

# **WOLFE** | World Ophthalmology Leaders Forum In Education

A Forum at the American Academy of Ophthalmology's Annual Meeting

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## **Global Quality of Care Forum**

2010 REPORT | Chicago, IL

American Academy of Ophthalmology

+1.415.447.0398

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## WOLFE: An Introduction

2010 saw global advancements in technology on an unprecedented scale. Methods of communication and connection have been invented, refined and expanded upon. Worldwide, these changes and advancements have had very different implications and applications.

As the world adapts and reinvents itself, so does the field of ophthalmology and ophthalmic education. What remains the same, however, regardless of where you live, what level of education you are pursuing or how you access that education is what all ophthalmologists strive for – to provide the best possible eye care to their patients.

To discuss how to improve the standard of care worldwide, amidst all of the cultural, technological and political barriers, ophthalmic educators representing 18 countries gathered at the 2010 American Academy of Ophthalmology's (AAO) Joint Meeting with the Middle East Africa Council of Ophthalmology on 17 October, for the World Ophthalmology Leaders Forum in Education (WOLFE). Now in its sixth year, WOLFE is organized by the AAO and brings together global leaders to discuss trends in ophthalmic education and resident training.

WOLFE provides educators with the opportunity to hold an open dialogue and exchange knowledge, information and expertise in a stimulating and supportive environment. Its broad goal is to improve ophthalmic education worldwide through the collective wisdom of practicing educators. The 2010 WOLFE theme was focused on improving the global standard of eye care, *Global Quality of Care Forum*. The forum addressed the structure, process and measurement of outcomes involved in establishing standards of care.

Ronald E. Smith, MD, program chairperson and AAO Secretary for Global Alliances, opened the session and introduced Paul Lee, MD, JD, the session moderator. The presentations included the process and implementation of quality of care initiatives, improving surgical performance and patient outcomes, improving ophthalmologist performance and competence, and national initiatives currently used to enhance quality of care.

To conclude the session, H. Dunbar Hoskins, MD, former executive vice president of the AAO, thanked participants for their attendance. "As educators and leaders we have a responsibility to our patients and those of our colleagues to ensure that they are receiving the best, clinically-proven treatment possible," said Dr. Hoskins. "It is important that we all recognize that you cannot manage what you cannot measure. I would like to thank everyone here today for their dedication to this cause and willingness to pursue globally-recognized and implemented standards of care."

The obstacles ophthalmic educators face today will only grow in importance in the future. "The global population is aging," said Dr. Lee in his introduction at WOLFE 2010. "Both in developing and industrialized nations, the age tiers will become increasingly even by 2050. With this development we can expect an uptick in instances of the common age-related eye diseases. As a field, we need to be ready to address this new challenge with standard, globally-accepted and regionally relevant, evidence-based practices."

You are encouraged to share this document with training programs in your country or region. This summary can be found on the AAO's website at [www.aao.org/international/wolf.cfm](http://www.aao.org/international/wolf.cfm).

## Executive Summary

The aging of populations around the world and competing societal needs have made the challenge of obtaining greater “value” in health care a leading concern for societies around the world. Defined as the benefit received for resources expended, this focus on value has reaffirmed the professional obligation of physicians and their professional organizations to improve the quality of care and the population outcomes of care.

This symposium was organized to highlight innovative work from around the world to improve the quality of eye care as a first step towards demonstrating greater benefit and value in eye care services. Using the Donabedian framework of structure, process, and outcomes as components of quality, leading authorities responsible for implementing programs described the results of their programs and offered helpful information for others interested in building upon their experiences.

Starting with those elements directly within the control of ophthalmologists, speakers described the importance of standardization in the processes of care, using the AAO Preferred Practice Patterns and how they were adapted for use in other countries such as China. Other benefits of standardization for improving performance and engaging in continuous improvement activities were noted, using Aravind Eye Hospital as a leading example.

Innovative methods of assessing and then improving outcomes of the most commonly performed ophthalmic surgery for the leading global cause of treatable blindness – cataracts – were described on both a population basis in Sweden and for a health system in Singapore. Together, the presentations allow a comprehensive overview of the considerations and benefits of how ophthalmologists can improve their own practices and as part of a larger societal endeavor.

Because of the central importance of the provider in improving care and outcomes on even a population basis, two speakers described the evolution and role of board certification in Mexico and the United States and how future efforts will be focused on ensuring lifelong practice competency. The last part of the symposium featured presentations on the quality agendas in three different countries – the United States, Kuwait, and the United Kingdom – as exemplars of how professional societies, individual physicians, and public entities can work together in different ways to improve the quality of eye care and its associated outcomes.

By sharing experiences, this WOLFE symposium will encourage attendees to exchange ideas and catalyze ongoing efforts to improve care on a global basis. As the world becomes ever more interdependent, we can all learn from each other to accelerate our own activities.

Paul Lee, MD, JD  
Session Moderator

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## Process of Quality of Care | Implementing and Using Practice Guidelines

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Creating Clinical Guidelines by a National Society – The China Experience  
Richard L. Abbott, MD

PPP Implementation in China  
Xiaoxin Li, MD

Enhancing Outcomes at Aravind – Focus on Compliance & Clinical Practice  
Naresh Babu, MD

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### **Creating Clinical Guidelines by a National Society – The China Experience**

Richard L. Abbott, MD, 2011 president of the AAO, played a key role in the establishment of nationally recognized clinical practice guidelines in China. In 2009, the ophthalmic clinical guidelines marked the first time the Chinese government formally endorsed standard of care guidelines for any medical specialty.

The success of the project was largely due to a joint effort of several motivated organizations, including the World Health Organization, the AAO, the International Council of Ophthalmology, and the Chinese Ophthalmology Society (COS). The initiative launched in 2002 and was implemented over the next seven years via a series of phases from development to promotion and implementation. A 'steering committee' of interested and influential ophthalmic leaders was established to help guide and manage the project.

The clinical foundation of the project was the AAO's established clinical practice guidelines (PPPs), which were used to provide a framework for the Chinese version. In cooperation with the COS, the guidelines were modified where appropriate and translated. Consensus was developed among ophthalmic leadership in China on the established evidence-based surgical techniques and processes of care, as well as those that needed to be modified.

After the guidelines were established, the team took on the difficult task of promoting the clinical guidelines to the many teaching hospitals, as well as to the general ophthalmic practitioners. The COS and ophthalmic leadership communicated through email and several meetings and used presentations at conferences as well as the dissemination of handheld books of the shortened-version of the guidelines (the summary benchmarks) to increase awareness and usage. The handheld books were especially effective because the ophthalmology students and practicing ophthalmologists could reference them in their clinics or in the hospital while examining patients.

The primary challenges of the project included promulgation of the Guidelines to the ophthalmic community, acceptance and compliance in using the established guidelines, and the cost related to implementation in one's practice. Dr. Abbott reinforced the importance of initially promoting evidence-based clinical guidelines that are relatively easy to incorporate into a practice, or they won't be used. If the change in practice suggested by the Guideline is too difficult to incorporate, it is unlikely to be used.

To combat these challenges, Dr. Abbott recommends increasing awareness through journals and congresses, both local and national, as well as working with the Ministry of Health, to endorse the adoption process. In

addition, partnering with the local ophthalmic societies to encourage their direct support was found to be helpful. Lastly, by providing ophthalmologists with incentives for using the guidelines, or penalties for not using them, it was believed that this would encourage their use in practice.

### **True gold does not fear fire: Incorporating Preferred Practice Patterns into clinical practice**

Xiaoxin Li, MD, was an instrumental member of the steering committee developed to bring evidence-based clinical guidelines to China. Through Dr. Li and the COS, the guidelines were reviewed and adapted to suit current Chinese ophthalmic practice.

The project's steering committee, along with chairpersons from Chinese subspecialty societies reviewed the AAO's preferred practice patterns, established their relevance, and then modified them where appropriate. In 2006, the PPPs were translated and edited into Chinese, and added to the COS website to encourage member access.

Throughout the process, Dr. Li found that government recognition was the most powerful way to encourage ophthalmologists in China to use the clinical guidelines. Furthermore, additional incentive was included into the professional evaluation system created by the Ministry of Health.

The COS worked with the Health and Human Resources Development Center of the Ministry of Health in order to establish the guidelines and make them a more integral part of ophthalmic education and a standard for ophthalmic knowledge. The center agreed to provide policy guidance to the translation and promotion, to actively participate in the promotion, and to actively promote the continuing education of ophthalmologists and evaluation of ophthalmic continuing education materials in China.

In addition, the Center and the Chinese Medical Association participated in instructive courses during the COS annual meeting in 2009. By including the CMA and the Ministry of Health Resources Development Center, the COS was able to involve the organizations responsible for both evaluations of ophthalmologists and accreditation. In 2010 the Center added questions that are related to the PPPs to the formal examination question bank.

Throughout the process, the COS has worked with primary and secondary teaching hospitals to promote the use of the Summary Benchmarks (the short version of the PPPs) and have seen success as ophthalmologists realize that acceptance of the PPPs is acceptance of evidence-based medicine. The challenge that now faces the COS is to continue to promote the usage of the PPPs and maintain the guidelines relevancy to improving the quality of care for all ophthalmic patients.

### **Enhancing Outcomes at Aravind**

Aravind Eye Hospitals function in seven locations and host five thousand beds throughout India. In the course of one day, the eye hospitals perform more than 850 surgeries and treat approximately six thousand outpatients. In addition, Aravind manages six outreach camps where about 1500 patients are examined, and three hundred are subsequently transported for surgery. Six to eight hundred telemedicine consultations are handled on a daily basis.

With the volume of patients seen through the Aravind network, it is extremely important to maintain a high standard of patient care that is also consistent across all of the interactions between patients and ophthalmologists.

When addressing the challenges of ensuring quality of care at Aravind, Dr. Naresh noted that enhanced outcomes are dependent not only on the clinical care but also patient compliance and adherence to clinical guidance. Within the sphere of clinical care, Dr. Naresh asserted the importance of measuring the surgical outcome based on the complication rate, infection rate and actual visual outcome.

The system of monitoring complications at Aravind includes five steps:

1. Entry into case sheet by the surgeon
2. Entry into database by the nurse
3. Report shared by surgeons
4. Review in weekly meeting where protocol is refined and training methods are discussed
5. Follow up on intended changes

By this method, each surgeon's performance is graphed on a global chart and monitored on a monthly basis. Since 2007, the intraoperative complication rate at Aravind (Madurai) has decreased from 1.45% to 1.06%.

In addition to the surgical complication rates, Aravind also measures patient compliance based on re-hospitalization, return visits, follow-up rate and acceptance of glasses. Dr. Naresh notes that Aravind's community outreach programs are particularly effective in increasing patient compliance. The community outreach programs feature a local 'eye advocate' who discusses the patients post operative care based on an Aravind supplied checklist.

## Focus on Outcomes | Improving Surgical Performance and Patient Outcomes

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 The Swedish Cataract Registry – 1 Million Surgeries for Clinical Improvement  
 Mats Lundström, MD

100% Surgical Video Monitoring at the Singapore National Eye Center – Big Brother is Watching!  
 Donald Tan, MD  
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### **Swedish Cataract Registry: 1 Million Surgeries for Clinical Improvement**

Measurement of surgical complications and the establishment of health registries is a heavily debated topic worldwide. In Sweden, EyeNet Sweden has established the Swedish Cataract Registry, which is showing promising results in complication management with few negative consequences.

The cataract registry is one of Sweden's 70 national quality of care registries that includes individual patient data on diagnosis, treatment and outcomes through customized outcome information systems. Each registry has been started by an interested doctor or medical society who then becomes the registry manager. As a result, responsibility for the registries and their management has been distributed among clinics throughout Sweden.

It is important to note that the registries have been created and designed for learning and quality improvement rather than supervision. Therefore, while the patient data can be aggregated and used in a variety of ways within the health care system, it is imperative that the data is useful for the clinic. Dr. Lundström suggests that only the professional medical groups themselves, rather than external organizations, will be able to build and maintain registries that produce good, valid outcome data.

The Swedish Cataract Registry, instituted in 1992, boasts participation from 100% of the eye clinics in Sweden, reports on 98.5% of all relevant surgeries, and features a database of more than one million procedures (as of 1 January, 2010). Since its establishment, the registry has seen the number of reported surgeries nearly triple.

A common question regarding the establishment of a registry is how surgeons and patients benefit from a registry. Dr. Lundström discussed the primary advantages of a registry, including comparative data and benchmarking for surgeons and clinics, analysis and risk of rare complications, and illustration of trends for improved technique and improved outcomes.

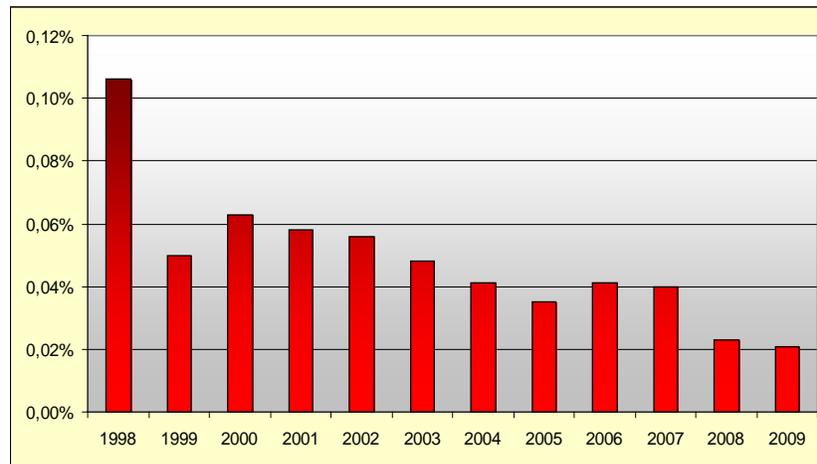
For example, in 1997 endophthalmitis was added to the list of variables collected by the registry. In 1998, after findings from a study at St. Erik's Eye Hospital in Stockholm were released, the benefit of using intracameral cefuroxime to decrease the risk of endophthalmitis was discussed at registry meetings. After a few years the majority of clinics and surgeons had started to use intracameral cefuroxime during cataract surgery. However, some clinics did not use intracameral antibiotics.

After three years (1999-2001) the registry demonstrated that the incidence of postoperative endophthalmitis in surgeries without intracameral antibiotics (N=6805) was 0.22 percent while in surgeries with intracameral

antibiotics (N=151,874) the incidence was 0.053 percent. After this finding, all of the clinics and surgeons in Sweden adopted the use of intracameral cefuroxime during cataract surgery.

“Comparatively, a clinical trial of this magnitude would have been impossible to set up,” said Dr. Lundström. “The finding from the registry has been able to significantly decrease the risk of postoperative endophthalmitis in Sweden.”

**Incidence of postoperative endophthalmitis in Sweden 1998-2009**



### **100% Surgical Video Monitoring at the Singapore National Eye Center – Big Brother is Watching!**

The Singapore National Eye Centre (SNEC) caters to approximately two-thirds of the population in Singapore, features eleven subspecialty departments and is supported by four clinical branches co-located with general hospitals throughout the island. SNEC manages more than 250,000 patient visits a year, from Singapore and Asia, including 14,000 day surgeries and 12,000 laser procedures.

Unlike other quality of care initiatives, SNEC launched its clinical auditing program at inception based on strong support from upper level management at the center. As a result, quality assurance has been ingrained into the culture of SNEC.

SNEC performs one hundred percent video recording of all microsurgical procedures as well as full audits of cataract surgery and other major surgical and laser procedures, with clear outcome indicators. Each year, SNEC hosts a clinical audit symposium featuring a presentation of the result by the various heads of departments or each subspecialty and clinical fellows. It is an active critique of the outcomes, data analysis and review of the outcome indicators.

One method SNEC uses to ensure a high quality of care is video recording in all operating theatres. Operating microscopes are fitted with video cameras and the nursing staff is responsible for recording the procedures. For uncomplicated cases, the recordings are kept for three months before they are recycled. If a complication occurs, the recording is automatically sent through SNEC's Clinical Audit Department to a Surgical Review Committee for

follow-up and action. These recordings are also kept for regular complication rounds and to assist in resident training. Additionally, surgeons regularly keep interesting recordings for their individual presentations or research.

Implementation of video recording requires an appropriate clinical audit culture that it is established in residency training and consistent throughout the growth of the ophthalmologist. Additionally, it requires acceptance from all of the surgeons and operating theatre staff. In this manner, new staff members quickly adjust to the recording process.

"The greatest challenge in implementing a 100% video recording of all microsurgical procedures was in gaining initial acceptance from surgeons of a "big brother is watching" mentality," said Dr. Tan. "However, this was overcome many years ago when our center started, and it is now so ingrained in our culture that our doctors expect automatic high quality video recordings which they can utilize in their teaching and research activities."

"Today, the main challenge is in approaching new surgeons who have higher complication rates than average," added Dr. Tan. "However, we have found that through constructive assistance and personal mentoring we are able to help these surgeons raise their standards and improve their outcomes."

For feedback, cataract surgeons receive confidential yearly posterior capsule rupture (PCR) rates that they can then benchmark against the centers mean rate. Many doctors also benefit from the audit data produced by the system because it contributes to their research initiatives within the various subspecialties.

To benchmark the cataract outcomes, SNEC uses PCR rates, endophthalmitis rates, and the percent of patients who attained 20/40 or better visual acuity, excluding co-morbidities. In May of 2009, SNEC was able to boast of zero infections in the prior year.

## Improving Performance | How Boards are Improving Competence and Performance

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Achievements of the Mexican Board of Ophthalmology in 36 Years

Arturo Espinosa-Velasco, MD

The Future of Maintenance of Certification

John Clarkson, MD

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### **Achievements of the Mexican Board of Ophthalmology in 36 Years**

At 36 years old, the Mexican Board of Ophthalmology is relatively young when compared to the Mexican Society of Ophthalmology (MSO), established in 1893, 117 years ago. However, it is equally valuable, and was established to help ensure that the people of Mexico were receiving consistent, quality eye care.

In 2010, the Mexican Society of Ophthalmology was made up of more than 3,000 members or associates, and the Board of Ophthalmology claimed more than 2,200 certified ophthalmologists. The board is comprised of one representative from each state, a representative from the Mexican Society of Ophthalmology, a representative from each MSO branch and a representative from each academic institution.

The main goals of the board are to evaluate knowledge and skills of Mexican ophthalmologists as well as provide certification and recertification. Ophthalmic certification is provided through a series of clinical and theoretical examinations. Recertification, which occurs every five years, is based on the ophthalmologist's record of academic activity.

Through certification and regular recertification, the board is able to recognize and promote good quality performance for the ophthalmologist and his or her patients. The board is always striving to increase the number of certified ophthalmologists, while maintaining a process that is both objective and fair. In the future, the board plans to collaborate to establish legally-mandated certification and recertification.

### **The Future of Maintenance of Certification**

In the United States, the American Board of Medical Specialties Maintenance of Certification (ABMS MOC) is a learning and improvement process created for practicing ophthalmologists by practicing ophthalmologists. It is designed to meet help physicians meet the education demands of today's practice environment.

Through ABMS MOC, physicians demonstrate that they have competency in medical knowledge, excellence in professional skills, a commitment to high standards of care, and evidence of continual learning and improvement. In contrast with the Mexican boards five year recertification, the ABMS MOC measures continued education over ten year cycles. The cycle is based on a common set of core competencies and standards developed by overarching medical governing bodies.

One of the primary features of MOC is part four (practice assessment), wherein physicians review their own performance and identify potential gaps in care. In effect the ophthalmologist functions as his or her own auditor and works to remedy the gaps in care.

The value of ABMS MOC lies beyond education for the ophthalmologist, however. MOC can provide the physician with additional payment eligibility from the U.S. Physician Quality Reporting System (PQRS) as well as benefits from private insurers, state licensing boards and consumers as well as consumer advocacy groups.

For the ophthalmologist, MOC becomes an annual process with a flexible learning and assessment activities designed to provide more meaningful feedback. In the future, the American Board of Ophthalmology will increase opportunities to further focus applicable educational activities on subspecialty areas.

## National Initiatives | Enhancing Quality of Eye Care

Hoskins Center Initiatives, AAO  
Anne L. Coleman, MD, PhD

Quality of Ophthalmology Care in Kuwait  
Manal Bouhaimed, MBChB, PhD

Quality Agenda in Ophthalmology in the United Kingdom  
Simon P. Kelly, FRCOphth, FEBO

### Hoskins Center Initiatives, AAO

In 2010, the AAO launched the H. Dunbar Hoskins Jr. MD Center for Quality Eye Care; its mission to advance the accessibility to and appropriateness of eye care services to reduce blindness and visual impairment. The Hoskins Center was established in order to emphasize the value and promote access to eye care, providing the right service to the right patient at the right time.

The center is guided by an Advisory Board comprised of U.S. leaders in the field of ophthalmology, with unique experience and expertise in health care financing and policy. The center, led by Director, Anne L. Coleman, MD, PhD, is responsible for a wide range of activities, including analysis and management of clinical guidelines, technology assessments, performance measurement, data registry, health information technology standards, comparative effectiveness research, and public health outreach.

In 2010, the Agency for Healthcare Research and Quality (AHRQ) issued a grant to Outcomes, Inc. and the Hoskins Center to compare the effectiveness of treatment strategies for primary open angle glaucoma (e.g. initial laser surgery, new surgical techniques, new medical treatments) particularly in minority populations to assess clinical and patient reported outcomes. This comparative effectiveness research will involve a data registry at approximately thirty clinical sites nationwide with a focus on minority populations and clinical outcomes.

Another new initiative by the Hoskins Center this year was the creation of a screening program targeting Latinos called EyeSmart EyeCheck. This screening program was part of the AAO's response to the unmet need of minorities as demonstrated by a recent publication from the Los Angeles Latino Eye Study, which found that Latinos have higher rates of vision disorders in the U.S. The first pilot screening was held in July of 2010, in coordination with an existing health fair in Los Angeles.

The screening was a clear success, resulting in 499 patients screened, the majority of whom did not have health insurance. Fifty percent of all patients screened had visual impairment and 70% were referred for follow-up care to services and doctors willing to provide care for no out-of-pocket costs. In 2011 and 2012, the AAO will hold four more pilot screenings, with the goal to refine the process and analyze the results on a larger scale. Eventually the AAO hopes that the national effort will evolve into a practice that states can implement autonomously.

## Quality of Ophthalmology Care in Kuwait: Patients Voices

Kuwait is a small, wealthy country fitting many of the characteristics of an industrialized country but that exhibits other qualities more indicative of a developing one. At birth, the average life expectancy is 76 for men, 78 for women. Kuwait is host 100 primary care clinical centers and six general hospitals, two of which have dedicated ophthalmic care units. In addition, there is currently one tertiary ophthalmic care center focusing on subspecialty care. There are an estimated one hundred and twenty five ophthalmologists practicing in Kuwait.

In 2006, Kuwait held a workshop focused on providing quality ophthalmic care and prevention of avoidable causes of blindness as defined by the "2020 Right for Sight International Initiative." Among the partners in this activity were representatives from the American Academy of Ophthalmology, the International Society of Ocular Trauma, the International Agency for the Prevention of Blindness and IMPACT-EMR (a registered prevention of blindness non-governmental organization). The workshop identified four main factors that influence quality of care: human resources, Infra-structure, training/education and management services. It also identified other guiding principles to improve quality of care, including teamwork, evidence-based medicine and engaged leadership.

With the impetus of the workshop, and the knowledge that 80% of blindness is avoidable, Kuwait University launched the Community Eye Health Initiative as a model for engaged leadership in academia and clinical practice to improve the quality of eye care services in the country. Through the 2010 *World Ophthalmology Leaders Forum in Education* (WOLFE) meeting, this ambitious initiative was introduced as an example of improving quality of care through public health activities and community involvement.

The Community Eye Health Initiative features a total of ten projects:

- Rapid Assessment of Avoidable Blindness (RAAB) Project:  
Targets around 3000 individuals above the age of fifty with mobile unit home eyecare visits.
- Screening of Kindergartens' Children:  
Provides vision exams for 1000 children and trains teachers to perform vision exams, facilitated by a mobile unit.
- Screening for Diabetic Retinopathy:  
Provides screening and follow up management for around 1000 patients of the 400,000 to 600,000 individuals in Kuwait have Type II diabetes. Three percent will have eye problems which need to be screened and treated.
- Assessment of the Quality of Visual Functioning across Demographics:  
Targets around 1000 individuals, including office workers, industrial workers, residents in the elderly or orphanage facilities, etc.
- Prevention of Ocular Trauma:  
Targets at-risk population for ocular trauma (approximately 1000 patients), including children, athletes and individuals with specific occupational hazards.

- International Low Vision and Rehabilitation Training:  
Kuwait currently does not have a low vision and rehabilitation training specialist. The project will focus on capacity building and the needs of the visually impaired.
- Ocular Surveillance for People with Down's Syndrome:  
Targets approximately 250 members in the Down's Syndrome society to professionally assess their visual functions.
- Retinopathy of Prematurity (ROP) Screening:  
Focuses on capacity building and training of staff (through visits to ten neonatology intensive care units in the Ministry of Health and private hospitals) and raising parents' awareness with total target of 500 individuals.
- Introduction of Primary Eye Care: A Pilot in One Governorate in Kuwait:  
A mobile unit will visit and facilitate training in four primary care units serving more than 1000 patients and sixty physicians.
- Vision for the Children: Eye Care Professionals in the Classroom:  
A mobile unit will visit a number of schools in both the governmental and private sector to introduce new content delivered by eye doctors and science teachers.

The biggest challenge that the initiative has faced thus far is to create a supportive environment to consistently deliver prevention measures and quality screening programs in Ophthalmic care in Kuwait.

### **Quality Agenda in Ophthalmology in the United Kingdom (UK)**

The role of professional organizations in the pursuit of quality care is long-established. In the UK the Royal College of Ophthalmologists (RCOphth) champions excellence in ophthalmology for the benefit of patients and the public. The National Health Service (NHS) has an interest in the quality of all care nationwide. The National Patient Safety Agency (NPSA), is an NHS body and currently responsible for a National Reporting and Learning Service (NRLS) in England and Wales.

In July 2010, the new U.K. administration reconfirmed a focus on quality in the white paper '*Liberating the NHS*'. The paper declared that the NHS will "ensure that patient safety is at [its] heart" and that there will be no "trade-off between safety and efficiency." As Mr. Kelly observed in his presentation, "efficiency without quality is unthinkable, just as quality without efficiency is unsustainable." Thus, the NHS has been tasked with providing a sustainable, efficient health service in the UK without sacrificing quality of care. In developments post-white paper it was announced that the tasks of the NPSA will transfer to a new NHS Commissioning Board in 2011.

One method that the NHS has undertaken to ensure quality and safety of care is the NRLS. The NRLS works to improve patient safety through considering and responding to patient safety incident reports occurring in NHS care. When a patient safety incident happens, NHS staff members create confidential reports via their local reporting systems. The report is then uploaded into the NRLS database where clinicians and safety experts

analyze the reports to identify any common risks. The findings are then shared back to NHS healthcare organizations with guidance if possible on how to avoid repeating the same errors.

To date, 4.5 million reports have been filed through NRLS, 27,000 of which were relevant to ophthalmology. Issues that have been recognized and addressed as a result of the ophthalmology reports include: intraocular injection and syringe hazards; delayed glaucoma follow-up; late administration of anti-VEGF agents and wrong site surgery or wrong IOLs.

An example of such an error reported via NRLS is incorrect IOL power implantation due to transcription errors in the operating room schedule or whiteboard handwriting. In the example the patient received an 11 diopter IOL whereas a 17 diopter was required and intended.

The RCOphth in partnership with the NPSA has adopted the World Health Organization (WHO) surgical checklist, and adapted it for cataract surgery. This [cataract checklist](#) was piloted at 12 NHS ophthalmic surgical sites and can be modified for local use. It is available on RCOphth and NPSA websites.

In addition to such partnership with the NHS, the RCOphth ensures quality that ophthalmic care exists in various settings, in providing clinical guidelines and standards and providing continuing professional development resources. The College also liaises with government on ophthalmic matters.

In conclusion, Mr. Kelly proposes that quality of ophthalmic care conditions can be improved, both in safety and in efficiency. It is important to focus on evidence-based care, and to shift from measuring the process to analyzing outcomes and measuring quality. To this end the RCOphth is now proposing a range of [quality metrics](#) and which are available on [RCOphth website](#).

## About WOLFE

Organized by the American Academy of Ophthalmology (AAO), the World Ophthalmology Leaders Forum in Education (WOLFE) is a collaborative effort among ophthalmic leaders to improve and advance ophthalmic education globally. WOLFE participants are leaders from ophthalmological societies and academic centers worldwide.

WOLFE participants gather annually during the AAO's Annual Meeting to discuss the challenges and issues in ophthalmic education. The Forum provides the opportunity for open communication and the exchange of knowledge, information and expertise.

The findings from WOLFE are collected and published as a white paper each year. You are encouraged to share this document with training programs and ophthalmic societies in your country or region. Summaries and presentations from 2010 and years past are available online at [www.aao.org/international/wolf.cfm](http://www.aao.org/international/wolf.cfm).

Presenters in the 2010 Global Quality of Care Forum included:

- Richard L. Abbott, MD
- Xiaoxin Li, MD
- Naresh Babu, MD
- Mats Lundström, MD
- Donald Tan, MD
- Arturo Espinosa-Velasco, MD
- John Clarkson, MD
- Anne L. Coleman, MD, PhD
- Manal Bouhaimed, MBChB, PhD
- Simon P. Kelly, FRCOphth, FEBO

Previous WOLFE topics include:

- *Teaching Surgical Skills to Trainees Today and Tomorrow* (2009)
- *Principles and Practices of Resident Education Around the World* (2008)
- *Guidelines for Developing Guidelines: Consensus versus Clinical Trials: Where Is the Future?* (2007)
- *Continuing Professional Development (CPD) Needs of Ophthalmologists* (2006)

## Additional Information and Resources

### 2010 Speaker Presentations

#### Introduction to WOLFE 2010

- World Ophthalmic Leaders Forum in Education - Ronald E. Smith, MD [[download](#)]
- Quality of Care Symposium: Sharing Lessons and Experience - Paul Lee, MD, JD [[download](#)]

#### Process of Quality of Care | Implementing and Using Practice Guidelines

- Creating Clinical Guidelines by a National Society – The China Experience  
Richard L. Abbott, MD [[download](#)]
- PPP Implementation in China  
Xiaoxin Li, MD [[download](#)]
- Enhancing Outcomes at Aravind – Focus on Compliance & Clinical Practice  
Naresh Babu, MD [[download](#)]

#### Focus on Outcomes | Improving Surgical Performance and Patient Outcomes

- The Swedish Cataract Registry – 1 Million Surgeries for Clinical Improvement  
Mats Lundström, MD [[download](#)]
- 100% Surgical Video Monitoring at the Singapore National Eye Center – Big Brother is Watching!  
Donald Tan, MD [[download](#)]

#### Improving Performance | How Boards are Improving Competence and Performance

- Achievements of the Mexican Board of Ophthalmology in 36 Years  
Arturo Espinosa-Velasco, MD [[download](#)]
- The Future of Maintenance of Certification  
John Clarkson, MD [[download](#)]

#### National Initiatives | Enhancing Quality of Eye Care

- Hoskins Center Initiatives, AAO  
Anne L. Coleman, MD, PhD [[download](#)]
- Quality of Ophthalmology Care in Kuwait  
Manal Bouhaimed, MBChB, PhD [[download](#)]
- Quality Agenda in Ophthalmology in the United Kingdom  
Simon P. Kelly, FRCOphth, FEBO [[download](#)]

### AAO's Preferred Practice Patterns (PPPs)

Preferred Practice Patterns (PPPs) are designed to identify characteristics and components of quality eye care. Developed by a panel of ophthalmologists with expertise in the guideline topic, a methodologist, and other experts (the Quality of Care Secretariat and the PPP Committee) and based on the best available scientific data, PPPs provide guidance for the pattern of practice, not for the care of a particular individual.

To ensure all PPPs are current, recommendations for care are reviewed annually. Each PPP is valid for five years from the date of issue unless superseded by a revision. Guidelines and Assessments are developed by the Hoskins Center for Quality of Care and AAO-approved without any external financial support. Authors and reviewers of PPPs are volunteers and do not receive any financial compensation for their contributions to the documents.

[Access the Preferred Practice Patterns](#)

### **AAO's Summary Benchmarks**

The Summary Benchmarks contain the most relevant information contained in the Preferred Practice Patterns, condensed for ease of access. Guidelines and Assessments are developed by the Quality of Care Secretariat, Hoskins Center, and approved by the AAO without any external financial support. Authors and reviewers of Summary Benchmarks are volunteers and do not receive any financial compensation for their contributions to the documents.

[Access the Summary Benchmarks](#)

Translated versions of the Summary Benchmarks:

- [Resumen de los Puntos de Referencia para las Guías de Patrones de Práctica Preferidos - 2008](#) (PDF 667k)
- [Arabic Translation: Summary Benchmarks for Preferred Practice Pattern Guidelines - 2008](#) (PDF 488k)