Chairperson’s Report
Daniel Karr, MD, FAAP

I am taking this opportunity to acquaint or reacquaint AAPOS members with the AAP Section on Ophthalmology (SOOp). All AAPOS members are eligible for membership in the SOOp, but currently only 200 or so have taken advantage of membership in the SOOp, but currently due to its small size.

Regarding our mission, the Section on Ophthalmology is dedicated to improving the care of infants, children, and adolescents with vision problems by providing an educational forum for the discussion of problems and treatments relating to eye disease in the pediatric population; stimulating research in, and the teaching of, pediatric ophthalmology; disseminating knowledge of pediatric ophthalmology through AAP channels and to the medical profession at large; and dedicating efforts to work towards the prevention and cure of amblyopia so that no child grows up with this condition.

The section is a vehicle bringing together pediatric ophthalmology and pediatrics, an educator on eye health issues for pediatricians, a political/legislative advocate on pediatric ophthalmic issues, and a strong venue for educating the public about children’s eye health.

I would like to highlight the Section’s high activity profile by summarizing current endeavors and recent accomplishments. The list is longer than you might expect, but please browse through the activities and consider potential areas for your involvement.

Governmental/National Advocacy Activities:
- Full time pediatric subspecialty advocate in the AAP DC office
- In June 2017, the AAP/SOOp worked with the AAO/AAPOS on a sign-on letter to the U.S. Senate re: Children’s Vision Coverage in American Health Care Act Essential Health Benefits.
- The AAP outlined its approach to engaging the new federal leadership team on health care reform in a letter dated January 6, 2017. Vision services for children are mentioned in the letter.
- In September 2016, the AAP released its Blueprint for Children: How the Next President Can Build a Foundation for a Healthy Future. The Blueprint was a comprehensive plan for advocating for children in the coming administration. Eleven months into the new administration, the Blueprint continues to guide the AAP’s advocacy for children.
- The AAP Department of Federal Affairs prepares a semi-annual Academic and Subspecialty Advocacy Report. Click here to view Fall 2017. For more information on the report, see page 6.
- In October 2017, the AAP obtained the signatures of over 60 societies – including the AAO and AAPOS – on a letter supporting a bill, the Ensuring Children’s Access to Specialty Care Act of 2017, that would strengthen the pediatric subspecialty workforce. The legislation would amend the Public Health Service Act to include pediatric subspecialties in primary health services for purposes of the National Health Service Corps (NHSC). These amendments would make pediatric subspecialists eligible for the NHSC fellowship program for the delivery of primary health services in health professional shortage areas, the NHSC Scholarship Program, and the NHSC Loan Repayment Program. The AAP Dept of Federal Affairs will be...

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Chairperson’s Report  
(Continued from page 1)  

strongly advocating for the passage of this legislation, which serves as a needed step toward curbing today’s demonstrated critical shortage of pediatric medical subspecialists, pediatric surgical specialists, and pediatric mental health specialists to help provide children with timely access to the vital health services they need.  

• Registration for the 2018 AAP Legislative Conference is open. The conference will take place April 8 – 10, in Washington, DC. Each year, the conference brings together pediatricians, residents and medical students from across the country who share a passion for child health advocacy. Participants attend skills-building workshops, hear from guest speakers, learn about policy priorities impacting children and pediatricians and go to Capitol Hill to urge Congress to support strong child health policies. The conference will once again feature a Pediatric Subspecialty Advocacy Track offering specific legislative and skills building workshops uniquely focused on the interests and needs of pediatric medical subspecialists and surgical specialists. For more information, see page 8.  

• Dr. David Granet, Immediate Past Chairperson of the Section, has been appointed to the AAP’s Committee on Federal Government Affairs (COFGA). As a surgical subspecialist, Dr. Granet is a unique addition to the COFGA; he is the one and only surgical subspecialist on the COFGA leadership roster.  

• Sharon Lehman, Immediate Past Section Chairperson, participated in the Ophthalmic Advocacy Leadership Group (OALG) Meeting in January 2017.  

• The SOOp has long been a supporter of the AAO’s Congressional Advocacy Day. The AAP Section participated as a supporting organization once again in 2017.  

• The AAP Section sponsored a participant, Dr. Megha Pansara, in the 2017 Advocacy Ambassador Program at the AAO’s Mid-Year Forum.  

Private Payer Advocacy:  

• On an ongoing basis, the SOOp works with the AAP Committee on Coding and Nomenclature (COCN) to resolve issues with existing CPT codes, to comment on proposals for new CPT codes, etc. For example, the Section and COCN have recently been involved with work related to the devaluation of existing code 99174 and the sundown of Cat III code 0333T (VEP).  

• On an ongoing basis, the AAP Section on Ophthalmology is asked by insurers and managed care companies to review new policies or policies being considered for release. For example, recently, the Section reviewed and provided feedback on an Amerihealth Caritas policy on Therapeutic Contact Lenses and on UnitedHealthcare policies on Instrument-Based Ocular Screening and Vision Screening.  

• In February 2017, the Section worked with the AAP Private Payer Advocacy Committee and the AAP Pennsylvania Chapter Pediatric Council to advocate for separate payment for vision screening, as currently two of the largest regional payers (Highmark BC and Independence BC) do not pay separately for vision screening.  

• In August 2017, the SOOp began work with the AAP Committee on Coding and Nomenclature to advocate for no limit on the number of sensorimotor examinations by Medicaid in Texas. The Texas Medicaid currently limits the number of exams to twice a year.  

Public Service Activities:  

• The section publishes a pamphlet for parents, titled “Your Child’s Eyes,” which explains how vision develops and alerts parents to specific problems by defining them and discussing warning signs that should be evaluated by a pediatrician or ophthalmologist. The most recent version of the “Your Child’s Eyes” brochure was released in May 2016 and is made available to subscribers of AAP’s PatientEducationOnline service. In addition, excerpts from the brochure are now available on HealthyChildren.org – Warning Signs of Vision Problems in Infants & Children, Vision screenings, and Infant Vision Development: What Can Babies See?.  

• The AAP actively supported the CDC’s third annual Contact Lens Health Week in August 2017.  

Membership Activities:  

• The Section hosted a social reception at the 2017 AAPOS meeting for networking and membership recruitment purposes.  

• In 2016, the Section appointed a liaison from the AAPOS Committee on Young Ophthalmologists to its Executive Committee. The Section leadership has engaged the liaison in discussions about how the section can do more to support young physicians, and in turn, draw in more young pediatric ophthalmologist members. This position is currently open, and SOOp leadership will be naming a new YO liaison in the near future.  

• The Section is working to establish subcommittees to engage members outside of the Executive Committee in the work of the section. During fiscal year 2016-17, we recruited new members for the Section’s Nominations Committee as well as its Committee on Retinopathy of Prematurity; in addition, we established a new committee on Concussion jointly with AAPON.  

Educational Activities/Awards:  

• At the 2017 AAP NCE (the annual AAP national meeting), the section sponsored two audience-response sessions titled, “Pediatric Ophthalmology: Visual Diagnosis,” two hands-on sessions titled “Eye Examination Skills Using the Ophthalmoscope,” and one audience-response session, “Pediatric Ocular Emergencies.”  

• The Section sponsors a workshop at the AAPOS meeting to explore conditions of concern for the pediatrician and pediatric ophthalmologist. At the 2017 AAPOS annual meeting in April, the SOOp offered a workshop titled, “Gene Therapy for Inherited Retinal Diseases – Answers for Common Questions”. The Section has submitted a proposal for the 2018 AAPOS meeting as well, “Cortical/ Cerebral Visual Impairment 2018: What You Need to Know Including Perspective from a Parent of a Child with CVI.”  

• In 2017, Dr. Marilyn Miller gave the Apt Lecture (sponsored by the AAP) on “Zika Virus: A New Kid on the Block of Ophthalmic Teratogens.”  

• At the AAPOS meeting, the SOOp annually presents an Award for Outstanding Service to the AAP Section on Ophthalmology. The 2017 award was presented in April to Dr. Jim Ruben for his many years of dedication to the mission and activities of the Section.  

• For the third time, the SOOp will partner with the American Association of Certified Orthoptists to offer a joint educational symposium at the AACO annual meeting this month, “When to Image the Pediatric Patient: A Team Approach”. See page 4 for more information about the symposium.  

• The SOOp has an agreement with AAPOS to co-sponsor the Pediatric Ophthalmology Subspecialty Day program that is held in conjunction with the AAO Annual Meeting. We look forward to the meeting this month. See page 17 for the upcoming subspecialty day schedule.  

• The Section has partnered with AAO, AAPOS, and CEF to support a joint children’s eye health exhibit booth, which travels to a number of important meetings annually (including the AAP’s National Conference and Exhibition).  

• The AAP is very proud to have been
selected to partner with the Maternal Child Health Bureau on a project designed to support the coordination of health professional educational and training efforts, including tele-mentoring, to increase the clinical expertise of primary care clinicians to ensure that family-centered, comprehensive, coordinated, and culturally effective care in the context of a medical home is provided for infants confirmed to have Zika virus syndrome. This project focuses on high-risk areas (including Puerto Rico) and aims to identify mechanisms to support clinicians in other public health emergencies. The Section worked with the AAP Disaster Preparedness Team and the Maternal Child Health Bureau to assure that there would be an ophthalmologist faculty member involved with this training program; Maria Tartarella, MD, PhD, from Brazil is participating.

- The AAP hosted a webinar on the Impact of Zika Virus on Vision and Hearing on September 5, 2017 (view archived webinar here)
- The AAP/SOOp co-sponsored an FDA ophthalmic digital health workshop on October 23, 2017, along with AAO, AAPOS, ASCRS, ARSRS, and Stanford University, which convened developers, clinicians, stakeholders, and patients to discuss digital health challenges and potential solutions (presentations are viewable here).
- The Section nominated member, Dr. Stacey Kruger, to participate in the AAO’s 2017 Leadership Development Program (LDP); Dr. Kruger was awarded a spot in the program. We are thrilled that this is the second year in a row that our Section’s nominee was selected.

Policy/Publications:
- The AAP recently endorsed the AAPOS policy statement on “Orhtoptists as Physician Extenders” (announcement in the December 2016 issue of Pediatrics).
- The AAP endorsed a new “Practical Guide for Primary Care Physicians: Instrument Based Vision Screening in Children” (announcement in the January 2017 issue of Pediatrics)
- In April 2017, the Section sponsored the publication of a “Focus on Subspecialties” article in AAP News: “Screen children with neurodevelopmental disabilities for vision problems” (The article is available on page 10 of this newsletter or online here)
- On an ongoing basis, the Section is asked to review and provide feedback on relevant AAP publications and policy statements as well as national health care related publications that the AAP is asked to review as an organization. For example, recently, the Section has been asked to provide feedback on the 2nd edition of an AAP publication, Caring for the Hospitalized Child, the Red Book 2018, 31st Edition policy manual, an AAP Council on Children with Disabilities clinical report entitled, “Shared Decision-Making in Childhood Disabilities: Pathways to Consensus,” an upcoming AAP consumer book titled Caring For Your School-Age Child: Ages 5 to 12, a HealthyChildren.org article on Screen Time and its Effects on Children’s Eyes, and the second edition of AAP’s title, Managing Chronic Health Needs in Child Care and Schools: A Quick Reference Guide.
- The Section periodically audits the full list of AAP statements, clinical reports, and technical reports in progress to determine if there are ophthalmic considerations that require review by the Section.
- In 2017, the SOOp/AAAP developed a subcommittee on Concussion. This new subcommittee has been charged with developing a joint organizational policy statement on Visual Symptoms in Concussion. Pediatricians need guidance in this area when it comes to making referrals so the AAP’s involvement is crucial.
- Work is underway to revise the 2013 joint AAP/AAPOS/AAO/AACO policy statement on the “Screening Examination of Premature Infants for Retinopathy of Prematurity.”
- Work is underway to revisit the 2010 clinical report on “The Eye Examination in the Evaluation of Child Abuse.”
- In July 2017, the AAP approved endorsement of a National Center for Children’s Vision and Eye Health (NCCVEH)/AAPOS “Position Statement on the Relationship between Visual Acuity and Refractive Error in the Context of Preschool Vision Screening Using Instrument-Based Technology”.
- In July 2017, the AAP approved endorsement of a NCCVEH statement, “Developing a Consensus on a Systems- Based Approach to Children’s Vision and Eye Health”
- In October 2017, the AAP approved endorsement of “Ophthalmic Screening of Children at Risk for Retinoblastoma: A Consensus Statement from the American Association of Ophthalmic Oncologists and Pathologists.” For more information, see page 4.

Leadership/Interaction Within the AAP
- Dr. Daniel Karr and Dr. Geoffrey Bradford attended the Surgical Advisory Panel (SAP) meeting at the AAP’s Annual Leadership Forum March 9-11, 2017. The SAP is a panel of the chairpersons of all the Surgical Sections of the AAP. The Chair of the SAP sits on the AAP Board as an advisor, representing the views of the Surgical Subspecialist within the AAP.
- Dr. Geoff Bradford has been appointed as the AAP Section on Ophthalmology representative to the SAP’s new Subcommittee on Optimal Timing for Surgery. Concern has been raised about the safety of the medicines used for anesthesia and sedation in young children. Given this, there is an interest within the SAP in developing a list of surgeries for which the timing of surgery is particular important with respect to the child’s development or for optimal function; 1-2 volunteers from each of the AAP’s surgical sections will serve on the subcommittee. Read the AAP’s response to the FDA’s December 2016 drug warning about the use of anesthetic and sedative drugs in children here.
- Dr. Gregg Lueder has been appointed as the AAP Section on Ophthalmology representative to the SAP’s new Subcommittee on Healthcare Transitions.

The SOOp is extremely busy, with much of our business handled by a core of volunteers and the Section Executive Committee. We heartily welcome increased participation by our section members. Additionally, new members are passionately solicited since increasing the size of the section membership can only increase the effectiveness of the Section in carrying out its mission to help our patients and thereby our members. Please encourage your colleagues to join the SOOp or consider joining yourself if you are not already a member.

Kindest regards,
Dan Karr, MD, FAAP

Calling for newsletter articles!
for our next SOOp newsletter, the Spring edition.
Please send proposals to Geoff Bradford, Newsletter Editor, at bradfordg@wvumedicine.org by January 31, 2018.
Joint AAP/AACO Symposium to Take Place November 13th

Please join us for the 3rd biennial joint AAP/AACO Symposium titled, **When to Image the Pediatric Patient: A Team Approach** to be held at the Sheraton New Orleans Hotel on November 13, 2017 from 8:25 to 10:05am at the National AACO meeting. There is no charge or pre-registration required; all are welcome!

**About the Symposium**

Ordering a MRI for our pediatric patient is a daily occurrence. Over the years, there have been great advances in imaging, yet with such advances there have also been increased discoveries of the risks associated. As the risk versus benefit of imaging has increased, the decision as to when to image the pediatric patient has become more challenging. There are many factors to consider. Sedation and gadolinium, often used when performing this test on the young patient, are two major concerns of both professionals and parents.

We all see common pediatric eye conditions that could potentially have serious consequences. But they do not all require imaging. The need to image may be very obvious like the child presenting with severe headache, vomiting and diplopia or subtle like the child who has no behavior changes but presents with a head position.

The decision about when to image the pediatric patient will be looked at from all angles in our joint AAP/AACO symposium. Certified Orthoptists Sarah Mackinnon and Shelley Klein will present cases and clinical signs observed during their evaluation, Pediatric neuro-ophthalmologists, Drs. Michael Siatkowski and Mitchell Strominger will review and highlight strabismic, nystagmus, pupillary and optic nerve abnormality cases with subtle ophthalmologic findings and Dr. Ken Ward, Chair of Radiology at Children’s Hospital of NOLA, our featured guest speaker, will conclude with an overview of MRI, risks and benefits along with Pediatric Neuroimaging of Ophthalmologic Disorders. We hope you will join us for this timely and pertinent topic.

Physicians attending have the opportunity to earn **AMA PRA Category 1 Credit(s)™** as described below:

- The American Academy of Pediatrics (AAP) is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.
- The AAP designates this live activity for a maximum of 1.50 **AMA PRA Category 1 Credit(s)™**. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

- This activity is acceptable for a maximum of 1.50 AAP credits. These credits can be applied toward the AAP CME/CPD Award available to Fellows and Candidate Members of the American Academy of Pediatrics.
- The American Academy of Physician Assistants (AAPA) accepts certificates of participation for educational activities certified for **AMA PRA Category 1 Credit™** from organizations accredited by ACCME. Physician assistants may receive a maximum of 1.50 hours of Category 1 credit for completing this program.
- This program is accredited for 1.50 NAPNAP CE contact hours of which 0 contain pharmacology (Rx) content, (0 related to psychopharmacology) (0 related to controlled substances), per the National Association of Pediatric Nurse Practitioners (NAPNAP) Continuing Education Guidelines.

For more information, please contact co-chairs Shelley Klein at sklein1@tuftsmedicalcenter.org or Geoffrey Bradford at bradfordg@wvumedicine.org

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**Welcome New Members**

**Since April 2017**

- Liyuan Chen, MD  
San Jose, CA
- Julia Stevens, MD  
Lexington, KY
- Sylvia Yoo, MD  
Boston, MA
- Sandra Brown, MD  
Concord, NC
- Sasapin Grace Prakalapakorn, MD, MPH, Durham, NC
- James Alan Deutsch, MD  
Brooklyn, NY
- Dorothy Reynolds, MD  
Sound Beach, NY
- Sindhura Kodali, MD  
Seattle, WA

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**AAP Endorses New Consensus Report from the American Association of Ophthalmic Oncologists and Pathologists**

A group of members of the American Association of Ophthalmic Oncologists and Pathologists (AAOOP) with support from the American Association for Pediatric Ophthalmology and Strabismus and the American Academy of Pediatrics (AAP) was recently convened to provide a set of surveillance guidelines for children at risk for development of retinoblastoma. The panel included representative ophthalmic oncologists, pathologists, and geneticists from retinoblastoma referral centers located in various geographic regions who met and discussed screening approaches for retinoblastoma. This work has culminated with the publication of a new Consensus Report from the American Association of Ophthalmic Oncologists and Pathologists, “**Screening Children at Risk for Retinoblastoma,**” in **Ophthalmology** this month; the report has been endorsed by the American Academy of Ophthalmology, the American Academy of Pediatrics, the American Association for Pediatric Ophthalmology and Strabismus and the American Society of Pediatric Hematology/Oncology.
Call for Nominations for 2018 Member Positions on AAP National Committees

The AAP Board of Directors is soliciting nominations to fill the following vacancies for Member positions on AAP National Committees for terms beginning July 1, 2018:

- Committee on Coding & Nomenclature (COCN)
- Committee on Continuing Medical Education (COCME)
- Committee on Development (CODe)
- Committee on Fetus and Newborn (COFN)
- Committee on Infectious Diseases (COID)
- Committee on Nutrition (CON)
- Committee on Pediatric AIDS (COPA)
- Committee on Pediatric Education (COPE)
- Committee on Pediatric Emergency Medicine (COPEM)
- Committee on Pediatric Workforce (COPW)
- Committee on Practice & Ambulatory Medicine (COPAM)
- Committee on Psychosocial Aspects of Child & Family Health (COPACFH)
- Committee on State Government Affairs (COSGA)

You can find the requirements, the statements of needs for each position, and the application materials on the AAP Member Center. To be considered complete upon submission, an application must include the following: (1) factsheet, (2) biographical summary, (3) letter of nomination, and (4) letter of support. Upon receipt, a request for Conflict of Interest Disclosure will be sent to the candidate which will finalize the application process.

The deadline for nominations is Friday, February 23, 2018. Nominees must submit the completed application materials to their Chapter President and the AAP Nominations Team (nominations@aap.org).

Members of AAP National Committees are re-appointed every two years and may be appointed up to three times for a total of six years. Committee member appointments are made on the basis of knowledge, expertise, and the documented needs of the committee. Within this context, Academy membership demographics such as professional activity, gender, ethnicity, and geographical distribution will be considered, as well as chapter activity.

The AAP Board of Directors will meet in May 2018 to review nominations and make final appointments.

Thank you for your review and contribution to the nominations process of AAP National Committees for the 2018 term. Please email any questions to nominations@aap.org.
New AAP Academic and Subspecialty Advocacy Report


The Report contains updates on the following topics:

- Access to Care
- Children's Health Insurance Program
- Current Health Reform Proposals
- ACE Kids Act
- Medical Foods Coverage
- Academic and Subspecialty Workforce
- Support for Pediatric Subspecialists
- Children's Hospital GME Funding and Reauthorization
- Defense Department Subspecialty Training
- Public Service Loan Forgiveness
- International Physician Legislation
- Immigration Policy
- Physician Payment
- Medicaid Payment Equity
- Pediatric Drugs and Devices
- Pediatric Drug Laws
- Pediatric Device Consortia Program Appropriations
- 21st Century Cures Act
- Opioids and Children
- FDA Approves Label Changes for Use of General Anesthetic and Sedation in Young Children
- Restricted Use of Codeine and Tramadol
- Pediatric Research
- National Institutes of Health Appropriations
- Precision Medicine Initiative
- Environmental influences on Child Health Outcomes (ECHO)
- Inclusion of Children in NIH-Funded Research
- Cancer “Moonshot” Initiative
- Indirect Costs in NIH Grants
- Budget and Appropriations
- Fiscal Year 2017 Appropriations
- President’s Fiscal Year 2018 Budget
- Fiscal Year 2018 Appropriations
- Emergency Medical Services for Children
- Federal Aviation Administration Emergency Medical Kits
- Protecting Patient Access to Emergency Medications Act
- AAP Blueprint for Children
- Grassroots Advocacy: AAP Key Contact Program
- How to Become a Key Contact
- FederalAdvocacy.aap.org: Dept. of Federal Affairs Online Resource Center
- Engage with AAP on Social Media

Children’s Health Insurance Program (CHIP): AAP Responds to Recent Developments

AAP Statement on House CHIP Legislation
10/31/2017

"The American Academy of Pediatrics is disappointed that the legislation currently advancing in the U.S. House of Representatives to extend funding for the Children’s Health Insurance Program (CHIP) does not continue the program’s strong bipartisan history. While the bill includes sound policy that pediatricians support—extending CHIP for five years, stabilizing enrollment, and preserving current funding levels through 2019—it is paid for in a way that may harm children’s health. Specifically, the bill cuts the Prevention and Public Health Fund, makes risky changes to Medicaid financing and puts in place new barriers for families to access affordable health care coverage in the private marketplace.

"CHIP funding expired one month ago. The nearly 9 million children who rely on the program, along with their families, have been forced to face an uncertain future as they hear conflicting reports of what this inaction means for them. These families do not follow the latest policy developments and they do not care about process. They simply want to know that they can continue to access reliable, affordable health care coverage for their children. Because of congressional inaction, they have not had that peace of mind.

"CHIP has been celebrated as a bipartisan success story since its very beginning 20 years ago. The program enjoys widespread support among both chambers and both political parties, and most importantly, it works for the children it serves. Like CHIP, the Maternal, Infant, and Early Childhood Home Visiting program also ran out of funding on Sept. 30. Like CHIP, home visiting is also a bipartisan program. And like CHIP, its bipartisan success is being needlessly jeopardized. These programs are too important for the children and families they serve to be caught up in politics.

It is past time that members of Congress come together to do what is right for children and families and extend CHIP funding for five years, without jeopardizing other important child health policies in the process."

Statement of Leading Children's Health, Medical and Advocacy Organizations: Congress' Failure to Secure Funding for the Children's Health Insurance Program Before September 30th Leaves Health Coverage for Nine Million Children in Jeopardy
9/29/2017

As advocates for children and pregnant women, we are deeply distressed by Congress’ failure to extend funding for the Children’s Health Insurance Program (CHIP) by the September 30th deadline. To depart Washington before this deadline without taking action to extend CHIP funding is irresponsible, and forces the families of the 9 million children who rely on the program to face an uncertain future. As such, we are urging the immediate passage of the Keep Kids' Insurance Dependable and Secure (KIDS) Act of 2017.

CHIP is a bipartisan success story that should be celebrated. The program was created in 1997 and has been championed by lawmakers on both sides of the aisle since its beginning. Together with Medicaid, CHIP has helped to reduce the number of uninsured children by a remarkable 68 percent, with more than 95 percent of all children in America currently being enrolled in some form of insurance coverage. Nineteen states also use CHIP to extend coverage to pregnant women, removing barriers to pregnancy coverage and prenatal care for about 370,000 women each year. This proven track record of providing high-quality, cost-effective coverage for low-income children and pregnant women in working families must be continued. The bipartisan KIDS Act would do just that and should be approved when Congress returns.

Continued on page 7
The September 30th deadline was not arbitrary; it has real implications for real families. States are taking action now to modify or end their programs because of continuing uncertainty. In her testimony to the Senate Finance Committee on September 7th, Linda Nablo, Chief Deputy Director of the Virginia Department of Medical Assistance Services and former Virginia CHIP director, emphasized that "there are serious consequences looming if [Congress] delays reauthorization— even for a few months." While the Medicaid and CHIP Payment and Access Commission (MACPAC) estimates that Virginia's CHIP allotment will not be exhausted until March, issues with health plan payment, adequate notice requirements, eligibility worker training, and system changes will require the state to start taking action in October in anticipation of exhausting their funding. Similarly, Cathy Caldwell, who runs the CHIP program in Alabama, said the state "is in the process of developing a contingency plan of shutting down our separate CHIP program."

And while some states are talking about the actions they will need to take in the upcoming weeks to prepare for their funding to end, other states are already beginning to act. The Minnesota State Health Department sent a letter to Congress warning that its CHIP funding would expire on September 30 and it would have to take "extraordinary measures" to continue coverage in October, including the possibility that pregnant women could "be at risk of losing coverage all together." Earlier in September, Colorado issued a notice on its website that CHIP funding might end. Utah officials say they will end their CHIP program if Congress doesn't provide new funding. Under current law, Arizona can choose to discontinue its CHIP program if funding from the federal government ends. In the states mentioned above, and many others, funding that is meant to provide care for children and pregnant women will be wasted on processes that states must undertake to shut down their programs because Congress has failed to act in a timely manner. This is a waste of taxpayer dollars.

Families who rely on CHIP already face uncertainty and challenges, whether managing a complicated health condition for their child or determining how to afford day-to-day living expenses. The last thing these families need is added uncertainty about the future of their children's medical and dental coverage or whether they will have continued access to necessary prenatal care services. By not acting in a timely manner to extend CHIP funding, Congress has caused them to face the threat of losing coverage altogether. Moreover, the patchwork of state funding deadlines means that a child's or pregnant woman's access to continued CHIP coverage will depend on his or her ZIP code.

Our children and pregnant women deserve better. We urge our nation's leaders to immediately enact the Keep Kids' Insurance Dependable and Secure (KIDS) Act of 2017 as an important opportunity for meaningful, bipartisan action; the health of 9 million children and pregnant women depends on it.

AAP Webinar: State Waivers: How they Could Alter Coverage and Care for Children

On October 18th the AAP hosted a webinar, State Waivers: How they Could Alter Coverage and Care for Children, where the issue of Medicaid Section 1115 and Affordable Care Act (ACA) 1332 waivers were discussed. Jane Perkins, Legal Director from the National Health Law Program (NHeLP), provided an overview of this issue and information on what has transpired recently with waivers.

States have historically utilized waivers of federal Medicaid law to create or test innovative demonstration programs to expand care to new populations, offer new services, and deliver care in new and different settings. However, now states are contemplating new waivers -- most frequently in the form of Medicaid Section 1115 and Affordable Care Act (ACA) 1332 waivers -- that would have the effect of restricting or limiting access to care.

Given the current and possible future use of these waivers, this AAP webinar can provide you with background on 1115 and 1332 waivers as well as information and guidance on how individuals/chapters can advocate to ensure all children maintain access to the care they need in the waiver process.

Now available is the recording of the webinar and the slides that were presented by Jane Perkins, JD of the National Health Law Program. The AAP will also be disseminating additional materials and tools for AAP members as proposals emerge for new Medicaid, CHIP and other waivers. We continue to be concerned that efforts to harm benefits and eligibility to key children's programs will be focused on waivers now that Congressional efforts to cut Medicaid have stalled.

October 10, 2017:
States Sound Alarm on CHIP

As the uninsured rate for children recently dropped to another historic low of only 4.5%, states are continuing to sound the alarm that the expiration of federal Children’s Health Insurance Program (CHIP) dollars will thwart this national progress. Utah became the first state to request permission to close its CHIP program, and Colorado issued a statement announcing no immediate changes but warning that CHIP might end when federal funds run out. Minnesota, facing an emergent CHIP funding crisis, reportedly received a $3.6 million infusion of unused CHIP funds to keep its program running, and Arizona, which is required by state law to end its CHIP program if funding is cut, announced it had received word of a similar influx of emergency funds to keep the program temporarily afloat.

Eleven (11) states (AZ, CA, CT, HI, ID, MS, NV, OH, OR, PA, and UT) are now projected to run out of federal CHIP funds by the close of 2017, and only 2 states, NH and OK, made state budget adjustments this year to address the possibility of federal CHIP funds expiring.

To help chapters advocate on this critical issue, the AAP has updated its CHIP advocacy toolkit.
Medicaid Managed Care and Children and Youth with Special Healthcare Needs

The National Academy for State Health Policy (NASHP)—a partner of the National Center for Medical Home Implementation within the American Academy of Pediatrics—has compiled a 50-state review of Medicaid managed care (MMC) programs that are designed to improve the quality of care while reducing costs for the 20 percent of children and youth with special health care needs (CYSHCN) in the United States. The NASHP MMC review examines how CYSHCN are enrolled, whether enrollment is mandatory or voluntary, the most common types of MMC programs, and how states assess the quality of the MMC programs. The findings are included in this issue brief and in the NASHP 50-state map and state-by-state table.

Attend the 2018 AAP Legislative Conference – Registration is Open!

The 2018 AAP Legislative Conference will take place April 8-10 in Washington, DC. Each year, the conference brings together pediatricians from across the country who share a passion for child health advocacy.

Participants attend skills-building workshops, hear from guest speakers, learn about policy priorities impacting children and pediatricians and go to Capitol Hill to urge Congress to support strong child health policies.

For the third consecutive year, the conference will include a Pediatric Subspecialty Advocacy Track. The track will feature specific workshops, advocacy and educational opportunities for specialists, including a skills-building workshop on how to frame specialty expertise to legislators and build relationships with congressional staff, advocacy on legislative priorities especially relevant to pediatric subspecialists and the patients they treat, networking opportunities and more.

Visit aap.org/legcon for more information and to register.

We hope to see you in April!

AAP Updates Guidance to Prevent Spread of Germs in Doctors’ Offices

Just in time for winter cough and cold season, the American Academy of Pediatrics (AAP) is updating its recommendations on the best ways to prevent the spread of germs during doctor visits. The policy statement, “Infection Prevention and Control in Pediatric Ambulatory Settings,” published in the November 2017 Pediatrics, (published online Oct. 23) acknowledges that the majority of patients are seen in outpatient facilities or doctor’s offices, and so infection control in these places should be just as strict as in hospitals. The AAP recommends mandatory annual influenza immunization for staff, and documentation of immunity or immunization against other vaccine-preventable infections including pertussis, measles, mumps, rubella, varicella and hepatitis B.

In the policy statement, the AAP emphasizes the importance of cough and sneeze etiquette and hand hygiene, and recommends that waiting rooms be equipped with alcohol-based sanitizers and masks. Pediatricians should also post visual reminders to cover your nose and mouth with your elbows rather than your hands when coughing and sneezing, and to properly dispose of tissues. Among other recommendations, the report recommends avoiding stocking the waiting room with plush toys like stuffed animals, which are difficult to clean and can harbor germs. Instead, parents should be encouraged to bring their own. New recommendations include special precautions for cystic fibrosis patients, whose lungs are especially vulnerable to drug-resistant bacterial infections. These high-risk patients should not share space in the waiting area and instead be placed directly into the exam room.

New Article: Key Considerations for Improving the Pediatric Primary Care and Specialist Interface

An article in the Journal of Pediatrics titled, “The Pediatric Primary Care-Specialist Interface: A Call for Action” outlines key considerations and solutions for improving relationships between pediatric primary care and subspecialists. The article summarizes key components of the family-centered medical home, including access, communication, coordination, and family-centered care, and provides solutions for enhancing the pediatric primary care and specialist relationship in the context of these components. Successful collaborative care models that can be replicated in other states and health care settings are also described.

From the Editor’s Desk – Geoff Bradford, MD, FAAP

We hope you enjoy reading this edition of the newsletter. Please share it with colleagues, patients and friends and let them know you are a member of the Section. Much of this newsletter is devoted to communicating the activities of the AAP and of our Section to you, as well as providing updates on clinical and advocacy topics. Our newsletter can be an important avenue of communication for our Section and for those who share our passion of providing the best care possible in our field for children.
Questions are sometimes raised about the diagnosis of shaken baby syndrome – or abusive head trauma – often in relation to possible wrongful conviction cases. Pediatric experts discussed why the science supports the syndrome during the 2017 American Academy of Pediatrics National Conference & Exhibition in Chicago in September.

While the veracity of shaken baby syndrome has been questioned in some media reports and as a courtroom defense, no controversy exists within the medical profession: Physicians agree that the diagnosis is scientifically valid.

That message was the topic of a plenary, "Shaken Baby Syndrome: Science vs. Myth," that was delivered by Sandeep Narang, MD, JD, FAAP, during the 2017 American Academy of Pediatrics National Conference & Exhibition.

In 2015, the Washington Post published a lengthy article detailing its investigation with the Medill Justice Project at Northwestern University that called into question the diagnosis of shaken baby syndrome. Similar stories have run in other major media outlets, including the New York Times, ABC News and NPR. Despite what the media have been reporting about the veracity of shaken baby syndrome, there are no data to support a significant controversy, said Sandeep Narang, MD, JD, FAAP, division head, child abuse pediatrics, Lurie Children's Hospital of Chicago, and associate professor of pediatrics, Northwestern University Feinberg School of Medicine.

"The misperception that's made is that there is a wave or shift in the medical community about the certainty of the diagnosis. That's not really the case based on a study I did in 2016," said Dr. Narang, a member of the AAP Committee on Medical Liability and Risk Management and Section on Child Abuse and Neglect.

Dr. Narang and his colleagues surveyed physicians who evaluate injured children at 10 leading children’s hospitals to assess their acceptance of shaken baby syndrome and abusive head trauma as medical diagnoses. Eighty-eight percent of the 628 physicians who responded considered shaken baby syndrome to be a valid diagnosis, and 93% said abusive head trauma was a valid diagnosis (Narang SK, et al. J Pediatr. 2016;177:273-278). In addition, a large majority of physicians said that shaking a baby, with or without impact, was likely or highly likely to result in subdural hematoma, severe retinal hemorrhages and coma or death.

During his presentation at the NCE, Dr. Narang focused on three areas:

- how the controversy has gained traction and how it has the potential to impact child protection;
- the importance of general pediatricians being aware of this potential controversy because it can impact their patients involved in child protection hearings; and
- what pediatricians can do to educate the courts, attorneys and child welfare services in their communities about the science underpinning the diagnosis.

Dr. Narang began his career as a prosecutor in the military. One of his last cases prior to starting medical school was a very difficult child sexual abuse case, which sparked his interest in the field. When he embarked on a fellowship in child abuse pediatrics, he was shocked to learn that the legal community embraced the concept of a “controversy” over the diagnosis of shaken baby syndrome.

“I had been a general pediatrician for two years prior to that and didn’t realize that kind of resistance, that kind of momentum against the diagnosis was starting to develop in the legal community,” he said. “Having a legal background, I took it to heart.”

He decided to survey physicians regarding their views of shaken baby syndrome so that the legal community could make decisions based on solid data. As his study showed, most doctors do not dispute the diagnosis. Rather, questions are being raised by a small cottage industry of physicians, groups such as the Innocence Project and the media, which are drawn to stories of possibly wrongfully convicted or wrongfully accused individuals based on a mistaken medical diagnosis, he said.

Disagreements over the shaken baby syndrome diagnosis bear a large resemblance to the debates over vaccines and autism, and climate change, Dr. Narang said. “You simply have people who are unwilling to accept the large body of data or evidence," he said.

Family Partnerships—New Article Type in PEDIATRICS

The editors of the AAP's peer-reviewed journal, Pediatrics, have introduced a new article type this year called “Family Partnerships”; these articles are written by a patient and/or a family member in conjunction with members of their health care team. More information about these articles and the guidelines for submitting articles for consideration can be found here. To date, five articles have been published under this new category.

Increasing Awareness of Sudden Death in Pediatric Epilepsy Together (February 2017)
Parent-Physician Partnership at the Edge of Viability (April 2017)
An Innovative Collaborative Model of Care for Undiagnosed Complex Medical Conditions (May 2017)
Patient and Researcher Engagement in Health Research: A Parent’s Perspective (September 2017)
Social Determinants of Health and Hospital Readmission (November 2017)

Normally, articles published in Pediatrics require a subscription to access; however, articles published under the “Family Partnerships” category are open for all to access.

Family members have been engaged, often informally, in AAP initiatives over many, many years. The introduction of the "Family Partnerships" section to Pediatrics is one of the ways that the AAP has recently expanded upon its more concrete opportunities for parent (family) input and participation in AAP activities and programs.
News Articles, Focus on Subspecialties

Screen children with neurodevelopmental disabilities for vision problems
by Sharon S. Lehman M.D., FAAP; Kenneth W. Norwood Jr. M.D., FAAP

Many children with neurodevelopmental disabilities such as cerebral palsy and spina bifida have deficits in their senses, with vision impairment perhaps being the most limiting to successful participation in life.

Several studies have found that vision care represents one of the greatest unmet needs for children with special health care needs. In addition, infants and toddlers who are socially at risk with functional vision difficulties make up one of the highest subgroups of developmental vulnerability.

Examination of the eyes is a routine part of a well-child check. Thus, pediatricians are in a unique position to detect vision impairment in children with neurodevelopmental disabilities and ensure that appropriate referrals and intervention occur and classroom accommodations are made.

In January 2016, the Academy published a clinical report and policy statement that provide guidance on how to evaluate and when to refer children for full ophthalmologic evaluation (see resources). The documents, issued along with the American Association of Certified Orthoptists, the American Association for Pediatric Ophthalmology and Strabismus, and the American Academy of Ophthalmology, emphasize that ocular problems can be the initial manifestation of systemic or neurologic disease such as retinoblastoma or neuroblastoma in addition to identifying vision-threatening ocular conditions.

Taking a history

Obtaining a history eliciting parental concerns and family history is essential. As discussed in the policy, identification of a family history of serious eye disorders such as retinoblastoma, childhood cataracts or glaucoma, strabismus and amblyopia are indications for evaluation by an ophthalmologist experienced in the care of children. Parental concerns about vision also are an indication for full ophthalmologic evaluation.

It is important to ask specifically about vision concerns when obtaining a history about a child with complex medical problems. The family may be more focused on concerns about respiratory or neurologic problems and forget to bring up vision issues, or they may have a misconception that nothing can be done to help their child use his or her vision more effectively.

Overcoming screening challenges

It is possible for pediatricians to screen children with neurodevelopmental disabilities for vision problems, but it may be challenging due to cognitive impairment, processing delays, inability to cooperate, multiple sensory deficits and expressive language delay. The screening may need to be adjusted and may take more time, for instance in children with cortical visual impairment who display latency due to a delayed response because of extra time needed for processing and responding to the visual stimuli.

It is important to match the screening technique to the developmental age of the child instead of chronologic age. Interesting toys and charts with pictures or symbols may be used for acuity testing. The recommended charts for younger children are those with Lea symbols or HOTV (limited number of symmetric letters). Providing the child with matching cards can be helpful in obtaining cooperation when testing acuity. Using critical line testing instead of threshold line testing as discussed in the 2016 clinical report takes less time and may be particularly helpful in children with neurodevelopmental disabilities.
noncontact and distraction techniques can be used to obtain cooperation. It requires less sustained attention from the child.

The physical exam of the eye looking at the alignment, eyelid position and anterior and posterior aspect (red reflex) also should be performed. If the recommended vision screening cannot be performed or abnormalities are found on physical examination, the child should be referred for full ophthalmologic evaluation.

Pediatricians should have a low threshold for sending a child with a neurodevelopmental disability for full ophthalmologic evaluation if there are any concerns about vision or if the child has a medical condition in which there is a significant risk of ocular abnormalities or visual conditions.

Complex neurodevelopmental disability is among the conditions where evaluation by a pediatric ophthalmologist or eye care specialist appropriately trained to treat pediatric patients is necessary because of the risk of significant visual disability affecting the child's ability to learn and reach his or her potential.

Dr. Lehman is immediate past chair of the AAP Section on Ophthalmology Executive Committee. Dr. Norwood is chair of the AAP Council on Children with Disabilities Executive Committee.

Resources

- AAP clinical report "Procedures for the Evaluation of the Visual System by Pediatricians"
- AAP policy statement "Visual System Assessment in Infants, Children, and Young Adults by Pediatricians"

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**On Direct to Consumer Genetic Testing**

by Brenda Jean Mears, MD, FAAP

My daughter, Rachael, has wanted me to have my “personal genomics” done since she learned it was possible. She is simply curious, but why do others want this information? Some want to expand their knowledge of their ancestry. Others want to learn if they will develop certain diseases or if they carry concerning recessive genes.

Certainly genetic information can provide powerful predictive information, but obtaining it through a physician or genetic counselor is time consuming, expensive and not always approved by insurance. There are a number of companies which will now do genotyping for individuals based on single nucleotide polymorphisms (snps) without a physician order. The benefits of using a direct to consumer test include accessibility, less cost and the ability to order online.

23andMe was founded in 2006. Their initial kit in the United States provided information on many diseases without physician involvement. This kit was removed from the market after the Food and Drug Administration expressed concerns. The new version includes ancestry information, carrier statuses, trait predictions and information on a few diseases. What is provided varies with jurisdiction and what is currently available. If you, the client, choose to do this, there are 19 pages of legal information and a 7 page consent form. If you choose to have testing done on your child, there is a link to talking points for discussion.

All this information is available to read at your computer. I somehow doubt many people read it. Among other information contained in these documents: you can consent or withdraw consent to research done on your information but the company says the database siting work they do is not research on human subjects. They won’t sell your information without your explicit consent but they do share aggregate information about user genomes to third parties. They encourage clients to speak to a genetic counselor prior to sending a sample, suggest speaking to a lawyer prior to sharing the information with anyone, warn that if you deny taking the test when asked it might be considered fraud, and warn that you may need further services from a physician or genetic counselor.

The client must use the correct name and address and send the sample from the address used. The client must guarantee it is personal saliva and not from an insurance company or employer. As well, you agree to no rights to research or commercial products.

In short, you are paying them money to give you genetic and ancestry information and they will then use your data to do research and make money selling the data. We might be contributing to medical advances, but we are also paying money...
to give this company access to our genetic, health and personal information.

This summer, I went through this process. I read most, if not all, of the pages available on their website, collected a sample, answered their questions, and, sent them money. A few weeks later I received a link to results. Since then I have continued to receive short surveys asking questions such as “Are you red green color blind?” “How many nosebleeds a year do you have?” “Does cilantro taste like soap?”

I wasn’t convinced I would learn much. My family is in the, perhaps lucky, position that we know a good deal about my portion of the family history. We have a family tree which in one line traces to the American colonial period. The lines for which we have records are English, Scottish and German.

Anyone using this may learn some interesting things. When I first opened the information the week before writing this I had 1182 DNA relatives listed in their files. As of August 24, it is up to 1194. Most of my listed relatives are in the third cousin or more distant category. But I also found first cousins I do not know. (My father is one of the younger children in a large family.)

You can access paternal and maternal haplogroups, ancestry composition and Neanderthal ancestry. As expected I have a high percentage of Northwestern Europe ancestry, 98.2%. They test for 2872 Neanderthal variants, I have 295, more than 76% of their population. One of my variants is associated with short height. I suppose this might explain my fifth percentile height.

Carrier status is determined for a number of dis-orders including polycystic kidney disease, Beta thalassemia, Bloom Syndrome, Cystic Fibrosis and, Tay-Sachs. I am negative for all of them. Genetic health risks are determined for late onset Alzheimer’s (the APOE gene), Parkinson’s, alpha 1 antitrypsin deficiency and hereditary thrombo-philia. I am negative for all of them as well. It doesn’t give information on other mutations such as the BRCA gene.

The traits and wellness section gives you your possibilities of having traits such as a second toe longer than the first toe or lactose intolerance. They are only possibilities so some are wrong. I have an increased probability of thinking cilantro tastes like soap. I do not, but my daughter does. I can even download the raw data if I wish.

This is a massive data gathering operation. Their web site states they have more than 2 million genotyped customers. 85% of their customers have opted in to the research portion. They have used individual survey responses to collect 600 million phenotypic data points. They state each individual contributes to over 200 research studies.

In consenting to this, I have in a sense consented for my children, my sisters and, my parents. I discussed this with Rachael but none of the others prior to testing. Did I have the right to consent for them without discussing it with them first? I decided this information does not belong only to me and sent the links to all 3 of my children. If my parents or sisters wish to see it I will give it to them but I find myself unwilling to share the detailed information with anyone else.

The only thing unexpected I learned was the Neanderthal gene information. Would I have found it distressing to know I might develop Alzheimer’s? Would I have had difficulty sharing this information with my parents, sisters or children? I don’t think so but certainly others might have problems. One thought is that the results should be given to an intermediary who can screen and review the results but this will certainly slow the process and decrease accessibility.

The company promises confidentiality but the information is out there. I have little confidence that it could not be hacked or pieces of information put together to locate me or my information. I have already received a message through the company’s message forwarding function from one second cousin (of whom I know nothing) wanting to compare family trees. I doubt it would be that hard to find me if she wanted to. When you google my name all but one listing on the first page concern me.

What happens to all this data if the company goes bankrupt? If I choose to withdraw from the program, can they possibly remove my data? Would they even try? If I take this information to my physician, will the information be placed in my medical record and be accessible to insurance companies? We don’t know.

For some people this program will cause unnecessary visits and costs for counseling or help interpreting information. Family secrets may come to light. It remains to be seen if the overall benefits outweigh the problems.

Employee Embezzlement
By Suzanne Berman, MD, FAAP

AAP Section on Administration and Practice Management Executive Committee Member
Dr Suzanne Berman is the co-founder and managing partner of Plateau Pediatrics, in Crossville, TN.

Employee embezzlement is sadly very common. The Medical Group Management Association (MGMA) surveyed practices in 2009 and found that 83% of respondents had been associated with a practice that was the victim of employee theft or embezzlement (http://bit.ly/2H51lu).

Of victimized practices, over half had had internal controls at the time of the theft, and nearly a third had had a recent audit by a CPA. Thus, while there are many preventive measures that practices can take to prevent embezzlement, it’s a good idea to have a fallback plan if (or perhaps when) your practice falls prey to an embezzler. Having a rapid-action plan prepared ahead of time is particularly essential because, upon discovering the theft, it’s likely the pediatrician have difficulty formulating a plan quickly when grappling with the natural embarrassment, shock, and sense of betrayal that ensues.

Assembling a team of advisers is the first step. The ideal team includes at least one IT person (for data gathering and preservation), a banking/accounting professional (to mitigate financial issues), and a fraud examiner. Fraud examiners are professionals with training in forensic accounting, fraud law, risk management, investigation techniques, and ethics.

Backing up key data is next. Your IT consultant should make rapid copies of your electronic data for archive and analysis. It also prevents existing data from being further manipulated and destroyed. Paper records like invoices or statements should also be copied, if feasible.

Changing information control is the first step in recovery. Thieves are successful because they can manipulate the flow of information. For example, they often re-route dunning letters from vendors to themselves, so that the pediatrician will not recognize that their vendors have not been paid. They will “handle” calls from angry patients themselves so the pediatrician will not know that the family has been billed three times for a co-pay already paid and pocketed by the thief. Changing information control includes rerouting mail, email, and phone calls, and resetting web accounts/passwords.

Digging for data is the first step in prosecution. The pediatrician and the team should evaluate the data for both “skimming” (theft of income) and fraudulent disbursements. Being aware of the variety of schemes for diversion of funds will help the team know where to look.

Evaluating your endgame is the penultimate step. By this time, the team should have a fairly good idea of the scope of fraud (amount stolen, method(s) used, identity of perpetrator(s).) Based on this, the practice should decide what its end goal is. That is, a practice who just wants the money back will have a different next step than a practice who wants to punish the thief publicly and prevent another practice from falling victim.

The finale involves confronting the thief in a forensic interview, which is best conducted by a fraud examiner or other expert. Depending on the practice’s end goals, the practice may seek criminal action, civil action, or regulatory action against the thief. It may be helpful to remember that thieves are responsible for paying income and self-employment taxes on their ill-gotten gains, and the IRS may prove to be an ally here.


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2017 National AAP Election: Results Are In!

Kyle Yasuda, M.D., FAAP, of Seattle, Washington, has been voted the AAP president-elect. He ran against Michael A. Weiss, D.O., FAAP, of Coto de Caza, Calif.

Dr. Yasuda will take over as president on Jan. 1, 2019, following Colleen A. Kraft, M.D., FAAP, of Cincinnati, who will serve as president in 2018. To read about Dr. Yasuda’s background, visit http://www.aappublications.org/news/2017/06/02/Yasuda060217.

Results for additional AAP national offices, which take effect Jan. 1, 2018, are below.

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<tr>
<th>District II – District Chairperson</th>
<th>District VIII – District Chairperson</th>
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<tr>
<td>Warren M. Seigel, M.D., M.B.A., FSAHM, FAAP (re-elected)</td>
<td>Martha C. Middlemist, M.D., FAAP</td>
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<td>District III – District Vice Chairperson</td>
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<td>John “Jay” Ludwicki, M.D., FAAP</td>
<td>Gregory S. Blaschke, M.D., MPH, FAAP</td>
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<td>District III – National Nominating Committee Representative</td>
<td>District VIII – National Nominating Committee Representative</td>
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<td>Danielle G. Dooley, M.D., M.Phil, FAAP</td>
<td>Melissa E. Mason, M.D., FAAP</td>
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<tr>
<td>District V – District Chairperson</td>
<td>District X – District Chairperson</td>
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<tr>
<td>Richard H. Tuck, M.D., FAAP (re-elected)</td>
<td>Lisa A. Cosgrove, M.D., FAAP</td>
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<tr>
<td>District VI – National Nominating Committee Representative</td>
<td>District X – District Vice Chairperson</td>
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<td>Barbara W. Bayldon, M.D., FAAP</td>
<td>Mobeen H. Rathore, M.D., FAAP</td>
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For more results, visit http://www.aappublications.org/news/2017/06/02/Yasuda060217.
Implementing a Patient Survey

By Sue Schleier, MD, FAAP, AAP Section on Administration & Practice Management Member & Emily Floyd, MBA, Pediatric Practice Management Alliance Member

The best way to find out what your patients think about you and your office is to ask them. In my experience, people are happy to share their thoughts about the healthcare they receive and there are always some surprising findings.

To get the information, implement a patient survey. With a good mix of questions about your office, your staff and the perceived quality of care you provide, you will get data that will tell you a lot about your patients and your office.

Follow these steps to get good information and take action with what you learn.

1. Decide what you are going to ask. Ask questions about your patients’ experience with your office, your staff, and the provider. Ask patients to rate these things on the following scale: 1) Highly Dissatisfied 2) Dissatisfied 3) Satisfied 4) Highly Satisfied; and include an option for N/A. Notice there are no neutral items. The most actionable surveys are going to force people to decide if they are satisfied or not. If you get a lot of neutral responses it might suggest a problem you don’t really have in your office. Leave room for comments after each question, asking patients to comment on any experience they have had in the office, particularly if they were dissatisfied with it. By allowing comments after every question you get insight into your patients’ rationale in answering each question.

2. Determine who to send it to. I recommend sending it to everyone who has visited your office in the last year, including those patients who have requested their medical records. This accounts for any seasonality that may exist in your practice and will include people who have left your practice to get care elsewhere. If you have a problem that causes people to go elsewhere, you want to know about it; you also want to know what it is about your office that keeps people coming back.

3. Send the survey via email. If you just hand patients a copy of the survey or information on completing the survey online, they are much more likely to discard it without even looking at it. You are also more likely to only hear from dissatisfied patients. Survey Monkey is a great way to gather lots of data, and you can do it anonymously. They do have a HIPAA-compliant version you can use, but if you aren’t asking for any medical or contact information, this step isn’t necessary.

4. Send a reminder. After several days you will need to send an email reminder to get another round of responses.

5. Analyze complete results. You will be tempted to open the first survey response you receive, but you have to stop yourself! If you start trying to draw conclusions from your first few responses, it will cloud your ability to step back and evaluate all of the responses before you form opinions about what issues to address. When you do get the results, create a list of all the questions and break the data into % favorable. From there you can see what is least favorable in the practice and start there. For example, you may find that you have three items where the % favorable is under 90%. That’s a great place to start.

6. Make a plan and share it. Once you have identified the areas that need attention, read through the comments to see what you need to work on and make a plan to address it. In our own office we received low favorability for patient comfort in the office. The comments let us know that the exam rooms are too cold for children in gowns. This was something that became an easy fix. When you do create your plan, be sure to have goals associated with it. One goal could be to see 90% or better favorability on these items the next time you perform the survey.

7. Don’t forget the positive. A lot of patients will have really great things to say about your practice. Be sure to recognize this with your staff and publicly recognize anyone who is named in your office for doing a great job. This will help reinforce the things people like in your practice and encourage this level of service in the future.

8. Repeat. Send the survey every six to nine months to see if you are making progress. You may learn you need different tactics or you may uncover new problems.

A patient survey is always a good idea. You may think your patients will tell you about any problems or concerns, but don’t rely on that as your only source of information. With a survey, you are sure to get some good information and you will find that most of your staff members will be looking for ways to improve.

Reprinted with permission from the Spring 2017 issue of the AAP Section on Administration & Practice Management Newsletter
Thank You to All of Our Current Members for Your Support
Attending the AAO Annual Meeting in New Orleans November 11-14?

Wish you had a Quick Reference Guide for All Events Focused on Pediatric Ophthalmology?

As the AAP Section on Ophthalmology, we figured we’d help you out. What follows is a listing of all pediatric-focused events at the upcoming AAO meeting, including the schedule for the Pediatric Subspecialty Day meeting, which will take place on Saturday, November 11, and the schedule for the American Association of Certified Orthoptists (AACO) educational program.

Section 1 (pages 17-19)

Subspecialty Day - Pediatric Ophthalmology and Strabismus: Sightseeing in New Orleans – For the Pediatric Ophthalmologist

Section 2 (pages 20-21)

AAO 2017 Annual Meeting Scientific Schedule Pediatric Ophthalmology and Strabismus Educational Sessions

Section 3 (pages 22-26)

AACO Educational Program
Pediatric Ophthalmology Subspecialty Day Schedule

In conjunction with the American Association for Pediatric Ophthalmology and Strabismus and the American Academy of Pediatrics

Sightseeing in New Orleans—For the Pediatric Ophthalmologist

Saturday, Nov. 11, 2017
New Orleans Theatre C, Ernest N. Morial Convention Center

7 a.m. CONTINENTAL BREAKFAST
8 a.m. Welcome and Introductions Yasmin Bradfield, MD and Jonathan M. Holmes, MD

Section I: The Heart and Soul—Bourbon Street and Strabismus
Moderator: Jonathan M. Holmes, MD
8:01 a.m. Introduction Jonathan M. Holmes, MD
8:02 a.m. Case 1: Stuck Outside—Paralytic Exotropia Following Sinus Surgery Jonathan M. Holmes, MD
8:07 a.m. Medial Rectus Retrieval Stacy L. Pineles, MD
8:12 a.m. Periosteal Fixation Gillian G. W. Adams, MD
8:17 a.m. Panel Discussion of Alternatives
8:22 a.m. Case 2: Struck Inside—Esotropia With Conjunctival Scarring Jonathan M. Holmes, MD
8:27 a.m. Conjunctival Dissection and Graft Malcolm R. Ing, MD
8:32 a.m. Amniotic Membrane Yi Ning Strube, MS, MD, FRCSC
8:37 a.m. Panel Discussion of Alternatives
8:42 a.m. Case 3: Down, Not Out—Hypotropia due to Brown Syndrome Jonathan M. Holmes, MD
8:47 a.m. Superior Oblique Suture Spacer Stacy L. Pineles, MD
8:52 a.m. Superior Oblique Silicone Band Spacer Yi Ning Strube, MS, MD, FRCSC
8:57 a.m. Panel Discussion of Alternatives
9:02 a.m. Case 4: Hanging Out—Exotropia After Scleral Buckle Jonathan M. Holmes, MD
9:07 a.m. Horizontal Rectus Muscle Surgery Malcolm R. Ing, MD
9:12 a.m. OnabotulinumtoxinA Gillian G. W. Adams, MD
9:17 a.m. Panel Discussion of Alternatives
9:22 a.m. Wrap-up Jonathan M. Holmes, MD
Section II: Lagniappe—"Bonus Gifts" to Enhance Your Strabismus Surgery Outcomes
Moderator: Sean P. Donahue, MD, PhD
9:30 a.m. Introduction Yasmin Bradfield, MD
9:31 a.m. Prism Adaptation Kyle A. Arnoldi, CO
9:40 a.m. Adhesion Barriers Yasmin Bradfield, MD
9:49 a.m. Pullover Traction Suture Burton J. Kushner, MD
9:58 a.m. Delayed Adjustable Suture Richard S. Freeman, MD
10:07 a.m. Phospholine Iodide for Residual Esotropia Laura B. Enyedi, MD
10:16 a.m. Postoperative Eye Exercises Cindy Pritchard, CO, COT
10:25 a.m. Wrap-up Yasmin Bradfield, MD
10:31 a.m. REFRESHMENT BREAK and AAO 2017 EXHIBITS

Section III: Architectural Details–Corneal Structure and Disease
Moderator: Serena X. Wang, MD
11:01 a.m. Advocating for Patients Pamela E. Williams, MD
11:06 a.m. Pediatric Keratoprosthesis: Con Kathryn A. Colby, MD, PhD
11:16 a.m. Pediatric Keratoprosthesis: Pro Sarah M. Nehls, MD
11:26 a.m. Ocular Surface Stem Cell Transplantation for Aniridia Edward J. Holland, MD
11:36 a.m. Pediatric Keratoconus: Crosslinking vs Penetrating Keratoplasty vs Deep Anterior Lamellar Keratoplasty Beatrice E. Frueh, MD
11:46 a.m. Red Eye in Children: A Cornea Specialist's View Kristin M. Hammersmith, MD
11:56 a.m. Wrap-up Serena X. Wang, MD
12:06 p.m. LUNCH and AAO 2017 EXHIBITS

Section IV: Ghost Tours–Frightening Postoperative Surprises
Moderator: Erick D. Bothun, MD
1:26 p.m. Introduction Erick D Bothun, MD
1:27 p.m. Case 1: What Did You Do to My Baby? A Ptosis Surgery Saga K. David Epley, MD
1:37 p.m. Case 2 Discomfort and Dyscoria Lawrence Tychsen, MD
1:47 p.m. Case 3: When the Third Eye Is Not So Wise Shira L. Robbins, MD
1:57 p.m. Case 4: That Bump Shouldn't Be There! Gregg T. Lueder, MD
2:07 p.m. Case 5: "Weird Vision" after Strabismus Surgery Deborah K. VanderVeen, MD
2:17 p.m. Case 6: Forgiving SINS Radha Ram, MD
2:27 p.m. Wrap-up Erick D. Bothun, MD

Section V: Satchmo's Got Nothing on Me—"Inventive" Management of Intermittent Exotropia
Moderator: Nils K. Mungan, MD
2:28 p.m. Classification of Intermittent Exotropia Katherine J. Fray, BS, CO
2:33 p.m. The Natural History of Intermittent Exotropia Donny Won Suh, MD
2:40 p.m. Occlusion for Intermittent Exotropia: (IXT–2 Results) Faruk H. Orge, MD
2:47 p.m. Overminus Spectacles for Intermittent Exotropia: Initial Results From a Pilot Study Sergül A. Erzurum, MD
2:54 p.m. Surgery for Intermittent Exotropia: Initial Results From the IXT–1 Trial Sean P. Donahue, MD, PhD
3:01 p.m. Wrap-up Nils K. Mungan, MD
3:02 p.m. REFRESHMENT BREAK and AAO 2017 EXHIBITS
Section VI: When the Complaints Go Marching In—Glasses Problems and How to Fix Them
Moderator: R. Michael Siatkowski, MD
3:32 p.m. Introduction  R. Michael Siatkowski, MD
3:33 p.m. Case 1 and Case 2: I Want My Money Back  David L. Guyton, MD
3:44 p.m. Case 3 and Case 4: These Glasses Make Me Sick  Michael X. Repka, MD, MBA
3:55 p.m. Case 5 and Case 6: My Child Will Not Wear His Glasses  Constance E. West, MD
4:06 p.m. Case 7 and Case 8: I Have Never Had a Pair of Glasses I Could See With  David G. Hunter, MD, PhD
4:17 p.m. Case 9 and Case 10: These Glasses Make Me See Double  Sarah E. Mackinnon, CO, COMT
4:28 p.m. Wrap-up  R. Michael Siatkowski, MD

Section VII: Jumbalaya—A "Mishmash" of Extreme Benign Disease
Moderator: Tammy L. Yanovitch, MD
4:32 p.m. Introduction  Tammy L. Yanovitch, MD
4:33 p.m. Case 1: Corneal Conundrum  Nandini G. Gandhi, MD
4:44 p.m. Case 2: Un-nerving—Optic Disc Drusen with Visual Field Loss and Nerve Fiber Layer Thinning on OCT  Erin O. Schotthoefer, MD
4:55 p.m. Case 3: Just Another Failed Vision Screen  Janine E. Collinge, MD
5:06 p.m. Case 4: What Is This White Spot?  S. Grace Prakalapakorn, MD, MPH
5:17 p.m. Case 5: An Extreme Case of Blepharitis  Michelle T. Cabrera, MD
5:28 p.m. Wrap-up  Tammy L. Yanovitch, MD
5:29 p.m. Closing Remarks  Yasmin Bradfield, MD and Jonathan M. Holmes, MD
5:30 p.m. ADJOURN
## AAO 2017 Annual Meeting Scientific Schedule Pediatric Ophthalmology and Strabismus Sessions

*Note: Because this information was pulled from the AAO website and is subject to change, the SOOp is not responsible for any published information that is inaccurate*

<table>
<thead>
<tr>
<th>Day/Time</th>
<th>Session</th>
<th>Location</th>
<th>Session Title</th>
<th>Session Type</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Saturday, 2:30PM - 4:30PM</td>
<td>LAB102</td>
<td>353-355</td>
<td>A Typical Day in the Operating Room of a Pediatric Ophthalmologist: Adjustable Sutures for Strabismus Surgery</td>
<td>Skills Transfer</td>
<td>Ticketed Event</td>
</tr>
<tr>
<td>Sunday, 7:30AM - 8:30AM</td>
<td>B121</td>
<td>Hall C</td>
<td>Management of Small Angle Strabismus in Adults</td>
<td>Breakfast With Experts</td>
<td>Ticketed Event</td>
</tr>
<tr>
<td>Sunday, 7:30AM - 8:30AM</td>
<td>B122</td>
<td>Hall C</td>
<td>Abusive Head Trauma</td>
<td>Breakfast With Experts</td>
<td>Ticketed Event</td>
</tr>
<tr>
<td>Sunday, 9:00AM - 10:00AM</td>
<td>LEC113</td>
<td>333-334</td>
<td>New Techniques for Strabismus Surgery</td>
<td>Skills Transfer</td>
<td>Academy Plus Course Pass</td>
</tr>
<tr>
<td>Sunday, 10:15AM - 12:30PM</td>
<td>206</td>
<td>389</td>
<td>Update on Diagnosis and Management of ROP: Pearls for ROP Screening, Introduction of Telmedicine, and Use of Anti-VEGF Medications in Practice</td>
<td>Instruction Course</td>
<td>Academy Plus Course Pass; Pre-approved for self-assessment CME (SACME)</td>
</tr>
<tr>
<td>Sunday, 10:30AM - 12:30PM</td>
<td>LAB113A</td>
<td>353-355</td>
<td>New Techniques for Strabismus Surgery</td>
<td>Skills Transfer</td>
<td>Ticketed Event</td>
</tr>
<tr>
<td>Sunday, 11:30AM - 12:30PM</td>
<td>221</td>
<td>396</td>
<td>Secondary IOL Implantation in Children</td>
<td>Instruction Course</td>
<td>Academy Plus Course Pass</td>
</tr>
<tr>
<td>Sunday, 2:00PM - 3:00PM</td>
<td>243</td>
<td>386-387</td>
<td>Pediatric Eye Emergencies You Don’t Want to Miss!</td>
<td>Instruction Course</td>
<td>Academy Plus Course Pass; Endorsed by Young Ophthalmologist Committee</td>
</tr>
<tr>
<td>Sunday, 3:45PM - 5:15PM</td>
<td>SYM20</td>
<td>243-245</td>
<td>Ophthalmoplegia: When the Eyes Won’t Move</td>
<td>Symposium</td>
<td></td>
</tr>
<tr>
<td>Monday, 7:30AM - 8:30AM</td>
<td>B147</td>
<td>HALL C</td>
<td>Management of Pediatric Uveitis</td>
<td>Breakfast With Experts</td>
<td>Ticketed Event</td>
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<tr>
<td>Monday, 7:30AM - 8:30AM</td>
<td>B148</td>
<td>HALL C</td>
<td>Comparison of Treatments for Congenital Nasolacrimal Duct Obstruction</td>
<td>Breakfast With Experts</td>
<td>Ticketed Event</td>
</tr>
<tr>
<td>Monday, 8:30AM - 10:00AM</td>
<td>SYM25</td>
<td>243-245</td>
<td>Genetic Disorders in Pediatric Ophthalmology</td>
<td>Symposium</td>
<td></td>
</tr>
<tr>
<td>Monday, 9:00AM - 10:00AM</td>
<td>PT04</td>
<td>HALL C</td>
<td>Poster Theater: Pediatric Ophthalmology, Strabismus</td>
<td>Poster Theater</td>
<td></td>
</tr>
<tr>
<td>Monday, 10:15AM - 12:30PM</td>
<td>442</td>
<td>398-399</td>
<td>Difficult Strabismus Problems: Diagnosis and Management 2017</td>
<td>Instruction Course</td>
<td>Academy Plus Course Pass</td>
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<tr>
<td>Monday, 10:30AM - 12:10PM</td>
<td>OP07</td>
<td>255-257</td>
<td>Pediatric Ophthalmology, Strabismus Original Papers and Best of AAPOS</td>
<td>Original Paper Session</td>
<td></td>
</tr>
<tr>
<td>Monday, 10:30AM - 10:37AM</td>
<td>PA042</td>
<td>255-257</td>
<td>Early Immunosuppressive Therapy Reduces Need for Surgery in Pediatric Uveitis</td>
<td>Paper</td>
<td></td>
</tr>
<tr>
<td>Day/Time</td>
<td>Session</td>
<td>Location</td>
<td>Session Title</td>
<td>Session Type</td>
<td>Notes</td>
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<tr>
<td>Monday, 10:42AM - 10:49AM</td>
<td>PA043</td>
<td>255-257</td>
<td>Vascular Endothelial Growth Factor and Recurrence after Intravitreal Ranibizumab for ROP</td>
<td>Paper</td>
<td></td>
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<tr>
<td>Monday, 10:54AM - 11:01AM</td>
<td>PA044</td>
<td>255-257</td>
<td>Anterior Segment OCT-Guided Corneal Surgery for the Management of Pediatric Corneal Disorders</td>
<td>Paper</td>
<td></td>
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<tr>
<td>Monday, 11:06AM - 11:13AM</td>
<td>PA045</td>
<td>255-257</td>
<td>A Model to Assess the Risk of Chemotherapy and Time to Treatment in Children with Optic Pathway Gliomas</td>
<td>Paper</td>
<td></td>
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<tr>
<td>Monday, 11:30AM - 12:30PM</td>
<td>460</td>
<td>242</td>
<td>Evaluation of and Clinical Advances in Early-Onset Hereditary Retinal Dystrophies in Infants and Children</td>
<td>Instruction Course</td>
<td>Academy Plus Course Pass; Best of</td>
</tr>
<tr>
<td>Monday, 11:30AM - 12:30PM</td>
<td>470</td>
<td>388</td>
<td>Ptosis, Tearing, and Tumors in Tots: Pediatric and Plastics Pearls for Everyday Practice</td>
<td>Instruction Course</td>
<td>Academy Plus Course Pass</td>
</tr>
<tr>
<td>Monday, 2:00PM - 4:15PM</td>
<td>494</td>
<td>388</td>
<td>Principles of Pediatric Ocular Trauma Management</td>
<td>Instruction Course</td>
<td>Academy Plus Course Pass; Pre-approved for self-assessment CME (SACME)</td>
</tr>
<tr>
<td>Monday, 3:15PM - 5:30PM</td>
<td>521</td>
<td>242</td>
<td>An International Perspective on Pediatric Cataract Surgery</td>
<td>Instruction Course</td>
<td>Academy Plus Course Pass</td>
</tr>
<tr>
<td>Monday, 4:30PM - 5:30PM</td>
<td>537</td>
<td>394</td>
<td>Pediatric Uveitis: What You Need to Know</td>
<td>Instruction Course</td>
<td>Academy Plus Course Pass</td>
</tr>
<tr>
<td>Monday, 4:30PM - 5:30PM</td>
<td>550</td>
<td>238</td>
<td>Pediatric Ocular Tumors</td>
<td>Instruction Course</td>
<td>Academy Plus Course Pass</td>
</tr>
<tr>
<td>Tuesday, 7:30AM - 8:30AM</td>
<td>B170</td>
<td>HALL C</td>
<td>Nonsurgical Management of Diplopia</td>
<td>Breakfast With Experts</td>
<td>Ticketed Event</td>
</tr>
<tr>
<td>Tuesday, 8:30AM - 10:00AM</td>
<td>SYM46</td>
<td>243-245</td>
<td>A Critical Evaluation of Pediatric Ophthalmology Papers That Will Change Your Practice</td>
<td>Symposium</td>
<td></td>
</tr>
<tr>
<td>Tuesday, 9:00AM - 11:15AM</td>
<td>619</td>
<td>388</td>
<td>Concise Review in 2017: The Developmental Glaucomas</td>
<td>Instruction Course</td>
<td>Academy Plus Course Pass</td>
</tr>
<tr>
<td>Tuesday, 10:15AM - 12:30PM</td>
<td>644</td>
<td>238</td>
<td>What’s New and Important in Pediatric Ophthalmology and Strabismus for 2017</td>
<td>Instruction Course</td>
<td>Academy Plus Course Pass; Endorsed by Young Ophthalmologist Committee</td>
</tr>
<tr>
<td>Tuesday, 2:00PM - 3:00PM</td>
<td>695</td>
<td>386-387</td>
<td>New Approaches to the Prevention and Treatment of Myopia</td>
<td>Instruction Course</td>
<td>Academy Plus Course Pass</td>
</tr>
</tbody>
</table>
# 2017 AACO National Meeting Scientific & Educational Schedule

## Instruction Course Schedule
Saturday, November 11, 2017

### Maurepas Room

<table>
<thead>
<tr>
<th>Time</th>
<th>Speaker(s)</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:30 – 9:30</td>
<td>Lee, A</td>
<td>Recognizing Dangerous Diplopia</td>
</tr>
<tr>
<td>9:45 – 10:45</td>
<td>Kazim, M</td>
<td>Successful Management of Thyroid Eye Disease</td>
</tr>
<tr>
<td>11:00 – 12:00</td>
<td>Jackson, et al</td>
<td>The Neuro Work-up: It’s Not Just for Braniacs!</td>
</tr>
<tr>
<td>12:00 – 1:30</td>
<td></td>
<td>Lunch</td>
</tr>
<tr>
<td>1:30 – 2:30</td>
<td>Roper-Hall, G</td>
<td>Fusion Mechanisms &amp; Disruptions</td>
</tr>
<tr>
<td>2:45 – 4:15</td>
<td>Shah, A</td>
<td>TBI &amp; Post-concussion Syndrome</td>
</tr>
</tbody>
</table>

### Napoleon A3 Room

<table>
<thead>
<tr>
<th>Time</th>
<th>Speaker(s)</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:30 – 9:30</td>
<td>Biernacki, et al</td>
<td>What You Should Know but may have Forgotten: Sensory Testing</td>
</tr>
<tr>
<td>9:45 – 10:45</td>
<td>Shah, M</td>
<td>Optical Abberations &amp; Monocular Diplopia</td>
</tr>
<tr>
<td>11:00 – 12:00</td>
<td>Shamis, D</td>
<td>The Effect of Refractive Error on Strabismus: There’s SO Much more than Accommodative ET!</td>
</tr>
<tr>
<td>12:00 – 1:30</td>
<td></td>
<td>Lunch</td>
</tr>
<tr>
<td>1:30 – 2:30</td>
<td>Klaehn, et al</td>
<td>Diplopia Associated with Macular Disease: Opening Pandora’s Box</td>
</tr>
<tr>
<td>2:45 – 3:45</td>
<td>Rainey, et al</td>
<td>Dyslexia &amp; Vision Therapy</td>
</tr>
<tr>
<td>4:00 – 5:00</td>
<td>Colpa, L</td>
<td>Dichoptic Therapy, Video Games, and Amblyopia: What Orthoptists need to know about gaming the visual system</td>
</tr>
</tbody>
</table>
AAO/AOC/AACO Sunday Symposium Schedule
Sunday, November 12, 2017
Ernest Morial Convention Center, Room 243-245

Ophthalmoplegia – When the Eyes Don’t Move

3:45 – 3:48  Casey Mickler, MD, Moderator
            Pensacola, FL
            Introduction

3:48 – 3:56  Katherine Fray, CO
            Little Rock, AR
            Lancaster Award Presentation

3:56 – 4:04  Lex Dietz, CO
            San Francisco, CA
            Ophthalmoplegia: Definition and Clinical Diagnostic
            Techniques

4:04 – 4:12  David Hunter, MD
            Boston, MA
            Infantile and Early Acquired Ophthalmoplegic Syndromes

4:12 – 4:20  Gill Roper-Hall, CO
            St Louis, MO
            Acquired Ophthalmoplegia in Older Children and Adults

4:20 – 4:28  Colin McClelland, MD
            Minneapolis, MN
            Ophthalmoplegic Red Flags

4:28 – 4:36  Kyle Arnoldi, CO
            Buffalo, NY
            Non-surgical Management of Ophthalmoplegia

4:36 – 4:44  Steven Archer, MD
            Ann Arbor, MI
            Surgical Management of Ophthalmoplegia

4:44 – 4:52  Stephen P. Christiansen, MD
            Boston, MA
            Ocular Dysmotility and Craniofacial Anomalies

4:52 – 5:00  Darren Oystreck, OC(C)
            Halifax, NS, Canada
            Congenital Cranial Dysinnervation Disorders

5:00 – 5:15  Stephen P. Christiansen, MD
            Boston, MA
            Discussion, Questions, Case Presentations
## AAP/AACO Symposium: When to Image the Pediatric Patient

**Moderator: Geoffrey Bradford, MD**

<table>
<thead>
<tr>
<th>Time</th>
<th>Speaker</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:30 – 8:40</td>
<td>Sarah Mackinnon, CO</td>
<td>Case Presentation and clinical signs</td>
</tr>
<tr>
<td>8:40 – 8:50</td>
<td>Shelley Klein, CO</td>
<td>Case Presentation and clinical signs</td>
</tr>
<tr>
<td>8:50 – 9:10</td>
<td>Mitchell Strominger, MD</td>
<td>When to Image the Child with Motility and Pupillary Abnormalities</td>
</tr>
<tr>
<td>9:10 – 9:30</td>
<td>Michael Siatkowski, MD</td>
<td>When to Image the Child with Nystagmus and Optic Nerve Abnormalities</td>
</tr>
<tr>
<td>9:30 – 9:55</td>
<td>Ken Ward, MD</td>
<td>Pediatric Neuroimaging of Ophthalmologic Disorders</td>
</tr>
<tr>
<td>9:55 – 10:15</td>
<td>Geoffrey Bradford, MD</td>
<td>Panel Discussion, Question &amp; Answer</td>
</tr>
<tr>
<td>10:15 – 10:30</td>
<td></td>
<td>BREAK</td>
</tr>
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</table>

## Scientific Session

**Moderator: Jennifer Lambert, CO**

<table>
<thead>
<tr>
<th>Time</th>
<th>Speaker</th>
<th>Title</th>
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<tbody>
<tr>
<td>10:30 – 10:45</td>
<td>Anna Schweigert, CO</td>
<td>Periocular Asymmetry in Patients with Deformational Plagiocephaly</td>
</tr>
<tr>
<td>10:45 – 11:00</td>
<td>Brenda Bohnsack, MD</td>
<td>Leukocoria</td>
</tr>
<tr>
<td>11:00 – 11:30</td>
<td>Manishi Desai, MD</td>
<td>The Latest and Greatest in Glaucoma &amp; Why it Matters To Orthoptists</td>
</tr>
<tr>
<td>11:30 – 12:00</td>
<td>Blair Armstrong, MD</td>
<td>The Latest and Greatest in Glaucoma &amp; Why it Matters To Orthoptists</td>
</tr>
<tr>
<td>12:00 – 12:15</td>
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<td>Panel Discussion</td>
</tr>
<tr>
<td>12:15 – 1:30</td>
<td></td>
<td>LUNCH</td>
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</table>
# AACO Scientific Session Schedule

**Monday, November 13, 2017**

**Grand A**

## 2017 Richard G Scobee Memorial Lecture

**Introduction to the 48th Richard G Scobee Lecturer**

<table>
<thead>
<tr>
<th>Time</th>
<th>Speaker</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>1:30 – 2:15</td>
<td>Steven Kraft, MD</td>
<td>What Did They Know Then? A Journey Among Giants of the Past</td>
</tr>
<tr>
<td>2:25 – 2:30</td>
<td>Award Presentations</td>
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## Scientific Session

**Moderator: Leslie France, CO**

<table>
<thead>
<tr>
<th>Time</th>
<th>Speaker</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>2:30 – 2:45</td>
<td>Cheryl McCarus, CO, COMT</td>
<td>Update on the Medical and Orthoptic Treatment of Multiple Sclerosis and Parkinson Disease</td>
</tr>
<tr>
<td>2:45 – 3:00</td>
<td>Jocelyn Zurevinsky, OC(C)</td>
<td>Ten TED Signs: How Many do you Remember?</td>
</tr>
<tr>
<td>3:00 – 3:15</td>
<td>Lindsay Klaehn, OC(C), CO</td>
<td>If Not Myasthenia, then What?</td>
</tr>
<tr>
<td>3:15 – 3:30</td>
<td>Discussion</td>
<td></td>
</tr>
<tr>
<td>3:30 – 3:45</td>
<td></td>
<td><strong>BREAK</strong></td>
</tr>
<tr>
<td>3:45 – 4:00</td>
<td>Kaylee Bram, 2nd year student</td>
<td>The Great Masquerader</td>
</tr>
<tr>
<td>4:00 – 4:15</td>
<td>Aaron Miller, MD</td>
<td>Treatment of Acquired Nystagmus</td>
</tr>
<tr>
<td>4:15 – 4:30</td>
<td>Jessica Lee, 2nd year student</td>
<td>Down and Out</td>
</tr>
<tr>
<td>4:30 – 4:45</td>
<td>Sarah Whitecross, OC(C), CO</td>
<td>Diplopia following Open Globe Injury</td>
</tr>
<tr>
<td>4:45 – 5:00</td>
<td>Discussion</td>
<td></td>
</tr>
</tbody>
</table>
AACO Instruction Course Schedule
Tuesday, November 14, 2017
Grand Chenier Room

Instruction Courses

8:30 – 9:30  Furr, et al  The Life and Legacy of Miss Ida Lucy Iacobucci, CO

9:45 – 10:45  Darren Oystreck, OC(C)  ABCs of the CCDDs – An overview of the Congenital Cranial Dysinnervation Disorders

11:00 – 12:00  Kyle Arnoldi, CO  The Good, the Bad, and the Ugly: A 200-year Debate on Binocular Correspondence

This Program has been approved for a maximum (per person) of:
17.00 AOC Core CE Credits
16.25 Category A JCAHPO CE Credits (Scobee lecture denied)