.

The CMS hopes to publish an interim report early in 2009.

The problems that occurred for the 2007 reporting period have been reviewed. The CMS is in the process of reconsidering some of the bonus denial that occurred due to technical issues such as the stripping of NPI numbers from claims, not recognizing all diagnosis codes listed on the claims, and the splitting of claims by clearinghouses or carriers. Providers who were denied bonus payments in 2007 due to the reasons just discussed may receive that bonus sometime in late 2009.

The reports of the 2008 and 2009 PQRI results will, again, be sent to the holder of the Tax Identification Number (TIN) but broken down by National Provider Identification (NPI) number.

The CMS is reviewing options for viewing the PQRI reports because many providers found the secure Internet IACS system burdensome to use.

The 2007 PQRI reporting results were not supposed to be made public; however, the CMS decided to publish the list of providers who attempted to report PQRI measures in 2007. The statement made to Medicare recipients is as follows:

“This initiative will help your doctor and Medicare provide the highest level of quality of care for people like you, who have Medicare. Medicare greatly appreciates that your doctor has chosen to join this important initiative.”

Reporting in 2009

For 2009, most providers may report in one of three ways: by claim-based reporting, by registry, or by measure groups reporting.

However, optometrists can only report by the claim-based method at this time.

To report, a provider must code a patient visit as he or she normally would and then add the applicable QDC codes to the same claim form. As well, the QDC should be linked to the proper diagnosis codes when applicable for the specific measure.

The exact order of the code listed on a claim form does not matter. However, the QDC has to be on the same claim form as the patient encounters. You cannot file or re-file a claim ONLY to add the QDC code. A patient encounter may require more than one QDC to meet the measure requirements. More than one measure may be reported on any given patient encounter when the requirements are met. (See the CMS1500 sample forms on the sidebar or the AOA Web site.)

See PQRI, page 18

2009 Eye Care Measures

Eye care-specific measures (Not changed from 2008)

Measure #12: 2027F Primary Open-Angle Glaucoma - Optic Nerve Evaluation
Measure #14: 2010F ARMD - Dilated Macular Examination
Measure #18: 2021F Diabetic Retinopathy Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy
Measure #19: 5010F Diabetic Retinopathy Communication with Physician Managing Ongoing Diabetes Care
Measure #17: 2022F, 2023F, 2026F, 3072F Dilated Eye Exam in Diabetic Patient

Eye care-specific measures new for 2009

Measure #140: 4177F AMD: Counseling on Antioxidant Supplements
Measure #141: 3284F, 0517F, 3285F POAG: Reduction of Intraocular Pressure (IOP) by 15 percent OR Documentation of a Plan of Care

2009 eye care measures - surgeons only

Measure #139: #139: 0014F Cataracts: Comprehensive Preoperative Assessment for Cataract Surgery with Intraocular Lens (IOL) Placement
Optometry does not report this measure.

2009 additional measures

These measures may be used by eye care professionals (and other providers):

Measure #114: Inquiry Regarding Tobacco Use
Measure #115: Advising Smokers to Quit
*Measure #124: HT: Adoption/Use of Health Information Technology (Electronic Health Records)
Measure #128: Universal Weight Screening and Follow-Up
*Measure #130: Documentation/Verification of Current Medications in the Medical Record

*These measures include 92 codes series

Thus, 12 measures are potentially available for use by eye care professionals. The guidelines still state you must report at least three measures, 80 percent of the time to be eligible for the bonus payment of 2.0 percent.

A provider does not have to attempt to file all 12 measures. To avoid confusion or feeling overwhelmed, a provider new to PQRI reporting might choose four to six of the measures to report for 2009.
2009 measure details

There are 153 measures listed for 2009. Participation is voluntary, and a provider does not have to register to participate.

The bonus amount for 2009 is 2.0 percent of all allowable Medicare charges, including the --TC components of procedures.

There are a total of eight eye care-specific measures listed for 2009; however, one of these measures is designated for surgeons only and will not be reported by optometrists. The 2008 eye care-specific measures that are included for 2009 have had very few edits. Three new measures for eye care have been added.

Please see the details of the measures later in this article for details.

The AOA Third Party Center recommends that providers do report at every opportunity for the measures they choose to report in order to achieve the "three measures, 80 percent of the time" threshold.

Bonus payments will be made in a one-time lump sum payment to the holder of the TIN sometime in 2010. The bonus payment made to the holder of the TIN will be broken down by NPI number.

The maximum bonus will be 2.0 percent of ALL Medicare allowable charges filed during the reporting period, including the --TC component of any diagnostic services.

In some instances, a cap may be applied to the bonus. This cap would be applied when an individual provider only has a small number of claims in which measures could apply compared to the total number of claims that provider actually filed.

Because there are seven eye care specific measures and five additional measures available for reporting, most optometrists will not be impacted by the bonus payment cap.

AOA resources can help navigate PQRI

The AOA offers a range of resources to assist member optometrists in providing the services encouraged under the PQRI. The AOA Communications and Membership Group’s AOA Eye Disease Management Program offers the AOA Eye Disease Management Kit, with a Recommended Nutrients for Healthy Eyes leaflet, to assist in antioxidant counseling for patients with age-related macular degeneration (AMD) and as well as other chronic eye conditions such as diabetic retinopathy.

The Practice Strategies section in the December edition of Optometry Journal of the American Optometric Association offers advice on the kit’s use. Additional information on antioxidant counseling for AMD patients appeared in the February edition of Optometry Journal. The AOA Clinical Care Group offers AOA Optometric Clinical Practice Guidelines on glaucoma, cataract, diabetic retinopathy, and AMD.

A revised edition of the AMD guideline with new guidelines on antioxidant counseling is scheduled for release next spring. Information on all of the AOA’s member resources can be accessed on the Doctors’ Page of the AOA Web site (www.aoa.org).

Details of how this cap is calculated can be found at www.cms.hhs.gov/PQRI or www.aoa.org/PQRI.xml.

Reporting quality measures – filing specifics

All the applicable measures will be detailed below.


Please note that you may be required to report many measures more than once within the reporting period because the reporting period covers an entire 12 months.

Again, as in previous years, the AOA recommend that is the measures be reported for every instance to ensure that an optometrist meets all the minimum coding guidelines to earn the bonus payments.

There is no penalty for reporting a measure more than once within the period defined by the measure guidelines. In fact, the guidelines typically state “at least once within the reporting period” for those measures with a defined range of time. Note that several of these measures are using HCPCS G codes for the reporting in addition to the more familiar CPTII codes.

HCPCS G codes are used when there is not a CPT II code to adequately describe the measure. When a G code is used, the modifiers 1P, 2P, 3P and 8P are not used.

Instead, a different G code is used to describe each coding situation. Together the CPT II codes and the HCPCS G codes are referred to as Quality Data Codes (QDC).

Again, the AOA Web site will have all the tools and background reference materials needed to properly utilize all the 2009 PQRI measures. Please visit this site frequently. Updates will be posted as they become available.

Measure #12: 2027F

Primary Open-Angle Glaucoma - Optic Nerve Evaluation

This measure applies to patients 18 years old and older diagnosed with primary open-angle glaucoma who have had an optic nerve evaluation at least once within the past 12 months.

Numerator: 2027F

Denominator: 18 years or older

365.01, 365.10, 365.11, 365.12, 365.15
99201 – 99205, 99212 – 99215, 99219 – 99224, 92002 – 92014, 99307-99310, 99324-99337

Modifiers:
1P: Optic nerve head evaluation not performed for documented medical reasons
3P: Optic nerve head evaluation not performed for system reason (provider is not primarily responsible for glaucoma management)
8P: Optic nerve head evaluation not performed, reason not otherwise specified

If a patient was seen prior to the reporting period for an optic nerve evaluation and returns for an IOP check during the reporting period but an optic nerve evaluation is not performed at that visit, the measure is still reported because the guidelines state “optic nerve evaluation at least once within 12 months.”

Thus, the measure should be reported or the encounter will count against your reporting totals as a missed reporting opportunity. Please note that you may be required to report this measure more than once within the reporting period because the reporting period covers an entire 12 months.

Measure #14: 2019F

ARMD - Dilated Macular Examination

This measure applies to patients 50 years old and older diagnosed with age-related macular degeneration (AMD) who have had a dilated macular examination performed at least once within the past 12 months. Documentation must include the presence or absence of macular thickening or hemorrhage AND the level of severity of the ARMD.

Numerator: 2019F

Denominator: 50 years or older

362.50, 362.51, 362.52
99201 – 99215, 99241 – 99245, 92002 – 92014, 99307-99310, 99324-99337

Modifiers:
1P: Documentation of medical reason dilated macular/fundus exam not performed
2P: Documentation of patient reasons dilated macular/fundus exam not performed
3P: Documentation of system reason for exclusion when the provider is not primarily responsible for the management of the retinopathy
8P: Documentation of other reasons dilated macular/fundus exam not performed

See PQRI, page 19

3P: Optic nerve head evaluation not performed for system reason (provider is not primarily responsible for ARM management)
8P: Other reasons for not performing a dilated macular examination

Measure #18: 2021F

Diabetic Retinopathy Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy

This measure applies to patients 18 years or older who have the diagnosis of diabetic retinopathy who have had a dilated macular or fundus examination at least once within the last 12 months.

The documentation must indicate the presence or absence of macular edema AND the level of severity of the diabetic retinopathy.

The classification guidelines for the levels of diabetic retinopathy are well documented. The summary of this classification is posted at www.aoa.org/7692.xml.

Please note that the correct use for the diabetic ICD-9 codes require that diabetic retinopathy (362.01 – 362.06) must be coded if you are going to code 362.07 for macular edema. Also note this measure is not used for diabetes without retinopathy.

Numerator: 2021F

Denominator: 18 years or older

362.01, 362.02, 362.03, 362.04, 362.05, 362.06
99201 – 99215, 99241 – 99245, 92002 – 92014, 99307-99310, 99324-99337

Modifiers:
1P: Documentation of medical reason diabetic dilated macular/fundus examination not performed
2P: Documentation of patient reasons dilated macular/fundus exam not performed
3P: Documentation of system reason for exclusion when the provider is not primarily responsible for the management of the retinopathy
8P: Documentation of other reasons dilated macular/fundus exam not performed

See PQRI, page 19
The AOA Third Party Center recommends that providers do report at every opportunity for the measures they choose to report in order to achieve the “three measures, 80 percent if the time” threshold.
Intraocular Lens (IOL) Placement

This measure was designed to only be used by the surgeon performing the cataract surgery. There is no mechanism for optometrists to report this measure even with a modifier.

Therefore:

OPTOMETRISTS DO NOT REPORT MEASURE #139.

Other measures potentially available for use by optometrists

Please note that the measures 114, 115, and 128 do not list the 92002 – 92014 series of codes as denominators for 2009.

The measures included here do list the 99201 - 99215 series of evaluation and management codes and are available for those optometrists who can and do utilize the 99 codes series for some of their patient encounters. Measures 124 and 130 do specifically list the 92 code series for 2009. These two measures will be detailed before measures 114, 115, and 128.

Measure #124: G8447 or G8448
HIT - Adoption/Use of Health Information Technology (Electronic Health Records)

This measure is to be reported at each visit occurring during the reporting period for patients 18 years and older seen during the reporting period. There is no diagnosis associated with this measure. This measure may be reported by clinicians who have adopted and are using health information technology.

Patient encounter documentation substantiates use of certified/qualified EMR (CCHIT) or the EMR is non-certified but is capable of:
1. Generating a medication list
2. Generating a problem list
3. Ability to manually enter or electronically receive, store, display laboratory tests as discrete searchable data elements.
4. Ability to meet basic privacy and security elements

To date, there are no commercially available, optometry-specific EMRs that have obtained certification.

Also note that this measure cannot be used if you do not have an EMR that meets the qualifications listed above.

Numerator: G8447
G8448
Denominator: 18 years or older

All patient encounters 90001-90009, 92002-92014, 92541-92544, 92548, 92552, 92553, 92555, 92557, 92561-92565, 92567, 92568, 92569, 92571, 92572, 92575-92577, 92579, 92582, 92584-92588, 92601-92604, 92620, 92621, 92625-92627, 92640, 90520, 96150-96152, 97001-97004, 97750, 97802-97804, 98940-98942, 9201-92025, 92921-929245, G71410, G72110, G10101, G10108, G10109, G0270, G0271

Modifiers:
None listed

*Note G8449 was deleted for 2009

G8447: Patient encounter documented using CCHIT Certified or Qualified EMR
G8448: Patient encounter documented using non-CCHIT certified EMR but the system was qualified (see above)

Measure #130: G8427, G8428, G8429, G8430, G8507
Documentation/Verification of Current Medications in the Medical Record

This measure is designed to encourage providers to gather all the details of a patient’s current medications, including dosages for all prescription, over-the-counter, herbal, vitamin/mineral/dietary supplements taken. As well these listings must be verified by the patient or caretaker, when applicable. When no documentation and/or verification is possible, then an alternative QDC is used.

Numerator: G8427 or G8438 or G8429 or G8430 or G8507
Denominator: 18 years and older

90001, 90002, 90004-90015, 90845, 90852, 96150, 96152, 97002-97004, 92920-92925, 92912-92915

Not associated with any specific ICD-9 diagnosis code

Modifiers:
8P: Tobacco used not assessed, reason not specified

1034F or 1035F: Current tobacco smoker

1035F: Current smokeless tobacco user

Other measures potentially available for use by optometrists

Free nutrition, eye health kit offer

The AOA, working in partnership with Kemin and DSM Nutritional Products, will be promoting the importance of caring for the eyes through proper nutrition. To help educate patients on the relationship between diet and eye health, a new member kit is available for display in office. This free member kit includes:

> Clear acrylic counter card with brochure pocket
> Two counter card inserts
> Two pads of the “Recommended Nutrients for Healthy Eyes” brochure
> Template news release

To order a kit, visit www.aoa.org/syvnmkits.xml and complete the requested information. Simply click submit, and your order will then be shipped to your office. Please allow five to seven business days for delivery.

not eligible if one or more of the following exist:

a. Patient refuses to participate.
b. Patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient’s health status
c. Patient cognitively impaired and no authorized representative available

Measure #114: 1000F and 1034F or 1035F Inquiry Regarding Tobacco Use

This measure applied to patients 18 years or older who are queried about their tobacco use at least once within the past 24 months. This measure requires two CPT II codes per submission.

Numerator: 1000F: Tobacco use assessed AND one of the following: 1034F: Current tobacco smoker
1035F: Current smokeless tobacco user
1036F: Current tobacco non-user

Denominator: 18 years or older

90001, 90002, 90004-90015, 90845, 90852, 96150, 96152, 97002-97004, 92920-92925, 92912-92915

Not associated with any specific ICD-9 diagnosis code

Modifiers:
8P: Tobacco used not assessed, reason not specified

1034F or 1035F: Current tobacco smoker

1035F: Current smokeless tobacco user

1036F: Current tobacco non-user

Definitions are as follows for Measure #130

1. Authorized Representative – A person who is acting on the patient’s behalf and who does not have a conflict of interest with the patient, when the patient is temporarily or permanently unable to act for him or herself. This person should have the patient’s best interests at heart and should be reasonably expected to act in a manner that is protective of the patient and the rights of the patient. Preferably, the patient appoints this individual.

2. Current Medications – All medications (includes prescription, over-the-counter, herbal, vitamin/mineral/dietary supplements) a patient may be taking routinely and/or on a PRN basis

3. Verification – Documentation of acknowledgment by the patient and/or authorized representative or provider that signifies discussion, assessment, or review to confirm accuracy of information.

4. Not Eligible – A patient is
4. **1000F 8P**: Tobacco use not assessed; reason not specified

**Measure #115**: 4000F, 4001F, G8455, G8456, G8457

**Advising Smokers to Quit**

This measure applies to patients age 18 years and older who are smokers and who received advice to quit smoking.

This measure is reported for all patients at least once per patient per reporting period.

All patients identified as tobacco smokers at any time during the reporting period should be advised to quit. If a smoker, must file with two appropriate QDCs. If not a current smoker, this measure should be reported with the appropriate G code designated below.

**Numerator**: G8455 and 4000F or 4001F OR G8456 OR G8457

**Denominator**: 18 years or older

99201-99205, 99212-99215, 99217-99220, 99241-99245

The combination of QDCs are as follows:
1. G8455: Current tobacco smoker & 4000F: Tobacco use cessation intervention, counseling OR
2. G8455: Current tobacco smoker & 4001F: Tobacco use cessation intervention, pharmacologic therapy OR
3. G8456: Current smokeless tobacco user OR
4. G8457: Current tobacco non-user

**Measure #120**: G8417, G8418, G8419, G8420, G8421, G8422

**Universal Weight Screening and Follow-up**

This measure is used to report patients who have a calculated Body Mass Index (BMI) within the past six months or current visit that is documented in record.

The provider must measure actual weight and height and calculate BMI or use a table or obtain it from another provider’s medical records. As well there must be documentation of a follow-up plan. The measurement application varies with age and BMI.

1. Age 65 and older BMI >30 or <22
2. Age 18 – 64 BMI >25 or <18.5

BMI is a number calculated from a person’s weight and height. BMI can be calculated using a chart or formula; however, the patient’s actual weight and height must be measured and cannot be merely reported by the patient.

Follow up can include documentation of a future appointment, education, referral, prescription/administration of medication/diet supplements and the like.

**Numerator**: G8417: Calculated BMI above upper parameter with documented follow-up plan
G8418: Calculated BMI below lower parameter with documented follow-up plan
G8419: Calculated BMI outside normal parameters but no documented follow-up plan
G8420: Calculated BMI with in normal limits documented
G8421: BMI not calculated
G8422: Patient not eligible for BMI calculation

**Denominator**: 18 years and up (application varies with calculated BMI)

90801-90890, 97001, 97003, 97802, 97803, 98960, 99201-99215, 99241-99245, 99324-99328, 99334-99337, 99341-99345, 99347-99350, D7140, D7210, G0101, G0108, G0270

**Modifiers**: None listed

*Note that 92 code series not listed*

Follow-up plan documentation could include the proposed outline of treatment to be conducted as a result of abnormal BMI measurement.

This plan could include:

a. Documentation of a future appointment
b. Education
c. Referral
d. Prescription/administration of medications/dietary supplements, etc.

Patients can be considered not eligible in the following situations:

1. Patient already documented as over or under weight
2. Record that weight problem managed by another provider
3. Patient has a terminal illness (within six months’ life expectancy)
4. Patient refuses BMI measurement
5. Any other reason documented by the provider explaining why BMI measurement was not appropriate
6. Urgent or emergent medical situation where delaying treatment would jeopardize the patient’s health status

**E-prescribing: A stand-alone bonus program**

E-prescribing is no longer a PQRI measure. The CMS opted to pull this measure out as a stand-alone bonus program. The bonus structure is laid out for 2009 – 2014 and beyond. This initiative marks the first time that the CMS will eventually involve penalties for NOT participating. The schedule is as follows:

- Separate bonus payments for using E-Rx:
  a. 2009 - 2010 is 2 percent
  b. 2011 - 2012 is 1 percent
  c. 2013 is 0.5 percent
- Reduction in payment for not using E-Rx:
  a. 1 percent for 2012
  b. 1.5 percent for 2013
  c. 2 percent for 2014 and each subsequent year

This measure is to be reported at each visit occurring during the reporting period for patients 18 years and older seen during the reporting period that is the same reporting period as the 2009 PQRI (Jan. 1, 2009, to Dec. 31, 2009).

There is no diagnosis associated with this measure. This measure may be reported by clinicians who have adopted a qualified e-prescribing system. Please note that this measure cannot be used if you do not have access to a qualified e-prescribing system.

Details of this program can be found at: [www.soa.org/HIT/HC]

A qualified e-Rx system must do all of the following:

1. Generate complete active medication list incorporating electronic data received from applicable pharmacies and benefit managers (PBMs) if available
2. Select medications, print prescriptions, electronically transmit prescriptions, and conduct all alerts (defined below)
3. Provide information related to lower cost, therapeutically appropriate alternatives (if any). (Tiered formulary information, if available, would meet this requirement)
4. Provide information on formulary or tiered formulary medications, patient eligibility, and authorization requirements received electronically from the patient’s drug plan (if available)

**Numerator**: G8443.

All prescriptions created during the encounter were generated using a qualified e-Prescribing system

**Denominator**: G8445: No prescriptions were generated during the encounter. Provider does have access to a qualified e-prescribing system

**G8446**: Some or all prescriptions generated during encounter were handwritten or phone-in due to a state law requirement, patient request, or qualified e-prescribing system was temporarily inoperable.

**Denominator**: 18 years or older

Reported on EVERY encounter

90801, 90802, 90804-90809, 90922-90929, 96150-96152, 99201-99215, 99241-99245, G0101, G0108, G0109

**Modifiers**: None listed

**Summary**

2. There are 12 measures available for use by optometrists for this reporting period
3. There are seven new measures available for use by optometrists
4. Some of the measures have minor modifications so review all measures carefully
5. Successful reporting requires reporting at least three measures, 80 percent of the time
6. Measures use Quality Data Codes (QDC) for reporting:
   a. G codes

See PQRI, page 22
AOA announces business card program for students, grads

The cards are essential tools for networking and generating referrals whether students are searching for their first practice opportunity or marketing themselves to the communities in which they will practice.

Incoming fourth-year students in the class of 2010 and soon-to-be-graduates in the class of 2009 who are enrolled in an accredited school or college of optometry in the United States, Puerto Rico or Canada are eligible for this program. Active AOA/AOSA membership is also required.

To request the business cards, visit www.aoa.org/cards.xml. The cards will be shipped within four to six weeks at no cost.

For more information, contact Denise Kincaid at dbkincaid@aoa.org or call 800-365-2219, ext. 4107.

The AOA thanks Alcon for its unrestricted grant in support of student and new graduate education.

LVU announces golf tour

Kemin Health is sponsoring a free three-hour, COPE-approved Low Vision University® (LVU) educational program at the Principal Charity Classic Champions Tour in May.

The program will be held at the Glen Oaks Country Club, West Des Moines, Iowa, which hosts the golf tour, on Saturday, May 30, 2009, from 8 a.m. to 11 a.m.

LVU is an educational program developed by the AOA Low Vision Rehabilitation Section (LRS) to provide primary care optometrists with the information needed to begin providing low vision rehabilitation in their practices to individuals with age-related vision loss.

Low vision rehabilitation is an important component in the continuum of care for individuals with vision loss. Low vision rehabilitation and nutritional supplements are the only nonsurgical treatments currently available for the majority of people with age-related vision loss.

LVU participants will receive a complimentary ticket to attend the golf event on Saturday and a free VIP parking pass. Register online for the Low Vision University® by visiting the AOA LVU registration Web page at www.aoa.org/s11832.xml.

For more information, contact Sections Coordinator Alisa Krewet at 800-365-2219, ext. 4137 or email AGKrewet@aoa.org. Early registration is recommended because space is limited.
Laser burn in one eye can disrupt immune privilege in both

Scientists at Schepens Eye Research Institute have shown for the first time that a laser burn to one retina can cause both eyes to lose a special protective ability known as immune privilege.

Immune privilege protects the eye without the inflammation of the body's normal immune response, which can further damage delicate eye tissue. This finding, published in the February 2009 American Journal of Pathology, has implications for treating patients with laser burns sustained on the battlefield and in other modern settings.

The discovery is also significant because it suggests a previously unknown communication between the two eyes.

"This deepens our understanding of the way immune privilege works," says Joan Stein-Streilein, M.D., principal investigator of the study and senior scientist at Schepens Eye Research Institute.

Immune privilege is a modification of the body's normal immune response. It protects the eye, the brain and the reproductive system without the full-blown immune response that uses inflammation to violently reject foreign tissue or invaders.

While inflammation in other parts of the body is a useful battle between immune and foreign cells, it is too aggressive for fragile eye tissues, brain and reproductive tissues, and, in the case of the eye, can even lead to blindness. Immune privilege, which intervenes in the battle, is also what prevents the eye from rejecting corneal transplants, making them the most common and successful of transplanted tissues.

In her laboratory, Stein-Streilein and her team made tiny laser burns in one of the retinas of 15 mice. They then injected either the burned or the unburned eyes of each mouse with the antigen ovalbumin. Antigens are substances that the body perceives as foreign and against which it mounts a defense.

They found that immune privilege was disrupted in both eyes after six hours and continued to be disrupted even after 56 days. When they injected the same antigen into the eyes of a group of control mice without burns, they observed no inflammation.

Since created in the 1960s, lasers have found their way onto the battlefield, into the operating rooms and into modern research laboratories. While ophthalmologists have been aware of the local damage done by laser burns to retinas, they have not been tuned into the possibility of long-term loss of immune privilege in one or both eyes.

Understanding mechanisms that destroy or disrupt immune privilege will ultimately lead to novel therapies to restore that special privilege not only in the eye but in the brain and the reproductive system as well, she adds.

The next steps for the team will be to study the novel mechanisms that allow for communication between the injured and non-injured eye.

Center
from page 9
vision care.

At the hearing, the Subcommittee assessed the efforts of the agencies as they work to ensure a seamless continuum of care for service members and veterans who have suffered eye injuries.

On the whole, the subcommittee determined that the sense of urgency now being felt by veterans is clear and that it is unacceptable that vets with eye injuries have to wait for this plan to be put into action.

The injuries of Operations Enduring Freedom and Iraqi Freedom are shaped by the widespread use of improvised explosive devices (IED).

IEDs increase the likelihood that combat troops will be exposed to incidents such as blasts that can cause TBI and other debilitating injuries.

Visual problems from TBI are often overlooked during initial treatment of injury. Frequently these problems are hidden or neglected, lengthening and impairing rehabilitation.

Because there is a close relationship between vision and the brain, TBI can disrupt the visual process, interfering with the flow and processing of information.

The result can be a TBI-related vision problem.

New in Practice?
Looking to Change Your Practice Setting?

Build your basic knowledge base or bolster your practice management savvy. The New in Practice Series was designed especially for you! An ever-popular feature at Optometry’s Meeting®, three New in Practice sessions will be offered June 25-26, 2009, in Washington, D.C.

Register for one or more of the following sessions taught by expert practitioners and world-class lecturers.

Staff Management and Training
Thursday, June 25, Noon – 2 p.m.
Function #0150 (Fee $15, includes boxed lunch)

Financial Management
Friday, June 26, 10 a.m. – Noon
Function #0220 (Fee $10)

Starting From Scratch: Leasing, Building Out, and Equipping a New Practice, Thursday, June 25, 2 p.m. – 4 p.m., Function #0160 (Fee $10)

You’ll learn how to:
> Develop your business plan and financial projections
> Evaluate lease and build-out options
> Develop a top-notch, highly efficient staff
> Avoid common pitfalls many new ODs face

To register or learn more, visit www.optometristsmeeting.org/newpractice.xml

The New in Practice Series
Information and insight to help your practice flourish!
Bob Woodruff to Speak at the Opening General Session on Thursday, June 25

Once again, Essilor is the generous sponsor of the Opening General Session featuring keynote speaker Bob Woodruff, ABC's *World News Tonight* former co-anchor. Woodruff joined ABC News in 1996 and has covered major stories throughout the country and around the world for the network. He was named co-anchor of ABC's *World News Tonight* in December 2005. On January 29, 2006, while reporting on U.S. and Iraqi security forces, Woodruff was seriously injured by a roadside bomb that struck his vehicle near Taji, Iraq. Woodruff continues outpatient rehabilitation in the New York area and has also returned to work at ABC News.

In February 2007, Bob Woodruff and his wife, Lee, released *In an Instant: A Family's Journey of Love, Courage, and Healing*, their personal memoir about Bob's recovery after his attack in Iraq and the medical and family support that helped him heal.

To register and learn more about Optometry's Meeting®, visit www.optometrysmmeeting.org

SPOTLIGHT ON AOA MEMBERS

Hawaii museum optometry exhibit educates, entertains children

The Children’s Discovery Center in Hawaii said aloha to an educational exhibit designed and produced by the Hawaii Optometric Association (HOA) last fall. The idea for an interactive exhibit came after one of HOA Executive Director Charlotte Nekota’s frequent visits to the world-class children’s museum with her grandchildren.

“I saw the dentists had an exhibit, and I thought this was a good idea for optometry,” said Nekota. “It was a perfect venue.”

Nekota spoke to the director of the center who agreed she was onto something.

Nekota went to work and arranged for donations of a vision chart, exam chair, frames, slit lamp and phoropter.

VSP agreed to provide a grant for funding, and the HOA was able to add a batting cage to the exhibit that would allow optometry to emphasize the importance of eye safety and sports.

An artist created a mural as part of the exhibit, and the HOA provided optical illusions to further engage the museum’s visitors.

Three months after the initial idea, the optometry exhibit was implemented.

For the grand opening of the exhibit, the HOA conducted free vision screenings and paid the day’s admission fees to the Children’s Discovery Center.

“They had a big thing on TV about it, and we had a couple hundred children screened by our HOA volunteers,” said Nekota.

Nekota said the HOA’s goals for the project were to educate visitors on the importance of eye exams for children and to familiarize children with optometry.

“With the slit lamp, they could look at someone else’s eyes and get used to the equipment found in an optometrist’s office,” said Nekota.

The exhibit is stocked with books related to optometry such as “My First Visit to the Optometrist.”

The HOA placed InfantSEE posters in the exhibit to raise awareness of the need for eye care to begin at an early age.

The museum is geared for children 8 and younger, though older children visit as well.

The optometry exhibit has become one of the more popular exhibits with the children, said Nekota.

Area schools often organize field trips to the center, and the HOA ordered AOA materials for packets that teachers can bring back to the classroom to further emphasize the importance of eye exams for children.

From left, Liane Usher, director of Exhibits & Programs at the Hawaii Children’s Discovery Center, Charlotte Nekota, executive director of the Hawaii Optometric Association, and Hervy Kurisu, president of Hawaii Winter Baseball, gather with players who participated in the exhibit’s grand opening.
Opening session to feature Woodruff, honor ODs

Bob Woodruff, the former co-anchor of ABC’s “World News Tonight,” will be the keynote speaker at the Opening General Session for the 2009 Optometry’s Meeting®.

Sponsored by Essilor, the Opening General Session will be Thursday, June 25 from 8 a.m. to 9:30 a.m.

The event will also honor the Distinguished Optometrist of the Year, the Optometrist of the Year and the Young Optometrist of the Year.

Woodruff himself was in the media spotlight when he was seriously injured by a roadside bomb while reporting on U.S. and Iraqi security forces in Taji, Iraq, in 2006.

Woodruff continues outpatient rehabilitation in the New York area and has since returned to work at ABC News covering major stories throughout the country and around the world.

In February 2007, Woodruff and his wife, Lee, published a personal memoir, “In an Instant: A Family’s Journey of Love, Courage, and Healing,” about his recovery and the medical and family support that helped him heal.

Woodruff won a 2008 Peabody Award for “Wounds of War—the Long Road Home for Our Nation’s Veterans,” a series of reports that aired on ABC.

Woodruff was also honored with the Daniel Pearl Award for Courage and Integrity in Journalism. In addition to his coverage of the war, Woodruff has reported on other top stories.

His reports from New Orleans in the aftermath of Hurricane Katrina helped focus the nation’s attention on the building tragedy there.

He was ABC’s lead correspondent on the Asian Tsunami, reporting from Banda Aceh, Indonesia, and Sri Lanka.

Woodruff has covered the “axis of evil” named by former President George W. Bush as Iran, Iraq and North Korea.

He covered the nuclear showdown in Iran and, in June 2005, was granted unprecedented access to the secretive country of North Korea.

He has reported extensively on the continuing unrest in Iraq from Baghdad, Najaf, Nassariya and Basra.

During the initial invasion of Iraq, Woodruff reported from the frontlines as an embedded journalist with the 1st Marine Division, 1st Light-Armored Reconnaissance Battalion.


After the Sept. 11 attacks, he was among the first Western reporters in Pakistan and was one of ABC’s lead foreign correspondents during the war in Afghanistan, reporting from Kabul and Kandahar on the fall of the Taliban.

His overseas reporting of the fallout from Sept. 11 was part of ABC News’ coverage recognized with the Alfred I. duPont Award and the George Foster Peabody Award, the two highest honors in broadcast journalism.

He was also a part of the ABC News team recognized with an Alfred I. duPont Award for live coverage of the death of Pope John Paul II and the election of Pope Benedict XVI.

Please do not miss the tremendous opportunity to hear Bob Woodruff speak about his amazing journey and his work to help those with war-related traumatic brain injuries (TBI), especially those with visually related challenges.

Reid Saito, O.D., waits to be interviewed as Loretta Yajima, president and CEO of the Hawaii Children’s Discovery Center, is interviewed. Roger Ede, O.D., screens a young child in the foreground.

Approximately 90,000 visitors a year come through the doors of the center.

Most large cities have similar children’s museums that may offer the same type of opportunity for state optometric associations, according to Nekota.

“You could replicate it in almost any environment,” said Nekota. “You don’t even need brand-new equipment; it just has to be sturdy.”

The HOA plans to host an optometry day at the center every year to encourage explorations of the exhibit. The events will continue to include screenings, free admission and, hopefully, TV coverage, Nekota said.

“I can’t believe I didn’t think of it a long time ago,” said Nekota. “It’s a real learning tool.”

Hawaii Winter Baseball players help children “decorate” their glasses as part of an added activity at the exhibit’s grand opening day.

Liane Usher, director of Exhibits & Programs at the Hawaii Children’s Discovery Center, Horvy Kurisu, president of Hawaii Winter Baseball, and Charlotte Nekota, executive director of the HOA, participate in the grand opening.
Students to capitalize on careers at Optometry’s Meeting®

Ryan Parker, O.D., chair of the Optometry’s Meeting®
Student Program Committee

In today’s economy, what can you possibly invest in that will give you a return on your investment? How about your future? Optometry’s Meeting® provides what students need in order to capitalize on their careers after graduation.

We all know that education is important, but often who you know can be just as important as what you know.

Optometry’s Meeting® provides the perfect balance of education and networking opportunities to advance your career.

A key reason the student program at Optometry’s Meeting® is so successful is that it is designed for students by students.

As the Student Program Committee chair, I feel this is instrumental to a successful program as the student volunteers on the committee are currently living the academic life and, therefore, understand what students need.

Our goal is to provide students with a program that focuses on their career after graduation.

We incorporate practice management courses into the program such as “Marketing Diamonds: How to Market Yourself and Your Future Practice,” sponsored by The Vision Care Institute® LLC, because we understand that students want to know how they are going to make money after graduation.

Students who want to learn more on a particular clinical topic are invited to take OD and/or paraoptometric continuing education courses at a reduced rate of only $5 per credit hour.

If you are preparing to take your board exams, Optometry’s Meeting® is the perfect place to brush up on what you have learned in optometry school.

There are 12 hours of National Board of Examiners in Optometry (NBEO) review courses that offer a comprehensive review of topics covered on the exam.

Students are also welcomed to the main Optometry’s Meeting® events such as the Wednesday Night Welcome Reception with live entertainment, sponsored by Bausch & Lomb, the Opening General Session featuring Bob Woodruff, sponsored by Essilor, Exhibit Hall events; and the Presidential Celebration, featuring Jeff Foxworthy, sponsored by HOYA.

Events such as these, while fun in nature, are a great opportunity for students to network with their peers, ODs and future business contacts.

One of these events could be where you meet your future employer or business partner.

Other great events that are designed specifically with students in mind are:

- The AOSA General Session kicks of the student program on Thursday afternoon. Thanks to VSP, students will release some stress with the sidesplitting humor of comedian Karyn Ruth White.
- The Varilux® Optometry Student Bowl™ and Reception continues as a Thursday night tradition at Optometry’s Meeting®. The enthusiasm of the students who attend is amazing. Students are so energized that Essilor, the sponsor of the event, instituted the “Spirit Award” given to the school that exemplifies the most team spirit.

- iConnect with TIC promises to be a rock-n-roll, sing-a-long good time this year. Dueling pianos have become so popular that TIC is bringing them to the Gaylord National®! Students who attend the TIC-sponsored lecture “Eye Want the Hook Up!” on Friday afternoon, and their registered guests, are invited to attend this event.

- The Optometric Residency Forum is a great resource for students who are considering a residency after graduation. On Friday, residency representatives from many optometry schools will be available to answer questions about their programs. This is a great opportunity to learn about what makes each residency program unique.

- Student Focus Hours in the Exhibit Hall have been dedicated specifically for students on Saturday from noon to 2 p.m. This is a great opportunity to start building vendor relationships.

By attending Optometry’s Meeting®, students will see firsthand who supports the AOSA and AOA.

Doing business with people who support optometry will continue to strengthen our profession and our associations.

Several prize drawings will be held throughout these dedicated hours just for students.

Optometry’s Meeting® is about your future. It is the meeting you can’t afford to miss!

Allegan, Essilor, HOYA, TIC, and The Vision Care Institute® know this is a meeting you can’t afford to miss so they generously sponsored travel grants and scholarships to ensure that students who want to attend can attend.

Talk to your school trustee to see how you can be one of the lucky recipients next year.

Visit www.optometrymeeting.org for more information, to register, and to book hotel reservations for the meeting.

See you at National Harbor!
VisionWeb appoints Crooks to advisory role

VisionWeb announced the appointment of C. Thomas Crooks III, O.D., as Professional Relations adviser.

In his new role at VisionWeb, Dr. Crooks will serve as the primary liaison to eye care professionals and professional organizations, providing strategic advice to the VisionWeb team on behalf of eye care professionals.

“VisionWeb is dedicated to providing technology that helps eye care providers to become more efficient and successful,” said Ken Engelhart, VisionWeb president and CEO. “Dr. Crooks is a respected eye care provider and business leader. We are extremely grateful to have his input and endorsement as we chart the course for the next generation of practice automation.”

Dr. Crooks brings more than 30 years of private practice experience to the VisionWeb team, in addition to his business acumen as a founder and CEO of one of the largest private independent practices in the country, EyeCare Associates, with 19 locations and 33 providers.

Zeiss launches HD progressives

Carl Zeiss Vision announced its high-definition (HD) series of customized progressives is now available with NuPolar® polarization in multiple material and color options.

Included in the line extension are Sola HD, SolaOne HD, Sola Compact Ultra HD and AO Easy HD. NuPolar polarized lenses offer 100 percent protection against ultraviolet (UV) A and B rays, while eliminating blinding sun glare.

“Polarized prescription sunwear delivers visual health, clarity and comfort outdoors,” said Bernadette Hiskey, Carl Zeiss Vision’s director of Customized Lenses. “The category is growing in double digits, but the great majority of progressive wearers still don’t have prescription sunwear, so there is plenty of opportunity for further growth.”

Each lens is individually optimized for the patient’s sphere, cylinder, axis and add using proprietary real-time customization software and then manufactured using the company’s patented back-surface freeform process.

Plus, Sola HDV is fully customized for the patient’s sphere, cylinder, axis and add using proprietary real-time customization software and then manufactured using the company’s patented back-surface freeform process.

For more information, visit www.zs vision.com.

Industry Profile: CooperVision

CooperVision is one of the world’s leading manufacturers of soft contact lenses, with a portfolio that includes the industry’s broadest range of soft toric and soft multifocal lenses. Dedicated to enhancing the contact lens experience for practitioners and patients, CooperVision is a global innovator in contact lens design, material development and manufacturing.

CooperVision’s expanding number of silicone hydrogel contact lens designs, the company recently introduced Biofinity Toric, a monthly silicone hydrogel lens that offers exceptional comfort, eye health, and vision quality. Utilizing the same material as Biofinity Sphere, Biofinity Toric is Food and Drug Administration-approved for both daily and extended wear (for up to six nights). Within the last year, CooperVision also released Avaira, a two-week silicone hydrogel lens.

These first-generation lenses feature CooperVision’s unique Aquafin™ technology, which creates a naturally wettable lens material without the need for internal wetting agents or surface treatments. The lenses offer a combination of high water content, low modulus and high oxygen transmissibility that provides maximum comfort, optimal health and excellent performance.

Biofinity Toric is the latest addition to The CooperVision Total Toric Solution, which offers the widest range of toric products and parameters. Only CooperVision lets practitioners fit virtually any astigmatic patient with a portfolio that includes Proclear® Toric and Proclear® Toric XR. As part of the PC Hydrogel™ family of lenses, Proclear Toric and Proclear Toric XR offer the excellent resistance to dehydration and deposits that create outstanding comfort.

The CooperVision Total Multifocal Solution contains the industry’s largest range of multifocal contact lenses and parameters, including: Biomedics® EP, Proclear® Multifocal and Proclear® Multifocal Toric. With sphere powers from +20.00D to -20.00D, cylinder powers up to -5.75 and add powers up to +4.00, practitioners can virtually fit all their presbyopic patients—from emerging to advanced.

For those interested in optimum health and ultimate convenience, CooperVision provides a 1-Day portfolio that includes Proclear® 1-Day, ClearSight® 1-Day, and ClearSight® 1-Day Toric.

Practitioner Resources

CooperVision has created a number of online training and practice building resources aimed at increasing patient loyalty, reducing contact lens drop out and helping practitioners increase their contact lens businesses. Programs include:

- CooperVision Online Learning Center—with this free resource, practitioners and staff receive highquality contact lens training designed to develop knowledge and hone skills on a broad range of topics ranging from contact lens basics to fitting advanced lens designs.
- CooperVision TV—practitioners can direct their patients to CooperDirect®—Shipping—to improve office efficiency and patient support, patients and practitioners can choose a delivery option that enables patients’ lenses to be shipped directly to their homes.
- Online Ordering and Customer Service Center—the MyCooperVision e-commerce site also features secure online ordering and access to shipment tracking, invoice lookup, payment history and product bank balances.
- For more information about CooperVision and its contact lenses, contact your CooperVision sales rep or visit www.coopervision.com.
INDUSTRY NEWS

B&L, Pfizer to co-promote ophthalmic pharmaceuticals

Bausch & Lomb and Pfizer Inc. announced a co-promotion agreement involving both companies’ prescription ophthalmic pharmaceuticals in the United States. The agreement will allow both companies to greatly increase the level of eye care industry support for these important medications that treat serious ophthalmic conditions.

The five-year agreement includes Pfizer’s Xalatan® (latanoprost ophthalmic solution) and Bausch & Lomb’s Alrex® (loteprednol etabonate ophthalmic suspension 0.2%), Lotemax® (loteprednol etabonate ophthalmic suspension 0.5%) and Zylet® (loteprednol etabonate 0.5% and tobramycin 0.3% ophthalmic suspension).

The co-promotion agreement also will apply to Bausch & Lomb’s investigational anti-infective eye drop, besifloxacin ophthalmic suspension 0.6%, which is currently awaiting approval from the U.S. Food and Drug Administration (FDA).

Under the terms of the agreement, both the Pfizer and Bausch & Lomb sales forces will promote Xalatan, Alrex, Lotemax, Zylet and besifloxacin (subject to FDA approval).

“Ophthalmic disorders cause significant disability in the United States,” said Olivier Brandicourt, president and general manager for Pfizer’s Specialty Business Unit. “This agreement with Bausch & Lomb combines our portfolios and further demonstrates our commitment to provide prescription medications that can benefit people living with serious eye conditions.”

Separate from this co-promotion agreement with Bausch & Lomb, Pfizer will continue to maintain three mid-stage development programs in its own pipeline.

“Working in collaboration, our U.S. sales organizations will now represent one of the broadest product offerings in the U.S. ophthalmic market,” said Flemming Ornskov, M.D., M.P.H., corporate vice president and global president, Pharmaceuticals, Bausch & Lomb. “We’ll be able to reach considerably more eye care practitioners and, in turn, better attend to the needs of millions of patients every year.”

In December 2008, the FDA’s Dermatologic and Ophthalmic Drugs Advisory Committee voted unanimously to recommend approval of besifloxacin for the treatment of bacterial conjunctivitis.

Bausch & Lomb anticipates a decision from the FDA in 2009. Financial terms of the agreement were not disclosed.

Transitions expands eye care academy

The expanded Academy for Eyecare Practicestm sponsored by Transitions Optical is designed to help practice owners and eye care professionals gain valuable insight into marketing and capturing new business.

The program is supported by industry laboratories and lens manufacturers and builds on the success of Transitions Academy – the company’s annual education event originally developed for laboratory partners – by providing eye care professionals an educational program that moves beyond abstract lectures.

With laboratory and lens manufacturer involvement at the local level, the program provides doctors and their staff proven methods for independent optometry practices to build profitable businesses.

Beyond the event, the program provides ongoing communications and support to help practitioners put what they have learned into practice.

The Academy for Eyecare Practicestm format was tested in three markets in 2008: Charlotte, Anaheim and Minneapolis.

Attendees received practical and valuable information on how to keep their practices viable, improve capture rates, quantify their work and use new approaches to educate staff and doctors about the importance of vision-enhancing eyewear. And, as a result, they reported increased sales of Transitions lenses.

Participants will benefit from a full day of interactive sessions highlighting topics such as marketing, management and finances. They will walk away with concrete materials, such as benchmarking tools, customizable materials for their office, and working knowledge of how to leverage their unique story to the community. They also have the opportunity to receive free fits for Transitions’ lenses with anti-reflective coatings.

Transitions and its lab partners have scheduled a total of 16 educational seminars this year, beginning in March, with more to be added.

For more information and to register for upcoming events, visit www.Transitions.com/ecpacademy.

Upcoming dates include:
- San Francisco: April 30
- Sacramento: May 1
- Phoenix: May 6
- Seattle: May 13 and 14
- Southbridge, Mass.: May 28 and 29
- East Rutherford: June 3
- Uniondale, N.Y.: June 5
- Fort Lauderdale: June 11 and 12
- Denver: June 18

Ray-Ban ads introduce its new Colors eyewear collection highlighting the iconic models worn by non-conformists and free spirits.

Immagine Eyewear presents a sneak preview of Wasty, a design from the new X-IDE® collection that was introduced at Mido 2009. The 2009 line is unparalleled in design as well as mood: 13 new designs, each with a story to tell. www.x-ide.it
MEETINGS

April

ARKANSAS OPTOMETRIC ASSOCIATION
2009 SPRING CONFERENCE
April 23-25, 2009
The Peabody Hotel, Little Rock, AR
Vicki Farmer
501/661-7675
FAX: 501/373-0233
ason@alltel.net
www.arkansasopectometric.org

MOUNTAIN WEST COUNCIL OF OPTOMETRISTS
April 23-25, 2009
Las Vegas, Nevada
Tracy Abel
888/376-6262 or 503/436-0796
FAX: 503/436-0612
tracy@allhealth.net
www.mwcoo.org

KENTUCKY OPTOMETRIC
ASSOCIATION 107TH ANNUAL SPRING CONGRESS April 23-26, 2009
Hyatt Regency Hotel, Louisville, Kentucky
Susan A. Jones
502/875-3516
FAX: 502/875-3792
sarah@kyeye.org www.kyeye.org

OPTOMETRIC EXTENSION PROGRAM VI STRABISMUS & ANISOMETROPIA April 23-26, 2009
Leuconia, Florida
Theresa Kriji 800 447 0370

UNIVERSITY OF CALIFORNIA, BERKELEY SCHOOL OF OPTOMETRY 24TH ANNUAL MORGAN/SWYER SYMPOSIUM April 24-26, 2009
Doubletree Hotel, Berkeley Marina, Berkeley
Berkeley, California
910/539-6847
FAX: 510/444-0279
optics@berkeley.edu http://optomaty.berkeley.edu

NEW JERSEY CHAPTER OF THE ACADEMY April 29-30, 2009
Kingston Plantation, Myrtle Beach, South Carolina
Dennis L. Ahlequah, O.D.
918/444-4033
FAX: 918/798-9032
417/377-8510

MOUNTAIN OPTOMETRIC ASSOCIATION 77TH INTERNATIONAL CONFERENCE ON LIGHT AND VISION April 28-May 2, 2009
Niagara Falls, Ontario, Canada
Ron Wahler, ABD 866/486-0190
FAX: 719/486-0190
syntics@bionet.net

May

FLORIDA CHAPTER OF THE AMERICAN ACADEMY OF OPTOMETRICAL EDUCATIONAL WEDNESDAY 2009 May 12, 2009
Mission Inn, Howey-in-the-Hills, Florida
Dr. Arthur T. Young 239/245-7494
FAX: 239/574-1374
Eyeguy4123@msn.com

ILLINOIS OPTOMETRIC
ASSOCIATION MIDWEST EYE CARE CONGRESS May 13, 2009
St. Louis Union Station Marriott
Charlene Marsh 800/931-7289
www.midwesteyecongress.com

NORTHEASTERN STATE UNIVERSITY, OKLAHOMA COLLEGE OF OPTOMETRY VISUAL CORRECTION May 13, 2009
TIC Oklahoma City, OK
Lisa McCormick 918/444-4033 mccormik@nsuk.edu

PENNSYLVANIA OPTOMETRIC ASSOCIATION SPRING CONFERENCE May 13, 2009
Skytop lodge, Skytop, Pennsylvania
Irena Saxe ting flenda@aoaeyes.org www.aoaeyes.org

BUILDING A THERAPEUTIC PRACTICE IN OCULAR SURFACE DISEASE Paul Kapke, O.D. and John Iatih, O.D. May 2, 2009
Birmingham, Alabama
Charlotte Iatih 917/761-0032
FAX: 212/791-4980
drcharllo@hotmail.com www.eyeseducators.com

ARIZONA OPTOMETRIC ASSOCIATION 2009 SPRING CONGRESS May 8-10, 2009
Sedona, Arizona
Glenda Kilby Spa Glendale, AZ
Dale DiLeonardio
toizona.org
www.aoaeyes.org

NEW MEXICO OPTOMETRIC ASSOCIATION 2009 ANNUAL CONVENTION May 14-17
Embank Suites Hotel Albuquerque, New Mexico
Richard Madsen 575/751-7242
madsen@aoaeyes.org

OPTOMETRIC EXTENSION PROGRAM 2009 EASTERN STATES CONFERENCE May 16-17, 2009
Courier Plaza, White Plains, New York
David Boman, O.D.
SWCDOB@aol.com

OPTOMETRIC EXTENSION PROGRAM, ACQUIRED BRAIN INJURY/TRAUMATIC BRAIN INJURY (TBI) (OEP Clinical Curriculum) May 16-18, 2009
Baltimore, Maryland
Theresa Kriji 800/447-0370

PHILADELPHIA COUNTY OPTOMETRIC SOCIETY & TELSIGHT

PHOTODOCUMENTATION IN MEDICAL EYE CARE May 26, 2009
Tiffany Dines, 501.10 Roosevelt Blvd., Philadelphia, PA 19115
Richard H. Silver, O.D.
215/474-3190
Brown1737@comcast.net www.philaoptometry.org

BRITISH CONTACT LENS ASSOCIATION 2009 CONFERENCE AND EXHIBITION May 24-31, 2009
Manchester, United Kingdom
+44 1700 7580 6661
FAX: +44 1700 7580 6669
collie@bcla.co.uk

PRINCIPAL CHAIRS CLASSIC CHAMPIONS TOUR LOW VISION UNIVERSITY Sponsored by Kamin Health.
Glen Oaks Country Club, West Des Moines, Iowa, May 30, 2009
www.aoa.org/x11836.mhtml

PARK ESSEX May 28-30, 2009
Center for Sight, Marlton, New Jersey
Jennifer Vermeeren
Jennifer@aoaeyes.org

NORTH CAROLINA STATE OPTOMETRIC SOCIETY 2009 ANNUAL SPRING CONGRESS June 12-14, 2009
Myrtle Beach, South Carolina
Sue Gardner
252/337-6197
www.ncos.org

OPTOMETRIC EXTENSION PROGRAM VI LEARNING RELATED VISUAL PROBLEMS (VT 2)
(OEP Clinical Curriculum) June 4-9, 2009
Baltimore, Maryland
Kailey Kriji 800/447-0370

WEST VIRGINIA OPTOMETRIC ASSOCIATION MEETING June 11-14, 2009
The Homestead Resort 304/720-9562
www.wvooa.com

OPTOMETRIC EXTENSION PROGRAM VI/LEARNING RELATED VISUAL PROBLEMS (VT 2)
(OEP Clinical Curriculum) June 22-27, 2009
Denver, Colorado
anessa Grosso 800/949-0060
FAX: 510/770-3777
970/272-7532
aoa.de@aoaeyes.org

NATIONAL OPTOMETRIC ASSOCIATION 49TH ANNUAL CONVENTION July 14-19, 2009
Charleston Place Hotel Charleston, SC
Dr. Charles Comer 877/394-2020 www.nationaloptometristsassociation.org

NORTHERN ROCKIES OPTOMETRIC CONFERENCE July 23-25, 2009
Snow King Conference Center Jackson Hole, WY
Don Lex, CAE www.NROCon.com Ph:307/637-7573

AOAN 47-14 AOAN_30.pdf
ASCO welcomes new school

The Association of School and Colleges of Optometry (ASCO) Board of Directors announced the approval of this University of the Incarnate Word School of Optometry’s (UIWSO) application for active membership in the organization. ASCO welcomes the school as its 20th active member school of optometry.

UIWSO’s mission is to educate and prepare future leaders in optometry through excellence in education, patient care, vision research and public service, within a context of faith and personal development.

The school’s primary location will be in the heart of San Antonio’s Medical Center, which will include the academic headquarters and one of two clinical facilities. The second clinic will be located on the east side of San Antonio.

“ASCO congratulates and welcomes UIWSO to its membership as the 20th school or college of optometry,” said John Amos, O.D., ASCO president. “We support the UIWSO’s mission, which is consistent with ASCO’s mission of reaching out to underserved and diverse populations. We look forward to UIWSO’s contributions to optometric education and the profession.”

UIWSO was granted “preliminary approval” by the Accreditation Council on Optometric Education (ACOE) in February 2009. “Preliminary approval is granted to a professional optometric degree program that has clearly demonstrated it is developing in accordance to council standards. The program has been approved to begin student recruitment, selection and admissions, and to begin offering the program,” according to the ACOE.

Optical family celebrates 50 years

Robertson Optical Laboratories celebrated its golden 50th anniversary with many events over the past year.

Jack Robertson founded Robertson Optical 50 years ago, and his sons, Richard and Calvin, continue the business today.

Richard is the president of the Loganville, Ga., lab and secretary-treasurer of the Columbia and Greenville, S.C., labs. Calvin is the president of the Columbia and Greenville labs and secretary-treasurer of the Loganville lab.

“The most satisfying part about being in business for 50 years is looking back to the beginning of our company,” said Calvin. “My father, Jack Robertson, called me by phone and asked ‘Calvin, do you want to join me in opening our new company, Robertson Optical Laboratories, Inc. in Atlanta, Georgia?’”

The family has experienced lots of change in the optical business over the course of 50 years. “When I started in the optical industry, the only material available was glass, and the grinding process was very labor intensive,” said Richard Robertson.

“We used the roughing pan to grind lenses. This was a process where we manually placed rough emery on a sphere tool while holding the blocked lens in our hands and rocked it back and forth until the desired cylinder is in the curve of the lens. Today, the computer grinder grinds these automatically,” Richard said.

Richard also noted that materials have evolved during his time in the industry. “No one had heard of materials such as CR-39™, polycarbonate and Trivex,” said Richard. “And anti-reflective coating and progressive lenses did not exist as they do today.”

“The optical industry has changed from manually fabricating lenses to increased automation of today’s equipment,” said Calvin. “The quality of lenses produced today is far superior. I must ask the question, ‘Can future machinery and equipment produce any better quality than today?’ And my answer is I can see this happening year after year for future generations.”

The Robertson brothers said they are very satisfied with what they have accomplished with their company. “When I think about how many lives we have improved by helping people see better, it is gratifying to me. It gives me great joy,” said Richard. “Watching our employees grow with the company and please our customers has been a very important and satisfying part of the last 50 years. I have always said, ‘Without customers and employees, one would not have a company.’”

“The other thrill of the 50-year period is the friendships developed with our wonderful employees, business partners, the three O’s and manufacturers,” said Calvin.

Robertson Optical services the United States from its three locations in Georgia and South Carolina.

In 2008, Robertson Optical was ranked ninth in prescription sales and jobs per day of all independent wholesale labs in the nation, according to Vision Monday. Neither of the Robertson’s has any plans for retirement.

“I am having too much fun now to retire and want to continue doing all I can to help eye care professionals and their patients, as well as our employees,” said Richard. “I plan to retire when I die unless the unknown happens sooner,” said Calvin.

PCO launches eye network

The Pennsylvania College of Optometry at Salus University (PCO), in collaboration with CenterVue SpA of Padova, Italy, announced the launch of a new service designed to increase dialogue among a worldwide network of vision care professionals that includes optometrists, ophthalmologists and optometric students.

The Eye Knowledge Network (EKN) is an interactive networking site designed to bridge boundaries that may exist due to geography or unintentional professional insulation.

Network contributors from the top of their professions will bring their expertise to EKN members via podcasts, screencasts, presentations, audio and video files and other formats that lend themselves to the exchange of information between members.

Members will be able to carry on electronic conversations, allowing for questions, comments and dialogue. CenterVue SpA, a technology company with strong links to universities, research centers and clinical departments, has combined the necessary competencies and technical expertise for the development and production of this professional social network on the Internet.

PCO will provide a link to the EKN network from its Web site at www.salus.edu.

Continuing education (CE) credits approved by the Council on Optometric Practitioner Education (COPE) for licensed professionals will be available on EKN.

The network expects to provide members with a minimum of 20 PCO practitioner faculty-authored courses in the first year.

With a primary mission to deliver education and to gather clinical collaborative expertise, the collaboration between the EKN and PCO is key to promoting a worldwide dialogue among professionals, experts and students in the world of vision care.
SHOWCASE

"Hit The Road – Pal"

We want you to enjoy the natural beauty of Grand Teton and Yellowstone National Parks. So after an excellent day of continuing education, please "hit the road" to the most beautiful place on earth.

Speakers:
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Dr. Leonard Messner
Dr. Paul Karpecki
Dr. William Jones

For more information about our 18 hour doctor program, exhibits, and paraoptometric program, in beautiful Jackson Hole, Wyoming, scheduled for July 19-21, 2007, please contact us at:

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MWCO
Mountain West Council of Optometrists
Annual Congress
April 23-25

This year’s speakers include:
Larry Alexander, OD
Mark Bloomstein, OD
Mark Pfirmenter, OD
Paul Kozlowski, OD
Christine Smith, OD
and many others!

OPTOMETRY
Geisinger Health System seeks a licensed optometrist to join its growing practice at Geisinger Wyoming Valley Medical Center, Wilkes-Barre, PA.

About this position:
• Residency training in ocular disease preferred
• Work with an ophthalmologist and a support team of nurses and techs within Geisinger’s large, multi-specialty Ophthalmology service line
• Assist with inpatient consults with the primary responsibility of covering hospital consults
• Opportunity to work with collegial staff and create new programs
• Growing department now features Pachymetry, OCT, Fundus Photography, HVF and offers Fluorescein Angiography with in-house eyewear/contact lens department

For more information, please contact Autumn Kline, Physician Recruiter, at 1-800-845-7112, email: auumkline@geisinger.edu or visit www.Join-Geisinger.org/98N/Optometry

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Virginia, Roanoke Metro Area. Optometrist F/T, top salary and benefits. Recent grads welcome to apply. Please call 732-502-6071

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The most desirable items that programs in developing countries need are: Trial lens kits, battery powered hand scoops, assorted pliers and optical tools, hand stones for edging glass lenses, uncut lenses (both SV and SF), manual lensometers, phoropters, lens docks, color vision tests, keratometers and biomicroscopes.

This list is certainly not complete but gives an idea of some of the basic needs these developing programs can benefit from. All items may be shipped directly to: VOSH INTERNATIONAL, O/C IMEC, 1600 Osgood Street North Andover, Mass. 01845.

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